Agenda Item No.

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Emma Hardwick Chief Nurse	Decision		High	Med	Low
	Discussion				
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Valarie Newton, Deputy Chief Nurse	Strategic				
	Operational				
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
Karen Mcguire, Associate Chief Nurse Tracey Oats , Associate Chief Nurse Lesley Deacon, Head of Midwifery Mark Webber, Management Accountant					
CQC Domain: (safe, caring, effective, responsive, well-led)	All				

Meeting Date: 31 July 2018
Report Title: Report on Nursing and Midwifery Skill Mix Review

PURPOSE:

This paper advises the Trust Board of Directors of skill mix reviews undertaken for inpatient adult wards, maternity and paediatrics.

SUMMARY:

This Nurse Establishment Review Report provides the Trust Board with an updated position statement in relation to nursing workforce requirements needed to achieve safe staffing levels in the general adult inpatient areas of the Trust.

While the Trust has been responsive to supporting immediate increases in establishment in response to professional judgement it is necessary for formal changes to a number of establishments to occur.
The Emergency department and Clinical Business Unit 4 (Women's and Children's services) are not included in this report and will be reported separately.

The report illustrates the continuing challenges of the local and national shortage of registered nurses and consequential impact on our ability to meet the intentions set out in the previously agreed nursing workforce model.

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience

RECOMMENDATION:

Note actual and planned staffing levels.
Note the need to reconcile the budgeted establishments to E rostering, understand variances to inform staffing needs and identify any risks in these areas

REPORT ON NURSING AND MIDWIFERY SKILL MIX REVIEW – JUNE 2018

1. INTRODUCTION

1.1 This establishment review outlines the work undertaken since the last review, provides an update on any continuous or on-going initiatives and outlines any future options to be undertaken in relation to maintaining safe and productive nurse staffing levels.

2. BACKGROUND

2.1 Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution in England (DoH 2015), and the Health and Social Care Act (DoH 2012) which make explicit the Board's corporate accountability for quality.

2.2 The Nursing and Midwifery Council (NMC 2015) sets out nurses' responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all healthcare providers must meet to comply with the Care Quality Commission's (CQC) regulation (CQC 2015). This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). The Carter report (DoH 2016) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards.

2.3 Two of the expectations are that Boards receive monthly updates on workforce information and staffing capacity and capability is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

2.4 The Trust continues to follow the national registered nurse staffing picture which continues to reflect consistent challenges in the recruitment and retention of registered nurses. More recently, these observations have aligned to reports from the Nursing and Midwifery Council (2017) that there are more nurses leaving the register than joining. This has prompted further concerns regarding the professional capacity to meet registered nurse demand and therefore central to decisions regarding safe staffing levels. Consequently, with no immediate forecast that the ongoing challenges of registered nurse recruitment will reduce, alternative approaches to developing and enhancing the registered and unregistered workforce have to be considered.

2.5 The QEHKL has recognised the need to be innovative and implement new routes for training registered nurses including the route of an apprenticeship model, currently the Trust is working as part of the Norfolk system with the implementation of the Nursing Associate training programme.

2.6 This establishment review was undertaken for a number of reasons, including:

- The need to provide assurance, both internally and externally, that ward establishments are appropriate to provide safe care to patients.
- To provide establishment data that will inform the Trust Workforce Strategy
- To deliver Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).

3. SUMMARY OF KEY ACTIONS IMPLEMENTED SINCE PREVIOUS ESTABLISHMENT REVIEW

3.1 The West Raynham Band 7 Ward Manager role that was supported at the last establishment review has now been implemented and recruited to.

3.2 The following ward areas have had an increase in establishment over this period of either Registered nurses or Healthcare Assistants: Necton Ward, Oxborough Ward, Terrington short stay, Marham and Elm Ward; this is due to increase in acuity, changes in ward configuration, such as medical outlier patients on surgical wards or following concerns that staffing levels were not sufficient to meet the care needs of the patients. These changes are detailed later in the report.

4. SAFE NURSE STAFFING LEVELS - PATIENT CARE AND WORKFORCE OUTCOME CONSIDERATIONS

4.1 Safe nurse staffing levels are integral to ensuring that patients receive care in the environment where their clinical needs can best be met. Proactive and reactive mitigation plans are required to minimise any risk that patient care will be compromised because nursing care activities may/will not be delivered.

4.2 A daily staffing meeting occurs each day led by senior nurse leaders and overseen by the Chief Nurse. This process is a control measure to ensure that nurse staffing is planned and utilised in the most effective and efficient way. Actions are agreed and implemented to mitigate and balance out identified risks associated with staffing levels.

5. EVIDENCE- BASED WORKFORCE PLANNING

5.1 The scope of available evidence does not describe a single definitive numerical formula for safe staffing in general inpatient areas. However, the National Quality Board (2016) and NICE (2014) guidance includes a variety of options to support staff measurements; albeit both are also equally clear that the emphasis of safe staffing levels should be on patient care and not the number of available staff.

5.2 All available evidence sources advocate that professional judgement is a significant influencing factor in safe staffing decisions for general inpatient care. That said there is acknowledgment of the relationship between patient harms and less than one registered nurse to eight patients.

5.3 Discrete specialty specific staffing guidelines apply to the intensive care unit, acute stroke services and level 2 ward based care provided in haematology, respiratory and cardiac settings.

5.4 Leading and coordinating the assessment, planning, implementation and evaluation of nursing care is the specific responsibility of a registered nurse. This can be a complex process and subject to constantly changing conditions, including patient acuity and dependency levels, and environmental factors. For this reason, it is essential that any changes to the nursing workforce have been assessed to ensure this unique skill base is not compromised.

5.5 However, given the reported decline in registered nurses maintaining their NMC registration it is likely that in the short to medium term, registered nurse vacancy levels will continue to be both a local and national problem. Consequently, if safe staffing levels are to be achieved we need to identify alternative approaches and embrace innovative new ways of working that will fill the void in our registered nurse establishments.

5.6 Working on the primary principle of maintaining an appropriate patient staff ratio, various options are being considered to create a workforce that is appropriately skilled and competent to meet the safety, experience and effectiveness standards of the patient care we aim to deliver. A Nursing and Midwifery Workforce Steering Group is being introduced with 5 work streams designed to deliver the workforce modernisation now required. The Chief Nurse and the Director of HR are conducting table top exercises initially with Oxborough and Gayton Ward to provide alternative skill mix options that will support safe patient care. Any variations to proposed staffing ratios will be reviewed and risk assessed by the senior nursing team and Chief Nurse.

6. ESTABLISHMENT REVIEW METHODOLOGY

6.1 The data collection for the nursing and midwifery establishment review was undertaken between 1st January 2018 and 31st March 2019. Actual staffing, along with patient acuity and dependency data, was collected over this 3 month period.

6.2 Calculations for the patient acuity and dependency metrics follow the Safer Nursing Care Toolkit (SNCT) and national guidelines via the Trust patient acuity reporting tool. Data collection for the staffing metric was taken from the Allocate nurse staffing rotas.

6.3 It is assumed that the roster is an accurate reflection of the work carried out and that the Trust acuity tool has accurate patient acuity and dependency scores inputted for each patient.

6.4 The process also considers incidents, quality metrics and associated risks external reviews and the professional judgement of the senior nursing team.

6.5 The SNCT is an evidence-based tool developed to help NHS hospitals measure patient acuity and dependency to inform decision making on staffing and workforce, this tool has an expected 10% variation.

6.6 For specialist areas of maternity, paediatrics, emergency department and critical care service specific tools have been used. The limited value of the SNCT is also acknowledged in surgical ward areas where the methodology does not recognise the turnaround of patients and it is in these areas that the triangulation using Care Hours per Patient Day (CHPPD) is anticipated to be of value in the future.

6.7 Although not directly referenced within this report, other quality indicators have been taken into consideration, i.e. red flags and the Nursing and Midwifery Quality Indicators. These indicators are considered and reported via the weekly senior nurse meeting with the Chief Nurse and as part of the divisional monthly Performance review meetings.

7. CURRENT ASSUMPTIONS – SKILL MIX AND REGISTERED NURSE TO BED RATIO

7.1 The nurse to patient ratio describes the number of patients allocated to each registered nurse. Nurse patient allocations are based on the acuity or needs of the patients on the ward. In critical care the ratio may be 1:1 for the sickest patients or 1:2 or 1:3 for patients who are acutely ill but stable. On general adult inpatient wards the nurse to patient ratio is higher, for example 1:6 or 1:8 depending on the type of service delivered and the needs of the patients.

7.2 It should be noted that although there has been considerable national debate on the subject of skill mix and nurse patient ratio to date no national standards for staffing

levels in patient areas have been mandated, although a minimum registered nurse to patient ratio of 1:8 in the day and 1:11 at night is supported by professional associations such as The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (RCN 2012) and NICE 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (NICE 2014).

7.3 For each clinical area the following information is presented in:

Appendix 1: the speciality bed base, current funded establishment, recommended staffing as per national guidelines, professional judgement recommendations, results from the SNCT acuity assessment

Appendix 2: the numbers of registered and un- registered nurses required for each shift for minimum safe staffing as funded in June 2018.

Appendix 3: National guidance for staffing modelling by speciality.

8. WARDS WHERE A CHANGE TO THE CURRENT FUNDED ESTABLISHMENT IS RECOMMENDED

8.1 The following section of this report provides details of proposed changes to the current nurse staffing establishments and is provided for information. These proposals will be reviewed by the Executive Directors and the Trust Executive Committee.

8.2 All costings include shift premium, National Insurance (employer contribution) and pension but do not take into consideration new pay increase July 2018.

9. DIVISION 1

9.1 CBU 1

Theatres and Day Surgery Unit

The Trust has supported the first year of the three year phased business case for Main Theatres and Day Surgery which supports working towards compliance with national recommendations and service delivery. These posts are now recruited to.

The second year approval in Main Theatres and Day Surgery business case over three years, to ensure compliance with national recommendations and service delivery.

Year 2 Total cost (£312,912)

9.2 CBU 2

9.2.1 Elm Ward (Emergency Surgical ward including Gynaecology)

To support the continued use of the ward for medical outlier patients an increase in band 2 HCA by 1.0 WTE per shift this equates to 5.75 WTE. This increase is currently supported by temporary staffing and is flexed depending on the level of medical outliers and overseen by the ACN for Division. It is recommended that this model continues and no additional changes are currently required but the cost pressure should be noted. However it will be important to consider how increases in staffing requirements in all areas for the winter are modelled going forward.

Total cost Band 2 5.75 WTE £144,969

9.2.2 **Marham Ward**

The level of activity being managed through the Admissions Unit Monday to Friday Professional judgement by the ACN and Chief Nurse is that an increase of Band 2 HCA is required.

Total cost Band 2 1.28 WTE £32,271

It is important to note that the recommendation from the Orthopaedic GIRFT visit in May 2018 has implications for the nursing establishment for this area. This will be considered as part of any future business case that is submitted.

As on Elm Ward additional HCA support is required when this area is used for medical outlier patients. This increase is currently supported by temporary staffing and is flexed depending on the level of medical outliers and overseen by the ACN for Division. It is recommended that this model continues and no additional changes are currently required but with the subsequent the cost pressure.

9.2.3 **Denver Ward**

Denver nurses the most acute surgical patients including the majority of the Critical care step down patients, acute surgical emergencies, complex cases and colorectal surgical patients. The ward continuously runs at 30 bed base and the staffing establishment has not been formally amended to support this increase. An additional 1.76 WTE unregistered nurse uplift is required on the late shift

This is currently being filled by temporary bank workers and a cost pressure.

Total cost Band 2 1.76 WTE £55,536

10. DIVISION 2

10.1 CBU 5

10.1.1 **Necton Ward**

This is an acute respiratory ward and provides care to patients with high acuity some who are receiving non-invasive ventilation. In order to be compliant with National standards for nursing these patients and professional judgement it has been important to increase the registered nurse levels at night from 3 Registered Nurses to 4. This is currently a cost pressure and the current establishment of registered nurses requires an uplift of 2.75 WTE.

This is currently being filled by temporary bank workers and a cost pressure.

Total cost Band 5 2.75 WTE £ 101,477

10.1.2 **Tilney Ward**

Since the last skill mix review in 2017 the case mix of patients on Tilney Ward has changed. Previous modelling has identified that there was a potential need to increase the establishment and this review indicates that the staffing establishment is well

below what is required. In the first instance an increase by 1 WTE HCA per shift is recommended.

Total cost Band 2 5.75WTE cost= £144,696

10.2 CBU 6

10.2.1 **Oxborough Ward**

Following the CQC visit in April 2018 to Oxborough Ward professional judgement has been applied and an agreed increase of 1 WTE HCA per shift (long day and each night) has been agreed by the Chief Nurse to support the increased in acuity and bed occupancy.

This is currently being filled by temporary bank workers and a cost pressure.

Total cost Band 2 5.75 WTE £137,319

10.2.2 **West Raynham Ward**

To ensure patient safety for this complex patient group the staffing template for was uplifted by 1.22 WTE Band 5, and 7.76 WTE Band 2 during 2016. This has continued to be an overspend to the funded establishment. This review and previous modelling consistently supports this is required as a minimal establishment for this area.

Total cost Band 5 1.22 WTE £45,018

Total cost Band 2 7.76 WTE £185,319

There is also a need to fund the HCA establishment of Band 2 1.8 WTE that is needed to staff the TIA clinic. This clinic is delivered 7 days per week, Monday – Friday 7-9 patients are seen, Saturday and Sunday 2 high risk patients will be seen

Total cost Band 2 1.8 WTE £42,986

10.2.3 **West Newton Ward:**

The current staffing figures used on West Newton were increased in 2015/16 following changes to the configuration of frailty care and the impact on patient case mix. This review and previous modelling consistently supports this is required as a minimal establishment for this area.

This continues to be an overspend to the funded establishment.

Total cost Band 5 1.4 WTE £51,660

Total cost Band 2 8.66 WTE £206,810

10.3 CBU 7

10.3.1 **Terrington Short Stay Ward**

Following the CQC visit in April 2018 to Terrington Short Stay Ward professional judgement has been applied and an agreed increase of 1 WTE HCA per shift (long day

and each night) has been agreed by the Chief Nurse to support the increased in acuity and bed occupancy.

This is currently being filled by temporary bank workers

Total cost Band 2 5.75 WTE £137,319

10.4 CBU 8

No proposed changes

11. NEXT STEPS

The proposals will go to the Trust Executive Committee for discussion and information.

12. RECOMMENDATIONS

The Board of Directors is asked to note the information provided in this report.

Emma Hardwick
Chief Nurse
July 2018

REFERENCES

British Association of Perinatal Medicine (BAPM) (2014) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing: A Framework for Practice
http://www.nna.org.uk/html/BAPM_Optimal%20NICU%20size%202014.pdf
(Accessed 19/10/2017)

Care Quality Commission (CQC) Regulation (2015) Guidance for providers on meeting the regulations
https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
(Accessed 19/10/2017)

DoH (2012) The Health and Social Care Act, The Stationary Office, London
http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf
(Accessed 19/10/2017)

DoH (2015) National Health Service Constitution for England
https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
(Accessed 19/10/2017)

DoH (2016) The Carter Report: Operational productivity and performance in English NHS acute hospitals: Unwarranted variations
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
(Accessed 19/10/2017)

NCEPOD (2017) The National Confidential Enquiry into Patient Outcome and Death: Inspiring Change, London **http://www.ncepod.org.uk/2017report2/downloads/InspiringChange_FullReport.pdf**
(Accessed 19/10/2017)

NICE (2014) 'Safe staffing for nursing in adult inpatient wards in acute hospitals'
https://www.nice.org.uk/guidance/sg1
(Accessed 19/10/2017)

Nursing and Midwifery Council (NMC) (2015)
https://www.nmc.org.uk/standards/code/
(Accessed 19/10/2017)

Shelford Group (2014) Safer Nursing Care Toolkit: Implementation Resource Pack
http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf
(Accessed 19/10/2017)

The Royal College of Nursing (RCN) (2012), Mandatory Nurse Staffing Levels'
https://my.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2_FINAL.pdf

APPENDIX 1

Directorate	*Ward*	*Beds*	*Current Funded RN WTE*	*Current Funded HCA WTE*	*Total establishment funded WTE*	*SCNT Jan – March 18*	*Ratio (RN;Patient) Day/Night*
Medical Services	***Necton Ward***	***33***	*26.41*	*24.6*	*51.01*	*49.9*	*1:5/1:11*
	Oxborough Ward	***33***	*24*	*22*	*48.48*	*50.89*	*1:6.8/1:11.3*
	Stanhoe Ward	***28 +5***	*24.59*	*24.83*	*49.42*	*45.89*	*1:7/1:9.3 1:5/1:5*
	Tilney Ward	***28***	*20.01*	*16.71*	*36.72*	*52.28*	*1:6.75/1:9*
	West Newton Ward	***28***	*18.84*	*28.61*	*47.45*	*47.83*	*1:7/1:9.3*
	West Raynham Ward	***29***	*27.55*	*16.87*	*44.42*	*48.22*	*1:5.8/1:9.6*
	Windsor Ward	***33***	*22.03*	*25.25*	*47.28*	*55.38*	*1:6.6/1:11*
	Leverington (escalation)	***13-19***					
Surgical Services	***Denver Ward***	***28 +2***	*24.16*	*18.48*	*42.64*	*48.09*	*1:8/1:10*
	Marham Ward	***33***	*25.67*	*15.6*	*41.27*	*27.26*	*1:8/1:11*
	Elm Ward	***21***	*14.8*	*14.49*	*29.29*	*25.95*	*1:7/1:10*
	Gayton Ward	***32 +1***	*22.03*	*23.24*	*45.27*	*49.24*	*1:7/1:11*
	CCU	***16***	*64.76*	*3.8*	*68.56*		*1:1 or 1:2*
	SAU	***12***	*17.92*	*6*	*23.92*	*13.02*	*1:4/1:4*
Oncology	***Shouldham Ward***	**12**	13.88	7.94	21.82	21.29	*1:4/1:6*
Emergency Services	***A & E***		59.43	18.15	77.58		*N/A*
	MAU	**25**	26.69	12.55	39.24	50.13	*1:5/1:5*
	Terrington Ward	**34**	25.78	16.05	41.83	40.29	*1:6.6/1:8.5*
	AEC	**10**	3.74	5.34	9.08		
Women & Children	***Castleacre Ward/CDS***		43.33	30.09	73.52		
	NICU		32.59	8.55	41.14		
	Rudham		30.56	11.42	41.98		
Theatre Services	***DCSU***		41.29	22.3	63.59		
	Main Theatres		84.60	25.71	109.81		
	Endoscopy		16.99	6.15	23.14		

APPENDIX 2

The following table shows the minimum levels of staffing (number of registered and unregistered nurses by shift) required to be able to deliver safe care. Where an increase in establishment has been recommended this is shown in red.(please put in red beside any uplift required)

Ward	EARLY		LATE		NIGHT		WTE required included 22% headroom	
	RN	HCA/NA	RN	HCA/NA	RN	HCA/NA	RN	HCA/NA
Denver (28) +2	4	4	4	5	3	2		
Marham - Elective (33)	3	3	3	2	2	2		
AU (no bed base)								
Gayton (32) +1	5	6	4	6	3	3		
Leverington escalation	2	2	2	2	2	2		
SAU (12)	3	1	3	1	3	1		
MAU (25)	5	2	6	2	5	2		
Necton (32)	6	4	6	4	4	3		
Oxborough (34)	5	5	4	5	3	3		
Windsor (33)	5	5	4	5	3	3		
Shouldham (12)	3	1	3	1	2	2		
Stanhoe (27)	4	4	4	4	3	2		
Stanhoe Isolation (5)	1	2	1	2	1	2		
Terrington (34)	5	4	5	4	4	3		
Tilney (28)	4	3	4	3	3	2		
West Raynham (28)	5	5	4	4	3	3		
A&E	9	4	9	6	7 + 2 TW	2 + 2TW		
NICU	4	2	4	2	4	2		

APPENDIX 3 - NATIONAL GUIDANCE FOR STAFFING MODELLING BY SPECIALITY

<table>
<tr><th>Area</th><th>Methodology</th></tr>
<tr><td>Inpatient general Wards</td><td>Safer Nursing Care Tool (SNCT)
1:5 during day and 1:8 at night (average 1:6)
NICE
Necton (Respiratory) In all areas providing acute non-invasive ventilation (NIV), a minimum staffing ratio of 1RN:2 acute NIV patients is required, as recommended in the BTS guideline (2016) and stated in NCEPOD report, “Inspiring Change (2017).”</td></tr>
<tr><td>Care of older persons wards
(Necton, Gayton, Windsor)</td><td>Royal College of Nursing Older: Staffing Older people’s Wards (RCN 2012)
<table>
<tr><th></th><th>Total Staff : Patients</th><th>Registered Nurse : Patients</th><th>Registered : Unregistered</th></tr>
<tr><td>Basically Safe Care</td><td>1 : 3.8</td><td>1 : 7</td><td>50 : 50 %</td></tr>
<tr><td>Ideal, Good Quality Care</td><td>1 : 3.3</td><td>1 : 5</td><td>65 : 35 %</td></tr>
</table></td></tr>
<tr><td>Intensive, Coronary and High Dependency units</td><td>British Association of Critical Care Nurses (BACCN) Royal College of Nursing (RCN guidelines)
o 1:1 level 3 – critical care, 1:2 level 2 – high dependency, 1:3 coronary care. Plus 1 coordinator for each shift</td></tr>
<tr><td>Emergency Department</td><td>Professional Guidelines and SNCT adapted
Baseline Emergency Staffing Tool (BASE)
RSEM ///</td></tr>
<tr><td>Hyper Acute Stroke Unit (HASU)</td><td>National Stroke Strategy –BSSP Guidance 2010
1· 72 hours of an acute strokes patient’s admission require level staffing numbers 1:2 (2.9 WTE per hyper acute bed inclusive of non-registered staff, suggest 80:20 (RN / non-RN) split
o Acute patients 1.35 WTE per bed @ 65/35 (RN / non-RN) split</td></tr>
<tr><td>Maternity Services</td><td>Birthrate Plus (1:29)
Ratio registered to unregistered MW 90:10
Supervisory coordinator 24/7 on delivery suite</td></tr>
<tr><td>Paediatrics</td><td>RCN guidelines 2013 and PANDA (paediatric acuity nurse dependency audit)
o 1:4 nurses during the day/night, under the age of 3 years of age the ratio is 1:3
o ward manager should be supervisory
o the skill mix for the ward should be RN 70:30 NA/SHC and the minimum standard for all inpatient Paediatric wards is to have 2 RSCN/RNC on duty/24hrs (DOH1996)</td></tr>
<tr><td>Neonatal Unit</td><td>British Association of Perinatal Medicine (BAPM)
o 1:4 special care, 1:1 intensive care, 1:2 high dependency</td></tr>
<tr><td>Shouldham – oncology/ haematology</td><td>Haematology peer review standards May 2013 1 RN to 2 neutropenic patients per shift (ward averages 3 neutropenic patients a shift)</td></tr>
</table>