

EASTKENTHOSPITALSUNIVERSITY NHS FOUNDATION TRUST

REPORT TO: BOARD OF DIRECTORS – 27 June 2014

SUBJECT: WARD ESTABLISHMENT REVIEW APRIL 2014

REPORT FROM: CHIEF NURSE AND DIRECTOR OF QUALITY & OPERATIONS

PURPOSE: TO INFORM THE TRUST BOARD OF THE OUTCOME OF THE APRIL 2014 WARD ESTABLISHMENT REVIEW

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Regular annual ward staffing reviews are undertaken to ensure that the nursing establishments provide an appropriate staffing level and skill-mix to support the delivery of safe and effective care to patients.

Ward staffing reviews will now take place every 6 months as a requirement of the National Quality Board (2013) expectations around safe staffing assurance.

SUMMARY:

This report outlines the April 2014 review of 46 adult wards, 2 Paediatric wards, Critical Care Units and the Neonatal Intensive Care Unit. The Summary of the findings are:

- The NHS Quality Board requirements in providing assurance on safe staffing are currently being met
- The full impact of the agreed investment of £2.9m is not yet fully seen in this staffing review as recruitment has been phased throughout 2014/15 to take account of the supply of registered nurses. It does include the impact of recruitment to maternity leave and to the additional establishment in paediatric wards. The impact of the full investment will see an increase in whole time equivalent (wte) staff per bed (patients) ratios across all areas.
- Average skill mix remains similar to that found in the previous review and a small reduction is seen in wards where the associate practitioner role has been fully implemented.
- Registered nurse vacancies in wards are currently 50.5 wte which is 10.wte higher than at the previous staffing review. The healthcare assistant vacancies have reduced to 26.3 wte. The surgical division has the highest number of total vacancies at 35 wte and have a plan in place to address the shortfall.
- 37 newly qualified nurses will commence employment during June & July 2014 following registration with NMC
- Sickness level at 4.9% is similar to that seen in the previous review. Higher than average rates were seen in stroke & acute frailty wards and in the surgical & orthopaedic wards at the WHH. Plans are in place to address the variation.
- In April 2014 there was a total of 36.2 wte (2.4%) staff on maternity leave across the 46 wards. Ward managers are now able to recruit to posts and this has significantly reduced the impact of maternity leave. Ward managers report that this has had a very positive impact.
- Overall turnover has increased in registered nurses and midwives from 9.5% in 2012 to 11.2% during 2013/14 (please note that nursing & midwifery turnover has not been separated) and is slightly above national and local averages. The turnover of healthcare assistants is stable at 10.6% and is

below national and local averages.

- The use of temporary staff through NHS-Professionals and agency has risen since December 2012, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds.
- There has been a significant improvement in roster quality since the last review. The average achievement of % time clinically effective across all 46 wards for April 2014 was 76.2% compared to 70.4% in December 2012.
- From June 2014 details and summary of planned and actual staffing on a shift-by-shift basis, is to be published in a form accessible to patients and the public on Trusts' websites (which will be supplemented by a dedicated patient friendly 'safe staffing' area on the Trust website) and be published on the relevant hospital profile(s) on NHS Choices. The first report highlights variation but on average 90.4% of actual day shifts were staffed and on average 100% of night shifts were staffed (please note that some wards had >100% staffing to take account of patient acuity & extra beds).
- The current funded establishments allow for at least a ratio of 1 registered nurse for every 8 patients on day shifts (except on one ward) and most wards are able to exceed this with a better than 1:8 ratio. In addition, the actual ratios were observed on 3 consecutive days and all wards had provided at least 1:8 ratio except for one ward with an average ratio of 1: 9. This will be addressed by the full impact of the investment. Further observations will take place to check the actual ratios during night-time shifts.
- The application of modelling methods has identified that:
 - a. Most wards are near or above calculated establishments using the Hurst (2012) method
 - b. Most wards have establishments higher than the nursing workload acuity dependency tool suggests. This is based on a monthly snapshot rather than calculating daily average workload measures
 - c. The Professional Judgement method showed the closest correlation between calculated establishments and actual for most wards. This means that ward establishments are in-line with the professional judgements made by ward managers
- Most wards demonstrated average Harm Free Care (acquired in hospital) of >95% in April 2014 and only 7 wards were <93% (national average). These wards have focussed improvement plans in place. This was using the national safety thermometer methodology.

The following priorities have been identified from the findings of the review:

1. Optimise the use of existing resources;
 - Address the vacancy levels for registered nurses by implementation of a robust plan to reduce ahead of winter 2014/15.
 - Work with NHS-P to increase fill rate to the required level;
 - Ensure accuracy of reporting actual against planned hours filled by revisiting all rosters as part of the roll out of the NHS-P interface with the E-Rostering system.
2. Improve clinical leadership and supervision of quality of care (next phase of agreed investment);
 - Implement the supervisory element of the ward manager role and evaluate the benefits through the ward manager accountability framework.
 - Ensure a plan is in place for all ward managers to undertake the clinical leadership programme over the next three years.

3. Improve alignment of staffing required to demand;
 - Adopt the Shelford Group adaptation of the Safer Nursing Care Tool criteria and develop more regular evaluation of assessed patient needs.
 - Include evaluation of missed or delayed vital signs observations, and delay in medications for pain relief in future reviews of ward staffing to better measure quality impacts.

4. Evaluate the size of wards to develop a model of best practice that achieves high level quality, safety, productivity, cost effectiveness and meets service needs;
 - Pilot the re-profiling of the ward staffing team in a designated area to incorporate and test an innovative skill mix matched to the patient pathway

5. Evaluate the impact of the investment into ward staffing;
 - Progress with the planned implementation of additional posts taking place across 2014/15.
 - Evaluate impact of the investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety.

The ward staffing review will be repeated every six months and the next review will include Midwifery, Emergency Departments and Theatres.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

1. Deliver excellence in the quality of care and experience of every person, every time they access our services
2. Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare
3. Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects, and rapidly implementing best practice from across the world
4. Identify and exploit opportunities to optimise and, where appropriate, extend the scope and range of service provision
5. Deliver efficiency in service provision that generates funding to sustain future investment in the Trust

FINANCIAL IMPLICATIONS:

Adequate staffing levels impact on the achievement of the of the required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2014/15 CQUINs which are valued at 2.5% of actual outturn, or around £10m.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust is required to meet CQC standards and is held to account for delivering harm free care, which has a direct effect on patient safety and experience. Inadequate staffing would present risks to the provision of safe and effective safe and would increase the likelihood of legal claims.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

Royal College of Nursing (RCN) and other professional guidance is incorporated within the review.

BOARD ACTION REQUIRED:

To consider the recommendations and either support, reject or modify

CONSEQUENCES OF NOT TAKING ACTION:

Insufficient numbers of staff, inappropriate skill mix and ineffective use of the existing workforce will impact upon the ability of the organisation to achieve the CQC standards and the quality outcomes within the operating framework and CQUINS for 2014/15.

WARD ESTABLISHMENT REVIEW (April 2014)

Contents	Page
1. Introduction	6
2. National Quality Board expectations on ward staffing	6
3. Investment into ward staffing in 2014/15 and implementation progress	7
4. Current ward establishments	8
5. Skill mix and whole time equivalent per bed	8
6. Workforce metrics	9
6.1 Vacancies	
6.2 Sickness	
6.3 Maternity leave	
6.4 Turnover	
7. Use of temporary staff	12
8. Roster performance and actual against planned filled hours	14
9. Triangulation between evidence based tools and professional judgement and scrutiny	15
9.1 Professional judgement	
9.2 Hurst Nurse per occupied bed	
9.3 Safer Nursing Care Tool	
9.4 Ratio of patients per registered nurse	
10. Harm Free Care – NHS Safety Thermometer performance	19
11. Analysis of specialties	20
12. Conclusions	31
13. Recommendations	32
Appendix 1 – Current funded establishments for all 46 wards, proportion of staff in post and adjusted establishments	
Appendix 2 – Modelling methods applied to adjusted establishment	
Appendix 3 - Total monthly hours actual against planned and % fill by ward May 2014	

1. INTRODUCTION

Regular ward staffing reviews have been undertaken since 2007/08 to ensure they are fit for purpose.

This report outlines the April 2014 review based on March 2014 data and has included 46 wards across the Trust including:

UC<C	Medicine Clinical Decision Units Coronary Care Stroke Health Care of the Older Person (HCOOP) / Frailty
Surgical Services	Surgery Trauma & Orthopaedics Critical Care
Specialist Services	Renal Haematology / Oncology Gynaecology Paediatrics Neonatal

This paper provides information on the findings of the review and outlines a number of recommendations to the Board of Directors.

2. NATIONAL QUALITY BOARD EXPECTATIONS ON WARD STAFFING

Recommendations for greater transparency of ward staffing levels has followed the Francis report on Mid Staffordshire (2013), the Keogh review (2013), the Berwick report on improving the safety of patients in England (2013) and the NHS England report on Hard Truths; The journey to putting patients first (2013).

As a result, in 2013 the NHS Quality Board published guidance 'How to ensure the right people, with the right skills, are in the right place at the right time' which identified new requirements in providing assurance on safe staffing. The requirements are related to three main areas of action:

- To clearly display information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. Displays should be in an area visible to patients, families and carers and explain the planned and actual numbers of staff for each shift as well as who is in charge of the shift;

Staffing boards have been in place since 15.4.14 in all inpatient wards. The template is currently undergoing modification following feedback and will be enlarged and produced by MedPhoto for each area.

- The board should receive monthly reports containing details and summary of planned and actual staffing on a shift-by-shift basis, is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap. Reports should be published the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a

dedicated patient friendly 'safe staffing' area on a Trust website) and be published on the relevant hospital profile(s) on NHS Choices;

Actual against planned staffing hours, by inpatient area, was first reported to the May Board as part of the Clinical Quality & Patient Safety Report and the Trust met the first UNIFY return deadline of 10th June.

- The Board should receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in the National Quality Board guidance and reflects a realistic expectation of the impact of staffing on a range of factors.

This review meets National Quality Board expectations of relevance to all wards and covers:

- Current establishments and allowances included for planned and unplanned leave;
- Skill mix
- Workforce metrics including vacancies including vacancies, sickness, staff turnover, use of temporary staff;
- Roster performance and actual against planned filled hours;
- Triangulation between the use of evidence based tools and professional judgement and scrutiny;
- Information on Safety Thermometer performance and;
- Investment into ward staffing during 2014.15 and progress in implementing.

It does not include Midwifery which will be included in the autumn review.

3. INVESTMENT INTO WARD STAFFING DURING 2014/15 AND PROGRESS IN IMPLEMENTING

Following the previous full staffing review presented to the Trust board in May 2013 a business case for investment of £2.9m, summarised in Figure 1, was agreed in November 2014 to support additional staffing to:

- Increase staffing in Paediatric wards and enable the development of an ambulatory model of care;
- Enable full recruitment to Maternity leave;
- Increase staffing levels in Stroke wards where Stroke Thrombolysis nurses spend 30% of their time away from the ward;
- Enable workforce development & re-design in frailty and rehabilitation wards
- Enable implementation of the ward manager assistant role to enable Ward managers/clinical leaders to be 100% clinically supervisory;
- Increase skill-mix in medical and surgical wards out of hours

Figure 1 - Summary of investment into Ward Staffing 2014/15.

Ward Staffing Business Case Investment Summary			
	Investment	Focus	£'000
1	Paediatric Establishment	Development of ambulatory model of care	£797
2	Maternity Leave	Enabling full recruitment to maternity leave	£400
3	Increasing stroke establishments	Additional band 5 and band 2 posts	£128
4	Workforce re-profiling in Harvey ward & HCOOP	Additional band 2 posts / development of AP role	£44
5	Increase clinical supervisory time for ward managers	Ward manager assistant posts	£425
6	Increase skill mix out of hours	Additional band 6 posts in medical and surgical wards	£1,182
Investment Total			£2,976

The Paediatric posts were fully recruited to by March 2014. Maternity leave is now being actively recruited to across all wards. All other additional posts are being recruited to against plan.

The full impact of this significant investment is not seen in this staffing review due to the planned implementation of additional posts taking place across 2014/15.

4. CURRENT WARD ESTABLISHMENTS

The structure of most ward budgets (33 out of the 46 reviewed) includes a separate bank line which provides a resource as part of the funded WTE to manage peaks and troughs in activity and flexible replacement for sickness. Some ward managers have converted an element of this resource to substantive posts since the previous review when 35 out of the 46 wards included a bank line.

Converting this budget into WTE represents an additional 22.2 WTE (30.3 WTE in the previous review) across the 33 wards, and it is this 'uplifted' total funded establishment that has been used as the baseline when making comparisons with the modelling methods within this review. However, operationally this component of the budget is not included in the establishment for E-Rostering and is utilised by requesting additional shifts within the system to provide additional cover for long-term sick leave.

Additional allowance or percentage headroom within funded establishments is 21% which includes a 3% allowance for sickness, 30 days annual leave plus bank holidays and study leave. In reality sickness is higher than 3% and not all staff are entitled to the 30 days annual leave if they have less than 5 years NHS service, but even if the calculated allowance is adjusted for a more accurate sickness level of 4.6% this should still allow staff an average of 4 study days per year.

Figure 2: Ward establishment allowance calculation adjusted for actual sickness absence levels

Nursing Rota - Headroom Calculation:

	Hours	Days
Total Hours Paid per Year 1.00 wte	1955.36	260.72
Annual Leave Average x 30 days	225.00	
Bank Holidays x 8	60.00	
Sickness 4.6%	89.95	11.99
Mandatory and other training x 4	30.00	
Total Hours Absent	404.95	
Headroom %age	20.71%	

Therefore, if sickness was managed more effectively it would enable some of the increased available hours to be invested into more training for staff and a reduction in the use of temporary staffing.

A summary of current funded establishments and staff in post is provided in Appendix 1.

5. SKILL MIX AND WHOLE TIME EQUIVALENT PER BED (WTE)

Skill mix is similar to the previous review but the impact of associate practitioners is reflected in a slightly reduced skill mix in surgical, orthopaedic and acute frailty wards where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies.

The impact of the investment into ward staffing is not yet fully realised but will increase WTE per bed across most areas.

Figure 3. Average ward staffing skill mix from 2007 to 2014

Average skill-mix across specialties						
Specialty	2007/08	2008/09	2011/12	2012/13	Mar-14	Impact 14/15
Medical	55/45	56/44	56/44	57/43	57/43	56/1/43
CDU	NR	NR	NR	62/38	65/35	64/36
CCU	78/22	76/24	81/19	81/19	81/19	78/1/21
Stroke	51/49	63/37	63/37	61/39	56/44	57/4/38
Acute frailty	48/52	53/47	54/46	55/45	53/47	52/3/45
Surgery	53/47	60/40	55/45	57/43	54/46	55/2/43
T+O	53/47	57/43	56/44	55/45	52/48	56/1/43
RVU	53/47	62/38	62/38	na	na	na
Renal				63/37	63/37	63/1/36
Haematology				69/31	83/17	81/19
Gynaecology				59/41	59/41	58/2/40

Figure 4. Average ward staffing WTE per bed from 2007 to 2014

Average WTE per bed							
Specialty	2007/08	2008/09	2011/12	2012/13	Mar-14	Impact 14/15	Hurst
Medical	1.14	1.19	1.28	1.33	1.29	1.35	1.37
CDU	NR	NR	NR	2.18	1.54	1.55	1.6
CCU	2.2	2.2	2.42	2.76	2.62	2.68	2.21
Stroke	1.19	1.52	1.57	1.75	1.79	1.82	1.9
Acute frailty	1.1	1.18	1.29	1.47	1.33	1.40	1.43
Surgery	1.09	1.28	1.46	1.38	1.45	1.48	1.26
T+O	1.12	1.17	1.21	1.32	1.36	1.56	1.12
RVU	1.06	1.23	1.18	na	na	na	
Renal				1.5	1.81	1.88	1.71
Haematology				1.38	2.09	2.16	1.82
Gynaecology				1.96	1.93	1.98	1.28

6. WORKFORCE METRICS

The impact of current vacancy levels, sickness and maternity leave across the 46 wards is 12.49%, similar to 2012 and is summarised in Figure 5. The absence associated with maternity leave is significant, at 36.16wte (2.38%), and there is an allowance for this in the establishments.

Figure 5. Wards staffing vacancy, sickness and maternity leave March 2014

Workforce indicators		
	Dec-12	Mar-14
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01
Registered Nursing vacancies (WTE)	44.00	73.88
HCA and other support staff vacancies (WTE)	28.00	5.13
Vacancy (%)	4.75	5.21
Sickness (%)	4.96	4.90
Maternity leave (%)	3.28	2.38

6.1 Vacancies

The resourcing team have made improvements to the recruitment process resulting in a reduction in average time between the date of an advert being opened on NHS Jobs and the date that all pre-employment clearances are completed from 18 to around 10 weeks thereby reducing the impact of vacancies, and have maintained this level over the past 3 years.

Vacancies across all wards (excluding critical care units), shown in Figure 6, show monthly variation but 50.52 WTE registered nursing and 26.31WTE healthcare assistant vacancies in April 2014. The majority of the registered nursing vacancies were band 5. The surgical division has the highest number of vacancies at over 35 WTE in April, shown in Figure 7.

Vacancy levels will reduce in May when 37 newly qualified nurses commence in post.

Figure 6. Ward vacancies Dec 13 – April 14

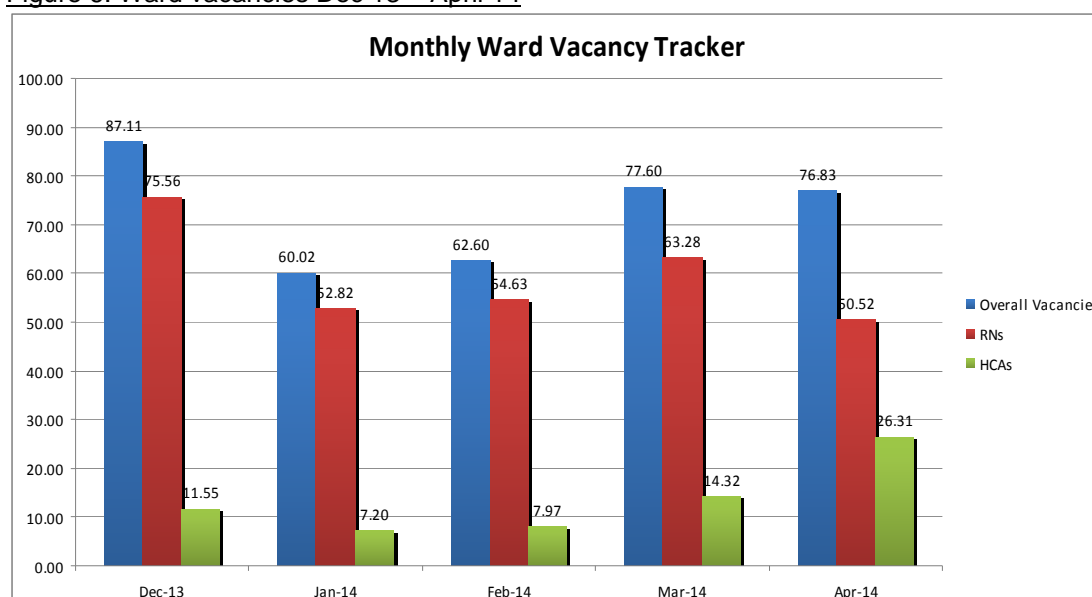
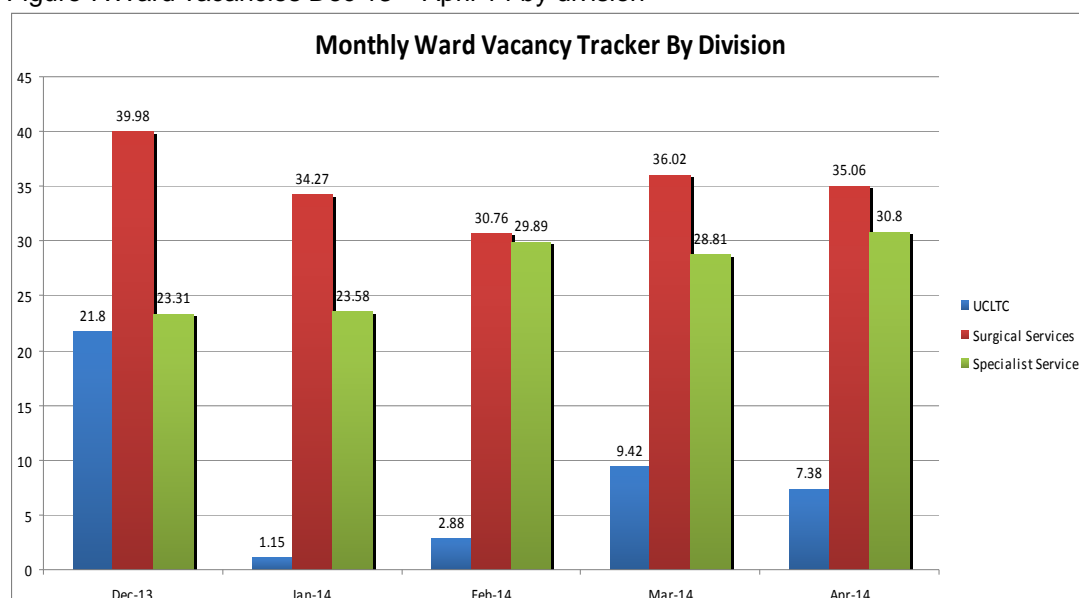


Figure 7. Ward vacancies Dec 13 – April 14 by division



6.2 Sickness absence

ESR data demonstrates that sickness absence rate across the 46 wards was 4.9% in March 2014. The average sickness rates during 2013/14 across all 46 wards, shown in Figure 8, show wide variation but higher average rates were seen in stroke & acute frailty wards and also the surgical & orthopaedic wards at the WHH. This reflects the high physical and emotional demands of ward work in some areas and also significant opportunity for improvement.

Figure 8. Average sickness rates 2013/14

	RN sickness 13/14 (%)	HCA sickness 13/14 (%)
Division / Ward		
Urgent Care & LongTerm Conditions		
1205 Cambridge J2 Ward - WHH	4.07	5.21
1208 Cambridge K Ward - WHH (Formerly Cambridge M1)	3.28	4.09
1209 Cambridge M Ward - WHH	1.97	9.7
1212 Coronary Care Unit (Taylor Ward) - KCH	1.37	0
1213 Coronary Care Unit - QMH	6.69	13.86
1214 Coronary Care Unit - WHH	2.76	2.82
1227 Minster Ward - QMH	4.1	6.78
1230 Oxford Ward - WHH	5.58	4.05
1231 Sandwich Bay Ward - QMH	2.59	4.66
1232 St Margaret's Frailty Ward - QMH	2.25	7.98
1233 Deal Ward - QMH	1.09	8.08
1259 Neurorehab Nursing	2.84	3.1
1270 Invicta Ward - KCH	3.43	2.71
1452 Cambridge L Frailty Ward - WHH	3.05	3.18
1463 Treble Ward - KCH (prev Harvey Ward)	4.38	6.72
1466 Mount & McMaster Ward - KCH	2.17	7.53
1470 Fordwich Stroke Ward QMH	8.69	3.29
1472 Kingston Stroke Unit - KCH	6.33	6.41
1474 Richard Stevens Stroke Unit - WHH	3.64	7.15
1479 Harbledown Frailty Ward - KCH	7.07	9.61
1625 CDU - WHH	2.56	4.77
1626 CDU - QMH	2.89	4.73
Surgical Services		
1613 Rotary Suite - WHH	2.8	2.61
2156 Cheerful Sparrows Ward Female - QMH	3.84	8.07
2157 Clarke Ward - KCH	4.87	11.61
2164 Cheerful Sparrows Ward Male - QMH	6.69	4.4
2165 Kent Ward - KCH	2.22	12.19
2167 Kings B Ward - WHH	6.19	8.95
2358 Kings A2 - WHH	10.48	12.39
2555 Kings C - WHH	6.9	6.91
2556 Kings C2 - WHH	6.68	10.13
2557 Kings D1 - WHH	5.27	3.34
2559 Quex Ward - QMH	4.44	5.42
2560 Seabathing Ward - QMH	4.96	6.25
2573 Kings D2 Ward - WHH	1.6	9.75
2574 Bishopstone Ward - QMH	3.7	1.99
2761 Critical Care - WHH	2.46	3.65
2762 Critical Care - KCH	7.33	0.3
2763 Critical Care - QMH	3.86	11.62
Specialist Services		
1240 Renal Marlowe Ward - KCH	4.54	10.56
3110 Neonatal Intensive Care Unit - WHH	4.5	4.35
3116 Padua Ward - WHH	4.47	0.99
3121 Rainbow Ward - QMH	3.29	1.98
3224 Birchington Ward - QMH	3.15	2.18
3225 Kennington Ward - WHH	1.99	12.6
3335 Brabourne Haematology Ward - KCH	4.71	8.32
Total		

Considerable work has been undertaken to support managers in ensuring robust management of sickness and return to work including the implementation of the Bradford score to identify staff who have frequent episodes of short term sickness. The Department of Occupational Health works with the divisional leadership teams to support efforts to ensure that the sickness absence policy is applied consistently. The Occupational Health team has implemented a motivational humanistic approach, working with health and well being initiatives to enable staff to return to work eg interventional physiotherapy. Those who are off sick are reviewed to ensure compliance with the policy and provided with early access to return to work initiatives which has demonstrated a considerable impact on absences by using early interventional physiotherapy. All divisions are now embracing this initiative, supported by the Occupational Health team.

The Trust recognises that a healthy, well motivated workforce deliver better care and have less absences and our Health and Wellbeing Strategy which addresses NICE public health priorities around obesity, smoking and mental health is now embedded.

Staff engagement through the We Care Programme has enabled feedback to be incorporated into practical solutions to improve staff well being. The 'Take 5' initiative, designed to help people make small changes to their lifestyle to improve their health and wellbeing, commenced with an 8 week pilot involving 60 members of staff, and Occupational Health are now signing up individuals and teams, including clinical and nonclinical staff.

6.3 Maternity leave

In April 2014 there was 2.38% (36.16wte) maternity leave across the 46 wards. Following the investment into ward staffing this element of absence is now recruited to thus reducing the impact of maternity leave.

6.4 Staff turnover

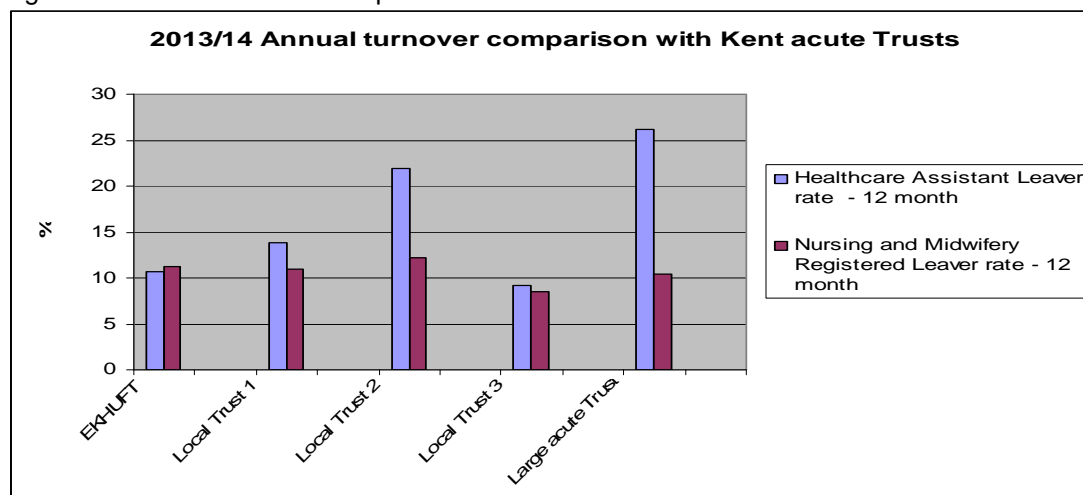
Turnover figures include only staff who have left the employment of the organisation and do not include staff who are internally promoted. ESR data (excluding TUPE staff) demonstrates that our overall turnover has increased in registered nurses and midwives from 9.5% in 2012 to 11.18% during 2013/14. The turnover of healthcare assistants is stable at 10.63%.

Figure 9. Average turnover of nursing, midwifery and care staff 2013/14

Turnover (%)			
	2011	2012	2013/14
Nursing & Midwifery	7.5	9.5	11.18
HCA and other support staff	12.6	10.6	10.63

Data from the Health and Social Care Centre (NHS I-View) illustrated in Figure 10 demonstrates that our turnover of registered nurses and midwives at 11.18% during 2013/14 is slightly higher than the average large acute Trust and two of the three local acute Trusts. The turnover of healthcare assistants at 10.63% is lower than both the average large acute Trust and two of the three local acute Trusts.

Figure 10. Annual turnover comparison with Kent acute Trusts



7. USE OF TEMPORARY STAFF

The level of temporary staff usage across the divisions is managed with appropriate controls and monitored in relation to total ward staffing expenditure. The current use of temporary staff through NHS Professionals provided 28,072 hours in April 2014 with 81% hours filled by the NHS-P bank and 19% filled by agency. This includes the

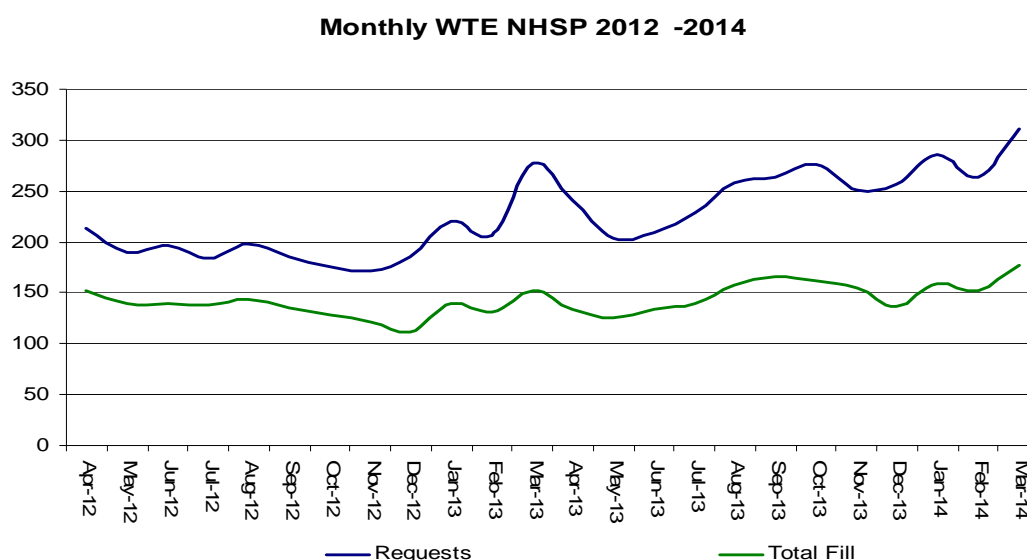
supply to theatres and the Emergency departments which accounts for nearly 40% of the agency hours used. Agency use has been minimised in ward areas and is now largely restricted to theatres, day surgery and the emergency departments.

The use of temporary staffing, including NHS-P bank and agency, is fairly consistent at delivering a combined fill rate (% of requested shifts actually filled) of around 64%. This partially closes the gap presented by vacancies and planned / unplanned absences but does operationally present a challenge for both the Trust and our supplier through NHS-P particularly in filling gaps at short notice. Issues surrounding NHSP bank fill rates, which are currently below the overall agreed target of 75% for registered nurse shifts and 90% for healthcare assistant shifts, are being addressed with the supplier through the appropriate contract management processes.

In order to address gaps in staffing due to vacancies other methods are used to close the gap between planned and actual staffing hours. Staff overtime expenditure in April 2014 of £115,000 indicates that the impact of vacancies is lessened through staff working additional hours. As we recruit to maternity leave we will see a reduction in the reliance on NHSP, agency and anticipate a reduction in overtime use also.

Even with rigorous management controls through the temporary staff booking process the use of NHS-P overall has risen since December 2012, largely to fill gaps due to vacancies, long term sickness and maternity leave and to provide safe staffing for additional beds. It should be noted that no substantive member of staff is permitted to work additional shifts for the Trust through an agency and the use of agency healthcare assistants has been completely eliminated since 2010. Seasonal fluctuations are seen in the trends in figure 11 e.g dips during Christmas week when staff annual leave is restricted, peaks in March when staff annual leave is higher and working back through NHSP is widely practised. An April/May and October dip is also seen as cohort recruitment of newly qualified nurses reduces the demand for NHSP.

Figure 11. Trend of NHS-P demand and fill in WTE from 2012 to 2014



Initiatives to reduce cost of temporary staff and improve fill rates have been implemented over the last two years:

- The Trust worked collaboratively with NHS-P to recruit 13 registered nurses from Portugal in February 2014. A further 25 registered nurses have been recruited from Italy who will commence work in summer 2014 to provide a dedicated resource ahead of the increased demand anticipated in winter 2014/15.

-
- Enabling newly qualified nurses to work through NHS Professionals during the Preceptorship period on the ward where they hold a substantive post three months after qualification since 2010/11.
 - Reduction of pay from agenda for change spine point 3 to 1 for healthcare assistants from August 2011
 - Providing an opportunity for healthcare assistants with nursing home experience to gain the skills and competence to work with the hospital environment from December 2011.
 - Winter incentives for NHS-P bank workers working additional shifts with no cancellations, to win shopping vouchers.

8. ROSTER PERFORMANCE AND ACTUAL AGAINST PLANNED FILLED HOURS

There has been a significant improvement in roster quality since the last review. The average achievement of % time clinically effective across all 46 wards, within E-Rostering, for April 2014 was 76.28% against 70.37% in December 2012. 28 of the 46 wards achieved more than the optimum 75%, against only 9 in December 2012, which demonstrates significant improvement.

Meeting the 75% clinically effective measure requires- effective annual leave planning to ensure it is evenly spread, effective sickness management, fair allocation of training days and effective use of management time. An annual leave wall planner to support ward managers in managing the spread of annual leave is in use in most wards.

From June 2014 details and summary of planned and actual staffing on a shift-by-shift basis, is to be published in a form accessible to patients and the public on Trusts' websites (which will be supplemented by a dedicated patient friendly 'safe staffing' area on the Trust website) and be published on the relevant hospital profile(s) on NHS Choices.

The first report to the board in May outlined staffing on a weekly basis during April represented by % hours actual versus planned. 83.9% was achieved in April. The first report was developed ahead of revised National Quality Board guidance which was published on 16th May and outlined the requirement for the % fill to be identified by registered nurse and care staff, by day and by night, and by individual hospital site.

The report below is the second of the monthly reports to the Board and outlines staffing on a monthly basis during May represented by % hours actual versus planned by registered nurse and care staff, by day and by night. It can be seen that the fill rate ranges between 82 – 115.9% at K&C, 90.2 – 103.5% at QEQM and 88.8 - 102.7% at the WHH site.

Figure 12. % hours filled – planned against actual May 2014

% Hours filled - planned against actual May 2014				
DAY			NIGHT	
Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
Hospital site				
Kent & Canterbury	89.1%	82.0%	98.5%	115.9%
Queen Elizabeth the Queen Mother	90.2%	95.7%	96.8%	103.5%
William Harvey	92.8%	92.7%	88.8%	102.7%

The detail by ward is included in Appendix 3. Work has been undertaken to explore the reasons for the gap, the impact and the actions being taken to address the gap. The % hours filled is influenced by vacancies, sickness, annual leave planning and additional shifts worked when demand rises.

It should be possible to fill 100% of hours if:

- There are no vacant posts
- All vacant planned shifts are covered by overtime or NHS-P shifts
- Annual leave, sickness and study leave is managed within 22%

Although the national RAG rating tolerances have not yet been determined, wards achieving under 80% have been RAG rated Red, in Appendix 3 and include:

- All three Coronary Care units and Critical Care QEQM achieved less than 60% support staff fill as they have a small number of healthcare assistant posts within their funded establishment and have vacancies e.g Taylor ward has only 0.66 band 2 post which is currently vacant and so achieved 0% filled day hours in May.
- Critical Care WHH (70.9% average support staff fill across days and 218% across nights) due to prioritising night cover for additional beds.
- Braebourne shows only 30.5% support staff fill but this is an artefact of the roster template which still has the required shifts for the ambulatory service included which should have been removed when its separate staffing roster was recently established.
- Several other wards achieved less than 80% due to a combination of vacancies, high sickness absence and higher than recommended % staff on annual leave.
- Some wards achieve higher than 100% due to additional shifts worked through NHS-P during times of increased demand and additional bed use.

Data validation and sign-off steps have been implemented and the data was reported externally via Unify/NHS Choices on 10th June. The national data will be published, by June 24th, and will be represented by hospital site on the NHS Choices website.

9. TRIANGULATION BETWEEN EVIDENCE BASED TOOLS AND PROFESSIONAL JUDGEMENT AND SCRUTINY

There is no single nursing staff to patient ratio that can be applied across all wards to safely or adequately meet the nursing care needs of patients. A range of tools, outlined in table 1 are available for use in evaluating individual specialties.

Table 1. Methodologies used to evaluate specialties

Area	Methodology
Wards	Association of United Kingdom University Hospitals (AUKUH, 2007) acuity dependency, Professional Judgement, Hurst Nursing Workforce Planning Tool (2012).
Stroke Units	NHS London guidance
Critical Care Units	British Association of Critical Care Nursing (2009)
Paediatrics	Royal College of Nursing (RCN 2003) guidelines
Neonatal Intensive Care	Toolkit for High Quality Neonatal Services (Neonatal Networks 2009), British Association of Perinatal medicine (BAPM 2001)

There are advantages and disadvantages to the different methods and tools used to model staffing levels, and also a view that none of them capture the communication aspects of nursing work (nurse-patient, nurse-family, nurse-doctor, nurse-other healthcare professionals and departments, nurse-other agencies). Different systems applied to the same care environment can produce different results, and so combining two or more methods is recommended to improve reliability and validity

9.1 Professional judgement

A component of the Hurst workforce planning tool includes a method of calculating required establishments using professional judgement. The feedback from ward managers on required staffing levels across the 24 hour period was utilised and there was a close correlation between calculated establishments and actual for most wards. However, the calculated establishments using this method were above actual establishment for 13 wards 7 of which were wards with additional capacity.

The Professional Judgement method showed the closest correlation between calculated establishments and actual for most wards.

9.2 Hurst Nurse per occupied bed

The Nurse per Occupied Bed (NPOB) formulae (Hurst 2014) were applied to the main specialties. These formulas are unique because they are derived from data collected in same specialty wards. The wards providing these data (across the UK) passed a quality test, that is, none fell below a pre-determined quality standard to avoid projecting from inadequately staffed wards. Hurst formulae are available for a wide range of specialties and all wards were benchmarked against the most appropriate 'fit'. The tool provides a calculated establishment in relation to number of beds and NPOB guidance per specialty.

Calculation of establishments using the NPOB method suggested that most ward establishments are near or above recommended Hurst levels.

9.3 Safer Nursing Care Tool

The dimensions of patient dependency and acuity are important variables in determining nursing workload and the Safer Nursing Care Tool (SNCT) was applied to study current nursing workload in all wards to calculate ward establishment. Monthly data has been collected during 2013/14 for all adult wards as part of the monthly NHS Safety Thermometer 'Harm Free Care' survey. Quality control is provided by matrons who consistency check submissions for all their wards.

Calculation of establishments using the SNCT method taking account of nursing workload associated with patient acuity and dependency demonstrated little correlation between calculated and actual establishment for most wards. Most wards have establishments higher than the nursing workload acuity dependency tool

suggests is appropriate, however, the monthly snapshot may not effectively capture average workload.

There was no correlation between the findings of the Hurst model and the SNCT tool so it was not possible to synthesise the findings from these two approaches. The lack of correlation may be due to normal variations of nursing workload and the limitations of extrapolating average nursing workload from the monthly 'snapshot' on one day per month. However, some ward managers have reported some variation in interpretation of the levels within the SNCT tool particularly over the past year as the proportion of highly dependent and acutely ill patients has increased.

Nursing workload is directly related to patient acuity and dependency. That is, the level of patient need in meeting activities of daily living combined with the complexity of treatment of the medical condition which necessitated admission to hospital. Examples of therapies and treatment which increase nursing workload include the care of patients requiring non-invasive respiratory support such as CPAP or BIPAP, caring for patients requiring enteral or parenteral nutrition, management of central venous lines, tracheostomy care, complex medication regimes including oral and intravenous therapy, neurological assessment, monitoring and observation for signs of deterioration and escalation of care.

Nursing workload is further increased when supporting patients with complex nursing care needs including altered states of consciousness, patients with dementia, complex mental health needs or complex communication difficulties associated with learning disability. Increasing the throughput of patients and decreasing length of stay generates additional nursing work related to assessment on admission, and planning safe discharges to tight time-frames.

The Nursing and Midwifery Council (NMC), the regulator for nurses and midwives whose main purpose is to protect the public, have set standards for the supervision and assessment of students and learners in practice which produces another level of work which is conducted without additional resource to the budgeted ward establishments. Mentors with responsibility and accountability for making the final sign-off in practice must have the equivalent of an hour per student per week allocated during their final period of practice learning. With around 150 students alone undertaking this assessment within EKHUFT annually this represents a significant workload that is also absorbed at ward level.

9.4 Ratio of patients per registered nurse

The RCN reported in 2009 that the average NHS hospital ward had a ratio of 7.9 patients per registered nurse during the daytime and where the ratio was higher than 9.3 patients per registered nurse care was compromised on most shifts. The Safer Staffing Alliance have more recently highlighted that when each registered nurse has more than 8 patients to care for there can be risks to patient safety.

The E-Rostering system is able to demonstrate that current funded establishments allow for no more than 8 patients per nurse on day shifts on almost all wards (figure 13). The exception is Mount McMaster ward which allows for 8.6 but in reality the ward has additional flexibility on a bank line within the ward budget which provides additional staff at times of high demand or when there is sickness absence.

Figure 13. Ratio of patients per registered nurse – E-Rostering system

Division / Ward	Ratio (Nurse to Bed)
Urgent Care & LongTerm Conditions	
Cambridge J	6
Cambridge K	5.1
Cambridge M2	6.1
Coronary Care Unit (K&C)	1.8
Coronary Care Unit (QEQMH)	3.3
Coronary Care Unit (WHH)	2.3
Minster	5.9
Oxford	5.7
Sandwich Bay	6.3
St Margarets	6.2
Deal	4.4
Harvey	6.3
Invicta	7
Cambridge L	3.7
Treble	5.6
Mount/McMaster	8.6
Fordwich Stroke Unit	3.4
Kingston Stroke Unit	4.7
Richard Stevens Stroke Unit	5.2
Harbledown	7.5
CDU WHH	5.5
CDU, QEQM	3.8
Surgical Services -	
Rotary Suite	3.9
Cheerful Sparrows Female	6.3
Clarke	5.8
Cheerful Sparrows Male	6.5
Kent	5.3
Kings B Ward - WHH	7.4
Kings A2	7
Kings C1	7
Kings C2	5.4
Kings D Female	6.8
Kings D Male	
Quex	5.3
Bishopstone - split	5.5
Seabathing -split	
Critical Care - WHH - add duties	1.5
Critical Care - KCH	1.3
Critical Care - QMH	1
Specialist Services	
KC Marlowe Ward	3.8
WH NICU	0.9
WH Padua Ward	3.9
QE Rainbow Ward	3.6
QE Birchington Ward	4.2
WH Kennington Ward	5.1
KC Brabourne Haematology Ward	2.5

Numbers of actual patients per registered nurse was evaluated on each adult ward on 3 separate days during May, on the day shift, and an average value calculated. The range of registered nurses per bed across the wards was 2.75 to 9.7. It can be seen in Appendix 2 that Mount McMaster achieved 7.44 and therefore had used temporary staff thereby reducing the patient per staff ratio from the 8.6 within the planned roster.

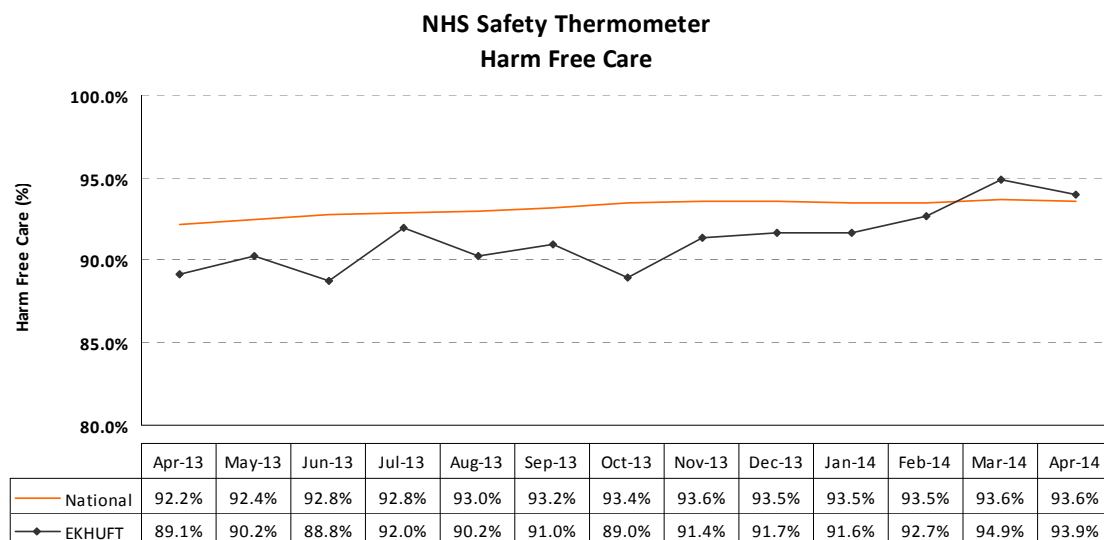
The only ward with an average ratio of more than 9.0 was Kings D1 which shares the nursing establishment with Kings D2 which achieved 6.7. In reality the nursing resource to these two wards is shared within one roster. The roster demonstrated 81% clinically effective time demonstrating optimal roster effectiveness and the Safety Thermometer revealed that no patient received any new harms in April 2014 which indicates safe care was delivered.

10. SAFETY THERMOMETER PERFORMANCE

Quality goal 2; 'Improve safety and reduce harm', within the EKHUFT Quality Strategy 2012 – 2015 includes the objective to achieve 95% Harm Free Care by 2015.

During 2013/14 the Trust improved against and exceeded the national average by year end by achieving 94.87% Harm Free Care for our patients against the 93.6% national average. Figure 14 shows that the Trust has performed above the national average since March 2014.

Figure 14. Harm free care performance against national average 2013/14



Most wards demonstrated average Harm Free Care (acquired in hospital) for >95% patients in April 2014 and only 7 wards were <93%.

11. ANALYSIS OF SPECIALTIES

11.1 Medical wards

Vacancy levels are high on 2 wards and sickness levels exceed 6% on 4 wards. Effective rostering is seen on all but Oxford ward which has 21% sickness. 8 wards fall below the Hurst recommended level of 1.37 for medical wards. Professional judgement determines higher staffing levels than current in most wards but acuity and dependency (SNCT) sees a closer fit in most wards. None of the wards exceeds 8 patients per registered nurse on day shifts. Only Treble ward showed a low % fill of actual against planned hours filled due to the creation of optional shifts that remained unfilled. 9 of the 11 wards achieved Harm Free Care (new harms only) during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Harvey ward	19	0	24.65	24.65	100.00%	1.19	0.00	79.80	56:44	1.29	34.40	24.80	27.90	6.69	72.4	121.8	90.3%	158.1%	94.70%
Treble ward	18	0	28.08	28.41	96.09%	6.34	0.00	76.00	56:44	1.57	34.40	24.40	24.90	4.42	100.9	58.5	111.3%	80.6%	93.30%
Mt McMaster	24	2	27.97	28.49	98.14%	7.99	0.00	73.50	51:49	1.18	39.90	33.90	28.60	7.44	93.0	79.4	100.0%	108.7%	94.70%
Invicta	24	0	28.06	28.42	99.51%	4.87	0.00	76.70	59:41	1.18	39.90	33.90	26.30	5.60	99.1	90.4	96.7%	150.1%	100.00%
Cambridge J	28	6	31.54	32.14	101.71%	4.77	0.71	74.60	58:42	1.14	44.50	38.40	30.80	6.00	110.1	113.6	80.9%	100.6%	90.00%
Cambridge K	28	2	33.79	34.35	85.47%	0.38	0.00	82.60	60:40	1.22	31.30	38.40	27.50	5.70	83.6	74.8	100.0%	93.5%	100.00%
Cambridge M	20	5	25.11	25.58	116.30%	3.61	3.28	76.90	57:43	1.27	30.10	29.40	37.70	6.97	119.9	85.5	98.0%	176.1%	100.00%
Oxford	14	0	22.11	22.41	87.95%	21.31	0.61	62.60	61:39	1.60	26.20	20.70	25.90	3.42	105.7	88.2	93.6%	112.9%	100.00%
Minster Ward	23	0	31.10	31.50	109.46%	7.21	0.00	73.30	55:45	1.36	34.40	32.80	32.60	6.67	100.5	85.6	112.9%	100.2%	100.00%
Sandwich Bay	21	0	25.62	25.93	104.63%	3.53	1.00	76.70	59:41	1.23	34.40	30.60	35.40	6.42	121.7	112.5	108.4%	78.0%	100.00%
Deal Ward	20	8	23.53	23.91	129.65%	1.32	0.00	79.80	56:44	1.19	32.70	29.40	38.90	6.92	89.8	82.4	100.3%	93.4%	92.60%

The impact of the investment into ward staffing will improve the WTE per bed ratio across the wards and will impact on skill mix slightly due to the implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Harvey ward	53/47	1.37
Treble ward	54/46	1.59
Mt McMaster	51/49	1.23
Invicta	59/41	1.23
Cambridge J	58/42	1.18
Cambridge K	59/3/38	1.22
Cambridge M	57/43	1.33
Oxford	61/39	1.69
Minster Ward	55/45	1.42
Sandwich Bay	59/41	1.29
Deal Ward	56/4/40	1.25
Average	56/1/43	1.35

11.2 Clinical Decision Units

Vacancy levels are low on both wards and sickness levels are average. Effective rostering is seen on both wards. The WHH CDU falls below the Hurst recommended level of 1.6 for acute admissions units but QEQM is above that levels. Professional judgement determines similar staffing levels to current in both wards but acuity and dependency (SNCT) determines lower levels than actual. Neither ward exceeds 8 patients per registered nurse on day shifts. NHS England has excluded CDUs from the assessment of % fill of actual against planned hours currently. Both wards achieved Harm Free Care (new harms only) during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
CDU WHH	47	4	63.77	64.88	96.66%	4.10	0.00	80.20	68:32	1.38	62.90	60.00	54.00	6.49	na	na	na	na	100.00%
CDU, QEQM	25	2	42.11	42.81	100.51%	5.53	0.00	79.90	61:39	1.71	43.00	48.40	31.00	4.55	na	na	na	na	100.00%

The impact of the investment into ward staffing will result in a similar WTE per bed ratio across the wards and will impact on skill mix slightly due to the implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
CDU WHH	67/33	1.37
CDU, QEQM	61/39	1.74
Average	64/36	1.55

11.3 Coronary Care

Vacancy levels are proportionally high on Taylor ward and sickness levels exceed 6% on CCU at QEQM. Effective rostering is seen on all units but the lowest level is associated with the high sickness at QEQM. Only the QEQM unit falls slightly below the Hurst recommended level of 2.21 for CCUs. Professional judgement shows a close correlation with current in all units but acuity and dependency (SNCT) determines significantly lower required establishments. None of the wards exceeds 8 patients per registered nurse on day shifts. 2 units showed a low % fill of actual against planned hours filled due to the creation of optional shifts that remained unfilled. All units achieved Harm Free Care (new harms only) during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Taylor KCH	5	2	15.66	15.66	80.33%	0.68	0.00	74.30	92:8	3.13	14.20	7.70	7.40	2.39	75.8	0.0	100.1%	#DIV/0!	100.00%
CCU WHH	11	0	31.41	31.54	91.72%	2.65	0.00	81.40	81:19	2.86	32.80	32.71	16.80	2.16	91.3	98.8	89.7%	51.6%	100.00%
CCU QEQM	12	0	22.50	22.65	91.26%	8.97	1.60	73.40	69:31	1.88	24.10	25.60	13.30	3.56	80.3	54.2	100.4%	101.7%	100.00%

The impact of the investment into ward staffing will result in a slightly higher WTE per bed ratio across the units and will impact on skill mix slightly due to the implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Taylor KCH	87/13	3.23
CCU WHH	80/3/17	2.90
CCU QEQM	67/33	1.92
Average	78/1/21	2.68

11.4 Stroke

Vacancy levels are high on 2 wards and sickness levels are near 6% on both wards. Effective rostering is seen on only 1 ward. All ward establishments are near the Hurst recommended level of 1.82 for stroke units but in the absence of a model specifically for Hype-acute stroke units (HASU) the London model was applied which recommends a staffing ratio of 3.5 WTE per bed for HASUs and 1.5 WTE per bed for stroke ward beds. Application of this model determines significantly higher establishments than current actual. The current funded establishments include around 5 WTE thrombolysis nurses for each stroke unit. These nurses have to be available to leave the ward to administer thrombolysis in A+E and provide 1:1 care for the first 24 hours and around 30% of their time is spent away from the ward. The associate practitioner role is embedded within establishments and provides skills specific to stroke care which is reflected in the skill-mix which is variable but still near 60:40.

Professional judgement determines similar staffing levels than current in two wards but acuity and dependency (SNCT) sees a closer fit in most wards. None of the wards exceeds 8 patients per registered nurse on day shifts. Two wards achieved more than 95% Harm Free Care (new harms only) during April but RSU achieved only 90.5%.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	London model	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
																Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Kingston	22	5	39.44	39.44	98.86%	4.14	2.00	72.80	60:40	1.79	42.10	41.70	49.00	41.90	5.00	79.2%	109.8%	98.5%	101.8%	96.00%
Richard Stevens Unit	24	0	38.94	39.38	84.59%	6.77	3.16	71.70	54:46	1.64	42.90	44.78	52.00	34.50	7.11	76.8%	90.2%	82.4%	108.1%	90.50%
Fordwich Ward	19	4	36.52	37.22	85.20%	5.87	0.00	78.60	55:45	1.95	30.10	37.07	44.50	33.40	6.42	78.8	132.3	101.2%	117.9%	95.00%

The impact of the investment into ward staffing will result in a similar WTE per bed ratio across the wards and will increase skill mix slightly due to the additional band 5 and band 2 posts as well as implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Kingston	60/2/38	1.90
Richard Stevens Unit	56/5/39	1.63
Fordwich Ward	56/6/38	1.95
Average	57/4/38	1.82

11.5 Acute Frailty

Two of the wards are over established due to planned staffing to cover additional capacity. Sickness levels are low and effective rostering is seen on two of the wards, all but Oxford ward which has 21% sickness. Two wards are close to but St Margarets ward is below the Hurst recommended level of 1.43 for frailty wards. Professional judgement and acuity and dependency (SNCT) determine higher staffing levels than current in all three wards but none of the wards exceeds 8 patients per registered nurse on day shifts. All wards achieve >80% fill of actual against planned hours. All the wards achieved Harm Free Care (new harms only) of 100% during April.

Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Harbledown	24	3	33.17	33.58	89.07%	1.95	2.00	81.40	54:46	1.39	36.10	33.90	35.00	6.17	118.6%	92.4%	100.0%	113.6%	100.00%
Cambridge L	21	5	30.24	30.82	121.64%	2.46	0.00	70.80	55:45	1.46	35.90	30.60	39.80	5.79	81.9	82.9	98.5%	115.4%	100.00%
St Margarets	22	3	25.19	25.66	105.81%	1.92	1.00	78.80	51:49	1.16	32.70	31.70	32.70	8.00	95.3	97.3	88.8%	182.6%	100.00%

The impact of the investment into ward staffing will result in a slightly higher WTE per bed ratio across the wards and will impact on skill mix slightly due to the additional band 2 posts as well as implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Harbledown	52/48	1.48
Cambridge L	53/3/44	1.55
St Margarets	50/7/43	1.17

11.6 Surgery

Vacancy levels are high on 2 wards. Sickness levels exceed 6% on 4 wards and associated lower roster effectiveness is seen on these wards. Most wards are near or above the Hurst recommended level of 1.26 for surgical wards. Professional judgement determines similar staffing levels to current in all wards but acuity and dependency (SNCT) predicts significantly lower levels than current actual. None of the wards exceeds 8 patients per registered nurse on day shifts. The wards with high sickness showed a lower % fill of actual against planned hours. Two wards achieved Harm Free Care (new harms only) lower than 90% during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Clarke	36+6	2	39.75	41.21	104.65%	9.65	1.29	74.70	53:47	1.14	45.9	48.4	29.40	3.5	84.2%	93.6%	98.3%	100.1%	100.00%
Kent	20+6	5	30.53	31.78	76.80%	4.4	0.00	79.80	56:44	1.58	32.8	25.7	18.50	3.8	95.5%	77.6%	100.0%	100.6%	94.70%
Kings A2	20	0	24.16	24.64	81.49%	10.86	0.00	72.20	54:46	1.23	26.2	25.10	19.90	6.4	96.5%	91.8%	95.8%	105.2%	100.00%
Kings B	27	0	31.57	32.95	86.67%	8.04	0.00	73.70	52:48	1.22	31.4	33.90	27.00	7.3	97.6%	73.0%	103.8%	73.3%	100.00%
Rotary	16	0	33.43	33.71	93.77%	3.00	2.00	77.80	53:47	2.10	30.5	20.10	17.70	4.5	95.7%	80.6%	100.0%	100.3%	100.00%
Cheerful Sp Male	18	8	27.14	27.14	88.98%	2.16	0.67	78.40	52:48	1.50	27.6	22.60	17.00	6.9	101.9%	106.6%	110.8%	102.2%	89.50%
Cheerful Sp Female	20	8	28.28	28.31	93.02%	9.15	1.00	67.50	58:42	1.41	27.6	25.10	23.40	6.1	127.3%	106.3%	89.4%	120.2%	85.70%

The impact of the investment into ward staffing will result in a similar WTE per bed ratio across the wards and will increase skill mix slightly due to the additional band 6 posts as well as implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Clarke	56/5/39	1.16
Kent	59/3/38	1.62
Kings A2	54/45	1.23
Kings B	56/44	1.24
Rotary	52/48	2.12
Cheerful Sp Male	51/4/45	1.54
Cheerful Sp Female	59/41	1.51
Average	55/2/43	1.48

11.7 Trauma and Orthopaedics

Vacancy levels are particularly high on Quex ward. Sickness levels do not exceed 6% on any ward but is associated with lower roster effectiveness on Bishopstone where it is at almost 6%. Most wards are well above the Hurst recommended level of 1.12 for orthopaedic wards and although Seabathing is lower its staffing resource is shared with Bishopstone which is significantly higher. Professional judgement determines variable staffing levels to current in all wards but acuity and dependency (SNCT) predicts significantly lower levels than current actual in most wards. Only one ward exceeds 8 patients per registered nurse on day shifts, this is Kings D male which shares its staffing resource with Kings D female which achieves 6.7. The two wards with highest sickness levels showed a lower % fill of actual against planned hours. All but one ward achieved Harm Free Care (new harms only) of 100% during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Kings D male(1)	21	4	51.09	51.97	85.80%	3.3	3.00	81.00	56:44	1.33	52.4	43.70	23.40	9.7	88.7%	113.8%	96.6%	96.4%	100.00%
Kings D female (2)	18	0				3.58													14.30
Kings C1	27	0	32.55	34.00	92.82%	4.75	0.00	78.90	47:53	1.25	39.3	30.30	29.90	6.2	99.6%	108.4%	100.0%	110.9%	100.00%
Kings C2	24	0	33.01	34.47	86.80%	5.18	2.80	79.00	53:47	1.43	31.4	26.90	19.90	6.9	69.3%	93.2%	81.2%	115.0%	100.00%
Bishopstone	22	0	33.16	34.65	94.44%	5.97	0.00	77.50	44:56	1.57	32.7	24.70	30.50	6.6	79.6%	101.7%	95.5%	104.0%	100.00%
Seabathing	26	0	23.83	24.84	93.71%	3.6	0.00		63:37	0.95	32.7	29.20	30.20	7.7				92.00%	
Quex	19	1	30.00	31.48	69.89%	2.3	0.00	79.30	52:48	1.65	25.5	21.30	15.00	3.8	93.4%	89.5%	97.0%	103.2%	100.00%

The impact of the investment into ward staffing will result in a similar WTE per bed ratio across the wards and will impact on skill mix slightly due to the additional band 6 posts as well as implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Kings D	55/45	1.40
Kings C1	51/49	1.27
Kings C2	55/45	1.40
Bishopstone	48/5/47	1.59
Seabathing	72/28	0.91
Quex	53/4/43	1.61
Average	56/1/43	1.36

11.8 Renal and Haematology/oncology

Vacancy levels are high particularly on Braebourne. Sickness is above 6% on Marlowe and this is reflected in low roster effectiveness.

Both wards have current establishments above those recommended by Hurst for renal (1.71) and Oncology wards (1.82). Professional judgement determines similar staffing levels to current in both wards but acuity and dependency (SNCT) determines lower levels than actual. Neither ward exceeds 8 patients per registered nurse on day shifts. Braebourne shows low % fill of actual against planned hours for support worker staff due to the vacancy factor and a small funded establishment for band 2s. currently. Both wards achieved Harm Free Care (new harms only) during April above 96%.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Marlowe	29+6	4	52.70	52.70	88.98%	6.31	0.67	71.90	63:37	1.81	55.3	50.5	45.90	2.75	88.0%	73.9%	93.0%	100.5%	96.30%
Brabourne	8	0	16.77	16.77	64.22%	1.86	0.00	77.70	83:17	2.09	15.9	14.6	13.60	3.33	83.6%	30.5%	110.6%		100.00%

The impact of the investment into ward staffing will result in a similar WTE per bed ratio across the wards and will impact on skill mix slightly due to the implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Marlowe	63/1/36	1.88
Brabourne	81/19	2.16

11.9 Gynaecology

Vacancy levels are particularly high on Kennington ward. Sickness levels are very high on Birchington and is associated with lower roster effectiveness. Both wards are well above the Hurst recommended level of 1.28 for Gynaecology wards but the establishments include staff to provide early pregnancy assessment clinics as well as inpatient beds. Professional judgement determines similar staffing levels to current in both wards but acuity and dependency (SNCT) predicts significantly lower levels than current actual. Neither ward exceeds 8 patients per registered nurse on day shifts. Kennington has a lower % fill of actual against planned hours for registered nurses due to vacancy levels and the creation of additional shifts within E-Rostering which are unused. Both wards achieved Harm Free Care (new harms only) of 100% during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Kennington	11	4	21.60	21.60	75.32%	0.89	0.00	82.60	55:45	1.96	22.30	15.9	8.70	7.50	87.6%	99.0%	48.0%	98.5%	100.00%
Birchington	15	4	28.71	28.71	98.40%	10.36	0.00	73.70	63:37	1.91	27.6	17.00	19.30	5.67	78.2%	132.7%	98.5%	96.8%	100.00%

The impact of the investment into ward staffing will result in a slightly higher WTE per bed ratio across the wards and will impact on skill mix slightly due to the implementation of the ward manager assistant role within the budgeted establishment.

Impact of investment		
	Skill mix	wte:bed
Kennington	54/46	2.01
Birchington	62/4/34	1.95
Average	58/2/40	1.98

11.10 Paediatrics

The paediatric wards have seen investment of almost £800K since the previous review and have recruited to all additional posts. Some vacancy exists on Padua ward but staff are planned to commence in post in April. Sickness levels are higher on Padua ward and is associated with lower roster effectiveness. The establishments of both wards are above RCN recommended levels and close to those predicted using the professional judgement method. Neither ward exceeds 8 patients per registered nurse on day shifts. Average % fill of actual against planned hours is above 80% in both wards and both wards achieved Harm Free Care (new harms only) of 100% during April.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	RCN	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Padua	28	4	45.39	45.53	87.00%	5.21	0.61	69.20	73:27	na	45.7	48.5	NA	4.13	82.7%	94.9%	97.0%	na	100.00%
Rainbow	20	4	35.54	35.54	98.54%	1.93	0.00	74.90	74:26	na	39	43.0	NA	3.52	81.2%	82.7%	93.9%	na	100.00%

11.11 Neonatal Unit

Neonatal services operate from 7 ITU, 4 HDU and 14 special care cots and staffing requirements are reviewed annually by the Neonatal network, part of the South East Coast Operational Delivery Network (ODN). The British Association of Perinatal Medicine (BAPM) and the DH Toolkit for High Quality Neonatal Services recommend 1:1 nursing in ITU, 1:2 in HDU and 1:4 in special care, with a supernumerary shift leader. Calculations are based on an average occupancy of 80% with 25% uplift for sickness and leave and are the recommended WTE for registered nurses, excluding support staff.

Current clinical nursing establishments are 56.98 WTE against a required establishment of 58.75. The recommended nurse to patient ratio is mainly achieved in the Special Care and High Dependency nurseries but 1:1 nursing for babies receiving intensive care is rarely possible within the current funded establishments and one registered nurse will usually care for an HDU baby as well as an ITU baby.

Roster effectiveness is fairly well managed and sickness levels are below average. % filled hours are above planned for support staff who are covering additional shifts.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE))	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	BAPM	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
													Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
Neonatal ITU	7	0	64.00	64.00	94.11%	3.84	2.00	75.20	88:12	9.14	58.8	1.56	100.0%	143.0%	73.0%	191.7%	90.50%

11.12 Critical Care (adult)

The critical care team use patient case mix and severity of illness data to guide a flexible approach to nursing workload in applying the current funded establishments to achieve the 'Standards for Nurse Staffing in Critical Care' (BACCN 2009) and RCN recommendation of not less than 1 nurse per level 3 (ITU) patient and 1 nurse per two level 2 (HDU) patients during each shift.

The higher nurses to patient ratio at KCH is required due to the geographically separate ITU and HDU and allows the flexibility to expand the provision of level 3 beds to 6. The majority of admissions to HDU are elective surgical patients, for whom the pressure to avoid cancellation is high, or those stepping down from level 3 care. The challenges imposed by this are the difficulty for the nurse in charge to oversee both units, movement of patients from one area to another with associated cleaning of vacated bed spaces, the high frequency of admissions and discharges, moving and handling issues due to limited staff numbers in each area and the need to nurse some level 2 patients on ITU due to lack of isolation facilities in HDU.

Ward	Beds Funded	Additional Capacity (Unfund)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness March 14 (%)	Maternity leave (WTE at 31.4.14 (WTE))	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	Ratio of patients per RN	DAY		NIGHT		Harm free care (new harms only) April 14
															Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	Average filled hours - actual v planned May 14 (%) RNs	Average filled hours - actual v planned May 14 (%) Support staff	
ITU WHH	11	0	63.63	63.63	73.22%	0.45	1.00	80.30	84:16	5.86	NA	NA	50.50	0.8	110.6%	70.9%	108.0%	218.1%	100.00%
ITU QE	8	0	46.86	46.86	93.58%	1.44	1.00	75.60	93:7	5.67	NA	NA	44.60	1.1	81.3%	56.6%	81.3%	na	100.00%
ITU KCH	8	0	39.80	39.80	98.02%	1.63	4.76	79.80	92:8	6.62	NA	NA	26.90	1.1	87.4%	152.5%	95.2%	na	100.00%

The bed capacity in WHH ITU has been expanded temporarily since December 2013 and additional resource provided. However there remains a significant vacancy factor despite innovative recruitment of newly qualified and also inexperienced nurses and there is some reliance on temporary staff to fill gaps in staffing which is reflected in the % filled hours at the WHH site.

12. CONCLUSIONS

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met
2. The full impact of the agreed investment of £2.9m is not yet fully seen in this staffing review as recruitment has been phased throughout 2014/15 to take account of the supply of registered nurses. It does include the impact of recruitment to maternity leave and to the additional establishment in paediatric wards. The impact of the full investment will see an increase in whole time equivalent (wte) staff per bed (patients) ratios across all areas.
3. Average skill mix remains similar to that found in the previous review and a small reduction is seen in wards where the associate practitioner role has been fully implemented.
4. Registered nurse vacancies in wards are currently 50.5 wte which is 10.wte higher than at the previous staffing review. The healthcare assistant vacancies have reduced to 26.3 wte. The surgical division has the highest number of total vacancies at 35 wte and have a plan in place to address the shortfall.
5. 37 newly qualified nurses will commence employment during June & July 2014 following registration with NMC
6. Sickness level at 4.9% is similar to that seen in the previous review. Higher than average rates were seen in stroke & acute frailty wards and in the surgical & orthopaedic wards at the WHH. Plans are in place to address the variation.
7. In April 2014 there was a total of 36.2 wte (2.4%) staff on maternity leave across the 46 wards. Ward managers are now able to recruit to posts and this has significantly reduced the impact of maternity leave. Ward managers report that this has had a very positive impact.
8. Overall turnover has increased in registered nurses and midwives from 9.5% in 2012 to 11.2% during 2013/14 (please note that nursing & midwifery turnover has not been separated) and is slightly above national and local averages. The turnover of healthcare assistants is stable at 10.6% and is below national and local averages.
9. The use of temporary staff through NHS-Professionals and agency has risen since December 2012, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds.
10. There has been a significant improvement in roster quality since the last review. The average achievement of % time clinically effective across all 46 wards for April 2014 was 76.2% compared to 70.4% in December 2012.
11. From June 2014 details and summary of planned and actual staffing on a shift-by-shift basis, is to be published in a form accessible to patients and the public on Trusts' websites (which will be supplemented by a dedicated patient friendly 'safe staffing' area on the Trust website) and be published on the relevant hospital profile(s) on NHS Choices. The first report highlights variation but on average 90.4% of actual day shifts were staffed and on average 100% of night shifts were staffed (please note that some wards had >100% staffing to take account of patient acuity & extra beds).
12. The current funded establishments allow for at least a ratio of 1 registered nurse for every 8 patients on day shifts (except on one ward) and most wards are able to exceed this with a better than 1:8 ratio. In addition, the actual ratios were observed on 3 consecutive days and all wards had provided at least 1:8 ratio except for one ward with an average ratio of 1: 9. This will be addressed by the full impact of the investment. Further observations will take place to check the actual ratios during night-time shifts.
13. The application of modelling methods has identified that:
14. Most wards are near or above calculated establishments using the Hurst (2012) method

-
15. Most wards have establishments higher than the nursing workload acuity dependency tool suggests. This is based on a monthly snapshot rather than calculating daily average workload measures
 16. The Professional Judgement method showed the closest correlation between calculated establishments and actual for most wards. This means that ward establishments are in-line with the professional judgements made by ward managers
 17. Most wards demonstrated average Harm Free Care (acquired in hospital) of >95% in April 2014 and only 7 wards were <93% (national average). These wards have focussed improvement plans in place. This was using the national safety thermometer methodology.

The following priorities have been identified from the findings of the review:

1. Optimise the use of existing resources;
 - Address the vacancy levels for registered nurses by implementation of a robust plan to reduce ahead of winter 2014/15.
 - Work with NHS-P to increase fill rate to the required level;
 - Ensure accuracy of reporting actual against planned hours filled by revisiting all rosters as part of the roll out of the NHS-P interface with the E-Rostering system.
2. Improve clinical leadership and supervision of quality of care (next phase of agreed investment);
 - Implement the supervisory element of the ward manager role and evaluate the benefits through the ward manager accountability framework.
 - Ensure a plan is in place for all ward managers to undertake the clinical leadership programme over the next three years.
3. Improve alignment of staffing required to demand;
 - Adopt the Shelford Group adaptation of the Safer Nursing Care Tool criteria and develop more regular evaluation of assessed patient needs.
 - Include evaluation of missed or delayed vital signs observations, and delay in medications for pain relief in future reviews of ward staffing to better measure quality impacts.
4. Evaluate the size of wards to develop a model of best practice that achieves high level quality, safety, productivity, cost effectiveness and meets service needs;
 - Pilot the re-profiling of the ward staffing team in a designated area to incorporate and test an innovative skill mix matched to the patient pathway
5. Evaluate the impact of the investment into ward staffing;
 - Progress with the planned implementation of additional posts taking place across 2014/15.
 - Evaluate impact of the investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety.

The ward staffing review will be repeated every six months and the next review will include Midwifery, Emergency Departments and Theatres.

Appendix 1: The current funded establishments for all 46 wards as at March 2014, proportion of staff in post, adjusted establishment incorporating the separate bank line.

Ward	Specialty	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	RN (WTE)	Ass Pract band 4 (WTE)	HCA (WTE)	Staff in Post (WTE)	RN (WTE)	Ass Pract band 4 (WTE)	Support worker (WTE)	Proportion staff in post (%)	Separate bank line (£000s)	RN Adjusted Bank (WTE)	SW Adjusted Bank (WTE)	Total Adjusted (WTE)	Full Establishment (WTE)
Kingston	Stroke	22	5	39.44	23.85	0.92	14.67	38.99	22.67	0.92	15.20	98.86%	0.00	0.00	0.00	0.00	39.44
Harvey ward	Neuro rehab	19	0	24.65	13.80	0.00	10.85	24.65	12.80	0.00	11.85	100.00%	0.00	0.00	0.00	0.00	24.65
Treble ward	Neurology	18	0	28.08	15.50	0.00	12.58	27.30	15.42	1.00	10.88	96.09%	10.28	0.33	0.00	0.33	28.41
Mount McMaster	Gastro	24	2	27.97	14.00	0.00	13.97	27.96	13.64	0.00	14.32	98.14%	16.19	0.52	0.00	0.52	28.49
Invicta	Respiratory	24	0	28.06	16.35	0.00	11.71	28.28	17.60	0.00	10.68	99.51%	11.24	0.36	0.00	0.36	28.42
Taylor KCH	Cardiac Care	5	2	15.66	14.33	0.00	1.33	12.58	11.91	0.00	0.67	80.33%	0.00	0.00	0.00	0.00	15.66
Harbledown	Acute frailty	24	3	33.17	17.59	0.00	15.58	29.91	15.80	0.00	14.11	89.07%	12.83	0.41	0.00	0.41	33.58
CDU WHH	Emergncy med	47	4	63.77	42.96	0.00	20.81	62.71	41.12	0.00	21.59	96.66%	34.66	1.11	0.00	1.11	64.88
Richard Stevens Unit	Stroke	24	0	38.94	20.87	2.00	14.07	33.31	18.55	2.00	12.76	84.59%	13.81	0.44	0.00	0.44	39.38
Cambridge J	Respiratory	28	6	31.54	18.04	0.00	13.50	32.69	18.09	0.00	14.60	101.71%	18.78	0.60	0.00	0.60	32.14
Cambridge K	Cardiology	28	2	33.79	20.12	1.00	12.67	29.36	17.69	0.00	11.67	85.47%	17.55	0.56	0.00	0.56	34.35
Cambridge M2	Gastro	20	5	25.11	14.18	0.00	10.93	29.75	15.60	0.00	14.15	116.30%	14.72	0.47	0.00	0.47	25.58
Cambridge L	Acute frailty	21	5	30.24	16.31	0.80	13.13	37.49	21.85	0.80	14.83	121.64%	18.03	0.58	0.00	0.58	30.82
Oxford	Infectious dis	14	0	22.11	13.36	0.00	8.75	19.71	11.10	0.00	8.61	87.95%	9.26	0.30	0.00	0.30	22.41
CCU WHH	Cardiac Care	11	0	31.41	25.41	1.00	5.00	28.93	24.93	1.00	3.00	91.72%	3.98	0.13	0.00	0.13	31.54
CDU, QEQM	Emergncy med	25	2	42.11	25.60	0.00	16.51	43.03	24.80	0.00	18.24	100.51%	21.94	0.70	0.00	0.70	42.81
Minster Ward	Cardiology	23	0	31.10	17.03	0.00	14.07	34.48	15.60	0.00	18.88	109.46%	12.34	0.40	0.00	0.40	31.50
Fordwich Ward	Stoke	19	4	36.52	19.82	2.00	13.01	31.71	19.44	4.00	10.27	85.20%	21.90	0.70	0.00	0.70	37.22
Sandwich Bay	Respiratory	21	0	25.62	15.06	0.00	10.56	27.13	15.69	0.00	11.44	104.63%	9.63	0.31	0.00	0.31	25.93
St Margarets	Gastro	22	3	25.19	12.73	2.00	10.46	27.15	14.47	2.00	10.68	105.81%	14.66	0.47	0.00	0.47	25.66
Deal	Endocrinology	20	8	23.53	13.01	1.00	9.52	31.00	16.87	2.00	12.13	129.65%	11.81	0.38	0.00	0.38	23.91
CCU QEQM	Cardiac Care	12	0	22.50	15.51	0.00	6.99	20.67	14.41	0.00	6.26	91.26%	4.78	0.15	0.00	0.15	22.65
Marlowe	Nephrology	29+6	4	52.70	33.26	0.50	18.94	46.89	30.72	0.50	15.67	88.98%	0.00	0.00	0.00	0.00	52.70
Brabourne	Oncology	8	0	16.77	13.97	0.00	2.80	10.77	7.97	0.00	2.80	64.22%	0.00	0.00	0.00	0.00	16.77
Kennington ward	Gynae	11	4	21.60	11.90	0.00	9.70	16.27	8.67	0.00	7.60	75.32%	0.00	0.00	0.00	0.00	21.60
Birchington	Gynae	15	4	28.71	18.13	1.00	9.58	28.25	17.85	1.00	9.40	98.40%	0.00	0.00	0.00	0.00	28.71
Neonatal ITU	NICU	7	0	64.00	56.54	2.35	3.61	60.23	54.88	2.35	3.00	94.11%	0.00	0.00	0.00	0.00	64.00
Padua	Paediatric	28	4	45.39	33.29	1.20	9.90	39.61	29.61	0.40	9.60	87.00%	4.51	0.14	0.00	0.14	45.53
Rainbow	Paediatric	20	4	35.54	26.34	1.40	8.80	35.02	25.16	0.80	9.07	98.54%	0.00	0.00	0.00	0.00	35.54
Clarke	Urology	36+6	2	39.75	21.85	2.00	15.90	43.13	22.16	2.00	18.97	104.65%	28.08	0.00	1.46	1.46	41.21
Kent	Vascular	20+6	5	30.53	17.80	1.00	11.73	24.41	13.08	1.00	10.33	76.80%	24.08	0.00	1.25	1.25	31.78
Kings A2	Gen Surg	20	0	24.16	13.31	0.00	10.85	20.08	9.24	0.00	10.84	81.49%	9.27	0.00	0.48	0.48	24.64
Kings B	Colorect Surg	27	0	31.57	17.21	0.00	14.36	28.56	14.23	0.00	14.33	86.67%	26.55	0.00	1.38	1.38	32.95
Kings D male(1)	T+O	21	4	51.09	28.95	0.00	23.38	44.59	24.34	0.00	20.25	85.80%	16.88	0.00	0.88	0.88	51.97
Kings D female (2)	T+O	18	0			0.00											
Kings C1	T+O eld trauma	27	0	32.55	16.14	0.00	16.41	31.56	16.15	0.00	15.01	92.82%	27.87	0.00	1.45	1.45	34.00
Kings C2	T+O elective	24	0	33.01	18.41	0.00	14.60	29.92	14.12	0.00	15.80	86.80%	28.02	0.00	1.46	1.46	34.47
Rotary	Max fax / ENT	16	0	33.43	17.68	0.00	15.75	31.61	17.53	0.00	14.08	93.77%	8.69	0.28	0.00	0.28	33.71
Cheerful Sp Male	Colorect Surg	18	8	27.14	14.18	1.00	11.96	24.15	11.35	1.00	11.80	88.98%	0.00	0.00	0.00	0.00	27.14
Cheerful Sp Female	Gen Surg	20	8	28.28	16.53	0.00	11.75	26.33	15.60	0.00	10.73	93.02%	0.51	0.00	0.03	0.03	28.31
Bishopstone	T+O eld trauma	22	0	33.16	15.34	2.00	15.82	32.72	15.27	2.00	15.45	94.44%	28.57	0.00	1.49	1.49	34.65
Seabathing	T+O trauma	26	0	23.83	15.71	0.00	6.12	23.28	10.07	1.00	12.22	93.71%	19.45	0.00	1.01	1.01	24.84
Quex	T+O elective	19	1	30.00	16.29	1.00	12.71	22.00	14.00	2.00	6.00	69.89%	28.40	0.00	1.48	1.48	31.48
ITU WHH	Critical care	11	0	63.63	53.34	0.00	10.29	46.59	39.77	0.00	6.83	73.22%	0.00	0.00	0.00	0.00	63.63
ITU QE	Critical care	8	0	46.86	43.36	0.00	3.50	43.85	40.05	0.00	3.80	93.58%	0.00	0.00	0.00	0.00	46.86
ITU KCH	Critical care	8	0	39.80	36.70	1.00	2.10	39.01	35.91	1.00	2.10	98.02%	0.00	0.00	0.00	0.00	39.80
				1514.01	961.66	25.17	521.23	1427.62				94.29	544.327	9.82	12.38	22.20	1535.73

Appendix 3: Total monthly hours actual against planned and % fill by ward during May 2014

DAY				NIGHT				DAY		NIGHT	
Registered nurses /Midwives		Care staff		Registered nurses /Midwives		Care staff		Average fill rate registered nurses & midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses & midwives (%)	Average fill rate care staff (%)
Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				

Division / Ward

Urgent Care & LongTerm Conditions

Cambridge J	1829.75	1831.17	853	969.04	914.5	740	976.5	982.33	100.1%	113.6%	80.9%	100.6%
Cambridge K	2149.5	1797.5	811	607	713	713	713	667	83.6%	74.8%	100.0%	93.5%
Cambridge M2	1280	1534.92	877	749.96	744	729.42	372	655.13	119.9%	85.5%	98.0%	176.1%
Coronary Care Unit (K&C)	1119.5	848.77	434	0	713	713.5	0	0	75.8%	0.0%	100.1%	
Coronary Care Unit (QEOMH)	1430	1149	595	322.5	620	622.25	310	315.25	80.3%	54.2%	100.4%	101.7%
Coronary Care Unit (WHH)	1917	1750.23	372	367.5	1426	1278.75	356.5	184	91.3%	98.8%	89.7%	51.6%
Minster	1536	1544	1362	1166	651	735	651	652.25	100.5%	85.6%	112.9%	100.2%
Oxford	958.75	1013.13	677.5	597.55	713	667.5	356.5	402.5	105.7%	88.2%	93.6%	112.9%
Sandwich Bay	1292.5	1572.5	1088.5	1224.03	651	706	651	508	121.7%	112.5%	108.4%	78.0%
St Margarets	1377.5	1312.85	1395	1357.66	620	550.25	310	566	95.3%	97.3%	88.8%	182.6%
Deal	1794	1611.25	1365	1124.5	620	622	620	579.25	89.8%	82.4%	100.3%	93.4%
Harvey	1180.5	854.5	1153.5	1405.5	713	644	356.5	563.5	72.4%	121.8%	90.3%	158.1%
Invicta	1345.5	1333.86	1074	970.5	744	719.5	372	558.5	99.1%	90.4%	96.7%	150.1%
Cambridge L	2236	1832	1218	1010.25	713	702.5	713	822.5	81.9%	82.9%	98.5%	115.4%
Treble	1254.5	1266.11	1489.5	871.8	713	793.5	356.5	287.5	100.9%	58.5%	111.3%	80.6%
Mount/McMaster	1090.5	1013.67	1423.5	1130.02	744	744	372	404.5	93.0%	79.4%	100.0%	108.7%
Fordwich Stroke Unit	2170.5	1710.98	990	1309.5	976.5	988	651	767.5	78.8%	132.3%	101.2%	117.9%
Kingston Stroke Unit	1850	1465.41	1099.5	1207.34	1069.5	1053.5	713	725.5	79.2%	109.8%	98.5%	101.8%
Richard Stevens Stroke Unit	1821	1398.75	1177.5	1061.84	1069.5	881	713	770.5	76.8%	90.2%	82.4%	108.1%
Harbledown	1246.5	1478.67	1182	1091.75	744	744	744	845.5	118.6%	92.4%	100.0%	113.6%

Surgical Services

Rotary Suite	1616	1547.25	1054	849.24	682	682	341	342	95.7%	80.6%	100.0%	100.3%
Cheerful Sparrows Female	1240	1578.77	928.5	986.67	620	554.5	620	744.98	127.3%	106.3%	89.4%	120.2%
Clarke	2445	2058.09	1458.75	1364.67	682	670.25	682	682.5	84.2%	93.6%	98.3%	100.1%
Cheerful Sparrows Male	1074	1094.08	900	959.17	594	658	682	697	101.9%	106.6%	110.8%	102.2%
Kent	1463.92	1398.75	1074	833.75	713	713	356.5	358.5	95.5%	77.6%	100.0%	100.6%
Kings B Ward - WHH	1417.05	1383.58	1340.75	978.73	713	740	565.75	414.57	97.6%	73.0%	103.8%	73.3%
Kings A2	1108.25	1069.61	1068.25	980.75	717	687	358.5	377	96.5%	91.8%	95.8%	105.2%
Kings C1	1495.53	1488.84	1157.72	1254.67	713	713	713	791	99.6%	108.4%	100.0%	110.9%
Kings C2	1746.5	1209.85	1146.5	1068.41	713	579	609.5	701	69.3%	93.2%	81.2%	115.0%
Kings D Male & Female	2239	1985.36	1684.25	1916.74	1426	1377.25	1069.5	1030.5	88.7%	113.8%	96.6%	96.4%
Quex	1400.5	1308.53	820	733.5	620	601.25	310	320	93.4%	89.5%	97.0%	103.2%
Bishopstone /Seabathing	3418	2721	2654.5	2700	1271	1214	1271	1322	79.6%	101.7%	95.5%	104.0%
Critical Care - WHH	2946.5	3259.09	721	511	2852	3080.08	138	301	110.6%	70.9%	108.0%	218.1%
Critical Care - KCH	2497	2182.51	200	305	2139	2036.5	0	243.5	87.4%	152.5%	95.2%	
Critical Care - QMH	3427.5	2787	432	244.5	2728	2218	0	0	81.3%	56.6%	81.3%	

Specialist Services

Marlowe	2994.5	2635.22	1729.5	1278.79	1380	1284	744	748	88.0%	73.9%	93.0%	100.5%
Neonatal Intensive Care Unit - WHH	3267.5	3266.77	462	660.78	4093.5	2988.25	132	253	100.0%	143.0%	73.0%	191.7%
Padua Ward - WHH	2798	2314.23	944	895.5	1426	1383.5	0	11.5	82.7%	94.9%	97.0%	
Rainbow Ward - QMH	2192.5	1780.17	848.5	701.83	1078	1012	0	11	81.2%	82.7%	93.9%	
Birchington	1417.67	1108.773	697.5	925.8367	682	672	341	330.25	78.2%	132.7%	98.5%	96.8%
Kennington	836.48	732.99	717.32	710.32	775	372	387.5	381.5	87.6%	99.0%	48.0%	98.5%
Brabourne	1275	1066	697.5	213	645.5	713.75	0	25	83.6%	30.5%	110.6%	
WHH Maternity Labour and Folkestone	4212.5	3873.59	1947.5	1688.5	3208.5	2709	1380	1081	92.0%	86.7%	84.4%	78.3%
MLU WHH	825	765	397.5	395	713	589.5	356.5	356.5	92.7%	99.4%	82.7%	100.0%
QE Maternity wards	3302.5	3166.4	2090	1469	2441.25	2172	1046.25	934	95.9%	70.3%	89.0%	89.3%
QE MLU	792.5	748	392.5	377.5	348.75	699	348.75	337.5	94.4%	96.2%	200.4%	96.8%
QE SCBU	1413.5	1207.51	0	247.5	1069.5	1070.5	0	0	85.4%		100.1%	