

<b>TRUST BOARD IN PUBLIC</b>		<b>Date: 27 November 2014</b>
		<b>Agenda Item: 2.3</b>
<b>REPORT TITLE:</b>		Safer Staffing Review Paper
<b>EXECUTIVE SPONSOR:</b>		Fiona Allsop Chief Nurse
<b>REPORT AUTHOR:</b>		Lynn Sanders Corporate Matron
<b>REPORT DISCUSSED PREVIOUSLY:</b> (name of sub-committee/group & date)		Nursing & Midwifery Professional Group – 18 November 2014
<b>Action Required:</b>		
<b>Approval ( )</b>	<b>Discussion (√)</b>	<b>Assurance (√)</b>
<b>Summary of Key Issues</b>		
<p>This paper is review of nurse staffing utilising the Safer Nursing Care Tool, current establishments and nurse sensitive indicators. It is presented in response to the National Quality Board paper published in November 2013 which requires that nursing staffing levels are reviewed twice a year to demonstrate that they are staff and appropriate.</p> <p>Key points are</p> <ul style="list-style-type: none"> <li>• The funded nursing establishment for the Trust as a whole is sufficient to meet the acuity and dependency needs of the patients once the agreed increase in establishments has been recruited.</li> <li>• The integrity of data in relation to patient group and staffing allocation needs further development so that assurance of accuracy is achieved.</li> <li>• There is some evidence on some wards that the relationship between staffing levels and performance outcome data needs further interrogation as there is no clear correlation between staffing levels, performance indicators and leadership. The data suggests that the quality and seniority of staff on a particular ward has as much impact as the quantity of staff available. It is known that good leadership impacts positively on patient outcomes.</li> <li>• In addition it should be noted that the Trust is currently managing a significant amount of nursing vacancies covered by bank and agency staff, this could also affect the nurse sensitive indicators and the team dynamics within any ward environment.</li> </ul>		
<b>Relationship to Trust Strategic Objectives &amp; Assurance Framework:</b>		
<p><b>SO1:</b> Safe -Deliver safe services and be in the top 20% against our peers  <b>SO2:</b> Effective - Deliver effective and sustainable clinical services within the local health economy  <b>SO3:</b> Caring – Ensure patients are cared for and feel cared about  <b>SO5:</b> Well - led</p>		
<b>Corporate Impact Assessment:</b>		
<b>Legal and regulatory implications</b>	yes	

<b>Financial implications</b>	yes
<b>Patient Experience/Engagement</b>	yes
<b>Risk &amp; Performance Management</b>	yes
<b>NHS Constitution/Equality &amp; Diversity/Communication</b>	yes
<b>Attachments:</b>	

**TRUST BOARD REPORT – 27<sup>TH</sup> November 2014**  
**SAFER STAFFING DATA REVIEW**

**1. Introduction**

The Safer Nursing Care Tool (SNCT) is one method that can be used to assist Chief Nurses to determine optimal nurse staffing levels in adult in-patient and acute admissions units. It is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity /dependency terms.

This element comprises of a decision matrix based upon the classification of levels of critical care patients (Comprehensive Critical Care, DH 2000) (Appendix 1), and is used to determine the level of acuity/dependency of all patients. When this is aligned to the evidence based nurse staffing multiplier, it allows recommendations for nurse staffing required per ward based on the actual needs of those patients.

**2. Method**

Each ward area completed a daily sheet to collect information about the patient category level in the previous 24hrs. The staffing levels on duty on a daily basis were also recorded.

This information was entered onto a database, where the nurse staffing multipliers were applied, and daily recommended ward establishment were produced. These figures were averaged over the whole collection period to produce total ward establishment recommendations and total ward actual staffing for the same period of time. These figures when compared with the funded establishment gives a comparison between staffing funded, staffing worked and staffing needed. The tools recommended figures are based on a 22% uplift being included. Currently the ward budgets have an 18% allowance included in the establishment, and the remaining 4% held centrally in the divisions.

In order for a true comparison to be made, the current ward establishment has been elevated to incorporate 22% uplift individually.

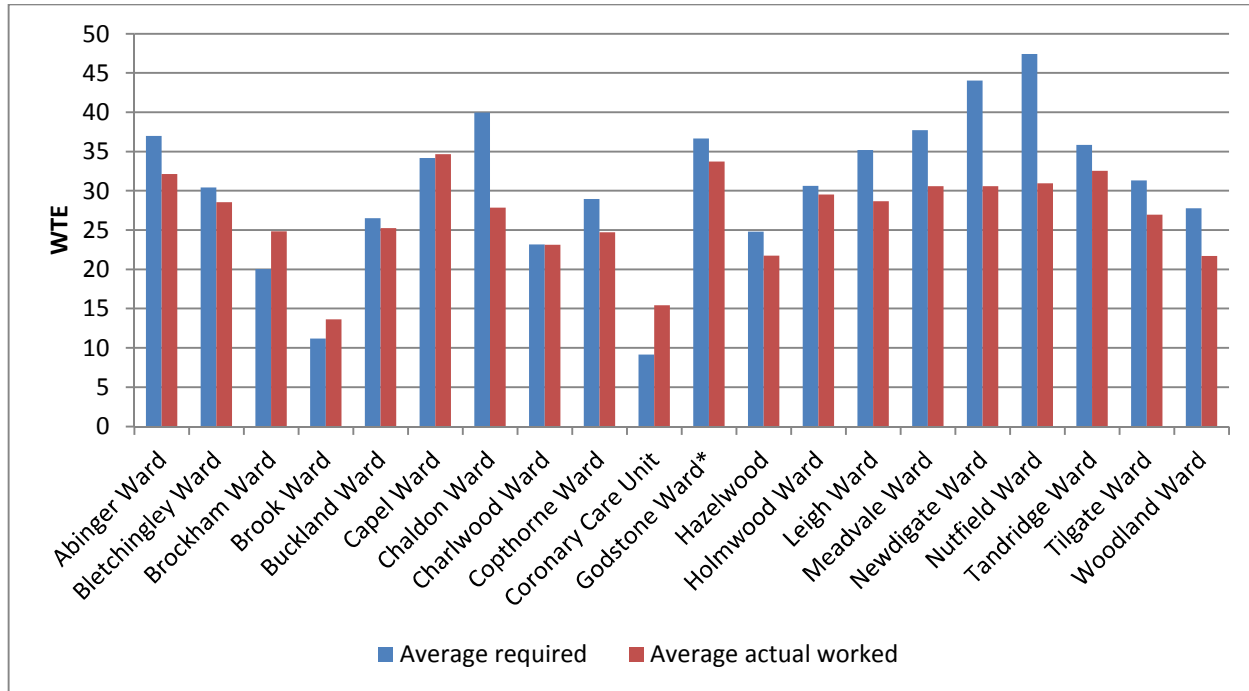
**3. Tool**

Level 0	Patient requires hospitalisation Needs met by provision of normal ward care
Level 1a	Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
Level 1b	Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.
Level 2	May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility /unit
Level 3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs.

#### 4. Results

The total period of data collected was from November 2013 -August 2014 (excluding December) over 20 inpatient adult ward areas. The detailed results are within Appendix 2.

Compliance of daily submission varied between areas but total compliance across whole site was 75%.



**Table 1 - Results graphs showing Average Tool requirements vs Actual staff on duty (including 22% uplift)**

\*Godstone figures based on activity between April and August due to new ward template.

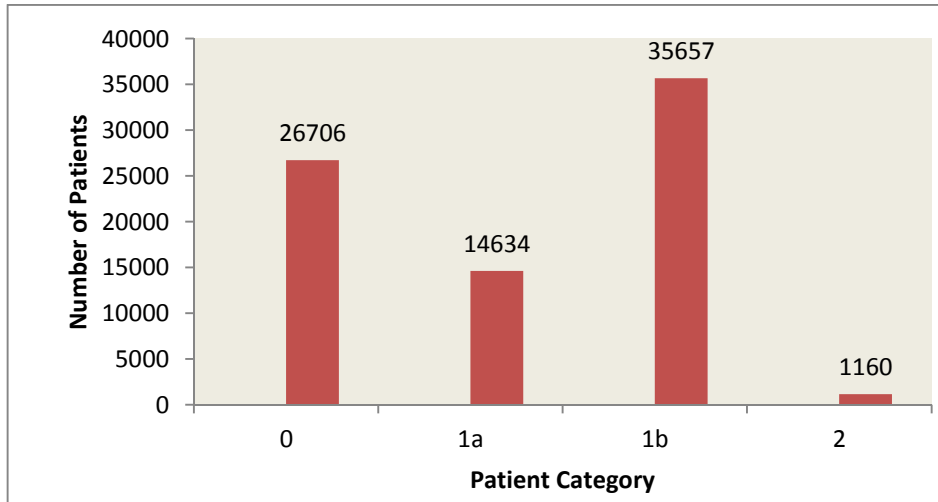
\*Brockham figures only include in patient activity on Brockham Ward. The Funded establishment also includes GAU and EPU.

Establishment required	612 WTE	Including 22% uplift
Funded Establishment	561 WTE	
Establishment actual worked	537 WTE	
Establishment required	502 WTE	Baseline- no uplift
Funded Establishment	459 WTE	
Establishment actual worked	440 WTE	

**Table 2 - Table to demonstrate comparison between recommended tool establishment, funded establishment and actual shifts covered. (Establishment data from Sept 2014 Finance budget statements)**

The actual shifts worked will include any specials allocated to support specific patient care needs, and also additional staffing required supporting the usage of escalation beds on Abinger and Meadvale.

**Table 3 - Patients level of care distribution**



### 5. Level 2 and 3 patients

The safer staffing tool is designed for the ward nurses to self-assess the patients level of acuity and dependency using the categories described in Appendix 1. It is possible for subjectivity to lead to variance in the results, for example, the categorisation of a level 3 patient is the requirement of multi organ support at a dedicated critical care facility. There may be times when a patient is deteriorating that they may reach this criteria and be supported by the critical care outreach team, however the tool is intended to capture ward staffing resources only.

In total through the 9 month period, 15 patients were categorised as level 3 in the study areas. Patients reaching this level of care would require critical care support in a dedicated facility with advanced skills. The outreach team were consulted with this information, and confirmed that this assessment was inaccurate, and therefore for this reason this group of patients have been corrected to a level 2.

### 6. Limitations/Issues

- There is an element of subjectivity, as indicated above, associated with the use of data collection using the categories within the SNCT. The descriptors require a degree of experience when scoring the ward acuity and dependency, and various factors may influence the nurse’s decision whilst completing the data collection, for example a ward with a challenging environment such a confused, dementia patients may feel particularly demanding on staffing requirements.
- The tool does not recognise wards with a high number of admissions and discharges where the nursing workload is increased due to tasks associated with these processes as there is a heavy burden on completion of assessment’s and paperwork when turnover of patients is increased. In addition, it is well recognised that when the clinical areas run with average bed occupancy over 85%, the ward area becomes less efficient.
- Monitoring of Nurse Sensitive Indicators (NSI) such as infection rates, complaints, pressure ulcers and falls is recommended to ensure that staffing levels deliver the patient outcomes that are aimed to achieve. This study has not recorded these indicators alongside the data

collected, but has cross referenced against ward performance information relating to Friends and Family Test, complaints and the safety thermometer.

- Whilst the establishment of the nursing team required to deliver safe patient care is essential, it is also important to recognise the other roles needed to ensure that the workforce are well managed and developed. The management (non- clinical) hours within the Senior Sisters/Charge Nurses working pattern are not included in this data. They are rostered for 50% of their contracted hours to work in a clinical capacity, and the remainder is for administration and management tasks. Audits and workplace assessments are often carried out during clinical shifts, for example the safety thermometer and hand hygiene audits are performed regularly during the shifts by the nursing team on duty.
- An additional requirement of a Practice Development Nurse is essential in order to ensure that the nursing team receives a good standard of clinical supervision, and that skills are developed in order to meet the needs of the patient group. This model would also support the career development and progression of the workforce.
- This method of staffing requirement calculation does not take into consideration of the needs of relatives and carers, particularly in areas with complex assessments and social care issues. Multidisciplinary team meetings in some clinical areas may take many hours per week of the nursing hours.

## 7. Professional Judgement

The results of any staffing tool should be aligned with the professional judgement of the senior nursing team to ensure that the outcome results match the operational demands of the area. The factors considered include the experience and skills of the staffing team, geography of the ward layout, nurse sensitive indicators and acuity and dependency of the patient case mix within the clinical area.

Following the publication of “Right Staffing” paper from the National Quality Board November 2013 and with the agreement of the Trust Board in March 2014, the qualified staffing ratio that this Trust is working towards is a 1:10 ratio at night and a 1:7 during the day, with long term objectives of achieving 1:7 on a 24 hour basis. In order for the initial ratios to be achieved, a number of posts have already been agreed for the divisions.

In medicine this will amount to 31.98 WTE and in Surgery 11.11 WTE (see Appendix 3)

On a daily basis, the staffing for each area is assessed by the Matron, Divisional Chief Nurses, and overseen by the Deputy Chief Nurse to ensure that the skill mix and competencies meet the needs of the patient group.

Establishment required	612 WTE	Including 22% uplift
Funded new Establishment	604 WTE	
Establishment required	502 WTE	Baseline- no uplift
Funded new Establishment	495 WTE	

**Table 4 - Table to demonstrate comparison between recommended tool establishment, proposed new funded establishment and actual shifts covered.**

## 8. Midwifery Workforce Analysis

An annual review of midwifery staffing was submitted to the board in May 2014. The review demonstrated a need for an increase in the current midwifery establishment and the number of specialist posts to be compliant with the national recommendations. The report demonstrated the contingencies that have been implemented to mitigate risks and ensure that 'the right staff are in the right place at the right time' and that safety and quality continues to be prioritised.

The national recommendations regarding midwifery staffing is outlined in the Safer Childbirth Document (2007) and stipulates a midwifery ratio of 1:28. At the time of the report the local ratio based on the 2013/2014 activity and acuity was 1:34. To achieve a ratio which is closer to the reported national average of 1:31, the review identified a shortfall of 11.67 wte midwives. The review also highlighted a shortfall of 5.9 wte specialist midwifery posts.

The Board agreed to fund the 11.67 wte posts in principle with a phased approach to funding. Funding has been allocated for 5 wte midwives in 2014/15 resulting in a current midwifery ratio of 1:33.

A full review of midwifery staffing will be repeated at the end of the financial year. It is anticipated that by that time NICE guidance on Midwifery Staffing will also be published.

## 9. Next Steps

The collection of acuity and dependency data will be collected on a twice yearly basis in March and September going forward, to allow for seasonal variations. Data validation will need to be more robust, with the additional support of the critical care outreach team to support decisions regarding the identification of level 2 patients within the ward area. This information will then form part of a staffing assessment paper which will be presented to the Board.

Benchmarking exercises prove challenging due to the differences between individual trusts, and the lack of readily available information regarding staffing numbers and patient acuity and dependency. A benchmarking exercise with similar size trusts and comparable patient groups would be beneficial in order to compare the nurse to bed ratio, and the different bandings within the qualified nursing teams.

However the Hurst model uses benchmarking data to form key information used to create the multiples within the Safer Nursing Care Tool, and therefore incorporates a standardised recommended staff level according to the patient mix.

An adjusted tool to reflect the needs of complex elderly care and dementia patients is available and consideration to the appropriateness of its use decided before the next assessment phase is carried out. This may be suitable for some of the areas within the trust that are dedicated elderly care facilities

Such patients are categorised as a level 2b, and multiples of nursing staff required is based on a 1:1 ratio where indicated for patient safety.

An agreed selection of nurse sensitive indicators should be collected alongside the next period of data collection to ensure that the staffing on the areas with any significant level of harm supports the workload in the area.

Models are in development for the purpose of a staffing review in Acute admissions and Emergency department settings, further discussion to be undertaken following their publication.

## **10. Conclusion**

The nurse staffing review carried out in the Trust over the last year has demonstrated that the funded nursing establishment for the Trust as a whole is sufficient to meet the acuity and dependency needs of the patients once the additional agreed increase in establishments is recruited to.

The integrity of data in relation to patient group and staffing allocation needs further development so that assurance of accuracy is achieved. This will be done by greater defining of data required and validation prior to submission.

There is some evidence on some wards that the relationship between staffing levels and performance outcome data needs further interrogation as there is no clear correlation between staffing levels, performance indicators and leadership. The data suggests that the quality and seniority of staff on a particular ward has as much impact as the quantity of staff available. It is known that good leadership impacts positively on patient outcomes.

In addition it should be noted that the Trust is currently managing a significant amount of nursing vacancies covered by bank and agency staff, this could also affect the nurse sensitive indicators and the team dynamics within any ward environment.

**Fiona Allsop**  
**Chief Nurse**  
**November 2014**



Appendix 1

## The Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care, DH 2000). These classifications have been adapted to support measurement across a range of wards/specialties.

Levels of Care	Descriptor
<b>Level 0</b> Patient requires hospitalisation Needs met by provision of normal ward cares.	<b>Care requirements may include the following</b> <ul style="list-style-type: none"> <li>• Elective medical or surgical admission</li> <li>• May have underlying medical condition requiring on-going treatment</li> <li>• Patients awaiting discharge</li> <li>• Post-operative/post-procedure care - observations recorded half hourly initially then 4-hourly</li> <li>• Regular observations 2 - 4 hourly</li> <li>• <b>Early Warning Score</b> is within normal threshold.</li> <li>• ECG monitoring</li> <li>• Fluid management</li> <li>• Oxygen therapy less than 35%</li> <li>• Patient controlled analgesia</li> <li>• Nerve block</li> <li>• Single chest drain</li> <li>• Confused patients not at risk</li> <li>• Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence</li> </ul>
<b>Level 1a</b> Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	<b>Care requirements may include the following</b> <ul style="list-style-type: none"> <li>• Increased level of observations and therapeutic interventions</li> <li>• <b>Early Warning Score</b> - trigger point reached and requiring escalation.</li> <li>• Post-operative care following complex surgery</li> <li>• Emergency admissions requiring immediate therapeutic intervention.</li> <li>• Instability requiring continual observation/invasive monitoring</li> <li>• Oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly</li> <li>• Arterial blood gas analysis - intermittent</li> <li>• Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains</li> <li>• Severe infection or sepsis</li> </ul>

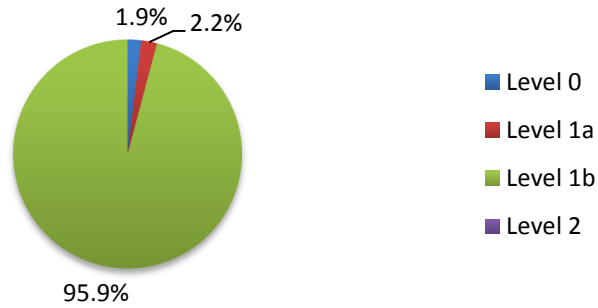
Levels of Care	Descriptor
<b>Level 1b</b> Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	<b>Care requirements may include the following</b> <ul style="list-style-type: none"> <li>• Complex wound management requiring more than one nurse or takes more than one hour to complete.</li> <li>• VAC therapy where ward-based nurses undertake the treatment</li> <li>• Patients with Spinal Instability/Spinal Cord Injury</li> <li>• Mobility or repositioning difficulties requiring the assistance of two people</li> <li>• Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration/post-administration care)</li> <li>• Patient and/or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome</li> <li>• Patients on End of Life Care Pathway</li> <li>• Confused patients who are at risk or requiring constant supervision</li> <li>• Requires assistance with most or all activities of daily living</li> <li>• Potential for self-harm and requires constant observation</li> <li>• Facilitating a complex discharge when this is the responsibility of the ward-based nurse</li> </ul>
<b>Level 2</b> May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit	<ul style="list-style-type: none"> <li>• Deteriorating /compromised single organ system</li> <li>• Post operative optimisation (pre-op invasive monitoring)/extended post-op care.</li> <li>• Patients requiring non-invasive ventilation/ respiratory support; CPAP/ BiPAP in acute respiratory failure</li> <li>• First 24 hours following tracheostomy insertion</li> <li>• Requires a range of therapeutic interventions including:</li> <li>• Greater than 50% oxygen continuously</li> <li>• Continuous cardiac monitoring and invasive pressure monitoring</li> <li>• Drug infusions requiring more intensive monitoring e.g. vasoactive drugs (amlodaron, inotropes, gtn) or potassium, magnesium</li> <li>• Pain management - intrathecal analgesia</li> <li>• CNS depression of airway and protective reflexes</li> <li>• Invasive neurological monitoring</li> </ul>
<b>Level 3</b> Patients needing advanced respiratory support and/or therapeutic support of multiple organs.	<ul style="list-style-type: none"> <li>• Monitoring and supportive therapy for compromised/ collapse of two or more organ/systems</li> <li>• Respiratory or CNS depression /compromise requires mechanical/invasive ventilation</li> <li>• Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection</li> </ul>

## Appendix 2

(Safety Thermometer (ST) figure is an average of no new harms % patients over a 12 month period. Complaints number if from the previous 12 months  
.Friends and Family (F&F) score is an average of 4 months, score is in green is response rate above 30%, and red is below 30%.

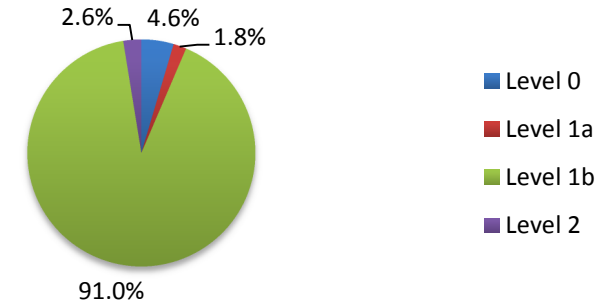
### Elderly Care

#### Nutfield Ward (28 Beds)



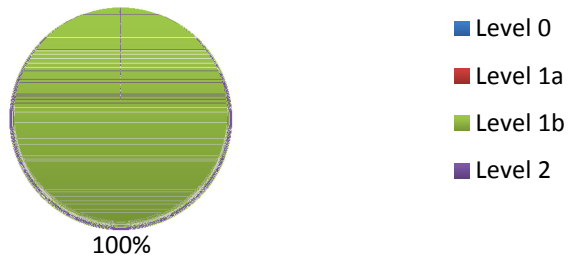
	Qual/Unqual	Actual worked	Tool Est	Funded Est
Inc 22%	58/42%	30.93	47.40	30.82
Baseline	58/42%	25.36	36.97	25.26
Indicators	ST 96.5%	F&F <b>94</b>	Comp 5	

#### Meadvale Ward (21+2 Beds)



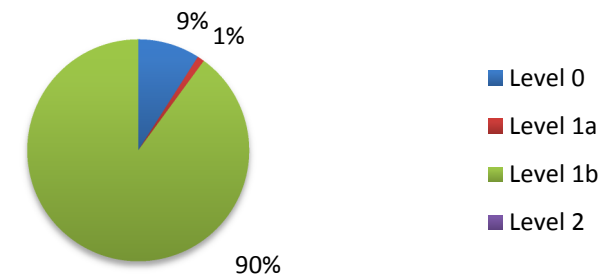
	Qual/Unqual	Actual worked	Tool Est	Funded Est
Inc 22%	54/46%	37.72	30.60	27.74
Baseline	54/46%	29.42	25.08	22.74
Indicators	ST 91%	F&F <b>80</b>	Comp 7	

#### Capel Ward (20 Beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	46/54%	34.67	34.19	33.44
Baseline	46/54%	28.42	26.66	27.41
Indicators	ST 94%	F&F <b>95</b>	Comp 5	

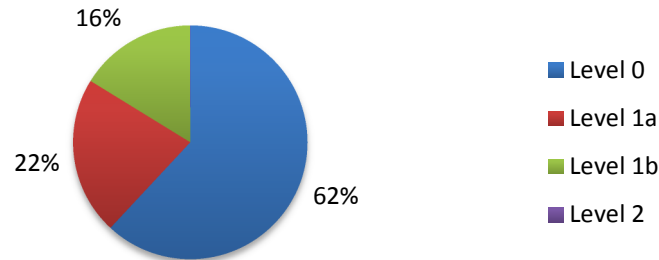
#### Abinger Ward (21 +2beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	54/46%	32.15	36.96	27.74
Baseline	54/46%	26.35	28.83	22.74
Indicators	ST 88%	F&F <b>38</b>	Comp 6	

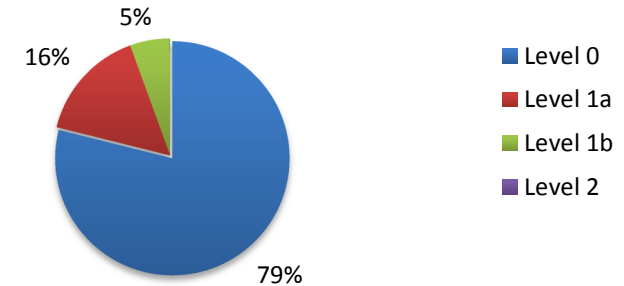
**Surgery**

**Brockham Ward (21 Beds)**



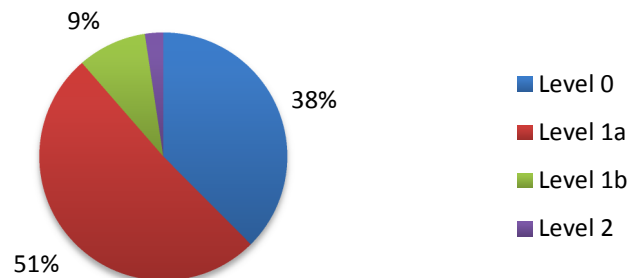
	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	61/39%	24.84	20.03	28.52
Baseline	61/69%	20.36	15.63	23.38
Indicators	ST 99%	F&F <b>75</b>	Comp 6	

**Brook Ward (10 Beds)**



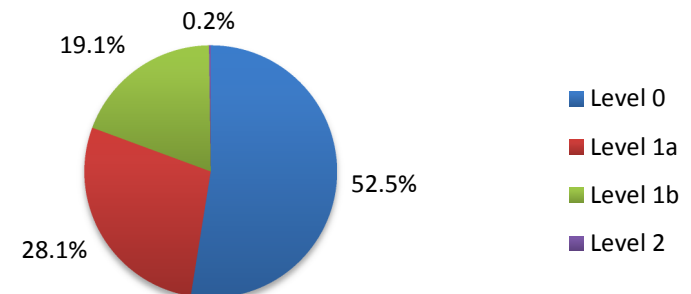
	Qual/Unqual	Actual worked	Tool Est	Funded Est
Inc 22%	82/18%	13.61	11.20	12.19
Baseline	82/18%	11.16	8.73	9.99
Indicators	ST 98.5%	F&F <b>94</b>	Comp 6	

**Buckland Ward ( 21 Beds)**



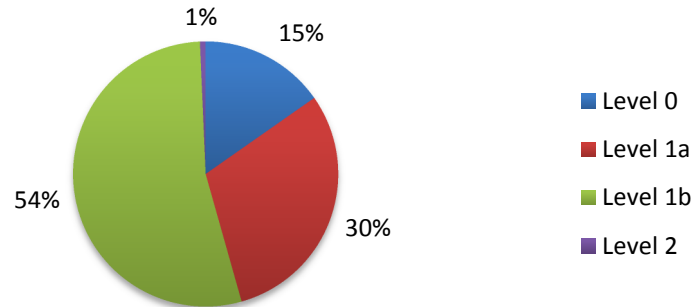
	Qual/Unqual	Actual worked	Tool Est	Funded Est
Inc 22%	65/35%	25.24	26.52	26.30
Baseline	65/35%	20.69	20.69	21.56
Indicators	ST 95%	F&F <b>83</b>	Comp 4	

**Woodland Ward (24 Beds)**



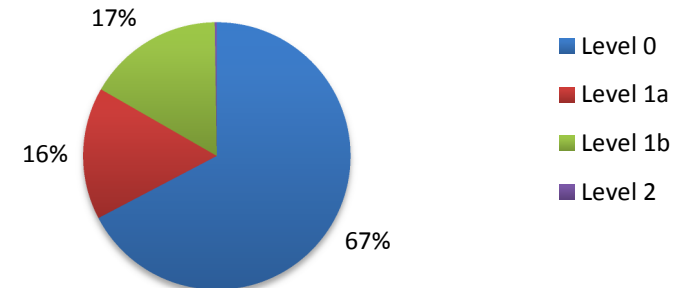
	Qual/Unqual	Actual worked	Tool Est	Funded Est
Inc 22%	62/38%	21.71	27.78	31.09
Baseline	62/38%	17.79	21.67	25.48
Indicators	ST 99.5%	F& <b>80</b>	Comp 10	

### Copthorne Ward (20 Beds)



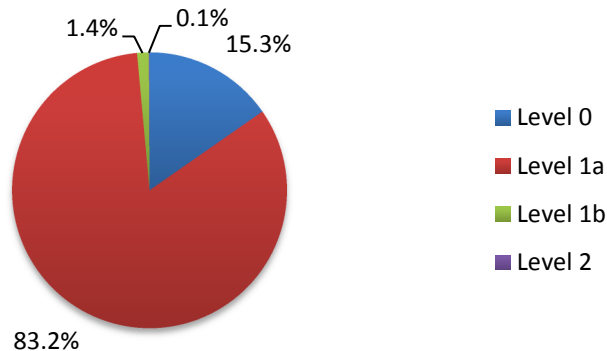
	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	60/40%	24.74	28.94	25.58
Baseline	60/40%	20.28	22.57	20.97
Indicators	ST 97%	F&F <b>81</b>	Comp 7	

### Charlwood Ward (20 Beds)



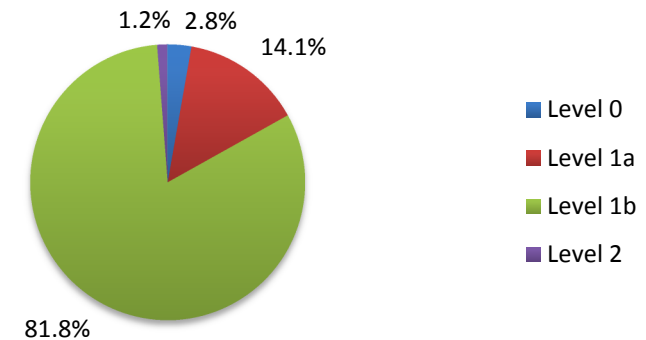
	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	60/40%	23.11	23.18	25.58
Baseline	60/40%	18.94	18.08	20.97
Indicators	ST 96.5%	F&F <b>92</b>	Comp 3	

### Leigh Ward (28 Beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	58/42%	28.67	35.20	30.82
Baseline	58/42%	23.50	27.46	25.26
Indicators	ST 96.5%	F&F <b>83</b>	Comp 7	

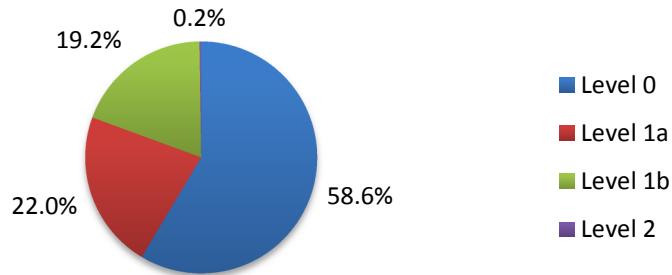
### Newdigate Ward (28 Beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	58/42%	30.58	44.04	30.82
Baseline	58/42%	25.06	34.35	25.26
Indicators	ST 96.5%	F&F <b>72</b>	Comp 5	

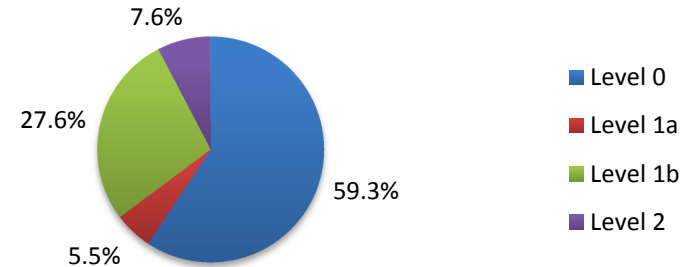
Medicine

### Tilgate Ward (28 Beds)



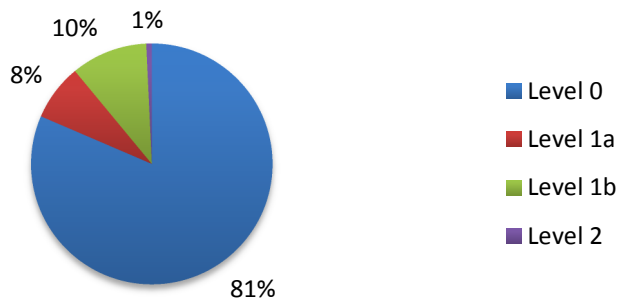
	Qual/Unqual	Actual worked	Tool Est	Funded Est
Inc 22%	67/33%	26.94	31.33	30.82
Baseline	67/33%	22.08	24.43	25.26
Indicators	ST 92%	F&F <b>75</b>	Comp 7	

### Tandridge Ward (28 Beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	58/42%	32.56	35.86	30.83
Baseline	58/42%	26.69	27.97	25.27
Indicators	ST 94.5%	F&F <b>60</b>	Comp 6	

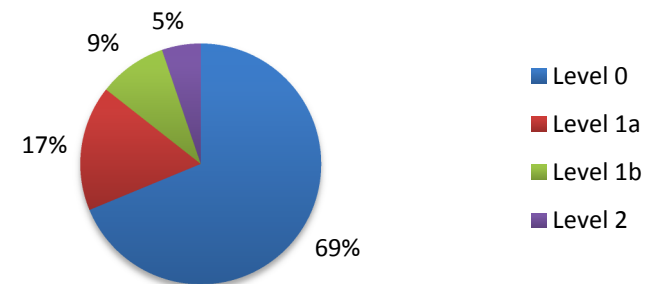
### Holmwood Ward(28 Beds)



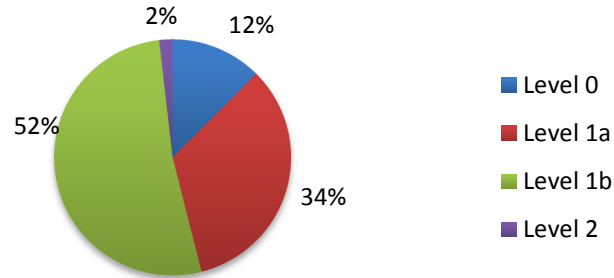
Combined totals between Holmwood and CCU

	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	71/29%	44.95	39.78	43.91
Baseline	71/29%	36.84	31.03	35.99
Indicators	ST 96.5%	F&F <b>62</b>	Comp 6	

### Coronary Care Unit (8 Beds)

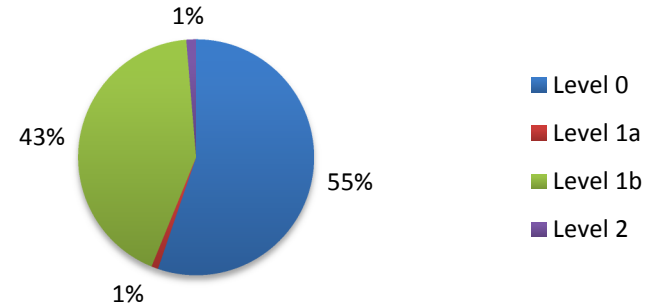


### Chaldon Ward (28 Beds)



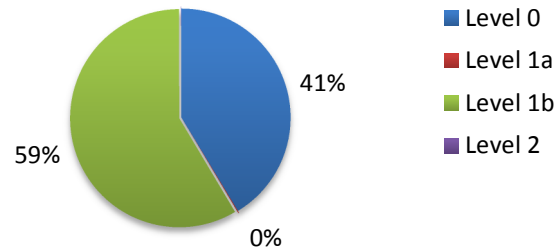
	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	57/43%	27.87	39.94	42.52
Baseline	57/43%	22.85	31.15	34.85
Indicators	ST 99%	F&F <b>86</b>	Comp 4	

### Godstone Ward(28 Beds)



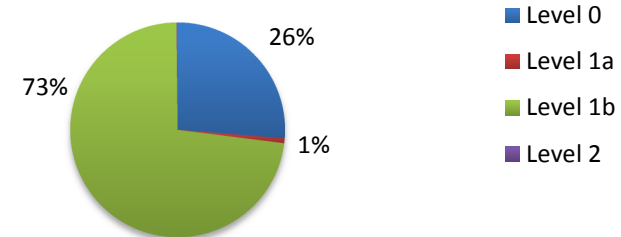
	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	54/46%	33.74	36.65	33.44
Baseline	54/46%	27.66	28.59	27.41
Indicators	ST 96.5%	F&F <b>69</b>	Comp 5	

### Bletchingley Ward(25 Beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	55/45%	28.54	30.42	28.19
Baseline	55/45%	23.39	28.73	23.11
Indicators	ST 95.5%	F&F <b>85</b>	Comp 6	

### Hazelwood(16 Beds)



	Qual/Unqual	Actual Worked	Tool Est	Funded Est
Inc 22%	62/38%	21.74	24.81	20.34
Baseline	62/38%	17.82	19.35	16.67
Indicators	ST 95%	F&F <b>69</b>	Comp 0	

Appendix 3

Table to demonstrate required increase of establishment to achieve 1:10 of qualified staff at night

Chief Nurse Review

Medicine Nursing Ratio Calculation

Priority	Ward	Beds	Current					Required					Pressure					New Ratio		Qualified % to HCA	
			Day	Night		Day HCA	Night HCA	Day	Night		Day HCA	Night HCA	Day	Night		Day HCA	Night HCA	Day	Night	Day	Night
			Qualified	Co-Ordinator	Qualified			Co-Ordinator	Qualified	Co-Ordinator			Qualified	Co-Ordinator	Qualified						
1	Tandridge	28	4.00	1.00	3.00	2.00	2.00	4.00	1.00	3.00	3.00	2.00	-	-	-	1.00	-	7.00	9.33	63%	60%
2	Godstone	28	4.00	1.00	3.00	2.00	3.00	5.00	1.00	3.00	3.00	2.00	1.00	-	-	1.00	-	5.60	9.33	67%	60%
3	Tilgate	26	4.00	1.00	3.00	3.00	1.00	4.00	1.00	3.00	3.00	2.00	-	-	-	-	1.00	6.50	8.67	63%	60%
4	Nutfield	28	4.00	1.00	3.00	2.00	2.00	4.00	1.00	3.00	3.00	2.00	-	-	-	1.00	-	7.00	9.33	63%	60%
5	Holmwood	28	4.00	1.00	2.00	2.00	2.00	4.00	1.00	3.00	3.00	2.00	-	-	1.00	1.00	-	7.00	9.33	63%	60%
6	Bletchingley	25	3.00	1.00	3.00	2.00	2.00	4.00	1.00	3.00	3.00	2.00	1.00	-	-	1.00	-	6.25	8.33	63%	60%
7	Abinger	23	3.00	0.82	3.00	2.00	2.00	3.00	1.00	3.00	3.00	2.00	-	0.18	-	1.00	-	7.67	7.67	57%	60%
7	Meadvale	23	3.00	0.82	3.00	2.00	2.00	3.00	1.00	3.00	3.00	2.00	-	0.18	-	1.00	-	7.67	7.67	57%	60%
Extra per shift													2.00	0.36	1.00	7.00	-				
Converted to WTE													2.53	2.53	2.53	2.53	2.53				
22% uplift													0.56	0.56	0.56	0.56	0.56				
													3.09	3.09	3.09	3.09	3.09				
Increase WTE													6.17	1.11	3.09	21.61	-	31.98			

Surgery Nursing Ratio Calculation

Priority	Ward	Beds	Current					Required					Pressure					New Ratio		Qualified % to HCA		
			Day	Night		Day HCA	Night HCA	Day	Night		Day HCA	Night HCA	Day	Night		Day HCA	Night HCA	Day	Night	Day	Night	
			Qualified	Co-Ordinator	Qualified			Co-Ordinator	Qualified	Co-Ordinator			Qualified	Co-Ordinator	Qualified							Co-Ordinator
	Leigh	28	4.00	0.65	3.00	2.34	2.00	4.00	1.00	3.00	3.00	2.00	-	0.35	-	0.66	-	7.00	9.33	63%	60%	
	Newdigate	28	4.00	0.65	3.00	2.34	2.00	4.00	1.00	3.00	3.00	2.00	-	0.35	-	0.66	-	7.00	9.33	63%	60%	
	Buckland	21	3.70	1.00	2.56	2.00	1.00	3.70	1.00	2.56	3.00	1.00	-	-	-	1.00	-	5.68	7.00	65%	75%	
	Woodland	24	3.80	1.00	2.42	2.42	2.00	3.80	1.00	2.42	3.00	2.00	-	-	-	0.58	-	6.32	8.00	66%	60%	
	Copthorne	20	3.00	1.00	2.00	2.00	2.00	3.00	1.00	2.00	3.00	1.00	-	-	-	1.00	-	6.67	6.67	67%	75%	
	Charlwood	20	3.00	1.00	2.00	2.00	2.00	3.00	1.00	2.00	3.00	1.00	-	-	-	1.00	-	6.67	6.67	67%	75%	
													-	0.70	-	4.90	-	2.00				
Converted to WTE													2.53	2.53	2.53	2.53	2.53					
22% uplift													0.56	0.56	0.56	0.56	0.56					
													3.09	3.09	3.09	3.09	3.09					
Increase WTE													-	2.16	-	15.12	-	6.17	11.11			

%