80. Reference Information

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1. Purpose of Paper

1.1. Why is this paper going to the Executive and what input is required?

The aim of this paper is to provide advice and assurance to the Trust's Quality & Safety Committee regarding the provision of Safer Nurse Staffing and adherence to national policy for January 2026

2. Executive Summary

2.1 Context

NHS provider Boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing that will support safe, effective, caring, responsive and well-led care.

2.2 Summary

- The Community Safer Staffing tool was introduced to the Trust in January 2023, however at the beginning of 2024 the National Team paused the tool due to issues with the efficacy of the tool. Following a refresh this has now been relaunched with some changes. Data collection will be collected in July 2026.
- Following the introduction of the National programme for Enhanced Therapeutic Observation and Care Collaborative (ETOC), we have seen a decrease in the need for enhanced care, this will be due to the Education and support given to staff to be able to support patients without the need for enhanced care.
- Safe care is now embedded in inpatient areas. Safe care provides staff with live visibility of staffing levels matching with patient demand, it can highlight areas with short workload-based care hours. It allows for the acuity and dependency of patients to be visible daily so wards can demonstrate how dependant their area is at all times. A weekly report is circulated to the team to monitor consistency of inputting data; this is also monitored and challenged at the monthly e-roster Check and Challenge meetings.
- The 4 inpatient areas now have had a third set of SNCT data, and the data suggests in 3 of the wards require an increase to establishment and for enhanced care support.
- The Rehabilitation and recovery Units (RRU) closed the end of November 2025 with all staff being redeployed to other areas of the Trust.
- The National directive to all Trusts that we can no longer use band 2/3 HCSW agency and this came into force January 2026. Wards are utilising bank when gaps arise and there have been no incidents of wards being unsafely staffed.

- Whitchurch beds were open to 29 beds at the time of data collection.
- The Workforce Safeguard Gap analysis action plan is fully compliant. The Trust has undertaken a review with the National Team as part of their bi-annual review with the Trust where all evidence is submitted and any action required are monitored.
- Due to fire regulations BCCH, Ludlow and Whitchurch have increased the staffing by 1 HCA on night duty, this was a cost pressure to the Trust but as of April 2026 this cost has been added to budgets.

2.3. Conclusion

The report shows us that benchmarking statics continue to be roughly 50:50 RN to HCA and we continue to see the RN to HCA ratio change when we have additional staff for enhanced care, but when we triangulate with quality and safety metrics and red flags there are no concerns regarding safe staffing.

When reviewing the performance of the National Developing Workforce Safeguards (DWS). We are fully complaint.

The Director of Nursing and Medical Director confirm they are satisfied with the safety, effectiveness and current sustainability of staffing levels at Shropshire Community Heath Trust.

3. Main Report

3.1 Introduction

NHS Provider Boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing that will support safe, effective, caring, responsive and well-led care.

Demonstrating safe staffing is one of the essential standards that all health care providers must comply with to meet Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2021) sets out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

It is well documented that ensuring adequate Registered Nurse (RN) staffing levels in line with national recommendations has many benefits including improved recruitment and retention, reduction in staff stress, reduction in patient mortality and improved quality and safety metrics.

The Developing Workforce Safeguards national policy (2018) identifies that NHS Trusts must ensure the below three components are used in their safe staffing processes:

- Evidence based tools and data.
- Professional judgement
- Outcomes

This paper confirms that we have adopted this triangulated approach. The Trust has a Workforce Safeguards Gaps analysis action plan which has 14 recommendations of which

we are fully complaint. The National team review the Workforce Safeguards every 6 months and SCHT remain green for all areas.

The Trust commenced using the validated inpatient tool (SNCT) in June 2023 once the required licence had been received, this tool is used widely in other Community Hospitals. The inpatient tool was updated in 2023 and released for use in 2024.The June 2025 data is the second set of data using this updated tool. The National Community Safer Staffing tool was introduced nationally in January 2023 but was paused in early 2024 by the National Team whilst further checks are undertaken however due to number of staff that require training and delays from the National team data collection will be undertaken in July 2026.

This report outlines the four set of data using the refreshed tool for the community inpatient wards captured via this validated, evidence-based method.

4.0 Nurse to Patient ratio – Inpatient wards

4.1 Nurse to patient ratios are a useful benchmark for assessing the average amount of patients each Nurse is caring for.

4.2 It should be noted that this method may not always accurately reflect the needs of the individual patient as their dependency on nursing input may differ at various points. Nevertheless, the Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals' (2014) suggest Acute inpatient wards must have a planned Registered Nurse (RN) to patient ratio of no more than 1:8 during the day. We acknowledge that these recommendations are for acute wards, but the community wards work to these numbers also alongside professional judgement as the model of care moves towards a more sub-acute specialty. The ratios are followed due to the number of beds within each inpatient area, making it difficult to reduce further. At present there is no national guidance of Nurse-to-patient ratios for night duty however professional judgement of the Director of Nursing (DoN) is 1:13.

4.3 Table 1 shows the average RN: Patient ratio at Shropcom during January 2026 for our community inpatient areas. It demonstrates that during January 2026 all community inpatient wards met the national acute requirement of an overall 1:8 for day shifts at the time of the data collection although it should be noted this national guidance is based on acute inpatient facilities.

Table 1: Actual Average RN: Patient ratio during January 2026

Hospital	RN: Patient Ratio- Day Shift
Ludlow	1:6
Bridgnorth	1:8.3
Whitchurch	1:7.2
BCCH	1:7

4.4 At Whitchurch the bed base is 25 beds but does have the ability to increase to 29 beds for escalation. For January 2026 data collection the ward was open to 29 beds and so had an additional RN on duty.

4.5 Nursing Associates (NA) are used in the Trust and the updated SNCT tool it includes NA in the Registered Nurse (RN) count. The use of NA to the Trust is now embedded to many of our areas but to ensure safety, professional judgement is applied with triangulation of quality and safety data as a standard daily expectation of leaders and managers.

4.6 Actual versus planned staffing numbers for January 2026 showed that 70% of all shifts (both RN and HCSW) were covered by substantive staff. This rate is lower than January 2025 data of 71% due to the vacancies at BCCH and Ludlow, 7% were filled by Agency staff and 23% were shifts filled by Bank staff. This demonstrates that the fill rate was over 100%.

5.0 Safer Nursing Care Tool (SNCT)

5.1 The gold standard for skill mix of staff would be 70% RN to 30% (Royal College of Nursing 2012) HCA linking to evidence suggestive that increasing RNs within a ward skill mix reduces mortality and increases patient safety and quality of Care. (Aiken et al 2010, 2013, 2016, 2018, Ball et al 2018, Blegan et al 2011, Estabrook et al 2005, Griffiths et al 2016, RCN 2021). Within the Community Wards the skill mix is often circa 50:50. It is to be noted that when benchmarking, most Trusts including acute Trusts, do not reach the standard of 70:30, the aim is to work towards increasing the Nurse-to-patient ratio on a trajectory to eventually get to 60% and that the 60% would include NAs. This is the professional judgement of the Director of Nursing. The data collection recommendations are based on a 60:40 skill mix.

5.2 The SNCT is an evidence-based tool that is recommended by NICE to measure individual patient acuity and dependency. It is proposed that using SNCT offers greater understanding regarding if actual hours match required hours.

5.3 Following the update on the SNCT tool in 2023, and the data collection period has changed is now 30 days and includes the weekends. The twice-yearly data collection continues (January & July). The tool collects individual patient acuity and dependency and in the updated version 2023 with the added categories 1C and 1D that enables us to monitor the use of enhanced care required by patients. The data collection is undertaken by trained senior Nurses in each team.

5.4 The SNCT allows clinical staff to assess the needs of every individual patient. It is worth noting that as a generic tool, subjective application of SNCT has an expected 10% variation from ward to ward and is not designed to indicate required skill mix. It should be used as part of professional judgement and patient outcomes as is the case with this review.

5.5 The Trust gained its licence in early 2023 but due to the refresh of the tool this data collection is the 4th set of data collected, we will continue to collect 2 sets per year, as this allows us to understand our adherence to the national standards and offer the Board greater assurance.

5.6 Training is in place for staff undertaking the SNCT data collection and will continue. Safe care is now being used in all inpatient areas, with weekly reports on compliance and compliance is discussed in the monthly Check and Challenge Roster meetings.

5.7 Bridgnorth has 25 beds with the daily average at 23.22 patients at the time of the data collection. The staffing split is 43:57 RN to HCA. The data also suggests that

and additional 1.80 WTE is required for the 1c & 1d patients. This means that there is a deficit of 0.80 WTE however due to the closure of the RRU wards, Bridgnorth is at present over established and therefore no deficit.

Beds 25	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment Based on 60:40
	12.16	0.00	11.61	0.56	RN 15.47 HCA 19.49	RN 20.42 HCA 13.61

5.8 Ludlow has reduced its bed occupancy from 24 to 19 due to fire regulations. The daily average at 18.01 patients at the time of the data collection. The staffing split is 50:50 RN to HCA. The data suggests that an additional 6.62 WTE is required for the 1c and 1d patients. With the actual Establishment at 28.72 there is a deficit of 4.52 WTE. However, a 3.0 WTE is being added to the establishment in April 2026 to account for the additional staffing on night duty due to fire regulations and therefore reduces the deficit to 1.52 WTE.

Beds 19	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment Based on 60:40
	7.35	0.0	8.60	2.06	RN 15.53 HCA 17.19	RN 15.93 HCA 10.62

5.9 Whitchurch has 25 beds but at the time of data collection the additional beds were open to 29 beds with a daily average of 27.40 at the time of data collection. The staffing split is 51:49 RN to HCA. With the establishment of 35.84 the data suggests a deficit of 5.47 and it also suggests a further 5.24 for 1c/d patients. Whitchurch also has a small over establishment of 1.00 WTE. They will also have an additional 1.80 WTE added to their budget in April 2026 to cover additional staffing at night due to fire regulations.

Beds 25	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment Based on 60:40
	10.90	0.00	8.61	1.50	RN 17.65 HCA 16.39	RN 24.84 HCA 16.54

5.10 Bishops Castle beds have been reduced to 14 due to fire regulations. The daily average at 12.52 patients at the time of the data collection. The data suggests an additional 1.03 WTE is required for the 1C/D patients. The staffing split is 50:50. With

the actual establishment of 19.00 WTE the staffing is sufficient without consideration for enhanced care. BCCH will also have 3.0 WTE added to the budget in April 2026 to cover the additional staffing for night duty to fire regulations.

Beds 14	Level 0	Level 1a	1B	1C	Actual Establishment	Suggested Establishment
	8.30	0.0	3.90	0.32	RN 11.68 HCA 7.32	RN 10.82 HCA 7.21

5.11 The Trust is part of the National Enhanced Therapeutic Observation and Care Collaborative (ETOC). We are working through the improvement action plan, that is monitored at Patient Safety Committee, to ensure progression of the programme. Good progress is being made, and we are seeing a reduction in the number of patients requiring enhanced therapeutic care.

5.12 The SNCT data suggests all of the community wards appear to need an increase in establishment to support the enhanced care needs of our patients. It would be worth reviewing the July 2026 data before this recommendation is made as we are seeing a decrease in the need for Enhanced supervision due to the work undertaken on the ETOC programme.

5.13 In January 2026 we stopped the use of band 2/3 HCSW as directed by the National teams. Alongside the work undertaken with ETOC the impact has been minimal, but we will continue to monitor this closely.

5.14 The cost to the Trust in January 2026 for substantive RN/HCSW staff was **419,545K** with an additional bank cost of **73,434K** and an agency cost of **42,617K**, which is a total additional cost of **116,051k** for staffing in January 2026. (see Table below). The additional costs were to cover the increase staffing at Ludlow, BCCH and Whitchurch at night for the fire risk, and to cover the additional staff required for enhanced care, escalation beds being opened and high-level sickness. For Whitchurch, Ludlow and BCCH an additional total of 7.81 WTE will be added to these budgets to cover the increased staffing for fire regulations at night.

Table 2 staffing costs for January 2026

	Substantive RN	Substantive HCA	Bank RN	Bank HCA	Agency RN	Agency HCA
WH	72,351	60,133	13,363	10,893	10,416	627
BH	64,603	77,631	1,547	4,584		
BCCH	30,306	14,750	6,646	19,385	12,256	1,312
LH	53,285	46,587	4,536	12,480	9,568	8,438

6.0 Community Safer Care Tool (CNSST)

6.1 The data for the CNSST has not been included following national instruction to pause it's use whilst further testing is undertaken. The tool has now been updated and launched, but training has been delayed, and the next data collection will take place in July 2026, and this data will be included in the next report.

7.0 Fill rates for inpatient wards

7.1 Trusts are required to collate and report staffing fill rates for external data submission to NHSE monthly. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and HCA.

7.2 The position for January 2026 Source (January 1st – 31st January 2026) is shown in table 3.

Table 3 – Fill rates (January 2026)

Key

90-100%
Over 100%

	Day		**Night**	
Hospital Site	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**	**Average fill rate – Registered nurses (%)**	**Average fill rate – care staff (%)**
Bridgnorth	108%	111%	100%	114%
Ludlow	107%	114%	119%	104%
Whitchurch	128%	134.%	98.9%	159.9%
BCCH	91%	103%	114.%	127%

7.3 We can see from the table that the fill rates for both RN and HCA are predominately over the 100% fill rates. HCA day and night shifts were higher than planned to maintain ongoing management and safety for patients requiring enhanced supervision. For Whitchurch they had escalation beds opened up to 29 beds. All wards had patients requiring enhanced supervision and therefore the fill rates were higher.

7.4 Fill rates do not take into account the skill mix within an area including what percentage of this fill was temporary staff, all of which are contributing factors to quality and safety within the clinical environment.

7.5 Bed occupancy rates reported for January 2026 were 98.3%. This breakdown for bed occupancy at each site as 99% Bridgnorth, 98.3% Ludlow, 92% BCCH and 94.1%Whitchurch.

7.6 For the 4 community inpatient areas, 1 shift was reported in January 2026 as 100% RN agency staff and this was at BCCH for night duty

7.7 All 4 ward areas were above the 90% fill rate for both days and nights in January 2026.

8.0 Care Hours per Patient Day (CHPPD)

8.1 Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Insight-Model Hospital website. SCHT data is available on the Model Hospital site and on performing benchmark analysis, for the last quarter (Dec 2025) the average overall for our Trust is 6.9 care hours per patient day (CHPPD), compared to with average of other similar community NHS trusts of 7.3 (as shown in table 4). This data cannot be viewed in isolation and when triangulating with other data and professional judgement and quality and safety indicators there is not a cause for concern. CHPPD will continue to be monitored monthly. In table 4 you can see that the Trust sits in the 2nd quartile, and this remains a consistent picture.

Table 4 - Model Hospital Benchmarking table

Organisation Name	CHPPD - overall
Derbyshire Community Health Service Foundation Trust	12.0
Kent Community Health NHS Foundation Trust	8.4
Hertfordshire Community	7.5
Lincolnshire Community	7.3
Central London Community	7.2
Average for Community Trust	7.3
Shropshire Community Health	6.9
Sussex Community	6.8
Bridgwater Community Healthcare	5.7

8.2 Table 5 shows the rolling care hours per day for the last year. Care hours per patient day are calculated by dividing the total number of nursing hours on a ward by the number of patients in beds at midnight. The calculation provides the average number of care hours available each patient on the ward and thus there is variation each month and for each ward.

Table 5– Care hours per patient day – total staffing

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Bridgnorth	6.5	6.1	5.4	5.8	7.6	7.4	6.7	6.3	6.0	6.3	6.4	6.9	6.7
Ludlow	7.11	7.1	7.7	6.4	6.5	6.7	7.1	7.1	7.3	7.8	6.6	7.7	7.9
Whitchurch	7.10	7.2	7.2	6.6	6.7	7.1	6.7	7.2	7.3	7.0	6.8	6.4	6.6
BCCH	6.67	6.6	7.3	6.7	6.5	6.7	7.4	7.4	7.3	7.1	7.8	6.2	7.7

9.0 Incidents

9.1 During January 2026 there were 0 reported staffing issues, at any of the inpatient wards and therefore no harm to patients due to staffing concerns.

9.2 During January 2026 there were 1 occasion that the Community inpatient wards had 100% RN agency on night duty, this was at Bishops Castle. There were no harms reported due to the 100% agency.

9.3 During January 2026 there were 13 inpatient falls reported which occurred across 5 of our inpatient areas which equates to a rate of 4.64 falls per 1000 Occupied Bed Days (OBDs).

9.4 Table 6 below shows the rolling year for falls, when we triangulate the data for falls in Jan 2026 in all areas staffing was not recorded or datixed as being attributed.

Table 6 – Falls Data

Year		M1 Apr	M2 May	M3 June	M4 July	M5 Aug	M6 Sep	M7 Oct	M8 Nov	M9 Dec	M10 Jan
2024/25	Falls	23	23	20	14	20	16	12	17	22	13
	Falls/ 1000 OBDs	5.80	5.27	5.36	3.95	5.14	4.67	3.6	6.1	7.69	4.64

10.0 Red Flags (Appendix 2)

10.1 There are 6 elements to the Nice Red Flags (see appendix 2), these include:

1. Omission in providing medication
2. Delay of more than 30 minutes in providing pain relief
3. Patients vital signs not assessed in line with care plan
4. Delay or omission of regular checks on patients to ensure care needs are met as outlined in the care plan
5. A shortfall of more than 8 hours or 25% (whichever is reach first) of registered nurse time available compared to the actual requirement of the shift.
6. Less than 2 Registered Nurses present on a ward during any shift

10.2 Table 7 shows the monthly metrics that are captured that relate to red flags. This metrics are reviewed in Quality and Safety Committee, and actions are taken when metrics are not compliant.

10.3 Datix is used to monitor any delays in pain relief, vital signs not being assessed and delays or omissions or regular check on patients. In January 2026 there were 2 datixes relating to 1 missed dose at Bridgnorth and 1 missed dose at BCCH, no harm to patients and appropriate action taken.

10.4 In line with safer staffing requirement, red flags are reported where there is a shortfall of more than 8 hours or 25% (whichever is reached first) of RN time available compared with the actual requirement for the shift or where fewer than two RNs are present on a ward during any shift. There have not been any incidents for any of the inpatient wards in January 2026.

10.5 When we review the incidents in table 7 for January 2026, we can see there were 16 medication incidents, 8 at BCCH, 4 at Ludlow, 2 at Whitchurch, 2 at Bridgnorth. These incidents were related to a variety of reasons including 2 omissions of medication, which caused no harm to patients, other issues were out of date stock and errors in prescription charts. These were dealt with safely and do not relate to staffing.

Table 7 - Monthly Quality data

Bishops Castle	Oct-25	Nov-25	Dec-25	Jan-26
Number of patient Safety incident investigation (PSII)	0	0	0	0
Number of Falls	5	6	1	4
Number of Category ¾ pressure ulcers in Service	0	0	0	0
Workload Resource Incidents	0	0	1	1
Medication Incident	3	4	5	8
Bridgnorth	**Oct-26**	**Nov-26**	**Dec-26**	**Jan-26**
Number of patient Safety incident investigation (PSII)	0	0	0	0
Number of Falls	5	2	5	2
Number of Category ¾ pressure ulcers in Service	0	0	0	0
Workload Resource Incidents	0	0	1	0
Medication Incident	0	1	1	2
Ludlow	**Oct-26**	**Nov-26**	**Dec-26**	**Jan-26**
Number of patient Safety incident investigation (PSII)	0	0	0	0
Number of Falls	4	0	7	0
Number of Category ¾ pressure ulcers in Service	0	0	0	0
Workload Resource Incidents	0	0	0	0
Medication Incident	0	8	6	4
Whitchurch	**Oct-26**	**Nov-26**	**Dec-26**	**Jan-26**
Number of patient Safety incident investigation (PSII)	0	0	0	0
Number of Falls	9	8	6	7
Number of Category ¾ pressure ulcers in Service	0	0	0	0

Workload Resource Incidents	0	1	4	0
Medication Incident	0	1	4	2

11.0 Risks to Safer Staffing

11.1 From January 2026 the national directive came into place that Trusts can no longer use agency for band 2/3 HCSW. The Trust has compiled with this directive, but we are monitoring closely as this could pose a risk to safely staffing wards. The National team have noted that whilst the use of agency for HCSW has come down they have seen an increase in agency use for RN, this has not been the case for the Trust.

11.2 We continue to increase our bank capacity, with rolling adverts and targeted recruitment days in areas of highest demand. It is important that we maintain a level that is sufficient to support the Trust.

11.3 The Trust is moving towards a centralised bank, with all new bank staff enrolled onto centralised bank, this has helped with staff being able to cross cover other areas, but the Trust does need to move to all staff to the centralised bank to allow maximise flexibility

11.4 National Health Service Professionals (NHSP) has been introduced to the Trust and went live in January 2026. We are yet to see the benefit of this service yet but will bring an update in the next paper.

12.0 Recommendations available to review and accept

12.1 To continue to embed the twice-yearly data collection tool for the Community inpatient areas.

12.2 To undertake the first data collection for Community District Nursing teams staffing tool in the July 2026 with the CNSST.

12.3 Whilst the data suggests that changes in establishment are required for 3 out of the 4 wards for establishment and for enhanced care at this time this would not be a recommendation. Whitchurch and Bridgnorth have some over establishment due to the RRU closing, the ETOC programme is seeing a reduction in the requirement for enhanced care and we also need to consider the increased capacity in the Urgent Care Response (UCR) opening hours increasing to 6am to 12 midnight this will allow more patients to be seen away from hospital care, and therefore the Trust should monitor these changes for the next 6 to 12 months and to see how these changes affect our patient cohort and then make a recommendation if change is required.

12.4 To continue to monitor the E-roster Safe Care weekly to ensure consistent compliance.

12.5 To continue to monitor the impact of the change in NHSE guidance that trusts no longer can use HCSW band 2/3 agency to ensure that we are compiling with these regulations and that we do not see an increase in agency RN as a result.

12.6 The ETOC 12-month improvement programme will come to an end in May 2026. However, we will still present our monthly data to the NHSE, and we will continue to present quarterly at Patient Safety Committee to demonstrate work against any remaining actions against the plan and to demonstrate improvement in supporting patients with enhanced needs.

12.7 Work to continue on the recruitment and retention plan, to support the Trust in filling the vacancy gaps thus improving overall safer staffing substantive numbers.

12.8 The Trust is moving to long day/night shifts at the request of the staff, and this has been taken through the correct process, Staff wishing to remain on a short-day shift will continue to be able to do so. This does support us when temporary staff are required particularly in our rural areas as staff are more inclined to travel for a long shift rather than a short shift.

12.9 Consideration should be taken to the cost of bank and agency that is being used for staffing gaps, enhanced care and escalation beds, for January 2026 the additional cost for staffing in the impatient wards was 116,051K. This has reduced by 89,156K from June 2025. With the changes to enhanced care and the continued reduced in patients requiring enhanced care it will be important to compare this after the July data collection before any establishment changes are made.

12.10 In 2025 the National Team introduced a National Developing Workforce Safeguards a biannual meeting with each Trust so we could provide evidence and discuss any gaps the Trust may have, on both meetings the Trust has demonstrated that we are compliant in all areas and therefore we have no actions and are fully compliant.

13.0 Revalidation of Registered Nurses/Pharmacy/ HCPC registered staff

13.1 Registered Nurses get notification from the NMC regarding their revalidation at the 100 and 60 days prior to revalidation and emails via ESR at 12, 8 and 4 months.

13.2 HCPC registrants receive notification from the HCPC regarding their renewal 2 months prior to renewal and emails via ESR at 3 and 1 month.

13.3 Registered Pharmacy staff receive notification from GPhC regarding their revalidation 2 months prior to revalidation and emails via ESR at 3 and 1 month.

13.4 Whilst the Trust puts reminders in place for staff it is the responsibility of the registrant to ensure that their registration is valid at all times.

13.5 The Trust has 642.02 WTE which equates to 900 individual Registered Nurses and Registered Nursing Associates that need to renew their PIN by paying their annual

fee and revalidate every 3 years. In the last 12 months June 2024 to June 2025 there has been 8 occasions where staff have failed to revalidate, immediate action was taken, and all 8 staff did not work without a current pin number.

13.6 The Trust employs 94.13 WTE paramedics, speech and language therapists, occupational therapists and diagnostic radiographers. These professions have gone through their biannual re-registration process between June 2025 and March 2026. HCPC re-registration requires both the payment of their fee, and the completion of a self-declaration to confirm adherence to the professional standards. Between June 2025 and March 2026, there have been 2 occasions where a staff member did not complete their re-registration within the deadline for their profession. Trust policy was followed with both members of staff and at no time did either staff member work as their registered profession whilst not on the HCPC register.

13.7 The Trust has 25.4 WTE Pharmacy staff which equated to 19 Pharmacists and 15 Pharmacy Technicians registered with GPhC. Revalidation takes place on an annual basis, whereby the registrant both pays their annual fee and revalidates. In the last 12 months, June 2024 to June 2025, there have been zero occasions where staff failed to revalidate.

13.8 Regular reporting is now set up from ESR to check the registration status of the profession the day after the registration deadline has passed allowing for assurance and early identification of any lapses in registration.

14.0 Conclusion

The report shows us that benchmarking statics continue to be roughly 50:50 RN to HCA and we continue to see the RN to HCA ratio change when we have additional staff for enhanced care, but when we triangulate with quality and safety metrics and red flags there are no concerns regarding safe staffing.

When reviewing the performance of the National Developing Workforce Safeguards (DWS). We are fully complaint.

The Director of Nursing and Medical Director confirm they are satisfied with the safety, effectiveness and current sustainability of staffing levels at Shropshire Community Heath Trust.

Supporting Literature

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Appendices

Appendix 1 – Inpatient Decision matrix

Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	Care requirements may include the following • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • Early Warning Score is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATERPOTENTIAL to deteriorate.	Care requirements may include the following: • Increased level of observations and therapeutic interventions • Early Warning Score - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation / invasive monitoring • Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living	Care requirements may include the following • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability / Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) • Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff(provided from within ward budget)as per local policy
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit	• Deteriorating / compromised single organ system • Post operative optimisation (pre-op invasive monitoring) / extended post-op care. • Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway and protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems • Respiratory or CNS depression / compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection

Appendix 2

Red Flags (NICE2021)

1	Unplanned omission in providing patient medications.
2	Delay of more than 30 minutes in providing pain relief.
3	Patient vital signs not assessed or recorded as outlined in the care plan
4	Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: – Pain: asking patients to describe their level of pain level using the local pain assessment tool. – Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration. – Placement: making sure that the items patient needs are within easy reach. – Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
5	A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
6	Less than 2 registered nurses present on a ward during any shift.