EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE**:** **7 AUGUST 2015**

SUBJECT: **WARD ESTABLISHMENT REVIEW APRIL 2015**

REPORT FROM: **CHIEF NURSE AND DIRECTOR OF QUALITY**

PURPOSE: **Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Regular annual ward staffing reviews are undertaken to ensure that the nursing establishments provide an appropriate staffing level and skill-mix to support the delivery of safe and effective care to patients.
Ward staffing reviews now take place every 6 months as a requirement of the National Quality Board (2013) expectations around safe staffing assurance.

SUMMARY:

This report outlines the April 2015 review of Adult wards, Paediatric wards and NICU, Critical Care Units, the Emergency Departments and Midwifery. The overall findings indicate that the aims of improving recruitment to vacancies and aiming for ward managers to be 100% supervisory with 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. Almost all of the impact of the agreed investment of £2.9m in 2014/15 is seen in this staffing review and 97% of posts are now recruited to. Recruitment was phased throughout 2014/15 to take account of the supply of registered nurses. It also includes the impact of recruitment to maternity leave and to the additional establishment in paediatric wards.
3. The impact of this investment into ward staffing is almost fully realised and has increased WTE per bed across most areas.
4. The further investment agreed in May following the October 2014 staffing review for Cambridge J, Deal, Kings C1 and Cambridge L ward is being actively recruited to.
5. Average skill mix is similar to the previous review but 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. Registered nurse vacancies in wards are 124 wte which is 87 wte higher than at the previous staffing review. Healthcare assistant vacancies have reduced from 39 wte to 12 wte.
7. There is a fall in % newly qualified nurses who are taking up their first post within EKHUFT. Only 27 out of the 51(53%) newly qualified nurses commenced employment in April 2015. Of 69 final placement 3rd year students due to qualify in September 2015 only 39 (56.5%) have applied for posts within EKHUFT.
8. Overseas recruitment of EU nurses continues. 41 EU nurses commenced in post during November 2014 and a further 16 in January 2015. An overseas recruitment programme is underway to recruit 160 EU nurses by November

2015.

9. Overall average sickness across all 47 wards was 5.1% in April 2015.
10. In April 2015 there was a total of 65 wte (3.89%) staff on maternity leave across the 45 wards. Ward managers are now able to recruit to posts and this has significantly reduced the impact of maternity leave. Ward managers report that this has had a very positive impact.
11. Overall turnover in registered nurses and midwives continues to increase year on year and is now at 12.8% during 2014/15 from 11.2% in 2013/14. The turnover of healthcare assistants, previously stable at 10.6% rose to 14% during 2014/15.
12. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of requested shifts filled by NHS-P was 43% and by agency 20% in April 2015. Overall fill rate of requested shifts has risen from 55% in October 2014 to 63% in April 2015.
13. The improvement in roster quality seen in previous reviews has been sustained with the average achievement of % time clinically effective (% time worked) across all wards, within E-Rostering for April 2015 at 74.5%.
14. Details and summary of planned and actual staffing on a shift-by-shift basis, is now published monthly. Gradual improvement has been seen over the first 12 months of reporting and aggregated fill rates in May are over 97% at WHH, over 96% at QEQM and almost 95% across K&C.
15. The average ratio of patients per registered nurse in April 2015 across each of the wards reviewed was not above 8 during day shifts. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 3 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. Further work is underway to explore how to achieve live reporting of staffing status including patient acuity/dependency and patients per registered nurse.
16. Most wards (41 out of 47) demonstrated average Harm Free Care (acquired in hospital) of 100% patients in April 2015 and only 2 wards was <95%.
17. The review concludes that:

Medical wards	Generally establishments are satisfactory, enabling teams to provide high levels of harm free care and good FFT results. Some investment was agreed for Cambridge J and Deal ward following the previous review.
CDUs	Generally establishments are satisfactory. Further exploration of recruitment, retention and turnover is required to support gaps in staffing.
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.
Stroke	Fordwich and Kingston ward establishments are close to the SEC network standards, but Richard Stevens is slightly below. A demand and capacity review is required to understand the required bed numbers on each site which will feed in to the clinical strategy and the workforce stream.
Acute frailty	The beds on Cambridge L are now funded on a permanent basis to support the consistency of use.
Surgery	Establishments are generally satisfactory and investment has been 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.

T& O	Establishments are generally satisfactory. A small investment has been agreed for Kings C1 based on nursing workload and acuity to bring levels to Hurst and closer to SNCT and professional judgement.
Renal & Haematology	Establishments are generally satisfactory. High vacancies on Marlowe ward may require an innovative approach to resolve.
Gynaecology	Wards appear over-established but Hurst and SNCT does not reflect day attendances and the establishments are close to professional judgement. Regular use of the contingency beds on both wards is facilitated effectively.
Paediatrics	Current RCN guidelines suggest investment to support the ratio of 1:4 at night. The Royal College of Paediatricians recently reviewed our services 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.
Neonatal Intensive Care	A comprehensive nurse staffing review, including scoping of other units, was undertaken for Neonatal Services in East Kent using national recommendations for neonatal staffing levels. The review indicated that investment is required in the WHH NICU and the QEQM SCBU. A business case is under development.
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 April 2015 was 1:27. A Maternity structural review will be undertaken in 2015/16.
Emergency Departments	Professional Judgement suggests that current staffing levels appear sub optimal but further review against NICE guidance ED staffing will not be possible as it will not be published. Some investment has been agreed and recruitment is underway.

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

1. Optimise the use of existing resources;
   - Develop a trajectory for agency reduction aligned to the EU recruitment programme;
   - Further reduce the vacancy levels for registered nurses by implementation of a robust recruitment and retention plan to include recruitment ahead of turnover;
   - Continue to work with NHS-P to increase fill rate to the required level and explore the development of an internal staff bank;
   - Ensure accuracy of reporting actual against planned hours filled by revisiting all rosters as part of the roll out of the NHS-P interface with the E-Rostering system.

2. Evaluate the impact of the investment into ward staffing;
   - Achieve full implementation of additional posts taking place across 2015/16.
   - Evaluate impact of the 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;
   - Fully implement the supervisory element of the ward manager role and

evaluate the benefits through the ward accreditation framework.
- Implement the plan for all ward managers to undertake the clinical leadership programme over the next three years.

4. Improve alignment of staffing required to demand;
   - Develop the availability of live staffing reporting in collaboration with MAPS Healthroster to enable reporting of staffing related to nursing workload and nursing red flag events.

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

The ward staffing review will be repeated every six months.

RECOMMENDATIONS:

The Board of Directors is asked to considers and agree the recommendations.

NEXT STEPS:

Continue to meet National Quality Board requirements for providing assurance of safe staffing levels.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

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

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Continued vacancy factor and reliance on temporary staffing, requires innovative recruitment approach to enable recruitment ahead of turnover and retention initiatives to reduce the level of turnover.

FINANCIAL AND RESOURCE IMPLICATIONS:

Adequate staffing levels impact on the achievement of the of the required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2015/16 CQUINs which are valued at 2.5% of actual outturn, or around £10m..

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

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

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

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

ACTION REQUIRED:

(a) To discuss
(b) To note.

CONSEQUENCES OF NOT TAKING ACTION:
Insufficient numbers of staff, inappropriate skill mix and ineffective use of the existing workforce will impact upon the ability of the organisation to achieve the CQC standards and the quality outcomes within the operating framework and CQUINS for 2015/16.

WARD ESTABLISHMENT REVIEW (April 2015)

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WARD ESTABLISHMENT REVIEW (April 2015)

1. INTRODUCTION

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

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

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

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

2. NATIONAL QUALITY BOARD EXPECTATIONS ON WARD STAFFING

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

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

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

  Staffing boards have been in place since April 2014 in all inpatient wards.

- The Board of Directors 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 of Directors 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, sickness, staff turnover, use of temporary staff;
- Roster performance and actual against planned filled hours;
- Triangulation between the use of evidence based tools and professional judgement and scrutiny;
- Information on Safety Thermometer performance and;
- Investment into ward staffing during 2014/15 and progress in implementing recommendations from the previous review.

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

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

Following the staffing review presented to the Trust board in May 2013 a business case for investment of £2.9m was agreed in November 2013 to support additional staffing to:

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

Almost all of the impact of this significant investment is seen in this staffing review due to the planned implementation of additional posts taking place across 2014/15.

The Paediatric posts were fully recruited to by March 2014. Maternity leave is now being actively recruited to across all wards. All 40 Ward Manager Assistant posts and 22 of the 24 additional band 6 posts have now been recruited to against plan. Some band 5 staff are undergoing development into the band 6 role with the aim of being in post by September 2015. 97% of the new posts are now recruited to.

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 wards, 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 ward to provide a consistent approach to making resources available, with substantive staff, to ensure safe and high quality patient care.

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

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

Recruitment to these additional posts is underway.

4. CURRENT WARD ESTABLISHMENTS

A summary of current funded establishments and staff in post in 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 April 2015.

The structure of most (70%) ward budgets (32 out of the 46 reviewed) includes a separate bank line which provides a resource as part of the funded WTE to manage peaks and troughs in activity and flexible replacement for sickness. Most ward managers have chosen not to convert an element of this resource to substantive posts due to the flexibility it provides.

Converting this budget into WTE represents an additional 23 WTE across the 32 wards, and it is this ‘uplifted’ total funded establishment that has been used as the baseline when making comparisons with the modelling methods within this review. However, operationally this component of the budget is not included in the establishment for E-Rostering and is utilised by requesting additional shifts within the system to provide additional cover for long-term sick leave.

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

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

Nursing Rota - Headroom Calculation:

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

Therefore, a reduction in sickness could enable some of the increased available hours to be invested into more training for staff and a reduction in the use of temporary staffing.

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

Skill mix is similar to the previous review but the impact of Associate Practitioners is reflected in a slightly reduced skill mix in medical wards, CCU, stroke and wards where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies. Associate Practitioners are highly trained support staff who undertake a Foundation Degree, equivalent to diploma level, and are able to undertake much of the work previously within the domain of the registered nurse. The skill- mix changes over time are shown in figure 3 and include registered nurses / associate practitioner / healthcare assistants and other support staff.

Figure 3. Average ward staffing skill mix from 2007 to 2015

Average skill-mix across specialties							
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Apr-15**
Medical	55/45	56/44	56/44	57/43	57/43	56/1/44	**56/44**
CDU	NR	NR	NR	62/38	65/35	63/37	**64/36**
CCU	78/22	76/24	81/19	81/19	81/19	80/1/19	**79/21**
Stroke	51/49	63/37	63/37	61/39	56/44	56/5/39	**55/45**
Acute frailty	48/52	53/47	54/46	55/45	53/47	55/1/44	**55/45**
Surgery	53/47	60/40	55/45	57/43	54/46	55/2/43	**54/46**
T+O	53/47	57/43	56/44	55/45	52/48	54/1/45	**54/46**
Renal				63/37	63/37	63/38	**63/38**
Haematology				69/31	83/17	83/18	**80/20**
Gynaecology				59/41	59/41	59/42	**60/40**

If the skill-mix is represented including those providing direct patient care only and excluding administrative staff (ward clerk and ward manager assistant roles) the skill-mix seen is slightly higher and close to 60/40 or more across all areas, seen in Figure 4.

Figure 4. Skill-mix including registered nurses / support staff

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

The impact of previous investment into ward staffing is almost fully realised and has increased WTE per bed across most areas, seen in figure 5.

Figure 5. Average ward staffing WTE per bed from 2007 to 2015

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

Following recruitment to the additional posts agreed for 2015/16 in medical and orthopaedic wards further impact will be seen in average WTE per bed across these specialties as funding is not drawn down into ward budgets until staff are in post.

The reduction seen in overall WTE per bed in CDUs is due to the split of the WHH CDU funded establishment, from 1st October 2014, to provide staffing for the 25 bedded acute assessment area and 18 short stay beds on Cambridge M1. This does not reflect the higher ratio of staff per bed retained in the acute assessment area.

6. WORKFORCE METRICS

The impact of current vacancy levels, sickness and maternity leave across the 47 wards is 17.2%, an increase from 12.5% in March 2014 and 13.2% in October 2014, and is summarised in Figure 6. The absence associated with maternity leave is significant, at 65.48 WTE (3.89%). 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 6. Wards staffing vacancy, sickness and maternity leave April 2015

Workforce indicators				
	Dec-12	Mar-14	Oct-14	Apr-15
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02	*1680.86
Registered Nursing vacancies (WTE)	44.00	73.88	37.66	124.71
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44	12.55
Vacancy (%)	4.75	5.21	6.08	8.16
Sickness (%)	4.96	4.90	4.60	5.15
Maternity leave (%)	3.28	2.38	2.53	3.89
* 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

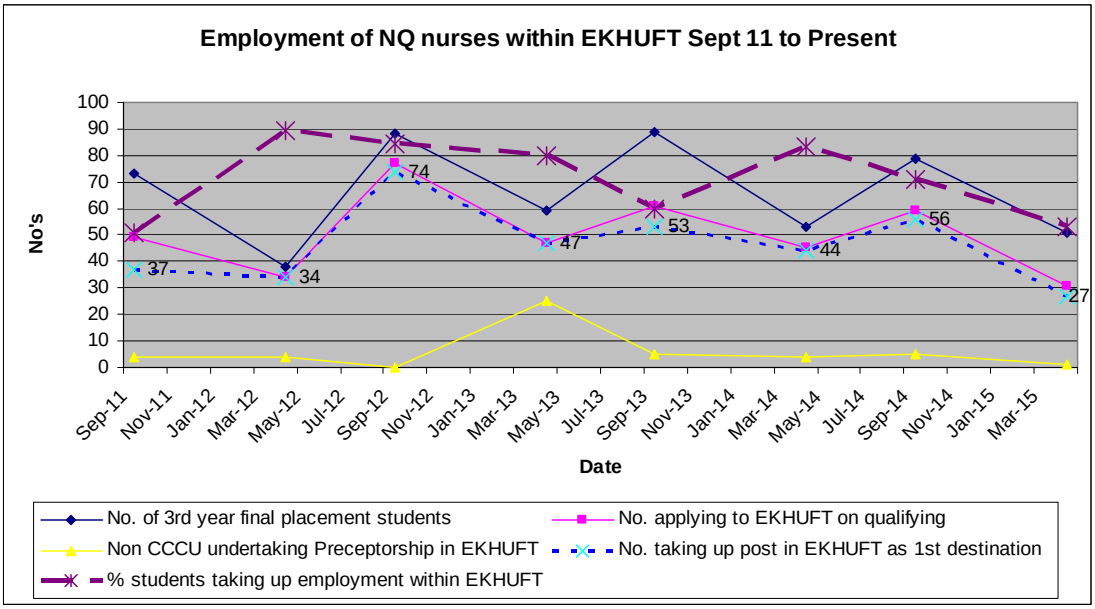
The resourcing team have made improvements to the recruitment process resulting in a reduction in average time between the date of an advert being opened on NHS Jobs and the date that all pre-employment clearances are completed from 12 to around 10 weeks since April 2014 thereby reducing the impact of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

The vacancy rate across all wards is over 8% and has increased from 6% over the last 6 months since October 2014. Registered nurse vacancies in wards are 124 wte which is 87 wte higher than at the previous staffing review. Healthcare assistant vacancies have reduced from 39 wte to 12 wte. The majority of the registered nursing vacancies are at band 5.

Several issues have contributed to the rise in vacancies:

- There is a national shortage of registered nurses.
- The shortage of candidates with the right skills and experience has created a competitive market and EKHUFT also suffers from a unique geographical position on a peninsula with ‘fast transport links’ into London.
- We compete with the London Healthcare Market and Private Healthcare Providers and other NHS providers in areas where the NHS High Cost Area Supplement (London Weighting) applies.
- NHS budget constraints led to reduced numbers of nurse training places from 2010 – 2013.
- There is a fall in % newly qualified nurses who are taking up their first post within EKHUFT, shown in Figure 7. Only 27 out of the 51(53%) newly qualified nurses commenced employment in April 2015. Of 69 final placement 3rd year students due to qualify in September 2015 only 39 (56.5%) have applied for posts within EKHUFT.

Figure 7. Employment of newly qualified nurses within EKHUFT 2011-2015



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

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

- Improving overall job satisfaction for our staff through regular opportunities for feedback and valuing and developing our staff their working environment and improving our retention rates;
- Develop a "Talent Pool" of candidates (previous applicants via NHS Jobs) who we can access immediately without the need to advertise.

The following actions are progressing:

1. A Head of Strategic Resourcing has been appointed to lead the implementation of an action plan to reduce nurse vacancies;
2. The recruitment process has been thoroughly reviewed and actions are in place to reduce delays;
3. Recruitment of 160 nurses from overseas (Portugal early July, Greece early August and Romania & Croatia early September). These nurses will join us in the autumn / winter.
4. Working with NHS-P to recruit 30 registered nurses from Italy in July with the aim of starting in post in autumn / winter;
5. Launch of a Trust campaign for nursing recruitment in late July. This will focus 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 will include a radio campaign, Spotify campaign and two Open Days, planned for 1st August and 8th August. UC&LTC and Surgery will be the predominant focus of these, with a particular focus on Emergency Departments, Endoscopy, Theatres and Wards.
6. Health Education Kent, Surrey & Sussex have confirmed an increase in training places by 10% in September 2015 and a further increase of 10% in September 2016;
7. The aim to recruit all newly qualified nurses who want to work within EKHUFT;
8. Establishing a 'snap shot' of current vacancies across the Trust, identifying hot spots and hard to recruit areas.

6.2 Sickness absence

ESR data demonstrates that average sickness absence rate across the wards was 5.1% in April 2015. The average monthly sickness rates show wide variation but higher average rates in excess of 10% were seen in stroke, respiratory 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 e.g. 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 April 2015 there was a total of 65 wte (3.89%) 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 has increased in registered nurses and midwives and is now at 12.8% during 2014/15 from 11.2% in 2013/14. The turnover of healthcare assistants, previously stable at 10.6% rose to 14% during 2014/15.

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

Turnover (%)				
	2011	2012	2013/14	2014/15
Nursing & Midwifery	7.5	9.5	11.18	12.8
HCA and other support staff	12.6	10.6	10.63	14.2

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

7. USE OF TEMPORARY STAFF

The level of temporary staff usage across the divisions is managed with appropriate controls and monitored in relation to total ward staffing expenditure. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of requested shifts filled by NHSP was 43% and by agency 20% in April 2015.

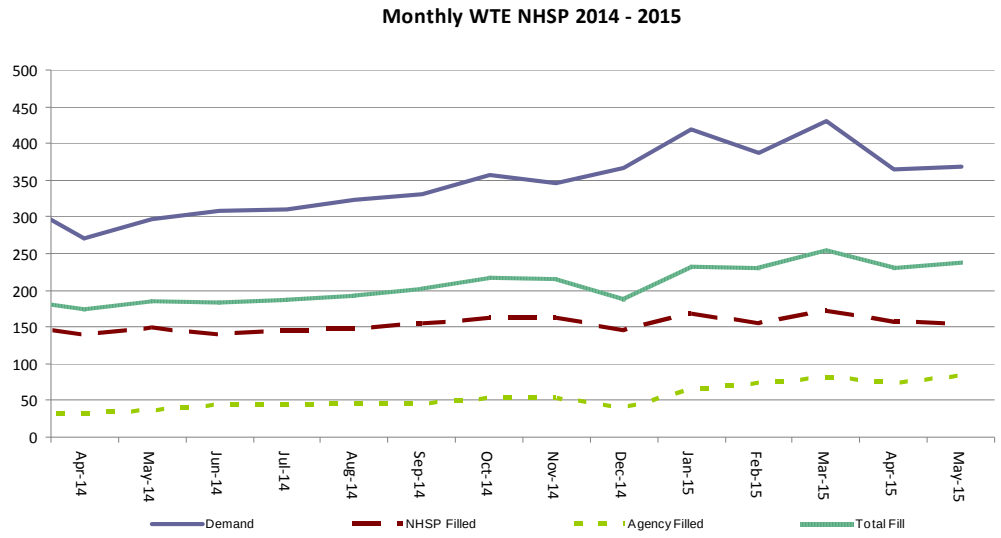
The use of temporary staffing, including NHS-P bank and agency, is variable and overall fill rate of requested shifts has risen from 55% in October 2014 to 63% in April 2015. This partially closes the gap presented by vacancies and planned / unplanned absences but does operationally present a challenge for both the Trust and our supplier through NHS-P particularly in filling gaps at short notice. Issues surrounding NHS-P bank fill rates, which are currently below the overall agreed target of 75% for registered nurse shifts and 90% for healthcare assistant shifts, are being addressed with the supplier through the appropriate contract management processes.

Even with rigorous management controls through the temporary staff booking process the use of NHS-P overall has risen over the past year, largely to fill gaps due to vacancies, long term sickness and maternity leave and to provide safe staffing for additional beds. It should be noted that no substantive member of staff is permitted to work additional shifts for the Trust through an agency and the use of agency healthcare assistants has been completely eliminated since 2010. Seasonal

fluctuations are seen in the trends in figure 9, e.g dips during Christmas week when staff annual leave is restricted, peaks in March when staff annual leave is higher and working back through NHSP is widely practised. An April/May and October dip is also seen as cohort recruitment of newly qualified nurses reduces the demand for NHSP.

Dependency on agency to meet the shortfall in NHS-P filled shifts has resulted in a significant cost pressure for the Trust and a trajectory for agency reduction is under developed aligned to the EU recruitment programme.

Figure 9. Trend of NHS-P demand and fill in WTE from 2012 to 2014



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

- Implementation of a 'Never Cancel Bank' initiative to improve the use of booked staff across wards.
- The Trust has worked collaboratively with NHS-P to recruit 13 registered nurses from Portugal in February 2014, 25 from Italy who commenced work in September 2014 and a programme of recruitment of 30 EU nurses is underway in July 2015 to provide a dedicated resource ahead of the increased demand anticipated in winter 2015/16.
- Enabling newly qualified nurses to work through NHS Professionals during the Preceptorship period on the ward where they hold a substantive post three months after qualification since 2010/11.
- Reduction of pay from agenda for change spine point 3 to 1 for band 2 healthcare assistants from August 2011.
- Providing an opportunity for healthcare assistants with nursing home experience to gain the skills and competence to work with the hospital environment from December 2011.
- Winter incentives for NHS-P bank workers working additional shifts with no cancellations, to win shopping vouchers.

8. ROSTER PERFORMANCE AND ACTUAL AGAINST PLANNED FILLED HOURS

The improvement in roster quality seen in previous reviews has been sustained with the average achievement of % time clinically effective (% time worked) across all wards, within E-Rostering for April 2015 at 74.5% against 74.59% in October 2014 and 70.37%in December 2012. 21 of the 45 wards achieved more than the optimum

75%, against only 9 in December 2012, and 27 in October 2014 which demonstrates sustained improvement.

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 are over 97% at WHH, over 96% at QEQM and almost 95% across K&C, shown in Figure 10.

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

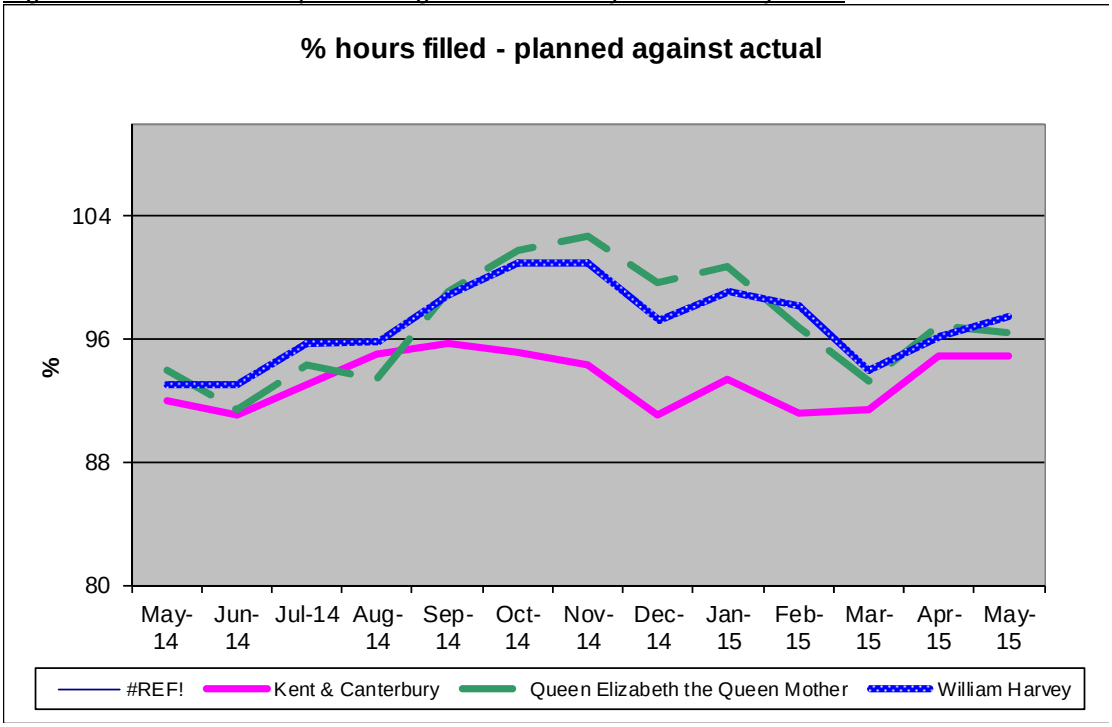
- There are no vacant posts
- All vacant planned shifts are covered by overtime or NHS-P shifts
- Annual leave, sickness and study leave is managed within 22%

Gradual improvement was seen over the first months of reporting, shown in figure 11. The slight reductions seen from December to March reflect the requirement for additional shifts during winter pressures not always being filled by NHSP. The reduction in March also reflects annual leave taken at year end. Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time.

Figure 10. % hours filled planned against actual by site during May 2015

	% Hours filled - planned against actual May 2015				
	DAY		NIGHT		
Hospital site	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Overall % hours filled
Kent & Canterbury	84.8%	99.6%	96.5%	122.5%	94.86
Queen Elizabeth the Queen Mother	90.1%	104.1%	97.4%	101.4%	96.41
William Harvey	91.7%	101.6%	97.7%	110.7%	97.45

Figure 11. % hours filled planned against actual May 2014 to May 2015



Senior nursing leaders have reported that:

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

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

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

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

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

Table 1. Methodologies used to evaluate specialties

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

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

9.1 Professional judgement

A component of the Hurst workforce planning tool includes a method of calculating required establishments using professional judgement. The feedback from ward managers on required staffing levels across the 24 hour period was utilised and there was a close correlation between calculated establishments and actual for most wards.

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

9.3 Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care 2000). These classifications have been adapted to support measurement across a range of wards and specialties.
The dimensions of patient dependency and acuity are important variables in determining nursing workload and the SNCT was applied to study current nursing workload in all wards to calculate ward establishment. Monthly data was collected since 2013/14 for all adult wards as part of the monthly NHS Safety Thermometer ‘Harm Free Care’ survey. However, the updated 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 critieria.

Calculation of establishments using the SNCT method taking account of nursing workload associated with patient acuity and dependency demonstrated some correlation between calculated and actual establishment for most wards. However, three wards had significantly higher calculated establishments required using this method than they have currently. Investment was agreed in May 2015 to address these deficiencies. The wards are:

- Cambridge J - dedicated 34 bedded respiratory ward had an average of 11 patients each day requiring non-invasive respiratory support.
- Deal - 28 beds mostly very highly dependent patients who require nursing care to meet all or most of their needs.
- Kings C1 – 27 bedded trauma ward. It should be noted that this ward has 4.0 wte dedicated therapy staff.

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.

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. Three of these posts have been recruited to and commenced in February 2015.

The application of modelling methods (summarised in figure 15) has identified that:

- There is a closer alignment of current funded staffing budgets and the establishments derived from application of the modelling methods than has been seen in previous reviews of ward staffing.
- There is alignment between current funded establishments and modelling tools applied (Professional Judgement, Hurst and the Safer Nursing Care Tool (SNCT) for most wards. However, acuity and dependency appeared lower in May 2015 than in October 2014 for some wards reflecting some variation in nursing workload between winter and spring.
- Three wards have lower current establishments than suggested by all three modelling approaches. These are Cambridge J, Deal ward and Kings C1 (although Kings C1 has the dedicated support of 4.0 wte Therapy staff).
- Both Professional Judgement and the RCN tool suggest higher establishments on the Paediatric ward at WHH to cover Day Surgery & Outpatients and at QE to cover outpatients and to ensure RCN ratio of 1:4 overnight. However, this is partially offset by a low average occupancy which in October was around 50%.

Figure 15. Triangulation between evidence based tools and professional judgement

Specialty	Ward	Full Est (WTE)	Prof judgment	Hurst NPOB or other appropriate model	SNCT	SNCT contingency beds	Comments
CDUs	CDU WHH	72.35	67.8	67.4	16.62	8.3	The SNCT does not capture bed utilisation and high turnover of patients
					23.25		
	CDU, QEQM	39.56			33.21		
	ECC	82.96	37.3	27.0			
			46.1	NA			
Medical	Harvey ward	26.00	28.6	24.6	25.74		Alignment for most wards except Cambridge J and Deal where current establishments are below that suggested by all 3 modelling methods. Additional investment has been agreed for both of these wards.Oxford ward establishment reflects higher requirement for single rooms.
	Treble ward	29.41	30.2	24.2	23.49		
	Mount McMaster	29.99	33.9	33.7	30.8	3.11	
	Invicta	29.92	31.0	33.7	29.81		
	Cambridge J	39.64	46.1	44.8	47.76		
	Cambridge K	34.69	31.2	38.1	33.69		
	Cambridge M2	27.08	28.6	29.2	27.42		
	Oxford	23.91	26.0	20.5	16.78		
	Minster Ward	31.97	32.7	32.6	35.65		
	Sandwich Bay	27.92	30.3	30.3	30.62		
	St Margarets	27.01	30.7	31.5	26.47	3.66	
	Deal	32.41	38.7	38.1	36.24		
Stroke	Kingston	40.43	42.3	42.1*	30.61	2.56	Alignment for Kingston and Fordwich (*SEC Network Stroke Model) but less so for Richard Stevens. SNCT does not capture stroke thrombolysis nursing work outside the ward.
	Richard Stevens	41.63	42.6	44.8*	37.04		
	Fordwich Ward	37.72	34.2	38.0*	30.52	4.26	
Frailty	Harbledown	35.08	31.8	32.2	29.36	0.00	Some alignment across both wards but higher PJ foe CL due to contingency beds.Additional investment has been agreed for these beds
	Cambridge L	32.88	40.8	29.3	38.81		
Coronary Care	CCU WHH	32.04	30.0	32.7	14.93		Alignment with PJ in all wards and Hurst for WHH. Increased K&C establishment reflects higher cost of staffing small wards.
	CCU QEQM	23.15	21.8	26.5	18.16		
	Taylor KCH	16.16	15.4	7.7	6.33	2.27	
Renal & Oncology	Marlowe	53.12	59.2	54.7	35.51	0.30	Some alignment on both wards but PJ higher than existing staffing on Marlowe.
	Brabourne	16.67	14.7	15.1	12.06		
Gynaecology	Kennington ward	22.18	20.9	16.8	11.10	3.96	Alignment with PJ but less so with Hurst and SNCT due to not able to capture outpatient and day attender activity.
	Birchington	30.45	27.5	23.0	15.29	3.17	
Paediatrics	Padua	45.80					PJ and RCN suggest higher establishments at WHH to cover Day Surgery & Outpatients and at QE to cover outpatients and to ensure RCN ratio of
	Rainbow	37.85					
Surgical	Clarke	44.11	44.6	44.7	36.73	0.30	Alignment for most wards except Rotary due to SNCT capturing inpatient and trolley activity but not outpatient activity.
	Kent	33.58	26.4	24.9	24.60	0.00	
	Kings A2	25.99	28.3	24.9	23.68		
	Kings B	35.30	34.6	33.6	37.35		
	Rotary	34.30	32.6	19.9	17.60		
	Cheerful Sp M	30.14	31.5	27.0	20.92	2.08	
	Cheerful Sp F	33.71	32.8	29.5	27.45	0.00	
Trauma & Orthopaedic	Kings D	62.29	64.8	59.7	44.40		Alignment for most wards except Kings C1 where PJ suggests higher workload than funded establishment allows for. However, the ward has 4.0 wte dedicated therapy staff.
	Kings C1	34.50	38.8	35.2	28.56		
	Kings C2	34.97	30.0	31.9	26.52		
	Bishopstone	34.55	32.0	29.6	33.71		
	Seabathing	35.44	36.1	34.1	33.18		
	Quex	25.35	26.9	26.3	21.74	0.58	

9.4 Ratio of patients per registered nurse

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

The average ratio of patients per registered nurse in April 2015 across each of the wards reviewed was not above 8 during day shifts. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 3 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. Further work is underway to explore how to achieve live reporting of staffing status including patient acuity/dependency and patients per registered nurse.

Figure 16. Ratio of patients per registered nurse average April 2015 – E-Rostering system

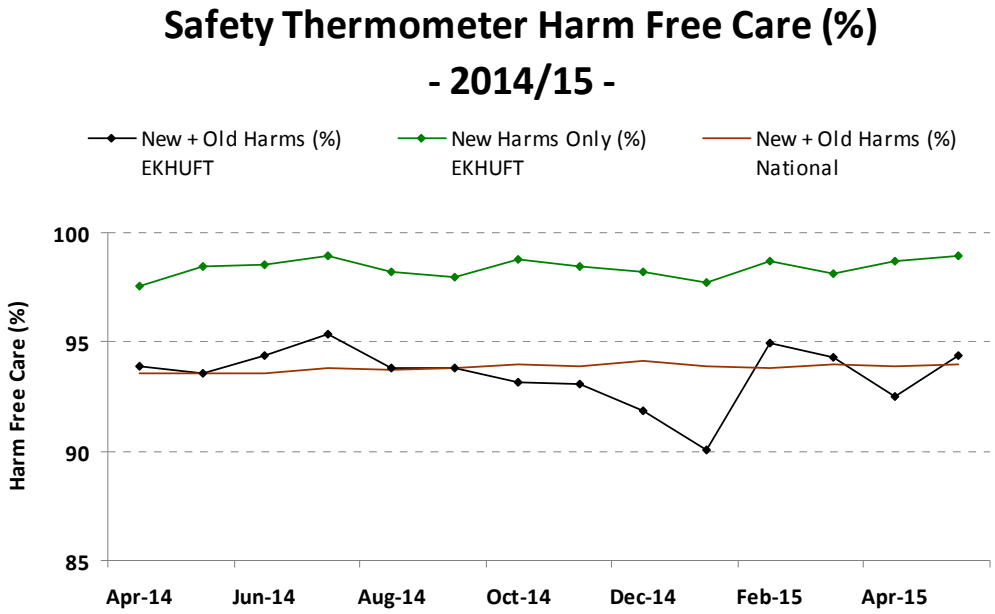
Ward	Ratio patients to RN - day shifts	Ratio patients to RN - night shifts
CDU WHH	3.54	4.50
CDU, QEQM	5.31	6.13
Harvey ward	7.11	9.50
Treble ward	6.93	9.30
Mount McMaster	7.91	11.88
Invicta	5.63	11.26
Cambridge J	7.47	12.85
Cambridge K	5.40	14.00
Cambridge M2	5.18	9.22
Oxford	4.37	6.85
Minster Ward	5.89	12.02
Sandwich Bay	6.02	10.63
St Margarets	5.68	11.22
Deal	5.49	15.97
Kingston	4.79	7.83
Richard Stevens Unit	5.80	10.32
Fordwich Ward	3.99	7.00
Harbledown	7.32	11.47
Cambridge L	5.99	11.82
CCU WHH	2.20	2.73
CCU QEQM	3.48	7.00
Taylor KCH	2.29	2.49
Marlowe	3.85	7.79
Brabourne	3.47	3.74
Kennington ward	4.66	5.41
Birchington	4.11	7.94
Clarke	6.32	17.95
Kent	5.55	10.00
Kings A2	5.98	9.00
Kings B	6.15	11.50
Rotary	3.41	8.36
Cheerful Sp Male	8.42	10.90
Cheerful Sp Female	6.85	11.67
Kings D male(1)	6.91	9.78
Kings D female (2)		
Kings C1	7.37	13.50
Kings C2	6.26	13.01
Bishopstone	3.04	5.83
Seabathing		
Quex	5.40	10.93

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 18:1 on Clarke ward reflects the exclusion of the registered nurse on a twilight shift (18.00 – midnight) which is included as a day shift. However, ensuring the ratio of patients to registered nurses at night is reduced on this ward is a current priority. Further work is required to enable live capture, reporting and escalation of staffing levels through the E-Rostering system.

10. SAFETY THERMOMETER PERFORMANCE

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

Figure 17. Harm free care performance against national average ((Apr-14 to May-15)



Most wards (41 out of 47) demonstrated average Harm Free Care (acquired in hospital) of 100% patients in April 2015 and only 2 wards were <95%.

11. ANALYSIS OF SPECIALTIES OUTSIDE WARD AREAS

11.1 Neonatal Intensive Care

A comprehensive nurse staffing review, including scoping of other units, was undertaken for Neonatal Services in East Kent in March 2015 using national recommendations for 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 rationale for the review was high use of agency staff to maintain activity, retirement of experienced staff and an imbalance against recommendations for nurses qualified in the specialty. The combination of these factors is affecting staff sickness, morale and the ability of the service to respond to peaks of high activity.

A national audit had also been undertaken by the Neonatal Clinical Reference Group which matched actual unit activity against actual in-post staffing. This audit highlighted a deficiency for the 2014 calendar year of 25.0 wte staff on the NICU at the William Harvey Hospital and 3.0 wte staff on the SCBU at the Queen Elizabeth Queen Mother Hospital.
Using 2 methods of calculating staffing requirements, the review recommended that nurse staffing on NICU be increased by 16.47 wte and by 3.25 wte in SCBU, recruiting staff over an agreed period of time. There would also be the need to explore different roles within the neonatal environment and alternative training options to increase the number of nurses trained in neonatal intensive care to match recommendations.

11.2 Paediatrics

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

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

Current RCN guidelines also suggest investment may be required 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. The suggested increase in establishments by 5.10 wte for Padua and 6.15 wte for Rainbow has been calculated assuming an average occupancy level of 80% during the day and 65-70% at night although the actual occupancy is lower than this.

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 ICNARC 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 high vacancy rate of 10 wte registered nurses in April has improved to 5.0 wte as a result of innovative recruitment of newly qualified and also inexperienced nurses. There some reliance on temporary staff to fill gaps in staffing which is reflected in the % filled hours at the WHH site.

Since the October 2014 review additional funded establishment has been secured for the 9th bed at QEQM. However, since April this is now not used for recruiting substantive staff but used to provide flexible cover. Vacancy levels have reduced and the Unit is almost fully established.

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; reducing patient transfers for non medical reasons and cancellation of elective surgery.

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 28.0 since November 2014. Staff in post excludes roles that are predominantly management in nature. If a proportion of clinical time associated with these roles was included, this would improve the ratio. However, for transparency and simplicity, the Trust has excluded these posts to date.

Month	Midwife to Birth ratio
01/11/2014	01:25.9
01/12/2014	01:25.0
01/01/2015	01:28.4
01/02/2015	01:26.6
01/03/2015	01:28.8
01/04/2015	01:27.8
01/05/2015	01:28.1
01/06/2015	01:30.6

A full structural review of the maternity services is planned during 2015/16. The Birthrate Plus tool is currently being remodelled and following publication of the revised model a full assessment will be conducted.

11.5 Emergency Departments

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

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

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

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

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

In October 2014 review the departments were reviewed against the only available methodology, the RCN Baseline Emergency Staffing Tool (BEST) to evaluate the volume and pattern of nursing workload against current establishments. It does not produce recommended staffing levels but allows EDs to work to reduce disparity between workload and staffing through improving patient pathways, processes, roster designs and actual staffing. The existing establishments are close to that determined by the BEST tool recommended level at WHH but data for QE was incomplete. BEST is a snapshot of one working week and so is unreliable to base a change in staffing requirements upon it. The tool excludes ENP, Nurse in Charge, Senior Matron and Matron level nursing and only reflects direct clinical nursing staff.

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

- A supervisory nurse in charge 24 hrs per day;
- The implementation of a band 6 majors coordinator and SECAmb triage role;
- A ratio of 1 band 5 nurse per 4 patients in the trolley area. This allows for a trolley patient to be 'turned over' every 2 hrs;
- ENP cover from 07:30 – 02:00 seven days per week;

- A paediatric area staffed with 1 RSCN 24/7 and 1 wte play assistant;
- Matron cover seven days per week at both QEQMH and the WHH;
- A second band 5 nurse in the resuscitation area on both sites;
- A trauma nurse specialist at the QEQMH site.

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

The investment of around £660K in 2015/16 is focused on an additional matron on each site and additional support workers, outlined below. Posts are recruited to but post holders have not yet commenced in post, as at mid July, with the exception of the additional band 8a Matrons.

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

A further investment of around £800K in 2016/17 is planned and will be focused across the emergency floor to develop different ways of working, to reduce the pressure on the ED and to improve the resource to deliver ambulatory pathways.

Current challenges include:

- Vacancy levels are more significant at QE than at WHH. Alternative staff groups i.e. paramedics have been considered for employment within the EDs as they have a suitable skill set to compliment the nursing and medical teams;
- Reliance on agency staff to fill gaps to ensure patient safety;
- Supporting the ED staff to deliver improvements in performance and developing an effective workplace culture at the frontline;
- Maintaining sickness levels which have significantly reduced on both sites recently and are around 2.5% in April 2015 on both sites.

12. CONCLUSIONS

The Summary of the findings are:

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met;
2. Almost all of the impact of the agreed investment of £2.9m in 2014/15 is seen in this staffing review and 97% of posts are now recruited to. Recruitment was phased throughout 2014/15 to take account of the supply of registered nurses. It also includes the impact of recruitment to maternity leave and to the additional establishment in paediatric wards;
3. The impact of this investment into ward staffing is almost fully realised and has increased WTE per bed across most areas;
4. The further investment agreed in May following the October 2014 staffing review for Cambridge J, Deal, Kings C1 and Cambridge L ward is being actively recruited to;
5. Average skill mix is similar to the previous review but 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. Registered nurse vacancies in wards are 124 wte which is 87 wte higher than at the previous staffing review. Healthcare assistant vacancies have reduced from 39 wte to 12 wte;
7. There is a fall in % newly qualified nurses who are taking up their first post within EKHUFT. Only 27 out of the 51(53%) newly qualified nurses commenced employment in April 2015. Of 69 final placement 3rd year students due to qualify in September 2015 only 39 (56.5%) have applied for posts within EKHUFT;
8. Overseas recruitment of EU nurses continues. 41 EU nurses commenced in post during November 2014 and a further 16 in January 2015. An overseas recruitment programme is underway to recruit 160 EU nurses by November 2015;
9. Overall average sickness across all 47 wards was 5.1% in April 2015;
10. In April 2015 there was a total of 65 wte (3.89%) staff on maternity leave across the 45 wards. Ward managers are now able to recruit to posts and this has significantly reduced the impact of maternity leave. Ward managers report that this has had a very positive impact;
11. Overall turnover in registered nurses and midwives continues to increase year on year and is now at 12.8% during 2014/15 from 11.2% in 2013/14. The turnover of healthcare assistants, previously stable at 10.6% rose to 14% during 2014/15;
12. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of requested shifts filled by NHS-P was 43% and by agency 20% in April 2015. Overall fill rate of requested shifts has risen from 55% in October 2014 to 63% in April 2015;
13. The improvement in roster quality seen in previous reviews has been sustained with the average achievement of % time clinically effective (% time worked) across all wards, within E-Rostering for April 2015 at 74.5%;
14. Details and summary of planned and actual staffing on a shift-by-shift basis, is now published monthly. Gradual improvement has been seen over the first 12 months of reporting and aggregated fill rates in May are over 97% at WHH, over 96% at QEQM and almost 95% across K&C;
15. The average ratio of patients per registered nurse in April 2015 across each of the wards reviewed was not above 8 during day shifts. However, the average ratio of patients per registered nurse during night shifts was higher and was above 13 in 3 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. Further work is underway to explore how to

achieve live reporting of staffing status including patient acuity/dependency and patients per registered nurse;

16. Most wards (41 out of 47) demonstrated average Harm Free Care (acquired in hospital) of 100% patients in April 2015 and only 2 wards was <95%.

The review concludes that:

Medical wards	Generally establishments are satisfactory, enabling teams to provide high levels of harm free care and good FFT results. Some investment was agreed for Cambridge J and Deal ward following the previous review.
CDUs	Generally establishments are satisfactory. Further exploration of recruitment, retention and turnover is required to support gaps in staffing.
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.
Stroke	Fordwich and Kingston ward establishments are close to the SEC network standards, but Richard Stevens is slightly below. A demand and capacity review is required to understand the required bed numbers on each site which will feed in to the clinical strategy and the workforce stream.
Acute frailty	The beds on Cambridge L are now funded on a permanent basis to support the consistency of use.
Surgery	Establishments are generally satisfactory and investment has been 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.
T& O	Establishments are generally satisfactory. A small investment has been agreed for Kings C1 based on nursing workload and acuity to bring levels to Hurst and closer to SNCT and professional judgement.
Renal & Haematology	Establishments are generally satisfactory. High vacancies on Marlowe ward may require an innovative approach to resolve.
Gynaecology	Wards appear over-established but Hurst and SNCT does not reflect day attendances and the establishments are close to professional judgement. Regular use of the contingency beds on both wards is facilitated effectively.
Paediatrics	Current RCN guidelines suggest investment to support the ratio of 1:4 at night. The Royal College of Paediatricians recently reviewed our services 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.
Neonatal Intensive Care	A comprehensive nurse staffing review, including scoping of other units, was undertaken for Neonatal Services in East Kent using national recommendations for neonatal staffing levels. The review indicated that investment is required in the WHH NICU and the QEQM SCBU. A business case is under development.
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 April 2015 was 1:27. A Maternity structural review will be undertaken in 2015/16.

Emergency Departments

Professional Judgement suggests that current staffing levels appear sub optimal but further review against NICE guidance ED staffing will not be possible as it will not be published. Some investment has been agreed and recruitment is underway.

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

1. Optimise the use of existing resources;
   - Develop a trajectory for agency reduction aligned to the EU recruitment programme;
   - Further reduce the vacancy levels for registered nurses by implementation of a robust recruitment and retention plan to include recruitment ahead of turnover;
   - Continue to work with NHS-P to increase fill rate to the required level and explore the development of an internal staff bank;
   - Ensure accuracy of reporting actual against planned hours filled by revisiting all rosters as part of the roll out of the NHS-P interface with the E-Rostering system.

2. Evaluate the impact of the investment into ward staffing;
   - Achieve full implementation of additional posts taking place across 2015/16;
   - Evaluate impact of the 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;
   - Fully implement the supervisory element of the ward manager role and evaluate the benefits through the ward accreditation framework.
   - Implement the plan for all ward managers to undertake the clinical leadership programme over the next three years.

4. Improve alignment of staffing required to demand;
   - Develop the availability of live staffing reporting in collaboration with MAPS Healthroster to enable reporting of staffing related to nursing workload and nursing red flag events.

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

The ward staffing review will be repeated every six months.

Appendix 1: The current funded establishments for all wards as at April 2015, proportion of staff in post, adjusted establishment incorporating the separate bank.line.

												Bank line				
Ward	Specialty	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)
CDU WHH	CDU	25	0	71.24	45.45	40.8	22.2	22.24	3.59	4.18	94.4%	34.7	1.11	0.00	1.11	72.35
	Cambridge M1	18	0									0	0.00	0.00	0.00	
CDU, QEQM	Emrgncy med	25	6	38.86	23.95	19.4	12.17	13.5	2.74	2.74	91.7%	21.9	0.70	0.00	0.70	39.56
ECC	CDU	18	0	82.96	54.89	49.71	17.33	18.66	10.74	9.41	93.8%	0.0	0.00	0.00	0.00	82.96
	ECC	NA	0									0	0.00	0.00	0.00	
Harvey ward	Neuro rehab	19	0	26.00	13.8	12.8	12.2	9.85			87.1%	0.0	0.00	0.00	0.00	26.00
Treble ward	Neurology	18	0	29.08	15.44	15.56	12.23	11.33	1.41	0.91	95.6%	10.3	0.33	0.00	0.33	29.41
Mount McMaster	Gastro	24	2	29.47	15	12.96	12.57	11.88	1.9	1.4	89.0%	16.2	0.52	0.00	0.52	29.99
Invicta	Respiratory	24	0	29.56	17.35	16.42	10.5	11.06	1.71	1.71	98.7%	11.2	0.36	0.00	0.36	29.92
Cambridge J	Respiratory	34	0	39.04	22.64	13.04	14.9	15.12	1.5	1.5	76.0%	18.8	0.60	0.00	0.60	39.64
Cambridge K	Cardiology	27	0	34.13	19.96	18.41	12.67	10.67	1.5	1.5	89.6%	17.6	0.56	0.00	0.56	34.69
Cambridge M2	Gastro	20	0	26.61	15.18	15.11	9.93	9.56	1.5	1.5	98.3%	14.7	0.47	0.00	0.47	27.08
Oxford	Infectious dis	14	0	23.61	14.36	14.09	7.75	8	1.5	1.1	98.2%	9.3	0.30	0.00	0.30	23.91
Minster Ward	Cardiology	23	0	31.57	15.2	14.19	14.87	13.4	1.5	1.5	92.1%	12.3	0.40	0.00	0.40	31.97
Sandwich Bay	Respiratory	21	0	27.61	16.27	13.8	9.54	11.81	1.8	1.8	99.3%	9.6	0.31	0.00	0.31	27.92
St Margarets	Gastro	22	3	26.54	16.08	14.44	9.46	11.62	1	1	102.0%	14.7	0.47	0.00	0.47	27.01
Deal	Endocrinology	28	0	32.03	17.61	16.6	12.72	13.93	1.7	1.67	100.5%	11.8	0.38	0.00	0.38	32.41
Kingston	Stroke	22	5	39.95	23.78	22.82	14.87	18.87	1.3	1.3	107.6%	15.1	0.48	0.00	0.48	40.43
Richard Stevens Unit	Stroke	24	0	41.19	21.87	19.19	17.82	16.56	1.5	1.5	90.4%	13.8	0.44	0.00	0.44	41.63
Fordwich Ward	Stroke	19	4	37.02	19.82	20.72	15.7	15.22	1.5	1.49	101.1%	21.9	0.70	0.00	0.70	37.72
Harbledown	Acute frailty	24	3	34.67	18.59	15.8	14.26	13.31	1.82	1.32	87.8%	12.8	0.41	0.00	0.41	35.08
Cambridge L	Acute frailty	21	5	32.30	18.11	16.15	12.69	15.08	1.5	1.5	101.3%	18.0	0.58	0.00	0.58	32.88
CCU WHH	Cardiac Care	11	2	31.91	25.41	24.97	5	5	1.5	1.5	98.6%	4.0	0.13	0.00	0.13	32.04
CCU QEQM	Cardiac Care	12	0	23.00	15.51	13.34	6.46	5.71	1.03	1.02	87.3%	4.8	0.15	0.00	0.15	23.15
Taylor KCH	Cardiac Care	5	2	16.16	14.33	12.9	0.66	0	1.17	0.67	84.0%	0	0.00	0.00	0.00	16.16
Marlowe	Nephrology	29 +6	4	53.12	33.26	26.26	17.56	13.37	2.3	2.3	78.9%	0.0	0.00	0.00	0.00	53.12
Brabourne	Oncology	8	0	16.67	13.37	13.37	2	2	1.3	0.9	97.6%	0.0	0.00	0.00	0.00	16.67
Kennington ward	Gynae	11+2	4	22.18	11.98	12.23	7.7	5.8	2.5	2	90.3%	0.0	0.00	0.00	0.00	22.18
Birchington	Gynae	15	4	30.45	19.87	17.46	8.58	7.79	2	2.5	91.1%	0.0	0.00	0.00	0.00	30.45
Neonatal ITU	NICU	7	0	64.05	57.09	54.34	5.96	6.95	1	1	97.3%	0	0.00	0.00	0.00	64.05
Padua	Paediatric	28	0	45.80	34	33.79	10	9.92	1.8	1.8	99.4%	0.0	0.00	0.00	0.00	45.80
Rainbow	Paediatric	20	0	37.85	28.35	29.83	8.5	7.19	1	1	100.4%	0	0.00	0.00	0.00	37.85
Clarke	Urology	36+6	2	42.65	24.25	19.96	15.9	17.41	2.5	2.5	93.5%	28.1	0.00	1.46	1.46	44.11
Kent	Vascular	20+6	5	32.33	19.1	17.54	10.73	11.72	2.5	2.5	98.2%	24.1	0.00	1.25	1.25	33.58
Kings A2	Gen Surg	20	0	25.51	14.66	10.23	9.85	9.02	1	1	79.4%	9.3	0.00	0.48	0.48	25.99
Kings B	Colorect Surg	27	0	33.92	18.56	15.58	12.83	14.04	2.53	2.53	94.8%	26.6	0.00	1.38	1.38	35.30
Rotary	Max fax / ENT	16	0	34.02	17.15	14.48	10.91	10.31	5.96	5.65	89.5%	8.7	0.28	0.00	0.28	34.30
Cheerful Sp Male	Colorect Surg	18	8	30.14	15.18	11.41	13.96	16.13	1	2	98.0%	0.0	0.00	0.00	0.00	30.14
Cheerful Sp Female	Gen Surg	20	8	33.68	16.93	11.14	14.15	13.53	2.6	2	79.2%	0.5	0.00	0.03	0.03	33.71
Kings D male(1)	T+O	43	0	60.32	33.1	23.42	23.14	23.54	4.08	4.08	84.6%	0	0.00	0.00	0.00	62.29
Kings D female (2)												37.8	0.00	1.97	1.97	
Kings C1	T+O eld trauma	27	0	33.05	16.14	14.57	14.4	13.48	2.51	2.6	92.7%	27.9	0.00	1.45	1.45	34.50
Kings C2	T+O elective	24	0	33.51	17.41	13.13	14.6	14.14	1.5	1.5	85.9%	28.0	0.00	1.46	1.46	34.97
Bishopstone	T+O eld trauma	22	0	33.06	16.34	12.26	14.92	12.83	1.8	1.47	80.3%	28.6	0.00	1.49	1.49	34.55
Seabathing	T+O trauma	26	0	33.96	18.29	15.29	14.17	13.17	1.5	1.5		28.4	0.00	1.48	1.48	35.44
Quex	T+O elective	19	1	24.47	15.71	14.53	6.73	6.8	2.03	0.27	88.3%	16.9	0.00	0.88	0.88	25.35
ITU WHH	Critical care	11	0	63.79	53.03	43.75	9.09	6.61	1.67	1.59	81.4%	0.0	0.00	0.00	0.00	63.79
ITU QE	Critical care	9	0	52.66	48.54	39.34	3.12	2.2	1	1	80.8%	0.0	0.00	0.00	0.00	52.66
ITU KCH	Critical care	8	2	39.16	36.06	37.13	2	2	1.1	1.1	102.7%	0.0	0.00	0.00	0.00	39.16
				1680.86	1058.97	934.26	529.30	522.33	92.59	87.01	91.8%	558.21	9.68	13.33	23.02	1703.88