EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE – 26 OCTOBER 2015

Subject: Update on the Nursing Workforce
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Status: D

PURPOSE OF THE REPORT

The purpose of this report is to inform the Trust Executive Group/Healthcare Governance Committee of the outcomes of the June 2015 assessment of staffing levels using the Safer Nursing Care Tool (SNCT), and other methodologies to triangulate the results.

KEY POINTS

- Provide an overview of Nurse staffing within ward areas
- Complies with the requirements relating to nurse staffing contained within Hard Truths: The Journey to Putting Patients First
- The overall results for the Trust in June 2015 indicate that the authorised funded establishment (AFE) for inpatient beds was 2515.15 Whole Time Equivalents (WTE)
- The SNCT data suggests that the required AFE was 2498.47 WTE giving a surplus of 16.68 WTE across the Trust
- Active on-going recruitment is underway to fill vacancies and the identified additional posts required.

IMPLICATIONS

1 Delive the Best Clinical Outcomes
2 Provide Patient Centred Services
3 Employ Caring and Cared for Staff
4 Spend Public Money Wisely
5 Deliver Excellent Research, Education & Innovation

RECOMMENDATIONS

TEG / Healthcare Governance Committee are asked to debate the contents of this report and discuss and approve the recommendations.

APPROVAL PROCESS

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
<th>Approved Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEG</td>
<td>14 October 2015</td>
<td></td>
</tr>
<tr>
<td>Healthcare Governance Committee</td>
<td>26 October 2015</td>
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</tr>
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</table>

1 Status: A = Approval
         A* = Approval & Requiring Board Approval
         D = Debate
         N = Note

2 Against the five aims of the STHFT Corporate Strategy 2012-2017
1. INTRODUCTION

The purpose of this report is to inform the Trust Executive Group and the Healthcare Governance Committee of the outcomes of the June 2015 assessment of staffing levels using the Safer Nursing Care Tool\(^1\) (SNCT), and other methodologies (Hurst 2003)\(^2\) to triangulate the results and give an indication of the Trust’s position in relation to the guidance published by the Royal College of Nursing\(^3\) (RCN 2010). The RCN suggests that to determine appropriate levels of staffing, best practice is to triangulate the results of different methodologies and to evaluate these regularly against patient outcome data. The models currently used within the Trust are SNCT, Professional Judgement and nursing hours per patient day (NHPPD).

The patient outcomes measured in the SNCT are infection rates, medication errors, falls, pressure sores, and complaints, collectively known as Nurse Sensitive Indicators (NSIs).

Following the publication of the National Quality Board\(^4\) report on nursing and midwifery staffing in 2013, Trusts are now mandated to report on staffing capacity and capability every six months at their public Board meetings. This report is expected to:

- Draw on expert professional opinion and insight into local clinical need and context
- Make recommendations to the Board which are considered and discussed
- Be presented to and discussed at the public Board meeting
- Prompt agreement of actions which are recorded and followed up on
- Be posted on the Trust’s public website along with all the other public Board papers

2. HOW TO ENSURE THE RIGHT PEOPLE, WITH THE RIGHT SKILLS, ARE IN THE RIGHT PLACE AT THE RIGHT TIME

The National Quality Board document entitled “How to ensure the right people, with the right skills, are in the right place at the right time; a guide to nursing, midwifery and care staffing capacity and capability” sets out ten expectations for NHS providers and commissioners in relation to nursing and midwifery staffing.

The guide states that Boards should ensure that there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

The guide also states that Boards should be actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made.

The Care Quality Commission (CQC) will be using this guide in its new approach to monitoring, inspecting and rating providers. The expectations set out in the guide will be used to inform their judgements and ratings for providers.

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\(^1\) Shelford Group (2013). Safer Nursing Care Tool. Implementation Resource Guide


\(^3\) RCN (2010) Guidance on safe nurse staffing levels in the UK. London. Royal College of Nursing

\(^4\) National Quality Board. (2013) How to ensure the right people, with the right skills, are in the right place at the right time, A guide to Nursing and Midwifery and care staffing Capacity and Capability. NHS England.
3. HARD TRUTHS COMMITMENTS REGARDING THE PUBLISHING OF STAFFING DATA

Following the publication of the National Quality Board guidance and Hard Truths: The Journey to Putting Patients First (2014)\(^5\), Jane Cummings, Chief Nursing Officer England, NHS England and Mike Richards, Chief Inspector of Hospitals, Care Quality Commission wrote to all Trusts and Foundation Trusts to give clear guidance on the delivery of commitments associated with publishing staffing data regarding nursing, midwifery and care staff.

They set out a number of milestones for the first phase, which focused on all inpatient areas; including acute, community, mental health, maternity and learning disability. The commitments were to publish staffing data at the latest, by the end of 2014 in the following ways:

- A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. This report will be presented to the Board every six months.
- Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level.
- A Board report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month. This report will be presented to the Board every month.
- The monthly report must also be published on the Trust's website, and Trusts will be expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices.

The Trust met all these milestones by 2014.

4. NICE GUIDANCE - SAFE STAFFING FOR NURSING IN ADULT INPATIENT WARDS IN ACUTE HOSPITALS

In July 2014 the National Institute for Health and Care Excellence (NICE) published the first of a planned series of guidelines on safe staffing; adult inpatient wards\(^6\). This guideline recommends a systematic approach at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. This guidance describes the factors that should be taken into consideration when determining ward establishments as well as those that may affect staffing requirements on a day-by-day, shift-by-shift basis. These could be patient, staff or environmental factors which will support the professional judgement method of calculating nurse staffing requirements. A series of outcome measures are identified together with nursing ‘Red Flags’. These ‘Red Flags’ are events which indicate the need to escalate concerns about the staffing level on a ward, for example, a 30 minute delay in administering pain relief.

The guideline identifies organisational and managerial factors that are required to support safe staffing for nursing, and makes recommendations for monitoring and taking action if there are not enough nursing staff available to meet the nursing needs of patients on the ward.

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A gap analysis has been undertaken at STH to ensure that the recommendations from this NICE guidance are fully implemented. The actions from this gap analysis are currently being implemented and work is in progress to address areas of partial compliance.

NICE offers a separate but aligned process to assess whether nurse staffing decision support toolkits such as SNCT intended to informing nursing staff requirements comply with the guideline recommendations.

NICE endorsed the SNCT as a nurse staffing decision support toolkit to be used alongside its guideline on safe staffing for nursing in acute hospitals in October 2014.

In June 2015, NICE suspended the development of safe staffing guidance planned for other care settings and it is suggested that this is taken forward by the wider programme of work to be undertaken by NHS Improvement.

5. CARE CONTACT TIME

In October, NHS England published Safe Staffing: A Guide to Care Contact Time\(^7\). This recognises that there is a balance between direct patient care, for example, attending to a patient’s hygiene needs; indirect patient care, such as discharge planning and other activities such as supervising student nurses. All these activities are required to ensure the provision of high quality care, good patient experience/outcomes and an excellent learning environment, but if the balance is wrong the clinical outcomes or patient/staff/student experience may be affected. The balance of these activities will differ according to the clinical speciality and the acuity/dependency of the patients.

The evidence around the relevance and significance of Care Contact Time remains weak as this is not necessarily a clear indicator that high quality care has been delivered. Anecdotally, if the balance between direct and indirect care is incorrect, care delivery or patient outcomes may be affected.

In August 2014, a pilot to determine Care Contact Time was undertaken on one ward in several Trusts including Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). This pilot used the ‘Activity Clock’ methodology created in Central Manchester University Hospitals NHS Foundation Trust, which is a variation of the Productive Ward methodology. The information gathered gave an indication of the amount of time Registered Nurses and Care Support Workers spent on direct care, indirect care and other activities.

NHS England’s Guide to Care Contact Time identifies a number of tools that may be used to determine how contact time may be measured and recommends that the same tool is used for each measurement cycle to ensure consistency. There is a requirement for providers to undertake a baseline assessment by Summer 2015. The Trust is working in collaboration with University College Hospitals, London and Keith Hurst to develop a robust methodology to assist with this. Comparable wards have been selected for the pilot and testing is planned for October/November 2015.

\(^8\) NHS Institute for Innovation and Improvement (2007): Releasing Time to Care – The Productive Ward
Following the baseline assessment, it is suggested that Care Contact Time should be measured twice a year alongside other indicators

- Planned versus actual staffing
- Quality metrics – national and locally agreed

6. SAFER NURSING CARE TOOL

The SNCT was originally developed in conjunction with the Association of UK University Hospitals (AUKUH) and has subsequently been reviewed and updated in 2013. A variation of the SNCT that addresses the specific staffing requirements of Assessment Units has been used as part of the overall assessment at STH since 2014.

The tool comprises 2 parts:

- An Acuity and Dependency Tool which has been developed to help acute NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.
  - The tool sets out how to measure the acuity (how ill a patient is) and dependency (how dependent a patient is to have their normal needs met, such as moving, eating and drinking, going to the toilet) of patients in a ward, what rules to follow to ensure that data are captured accurately and how to use this information to calculate the optimal level of staff needed in a particular ward using nursing multipliers to ensure the delivery of safe patient care.

- Nurse Sensitive Indicators (NSIs) which have been identified as quality indicators of care with specific sensitivity to nursing intervention. They can be used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. The SNCT demonstrates how NSI outcome data can be used alongside acuity and dependency information to monitor the relationship between ward staffing and nursing outcomes.

Expectation 6 of the National Quality Board recommendations state that Nurses, Midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties; therefore staffing establishments should take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles.

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

At STHFT the level of cover built into ward establishments is 24.3% (474 hours) per Whole Time Equivalent Staff Member:

- 15.3% (298 hours) annual leave
- 4% (78 hours) sickness
- 2.5% (49 hours) study leave
- 2% (39 hours) parenting leave
- 0.5% (10 hours) special leave

This headroom calculation is specific to STHFT and was agreed by the Nurse Executive Group and approved by the Trust Executive Group.
Authorised funded establishments should also afford staff in leadership roles the time to assume supervisory status which is evidenced to improve staff engagement and improve patient outcomes. The SNCT includes an allowance for ward leaders to undertake their leadership roles in a supervisory capacity for 40% of their time.

7. PROFESSIONAL JUDGEMENT

Allied to the use of the SNCT at STHFT is the use of Professional Judgement to confirm appropriate nurse staffing levels. The Professional Judgement model is a bottom up approach used to determine ward staffing requirements and is based on the judgement of experienced nurses to agree the number and grade of staff required to provide care on a specific ward.

The standard formula used to calculate the whole time equivalents (WTEs) required to staff the ward is:

\[
\text{No. of nurses} \times \text{No. of days} \times \text{shift length} + 24.3\% \\
37.5
\]

Worked example

A ward needs 6 nurses in the morning, 4 nurses in the afternoon and 3 nurses on nights. Shifts in the day are 7.5hrs and at night are 9.22hrs. The ward is in use every day.

**Day staffing**

\[
\frac{10 \times 7 \times 7.5}{37.5} = 14 + 24.3\% (3.4) \text{ Day staff =17.4WTE}
\]

**Night staffing**

\[
\frac{3 \times 7 \times 9.22}{37.5} = 5.16 + 24.3\% (1.25) \text{ Night staff =6.41WTE}
\]

The total staffing requirement for the ward including cover would be 23.81 WTE

As well as considering the acuity and dependency of the patients normally cared for by the ward speciality, other factors which can affect staffing requirements include:

- The layout and design of the ward, wards with multiple single rooms or bays may require higher staffing capacity and capability
- The number of housekeepers and other support staff available, employing ward clerks and housekeepers on wards can assist nurses, midwives and care staff by undertaking tasks not directly related to patient care
- Patient throughput, with a high throughput needing more staff to help maintain patient flow.

8. NURSING HOURS PER PATIENT DAY

Historically Trusts have used the nurse per bed ratio to inform nurse staffing levels. However this methodology is relatively simplistic, and with the completion of the implementation of eRostering at STHFT during 2014/15, a more reliable method of calculating the nursing hours per patient is to be used as a third method of determining staffing requirement and is included in this report.

The methodology uses the planned number of nursing hours in a 24 hour period and divides this by the number of patients on the ward to give the nursing hours per patient day based on the funded establishment. This can then be compared to the actual nursing hours
available and comparisons can be drawn between actual and planned by ward. Alternatively the currency for SNCT nursing multipliers could be changed to hours rather than WTE.

9. SKILL MIX

The minimum skill mix recommended by the RCN is a ratio of 65/35 registered nurses/clinical support workers and the target agreed within STHFT is that there should be an average ratio of 70/30 registered nurses/clinical support workers across all inpatient areas, (this is greater than the minimum as it incorporates the higher skill mix required in critical care and other specialist areas).

The ratio of registered nurses to clinical support workers may be lower where other staff are involved in delivering care. For example, Assistant Practitioners, Allied Health Professionals, Operating Department Practitioners; the latter two of which are registered professionals in their own right and contribute significantly towards meeting patient needs.

10. NURSE SENSITIVE INDICATORS

It is acknowledged that SNC data should not be acted upon in isolation and quality aspects of patient care, particularly outcomes must be taken into account. Nationally this is undertaken by means of Nurse Sensitive Indicators (NSIs). These are infection rates (hospital acquired MRSA infection and colonisations and C.Difficile rates); formal complaints related to nursing care, falls, medication errors and pressure sore rates.

After the data collection is completed, the NSIs are adjusted using a denominator of 10,000 bed days, which allows comparison between wards within an organisation and on a national basis amongst those organisations using this methodology. This is analysed using WinChart© software. At STHFT the collection and reporting of NSIs is undertaken throughout the year not just during the SNCT data collection months and is reported, discussed and actions agreed at the monthly Nurse Executive Group.

11. SAFETY THERMOMETER

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ during their hospital stay. This helps teams to assess, learn and improve the safety of the care they provide measuring 4 harms (Pressure ulcers, falls, catheter associated urinary tract infections and risk factors associated with venous thromboembolism). Patients experiencing no harms are classified as receiving harm-free care. However, the tool does not attribute where the harm occurred so a patient who was admitted to hospital with a urinary tract infection associated with a urinary catheter, which developed at home would still be considered to have suffered harm within the hospital. The Safety Thermometer was introduced in 2012 and the Health and Social Care Information Centre (HSCIC) has stated from April 2015 data collected using the NHS Safety Thermometer is included in the NHS Standard Contract under Schedule 6B.

12. SNCT AT SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

STHFT has been involved in the development of the SNCT since 2006 and has robust processes in place, described in a standard operating procedure, for undertaking bi-annual assessments of the nursing establishments of inpatient care areas across the Trust over a four week period. To overcome seasonal variation and to allow national benchmarking, June and January have been selected as the assessment months.

During these months daily assessments of patients are undertaken using the criteria definitions (revised and updated in 2013) and each patient is scored at one of five levels of care. Each level of care has an assigned multiplier which represents the number of nursing staff required to provide care to the patient over a 24 hour period according to their level of acuity or dependency:

<table>
<thead>
<tr>
<th>Level</th>
<th>Level Descriptor</th>
<th>Multiplier (General)</th>
<th>Multiplier (Assessment Units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal patients who can be cared for on a general ward</td>
<td>1.01</td>
<td>1.29</td>
</tr>
<tr>
<td>1a</td>
<td>Acutely ill patients who can be cared for on a general ward</td>
<td>1.41</td>
<td>1.69</td>
</tr>
<tr>
<td>1b</td>
<td>Stable patients with an increased dependency on nurses</td>
<td>1.76</td>
<td>2.11</td>
</tr>
<tr>
<td>2</td>
<td>Patients in ward areas awaiting transfer to High Dependency care</td>
<td>2.01</td>
<td>2.3</td>
</tr>
<tr>
<td>3</td>
<td>Patients in ward areas awaiting transfer to Intensive Care</td>
<td>6.09</td>
<td>6.09</td>
</tr>
</tbody>
</table>

The scores for every patient are then added together to calculate the nursing establishment required to provide the required level of care to each patient and collectively, for the in-patient area concerned. Comparisons are drawn between this information and the Authorised Funded Establishment (AFE) for each ward which is adjusted to reflect the number of nurses who provide direct care to patients, i.e. housekeepers, ward clerks; support workers to junior doctors are not included in the calculation as they do not provide direct nursing care to patients.

The 2013 multipliers account for the nursing staff required to manage patient flow (i.e. the number of admissions, discharges, transfers, escorts and deaths) within the multiplier and different multiplier values have been developed and validated for use in Assessment Units. In addition, an adjustment is made to factor in the period of time patients in the Renal unit spend on haemodialysis as this increases their acuity/dependency level.

The aim of these processes is to use the outcomes of the SNCT to inform appropriate levels of nursing staff and since 2006 good progress has been made across the organisation to address issues such as increases/decreases in demand or acuity. Directorates have taken the opportunity afforded to them by reductions in length of hospital stay to close or reconfigure small wards. These wards often presented as “over staffed” in the SNCT due to the need to have a specific number of registered nurses on duty at all times even if the care needs of patients didn’t warrant this. In other directorates, it has been possible to safely and appropriately reduce nurse staffing levels in one area and increase them in another based on patient acuity.

13. NURSE RECRUITMENT

Since the publication of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013)\textsuperscript{10}, many hospitals have increased their nursing establishment and this, coupled with national reductions in pre-registration commissions, has led to a general shortage in the number of nurses available to recruit. To address this, the Trust continues to work with our higher education providers in the city to maximise the numbers of qualifying student nurses that we recruit, and with Health Education England / Yorkshire and the Humber to ensure the optimum level of pre-registration commissions for nursing.

In partnership with Sheffield Hallam University, a Return to Practice programme to attract former nurses back into the profession has being launched.

The internet site and job adverts have been refreshed to ensure the Trust is seen as an attractive employer. We held a second Careers Fair at the Northern General Hospital in May to attract nurses into the Trust.

A rolling plan to recruit Band 2 and Band 5 staff in particular is in place to try to ensure that all posts within funded establishments are filled.

\textsuperscript{10} Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, The Mid-Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Available at \url{http://www.midstaffspublicinquiry.com/}
This process is constantly under review to ensure STHFT continues to attract high calibre candidates.

Whilst recruiting staff to permanent posts, we will continue to work with NHS Professionals (NHSP) who are the main supplier of nurses on a temporary basis (often described as “bank” nurses) to ensure that we fill any vacant shifts.

The Trust, in a joint venture with NHSP, undertook recruitment within the EU, with the first group of 11 qualified nurses commencing placement on a selected wards in October/November 2015.

14. OVERALL RESULTS

The overall results for the Trust in June 2015 indicate that the authorised funded establishment (AFE) for inpatient beds was 2515.15 WTE and the SNCT data suggests the required AFE was 2498.47 WTE giving a surplus of 16.68 WTE (0.67%) across the Trust.

It should be noted that the 44.6 additional posts authorised in 2014 (see Emergency Care & Combined Community and Acute Care (CCAC) page 12) are included in the AFE in June. The vacancy and staff unavailability position is identified in the table below.

<table>
<thead>
<tr>
<th>June 2015</th>
<th>Authorised Funded Establishment (WTE)</th>
<th>SNCT assessment (WTE)</th>
<th>Difference (WTE)</th>
<th>Skill Mix</th>
<th>Vacancy (WTE)</th>
<th>Number of Bank nurses used (WTE)</th>
<th>Sick Leave</th>
<th>Parenting Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>2515.15</td>
<td>2498.47</td>
<td>+16.68</td>
<td>71:29</td>
<td>150.89*</td>
<td>145.91</td>
<td>6.3%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

*Active on-going recruitment is underway to fill vacancies and identified additional posts required.

Comparison with previous positions over the past 3 years in June is illustrated in the table below. The results have been adjusted to take account of the changes in service provision and the reconfiguration of the Care Groups and do not include data from wards that have closed. The June 2015 position reflects the acuity and dependency of patients where a 7% increase in the number of patients with a higher dependency was identified with a corresponding decrease in Level 0 patients. It is important to note that the results in June 2014 and June 2015 are calculated using the revised criteria definitions and multiplier values, so are not directly comparable with results in 2013.

<table>
<thead>
<tr>
<th>Month</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 0</td>
</tr>
<tr>
<td>June 2013</td>
<td>+25.92</td>
<td>42</td>
</tr>
<tr>
<td>June 2014</td>
<td>+12.58</td>
<td>43</td>
</tr>
<tr>
<td>June 2015</td>
<td>+16.68</td>
<td>36</td>
</tr>
</tbody>
</table>

The overall skill mix ratio for the Trust was 71:29 Registered Nurses to Support Workers, which is in line with Trust standards and the national expectation of 65:35 Registered Nurses to Support Workers in general wards. The results are reflective of the higher skill mix ratios required for Critical Care areas.
Anecdotally, it has been suggested nationally that the number of patients who require an increased level of supervision on adult inpatient wards i.e. ‘specialling’ has increased and this has been estimated at 8% within STHFT when compared to the same period last year. Further work is planned this year to test new criteria definitions for this group of patients determine the nursing requirements to meet their needs.

The overall nurse to patient ratio for the Trust was 1 RN for every 5.13 patients during the day and 1 RN for every 8.14 patients at night. These ratios have improved from last year as a result of the investment in staffing within Emergency Care and CCAC and vary between each Care Group.

**Safety Thermometer**

During June 2015 the Trust was assessed through Safety Thermometer data as delivering 92.72% harm-free care.

**15. NURSE STAFFING BY CARE GROUP**

Using the data gathered in the nurse staffing assessment, the overall summary is that all of the care groups are staffed appropriately against the SNCT criteria apart from the Emergency Care Group, CCAC and Musculo-Skeletal (MSK) to a lesser extent. Further detail about each care group is detailed in this paper.

**Operating Services, Critical Care and Anaesthesia (OSCCA)**

The British Association of Critical Care Nurses recommend a ratio of 1 nurse to 1 patient in an Intensive Care (Level 3) bed and 1 nurse to 2 patients in a High Dependency (Level 2) bed and that staffing should be sufficient to accommodate 95% of all referrals for Level 3 care.¹¹ Within STHFT, Critical Care areas are currently staffed to 100% occupancy using the nurse to patient ratios that reflect the BACCN recommendations. In June 2015 there was an overall bed occupancy of 85% within this Care Group in comparison to June 2014 (93%). The bed occupancy for Level 3 patients equated to 70% which affected the results, showing a surplus of 52.98 WTE. On a day by day basis any surplus staff are being utilised to support staffing in other areas in the Trust.

A total of 5.46 WTE bank nurses were used to supplement staffing levels to accommodate an increased percentage of sick leave. The skill mix ratio for this Care Group was 87:13. Registered Nurses to Support Workers, which is appropriate for a critical care setting. The design of the Critical Care Unit provides 50% of the beds in single rooms, necessitating the employment of additional support staff over BACCN levels to assist in the delivery of care and maintain patient safety.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>AFE (WTE)</th>
<th>SNCT (WTE)</th>
<th>Difference (WTE)</th>
<th>Skill Mix</th>
<th>Vacancy (WTE)</th>
<th>Bank (WTE)</th>
<th>Sick Leave</th>
<th>Parenting Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>205.4</td>
<td>152.42</td>
<td>+52.98</td>
<td>87:13</td>
<td>6.75</td>
<td>5.46</td>
<td>7.6%</td>
<td>4.7%</td>
</tr>
</tbody>
</table>


**Historical Information**

Comparison with the position in June over the past 3 years is illustrated in the table below.
<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 0</td>
<td>Level 1a</td>
</tr>
<tr>
<td>June 2013</td>
<td>+47.16</td>
<td>0</td>
</tr>
<tr>
<td>June 2014</td>
<td>+44.9</td>
<td>0</td>
</tr>
<tr>
<td>June 2015</td>
<td>+52.98</td>
<td>0</td>
</tr>
</tbody>
</table>

**Professional Judgement**

Using this methodology, the establishment required was 201.09 WTE, a surplus of 4.31 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 1.3 patients during the day and 1 RN for every 1.3 patients at night.

**Nursing Hours per Patient Day**

The planned NHPPD was 25.62 hours per patient compared to the actual of 22.77 hours. The difference between the planned and actual NHPPD was due to having fewer Level 3 patients than planned.

**Safety Thermometer**

The Safety Thermometer data for OSCCA showed the Directorate delivered 96.43% harm free care in June 2015.

**Nurse Sensitive Indicators**

There were 4 red scores for NSIs across this Care Group which relate to medication incidents (2) and pressure ulcers (2). This compares 5 red scores last year – pressure ulcers (2), medication incidents (2) and infection rates (1).

**Emergency Care (EC)**

In October 2014 the services in the Care Group were reorganised and the elderly care and stroke medicine wards were moved into the new Combined Community and Acute Care Group. This also involved the transfer of a ward from the Royal Hallamshire site to the Northern Campus and several ward moves within the Care Group to ensure the co-location of the Gastroenterology wards.

The deficit between the AFE and that recommended by the SNCT is 47.5 WTE for June 2015. Increased acuity and dependency of patients together with a rise in demand and delayed transfers of care have been key factors in the assessed increase in nurse staffing required.

Previous reports on nurse staffing have described how changes to how care was delivered had led to appropriately and safely planned reductions in the number of beds required to be staffed in the Care Group. During 2012/13, these reductions were reversed to accommodate increased demand and patient numbers, leading to all of the beds that had previously been closed being re-opened to accommodate patients requiring admission. Despite a great deal of effort and investment across health and social care services, these beds have remained open, through 2014 and into 2015, some closing mid-June 2015. This position of sustained increased demand was reflected across services nationally, not just at STHFT. The SNCT assessments confirm that that this has had an impact on nurse staffing levels in the Emergency Care Group.

Assessment of changes to the dependency levels in the Emergency Care Group also identified a number of factors which increased the assessed need for nursing staff.
• Outliers – during June 2015, due to increased demand there were a number of patients cared for in beds outside of the specialty concerned. For example, a patient under the care of a Respiratory Physician may be cared for in a surgical ward due to demand. Normally it is those patients with the lowest level of care need or dependency who are placed in other specialty beds hence increasing the concentration of the more sick and dependant patients on base Emergency Care wards.

• Huntsman 5 – this ward cared for patients who were to be discharged within a week from both the assessment centres and from the base wards; however the ward now admits acute medical patients with increased levels of dependency.

• Increased Dependency of patients – although it is not clear why, the dependency of patients across the country was higher; this was particularly evident in the older population. This was reflected in the emergency admission profile through Accident and Emergency / Bed Bureau which saw an 3% increase in the admission of people over the age of 85 in June 2015 compared to the same period last year.

By using the SNCT outcomes, together with the NSIs and Professional Judgement, wards and shifts where initial additional nurse staffing investment is required have been identified. These areas require 20.23 WTE staff at a total cost of £658,800. The Trust Executive Group identified funding in the 2014/15 financial plan to address these priority areas and recruitment to the additional posts has been integrated to overall recruitment to posts in the Care Group.

The shortfall from the SNCT and the 37.6 WTE vacancies are currently being addressed by the use of 47.67 WTE bank nurses during this period. In addition some of this shortfall has been met by appropriately skilled staff being deployed from other roles such as Clinical Education, or other areas such as Critical Care or non-Emergency Care wards at the Royal Hallamshire Hospital.

The Care Group, as a result of implementation of the Right First Time strategy, is expecting to need fewer wards as patients are appropriately cared for in their own home and this may reduce any remaining deficit further.

### Historical Information

Comparison with the position in June over the past 3 years is illustrated in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 0</td>
</tr>
<tr>
<td>June 2013 (Winter bed ward not included)</td>
<td>-24.59</td>
<td>52</td>
</tr>
</tbody>
</table>
Professional Judgement

Using this methodology, the establishment required was 477.37 WTE, a shortfall of 7.31 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 6 patients during the day and 1 RN for every 8.2 patients at night. The investment in nurse staffing has improved the RN to patient ratios at night.

Nursing Hours per Patient Day

The planned NHPPD was 5.77 hours compared to the actual of 5.72 hours.

Safety Thermometer

The Safety Thermometer data shows the Care Group delivered 88.37 % harm free care in June 2015.

Nurse Sensitive Indicators

There were 1 red – related to infection rates and 5 amber scores for NSIs within this Care Group; compared to 4 red and 5 amber scores last year.

Combined Community and Acute Care Group

The Combined Community and Acute Care Group was formed in November 2014 and includes the elderly care and stroke medicine wards together with the 31 in-patient beds at Beech Hill. The inpatient wards were previously part of the Emergency Care Group and the new CCAC Care Group have faced the same issues this winter as Emergency Care, which were highlighted in the previous section. The SNCT assessment in January reflected the impact of these issues on nurse staffing requirements.

Beech Hill is an intermediate care facility that provides rehabilitation for patients who have suffered a stroke or are recovering from orthopaedic surgery. These patients have been transferred from acute in-patient beds and as the focus is on rehabilitation prior to their return home, these patients are not acutely ill and their care needs are less than those of an acute hospital in-patient. It should be noted that the ratio of registered nurses to clinical support workers is less than would be found in an acute in-patient setting as a proportion of the unqualified staff are therapy assistants and other staff are involved in delivering care. This would also include Physiotherapists and Occupational Therapists, both of which are registered professionals in their own right and contribute significantly towards meeting patient needs. These arrangements impact on the overall skill mix for the Care Group, which is lower than the national expectation for acute wards.

The deficit between the AFE and that recommended by the SNCT is 39.67 WTE for June 2015.

Changes to how care was delivered had led to appropriately and safely planned reductions in the number of beds required to be staffed in the Care Group. Despite a great deal of effort and investment across health and social care services, these beds have remained open. This position of sustained increased demand was reflected across services nationally, not just at STHFT. The SNCT assessment in June reflects the impact of the increased demand on nurse staffing requirements.

By using the SNCT outcomes, together with the NSIs and Professional Judgement, wards and shifts where initial additional nurse staffing investment is required have been identified.
These areas require 26.45 WTE staff at a total cost of £880,300. The Trust Executive Group identified funding in the 2014/15 financial plan to address these priority areas and recruitment to the additional posts has been integrated to overall recruitment to posts in the Care Group.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>AFE (WTE)</th>
<th>SNCT (WTE)</th>
<th>Difference (WTE)</th>
<th>Skill Mix</th>
<th>Vacancy (WTE)</th>
<th>Bank (WTE)</th>
<th>Sickness</th>
<th>Parenting Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Community &amp; Acute Care</td>
<td>376.85</td>
<td>416.52</td>
<td>-39.67</td>
<td>61:39</td>
<td>27.39</td>
<td>27.66</td>
<td>6.9%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

**Historical Information**

Comparison with the position in June over the past 3 years is illustrated in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 0</td>
<td>Level 1a</td>
</tr>
<tr>
<td>June 2013</td>
<td>-32.68</td>
<td>38</td>
</tr>
<tr>
<td>June 2014</td>
<td>-36.66</td>
<td>37</td>
</tr>
<tr>
<td>June 2015</td>
<td>-39.67</td>
<td>28</td>
</tr>
</tbody>
</table>

**Professional Judgement**

Using this methodology, the establishment required was 377.46 WTE, a deficit of 0.61 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 5.6 patients during the day and 1 RN for every 10 patients at night.

**Nursing Hours per Patient Day**

The planned NHPPD was 6.03 hours compared to the actual of 5.84 hours.

**Safety Thermometer**

The Safety Thermometer data shows the Directorate delivered 88.41 % harm free care in June 2015.

**Nurse Sensitive Indicators**

There were 7 red (related to falls (4), pressure ulcers (1) and infection rates (2)) and 6 amber scores for NSIs across the Care Group. This compared to 1 red and 5 amber score last year.

The Geriatric and Stroke Medicine wards within the Care Group continue to participate in the falls work stream to try to reduce patient falls.

**Head and Neck**

The results for June 2015 indicate a surplus of 23.86 WTE between the AFE and the SNCT assessment.

A skill mix of 71:29 is close to the Trust standard.
Historical Information

Comparison with the position in June over the past 3 years is illustrated in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 0</td>
</tr>
<tr>
<td>June 2013</td>
<td>-3.6</td>
<td>37</td>
</tr>
<tr>
<td>June 2014</td>
<td>+8.83</td>
<td>34</td>
</tr>
<tr>
<td>June 2015</td>
<td>+23.86</td>
<td>36</td>
</tr>
</tbody>
</table>

Professional Judgement

Using this methodology, the establishment required was 265.03 WTE, a surplus of 6.59 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 4.8 patients during the day and 1 RN for every 9.2 patients at night.

Nursing Hours per Patient Day

The planned NHPPD was 8.64 hours compared to the actual of 8.12 hours.

Safety Thermometer

The Safety Thermometer data shows the Care Group delivered 96.94% harm free care in June 2015.

Nurse Sensitive Indicators

This Care Group achieved green scores for the NSIs compared to 2 red and 1 amber scores to last year.

Laboratories, Engineering, Gynaecology, Imaging, Obstetrics and Neonatology (LEGION)

The data shows that within Gynaecology there is a deficit of 1.12 WTE in June 2015, which reflects the impact of patients from other specialities outlying on this ward. Operational changes were made to the service last year to flexibly reduce bed numbers, attempting to meet fluctuating occupancy levels. On a day by day basis any surplus is being utilised to support staffing in other areas in the Trust.

The skill mix 69:31 and is in line with the Trust standard.
**Historical Information**

Comparison with the position over the past 3 years is illustrated in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 0</td>
</tr>
<tr>
<td>June 2013</td>
<td>+4.87</td>
<td>71</td>
</tr>
<tr>
<td>June 2014</td>
<td>+6.74</td>
<td>77</td>
</tr>
<tr>
<td>June 2015</td>
<td>-1.12</td>
<td>63</td>
</tr>
</tbody>
</table>

**Professional Judgement**

Using this methodology, the establishment required was 26.41 a surplus of 1.88 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 7.3 patients during the day and 1 RN for every 10.5 patients at night.

**Nursing Hours per Patient Day**

The planned NHPPD was 4.62 hours compared to the actual of 4.59 hours.

**Safety Thermometer**

The Safety Thermometer data shows the Directorate delivered 100% harm free care in June 2015.

**Nurse Sensitive Indicators**

There was 1 red score related to complaints and 1 amber score in this Care Group in comparison to all green scores for the NSIs in June 2014.

**South Yorkshire Regional Services (SYRS)**

The data show that within SYRS there is a surplus of 27.8 WTE in June 2015. Most of this is attributable to lower than anticipated occupancy levels in the Cardiac Intensive Care Unit (CICU). CICU have increased the number of beds they use this year. The WTE reflects the number of staff that are required to achieve this increased number of beds, whilst newly recruited staff are being trained, not all the CICU beds have been available for patients.

In addition to the reduced bed occupancy of 85% in the Cardiac Intensive Care Unit there were only 2 occasions in the month when there were 12 patients requiring care in a Level 3 bed.

The Vascular ward has reviewed their rosters to maximise the use of the resource they have available (such as introducing 12 hours shifts for all staff) but otherwise there are no significant changes.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>AFE (WTE)</th>
<th>SNCT (WTE)</th>
<th>Difference (WTE)</th>
<th>Skill Mix</th>
<th>Vacancy (WTE)</th>
<th>Bank (WTE)</th>
<th>Sickness %</th>
<th>Parenting Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYRS</td>
<td>395.31</td>
<td>367.51</td>
<td>+27.8</td>
<td>77:23</td>
<td>9.7</td>
<td>14.88</td>
<td>6.2%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>
### Historical Information

Comparison with the position in June over the past 3 years is illustrated in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 0</td>
</tr>
<tr>
<td>June 2013</td>
<td>+11.16</td>
<td>38</td>
</tr>
<tr>
<td>June 2014</td>
<td>+35.25</td>
<td>44</td>
</tr>
<tr>
<td>June 2015</td>
<td>+27.8</td>
<td>46</td>
</tr>
</tbody>
</table>

### Professional Judgement

Using this methodology, the establishment required was 386.19 WTE, and is a surplus of 9.12 WTE against the AFE, this figure assumes that CICU is operating to its new increased occupancy level and the changes made to shift patterns. The overall nurse to patient ratio for the Care Group was 1 RN for every 3.8 patients during the day and 1 RN for every 6 patients at night.

### Nursing Hours per Patient Day

The planned NHPPD was 10.97 hours compared to the actual of 10.3 hours.

### Safety Thermometer

The Safety Thermometer data shows the Care Group delivered 96.69% harm free care in June 2015.

### Nurse Sensitive Indicators

There were 4 red (related to pressure ulcers, complaints, medication incidents and infection rates) and 1 amber score for NSIs across the Care Group, this compared to 1 red and 3 amber scores in June last year.

### Specialised Medicine, Rehabilitation and Cancer Services

The results for this Care Group show a surplus of 18.75 WTE. The closure of beds due to infection control constraints and refurbishment of the wards within Spinal Injuries and a subsequent reduced bed occupancy (84% compared to 88% last year) have affected these results.

Temporary staffing is being used to offset the higher than usual number of vacancies within this Care Group.

### Historical Information

Comparison with the position over the past 3 years is illustrated in the table below.
<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 0</td>
<td>Level 1a</td>
</tr>
<tr>
<td>June 2013</td>
<td>+6.68</td>
<td>17</td>
</tr>
<tr>
<td>June 2014</td>
<td>+7.63</td>
<td>27</td>
</tr>
<tr>
<td>June 2015</td>
<td>+18.75</td>
<td>22</td>
</tr>
</tbody>
</table>

**Professional Judgement**

Using this methodology, the establishment required was 294.83 WTE, a surplus of 14.97 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 4.5 patients during the day and 1 RN for every 7.9 patients at night.

**Nursing Hours per Patient Day**

The planned NHPPD across the Care Group was 8.4 hours compared to the actual of 7.89 hours.

**Safety Thermometer**

The Safety Thermometer data shows the Care Group delivered 95.39 % harm free care in June 2015.

**Nurse Sensitive Indicators**

There were 1 red (related to infection rates) and 2 amber scores for NSIs across the Care Group and this compared to 3 amber scores last year.

**Surgical Services**

Reconfiguration of services within the Care Group was planned from 1st July 2015 and these results reflect the changes. There is a deficit of 1.86 WTE between the AFE and the requirements for the SNCT in June 2014.

There has been an increase in the number of acutely ill patients and a corresponding decrease in the number of patients at level 0.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>AFE (WTE)</th>
<th>SNCT (WTE)</th>
<th>Difference (WTE)</th>
<th>Skill Mix</th>
<th>Vacancy (WTE)</th>
<th>Bank (WTE)</th>
<th>Sickness Leave</th>
<th>Parenting Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Services</td>
<td>281.3</td>
<td>283.16</td>
<td>-1.86</td>
<td>68:32</td>
<td>12.73</td>
<td>13.8</td>
<td>4.4%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

**Historical Information**

Comparison with the position in June over the past 3 years is illustrated in the table below.
### Professional Judgement

Using this methodology, the establishment required was 271.18 WTE, a surplus of 10.12 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 5.4 patients during the day and 1 RN for every 8.2 patients at night.

### Nursing Hours per Patient Day

The planned NHPPD across the Care Group was 7.63 hours compared to the actual of 6.94 hours.

### Safety Thermometer

The Safety Thermometer data shows the Care Group delivered 93.99% harm free care in June 2015.

### Nurse Sensitive Indicators

There were 2 red (related to infection rates and complaints) and 4 amber scores for NSIs across the Care Group. This compared to 1 red and 3 amber scores last year.

### Musculo-Skeletal Group (MSK)

This Care Group became operational on 1 July 2015 and for reporting purposes the results have been removed from the original Surgical Services Group to allow the new management team to address issues arising from the results.

There is a deficit of 16.56 WTE between the AFE and the requirements for the SNCT in June 2015.

There has been an increase in the number of dependent patients and a corresponding decrease in the number of patients at level 0.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>AFE (WTE)</th>
<th>SNCT (WTE)</th>
<th>Difference (WTE)</th>
<th>Skill Mix</th>
<th>Vacancy (WTE)</th>
<th>Bank (WTE)</th>
<th>Sickness Leave</th>
<th>Parenting Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSK</td>
<td>176.57</td>
<td>193.13</td>
<td>-16.56</td>
<td>63:37</td>
<td>15.22</td>
<td>19.40</td>
<td>8.5%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

### Historical Information

Comparison with the position in June over the past 3 years is illustrated in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surplus/Deficit</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level 0</td>
</tr>
<tr>
<td>June 2013</td>
<td>+10.77</td>
<td>48</td>
</tr>
<tr>
<td>June 2014</td>
<td>+0.97</td>
<td>54</td>
</tr>
<tr>
<td>June 2015</td>
<td>-1.86</td>
<td>42</td>
</tr>
</tbody>
</table>
Professional Judgement

Using this methodology, the establishment required was 169.35 WTE, a surplus of 7.22 WTE against the AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 6.8 patients during the day and 1 RN for every 9.7 patients at night.

Nursing Hours per Patient Day

The planned NHPPD across the Care Group was 5.55 hours compared to the actual of 5.48 hours.

Safety Thermometer

The Safety Thermometer data shows the Care Group delivered 90.27% harm free care in June 2015.

Nurse Sensitive Indicators

There were 3 red (related to infection rates) and 1 amber scores for NSIs across the Care Group. This compared to 2 amber scores last year.

16. FUTURE DEVELOPMENTS

Work is on-going in relation to the Safer Nursing Care Tool and it is anticipated that there will be a set of specific criteria definitions and multipliers developed and validated for use in the following areas:

- Long-stay elderly care wards (including patients whose transfer of care is delayed)
- Community settings
- Emergency Departments
- The care of patients who require specialising

The evidence based tools in use and those under development are being reviewed and the SNCT for adult inpatient areas has been endorsed for use by NICE. STHFT participated in the field testing for the NICE staffing guidance on Adult Inpatient Wards in Acute Hospitals and would be keen to be involved in the field testing for other relevant staffing guidance that may be issued by NHS Improvement such as Emergency Departments, and community nursing if invited to do so. An IT solution, including an App is also in the development phase and should be available later this year.

17. RECOMMENDATIONS AND FURTHER WORK

Significant progress continues to be made to ensure that data gathered to measure the Safer Nursing Care of patients within STHFT are accurate, reliable, valid and timely. As a result of this it is clear that a number of issues need to be addressed:

- It should be noted that there a number of challenges in relation the vacancy position and on-going recruitment, increasing parenting leave and high levels sickness which continue to impact on the nursing workforce.
- Staffing levels in Critical Care are currently being reviewed to produce a cost effective solution to the apparent imbalance. Work has being undertaken to allow more flexibility in the use of Level 2 and Level 3 beds and the corresponding nurse
staffing requirements. Changes to the service has increased the Level 2 capacity to meet unmet need for High Dependency Care for patients undergoing elective surgery and a further increase is planned to accommodate the anticipated demand over the winter period.

The OSCCA Care Group are working towards a zero tolerance approach to medication errors and a further awareness raising campaign has been held in relation to pressure ulcers.

- Permanent staffing levels on the wards in Emergency Care and Combined Community and Acute Care are being addressed. Recruitment of staff to the current vacant posts is ongoing. Both Care Groups are considering how many inpatient beds they require and how much this should increase over winter. Once this exercise has been completed, the impact on nurse staffing for these Care Groups can be assessed.

- The Emergency Care Group are reviewing a number of clinical pathways including an increase in the number of Respiratory Support beds and a redesign of the Medical Assessment Unit to incorporate ambulatory care. It was acknowledged that the requirement to provide additional capacity when operational pressures increase should be considered in this work.

- Within the Combined Community and Acute Care Group the planned bed capacity for winter proved insufficient to meet the twin pressures of increased numbers of admissions and delayed transfers of care. The Care Group are also considering the redesign of the clinical pathway for Stroke patients.

- The Head and Neck Care Group are anticipating an increase in major Head and Neck surgery from April 2015 when some major cancer surgery transfers from Chesterfield and the impact of this on nurse staffing will need monitoring.

There has been an increase in nurse staffing within Neuro-rehabilitation to meet the needs of patients with challenging behaviour and this is to be reviewed over the next year.

- The LEGION Care Group are reviewing the patient pathways within Gynaecology services with a focus on increasing ambulatory care and bed occupancy levels.

Within Midwifery services, the current tool of choice nationally is Birthrate Plus, however further work has been undertaken to develop a more user friendly tool. NICE have developed Safe Staffing Guidance for Midwifery services, published in February 2015 and the Care Group are to report on progress in implementation in Autumn 2015.

- Within the SYRS Care Group there are plans to open a fifth operating theatre and to improve the utilisation of CICU. There are plans to review the skill mix within CICU and re-invest any surplus in the nursing resource within Cardiology. There is also a drive to reduce length of stay by the introduction of an enhanced recovery programme. In addition Renal services are to increase their ambulatory care pathways. Both of these initiatives will need monitoring for their impact on nurse staffing.

- Within Specialised Medicine, Cancer and Rehabilitation services there are a number of initiatives to review clinical pathways which may impact on nurse staffing levels. It is anticipated that the level of activity within the Bone Marrow Transplant service will increase and the reconfiguration and refurbishment of existing wards at the Royal Hallamshire Hospital will accommodate this. In particular the conversion of one ward to all single rooms may impact on the nurse staffing requirement and this will be monitored over the next year.
The refurbishment of the wards within the Spinal Injury unit and the reconfiguration of the wards is expected to be complete by January 2016. It is anticipated that the number of beds required for patients who require respiratory ventilator support will also increase.

- The Surgical Services Care Group are reviewing clinical pathways within Urology with a view to potential reconfiguration/relocation of services. This work may affect the nurse staffing levels required in this Care Group.

- The newly formed MSK Care Group are currently reviewing their clinical pathways and bed requirements which may affect nurse staffing levels.

- It is recommended that all Care Groups should ensure that the staffing demand templates within the eRostering system are in line with the AFE for each ward.

- The outcome measures used in the Trust including Safety Thermometer and NSI results continue to be subject to appropriate action to address any preventable shortfalls.

- The Trust will continue to be involved in the national developments related to the Safer Nursing Care Tool and participate in the testing and validation of speciality specific multipliers as they become available. In particular, further work is underway to test the new criteria definitions for those patients who require ‘specialling’ to review the nurse staffing requirement to care for this group of patients.

In addition, STHFT is to work collaboratively with University College Hospitals London, and have engaged the services of Dr Keith Hurst to assist us to determine the Care Contact Time baseline on wards using SNCT data as agreed by the Nursing Executive Group in April 2015. The methodology is to be tested on a group of wards in October/November 2015.

- Nurse Directors are required to produce action plans based on the SNCT results for their Care Group with recommendations for adjustments to AFEs that will be discussed and agreed within the Care Group and approved by the Chief Nurse.

- A review of nursing establishments is undertaken annually and this will consider skill mix ratios for individual wards to ensure that they remain relevant, reflect service changes, national guidance and are within the parameters agreed with the Chief Nurse.

- An option appraisal has been undertaken to consider whether investment in a system that will deliver real time assessment of nurse staffing and patient acuity and dependency will allow for more efficient use of the nursing resource to ensure high quality patient care and meet the requirements of the NICE safe staffing guidance. Following discussion at NEG it was agreed that this should not be pursued whilst the Trust was focusing on the implementation of the Electronic Patient Record.

- The Safe Staffing guidance issued by NICE has been reviewed and an action plan to address any shortfalls in compliance is being implemented by NEG. Further work has been undertaken in relation to Red Flag events and agreement is required to determine how these are monitored and reported.

- Work should continue to reduce the levels of sickness/absence seen across the Trust.
18. CONCLUSIONS

Overall the staffing requirement to meet the needs of patients in the adult inpatient wards broadly reflects the staffing resource currently allocated. To maintain this position, active recruitment continues for both Registered Nurses and Clinical Support Workers in order to address vacancies as they arise and to fill the additional posts created last year in the Emergency Care and Combined Community and Acute Care Groups. Robust systems, policies and procedures are employed to ensure staff are deployed and redeployed to meet patient demand on a shift by shift basis.

The triangulation of the Safer Nursing Care Tool, professional judgement, NHPPD and RN to patient ratios, demonstrates that the Trust has a reliable framework in place to ensure nurse staffing levels are commensurate with workload and patient outcomes and the Trust Executive Group / Healthcare Governance Committee are asked to note the contents of this report.