



MEETING OF THE TRUST BOARD OF DIRECTORS – February 12th – March 12th 2024			
Nurse Staffing Annual Capacity and Capability Report			AGENDA ITEM:
Report Author and Job Title:	Debi McKeown NMAHP Workforce Lead	Responsible Director:	Lindsay Garcia Director of Nursing
Action Required	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/>		
Situation	To provide a comprehensive review of inpatient/ward nurse staffing for South Tees Hospitals NHS Foundation Trust		
Background	The requirement to publish nursing and midwifery establishment reviews based on evidenced based tools such as the Safer Nursing Care Tool (SNCT) on a biannual basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016) Data collection through February/March 24, repeat planned for September 24.		
Assessment	This report provides an overview of nurse staffing for adult and paediatric inpatient and acute assessment wards in South Tees Trust.		
Recommendation	The Board of Directors are asked to note the content of this report and to be assured that there are systems and process in place to ensure registered nurse staffing levels are sufficient to deliver safe, high-quality care.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	<p>BAF risk 5.1 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit.</p> <p>Threat - Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources.</p> <p>Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans</p>		
Legal and Equality and Diversity implications	<ul style="list-style-type: none"> Care Quality Commission NHS England /Improvement 		
Strategic Objectives	Excellence in patient outcomes and experience <input checked="" type="checkbox"/>	Excellence in employee experience <input checked="" type="checkbox"/>	
	Drive operational performance <input type="checkbox"/>	Long term financial sustainability <input type="checkbox"/>	
	Develop clinical and commercial strategies <input type="checkbox"/>		

South Tees Hospitals NHS Foundation Trust Nurse Staffing Annual Capacity & Capability Review

Introduction

This report provides a comprehensive review of the nurse staffing for South Tees Hospitals NHS Foundation Trust. It is in line with the requirements set out by the National Quality Board (NQB): *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – safe, sustainable, and productive staffing (July 2016)*.

This guidance is supported by further publication from the National Institute for Improvement (NHSI) *'The Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing' (October 2018)*. It supports providers to use best practice in effective staff deployment and workforce planning. This paper builds upon the NICE guidance *'Safer Staffing for nursing in adult inpatient wards in acute hospitals' (2014)*.

NHSI have published a suite of staffing improvement resources, including NHSI collaborative events aligned to the NQB guidance. These have been utilised in the Trust to support recruitment, retention, and redeployment of nursing staff.

Developing Workforce Safeguards Guidance

NHSI *'Developing Workforce Safeguards'* was published by NHSI in October 2018 to support organisations to use best practice in effective staff deployment and workforce planning. It offers advice on governance issues relating to redesigning roles and responding to unplanned changes in workforce and describes NHSI's role in helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards to strengthen the commitment to safe, high-quality care in the current climate.

NHSI will assess Trust's compliance with the 'triangulated approach' to deciding staffing requirements described in the National Quality Board (NQB) guidance. This includes the requirement to complete a Quality Impact Assessment (QIA) for all skill mix changes across the workforce. NHSI will measure compliance using information collected through the Single Oversight Framework (SOF) and will also ask Trusts to include specific workforce statement in their annual governance statement.

From a nursing perspective, all required data is available to inform board reporting and provide assurance to the board that we are meeting the standards and recommendations. As a Trust, we have assessed ourselves against the recommendations of the workforce safeguards to understand our current level of assurance and we report we are fully compliant and have relevant policies in place.

Review of Staffing Establishments

National guidance recommends that inpatient ward staffing is determined using valid, evidence-based methodology. The Trust has an embedded process for nurse staffing establishments for acute inpatient wards which are undertaken utilising the following:

- Safer Nursing Care Tool (SNCT)
- NQB/ NICE Guidance
- Nurse sensitive outcome indicators
- Professional judgement
- Review of current establishments

The Trust uses the Safer Care Nursing Tool (SNCT) as evidence-based establishment staffing tool. The process triangulates this evidence-based methodology (SNCT) with professional judgement of experienced ward managers, matrons, heads of nursing, associate directors of nursing and the deputy chief nurse operational to ensure wards are safely staffed and that the skill mix is balanced. The triangulation also includes patient and nurse sensitive outcome data and adjusts the care environment.

Safer Nursing Care Tool

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

The Developing Workforce Safeguards (NHSI, 2018) guidance states that to use the SNCT, the Trust must sign a license to ensure the tool is used appropriately and is free from local manipulation. The Trust has SNCT licenses which cover all inpatient wards, acute assessments units and paediatrics. Senior ward staff and matrons have been trained in the inter-rater reliability assessment process. The Trust has also been part of the Beta testing of the new Emergency Department SNCT published in October 2021 and is currently part of the community SNCT development which will enable these areas to be assessed in line with the NQB Standards.

It is important to note that the SNCT tool assumes at least 22% uplift when setting establishments (i.e., headroom for annual leave, sickness, training etc.) The Trust standards of 21% uplift which is included in the establishment for inpatient areas means that the SNCT output will include a 1% differential requirement. This is well known and understood and is not viewed as a risk as SNCT metrics are always triangulated in conjunction with professional judgement and other safe staffing metrics to inform establishment settings.

Every ward collects SNCT data for a minimum of 30 consecutive days 2-3 times a year, the data collection for February/March 2024 ran over one full month. This involves scoring each patient's episode of care. Staffing multipliers are applied at each acute and dependency care level. These multipliers factor in nursing time spent on the following:

- Direct and indirect care
- Ward management (0.2 WTE)
- Education and training
- Staff performance review
- Staff breaks.
- Associated work such as administration and clerical
- Bed occupancy.

These results are then considered alongside the current establishments and nurse quality indicators. All matrons and senior ward staff are required to complete inter-rater reliability scoring to assure validity of the levels of care identified by staff for the establishment setting.

Collaborative Approach to Safer Staffing

As we see a return to the normal cycle of business for the nurse staffing review process, assurance can be given to the Trust Board that the staffing establishments are based on acuity, dependency profiles and professional judgement using SNCT methodology. This is then aligned with whole time equivalent RN and unregistered staffing resource and associated financial budget and rostering profiles.

Staffing review meetings were held with the Associate Directors of Nursing and Heads of Nursing, following discussion with their Matrons and ward managers, to review the agreed staffing levels. Robust conversations and decision-making meetings were held with the Deputy Chief Nurse and finance to finalise the staffing levels to ensure continuity of safe nursing care.

As part of the review, once any new staffing levels are identified the required establishments are calculated and compared to the current funded establishment to determine whether any adjustments to skill mix and findings are required. Where this is the case, a business case will be produced. The agreed staffing establishments for 2024/2025 were created in line with the SNCT recommendations and are detailed below, with any changes detailed in the comments.

Acute Inpatient Wards

Requested staffing levels (**Appendix 2**) provide the planned staffing numbers on a shift-by-shift basis on acute inpatient wards and rationale for changes. These staffing levels have been set using the described methodology and are based on the ration of 1:8 qualified nurses to patient ratio (plus a co-ordinator for Acute Assessment Units and Acute Stroke) except for the following areas:

- Acute Stroke 1:2 – for the first 72hrs of acute onset
- Respiratory Support Units 1:2 – for the first 24hrs of admission
- Acute Oncology 1:2 – for patients undergoing chemotherapy.
- Stroke Rehab 1:6

Staffing Calculation Tools

A recommendation in NICE guidance (2018) is that the assessment and review of staffing levels is based on average nursing hours per patient. Subsequently this has emerged as a key recommendation from the Carter report (2016) and described as Care Hours per Patient Day (CHPPD) and is now the primary measure of safe staffing replacing planned vs actual data. Care Hours per Patient Day is also included as a key metric in the development of the model hospital nursing and midwifery. It is published on 'My NHS' and NHS Choices for acute trusts.

Care Hours per Patient Day (CHPPD) can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions. It can be broken down by grade – initially registered nurses and healthcare support staff, but ultimately bands/grades within these groups and all other staff groups contributing to ward-based care, including AHPs.

$$\text{Care Hours Per Patient Day} = \frac{\text{Hours of registered nurses} + \text{Hours of healthcare support workers}}{\text{Total number of inpatients}}$$

This is about much more than numbers with skill mix, capacity and competence being critical in terms of establishing appropriate staffing levels. The impact of both the number and qualification of nurses has been suggested with reduced mortality found when care is delivered by graduate nurses caring for fewer patients (Aiken *et al.*, 2014).

Action Area 5 within Compassion in Practice (2012) relates to ensuring we have the right staff, with the right skills in the right place as the document clearly sets out the expectation that evidence-based, patient need-driven staffing levels in all care settings should be established.

The Safer Nursing Care Tool (Shelford Group, 2013) is currently the most used method (previously known as the AUKUH Acuity and Dependency Measurement Tool)

The Safer Nursing Care Tool (SNCT) is:

- An evidence-based tool which allows nurses to assess patient acuity and dependency. The data is collected and matched with pre-set staffing multipliers to ensure that nursing establishments reflect patient needs in acuity / dependency terms. The recommended number of staff following analysis is in whole time equivalent only i.e., registered, and unregistered staff and includes 21% uplift (holiday, sickness, study leave). The revised electronic tool provides a breakdown of staff by group i.e., RN and Support staff but does not reference allocation for a supervisory ward co-coordinator (if appropriate) or supervisory ward leader (the tool allocates 0.2 WTE).
- Recommended staffing levels are based on an analysis of the actual patient acuity and dependency on the ward at the time of data collection
- The tool is appropriate for use in any acute hospital.

No national workforce tool can incorporate all factors and therefore triangulation with professional judgement is essential to arrive at optimal staffing levels. The Operational Lead Nurse, Deputy Chief Nurse and Workforce Lead were central to the delivery of professional judgement. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide balanced assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT.

There are also a minimum number of nurses required to deliver safe care regardless of ward size, 11.5 whole time equivalent (WTE) Registered Nurses (RN's) are required to provide 2 nurses 24/7. The SNCT may indicate that smaller wards are over established however the reality is reductions in staffing levels would be inappropriate. Therefore, caution is advised when interpreting results from smaller areas.

South Tees Staffing Reviews

Twice a year a review of patient acuity and dependency is undertaken Trust wide. During this review period daily assessments of patients are undertaken using clinical descriptors as detailed in **Appendix I**

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. 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.

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 South Tees Hospitals NHS Foundation Trust, the level of cover or 'uplift' built into ward establishments is 21% per Whole Time Equivalent staff member and excludes parenting leave:

- 14% (273hrs) annual leave.
- 3.9 % (70.2hrs) sickness.
- 2.0% (39 hrs) study leave.
- 1.1% (19.5hrs) Working Day i.e., Management Day, non-clinical day.

This headroom calculation is specific to South Tees Hospitals NHS Foundation Trust and was agreed by the Trust Board.

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.

Authorised funded establishments versus professional judgement recommended establishment:

- At the end of March 2024, the RN budget for inpatient beds (excluding critical care) was 754.66 WTE against a working professional judgement establishment of 840.56 WTE suggesting a deficit of 85.90 WTE. However, actual staffing was 806.69 showing a surplus of 52.03 WTE against budget
- The HCA budget for inpatient beds (excluding the critical care areas) was 584.00 WTE against a working professional judgement establishment of 623.12 WTE suggesting a deficit of 39.12 WTE. However, actual staffing was 555.73 showing a deficit of 28.27 WTE.

Safer nursing care tool recommended establishment versus funded establishment:

- The SNCT data suggests that the required number of RNs was 887.96 WTE suggesting a deficit of 133.30 WTE against current budget of 2023/2024 across the Trust. It must be noted that SNCT does not calculate correctly for small wards.
- The SNCT data suggests that the required HCA was 476.86 WTE suggesting a surplus of 107.14 WTE against authorised funded establishments across the Trust. However, the data demonstrates that this does contribute to backfill of RN gaps. The professional judgement exceeds both the current budget and actual staffing. This is based on the ward footprint, patient flow and 1:1 support. The SNCT does not account for enhanced observation requirements for patients requiring 1:1 care. An update of the tool released in 2023, the trust will use this new model in the second audit due September 2024. This will offer the opportunity to record data that does account for enhanced observation for patients requiring 1:1 care.

Collab	RN						HCA					
	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance	
	Budget RN WTE *includes WM	Sept 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Budget HCA WTE	Sept 24 Contracted RN WTE *includes WM	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ
Cardio Vas	97.89	105.28	106.24	100.17	-2.28	-8.35	52.00	51.01	52.02	53.95	-1.95	-0.02
DDUGs	63.89	87.51	81.10	106.42	-42.53	-17.21	70.17	68.55	74.52	57.33	12.84	-4.35
Growing FHN & Comm	112.58	114.06	122.00	152.94	-40.36	-9.42	125.19	118.31	136.65	82.42	42.77	-11.46
Head, Neck & Ortho	82.27	88.90	93.20	80.83	1.44	-10.93	69.69	57.22	72.10	43.64	26.05	-2.41
JCCI & Spec Med	63.88	63.80	67.80	67.74	-3.86	-3.92	34.78	33.64	41.50	36.50	-1.72	-6.72
Med & Emerg	191.84	200.94	216.40	237.04	-45.20	-24.56	139.15	140.84	144.69	127.65	11.50	-5.54
Neuro & Spinal	91.36	94.88	102.90	104.64	-13.28	-11.54	70.12	66.04	80.40	55.94	14.18	-10.28
Women & Children	50.95	51.32	50.92	38.18	12.77	0.03	22.90	20.12	21.24	19.44	3.46	1.66
Totals	754.66	806.69	840.56	887.96	-133.30	-85.90	584.00	555.73	623.12	476.86	107.14	-39.12

Table 1 – South Tees Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

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 agreed ratio overall for STHFT is an average ratio of 60/40 registered nurses/Health Care support workers across all inpatient areas except for critical care who undertake a separate staffing review against the GPICS standard.

The ratio of registered nurses to health care 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, Registered Nursing Associates (RNA), Assistant Practitioners (AP) and Allied Health Professionals (AHPs) contribute significantly towards meeting patient needs.

Nurse Staffing by Collaborative

Using the data gathered in the nurse staffing assessment, the overall summary indicates whether the collaborative is established appropriately against the SNCT criteria or not.

Further detail and the results for each care group are given in **Appendix 2**

Conclusion

It is recognised that this data does have clear variations between current and actual budget in relation to SNCT recommendations and professional judgement. The tool used provides data that relies on staff submitting accurate data that reflects the previous 24 hours. Ward configurations and clinical pressures can impact on compliance with this data collection. As the trust begins its workforce staffing assurance programme, greater insight will be provided to all levels of staff within collaboratives. This data will evidence the importance of compliance with data submissions and the direct connection to patient acuity and patient outcomes.

The daily SafeCare process ensures that safe staffing is provided by current workforce and where required temporary workforce solutions.

Recommendations

The Board is asked to receive this report for information and assurance

Debi McKeown
Interim NMAHP Workforce Lead

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 need is in the table below.

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 were used alongside acuity and dependency information to monitor the relationship between ward staffing and nursing outcomes.

Professional Judgement (PJ)

STFT use professional judgement alongside SNCT 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) 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.

The PJ templates have been agreed with the Deputy Operational Chief Nurse, calculated with the agreed allowance for uplift (headroom), to calculate the whole-time equivalents (WTEs) required to staff each 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.
- 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.

Nurse Staffing by Collaborative

Cardiovascular Care

Using the data gathered in the SNCT audit and Professional Judgement template assessment, the overall summary indicates whether the Collaborative is optimally staffed against the SNCT criteria or not.

Cardiovascular Care	
Helen Wilson, Associate Director of Nursing	
Karen Strickland, Clinical Matron Cardiology and Vascular	
Maria Stokes, Clinical Matron Surgery and Cardiac Anaesthesia	

Professional Judgement WTE Templates for Cardiovascular Care Services

Using this methodology, outlined in Table 2 the current budget for RN was 97.89 WTE against the professional judgement of 106.24 WTE suggesting a deficit of 8.35 WTE. For HCA the budget was 52 WTE against the professional judgement of 52.02 suggesting no variance.

Table 2 - Cardiovascular Care Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
					Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26 WTE	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
CCU	14	14	13.8	98.57%	34.90	33.24	36.00	15.77	19.13	-1.10	36.60	1.94	1.92	2.00	8.53	-6.59	-0.06	2.68
Ward 28 Vas	30	30	28	93.33%	17.30	23.00	21.68	31.04	-13.74	-4.38	22.28	18.10	18.64	18.76	16.76	1.34	-0.66	18.76
Ward 29	27	27	26.4	97.78%	18.67	19.32	19.56	24.00	-5.33	-0.89	19.56	13.90	11.89	12.86	12.89	1.01	1.04	13.40
Cardio MB	9	9	8.9	98.89%	10.93	9.24	11.00	9.03	1.90	-0.07	11.44	5.16	5.16	5.00	4.86	0.30	0.16	5.36
Ward 32 (JCCT)	22	21	20.6	98.10%	16.09	20.48	18.00	20.33	-4.24	-1.91	16.85	12.90	13.40	13.40	10.91	1.99	-0.50	13.40
Totals	102	101	97.7	96.73%	97.89	105.28	106.24	100.17	-2.28	-8.35	106.73	52.00	51.01	52.02	53.95	-1.95	-0.02	53.60

Table 2 – Cardiovascular Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 96.73%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

Table 2 also compares the current budget against the SNCT WTE. Using this calculation there was a suggested deficit between the RN budget of 2.28 WTE and deficit HCA budget of 1.95 WTE. To note the SNCT tool does not take into consideration the specialist requirement for wards.

Figure 1 - Patient Acuity and Dependency scores during the audit period broken down by percentage

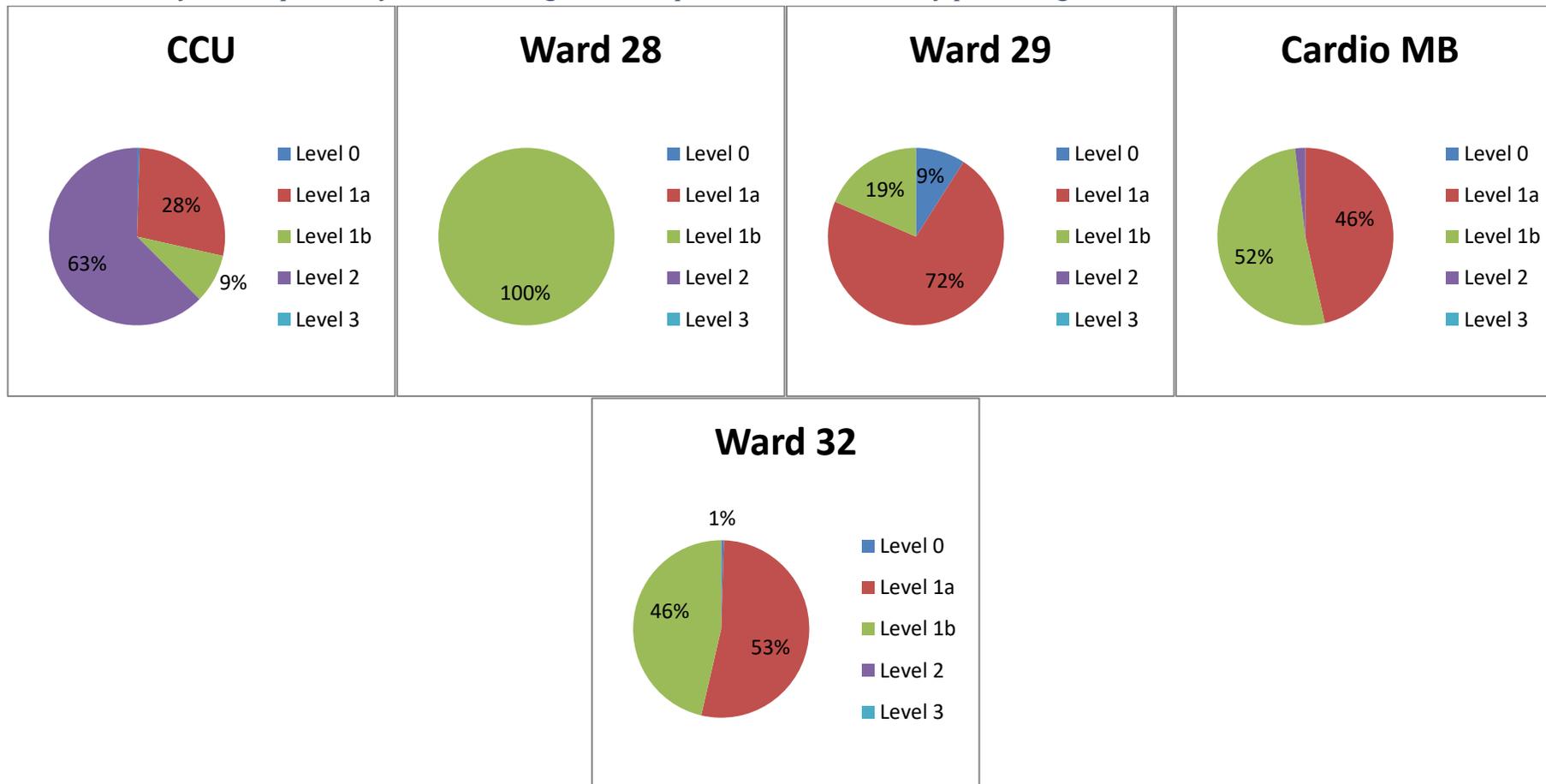


Figure 1 – Cardiovascular Acuity and dependency scores

Table 3 - Cardiovascular activity and patient harms recorded during the census period

CCU		Ward 28 Vas		Ward 29		Cardio MB		Ward 32 (JCCT)	
Level 0	2	Level 0	0	Level 0	72	Level 0	0	Level 0	3
Level 1a	116	Level 1a	0	Level 1a	573	Level 1a	124	Level 1a	328
Level 1b	37	Level 1b	841	Level 1b	147	Level 1b	138	Level 1b	286
Level 2	259	Level 2	0	Level 2	0	Level 2	5	Level 2	0
Level 3	0	Level 3	0	Level 3	0	Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
CCU	125	70	34	42	5	4	65	2	4	8	0	0	0	2	0	97.06
Ward 28 Vas	39	82	55	19	0	1	0	0	0	0	3	0	1	10	1	82.77
Ward 29	62	117	77	22	5	1	38	0	1	6	1	0	2	5	0	92.48
Cardio MB	17	25	23	8	1	0	3	0	0	6	0	0	0	0	0	NA
Ward 32 (JCCT)	87	114	119	85	36	0	0	0	0	0	0	0	0	0	0	93.09

Table 3 – Cardiovascular Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Ward 29 – The SNCT recommendation of less HCAs does not reflect the need of additional HCA support to ensure safe patient care at night when there is an increased risk of falls.

Ward 29 Monitored Bay – Staffing establishment is at the correct levels.

Ward 28 – Based on the current footprint and high acuity, the staffing establishment should remain the same.

Ward 32 – SNCT supports the need for an additional RN on nights and no change in HCA numbers.

CCU – It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area.

Digestive Diseases, Urology and General Surgery

Digestive Diseases, Urology and General Surgery	
Nicola Metcalfe, Associate Director of Nursing	
Aideen Cullen, Clinical Matron General Surgery	
Claire Connelly, Clinical Matron Gastro & Urology	
Jo Bradley, Clinical Matron	

Professional Judgement WTE Templates for Digestive Diseases, Urology and General Surgery

Using this methodology, outlined in Table 4 the current budget for RN was 63.89 WTE against the professional judgement of 81.10 WTE suggesting a deficit in funding of 17.21 WTE. For HCA the requirement was 70.17 WTE against the professional of 74.52 WTE suggesting a deficit of 4.35 WTE.

Table 4 - Digestive Diseases, Urology and General Surgery Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Ward 5	30	30	24	80.00%	15.78	20.28	22.10	21.62	-5.84	-6.32	22.28	14.74	15.32	18.00	11.70	3.04	-3.26	18.76
Ward 6 Gastro	31	31	30.6	98.71%	16.39	16.95	19.00	28.17	-11.78	-2.61	21.37	20.31	21.47	19.00	15.17	5.14	1.31	17.99
Ward 7 Colo	31	31	29.1	93.87%	14.46	25.44	20.00	29.95	-15.49	-5.54	22.28	17.06	17.00	18.76	16.07	0.99	-1.70	18.76
Ward 8	30	30	28.7	95.67%	17.26	24.84	20.00	26.68	-9.42	-2.74	22.28	18.06	14.76	18.76	14.38	3.68	-0.70	18.76
Totals	122	122	112.4	92.13%	63.89	87.51	81.10	106.42	-42.53	-17.21	88.21	70.17	68.55	74.52	57.33	12.84	-4.35	74.27

Table 4 – DDUGs Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 92.13%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

The figures above in Table 4 compare the current budget against the SNCT WTE. Using this calculation there was a suggested deficit between the RN budget of 42.53 WTE and surplus HCA budget of 12.84 WTE. To note the SNCT tool does not take into consideration the specialising requirement for wards.

The current budget does not reflect the actual budget required for this collaborative. The previous establishment review requested an increase to both nurse and HCAs, however the budget that was approved was significantly lower than the requested establishment. The acuity of the patients within this collaborative therefore does reflect the higher professional judgement and SNCT outcomes.

Figure 2 - Digestive Diseases, Urology and General Surgery Patient Acuity and Dependency scores during the audit period broken down by percentage

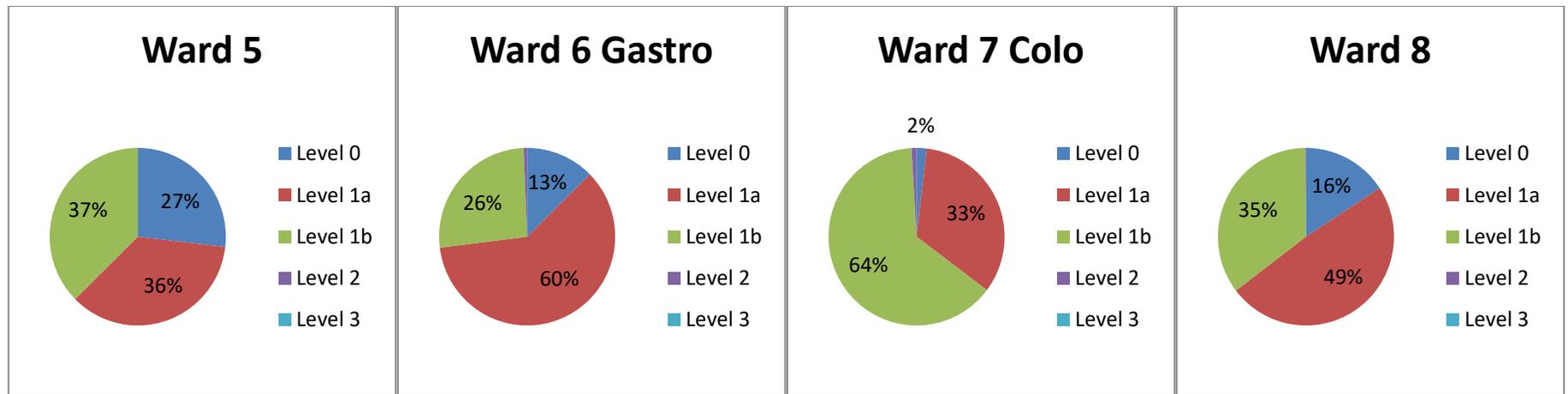


Figure 2 – DDUGs Acuity and Dependency Scores

Table 5 – Digestive Diseases, Urology and General Surgery activity and patient harms recorded during the census period

Ward 5		Ward 6 Gastro		Ward 7 Colo		Ward 8	
Level 0	193	Level 0	116	Level 0	16	Level 0	136
Level 1a	257	Level 1a	555	Level 1a	292	Level 1a	421
Level 1b	269	Level 1b	242	Level 1b	557	Level 1b	304
Level 2	0	Level 2	6	Level 2	8	Level 2	1
Level 3	0	Level 3	0	Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 5	45	213	231	114	1	1	21	5	0	3	1	0	1	3	0	86.51
Ward 6 Gastro	43	83	87	46	0	5	6	1	2	0	1	0	3	6	0	79.45
Ward 7 Colo	56	103	75	35	0	1	0	0	0	0	2	0	1	5	0	82.71
Ward 8	91	160	103	54	0	0	0	0	0	0	2	0	4	3	0	87.14

Table 5 – DDUGs Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Ward 5 – This ward area continuously opens to 31 beds. This will account for the variation between current and actual staffing against professional judgement and SNCT recommendations.

Ward 6 – The patient cohort for this ward is highly dependent on extensive support from staff. The impact on behaviours due to the nature of their conditions leads to a higher need for 1:1 support to ensure the patients are safely cared for. This is reflected in the professional judgement and SNCT outcomes.

Ward 7 – The SNCT outcomes show an excessively high requirement for RNs. The acuity of the patients and the often rapid decline would show the higher need for RN provision. However, the care provided from the HCAs ensures that safe care is provided alongside the clinical interventions from registered staff.

Ward 8 – Ward 8 continues to have a high number of medical outliers, therefore the professional judgement demonstrated the need for additional nursing staff.

Growing the Friarage & Community

Growing the Friarage & Community	
Christine Jackson, Associate Director of Nursing FHN and H&R	
Kelly Kirtley Associate Director of Nursing Tees	
Lisa Swales, Clinical Matron Friarage Hospital	
Kath Young, Clinical Matron Community Hospitals	

Professional Judgement WTE Templates for Community

Using this methodology, outlined in Table 6 the current budget for RN was 37.93 WTE against the professional judgement of 40 WTE suggesting a deficit in funding of 2.07 WTE. For HCA the budget was 53.22 WTE against the professional judgement of 60.25 WTE suggesting a deficit of 7.03 WTE.

Table 6 - Community Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Tocketts	30	26	28.1	108.08%	16.67	19.81	19.00	30.05	-13.38	-2.33	19.56	23.22	20.91	25.08	16.17	7.05	-1.86	24.13
Zetland	31	29	28.5	98.28%	21.26	18.91	21.00	28.37	-7.11	0.26	22.28	30.00	27.84	35.17	15.27	14.73	-5.17	32.16
Totals	61	55	56.6	102.91%	37.93	38.72	40.00	58.42	-20.49	-2.07	41.84	53.22	48.75	60.25	31.44	21.78	-7.03	56.29

Table 6 - Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 102.91%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

The figures above in Table 6 also compare the current budget against the SNCT WTE. Using this calculation there was a suggested deficit between the RN budget of 20.49 WTE and surplus HCA budget of 21.78 WTE. To note the SNCT tool does not take into consideration the 1:1 requirements for these wards.

Both community hospitals are in remote locations with no adjacent wards to assist with staffing issues. Tocketts ward layout is difficult to observe patients and therefore requires more HCAs for patient safety. Zetland ward consists of all single rooms and the ward layout requires more HCAs to support patient safety.

Figure 3 – Community Patient Acuity and Dependency scores during the audit period broken down by percentage

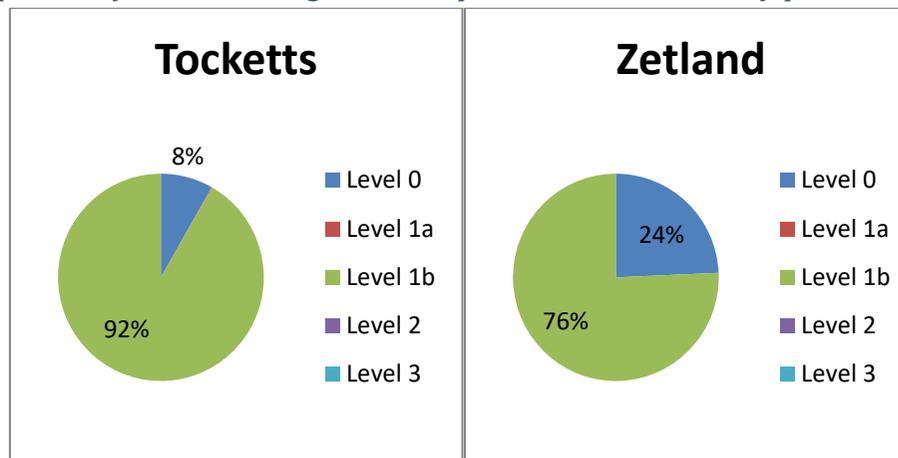


Figure 3 – Community Acuity and Dependency Scores

Professional Judgement WTE Templates for Growing the Friarage

Using this methodology, outlined in Table 7 the current budget for RN was 74.65 WTE against the professional judgement of 82 suggesting a deficit in funding of 7.35 WTE. For HCA the requirement was 71.97 WTE against the professional judgement of 76.40 WTE suggesting a deficit of 4.43 WTE.

During March 2024 the bed occupancy across this collaborative was an average of 95.64%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for Romanby which was 50/50.

Table 7 - Growing the Friarage Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Ainderby	27	22	23.3	105.91%	14.87	15.41	16.00	21.62	-6.75	-1.13	16.18	16.10	19.11	18.00	11.70	4.40	-1.90	17.99
CDU	22	22	16.8	76.36%	19.39	20.48	23.00	15.27	4.12	-3.61	23.97	9.36	9.35	12.60	8.23	1.13	-3.24	12.84
Friary	18	18	14	77.22%	12.97	11.28	14.00	15.27	-2.30	-1.03	13.58	14.84	10.83	14.80	8.23	6.61	0.04	15.41
Romanby	26	22	25.7	116.82%	14.45	16.41	16.00	24.10	-9.65	-1.55	16.18	18.31	17.30	18.00	12.99	5.32	0.31	17.99
Rutson	17	17	16.9	99.41%	12.97	11.76	13.00	18.25	-5.28	-0.03	13.58	13.36	12.97	13.00	9.82	3.54	0.36	13.58
Totals	110	101	96.6	95.64%	74.65	75.34	82.00	94.52	-19.87	-7.35	83.49	71.97	69.56	76.40	50.98	20.99	-4.43	77.81

Table 7 Growing the FHN - Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

The figures above in Table 7 also compare the current budget against the SNCT WTE. Using this calculation there was a suggested deficit between the RN budget of 19.87 WTE and surplus HCA budget of 20.99 WTE. To note the SNCT tool does not take into consideration the specialising requirement for wards.

The FHN is often required to absorb the enhanced observation requirements for patients, they have therapeutic care support and rely on NHSP filling short notice requests.

Figure 4 – Growing the Friarage and Community Patient Acuity and Dependency scores during the audit period broken down by percentage

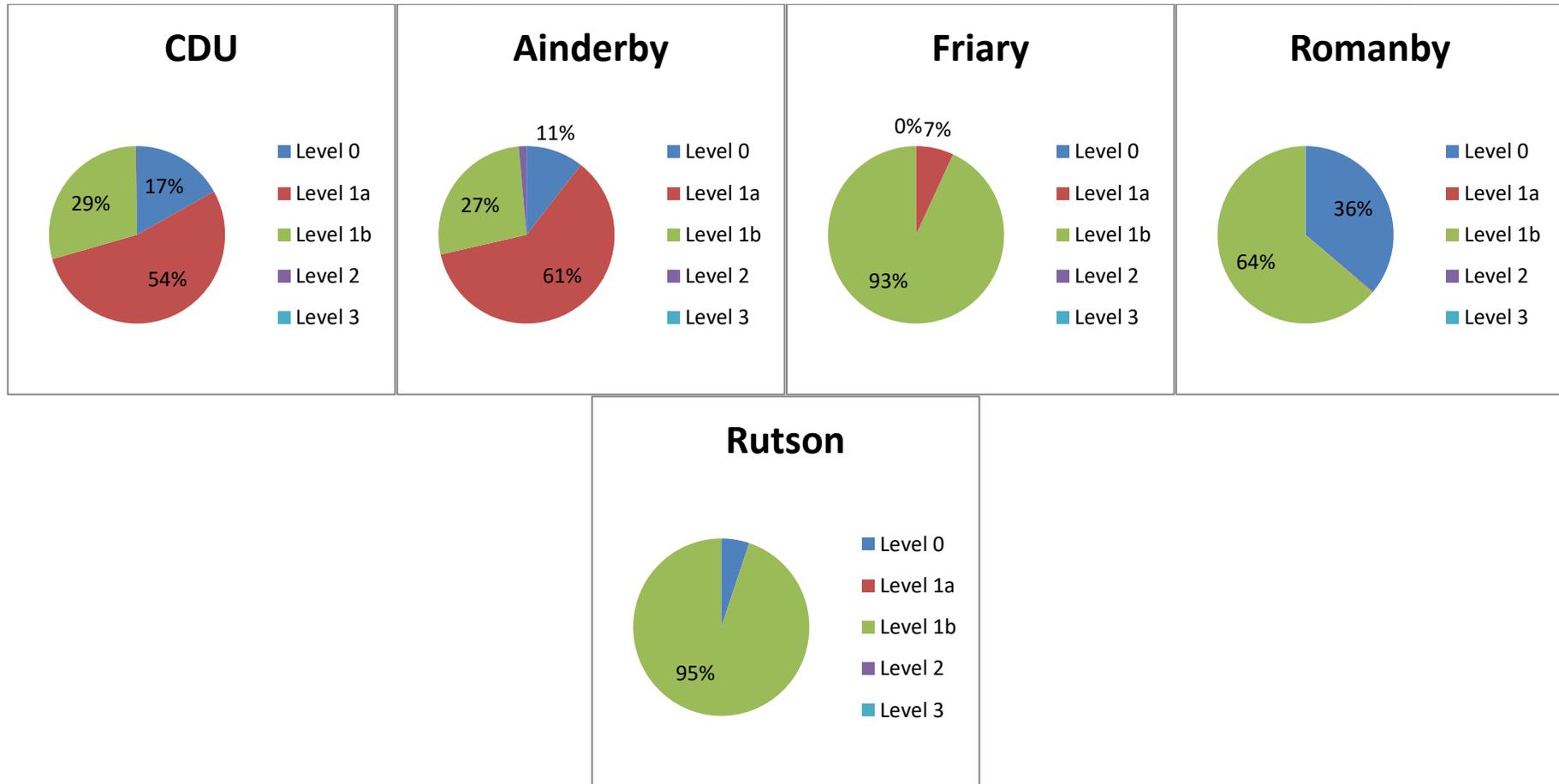


Figure 4 – Growing the FHN Acuity and Dependency scores

Table 8 - Growing the Friarage activity and patient harms recorded during the census period

Ainderby		CDU		Friary		Romanby		Rutson	
Level 0	74	Level 0	85	Level 0	0	Level 0	278	Level 0	26
Level 1a	426	Level 1a	270	Level 1a	29	Level 1a	1	Level 1a	0
Level 1b	190	Level 1b	147	Level 1b	389	Level 1b	491	Level 1b	480
Level 2	10	Level 2	1	Level 2	0	Level 2	0	Level 2	0
Level 3	0								

Tocketts		Zetland	
Level 0	69	Level 0	208
Level 1a	1	Level 1a	0
Level 1b	773	Level 1b	648
Level 2	0	Level 2	0
Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ainderby	51	74	37	6	0	2	3	0	64	2	6	0	0	0	0	92.29
CDU	273	152	5	150	0	10	143	1	9	11	1	0	0	2	2	94.22
Friary	27	26	0	0	0	4	0	0	1	0	1	0	2	2	0	87.72
Romanby	1	59	86	20	0	7	8	0	4	91	3	0	1	0	0	88.55
Rutson	2	12	11	1	0	1	0	1	6	1	1	0	0	0	0	88.87
Tocketts	37	38	14	5	9	2	4	5	29	19	1	1	0	0	0	91.69
Zetland	31	32	3	2	8	2	6	3	5	18	1	0	2	0	0	95.5

Table 8 – Growing the FHN Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Zetland Ward (Redcar Primary Care Hospital) – This 31 bedded rehabilitation ward provides care in single rooms. This is the reason that SNCT recommends a decrease in HCAs, however due to the risk to patients in this side room layout there should not be a reduction to HCA workforce.

Tocketts Ward (East Cleveland Hospital) – The nurse to patient ration when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need.

Victoria ward (The Friary Hospital Richmond) – This ward is based in a remote area with no internal support structures, therefore the recommendation from SNCT to increase the nursing establishment does reflect the current need.

Rutson Ward – is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment.

Ainderby ward (FHN) – This ward with frail and complex medical patients has a need for additional RN support.

Romanby ward (FHN) – This 22 bedded medical ward is providing safe care within the current establishment.

Clinical Decision Unit (FHN) – is a 22 bedded admission ward for medical patient admissions. The need to cover telemetry over a 24 hour period would require additions to the RN workforce.

The Staffing establishment for FHN does not take into account that the Band 7's and some 6's have to carry the 627 bleep from 4pm to 8pm on week days and 8m to 8pm on weekends.

Head & Neck, Orthopaedic and Reconstructive

Head & Neck, Orthopaedic and Reconstructive																			
Keir Rumins, Associate Director of Nursing																			
Stacey Brown, Clinical Matron Trauma & Orthopaedics																			
Anthea Davidson, Clinical Matron ENT, OMFS, Plastics & Ophthalmology																			

Professional Judgement WTE Templates for Head & Neck, Orthopaedic and Reconstructive

Using this methodology, outlined in Table 9 the current budget was RN was 82.27 WTE against the professional judgement of 93.20 WTE suggesting a deficit in funding of 10.93 WTE. For HCA the requirement was 69.69 WTE against the professional judgement of 72.10 WTE suggesting a deficit in funding of 2.41 WTE.

Table 9 - Head & Neck, Orthopaedic and Reconstructive Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Gara	21	21	9.2	43.81%	11.97	12.37	13.50	9.12	2.85	-1.53	13.58	9.89	6.92	9.80	4.96	4.93	0.09	10.27
Ward 25 Hip/Femur Fracture Unit	21	21	16.6	79.05%	18.67	19.92	19.00	17.55	1.12	-0.33	19.56	12.90	12.39	13.00	9.42	3.48	-0.10	13.4
Ward 27 Elec Ortho	15	15	7.8	52.00%	10.97	13.37	14.50	8.13	2.84	-3.53	13.58	9.89	6.83	9.80	4.36	5.53	0.09	10.27
Ward 35	26	26	20.4	78.46%	19.78	19.88	22.70	20.33	-0.55	-2.92	22.28	16.37	16.24	18.50	11.01	5.36	-2.13	18.76
Ward 36 Trauma	34	34	29.7	87.35%	20.88	23.36	23.50	25.69	-4.81	-2.62	24.99	20.64	14.84	21.00	13.89	6.75	-0.36	21.44
Totals	117	117	83.7	71.54%	82.27	88.90	93.20	80.83	1.44	-10.93	93.99	69.69	57.22	72.10	43.64	26.05	-2.41	74.14

Table 9 – Head, Neck & Ortho Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 71.54%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for ward 25 which was 50/50.

The figures above in Table 9 also compare the current budget against the SNCT WTE. Using this calculation there was a suggested surplus between the RN budget of 1.44 WTE and surplus HCA budget of 26.05 WTE. To note the SNCT tool does not take into consideration the specialing requirement for wards.

Figure 5 – Head & Neck, Orthopaedic and Reconstructive Patient Acuity and Dependency scores during the audit period broken down by percentage

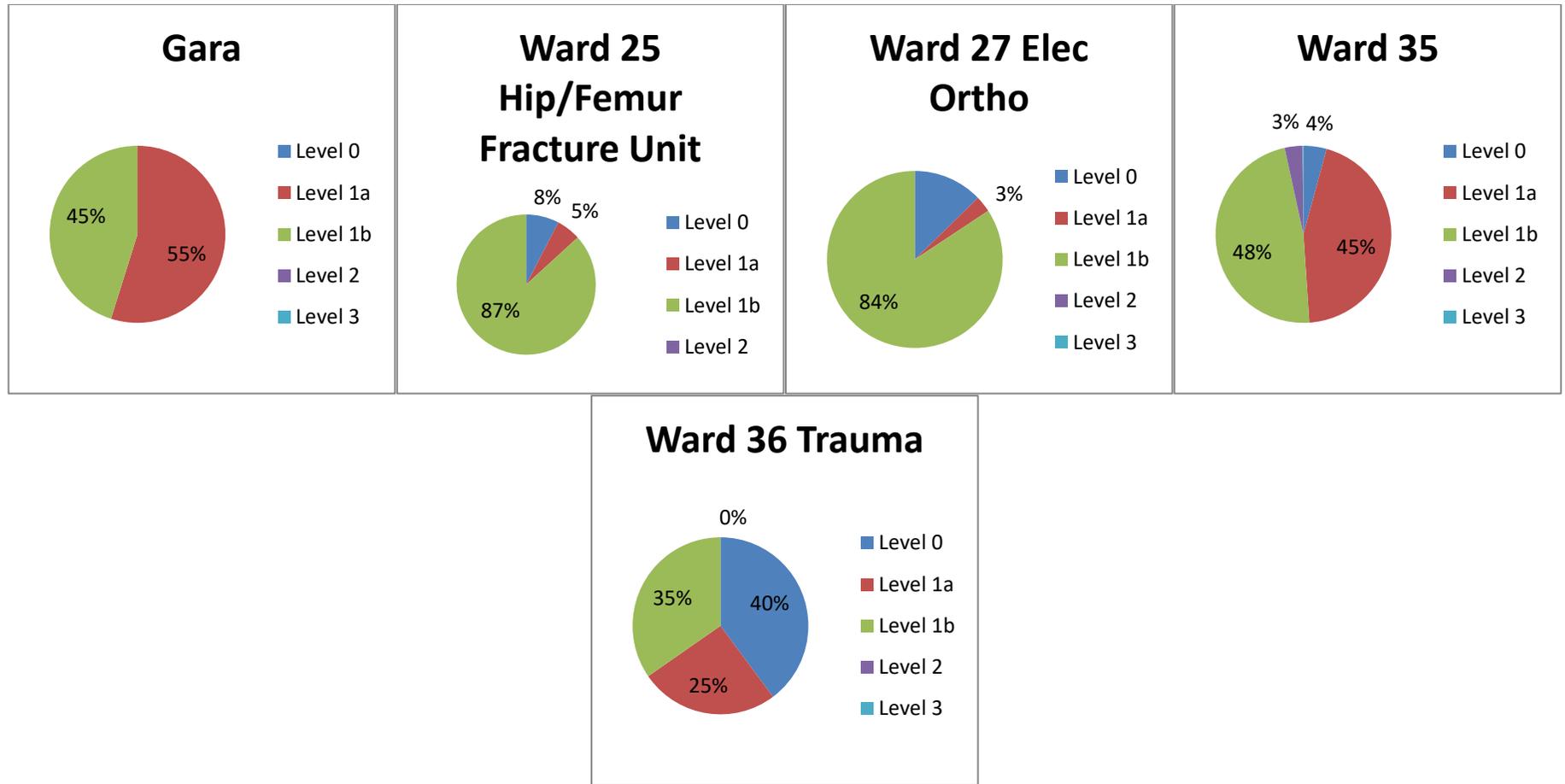


Figure 5 – Head, Neck & Ortho Acuity and Dependency scores

Table 10 - Head & Neck, Orthopaedic and Reconstructive activity and patient harms recorded during the census period

Gara		Ward 25 Hip/Femur Fracture Unit		Ward 27 Elec Ortho		Ward 35	
Level 0	0	Level 0	38	Level 0	30	Level 0	26
Level 1a	152	Level 1a	28	Level 1a	7	Level 1a	273
Level 1b	125	Level 1b	431	Level 1b	198	Level 1b	291
Level 2	0	Level 2	0	Level 2	0	Level 2	20
Level 3	0	Level 3	0	Level 3	0	Level 3	1

Ward 36 Trauma	
Level 0	355
Level 1a	228
Level 1b	309
Level 2	0
Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Gara	0	161	160	2	0	0	0	0	0	0	0	0	3	0	0	95.96
Ward 25 Hip/Femur Fracture Unit	41	33	27	25	0	3	37	0	15	0	1	1	1	1	0	91.82
Ward 27 Elec Ortho	13	34	34	3	29	0	109	0	13	3	0	0	0	1	0	96.54
Ward 35	102	148	30	31	10	0	2	2	0	8	0	0	1	4	0	88.19
Ward 36 Trauma	146	108	14	40	2	0	0	0	13	5	0	0	1	5	0	NA

Table 10 – Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Gara (FHN) – Gara is fully established and requires no change.

Ward 25 – Does not require any changes to the current staffing establishment.

Ward 27 – As beds can be closed, no change is required to the current staffing establishment.

Ward 35 - The ward requires an extra RN/AP support two to three times per week for complex care post-surgery (L2) and to support any emergency high level patients (free flap/trach) (L2), this is factored into the professional judgement calculation above. There is high complexity of patients and patient throughput. The ward also supports the plastics clinics and other drop-in services that is not factored into the ward staffing calculations (PDC is on the ward however has own staffing model, separate). On a weekend and out of hours the ward supports any patient requiring urgent plastics treatment.

Ward 36 - This trauma ward is a critical care step down area and sees high numbers of overnight trauma admissions. As such the staffing template would benefit from an additional RN for the patient group and ward setting.

James Cook Cancer Institute & Specialty Medicine

James Cook Cancer Institute & Speciality Medicine	
Jo Foster, Head of Nursing	
Claire Allinson, Clinical Matron	

Professional Judgement WTE Templates for James Cook Cancer Institute & Speciality Medicine

Using this methodology, outlined in Table 11 the current budget was RN was 63.88 WTE against the professional judgement of 67.80 WTE suggesting a deficit in funding of 3.92 WTE. For HCA the requirement was 34.78 WTE against the professional judgement of 41.50 WTE suggesting a deficit of 6.72 WTE.

Table 11 - James Cook Cancer Institute & Speciality Medicine Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Ward 4	24	24	22.9	95.42%	22.36	21.28	23.20	25.29	-2.93	-0.84	23.44	10.94	12.36	14.50	13.69	-2.75	-3.56	16.08
Ward 14 Oncology	23	23	20.8	90.43%	21.26	22.64	22.30	20.43	0.83	-1.04	22.28	11.94	7.48	13.00	11.01	0.93	-1.06	13.4
Ward 33 Specialty	23	23	20.2	87.83%	20.26	19.88	22.30	22.02	-1.76	-2.04	22.28	11.90	13.80	14.00	11.80	0.10	-2.10	16.08
Totals	70	70	63.9	91.29%	63.88	63.80	67.80	67.74	-3.86	-3.92	68.00	34.78	33.64	41.50	36.50	-1.72	-6.72	45.56

Table 11 – JCCI Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 91.29%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

The figures above in Table 11 also compare the current budget against the SNCT recommended WTE. There was a suggested deficit between the RN budget of 3.86 WTE and HCA budget deficit of 1.72 WTE. To note the SNCT tool does not take into consideration the specialing requirement for wards.

Ward 14 and 33 facilitate a support line out of hours which helps with admission avoidance but takes RN time to facilitate. These calls can take between 15 minutes to one hour. Patients with cancer and those receiving chemotherapy require close monitoring, extended time for psychological support and complex discharge planning.

Figure 6 - James Cook Cancer Institute & Speciality Medicine Patient Acuity and Dependency scores during the audit period broken down by percentage

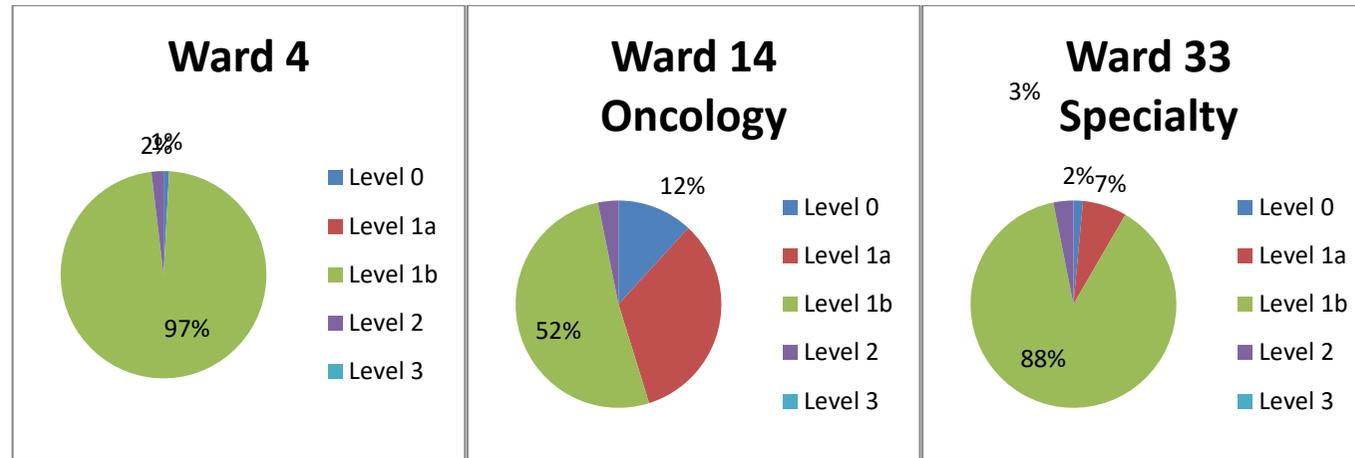


Figure 6 – JCCI Acuity and Dependency scores

Table 12 - James Cook Cancer Institute & Speciality Medicine activity and patient harms recorded during the census period

Ward 4		Ward 14 Oncology		Ward 33 Specialty	
Level 0	6	Level 0	74	Level 0	9
Level 1a	0	Level 1a	208	Level 1a	42
Level 1b	668	Level 1b	322	Level 1b	535
Level 2	13	Level 2	20	Level 2	19
Level 3	0	Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 4	65	90	37	17	18	7	60	0	9	7	1	0	1	4	0	89.4
Ward 14 Oncology	35	48	13	4	14	4	34	4	5	3	0	0	3	1	0	91.69
Ward 33 Specialty	66	57	14	10	16	3	22	0	0	0	1	0	4	2	2	85.73

Table 12 – JCCI Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Ward 4 Renal – Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes.

Ward 14 Oncology – No change to establishment is required.

Ward 33 Haematology – Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended.

Medicine & Emergency Care

Medicine & Emergency Care excluding ED	
Beth Swanson, Associate Director of Nursing	
Stephen McKenna, Clinical Matron Emergency Medicine	
Jess Farman, Clinical Matron Acute Medicine	
David Whitelock, Clinical Matron OPM & Respiratory	
Jackie Hoggart, Clinical Matron ID & Diabetes	

Professional Judgement WTE Templates for Admissions Units

Using this methodology, the current budget outlined in Table 13 for RN was 90.16 WTE against the professional judgement of 96, suggesting a deficit of 5.84 WTE. For HCA the budget was 64.5 WTE against the professional judgement of 66.84 WTE suggesting a deficit of 2.34.

Table 13 - Admissions Units Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
					Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Ward 1 AAU	31	30	28.5	95.00%	30.58	32.96	33.00	27.47	3.11	-2.42	33.11	20.64	18.20	21.44	14.78	5.86	-0.80	21.44
Ward 31 AAU	35	35	34	97.14%	28.00	28.84	30.00	30.35	-2.35	-2.00	30.40	23.22	24.00	24.00	16.36	6.86	-0.78	24.13
Ward 37 (AMU)	30	30	27.5	91.67%	31.58	29.88	33.00	27.08	4.50	-1.42	33.11	20.64	22.01	21.40	14.58	6.06	-0.76	21.44
Totals	96	95	90	94.74%	90.16	91.68	96.00	84.90	5.26	-5.84	96.62	64.50	64.21	66.84	45.72	18.78	-2.34	67.01

Table 13 – Admissions Units Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 94.74%. The skill mix ratio for this care setting is 70% RNs to 30% HCAs.

The figures above in Table 13 also compares the current budget against the SNCT recommended WTE. There was a suggested surplus between the RN budget of 5.26 WTE and HCA budget surplus of 18.78 WTE. To note the SNCT tool does not take into consideration the specialising requirement for wards.

Figure 7 – Admissions Units Patient Acuity and Dependency scores during the audit period broken down by percentage

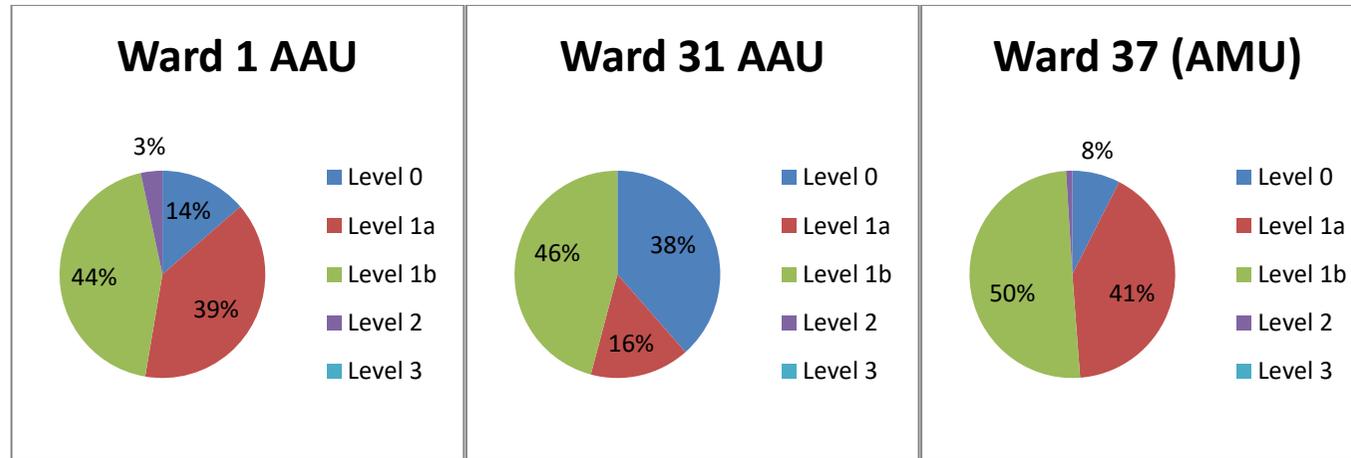


Figure 7– Admissions Units Acuity and Dependency scores

Professional Judgement WTE Templates for Medicine & Emergency Care

Using this methodology, outlined in Table 14 the current budget for RN was 101.68 WTE against the professional judgement of 120.40 WTE suggesting a deficit in funding of 18.72 WTE. For HCA the budget was 74.65 WTE against the professional judgement of 77.85 WTE suggesting a deficit of 3.20 WTE.

Table 14 - Medicine & Emergency Care Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Ward 2	30	30	29.6	98.67%	16.92	17.84	18.50	28.27	-11.35	-1.58	18.78	13.36	14.79	12.60	15.17	-1.81	0.76	12.84
Ward 3	28	28	27.8	99.29%	18.23	20.74	18.50	27.97	-9.74	-0.27	18.78	12.75	13.45	12.84	15.08	-2.33	-0.09	12.84
Ward 9 incl RSU	34	32	33	103.13%	30.40	29.40	39.00	36.20	-5.80	-8.60	39.56	9.84	14.87	15.41	19.54	-9.70	-5.57	15.41
Ward 11 (OPM)	28	28	27.4	97.86%	20.46	19.56	22.20	30.25	-9.79	-1.74	22.28	20.64	19.52	18.50	16.27	4.37	2.14	18.76
Ward 12 OPM	27	27	27	100.00%	15.67	21.72	22.20	29.46	-13.79	-6.53	22.28	18.06	14.00	18.50	15.87	2.19	-0.44	18.76
Totals	147	145	144.8	99.86%	101.68	109.26	120.40	152.14	-50.46	-18.72	121.68	74.65	76.63	77.85	81.92	-7.27	-3.20	78.61

Table 14 – Med & Emerg Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

To note ward 9 has x 2 Respiratory Support Unit bays requiring 1:2 staffing for the first 24hrs of BIPAP and ward 3 multispecialty assessment ward.

During March 2024 the bed occupancy across this collaborative was an average of 99.86%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

The figures above in Table 14 also compare the current budget across the medical wards against the SNCT recommended WTE. There was a suggested deficit between the RN budget of 50.46 WTE and deficit of HCA budget of 7.27 WTE. To note the SNCT tool does not take into consideration the specialising requirement for wards.

Figure 8 - Medicine & Emergency Care Patient Acuity and Dependency scores during the audit period broken down by percentage

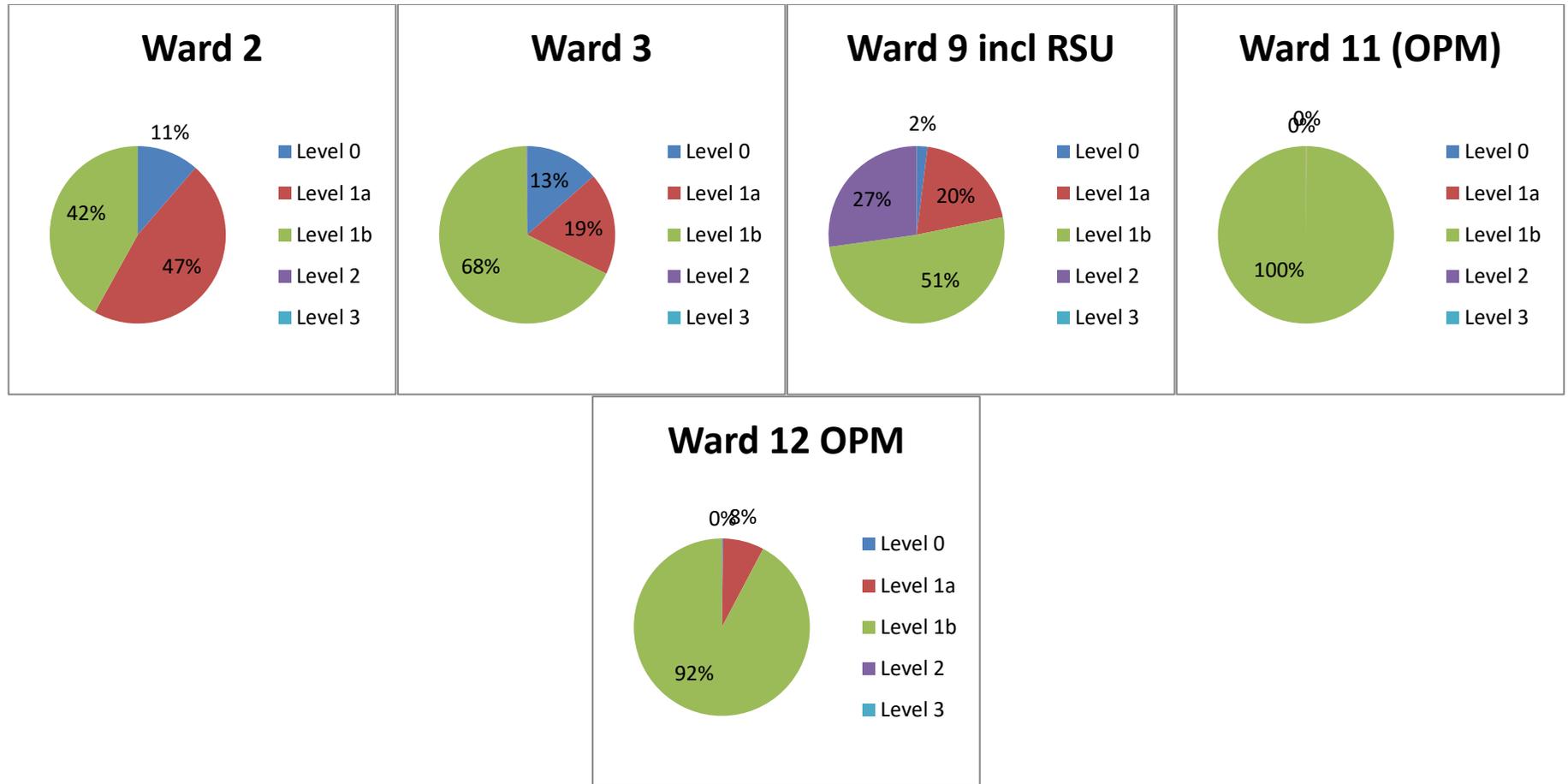


Figure 8 – Med & Emerg Acuity and Dependency score

Table 15 - Medicine & Emergency Care activity and patient harms recorded during the census period

Ward 1 AAU		Ward 2		Ward 3		Ward 9 incl RSU		Ward 11 (OPM)	
Level 0	117	Level 0	101	Level 0	113	Level 0	20	Level 0	0
Level 1a	334	Level 1a	415	Level 1a	156	Level 1a	196	Level 1a	1
Level 1b	376	Level 1b	372	Level 1b	565	Level 1b	505	Level 1b	820
Level 2	29	Level 2	0	Level 2	1	Level 2	269	Level 2	0
Level 3	0	Level 3	0	Level 3	0	Level 3	0	Level 3	0

Ward 12 OPM		Ward 31 AAU		Ward 37 (AMU)	
Level 0	2	Level 0	393	Level 0	62
Level 1a	61	Level 1a	160	Level 1a	340
Level 1b	747	Level 1b	468	Level 1b	414
Level 2	0	Level 2	0	Level 2	8
Level 3	0	Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 1 AAU	317	222	300	388	7	4	331	1	16	4	1	0	4	6	0	91.49
Ward 2	60	58	0	2	0	4	63	0	28	0	2	0	0	5	0	NA
Ward 3	2	88	100	10	0	6	42	1	86	0	1	0	1	2	1	86.75
Ward 9 incl RSU	138	122	8	7	14	16	211	2	14	12	10	0	5	6	0	87.63
Ward 11 (OPM)	50	60	25	7	2	13	62	0	23	41	2	0	1	6	1	84.86
Ward 12 OPM	40	55	11	3	0	8	57	0	25	42	5	0	1	5	0	92.26
Ward 31 AAU	315	316	2	18	0	3	94	5	34	31	1	0	1	3	0	93.29
Ward 37 (AMU)	883	873	0	607	0	6	1582	0	28	27	7	0	0	7	0	90.65

Table 15 – Med & Emerg Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Ward 1 Male Assessment Unit – It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

Ward 37 Female Assessment Unit – It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

Ward 31 Short Stay – Professional judgement and actual staffing are appropriate for Ward 31, no change is required.

Ward 3 Infectious Diseases – No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3.

Ward 9 Respiratory - is a 32 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays offering dedicated male and female beds. The ward footprint is large and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require level 2 nurse to patient ratios and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increases. SNCNT and professional judgement both indicate a requirement for an increase in both RN and HCA numbers in this area. This is reflective of the patient need.

Ward 12 –The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.

Ward 11 Older Peoples Medicine – The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.

Ward 2 – SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year.

Neurosciences & Spinal Care

Neurosciences & Spinal Care	
Helen Wilson, Associate Director of Nursing	
Julie Carr, Clinical Matron Neurology including Spinal Injuries	
Kathy Collighan, Clinical Matron Neuro	

Professional Judgement WTE Templates for Neurosciences & Spinal Care

Using this methodology, outlined in Table 16 current budget for RN was 91.36 WTE against the professional judgement of 102.90 WTE suggesting a deficit in funding of 11.54 WTE. For HCA the budget was 70.12 WTE against the professional judgement of 80.40 WTE suggesting a deficit of 10.28 WTE.

Table 16 - Neurosciences & Spinal Care Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

Ward	Bed Management				RN							HCA						
					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Spinal Injuries +HDU	24	24	18.7	77.92%	29.60	33.84	31.00	32.83	-3.23	-1.40	31.00	24.22	19.72	24.00	17.65	6.57	0.22	24.12
Ward 24	23	23	20.4	88.70%	18.67	18.72	19.50	20.13	-1.46	-0.83	19.56	13.90	13.52	18.00	10.51	3.39	-4.10	18.76
Ward 26	19	19	17.8	93.68%	13.51	15.08	15.40	19.04	-5.53	-1.89	15.36	12.90	12.76	13.40	10.22	2.68	-0.50	13.40
Ward 34 NASU	34	34	28.8	84.71%	29.58	27.24	37.00	32.63	-3.05	-7.42	38.54	19.10	20.04	25.00	17.55	1.55	-5.90	25.27
Totals	100	100	85.7	85.70%	91.36	94.88	102.90	104.64	-13.28	-11.54	104.46	70.12	66.04	80.40	55.94	14.18	-10.28	81.55

Table 16 – Neuro & Spinal Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across this collaborative was an average of 85.70%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for ward 26 which was 50/50.

The figures above in Table 16 also compare the current budget against the SNCT WTE. Using this calculation there was a suggested deficit between the RN budget of 13.28 WTE and surplus HCA budget of 14.18 WTE. To note the SNCT tool does not take into consideration the specialising requirement for wards.

Figure 9 - Neurosciences & Spinal Care Patient Acuity and Dependency scores during the audit period broken down by percentage

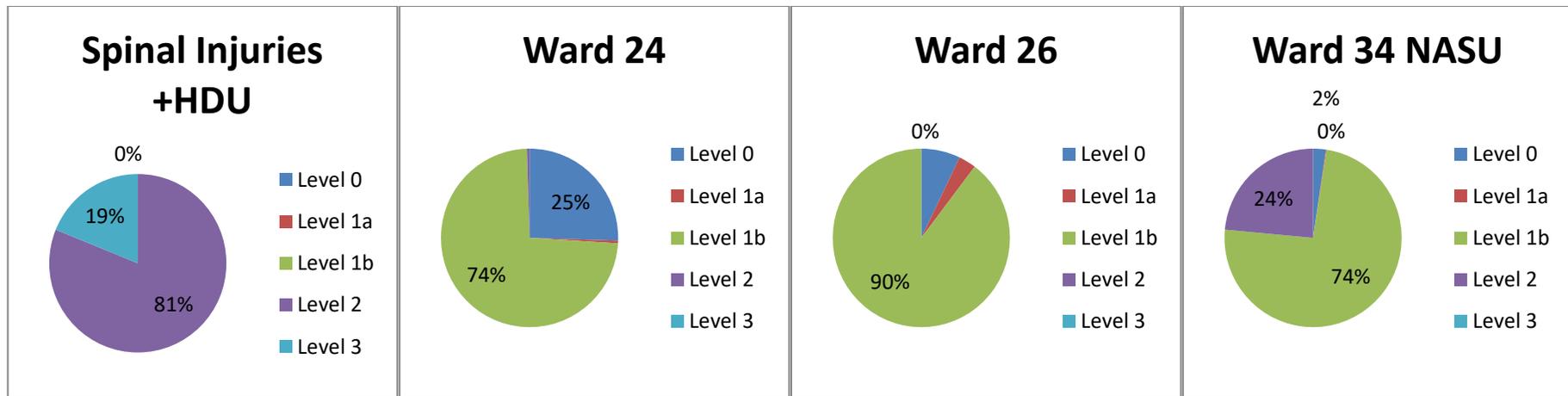


Figure 9 – Neuro & Spinal Acuity and Dependency scores

Table 17 - Neurosciences & Spinal Care activity and patient harms recorded during the census period

Spinal Injuries +HDU		Ward 24		Ward 26		Ward 34 NASU	
Level 0	0	Level 0	156	Level 0	38	Level 0	20
Level 1a	0	Level 1a	3	Level 1a	17	Level 1a	1
Level 1b	0	Level 1b	450	Level 1b	479	Level 1b	639
Level 2	456	Level 2	3	Level 2	0	Level 2	203
Level 3	106	Level 3	0	Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Spinal Injuries +HDU	15	10	2	1	0	0	3	3	0	0	0	0	0	0	0	91.37
Ward 24	47	65	39	19	45	14	9	0	18	118	0	0	3	5	0	91.49
Ward 26	2	7	7	2	0	0	8	1	112	23	0	0	0	4	0	85.91
Ward 34 NASU	94	99	13	3	11	6	82	1	1	1	1	0	2	6	0	NA

Table 17 – Neuro & Spinal Ward Activity and Nurse Sensitive Indicators

Associate Director of Nursing Comments and Actions

Ward 24 – There is still a requirement for an increase in HCAs with the extra spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year.

Ward 26 – The data suggests the ward would benefit from an increase in RN establishment.

Ward 34 - Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a mixture of Acute strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a Health care assistant and the beds are used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area.

Spinal injuries – As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernummary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an HCA. The recommendations from professional judgement and SNCT support this requirement.

Women & Children

Women & Children	
Cathy Brammer, Lead Nurse Paediatrics	
Nicola Howe, Clinical Matron Paediatrics	

Professional Judgement WTE Templates for Women & Children

Using this methodology, outlined in Table 18 the current budget for RN was 50.95 WTE against the professional judgement of 50.92 suggesting no variance. For HCA the budget was 22.90 WTE against the professional judgment of 21.24 WTE suggesting a surplus of 1.66 WTE. However, these surplus hours are filled by play support staff who appear on the HCA budget line and have a very separate, non-clinical role.

Table 18 - Women and Children Planned Staffing, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

					RN							HCA						
Bed Management					Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN	Variance		Planned Staffing	Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT HCA	Variance		Planned Staffing
Ward	Physical Bed Capacity	Open Bed Capacity	No of Patients 12th Feb-12th Mar 24	% Occupancy	Budget RN WTE *includes WM	Mar 24 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	RN Variance Budget to PJ	Recommendations 25/26	Budget HCA WTE	Mar 24 Contracted HCA WTE	Required HCA WTE	Trust Headroom 21%	Excess or deficit (-) SNCT against the Current Budget	HCA Variance Budget to PJ	Recommendations 25/26
Ward 21	30	25	19.2	76.80%	33.20	33.40	33.00	25.09	8.11	0.20	33.00	13.20	10.88	12.00	12.79	0.41	1.20	12.00
Ward 22	17	17	10.4	61.18%	17.75	17.92	17.92	13.09	4.66	-0.17	17.92	9.70	9.24	9.24	6.65	3.1	0.46	9.24
Totals	47	42	29.6	70.48%	50.95	51.32	50.92	38.18	12.77	0.03	50.92	22.90	20.12	21.24	19.44	3.46	1.66	21.24

Table 18 – Women & Children Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE with Temporary Staffing and Unavailability

During March 2024 the bed occupancy across the paediatric ward areas was an average of 70.48% (Ward 21 76.80% and Ward 22 61.18%). The skill mix ratio for this care setting is 70% RNs to 30% HCAs.

The figures above in Table 18 also compare the current budget against the SNCT WTE. Using this calculation there was a suggested surplus between the RN budget of 12.77 WTE and surplus HCA budget of 3.46 WTE (however play staff are part of HCA budget as above.)

Paediatric surgery has a lot of short stay patient activity, as can be seen on ward 22 with children only staying overnight if necessary following surgery.

Figure 10 – Women & Children Patient Acuity and Dependency scores during the audit period broken down by percentage

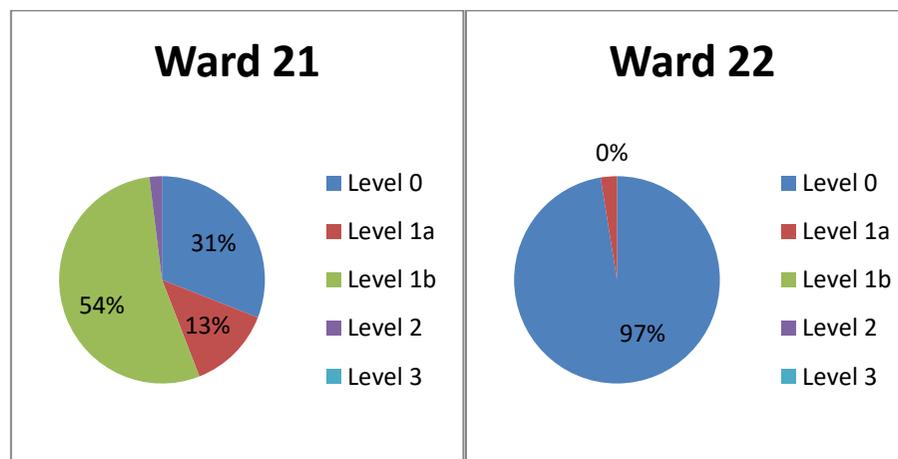


Figure 10 – Women & Children Acuity and Dependency scores

Table 19 - Women & Children activity and patient harms recorded during the census period

Paediatrics have a lot of short stay patients activity as can be seen on ward 22 with children only staying overnight if necessary following surgery.

Ward 21		Ward 22	
Level 0	47	Level 0	305
Level 1a	20	Level 1a	8
Level 1b	82	Level 1b	0
Level 2	3	Level 2	0
Level 3	0	Level 3	0

Ward	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 21	178	139	11	4	14	0	8	0	0	0	0	0	0	0	0	NA
Ward 22	144	129	5	2	41	0	0	0	0	0	0	0	2	0	0	NA

Table 19 –Women & Children Ward Activity and Nurse Sensitive Indicators

Head of Nursing Comments and Actions

The data above demonstrates that across the two children's inpatient wards average bed occupancy was 70.48% in March and 58.57% in September 2024. It suggests that for this level of activity RN numbers could be reduced across both areas. However, if both wards were full with similar acuity patients, Ward 21 RN establishment would be correct at 33.2 WTE and Ward 22 current RN establishment would be in deficit by 5.35 WTE (however this is mitigated due to less surgical list on a weekend there for staffing allocation is reduced.) HCA establishments would suggest being accurate when taking into consideration play staff. Bed occupancy and levels of acuity fluctuate greatly on a day-to-day basis across children and young people services.

As well as the standards for staffing as set by the SNCT, the Royal College of Nursing staffing guidance (RCN 2013) for Paediatric areas is available to benchmark against and is used nationally when setting nursing establishments for CYP areas. This guidance stipulates a set of core standards to be applied in services providing health care for children and young people which includes a nurse-to-patient ratio of 1:3 for patients under 2 years and 1: 4 for over. NHSE&I have published a Children's safer nurse staffing framework for inpatient care in acute hospitals (NHSE&I, 2021). It also suggests a 70/ 30% ration of registered to unregistered staff rather than 66%/ 36% used above and a headroom of 25% as opposed to the Trusts 21%. This document identifies as a minimum, there should be a co-ordinating nurse on each shift who is supernumerary where possible.

There is a general perception that children always have carers present however this is not an accurate reflection of reality. Children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Parents and carers often also need a high level of support. There has been a noticeable increase in the number of young people admitted requiring mental health support with increased pressure on inpatient mental health beds locally and nationally. These patients need an enhanced level of care and support.

The number of premature children surviving early childhood significant complex conditions requiring higher ratios of nursing care regardless of age such as tracheostomy, respiratory support, complex neurological disability, and safeguarding concerns. Teaching and supporting parents and carers to look after children affected by illness, e.g., naso gastric feeding - to enable safe discharge home also impacts on nurse time as do other tasks specific to children's nursing such as calculation of medicine doses and double checking by 2 registered nurses.

Staff within neonatal and paediatric areas are moved to other areas to support on a daily basis, but this is not always evident on safe care, likewise staff do not always enter all nurse tasks on SNCT collection. This something we need to improve.

Actions

- Continue to review staffing on a 6 monthly basis in line with NHSI workforce Safeguards
- Promote robust data entry

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