Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the HR & OD Committee

Being Held on 13 June 2022

Subject	Update on the Nursing Workforce – February 2022
Supporting TEG Member	Professor Chris Morley, Chief Nurse
Authors	Ms Emma Roberts, Associate Chief Nurse, Central Nursing Mrs Karen Jessop, Deputy Chief Nurse
Status[1]	D

PURPOSE OF THE REPORT

The purpose of this report is to inform the HR & OD Committee of the outcomes of the February 2022 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 adult inpatient wards, based on actual funded establishments.
- Considers updated nurse staffing reporting recommendations contained within recent publications
- The overall results for the Trust in February 2022 indicate that the authorised funded establishment (AFE) for inpatient beds was 2175.21 Whole Time Equivalents (WTE). This report excludes critical care areas, operating theatres and the Emergency Department.
- The SNCT data suggests that the required AFE was 2056.98 WTE giving a surplus against funded establishments of 118.23 WTE across the Trust.
- Professional Judgement scores suggest that a WTE of 2175.87 is required when accounting for risks and challenges in relation to current patient presentation and care needs following the impact of Covid -19 pandemic.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver 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	✓
6	Create a Sustainable Organisation	✓

RECOMMENDATIONS

The HR & OD Committee are asked to debate the contents of this report and discuss and approve the recommendations.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Trust Executive Group	1 June 2022	Y
HR/OD Committee	13 June 2022	

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

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1. INTRODUCTION

The purpose of this report is to inform the Trust Executive Group (TEG) and the HR&OD committee of the outcomes of the STHFT February 2022 assessment of staffing levels using the Safer Nursing Care Tool (SNCT, Shelford Group 2013)[1] and professional judgement. The Developing Workforce Safeguards, published by NHS improvement in 2018[2], builds on various publications by the National Quality Board (2018) and Lord Carter of Coles review (February 2016)[3] providing guidance and recommendations in relation to the reporting of safe staffing to Trust Boards.

The paper focuses specifically on a review of nursing levels for acute in-patient ward areas. Areas such as critical care, theatres and ED are not included as the original tool was not designed to be used in these areas, a tool specifically for the Emergency Department has been developed and a single data cycle has been undertaken with a second planned for later this year whereupon a report will follow.

The impact of Covid-19 resulted in 'light touch; staffing reviews during 2020 and 2021.The impact of the pandemic has resulted in all ward establishments and ward staffing levels flexing in terms of ward function, speciality and acuity/ dependency levels in relation to patient care needs, which still continues to be necessary at the present time.

The Developing Workforce Safeguards (NHSI 2018) reinforces the requirement for Trusts to adopt a triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing. Compliance with the principles outlined in the document is to be assessed annually.

In relation to workforce planning, the guidance recommends that establishment setting must be undertaken annually, with a mid-year review and this process should consider the following:

- Patient acuity and dependency using Shelford Safer Nursing Care Tool
- Activity levels
- Professional Judgement
- Seasonal variation in demand
- Service developments/changes and commissioning
- Staff supply and experience including e-rostering data
- The use of temporary staffing above the set establishment
- Patient and staff outcome measures
- STHFT undertake a formal evaluation of the care group establishments led by the Associate Chief Nurse, Nurse Directors, finance colleagues and the eroster team in February of each year to ensure that any amendments to rota templates and establishments are agreed prior to the new financial year. A mid-year review as a paper return is planned for August completed by the care group Nurse Director following the July acuity and dependency data collection and review.

Additionally, comprehensive quality impact assessments are recommended when new roles are introduced, there is workforce redesign or a change in skill mix is considered.

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[1] The Shelford Group. (2018). Safer Nursing Care Tool: Implementation Resource Pack. Retrieved from The Shelford Group: http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

[2] NHS Improvement. (October 2018). Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing. https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

[3] Lord Carter of Coles, P. (2016, February). Operational productivity and performance in English NHS acute Hospitals: Unwarranted variations. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

It should be noted that a number of wards have been reconfigured in response to the changing Covid-19 situation and a number of rostering template adjustments were made based on changes to patient demographic and care needs. The resulting change in patient care requirements on these wards has resulted in changes to expected acuity and dependency which is why it is necessary to take a triangulated view with professional judgement and quality indicators.

Twice a year a formal review of patient acuity and dependency is undertaken Trust wide. During these months (usually January and June) daily assessments of patients are undertaken using clinical descriptors as detailed in **Appendix one**

These descriptors are in the process of being reviewed as part of a refresh of the SNCT multipliers overseen by the Shelford Group, to ensure they accurately reflect current patient requirements- with the updated multipliers expected later in 2022. As an example, the current multipliers do not account for patients who may require an enhanced level of observation e.g. to reduce falls risks. 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. The scores for every patient are then added together to calculate the nursing establishment needed to provide the required level of care to each patient, and collectively, for the inpatient 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. Housekeepers, ward clerks and Doctor support workers are not included in the calculation as they do not provide direct nursing care to patients. 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;

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.

2. SKILL MIX

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of 65/35 registered nurses/clinical support workers. The current overall for STHFT is an average ratio of 62/38 registered nurses/clinical support workers across all inpatient areas which is a change to the previously agreed 70/30 ratio. Some of this change can be attributed to the addition of Registered Nursing Associates to the workforce from January 2021 onwards.

Skill mix continues to evolve due to the development and introduction of new roles within the Nursing and Midwifery workforce. In many areas where the acuity and intensity of patients has increased and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision. Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes.

The ratio of registered nurses to clinical support workers may be lower in some less acute areas such as Specialised Rehabilitation, or where other staff are involved in delivering care, for example, Assistant Practitioners. Allied Health Professionals contribute significantly

towards meeting patient needs; the latter of which are registered professionals in their own right. Establishment reviews will further interrogate ward specific detail to ensure that the right balance is achieved particularly in consideration of reduced RN vacancies due primarily to the planned international recruitment.

Work continues to gather robust information regarding the impact on the workforce in caring for patients who require 1:1 supervision to minimise risk of harm. The anticipated SNCT version 2022 will provide guidance and data capture regarding the staffing of this patient cohort. Observational reports suggest that general condition of patients has deteriorated as a result of the pandemic, resulting in increasing risk of harm from falls or skin damage. This additional need for 1:1 care can be seen in the demand for bank staff, as the SafeCare functionality of HealthRoster is rolled out across the Trust, these requests will be formally captured in real time providing further intelligence on changes in patient dependency and staffing requirements. The acuity of these patients is not currently captured fully by SNCT multipliers and therefore professional judgment is used in terms of recognising the need for 1:1 care or bay cohort nursing.

Trust wide we continue to see an increase in the complexity of patients particularly in relation to mental health need, including dementia and patients remaining in the acute setting for prolonged lengths of time whilst awaiting appropriate placements or arrangements to facilitate discharge.

The overall nurse to patient ratio based on the Trust establishment for the Trust was 1 RN for every 5.23 patients during the day and 1 RN for every 8.36 patients at night. These ratios vary between each Care Group and are influenced by the ratios of care required on individual wards.

3. CARE HOURS PER PATIENT DAY (**APPENDIX TWO**)·

Planned total Care Hours Per Patient Day (CHPPD) range from 5.07 (Robert Hadfield 3) – 16.4 (Osborn 1) and average at 7.6

Registered care hours per patient day range from 2.57 (Huntsman 7) – 8.52 (Firth 7) and average at 4.7.

Unregistered care hours per patient day range from 1.14(Chesterman 1) – 7.13 (Osborn 1) and average at 2.6.

4. QUALITY INDICATORS

It is acknowledged that SNCT data should not be acted upon in isolation and quality aspects of patient care, particularly outcomes, must be taken into account. Nationally this was undertaken by means of monitoring Nurse Sensitive Indicators (NSIs), which were infection rates (hospital acquired MRSA infection and colonisations and C.Difficile rates); formal complaints related to nursing care, falls, medication errors and pressure ulcer rates. Whilst NSI's have now been replaced by information held in STHFT QUEST (The Quality and Excellent Standards) system: specifically, the Safety Risk and Quality dashboard the indicators and data source remain the same.

At STHFT, QUEST compliance and outputs are undertaken throughout the year and reported, discussed and actions agreed at the monthly Professional Assurance Committee, a subcommittee of the Nurse Executive Group. For the purpose of this report the Safety Risk and Quality Dashboard rates, have been reviewed in the context of SNCT requirements and relate to incidents recorded against each Care Group during the data collection period, February 2022, and compared against those recorded in each Care Group over the winter from previous formal data collections, period in January 2020.

The use of QUEST has been tested as an accurate means for reporting NSIs. The system provides visibility of ward/directorate/care group performance against nursing and midwifery

quality indicators and is now live across the Trust. The Nurse Executive Group has agreed a methodology to identify where lapses in care may affect the quality of care delivered in wards/departments. The agreed metrics that would indicate the need for further support and review are CHPPD below 85% and QUEST compliance of less than 75%; this is reported monthly. The Nurse Director (ND) with responsibility for the ward that triggers, undertakes a professional judgment review within the clinical area ensuring any identified issues are actioned locally, as part of the Ward Assurance Framework ("How Healthy is Your Ward"). Quest metrics also now form part of the reports provided as part of the Trust's Performance Management Framework.

5. CURRENT CONTEXT

The results for each inpatient area in each care group are included in Appendix four.

These results need to be taken in context against the back drop of the Covid-19 pandemic and the ensuing reduction in elective procedures, continued high numbers of patients who are waiting for care arrangements outside of hospital and the increase of non-elective admission of MAPs and GSM patients. As previously described SNCT should not be viewed in isolation and therefore professional judgement has also been applied in conjunction with SNCT acuity scores against current AFEs.

Figure1: Trust SNCT Acuity Levels 2018 -2022

Date	Surplus / Deficit	% of patients at SNCT acuity levels				
		Level 0	Level 1a	Level 1b	Level 2	Level 3
February2022	+118.23	26.89	16.13	54.2	2.66	0.05
January 2020	+56.67	19.76	18.30	56.54	4.17	0.92
February 19	+93.36	26.88	15.23	50.62	5.04	2.23
January 18	-96.16	22.6	16.8	52.6	5.7	2.3

The data does not show any increase in acuity, however SNCT descriptors do not fully capture dependency with regards to patients requiring 1:1 care to minimise risk of falls or other harms. Bay cohort nursing is also not currently captured. Total number of falls have been seen to increase from January 2020 – 314 in total to 520 in February 2022 this may be indicative of a change to patient condition following the pandemic or in relation to increased numbers of patients medically fit awaiting appropriate post discharge arrangements.

Figure 2: Trust Acuity Levels

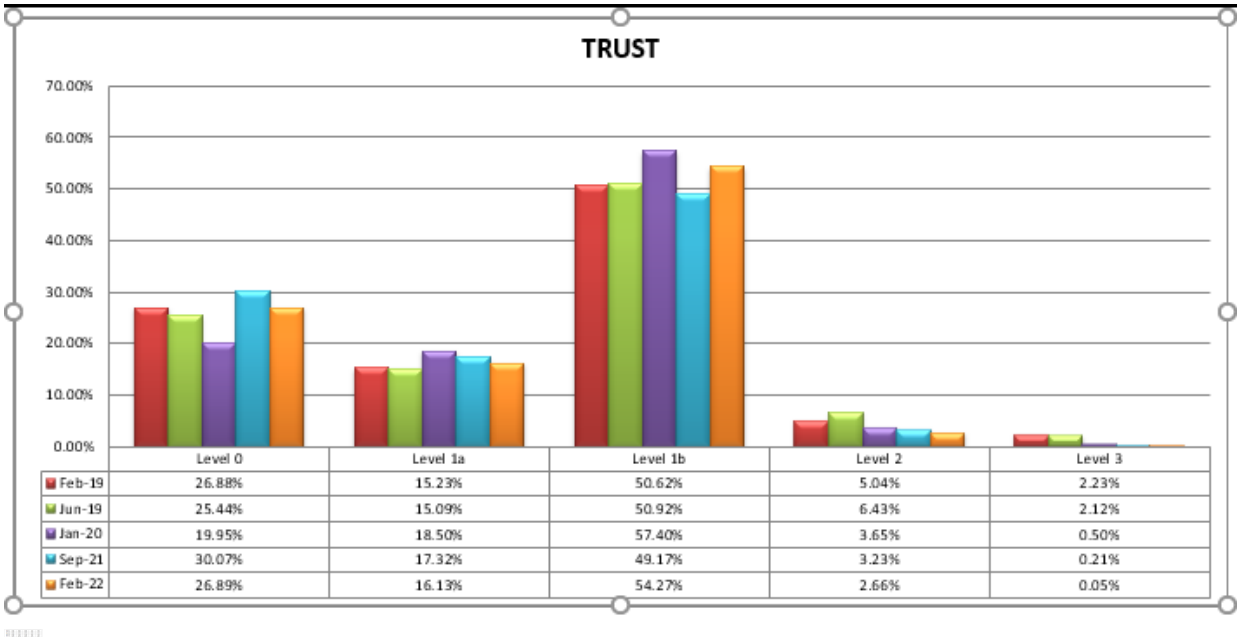
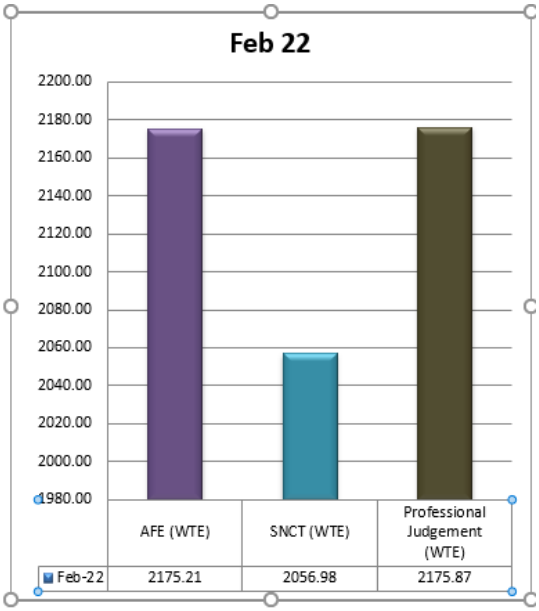


Figure 3: AFE, ACUITY & PROFESSIONAL JUDGEMENT SCORES



Allied to the use of the SNCT at STHFT is the use of Professional Judgement to confirm appropriate nurse staffing levels. This consultative evidence based approach to the determination of nurse staffing requirements was first developed in 1979 by Telford (Telford, 1979)[4] and is a bottom up approach used to determine ward staffing requirements, based on the judgement of experienced nurses to agree the number and grade of staff required to provide care on a specific ward. This is agreed with the care group Nurse Directors and together with the agreed allowance for uplift a standard formula is used to calculate the wholetime equivalents (WTEs) required to staff the ward. As well as considering the acuity and dependency of the patients normally cared for by the ward, 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 - high throughput needing more staff to help maintain patient flow.
- 1:1 care and bay cohort nursing.
- The provision of supervisory time required by the Ward Manager to undertake the management requirements of the post, together with the amount of time required to support, supervise and mentor students and newly appointed staff.
- Increased IPC requirements in relation Covid-19 pandemic.

6. VACANCY POSITION

The planned international recruitment has reduced the RN vacancy position across all nursing posts to 119.5 WTE = 3.22% as of February 2022. The position in January 2020 was 336.17 WTE RN vacancy = 16.76%. 576 International nurses have joined the Trust since November 2019, with 429 gaining NMC registration, several gaining promotions set against a 99% retention rate.

Clinical support worker vacancies are currently proving harder to fill and retention within these roles is currently being reviewed in terms of recruitment, on-boarding and development.

[4] Telford, W. (1979). A Method of Determining Nursing Establishments, Hospital Health Services Review, 5,4. pp 11-17

7. NURSE STAFFING BY CARE GROUP

Using the data gathered in the nurse staffing assessment, the overall summary indicates whether or not the care groups are established appropriately against the SNCT criteria, however these need to be considered with the changes that some ward areas have experienced in relation to patient group as a consequence of the pandemic both in terms of safety, reduced elective activity and changes to patient demographics.

Further detail and the results for each care group are given in **Appendix Three**

8. FUTURE DEVELOPMENTS

National development of Safer Nursing Care Tool by the Shelford group of hospitals was delayed due to operational pressures during theCovid-19 pandemic, STHFT continues to input and have representation in this work. The Shelford Group, with the support of NHS Improvement, commissioned a review of the adult inpatient SNCT to take account of the changes in care pathways, the impact of the role of the Nursing Associate and to align CHPPD with SNCT multipliers to inform the safe deployment of staff. STHFT is identified one of the beta test sites for trialling the updated tool It is anticipated that the refreshed version of SNCT will have 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).
- The care of patients who require specialling (enhanced care).
- Community caseloads and nursing care.

The SNCT tool for Emergency Departments was launched in December 2021 and the first data collection within STHFT was completed in March 2022 and data is currently being analysed a second data collection is planned for later this year.

9. FURTHER ACTIONS

- SNCT champions have been identified for each Care Group to ensure acuity scoring is understood and embedded across ward areas.
- Further acuity score training to be rolled out prior to July collection to provide further reliability of scoring.
- Allocate Health Roster - Safe Care functionality is being piloted within 5 wards of SYRS with the plan to roll out across all inpatient areas prior to December 2022.
- Continuing review of recruitment, retention and workforce redesign aligning to NHS interim people plan and Trust processes and strategies.
- Establishment review process revised to include CHPPD, Skill mix and understand any changes to ward speciality/patient cohorts.

10. CONCLUSION

In summary these data suggest a surplus of RNs when considered against the authorised funded establishments, however the continued impact of Covid19 in relation to bed occupancy and ward speciality changes continues to add a further dimension to the understanding of nurse staffing and patient acuity and dependency. It is therefore recommended that based on this assessment, that the overall establishments remain unchanged. It should also be noted that there are an additional 56 beds open to support patient flow, at the time of this assessment, that are not funded/established and have not been included in this review This report refers to the establishments as outlined in budgets and not the numbers of staff currently in post.

11. APPENDICES

Appendix One: Safer Nursing Care Tool

Appendix Two: CHPPD

Appendix Three: Nurse Staffing by Care Group

Appendix one

SAFER NURSING CARE TOOL (SNCT)

- 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 decision matrix allows staff to measure the acuity (how ill a patient is) and dependency (how dependent a patient is on nursing staff to have their normal needs met, such as moving, going to the toilet, eating and drinking) of patients in a ward. It incorporates the 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. The description used to determine the level of care a patient needs is in the table below.

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Level	Level Descriptor
0	Normal patients who can be cared for on a general ward
1a	Acutely ill patients who can be cared for on a general ward
1b	Stable patients with an increased dependency on nurses
2	Patients in ward areas awaiting transfer to High Dependency care
3	Patients in ward areas awaiting transfer to Intensive Care

- Nurse Sensitive Indicators (NSIs) had been identified as quality indicators of care with specific sensitivity to nursing intervention and were 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.

  NSI's have now been replaced by information held in STHFT QUEST (The Quality and Excellent Standards) system: specifically the Safety Risk and Quality dashboard the indicators and data source remain the same. This data will now be used alongside acuity and dependency information to monitor the relationship between ward staffing and nursing outcomes.

PROFESSIONAL JUDGEMENT

Allied to the use of the SNCT at STHFT is the use of Professional Judgement to confirm appropriate nurse staffing levels. This consultative approach to the determination of nurse staffing requirements was first developed in 1979 by Telford (Telford, 1979)[5] and is a bottom up approach used to determine ward staffing requirements, based on the judgement of experienced nurses to agree the number and grade of staff required to provide care on a specific ward. This is agreed with the care group Nurse Directors and together with the agreed allowance for uplift a standard formula is used to calculate the whole time equivalents (WTEs) required to staff the ward. As well as considering the acuity and dependency of the patients normally cared for by the ward, 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 - high throughput needing more staff to help maintain patient flow.

[5] Telford, W. (1979). A Method of Determining Nursing Establishments, Hospital Health Services Review, 5,4. pp 11-17

- The provision of supervisory time required by the Ward Manager to undertake the management requirements of the post, together with the amount of time required to support, supervise and mentor students and newly appointed staff.
- Donning and Doffing for IPC requirements in relation Covid-19 pandemic.

CALCULATING PLANNED AND ACTUAL CHPPD

CHPPD is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24 hour period by the number of patients on the ward that day including the number of babies. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.

Twice a year each inpatient clinical area assesses the care needs of patients in their ward/department, using an evidence based tool to help determine the Nurse/Midwifery staffing required to provide safe, compassionate and effective care to meet the needs of those patients, in Nursing the tool is the Safer Nursing Care Tool (SNCT) and in Midwifery it is Birthrate+©. Working with Birthrate Plus® [6] The result of this assessment, together with professional judgement is used to inform the number of Nursing and Care Staff needed on each shift. This forms the basis of the templates entered onto the eRostering system to calculate the planned staffing hours each calendar month.

The actual number of hours worked by permanent Nursing/Midwifery/Care Staff and those worked by temporary Nursing/Midwifery/Care Staff on a ward or department during that calendar month is extracted from the eRostering and NHSP systems. Both these systems should be up-to-date and accurate, however, the logistics of extracting data from clinical areas involving over 3000 individual members of staff are complex and there is a degree of manual adjustment required in addition to the data extract. As a result, the data will be accurate at a Trust and Hospital level, but this is more difficult to achieve at a ward level.

Calculating CHPPD requires taking the actual hours from the safe staffing return and the daily patient count at midnight aggregated over the course of the month for each ward or department.

STH's current reporting for CHPPD includes Registered Nurses/Registered Midwives (RNs/RMs) and Clinical Support Workers (CSWs). Trainee Nursing Associates (TNAs) and Nursing Associates (NAs) are also included in CHPPD reporting as are Allied Health Professionals (AHPs), such as physiotherapists who are included in a ward establishment (and e roster). AHPs, TNAs and NAs are reported as individual groups of staff.

CHPPD is different to the previously used planned hours versus actual hour's methodology in that it allows comparisons between staffing levels of different sized wards/departments; it is a single comparable figure using patient and staffing data, rather than considering each in isolation and it enables the differentiation between RN and CSW skill mix for reporting purposes. It will be expected that the CHPPD will differ between wards and specialties to reflect the different needs of the patients being cared for; Critical Care areas for instance are likely to have much higher CHPPD than other areas because their patients will be receiving either 1:1 care (CHPPD would be a minimum of 24) or 1:2 care (CHPPD would be a minimum of 12).

Example:

$$\textbf{CHPPD} = \frac{\text{RN hours worked (24 hour)} + \text{CSW hours worked (24 hour)}}{\div}$$
$$\text{Average daily count of patients in beds at 23.59 for the month}$$

The limitations of using the 23.59 daily count for patients is acknowledged within the guidance as this single figure does not take into account hour by hour fluctuations in ward activity and is particularly limiting to those wards/departments that undertake large amounts of day case type activity, or have a high throughput such as assessment units, however, it offers a consistent point of time for benchmarking. CHPPD data will need to be used in triangulation with other methods for assessing staffing demand and patient acuity and dependency and should not be used in isolation. Furthermore, it does not take into consideration the competencies and level of experience required and other activities required on wards for example mentorship, preceptorship, training and appraisal completion.

[6] Birthrate Plus® Consultancy Ltd|Safe Staffing for Maternity Services

NURSE STAFFING BY CARE GROUP

Using the data gathered in the nurse staffing assessment, the overall summary indicates whether or not the care groups are staffed optimally against the SNCT criteria.

Acute & Emergency Medicine (AEM)

The figures below only include AMU. SNCT emergency department acuity scoring tool has been completed during March 2022. The results are currently being reviewed.

The data suggest a surplus between the AFE and that recommended by the SNCT of 18.36 WTE in February 2022

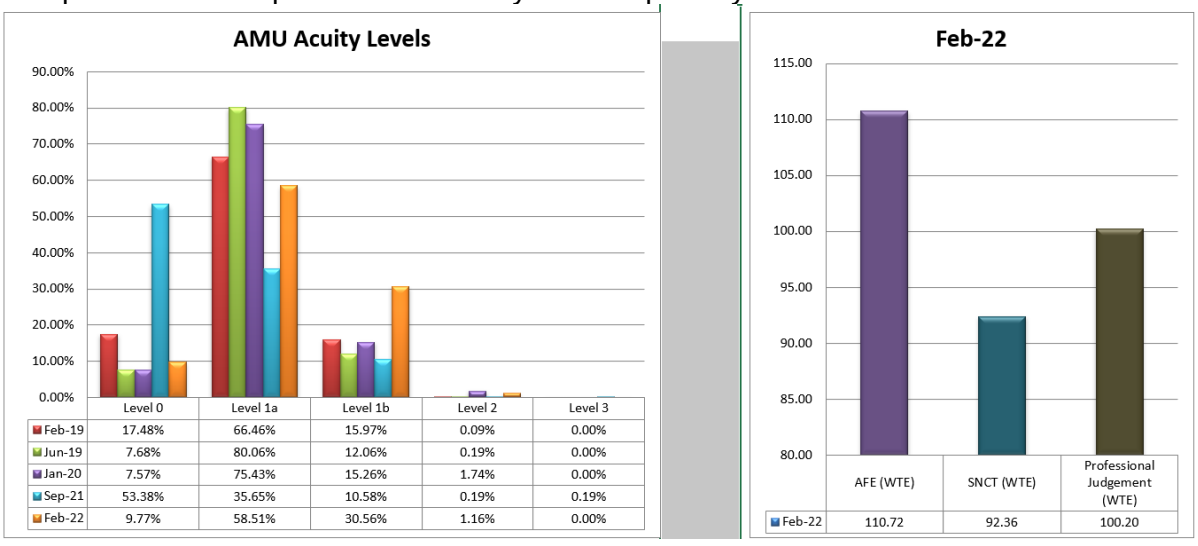
The skill mix ratio for this care setting is 71% RNs to NAs / CSWs.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
AEM	February 2022	110.72	92.36	18.36	71%	-9.77	12.79	9.2%	3.1%
	January 2020	104.72	86.00	18.72	71%	-3.85	6.93	5.3%	7.9%
	June 2019	105.2	111.80	-6.60	74%	-15.74	18.7	4.0%	4.1%
	February 2019	103.68	108.59	-5.01	76%	-10.63	19.81	2.3%	5.5%

It should be noted that complex mental health patients are often cared for in AMU whilst awaiting transfer to a more appropriate facility. SNCT does not apply to patients with specific mental health needs.

Historical Information

Comparison with the position in February over the past 3 years is illustrated in the chart below:



Professional Judgement

Using this methodology, the establishment required was 100.20 WTE, a surplus of 10.52 WTE against the AFE.

The overall nurse to patient ratio for the Care Group was 1 RN for every 5 patients during the day and 1 RN for every 5 patients at night

Care Hours per Patient Day

The overall (RN & CSW) planned CHPPD was 6.26 hours compared to the actual of 5.66 hours- this can be attributed to sickness and vacancy.

QUEST Safety Risk and Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**10**	**15**
Pressure ulcers	**4**	**5**
Complaints	1	1
Medication incidents	**16**	**9**
MSSA infection	0	0

Medicine and Pharmacy Services (MaPS)

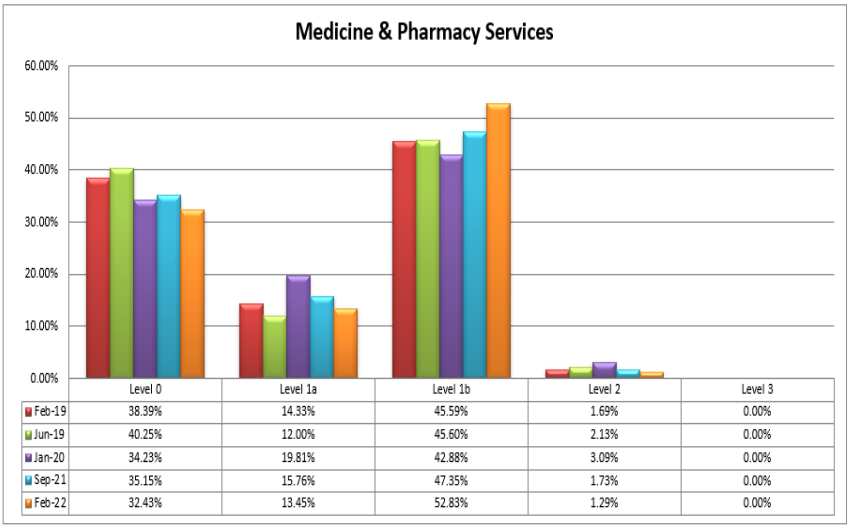
The deficit between the AFE and that recommended by the SNCT was 24.42 WTE for February 2022.

The skill mix for this care group is 62% RNs to CSWs/ NAs.

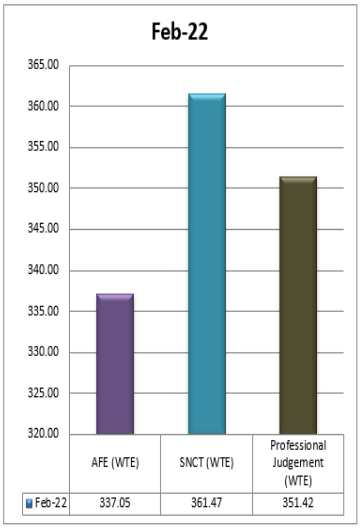
	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
MaPs	February 2022	337.05	361.47	-24.42	62%	-15.91	33.73	9.1%	5.6%
	January 2020	366.10	372.00	-5.9	64%	-37.19	64.0	6.9%	4.5%
	June 2019	357.20	359.86	-2.65	64%	-41.41	122.5	5.3%	2.6%
	February 2019	356.36	371.84	-15.48	60%	-35.51	60.77	7.1%	2.7%

Historical Information

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



	Level 0	Level 1a	Level 1b	Level 2	Level 3
Feb-19	38.39%	14.33%	45.59%	1.69%	0.00%
Jun-19	40.25%	12.00%	45.60%	2.13%	0.00%
Jan-20	34.23%	19.81%	42.88%	3.09%	0.00%
Sep-21	35.15%	15.76%	47.35%	1.73%	0.00%
Feb-22	32.43%	13.45%	52.83%	1.29%	0.00%



	AFE (WTE)	SNCT (WTE)	Professional Judgement (WTE)
Feb-22	337.05	361.47	351.42

Professional Judgement

Using this methodology, the establishment required for the Care Group was 351.42 WTE compared to the AFE of 337.05 WTE - a difference of 14.37 WTE. The single rooms within Robert Hadfield wards were taken into consideration, however there was also an additional requirement for staff based on surge beds open on Robert Hadfield 5 during the data collection period that are unaccounted for in terms of AFE. The overall nurse to patient ratio for the Care Group was 1 RN for every 6.0 patients during the day and 1 RN for every 8.38 patients at night.

Care Hours per Patient Day

The overall (RN & CSW) planned CHPPD was 5.99 hours compared to the actual of 5.46 hours.

QUEST Safety, Risk &Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2021 is indicated in the table below. Falls have increased this would appear to be due to the general presentation of the patient at admission and associated de-conditioning due to length of stay. increase in falls may be attributable to patients with increasing dependency or the increased amount of side rooms within the Robert Hadfield wards.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**50**	**26**
Pressure ulcers	**9**	**29**
Medication Incidents	**15**	**18**
Complaints	**0**	**2**
C.Difficile infection	**1**	**1**
MSSA infection	**0**	**0**

Combined Community and Acute Care Group

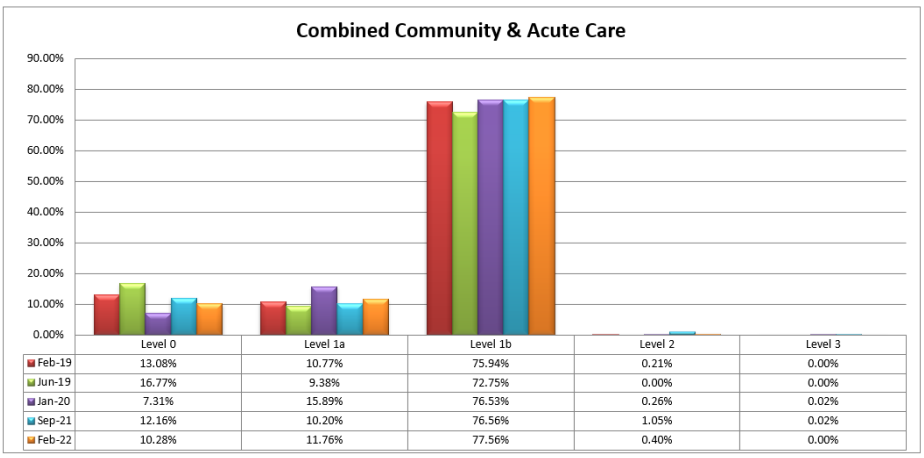
The Combined Community and Acute Care Group include the Acute elderly care and stroke medicine wards.

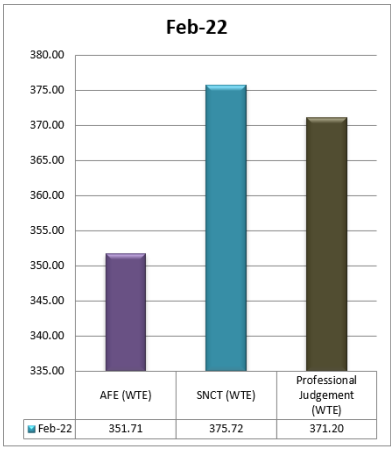
The deficit between the AFE and that recommended by the SNCT is 24 WTE for January 2020. The skill mix for this care group is 57% RNs to NAs/CSWs.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
Combined Community & Acute Care	February 2022	351.73	377.72	-23.99	57%	-9.74	33.37	8.2%	2.1%
	January 2020	383.98	390.27	-6.29	55.2%	-54.21	61.08	9.0%	2.8%
	June 2019	371.27	389.95	-18.65	56%	-44.49	46.12	6.8%	3.0%
	February 2019	407.28	426.08	-18.8	56%	-58.69	55.32	7.9%	3.6%

Historical Information

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





Professional Judgement

Using this methodology, the establishment required was 371.20 WTE, compared to the AFE of 351.71 - a difference of 19.47 WTE. Observed regular 1:1 care needs and cohort nursing during the data collection periods which increased the number of staff required. The overall nurse to patient ratio for the Care Group was 1 RN for every 5.09 patients during the day and 1 RN for every 8.36 patients at night.

Care Hours per Patient Day

The overall (RN & CSW) planned CHPPD was 6.83 hours compared to the actual of 6.43 hours.

QUEST Safety, Risk and Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**77**	**74**
Pressure ulcers	**10**	**8**
Medication Incidents	**16**	**20**
Complaints	**6**	**4**
C.Difficile infection	**0**	**1**
MSSA infection	**0**	**0**

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

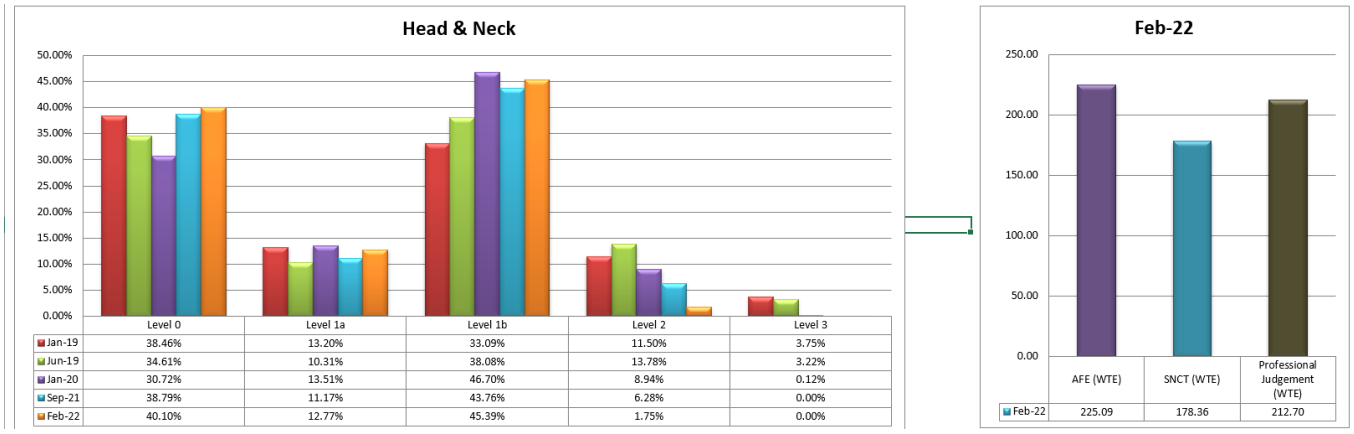
Head and Neck

The results for January 2020 indicate a surplus of 46.73 WTE between the AFE and the SNCT assessment. H&N care group has been impacted by Covid-19 pandemic in terms of I1 and N2 activity and patient placement of this cohort, with beds being used to provide medical care. These data should be interpreted with caution as the current patient group is different to the patient cohort being cared for when the establishment was set and will with elective recovery change back.
The skill mix for this care group has reduced from 65% to 52% RNs to NAs/CSWs.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
Head & Neck	February 2022	225.09	178.36	+46.73	52%	-32.67	20.26	4.2%	3.9%
	January 2020	228.73	189.93	+38.80	57%	-20.69	16.55	2.8%	2.7%
	June 2019	281.04	261.68	+19.38	66%	-24.21	12.97	2.9%	3.25%
	February 2019	282.26	237.47	+44.79	65%	-38.73	10.64	4%	3.6%

Historical Information

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



Professional Judgement

Using this methodology, the establishment required was 212.70 WTE compared to the AFE of 225.08 WTE a difference of -12.38 WTE.

The overall nurse to patient ratio for the Care Group was 1 RN for every 5 patients during the day and 1 RN for every 8.94 patients at night.

Care Hours per Patient Day

The planned CHPPD was 8.07 hours compared to the actual of 7.5 hours.

QUEST: Safety, Risk and Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**14**	**14**
Pressure ulcers	**1**	**1**
Medication Incidents	**17**	**3**
Complaints	**4**	**1**
C.Difficile infection	**1**	**2**
MSSA infection	**0**	**0**

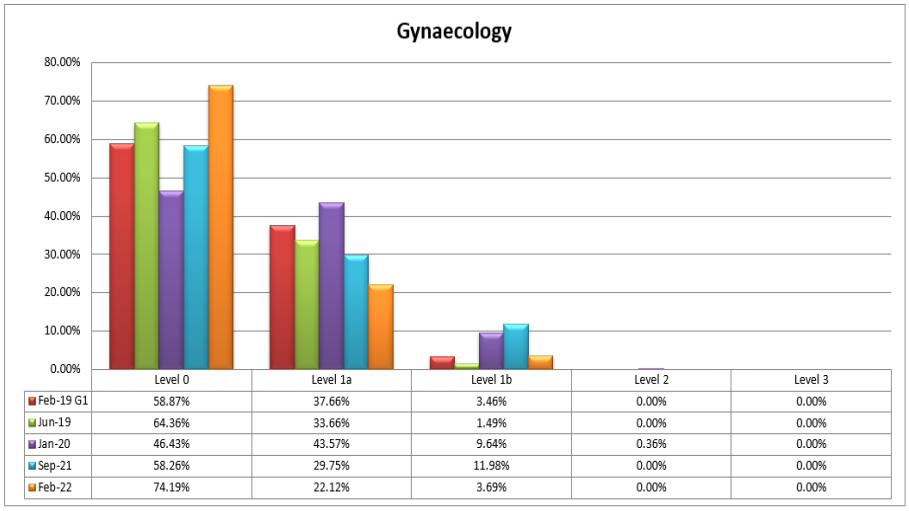
Obstetrics, Gynaecology and Neonatology (OGN)

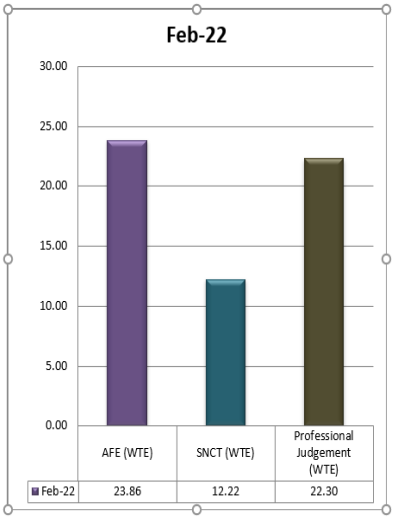
The SNCT data show that within Gynaecology there is a surplus of 11.64 WTE in February 2022 against the AFE. Operational changes were made to the service to use the beds more flexibly to meet fluctuating occupancy levels, increasing ambulatory care and changes in case mix. The ward has 16 beds which requires staffing to minimal level of 2 x RN per shift which may not always be reflective of the levels of acuity and patient care required.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
Gynae	February 2022	23.86	12.22	11.64	66%	2.53	0.44	7.6%	11.4%
	January 2020	21.43	17.64	+3.79	68%	+3.35	0.12	4.0%	8.5%
	June 2019	16.71	12.01	+4.7	67%	-0.78	0.2	1.8%	11.3%
	February 2019	16.71	13.84	+2.87	67%	Nil	0.26	0%	8.8%

Historical Information

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





Professional Judgement

Using this methodology, the establishment required was 22.3 WTE against the AFE of 23.86 WTE giving a difference of -1.56 WTE. The overall nurse to patient ratio for the Care Group was 1 RN for every 8 patients during the day and 1 RN for every 8 patients at night.

Care Hours per Patient Day

The planned CHPPD was 7.73 hours compared to the actual of 6.70 hours.

QUEST: Safety, Risk and Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2019*	*January 2020*
Patient falls	**2**	**0**
Pressure ulcers	**0**	**0**
Medication Incidents	**0**	**0**
Complaints	**1**	**1**
C.Difficile infection	**0**	**0**
MSSA infection	**0**	**0**

South Yorkshire Regional Services (SYRS)

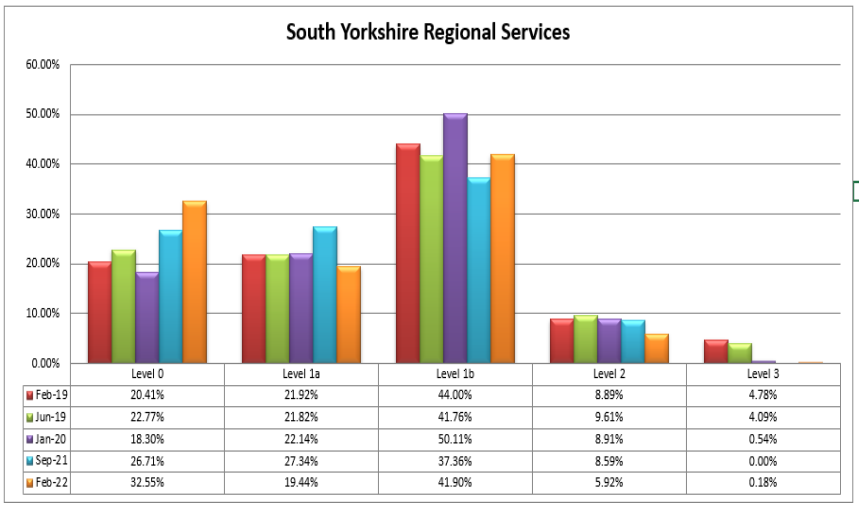
The SNCT data shows that within SYRS there is a surplus of 25.61 WTE in January 2020

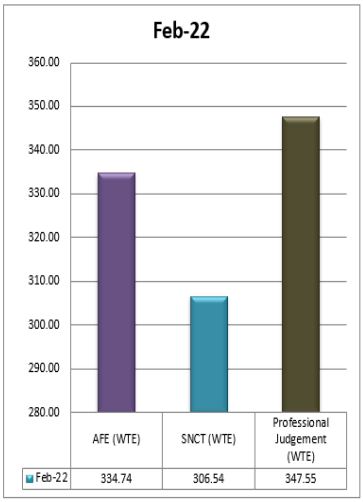
The skill mix for this care group has decreased to 65% RNs to CSWs – this could be due to Pre-registered international nurses who sit in CSW finance lines until gaining UK registration.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
SYRS	February 2022	334.74	306.54	+28.29	65%	-25.61	28.7	6.7%	6.3%
	January 2020	322.38	315.18	+7.21	73.4%	-19.79	61.91	7.9%	3.2%
	June 2019	405.21	400.18	+5.03	77%	-29.81	49.42	6.4%	4.2%
	February 2019	402.74	388.46	+17.29	77%	-26.82	41.01	4.%	4.5%

Historical Information

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





Professional Judgement

Using this methodology, the establishment required was 347.55 WTE against the AFE of 334.74, a difference of 12.81 WTE, this can be attributed to the increased patient needs of CCU and PCU patients who have a higher acuity across a small bed base. The overall nurse to patient ratio for the Care Group was 1 RN for every 4.15 patients during the day and 1 RN for every 7.98 patients at night.

Care Hours per Patient Day

The planned CHPPD was 9.52 hours compared to the actual of 8.53 hours.

QUEST: Safety, Risk & Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**28**	**25**
Pressure ulcers	**10**	**7**
Medication Incidents	**30**	**8**
Complaints	**1**	**2**
C.Difficile infection	**0**	**2**
MSSA infection	**0**	**0**

Specialised Cancer, Medicine and Rehab Services

The SNCT data for this Care Group show a surplus of 45.90 WTE against the AFE in January 2020.

SCMR care group has also been impacted by Covid-19 pandemic in terms of Osborn 1 and Osborn 2 activity and patient placement of this cohort, with beds being used to provide medical care

The skill mix for this care group is 65% RNs to NA/ CSWs.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
Specialised Medicine	February 2022	340.11	294.21	+45.90	65%	5.98	21.89	9.3%	4.9%
	January 2020	323.46	323.10	+0.36	71.4%	-56,11	46.83	7.5%	2.1%
	June 2019	314.31	298.02	+16.29	72%	-54.36	28.01	4.2%	4.9%
	February 2019	296.17	289.96	+6.75	65%	-53.91	28.54	6.5%	8%

Historical Information

Comparison with the position in February over the past 3 years is illustrated in the chart above.

Professional Judgement

Using this methodology, the establishment required was 327.80 WTE against the AFE of 340.11 a difference of -12.31 WTE, however the AFE is reflective of the high care needs across the differing patient cohorts including infectious diseases, bone marrow transplant patients, ventilated rehab beds and management of complex chemotherapy. Professional judgment did apply uplift for infectious diseases and Osborn 1 care . The overall nurse to patient ratio for the Care Group was 1 RN for every 4.42 patients during the day and 1 RN for every 7.79 patients at night.

Care Hours per Patient Day

The planned CHPPD across the Care Group was 9.38 hours compared to the actual of 8.19 hours.

QUEST: Safety, Risk & Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**17**	**17**
Pressure ulcers	**7**	**3**
Medication Incidents	**13**	**8**
Complaints	**1**	**1**
C.Difficile infection	**2**	**1**
MSSA infection	**0**	**0**

Surgical Services

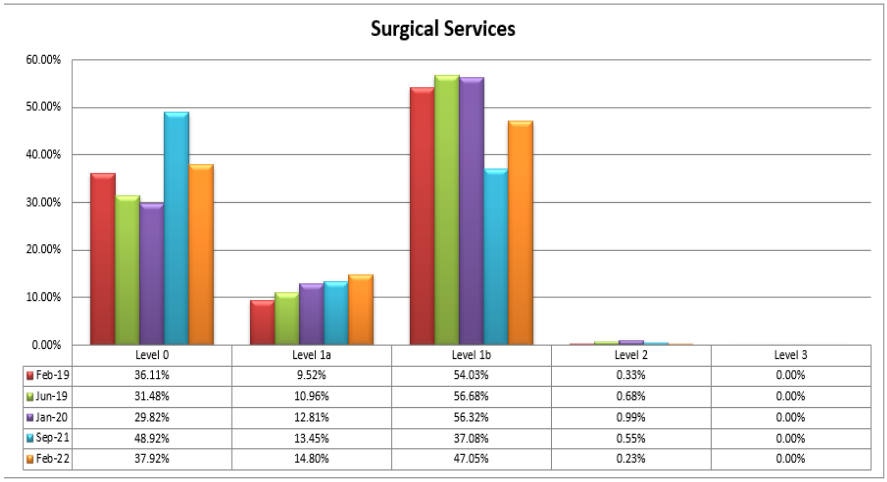
The SNCT data shows a surplus of 1.74 WTE between the AFE and the requirements for the SNCT for February 2022.

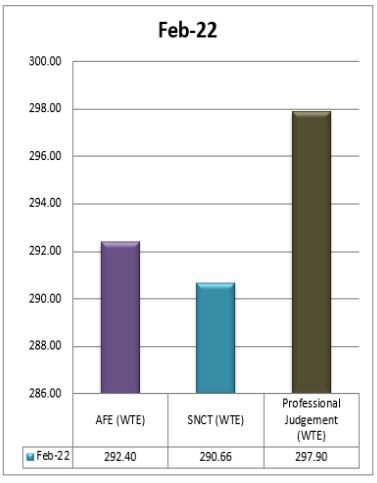
The skill mix for this care group is 63% RNs to CSWs.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
Surgical Services	February 2022	292.40	290.66	1.74	63%	-6.97	24.32	10.9 %	2.1%
	January 2020	273.34	271.00	2.34	65%	-32.26	35.54	7.6%	6.9%
	June 2019	269.20	276.59	-7.39	65%	-36.03	31.54	5.3%	3.8%
	February 2019	270.21	279.33	-9.12	66%	-28.59	24.95	8.1%	3.2%

Historical Information

Comparison with the position in February over the past 3 years is illustrated in the chart below. However, it should be noted that due to the significant reduction in elective surgical activity and the changes to patient pathways associated with the covid 19 pandemic response data should be interpreted with caution.





Professional Judgement

Using this methodology, the establishment required was 297.90 WTE compared to the AFE of 292.40 a difference of 5.5 WTE. The overall nurse to patient ratio for the Care Group was 1 RN for every 5.49 patients during the day and 1 RN for every 8.84 patients at night.

Care Hours per Patient Day

The planned CHPPD across the Care Group was 6.87 hours balancing with the actual of 6.43 hours.

QUEST: Safety, Risk & Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**14**	**11**
Pressure ulcers	**2**	**4**
Medication Incidents	**13**	**14**
Complaints	**1**	**2**
C.Difficile infection	**1**	**20**
MSSA infection	**0**	**0**

Musculo-Skeletal Group (MSK)

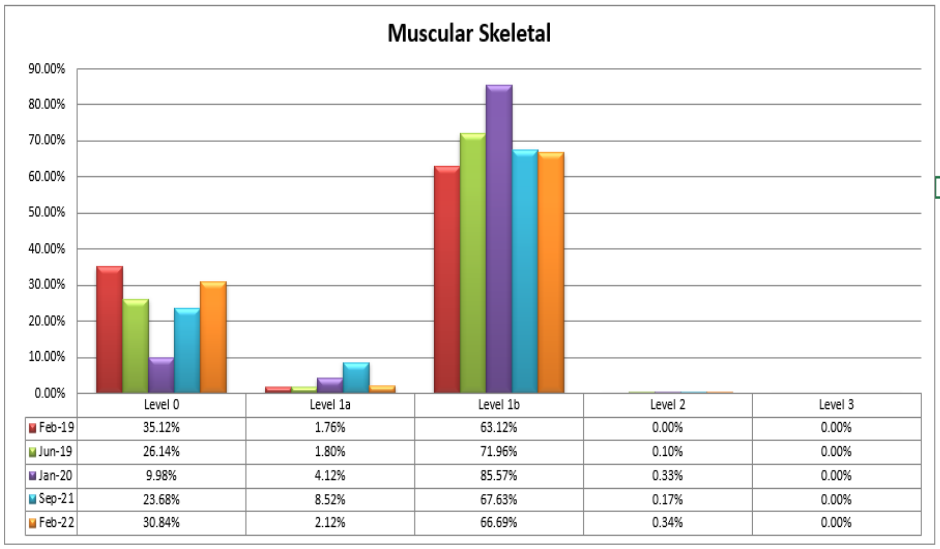
The data shows a surplus of 1.98 WTE between the AFE and the requirements for the SNCT in February 2022.

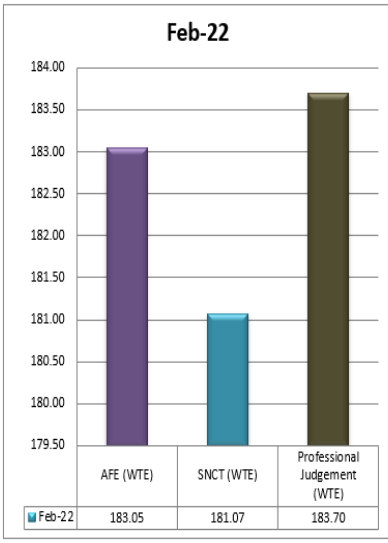
The skill mix for this care group is 60% RNs to CSWs.

	Date	AFE (WTE)	SNCT (WTE)	Difference (WTE)	Skill Mix	Vacancy (WTE)	Bank (WTE)	Sick Leave	Parenting Leave
MSK	February 2022	183.05	181.07	+1.98	60%	7.60	37.66	10.7%	5.4%
	January 2020	176.08	178.44	-2.36	57.4%	-43.07	27.97	7.6%	1.5%
	June 2019	178.55	168.79	+9.76	53%	-27.19	31.26	5.1%	3.9%
	February 2019	182.04	169.53	+12.51	56%	-34.93	32.13	9.5%	2.7%

Historical Information

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





Professional Judgement

Using this methodology, the establishment required was 183.70 WTE compared to the AFE 183.05 WTE, a difference of 0.65 WTE. The overall nurse to patient ratio for the Care Group was 1 RN for every 6.18 patients during the day and 1 RN for every 9.26 patients at night.

Care Hours per Patient Day

The planned CHPPD across the Care Group was 6.74 hours compared to the actual of 5.94 hours.

QUEST: Safety, Risk & Quality Dashboard

The number of incidents for the month of February 2022 compared to January 2020 is indicated in the table below.

Quality Indicator	*February 2022*	*January 2020*
Patient falls	**43**	**21**
Pressure ulcers	**10**	**3**
Medication Incidents	**4**	**1**
Complaints	**3**	**4**
C.Difficile infection	**0**	**0**
MSSA infection	**0**	**0**