EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**STRATEGIC WORKFORCE COMMITTEE**
DATE**:**	**22nd JANUARY 2016**
SUBJECT:	**WARD ESTABLISHMENT REVIEW OCTOBER 2015**
REPORT FROM:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Regular annual ward staffing reviews are undertaken to ensure that the ward nursing establishments provide an appropriate staffing level and skill-mix to support the delivery of safe and effective care to patients.
Ward staffing reviews 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 October 2015 review of Adult wards, Paediatric wards and NICU, Critical Care Units, the Emergency Departments and Midwifery. The overall findings indicate that the aims of improving recruitment to vacancies and effective rostering are the priorities.

The Summary of the findings are:

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met.
2. The impact of the £2.9m investment into ward staffing in 2014/15 is fully realised and has increased WTE per bed across most areas.
3. The further investment of £387K agreed in May-15 following the Oct-14 staffing review for Cambridge J, Deal, Kings C1 and Cambridge L has been recruited to.
4. Average skill mix is similar to the previous review and close to 60/40 or more across most areas. The impact of associate practitioners is reflected in a slightly reduced skill mix over the last two years in most specialties where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies.
5. The vacancy rate across all wards is 9.2% and has increased from 8% over the last 6 months since Apr-15. Registered nurse vacancies in wards are 121 wte with the majority at band 5. Healthcare assistant vacancies have increased from 12 wte to 29 wte.
6. Although only 55% of newly qualified nurses took up their first post within EKHUFT in April and Sept-15 this is expected to improve to over 75% with 32 expected in Apr-16 and 50 in Sept-16.
7. The impact of overseas recruitment of EU nurses is not seen in this review due to the 33 starting in Oct-15 being employed as Healthcare Assistants whilst awaiting their UK NMC PIN no. The EU recruitment programme aims to

recruit 160 EU nurses by the end of 2015/16.

8. Overall average sickness across all 47 wards has fallen from 5.1% in Apr-15 to 3.8% in Oct-15.
9. In Oct-15 there was a total of 52 wte (3.0%) staff on maternity leave across the 47 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.
10. Overall turnover in registered nurses and midwives has stabilised during 2015 at 12.6% following increases from 11.2% in 2013/14 to 12.8% in 2014/15. The turnover of healthcare assistants has fallen during 2015 to 12.8% from 14% during 2014/15.
11. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of requested shifts filled by NHSP was 35% and by agency 25.5% in Oct-15. This does not include off framework agency use. Divisional trajectories for agency reduction are being monitored aligned to the EU recruitment programme.
12. The improvement in roster quality seen in previous reviews has not been sustained with the average achievement of % time clinically effective (% time worked) across all wards reviewed, within E-Rostering for Oct-15 at 71.9%, compared to 74.5% in Apr-15. Only 17 of the 47 wards achieved more than the optimum 75%.
13. Details and summary of planned and actual staffing on a shift-by-shift basis, continues to be published monthly. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in October are over 94% on all three acute sites. The trend in performance over time reflects the national trend.
14. The average ratio of patients per registered nurse in Oct-15 across each of the wards reviewed was not above 8 during day shifts except on 2 wards. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 4 wards. 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 all wards.
15. Further work has been undertaken to enable live capture, reporting and escalation of staffing status through a dedicated safer staffing tool within Qlikview which has been implemented and enables the capture of daily planned, actual and required staffing linked to acuity and dependency. This system will be further developed and embedded during 2016.
16. Most wards (33 out of 47) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in Oct-15 and only 5 wards were <95%.
17. The review concludes that:

CDUs	Generally establishments are satisfactory although the model of care, geography of the unit and requirement to use staff flexibly to cover contingency beds at times of high demand is challenging at QEQM.
Medical wards	Generally establishments are satisfactory, enabling teams to provide high levels of harm free care and good FFT results. Cambridge J (CJ), Deal and St Augustines have seen an increase in acuity and dependency of patients. This is particularly notable on CJ due to the change in service model from a 34 bedded respiratory ward to respiratory (15 beds) and HCOOP (19 beds).
Stroke	Fordwich and Kingston ward establishments are close to the SEC network standards, but Richard Stevens is slightly below. A demand and capacity review is required to understand the required bed

	numbers on each site which will feed in to the clinical strategy workforce stream. Further exploration of recruitment, retention and turnover is required to support gaps in staffing on RSU.
Acute frailty	The beds on Cambridge L are now funded on a permanent basis to support the consistency of use.
CCUs	Establishments are satisfactory. Taylor ward due to small ward size appears over-staffed but reflects the higher cost of small wards. This issue will need to feed into the clinical strategy workforce stream.
Renal & Haematology	Establishments are generally satisfactory and the high vacancies on Marlowe ward are resolving.
Gynaecology	Establishments are satisfactory. The Hurst and SNCT modelling methods do not reflect outpatient and day attendances but the establishments are close to professional judgement.
Paediatrics	Current RCN guidelines suggest investment to support the ratio of 1:4 at night. The Royal College of Paediatricians reviewed our services in early 2015 and gave advice about the clinical strategy for child health. They considered current staffing levels appropriate but suggested the consideration of an additional staff member at night because of acuity even though bed occupancy is relatively low. Slightly higher required staffing levels may be required due to the relocation of outpatient clinics to dedicated Paediatric areas.
Surgery	Establishments are generally satisfactory and some previous investment was made to properly establish the additional beds on both cheerful sparrows wards as they are frequently used and it is otherwise challenging to provide a consistent approach to making resources available. Further work is required to evaluate the impact of the increase in ward size.
T& O	Establishments are generally satisfactory.
Neonatal Intensive Care	A comprehensive nurse staffing review, including scoping of other units, was undertaken for Neonatal Services in East Kent using national guidance for neonatal staffing levels. The review indicated that investment may be required in the WHH NICU and the QEQM SCBU. Further work is underway to understand the level of investment that may be required alongside workforce planning solutions to support flexible safer staffing.
Critical Care	Budgeted establishments are slightly below the Intensive Care Society standard in two units which does not consistently allow for a dedicated shift leader.
Midwifery	The average Midwife to birth ratio in Oct-15 was 1:30. A full Maternity structural review will be reported in the next staffing review.
Emergency Departments	Professional judgement suggests that current staffing levels appear sub optimal but further work is required to benchmark current staffing against peers and evaluate the impact of changing models of care on

nursing workload.

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

1. Optimise the use of existing resources;
   - Deliver against the trajectory for agency reduction aligned to the EU recruitment programme;
   - Further reduce the vacancy levels for registered nurses by continuing the implementation of a robust recruitment and retention plan to include recruitment ahead of turnover;
   - Continue to work with NHS-P to increase fill rate to the required level and explore the development of an internal staff bank;
   - 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. Evaluate the impact of the investment into ward staffing and identify if further investment is required;
   - Evaluate impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety;
   - Undertake further work to evaluate the impact of contingency bed use on the QEQM CDU;
   - Undertake further work to develop new and improved ways of working across NICU, HDU and SCBU and identify what level of investment may be required alongside a robust plan for agency reduction;
   - Consider the full structural review of the maternity services against the remodelled Birthrate Plus tool when completed in spring 2016;
   - Undertake a systematic review of the Emergency Departments.

3. Improve clinical leadership and supervision of quality of care;
   - Fully implement the supervisory element of the ward manager role and evaluate the benefits through the ward heatmap and dashboards;
   - Implement the plan for all ward managers to undertake the clinical leadership programme over the next three years.

4. Improve alignment of staffing required to demand;
   - Further develop and embed live capture, reporting and escalation of staffing status through the dedicated safer staffing tool within Qlikview which enables the capture of daily planned, actual and required staffing linked to acuity and dependency.

5. 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

The ward staffing review will be repeated every six months

RECOMMENDATIONS:
The board is asked to consider and discuss the recommendations.

NEXT STEPS:
Continue to meet NQB requirements for providing assurance of safe staffing levels.

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

LINKS TO BOARD ASSURANCE FRAMEWORK:
AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
Continued vacancy factor and reliance on temporary staffing, requires innovative recruitment approach to enable recruitment ahead of turnover.

FINANCIAL AND RESOURCE 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 2015/16 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 NICE guidance is incorporated within the review

ACTION REQUIRED:
To discuss

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 CQC standards and the quality outcomes within the operating framework/ CQUINS 2015/16.

WARD ESTABLISHMENT REVIEW (October 2015)

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WARD ESTABLISHMENT REVIEW (October 2015)

1. INTRODUCTION

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

This report outlines the October 2015 review and has included all wards as well as the Emergency Departments and Midwifery across the Trust including:

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

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 April 2014 in all inpatient wards.

- 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.

Actual against planned staffing hours, by inpatient area, is reported to the Board as part of the monthly Clinical Quality & Patient Safety Report. This report is accessible to patients and the public on a dedicated area of the Trust website and is published on the relevant hospital profile on NHS Choices.

- 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 & 2015/16 and progress in implementing recommendations from previous review.

All the NHS Quality Board requirements in providing assurance on safe staffing are currently being met.

3. INVESTMENT INTO WARD STAFFING DURING 2014/15 & 2015/16 AND PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM THE PREVIOUS REVIEW

Following the staffing review presented to the Trust board in May 2013 a business case for investment of £2.9m was agreed in November 2013 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 work towards being 100% clinically supervisory;
- Increase skill-mix in medical and surgical wards out of hours

Following the October 2014 staffing review presented to the Trust board in January 2015 a business case for investment of £387K, summarised in Figure 1, was agreed in May 2015 to support additional staffing to:

- Keep pace with the acuity and dependency of patients on Deal, Kings C1 and Cambridge J, and enable a senior experienced nurse to be on duty 24/7 on

Cambridge J where high numbers of patients require complex advanced respiratory support;

- Extend funding of contingency beds beyond the winter period on Cambridge L to provide a consistent approach to making resources available, with substantive staff, to ensure safe and high quality patient care.

Figure 1 - Summary of investment into Ward Staffing 2015/16

Ward Staffing Business Case Investment 2015/16 summary			
	Ward	Investment	£ ' 000
1	Cambridge J	2.0 wte band 6 RNs & 3.0 wte band 2 HCAs	
2	Deal	1.0 wte band 5 RN & 1.0 wte HCA	
3	Kings C1	1.0 wte band 5 RN & 1.0 wte HCA	
4	Cambridge L	2.0 wte band 5 RNs & 3.0 wte band 2 HCAs	
	Investment total	**14.0 wte**	**387,006**

The impact of these significant investments are seen in this staffing review.

4. CURRENT WARD ESTABLISHMENTS

A summary of current funded establishments and staff in post is provided in Appendix 1. This includes the detail, by ward, of funded registered nurse, support worker, administrative support posts and actual staff in post at Oct-15.

The structure of most (63%) ward budgets (31 out of the 49 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. Most ward managers have chosen not to convert an element of this resource to substantive posts due to the flexibility it provides.

Converting this budget into WTE represents an additional 23.4 WTE across the 31 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 average 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, seen in figure 2.

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%**	

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 stroke and orthopaedic wards where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies. Associate Practitioners are highly trained support staff who undertake a Foundation Degree, equivalent to diploma level, and are able to undertake much of the work previously within the domain of the registered nurse. Skill-mix is represented including those providing direct patient care only and excluding administrative staff (ward clerk and ward manager assistant roles) and close to 60/40 or more across most areas, seen in Figure 3.

Figure 3. Skill-mix including registered nurses / support staff

Skill-mix - Direct patient care				
Specialty	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**
Medical	59/41	59/41	59/41	**59/41**
CDU	69/31	67/33	70/30	**69/31**
CCU	82/18	82/18	83/17	**83/17**
Stroke	63/37	59/41	57/43	**58/42**
Acute frailty	57/43	57/43	58/42	**56/44**
Surgery	60/40	59/41	59/41	**59/41**
T+O	58/42	57/43	57/43	**57/43**
Gynaecology	65/35	65/35	65/35	**63/37**
Paediatrics	80/20	77/23	77/23	**80/20**

The impact of previous investment into ward staffing has increased WTE per bed across most areas, seen in figure 4. The slight reduction in WTE per bed in frailty reflects the modest additional investment (5.0 wte equating to 1.0 wte per bed) to allow substantive recruitment to the additional beds on Cambridge L to improve patient safety and experience.

Figure 4. Average ward staffing WTE per bed from 2007 to 2015

Average WTE per bed									
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**	**Hurst**
Medical	1.14	1.19	1.28	1.33	1.29	1.29	1.34	**1.36**	1.38
CDU	NR	NR	NR	2.18	1.54	1.92	1.61	**1.81**	1.71
CCU	2.2	2.2	2.42	2.76	2.62	2.68	2.69	**2.56**	2.21
Stroke	1.19	1.52	1.57	1.75	1.79	1.84	1.85	**1.84**	1.9
Acute frailt	1.1	1.18	1.29	1.47	1.33	1.34	1.51	**1.38**	1.43
Surgery	1.09	1.28	1.46	1.38	1.45	1.5	1.57	**1.53**	1.43
T+O	1.12	1.17	1.21	1.32	1.36	1.37	1.40	**1.41**	1.42
Renal				1.5	1.81	1.81	1.83	**1.91**	1.71
Haematology				1.38	2.09	2.09	2.08	**2.06**	1.82
Gynaecology				1.96	1.93	1.93	2.02	**1.97**	1.53

The reduction seen in overall WTE per bed in CDUs in the Apr-15 review was due to the split of the WHH CDU funded establishment, from Oct-14 to Aug-15, to provide staffing for the 25 bedded acute assessment area and 18 short stay beds on Cambridge M1. This did not reflect the higher ratio of staff per bed retained in the acute assessment area.

6. WORKFORCE METRICS

The total budgeted establishment across the wards reviewed has increased over time, seen in Figure 5. The increase in 48.0 WTE seen since the previous review reflects the additional investment of 14 WTE into Cambridge J, Cambridge L, Deal and Kings C1 and the establishment of St Augustines ward with substantive staff.

The impact of current vacancy levels, sickness and maternity leave across the 47 wards is 16%, a reduction from 17.2% in April 2015 but an increase from 13.2% in October 2014, also summarised in Figure 5. The absence associated with maternity leave is significant, at 52.00 wte (3.0%). 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.

Figure 5. Wards staffing vacancy, sickness and maternity leave Oct-15

Workforce indicators					
	Dec-12	Mar-14	Oct-14	Apr-15	Oct-15
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02	1680.86	1728.21
Registered Nursing vacancies (WTE)	44.00	73.88	37.66	124.71	120.58
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44	12.55	38.72
Vacancy (%)	4.75	5.21	6.08	8.16	9.20
Sickness (%)	4.96	4.90	4.60	5.15	3.80
Maternity leave (%)	3.28	2.38	2.53	3.89	3.00
* includes 82.9 wte ECC/CDU which was not included in previous reviews					

The majority of maternity leave is recruited to, in accordance with guidance issued to ward managers, but further work is required to ensure that the process of recruitment is undertaken in a timely fashion to ensure availability of replacement staff to reduce gaps.

6.1 Vacancies and recruitment initiatives

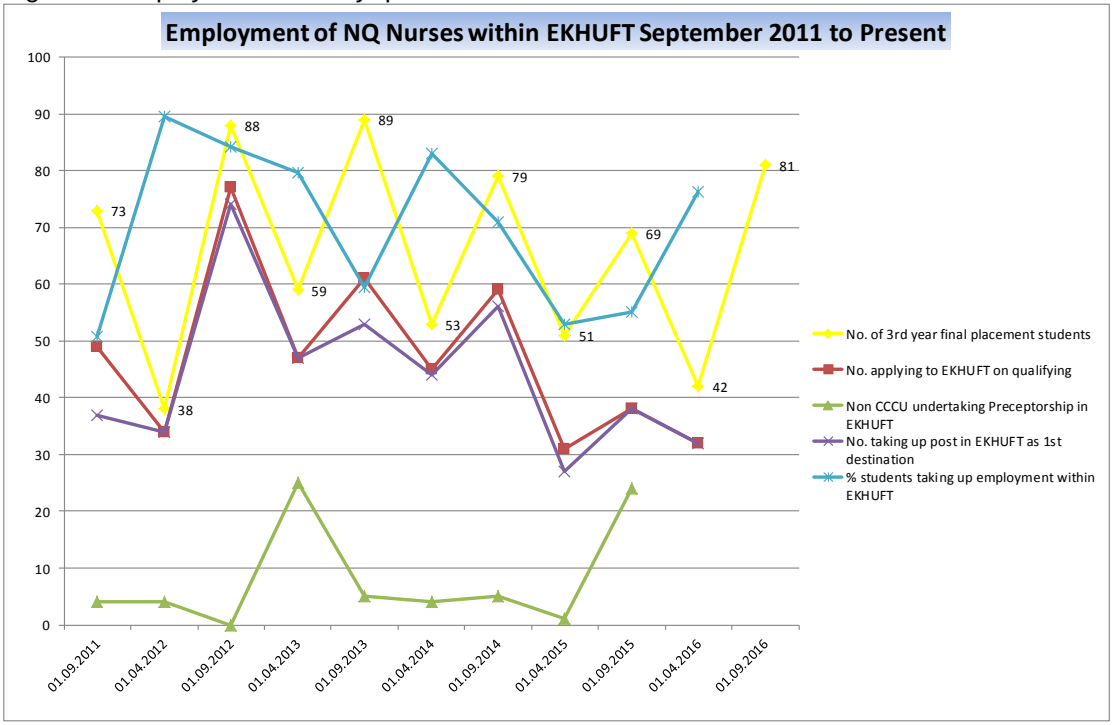
The resourcing team have made improvements to the recruitment process resulting in a reduction in average time between the date of an advert being opened on NHS Jobs and the date that all pre-employment clearances are completed from 12 to around 10 weeks since April 2014 thereby reducing the impact of vacancies

The vacancy rate across all wards is 9.2% and has increased from 8% over the last 6 months since April 2015. Registered nurse vacancies in wards are 121 wte with the majority at band 5. Healthcare assistant vacancies have increased from 12 wte to 29 wte.

Several issues have contributed to the rise in vacancies:

- There is a national shortage of registered nurses;
- The shortage of candidates with the right skills and experience has created a competitive market and EKHUFT also suffers from a unique geographical position on a peninsula with ‘fast transport links’ into London;
- We compete with the London Healthcare Market and Private Healthcare Providers and other NHS providers in areas where the NHS High Cost Area Supplement (London Weighting) applies;
- NHS budget constraints led to reduced numbers of nurse training places from 2010 – 2013;
- There was a fall in % newly qualified nurses who took up their first post within EKHUFT in April and Sept-15, shown in Figure 6. Only 27 out of the 51(53%) newly qualified nurses commenced employment in April 2015 and only 38 out of 69 (55%) in September 2015. However, 32 out of 42 (76%) of those due to qualify in April 2016 have applied for posts within EKHUFT and it is anticipated that a similar proportion of the 81 due to qualify in September 2016 will take up their first post within EKHUFT.

Figure 6. Employment of newly qualified nurses within EKHUFT 2011-2016



Addressing these issues has been incorporated into the 2015 Trust Strategic Recruitment & Retention Strategy. The key objectives of this strategy are:

- To reduce the Trusts dependency on temporary staffing (agency and bank staff) and therefore reduce overall workforce costs and ensuring the provision of consistent high quality care through a substantive workforce;
- Increase Nurse/Midwifery establishments in line with DH recommendations and best practice models with regards to staff to patient ratios and ensuring safe staffing levels;
- Raise the profile of the Trust as ‘a great place to work’;
- Ensure a regular and consistent flow of both trained and untrained healthcare workers to meet vacancy needs as a result of on-going recruitment in areas of high turnover and hard to recruit areas;
- Continue to recruit nurses internationally where relevant and appropriate in hard to recruit areas or to specialised roles to complement other UK and more local recruitment campaigns and initiatives;
- Maximise cost effectiveness of recruitment advertising across the Trust and take a more strategic approach by developing an attraction strategy which includes a mix of strategies enabling/catering to the various demographic needs of the changing workforce. Developing and further improving use of Social Media platforms, job boards, direct sourcing and development of a Trust “Brand”. For example Linkedin, Trust Website, Twitter;
- Improve the efficiency and dispel perceptions of the recruitment process being lengthy and with unnecessary delays;
- Reduce the time taken to recruit and fill a vacancy;
- Ensure Managers are clear about their responsibilities within a recruitment process and how to minimise delays within the process by “project planning” the recruitment from the outset and before employees formally resign;
- Develop new roles and innovative new ways of working in order to re-skill and flex our workforce to deliver care in different ways;

- Monitor recruitment activity and outcomes and produce management information to illustrate such activity in partnership with recruitment and workforce information teams;
- Improving overall job satisfaction for our staff through regular opportunities for feedback and valuing and developing our staff their working environment and improving our retention rates;
- Develop a "Talent Pool" of candidates (previous applicants via NHS Jobs) who we can access immediately without the need to advertise.

The following actions are progressing:

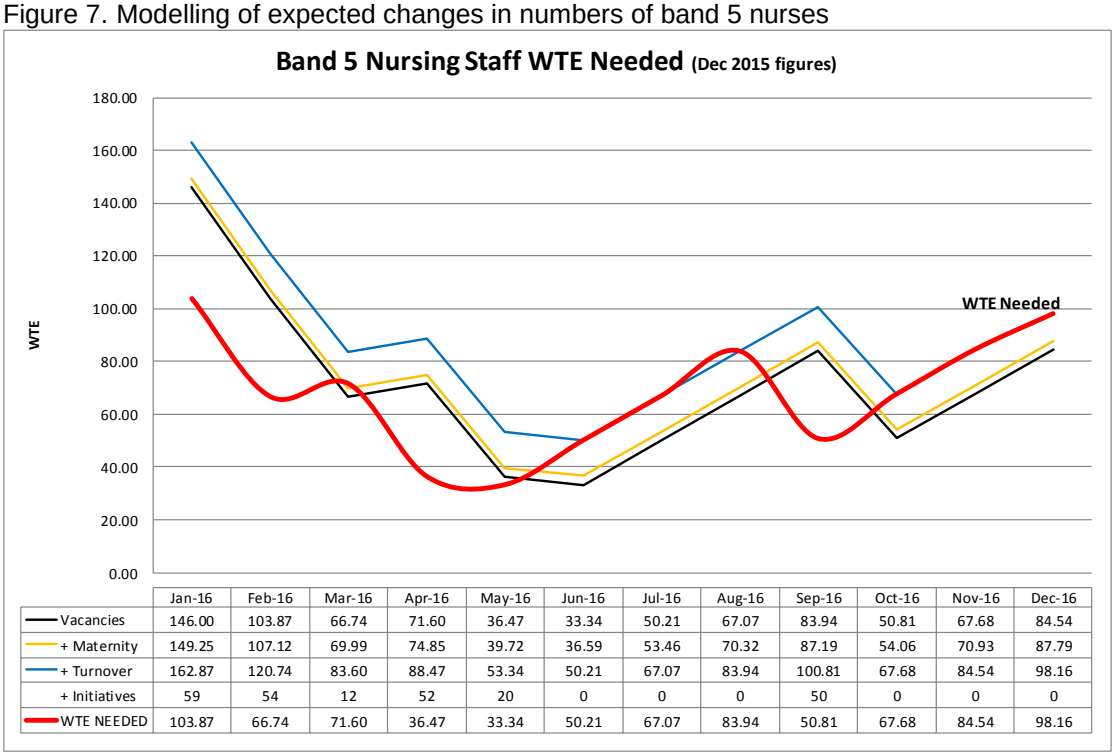
1. Weekly vacancy data is now provided by the Information team, by professional group, pay band and ward/department;
2. The Head of Strategic Resourcing, appointed to lead the implementation of an action plan to reduce nurse vacancies, implemented a Trust campaign for nursing recruitment in July-15. This focuses on selling the organisation as a brand, promoting the opportunities that we can offer and direct people to how they can apply for jobs with our Trust. This included a radio campaign, Spotify campaign and two Open Days in August with a particular focus on Emergency Departments, Endoscopy, Theatres and Wards;
3. The recruitment process has been thoroughly reviewed and actions are in place to reduce delays;
4. Health Education Kent, Surrey & Sussex agreed an increase in training places by 10% in Sept-15 and a further increase of 10% in Sept-16. Confirmation of a requested further 10% commissioned places for Sept-17 is awaited;
5. The aim to recruit all newly qualified nurses who want to work within EKHUFT;
6. Recruitment of 160 nurses from the EU. These nurses are joining us in 3 main cohorts; 33 commenced on 19th Oct-15, 38 on 16th Nov-15, 12 on 14th Dec-15 and the remainder will join us during Jan-Mar-16;
7. Working with NHSP to recruit around registered nurses from the EU to support NHSP fill rates. 16 joined us on 12th Nov-15 and a further 17 are expected in Feb-Mar-16.

In order to plan for a substantial reduction in vacancies and to reduce agency use the expected movement and numbers of wte Band 5 nursing staff needed has been modelled, seen in figure 7. The figures are based on current establishment (1300 wte) and vacancies for Band 5 nursing staff (excluding midwifery). Maternity leave rate of 3% and turnover rate of 12.57% has been factored in as well as the current recruitment initiatives for overseas nurses and our own newly qualified nurses expected to join us in 2016.

Current initiatives are expected to add 220 wte Band 5 nursing staff during 2016. Taking current initiatives and maternity/turnover together, the calculated the current vacancy wte of 146 nurses (across all specialties including outside ward areas) will only reduce to around 98 wte by Dec-16.

Therefore, in order to be fully established within Band 5 nursing and to keep pace with turnover and maternity cover, recruitment of approximately 98 wte nurses during 2016 over and above the current expected intake of overseas nurses and newly qualified recruitment will be required. The Executive Management Team will be presented with further detail in order to consider the way forward.

Figure 7. Modelling of expected changes in numbers of band 5 nurses



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Vacancies	146.00	103.87	66.74	71.60	36.47	33.34	50.21	67.07	83.94	50.81	67.68	84.54
+ Maternity	149.25	107.12	69.99	74.85	39.72	36.59	53.46	70.32	87.19	54.06	70.93	87.79
+ Turnover	162.87	120.74	83.60	88.47	53.34	50.21	67.07	83.94	100.81	67.68	84.54	98.16
+ Initiatives	59	54	12	52	20	0	0	0	50	0	0	0
WTE NEEDED	103.87	66.74	71.60	36.47	33.34	50.21	67.07	83.94	50.81	67.68	84.54	98.16

6.2 Sickness absence

ESR data demonstrates that average sickness absence rate across the wards was 3.8% in Oct-15 (RN 3.0% and HCA 5.38%). The average monthly sickness rates show wide variation but higher average rates in excess of 5% were seen in some stroke and medical wards and between 6-11% in frailty wards. This reflects the high physical and emotional demands of ward work in some areas and also significant opportunity for further improvement.

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, is also now embedded.

6.3 Maternity leave

In Oct-15 there was a total of 51.96 wte (3.0%) staff on maternity leave across the wards reviewed. Following the investment into ward staffing this element of absence is now recruited to thus reducing the impact of maternity leave. The majority of maternity leave is recruited to, in accordance with guidance issued to ward managers, but further work is required to ensure that the process of recruitment is undertaken in a timely fashion to ensure availability of replacement staff to reduce gaps. Ward managers report that this has had a very positive impact.

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 of registered nurses and midwives increased to 12.8% during 2014/15 from 11.2% in 2013/14 but has stabilised during 2015 at 12.6%. The turnover of healthcare assistants, previously stable at 10.6% in 2013/14 rose to 14% during 2014/15 but has fallen during 2015 to 12.8%.

Figure 8. Average turnover of nursing, midwifery and care staff 2011 to 2015

Turnover (%)					
	2011	2012	2013/14	2014/15	Oct-14-Sept-15
Nursing & Midwifery	7.5	9.5	11.2	12.8	12.6
HCA and other support staff	12.6	10.6	10.6	14.2	12.8

The Trust turnover, including all staff, was 16.34% for 2014/15 which is comparable across Kent, Surrey and Sussex Trusts with most falling with a range of 14-16%. Currently exit interviews are held for leavers but feedback is not formally collated. Planned work led by HR will introduce analysis of the themes from these.

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 use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of requested shifts filled by NHSP was 35% and by agency 25.5% in Oct-15.

The use of temporary staffing, including NHS-P bank and framework agency, is variable and overall fill rate of requested shifts has reduced from 63% in Apr-15 to 60% in Oct-15. 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 69% for registered nurse shifts and 68% for healthcare assistant shifts, are being addressed with the supplier through the appropriate contract management processes.

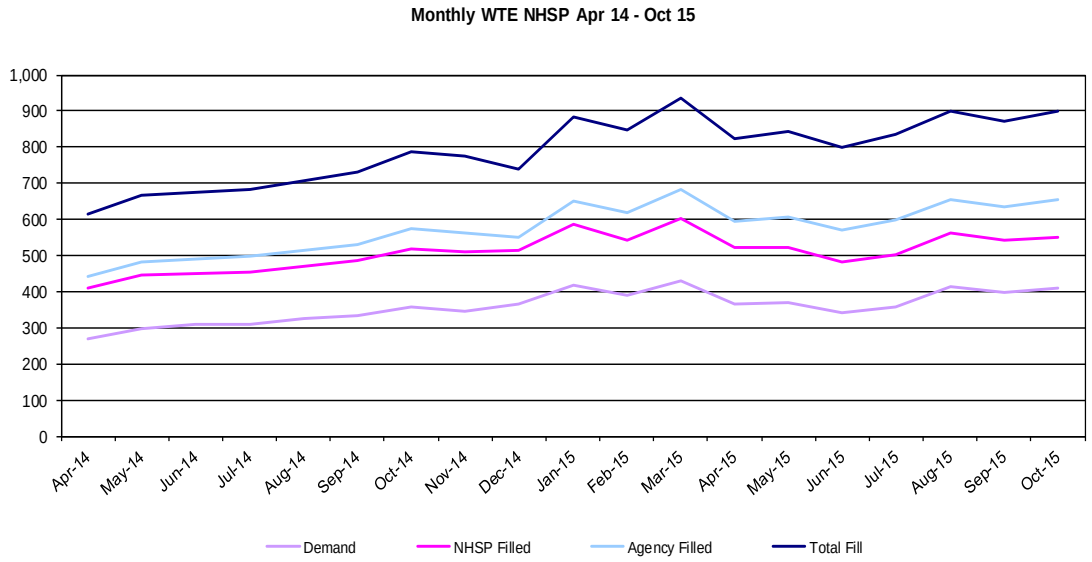
Off framework agency use is not included in the fill rates outlined above and is utilised to maintain patient safety when supply by NHS-P and framework agency supply falls short of demand.

Even with rigorous management controls through the temporary staff booking process the use of NHS-P overall has risen over the past year, 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 9 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 September dip is also seen as cohort recruitment of newly qualified nurses reduces the demand for NHSP.

Dependency on agency to meet the shortfall in NHSP filled shifts has resulted in a significant cost pressure for the Trust and divisional trajectories for agency reduction are being monitored aligned to the EU recruitment programme.

Figure 9. Trend of NHS-P demand and fill in WTE from Apr-14 to Oct-15



The highest volume of requests for temporary staffing cover through NHSP remains vacancies, followed by additional beds and to a lesser degree sickness and specialling, seen in figure 10.

Figure 10. Reason for requests through NHSP Aug – Oct-15

Reason	August	August WTE	September	September WTE	Variance	October	October WTE	Variance
Vacancy	39,881	245	36,388	224	-21	38,460	237	13
Extra beds/Initiative	9,715	60	12,361	76	16	12,206	75	-1
Sickness	9,926	61	8,681	53	-8	7,995	49	-4
Specialing	6,303	39	5,966	37	-2	6,197	38	1
Parenting leave	737	5	1,082	7	2	977	6	-1
Unplanned leave	516	3	410	3	-1	409	3	0

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

- Implementation of a ‘Never Cancel Bank’ initiative to improve the use of booked staff across ward;
- The Trust has worked collaboratively with NHS-P to recruit 38 registered nurses from Portugal and Italy in 2014/15. A further 16 further EU nurses commenced in Nov-15 and 17 more are expected in Feb/Mar-16 to provide a dedicated resource ahead of the increased demand anticipated this winter;
- 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 band 2 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

The improvement in roster quality seen in previous reviews has not been sustained with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for Oct-15 at 71.9%. This compares to 74.5% in Apr-15, 74.59% in Oct-14 and 70.37% in Dec-12. Only 17 of the 47 wards achieved more than the optimum 75%, against 21 in Apr-15.

Meeting the 75% time worked 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.

Revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff, by day and by night, and by individual hospital site. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in October are over 94% on all three acute sites, shown in Figure 11.

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

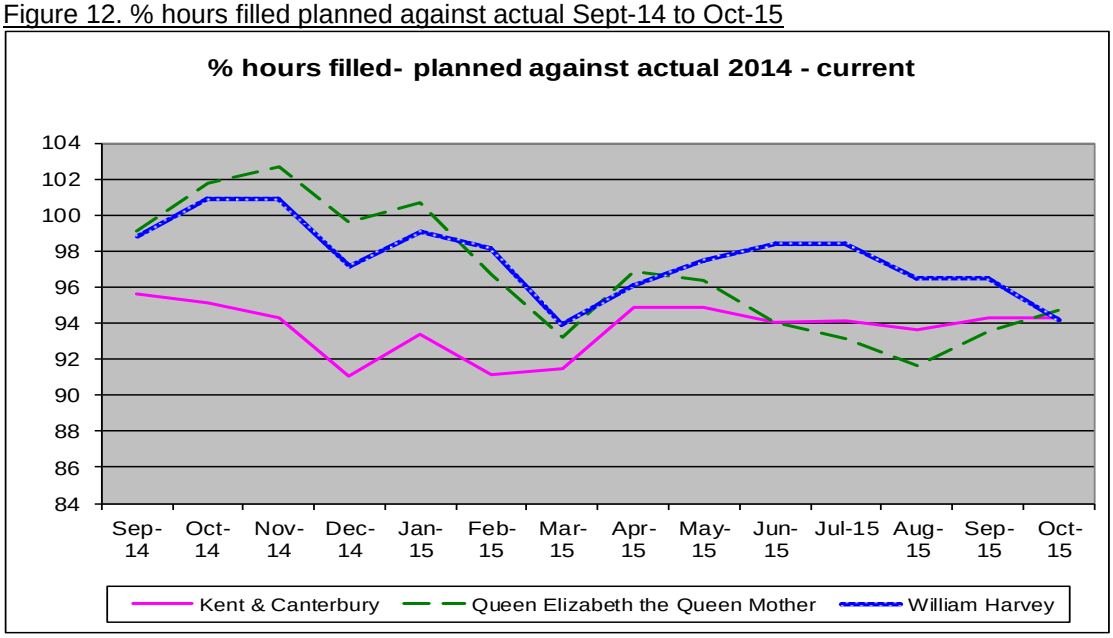
- There are no vacant posts;
- All vacant planned shifts are covered by overtime or NHS-P shifts;
- Annual leave, sickness and study leave is managed within 21%.

The slight reductions seen from December to March, shown in figure 12, reflect the requirement for additional shifts during winter pressures not always being filled by NHSP. The reduction in March and August also reflects periods of higher annual leave. Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time.

Figure 11. % hours filled planned against actual by site during Oct-15

	% Hours filled - planned against actual Oct 2015				
	DAY		NIGHT		
Hospital site	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Overall % hours filled
Kent & Canterbury	81.7%	97.5%	97.0%	134.8%	94.31
Queen Elizabeth the Queen Mother	85.7%	105.4%	95.2%	106.3%	94.71
William Harvey	89.2%	97.2%	95.9%	101.9%	94.14

Figure 12. % hours filled planned against actual Sept-14 to Oct-15



The trend in performance over time reflects the analysis of safe staffing levels reported by 225 acute trusts, reported in the Health Service Journal recently, which shows a gradually worsening position for nurse staffing during 2015 with 85% trusts missing staffing targets for day nursing hours in January and 92% in August.

Senior nursing leaders have reported that:

- It is still too soon to say which organisations have concerning levels of staffing using this data;
- Some Trusts may achieve high % fill rates but have planned for what are already sub-optimal levels;
- Many Trusts reporting the lowest fill rates have invested in to nursing in the last year;
- There may be inconsistencies in the methodology as those Trusts using E-Rostering tend to report lower fill rates.

Work has been undertaken to explore the reasons for the gap, the impact and the actions being taken to address the gap. Some wards achieve higher than 100% due to additional shifts worked through NHS-P during times of increased demand and additional bed use. The main contributory factors for below 80% filled hours are vacancies, maternity leave and sickness which is not able to be backfilled by NHSP. Reporting of January, February and March fill rates will need to include shifts required to staff funded winter contingency beds as well as those that are filled as required when additional beds are used on an ad hoc basis.

The monthly reports are published in a form accessible to patients and the public on the Trusts websites (which is supplemented by a dedicated patient friendly ‘safe staffing’ area on the Trust website) and is published on the relevant hospital profile(s) on NHS Choices.

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	The Safer Nursing Care Tool (Shelford Group 2013), Professional Judgement, Hurst Nursing Workforce Planning Tool (2012 & 2014).
Stroke Units	SEC Cardiovascular Strategic Network Stroke and TIA Service & Quality Standards (2014)
Critical Care Units	British Association of Critical Care Nursing (2009)
Paediatrics	Royal College of Nursing (RCN 2012) guidelines
Emergency Departments	Baseline Emergency Staffing Tool (BEST - RCN)
Midwifery	Birthrate Plus (RCM)
NICU	Department of Health Toolkit for High Quality Neonatal Services 2009. British Association of Perinatal Medicine 2011.

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.

The QEQM CDU identified significantly higher staffing levels than current, using this tool, due to the requirement to staff the 7 contingency beds during periods of high demand when the hot ambulatory area is relocated to provide additional capacity. Further work is required to understand the impact on nursing workload and to consider whether increased funded establishment is required to provide a consistent approach to making resources available, with substantive staff, to ensure safe and high quality patient care.

Cambridge M1, as a contingency ward, does not have a dedicated funded establishment but 1.0 wte RN and 1.0 HCA from 8 wards (CJ, CK, CL, CM2, Oxford, RSU, CDU & CCU) have been seconded to provide a core staffing team and additional resource is provided by NHSP to meet Professional Judgement, which is aligned to Hurst requirements for this ward.

9.2 Hurst Workforce Planning Tool

The Hurst Nurse per Occupied Bed 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 recommended Hurst levels. However, the calculated establishments were significantly lower than current for Rotary, Birchington and

Kennington wards as the tool does not enable capture of trolley, ward attender and outpatient activity.

9.3 Shelford Safer Nursing Care Tool

The Shelford Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care 2000). These classifications have been adapted to support measurement across a range of wards and specialties.
The dimensions of patient dependency and acuity are important variables in determining nursing workload and the SNCT was applied to study current nursing workload in all wards to calculate ward establishment. Monthly data was collected since 2013/14 for all adult wards as part of the monthly NHS Safety Thermometer 'Harm Free Care' survey. However, the updated Shelford SNCT (2013) reiterates the requirement for assessment over a longer period so this approach was used and quality control was provided by matrons who consistency checked submissions for all their wards. Further consistency checking was provided by a senior nurse to ensure common understanding and appropriate application of the criteria.

The capture of the dependency and acuity of patients has moved from paper-based to electronic with the development of a dedicated safer staffing tool within Qlikview. This will enable live capture, reporting and escalation of staffing status with daily planned, actual and required staffing linked to acuity and dependency. This system will be further developed and embedded during 2016. An example of the live reporting that is available is included in Appendix 2.

Calculation of establishments using the SNCT method taking account of nursing workload associated with patient acuity and dependency demonstrated some correlation between calculated and actual establishment for most wards. However, three wards had moderately higher calculated establishments required using this method than they have currently indicating that patient dependency has increased. The wards are:

- Cambridge J – Since the previous review has changed from a dedicated 34 bedded respiratory ward with a high number of patients each day requiring non-invasive respiratory support to a 15 bedded respiratory and 19 bedded HCOOP ward. Dependency has therefore increased and average acuity fallen across the ward;
- Deal - 28 beds mostly very highly dependent patients who require nursing care to meet all or most of their needs;
- St Augustines - 27 beds mostly very highly dependent patients who require nursing care to meet all or most of their needs.

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. Further experience in the use of the tool and continued consistency checking will lead to increased confidence in the use of the SNCT particularly in its new electronic format.

Table 2. Drivers of nursing workload

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.

The Trust has invested in an additional 6 WTE Practice Educators to improve clinical support to students as well as newly qualified nurses and overseas EU nurses. Although these posts have been recruited in Feb-15 there has been sickness absence leading to less available support to wards.

The application of modelling methods (summarised in figure 13) has identified that:

- There is a fairly close alignment of current funded staffing budgets and the establishments derived from application of the modelling methods following previous investment into ward staffing;
- There is alignment between current funded establishments and modelling tools applied (Professional Judgement, Hurst and the Shelford SNCT for most wards. However, acuity and dependency appeared higher in Oct-15 than in May-15 for some wards reflecting some variation in nursing workload between winter and spring.

Figure 13. Triangulation between evidence based tools and professional judgement

Specialty	Ward	Full Est (WTE)	Prof judgment (PJ)	Hurst NPOB or other appropriate model	SNCT	Comments
CDUs	CDU WHH	72.05	67.8	72.3	62.55	SNCT does not capture bed utilisation and high turnover of patients. The K&C CDU is difficult to assess due to the combined establishment with ECC. PJ high at QEQM due to contigency bed use.
	CDU, QEQM	44.99	54.2	44.3	42.53	
	ECC (incl. CDU)	84.96	37.3	27		
			46.1			
Medical	Cambridge J	44.64	50.1	50.6	58.21	Alignment for most wards but establishments below that suggested by the SNCT on CJ, Deal and St As where acuity and dependency has increased. * Cambridge M1, as a contingency ward, does not have a dedicated funded establishment but 1.0 wte RN and 1.0 HCA from 8 wards (CJ, CK, CL, CM2, Oxford, RSU, CDU & CCU) have been seconded to provide a core staffing team and additional resource is provided by NHSP to meet PJ, which is aligned to Hurst requirements for this ward.
	Cambridge K	34.69	31.2	37	31.92	
	Cambridge M2	27.08	28.6	29.2	25.82	
	Minster Ward	31.97	31.7	32.6	36.03	
	Oxford	23.91	26	20.7	22.83	
	Sandwich Bay	27.92	30.3	30.3	32.12	
	St Margarets	27.01	30.7	31.5	32.45	
	Deal	34.41	38.4	38.1	37.86	
	Harvey ward	27.50	29.1	24.6	23.92	
	Invicta	29.92	31	33.7	28.42	
	Treble ward	29.41	30.2	24.2	25.02	
	Mount McMaster	29.99	32.5	33.7	29.61	
	St Augustines	33.44	34.4	37	43.28	
	Cambridge M1	24.90*	24.9	27	24.13	
Stroke	Fordwich Ward	37.72	34.2	38.0*	39.26	Alignment for Kingston and Fordwich (*SEC Network Stroke Model) but less so for RSU. SNCT does not capture stroke thrombolysis nursing work outside the ward
	Kingston	40.43	42.3	42.1*	41.58	
	Richard Stevens Unit	40.63	42.6	44.8*	33.44	
Frailty	Harbledown	35.08	31.8	32.1	36.57	Some alignment across both wards. Acuity and dependency on CL has increased..
	Cambridge L	37.88	40.6	34.1	43.51	
Coronary Care	Taylor KCH	14.07	15.6	10.8	10.69	Alignment with PJ and Hurst but SNCT does not capture intensity of pPCI nursing work.
	CCU QEQM	23.49	22.8	25.8	16.55	
	CCU WHH	32.00	30	32.7	16.48	
Renal & Haematology	Marlowe	55.41	59.2	54.7	32.69	Alignment on both wards with PJ and Hurst but less so with SNCT
	Brabourne	16.47	14.7	15.1	7.15	
Gynaecology	Birchington	28.97	27.5	23.9	18.55	Alignment on both wards with PJ and Hurst but less so with SNCT due to not capturing outpatient and day attender activity
	Kennington ward	22.18	20.9	19.7	10.02	
Paediatrics	Padua	45.60	49.1	50.3*		PJ and *RCN suggest higher establishments to cover day surgery & relocated outpatients
	Rainbow	38.27	47.3	47.3*		
Surgery	Rotary	35.34	32.6	19.9	19.03	Alignment for most wards except Rotary due to SNCT not capturing outpatient activity. On Clarke & Kent the SNCT does not capture trolley activity
	Cheerful Sp Female	33.11	32.8	32.1	29.6	
	Clarke	44.41	44.6	47.7	33.61	
	Cheerful Sp Male	30.32	31.5	29.6	26.22	
	Kent	33.28	31.5	32.6	25.25	
	Kings B	35.15	36.1	33.7	34.76	
	Kings A2	25.26	29.5	24.9	24.18	
Trauma & Orthopaedic	Kings C1	36.31	38.8	35.2	28.56	Alignment with PJ and Hurst but less so with SNCT on WHH wards
	Kings C2	34.97	30	31.3	25.94	
	Kings D male(1)	60.44	57.1	59.7	50.02	
	Kings D female (2)					
	Quex	25.35	27.3	25.9	19.49	
	Bishopstone	34.26	32	34.3	34.5	
	Seabathing	35.24	33.7	34.8	32.14	

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 during the day there can be risks to patient safety.

The average ratio of patients per registered nurse in Oct-15 across each of the wards reviewed was not above 8 during day shifts except on 2 wards, Minster and Mount McMaster, seen in figure 14. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 4 wards. 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 all wards.

Figure 14. Ratio of patients per registered nurse average Oct-15 – E-Rostering system

Ward	Beds Funded	Ratio of patients per RN Oct 15 Days	Ratio of patients per RN Oct 15 Nights
Cambridge J	34	7.81	11.74
Cambridge K	27	6.15	13.55
Cambridge M2	20	5.37	9.39
Taylor KCH	5	2.24	2.49
CCU QEQM	12	3.70	7.76
CCU WHH	11	2.14	2.98
Minster Ward	23	8.25	15.16
Oxford	14	4.54	7.58
Sandwich Bay	21	6.43	9.51
St Margarets	22	5.87	12.45
Deal	28	5.96	16.90
Harvey ward	19	6.28	9.82
Invicta	24	6.77	11.56
Cambridge L	26	7.49	14.07
Treble ward	18	7.06	8.45
Mount McMaster	24	9.94	12.29
Fordwich Ward	19	4.20	7.14
Kingston	22	5.73	8.20
Richard Stevens Unit	24	6.89	11.71
Harbledown	24	6.82	12.74
St Augustines	27	10.77	12.36
Cambridge M1	18	na	na
CDU, QEQM	25	5.41	6.68
CDU WHH	43	4.99	6.71
ECC	18	na	na
	NA	na	na
A+E WHH	NA	na	na
A+E QEQM	NA	na	na
Rotary	16	3.81	8.36
Cheerful Sp Female	20	5.10	11.07
Clarke	36	6.59	17.11
Cheerful Sp Male	18	8.13	11.11
Kent	20	4.55	10.00
Kings B	27	7.23	12.84
Kings A2	20	6.34	9.73
Kings C1	27	7.19	13.50
Kings C2	24	7.76	12.80
Kings D male(1)	43	6.88	9.54
Kings D female (2)			
Quex	19	6.19	11.39
Bishopstone	22	3.33	6.34
Seabathing	26		
ITU WHH	11	1.09	1.11
ITU QE	9	1.37	1.54
ITU KCH	8	0.98	1.20
Marlowe	29	3.98	7.85
Neonatal ITU	7	0.93	0.93
Padua	28	4.10	7.28
Rainbow	20	3.17	6.97
Birchington	15	4.38	7.59
Kennington ward	11	4.37	5.29
Brabourne	8	3.50	3.89

The Safer Staffing Alliance do not support that it is acceptable to have higher ratios of patients per registered nurse at night but many Trusts, whilst meeting the 8:1 on day shifts, report ratios of around 12:1 at night. The ratio of 17:1 on Clarke ward reflects the exclusion of the registered nurse on a twilight shift ((18.00 – midnight) as only a small proportion of these shifts are filled. However, ensuring the ratio of patients to registered nurses at night is reduced on this ward is a current priority.

Further work has been undertaken to enable live capture, reporting and escalation of staffing status through a dedicated safer staffing tool within Qlikview which has been implemented and enables the capture of daily planned, actual and required staffing linked to acuity and dependency. This system will be further developed and embedded during 2016.

10. SAFETY THERMOMETER PERFORMANCE

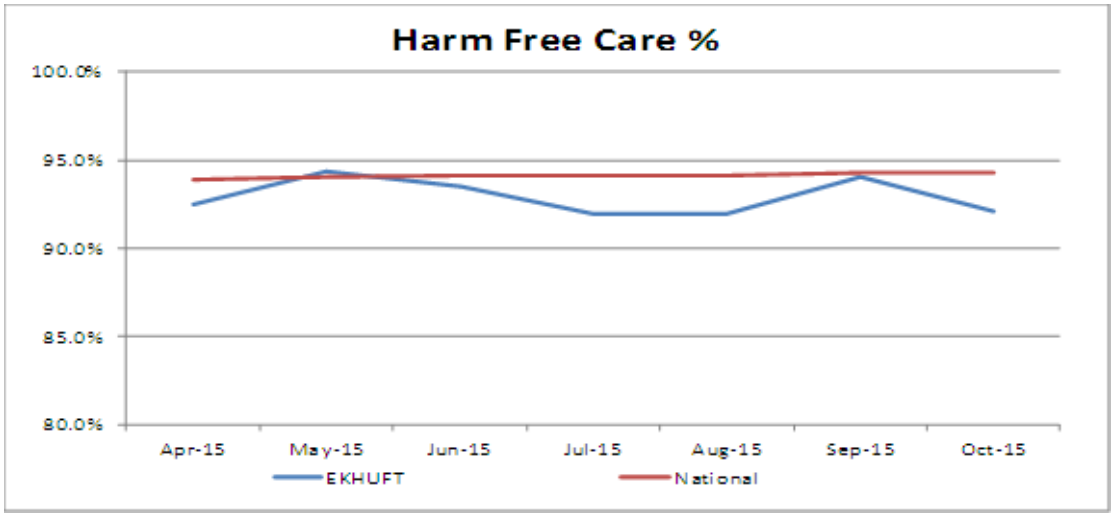
During 2014/15 the Trust improved Harm Free Care by 2.3% from 91.2% in 2013/14 to 93.5% in 2014/15. At year end the Trust exceeded the national average of 94% by achieving 94.3% Harm Free Care for our patients in March 2015.

Average performance of Harm Free Care at 92.9% was slightly below the national average of 94.1% in the first 7 months of 2015/16. However, hospital acquired harms (new harms) at 1.62% are now significantly lower than the national average of 2.2% and show a reduction from 3.5% in 2013/14 and 1.7% in 2014/15.

Most wards (33 out of 47) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in Oct-15 and only 5 wards were <95%.

Figure 15. Harm free care performance against national average ((Apr-15 to Oct-15)

Area	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
EKHUFT	92.5%	94.4%	93.5%	91.9%	91.9%	94.1%	92.1%
National	93.9%	94.0%	94.1%	94.1%	94.1%	94.3%	94.3%



11. ANALYSIS OF SPECIALTIES OUTSIDE WARD AREAS

11.1 Neonatal Intensive Care

A comprehensive nurse staffing review, including scoping of other units, was undertaken for Neonatal Services in East Kent in March 2015 using national guidance for recommended neonatal staffing levels. These included the Department of Health Toolkit for High Quality Neonatal Services 2009 and the British Association of Perinatal Medicine 2011. There no mandated minimum staffing levels for NICU nationally and the review was based on guidance on staffing requirements.

The rationale for the review was high use of agency staff to maintain activity, retirement of experienced staff, an imbalance against recommendations for nurses qualified in the specialty and challenges in responding to peaks of high activity. A national audit had also been undertaken by the Neonatal Clinical Reference Group which matched actual unit activity against actual in-post staffing. This audit highlighted a deficit for the 2014 calendar year of 25.0 wte staff on the NICU at the William Harvey Hospital and 3.0wte staff on the SCBU at the Queen Elizabeth Queen Mother Hospital. Using 2 methods of calculating staffing requirements, the review recommended that nurse staffing on NICU be increased by 16.47 wte and by 3.25 wte in SCBU, recruiting staff over an agreed period of time.

Workforce development planning workshops, supported by Service Improvement, Information and Finance, commenced early Jan-16 to explore different and improved ways of working, different roles (including Outreach) and alternative training options across NICU, SCBU, HDU and Maternity services. A PID will be produced detailing the work streams identified across the services and Strategic Development are also supporting further work to identify what level of investment may be required alongside a robust plan for agency reduction.

11.2 Paediatrics

The paediatric wards have seen investment of almost £800K during 2014/15 and have recruited to all additional posts.

Following the 2014 CQC inspection it was identified that there was shortfall in Paediatric staff outside designated paediatric areas. Professional Judgement / RCN tool identify that slightly higher required staffing levels are required due to the relocation of outpatient clinics to dedicated Paediatric areas. Further work is planned to explore the impact of the relocation of outpatient clinics on nursing workload.

Current RCN (2013) guidelines make the recommendations of nurse:child ratios of 1:3 for children <2 years of age and 1:4 for children >2 years of age during the day and night and this is not currently consistently achieved. The Royal College of Paediatricians reviewed our services in early 2015 and gave advice about the clinical strategy for child health. They considered current staffing levels appropriate but suggested the consideration of an additional staff member at night because of acuity even though bed occupancy is relatively low at an average of 60% during 2015.

11.3 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 the Intensive Care Society (ICS) Core Standards for Intensive care (2013) 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 Critical Care Unit's work closely together and have strong medical and nursing leadership on each site. All three units subscribe to the Intensive Care National Audit & Research Centre and the reports that are generated indicate that compliance with all the critical care quality indicators are comparable and in most cases better than the national average.

The bed capacity in WHH ITU has been expanded from 9 to 11 beds since December 2013 and additional resource provided. The vacancy rate is 6.2 wte registered nurses in Oct-15 and there remains a reliance on temporary staff to fill gaps in staffing which is reflected in the % filled hours at the WHH site. An additional risk is the percentage of junior staff now employed on the unit with 30% of staff having less than 12 months critical care experience.

Bed capacity at QEQM reduced from 9 beds to 8 in Apr-15 although the additional bed is used around 70% of the time. This presents challenges when additional staffing resource is not consistently available through NHSP.

Funded establishments, at 5.8 wte per bed, do not allow each of the three critical care units to consistently have a supervisory shift leader as recommended by the ICS. Nevertheless, the service continues to develop a flexible responsive workforce with competent and skilled practitioners to meet the increasing throughput year on year.

11.4 Maternity

The current gold standard methodology used to evaluate midwifery staffing levels is Birth-rate Plus which includes the principles of one to one care in labour and delivery, capture of real time data on care required during labour, and a classification of intrapartum care which uses clinical indicators to assess the level of need of both mother and baby.

One element of Birth-rate Plus, Midwife to birth ratio, is currently monitored monthly. Birth-rate Plus, suggests that the most appropriate ratio will vary by Trust (e.g. according to demographics, case-mix and the acute v community split) but that 1:28 is optimum. Birth-rate Plus includes all registered midwife and support staff in clinical roles only and excludes midwives engaged in leadership / management or specialty work (Matrons, Consultant Midwives, Head of Midwifery and Deputy). Recent research suggests that a ratio of 1.29.5 may now be more relevant today.

Midwife to birth ratio has not exceeded 30.00 since November 2014. Staff in post excludes roles that are predominantly management in nature. If a proportion of clinical time associated with these roles was included, this would improve the ratio. However, for transparency and simplicity, the Trust has excluded these posts to date.

Month	In Post	Total Births	**Ratio**
01/10/2014	245.48	636	**31.09**
01/11/2014	253.16	547	**25.93**
01/12/2014	253.37	528	**25.01**
01/01/2015	249.27	590	**28.40**
01/02/2015	245.27	544	**26.62**
01/03/2015	245.87	589	**28.75**
01/04/2015	245.61	568	**27.75**
01/05/2015	244.92	574	**28.12**
01/06/2015	242.68	619	**30.61**
01/07/2015	244.17	638	**31.36**
01/08/2015	243.77	604	**29.73**
01/09/2015	241.14	621	**30.90**
01/10/2015	242.28	608	**30.11**

A full structural review of the maternity services has been undertaken against the remodelled Birthrate Plus tool and an external review was undertaken in Nov-15. The outcome of the review is awaited.

11.5 Emergency Departments

The WHH and QEQM EDs each have around 200,000 attendances per annum and have similar funded establishments. Investment of £794K followed a Demand and Capacity review undertaken as part of the FTN in 2011/12. This resulted in the implementation of a service based model with shifts (capacity) constructed around patient profile (demand). Dedicated Matron posts were introduced, establishments reprofiled to expand the skilled support worker resource and posts were fully recruited. The figure below outlines changes in funded establishment and skill mix from 2013 – 2015.

	Funded establishment								
	WHH A&E					**QEQM A&E**			
	Mar-13	Mar-14	Mar-15	Apr-15		Mar-13	Mar-14	Mar-15	Apr-15
Band 8c	1.0					1.0			
Band 8b		1.0	1.0	1.0			1.0	1.0	1.0
Band 8a		1.0	1.0	1.0			1.0	1.0	1.0
Band 7	7.0	10.9	8.0	8.0		9.6	6.9	7.9	7.9
Band 6	12.8	13.1	14.2	14.2		9.2	10.9	10.3	10.3
Band 5	25.4	29.5	27.3	27.3		29.3	29.7	29.7	29.7
Band 4									
Band 3	13.3	14.3	14.3	16.3		12.3	14.7	14.7	14.7
Band 2	2.0					3.0			
	61.5	**69.8**	**65.8**	**67.8**		**64.4**	**64.2**	**64.6**	**64.6**

Demand within the emergency departments has increased since 2013 with a 6% increase in attendance and therefore there is a need to continue to regularly review staffing establishments for appropriateness.

NICE published a consultation on national guidance, based on an initial scoping exercise, in January 2015 and guidance was expected to be published in May 2015. NICE have recently been asked to suspend all current developments on staffing guidance and so the ED guidance will not be published. There is therefore no available validated method of robustly evaluating ED staffing against:

- A range of patient, environmental and staffing factors that may impact on safe nursing staff requirements at the department level.
- Attendance rates and patterns, including patient volumes and case mix, patient acuity and dependency, department type (such as whether it is a major trauma centre); department size and physical layout
- The division and balance of tasks between registered nurses and healthcare assistants; experience, skill mix and specialisms; proportion of temporary nursing staff; availability of care and services provided by other healthcare staff; management factors, such as management and administrative approaches and teaching and supervision arrangements.

In October 2014 review the departments were reviewed against the only available methodology, the RCN Baseline Emergency Staffing Tool (BEST) to evaluate the volume and pattern of nursing workload against current establishments. It does not produce recommended staffing levels but allows EDs to work to reduce disparity between workload and staffing through improving patient pathways, processes,

roster designs and actual staffing. The existing establishments are close to that determined by the BEST tool recommended level at WHH but data for QE was incomplete. BEST is a snapshot of one working week and so is unreliable to base a change in staffing requirements upon it. The tool excludes ENP, Nurse in Charge, Senior Matron and Matron level nursing and only reflects direct clinical nursing staff.

During the CQC 2014 inspection the need for increased senior nursing cover within the EDs seven days per week was outlined and establishments were further reviewed. Professional judgement on how many staff are required on each shift was applied and identified that the funded establishments did not fully provide for the following areas of priority:

- A supervisory nurse in charge 24 hrs per day
- The implementation of a band 6 majors coordinator and SECAmb triage role
- A ratio of 1 band 5 nurse per 4 patients in the trolley area. This allows for a trolley patient to be 'turned over' every 2 hrs.
- ENP cover from 07:30 – 02:00 seven days per week
- A paediatric area staffed with 1 RSCN 24/7 and 1 wte play assistant
- Matron cover seven days per week at both QEQMH and the WHH
- A second band 5 nurse in the resuscitation area on both sites
- A trauma nurse specialist at the QEQMH site

The calculated additional staff required was 77.79wte overall including an additional matron for each site, additional higher level support workers and some registered nurses. It should be noted that the use of a single method for evaluation of staffing levels should be avoided but was the only option in the absence of other methodologies. A business case was developed and additional investment was agreed, to be phased over 2015/16 and 2016/17 as part of the CQC action plan.

The investment of around £660K in 2015/16 was focused on an additional matron on each site and additional support workers, outlined below.

	WHH	QEQM
Band 8a	1.0	1.0
Band 5	5.8	
Band 4		6.0
Band 3		5.0
	6.8	**12.0**

The Emergency Care Programme Team (ECIP) recently recommended the introduction of a stand-alone model of emergency nurse practitioner (ENP). The current establishment of registered nurses are required to provide both ENP skills and management of the Majors area within the department. This has allowed for the optimisation of nurses across the floor when deficits have arisen, but does not allow for a pure minor injury management professional choice. Nationally the specialisation of ENPs who diagnose, treat and discharge autonomously are recognised at band 7. The loss of these highly experienced well trained nurses from EKHUFT to alternative health care providers is occurring due to this pay banding disparity. Additional investment is likely to be required to address this in order to reduce turnover and stabilise the ENP service.

Crowding within the departments occurs frequently, with capacity issues arising between 10:00 – 22:00 daily when patients require acute care beds but experience delays in bed availability. Current staffing allows for 1 nurse per 4 patients on trolleys

within the majors area, but no accommodation for patient who 'overflow' into the body of the department.

A systematic review is planned to:

- Benchmark current establishments in both EDs and the ECC against our peers;
- Evaluate acuity and dependency of patients and nursing workload using the most appropriate tools available;
- Evaluate the impact of 'see and treat', the 'Safer' initiative and the 'RAT' model on staffing requirements;
- Describe progress in implementing new ways of working to increase effectiveness and any associated cost implications e.g provision of paediatric nurse cover, ENP re-banding, physician's assistant, majors practitioners, higher level support workers and the associate practitioner role;
- Explore how the use of the existing resource can be optimised with evaluation of roster effectiveness and management of planned and unplanned leave;
- Measure the impact of previous investment including the additional matron cover;
- Describe the staffing establishment, skill mix required aligned to demand across the 24 hour period

12. CONCLUSIONS

The overall findings indicate that the aims of improving recruitment to vacancies and effective rostering are the priorities.

The Summary of the findings are:

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met.
2. The impact of the £2.9m investment into ward staffing in 2014/15 is fully realised and has increased WTE per bed across most areas.
3. The further investment of £387K agreed in May-15 following the Oct-14 staffing review for Cambridge J, Deal, Kings C1 and Cambridge L has been recruited to.
4. Average skill mix is similar to the previous review and close to 60/40 or more across most areas. The impact of associate practitioners is reflected in a slightly reduced skill mix over the last two years in most specialties where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies.
5. The vacancy rate across all wards is 9.2% and has increased from 8% over the last 6 months since Apr-15. Registered nurse vacancies in wards are 121 wte with the majority at band 5. Healthcare assistant vacancies have increased from 12 wte to 29 wte.
6. Although only 55% of newly qualified nurses took up their first post within EKHUFT in April and Sept-15 this is expected to improve to over 75% with 32 expected in Apr-16 and 50 in Sept-16.
7. The impact of overseas recruitment of EU nurses is not seen in this review due to the 33 starting in Oct-15 being employed as Healthcare Assistants whilst awaiting their UK NMC PIN no. The EU recruitment programme aims to recruit 160 EU nurses by the end of 2015/16.
8. Overall average sickness across all 47 wards has fallen from 5.1% in Apr-15 to 3.8% in Oct-15.
9. In Oct-15 there was a total of 52 wte (3.0%) staff on maternity leave across the 47 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.
10. Overall turnover in registered nurses and midwives has stabilised during 2015 at 12.6% following increases from 11.2% in 2013/14 to 12.8% in 2014/15. The turnover of healthcare assistants has fallen during 2015 to 12.8% from 14% during 2014/15.
11. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of requested shifts filled by NHSP was 35% and by agency 25.5% in Oct-15. This does not include off framework agency use. Divisional trajectories for agency reduction are being monitored aligned to the EU recruitment programme.
12. The improvement in roster quality seen in previous reviews has not been sustained with the average achievement of % time clinically effective (% time worked) across all wards reviewed, within E-Rostering for Oct-15 at 71.9%, compared to 74.5% in Apr-15. Only 17 of the 47 wards achieved more than the optimum 75%.
13. Details and summary of planned and actual staffing on a shift-by-shift basis, continues to be published monthly. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in October are over 94% on all three acute sites. The trend in performance over time reflects the national trend.

14. The average ratio of patients per registered nurse in Oct-15 across each of the wards reviewed was not above 8 during day shifts except on 2 wards. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 4 wards. 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 all wards.
15. Further work has been undertaken to enable live capture, reporting and escalation of staffing status through a dedicated safer staffing tool within Qlikview which has been implemented and enables the capture of daily planned, actual and required staffing linked to acuity and dependency. This system will be further developed and embedded during 2016.
16. Most wards (33 out of 47) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in Oct-15 and only 5 wards were <95%.
17. The review concludes that:

CDUs — Generally establishments are satisfactory although the model of care, geography of the unit and requirement to use staff flexibly to cover contingency beds at times of high demand is challenging at QEQM.

Medical wards — Generally establishments are satisfactory, enabling teams to provide high levels of harm free care and good FFT results. Cambridge J (CJ), Deal and St Augustines have seen an increase in acuity and dependency of patients. This is particularly notable on CJ due to the change in service model from a 34 bedded respiratory ward to respiratory (15 beds) and HCOOP (19 beds).

Stroke — Fordwich and Kingston ward establishments are close to the SEC network standards, but Richard Stevens is slightly below. A demand and capacity review is required to understand the required bed numbers on each site which will feed in to the clinical strategy workforce stream. Further exploration of recruitment, retention and turnover is required to support gaps in staffing on RSU.

Acute frailty — The beds on Cambridge L are now funded on a permanent basis to support the consistency of use.

CCUs — Establishments are satisfactory. Taylor ward due to small ward size appears over-staffed but reflects the higher cost of small wards. This issue will need to feed into the clinical strategy workforce stream.

Renal & Haematology — Establishments are generally satisfactory and the high vacancies on Marlowe ward are resolving.

Gynaecology — Establishments are satisfactory. The Hurst and SNCT modelling methods do not reflect outpatient and day attendances but the establishments are close to professional judgement.

Paediatrics — Current RCN guidelines suggest investment to support the ratio of 1:4 at night. The Royal College of Paediatricians reviewed our services in early 2015 and gave advice about the clinical strategy for child health. They considered current staffing levels appropriate but suggested the consideration of an additional staff member at night because of acuity even though bed occupancy is relatively low. Slightly higher required staffing levels may be required due to the relocation of outpatient clinics to dedicated Paediatric areas.

Surgery Establishments are generally satisfactory and some previous investment was made to properly establish the additional beds on both cheerful sparrows wards as they are frequently used and it is otherwise challenging to provide a consistent approach to making resources available. Further work is required to evaluate the impact of the increase in ward size.

T& O Establishments are generally satisfactory.

Neonatal Intensive Care

A comprehensive nurse staffing review, including scoping of other units, was undertaken for Neonatal Services in East Kent using national guidance for neonatal staffing levels.
The review indicated that investment may be required in the WHH NICU and the QEQM SCBU. Further work is underway to understand the level of investment that may be required alongside workforce planning solutions to support flexible safer staffing.

Critical Care Budgeted establishments are slightly below the Intensive Care Society standard in two units which does not consistently allow for a dedicated shift leader.

Midwifery The average Midwife to birth ratio in Oct-15 was 1:30. A full Maternity structural review will be reported in the next staffing review.

Emergency Departments

Professional judgement suggests that current staffing levels appear sub optimal but further work is required to benchmark current staffing against peers and evaluate the impact of changing models of care on nursing workload.

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

1. Optimise the use of existing resources;
   - Deliver against the trajectory for agency reduction aligned to the EU recruitment programme;
   - Further reduce the vacancy levels for registered nurses by continuing the implementation of a robust recruitment and retention plan to include recruitment ahead of turnover;
   - Continue to work with NHS-P to increase fill rate to the required level and explore the development of an internal staff bank;
   - 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. Evaluate the impact of the investment into ward staffing and identify if further investment is required;
   - Evaluate impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety;
   - Undertake further work to evaluate the impact of contingency bed use on the QEQM CDU;
   - Undertake further work to develop new and improved ways of working across NICU, HDU and SCBU and identify what level of investment may be required alongside a robust plan for agency reduction;

- Consider the full structural review of the maternity services against the remodelled Birthrate Plus tool when completed in spring 2016;
- Undertake a systematic review of the Emergency Departments.

3. Improve clinical leadership and supervision of quality of care;
   - Fully implement the supervisory element of the ward manager role and evaluate the benefits through the ward heatmap and dashboards;
   - Implement the plan for all ward managers to undertake the clinical leadership programme over the next three years.

4. Improve alignment of staffing required to demand;
   - Further develop and embed live capture, reporting and escalation of staffing status through the dedicated safer staffing tool within Qlikview which enables the capture of daily planned, actual and required staffing linked to acuity and dependency.

5. 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

The ward staffing review will be repeated every six months

Appendix 1. Current funded establishments for all wards Oct-15, proportion of staff in post, adjusted establishment incorporating bank line

Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	RN Est (WTE)	RN in post (WTE)	Support worker Est (WTE)	Support worker in post (WTE)	Admin (WTE)	Admin in post (WTE)	Proportion staff in post (%)	Separate bank line (£000s)	RN Adjusted Bank (WTE)	SW Adjusted Bank (WTE)	Total Adjusted (WTE)	Full Establishment (WTE)
Cambridge J	34	0	44.04	24.64	16.65	17.9	16.08	1.50	1.53	77.8%	18.8	0.60	0.00	0.60	44.64
Cambridge K	27	0	34.13	19.96	17.8	12.67	12.01	1.5	1.5	91.7%	17.5	0.56	0.00	0.56	34.69
Cambridge M2	20	0	26.61	15.18	15.75	9.93	9.88	1.5	1.5	102.0%	14.7	0.47	0.00	0.47	27.08
Taylor KCH	5	2	14.07	12.9	12.91	0	0	1.2	0.7	96.5%	0.0	0.00	0.00	0.00	14.07
CCU QEQM	12	0	23.34	14.85	11.87	7.46	6.31	1.0	1.0	82.3%	4.8	0.15	0.00	0.15	23.49
CCU WHH	11	0	31.87	25.37	24.64	5	5	1.5	1.5	97.7%	4.0	0.13	0.00	0.13	32.00
Minster Ward	23	0	31.57	15.2	12.99	14.87	15.4	1.5	1.5	94.7%	12.3	0.40	0.00	0.40	31.97
Oxford	14	0	23.61	14.36	13.69	7.75	8.41	1.5	1.1	98.1%	9.3	0.30	0.00	0.30	23.91
Sandwich Bay	21	0	27.61	16.27	16.67	9.54	11.81	1.8	1.8	109.7%	9.6	0.31	0.00	0.31	27.92
St Margarets	22	3	26.54	16.08	12.8	9.46	7.62	1.0	1.0	80.7%	14.7	0.47	0.00	0.47	27.01
Deal	28	0	34.03	18.61	16.8	13.72	15.53	1.7	1.6	99.7%	11.8	0.38	0.00	0.38	34.41
Harvey ward	19	0	27.50	13.8	13.8	12.2	9.35	1.5	1.5	89.6%	0.0	0.00	0.00	0.00	27.50
Invicta	24	0	29.56	17.35	16.62	10.5	10.46	1.7	1.7	97.4%	11.2	0.36	0.00	0.36	29.92
Cambridge L	26	0	37.30	20.11	16.22	15.69	17.94	1.5	1.5	95.6%	18.0	0.58	0.00	0.58	37.88
Treble ward	18	0	29.08	15.44	12.48	12.23	11.45	1.41	0.91	85.4%	10.3	0.33	0.00	0.33	29.41
Mount McMaster	24	2	29.47	15	12.96	12.57	11.88	1.9	1.9	90.7%	16.2	0.52	0.00	0.52	29.99
Fordwich Ward	19	4	37.02	19.82	18.92	15.7	13.57	1.5	0.49	89.1%	21.9	0.70	0.00	0.70	37.72
Kingston	22	5	39.95	23.78	20.03	14.87	12.93	1.3	1.27	85.7%	15.1	0.48	0.00	0.48	40.43
Richard Stevens Unit	24	0	40.19	20.87	16.55	17.82	16.28	1.5	1.14	84.5%	13.8	0.44	0.00	0.44	40.63
Harbledown	24	2	34.67	18.59	13.24	14.26	13.48	1.82	1.82	82.3%	12.8	0.41	0.00	0.41	35.08
St Augustines	27	0	33.06	18.56	6.8	13	9.6	1.5	0	49.6%	11.8	0.38	0.00	0.38	33.44
Cambridge M1	0	18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	na	0.00	0.00	0.00	0.00	0.00
CDU, QEQM	24	0	44.29	29.38	22.4	12.17	11.96	2.74	2.74	83.8%	21.9	0.70	0.00	0.70	44.99
CDU WHH	41	0	70.94	45.15	45.52	22.2	22.2	3.59	3.51	100.4%	34.7	1.11	0.00	1.11	72.05
ECC (incl. CDU)	18	0	84.96	56.89	50.8	17.33	17.37	10.74	7.65	89.2%	0.0	0.00	0.00	0.00	84.96
	NA	0									0.0	0.00	0.00	0.00	
Rotary	16	0	35.06	16.7	16.48	12.71	10.11	5.65	5.65	92.0%	8.7	0.28	0.00	0.28	35.34
Cheerful Sp Female	22	6	33.08	16.93	13.56	14.15	11.53	2	1.8	81.3%	0.5	0.00	0.03	0.03	33.11
Clarke	36+6	2	42.95	26.55	21.19	13.9	13.61	2.5	2.5	86.8%	28.1	0.00	1.46	1.46	44.41
Cheerful Sp Male	20	6	30.32	14.76	12.61	13.56	13.33	2	2	92.2%	0.0	0.00	0.00	0.00	30.32
Kent	20+6	5	32.03	19.8	21.34	9.73	10.72	2.5	2.5	107.9%	24.1	0.00	1.25	1.25	33.28
Kings B	27	0	33.77	18.41	16.16	12.83	10.19	2.53	2.53	85.5%	26.5	0.00	1.38	1.38	35.15
Kings A2	20	0	24.78	13.93	12.59	9.85	9.82	1	1	94.5%	9.3	0.00	0.48	0.48	25.26
Kings C1	27	0	34.86	17.57	14.57	14.78	13.11	2.51	2	85.1%	27.9	0.00	1.45	1.45	36.31
Kings C2	24	0	33.51	17.41	14.93	14.6	13.94	1.5	1.5	90.6%	28.0	0.00	1.46	1.46	34.97
Kings D male(1)	43	0	60.44	32.22	25.56	24.14	23.55	4.08	3.08	86.4%	37.8	0.00	1.96	2.96	60.44
Kings D female (2)												0			
Quex	19	0	24.47	15.71	15.8	6.73	3.96	2.03	1.91	88.6%	16.9	0.00	0.88	0.88	25.35
Bishopstone	22	0	32.77	16.34	14.33	14.71	14.2	1.72	1.72	92.3%	28.6	0.00	1.49	1.49	34.26
Seabathing	26	0	33.76	18.09	19.06	14.17	13.24	1.5	1.47	100.0%	28.4	0.00	1.48	1.48	35.24
ITU WHH	11	0	63.83	57.47	48.97	4.69	5	1.67	1.59	87.0%	0.0	0.00	0.00	0.00	63.83
ITU QE	8	0	47.06	42.94	43.1	3.12	2.8	1	1	99.7%	0.0	0.00	0.00	0.00	47.06
ITU KCH	4 + 4	0	39.16	37.06	37.28	1	1	1.1	1.1	100.6%	0.0	0.00	0.00	0.00	39.16
Marlowe	29 +6	4	55.41	36.25	29.3	16.56	15.27	2.6	2	84.0%	0.0	0.00	0.00	0.00	55.41
Neonatal ITU	7	0	64.05	59.44	56.31	3.61	2.6	1	1	93.5%	0.0	0.00	0.00	0.00	64.05
Padua	28	0	45.60	35.8	33.02	8	8.52	1.8	1.8	95.0%	0.0	0.00	0.00	0.00	45.60
Rainbow	20	0	38.27	29.97	28.12	7.3	8.68	1	1	98.8%	0.0	0.00	0.00	0.00	38.27
Birchington	15	4	28.97	17.89	19.25	8.58	8.58	2.5	2.5	104.7%	0.0	0.00	0.00	0.00	28.97
Kennington ward	11+2	0	22.18	11.98	11.36	7.7	5.8	2.5	3.29	92.2%	0.0	0.00	0.00	0.00	22.18
Brabourne	8	0	16.47	13.17	10.17	2.7	2.69	0.6	0.4	80.5%	0.0	0.00	0.00	0.00	16.47
		63	1728.21	1094.55	973.97	537.96	508.77	95.70	86.17	90.8%				24.39	

Appendix 2. Qlikview Safer Staffing tool