REPORT TO:	STRATEGIC WORKFORCE COMMITTEE
DATE:	31 JULY 2017
SUBJECT:	WARD ESTABLISHMENT REVIEW MAY 2017
BOARD SPONSOR:	CHIEF NURSE AND DIRECTOR OF QUALITY
PAPER AUTHOR:	ASSOCIATE CHIEF NURSE
PURPOSE:	Discussion

BACKGROUND AND EXECUTIVE SUMMARY

Annual staffing reviews are now required with six monthly updates to the Strategic Workforce Committee. It should be noted that this review took place in May-17 which does not reflect the changes that took place with movement of services from K&C from 19th June.

The findings from the review are:

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met;
2. To improve alignment of staffing required to demand the implementation of Safe Care commenced in June-17;
3. The implementation of the Nurse Associate role to support safe staffing commenced in April-17 and candidates are progressing well;
4. The impact of previous investment into ward staffing has increased WTE per bed across most areas;
5. 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;
6. The vacancy rate across all wards is 10.28%, an increase from the previous review in May-16 (9.0%). Registered nurse vacancies in wards are 148 WTE, an increase from 91 WTE in the previous review, with the majority at band 5. Healthcare assistant vacancies have remained at 34 WTE, similar to the previous review (33 WTE);
7. Overall average sickness across all 49 wards is at 4.4% and has fallen from 4.47% in May-16.
8. The absence associated with maternity leave in May-17 across the 49 wards is significant, at 35 WTE (1.96%), similar to May-16 (2%). Ward managers are now able to recruit to posts and this has significantly reduced the impact of maternity leave;
9. Overall turnover of registered nurses and midwives has increased from 8.9% in 2015/16 to 13.0% during 2016/17. The turnover of healthcare assistants also increased, from 12.8% in 2016/17 to 13.2% in 2017/18 indicating a less stable workforce;
10. Improvement in roster quality has been sustained with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-17 at 78.7%, similar to May-16 (78%) from just 72% In Oct-15. Almost all (41 out of 49) wards achieved more than the optimum 75%;
11. 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-17 are near or over 100% on all three acute sites. The trend in performance

over time reflects the national trend. Average hours filled during day shifts in May-17 were above 80% in all wards except Taylor (75%) which reflects the impact of planned and unplanned leave on small funded establishments.

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. However, the bank line within ward budgets is not reflected in roster templates, which has the effect of slight over-inflation of %filled hours against planned. 45 out of the 49 wards have a bank line which represents 43.27WTE not included in roster templates.

12. 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.
13. 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-17 than in Nov-16 for some wards not reflecting the expected variation in nursing workload between winter and spring.

Evaluation of the triangulation of the modelling methods is summarised as:

CDUs	Current establishments show alignment to Shelford but less so to Professional Judgement. The K&C CDU was difficult to assess due to the combined establishment with UCC.
Medical wards	Alignment for most wards but establishments below that suggested by Shelford on CJ, Sandwich Bay, St Margarets, Deal, Invicta, Mount McMaster, St Augustines and CM1 where acuity and dependency has increased. Correlation of Shelford and Professional Judgement which suggest lower than required staffing establishments on CJ, Sandwich Bay, St Margarets, Invicta and CL which may require higher staffing levels and will require close monitoring. Acuity and dependency appear to have increased since May-16 particularly on Mount McMaster, St Augustines and CM1.
Stroke Units	Alignment for all wards (*SEC Network Stroke Model). Shelford does not capture stroke thrombolysis nursing work outside the ward.
Frailty	Increased acuity and dependency is seen on both wards but Professional Judgement does not indicate the requirement for more staff.
Coronary Care Units	Alignment with Professional Judgement and Hurst but Shelford does not capture intensity of pPCI nursing work.
Renal & Haematology	Alignment on both wards with Professional Judgement and Hurst but less so with Shelford.
Paediatrics	*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua.

Surgery	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity
Trauma and Orthopaedics	Alignment with Professional Judgement 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 Professional Judgement and Shelford both suggest a higher required establishment.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Continued vacancy factor and reliance on temporary staffing will require further 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 required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2017/18 CQUINs which are valued at 2.5% of actual outturn, or around £5.7M.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Divisional Heads of Nursing meeting.
PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

1. To review the impact of the movement of services from K&C to WHH and QEQM on appropriateness of staffing;
2. Closely monitor acuity and dependency trends monthly particularly on medical wards where higher staffing levels may be required, to determine appropriateness of current staffing;
3. Support full implementation of Safecare during 2017/18 to enable alignment of staffing to demand;
4. To continue phased recruitment to the investment approved into the Emergency Departments and NICU. Further work to be undertaken to explore further investment required into Maternity;
5. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
6. Undertake further work to understand the complexity of evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation and report to the Strategic Investment Group.

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WARD ESTABLISHMENT REVIEW MAY 2017

1. INTRODUCTION

Regular ward staffing reviews have been undertaken since 2007/08 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 annually, with a six monthly update, to fulfil the requirements set out by the NHS Quality Board.

In July 2016 the National Quality Board published updated guidance, building on the 2013 guidance, to provide an updated safe staffing improvement resource.

This report provides:

1. An overview of the updated guidance and a gap analysis on current Trust compliance;
2. A progress update on the recommendations from the previous ward staffing review update (Nov-16) reported to the Strategic Workforce Committee in January 2017;
3. The May 2017 review including all wards across the Trust including:

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

2.1 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 were 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 Integrated Performance 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.

2.2 In July 2016 the National Quality Board (NQB) published updated guidance 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' building on the 2013 guidance to provide an updated safe staffing improvement resource.

The priorities reflect the NQB expectations in three areas; Right staff, right skills and right place. A gap analysis has been undertaken (Appendix 1) against this recent guidance and the following key areas of work have been identified:

- Annual staffing reviews, using a triangulated approach (i.e the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans, should be reported to Trust Boards. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

  The previous requirement was six monthly full reviews. The last full review was undertaken in May 2016 and an update was reported to the Strategic Workforce Committee in January 2017.

- Care Hours Per Patient Day (CHPPD) should be included in the local quality dashboard. CHPPD are also included, by ward, and include registered nurse and care staff hours against the cumulative total of patients on the ward at 23.59 each day during the month, to relate actual staffing to patient numbers. This is reported every month to the Quality Committee and up to the Board of Directors. These data have been included in the Quality heatmap since February 2017.

- The current approach to improve alignment of staffing required to demand focusses on the further development and embedding of 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. However, this system is not sufficiently sophisticated to enable live view of patient acuity dependency and skill mix linked to the Healthroster to enable optimised deployment of staff. A business case aligned to the workforce CIP programme to implement Healthroster Safe Care was approved and implementation began on 26th June 2017.

3. PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM THE PREVIOUS REVIEW

1. Annual staffing reviews are now undertaken with six monthly updates to the Strategic Workforce Committee;
2. Care Hours Per Patient Day (CHPPD) are now included in the ward Quality Heatmap;
3. To improve alignment of staffing required to demand the business case aligned to the workforce CIP programme to implement Safe Care was approved and implementation commenced in June-17;
4. The 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme is being finalised;
5. Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation was reported to the Strategic Investment Group in February 2017. Further work is planned to understand the complexity of evaluating the impact of this investment;
6. The implementation of the Nurse Associate role to support safe staffing commenced in April-17 with 20 trainees. The Trust is leading the East Kent Partnership across EKHUFT and KCHFT;
7. Phased recruitment to the investment approved into Neonatal services and the investment into the Emergency Departments is progressing. Further work is to be undertaken to explore further investment required into Maternity.

4. CURRENT WARD ESTABLISHMENTS

A summary of current funded establishments and staff in post is provided in Appendix 2. This includes the detail, by ward, of funded registered nurse, support worker, administrative support posts and actual staff in post at May-17.

The structure of most (90%) ward budgets (44 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 43.27 WTE across the 49 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 is close to 60/40 or more across most areas, seen in Figure 1.

Figure 1. Skill-mix including registered nurses / support staff

Skill-mix - Direct patient care						
Specialty	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**	**May-16**	**May-17**
Medical	59/41	59/41	59/41	59/41	58/42	**59/41**
CDU	69/31	67/33	70/30	69/31	66/34	**66/34**
CCU	82/18	82/18	83/17	83/17	83/17	**83/17**
Stroke	63/37	59/41	57/43	58/42	58/42	**58/42**
Acute frailt	57/43	57/43	58/42	56/44	57/43	**56/44**
Surgery	60/40	59/41	59/41	59/41	60/40	**59/41**
T+O	58/42	57/43	57/43	57/43	57/43	**57/43**
Gynaecolo	65/35	65/35	65/35	63/37	67/33	**67/33**
Paediatrics	80/20	77/23	77/23	80/20	80/20	**80/20**

The impact of previous investment into ward staffing has increased WTE per bed across most areas, seen in Figure 2.

Figure 2. Average ward staffing WTE per bed from 2007 to 2017

Average WTE per bed											
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**	**May-16**	**May-17**	**Hurst**
Medical	1.14	1.19	1.28	1.33	1.29	1.29	1.34	1.36	**1.36**	**1.38 ↑**	1.38
CDU	NR	NR	NR	2.18	1.54	1.92	1.61	1.81	**1.87**	**1.75 ↓**	1.71
CCU	2.2	2.2	2.42	2.76	2.62	2.68	2.69	2.56	**2.54**	**2.54 ↔**	2.21
Stroke	1.19	1.52	1.57	1.75	1.79	1.84	1.85	1.84	**1.84**	**1.84 ↔**	1.9
Acute frailty	1.1	1.18	1.29	1.47	1.33	1.34	1.51	1.38	**1.46**	**1.45 ↓**	1.43
Surgery	1.09	1.28	1.46	1.38	1.45	1.5	1.57	1.53	**1.50**	**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 ↑**	1.42
Renal				1.5	1.81	1.81	1.83	1.91	**1.90**	**2.09 ↑**	1.71
Haematology				1.38	2.09	2.09	2.08	2.06	**2.03**	**2.20 ↑**	1.82
Gynaecology				1.96	1.93	1.93	2.02	1.97	**2.09**	**2.31 ↑**	1.53

6. WORKFORCE METRICS

The total budgeted establishment across the wards reviewed has increased over time, seen in Figure 5, following previous investment into ward staffing. The impact of current vacancy levels, sickness and maternity leave across the 49 wards is 16.75%, an increase from 15.5% in May-16, summarised in Figure 3.

Figure 3. Wards staffing vacancy, sickness and maternity leave May-17

Workforce indicators							
	Dec-12	Mar-14	Oct-14	Apr-15	Oct-15	May-16	May-17
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02	1680.86	1728.21	1746.45	1774.64
Registered Nursing vacancies (WTE)	44.00	73.88	37.66	124.71	120.58	91.43	148.06
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44	12.55	38.72	32.90	34.48
Vacancy (%)	4.75	5.21	6.08	8.16	9.20	9.00	10.28
Sickness (%)	4.96	4.90	4.60	5.15	3.80	4.47	4.51
Maternity leave (%)	3.28	2.38	2.53	3.89	3.00	2.01	1.96

* 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

The vacancy rate across all wards is 10.28%, an increase from the previous review (9.0%). Registered nurse vacancies in wards are 148 WTE, an increase from 91 WTE in the previous review, with the majority at band 5. Healthcare assistant vacancies have remained at 34 WTE, similar to the previous review (33 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 gradual fall in % newly qualified nurses who take up their first post within EKHUFT since 2013 with only 55% of the Canterbury Christ Church University (CCCU) newly qualified cohort taking up a band 5 post within EKHUFT in Apr-17. This is due to many factors including relocation back to home and taking up posts in London. Feedback from students has led to cohort recruitment one year before qualifying and rotational opportunities being created to improve retention;
- There have been delays in the arrival of overseas nurses recruited in 2016/17 due to challenges in achieving the required IELTS level 7 English language qualification.

6.2 Sickness absence

ESR data demonstrates that average sickness absence rate across the wards has fallen slightly from 4.47% in May-16 to 4.4% in May-17. Average rates in excess of 5% were seen in some stroke, medical, frailty, surgical and orthopaedic wards with higher rates of HCA sickness in excess of 10% on two medical wards. This reflects the high physical and emotional demands of ward work in some areas and also significant opportunity for further improvement.

6.3 Maternity leave

The absence associated with maternity leave in May-17 across the 49 wards is significant, at 35 wte (1.96%), similar to May-16 (2%). Following 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 from 8.9% in 2015/16 to 13.0% during 2016/17, seen in Figure 4. The turnover of healthcare assistants also increased, from 12.8% in 2016/17 to 13.2% in 2017/18.

Figure 4. Average turnover of nursing, midwifery and care staff 2011 to 2017

Turnover (%)						
	2011	2012	2013/14	2014/15	2015/16	2016/17
Nursing & Midwifery	7.5	9.5	11.2	12.8	8.9	13
HCA and other support staff	12.6	10.6	10.6	14.2	12.8	13.2

7. Roster performance, actual against planned filled hours and Care Hours per Patient Day

7.1 Roster performance

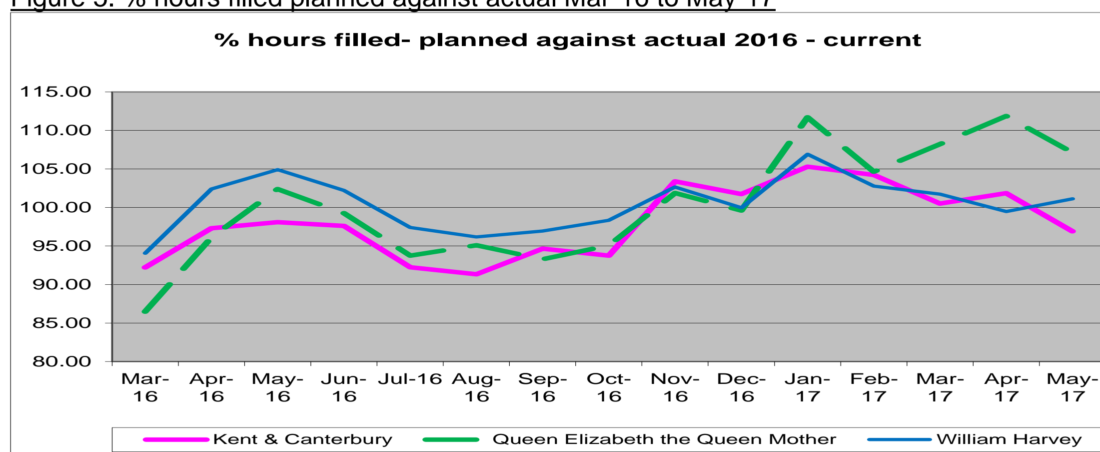
Improvement in roster quality has been sustained with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-17 at 78.7%, similar to May-16 (78%) from just 72% In Oct-15. Almost all (41 out of 49) wards achieved more than the optimum 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.

7.2 Actual against planned filled hours

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-17 are near or over 100% on all three acute sites, shown in Figure 5.

Figure 5. % hours filled planned against actual Mar-16 to May-17



Average hours filled during day shifts in May-17 were above 80% in all wards except Taylor (75%) which reflects the impact of planned and unplanned leave on small funded establishments.

Low fill rates are also seen:

- In registered nurse shifts on Harvey and Fordwich wards due to vacancies, on Kingston due to high sickness and Kings C2 due to maternity leave;
- For support workers shifts in CCUs and Treble ward due to high levels of sickness;
- Other wards (Critical care units, Padua, Kennington, Braeborne, Maternity areas) show low fill rates for support worker shifts demonstrating the impact of sickness and parenting leave on % fill where small WTE exist within the ward establishment.

Actions in place include:

- Matrons and non ward-based staff often cover the shifts that are short of staff. This is not reflected in the filled hours as it is not captured on the E-Roster currently;
- The roll out of Safecare has commenced at WHH which will allow the live capture of patient acuity dependency and improved matching of staffing to demand;
- Skill-mix changes are made, such as using a healthcare assistant if a registered nurse is not available. This explains why some fill rates are high for 'Care Staff';
- Recruitment campaigns continue both locally and overseas;
- Retention is being addressed with wards and teams with support from the HR Business Partners.

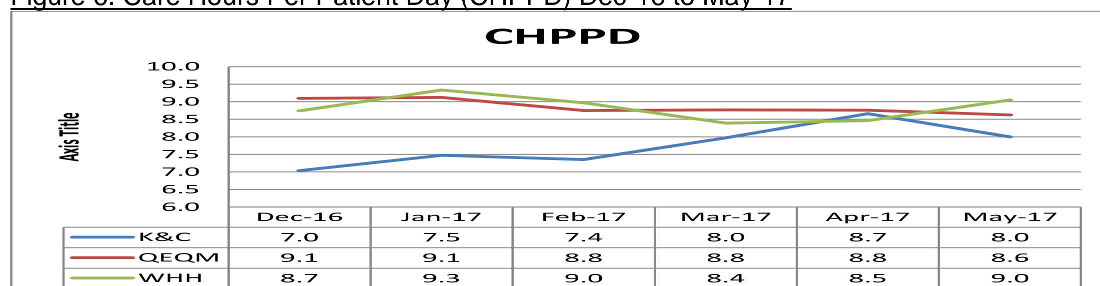
Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time. However, the bank line within ward budgets is not reflected in roster templates, which has the effect of slight over-inflation of %filled hours against planned. 45 out of the 49 wards have a bank line which represents 43.27WTE not included in roster templates.

7.3 Care Hours Per Patient Day (CHPPD)

CHPPD have also been reported since May-16, to relate actual staffing to patient numbers and includes registered nurse and care staff hours against the cumulative total of patients on the ward at 23.59 each day during the month. The range is from around 5 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required. The trend in Figure 6 shows some consistency by site and slightly higher CHPPD at QEQM and WHH reflecting the specialty of provision on those sites. CHPPD has been included in the Quality Heatmap, by ward, since Feb-17.

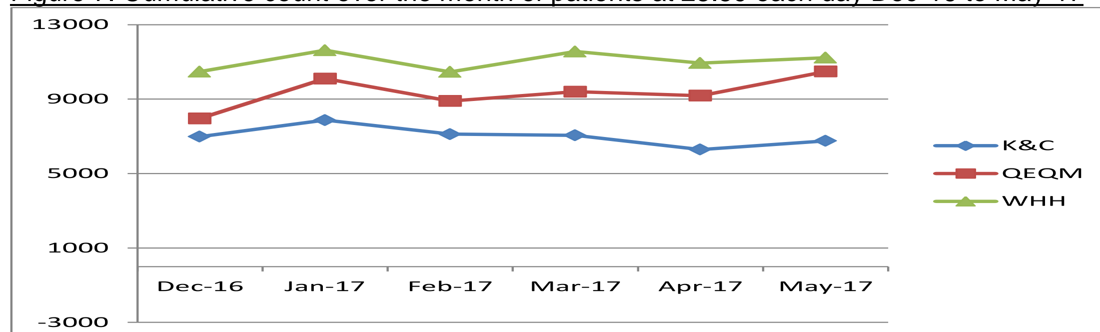
Comparative data within the Model Hospital dashboard for Jan-17 shows EKHUFT average of 8.8 against a peer median (based on both spend and clinical output) of 8.2 and a national median of 7.6 (all Acute Trusts, Mental Health Trusts and Community Trusts). Reasons for the variance against the peer value may be linked to the high numbers of patients requiring Specialling within our wards. The EKHUFT overall average CHPPD in May-17 is 8.4 (8.6 in April).

Figure 6. Care Hours Per Patient Day (CHPPD) Dec-16 to May-17



CHPPD has been sustained in May against a slight increase in activity and use of contingency beds shown in Figure 7 and this has contributed to the continued rate of over 100% seen this month in %fill against budgeted establishments.

Figure 7. Cumulative count over the month of patients at 23.59 each day Dec-16 to May-17



8. 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.

8.1 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 (48 out of 49) 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.

8.2 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 except Cambridge J and Kingston ward. 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.

8.3 Alignment of staffing required to demand though the 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 in 2015. This enables live capture, reporting and escalation of staffing status with daily planned, actual and required staffing linked to acuity and dependency. However, this system is not sufficiently sophisticated to be linked to Healthroster to readily allow reallocation to staff to areas of high demand.

Average March to May-17 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, Cambridge J, Sandwich Bay, St Margarets, Invicta and Cambridge L wards saw an increase in acuity and dependency of patients matched by professional judgement.

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. Drivers of nursing workload related to acuity and dependency are outlined in table 2, but additional workload is presented with increased throughput of patients for example taking drug charts to pharmacy and collecting take home medications which can mean significant time away from the ward for nursing staff. Further experience in the use of the tool and continued consistency checking will lead to increased confidence in the use of the SNCT particularly as Safecare is rolled out across all adult wards during 2017/18. Safecare will provide more sophisticated information to enable staff to be available to meet patients’ needs. An example of the reporting capability is included in Appendix 3.

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 application of modelling methods (summarised in figure 8) 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-17 than in Nov-16 for some wards not reflecting the expected variation in nursing workload between winter and spring. There has been an increase in acuity dependency over time on some wards.

Evaluation of the triangulation of the modelling methods is summarised as:

CDUs	Current establishments show alignment to Shelford but less so to Professional Judgement. The K&C CDU was difficult to assess due to the combined establishment with UCC.
Medical wards	Alignment for most wards but establishments below that suggested by Shelford on CJ, Sandwich Bay, St Margarets, Deal, Invicta, Mount McMaster, St Augustines and CM1 where acuity and dependency has increased. Correlation of Shelford and Professional Judgement which suggest lower than required staffing establishments on CJ, Sandwich Bay, St Margarets, Invicta and CL which may require higher staffing levels and will require close monitoring.

	Acuity and dependency appear to have increased since May-16 particularly on Mount McMaster, St Augustines and CM1.
Stroke Units	Alignment for all wards (*SEC Network Stroke Model). Shelford does not capture stroke thrombolysis nursing work outside the ward.
Frailty	Increased acuity and dependency is seen on both wards but Professional Judgement does not indicate the requirement for more staff.
Coronary Care Units	Alignment with Professional Judgement and Hurst but Shelford does not capture intensity of pPCI nursing work.
Renal & Haematology	Alignment on both wards with Professional Judgement and Hurst but less so with Shelford.
Paediatrics	*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua.
Surgery	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity.
Trauma and Orthopaedics	Alignment with Professional Judgement 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 Professional Judgement and Shelford both suggest a higher required establishment.

Figure 8. Triangulation between professional judgement and evidence based tools.

May-17

Specialty	Ward	Full Est (WTE)	Prof judgment (PJ)	Hurst NPOB or other appropriate model	Shelford May-16	Shelford Nov-16	Shelford May-17	CHPPD	Comments
CDUs	CDU WHH	63.47	56.69	76.2	58.14	68.57↑	66.09	13.3	Alignment to Shelford but less so to PJ. The K&C CDU is difficult to assess due to the combined establishment with UCC.
	CDU, QEQM	47.88	55.64	44.3	42.73	42.19	43.14	10.2	
	UCC (incl. CDU)	85.70	48.04	27.0					
Medical	Cambridge J	44.65	52.0	50.6	72.64 ↑	58.31	54.61	6.2	Alignment for most wards but establishments below that suggested by Shelford on CJ, Sandwich Bay, St Margarets, Deal, Invicta, Mount McMaster, St Augustines and CM1 where acuity and dependency has increased. PJ also suggests lower than required staffing establishments on CJ, Sandwich Bay, St Margrets, Invicta and CL. Acuity and dependency appear to have increased since May-16 on Mount McMaster, St Augustines and CM1.
	Cambridge K	34.70	32.9	37.0	32.39	32.33	33.83	5.6	
	Cambridge M2	27.09	31.6	28.3	29.66	29.19	27.53	6.2	
	Minster Ward	31.77	35.2	32.6	34.41	34.41	33.79	6.6	
	Oxford	23.91	25.5	20.9	23.34	23.71	24.01	8.0	
	Sandwich Bay	27.62	36.5	30.3	33.73	33.73	33.73	9.0	
	St Margarets	26.71	31.5	31.5	42.67 ↑	42.67	32.45	6.7	
	Deal	35.31	36.2	38.1	43.13 ↑	43.56	43.78	6.8	
	Harvey ward	27.96	30.3	24.6	27.37	27.37	27.37	6.7	
	Invicta	29.92	34.5	33.7	30.75	34.14	34.14	5.5	
	Treble ward	29.41	30.2	24.2	18.91	22.14	23.31	6.3	
	Mount McMaster	30.49	34.7	33.7	39.80 ↑	45.03↑	50.57	5.1	
	St Augustines	34.04	35.9	37.0	40.81	43.49↑	48.12	4.5	
	Cambridge M1	26.69	28.9	27.2	25.29	34.3↑	44.47	6.2	
Stroke	Fordwich Ward	39.22	44.8	38.0*	37.43	39.06	39.06	9.4	Alignment for all wards (*SEC Network Stroke Model. Shelford does not capture stroke thrombolysis nursing work outside the ward.
	Kingston	36.83	38.9	42.1*	31.76	36.57	36.82	6.2	
	Richard Stevens Unit	42.64	44.4	44.8*	41.55	39.44	39.95	7.0	
Frailty	Harbledown	34.59	35.5	32.1	54.45 ↑	55.76	64.87	5.9	Some alignment across both wards with PJ and Hurst. Increased acuity and dependency is seen on both wards but PJ does not indicate the requirement for more staff
	Cambridge L	38.22	41.2	34.1	43.10	43.62	43.84	6.4	
Coronary Care	Taylor KCH	14.07	13.4	10.8	7.78	8.57	8.79	7.0	Alignment with PJ and Hurst but Shelford does not capture intensity of pPCI nursing work.
	CCU QEQM	22.90	22.6	25.8	18.29	18.39	17.77	7.8	
	CCU WHH	31.75	30.2	32.7	17.33	17.36	16.45	13.5	
Renal & Haematology	Marlowe	60.84	61.8	54.7	27.67	34.61↑	30.19	9.4	Alignment on both wards with PJ and Hurst but less so with Shelford
	Brabourne	17.57	14.6	15.1	5.11	9.42	10.02	14.4	
Gynaecology	Birchington	33.81	36.8	23.9	17.10	18.15	17.20	6.4	Alignment on both wards with PJ but less so with Shelford and Hurst due to not capturing outpatient and day attender activity
	Kennington ward	26.27	22.3	19.7	9.56	10.45	10.45	9.8	
Paediatrics	Padua	48.45	53.5	50.3		54.4		10.3	*RCN and PJ suggest higher establishments to cover day surgery & relocated outpatients
	Rainbow	39.48	48.2	47.3		46.9		12.3	
Surgery	Rotary	35.34	34.4	19.9	16.44	17.04	17.62	9.0	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity
	Cheerful Sp Female	36.02	34.4	38.7	30.15	29.54	29.98	5.8	
	Clarke	46.35	41.6	47.7	37.26	38.8	28.41	6.2	
	Cheerful Sp Male	40.65	38.4	38.7	31.04	28.89	28.89	6.7	
	Kent	33.30	30.2	32.6	20.20	23.36	22.95	7.7	
	Kings B	35.21	39.2	33.7	36.67	34.63	34.63	5.7	
	Kings A2	25.27	30.6	24.9	22.65	23.77	23.68	6.1	
Trauma & Orthopaedic	Kings C1	36.00	41.8	35.2	42.92 ↑	36.76	39.59	5.5	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	34.98	38.7	31.3	24.09	24.70	25.97	5.7	
	Kings D male(1)	62.21	65.6	66.4	57.08	59.09	57.64	5.7	
	Quex	25.33	25.4	25.9	19.49	21.35	18.94	5.4	
	Bishopstone	34.00	36.1	34.3	34.50	35.87	28.61	5.3	
	Seabathing	36.47	35.9	34.8	32.14	35.7	38.14	9.2	

9. PROGRESS IN IMPLEMENTATING RECOMMENDATIONS IN THE EMERGENCY DEPARTMENTS, NEONATAL INTENSIVE CARE AND MIDWIFERY

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9.1 Emergency Departments

A business case was submitted to the Strategic Investment Group in December 2016 and the preferred option 2 was agreed in May 2017. The aim of the Business Case is to ensure a future proofed robust nursing workforce to enable a patient focussed safe service.

Emergency Department (ED) attendances have been rising every year since 2001/02, with an increase in conversion to admission. This coupled with overcrowding largely as a result of exit block and significant delays in ambulance handover have had a profound effect on the Emergency Departments and its ability to deliver a timely, safe quality service and maintain adequate flow.

Staffing concerns within the two Emergency Departments (ED) and the Minor injuries Units (MIU) have been highlighted by the Emergency Care Improvement Programme Team (ECIP) who advise that there should be a band 7 Nurse in Charge 24/7. This nurse works alongside the senior doctor to provide a safe quality service and a supervisory role for the nursing staff in all areas of the department.

Additionally they advise Emergency Nurse Practitioners (ENP) should be working at band 7 level and that there should be a stand-alone ENP service. This would provide a minor injuries service in the two EDs staffed by appropriately trained practitioners from 8am to midnight 7 days a week. The benefits of this service would be comparable to those at Kent and Canterbury and Buckland Hospitals minor injuries units.

In order to improve patient flow and streaming at the front door new ways of working are being introduced nationally and locally we have adopted improved assessment pathways for our patients. This is to ensure that they are seen in a timely manner by the most appropriate clinician. These new ways of working also require additional resources.

In order to deliver the above mentioned staffing resource the department relies heavily on agency staff, whilst it is understood the large financial impact of these additional staff it should be noted there are other issues in relying on agency staff in terms of quality, training and the constraints of a transient workforce.

The staffing review undertaken in 2016 highlighted the following:

- There is no national tool available to adequately determine appropriate staffing levels, therefore professional judgement and benchmarking with other Trusts was undertaken.
- A need to increase the establishment by 30 wte nurses during times of escalation. The UCLTC Division manage this risk by covering the EDs with additional temporary staff.
- The review showed that when benchmarked against similar Trusts we broadly have the correct establishment assuming a business as usual context in relation to nursing staff at bands 6 and below.
- The Review proposed that we need an uplift of the band 7 ENPs and nurse in charge roles in order to bring us in line with other similar Trusts.
- Overcrowding and flow issues are being actively managed internally and also externally through a number of improvement plans and mitigating actions including:
    - 3 times daily site meetings
    - Site situation and risk assessment monitoring

- Senior support by Site Operations Managers, Matrons, General Managers and a dedicated Head of Nursing for the EDs
- Roster changes to manage peak attendance patterns
- New models of ambulatory care led by consultant nurses
- Ensuring patient safety during overcrowding in the departments
- Monitoring quality and safety.

The preferred option 2 agreed is to:

1) Increase the establishments at QEQMH and WHH to ensure band 7 available 24/7, it is proposed that this be 6 wte who are able to undertake this role. This is a slight increase to the usual 5.69 wte required for 24/7 cover to take into account the increased training requirements that ED nurses require. This equates to an increase of:
    - Nurse in charge at QEQMH - 3.0 wte
    - Nurse in charge at WHH - 1.0 wte
2) Increase the banding of all ENPs Trust wide to band 7 provided they achieve the appropriate competencies. This will ensure that we are in line with national standards where ENPs are banded at band 7as a minimum and to increase the establishment of ENP posts at QEQMH and WHH only to provide a 8am to midnight service 7 days a week with 3 ENPs covering this time period in a staggered shift pattern. In addition a band 2 technician at BHD MIU to bring this in line with the other MIUs across the Trust. This equates to an increase of:
    - ENP at QEQMH (including increased service cover) increase 3.5 band 6 to band 7 and an additional 1.2 wte band 7
    - ENP at WHH (including increased service cover) increase 3.7 wte band 6 to band 7 and an additional 2.43 band 7 posts
    - ENP at K&CH increase 10.71 wte band 6 to band 7
    - ENP at BHD increase 3.48 wte band 6 to band 7
    - Band 2 technician at BHD 2.80 wte
3) Increased establishment to safely staff the increased demand on the ED service and to ensure appropriate streaming and assessment at the front door. This equates to an increase of :
    - Band 5 at QEQMH of 8.53wte
    - Band 2 at QEQMH of 5.69 wte
    - Band 5 at WHH of 8.53wte
    - Band 2 at WHH of 5.69 wte

The proposal was that the staffing for this option be managed in a phased approach as follows:

Phase 1:

- Ensure band 7 nurse in charge role to cover 24/7 period, likely to take 3-4 months to enable recruitment of new pots to take place. (WHH & QEQMH)

- Recruit to increased ENP posts at band 7 and increase existing band 6 posts to band 7 likely to take approximately 6 months for recruitment to posts and ensuring competencies met to upgrade staff. (All sites)

Phase 2

- Recruit to band 5 and band 2 posts at WHH & QEQMH in a phased way over a period of 1 year.

Phase 3

- Recruit to the band 2 posts at BHD minor injuries unit, this will make this come in line with equivalent staffing levels to the other minor injuries units across the Trust, also taking into account the increasing number of attendances there.

Due to the need to implement the business case ahead of winter it has been agreed that posts within all 3 phases be recruited to as soon as possible and recruitment is underway.

9.2 Neonatal Intensive Care

A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment was required in the WHH NICU and the QEQM SCBU. A business case for phased investment was predicated on the fact that, within EKHUFT, neonatal staffing levels were inadequate in comparison to national recommendations (British Association of Perinatal Medicine) and national published guidelines (NICE, Department of Health (2009) Toolkit for High Quality Neonatal Services, Bliss (2011) The Bliss Baby Charter Standards) and was agreed in July-16.

The Phase 1 increase in 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 has been achieved . The Band 6 new posts were recruited to mainly by internal promotion however due to subsequent leavers and internal promotions to Band 7 a small vacancy remains. The band 4 and 5 posts are fully recruited to with almost 20 WTE staff recruited in the past year.

The Business Case recognised that there was a national shortage of Neonatal nurses and there would be a challenge to recruit, therefore plans to train and "grow our own" for the future have been implemented with 8 nurses undertaking training this coming year.

A further phased increment of staffing levels was 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. A report to the Specialist Services Division and the Strategic Investment Group is being prepared outlining progress against the operational performance criteria in order for the second phase of the Business Case to be released.

Evaluation of appropriate staffing will be one of the clinical indicators included in benchmarking as part of the Neonatal services Peer review planned in autumn 2017.

9.3 Midwifery

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 were undertaken by clinical staff, at that time. 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 was undertaken to seek suggestions and views on adjusting current working patterns and shift times to provide improved cover with the existing resource. A consultation was completed on working hours that resulted in releasing 2.9 WTE midwifery time across the acute sites with the change in hours that commenced on 1.4.17.

The shortfall that was identified in the Birthrate Plus in the additional resource required to sustain the specialist roles that were required that were being undertaken in clinical time has been resolved. Supervision of midwifery was removed from statute in April this year, 13 Supervisors of Midwives have transferred to the Professional Midwifery Advocate role and the remaining 11 Supervisors resigned from this role, opting to revert to a purely clinical role. The Midwifery Support Worker role (MSW) is being utilised in the community setting to provide support to the Community Midwife and a development programme to train further Midwifery Care Assistants (MCA) to the MSW role is awaiting sign off.

The average Midwife to birth ratio in May-17 was 1:30 but has reduced slightly in June-17 shown in Figure 9. Another important measure of safety, 1:1 care in active labour, has shown improvement with achievement of 93.9% in May-17 and 94% in June-17.

Figure 9. Monthly Midwife to birth ratio June-16 to June-17.

Midwife to Birth Ratio

June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
30.5	29.3	30.4	29.7	27.4	28.1	20.2	25.6	27.0	29.9	28.5	30.7	28.9

High levels of sickness has impacted on staffing over the last 3 months and continues to do so and all sickness is being managed appropriately. NHS Professionals is been used to supply temporary midwifery staffing. Agency staffing is no longer used due to lack of midwives registered with them and high costs. The use of registered general nurses is being explored and proposed as a viable option to support the postnatal wards in the absence of trained midwives so that the midwifery expertise can be utilised in other areas of the maternity unit.

Vacancy rate for June-17 was 8.1% compared to 4.7% at this time last year. Several members of staff have taken retirement, some have taken flexible retirement and others have left for personal reasons. It is encouraging that staff resignations are very different to that of 2 years ago when staff were leaving for reasons of work place stress and culture of the department. Active recruitment continues with midwifery open days, recruitment drives and the offer of observational placements to those on nursing/midwifery pathways to attract new members of staff.

10. Priorities identified from this review are:

1. To review the impact of the movement of services from K&C to WHH and QEQM on appropriateness of staffing;
2. Closely monitor acuity and dependency trends monthly particularly on medical wards where higher staffing levels may be required, to determine appropriateness of current staffing;
3. Support full implementation of Safecare during 2017/18 to enable alignment of staffing to demand;
4. To continue phased recruitment to the investment approved into the Emergency Departments and NICU. Further work to be undertaken to explore further investment required into Maternity;
5. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
6. Undertake further work to understand the complexity of evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation and report to the Strategic Investment Group.

Appendix 1 – National Quality Board 2016 expectations on safe staffing

Expectations			Compliance
1	Right staff ➢ Evidence based workforce planning ➢ Professional judgement ➢ Compare staffing with peers	➢ Annual strategic staffing review using a triangulated approach (evidence-based tool, professional judgement and comparison with peers) which takes account of all professional groups and is in line with financial plans. This should be followed by a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. ➢ Review of comparative data on actual staffing which provides context for differences in staffing requirements such as case mix, patient movement and acuity and dependency. ➢ Local quality dashboard for sustainable safe staffing which triangulates comparative data on staffing with other efficiency and quality metrics to include Care Hours per Patient Day (CHPPD).	The next full review based on April 2017 will be reported to the SWC July 2017. A triangulated approach will again be used including these methods. CHPPD was included in the Quality dashboard from February-17.
2	Right skills • Mandatory training, development and education • Working as a multi-professional team • Recruitment and retention	➢ Staffing establishments take account of the need for staff to undertake mandatory training and continuous professional development. ➢ Sufficient time allocated for team leaders to discharge supervisory responsibilities ➢ Commitment to investing in new roles and skill mix to enable nursing and midwifery staff to spend more time using their specialised training to focus on clinical duties and decisions about patient care. A strong multi-professional approach avoids placing demands solely on any one profession. ➢ Flexible and effective strategies to recruit, retain and develop staff as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Average 22% headroom is included in budgeted establishments currently. Investment in the ward manager assistant role has supported. Future Workforce Steering Group has been implemented to take forward standardisation of expectations and education preparation for Advanced Clinical Practice roles.
3	Right place and time	➢ The organisation uses lean working principles such as the	Productive ward principles are

	• Productive working and eliminating waste • Effective deployment and flexibility • Efficient employment and minimising agency	productive ward as a way of eliminating waste ➢ The organisation designs pathways to optimise patient flow ➢ Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs ➢ Systems for managing staff use responsive risk management processes, from frontline to board level, which clearly demonstrates how staffing risks are identified and managed. ➢ Clinical capacity and skill mix are aligned to the needs of patients thus making the best use of resources and facilitating effective patient flow ➢ Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs ➢ Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of steps to take where capacity problems cannot be resolved. Report, investigate and act on red flag incidents. ➢ Meaningful application of effective e-rostering policies is evident. ➢ The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. ➢ The organisation is working to reduce and eradicate the use of agency staff in line with NHS Improvement's nursing agency rules.	embedded within wards. Identification and management of staffing risks are part of the role of the matron. Current system does not enable live view of patient acuity dependency and skill mix to enable deployment of staff. A Business case aligned through workforce CIP programme to implement Safe Care has been approved and implementation commenced in June-17. Daily site situation and escalation report identifies patient flow, bed status and staffing appropriateness. Improvement required to the use of the NHSP interface. Service improvement team led project Smarter Agency Reduction

FRONT SHEET – VERSION 5 – Issued July 2016

Appendix 2 - Current funded establishments and staff in post

Review of ward staffing May-17

											Bank line					AP role	Attendance			Evaluation methods							Shift fill - DAY	
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)	Band 4 AP (WTE)	Sickness May-17 (%)	Maternity leave (WTE at 31.05.17 WTE)	E-Rostering effectiveness (%time worked)	Skill mix	WTE/Bed	Prof judgment (clinical)	Prof judgment (total)	Hurst NPOB	Shelford acuity & dependency	CHPPD	Average filled hours DAY - May-17 (%)	Average filled hours NIGHT- May-17 (%)
Cambridge J	**34**	**0**	44.04	24.64	19.23	17.90	13.15	1.50	1.53	77.0%	19.0	0.61	0.00	0.61	44.65	0.00	10.1%	0.00	81.4%	60/40	1.31	50.5	52.0	50.6	54.61	6.2	120	109
Cambridge K	**27**	**0**	34.13	19.96	18.83	12.67	11.22	1.50	1.50	92.4%	17.7	0.57	0.00	0.57	34.70	1.00	4.6%	0.00	82.1%	61/39	1.29	31.4	32.9	37.0	33.83	5.6	104	114
Cambridge M2	**19**	**0**	26.61	15.18	15.04	9.93	8.68	1.50	1.50	94.8%	14.9	0.48	0.00	0.48	27.09	0.00	7.8%	0.64	77.4%	60/40	1.43	30.1	31.6	28.3	27.53	6.2	105	113
Taylor KCH	**5**	**2**	14.07	12.90	11.46	0.00	0.00	1.20	0.50	85.0%	0.0	0.00	0.00	0.00	14.07	0.00	2.7%	0.00	78.4%	100/0	2.81	12.2	13.4	10.8	8.79	7	75	100
CCU QEQM	**12**	**0**	22.75	14.50	12.87	7.22	6.51	1.00	1.00	89.7%	4.8	0.15	0.00	0.15	22.90	1.80	6.0%	0.00	78.0%	66/34	1.91	21.6	22.6	25.8	17.77	7.8	91	102
CCU WHH	**11**	**0**	31.62	25.62	22.67	4.50	3.50	1.50	1.50	87.5%	4.0	0.13	0.00	0.13	31.75	0.50	2.0%	0.00	83.9%	85/15	2.89	28.7	30.2	32.7	16.45	13.5	102	83
Minster Ward	**23**	**0**	31.37	15.00	15.98	14.87	12.60	1.50	1.50	95.9%	12.5	0.40	0.00	0.40	31.77	1.80	2.4%	0.00	83.5%	50/50	1.38	33.7	35.2	32.6	33.79	6.6	105	112
Oxford	**14**	**0**	23.61	14.36	13.19	7.75	6.51	1.50	1.30	88.8%	9.3	0.30	0.00	0.30	23.91	0.00	1.9%	0.00	81.4%	65/35	1.71	24.0	25.5	20.9	24.01	8	113	113
Sandwich Bay	**21**	**0**	27.31	15.97	16.80	9.54	7.88	1.80	2.80	100.6%	9.7	0.31	0.00	0.31	27.62	0.00	6.3%	1.60	79.5%	63/37	1.32	34.7	36.5	30.3	33.73	9	161	210
St Margarets	**22**	**3**	26.24	14.98	10.20	10.26	10.66	1.00	1.00	83.3%	14.8	0.47	0.00	0.47	26.71	0.80	7.6%	0.00	77.5%	59/41	1.21	30.5	31.5	31.5	32.45	6.7	124	150
Deal	**28**	**0**	34.93	19.61	15.60	13.72	12.13	1.60	1.60	84.0%	11.9	0.38	0.00	0.38	35.31	1.00	1.2%	3.00	78.2%	59/41	1.26	34.6	36.2	38.1	43.78	6.8	112	136
Harvey ward	**19**	**0**	27.50	13.80	12.00	12.20	10.24	1.50	1.00	84.5%	14.2	0.46	0.00	0.46	27.96	0.00	1.0%	0.00	84.8%	53/47	1.47	28.8	30.3	24.6	27.37	6.7	106	142
Invicta	**24**	**0**	29.56	16.35	14.26	11.50	9.88	1.70	1.20	85.8%	11.4	0.36	0.00	0.36	29.92	0.00	12.7%	0.00	75.0%	59/41	1.25	32.8	34.5	33.7	34.14	5.5	92	134
Cambridge L	**26**	**0**	37.64	20.11	18.70	16.03	16.44	1.50	1.50	97.3%	18.2	0.58	0.00	0.58	38.22	0.00	10.7%	0.00	71.5%	56/44	1.47	39.7	41.2	34.1	43.84	6.4	101	129
Treble ward	**18**	**0**	29.08	15.44	11.76	12.23	11.50	1.41	0.99	83.4%	10.4	0.33	0.00	0.33	29.41	1.00	7.8%	0.92	72.9%	56/44	1.63	28.8	30.2	24.2	23.31	6.3	80	132
Mount McMaster	**24**	**2**	29.97	16.50	7.80	11.57	10.59	1.90	1.90	67.7%	16.4	0.52	0.00	0.52	30.49	0.00	9.6%	0.00	79.4%	59/41	1.27	32.8	34.7	33.7	50.57	5.1	93	127
Fordwich Ward	**19**	**5**	38.51	21.79	19.60	15.22	12.31	1.50	1.49	86.7%	22.1	0.71	0.00	0.71	39.22	1.52	3.7%	2.32	76.8%	59/41	2.06	43.3	44.8	38.0*	39.06	9.4	114	121
Kingston	**22**	**5**	36.34	20.17	23.03	14.87	12.14	1.30	1.29	100.3%	15.2	0.49	0.00	0.49	36.83	1.00	10.2%	0.00	72.6%	58/42	1.67	37.6	38.9	42.1*	36.82	6.2	92	110
Richard Stevens Unit	**24**	**0**	42.19	22.87	18.50	17.82	14.91	1.50	1.86	83.6%	13.9	0.45	0.00	0.45	42.64	2.00	4.8%	1.43	72.3%	56/44	1.78	42.9	44.4	44.8*	39.95	7	96	88
Harbledown	**24**	**2**	34.17	18.09	13.24	14.26	13.63	1.82	1.50	83.0%	13.0	0.42	0.00	0.42	34.59	0.00	5.1%	0.00	82.3%	56/44	1.44	33.7	35.5	32.1	64.87	5.9	92	109
St Augustines	**27**	**2**	33.06	18.56	13.40	13.00	17.80	1.50	1.50	98.9%	30.7	0.98	0.00	0.98	34.04	1.00	3.3%	0.00	77.8%	59/41	1.26	34.4	35.9	37.0	48.12	4.5	104	111
Cambridge M1	**18**	**0**	26.69	15.23	7.80	9.96	8.61	1.50	1.50	67.1%	0.00	0.00	0.00	0.00	26.69	0.00	7.8%	0.64	77.4%	60/40	1.48	27.4	28.9	27.2	44.47	6.2	105	113
CDU, QEQM	**24**	**0**	46.89	29.28	21.20	15.37	21.38	2.24	2.84	96.9%	30.9	0.99	0.00	0.99	47.88	0.00	4.5%	1.00	78.9%	66/34	2.00	53.4	55.6	44.3	43.14	10.2	118	165
CDU WHH	**42**	**0**	61.87	39.21	35.24	19.07	18.04	3.59	3.51	91.8%	50.0	1.60	0.00	1.60	63.47	1.00	5.2%	0.00	73.9%	67/33	1.51	53.1	56.7	76.2	66.09	13.3	99	107
UCC (incl. CDU)	**18**	**0**	83.44	55.46	48.44	17.24	16.81	10.74	10.41	90.7%	70.5	2.26	0.00	2.26	85.70	*0.00*	9.9%	0.48	72.1%	76/24		37.3	48.0	27.0				
Rotary	**16**	**0**	35.06	16.70	16.00	12.71	10.11	5.65	4.65	87.7%	8.8	0.28	0.00	0.28	35.34	2.40	3.3%	0.00	82.8%	57/43	2.21	28.7	34.4	19.9	17.62	9.00	101	107
Cheerful Sp Female	**27**	**0**	35.75	20.69	10.99	15.06	15.19	0.00	0.00	73.2%	8.2	0.25	0.03	0.27	36.02	0.00	7.3%	0.00	77.5%	58/42	1.33	34.4	34.4	38.7	29.98	5.80	93	89
Clarke	**36+6**	**2**	44.87	27.87	21.96	14.50	12.80	2.50	2.50	83.0%	28.4	0.00	1.48	1.48	46.35	0.60	9.0%	0.00	78.3%	66/34	1.29	39.1	41.6	47.7	28.41	6.20	89	90
Cheerful Sp Male	**27**	**0**	40.40	17.67	13.12	18.73	15.53	4.00	4.00	80.8%	7.7	0.25	0.00	0.25	40.65	2.00	8.4%	0.60	74.8%	49/51	1.51	34.4	38.4	38.7	28.89	6.70	91	99
Kent	**20+6**	**2**	32.03	19.80	18.95	9.73	9.32	2.50	2.00	94.5%	24.3	0.00	1.27	1.27	33.30	0.00	1.9%	0.92	82.4%	67/33	1.66	27.7	30.2	32.6	22.95	7.70	102	93
Kings B	**27**	**0**	33.81	17.89	15.02	13.39	14.55	2.53	1.61	92.2%	26.8	0.00	1.40	1.40	35.21	0.00	2.8%	1.00	79.1%	57/43	1.30	36.7	39.2	33.7	34.63	5.70	97	118
Kings A2	**20**	**0**	24.78	13.93	12.39	9.85	8.73	1.00	1.00	89.3%	9.4	0.00	0.49	0.49	25.27	0.00	7.2%	0.00	82.0%	58/42	1.26	29.6	30.6	24.9	23.68	6.10	97	110
Kings C1	**27**	**0**	34.53	17.57	14.57	14.46	15.44	2.50	1.50	91.3%	28.2	0.00	1.47	1.47	36.00	0.00	4.6%	0.96	85.9%	55/45	1.33	39.3	41.8	35.2	39.59	5.50	112	100
Kings C2	**24**	**0**	33.51	17.41	14.13	14.60	13.14	1.50	1.50	85.9%	28.3	0.00	1.47	1.47	34.98	1.00	1.6%	1.00	80.0%	54/46	1.46	37.2	38.7	31.3	25.97	5.70	83	94
Kings D	**43**		60.22	32.30	31.34	23.84	21.98	4.08	4.07	95.3%	38.1	0	1.99	1.99	62.21	1.00	3.0%	3.40	83.8%	57/43	1.44	61.5	65.6	66.4	57.64	5.65	105	122
Quex	**19**	**1**	24.65	15.66	14.94	6.96	7.16	2.03	1.91	97.4%	13.0	0.00	0.68	0.68	25.33	0.00	8.8%	0.43	81.3%	69/31	1.33	23.4	25.4	25.9	18.94	5.40	101	98
Bishopstone	**22**	**0**	32.50	17.34	14.60	13.44	11.88	1.72	1.64	86.5%	28.9	0.00	1.50	1.50	34.00	0.00	4.5%	0.00	84.1%	56/44	1.55	34.4	36.1	34.3	28.61	5.30	87	102
Seabathing	**26**	**0**	34.98	18.00	13.73	15.48	14.84	1.50	1.47	85.9%	28.7	0.00	1.49	1.49	36.47	0.00	4.5%	0	84.1%	54/46	1.40	34.4	35.9	34.8	38.14	9.20		
ITU WHH	**11**	**0**	63.60	56.52	56.37	5.41	5.41	1.67	1.59	99.6%	0.0	0.00	0.00	0.00	63.60	1.00	6.4%	3.83	73.8%	91/9	5.78					33.2		
ITU QE	**8**	**0**	46.52	42.72	37.86	2.80	2.80	1.00	1.00	89.6%	5.5	0.00	0.29	0.29	46.81	0.00	4.7%	1.80	77.7%	94/6	5.85					26.8	91	113
ITU KCH	**4 + 4**	**0**	39.06	37.13	35.90	1.00	1.00	0.93	0.93	96.9%	0.0	0.00	0.00	0.00	39.06	0.00	1.9%	3.28	75.6%	97/3	4.88					28.7	91	102
Marlowe	**29 +6**	**4**	54.88	35.01	28.23	17.27	15.12	2.60	2.60	83.7%	152.3	3.17	2.79	5.96	60.84	0.00	7.1%	1.00	78.4%	67/33	2.09	59.2	61.8	54.7	30.19	9.4	94	96
Neonatal ITU	**7**	**0**	72.74	66.74	63.27	3.60	4.00	2.40	1.00	93.9%	19.0	0.61	0.00	0.61	73.35	0.00	4.6%	1.00	76.8%	95/5	10.48					9.3	101	101
Padua	**28**	**0**	45.67	35.61	29.80	7.76	10.43	2.30	1.80	92.0%	86.8	2.78	0.00	2.78	48.45	0.00	6.9%	2.61	67.9%	80/20	1.73	51.2	53.5	50.3		10.3	92	96
Rainbow	**20**	**0**	38.58	30.28	27.61	7.30	8.36	1.00	1.00	95.8%	25.4	0.68	0.22	0.90	39.48	0.00	3.4%	1.00	76.5%	80/20	1.97	47.2	48.2	47.3		12.3	102	114
Birchington	**15**	**4**	33.12	19.50	18.75	10.05	8.99	3.57	3.57	94.5%	14.0	0.07	0.61	0.69	33.81	1.00	0.6%	0.00	87.8%	66/34	2.25	33.2	36.8	23.9	17.2	6.4	102	99
Kennington ward	**11+2**	**0**	23.88	14.78	12.27	6.60	5.53	2.50	2.49	85.0%	65.6	1.65	0.74	2.39	26.27	0.00	4.4%	0.00	80.4%	69/31	2.38	19.8	22.3	19.7	10.45	9.8	87	97
Brabourne	**8**	**0**	15.91	12.84	12.84	2.67	2.00	0.40	0.93	99.1%	50.3	1.53	0.14	1.66	17.57	0.00	6.7%	0.00	79.2%	83/17	2.20	14.2	14.6	15.1	10.02	14.4	81	104
		34	**1774.64**	**1119.54**	**971.48**	**555.91**	**521.43**	**99.18**	**92.98**	**89.4%**	**1133.23**	**25.22**	**18.06**	**43.27**	**1817.91**	**23.42**		**34.86**	**78.7%**									

Appendix 3 – Example of Safecare reporting capability

Selecting a unit will then display metrics for that individual unit: