University Hospital Southampton NHS Foundation Trust

[5.13]	Report to the Trust Board of Directors, 13th January 2026
Title:	***Ward Staffing Nursing Establishment Review July 2025 – October 2025***
Sponsor:	***Natasha Watts – Acting Chief Nursing Officer***
Author:	***Rosemary Chable, Head of Nursing for Education, Practice and Staffing***

Purpose *(type an 'x' in the appropriate box(es))*

(Re)Assurance	Approval	Ratification	Information
X			

Strategic Theme *(type an 'x' in the appropriate box(es))*

Outstanding patient outcomes, safety and experience	Pioneering research and innovation	World class people	Integrated networks and collaboration	Foundations for the future
X		X		

Executive Summary:

a) The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from July 2025 – October 2025.

Recommendations in this report link to the statutory responsibilities arising from the National Quality Board (2016) expectations on ensuring safe, sustainable, and productive staffing, the NHS Improvement Developing Workforce Safeguards guidance (2018) and the Nursing Workforce Standards (RCN May 2021 refreshed 2025) assessed as part of CQC 'safe' and 'well-led' domain.

The report outlines UHS progress in meeting the 38 recommendations included in the NICE guideline (2014) on safe staffing for in-patient wards and provides an update on the action – plan to achieve the recommendations in the national staffing levels guidance published by the National Quality Board in July 2016 (a key requirement of the NHSI 'Developing workforce safeguards' guidance October 2018).

b) To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:

- Overall, the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and growing demand continue to outstrip the nursing ratios, coupled with the impact of ward reconfigurations or service model changes – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

- UHS nursing establishments for the 55 areas reviewed are set to achieve a range of 1:1 to 1:9 registered nurse to patient ratio in most areas during the day with the majority (40) set between 1:4 to 1:8. Differences relate to specialty and overall staffing model.
- The majority of wards (31) are staffed at between 50:50 and 80:20 registered/unregistered ratio or above. Those wards with lower ratios (22 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (2) are both higher intensity cancer care areas requiring a higher registered skill. 31 wards (down from 33 last year but remaining up significantly from 25 in 2019) are below the 60:40 ratio.
- Total (RN and unregistered) Planned Care Hours Per Patient Day (CHPPD) range from 4.4 – 19.2 and average at 7.8
- Continued high levels of enhanced care demand, a significantly more junior workforce,

managing additional surge areas and impact of financial controls have been highlighted as ongoing challenges for mitigation to ensure safe staffing.

The paper is presented for DISCUSSION.

a) ***The report is presented in full to Trust Board as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board on all aspects of the staffing reviews.***

Contents:

Paper; Appendix 1: National Quality Board (NQB Expectations for safe staffing Safe, Sustainable, and productive staffing; Appendix 2: NQB Safe Staffing Recommendations – UHS action plan; Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospital - UHS action plan; Appendix 4: Ward by Ward staffing review metrics spreadsheet; Appendix 5: Specific Divisional issues emerging; Appendix 6: RCN Workforce Standards; Appendix 7: RCN Revised Nursing Workforce Standards – May 2025 - UHS summary and assessment

Risk(s):

1b – Due to the current challenges we fail to provide patients and families/carers with a high-quality experience of care and positive patient outcomes.
3a – We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.

Equality Impact Consideration:	**NO**

1.0 Introduction or Background

1.1 The purpose of this paper is to report on the outcomes of the review of ward staffing nursing establishments undertaken from July 2025 – October 2025. This 6-monthly review forms part of the Trust approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs.

1.2 This paper focuses specifically on a review of nursing levels for in-patient ward areas. Areas such as maternity, critical care, theatres and the emergency department are reviewed separately.

1.3 Divisional 'light touch' 6 monthly staffing reviews took place in March/April 2025 for 3 of the clinical divisions (at the time) and were reported to their relevant divisional boards and Nursing and Midwifery Staffing Review Group. Emergent themes have been incorporated into this review. Division A did not complete a light touch review for their inpatient areas and a full annual review has been completed as part of this cycle.

1.4 Following a recent national review of the workforce safeguard standards (paper received at trust board in November 2025), as a key action, these light touch reviews will now be reported directly to trust board to ensure the board receives a 6 monthly update on nurse staffing establishments.

1.5 The ward staffing review this year has again taken place against the backdrop of financial recovery measures, some of which came into effect in Q4 of 2024/25 after the last annual staffing review with increasing measures being introduced in 2025/26. Discussions at the staffing review meetings focussed on impacts arising from the close monitoring and management of establishment levels (including temporary resourcing) and identification of any mitigations/adjustments needed to continue to assure the delivery of safe care in each area.

1.6 It should also be noted that there were some key ward reconfigurations, some ward moves and ward/bed closures since the last annual review and these changes have now been fully included in the annual cycle.

1.7 The report also includes an update on the NICE clinical guideline 1 – Safe Staffing for nursing in adult inpatient wards in acute hospitals, issued in July 2014 and details progress with the action plan for adopting this guideline within UHS.

1.8 This report fulfils expectation 1 and 2 of the National Quality Board requirements for Trusts in relation to safe nurse staffing and fulfils a number of the requirements outlined in the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) which sets out to support providers to deliver high quality care through safe and effective staffing. This review also meets recommendations outlined in the RCN Nursing Workforce Standards (May 2021 refreshed in 2025). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both the 'safe' and 'well led' domains.

2.0 Analysis and Discussion

2.1 Ward staffing review methodology

2.1.1 In 2006 UHS established a systematic, evidence based and triangulated methodological approach to reviewing ward staffing levels on an annual basis linked to budget setting and to staffing requirements arising from any developments planned in-year. This was aimed to provide safe, competent and fit for purpose staffing to deliver efficient, effective and high-quality care and has resulted in consistent year-on-

year review of the nursing workforce matched by investment/disinvestment where required.

2.1.2 Following the National Quality Board expectations in 2014 and the refresh in 2016, a full review of ward establishments is now undertaken annually (with a light touch review at 6 months reporting to Divisional boards to ensure ongoing quality). As outlined previously, these light touch reviews will now be reported directly to Trust Board, in addition to the annual reporting to Trust Board in October/November. This is in response to the Developing Workforce Safeguards Standards.

2.1.3 The approach utilises the following methodologies:

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 - previously AUKUH acuity tool). Now incorporated into the Healthroster Safecare system
- Care Hours Per Patient Day (CHPPD)
- Professional Judgement
- Peer group validation
- Benchmarking and review of national guidance including Model Health System data
- Review of eRostering data
- Review of ward quality metrics

2.2 National guidance

2.2.1 In 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) *'How to ensure the right people, with the right skills, are in the right place at the right time.'* This guidance was refreshed, broadened to all staff, and re-issued in July 2016 to include the need to focus on safe, *sustainable and productive* staffing. The NQB further reviewed this document and issued an updated recommendations brief in July 2017. The expectations outlined in this guide are presented in Appendix 1.

These expectations are fulfilled in part by this review and the detailed action plan (Appendix 2) has been updated with progress towards achieving compliance with the 37 recommendations that make up the 3 over-arching expectations.

2.2.2 The latest 4 monthly review of the action plan (November 2025) shows maintenance of compliance levels despite the ongoing activity and financial challenges. UHS remains compliant with 35 of the 37 recommendations. The following 2 outstanding areas require further action before being signed off:

Allocated time for the supervision of students and learners: *Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.* Whilst there is some allowance within the 23% headroom, requirements for supervision are growing with revised initiatives around preceptorship, staff wellbeing and student supervision. Learner numbers (including undergraduate students, apprentices and preceptees) are increasing with limited additional supervisory support available. It is also important to note that the Ward Leader Supervisory allowance is used flexibly and has at times

been put on hold to support the staffing position with ward leaders being included regularly in the safe staffing numbers.

Equality and diversity: *The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.* Ongoing action through Equality & Diversity Group which is reported to Board separately.

2.2.3 In July 2014 NICE published *Clinical Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals.* This guideline is made up of 38 recommendations. A detailed action plan was developed within UHS and is reviewed 4 monthly by the Nursing and Midwifery Staffing review group. The current assessment (November 2025) shows UHS has maintained compliance in 37 of the 38 recommendations.

The 1 remaining recommendation is:

Escalation actions taken to address deficits on one ward should not compromise another. Management of trustwide staffing deficits and thrice daily reviews of staffing via the staffing hub, as well as an improved recruitment situation, have reduced the incidents of this however these have climbed again recently as we manage the ongoing capacity and management of surge areas specifically. The close management and maintenance of minimal staffing levels and regular redeployment of staff, does not enable assurance that wards are not compromised by staff movements in extremis.

The ongoing action plan is included at Appendix 3 detailing the recommendations and the UHS compliance position and actions in progress.

2.2.4 In October 2018 NHS Improvement published 'Developing Workforce Safeguards' guidance which sets out to support providers to deliver high quality care through safe and effective staffing. It includes many of the actions identified in both the NICE guidance and the National Quality Board recommendations broadened to all staff groups.

2.2.5 In July 2025 a national audit and self-assessment process was launched by NHSE to review trust compliance with the recommendations included in the Developing Workforce Safeguards guide. A separate paper was presented to board in November 2025 outlining the self-assessment for UHS and the actions required to assure compliance, including the development of a comprehensive safe ward staffing policy.

2.2.6 In May 2021 the Royal College of Nursing published their Nursing Workforce Standards (Appendix 6), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterates the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trustboard. Self-assessment undertaken by the Nursing and Midwifery Staffing Review Group (NMSRG) showed UHS was compliant with these standards.

2.2.7 During 2024 these standards were refreshed and a revised set of standards was published in May 2025. NMSRG completed a self-assessment (Appendix 7) which confirmed that UHS remain compliant with the majority of standards. One key standard that has changed is the recommendation that headroom should be set at a minimum of 27% as a realistic assessment of the requirement. UHS level is currently set at 23% and is consistently exceeded in most areas, particularly in specialty areas such as ED and Critical Care.

2.2.8 In September 2022 a key research study was published (Zaranko B, Sanford NJ, Kelly E et al. BMJ Quality and Safety Epub) which highlights the link between higher registered nurse numbers and seniority and improved patient outcomes. Additionally in August 2024 an additional follow-up article (Griffiths, P; Saville C; Ball, J JAMA Network open) identified that substitution of registered gaps with temporary staff does not necessarily significantly lower the risks for patients.

2.2.9 In late 2023 NIHR published an evidence based Professional Judgement Framework to support the application of professional judgement in nurse staffing reviews. Rosemary Chable and Natasha Watts from UHSFT were contributors to this guidance and are acknowledged in the authorship. This framework has been used as the basis for professional judgement throughout the staffing reviews and is being used as part of the NHSE refreshed drive on safe staffing.

2.3 6 monthly Ward Staffing review July 2025 – October 2025 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2025 – October 2025 with initial review meetings taking place with each Division (attended by DDN, Matrons, Ward Leaders, Finance representatives, workforce representatives and facilitated by the Head of Nursing for Education, Practice and Staffing). The same triangulated methodology was used as in previous reviews. An update on the latest guidance and reporting requirements in relation to staffing were also included in the divisional review meetings.

2.3.2 The detailed spreadsheet with ward-by-ward findings is included at Appendix 4. This provides information on the current establishment data broken down by shift and assessing against registered/unregistered ratios; CHPPD; nurse to patient ratios by registered and total nurse staffing and acuity information from Safecare where appropriate. Following key changes within the data team in workforce systems, the processes for capturing and reporting this information, and linking it accurately to finance data, are being reviewed with the Head of Nursing to ensure it remains fit for purpose.

2.3.3 It should be noted that a number of wards continue to be regularly reconfigured in response to the changing capacity and service pressures or increase footprint to respond to surges in activity. Several rostering template reviews were therefore instigated as a result of the discussions, so some figures may have changed for individual wards since the review.

2.3.4 Other staff groups (e.g Housekeepers, administrative staff, Allied Health Professionals (AHP's), Enhanced and Advanced Practitioners) also provide vital support to the ward areas, and these are taken into consideration in setting the establishment levels.

2.3.5 The ***staffing hub*** which was established in April 2020 to co-ordinate and oversee the real-time nurse staffing levels across the hospital in support of the clinical site function has continued to operate and adapt. It now maintains a strong role in the daily deployment of staff and the ongoing management of additional temporary resourcing bookings, whilst maintaining the strong clinical focus on safe and effective care and appropriate escalation. This is particularly evident in the review and deployment of staff to support enhanced care needs.

The hub activity is led by a daily designated staffing matron who takes responsibility for leading the continuous review and reassignment of the nurse staffing resource throughout the day.

2.3.6 ***Nurse to patient ratios by registered and total nursing***

2.3.6.1 The ward establishments across UHS allow for registered nurse to patient ratios **during the day** to range from 1:1 (Piam Brown – Children) to 1:9 (Bassett, D6, D7

G6, G8, E7 and E12) depending on specialty and overall staffing model. This is a slight decrease in the number of wards with lower RN: patient ratios (down from 8 to 7 with all areas in medicine). It should be noted that medicine has this lower base than other areas.

2.3.6.2 The average level is set to achieve 1:4 to 1:8 registered nurse to patient ratio in most areas during the day (40 wards, previously 43) with 36 wards set between 1:4 to 1:7 (down from 42). 16 wards are set to achieve 1:1 to 1:3 ratios, these are all speciality areas such as cancer, and children or direct admission areas, that require a higher level of registered nurse intervention.

2.3.6.3 The areas on or above 1:7 (20 previously 22 wards) include the medicine wards, Medicine for Older People wards, some Trauma and Orthopaedic wards, including Brooke and the Acute Stroke Unit. These areas include a higher ratio of band 2 to 4 staff creating a total nurse to patient ratio of 1:3 – 1:4. It should be noted that the ratio of patients to registered nurse can regularly increase when wards are not fully established and these wards with lower RN to patient ratios are working on their minimum safe levels.

2.3.6.4 Planned staffing ratios at **night** require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours.

- In areas that are working on lower staffing ratios, managing the workload at night has again emerged as an area that still requires action in a number of ward areas.
- Wards are piloting different twilight shift patterns (within existing budget) to continue to support the demands at night.
- Rising acuity of patients, more therapeutic activity taking place overnight and the impact of more geographically spread clinical areas has increased the pressure on the staffing resource at night.
- This also highlights the importance of supernumerary bleep-holders in supporting the ward areas. During 2025/26 to support measures to reduce temporary staffing demand and also to support the new 'Release to Respond' initiative or surge activity, supernumerary bleep-holders have been increasingly removed on a shift basis. Staff reported the impacts of this on support to the wards particularly at night as well as on maintaining patient flow.
- There is now 1 remaining in-patient ward area (F7) with ratios of 1:11 (RN to patient) at night. This is offset by a total nurse to patient ratio of 1:6 with the utilisation of support staff.

2.3.7 ***Registered to unregistered ratios***

2.3.7.1 UHS ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should ideally not fall below unless planned as the model of care.

2.3.7.2 15 wards are now rostered at between 60:40 and 70:30.

2.3.7.3 31 wards are below the 60:40 ratio. An improvement on the 32 in the previous year but still remaining up significantly from 25 in 2019. These wards are utilising band 4 staff as a key contribution to the model of care and are areas where there is a wider multidisciplinary team contributing to care (e.g., MOP, T & O, Medicine, Acute Stroke). It should be noted however that with changing acuity and dependency of patients, these areas need to be kept under close review against other metrics to ensure safe,

quality care can be provided within the establishments. As mentioned previously, recent research highlights the impact on patient outcomes in areas with reduced registered nurse cover.

2.3.7.4 9 wards (1 more than 2024) are above the 70:30 ratio reflecting the increased specialism of our regional specialties where the intensity of the patient needs requires a higher ratio of registered staff (Child Health, CV&T, Neurosciences, and Cancer Care areas).

2.3.7.5 The support of band 4 roles continues to be supported as part of a model of care in a number of areas linked to the further development of apprenticeship opportunities. This has also provided a role in which to appoint the emerging cohorts of nursing associates who have qualified and registered with the NMC from January 2019 onwards.

2.3.7.6 During 2025 a re-banding exercise was also completed moving our ward-based band 2 support staff to band 3 in the majority of cases and creating the progressive band 2/3 role for new starters. This has provided more robust support to clinical care, backed up by clear competencies.

2.3.7.7 In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision.

2.3.7.8 Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes and are accompanied by appropriate quality impact assessment and evaluation.

2.3.8 ***Assessment against the Safer Nursing Care Tool (acuity/dependency model***

2.3.8.1 The Safer Nursing Care Tool (SNCT - acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all the areas. Within UHS this is integrated into the health roster system as part of the safe-care tool and provides information on acuity/dependency levels and corresponding staffing levels on a real-time basis converted into recommended care hours per patient day.

2.3.8.2 Where the predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the speciality and number of beds.

2.3.8.3 The recent review and self-assessment of the Workforce Safeguards has highlighted the need to review the use of the SNCT within the trust and to undertake a separate focussed review in clinical areas to support establishment setting. A programme of work to support this is planned for 2026/27 to support next year's staffing reviews.

2.3.8.4 There is also ongoing education and support work taking place to ensure all areas are using the tool in line with the recommendations to ensure consistency.

2.3.9 ***Care Hours Per Patient Day***

2.3.9.1 Planned total Care Hours Per Patient Day (CHPPD) range from 4.4 (E7) rising to 19.2 (Piam Brown) and average at 7.8. The average is the same level as the previous year

2.3.9.2 Planned Registered care hours per patient day range from 1.9 (G5) rising to 14.5 (Piam Brown) and average at 4.5. This average is slightly lower this year.

2.3.9.3 Planned Unregistered care hours per patient day range from 1.3 (C6 TYA) – 8.7 (G2 Neuro) and average at 3.2. This average is slightly lower than last year.

2.3.9.4 Actual CHPPD fluctuate significantly across the year and are strongly linked to patient numbers and changes in patient acuity. For example, additional staffing for patients requiring enhanced care will increase the overall CHPPD numbers attributed to a ward

whilst not really increasing the hours assigned for each patient, giving a false confidence around overall levels. For these reasons, an aggregated Trust-wide average, whilst useful to review month by month and annually for a trend, are less meaningful than the granular review of each ward CHPPD.

2.3.10 ***Allowance for additional headroom requirements and supervisory ward leader model***

2.3.10.1 All areas have 23% funding allocated to allow for additional headroom requirements arising from non-direct care time. It is recognised that in a number of areas this percentage is too low to cover all of the indirect requirements in an area, particularly related to speciality and supervisory and training needs. There remains significant pressure on maintaining staffing within the allowed headroom. This is due to high training levels (resulting from the more junior workforce) and maternity/paternity levels that consistently exceed the allowance. As highlighted previously the RCN now recommend an uplift of 27% as a minimum to cover all requirements as one of their safe staffing recommendations.

2.3.10.2 New national initiatives and requirements of the NHS contract such as the implementation of Professional Nurse Advocacy for all staff and Preceptorship support for all new registrants has further increased the pressure on this set level of headroom.

2.3.10.3 A discussion around management of headroom was included in each of the ward staffing reviews which took place with clear actions for the ward leaders to implement.

2.3.10.4 UHS has an established Ward Leader Supervisory model which means the Ward Leader is not included in the established numbers required to deliver safe care per shift. This enables them to focus more time on supervising and leading the ward team whilst supporting clinical care. This proved particularly important during recent years with developing the junior workforce.

2.3.10.5 This model has been paused intermittently in areas as part of the financial recovery plan and Ward Leaders were rostered directly to support shifts. This impacted a range of indicators including appraisal completion, sickness reviews, roster management and learner development. The model is used flexibly whilst the priority is always to ensure safe staffing levels on the wards. Ward Leaders clearly articulated the personal and professional impact of losing this protected time to undertake the wider aspects of their role.

2.3.11 ***Specific Divisional issues emerging***

Specific Divisional issues highlighted in the review are contained in Appendix 5.

2.4 <u>Trust wide risks and issues considered in the review</u>

2.4.1 ***Establishment monitoring and controls in line with financial recovery***

2.4.1.1 The staffing reviews took place against the backdrop of ongoing financial recovery. During the review period inpatient areas have been working to 97% of establishments (with identified exceptions) as a control measure and this is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards. Issues arising from these measures were openly discussed at the staffing reviews.

2.4.2 ***Increasing patient acuity/dependency***

2.4.2.1 The ongoing development of our defining services continues to result in an evidenced increase in the complexity, acuity and dependency of the patients cared for in our general ward beds, also linked to reducing length of stay.

2.4.2.2 Since Covid-19 it is clear that our patients are definitely presenting with a higher level of both acuity and dependency, and this has been highlighted by ward leaders across a number of specialties including cancer care and neurosciences.

2.4.2.3 Information on the acuity and dependency of our patients is available via the 'Safe Care' functionality in health roster and is used in real time as part of our daily staffing meetings. The information is also used at the 6 monthly reviews as part of the professional judgment assessment.

2.4.3 ***Increasing enhanced care needs***

2.4.3.1 Trust wide we have continued to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements.

2.4.3.2 We have also seen a significant rise in the episodes of violence and aggression experienced in our clinical areas which creates additional needs for staffing support.

2.4.3.3 This continues to have an impact on the ability to support the additional enhanced care needs that arise for these groups of patients particularly across key specialties (MOP, Medicine, Child Health, Neurosciences, T & O and Surgery).

2.4.3.4 Division B retain the Trustwide overview for enhanced care, specifically mental health support, and provide an advice service, supporting clinical areas in their decision making around the need for additional support.

2.4.3.5 Divisions have then developed enhanced care bays on wards and/or a local pool of staff to deploy to support enhanced care needs. Ward leaders report that this has made a major difference to the management of patients with these enhanced needs and has reduced the reliance on last minute agency to support.

2.4.3.6 The numbers however remain unpredictable and are therefore managed in real-time as part of overall considerations around safe staffing.

2.4.3.7 The management of additional enhanced care needs extends beyond the definition of patients requiring formal mental health support. Increased numbers of patients with challenging behaviour or needing 1:1 presence brings additional pressures to ward establishments but are necessary to keep the environment safe for all patients.

2.4.3.8 During 25/26 the staffing hub has increased its role in co-ordinating and deploying the requests for additional staff with additional mental health needs specifically linked to the mental health support team. Whilst this has shown key improvements in the management of staffing resource, the demand and increase in patients presenting has continued.

2.4.3.9 In October 2025 UHS joined a cohort of the NHSE ETOC (Enhanced Therapeutic Observations and Care) programme. This programme will support the ongoing improvements around the provision of enhanced care.

2.4.4 ***Supervising and supporting the junior workforce***

2.4.4.1 The professional judgement discussions with all the Ward Leaders again highlighted the additional challenges posed to the staffing models, of appropriately supervising and supporting the increasing range of learners with placements on the ward areas.

This includes the ability to meet the supervisory standards with an increasingly junior workforce.

2.4.4.2 National standards and a quality mark for preceptorship was established in October 2022 and implemented within UHS during 2023 with additional requirements in relation to the provision for all staff new to registration. Protected time for both preceptors and preceptees is now an expectation for organisations. In 2025 UHS was awarded the quality mark for preceptorship – one of the first trusts in the Southeast region to attain this.

2.4.4.3 The robust retention and recruitment strategies across the Trust and the strong vision to 'grow our own' nurses for the future have been sustained this year. This means that wards continue to support a range of learners including undergraduate students, trainee nursing associates, nurse degree apprentices and newly registered staff undergoing preceptorship.

2.4.4.4 Education teams across the trust have proved key to supporting the development and learning into the wards and particularly in continuing to train and support learners to full registration and into preceptorship.

2.4.4.5 The capacity and capability within the education and support teams is being further reviewed for 25/26 and beyond to ensure they can continue to support the further increase in numbers which will be required for UHS to meet the challenging workforce targets likely to emerge from the revised 10 year workforce plan.

2.4.5 *Benchmarking using the Model Health System*

2.4.5.1 UHSFT provides data monthly to the national Model Hospital System (MHS) detailing the actual CHPPD provided (based on patient numbers) for all clinical areas including critical care.

2.4.5.2 An overall average of total CHPPD is available to review via peer group and this is used as part of the staffing review. (Table 1)

2.4.5.3 Hospitals with a high volume of critical care beds (providing 1:1 care) will have a higher CHPPD.

2.4.5.4 Information from MHS of some general specialties is also included for information, however it is noted that category descriptions and case mix on wards can vary across organisations and therefore caution should be shown when making any direct comparison. (Table 2)

Table 1

Organisation/Group	Total CHPPD	Registered CHPPD	Unregistered CHPPD
UHS excl. Critical Care	8.7	4.8	3.9
UHS with Critical Care	10.5	6.7	3.8
Shelford Group	9.8	6.7	3.2
MHS Peer Group	9.56	5.7	3.4
Region	8.9	5.6	3.3
National	8.7	5.1	3.5

All data submissions (registered and unregistered) are averaged so will not necessarily equal the total CHPPD)

Data is from the MHS July 2025 (latest figure) and includes nursing and midwifery and ward AHP staffing. The UHS excluding critical care is UHS reporting July 2025 figure from People Report just for nursing.

Table 2

Speciality grouping	Total CHPPD - UHS	Total CHPPD – MHS Peer group
General Surgery	7.16	8.27
Trauma and Orthopaedics	9.21	8.96 (not trauma centres)
Cardiovascular	10.74	13.28
Neurosciences (specialty)	8.54	8.47
Medicine for Older People	6.05	8.49
General Medicine	7.04	8.13
Child Health	10.73	8.01

2.4.6 ***Review of quality metrics and staffing incidents***

2.4.6.1 The NICE guidance outlines some key quality metrics that should be considered as part of the staffing reviews. The safety metrics defined are patient falls, pressure ulcers and medicine administration errors. These metrics, along with a range of other UHS defined quality indicators are already monitored through our internal clinical quality dashboard and are discussed ward by ward as part of the professional judgement methodology in the reviews.

2.4.6.2 In addition, there is ongoing review of red flags raised as part of the adverse event reporting system and on 'safecare'. These elements are now also all brought together in the new quality report that is presented to trust board quarterly.

3.0 Conclusion

3.1 A robust ward staffing establishment review was undertaken using a mixed methodology of approaches and in line with recommendations from the National Quality Board, NICE guidance, Developing Workforce Safeguards and the RCN Nursing Workforce Standards.

3.2 Overall the staffing establishments remain appropriate and within recommended guidelines. These levels are however severely stretched when there is a requirement to support additional needs arising from enhanced care, opening of surge areas and Release to Respond.

3.3 There are some key exceptions where acuity and dependency levels and growing demand continue to outstrip the nursing ratios, coupled with the impact of ward reconfigurations – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

4.0 Recommendations

4.1 To discuss the report at Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance.

4.2 To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.

4.3 To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable, and productive staffing.

4.4 To note the ongoing progress in UHS compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards.

4.5 To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels and to agree the continuous monitoring of this with the introduction of any additional financial recovery measures.

4.6 To support the continued Trust wide commitment and momentum on actions to fill clinical nursing vacancies and further reduce the reliance on temporary resourcing agency against the backdrop of rising acuity and emergency and elective recovery.

4.7 Systematic ward staffing reviews now to be reported to trust board 6 monthly. The Spring, 6-monthly light touch review reported through Divisional Boards and the next full staffing review to be presented to Trust Board in December 2026.

5.0 Appendices

Appendix 1: National Quality Board (NQB Expectations for safe staffing Safe, Sustainable, and productive staffing

Appendix 2: NQB Safe Staffing Recommendations – UHS action plan

Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospital - UHS action plan

Appendix 4: Ward by Ward staffing review metrics spreadsheet

Appendix 5: Specific Divisional issues emerging

Appendix 6: RCN Workforce Standards

Appendix 7: RCN Revised Nursing Workforce Standards – May 2025 – UHS summary and assessment

Appendix 1

National Quality Board Expectations for safe staffing - Safe, Sustainable, and productive staffing (July 2016)

Expectation 1: Right staff	• Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. • Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e., the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. • This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. • There should also be a review following any service change or where quality or workforce concerns are identified. • Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. • Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.
Expectation 2: Right skills	• Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi professional team approach. • Decisions about staffing should be based on delivering safe, sustainable, and productive services. • Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.
Expectation 3: Right place and time	• Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. • Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

NATIONAL QUALITY BOARD - JULY 2016

Appendix 2

Supporting NHS Providers to deliver the right staff with the right skills, in the right place at the right time - safe sustainable and productive staffing - NURSING & MIDWIFERY

	Descriptor	No.	Recommendation	Current measures in place	Assessed UHS rating (Nov 2025) C = compliant A = Actions required	Identified actions required and notes on compliance	Timescale	Lead
Expectation 1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	**1.1 Evidence-based workforce planning**						
		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).	Triangulated approach to staffing establishments well embedded. Shelford SNCT used and embedded in 'safecare' as part of eRostering. NICE guidance systematically reviewed 3 x per year.	C	Continue with current approach and strengthen with the use of CHPPD and safecare. Nov. 2025 refreshing use of SNCT as a result of the Workforce Safeguards review. To introduce more formal programme in Q1/Q2 2026/27	complete	Head of Nursing - staffing/DMT
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	C	Need to ensure there is corporate rigour on adapting SNCT while rolling out 'safecare'. Monitor the impact on the inclusion of 'enhanced care' scoring. Participate in the national NIHR research. Nov. 2025 refreshing use of SNCT as a result of the Workforce Safeguards review. To introduce more formal programme in Q1/Q2 2026/27	complete	Head of Nursing - staffing/DMT
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training and supervision requirements.	23% included in all direct care in-patient areas. Compliance monitored as part of healthroster reporting suite	C	Ongoing compliance monitored as part of healthroster reporting suite. Increased headroom requirement due to COVID-19. Acknowledgement that 23% headroom is not adequate in many settings. Discussed as part of staffing reviews.	complete	DoF/Chief Nurse
		1.2 Professional judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/DDN/Matron/ward leaders as well as workforce systems and finance. Professional judgement key part of the reviews.	C	Continue with current approach and strengthen with the use of CHPPD and safecare. Senior UHS team invovled in the authorship of the national professional judgement guide	complete	Head of Nursing - staffing/DMT
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.	As above. Professional judgement also used as part of the daily staffing review meetings through site control.	C	Continue with current approach. Professional judgement remains the ultimate measure of safe staffing. Key part of the staffing hub discussions.	complete	Head of Nursing - staffing/DMT/site team
		1.3 Compare staffing with peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous ad hoc benchmarking included through AUKUH network and targeted at specific services under development. Need to strengthen and formalise	C	Build on the current benchmarking capabilities included in the Model Hospital and N&M Dashboard. Work with eRoster provider to introduce reporting that includes benchmarking data	complete	Head of Nursing - staffing/workforce systems team
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.	All considered as part of the systematic staffing reviews	C	Model hospital benchmarking now being used routinely. All services benchmark with other areas where appropriate	complete	Head of Nursing - staffing/DMT
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Clinical Quality Dashboard (CQD) includes all staffing and quality metrics. Used as part of the systematic clinical accreditation scheme reviews	C	Build the model hospital work into the CQD	complete	Head of Quality and Clinical Assurance

Expectation 2: Right skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.	**2.1 Mandatory training, development and education**						
		2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	All frontline leaders skilled to manage staffing agenda. Included in competencies for ward leaders	C	Continue to maintain competence, skills and knowledge through master classes and staffing review meetings	complete	Head of Nursing - staffing/DMT
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.	23% headroom allowance and provision of supervisory ward leader role covers most aspects of time identified but not fully assured around adequate time for supervision of all learners. Backfill provided for some roles in development - degree apprenticeships but does not cover release for all staff	A	23% headroom is included in all nursing establishments as well as an allowance in all areas for the Ward Leader to be supervisory. A number of additional requirements e.g. increased student numbers and supervision, increased numbers of junior staff needing more supernumerary training time, preceptorship support and professional nurse advocacy have led to the 23% allocation falling short of the needs in a number of areas. This is particarly notable in critical care and ED where the training needs outstrip the provision in the 23% headroom. Important to note that the Ward Leader Supervisory allowance was put on hold in Q4 2023/24 and reinstated slowly from Q1 2024/25 as part of the trust recovery plan. This impacted short term on some of the non-direct activities and KPI's eg appraisal. rates/progression/HR actions. Reviewed against the revised RCN workforce standards which recommend 27% headroom. Critical Care staffing review also highlighted a shortfall in allowances to account for ensuring staff are qualified in specialty (QuIS). Paper being developed to outline the need.	Unable to identify an expected date for compliance. Mitigations in place	Head of Nursing - staffing/DDN's/Divisional Education Leads/Education Quality Lead
		2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	C	Monitored as part of ongoing HR key performance metrics	complete	Associate Director of People/DMT
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Annual training needs analysis process well embedded within the annual cycle for the trust	C	Continue with current approach with review in 2026 to further streamline priorities to staffing needs and match to changed CPD arrangements .	complete	Divisional Education Leads/Education Quality Lead/DMT
		2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads//DMT
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads//DMT
		2.1.7	The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time provided in all inpatient direct care areas.	C	Continue to review % of time achieved as supervisory linked to ongoing vacancy position	complete	Head of Nursing - staffing/DMT/workforce systems
		2.2 Working as a multiprofessional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed and evaluated within the organisation.	C	Further strengthen the trustwide approach to service by service workforce development	complete	Director of TD&W/Divisional Education Leads//DMT
		2.2.2	The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department	C	Continue with current approach and strengthen integration	complete	Director of TD&W/Divisional Education Leads//DMT
		2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HEI/FE sector.	C	Continue with current approach and strengthen partnership working through STP projects	complete	Director of TD&W/Divisional Education Leads//DMT

		2.3 Recruitment and retention						
		2.3.1	The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	Full action plan in place to address equality and diversity within trust linked to WRES data	A	Detailed in separate ED&I action plan. Ensuring any N&M specific actions are also incorporated into the retention toolkit and action plan	ongoing through E & D	Chief Nurse/People Director
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Full retention and recruitment programme of work ongoing and a workforce project management office established to maintain the focus	C	Confident that there are effective strategies in place and remains an area for ongoing action. Continued focus and evaluation of the wide ranging streams of work in place to support retention and recruitment	ongoing through R & R steering group	People Director /DMT
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically around preceptorship.	C	Research partnership with Burdett and Birmingham to review self rostering. Flexibility sub group established as part of R & R actions to review different approaches to flexibility for generational needs. Joined RePAIR work on flexibility and NHSI retention collaborative	ongoing through R & R steering group	Associate Director of People/Director of TD&W/DMT
	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	**3.1 Productive working and eliminating waste**						
		3.1.1	The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.	Transformation work incorporates lean techniques and productive ward techniques applied as appropriate including reviews of care hours, safety crosses, knowing how we're doing boards and patient status at a glance	C	Lean techniques used systematically as part of transformation	complete	Head of transformation/DMT
		3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated into all service redesign	C	Clear focus on flow and avoiding bottle-necks in service design.	complete	Head of transformation/DMT
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct care	C	Continue with current approach	complete	Chief Nurse/DMT
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register and AER system used to record, review and learn from any staffing issues	C	Continue with current approach and monitor ongoing trends with staffing risks	complete	Chief Nurse/DMT

Expectation 3: Right place and time		**3.2 Efficient deployment and flexibility**					
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systemetically reviewed through 6 monthly staffing reviews reported to board	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways inlcuded as part of the systematic review of staffing levels	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Regular reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily stafifng meetings linked to site	C	Continue to strenghten the daily staffing meetings and utilise safecare information	complete	Head of Nursing - staffing/DDN/Matrons/Site
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared trustwide when required	C	Continue ot strengthen the information into site around staffing resource	complete	Head of Nursing - staffing/DDN/Matrons/workforce systems team
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Best practice guidance included in UHS poilicies around application of eRostering. Use of eRoster systematically reviewed and managed through the management team structure	C	Continue to strenthen the use of eRoster by utilising report function and reviewing compliance levels - specifically for: Approvals, unused hours, safecare	complete	Head of Nursing - staffing/DDN/Matrons
		3.3 Efficient employment, minimising agency use					
		3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	Currently undertake 6 monthly staffing reviews that take account of all of the recommendations. Staffing reviews closely aligned to the Retention & Recruitment and temporary staffing strategies and clear actions in place to maximise bank use (NHSP) and reduce agency	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	Chief Nurse/Associate Director of People/DMT
		3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Plan in place to reduce agency usage in line with NHSI guidance	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	Chief Nurse/Associate Director of People/DMT
		3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	UHS fully engaged in development of STP workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/DoE
		3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.	UHS fully engaged in development of STP workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/DoE
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.	Strong systems in place to idetnfiying palcement capacity and monitor student allocation and quality across all staff groups	C	Continue with current model. Work with universities to constantly review the placement models for students in line of developing undergraduate programmes and apprenticeships	complete	DoE/Education leads

37 recommendations: 35 compliant 2 require further action

Appendix 3

Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals : 38 recommendations

UHS FT self-assessment and action plan

	No.	Recommendation	NICE category Must (M) Should (S) Consider (C)	Current measures in place	Initial Assessed UHS rating (July 2014) C = compliant A = Actions required	Identified actions required (24 compliant, 14 action)	Timescale	Lead	November 2025 compliance	November 2025 (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations	1.1.1	Ensure patients receive nursing care they need regardless of ward, time, day.	M	Specialty and sub-specialty ward system in place Outlying/inlying patients monitored through site	C	Continued monitoring of compliance	Maintain	Clinical teams/DMT	C	Continued monitoring of compliance.
	1.1.2	Develop procedures to ensure ward staff establishments are sufficient to provide safe nursing care for each patient	M	6 monthly establishments reviews in place led by DoN team with DDN/Matron/ward leaders as appropriate.	C	Continued development of staffing review methodology linked to NICE guidance	Maintain	Chief Nurse/Head of Nursing - staffing/ DDN	C	6 monthly light touch review not completed in all divisions in March due to COVID-19 but all establishments reviewed regularly during crisis and as part of restart. Full reviews scheduled for July/Aug 2020
	1.1.3	Ensure final ward establishments developed with registered nurses responsible and approved through chief nurse and trust board	M	6 monthly establishments reviews in place led by DoN team with DDN/Matron/ward leaders as appropriate. Reported and discussed through board	C	Strengthen involvement of ward sisters through supervisory competencies	Maintain	Chief Nurse/Head of Nursing - staffing/ DDN	C	6 monthly reviews involve ward leaders
	1.1.4	Ensure senior nursing managers are accountable for nursing rosters produced	M	Reflected in job descriptions for DDN/Matrons/Ward Leader and included in ward leader competencies Hierarchy in eRoster reinforces requirements	C	Strengthen the monitoring and follow up of roster KPI's	Maintain	Chief Nurse/Head of Nursing - staffing/DDN/ HR	C	Roster audits now reinstated and accountability for rosters clearly within ward leader and matron job roles.
	1.1.5	Ensure inclusion of adequate 'uplift' to support staffing establishment	M	23% uplift included in all inpatient nursing establishments	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's	Maintain	DDN/Matron/Ward Leaders	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's.
	1.1.6	Include seasonal variation/fluctuating patient need when setting establishments	M	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews		Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.1.7	Establishments should be set appropriate to patient need taking account of registered/unregistered mix and knowledge and skills required	S	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.1.8	Ensure procedures in place to identify differences between on the day requirements and staff available	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily	C	Further strengthen the daily review processes through site. Strengthen the matron out of hours model to provide further oversight for staffing through to site		Head of Nursing - staffing/DDN/Matrons/Site	C	Staffing hub model now in place which provides the ongoing assurance and review of staffing.
	1.1.9	Hospital to have a system in place for nursing red flag events to be reported by nursing teams, patients, relatives to registered nurse in charge (see separate tab)	M	eReporting of incidents becoming embedded. Staff informally include red flag information	A	Formalise 'red flag' inclusions on e incident reporting. Educate staff on 'red flag' events through safe staffing master classes and local care group/divisional updates. Review 'red flags' on all quality review visits to ward areas.	Maintain	Head of Nursing - staffing/DDN/safety team	C	Red flag information now routinely captured through safecare (real-time) and reviewed through staffing hub. AER's also capture red flag information and this is reviewed systematically monthly and reported to board for trends. Included in staffing establishment reviews.
	1.1.10	Ensure procedures in place for effective response to unplanned variations in patient need - including ability to increase/decrease staffing	M	Clear escalation processes and review of staffing actioned through bleep holding arrangements in Divisions	A	Continued monitoring of effectiveness of escalation and staffing status	Maintain	Head of Nursing - staffing/DDN	C	Escalation clear and embedded through to the staffing hub function. Enhanced care requirements specifically flagged and linked to the policy and staff deployment co-ordinated through staffing hub.
	1.1.11	Actions to respond to nursing staff deficits on a ward should not compromise staff nursing on other wards	S	Escalation processes include the need to review other wards/departments. All ward normal staffing included on trust wide spreadsheet daily	A	Continued monitoring of effectiveness of escalation and staffing status	Unable to identify a time when the organisation will be able to assure this. Mitigations in place.	Head of Nursing - staffing/DDN	A	Management of trustwide staffing deficits via the staffing hub have minimised the risk of this however the recruitment position, the dilute skillmix, the additional workforce controls in place and the capacity situation does not enable assurance that wards are not compromised by staff movements. Important to note that due to improved staffing levels, episodes of staffing in extremis to balance deficits have reduced however still unable to assure fully. Particularly noting challenges (November) with covering enhanced care needs and 'Release to Respond' necessitating staff moves to cover shortfalls.
	1.1.12	Ensure there is a separate contingency and response for patients requiring continuous presence 'specialling'	M	Specialling processes in place and agreed escalation process within divisions.	C	Review the process for requesting specialling support.	Maintain	Head of Nursing - staffing/DDN	C	Escalation processes clear. Policy updated in 2022
	1.1.13	Consider implementing approaches to support flexibility such as adapting nursing shifts, skill mix, location and employment contracts	C	Variety of shift patterns worked within the trust and flexibility within rostering policy allows for variation	C	Continue to review as part of professional judgement element of staffing reviews	Maintain	Head of Nursing - staffing/DDN	C	Continue to review as part of professional judgement element of staffing reviews
	1.1.14	Ensure procedures in place for systematic ongoing monitoring of safe nursing indicators and formal review of nursing establishments twice a year	M	Nursing indicators monitored through incident reporting, ongoing monitoring and through CQD. Twice yearly formal staffing reviews embedded and managed through DON team	C	Continue to strengthen the process	Maintain	Head of Nursing - staffing/DDN	C	Included at establishment reviews

	1.1.15	Make appropriate changes to ward establishments as a response to reviews	M	Establishments amended as result of staffing reviews. Staffing review linked to budget setting process. Evidenced increases noted through trust board reporting	C	Continue to strengthen and evidence the process	Maintain	Head of Nursing - staffing/DDN	C	Continue to strengthen and evidence the process
	1.1.16	Enable nursing staff to have appropriate training for the care they are required to provide	M	Strong track record of training within Trust. Individual care group education teams support ongoing development needs	C	Continue to strengthen and evidence the process	Maintain	Head of Nursing - staffing/DDN/ Education leads	C	Continue to strengthen and evidence the process
	1.1.17	Ensure there are sufficient registered nurses who are experienced and trained to determine day-to-day staffing needs in 24 hour period	M	Bleep-holder role includes requirement to assess and review staffing and risk assess	A	Review to ensure all bleep-holders are competent and capable in staffing assessment and risk management	Maintain	DDN/Matron	C	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review
	1.1.18	Organisation should encourage staff to take part in programmes to assure quality of nursing care and care standards	S	Nursing staff involved in range of quality improvement programmes e.g. essence of care, nursing practice, turnaround, clinical accreditation scheme	C	Continue to involve staff at all levels in nursing quality standard development	Maintain	DDN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing quality standard development
	1.1.19	Involve nursing staff in developing nursing policies which govern nursing staff requirements such as escalation policies	S	Nursing staff involved in developing policy through groups and consultation	C	Continue to involve staff at all levels in nursing policy development	Maintain	DDN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing policy development
Principles for determining nursing staffing requirements - Recommendations for registered nurses in charge of individual wards or shifts	**Principles for determining nursing staffing requirements -** Recommendations for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements									
	1.2.1	Use systematic approach to determining nursing staff requirements when setting nursing establishments and on day to day	M	Professional judgement and SNCT embedded for use within the Trust. Clear 'established levels' identified on eRoster	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DDN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Staffing hub has strengthened the understanding of staff at different levels
	1.2.2	Use a decision support toolkit endorsed by NICE to determine nursing staff requirements		Not yet available through NICE but UHS already uses nationally validated Safer Nursing Care Tool (SNCT) as part of methodology for reviewing staffing levels	C	Review NICE endorsed tools as they emerge	Continuous review of emerging national guidance	Head of Nursing - staffing	C	Review NICE endorsed tools as they emerge. Continue to use endorsed SNCT and incorporate into safe care module.
	1.2.3	Use informed professional judgement to make a final assessment of nursing staff requirements	M	Professional judgement used as mainstay of methodology for reviewing establishments and day to day staffing	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DDN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Stregnthened through the staffing hub
	1.2.4	Consider using nursing care activities included in guidance as a prompt to help inform professional judgement (see separate tab)	C	Already considered routinely as part of professional judgement and methodology	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DDN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models
Setting the ward nursing staff establishment - Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment	**Setting the ward nursing staff establishment -** Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward									
	1.3.1	Setting ward establishments should involve designated senior registered nurses at ward level experienced and trained in determining nursing staff requirements using recommended tools	S	Ward sisters already involved in ward establishment reviews but approach needs strengthening. Competency for establishment review included in ward leader competencies	A	Strengthen involvement and training of ward leaders and other nurses through staffing master classes	Maintain	Head of Nursing - staffing/DDN/Workforce Systems	C	Current staffing review has full representation from ward leaders
	1.3.2	Routinely measure the average amount of nursing time required throughout a 24 hour period for each patient expressed as nursing hours per patient.	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016. reviewed as a metric in the staffing hub
						Introduce next version of eRostering which has functionality to convert data into hours per patient	Maintain	Head of Nursing - staffing/Workforce Systems	C	Safe care rollout complete
	1.3.3	Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishments	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016
	1.3.4	Multiply the average number of nursing hours per patient by the average daily bed utilisation	S	Methodologies currently based on using 100% bed occupancy - bed utilisation considered as part of the professional judgement	A	Introduce bed utilisation into the staffing review methodology for November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Bed utilisation discussed as part of the staffing review sonce July - Sept 2015 particularly in admission areas. Continue to calculate on 100% bed occupancy
	1.3.5	Add an allowance for additional nursing workload based on the relevant ward factors such as turnover, layout and size and staff factors	S	Already included in professional judgment considerations	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.3.6	Identify appropriate knowledge and nursing skill mix required - registered to unregistered - reviewing appropriate delegation	S	Trust baseline registered: unregistered 60:40 - no inpatient ward establishment drop below this. Assessed as part of professional judgement	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.3.7 and 1.3.8	Ensure planned uplift included in the calculation on average patients nursing needs	S	Trust baseline to include 23% on all ward establishments to cover uplift. Additional 0.8 wte uplift being rolled out for supervisory ward leader model	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering
Assessing if nursing staff available on the day meet patients' nursing needs - Recommendations for registered nurses in charge of shifts	**Assessing if nursing staff available on the day meet patients' nursing needs -** Recommendations for registered nurses on wards who are in charge of shifts									
	1.4.1	Systematically assess that the available nursing staff for each shift or at least each 24 hour period is adequate to meet the actual nursing needs of patients on the ward	S	Daily spreadsheet used in site to review safe staffing - Matrons expected to link with all wards to determine staffing levels	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	Maintain	Ward Leaders/ Matrons/ DDN	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role. Oversight from the staffing hub now enhancing the 24 hr view

Assessing if nursing staff available o patients' nursing needs - Recommendati nurses on wards	1.4.2	Monitor the occurrence of the nursing red flag events throughout a 24hour period	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DDN	C	Monitoring of red flags on ongoing basis and key metric considered at staffing hub huddles. Reflected in AER reporting
	1.4.3	If a nursing red flag occurs it should prompt an immediate escalation response by the registered nurse in charge - with potential to allocate additional nursing staff	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DDN	C	Monitoring of red flags on ongoing basis. Reflected in AER reporting and noted in bleep-holder logs
	1.4.4	Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning or establishments	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DDN	C	On the day records maintained and all red flag events captured through AER. Information used as part of the annual staffing reviews for each area to inform establishment changes. Examples at budget setting of changes as a result.
Monitor & evaluate ward nursing establishments - Recommendations for senior management and matrons	**Monitor and evaluate ward nursing staff establishments -** Recommendations for senior management and nursing managers or matrons to support safe staffing for nursing at ward level									
	1.5.1	Monitor whether the ward nursing staff establishment adequately meets patients nursing needs using safe nursing indicators. Consider continuous data collection of these nursing indicators	S	Majority of safe nursing indicators already included as part of the clinical quality dashboard	A	Expand the clinical quality dashboard to include the identified safe nursing indicators	Maintain	DDN/Head of Nursing - staffing/Head of Quality and Clinical Assurance	C	Clinical Quality Dashboard reviewed and relaunched September 2015. Review of indicators included as part of clinical accreditation scheme completed
	1.5.2	Compare results of safe nursing indicators with previous results over 6 month period	S	Review as part of monitoring of clinical quality dashboard	A	Include review of safe nursing indicators as part of staffing reviews from 2015 onwards	Maintain	Matrons	C	Review of indicators included as part of clinical accreditation scheme and annual matron reviews completed
	1.5.3	Monitor all of the nursing red flags and safe nursing indicators linked to wards exceeding 1 RN to 8 patients during the day	S	1:8 indicator included in daily staffing spreadsheet as a trigger to review staffing	A	Matrons to review all safe nursing indicators routinely for all ward areas	Maintain	Matrons	C	Matrons review all safe nursing indicators routinely for all ward areas. Retrospective review of red flag/AER incidents included as part of staffing discussions.

Appendix 4

Staffing figures extracted from healthroster for September 2025

Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward

Actual demand CHPPD is calculated based on the Type and number of the patients in the ward

Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight

Safe care assess + is higher than recommended - is lower

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)			Actual demand average(In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Total Nursing Establishment (WTE)**	**Budgeted Registered Staff (WTE)**	**Budgeted Unregistered Staff (WTE)**	**Demand Registered (Count)**	**Demand Unregistered (Count)**	**Total nurse per shift**	**Skill Mix (RN:URN)**	**Patients RN Ratio (RN: Patient)**	**Patients Nursing Ratio (Total Nurse: Patient)**	**Planned Registered (CHPPD)**	**Planned Unregistered (CHPPD)**	**Total Planned CHPPD**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division A	Surgery	SUR E5 Lower GI	Early	18	24.3	14.8	9.5	4	3	7	58 : 42	1 : 5	1 : 3	4.1	3.3	7.4	8.1	7.0
		SUR E5 Lower GI	Late	18				4	2	6	67 : 33	1 : 5	1 : 3					
		SUR E5 Lower GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5					
		SUR E5 Upper GI	Early	18	24.9	15.4	9.5	4	3	7	55 : 45	1 : 5	1 : 3	3.8	3.2	7.0	8.3	7.0
		SUR E5 Upper GI	Late	18				4	3	6	56 : 44	1 : 6	1 : 3					
		SUR E5 Upper GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5					
		SUR E8 Ward	Early	26	48.1	25.6	22.5	6	3	9	67 : 33	1 : 5	1 : 3	4.9	2.7	7.6	7.2	7.8
		SUR E8 Ward	Late	26				4	3	7	57 : 43	1 : 7	1 : 4					
		SUR E8 Ward	Night	26				4	3	7	57 : 43	1 : 7	1 : 4					
		SUR F11 IF	Early	17	31.8	22.8	9.0	4	2	6	67 : 33	1 : 5	1 : 3	5.0	2.8	7.7	10.4	7.6
		SUR F11 IF	Late	17				4	2	6	67 : 33	1 : 5	1 : 3					
		SUR F11 IF	Night	17				2	2	4	51 : 49	1 : 9	1 : 5					
		SUR Acute Surgical Unit	Early	12	24.1	15.1	9.0	4	2	6	67 : 33	1 : 3	1 : 3	4.8	4.1	8.9	10.3	11.4
		SUR Acute Surgical Unit	Late	12				4	2	6	67 : 33	1 : 3	1 : 3					
		SUR Acute Surgical Unit	Night	12				2	2	4	50 : 50	1 : 7	1 : 4					
		SUR Acute Surgical Admissions	Early	30	38.5	19.8	18.7	6	3	9	66 : 34	1 : 6	1 : 4	3.1	2.0	5.1	7.5	7.3
		SUR Acute Surgical Admissions	Late	30				6	2	8	70 : 30	1 : 6	1 : 4					
		SUR Acute Surgical Admissions	Night	30				3	3	6	50 : 50	1 : 11	1 : 6					
		SUR F5 Ward	Early	28	36.6	19.4	17.2	6	2	8	75 : 25	1 : 5	1 : 4	3.8	2.0	5.7	6.7	6.1
		SUR F5 Ward	Late	28				6	2	8	75 : 25	1 : 5	1 : 4					
		SUR F5 Ward	Night	28				3	2	5	61 : 39	1 : 10	1 : 6					
	Cancer Care	CAN Acute Onc Services	Early	12	24.3	19.2	5.2	5	3	8	63 : 37	1 : 3	1 : 2	4.9	4.3	9.2	#N/A	12.7
		CAN Acute Onc Services	Late	12				2	0	2	100 : 0	1 : 6	1 : 6					
		CAN Acute Onc Services	Night	12				2	2	4	50 : 50	1 : 7	1 : 4					
		CAN C4 Solent Ward Clinical Oncology	Early	23	35.3	22.1	13.2	5	3	8	63 : 38	1 : 5	1 : 3	3.9	2.4	6.4	8.0	7.9
		CAN C4 Solent Ward Clinical Oncology	Late	23				5	3	8	63 : 37	1 : 5	1 : 3					
		CAN C4 Solent Ward Clinical Oncology	Night	23				3	2	5	60 : 40	1 : 8	1 : 5					
		CAN C6 Leukaemia/BMT Unit	Early	21	40.2	39.1	1.1	8	2	10	80 : 20	1 : 3	1 : 3	7.6	1.5	9.2	6.5	9.4
		CAN C6 Leukaemia/BMT Unit	Late	21				8	2	10	80 : 20	1 : 3	1 : 3					
		CAN C6 Leukaemia/BMT Unit	Night	21				6	1	7	86 : 14	1 : 4	1 : 4					
		CAN C6 TYA Unit	Early	10	11.8	10.7	1.1	3	1	4	75 : 25	1 : 4	1 : 3	5.7	1.4	7.1	6.6	9.8
		CAN C6 TYA Unit	Late	10				3	1	4	74 : 26	1 : 4	1 : 3					
		CAN C6 TYA Unit	Night	10				2	0	2	100 : 0	1 : 6	1 : 6					
		CAN C2 Haematology	Early	27	35.6	23.2	12.4	8	3	11	73 : 27	1 : 4	1 : 3	5.5	2.6	8.1	9.3	9.5
		CAN C2 Haematology	Late	27				8	3	11	73 : 27	1 : 4	1 : 3					
		CAN C2 Haematology	Night	27				6	3	9	67 : 33	1 : 5	1 : 4					
		CAN D12	Early	24	31.8	22.9	8.9	5	3	8	62 : 38	1 : 5	1 : 4	4.3	2.3	6.6	6.8	8.8
		CAN D12	Late	24				5	3	8	63 : 37	1 : 5	1 : 4					
		CAN D12	Night	24				4	2	6	67 : 33	1 : 7	1 : 5					
Division B	Medicine	MED D5 Ward	Early	28	38.7	19.0	19.7	4	5	9	44 : 56	1 : 7	1 : 4	3.0	2.8	5.7	7.2	7.6
		MED D5 Ward	Late	28				4	4	8	50 : 50	1 : 7	1 : 4					
		MED D5 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5					
		MED D6 Ward	Early	24	34.0	14.7	19.3	3	5	8	38 : 62	1 : 9	1 : 4	2.9	3.4	6.3	9.1	8.5
		MED D6 Ward	Late	24				3	5	8	38 : 62	1 : 9	1 : 4					
		MED D6 Ward	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					
		MED D7 Ward	Early	16	23.7	12.0	11.7	2	3	5	40 : 60	1 : 9	1 : 4	2.9	3.7	6.5	9.6	0.0
		MED D7 Ward	Late	16				2	3	5	40 : 60	1 : 9	1 : 4					
		MED D7 Ward	Night	16				2	2	4	50 : 50	1 : 9	1 : 5					
		MED D8 Ward	Early	24	39.5	20.7	18.8	3	5	8	38 : 63	1 : 8	1 : 3	2.9	3.1	6.0	9.7	8.6
		MED D8 Ward	Late	24				3	4	7	43 : 57	1 : 8	1 : 4					
		MED D8 Ward	Night	24				3	3	6	50 : 50	1 : 8	1 : 4					
		MED D9 Ward	Early	28	39.3	19.0	20.3	4	5	9	45 : 55	1 : 8	1 : 4	2.8	2.7	5.5	#N/A	8.0
		MED D9 Ward	Late	28				4	4	8	50 : 50	1 : 8	1 : 4					
		MED D9 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5					
		MED E7 Ward	Early	26	31.5	15.5	16.1	3	5	8	38 : 63	1 : 9	1 : 4	2.3	2.1	4.4	11.0	7.8
		MED E7 Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
		MED E7 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
		MED F7 Ward	Early	20	17.0	1.0	16.0	3	3	6	50 : 50	1 : 7	1 : 4	3.4	3.4	6.8	9.5	1.7
		MED F7 Ward	Late	20				3	3	6	50 : 50	1 : 7	1 : 4					
		MED F7 Ward	Night	20				2	2	4	50 : 50	1 : 11	1 : 6					
		MED C5 Isolation Ward	Early	14	26.4	15.2	11.2	2	4	6	34 : 66	1 : 8	1 : 3	3.5	4.9	8.4	10.5	16.2
		MED C5 Isolation Ward	Late	14				2	4	6	34 : 66	1 : 8	1 : 3					
		MED C5 Isolation Ward	Night	14				2	2	4	50 : 50	1 : 8	1 : 4					
		MED D10 Isolation Unit	Early	18	32.1	15.5	16.7	3	4	7	43 : 57	1 : 7	1 : 3	3.3	3.8	7.2	7.2	13.2
		MED D10 Isolation Unit	Late	18				3	4	7	43 : 57	1 : 7	1 : 3					
		MED D10 Isolation Unit	Night	18				2	2	4	51 : 49	1 : 9	1 : 5					
		MED G5 Ward	Early	28	39.2	15.5	23.8	4	5	9	44 : 56	1 : 7	1 : 4	2.6	2.8	5.3	8.9	6.5
		MED G5 Ward	Late	28				4	5	9	44 : 56	1 : 7	1 : 4					
		MED G5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6					
		MED G6 Ward	Early	26	38.9	15.5	23.4	3	5	7	39 : 61	1 : 9	1 : 4	2.5	3.0	5.5	9.1	6.0
		MED G6 Ward	Late	26				3	5	7	39 : 61	1 : 9	1 : 4					
		MED G6 Ward	Night	26				3	2	5	59 : 41	1 : 10	1 : 6					
		MED G7 Ward	Early	14	32.2	12.4	19.9	2	3	5	40 : 60	1 : 7	1 : 3	3.2	3.3	6.5	10.3	7.9
		MED G7 Ward	Late	14				2	3	5	40 : 60	1 : 7	1 : 3					
		MED G7 Ward	Night	14				2	2	4	50 : 50	1 : 7	1 : 4					
		MED G8 Ward	Early	26	36.8	15.5	21.4	3	5	8	38 : 63	1 : 9	1 : 4	2.5	2.9	5.4	No measure	6.1
		MED G8 Ward	Late	26				3	5	8	38 : 62	1 : 9	1 : 4					
		MED G8 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
		MED G9 Ward	Early	26	38.2	15.5	22.8	3	5	8	38 : 63	1 : 9	1 : 4	2.6	3.0	5.6	7.5	6.1
		MED G9 Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
		MED G9 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
		MED Bassett Ward	Early	26	28.8	12.4	16.4	3	6	9	33 : 67	1 : 9	1 : 3	3.0	4.4	7.4	12.3	7.0
		MED Bassett Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
		MED Bassett Ward	Night	26				3	4	7	43 : 57	1 : 9	1 : 4					
		MED E12	Early	24	0.0	0.0	0.0	3	5	8	38 : 62	1 : 9	1 : 4	2.4	3.4	5.7	10.9	4.4
		MED E12	Late	24				2	5	7	29 : 71	1 : 13	1 : 4					
		MED E12	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					
Division C	Child Health	CHI Paed Medical Unit	Early	18	40.7	28.6	12.2	6	2	8	75 : 25	1 : 4	1 : 3	7.9	2.4	10.4	8.2	12.0
		CHI Paed Medical Unit	Late	18				6	2	8	75 : 25	1 : 4	1 : 3					
		CHI Paed Medical Unit	Night	18				6	2	8	75 : 25	1 : 4	1 : 3					
		CHI Piam Brown Unit	Early	12	38.3	37.3	1.0	13	3	16	83 : 17	1 : 1	1 : 1	14.5	4.7	19.2	9.5	18.0
		CHI Piam Brown Unit	Late	12				5	2	7	71 : 29	1 : 3	1 : 2					
		CHI Piam Brown Unit	Night	12				4	2	6	67 : 33	1 : 5	1 : 3					
		CHI Ward E1 Paed Cardiac	Early	16	36.5	28.9	7.6	7	2	9	79 : 21	1 : 3	1 : 2	9.2	2.2	11.4	8.5	13.2
		CHI Ward E1 Paed Cardiac	Late	16				6	2	8	75 : 25	1 : 3	1 : 3					
		CHI Ward E1 Paed Cardiac	Night	16				5	1	6	83 : 17	1 : 4	1 : 3					
		CHI Ward G2 Neuro	Early	6	12.1	12.1	0.0	2	2	4	50 : 50	1 : 4	1 : 2	7.9	8.5	16.5	8.4	10.8
		CHI Ward G2 Neuro	Late	6				2	2	4	50 : 50	1 : 4	1 : 2					
		CHI Ward G2 Neuro	Night	6				2	2	4	50 : 50	1 : 4	1 : 2					
		CHI Ward G3	Early	16	43.7	30.5	13.2	6	4	10	60 : 40	1 : 3	1 : 2	8.2	5.3	13.5	8.2	14.0
		CHI Ward G3	Late	16				6	4	10	60 : 40	1 : 3	1 : 2					
		CHI Ward G3	Night	16				5	3	8	63 : 38	1 : 4	1 : 3					
		CHI Ward G4 SUN	Early	18	50.2	38.6	11.6	6	3	9	68 : 32	1 : 3	1 : 3	7.3	3.5	10.7	8.2	12.5
		CHI Ward G4 SUN	Late	18				6	3	9	68 : 32	1 : 3	1 : 3					
		CHI Ward G4 SUN	Night	18				5	2	7	71 : 29	1 : 4	1 : 3					
	Women & Newborn	W&N Bramshaw Womens Unit	Early	18	33.3	17.9	15.3	3	2	5	62 : 38	1 : 7	1 : 4	3.5	2.2	5.7	#N/A	9.9
		W&N Bramshaw Womens Unit	Late	18				3	2	5	61 : 39	1 : 7	1 : 4					
		W&N Bramshaw Womens Unit	Night	18				2	2	4	57 : 43	1 : 8	1 : 5					
	Cardiovascular & Thoracic	CAR Ward D3 Cardiac	Early	22	49.2	28.6	20.6	7	2	9	75 : 25	1 : 4	1 : 3	5.6	2.2	7.8	8.8	8.1
		CAR Ward D3 Cardiac	Late	22				6	2	8	72 : 28	1 : 4	1 : 3					
		CAR Ward D3 Cardiac	Night	22				4	2	6	67 : 33	1 : 6	1 : 4					
		CAR Ward D4 Vascular	Early	22	34.3	19.3	14.9	5	3	8	63 : 37	1 : 5	1 : 3	4.6	3.1	7.7	8.3	8.5
		CAR Ward D4 Vascular	Late	22				5	3	8	62 : 38	1 : 5	1 : 3					
		CAR Ward D4 Vascular	Night	22				3	3	6	50 : 50	1 : 8	1 : 4					
		CAR Ward E2 YACU	Early	17	28.1	18.8	9.2	4	2	6	67 : 33	1 : 5	1 : 3	5.3	3.3	8.5	#N/A	0.0
		CAR Ward E2 YACU	Late	17				4	2	6	67 : 33	1 : 5	1 : 3					
		CAR Ward E2 YACU	Night	17				2	2	4	51 : 49	1 : 9	1 : 5					
		CAR Ward E3 Green	Early	24	53.3	27.5	25.8	5	3	8	64 : 36	1 : 5	1 : 4	4.0	2.0	6.0	7.9	7.0
		CAR Ward E3 Green	Late	24				5	2	7	75 : 25	1 : 5	1 : 4					
		CAR Ward E3 Green	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					

Appendix 4

Staffing figures extracted from healthroster for September 2025

Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward

Actual demand CHPPD is calculated based on the Type and number of the patients in the ward

Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight

Safe care assess + is higher than recommended - is lower

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)			Actual demand average(In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Total Nursing Establishment (WTE)**	**Budgeted Registered Staff (WTE)**	**Budgeted Unregistered Staff (WTE)**	**Demand Registered (Count)**	**Demand Unregistered (Count)**	**Total nurse per shift**	**Skill Mix (RN:URN)**	**Patients RN Ratio (RN: Patient)**	**Patients Nursing Ratio (Total Nurse: Patient)**	**Planned Registered (CHPPD)**	**Planned Unregistered (CHPPD)**	**Total Planned CHPPD**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division A		CAR Ward E3 Blue	Early	18	0.0	0.0	0.0	4	2	6	68 : 32	1 : 5	1 : 4	4.3	2.5	6.8	7.9	7.6
		CAR Ward E3 Blue	Late	18				4	2	6	67 : 33	1 : 5	1 : 4					
		CAR Ward E3 Blue	Night	18				2	2	4	50 : 50	1 : 10	1 : 5					
		CAR Ward E4 Thoracics	Early	20	40.4	24.9	15.6	6	2	8	76 : 24	1 : 4	1 : 3	5.9	2.8	8.7	7.1	9.8
		CAR Ward E4 Thoracics	Late	20				6	3	9	67 : 33	1 : 4	1 : 3					
		CAR Ward E4 Thoracics	Night	20				4	2	6	66 : 34	1 : 6	1 : 4					
		CAR Ward D2 Cardiology	Early	15	30.4	16.9	13.5	3	2	5	61 : 39	1 : 5	1 : 4	4.5	3.0	7.5	10.1	8.1
		CAR Ward D2 Cardiology	Late	15				3	2	5	60 : 40	1 : 6	1 : 4					
		CAR Ward D2 Cardiology	Night	15				2	2	4	51 : 49	1 : 8	1 : 4					
		NEU Acute Stroke Unit	Early	28	61.6	23.6	38.1	4	6	10	40 : 60	1 : 8	1 : 3	2.9	4.0	6.9	11.3	7.0
		NEU Acute Stroke Unit	Late	28				4	6	10	40 : 60	1 : 8	1 : 3					
		NEU Acute Stroke Unit	Night	28				3	4	7	43 : 57	1 : 10	1 : 5					
		NEU Regional Transfer Unit	Early	10	30.0	22.5	7.5	3	1	4	75 : 25	1 : 4	1 : 3	5.9	3.0	9.0	9.8	13.0
		NEU Regional Transfer Unit	Late	10				3	1	4	75 : 25	1 : 4	1 : 3					
		NEU Regional Transfer Unit	Night	10				2	2	4	54 : 46	1 : 6	1 : 3					
	Neurosciences	NEU ward E Neuro	Early	26	48.0	30.3	17.7	5	3	8	59 : 41	1 : 6	1 : 4	4.0	3.0	7.0	8.7	7.3
		NEU ward E Neuro	Late	26				5	3	8	59 : 41	1 : 6	1 : 4					
		NEU ward E Neuro	Night	26				4	3	7	54 : 46	1 : 7	1 : 4					
		NEU HASU	Early	13	30.6	22.6	8.0	4	1	5	79 : 21	1 : 4	1 : 3	7.2	1.8	8.9	15.4	10.4
		NEU HASU	Late	13				4	1	5	79 : 21	1 : 4	1 : 3					
		NEU HASU	Night	13				4	1	5	79 : 21	1 : 4	1 : 3					
		NEU Ward D Neuro	Early	27	60.6	30.3	30.3	5	5	10	51 : 49	1 : 6	1 : 3	3.9	4.0	7.8	10.8	10.6
		NEU Ward D Neuro	Late	27				5	5	9	51 : 49	1 : 6	1 : 3					
		NEU Ward D Neuro	Night	27				4	5	9	45 : 55	1 : 7	1 : 4					
	Spinal Service	SPI Ward F4 Spinal	Early	22	42.2	22.7	19.5	4	3	7	57 : 43	1 : 6	1 : 4	3.8	3.1	6.9	8.6	8.0
		SPI Ward F4 Spinal	Late	22				4	3	7	57 : 43	1 : 6	1 : 4					
		SPI Ward F4 Spinal	Night	22				3	3	6	50 : 50	1 : 8	1 : 4					
	Trauma & Orthopaedics	T&O Ward Brooke	Early	18	25.4	17.4	8.0	3	3	6	50 : 50	1 : 7	1 : 4	3.3	3.7	7.0	10.9	6.4
		T&O Ward Brooke	Late	18				3	3	6	50 : 50	1 : 7	1 : 4					
		T&O Ward Brooke	Night	18				2	3	5	40 : 60	1 : 10	1 : 4					
		T&O Trauma Admissions Unit	Early	8	26.1	13.2	13.0	3	2	5	58 : 42	1 : 4	1 : 2	6.5	5.7	12.2	#N/A	19.7
		T&O Trauma Admissions Unit	Late	8				2	2	4	50 : 50	1 : 5	1 : 3					
		T&O Trauma Admissions Unit	Night	8				2	2	4	50 : 50	1 : 5	1 : 3					
		T&O Ward F1 Major Trauma Unit	Early	32	66.2	36.8	29.4	6	5	11	55 : 45	1 : 6	1 : 4	4.1	3.5	7.6	11.6	9.1
		T&O Ward F1 Major Trauma Unit	Late	32				6	5	11	55 : 45	1 : 6	1 : 4					
		T&O Ward F1 Major Trauma Unit	Night	32				5	5	10	50 : 50	1 : 7	1 : 4					
		T&O Ward F2 Trauma	Early	26	51.8	23.6	28.2	4	5	9	44 : 56	1 : 7	1 : 3	3.3	3.9	7.2	11.2	8.4
		T&O Ward F2 Trauma	Late	26				4	5	9	44 : 56	1 : 7	1 : 3					
		T&O Ward F2 Trauma	Night	26				3	4	7	43 : 57	1 : 9	1 : 4					
		T&O Ward F3 Trauma	Early	24	50.6	21.6	29.0	4	6	10	40 : 60	1 : 7	1 : 3	3.5	5.0	8.5	11.2	8.8
		T&O Ward F3 Trauma	Late	24				4	5	9	44 : 56	1 : 7	1 : 3					
		T&O Ward F3 Trauma	Night	24				3	5	8	38 : 63	1 : 9	1 : 4					
		T&O Ward F4 Elective	Early	18	33.2	21.3	11.9	4	2	6	67 : 33	1 : 5	1 : 4	3.6	3.4	7.0	7.9	7.0
		T&O Ward F4 Elective	Late	18				3	3	6	50 : 50	1 : 7	1 : 4					
		T&O Ward F4 Elective	Night	18				2	3	5	40 : 60	1 : 10	1 : 4					

Specific Divisional issues emerging - Ward Staffing Review 2025

Division A

The establishment staffing levels are appropriate in most wards areas. Relatively low trained nurse vacancy but high untrained vacancy up to 40% in some areas. Recruitment and retention remain a challenge, for untrained nurses.

The ask for inpatient areas to work to 97% of establishments as a control measure in response to the ongoing financial position is being monitored by the matron teams via staffing AERs, quality indicators and red flags.

Ward lead supervisory time has been impacted throughout the year, these shifts have often been cancelled to support safe staffing on the ward areas. This leads to a direct impact on leadership and development of more junior staff, and managing the HR workload such as sickness and absence. Most ward areas have a junior workforce and at times the skill mix is not adequate. With pipeline recruitment focused on newly qualified nurses this is set to continue.

Surge areas continue to open when there is a high demand on beds. There is no funding for the workforce in SDU (above 6 inpatient beds), Cathlab Day Unit (overnight patients) and Neuro day case (overnight patients). Staffing these areas continues to put strain on the existing staff resource.

Enhanced care and patients requiring 1:1 staffing due to mental health conditions continues to be a challenge for inpatient ward areas. There is very little allocated funding for this workforce. Allocation has improved with the staffing hub leading on the booking of registered mental health nurses but we have seen a decrease in fill for unregistered mental health nurses. There have been shifts that have remained unfilled, necessitating a risk assessment to be made by the matron team as to which patient is allocated the health care support worker. This is often done with the help of the mental health team.

Violence and aggression incidents continue to remain a concern across ward areas. Orthopaedics and Neurosciences seem to be the areas affected most. This group of complex patients can be very time consuming and place significant demands on resources, particularly the security team, who are often required to de-escalate situations where staff are potentially put at risk. Private security firms have been used for several incidents this year, to protect staff and other patients. Staff wellbeing is affected when they have been involved in these incidents, with an increase in sickness, and low morale.

E2 cardiac ward was closed for 4 months over the summer, due to low bed occupancy and reduced operating. All staff were deployed within the cardiac ward footprint reducing the usage of bank and agency.

Supernumerary bleep holders remain unfunded in most areas. When there is opportunity to allocate to this role, they are often required to fill the R2R (release to respond) role in the Emergency Department. They are, however often needed to work clinically which means that they are both unable to support the Emergency Department and their own Care Groups with flow.

Areas to be put forward at budget setting post 2025 review – Division A:

- Review of supernumerary bleep holder funding to care groups.
- Enhanced care budget allocated to high using areas.

Division B

The established staffing levels are appropriate in most wards and registered nurse vacancy levels are low, however healthcare assistant vacancies remain challenging.

The ask for inpatient areas to work to 97% of establishments as a control measure in response to the ongoing financial position is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards.

Lack of Ward leader supervisory time is impacting on workload and wellbeing amongst this group. Particularly in their ability to effectively manage a team, such as absence management and appraisals. Supervisory time is inconsistent and often cancelled to support achieving safe staffing levels across the division, which is something we are monitoring to ensure balance.

In medicine for older persons - G5 and G7 wards the alignment with other inpatient wards improved their CHPPD position slightly and this change has been positively noted by staff to be making a difference. Overall, across Medicine and MOP their nurse: patient ratios and CHPDD planned remain lower than the rest of the trust.

Enhanced care including mental health remains a significant challenge for medicine inpatient wards and AMU. Cancer care, similar but less impacted by mental health. Recognition of this and agreement to fund this in addition to our establishments as part of the affordable workforce limit has continued to be a positive step forward, though the unpredictability of demand, and complexity of some cases has at times exceeded this limit. At times there has also been a need to fund private security to protect staff and patients. There is an ongoing need to work collaboratively with partners to ensure this patient group are receiving care in the right setting, as many do not have a criteria to reside in an acute hospital setting.

Violence and aggression incidences remain a concern across the division and particularly within AMU and medicine inpatient ward areas. Many nursing hours are lost in managing and de-escalating these incidences and time needed for debriefing and sign-posting staff to support wellbeing. We are engaged in the work the wider trust is doing around violence and aggression and monitoring closely.

Medicine/MOP

The temporary closure of ward F7 has supported a reduction in vacancy across the medicine/mop footprint and we have seen a link to reduced bank usage.
A reduction in NHSP fill rate, particularly for enhanced care has been challenging across the care group and impacting on fundamentals of care and staff wellbeing. Quality metrics are being closely monitored through our governance processes and escalations through to Divisional board.

AMU

Requirement to support escalation beds continues (AMU 4/5). This significantly increases the number of patients across the AMU footprint and stretches the clinical leadership model. The impact on quality and safety continues to be closely monitored through our governance processes and escalations through divisional board.

Cancer Care

Cancer care has seen a rise in the number of patients outside the cancer care footprint who require administration of chemotherapy, and this is currently being supported by releasing registered nurses from ward-based establishments impacting at times on achieving safe staffing levels.
This is currently under review and may lead to an ask through budget setting 2025/26.

Areas to be put forward at budget setting post 2025 review – Division B:

- D12 ward has continued to see a significant rise in their acuity on the ward and this has been further impacted by changes to pathways and the geography of the ward resulting in a requirement for an additional registered nurse on the early and late shift to ensure safe staffing levels. This is currently being achieved through use of bank when required. This will be highlighted through budget setting again.

- Enhanced care, including mental health, remains challenging, likely ask through budget setting to maintain funding for this separate to establishments.

- Medicine care group still have a proportion of Band 4 nurses as part of a mitigation when band 5 vacancies were high, likely ask through budget setting to convert remaining posts back to band 5 model.

Division C (excluding Midwifery)

There is increasing acuity and complexity across paediatric services, the following summarises the current staffing position in Division C, highlighting the impact on safe staffing and service delivery.

Paediatric services within Division C encompass a wide spectrum of care needs, ranging from day cases to high-dependency and level 2 critical care. These services are delivered within integrated clinical environments, requiring a highly adaptable and skilled nursing workforce. The diversity of acuity across wards necessitates dynamic staffing models that can flex in response to patient needs while maintaining safety and quality of care.

NHSP shift demand and fill had significantly decreased in Q1 and Q2. Since spring 2025 Child Health have been flexing down bed capacity overnight and at weekends to achieve financial savings. This approach has had no adverse effect on elective activity and performance and Child Health has remained underspent in nursing YTD.

As of month 6, the substantive fill rate stood at 82%, with an overall fill rate of 85%. While the persistently low overall fill has been managed by flexing down bed capacity, this approach is no longer sustainable to meet increasing operational demand as we move into winter.

To meet the demands of winter pressures, we have implemented a robust strategy to achieve staffing levels above 90%. This required a coordinated approach that combined targeted recruitment (28 newly qualified nurses are on staggered start between October 2025 and Feb 2026) with renewed efforts to enhance NHSP engagement, ensuring bank shifts are both attractive and accessible to staff, with particular attention given to recognising specialist skills and providing appropriate financial incentives where higher levels of expertise are required and the skills required are recognised appropriately.

PICU

There is a recognised national shortage of paediatric critical care capacity, with demand increasing year-on-year. The Children's Hospital is funded for 14 beds, with NHSE surge funding enabling flex to 16 beds, and occasionally up to 18 beds in exceptional circumstances to maintain elective flow and respond to increased emergency demand (e.g., congenital cardiac and spinal cases). Appropriate skill mix is required to manage this safely.

PHDU

PHDU routinely flex from 6 beds to 7 beds to meet demand, enabled by the unit's relocation and additional NHSE funding. However, as the 7th bed is only partially funded, there are constraints on the

ability to operate at full capacity around the clock. This has a direct impact on step-down flow from PICU, contributing to pressure points within the paediatric critical care pathway.
To establish a sustainable 7-bed model and ensure consistent support for critical care flow, an uplift of 3.0 WTE registered nurses is required.

E1 Ward

E1 Children's Cardiac Ward has successfully expanded from 4 HDU beds to 6. To ensure continual improvements, the ward is planning to open a dedicated day case bay within the inpatient ward footprint. This initiative is designed to ease patient flow and reduce pressure on inpatient beds by streamlining care for patients requiring short-stay procedures. The bay will support improved throughput and enhance the ward's ability to manage acuity more effectively. Embedding the day unit within the existing ward footprint is expected to reduce the scale of additional staffing required, compared to establishing a separate standalone area, though some increase in workforce will still be necessary to ensure safe and effective service delivery

PB Ward

Piam Brown are experiencing increased demand for both inpatient and day case activity. The existing footprint is insufficient to manage current and projected demand. We are reviewing the potential need for a satellite area to accommodate overflow and maintain patient flow. Workforce planning and uplift to support a satellite staffing model will be required, to ensure safe and sustainable care delivery.

Paediatric Medical Unit (PMU)

Transitioning patients and beds to Robbie's Rehabilitation (RR) as part of service redesign. This development has released a bay that could serve as a satellite area for oncology overflow or additional day case capacity to improve patient flow and reduce pressure on inpatient beds. This will have implications for staffing and require resource modelling to support dual-function and ensure safe staffing levels.

Neonates

The current Neonatal footprint at UHS comprises 43 cots:

15 ICU cots

12 HDU cots

16 SCBU cots

Neonatal services continue to face significant workforce pressures despite recent expansion efforts, including the commissioning of three additional cots and a 13 WTE uplift in establishment.

As of March 2025, high vacancy levels have limited operational capacity to 20 cots, with seven remaining closed or flexed. Recruitment has gained momentum, with 22 nurses appointed across experience levels, and a continued focus on developing existing staff to achieve Qualified in Specialty (QIS) status. Rising acuity and ongoing vacancies have created operational challenges, with the service frequently operating at OPEL 3 or 4, there is a clear requirement for sustained investment to safely open the remaining cots over the next 18 months.

Bramshaw (Breast and Gynaecology)

The established staffing levels within Bramshaw, at Princess Anne Hospital (PAH) are deemed appropriate to support the acuity of patients. The recent reduction in gestational age for baby loss has

positively influenced staffing acuity, enabling the team to maintain safe and effective care within the current establishment

Areas to be put forward at budget setting post 2025 review – Division C:

- Division C's paediatric and neonatal services are under increasing pressure due to rising acuity, demand for flexible bed capacity, and persistent workforce gaps. AWL and fill data shows the need for targeted nursing investment to safeguard care quality and sustainability. Strategic funding will be key to maintaining patient flow, minimising delays, supporting critical care pathways, and promoting staff wellbeing and retention.

- While further work is required to fully scope the additional staffing requirements, it is recognised that progressing this ahead of budget setting is essential. This should be undertaken with careful consideration of the current financial climate, ensuring that any proposed investment across PICU, HDU, E1, PB, and PMU is both targeted and sustainable. The aim is to future-proof paediatric care, uphold safety standards, and support the delivery of key performance requirements across the division.

Royal College of Nursing

NURSING WORKFORCE ACADEMY

NURSING WORKFORCE STANDARDS

Supporting a safe and effective nursing workforce

RCN INSTITUTE OF NURSING EXCELLENCE



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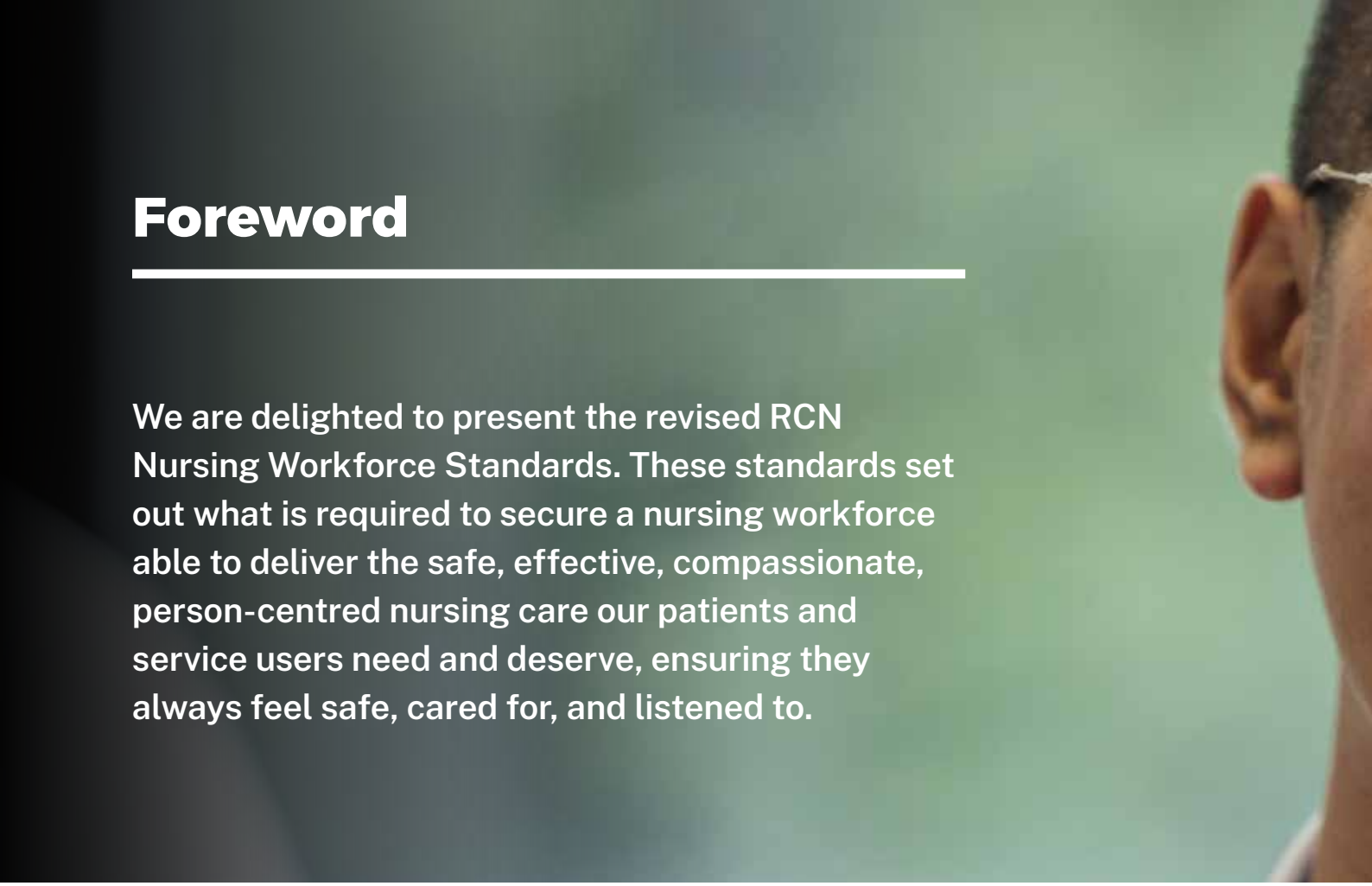
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Foreword

We are delighted to present the revised RCN Nursing Workforce Standards. These standards set out what is required to secure a nursing workforce able to deliver the safe, effective, compassionate, person-centred nursing care our patients and service users need and deserve, ensuring they always feel safe, cared for, and listened to.

The RCN's *Nursing Workforce Standards* were originally introduced in 2021 and were backlit by the effects of the COVID-19 pandemic. They were the first national blueprint for addressing nursing shortages, setting out the standards we expect of a nursing workforce in all health and care settings across the UK.

Since then, and in the face of government inaction across the UK, the nursing workforce crisis has deepened. It is therefore vital that we equip our profession with this revised set of standards, ensuring they remain relevant, incorporate feedback from our members, and reflect new evidence and policies.

They must be ready to empower the nursing profession to tackle the challenges it is facing today.

While the environment we work in has changed, the need for quality care remains. The COVID-19 pandemic's significant impact on health and care services is still being felt today. The nursing profession continues to face many challenges, and a strong focus on recruitment and retention is essential. Health and social care services are in urgent need of investment and reform. So, the Nursing Workforce Standards have now been revised to update, clarify, and strengthen our position to meet the scale and urgency of the current challenge.

Nursing is the largest safety critical profession in health care. Getting the right numbers of nursing staff with the right skills in place is, quite literally, a matter of life and death.

Working with our members and listening to their professional nursing expertise, we've made evidence-based changes.

Our standard on the setting of workforce establishments now states that nurse staffing must always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Setting the right establishment must inform budget setting, not be driven by financial constraints. We have updated our standard on the calculation of the uplift (or headroom) in a



nursing establishment to stipulate that this must be a minimum of 27% to maintain safe and effective staffing during planned and unplanned leave. This should help to ensure that patients and service users always have access to continuous high-quality nursing care.

We have strengthened our standards on access to continuing professional development, and the right to work in healthy and safe environments.

The standards are for all nursing staff and alongside them, we offer practical tools to support you in your workplace. So, no matter where you work or your nursing role, these standards are for you. They set out our expectations of employers in providing a safe and effective nursing workforce which in turn will have a positive impact of the care patients and service users receive.

The changes we have made are important and necessary. They include new information about tackling racism and discrimination in the workplace and preparing for future health and climate emergencies. There is new guidance on the right to ask for reasonable adjustments during pregnancy, and for those with a disability.

As the Voice of Nursing, it is our responsibility to stand up for the profession across the UK. We believe that strong, visible nursing leadership is needed at board level, and that all nursing staff can make a real difference to influence the shape of service provision and the quality of nursing care. Investment in the nursing workforce provides evidenced benefits in the health and wealth of the nation.

Nicola Ranger
RCN General Secretary and Chief Executive

Rachel Hollis
FRCN Chair of RCN Professional Nursing Committee

Introduction

These standards apply across all settings in which nursing care is provided, and across the whole of the United Kingdom. The standards are designed to support a safe and effective nursing workforce alongside each nation's legislation.

They are to be used by:

- those responsible for funding, planning, contracting, commissioning, designing and providing services which require a nursing workforce in any setting
- nurse leaders involved in workforce planning and setting nurse staffing establishments
- all members of executive/corporate boards who are accountable and responsible for ensuring the safety and effectiveness of nursing services
- employers responsible for improving the health, wellbeing and safety of the nursing workforce
- local, regional and national organisations seeking to effect positive change for the nursing workforce
- regulators of health and care services
- professional regulators, for example, the Nursing and Midwifery Council (NMC)
- universities delivering courses for pre- and post-registration nursing students
- the nursing workforce to understand their rights and the support needed to deliver safe and effective care.

The standards are aligned to and may be used alongside the *RCN Employment Standards for Independent Health and Social Care Sectors.*

Key references to support the standards have been included for the first time. They can be found on pages 34-38.

Robust workforce planning is fundamental to the standards, although they do not define specific models or tools of nursing workforce planning. Nursing establishments should be set to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Where there is established practice or setting specific guidance, this should be followed, and the nursing workforce standards are to be used alongside such guidance.

When setting establishments a 27% minimum uplift or headroom must be implemented to support safe and effective staffing during planned and unplanned absences.

The recommendation of 100% supervisory or supernumerary status for registered nurse leads such as ward, department or nursing home managers will promote strong, visible nursing leadership to support and supervise the delivery of high-quality nursing care for patients and service users.

The standards support continued professional development for the nursing workforce. They promote the emotional, psychological, mental, and physical health and wellbeing of all nursing staff. The nursing workforce should work in environments that are safe, just and inclusive, this must be a priority for all employers.

The nursing workforce as defined in this resource is intended to include registered nurses, and nursing support workers (including registered nursing associates). It does not include supernumerary students, volunteer staff or others such as housekeeping and clerical staff. Midwifery is not included as they have their own guidance.

The 14 workforce standards are grouped into 3 key themes:

Responsibility and accountability

These 4 standards outline where the responsibility and accountability lie within an organisation for setting, reviewing and taking decisions and action regarding the nursing workforce.

Clinical leadership and safety

These 6 standards outline the need for registered nurses with lead clinical professional responsibility for teams, their role in nursing workforce planning and the professional development of that workforce.

Health, safety and wellbeing

These 4 standards outline the health, safety, dignity, respect and inclusive values of the nursing workforce to enable them to provide the highest quality of care.



The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.



The nursing workforce should be recognised and valued through fair pay, terms and conditions.

Key Definitions

Executive level registered nurse
A registered nurse who has executive responsibility on the corporate board and is ordinarily responsible for assuring the board in nursing workforce issues. Executive level registered nurses have a pivotal and transformational role in an organisation. They navigate a complex set of stakeholders and partners in the service of organisational values and must use their influence at board level to guide nursing priorities for their organisation.

Designated senior registered nurse lead
A nurse leader in smaller organisations where there is no executive nurse who has authority to make decisions about setting nursing establishment. They will report directly to the responsible board or senior management team.

Registered nurse lead
Each clinical team or service that provides nursing care must have a registered nurse lead. This function may be fulfilled by registered nurses holding different titles, but the requirement of the role is set out in the descriptor for Standard 5.

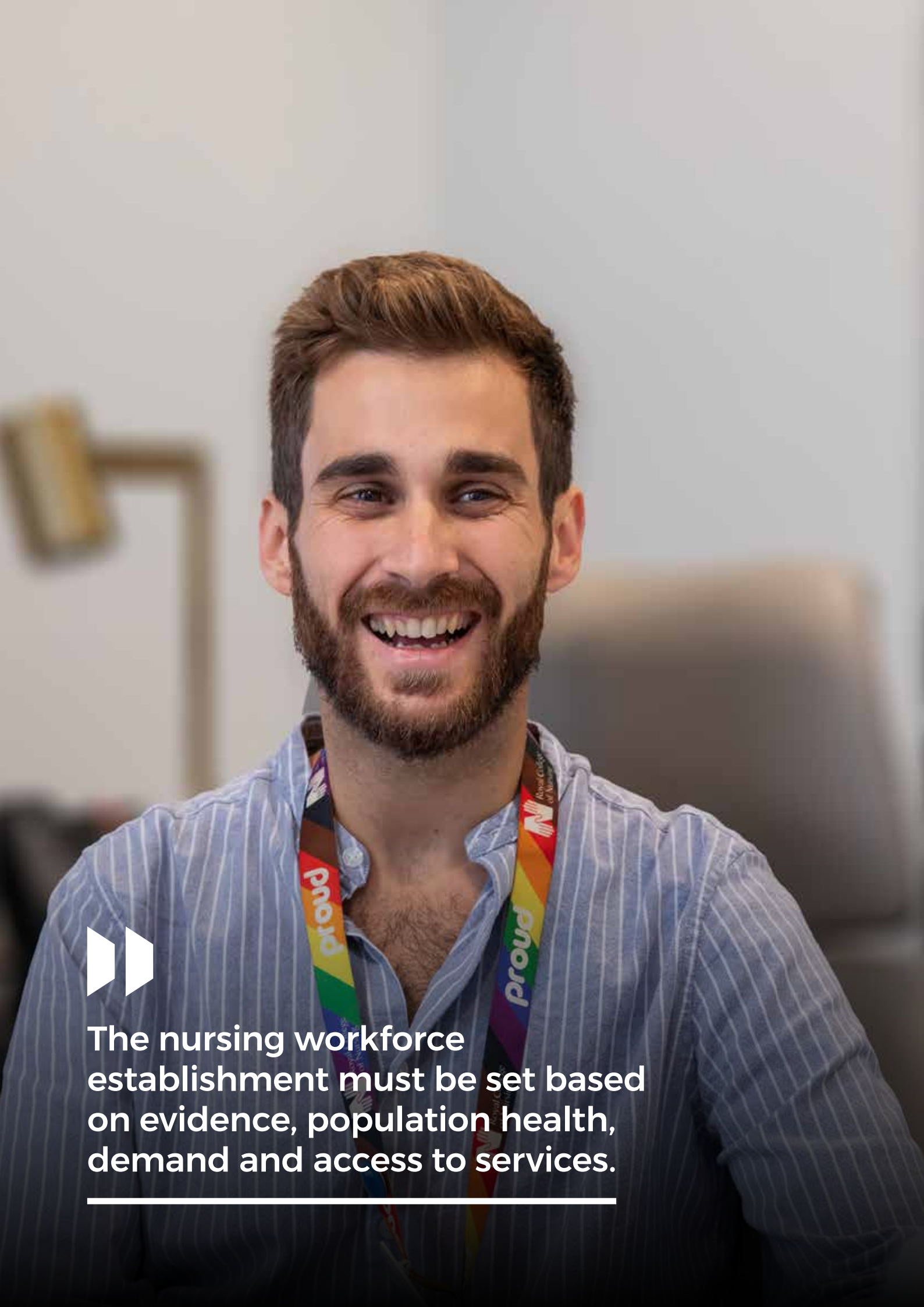
Staffing for safe and effective care
Having the right number of registered nurses and nursing support workers with the right knowledge, skills and experience in the right place at the right time is critical to the delivery of safe and effective care for all those who use health and care services.

Nursing support workers
Support the registered nurse in the provision of nursing care. This term encompasses a wide range of roles and titles which may include registered nursing associates, assistant practitioners, health care assistants, health care support workers and nursing assistants.

Corporate board
The body with the ultimate governance responsibility for any organisation providing health and care services.

Patients/service users
In these standards, this refers to those who use or are affected by the services of professionals within the nursing workforce. This umbrella term also covers clients, residents, children, and other common terms.

Pre-registration nursing students
Any individual enrolled onto an NMC-approved education programme whether full-time or part-time. This also includes student nursing associates and student nurse apprentices.



The nursing workforce establishment must be set based on evidence, population health, demand and access to services.

Responsibility and Accountability

Standard 1

All organisations providing, contracting, or commissioning nursing services must have an executive level registered nurse on the board who is responsible for setting the nursing workforce establishment and the standards of nursing care. All members of the board are accountable for the provision of a nursing workforce that will ensure the safety and effectiveness of service provision.

a. The executive level registered nurse gives assurance to the board. They must be accessible to the nursing workforce and provide strong, visible nursing leadership. The duty placed on registered nurses by the Nursing and Midwifery Council (NMC) Code to raise concerns to protect the public must be upheld.[1]

b. In smaller organisations such as general practices, care homes, and some third sector organisations, there may not be an executive level registered nurse. This exception must be recognised within the documented organisational structure. The organisation must evidence the use of nursing expertise within their commissioning body/partner organisation. A designated senior registered nurse lead with the authority to make decisions must be identified. They are responsible for reporting to the board, senior management team or a named individual accountable for safe nurse staffing.

c. The executive level nurse (or designated senior registered nurse lead) is responsible for providing professional, strategic, and operational advice and assurance to boards and commissioners on nurse staffing.[2] This is to ensure that those accountable fully understand nursing workforce demands, and this must be recorded and visible in board papers and minutes. The board are accountable for the decisions they make and the actions they do, or do not take in response to information, advice and recommendations. Any such decisions and actions must also be recorded.

d. Safe and effective nurse staffing should be a standing item at every board meeting. The record of this discussion and any decisions made will allow for scrutiny of staffing decisions by patients and service users, the public, staff, commissioners, board of governors, regulators and staff representatives.

e. Each organisation should have a board-approved risk management and escalation process in place to enable real-time nurse staffing risk escalation and mitigation, with a clear and transparent procedure to address severe and recurrent risks.

Responsibility and Accountability

Standard 2

The nursing workforce establishment must be set based on evidence, population health, demand and access to services. This should be reviewed, recorded and reported regularly and at least annually by the board.

a. Workforce planning and setting the nursing establishment and skill mix, using appropriate data and methodologies,[3] should be led by the professional nursing knowledge and experience of the executive registered nurse, who should sign off that establishment on behalf of the board.

b. Setting the nursing workforce establishment at safe and effective levels should explicitly inform the organisation's financial planning and budget setting, rather than being driven by financial constraints.

c. A continuous quality improvement approach to setting nurse staffing establishments should be taken to ensure the nurse staffing for each unit/service is sufficient to meet predicted levels of need. A triangulated approach is required and will include (but is not limited to):

   - evidence-based workforce planning tools
   - patient/service users' dependency, acuity and complexity
   - professional judgement[4]
   - clinical quality indicators
   - benchmark data from matched comparators
   - minimum 27% uplift or headroom (see Standard 8).

d. Establishments should be set in such a way as to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio).[5] Where a registered nurse-to-patient ratio has been set (through legislation or evidence-based guidance supported by professional consensus), employers must ensure that establishments are sufficient to always exceed the minimal level.

e. When planning and setting the nursing establishment the right skill mix must be deployed to meet the needs of patients/services users and services. Nursing is a safety-critical profession and evidence has shown that having more registered nurses with degree level education offers patients and service users better outcomes, including reduced mortality rates.[6]

f. A sustainable nursing educator workforce must be in place to support and develop nursing staff and students to deliver evidence-based, high-quality, and compassionate nursing care.

Responsibility and Accountability

g. A framework should be in place that enables regular review of the nursing establishment, and whether safe staffing levels are achieved or not. This framework should include the metrics to be considered (quality of care, patient outcomes and workload) as well as the trigger points for when a review should take place, for example, when serious concerns have been raised about quality of care, never events, increased incident reporting, sickness levels or a change in service provision.

h. Once any review is completed, the findings and any recommendations must be presented to the board accountable for decision making on resourcing service provision and workforce. An action plan should be created to address any issues identified and decisions taken.

i. Workforce data should be reviewed at least monthly, alongside care quality data,[7] by the executive nurse (or designated senior registered nurse lead) and red flags must be investigated and reported with transparency. Workforce red flags include (but are not limited to):

   - high vacancy rate
   - when substantive staff are less than 80% (see Standard 9)
   - inability to meet the agreed skill mix
   - increased temporary staffing
   - increased staff redeployment
   - increased overtime/unpaid breaks
   - high sickness and turnover rates
   - increased staff disciplinaries
   - negative staff and patient feedback.

j. Where registered nurses such as advanced nurse practitioners work in inter-disciplinary or medical rosters, they must not also be counted as part of the nursing establishment.

k. Essential support staff such as clerical, housekeeping and catering staff, should not be considered as part of the nursing workforce when determining the nursing establishment to meet clinical need.

l. All pre-registration nursing students must be 100% supernumerary whilst on placement. Protected supernumerary time must be given as stipulated within their education programmes. All students must be supported to raise concerns when supernumerary time is not protected whilst on placements.

Responsibility and Accountability

Standard 3

Up-to-date business continuity plans must always be in place to enable staffing for safe and effective care during critical incidents or events.

a. Business continuity plans need to be developed with nursing leadership, taking into consideration:
    - the ability to manage and react to critical incidents, pandemics and climate emergencies
    - situations in which the nursing workforce is compromised, understaffed or redeployed
    - that contingency plans should align to the organisational risk management and escalation processes.
b. Partnership working and staff-side engagement with recognised trade unions on the principles, development and outcomes of business continuity planning and review is vital to accurately reflect nursing, foster collaboration and build organisational cohesion.[8]
c. The business continuity plan should be reviewed and tested at least annually.
d. Serious concerns and/or incidents affecting safety and/or quality of care must also trigger a review of the business continuity plan.
e. The nursing workforce must be supported and encouraged to raise concerns and report incidents or near misses that negatively impact on patients or service users, services and the nursing workforce.[9]
    - Staff must be supported to raise concerns in ways that feel safe and in which they have confidence, without fear of detriment. This may include using their trade union staff representatives, trusted impartial individuals within organisations, and Freedom to Speak Up Guardians/champions.[10]
    - Local processes must be in place and used to raise concerns. These processes must be developed in partnership with staff and representatives to encourage more reporting and to make the process easy, fast and reliable.
    - All concerns raised must be documented, appropriately investigated and responded to. Boards and senior managers must have oversight of the different concerns raised across their organisations.
    - Effectively using duty of candour will further develop trust in nursing by patients, servicer users, families and carers.
    - Appropriate follow up, action, and response by accountable managers creates psychologically safe environments, just and learning cultures.[11]

Standard 4

The nursing workforce should be recognised and valued through fair pay, terms and conditions.

a. Employers should have a transparent pay policy which sets out pay structures, pay progression and the criteria for how pay is increased annually to reflect changes in the cost of living. Pay should reflect the experience, expertise and level of nursing practice at which individuals are working.

b. All nursing staff require a written contract of employment issued before the first day of their new employment. On commencement of employment, pay scales must be built upon the Real Living Wage.[12]

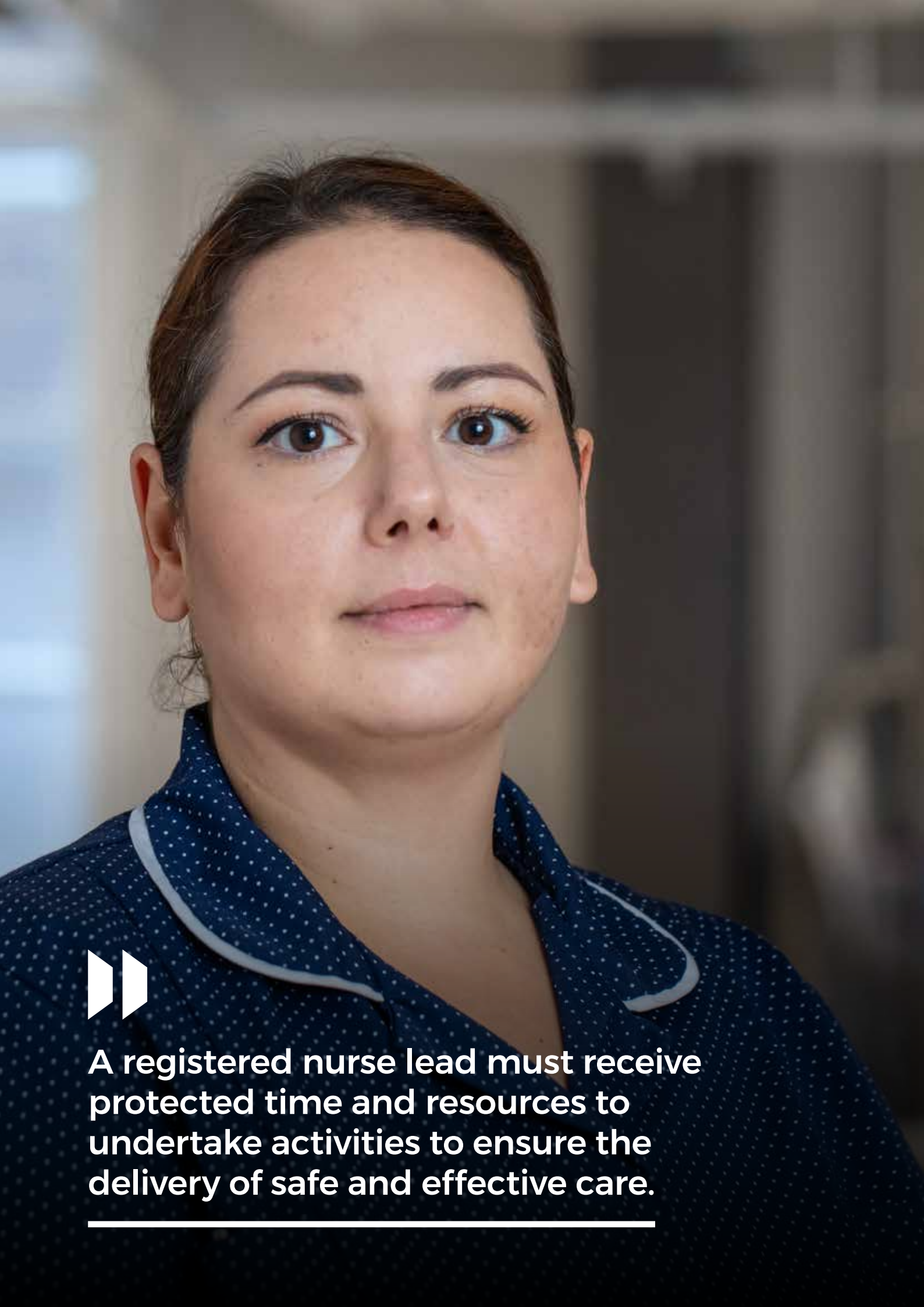
c. All members of the nursing workforce:

- must be compensated for any additional costs of working including unsocial or additional hours worked
- should have access to good quality, sustainable pension provision beyond the statutory minimum
- should have contractual sick pay, parental leave and annual leave beyond the statutory minimums
- should have a fair and transparent process to request a grading/banding review or job evaluation review if they believe that their role has changed beyond their current job description.[13]

d. Fair and equitable pay, terms and working conditions are achieved by engaging directly with the nursing workforce, through the RCN and any other recognised trade unions/ professional organisations.

e. The right to membership of a trade union and/or professional body should be presented to and/or discussed with all new employees at their induction.[14]

f. Employers have vicarious liability for their nursing staff and therefore employers are required to have employer indemnity insurance to insure employees' work.



A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care.

Clinical Leadership and Safety

Standard 5

Each clinical team or service that provides nursing care must have a registered nurse lead.

a. The registered nurse lead provides visible nursing leadership, knowledge, skills and expertise and is responsible for the maintenance of the standards of nursing care within the team or service.[15, 16]

b. The registered nurse lead will have the responsibility to identify the nursing workforce required to provide safe, effective, high quality and compassionate care.[17]

c. They will respond to real time and recurrent risks to nurse staffing levels and take actions to mitigate risks to patients/service users and to nursing staff.

d. If risk mitigation such as reducing caseloads or bed closures cannot be achieved, the registered nurse lead will escalate the risk in line with the organisational policy. Risk escalation and response must be documented.

e. The escalation and reporting line should lead to the executive level nurse (or the designated senior registered nurse lead) and hence the accountable board (See Standard 1).

f. Where the registered nurse lead does not have another (senior) registered nurse as a direct line manager they must have a clear professional line to alternative nursing leadership.[18]

Clinical Leadership and Safety

Standard 6

A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care.[19]

a. Their role in the leadership team as the senior voice of nursing in the workplace must be reflected and incorporated into role descriptions and job plans.

b. The registered nurse lead will be 100% supervisory/supernumerary and not counted in the numbers as part of the nursing workforce allocation.[20] Exceptions to this should be considered as a red flag and a clear rationale must be documented, agreed by the board, highlighted and made accessible to commissioners, regulators, staff representatives and/or recognised trade unions.

c. The registered nurse lead provides strong visible leadership across the 4 pillars of nursing: clinical, research, education and leadership.[21, 22] Time and resource are required for (but not limited to):

   - leading and managing the team
   - improving and monitoring the safety and quality of care delivered
   - improving and monitoring patient and service-user experience
   - improving and monitoring workforce experience and wellbeing
   - workforce planning, monitoring, recruitment and retention
   - budget management
   - clinical and regulatory audits
   - initiating quality improvement programmes
   - research and innovation
   - clinical supervision, staff development and succession planning
   - monitoring health and safety data from adverse incidents and near misses involving staff and people who use services
   - listening, supporting and engaging with families, carers and relatives of patients/service users, as appropriate.

d. Organisations must invest in the leadership and management skills and capabilities of all their nursing leaders through personal and professional development.

Standard 7

All members of the nursing workforce must have access to high quality, contractually funded continuing professional development (CPD) with protected (paid) time to undertake it.

a. Workforce planning and setting of the nursing establishment should include a learning needs analysis to inform the commissioning and provision of education and training.

b. All education and training must align to the needs of those using services, the practice setting, and the professional development needs of the nursing workforce.[23]

c. The delivery of high quality, evidence-based care requires nursing staff to undertake CPD beyond mandatory and/or statutory training and to be supported to engage in lifelong learning.[24]

d. Provision should be made for (but not be limited to) the following:
   - support with revalidation (for NMC registrants)[25]
   - supervision (clinical/restorative) and reflective practice
   - assessment, supervision, and teaching
   - coaching and mentorship
   - access to formal education and research opportunities
   - personal and professional development plans and reviews, including annual appraisal
   - careers support and succession planning
   - leadership training for all the nursing workforces.

e. The nursing workforce has a right to complete all their statutory, mandatory and CPD training within working time/hours or given time back in lieu.

f. Resources, including protected time for regular professional reflection, should be in place to support ongoing learning and evidence-based practice development.[26] The nursing workforce must have access to nursing educators and professional development teams to support evidence-based nursing, lifelong learning and CPD.

g. Organisations should monitor, report on and record the number of training sessions cancelled due to staffing shortages and how much CPD is undertaken outside working hours, to make meaningful improvements.

Clinical Leadership and Safety

Standard 8

When calculating the nursing workforce establishment whole time equivalent, a minimum uplift (or headroom) of 27% will be applied that allows for the management of planned and unplanned absence.

a. An agreed tool for calculating uplift/headroom should be used which must consider each of the following (as a minimum):[27]
    - annual leave – reflective of length of service
    - study leave/continuing professional development (CPD) – this must meet or exceed the statutory requirements for NMC registrants
    - sickness absence – which should reflect the actual sickness level in an organisation rather than the target level
    - parental leave – for staff with children under 18 years old
    - other leave, which includes (but is not limited to): carer's leave, jury service, and compassionate leave
    - maternity, paternity or adoption leave – the level of uplift should reflect the fact that nursing remains an almost 90% female profession.[28]
b. Professional judgement considerations for nursing workforce establishment and uplift/headroom should include (but not be limited to):[29]
    - environmental issues, for example, single rooms, layout
    - geographical issues, for example, travel requirements for community-based staff
    - shift patterns/length of the working day/flexible working
    - patient/service user acuity, complexity and dependency
    - high enhanced observation/1:1 requirement
    - patient/service user high turnover
    - professional regulatory requirements
    - staffing skill mix, levels of registered nurse required (enhanced/advanced/consultant)
    - time required to support/mentor students
    - time required to support staff, for example, phased return, clinical/restorative supervision, capability support, time to access nurse advocates/clinical psychologists, team building/meetings.

Standard 9

If the substantive nursing workforce falls below 80% for a department/ team, this should be an exception, a red flag. It must be escalated, recorded and reported to the board/senior management and shared with staff representatives/trade unions.[30]

a. All vacancies in the nursing workforce should be recruited to as soon as they arise.

b. If redeploying nursing staff, their knowledge, skills and competence must be considered to protect both patients/service users and the nursing workforce.[31]

   - Redeployed staff must always have an induction, orientation and handover.
   - Redeployed staff should never be expected to take charge of the area to which they are redeployed.
   - Redeployed staff should be supported to raise concerns when asked to work outside their limits of competence.
   - All staff redeployment must be done fairly, with support, and consideration of psychological safety and staff wellbeing.
   - The frequency and extent of staff redeployment must be monitored, recorded and reported by all organisations for transparency, accountability and review (See Standard 2i).

c. Bank and agency nursing work provides services and nursing staff with flexibility on both an individual and an organisational level. When using nursing staff from bank or agency, the service must be assured that they are competent and confident to work in the role or setting to which they are allocated. Staff skill mix should be matched to the acuity and dependency of patients/service users, within approved guidelines.

d. The bank or agency workforce must follow approved employment practices and clearance. The host organisation and employer must co-operate and communicate on the management of the health and safety risks to the temporary worker.

e. All staff from bank or agency will be provided with orientation and local induction which must include access to incident reporting systems and how to escalate concerns. A welcoming and supportive work environment offers psychological safety and can ensure the quality and safety of the care provided.[32]

Clinical Leadership and Safety

Standard 10

All members of the nursing workforce must be appropriately prepared and work within their scope of practice and (for registrants) in accordance with the NMC Code.[33]

a. The nursing team is diverse and includes registered nurses, nursing support workers and nursing students. All members of the nursing team must work within the limits of their competence and have access to the right education, training, development and supervision in keeping with their level of practice and the setting in which they work.[34]

b. A registered nurse must never be substituted with a nursing support worker (which includes registered nursing associates) or any other health care professionals.[35]

c. The work of the registered nurse increases in its complexity beyond the point of registration. Employers should recognise the level of nursing practice required within the workforce to meet nursing care needs in the services they provide[36] (See Standard 7).

d. The registered nurse lead will ensure that:

- all newly appointed members of the nursing workforce are allocated a period of supernumerary time and structured induction
- newly registered nurses have a period of structured preceptorship[37]
- individuals with no or limited previous experience in an area have tailored preceptorship periods, which includes structured inductions and close supervision, until specialty competence and confidence are achieved
- for more senior/experienced staff taking on additional or different roles, including promotions, management and leadership, a preceptorship period is still needed until competence and confidence are achieved
- all nursing students must have support and supervision whilst on placement (see Standard 2l)
- practice learning supervisors and assessors must have access to professional development specific to these roles and time and resource to liaise with the approved education institution
- there is an up-to-date NMC placement audit to support students in placement.[38]

e. Fostering leadership capability is integral to all members of the nursing workforce throughout their careers, to embed just and psychologically safe cultures and strengthen the nursing voice.



The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.

Health, Safety and Wellbeing

Standard 11

Working patterns for the nursing workforce must be based on best practice and safe working. Working patterns must be agreed in consultation with staff, and their trade union representatives.

a. Where longer working hours may be preferred, the risk must be recognised and steps taken to mitigate fatigue-related incidents and errors and potential burnout. Best practice advice on mitigating fatigue risks from organisations such as the Health and Safety Executive should be followed, including adequate rest breaks, limits to the number of back-to-back long days and nights, avoidance of shifts longer than 8 hours, and time to recuperate after a stretch on night shifts or on-call shifts.[39]

b. Employers should support opportunities for nursing staff to work flexibly, with the criteria for doing so set out in a policy that is applied fairly to everyone. All posts should be included for consideration of flexible working, including for example, more senior roles. Self or team rostering and internal rotations can also be considered.[40]

c. Flexibility with annual leave should be considered to support the diverse needs of the nursing workforce. Annual leave must never be used to manage sickness absence.

d. The nursing workforce should have timely access to work schedules/rotas. A minimum of 8 weeks in advance will support staff to plan and have improved life-work balance.

e. All work schedules/rotas must ensure that that the right skill mix is in place to meet the needs of patients/services users and services (See Standard 2).

f. Any member of the nursing workforce with a disability is entitled to reasonable adjustment to support them at work.[41]

g. The nursing workforce must always be supported to take breaks during their working hours. Staffing levels and rotas/schedules should allow for staff to have uninterrupted breaks. Any breaks missed must be a red flag and be visible on schedules/rotas.[42]

Standard 12

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.[43]

a. Employers should be able to demonstrate sustained investment and improvement in ensuring that their workplaces are fully inclusive in culture and are anti-discriminatory and anti-racist.

b. Employment policies, practices, processes and cultures, as well as leadership styles, must intentionally support and nurture psychological safety to create inclusive workplaces for all. This includes freedom from all forms of bias, discrimination, bullying, incivility, sexism, and inequity.[44]

c. The nursing workforce must be treated with dignity by their employers, managers, colleagues, patients/service users, and the public.

d. Employers should support and facilitate access to training that supports inclusive workplaces, such as the RCN Cultural Ambassador Programme. Training should include engaging with a variety of groups to understand the full range of different people's needs, cultures and risk factors.[45]

e. Employers should promote and encourage the development of support networks or groups which offer a sense of belonging, safe spaces, and additional support for their staff with protected characteristics.[46]

f. All organisations must monitor, record and publish data on their workforce's protected characteristics.

g. Employers must abide with the 2010 World Health Organization (WHO) *Global Code of Practice on the International Recruitment of Health Personnel* when recruiting staff from outside the United Kingdom (UK).[47]

h. The nursing workforce recruited from outside the UK must be recognised for their prior skills, knowledge and expertise and supported in their career development and career progression.

i. Equitable access to continued professional development (CPD) should be in place to reduce underrepresentation of minoritised groups in nursing leadership roles and increase opportunities for career progression.

Health, Safety and Wellbeing

Standard 13

The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety.

a. Employers must meet their legal duties and put measures in place to reduce risks to health and safety, including (but not limited to):[48]
   - violence and aggression
   - back and musculoskeletal disorders
   - work-related stress
   - occupational infections
   - exposure to chemical and biological hazards
   - hazardous work environments, for example, overcrowding and "corridor care", wet floors, presence of mould and reinforced autoclaved aerated concrete (RAAC).

b. The employer must identify additional risks to new and expectant mothers and put measures in place to reduce those risks.

c. The nursing workforce have a professional responsibility to create healthy environments that improve health and wellbeing, and their employers must support them in this. Health, safety and wellbeing is more than just the absence of work-related disease or injury, rather, an emphasis on achieving good physical and mental health.[49]

d. The Health and Safety Regulations require the provision of safe and well-maintained buildings with adequate welfare facilities, for example, break/rest rooms, changing facilities and personal lockers. Where indicated by a risk assessment there must be access to suitable and sufficient, well-maintained resources (eg PPE, moving and handling equipment).

e. The risks to members of the nursing workforce working in people's homes or community settings should be assessed and managed by their employer. The nursing workforce must be given adequate information and training to undertake a dynamic risk assessment when carrying out home visits and know what steps to take if they feel in danger.

f. Nursing staff who are lone workers must have suitable means of raising the alarm and access to appropriate safety equipment, such as (but not limited to) lone worker devices, mobile phones, high-vis jackets, torches, GPS safety devices, SOS/panic alarms, and prompt access to support and advice.[50]

g. To prevent fatigue, safe driving rules must be adhered to when nursing staff drive as part of their work, for example, taking at least a 15-minute break after every 2 hours of driving. Therefore, enough time must be allocated between patient/service user visits for the nursing workforce working in communities. Access to safe parking is needed for staff safety and wellbeing.[51]

Standard 14

Employers must actively protect, promote and support the wellbeing of the nursing workforce.

a. Utilising the working environment as a place for promoting health and wellbeing is vital to enable a healthy and safe workforce. Meeting core wellbeing needs is non-negotiable. Nursing staff must always have access to drinking water alongside comfortable and relaxing spaces, away from working areas to take their breaks, eat, and drink.[52]

b. The nursing workforce, regardless of where and when they work must have access to healthy eating options. As a minimum, staff should have access to a fridge, microwave, kettle and/or access to food, canteens, shops and/or restaurants. Where staff work in 24-hour and 7-day services, all staff, especially those working nights, weekends or in the community must have 24/7 access to facilities.[53]

c. The psychological health and wellness of nursing staff must be a priority for all employers. Acknowledging the nature of nursing work, employers should proactively support the emotional wellbeing of the workforce. Good practice anticipates and expects the need for support with emotional and psychological wellbeing. Support should be planned for and a normalised component of practice.[54, 55]

d. Employers should provide opportunities for participation in health and wellbeing initiatives and facilitate access to proactive sessions that promote physical and mental good health. Team building and social interactions can be beneficial for staff wellbeing.

e. The nursing workforce must have access to occupational health services or employee assistance programmes. All recommended occupational health screening, vaccines and immunisations and physical/psychological support must be made easily accessible by employers.

f. The nursing workforce must be given manageable workloads to be able to deliver care safely and effectively (using Standards 2 and 3) and to protect staff wellbeing and reduce risk of moral injury, associated work-related stress and burnout. Nurses who are well, deliver safer and more compassionate care.[56]



The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety.

Glossary

Absences
Agreed and non-agreed non-attendance at a workplace. Absenteeism is habitual absence from work.

Corridor care
Corridor care is a term which has gained widespread usage to describe the provision of care in non-designated areas (including corridors). This is usually due to overwhelming demand or lack of available resources. Other terms include, temporary escalation areas, ‘fit to sit’, 'one upping', or 'boarding'.

Direct care
Care provided personally by a member of staff. May involve any aspect of health care including treatments, counselling and education regarding people who use services.

Duty of candour
Is a legal and ethical obligation for health and social care providers to be open and transparent with patients, service users and their next of kin when things go wrong with their care or treatment.

Indirect care
Nursing interventions that are performed to benefit people who use services but do not involve direct contact with these individuals and communities.

Independent employer
Any independent contractor, employer organisations that may or may not be commissioned by the public sector. This will include private employer health care providers, most social care providers; GP practices; out of hours/call centres; social enterprises and community interest companies; charities, private surgical, mental health and learning disability hospitals; independent treatment centres; public/private schools; private industry.

Missed care
Required care for people who use or need services that is omitted in part or fully, or care that is delayed.

Nurse retention
A strategy which focuses on preventing nurse turnover and keeping nurses in an organisation’s employment.

Nursing establishment
The total number of staff needed to provide sufficient resource to deploy a planned roster, which will enable registered nurses and nursing support workers to provide care to people who need or use services and that meets all reasonable requirements in the relevant situation. This includes adding an allowance when calculating staffing numbers for planned and unplanned staff absence.

Never events
Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all health care providers.

Nurse staffing
Rota and whole time equivalent (WTE) for a nursing team. The nurse staffing level refers to both the required establishment and the actual staffing level per shift/allocated workday. The maintenance of the nurse staffing level should be funded from the organisation's revenue allocation.

Nursing workforce
The total number of nursing staff (registered nurses and nursing support workers) working within an organisation, sector or country.

Patient/service user acuity
This refers to how ill the patient is, their increased risk of clinical deterioration and how complex their care needs are. This term is sometimes used interchangeably with the terms 'patient complexity' and 'nursing intensity'. An acuity-based staffing system regulates the number of nurses in a nursing service according to the individual's needs and not according to numbers of people who use or need services.

Patient/service user dependency
The level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care, hygiene and mobilisation.

Patient/service user safety
Patient safety is the prevention of errors and adverse effects to patients and service users associated with health care. It is closely correlated to safe staffing levels.

Public sector
Refers to employers that are publicly funded – either as an arm's length body of the Department of Health and Social Care, or via another government department or directorate such as education, home office, and criminal justice. Examples include local authorities, statutory agencies such as inspectorates and regulators.

Protected time
'Protected learning time' is time spent by students on pre-registration programmes in a health, care or other setting during which students are learning and are supported to learn.

Real Living Wage
The Real Living Wage is a voluntary hourly wage rate in the UK, calculated based on the actual cost of living. It is higher than the government-mandated National Minimum Wage and National Living Wage.

Red flag
Warning signs or indicators that something might be wrong or problematic. Recognising these red flags can help in making informed decisions and to protect from potential harm.

Registered nurse-patient/service user ratios
Number of people who need or use services assigned to an individual registered nurse; based upon the acuity and/or dependency of the patient/service user for nursing care.

Seasonal variation in nursing workload
Variations and fluctuations in demands for care by people who need or use services, such as differing attendance rates.

Shift patterns
The organising of shifts to ensure patients have continued access to nursing care whatever the day or time of day. The shifts could be rotational between day, night and weekend working, or fixed or a continuous working pattern.

Skill mix
Percentage of different health care personnel involved in provision of care, for example, between registered nurses and nursing support workers, or between different health care professions.

Social care
Health, care and practical support services provided to individuals to support with activities of living (which may include nursing care) in their own homes, residential homes, nursing homes and communities. Most of the UK residential care (with or without nursing) and domiciliary care is provided by independent employers, which include charities and private care management companies, however most social care services are delivered by independent sector home care and residential care providers.

Staff rotas/schedules/rosters
A list of staff and associated information such as working times, responsibilities and locations for a given time period.

Substantive position
An employee's permanent position of employment.

Supernumerary (nursing students)
Is when students in practice or work placed learning are supported to learn without being counted as part of the rostered staffing establishment.

Supernumerary/supervisory (registered nurse lead)
The registered nurse lead is not counted in the regular staffing numbers. They oversee and manage others. They are responsible for guiding, directing, and evaluating the performance of employees or team members in delivering safe and effective nursing care.

Team
A group of staff brought together to achieve a common goal. Often associated with an inter-disciplinary approach to care for people who use services.

Understaffing
A situation where there are insufficient numbers of staff to operate effectively, with an impact on patient/service user and staff safety.

Uplift/headroom
Adding an allowance when calculating staff numbers for planned and unplanned staff absence.

Vacancies
Paid posts which are newly created, unoccupied, or about to become vacant and the employer is actively searching for suitable staff. Temporary staff may be able to fulfil posts during the recruitment of permanent staff.

Whole time equivalent
Also known as full time equivalent (FTE), is a standardised measure that represents the workload of an employee. It is commonly used in workforce planning and budgeting to standardise the working hours of part time employees into the equivalent of full time employees.

Workforce planning
The process of analysing the current workforce and determining future needs, including identifying any gaps between current and future provision. This should be based on the demand for the services the workforce will provide.



Employers must actively protect, promote and support the wellbeing of the nursing workforce.

Key references

1 Nursing and Midwifery Council (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associate*. Available at: **nmc.org.uk/standards/code/** (Accessed 22 January 2025).

2 See for example the NHS Leadership Academy guide: Executive_nurse_handbook_mar19.pdf

3 Griffiths P, Saville C, Ball J, Jones J, Pattison N and Monks T (2020) Nursing workload, nurse staffing methodologies and tools: A systematic scoping review and discussion, *International Journal of Nursing Studies*, 103, p. 103487. Available at: **sciencedirect.com/science/article/pii/S0020748919302949** (Accessed 14 January 2025).

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Each clinical team or service that provides nursing care must have a registered nurse lead.



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RCN Revised Nursing Workforce Standards – May 2025
UHS Self assessment – June 2025

Standard	Description – Responsibility and Accountability	Assess
1	All organisations providing, contracting or commissioning nursing services must have an executive level registered nurse on the board who is responsible for setting the nursing workforce establishments and the standard of nursing care. All members of the board are accountable for the provision of a nursing workforce that will ensure the safety and effectiveness of service provision.	Yes Chief Nurse and scheduled board reports/ approvals
2	The nursing workforce establishment must be set based on evidence, population health, demand and access to services. This should be reviewed, recorded and reported regularly and at least annually to the board.	Yes Annual cycle
3	Up to date business continuity plans must be in place to enable staffing for sage and effective care during critical incidents or events.	Yes Included in MI planning
4	The nursing workforce should be recognised and valued through fair pay, terms and conditions.	Yes – clear links to pay review group

RCN Revised Nursing Workforce Standards – May 2025

Standard	Description – Clinical Leadership and Safety	Assess
5	Each clinical team or service that provides nursing care must have a registered nurse lead – accountable for workforce requirements and linked into the executive nurse lead	Yes ward leaders/ Matron/DDN
6	A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care	Yes Ward leaders (WLS) /Matron/DDN
7	All members of the nursing workforce must have access to high quality, contractually funded continuing professional development (CPD) with protected (paid) time to undertake it.	Yes Headroom LNA Induction
8	When calculating the nursing workforce establishment whole time equivalent, a minimum uplift (headroom) of 27% will be applied that allows for the management of planned and unplanned absence.	NO 23% uplift WLS
9	If the substantive nursing workforce falls below 80% for a department this should be an exception, a redd flag. It must be escalated, recorded and reported to the board/senior management and shared with staff representatives/trade unions	Yes Board reporting CHPPD
10	All members of the nursing workforce must be appropriately prepared and work within their scope of practice and (for registrants) in accordance with the NMC code.	Yes Induction/CPD

RCN Revised Nursing Workforce Standards – May 2025

Standard	Description – Health, Safety and Wellbeing	Assess
11.	Working patterns for the nursing workforce must be based on best practice and safe working. Working pattens must be agreed in consultation with staff and their trade union representatives.	Yes Roster policy/rules Team roster
12	The nursing workforce should be treated with dignity and respect and work in environments where equality, diversity and inclusion are embedded in the workplace culture.	Yes AER reporting EDI FTSU
13	The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety	Yes H&S Staff facilities PNA
14	Employers must actively protect, promote and support the wellbeing of the nursing workforce.	Yes Wellbeing OH and EAP PNA