REPORT TO:	**STRATEGIC WORKFORCE COMMITTEE**
DATE:	**22nd JULY 2016**
SUBJECT:	**WARD ESTABLISHMENT REVIEW MAY 2016**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**ASSOCIATE CHIEF NURSE**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

Regular six monthly 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.

This report outlines the May 2016 review of Adult wards, Paediatric wards and Critical Care Units and includes NICU 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 previous investment into ward staffing has increased WTE per bed across most areas.
3. 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.
4. The vacancy rate across all wards is 9.0% and has fallen slightly from 9.2% since Oct-15. Registered nurse vacancies in wards have reduced from 121 wte to 91 wte since Oct-15 with the majority at band 5. Healthcare assistant vacancies remain at a similar level of 33 wte.
5. Although only 55% of newly qualified nurses took up their first post within EKHUFT in April and Sept-15 this has improved to 78% in Apr-16.
6. Most of the impact of overseas recruitment of EU nurses is seen in this review due to the 114 recruited during 2015/16, although a small number are still being employed as Healthcare Assistants whilst awaiting their UK NMC PIN no. In 2016/17 to date five overseas recruitment trips have been undertaken to Romania, Croatia and India and 164 offers have been made with the first 22 arriving week ending 15th July-16.
7. Overall average sickness across all 47 wards is at 4.47% and has fallen from 5.1% in Apr-15.
8. In May-16 there was a total of 35 wte (2.0%) staff on maternity leave across the 47 wards, compared to 52 wte (3%) in Oct-15. 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.
9. Overall turnover of registered nurses and midwives has fallen from 12.8% during 2014/15 to 8.9% in 2015/16. The turnover of healthcare assistants has also fallen from 14% during 2014/15 to 12.8% during 2015/16 indicating a more stable workforce.
10. The use of temporary staff through NHS-Professionals and agency has

stabilised, 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 40.9% and by agency 31.5% in May-16. This include off framework agency use. Divisional trajectories for agency reduction are being monitored aligned to the EU recruitment programme.

11. Roster quality has markedly improved with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-16 at 78% from just 72% In Oct-15. Almost all (41 out of 47) wards achieved more than the optimum 75%.
12. 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 May-16 are near or over 100% on all three acute sites. The trend in performance over time reflects the national trend.
13. The average ratio of patients per registered nurse in May-16 across each of the wards reviewed was not above 8 during day shifts except on St Augustines ward where there were 7 wte registered nurse vacancies in May-16. However, 100% planned shifts were filled and skill mix adjusted to an appropriate level to meet patients needs with NHSP cover. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 6 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.
14. 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.
15. Most wards (34 out of 47) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in May-16 and only 5 wards were <95%.
16. Most ward managers reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.
17. The increase in both professional judgement and acuity dependency on some wards may be linked to the emerging data within the dementia dashboard, which highlights an increase in patients with dementia at WHH (76% increase year-on-year, approx. 1000 extra patients), and to a lesser degree at QEQM and K&C.
18. 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, Sandwich Bay, St Margarets and Mount McMaster have seen an increase in acuity and dependency of patients matched by professional judgement that higher levels of staffing may be required. 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 underway 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. Although acuity and dependency has risen on both wards professional judgement suggests satisfactory current staffing levels.
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. Capture of acuity and dependency through the live safer staffing tool within Qlikview is progressing.
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. Kings C1 has seen an increase in acuity and dependency of patients matched by professional judgement that higher levels of staffing may be required.
Neonatal Intensive Care	A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment is required in the WHH NICU and the QEQM SCBU. A business case for phased investment has been agreed 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 May-16 was 1:28. A full Birthrate Plus assessment was reported in May-16 which indicated that current staffing levels meet or exceed recommended levels for clinical midwives and support staff. However, the outcome of the review

suggests additional staff are required to provide a sustainable resource for specialist midwifery support roles e.g Safeguarding, bereavement, obesity, ante-natal, per-natal care which are currently undertaken by clinical staff. Priorities are focused currently on up-skilling band 2 and 3 support workers to enable release of midwives to provide greater clinical contact time with women. Engagement and discussion with midwifery staff is underway to seek suggestions and views on adjusting current working patterns and shift times to provide improved cover with the existing resource.

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;
   - Continue to 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. 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;

3. Improve clinical leadership and supervision of quality of care;
   - Monitor 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 two 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;
   - Incorporate optimum ward size and modelling of skill mix matched to patient pathway within the workforce modelling work programme against the options within the clinical strategy.

A gap analysis will be undertaken against the recently published National Quality Board (NQB) publication “Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing” to identify key areas of work required whilst further guidance is awaited , to be released later in 2016/17, to identify key areas of work required.

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IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Continued vacancy factor and reliance on temporary staffing has led to innovative recruitment approaches to enable recruitment ahead of turnover.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR8 Ability to attract, recruit and retain high calibre staff to the Trust.
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.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Divisional Heads of Nursing meeting

PRIVACY IMPACT ASSESSMENT: *NO**	**EQUALITY IMPACT ASSESSMENT:** *NO*

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

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1. INTRODUCTION

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

This report outlines the May 2016 review and has included all wards across the Trust including:

UC&LTC	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 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.

Following the Carter review, Care Hours Per Patient Day (CHPPD) are also required to be reported from May-16, to relate actual staffing to patient numbers. This enables the calculation of Cost per Care Hour (CPCH) and the reporting of the cost of care delivered by Registered Nurses, Midwives, and care workers on inpatient wards. Costs recorded for each staff group include pay costs, including the costs of unproductive time (e.g.training, annual leave, sickness, maternity leave and paternity leave). Care hours per patient day are now included in the monthly safer staffing reporting and include, by ward, registered nurse and care staff hours against the cumulative total of patients during the month. The range is from around 5 hours of care per patient on medical wards to 33 within critical care areas where one to one care is required. National comparative data is expected to be available from July-16.

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

This month, July 2016, the National Quality Board (NQB) published "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing". This safe staffing improvement resource provides an updated set of expectations for nursing and midwifery care staffing, to help NHS provider boards make local decisions that will support the delivery of high quality care for patients within the available staffing resource. This resource:

- sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service, including introducing the care hours per patient day (CHPPD) metric;
- identifies three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions; and

- offers guidance for local providers on using other measures of quality, alongside CHPPD, to understand how staff capacity may affect the quality of care.

This safe staffing improvement resource replaces the 2013 NQB guidance "How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability". Further improvement resources will be released later in 2016/17 to support implementation. In the meantime a gap analysis will be undertaken to identify key areas of work required.

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

The impact of significant investments in 2014/15 and 2015/16, outlined in figure 1, are seen in this staffing review.

Figure 1. Investment into ward staffing 2014 to 2016

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.

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 May-16.

The structure of most (73%) ward budgets (36 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 30 WTE across the 36 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 22% which includes a 3% allowance for sickness, 30 days annual leave plus bank holidays and study leave of around 4 days per year.

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

Skill mix is similar to the previous review. The impact of associate practitioners is reflected in a slightly reduced skill mix in stroke, orthopaedic and some medical wards, over time, 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**	**May-16**
Medical	59/41	59/41	59/41	59/41	**58/42** ↓
CDU	69/31	67/33	70/30	69/31	**66/34** ↓
CCU	82/18	82/18	83/17	83/17	**83/17** ↔
Stroke	63/37	59/41	57/43	58/42	**58/42** ↔
Acute frailty	57/43	57/43	58/42	56/44	**57/43** ↑
Surgery	60/40	59/41	59/41	59/41	**60/40** ↑
T+O	58/42	57/43	57/43	57/43	**57/43** ↔
Gynaecology	65/35	65/35	65/35	63/37	**67/33** ↑
Paediatrics	80/20	77/23	77/23	80/20	**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 surgery reflects the modest additional investment (6.0 wte equating to 1.0 wte per bed) to allow substantive recruitment to the additional beds on Cheerful Sparrows Male and Female wards to improve patient safety and experience.

Figure 4. Average ward staffing WTE per bed from 2007 to 2016

Average WTE per bed										
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**	**May-16**	**Hurst**
Medical	1.14	1.19	1.28	1.33	1.29	1.29	1.34	1.36	**1.36** ↔	1.38
CDU	NR	NR	NR	2.18	1.54	1.92	1.61	1.81	**1.87** ↑	1.71
CCU	2.2	2.2	2.42	2.76	2.62	2.68	2.69	2.56	**2.54** ↔	2.21
Stroke	1.19	1.52	1.57	1.75	1.79	1.84	1.85	1.84	**1.84** ↔	1.9
Acute frailt	1.1	1.18	1.29	1.47	1.33	1.34	1.51	1.38	**1.46** ↑	1.43
Surgery	1.09	1.28	1.46	1.38	1.45	1.5	1.57	1.53	**1.50** ↔	1.43
T+O	1.12	1.17	1.21	1.32	1.36	1.37	1.40	1.41	**1.41** ↔	1.42
Renal				1.5	1.81	1.81	1.83	1.91	**1.90** ↔	1.71
Haematology				1.38	2.09	2.09	2.08	2.06	**2.03** ↔	1.82
Gynaecology				1.96	1.93	1.93	2.02	1.97	**2.09** ↑	1.53

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 49 wards is 15.5%, a reduction from 16% in Oct-15 and 17.2% in Apr-15 but an increase from 13.2% in Oct-14, also summarised in Figure 5. The absence associated with maternity leave is significant, at 35 wte (2.01%). 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 May-16

Workforce indicators						
	Dec-12	Mar-14	Oct-14	Apr-15	Oct-15	May-16
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02	1680.86	1728.21	1746.45
Registered Nursing vacancies (WTE)	44.00	73.88	37.66	124.71	120.58	91.43
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44	12.55	38.72	32.90
Vacancy (%)	4.75	5.21	6.08	8.16	9.20	9.00
Sickness (%)	4.96	4.90	4.60	5.15	3.80	4.47
Maternity leave (%)	3.28	2.38	2.53	3.89	3.00	2.01
* 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 9.0%, slightly reduced from the previous review (9.2%). Registered nurse vacancies in wards are 91 wte, reduced from 121 wte in the previous review, with the majority at band 5. Healthcare assistant vacancies have remained at 33 wte, similar to the previous review (29 wte).

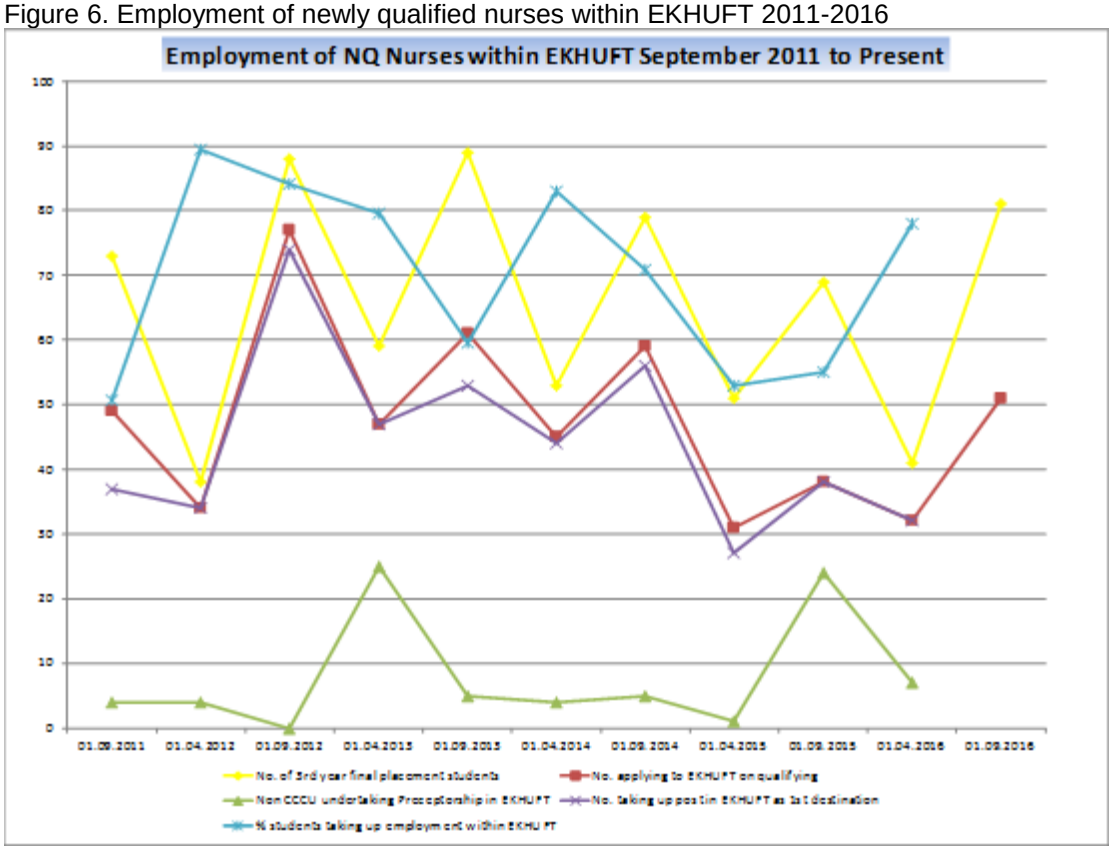
Several issues have contributed to the rise in vacancies:

- 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. Although a 10% increase in training places was agreed for 2015/16, a further increase for the 2016/17 academic year entry was not supported, following the 2015 Comprehensive Spending Review.
- There has been a fall in % newly qualified nurses who take up their first post within EKHUFT since 2013 although this has started to improve with 78% of

the Canterbury Christ Church University (CCCU) newly qualified cohort taking up a band 5 post within EKHUFT In Apr-16, shown in Figure 6.

A small number of newly qualified nurses also joined from other universities and return to practice nurses are actively supported into posts. However, these numbers will not keep pace with demand and additional options will need to be explored to ensure a sustainable supply of nurses over the next decade as the clinical strategy is implemented and the demand for registered nurses across the health economy potentially rises.

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.

The following actions are progressing:

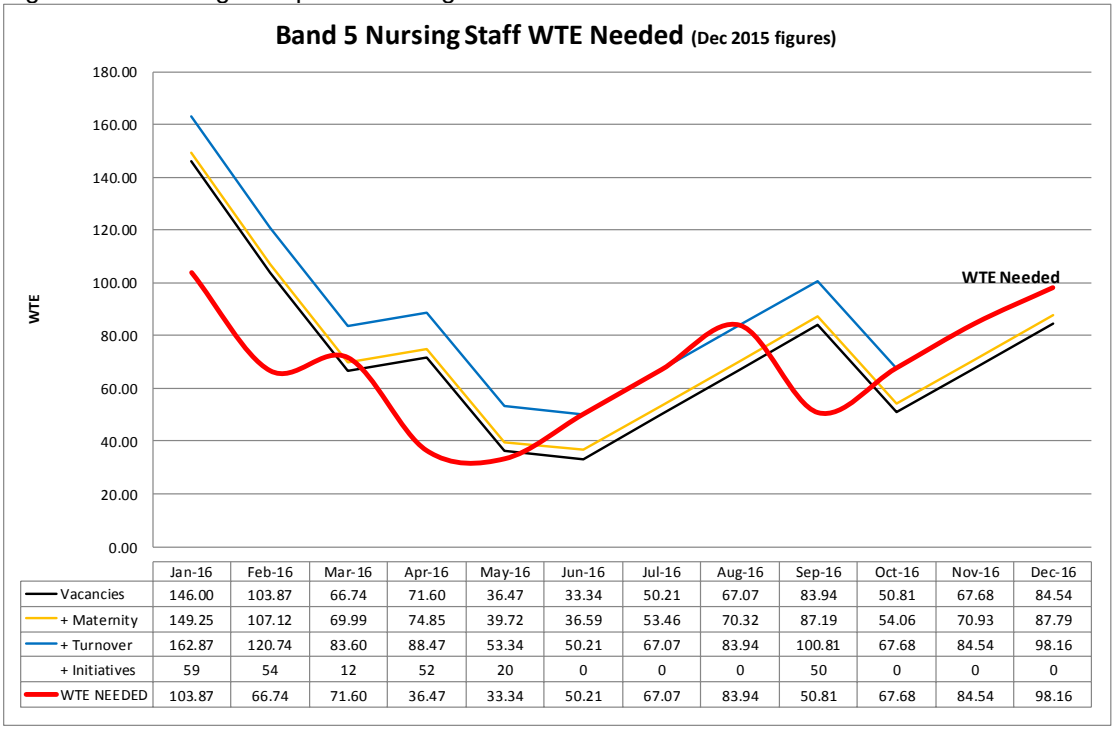
1. Weekly vacancy data is now provided by the Information team, by professional group, pay band and ward/department;
2. The Head of Strategic Resourcing, appointed to lead the implementation of an action plan to reduce nurse vacancies, is leading the Trust campaign for nursing recruitment which launched 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 has included an international recruitment programme;
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. However, following the Carter review the requested further 10% commissioned places for Sept-17 was not supported;
5. The aim to recruit all newly qualified nurses who want to work within EKHUFT;
6. The aim to recruit 160 nurses from the EU. The recruitment of 114 nurses was achieved in 2015/16. These nurses joined us in 4 main cohorts; 33 commenced on 19th Oct-15, 38 on 16th Nov-15, 12 on 14th Dec-15 and a further 31 joined 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 in Nov-15 and a further 7 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 was modelled in late 2015, seen in figure 7. The figures were 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% were factored in as well as the planned recruitment initiatives for overseas nurses and our own newly qualified nurses who were expected to join us in 2016. The planned initiatives were expected to add 220 wte Band 5 nursing staff during 2015/16. Taking planned initiatives and maternity/turnover together, the calculated the current vacancy wte of 146 nurses (across all specialties including outside ward areas) were predicted to only reduce to around 98 wte by Dec-16. However, due to only 114 of the planned 160 EU nurses (a

deficit of 46) being successfully recruited the vacancy factor has not fallen as quickly as anticipated.

Therefore, in order to be fully established within Band 5 nursing and to keep pace with turnover and maternity cover, recruitment of approximately 165 wte nurses during 2016 over and above the current expected intake of overseas nurses and newly qualified recruitment is progressing. Five overseas recruitment trips have been undertaken to Romania, Croatia and India and 164 offers have been made with the first 22 arriving week ending 15th July-16.

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 has risen from 3.8% in Oct-15 to 4.47% in May-16. The average monthly sickness rates show wide variation but higher average rates in excess of 5% were seen in some stroke, medical, CCU and orthopaedic 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 May-16 there was a total of 35 wte (2%) 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 reduced during 2015/16 to 8.9%. The turnover of healthcare assistants, previously stable at 10.6% in 2013/14 rose to 14% during 2014/15 but has fallen during 2015/16 to 12.8%.

Figure 8. Average turnover of nursing, midwifery and care staff 2011 to 16

Turnover (%)					
	2011	2012	2013/14	2014/15	2015/16
Nursing & Midwifery	7.5	9.5	11.2	12.8	8.9
HCA and other support staff	12.6	10.6	10.6	14.2	12.8

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 has stabilised, 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 40.9% and by agency 31.5% in May-16.

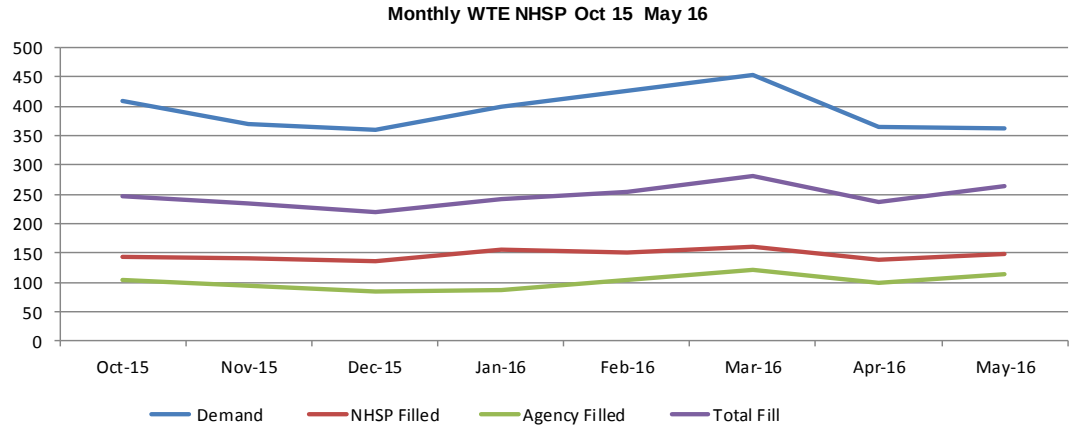
The use of temporary staffing, including NHS-P bank and framework agency, is variable and overall fill rate of requested shifts has increased 60% in Oct-15 to 72.3% in May-16. This partially closes the gap presented by vacancies and planned / unplanned absences but does operationally present a challenge 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 74% for registered nurse shifts and 80% for healthcare assistant shifts, are being addressed with the supplier through the appropriate contract management processes.

Even with rigorous management controls through the temporary staff booking process the use of NHS-P and agency 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 Oct-15 to May-16



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 Mar – May-16

Reason	March	March WTE	April	April WTE	Variance	May	May WTE	Variance
Vacancy	48,857	301	37,270	229	-71	35,490	218	-11
Extra beds/Initiative	6,743	41	5,958	37	-5	8,459	52	15
Sickness	9,913	61	7,011	43	-18	7,482	46	3
Specialing	6,573	40	7,481	46	6	6,944	43	-3
Parenting leave	948	6	999	6	0	166	1	-5
Unplanned leave	412	3	643	4	1	431	3	-1

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. This has resulted in a 14% reduction of cancelled shifts since Mar-16;
- 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 7 in Mar-16 to provide a dedicated resource ahead of the increased demand anticipated over winter. Further overseas recruitment is planned in Feb-17 in India or the Philippines;

- 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. 27 out of the total of 80 recruited to NHSP are still working shifts with EKHUFT;
- Winter incentives for NHS-P bank workers working additional shifts with no cancellations, to win shopping vouchers.

8. ROSTER PERFORMANCE, ACTUAL AGAINST PLANNED FILLED HOURS AND CARE HOURS PER PATIENT DAY (CHPPD)

Roster quality has markedly improved with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-16 at 78% from just 72% In Oct-15. Almost all (41 out of 47) wards achieved more than the optimum 75%.

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 May-16 are near or over 100% 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 in March and August, shown in figure 12, reflect periods of higher annual leave and requirement for additional shifts during winter pressures not always being filled by NHSP. 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.

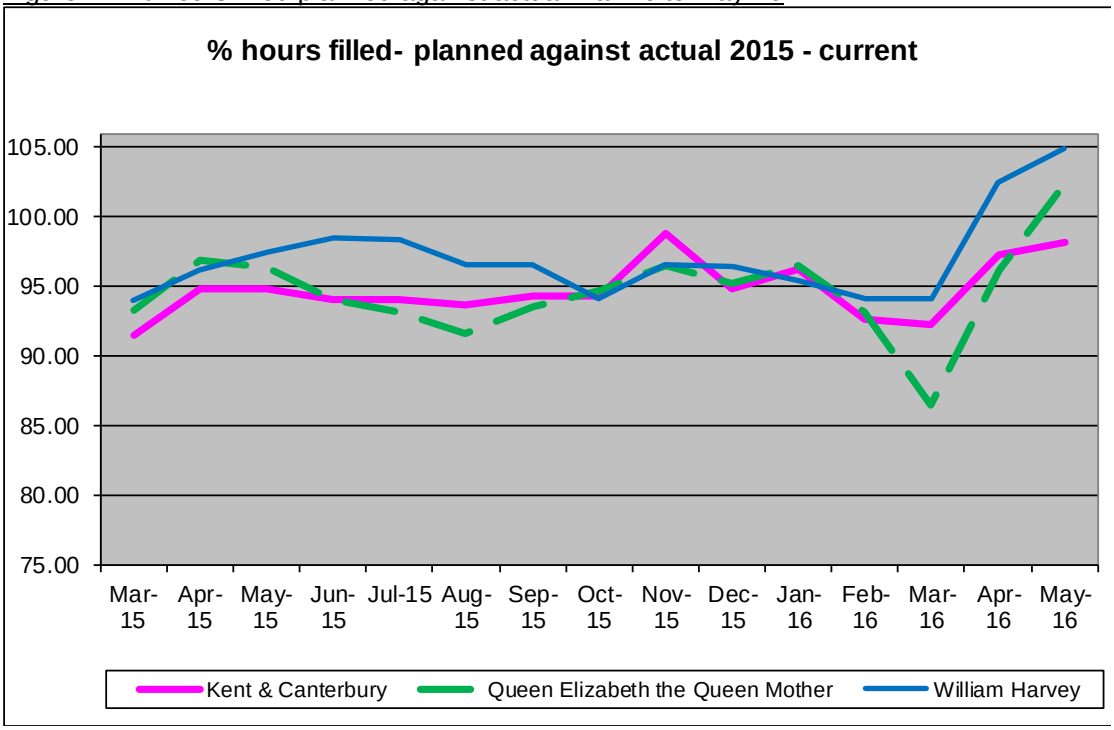
Following the Carter review, Care Hours Per Patient Day (CHPPD) are also required to be reported from May-16, to relate actual staffing to patient numbers, also shown in figure 11. This enables the calculation of Cost per Care Hour (CPCH) and the reporting of the cost of care delivered by Registered Nurses, Midwives, and care workers on inpatient wards. Costs recorded for each staff group include pay costs, including the costs of unproductive time (e.g.training, annual leave, sickness, maternity leave and paternity leave).

Care hours per patient day, by site, are included, and include registered nurse and care staff hours against the cumulative total of patients during the month. The range is from around 5 hours of care per patient on medical wards to 33 within critical care areas where one to one care is required. National comparative data is expected to be available from July-16.

Figure 11. % hours filled planned against actual by site during May-16

	% Hours filled - planned against actual May 2016					Care Hours Per Patient Day (CHPPD) May-16			
	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	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Kent & Canterbury	98.5%	89.8%	98.2%	116.2%	98.1%	6177	5.1	2.6	7.7
Queen Elizabeth the Queen Mother	100.6%	97.4%	107.3%	110.1%	102.4%	8233	5.6	3.1	8.7
William Harvey	104.4%	107.1%	101.6%	109.8%	104.9%	11263	5.5	2.8	8.3

Figure 12. % hours filled planned against actual Mar-16 to May-16



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 showed a gradually worsening position for nurse staffing during 2015..

Senior nursing leaders have reported that:

- It is not possible to determine 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.

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 Shelford 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. Most ward managers reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.

Professional judgement indicated higher required staffing levels than current across 13 of the 47 wards.

- Surgical wards Rotary, Clarke, Cheerful Sparrows Male, Kings B and Kings A2. However the Shelford tool indicates lower required establishments, based on patient acuity and dependency, than professional judgement suggests;
- Orthopaedic ward Kings C1 where Shelford also indicates slightly higher required staffing requirements;
- Medical wards Cambridge J, Sandwich Bay, St Margarets, MountMcMaster where Shelford also indicates slightly higher required staffing requirements;

- Medical wards CDU QEQM and Invicta although Shelford indicates lower required establishments, based on patient acuity and dependency, than professional judgement suggests;
- Richard Stevens stroke unit where the SEC Network Stroke Model also indicates slightly higher staffing requirements.

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.

The increase in both professional judgement and acuity dependency on some wards may be linked to the emerging data within the dementia dashboard, which highlights the absolute and relative increase in patients with dementia at WHH (76% increase year-on-year, approx. 1000 extra patients), and to a lesser degree at QEQM and K&C.

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. 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 enables 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, nine 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 – Changed in Aug-15 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 and the combination of frail elderly patients within an acute environment creates a higher nursing workload the ensure patient safety;
- Sandwich Bay – 21 beds respiratory ward with high numbers of patients requiring non-invasive respiratory support;
- Mount McMaster – 24 beds mostly highly dependent patients, dedicated End of Life ward and many patients with complex wound management. The SNCT captures the nursing workload associated with additional capacity beds;
- St Margarets – 22 beds mostly very highly dependent patients who require nursing care to meet all or most of their needs. The SNCT captures the nursing workload associated with additional capacity beds;
- 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.
- Harbeldown – 24 beds mostly very highly dependent patients who require nursing care to meet all or most of their needs. The SNCT captures the nursing workload associated with additional capacity beds;
- Cambridge L – 26 beds mostly very highly dependent patients who require nursing care to meet all or most of their needs.
- Kings C1 – 27 beds for frail elderly who have sustained major fractures. Mostly very highly dependent patients. The ward had dedicated therapy support.

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 to 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 some 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 May-16 than in Oct-15 for some wards not reflecting the expected 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	Shelford	Comments
CDUs	CDU WHH	72.53	71.39	72.3	58.14	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. No significant change since Oct-15 review
	CDU, QEQM	47.17	56.94	44.3	42.73	
	ECC (incl. CDU)	86.16	48.04	27		
Medical	Cambridge J	44.64	52.0	50.6	72.64 ↑	Alignment for most wards but establishments below that suggested by the SNCT on CJ, Deal, St Margarets and MountMcMaster 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 although acuity dependency suggests higher staffing requirement than current.
	Cambridge K	34.69	32.9	37.0	32.39	
	Cambridge M2	27.08	31.6	29.2	29.66	
	Minster Ward	31.77	33.2	32.6	34.41	
	Oxford	23.91	25.5	20.7	23.34	
	Sandwich Bay	27.62	35.8	30.3	33.73	
	St Margarets	26.72	34.2	31.5	42.67 ↑	
	Deal	35.41	36.8	38.1	43.13 ↑	
	Harvey ward	27.50	30.8	24.6	27.37	
	Invicta	29.92	34.5	33.7	30.75	
	Treble ward	29.41	30.2	24.2	18.91	
	Mount McMaster	29.99	34.7	33.7	39.80 ↑	
	St Augustines	34.03	34.1	37.0	40.81	
	Cambridge M1	24.60*	24.6	27.0	25.29	
Stroke	Fordwich Ward	37.72	35.7	38.0*	37.43	Alignment for Kingston and Fordwich (*SEC Network Stroke Model) but less so for RSU. Shelford does not capture stroke thrombolysis nursing work outside the ward
	Kingston	40.43	36.3	42.1*	31.76	
	Richard Stevens Unit	40.63	44.2	44.8*	41.55	
Frailty	Harbledown	35.08	34.2	32.1	54.45 ↑	Some alignment across both wards. An increase in acuity and dependency is seen on CL but PJ does not indicate the requirement for more staff
	Cambridge L	38.22	41.2	34.1	43.10	
Coronary Care	Taylor KCH	14.07	16.8	10.8	7.78	Alignment with PJ and Hurst but Shelford does not capture intensity of pPCI nursing work.
	CCU QEQM	22.90	23.0	25.8	18.29	
	CCU WHH	32.00	30.2	32.7	17.33	
Renal & Haematology	Marlowe	55.12	61.8	54.7	27.67	Alignment on both wards with PJ and Hurst but less so with Shelford
	Brabourne	16.26	14.6	15.1	5.11	
Gynaecology	Birchington	32.71	33.2	23.9	17.10	Alignment on both wards with PJ and Hurst but less so with Shelford due to not capturing outpatient and day attender
	Kennington ward	23.91	21.4	19.7	9.56	
Paediatrics	Padua	48.19	41.3	50.3*		*RCN suggest higher establishments to cover day surgery & relocated outpatients
	Rainbow	39.23	37.5	47.3*		
Surgery	Rotary	35.34	37.9	19.9	16.44	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity
	Cheerful Sp Female	39.51	40.9	32.1	30.15	
	Clarke	44.33	47.1	47.7	37.26	
	Cheerful Sp Male	36.72	40.9	29.6	31.04	
	Kent	33.28	34.0	32.6	20.20	
	Kings B	35.15	39.4	33.7	36.67	
	Kings A2	25.26	32.1	24.9	22.65	
Trauma & Orthopaedic	Kings C1	36.30	41.3	35.2	42.92 ↑	Alignment with PJ and Hurst but less so with Shelford on KC2 & Quex due to it not capturing high throughput on these wards. Acuity and dependency has increased on KC1 where PJ and Shelford both suggest a higher required establishment
	Kings C2	34.97	31.5	31.3	24.09	
	Kings D male(1)	62.28	64.3	59.7	57.08	
	Kings D female (2)					
	Quex	25.35	26.1	19.2	19.49	
	Bishopstone	33.99	37.6	34.9	34.50	
	Seabathing	35.73	37.9	36.8	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 May-16 across each of the wards reviewed was not above 8 during day shifts except on St Augustines ward, where there were 7 wte registered nurse vacancies in May-16. However, 100% planned shifts were filled and skill mix adjusted to an appropriate level to meet patients needs with NHSP cover, seen in figure 14. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 6 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 May-16 – E-Rostering system

Ward	Beds Funded	Ratio of patients per RN May-16 Days	Ratio of patients per RN May-16 Nights
Cambridge J	34	6.87	11.83
Cambridge K	27	5.16	11.06
Cambridge M2	20	5.18	10.10
Taylor KCH	5	2.01	2.61
CCU QEQM	12	4.14	7.02
CCU WHH	11	2.13	2.90
Minster Ward	23	6.21	12.51
Oxford	14	4.55	7.25
Sandwich Bay	21	5.61	8.15
St Margarets	22	6.11	11.68
Deal	28	6.18	16.79
Harvey ward	19	6.22	9.91
Invicta	24	5.84	13.14
Cambridge L	26	4.74	11.51
Treble ward	18	4.45	9.39
Mount McMaster	24	6.92	12.15
Fordwich Ward	19	3.66	6.91
Kingston	22	4.55	7.63
Richard Stevens Unit	24	4.45	10.78
Harbledown	24	5.36	12.00
St Augustines	27	9.75	15.34
CDU, QEQM	25	3.46	4.59
CDU WHH	43	4.11	5.91
ECC	18	na	na
	NA	na	na
A+E WHH	NA	na	na
A+E QEQM	NA	na	na
Rotary	16	3.87	9.31
Cheerful Sp Female	20	5.69	7.06
Clarke	36	6.61	22.68
Cheerful Sp Male	18	4.06	6.25
Kent	20	4.12	10.42
Kings B	27	6.71	13.32
Kings A2	20	6.97	10.97
Kings C1	27	7.13	14.09
Kings C2	24	7.68	12.93
Kings D male(1)	43	5.86	10.27
Kings D female (2)			
Quex	19	4.80	11.93
Bishopstone	22	5.17	10.06
Seabathing	26		
ITU WHH	11	0.90	1.13
ITU QE	9	1.21	1.61
ITU KCH	8	1.12	1.36
Marlowe	29	3.66	7.86
Neonatal ITU	7	na	na
Padua	28	na	na
Rainbow	20	na	na
Birchington	15	3.52	8.13
Kennington ward	11	3.69	6.76
Brabourne	8	2.66	3.83

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 22:1 on Clarke ward reflects the exclusion of the band 6 nurse supporting out of hours across the surgical floor but who is based on Clarke. 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 2016/17.

10. SAFETY THERMOMETER PERFORMANCE

Average performance of Harm Free Care in EKHUFT at 92.5% was below the national average of 94.2% in 2015/16.

However, hospital acquired harms (new harms) rate of at 1.8% is significantly lower than the national average of 2.2%, shown in figure 15, and show a reduction from 3.5% in 2013/14 and a similar rate of 1.7% in 2014/15. This indicates that the care patients receive when in hospital in EKHUFT is associated with lower harm than the national average.

Most wards (34 out of 47) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in May-16 and only 5 wards were <95%.

Figure 15. Average Harm Free Care Comparison of Trust, acute hospitals and National performance Apr-15 to Mar-16

	Harm Free	Harms - All	Harms - New
National	94.2%	5.8%	2.2%
Acute Hospitals	94.1%	5.8%	2.2%
EKHUFT	92.5%	7.5%	1.8%

11. ANALYSIS OF SPECIALTIES OUTSIDE WARD AREAS

11.1 Neonatal Intensive Care

A comprehensive nurse staffing review 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. The outcome revealed that EKHUFT does not meet national recommendations for staffing within its 2 neonatal units and this has had an impact on the unit's ability to maintain activity and deliver optimum care. As a result, the units have either had to close to admissions or use expensive agency nurses to maintain services.

A business case for phased investment has been agreed. Phase 1 will increase the nursing establishment by 6.9 wte at WHH, 4.7 wte at QEQM and additional administrative support to compliment the nursing team and patient care and to enhance parental experience. A further phased increment of staffing levels has been approved over 2017/18 and 2018/19 dependent on a range of operational performance triggers based on unit activity, reduction in frequency of unit closures, reduction in the use of agency staff and improvements in staff sickness levels.

11.2 Paediatrics

The paediatric wards saw investment of almost £800K during 2014/15 following the 2014 CQC inspection when it was identified that there was shortfall in Paediatric staff outside designated paediatric areas.

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. Bed occupancy is relatively low at 60% (67% midday and 59% midnight) on Padua and 49% (54% midday and 49% midnight) on Rainbow ward over the last 3 months. This represents spring/summer activity and the wards are using seasonal pressures monies to support the use of additional nursing staff via NHSP or additional hours at peak times.

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.

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 4.0 wte registered nurses in May-16 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 more than 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 80% of the time. This presents challenges when additional staffing resource is not consistently available through NHSP. A business case for the 9th bed to be funded has recently been agreed through the Executive Management Team.

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 Nov-15. 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
01/11/2015	244.55	571	28.02
01/12/2015	246.67	546	26.56
01/01/2016	246.6	571	27.79
01/02/2016	247.21	595	28.88
01/03/2016	244.81	631	30.93
01/04/2016	244.53	588	28.86
01/05/2016	246.03	572	27.90
01/06/2016	260.83	537	24.71
Previous 12 months			28.78

WARD ESTABLISHMENT REVIEW MAY 2016

A full structural review of the maternity services was undertaken against the remodelled Birthrate Plus tool during Q4 of 2015/16. Current staffing levels meet or exceed recommended levels for clinical midwives and support staff. However, the outcome of the review suggests additional staff are required to provide a sustainable resource for specialist midwifery support roles e.g Safeguarding, bereavement, obesity, ante-natal, per-natal care which are currently undertaken by clinical staff.

Priorities are focused currently on up-skilling band 2 and 3 support workers to enable release of midwives to provide greater clinical contact time with women. Engagement and discussion with midwifery staff is also underway to seek suggestions and views on adjusting current working patterns and shift times to provide better cover with the existing resource.

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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:

8. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met.
9. The impact of previous investment into ward staffing has increased WTE per bed across most areas.
10. 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.
11. The vacancy rate across all wards is 9.0% and has fallen slightly from 9.2% since Oct-15. Registered nurse vacancies in wards have reduced from 121 wte to 91 wte since Oct-15 with the majority at band 5. Healthcare assistant vacancies remain at a similar level of 33 wte.
12. Although only 55% of newly qualified nurses took up their first post within EKHUFT in April and Sept-15 this has improved to 78% in Apr-16.
13. Most of the impact of overseas recruitment of EU nurses is seen in this review due to the 114 recruited during 2015/16, although a small number are still being employed as Healthcare Assistants whilst awaiting their UK NMC PIN no. In 2016/17 to date five overseas recruitment trips have been undertaken to Romania, Croatia and India and 164 offers have been made with the first 22 arriving week ending 15th July-16.
14. Overall average sickness across all 47 wards is at 4.47% and has fallen from 5.1% in Apr-15.
15. In May-16 there was a total of 35 wte (2.0%) staff on maternity leave across the 47 wards, compared to 52 wte (3%) in Oct-15. 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.
16. Overall turnover of registered nurses and midwives has fallen from 12.8% during 2014/15 to 8.9% in 2015/16. The turnover of healthcare assistants has also fallen from 14% during 2014/15 to 12.8% during 2015/16 indicating a more stable workforce.
17. The use of temporary staff through NHS-Professionals and agency has stabilised, 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 40.9% and by agency 31.5% in May-16. This include off framework agency use. Divisional trajectories for agency reduction are being monitored aligned to the EU recruitment programme.
18. Roster quality has markedly improved with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-16 at 78% from just 72% In Oct-15. Almost all (41 out of 47) wards achieved more than the optimum 75%.
19. 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 May-16 are near or over 100% on all three acute sites. The trend in performance over time reflects the national trend.
20. The average ratio of patients per registered nurse in May-16 across each of the wards reviewed was not above 8 during day shifts except on St Augustines ward where there were 7 wte registered nurse vacancies in May-16. However, 100% planned shifts were filled and skill mix adjusted to an appropriate level to meet patients needs with NHSP cover. However, the

average ratio of patients per registered nurse during night shifts was higher and was above 13 in 6 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.

21. 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.
22. Most wards (34 out of 47) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in May-16 and only 5 wards were <95%.
23. Most ward managers reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.
24. The increase in both professional judgement and acuity dependency on some wards may be linked to the emerging data within the dementia dashboard, which highlights an increase in patients with dementia at WHH (76% increase year-on-year, approx. 1000 extra patients), and to a lesser degree at QEQM and K&C.
25. 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, Sandwich Bay, St Margarets and Mount McMaster have seen an increase in acuity and dependency of patients matched by professional judgement that higher levels of staffing may be required. 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 underway 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. Although acuity and dependency has risen on both wards professional judgement suggests satisfactory current staffing levels.
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. Capture of acuity and dependency through the live safer staffing tool within Qlikview is progressing.

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. Kings C1 has seen an increase in acuity and dependency of patients matched by professional judgement that higher levels of staffing may be required.

Neonatal Intensive Care
A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment is required in the WHH NICU and the QEQM SCBU. A business case for phased investment has been agreed 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 May-16 was 1:28. A full Birthrate Plus assessment was reported in May-16 which indicated that current staffing levels meet or exceed recommended levels for clinical midwives and support staff. However, the outcome of the review suggests additional staff are required to provide a sustainable resource for specialist midwifery support roles e.g Safeguarding, bereavement, obesity, ante-natal, per-natal care which are currently undertaken by clinical staff. Priorities are focused currently on up-skilling band 2 and 3 support workers to enable release of midwives to provide greater clinical contact time with women. Engagement and discussion with midwifery staff is underway to seek suggestions and views on adjusting current working patterns and shift times to provide improved cover with the existing resource.

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;

- Continue to 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. 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;

3. Improve clinical leadership and supervision of quality of care;
   - Monitor 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 two 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;
   - Incorporate optimum ward size and modelling of skill mix matched to patient pathway within the workforce modelling work programme against the options within the clinical strategy.

A gap analysis will be undertaken against the recently published National Quality Board (NQB) publication “Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing” to identify key areas of work required whilst further guidance is awaited , to be released later in 2016/17, to identify key areas of work required.

Appendix 1. Current funded establishments for all wards May-16, proportion of staff in post, adjusted establishment incorporating bank line

											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	20.95	17.9	14.72	1.50	1.53	84.5%	18.8	0.60	0.00	0.60	44.64
Cambridge K	27	0	34.13	19.96	18.4	12.67	11.53	1.5	1.0	90.6%	17.5	0.56	0.00	0.56	34.69
Cambridge M2	20	0	26.61	15.18	14.15	9.93	8.52	1.5	1.5	90.8%	14.7	0.47	0.00	0.47	27.08
Taylor KCH	5	2	14.07	12.9	10.3	0	0	1.2	1.2	81.5%	0.0	0.00	0.00	0.00	14.07
CCU QEQM	12	0	22.75	14.5	12.87	7.22	7.51	1.0	1.0	94.1%	4.8	0.15	0.00	0.15	22.90
CCU WHH	11	0	31.87	25.37	24.03	5	3	1.5	1.0	88.0%	4.0	0.13	0.00	0.13	32.00
Minster Ward	23	0	31.37	15	16.19	14.87	14.6	1.5	1.5	102.9%	12.3	0.40	0.00	0.40	31.77
Oxford	14	0	23.61	14.36	11.33	7.75	8.61	1.5	1.1	89.0%	9.3	0.30	0.00	0.30	23.91
Sandwich Bay	21	0	27.31	15.97	13.8	9.54	8.28	1.8	1.8	87.4%	9.6	0.31	0.00	0.31	27.62
St Margarets	22	3	26.25	14.99	13.4	10.26	8.66	1.0	1.0	87.8%	14.7	0.47	0.00	0.47	26.72
Deal	28	0	35.03	19.61	14.8	13.72	13.13	1.7	1.6	84.3%	11.8	0.38	0.00	0.38	35.41
Harvey ward	19	0	27.50	13.8	13.8	12.2	11.24	1.5	1.0	94.7%	0.0	0.00	0.00	0.00	27.50
Invicta	24	0	29.56	17.35	15.17	10.5	10.42	1.7	1.7	92.4%	11.2	0.36	0.00	0.36	29.92
Cambridge L	26	0	37.64	20.11	18.12	16.03	14.08	1.5	1.5	89.5%	18.0	0.58	0.00	0.58	38.22
Treble ward	18	0	29.08	15.44	15.48	12.23	11.5	1.41	1.49	97.9%	10.3	0.33	0.00	0.33	29.41
Mount McMaster	24	2	29.47	15	14.04	12.57	10.88	1.9	1.9	91.0%	16.2	0.52	0.00	0.52	29.99
Fordwich Ward	19	4	37.02	19.82	17.84	15.7	14.42	1.5	1.49	91.2%	21.9	0.70	0.00	0.70	37.72
Kingston	22	5	39.95	23.78	24.64	14.87	14.54	1.3	0.8	100.1%	15.1	0.48	0.00	0.48	40.43
Richard Stevens Unit	24	0	40.19	20.87	17.9	17.82	16.23	1.5	2.17	90.3%	13.8	0.44	0.00	0.44	40.63
Harbledown	24	2	34.67	18.59	14.44	14.26	11.75	1.82	1.82	80.8%	12.8	0.41	0.00	0.41	35.08
St Augustines	27	0	33.06	18.56	11.2	13	8.8	1.5	1.5	65.0%	30.4	0.97	0.00	0.97	34.03
Cambridge M1	0	18	0.00	0.00	8.80	0.00	9.00	0.00	1.00		0.00	0.00	0.00	0.00	0.00
CDU, QEQM	24	0	46.19	28.58	20.36	15.37	17.69	2.24	3.94	90.9%	30.6	0.98	0.00	0.98	47.17
CDU WHH	41	0	70.94	45.15	47.64	22.2	21.96	3.59	2.15	101.1%	49.5	1.59	0.00	1.59	72.53
ECC (incl. CDU)	18	0	83.92	55.94	50.99	17.24	18.25	10.74	9.65	94.0%	69.83	2.24	0.00	2.24	86.16
	NA	0													
Rotary	16	0	35.06	16.7	15.8	12.71	11.71	5.65	5.65	94.6%	8.7	0.28	0.00	0.28	35.34
Cheerful Sp Female	28	6	39.48	22.13	15.19	15.35	10.93	2	2	71.2%	0.5	0.00	0.03	0.03	39.51
Clarke	36+6	2	42.87	26.47	27	13.9	11.89	2.5	2.5	96.5%	28.1	0.00	1.46	1.46	44.33
Cheerful Sp Male	26	6	36.72	18.96	12.12	15.76	13.73	2	2	75.8%	0.0	0.00	0.00	0.00	36.72
Kent	20+6	5	32.03	19.8	20.95	9.73	9.72	2.5	2	102.0%	24.1	0.00	1.25	1.25	33.28
Kings B	27	0	33.77	18.41	16.25	12.83	13.39	2.53	2.53	95.3%	26.5	0.00	1.38	1.38	35.15
Kings A2	20	0	24.78	13.93	13.91	9.85	8.58	1	1	94.8%	9.3	0.00	0.48	0.48	25.26
Kings C1	27	0	34.85	17.57	15.57	14.78	14.11	2.5	2	90.9%	27.9	0.00	1.45	1.45	36.30
Kings C2	24	0	33.51	17.41	17.12	14.6	12.55	1.5	1.5	93.0%	28.0	0.00	1.46	1.46	34.97
Kings D male(1) / Kings D female (2)	43	0	60.31	32.39	30.37	23.84	24.34	4.08	4.08	97.5%	37.8	0	1.97	1.97	62.28
Quex	19	0	24.47	15.71	15.74	6.73	3.96	2.03	1.91	88.3%	16.9	0.00	0.88	0.88	25.35
Bishopstone	22	0	32.50	16.34	14.6	14.44	13.56	1.72	1.72	91.9%	28.6	0.00	1.49	1.49	33.99
Seabathing	26	0	34.25	18.31	17.13	14.44	12.84	1.5	1.47	91.8%	28.4	0.00	1.48	1.48	35.73
ITU WHH	11	0	63.83	57.47	53.52	4.69	4	1.67	1.59	92.6%	0.0	0.00	0.00	0.00	63.83
ITU QE	8	0	46.52	42.72	43.16	2.8	2.8	1	1	100.9%	5.4	0.00	0.28	0.28	46.80
ITU KCH	4 + 4	0	39.16	37.06	34.04	1	1	1.1	0.93	91.9%	0.0	0.00	0.00	0.00	39.16
Marlowe	29 +6	4	55.12	35.25	30.97	17.27	16.27	2.6	2	89.3%	0.0	0.00	0.00	0.00	55.12
Neonatal ITU	7	0	64.21	59.61	54.03	3.6	2	1	1	88.8%	0.0	0.00	0.00	0.00	64.21
Padua	28	0	45.63	35.57	31.93	7.76	9.02	2.3	1.8	93.7%	80.0	2.56	0.00	2.56	48.19
Rainbow	20	0	38.27	29.97	27.81	7.3	7.68	1	1	95.3%	30.0	0.96	0.00	0.96	39.23
Birchington	15	4	32.71	19.49	20.93	10.05	9.98	3.17	1.17	98.1%	0.0	0.00	0.00	0.00	32.71
Kennington ward	11	0	23.91	14.81	12.67	6.6	6.6	2.5	2.49	91.0%	0.0	0.00	0.00	0.00	23.91
Brabourne	8	0	16.26	13.17	11.84	2.69	2.69	0.4	0.4	91.8%	0.0	0.00	0.00	0.00	16.26
		63	1728.06	1091.89	1002.10	540.01	507.48	96.16	90.05	92.6%	779.09	16.59	13.62	30.21	1758.27

Appendix 2. Qlikview Safer Staffing tool