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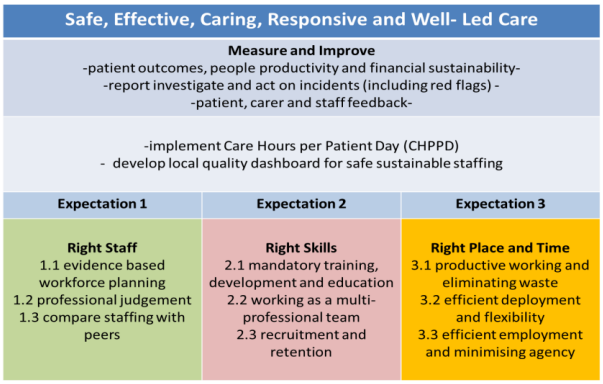
MEETING OF THE TRUST BOARD OF DIRECTORS – May 2025			
Safer Staffing Bi-Annual Establishment Review			**AGENDA ITEM:**
Report Author and Job Title:	Debi McKeown NMAHP Workforce Lead	**Responsible Director:**	Lindsay Garcia Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☒		
Situation	The requirement to publish bi-annual nurse establishment reviews is set out by the National Institute for Improvement (NHSI) *'The Developing Workforce Safeguards (October 2018).* It supports providers to use best practice in effective staff deployment and workforce planning. This is in conjunction with the National Quality Board (NQN) (2016) who provide a guidance framework containing the key expectations that must be considered as part of the safe staffing establishment reviews. South Tees Hospitals NHS Foundation Trust provides a comprehensive review of staffing for adult inpatient wards, adult acute assessments units and children's & young people's inpatient wards using the licensed Safer Care Nursing Tool (SNCT) produced by The Shelford Group (2018) and endorsed by NICE. The results from the data collection are triangulated with patient quality indicators, financial and workforce data. A professional judgement framework is then applied. Data collection to support the staffing review occurred through March/April 25 using SNCT, with a repeat data collection period planned for September 25. Critical Care, Theatres, A&E, Community Nursing and Maternity are not included in this paper, however annual workforce reviews have been undertaken in these areas using similar tools. A plan is underway to include A&E and Community Nursing in this report going forward.		
Background	The NQB guidance framework (2016) supports us to develop a workforce that is fit for purpose, making sure it is safe, sustainable and productive. The structure of this is demonstrated below.		



The Trust has been using the SNCT tool since 2018. It was republished in October 23. This is the second data set that now includes the two new multipliers, 1C 'patients requiring 1-1 care' and 1D 'patients requiring 2-1 care as well as specific multipliers for units that have 75% or more single side rooms. The new levels allow us to break down the enhanced care requirements of our areas to enable us to monitor and manage how best to care for these patients and align our establishments to allow for this level of care.

The workforce lead provided training sessions for the Matrons, Ward Managers and Sisters to ensure the scoring is reliable and high quality. The training is provided in person and via teams. All attendees are assessed and must pass to be allowed access to update the daily data collection sheets. The data should then be peer reviewed by the matrons to provide assurance that the information provided is an accurate reflection of the patients on the ward and the level of activity required at the time of the data collection.

It is important to note that the SNCT tool assumes at least 22% uplift when setting establishments (i.e., headroom for annual leave, sickness, training etc.) The Trust standards of 21% uplift which is included in the establishment for inpatient areas means that the SNCT output will include a 1% differential requirement. This is well known and understood and is not viewed as a risk as SNCT metrics are always triangulated in conjunction with professional judgement and other safe staffing metrics to inform establishment settings.

Requested staffing levels provide the planned staffing numbers on a shift-by-shift basis on acute inpatient wards and rationale for changes. These staffing levels have been set using the described methodology and are based on the ration of 1:8 qualified nurses to patient ratio (plus a co-ordinator for Acute Assessment Units and Acute Stroke) except for the following areas:

- Acute Stroke 1:2 – for the first 72hrs of acute onset

	• Respiratory Support Units 1:2 – for the first 24hrs of admission • Acute Oncology 1:2 – for patients undergoing chemotherapy. • Stroke Rehab 1:6
Assessment	Every ward collects SNCT data for a minimum of 30 consecutive days 2-3 times a year, the data collection for March/April 2025 ran over one full month using the refreshed tool and descriptors. This involves scoring each patient's episode of care. Staffing multipliers are applied at each acute and dependency care level. These multipliers factor in nursing time spent on the following: • Direct and indirect care • Ward management (0.4WTE) • Education and training • Staff performance review • Staff breaks. • Associated work such as administration and clerical • Bed occupancy. Once the results have been published the Deputy Director of Nursing, Heads of Nursing, Matron, Ward Mangers from each ward and Lead for Workforce meet face to face to review the SNCT results and apply professional judgement. Once any new staffing levels are identified the required establishments are calculated and compared to the current funded establishment to determine whether any adjustments to skill mix and findings are required. Where this is the case, a business case will be produced. The agreed staffing establishments for 2024/2025 were created in line with the SNCT recommendations alongside the Chief Nurse and Finance.
Recommendation	The Board of Directors are asked to note the content of this report and to be assured that there are systems and process in place to ensure registered nurse staffing levels are sufficient to deliver safe, high-quality care.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit. Threat - Ability to attract and retain competent staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans
Legal and Equality and Diversity implications	• Care Quality Commission • NHS England /Improvement
Strategic Objectives	Excellence in patient outcomes and experience ☒ | Excellence in employee experience ☒

	Drive operational performance ☐	Long term financial sustainability ☒
	Develop clinical and commercial strategies ☐	

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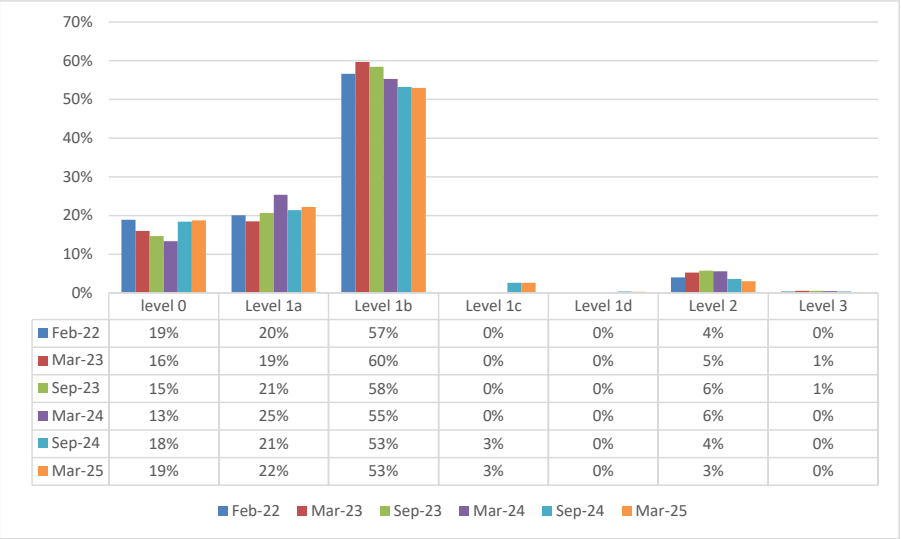
South Tees Hospitals NHS Foundation Trust Safer Staffing Bi-Annual Establishment Review

1. Establishment Review March/April 25

1.1 SNCT Patient Acuity Levels Trust Wide

The figure below shows a summary of the overall patient acuity levels for the Trust as a percentage for all areas collected over 30 days in March/April 2025 compared to previous reports from 2021.

Figure 1: Trust Acuity Levels by total %



	level 0	Level 1a	Level 1b	Level 1c	Level 1d	Level 2	Level 3
Feb-22	19%	20%	57%	0%	0%	4%	0%
Mar-23	16%	19%	60%	0%	0%	5%	1%
Sep-23	15%	21%	58%	0%	0%	6%	1%
Mar-24	13%	25%	55%	0%	0%	6%	0%
Sep-24	18%	21%	53%	3%	0%	4%	0%
Mar-25	19%	22%	53%	3%	0%	3%	0%

The data shows consistency in scoring of patients across most levels with a difference in patients recorded as Level 2 now recorded as Level 1c. This shows that patients requiring enhanced observations were coded as the higher need level 2 and are now recorded appropriately as level 1c.

For the next data collection period in September 2025 the areas will be peer reviewed by the Workforce Lead and Therapeutic Care Lead regarding patients recorded as level 1c and 1d to ensure they have been correctly assessed. This data will also be cross checked with MIYA to check the number of patients recorded during the collection period match those recorded on MIYA and ETOC.

1.2 Headroom Review

When planning the staffing of wards there is a need for an allowance to be made for periods of leave to ensure that there are sufficient nurses available to provide the planned level of nurse staffing.

At South Tees Hospitals NHS Foundation Trust, the level of cover or ‘uplift’ built into ward establishments is 21% per Whole Time Equivalent staff member and excludes parenting leave:

- 14% (273hrs) annual leave.
- 3.9 % (70.2hrs) sickness.
- 2.0% (39 hrs) study leave.
- 1.1% (19.5hrs) Working Day i.e., Management Day, non-clinical day.

This headroom calculation is specific to South Tees Hospitals NHS Foundation Trust and was agreed by the Trust Board.

1.3 Skill Mix review

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of 65/35 registered nurses/clinical support workers. The agreed ratio overall for STHFT is an average ratio of 60/40 registered nurses/Health Care support workers across all inpatient areas except for critical care who undertake a separate staffing review against the GPICS standard.

The ratio of registered nurses to health care support workers may be lower in some less acute areas such as specialised rehabilitation, or where other staff are involved in delivering care, for example, Registered Nursing Associates (RNA), Assistant Practitioners (AP) and Allied Health Professionals (AHPs) contributing significantly towards meeting patient needs.

1.4 Quality Indicators

Nurse Sensitive Indicators (NSIs) had been identified as quality indicators of care with specific sensitivity to nursing intervention and were used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. NSI's were used alongside acuity and dependency information to monitor the relationship between ward staffing and nursing outcomes.

1.5 Professional Judgement (PJ)

STFT use professional judgement alongside SNCT to confirm appropriate nurse staffing levels. This consultative approach to the determination of nurse staffing requirements was first developed in 1979 by Telford (Telford, 1979) and is a bottom-up approach used to determine ward staffing requirements, based on the judgement of experienced nurses to agree the number and grade of staff required to provide care on a specific ward.

The PJ templates have been agreed with the Deputy Director of Nursing, calculated with the agreed allowance for uplift (headroom), to calculate the whole-time equivalents (WTEs) required to staff each ward. As well as considering the acuity and dependency of the patients normally cared for by the ward, other factors which can affect staffing requirements include:

- The layout and design of the ward - wards with multiple single rooms or bays may require higher staffing capacity and capability.
- The number of housekeepers and other support staff available - employing ward clerks and housekeepers on wards can assist nurses, midwives, and care staff by undertaking tasks not directly related to patient care.
- Patient throughput - high throughput needing more staff to help maintain patient flow.
- The provision of supervisory time required by the Ward Manager to undertake the management requirements of the post, together with the amount of time required to support, supervise, and mentor students and newly appointed staff.

1.6 Agreed Funded Establishments vs Professional Judgement

Authorised funded establishments should also afford staff in leadership roles the time to assume supervisory status which is evidenced to improve staff engagement and improve patient outcomes.

Authorised funded establishments versus professional judgement recommended establishment:

- The current RN budget for inpatient beds (excluding critical care) was 754.66 WTE against a working professional judgement establishment of 855.94 WTE suggesting a deficit of 101.28 WTE. However, actual staffing was 849.43 showing a surplus of 94.77 WTE against budget. However, budgets are from 23/24 as still awaiting agreement for 24/25 and 25/26. Rational for this request for establishment and current expenditure to ensure safe care delivery is explained in the narrative from Heads of Nursing of collaboratives.
- The current HCA budget for inpatient beds (excluding the critical care areas) was 595.96 WTE against a working professional judgement establishment of 602.40 WTE suggesting a deficit of 6.44 WTE. However, actual staffing was 540.30 showing a deficit of 55.66 WTE against the current budget.

1.7 Safer Care Nursing Tool Results vs Funded Establishment

Safer nursing care tool recommended establishment versus funded establishment:

- The SNCT data suggests that the required number of RNs was 1184.21 WTE suggesting a deficit of 419.51 WTE against current budget of 2023/2024 across the Trust.
- The SNCT data suggests that the required HCA was 455.85 WTE suggesting a surplus of 140.11 WTE against authorised funded establishments across the Trust. However, the data demonstrates that this does contribute to backfill of RN gaps. The professional judgement exceeds both the current budget and actual staffing.

Table 1: South Tees Professional Judgement WTE templates compared to Agreed Funded **Establishment WTE and AFE compared to SNCT recommended WTE**

Collab	RN							HCA						
	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**
Cardio Vas	97.89	105.16	106.73	115.69	113.56	-17.80	-8.84	60.96	59.72	50.95	43.77	43.88	17.19	10.01
DDUGs	63.89	87.92	88.21	121.40	119.91	-57.51	-24.32	70.17	54.83	69.16	46.69	46.12	23.48	1.01
Growing FHN & Comm	112.58	113.20	125.33	207.84	200.65	-95.26	-12.75	125.19	108.40	122.41	79.96	77.20	45.23	2.78
Head, Neck & Ortho	82.27	99.22	93.99	145.57	135.48	-63.30	-11.72	70.69	61.32	76.76	56.00	52.11	14.69	-6.07
JCCI & Spec Med	63.88	74.36	68.00	79.89	78.31	-16.01	-4.12	36.78	39.00	45.59	30.73	30.12	6.05	-8.81
Med & Emerg	191.84	216.40	218.30	324.64	298.10	-132.80	-26.46	139.15	135.87	149.04	124.87	114.68	14.28	-9.89
Neuro & Spinal	91.36	100.77	104.46	138.08	121.27	-46.72	-13.10	70.12	62.24	69.72	53.12	46.64	17.00	0.40
Women & Children	50.95	52.40	50.92	41.06	41.06	9.89	0.03	22.90	18.92	18.77	20.70	20.70	2.20	4.13
Totals	**754.66**	**849.43**	**855.94**	**1174.17**	**1108.34**	**-419.51**	**-101.28**	**595.96**	**540.30**	**602.40**	**455.85**	**431.46**	**140.11**	**-6.44**

1.8 Recommendations

The Board is asked to receive this report for information and assurance

1.9 Conclusion

It is recognised that this data does have clear variations between current and actual budget in relation to SNCT recommendations and professional judgement. The tool used provides data that relies on staff submitting accurate data that reflects the previous 24 hours. Ward configurations and clinical pressures can impact on compliance with this data collection. As the trust continues its workforce staffing assurance programme, greater insight will be provided to all levels of staff within collaboratives. This data will evidence the importance of compliance with data submissions and the direct connection to patient acuity and patient outcomes.

The daily SafeCare process ensures that safe staffing is provided by current workforce and where required temporary workforce solutions.

Debi McKeown
Interim NMAHP Workforce Lead

1.10 Appendices

Appendix 1 Nursing Workforce Establishment Reviews by Collaborative including SNCT Results compared to Agreed Funded Establishment and Professional Judgement

1.11 References

Telford, W. (1979). A Method of Determining Nursing Establishments, Hospital Health Services Review, 5,4. pp 11-17

The Shelford Group. (2018). Safer Nursing Care Tool: Safer Nursing Care Tool - Shelford Group

NHS Improvement. (October 2018). Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing. https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

Lord Carter of Coles, P. (2016, February). Operational productivity and performance in English NHS acute Hospitals: Unwarranted variations. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

The Royal College of Nursing (2021) Nursing Workforce Standards: Supporting a safe and effective nursing workforce. RCN, London. https://www.rcn.org.uk/professional-development/publications/rcn-workforce-standards-uk-pub-009681

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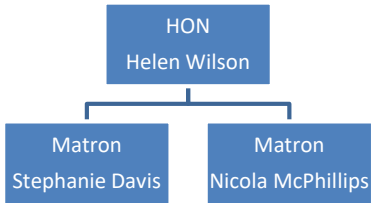
Appendix 1

Nursing Workforce Establishment Reviews by Collaborative

Using the data gathered in the SNCT audit and Professional Judgement template assessment, the overall summary indicates whether the Collaborative is optimally staffed against the SNCT criteria or not.

Contents

1. Cardiovascular Care



1.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Cardiovascular Care Services

Table 2 below shows during March 2025 the bed occupancy across this collaborative was an average of 96.94%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs. The current budget for RN was 97.89 WTE against the professional judgement of 106.73 WTE suggesting a deficit of 8.84 WTE. For HCA the budget was 60.96 WTE against the professional judgement of 50.95 WTE suggesting a surplus of 10.01 WTE.

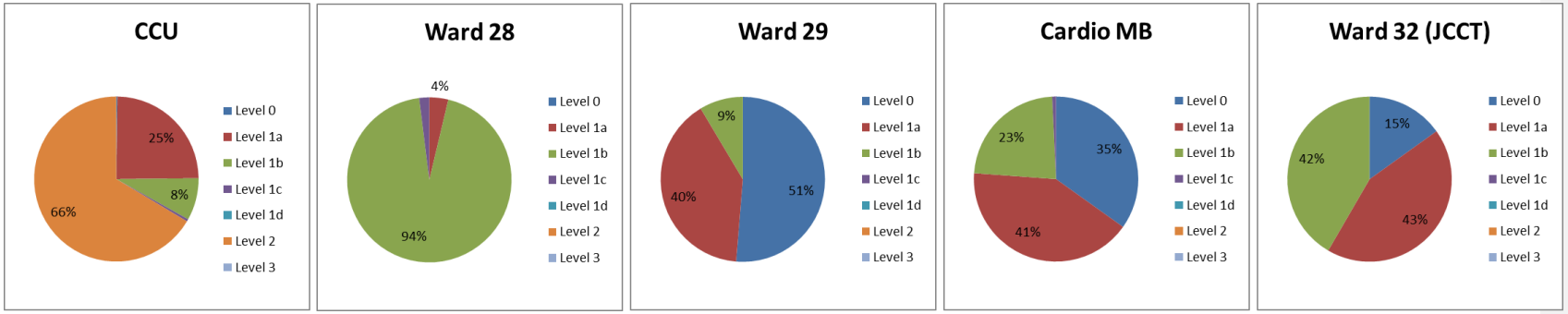
Using the SNCT tool there was a suggested deficit between the RN budget of 17.80 WTE and surplus against the HCA budget of 17.19 WTE.

Table 2: Cardiovascular Care Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to PJ**
CCU	14	14	14.50	103.57%	34.90	33.96	36.60	22.09	21.94	12.81	-1.70	1.94	2.40	2.68	8.50	8.44	-6.56	-0.74
Ward 28 Vas	30	30	28.67	95.57%	17.30	21.60	22.28	40.49	38.85	-23.19	-4.98	18.10	17.08	18.77	14.74	14.94	3.36	-0.67
Ward 29	27	27	25.67	95.07%	18.67	20.40	19.56	22.45	22.45	-3.78	-0.89	13.90	11.04	13.41	8.64	8.64	5.26	0.49
Cardio MB	9	9	8.80	97.78%	10.93	9.24	11.44	8.52	8.36	2.41	-0.51	10.93	9.24	5.36	3.28	3.22	7.65	5.57
Ward 32 (JCCT)	22	21	20.27	96.52%	16.09	19.96	16.85	22.14	21.96	-6.05	-0.76	16.09	19.96	10.73	8.61	8.64	7.48	5.36
Totals	**102**	**101**	**97.91**	**96.94%**	**97.89**	**105.16**	**106.73**	**115.69**	**113.56**	**-17.80**	**-8.84**	**60.96**	**59.72**	**50.95**	**43.77**	**43.88**	**17.19**	**10.01**

1.2 Patient Acuity and Dependency Scores for Cardiovascular Care Services by Ward

Figure 2: Patient Acuity and Dependency scores during the audit period broken down by percentage



1.3 Cardiovascular activity and patient harms recorded during the audit period

Table 3: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
CCU	119	70	33	39	1	5	81	1	11	6				1		
Ward 28	25	66	49	13	0	2	2	0	0	0	7			12		88%
Ward 29	55	134	88	25	1	4	21	4	2	3	3	1		4		95.2%
Cardio MB	26	39	22	2	0	0	4	1	3	3			2			100%
Ward 32 (JCCT)	77	98	134	78	19	0	9	0	0	3				1	1	100%

1.4 Head of Nursing Comments and Actions – Helen Wilson

Ward 29 – The SNCT recommendation of less HCAs does not reflect the need of additional HCA support to ensure safe patient care at night when there is an increased risk of falls. I recommend the increase in RN numbers for 1 extra nurse during the day as currently no coordinator for a 36 bedded ward, to support the flow throughout the department and coordinate the ACS transfers.

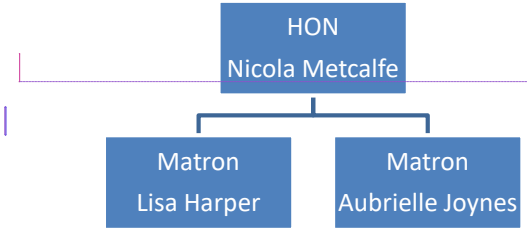
Ward 29 Monitored Bay – Staffing establishment is at the correct levels. We cannot reduce the number of RN's as suggested as we currently only have 2 Nurses for 9 patients and require a HCA around the clock for support and to ensure telemetry is monitored and alarms responded to.

Ward 28 – Based on the current footprint and high acuity, the staffing establishment should remain the same at least with a firm argument to increase numbers to 4 RNs on a night as they currently struggle due to patient acuity. The percentage of level 1B captures the number of patients with complex wounds that takes a considerable amount of time, and numbers of amputee patients who require the assistance of 2 or more nursing team members. Recommend Further review of this on the next SNCT audit.

Ward 32 – SNCT supports the need for an additional RN on nights but not the reduction in HCA numbers as already minimal HCA numbers.

CCU – It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area. The audit tool is not fit for purpose for this level of acuity and the responsiveness required to leave the unit for emergency care provision outreaching (cath labs, cardiac arrest bleep).

2. Digestive Diseases, Urology and General Surgery



Commented [AO1]: Only 2 matrons not 3

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2.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Digestive Diseases, Urology and General Surgery

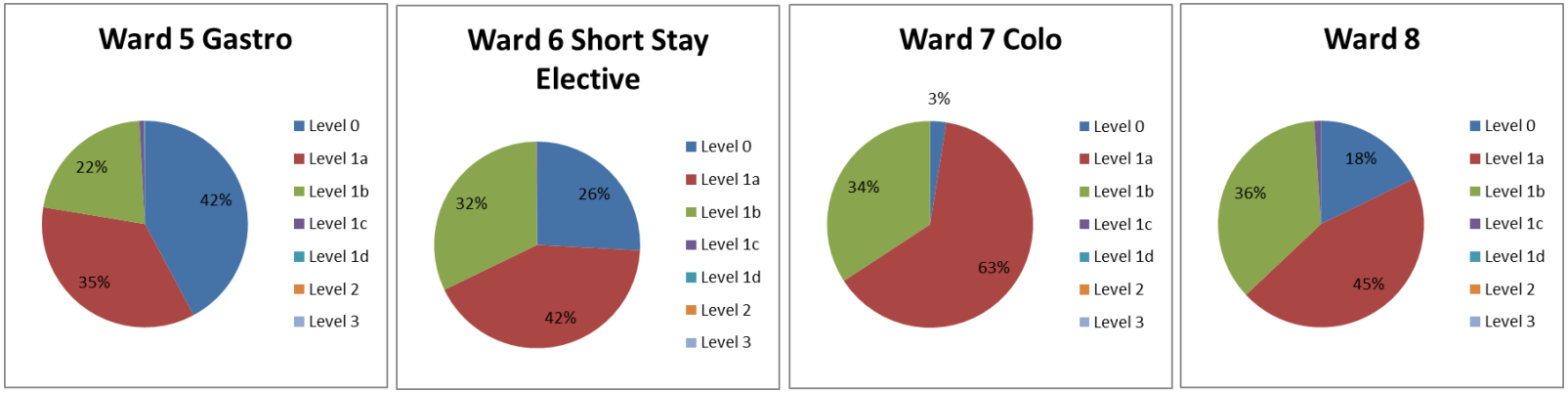
During March 2025 the bed occupancy across this collaborative was an average of 93.43%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs. The current budget for RN was 63.89 WTE against the professional judgement of 88.21 WTE suggesting a deficit of 24.32 WTE. For HCA the budget was 70.17 WTE against the professional judgement of 69.16 WTE suggesting a surplus of 1.01 WTE. Using the SNCT tool there was a suggested deficit between the RN budget of 57.51 WTE and surplus against the HCA budget of 23.48 WTE. The current budget does not reflect the actual budget required for this collaborative. The previous establishment review requested an increase to both nurse and HCAs, however the budget that was approved was significantly lower than the requested establishment. The acuity of the patients within this collaborative therefore does reflect the higher professional judgement and SNCT outcomes.

Table 4: Digestive Diseases, Urology and General Surgery Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to PJ**
Ward 5 Gastro	24	31	30.83	99.45%	16.39	20.40	22.28	28.98	28.27	-12.59	-5.89	20.31	15.43	12.85	11.15	10.87	9.16	7.46
Ward 6 Short Stay Elective	31	31	26.43	85.26%	15.78	20.68	21.37	29.57	29.49	-13.79	-5.59	14.74	13.48	18.77	11.37	11.34	3.37	-4.03
Ward 7 Colo	31	31	29.03	93.65%	14.46	22.84	22.28	31.84	31.84	-17.38	-7.82	17.06	13.44	18.77	12.24	12.24	4.82	-1.71
Ward 8	30	30	28.63	95.43%	17.26	24.00	22.28	31.01	30.32	-13.75	-5.02	18.06	12.48	18.77	11.93	11.67	6.13	-0.71
Totals	**116**	**123**	**114.92**	**93.43%**	**63.89**	**87.92**	**88.21**	**121.40**	**119.91**	**-57.51**	**-24.32**	**70.17**	**54.83**	**69.16**	**46.69**	**46.12**	**23.48**	**1.01**

2.2 Patient Acuity and Dependency Scores for Digestive Diseases Urology & Gastro

Figure 3: Patient Acuity and Dependency scores during the audit period broken down by percentage



2.3 Digestive Diseases, Urology & Gastro activity and patient harms recorded during the audit period

Table 5: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 5 Gastro	48	73	58	22	1	4	84	6	4	8	3		5	4		94.4%
Ward 6 Short Stay	84	204	273	192	0	1	18	3	0	4						
Ward 7 Colo	51	119	90	25	2	5	10	1	2	0			6			
Ward 8 MB	92	148	135	66	2	2	16	0	1	10						

2.4 Head of Nursing Comments and Actions – Nicola Metcalfe

Ward 5 Gastroenterology – The patient cohort for this ward is highly dependent on extensive support from staff. The impact on behaviours due to the nature of their conditions often leads to a higher need for 1:1 support to ensure the patients are safely cared for. This is reflected in the professional judgement and SNCT outcomes.

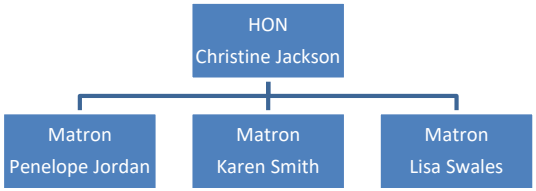
Ward 6 Short Stay Elective Unit – This ward area is currently open to 31 beds although is only budgeted for 28 beds. The ward has been displaced from Ward 5 to Ward 6 due to the life cycle work on the first floor. Alongside of this the ward is planned to reduce to 16 beds over the weekend period and as a result staffing is reduced on a weekend. However, to support the non-surgical admissions across the organisation it is continuously open to 31 beds including the weekend. This will account for the variation between current and actual staffing against professional judgement and SNCT recommendations.

Ward 7 – The SNCT outcomes show an excessively high requirement for RNs. The acuity of the patients and the often-rapid decline would show the higher need for RN provision. The ward also takes the majority of critical care and PACU step downs who require higher need to RN provision due to TPN, IVAB's, chest drains, complex nutritional patients and complex wound dressings. However, the care provided from the HCAs ensures that safe care is provided alongside the clinical interventions from registered staff.

Ward 8 – Ward 8 continues to have a high number of medical outliers; therefore, the professional judgement demonstrated the need for additional nursing staff. The ward also accepts critical care steps downs, patients discharged from PACU and urology patients across the Tees Valley including patients from County Durham and Darlington.

3. Growing the Friarage & Community

3.1 Friarage Hospital & H&R Community Services



3.1.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for FHN & H&R

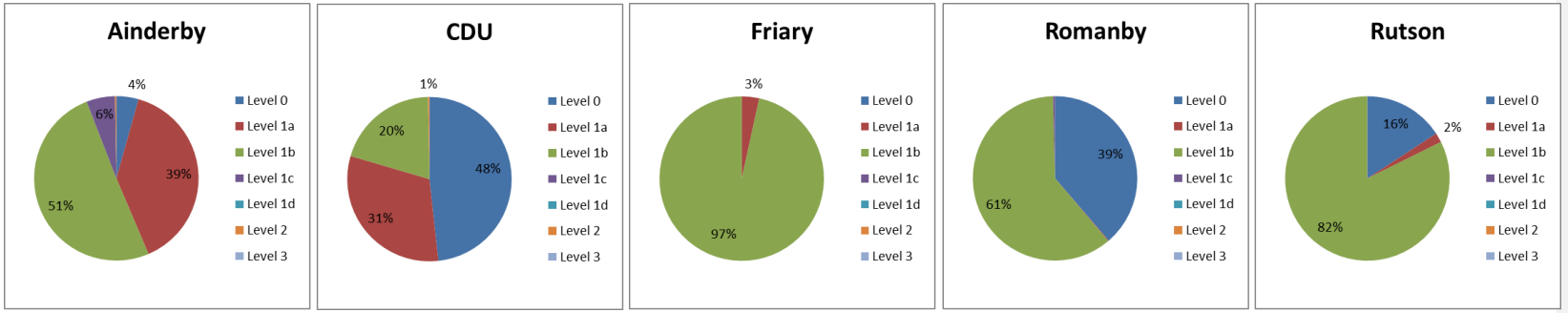
During March 2025 the bed occupancy across this collaborative was an average of 94.21%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for Romanby which was 50/50. The current budget for RN was 74.65 WTE against the professional judgement of 83.49 suggesting a deficit in funding of 8.84 WTE. For HCA the requirement was 71.97 WTE against the professional judgement of 77.10 WTE suggesting a deficit of 5.13 WTE. Using the SNCT tool there was a suggested deficit between the RN budget of 55.59 WTE and surplus HCA budget of 21.86 WTE. To note the FHN is often required to absorb the enhanced observation requirements for patients, they have therapeutic care support and rely on NHSP filling short notice requests.

Table 6: FHN & H&R Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to New PJ**
Ainderby	27	27	26.07	96.56%	14.87	15.33	16.18	32.98	29.61	-18.11	-1.31	16.10	15.00	17.99	12.69	11.39	3.41	-1.89
CDU	21	22	22.17	100.77%	19.39	18.06	23.97	26.44	26.44	-7.05	-4.58	9.36	8.62	12.85	10.17	10.17	-0.81	-3.49
Friary	18	18	15.57	86.50%	12.97	10.59	13.58	22.52	22.52	-9.55	-0.61	14.84	12.44	15.42	8.66	8.66	6.18	-0.58
Romanby	22	27	24.73	91.59%	14.45	16.10	16.18	27.71	27.48	-13.26	-1.73	18.31	15.19	17.99	10.67	10.58	7.64	0.32
Rutson	17	17	16.03	94.29%	12.97	12.92	13.58	20.59	20.59	-7.62	-0.61	13.36	11.28	12.85	7.92	7.92	5.44	0.51
Totals	**105**	**111**	**104.57**	**94.21%**	**74.65**	**73.00**	**83.49**	**130.24**	**126.64**	**-55.59**	**-8.84**	**71.97**	**62.53**	**77.10**	**50.11**	**48.72**	**21.86**	**-5.13**

3.1.2 Patient Acuity and Dependency Scores for FHN & H&R

Figure 4: Patient Acuity and Dependency scores during the audit period broken down by percentage



3.1.3 FHN & H&R activity and patient harms recorded during the audit period

Table 7: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ainderby	6	43	53	19	9	7	44	0	44	8	2		2	4		90.9%
CDU	272	146	28	147	0	6	218	0	5	9	4			4		87.5%
Friary	19	16	2	3	0	3	0	0	16	2	1			3		100.0%
Romanby	2	62	74	12	0	6	17	2	4	0			1	2	1	90.9%
Rutson	5	19	19	5	0	2	0	5	0	76			1	3		100.0%

3.1.4 Head of Nursing Comments and Actions – Christine Jackson

Ainderby ward (FHN) – This ward with frail and complex medical patients has a need for additional RN support.

Clinical Decision Unit (FHN) – is a 22 bedded admission ward for medical patient admissions. The need to cover telemetry over a 24 hour period would require additions to the RN workforce.

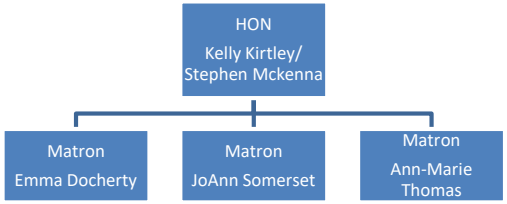
Victoria ward (The Friary Hospital Richmond) – This ward is based in a remote area with no internal support structures, therefore the recommendation from SNCT to increase the nursing establishment does reflect the current need.

Romanby ward (FHN) – This 22 bedded medical ward is providing safe care within the current establishment.

Rutson Ward – is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment.

The Staffing establishment for FHN does not take into account that the Band 7's and some 6's have to carry the site management 627 bleep from 4pm to 8pm on week days and 8m to 8pm on weekends.

3.2 Tees Community



3.2.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Tees Community

During March 2025 the bed occupancy across this collaborative was an average of 95.52%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs. The current budget for RN was 37.93 WTE against the professional judgement of 41.84 WTE suggesting a deficit in funding of 3.91 WTE. For HCA the budget was 53.22 WTE against the professional judgement of 45.31 WTE suggesting a surplus of 7.91 WTE.

Using the SNCT tool there was a suggested deficit between the RN budget of 39.67 WTE and surplus HCA budget of 23.36 WTE.

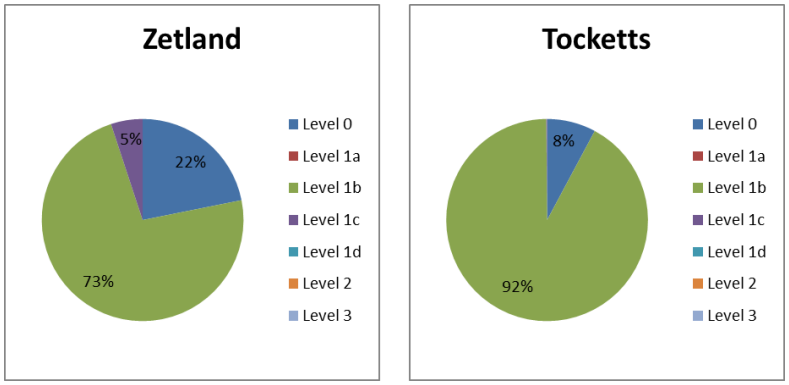
Both community hospitals are in remote locations with no adjacent wards to assist with staffing issues. Tocketts ward layout is difficult to observe patients and therefore requires more HCA's for patient safety. Zetland ward consists of all single rooms and the ward layout requires more HCA's to support patient safety.

Table 8: Tees Community Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to New PJ**
Tocketts	30	30	28.07	93.57%	16.67	19.77	19.56	37.95	37.87	-21.28	-2.89	23.22	21.95	24.13	14.60	14.57	8.62	-0.91
Zetland	31	31	30.20	97.42%	21.26	20.43	22.28	39.65	36.14	-18.39	-1.02	30.00	23.92	21.18	15.26	13.90	14.74	8.82
Totals	**61**	**61**	**58.27**	**95.52%**	**37.93**	**40.20**	**41.84**	**77.60**	**74.01**	**-39.67**	**-3.91**	**53.22**	**45.87**	**45.31**	**29.86**	**28.47**	**23.36**	**7.91**

3.2.2 Patient Acuity and Dependency Scores for Tees Community

Figure 5: Patient Acuity and Dependency scores during the audit period broken down by percentage



3.2.3 Tees Community activity and patient harms recorded during the audit period

Table 9: Activity and Patient Harms by Ward for March 25

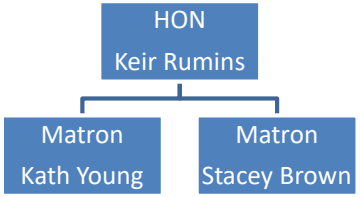
Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Tocketts	33	29	25	4	10	2	0	3	1	9		1		6	1	96.0%
Zetland	31	21	1	6	3	2	0	7	45	24	4	1		6	1	93.1%

3.2.4 Head of Nursing Comments and Actions – Stephen McKenna

Zetland Ward (Redcar Primary Care Hospital) – This 31 bedded rehabilitation ward provides care in single rooms. This is the reason that SNCT recommends a decrease in HCAs, however due to the risk to patients in this side room layout there should not be a reduction to HCA workforce. The estate is very problematic and has a difficult footprint being a H- shape with arms coming off intermittently.

Tocketts Ward (East Cleveland Hospital) – The nurse to patient ratio when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need.

4. Head, Neck, Orthopaedic and Reconstructive



4.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for HNOR

During March 2025 the bed occupancy across this collaborative was an average of 78.09%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for ward 25 which was 50/50.

The current budget was RN was 82.27 WTE against the professional judgement of 93.99 WTE suggesting a deficit in funding of 11.72 WTE. For HCA the requirement was 70.69 WTE against the professional judgement of 76.76 WTE suggesting a deficit in funding of 6.07 WTE.

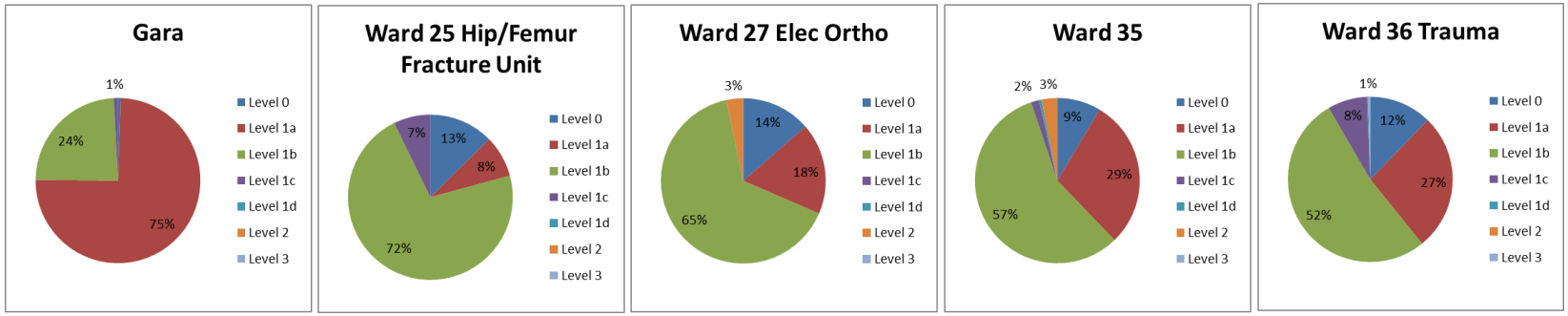
Using the SNCT tool there was a suggested deficit between the RN budget of 63.30 WTE and surplus HCA budget of 14.69 WTE.

Table 10: HNOR Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to PJ**
Gara	21	21	12.20	58.10%	11.97	13.77	13.58	18.70	18.47	-6.73	-1.61	10.89	7.61	10.28	7.19	7.10	3.70	0.61
Ward 25 Hip/Femur Fracture Unit	21	21	17.97	85.57%	18.67	20.52	19.56	32.17	29.46	-13.50	-0.89	12.90	12.39	13.41	12.38	11.33	0.52	-0.51
Ward 27 Elec Ortho	15	15	10.07	67.13%	10.97	14.33	13.58	15.54	15.54	-4.57	-2.61	9.89	9.44	12.85	5.98	5.98	3.91	-2.96
Ward 35	26	26	19.40	74.62%	19.78	24.40	22.28	36.28	35.15	-16.50	-2.50	16.37	14.40	18.77	13.96	13.52	2.41	-2.40
Ward 36 Trauma	34	34	31.73	93.32%	20.88	26.20	24.99	42.88	36.87	-22.00	-4.11	20.64	17.48	21.45	16.49	14.18	4.15	-0.81
Totals	**117**	**117**	**91.37**	**78.09%**	**82.27**	**99.22**	**93.99**	**145.57**	**135.48**	**-63.30**	**-11.72**	**70.69**	**61.32**	**76.76**	**56.00**	**52.11**	**14.69**	**-6.07**

4.2 Patient Acuity and Dependency Scores for HNOR

Figure 6: Patient Acuity and Dependency scores during the audit period broken down by percentage



4.3 HNOR activity and patient harms recorded during the audit period

Table 11: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Gara	103	179	95	1	11	0	0	0	1	0			1	1		100.0%
Ward 25 Hip/Femur Fracture Unit	47	39	11	18	0	1	68	1	27	15	2		1	4		85.7%
Ward 27 Elec Ortho	42	57	25	0	56	0	65	0	0	14	2			2		100.0%
Ward 35	113	149	84	42	0	0	4	0	4	4			3	2		95.5%
Ward 36 Trauma	118	116	38	37	2	2	0	0	27	31	2	1	3	2		95.6%

4.4 Head of Nursing Comments and Actions – Keir Rummins

Gara (FHN) – Gara has a fully established workforce, with the surgical hub at FHN approaching opening I have requested a review (data submitted) to ensure appropriate staffing levels are maintained and staffing is incorporated with this focus (SOP produced from surgical hub lead), for the inpatient bed base of 21 and incorporating day case/day zero patients (who attend the ward for post-surgical care).

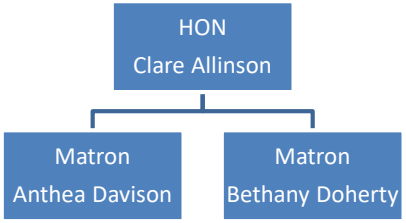
Ward 25 – Request sent to review current staffing establishment (due to complexity of patient group, NHSP consistent request/spend re falls risk and patients requiring intervention on a continual focus, that however do not reach the CG47), also aligned with the above data evident and SNCT data.

Ward 27 – 15 bedded elective orthopaedic ward, no change is required to the current staffing establishment currently.

Ward 35 - The ward requires an extra RN support two to three times per week for complex care post-surgery (L2) and to support any emergency high level patients (free flap/trach) (L2) requiring 1:1 observation and oversight. This is factored into the professional judgement calculation above. There is high complexity of patients and patient throughput. The ward also supports the plastics clinics and other drop-in services that is not factored into the ward staffing calculations (PDC is on the ward however has own staffing model, separate). On a weekend and out of hours the ward supports any patient requiring urgent plastics treatment. An agreement has been given verbally via SLT to have the increase in RN, this needs to progress to budget alignment to allow and recruitment and training.

Ward 36 - This trauma ward is a critical care step down area and sees high numbers of overnight trauma and major trauma admissions, as well as in hours. The ward consistently sees complex patients beyond the trauma speciality in terms of need and care input. As such the staffing template will continue to be reviewed within collaborative and escalation as needed to review/discuss.

5. James Cook Cancer Institute & Specialty Medicine



5.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for JCCISM

During March 2025 the bed occupancy across this collaborative was an average of 91.14%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs. The current budget was RN was 63.88 WTE against the professional judgement of 68 WTE suggesting a deficit in funding of 4.12 WTE. For HCA the requirement was 36.78 WTE against the professional judgement of 45.59 WTE suggesting a deficit of 8.81 WTE.

Using the SNCT tool there was a suggested deficit between the RN budget of 16.01 WTE and HCA budget surplus of 6.05 WTE.

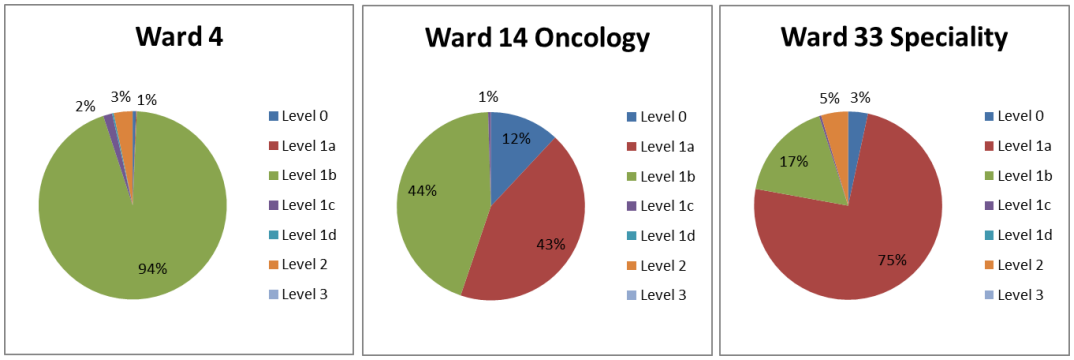
Ward 14 and 33 facilitate a support line out of hours which helps with admission avoidance but takes RN time to facilitate. These calls can take between 15 minutes to one hour. Patients with cancer and those receiving chemotherapy require close monitoring, extended time for psychological support and complex discharge planning.

Table 12: JCCISM Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to PJ**
Ward 4	24	24	23.70	98.75%	22.36	24.64	23.44	33.41	32.22	-11.05	-1.08	11.94	11.84	16.09	12.85	12.39	-0.91	-4.15
Ward 14 Oncology	23	23	21.43	93.17%	21.26	24.28	22.28	24.39	24.16	-3.13	-1.02	12.94	11.68	13.41	9.38	9.29	3.56	-0.47
Ward 33 Specialty	23	23	18.67	81.17%	20.26	25.44	22.28	22.09	21.93	-1.83	-2.02	11.90	15.48	16.09	8.50	8.44	3.40	-4.19
Totals	**70**	**70**	**63.80**	**91.14%**	**63.88**	**74.36**	**68.00**	**79.89**	**78.31**	**-16.01**	**-4.12**	**36.78**	**39.00**	**45.59**	**30.73**	**30.12**	**6.05**	**-8.81**

5.2 Patient Acuity and Dependency Scores for JCCISM

Figure 7: Patient Acuity and Dependency scores during the audit period broken down by percentage



5.3 JCCISM activity and patient harms recorded during the audit period

Table 13: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 4	44	71	64	31	15	6	72	0	2	11	3			3		88.9%
Ward 14 Oncology	70	81	11	9	15	7	31	0	6	8			2	9		100.0%
Ward 33 Specialty	32	45	22	9	7	2	19	1	1	14				1		92.9%

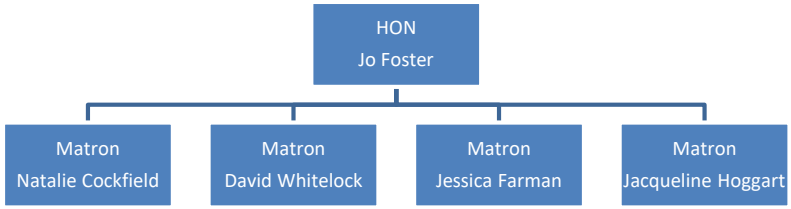
5.4 Head of Nursing Comments and Actions – Clare Allinson

Ward 4 Renal – Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes. Ward 4 offers a telephone support line at night and weekends for patients requiring Nephrology advice this includes renal transplantation open access. Ward 4 also delivers a vascular access service, which requires the assistance of a HCA with the procedure I would support the additional HCA for this as it has never been factored in the establishment, we also have a higher risk of falls due to the patient group and the value for a third HCA overnight would be safer care.

Ward 14 Oncology – No change to establishment is required. Ward 14 offers a telephone support line at nights and weekends for patients requiring oncology advice as per UKONS guidance. It was expected additional HCA support recommendation given the complexities of EOLC patients and complexities of pain management and syringe drivers.

Ward 33 Haematology – Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice as per UKONS guidance. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended. Agreed.

6. Medicine & Emergency Care



6.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Medicine & Emergency Admission Units

During March 2025 the bed occupancy across this collaborative was an average of 95.55%. The skill mix ratio for this care setting is 70% RNs to 30% HCAs.

The current budget for RN was 90.16 WTE against the professional judgement of 96.62, suggesting a deficit of 6.46 WTE. For HCA the budget was 64.5 WTE against the professional judgement of 67.03 WTE suggesting a deficit of 2.53.

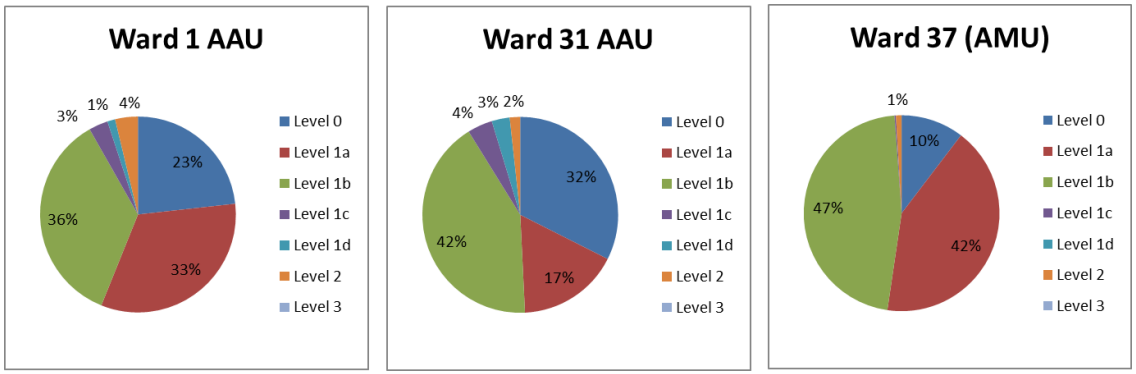
Using the SNCT tool there was a suggested deficit between the RN budget of 57.92 WTE and HCA budget surplus of 11.39 WTE.

Table 14: Admissions Units Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to New PJ**
Ward 1 AAU	30	31	28.40	91.61%	30.58	36.80	33.11	43.68	40.11	-13.10	-2.53	20.64	19.24	21.45	16.80	15.43	3.84	-0.81
Ward 31 AAU	35	35	34.73	99.23%	28.00	30.16	30.40	53.77	45.86	-25.77	-2.40	23.22	23.08	24.13	20.68	17.64	2.54	-0.91
Ward 37 (AMU)	30	30	28.60	95.33%	31.58	33.52	33.11	40.63	40.51	-9.05	-1.53	20.64	22.65	21.45	15.63	15.58	5.01	-0.81
Totals	**95**	**96**	**91.73**	**95.55%**	**90.16**	**100.48**	**96.62**	**138.08**	**126.47**	**-47.92**	**-6.46**	**64.50**	**64.97**	**67.03**	**53.11**	**48.66**	**11.39**	**-2.53**

6.2 Patient Acuity and Dependency Scores for Med & Emerg Admissions Units

Figure 8: Patient Acuity and Dependency scores during the audit period broken down by percentage



6.3 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Medicine & Emergency Acute Inpatient Wards

To note ward 9 has x 2 Respiratory Support Unit bays requiring 1:2 staffing for the first 24hrs of BIPAP and ward 3 multispecialty assessment ward.

During March 2025 the bed occupancy across this collaborative was an average of 93.49%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

Using this methodology, outlined in Table 14 the current budget for RN was 101.68 WTE against the professional judgement of 121.68 WTE suggesting a deficit in funding of 20 WTE. For HCA the budget was 74.65 WTE against the professional judgement of 82.01 WTE suggesting a deficit of 7.36 WTE.

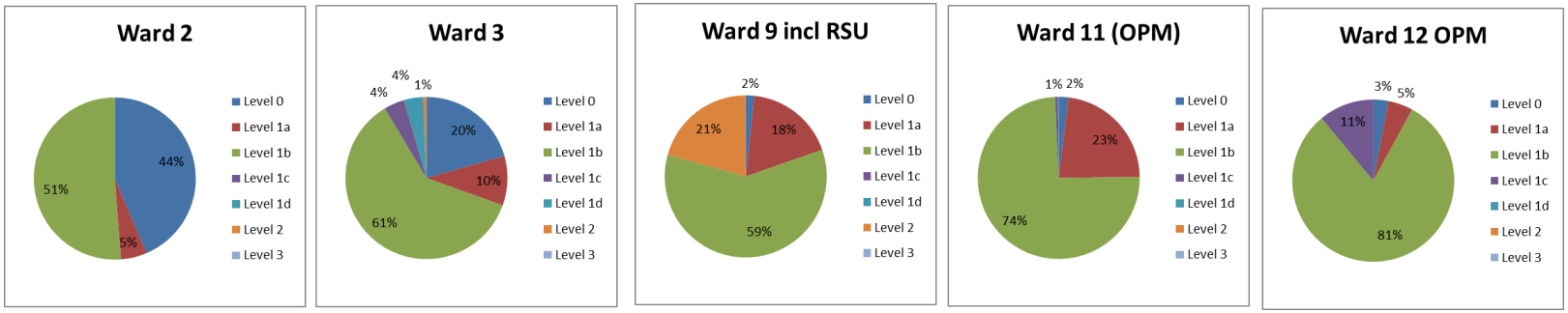
Using the SNCT tool there was a suggested deficit between the RN budget of 84.88 WTE and surplus of HCA budget of 2.89 WTE.

Table 15: Med & Emerg AIW Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to New PJ**
Ward 2	26	30	28.83	96.10%	16.92	21.45	18.78	31.00	31.00	-14.08	-1.86	13.36	15.75	12.85	11.93	11.93	1.43	0.51
Ward 3	28	28	26.03	92.96%	18.23	18.43	18.78	38.41	30.69	-20.18	-0.55	12.75	10.84	12.85	14.78	11.80	-2.03	-0.10
Ward 9 incl RSU	32	34	28.97	85.21%	30.40	34.72	39.56	42.76	42.76	-12.36	-9.16	9.84	12.11	16.09	16.44	16.44	-6.60	-6.25
Ward 11 (OPM)	28	28	27.27	97.39%	20.46	20.80	22.28	34.64	34.08	-14.18	-1.82	20.64	19.52	21.45	13.32	13.11	7.32	-0.81
Ward 12 OPM	24	27	26.33	97.52%	15.67	20.52	22.28	39.74	33.10	-24.07	-6.61	18.06	12.68	18.77	15.29	12.74	2.77	-0.71
Totals	**138**	**147**	**137.43**	**93.49%**	**101.68**	**115.92**	**121.68**	**186.56**	**171.62**	**-84.88**	**-20.00**	**74.65**	**70.90**	**82.01**	**71.76**	**66.02**	**2.89**	**-7.36**

6.4 Patient Acuity and Dependency Scores for Med & Emerg Acute Inpatient Wards

Figure 9: Patient Acuity and Dependency scores during the audit period broken down by percentage



6.5 Med & Emergency Care activity and patient harms recorded during the audit period

Table 16: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 1 AAU	343	233	395	470	54	10	377	0	27	30	3		4	11		90.9%
Ward 2	53	77	11	10	12	4	72	20	13	12	4			13		75.0%
Ward 3	3	85	106	6	9	2	66	4	24	19	3	1		5		80.0%
Ward 9 incl RSU	92	78	8	4	19	10	240	0	2	0	10	1	2	7	1	25.0%
Ward 11 (OPM)	48	49	17	5	2	7	35	1	12	25	3			8		100.0%
Ward 12 OPM	11	47	43	4	0	2	45	0	58	36	1	1	1	9		100.0%
Ward 31 AAU	356	347	9	7	2	3	304	0	37	45	1		2	2	2	100.0%
Ward 37 (AMU)	604	207	7	271	0	12	1057	0	8	3	6		4	10		93.2%

6.6 Head of Nursing Comments and Actions – Jo Foster

Ward 1 Male Assessment Unit – It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

Ward 37 Female Assessment Unit – It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 37 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

Ward 31 Short Stay – Professional judgement and actual staffing are appropriate for Ward 31; no change is required.

Ward 3 Infectious Diseases – No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3.

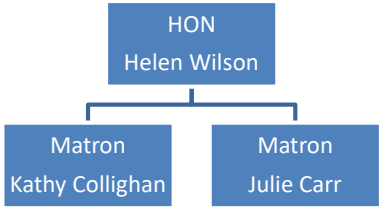
Ward 9 Respiratory - is a 32 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays offering dedicated male and female beds. The ward footprint is large, and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require British Thoracic Society recommended level 2 nurse to patient ratios (1:2 – 1:4) and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increases. SNCT and professional judgement both indicate a requirement for an increase in both RN and HCA numbers in this area. This is reflective of the patient need.

Ward 12 –The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.

Ward 11 Older Peoples Medicine – The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.

Ward 2 – SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year.

7. Neurosciences & Spinal Care



7.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Neurosciences & Spinal Care

During March 2025 the bed occupancy across this collaborative was an average of 92.99%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for ward 26 which was 50/50.

The current budget for RN was 91.36 WTE against the professional judgement of 104.46 WTE suggesting a deficit in funding of 13.10 WTE. For HCA the budget was 70.12 WTE against the professional judgement of 69.72 WTE suggesting a surplus of 0.40 WTE.

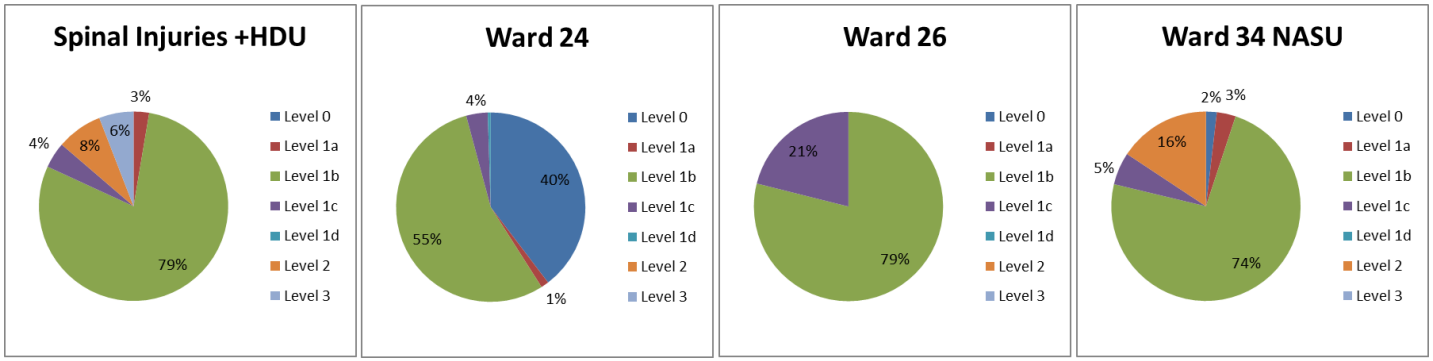
Using the SNCT tool there was a suggested deficit between the RN budget of 46.72 WTE and surplus HCA budget of 17 WTE.

Table 17: Neurosciences & Spinal Care Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to PJ**
Spinal Injuries +HDU	24	20	22.60	113.00%	29.60	32.77	31.00	34.78	32.49	-5.18	-1.40	24.22	20.00	21.45	13.38	12.50	10.84	2.77
Ward 24	23	23	19.93	86.65%	18.67	19.36	19.56	25.56	23.35	-6.89	-0.89	13.90	12.52	13.41	9.83	8.98	4.07	0.49
Ward 26	18	19	17.87	94.05%	13.51	15.40	15.36	31.16	22.52	-17.65	-1.85	12.90	13.96	13.41	11.99	8.66	0.91	-0.51
Ward 34 NASU	34	34	28.87	84.91%	29.58	33.24	38.54	46.58	42.91	-17.00	-8.96	19.10	15.76	21.45	17.92	16.50	1.18	-2.35
Totals	**99**	**96**	**89.27**	**92.99%**	**91.36**	**100.77**	**104.46**	**138.08**	**121.27**	**-46.72**	**-13.10**	**70.12**	**62.24**	**69.72**	**53.12**	**46.64**	**17.00**	**0.40**

7.2 Patient Acuity and Dependency Scores for Neurosciences & Spinal Care

Figure 10: Patient Acuity and Dependency scores during the audit period broken down by percentage



7.3 Neurosciences & Spinal Care activity and patient harms recorded during the audit period

Table 18: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Spinal Injuries +HDU	18	18	2	0	0	0	0	0	1	0						100.0%
Ward 24	44	75	63	29	40	0	27	0	20	14						100.0%
Ward 26	0	7	9	0	14	0	6	0	100	15				2		100.0%
Ward 34 NASU	85	60	12	12	25	5	157	7	44	27	2			3		100.0%

7.4 Head of Nursing Comments and Actions – Helen Wilson

Ward 24 – There has been an ongoing requirement for an increase in HCAs with a consistent additional spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year however has not been realised in the budget. It is not safe to reduce NHSP spend on this ward for HCSW however the number of RNS in budget is appropriate.

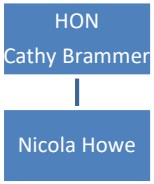
Ward 26 – The data suggests the ward would benefit from an increase in RN establishment which I would agree as it feels we have a short fall of RN's during the day requiring an increase to 4 rather than 3. We have requested an increase year on year for HCA on this ward due to the number of patients requiring 1-1 level care due to the risk of falls and cognitive problems, again unable to reduce NHSP spend due to the requirement to maintain safety.

Ward 34 - Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a combination of Acute Strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a Health care assistant with the beds used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area. The monitored bay requires an increase in RN's to 3 day and nights, due to patient acuity and being a level 2 facility. In addition the nurses spend a significant amount of time away from the ward with emergency admissions having diagnostics as part of the pathway for example. Although SNCT recommends a further uplift the investment requested here would be adequate.

Spinal injuries – As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernumerary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an HCA. The recommendations from professional judgement and SNCT support this requirement. However, the reduction in the number of HCA wouldn't allow the spinal injuries unit to run safely and patient care and safety couldn't be maintained at the levels if reduced to SNCT figures. The HCA figures are not capturing the level of support and care that is required for this type of injury.

Overall for the majority of the areas the increase in the numbers of the RNs including level 1C and D should be represented in the HCA column which would justify the increase that has been requested over recent years.

8. Women & Children



8.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Women & Children

During March 2025 the bed occupancy across the paediatric ward areas was an average of 75% (Ward 21 83.20% and Ward 22 62.94%). The skill mix ratio for this care setting is 70% RNs to 30% HCAs. Paediatric surgery has a lot of short stay patient activity, as can be seen on ward 22 with children only staying overnight if necessary following surgery. The current budget for RN was 50.95 WTE against the professional judgement of 50.92 suggesting no variance. For HCA the budget was 22.90 WTE against the professional judgment of 18.377 WTE suggesting a surplus of 4.13 WTE. However, these surplus hours are filled by play support staff who appear on the HCA budget line and have a very separate, non-clinical role.

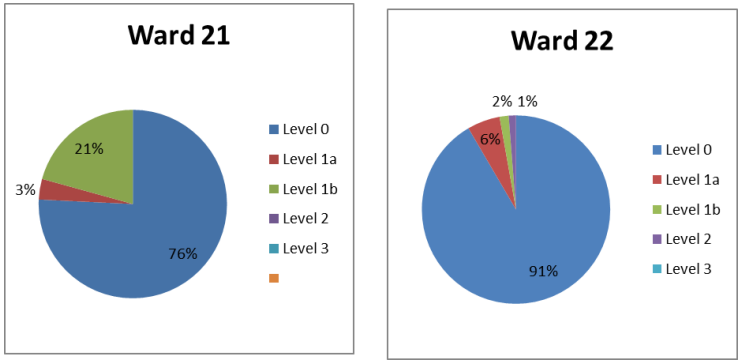
Using the SNCT tool there was a suggested deficit suggested surplus between the RN budget of 9.89 WTE and surplus HCA budget of 2.20 WTE (however play staff are part of HCA budget as above.)

Table 19: Women & Children Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
	Bed Management				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA		Variance	
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Mar 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget HCA WTE	Mar 25 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	HCA Variance **Budget to PJ**
Ward 21	25	25	20.80	83.20%	33.20	34.68	33.00	27.47	27.47	5.73	0.20	13.20	9.72	10.73	13.83	13.83	-0.63	2.47
Ward 22	17	17	10.70	62.94%	17.75	17.72	17.92	13.59	13.59	4.16	-0.17	9.70	9.20	8.04	6.87	6.87	2.83	1.66
Totals	**42**	**42**	**31.50**	**75.00%**	**50.95**	**52.40**	**50.92**	**41.06**	**41.06**	**9.89**	**0.03**	**22.90**	**18.92**	**18.77**	**20.70**	**20.70**	**2.20**	**4.13**

8.2 Patient Acuity and Dependency Scores for Women & Children

Figure 11: Patient Acuity and Dependency scores during the audit period broken down by percentage



8.3 Women & Children activity and patient harms recorded during the audit period

Table 20: Activity and Patient Harms by Ward for March 25

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 21	153	153	23	4	16	0	12	1	0	0						95.4%
Ward 22	160	155	20	11	30	0	323	0	0	0						96.9%

8.4 Head of Nursing Comments and Actions – Cathy Brammer

The data above demonstrates that across the two children's inpatient wards average bed occupancy was 75% in March (83.20% children's medicine and 62.6 % children's surgery). It suggests that for this level of activity RN numbers could be reduced across both areas. However, if both wards were full with similar acuity patients, Ward 21 RN establishment would be correct at 33.2 WTE and Ward 22 current RN establishment would be in deficit by 5.35 WTE (however this is mitigated due to less surgical list on a weekend there for staffing allocation is reduced to 2 RN's per shift .) HCA establishments would suggest being accurate when taking into consideration play staff. Bed occupancy and

levels of acuity fluctuate greatly on a day-to-day basis across children and young people services. Bed occupancy on Ward 22 is greatly impacted by the frequency and population of theatre lists for children and young people and this is continuing to increase but is not yet back to a level seen pre-covid.

As well as the assessment for staffing as set by the SNCT, the Royal College of Nursing staffing guidance (RCN 2013) for Paediatric areas is available to benchmark against and is used nationally when setting nursing establishments for CYP areas. This guidance stipulates a set of core standards to be applied in services providing health care for children and young people which includes a nurse-to-patient ratio of 1:3 for patients under 2 years and 1: 4 for over. NHSE&I have published a Children's safer nurse staffing framework for inpatient care in acute hospitals (NHSE&I, 2021). It also suggests a 70/ 30% ration of registered to unregistered staff rather than 66%/ 36% used above and a headroom of 25% as opposed to the Trusts 21%. This document identifies as a minimum, there should be a co-ordinating nurse on each shift who is supernumerary. Revised National guidance on Children's nurse staffing is currently in progress.

There is a general perception that children always have carers present however this is not an accurate reflection of reality. Children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Parents and carers often also need a high level of support. There has been a noticeable increase in the number of young people admitted requiring mental health support with increased pressure on inpatient mental health beds locally and nationally. These patients need an enhanced level of care and support.

The number of premature children surviving early childhood significant complex conditions requiring higher ratios of nursing care regardless of age such as tracheostomy, respiratory support, complex neurological disability, and safeguarding concerns. Teaching and supporting parents and carers to look after children affected by illness, e.g., naso gastric feeding - to enable safe discharge home also impacts on nurse time as do other tasks specific to children's nursing such as calculation of medicine doses and double checking by 2 registered nurses.

Staff within neonatal and paediatric areas are moved to other areas within speciality to support as needed on a daily basis, as due to the skill set, help cannot be sourced from any other areas of the Trust. Due to this , NHSP spend is minimal.

Actions

- Continue to review staffing on a 6 monthy basis in line with NHSI workforce Safeguards
- Promote robust data entry

South Tees Hospitals NHS Foundation Trust

Appendix 2

Actual staffing v SNCT outcomes

Collab	Ward	SNCT Outcome RN	Actual RN	Variance (- deficit)	SNCT Outcome HCA	Actual HCA	Variance (- deficit)	HON Comments
Cardiovascular Care	**CCU**	22.09	33.96	11.87	8.50	2.40	-6.1	It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area. The audit tool is not fit for purpose for this level of acuity
	Ward 28 Vas	40.49	21.60	-18.89	14.74	17.08	2.34	Based on the current footprint and high acuity, the staffing establishment should remain the same or increase numbers to 4 RNs on a night as they currently struggle due to patient acuity. The percentage of level 1B captures the number of patients with complex wounds that takes a considerable amount of time, and numbers of amputee patients who require the assistance of 2 or more patients. Although would recommend checking this on the next SNCT audit.
	Ward 29	22.45	20.40	-2.05	8.64	11.04	2.4	The SNCT recommendation of less HCAs does not reflect the need of additional HCA support to ensure safe patient care at night when there is an increased risk of falls. I recommend the increase in RN numbers for 1 extra nurse during the day as currently no coordinator for a 36 bedded ward, to support the flow throughout the department and coordinate the ACS transfers.
	Cardio MB	8.52	9.24	0.72	3.28	9.24	5.96	Staffing establishment is at the correct levels. We cannot reduce the number of RN's as suggested as we currently only have 2 Nurses for 9 patients and require a HCA around the clock for support and to ensure telemetry Is monitored
	Ward 32	22.14	19.96	-2.18	8.61	19.96	11.5	SNCT supports the need for an additional RN on nights but not the reduction in in HCA numbers as already minimal HCA numbers.
Digestive Diseases, Urology & Gastro	**Ward 5**	28.98	20.40	-8.58	11.15	15.43	4.28	The patient cohort for this ward is highly dependent on extensive support from staff. The impact on behaviours due to the nature of their conditions leads to a higher need for 1:1 support to ensure the patients are safely cared for. This is reflected in the professional judgement and SNCT outcomes.
	Ward 6	29.57	20.68	-8.89	11.37	13.48	2.11	This ward area is currently open to 31 beds although is only budgeted for 28 beds. The ward has been displaced from Ward 5 to Ward 6 due to the life cycle work on the first floor. Alongside of this the ward is planned to reduce to 16 beds over the weekend period and as a result staffing is reduced on a weekend. However, to support the non-surgical admissions across the organisation it is continuously open to 31 beds including the weekend. This will account for the variation between current and actual staffing against professional judgement and SNCT recommendations.
	Ward 7	31.84	22.84	-9	12.24	13.44	1.2	The SNCT outcomes show an excessively high requirement for RNs. The acuity of the patients and the often-rapid decline would show the higher need for RN provision. The ward also takes the majority of critical care and PACU step downs who require higher need to RN provision due to TPN,

								IVAB's, chest drains, complex nutritional patients and complex wound dressings. However, the care provided from the HCAs ensures that safe care is provided alongside the clinical interventions from registered staff.
	Ward 8	31.01	24	-7.01	11.93	12.48	0.55	Ward 8 continues to have a high number of medical outliers; therefore, the professional judgement demonstrated the need for additional nursing staff. The ward also accepts critical care steps downs, patients discharged from PACU and urology patients across the Tees Valley including patients from County Durham and Darlington.
Collab	**Ward**	**SNCT Outcome RN**	**Actual RN**	**Variance (- deficit)**	**SNCT Outcome HCA**	**Actual HCA**	**Variance (- deficit)**	**HON Comments**
Friarage Hospital & H&R Community Services The Staffing establishment for FHN does not take into account that the Band 7's and some 6's have to carry the 627 bleep from 4pm to 8pm on week days and 8m to 8pm on weekends.	**Ainderby**	32.98	15.33	-17.65	12.69	15	2.31	This ward with frail and complex medical patients has a need for additional RN support.
	CDU	26.44	18.06	-8.38	10.17	8.62	-1.55	is a 22 bedded admission ward for medical patient admissions. The need to cover telemetry over a 24 hour period would require additions to the RN workforce.
	Friary	22.52	10.59	-11.93	8.66	12.44	3.78	This ward is based in a remote area with no internal support structures, therefore the recommendation from SNCT to increase the nursing establishment does reflect the current need.
	Romanby	27.71	16.10	-11.61	10.67	15.19	4.52	This 22 bedded medical ward is providing safe care within the current establishment.
	Rutson	20.59	12.92	-7.67	7.92	11.28	3.36	is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment.
Tees Community	**Tocketts**	37.95	19.77	-18.18	14.60	21.95	7.35	This 31 bedded rehabilitation ward provides care in single rooms. This is the reason that SNCT recommends a decrease in HCAs, however due to the risk to patients in this side room layout there should not be a reduction to HCA workforce. The estate is very problematic and has a difficult footprint being a H- shape with arms coming off intermittently.
	Zetland	39.65	20.43	-19.22	15.26	23.93	14.67	The nurse to patient ration when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need.
Head, Neck, Orthopaedic and Reconstructive	**Gara**	18.70	13.77	-4.93	7.19	7.61	0.42	Gara has a fully established workforce, with the surgical hub at FHN approaching opening I have requested a review (data submitted) to ensure appropriate staffing levels are maintained and staffing is incorporated with this focus (SOP produced from surgical hub lead), for the inpatient bed base of 21 and incorporating day case/day zero patients (who attend the ward for post-surgical care).
	Ward 25	32.17	20.52	-11.65	12.38	12.39	0.01	Request sent to review current staffing establishment (due to complexity of patient group, NHSP consistent request/spend re falls risk and patients requiring intervention on a continual focus, that however do not reach the CG47), also aligned with the above data evident and SNCT data.
	Ward 27	15.54	14.33	-1.21	5.98	9.44	3.46	15 bedded elective orthopaedic ward, no change is required to the current staffing establishment currently.
	Ward 35	36.28	24.40	-11.88	13.96	14.40	0.44	The ward requires an extra RN support two to three times per week for complex care post-surgery (L2) and to support any emergency high level patients (free flap/trach) (L2) requiring 1:1 observation and oversight. This is factored into the professional judgement calculation above. There is

								high complexity of patients and patient throughput. The ward also supports the plastics clinics and other drop-in services that is not factored into the ward staffing calculations (PDC is on the ward however has own staffing model, separate). On a weekend and out of hours the ward supports any patient requiring urgent plastics treatment. An agreement has been given verbally via SLT to have the increase in RN, this needs to progress budget wise and fill the vacant post.
	Ward 36	42.88	26.20	-16.68	16.49	17.48	0.99	This trauma ward is a critical care step down area and sees high numbers of overnight trauma and major trauma admissions, as well as in hours. The ward consistently sees complex patients beyond the trauma speciality in terms of need and care input. As such the staffing template will continue to be reviewed within collaborative and escalation as needed to review/discuss.
Collab	**Ward**	**SNCT Outcome RN**	**Actual RN**	**Variance (- deficit)**	**SNCT Outcome HCA**	**Actual HCA**	**Variance (- deficit)**	**HON Comments**
James Cook Cancer Institute & Speciality Medicine	**Ward 4**	33.41	24.64	-8.77	12.85	11.84	-1.01	Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes. Ward 4 offers a telephone support line at night and weekends for patients requiring Nephrology advice this includes renal transplantation open access. Ward 4 also delivers a vascular access service, which requires the assistance of a HCA with the procedure I would support the additional HCA for this as it has never been factored in the establishment, we also have a higher risk of falls due to the patient group and the value for a third HCA overnight would be welcomed
	Ward 14	24.39	24.28	-0.11	9.38	12.94	3.56	No change to establishment is required. Ward 14 offers a telephone support line at nights and weekends for patients requiring oncology advice as per UKONS guidance. I expected additional HCA support given the complexities of EOLC patients and complexities of pain and syringe drivers
	Ward 33	22.09	25.44	3.35	8.50	11.90	3.4	Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice as per UKONS guidance. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended. Agreed.
Medicine & Emergency Care	**Ward 1 AAU**	43.68	36.80	-6.88	16.80	19.24	2.44	It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

	Ward 31 AAU	53.77	30.16	-23.61	20.68	23.08	2.4	Professional judgement and actual staffing are appropriate for Ward 31; no change is required.
	Ward 37 AMU	40.63	33.52	-7.11	15.63	22.65	7.02	It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 37 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.
	Ward 2	31.00	21.45	-9.55	11.93	15.75	3.82	SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year.
	Ward 3	38.41	18.43	-19.98	14.78	10.84	-3.94	No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3.
	Ward 9	42.76	34.72	-8.04	16.44	12.11	-4.33	is a 32 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays offering dedicated male and female beds. The ward footprint is large, and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require British Thoracic Society recommended level 2 nurse to patient ratios (1:2 – 1:4) and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increases. SNCT and professional judgement both indicate a requirement for an increase in both RN and HCA numbers in this area. This is reflective of the patient need.
	Ward 11	34.64	20.80	-13.84	13.32	19.52	6.2	The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.
	Ward 12	39.74	20.52	-19.22	15.29	12.68	-2.61	The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.
Collab	**Ward**	**SNCT Outcome RN**	**Actual RN**	**Variance (- deficit)**	**SNCT Outcome HCA**	**Actual HCA**	**Variance (- deficit)**	**HON Comments**
	Spinal Injuries & HDU	34.78	32.77	-2.01	13.38	20	6.62	As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernumerary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an HCA. The recommendations from professional

								judgement and SNCT support this requirement. However, the reduction in the number of HCA wouldn't allow the spinal injuries unit to run safely and patient care and safety couldn't be maintained at the levels if reduced to SNCT figures. The HCA figures are not capturing the level of support and care that is required for this type of injury.
	Ward 24	25.56	19.36	-6.2	9.83	12.52	2.69	There is still a requirement for an increase in HCAs with the extra spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year but still not in the budget but unable to reduce NHSP spend to maintain patient safety. Happy with the number of RNS in current professional judgement
Neurosciences & Spinal Care	**Ward 26**	31.16	15.40	-15.76	11.99	13.96	1.97	The data suggests the ward would benefit from an increase in RN establishment which I would agree that we have a short fall of RN's during the day and should be an increase to 4 rather than 3. We have asked for an increase year on year for HCA for this ward due to the number of patients requiring 1-1 level care due to the risk of falls and cognitive problems, again unable to reduce NHSP spend in order to maintain safety
	Ward 34	46.58	33.24	-13.33	17.92	15.76	-2.16	Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a mixture of Acute strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a Health care assistant and the beds are used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area. The monitored bay requires an increase in RN's to 3 day and nights, due to patient acuity and level 2 facility and the amount of time nurses are away from the ward with emergency admissions. Would happy to see an increase in budget to the levels of professional judgement but further increase is not required
Collab	**Ward**	**SNCT Outcome RN**	**Actual RN**	**Variance (- deficit)**	**SNCT Outcome HCA**	**Actual HCA**	**Variance (- deficit)**	**HON Comments**
Women & Children	**Ward 21**	27.47	34.68	7.21	13.83	9.72	-4.11	The data above demonstrates that across the two children's inpatient wards average bed occupancy was 75% in March (83.20% children's medicine and 62.6 % children's surgery). It suggests that for this level of activity RN numbers could be reduced across both areas. However, if both wards were full with similar acuity patients, Ward 21 RN establishment would be correct at 33.2 WTE and Ward 22 current RN establishment would be in deficit by 5.35 WTE (however this is mitigated due to less surgical list on a weekend there for staffing allocation is reduced to 2 RN's per shift .) HCA establishments would suggest being accurate when taking into consideration play staff. Bed occupancy and levels of acuity fluctuate greatly on a day-to-day basis across children and young people services. Bed occupancy on Ward 22 is greatly impacted by the frequency and population of theatre lists for children and young people and this is continuing to increase but is not yet back to a level seen pre-covid. As well as the assessment for staffing as set by the SNCT, the Royal College of Nursing staffing guidance (RCN 2013) for Paediatric areas is available to benchmark against and is used nationally when setting nursing
	Ward 22	13.59	17.72	4.13	6.87	9.20	2.33	

								establishments for CYP areas. This guidance stipulates a set of core standards to be applied in services providing health care for children and young people which includes a nurse-to-patient ratio of 1:3 for patients under 2 years and 1: 4 for over. NHSE&I have published a Children's safer nurse staffing framework for inpatient care in acute hospitals (NHSE&I, 2021). It also suggests a 70/ 30% ration of registered to unregistered staff rather than 66%/ 36% used above and a headroom of 25% as opposed to the Trusts 21%. This document identifies as a minimum, there should be a co-ordinating nurse on each shift who is supernumerary. Revised National guidance on Children's nurse staffing is currently in progress. There is a general perception that children always have carers present however this is not an accurate reflection of reality. Children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Parents and carers often also need a high level of support. There has been a noticeable increase in the number of young people admitted requiring mental health support with increased pressure on inpatient mental health beds locally and nationally. These patients need an enhanced level of care and support. The number of premature children surviving early childhood significant complex conditions requiring higher ratios of nursing care regardless of age such as tracheostomy, respiratory support, complex neurological disability, and safeguarding concerns. Teaching and supporting parents and carers to look after children affected by illness, e.g., naso gastric feeding - to enable safe discharge home also impacts on nurse time as do other tasks specific to children's nursing such as calculation of medicine doses and double checking by 2 registered nurses. Staff within neonatal and paediatric areas are moved to other areas within speciality to support as needed on a daily basis, as due to the skill set, help cannot be sourced from any other areas of the Trust. Due to this , NHSP spend is minimal.