EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**29 JANUARY 2015**
SUBJECT:	**WARD ESTABLISHMENT REVIEW OCTOBER 2014**
REPORT FROM:	**CHIEF NURSE AND DIRECTOR OF QUALITY** **DEPUTY CHIEF EXECUTIVE**
PURPOSE:	I**nformation**

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 October 2014 review of Adult wards, Paediatric wards, Critical Care Units, the Emergency Departments, Ambulatory Care, Theatres and Midwifery. The overall findings indicate that the aims of recruiting fully to the investments made in the previous year still have to be our priority, and aiming for ward managers to be 100% supervisory, with effective rostering and a minimal vacancy factor.

The Summary of the findings are:

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met
2. Most of the impact of the agreed investment of £2.9m is seen in this staffing review and 88% of posts are now recruited to. Recruitment has been 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 the investment into ward staffing is almost fully realised and has increased WTE per bed across most areas.
4. Average skill mix is similar to the previous review but the impact of associate practitioners is reflected in a slightly reduced skill mix in medical, CCU, stroke and frailty wards where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies.
5. Registered nurse vacancies in wards are currently 37 wte which is 13 wte lower than at the previous staffing review. Healthcare assistant vacancies have increased by 10 wte to 36 wte.
6. 56 newly qualified nurses commenced employment in September 2014 and a further 45 are expected to commence in April 2015.
7. Overseas recruitment of EU nurses continues. 50% turnover has been seen in the 52 nurses recruited over the last 2 years. A further 41 EU nurses will commence between October and November 2014 and another 16 in January 2015.

8. Excellent progress is being made towards achieving and sustaining the target 4% registered nurse and 5% HCA sickness aimed for following the staffing investment. Registered nurse sickness was below 3% and HCA sickness 5% in September 2014.
9. In October 2014 there was a total of 41 wte (2.53%) 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.
10. Overall turnover increased in registered nurses and midwives from 9.5% in 2012 to 11.2% during 2013/14 and was slightly above national and local averages. The turnover of healthcare assistants was stable at 10.6% and is below national and local averages.
11. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of shifts filled by agency has increased to 24% from 19% since April 2014.
12. The improvement in roster quality seen in the last review has been sustained with the average achievement of % time clinically effective (% time worked) across all wards, within E-Rostering for October 2014 at 74.51% against 70.37% in December 2012.
13. 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 6 months of reporting and aggregated fill rates in October are over 100% at QEQM and WHH and over 95% across K&C.
14. The average ratio of patients per registered nurse in October 2014 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 6 wards. The E-Rostering system is able to demonstrate that current funded establishments allow for no more than 8 patients per nurse on day shifts on all wards. Further work is underway to explore how to achieve live reporting of staffing status including patient acuity/dependency and patients per registered nurse.
15. Most wards (34 out of 45) demonstrated average Harm Free Care (acquired in hospital) of 100% patients in October 2014 and only 1 ward was <95%.
16. 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 may be required for Cambridge J and Deal ward.
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 and all areas will need to be reviewed over the next few months to capture average acuity. Both these issues will need to feed into the clinical strategy workforce stream.
Stroke	K&C and WHH stroke units require investment to meet the SEC network standards. 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 should be funded on a permanent basis to support the consistency of use. This will need to be reviewed as part of a demand and capacity review by the division.
Surgery	Establishments are generally satisfactory but consideration should be made to properly establish the additional beds on both cheerful sparrows wards as they are frequently used and it is challenging to

	provide a consistent approach to making resources available.
T& O	Establishments are generally satisfactory. Kings D will require further review and may need investment in the future. Kings C1 based on nursing workload and acuity will require a small investment 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. The division should explore the possible alignment of breast services with gynaecology to create wards that deal with women's needs. This will need to be explored as part of the clinical strategy and would align skills and competencies of staff more effectively than the current medical / HCOOP outliers occupying the additional beds on these wards.
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.
Critical Care	Available staffing is below the Intensive Care Society standard due to vacancies and the use of additional beds and this will need to be addressed as part of the clinical strategy.
Midwifery	The average Midwife to birth ratio in the first 8 months of 2014/15 is 1:29.40. A Maternity structural review and implementation of a new community service model is planned in 2015/16.
Theatres	Staffing reflects AFPP guidance but to enable full utilisation of theatres at weekends further theatre co-ordinator and recovery staff are required.
Emergency Departments	The review is inconclusive. Professional Judgement suggests that current staffing levels appear sub optimal but further review will be undertaken against the recently published NICE guidance ED staffing tool.
Ambulatory Care	Recent investment to extend the service to 7 day working during winter has been made but professional judgement suggests that additional staff are required to meet current demand due to the increase in activity seen over the last three years.

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

1. Evaluate the impact of the investment into ward staffing;
    - Achieve full implementation of additional posts taking place across 2014/15.
    - Evaluate impact of the investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety.
    - Consider further phased investment for wards where evidence suggests more staff are required to keep pace with acuity and dependency of patients. Present Business case for investment to FIC in February 2015.
    - Consider extending funding of contingency beds beyond the winter

period.

2. Optimise the use of existing resources;
   - Further reduce the vacancy levels for registered nurses by implementation of a robust plan to recruit 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.

3. Improve clinical leadership and supervision of quality of care (next phase of agreed investment);
   - Implement the supervisory element of the ward manager role and evaluate the benefits through the ward manager accountability framework.
   - 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 is asked to considers and agree the recommendations

NEXT STEPS:

Business case for investment to FIC in February 2015.

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:

- Delayed recruitment to investments made from the previous year 2014/15. Recruitment plan underdevelopment, in collaboration with HR
- Continued vacancy factor and reliance on temporary staffing, requires innovative recruitment approach to enable recruitment ahead of turnover.
- Increasing acuity and dependency on some wards demonstrates requirement for further investment.

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 2014/15 CQUINs which are valued at 2.5% of actual outturn, or around £10m..

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

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

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

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

ACTION REQUIRED:

(a) To approve.

CONSEQUENCES OF NOT TAKING ACTION:
Insufficient numbers of staff, inappropriate skill mix and ineffective use of the existing workforce will impact upon the ability of the organisation to achieve the CQC standards and the quality outcomes within the operating framework and CQUINS for 2014/15

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Appendix 2 – Modelling methods applied to adjusted establishment

WARD ESTABLISHMENT REVIEW (October 2014)

1. INTRODUCTION

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

This report outlines the October 2014 review and has included 45 wards as well as the Emergency Departments, Ambulatory Care, Theatres 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
	Ambulatory Care
Surgical Services	Surgery
	Trauma & Orthopaedics
	Critical Care
	Theatres
Specialist Services	Renal
	Haematology / Oncology
	Gynaecology
	Paediatrics
	Midwifery

The NICU is not included as the Trust is currently participating in a review across the Clinical Network.

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

2. NATIONAL QUALITY BOARD EXPECTATIONS ON WARD STAFFING

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

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

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

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

- The board should receive monthly reports containing details and summary of planned and actual staffing on a shift-by-shift basis, is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap.

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

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

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

- Current establishments and allowances included for planned and unplanned leave;
- Skill mix
- Workforce metrics including vacancies including vacancies, sickness, staff turnover, use of temporary staff;
- Roster performance and actual against planned filled hours;
- Triangulation between the use of evidence based tools and professional judgement and scrutiny;
- Information on Safety Thermometer performance and;
- Investment into ward staffing during 2014/15 and progress in implementing recommendations from previous review.

3. INVESTMENT INTO WARD STAFFING DURING 2014/15 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, summarised in Figure 1, 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

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

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

The majority 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. 38 out of the 40 Ward Manager Assistant posts and 17 of the 24 additional band 6 posts have now been recruited to against plan. 88% of the new posts are now recruited to.

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 and support worker posts (associate practitioners and healthcare assistants) and actual staff in post at October 2014.

The structure of most ward budgets (33 out of the 45 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 25 WTE across the 33 wards, and it is this 'uplifted' total funded establishment that has been used as the baseline when making comparisons with the modelling methods within this review. However, operationally this component of the budget is not included in the establishment for E-Rostering and is utilised by requesting additional shifts within the system to provide additional cover for long-term sick leave.

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

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

Nursing Rota - Headroom Calculation:

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

Therefore, 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. Excellent progress is being made towards achieving and sustaining the target 4% registered nurse and 5% HCA sickness aimed for following the ward staffing investment. Registered nurse sickness was below 3% and HCA 5% in September 2014.

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, CCU, stroke and frailty 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 2014

Average skill-mix across specialties							
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Impact 14/15**
Medical	55/45	56/44	56/44	57/43	57/43	56/1/44	**56/1/43**
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	**78/1/21**
Stroke	51/49	63/37	63/37	61/39	56/44	56/5/39	**57/4/38**
Acute frailty	48/52	53/47	54/46	55/45	53/47	55/1/44	**52/3/45**
Surgery	53/47	60/40	55/45	57/43	54/46	55/2/43	**55/2/43**
T+O	53/47	57/43	56/44	55/45	52/48	54/1/45	**56/1/43**
Renal				63/37	63/37	63/38	**63/1/36**
Haematology				69/31	83/17	83/18	**81/19**
Gynaecology				59/41	59/41	59/42	**58/2/40**

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.

Figure 4. Skill-mix including registered nurses / support staff (associate practitioners and healthcare assistants.

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

The impact of the 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 2014

Average WTE per bed								
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Impact 14/15**	**Hurst**
Medical	1.14	1.19	1.28	1.33	1.29	1.29	**1.35**	1.38
CDU	NR	NR	NR	2.18	1.54	1.92	**1.55**	1.71
CCU	2.2	2.2	2.42	2.76	2.62	2.68	**2.68**	2.21
Stroke	1.19	1.52	1.57	1.75	1.79	1.84	**1.82**	1.9
Acute frailty	1.1	1.18	1.29	1.47	1.33	1.34	**1.40**	1.43
Surgery	1.09	1.28	1.46	1.38	1.45	1.5	**1.48**	1.43
T+O	1.12	1.17	1.21	1.32	1.36	1.37	**1.56**	1.42
Renal				1.5	1.81	1.81	**1.88**	1.71
Haematology				1.38	2.09	2.09	**2.16**	1.82
Gynaecology				1.96	1.93	1.93	**1.98**	1.53

Following the 2014/15 investment six junior sister (band 6) and three ward manager assistant (band 3) posts have not yet successfully been recruited to. Therefore the full impact of the investment is not yet seen in medical, CDU and Orthopaedic wards (figure 5) 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 20124, to provide staffing for the 14 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.

38 out of the 40 Ward Manager Assistant posts and 17 of the 24 additional band 6 posts have now been recruited to against plan. 88% of the new posts are now recruited to. Active recruitment is ongoing for the band 6 posts and some band staff are undergoing development into the role with the aim of being in post by April 2015. The full impact of the investment will be seen when all posts have been recruited to and the full funding drawn down into all ward budgets.

6. WORKFORCE METRICS

The impact of current vacancy levels, sickness and maternity leave across the 46 wards is 13.3%, similar to March 2014 and is summarised in Figure 6. The absence associated with maternity leave is significant, at 41 WTE (2.53%), and there is an allowance for this in the establishments.

Figure 6. Wards staffing vacancy, sickness and maternity leave Oct 2014

Workforce indicators			
	Dec-12	Mar-14	Oct-14
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02
Registered Nursing vacancies (WTE)	44.00	73.88	37.66
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44
Vacancy (%)	4.75	5.21	6.08
Sickness (%)	4.96	4.90	4.60
Maternity leave (%)	3.28	2.38	2.53
* includes 56.0 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, shown in figure 7. This has reduced the backlog of new applicants in the recruitment process from 400 down to 139 in December 2014.

Figure 7. Time from date of advert to last pre-employment clearance (weeks)

Apr	12.0
May	11.2
Jun	10.5
Jul	11.6
Aug	12.4
Sep	12.6
Oct	12.2
Nov	10.2
Dec	10.7

Vacancies across all wards (excluding paediatric wards), shown in Figure 8, show 37 WTE registered nursing and 36 WTE healthcare assistant vacancies in October 2014. The majority of the registered nursing vacancies are at band 5. Vacancy levels are lower on wards than across the overall average when all departments and specialties are included (Registered nursing 4.32% against 6.82% average and HCA 7.88% against 9.85% average).

When all departments and specialties are included the vacancy level is 122 WTE registered nurses. The 84 WTE outside wards are mostly in theatres (16 WTE), Emergency Departments (15 WTE), ITUs (10 WTE), Endoscopy (8 WTE), and Hospital@Home (9 WTE).

Figure 8. Nursing, Midwifery and HCA vacancies Oct-14

	All wards (except Paediatric wards)				All departments / specialties			
October 2014	**Funded Est.**	**Staff In post**	**WTE Vacancy**	**%**	**Funded Est.**	**Staff In post**	**WTE Vacancy**	**%**
Vac % RN	**872.62**	**834.96**	**37.66**	**4.32**	**1789.52**	**1667.42**	**122.10**	**6.82**
Vac % RM					254.04	240.87	13.17	**5.18**
Vac % HCA	**462.50**	**426.06**	**36.44**	**7.88**	**778.80**	**702.10**	**76.70**	**9.85**

Recruitment initiatives to reduce vacancy levels and support additional bed capacity during winter include:

- Aiming to recruit all newly qualified nurses who want to work within EKHUFT. Around 80% of each student cohort are recruited to EKHUFT. 56 joined the Trust in September 2014 and around 45 are expected to commence in April 2015.
- Introduction of a site based recruitment approach for ward nurses and HCAs. This has had some success for HCAs which will enable a reduction from the current 9.8% vacancy level. The approach was not found appropriate for registered nursing posts due to the generic nature of the adverts not proving attractive to candidates.
- Continued recruitment of EU nurses to support winter pressures. Of 52 who commenced between November 2012 to January 2014 only 25 remained in the Trust at the end of September 2014, seen in figure 9.

Figure 9. Recruitment of EU nurses to EKHUFT 2012 - 2014

Overseas recruitment of Registered Nurses				
Group	No. employed	Start date	No. still working in EKHUFT 30.9.14	% remaining
1	26	Nov-12 to Jan-13	5	19%
2	26	Jan-14	20	77%
3	41	Oct-14 to Nov-14	NA	NA
4	16	Jan-15	NA	NA

The HR Director is leading work to support further vacancy reduction which will include a UK recruitment initiative, overseas recruitment to substantive posts, incentives and linkage with London Trusts to share costs of recruitment to reflect high turnover of EU nurses within one year of joining the Trust.

6.2 Sickness absence

ESR data demonstrates that sickness absence rate across the wards was 4.6% in October 2014. Excellent progress is being made towards achieving and sustaining the target 4% registered nurse and 5% HCA sickness aimed for following the staffing investment, particularly since June 2014. Registered nurse sickness was below 3% and HCA sickness 5% in September 2014

The average monthly sickness rates during 2014/15 across all wards, shown in Figure 10, show wide variation but higher average rates are 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 eg interventional physiotherapy. Those who are off sick are reviewed to ensure compliance with the policy and provided with early access to return to work initiatives which has demonstrated a considerable impact on absences by using early interventional physiotherapy. All divisions are now embracing this initiative, supported by the Occupational Health team.

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

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

Figure 10. Average sickness rates 2014/15

Division / Ward	Sickness 13/14 (%) RN		Sickness April 14 (%)		Sickness May 14 (%)		Sickness June 14 (%)		Sickness July 14 (%)		Sickness Aug 14 (%)		Sickness Sep 14 (%)	
	RN sickness 13/14 (%)	HCA sickness 13/14 (%)	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
Urgent Care & LongTerm Conditions														
1205 Cambridge J2 Ward - WHH	4.07	5.21	4.36	7.58	1.78	10.31	4.2	22.64	9.54	9.97	8.27	9.47	8.16	11.01
1208 Cambridge K Ward - WHH (Formerly Cambridge M1)	3.28	4.09	0	1.23	2	1.93	0.18	2.69	0.78	0.37	0	7.56	0.1	2.03
1209 Cambridge M Ward - WHH	1.97	9.7	0.64	7.78	2.45	13.88	1.42	4.64	3.02	1.3	7.89	5.35	4.31	1.65
1212 Coronary Care Unit (Taylor Ward) - KCH	1.37	0	0.34	0	0.46	0	2.24	0	7.6	0	9.39	0	6.16	0
1213 Coronary Care Unit - QMH	6.69	13.86	7.56	14.74	14.84	10.23	16.64	2.64	7.39	1.28	7.5	0.33	5.69	2.86
1214 Coronary Care Unit - WHH	2.76	2.82	3.07	0	8.46	1.39	6.7	0	8.64	1.29	9.43	0.65	8.24	0.67
1227 Minster Ward - QMH	4.1	6.78	0.22	13.95	0	25.51	0.56	7.56	0.49	10.86	0.64	8.18	0.48	7.76
1230 Oxford Ward - WHH	5.58	4.05	25.08	2.19	12.58	9.58	1.14	7.44	0.83	9.75	10.92	4.24	8.55	7.01
1231 Sandwich Bay Ward - QMH	2.59	4.66	5.16	1.04	4.89	0	4.78	0	6.15	0.73	5.56	0.37	0.72	1.58
1232 St Margaret's Frailty Ward - QMH	2.25	7.98	3.48	0.29	6.15	1.63	0.43	2.37	2.04	0.79	4.52	3.99	0.16	6.74
1233 Deal Ward - QMH	1.09	8.08	0.38	3.1	1.76	1.79	0.65	1.29	0.78	1.74	1.73	4.55	0.21	5.53
1259 Neurorehab Nursing	2.84	3.1	1.69	0.57	10.52	3.86	0.97	3.14	0.23	1.78	0	2	7	7.87
1270 Invicta Ward - KCH	3.43	2.71	7.1	1.53	10.71	12.84	9	13.21	8.68	12.34	6.57	16.23	6.74	8.69
1452 Cambridge L Frailty Ward - WHH	3.05	3.18	1.89	3.13	1.13	9.88	0.33	16.71	1.45	7.07	0.99	5.13	1.82	2.24
1463 Treble Ward - KCH (prev Harvey Ward)	4.38	6.72	1.69	13.33	0.5	21.75	1.73	12.33	0.95	9.35	2.22	7.9	1.04	6.68
1466 Mount & McMaster Ward - KCH	2.17	7.53	9.84	6.54	7.05	7.4	6.15	1.79	2.86	2.57	0.44	0.22	0	9.53
1470 Fordwich Stroke Ward QMH	8.69	3.29	4.75	8.3	7.73	8.06	6.85	11.45	0.33	17.16	1.56	15.64	5.21	4.13
1472 Kingston Stroke Unit - KCH	6.33	6.41	4.45	4.01	2.14	4.86	3.73	12.97	8.03	8.42	3.48	12.17	4.7	10.8
1474 Richard Stevens Stroke Unit - WHH	3.64	7.15	9.55	3.4	4.65	0.53	1.07	5.88	0.74	1.09	5.15	5.95	4.85	1.72
1479 Harbledown Frailty Ward - KCH	7.07	9.61	2.18	0.91	0	0.25	4.56	2.29	5.8	4.44	0.36	1.54	1.39	7.65
1625 CDU - WHH	2.56	4.77	3.06	7.28	2.78	11.57	0.72	8.96	1.66	11.96	2.75	13.12	3.3	10.73
1626 CDU - QMH	2.89	4.73	6.55	5.24	1.04	4.33	3.17	6.05	6.37	13.04	3.23	8.41	1.25	12.94
Surgical Services														
1613 Rotary Suite - WHH	2.8	2.61	4.44	1.72	0.74	1.06	4.61	0.61	3.75	0.34	1.71	0.33	0	0.74
2156 Cheerful Sparrows Ward Female - QMH	3.84	8.07	6.28	11.77	5.85	2.55	5.57	0.93	0.35	2.59	2.28	6.52	2.58	8.19
2157 Clarke Ward - KCH	4.87	11.61	2.86	11.79	1.43	13.46	1.82	9.98	5.16	9.82	0.91	6.34	2.33	2.55
2164 Cheerful Sparrows Ward Male - QMH	6.69	4.4	2.92	1.58	0.85	1.17	0.73	4.86	8	1.61	10.83	4.73	9.11	3.86
2165 Kent Ward - KCH	2.22	12.19	0.75	12.06	0	10.88	0.21	13.3	0.77	10.93	1.34	12.17	0.2	11.59
2167 Kings B Ward - WHH	6.19	8.95	3.07	7.07	2.97	11.8	5.94	14.49	9.75	23.53	3.83	6.16	0.2	2.38
2358 Kings A2 - WHH	10.48	12.39	7.94	14.65	0	6.59	0	8.94	2.29	2.77	0.82	1.82	0	3.6
2555 Kings C - WHH	6.9	6.91	7.43	2.08	3.8	10.04	1.85	12.5	5.39	19	3.98	19.67	1.58	16.17
2556 Kings C2 - WHH	6.68	10.13	1.58	10.32	1.61	0.82	3.06	9.37	7.79	5.17	0	0	0	0.3
2557 Kings D1 - WHH	5.27	3.34	1.08	7.2										
2559 Quex Ward - QMH	4.44	5.42	2.76	1.44	4.49	1.21	8.03	0	0.45	9.31	3.42	14.42	5.4	15.19
2560 Seabathing Ward - QMH	4.96	6.25	7.77	2.25	7.36	0.82	3.92	4.06	0.99	19.36	1.87	17.24	1.1	11.49
2573 Kings D Ward - WHH	1.6	9.75	0.43	9.07	2	6.16	0.53	5.64	0.42	5	0.3	3.54	0.38	0.69
2574 Bishopstone Ward - QMH	3.7	1.99	7.35	2.43	7.01	1.45	1.68	1.99	2.26	6.49	0	0.32	0.47	0.48
2761 Critical Care - WHH	2.46	3.65	0.4	2.47	3.07	0.66	6.37	6.82	1.96	2.48	3.12	5.54	2.36	0
2762 Critical Care - KCH	7.33	0.3	1.58	3.33	0.66	0	1.04	0	1.72	0	5.04	3.23	5.5	0
2763 Critical Care - QMH	3.86	11.62	0.17	24.07	2.49	0	3.22	0	7.9	0	10.11	0	5.04	0.95
Specialist Services														
1240 Renal Marlowe Ward - KCH	4.54	10.56	5.24	14.44	6.23	22	5.38	12.88	1.2	0.52	0.43	3.76	1.71	4.38
3110 Neonatal Intensive Care Unit - WHH	4.5	4.35	3.77	4.23	2.35	4.92	2.54	0	2.85	0	1.97	1.14	5.28	0.76
3116 Padua Ward - WHH	4.47	0.99	2.8	4.88	1.54	12.7	1.49	11.08	4.92	13.5	0.59	11.94	1.16	8.38
3121 Rainbow Ward - QMH	3.29	1.98	1.42	3.67	5.43	0.82	3.42	0	0.33	0.82	0.46	3.71	0.52	1.97
3224 Birchington Ward - QMH	3.15	2.18	16.39	0	14.38	4.22	6.65	0.4	5.6	11.57	0.72	0.85	2.21	0
3225 Kennington Ward - WHH	1.99	12.6	0	1.82	9.68	0.49	0.38	0.4	0.74	6.26	1.01	14.96	2.75	10.11
3335 Brabourne Haematology Ward - KCH	4.71	8.32	0	10	2.81	3.23	1.05	1.67	3.23	0	1.31	0	0.47	0
Total	**4.21**	**6.24**	**4.16**	**5.88**	**4.23**	**6.19**	**3.26**	**5.91**	**3.60**	**6.19**	**3.30**	**6.03**	**2.90**	**5.19**

Key RAG ratings RN

4.1 or below
4.2 - 4.69
4.7 or above

Key RAG ratings HCA

5.1 or below
5.2 - 5.69
5.7 or above

6.3 Maternity leave

In October 2014 there was 2.53% (41 WTE) 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.

6.4 Staff turnover

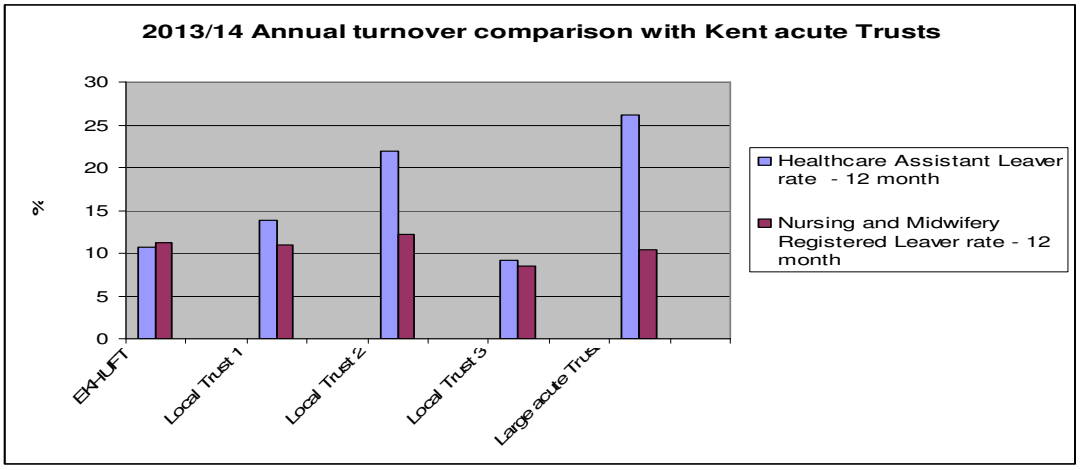
Turnover figures include only staff who have left the employment of the organisation and do not include staff who are internally promoted. ESR data (excluding TUPE staff) demonstrates that our overall turnover has increased in registered nurses and midwives from 9.5% in 2012 to 11.18% during 2013/14.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

Figure 11. Average turnover of nursing, midwifery and care staff 2013/14

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

Data from the Health and Social Care Centre (NHS I-View) illustrated in Figure 12 demonstrates that our turnover of registered nurses and midwives at 11.18% during 2013/14 is slightly higher than the average large acute Trust and two of the three local acute Trusts. The turnover of healthcare assistants at 10.63% is lower than both the average large acute Trust and two of the three local acute Trusts.

Figure 12. Annual turnover comparison with Kent acute Trusts



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 current use of temporary staff through NHS Professionals provided 35,036 hours in October 2014 with 75% hours filled by the NHS-P bank and 24% filled by agency. This includes the supply to theatres and the Emergency departments which accounts for nearly 40% of the agency hours used. Agency use has been minimised in ward areas and is now largely restricted to theatres, day surgery, critical care and the emergency

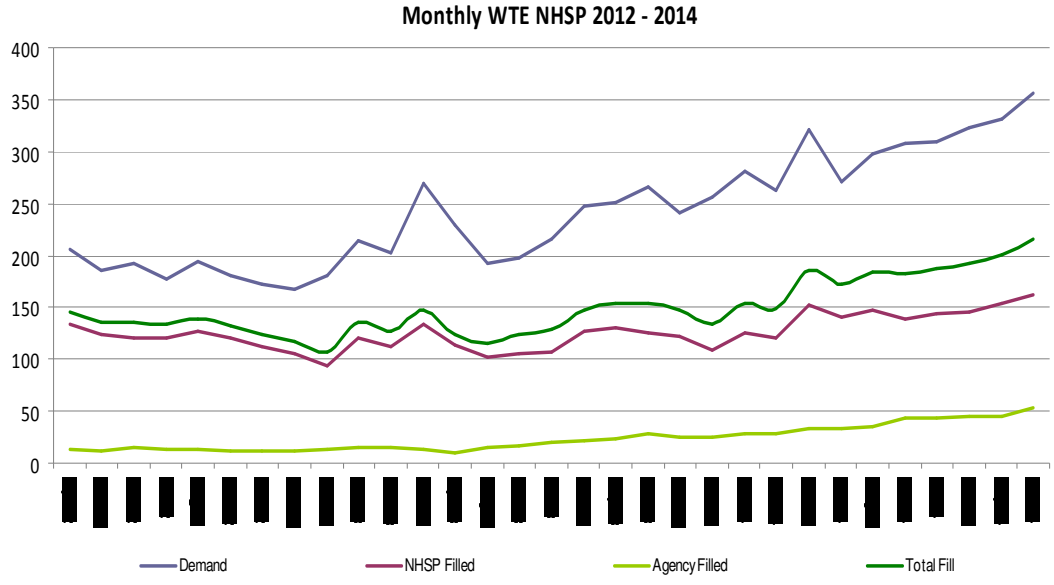
departments. The proportion of shifts filled by agency has increased to 24% from 19% since April 2014.

The use of temporary staffing, including NHS-P bank and agency, is fairly consistent at delivering a combined fill rate (% of requested shifts actually filled) of around 60%. This partially closes the gap presented by vacancies and planned / unplanned absences but does operationally present a challenge for both the Trust and our supplier through NHS-P particularly in filling gaps at short notice. Issues surrounding NHSP bank fill rates, which are currently below the overall agreed target of 75% for registered nurse shifts and 90% for healthcare assistant shifts, are being addressed with the supplier through the appropriate contract management processes.

Even with rigorous management controls through the temporary staff booking process the use of NHS-P overall has risen since December 2012, largely to fill gaps due to vacancies, long term sickness and maternity leave and to provide safe staffing for additional beds. It should be noted that no substantive member of staff is permitted to work additional shifts for the Trust through an agency and the use of agency healthcare assistants has been completely eliminated since 2010. Seasonal fluctuations are seen in the trends in figure 13 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.

The approach to funding contingency beds for winter pressures includes the funding of an additional 44 beds from 1st January to 31st March. Although additional recruitment of overseas EU nurses will fill some of this gap the majority will be staffed through NHSP as in previous winters.

Figure 13. Trend of NHS-P demand and fill in WTE from 2012 to 2014



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

- The Trust has worked collaboratively with NHS-P to recruit 13 registered nurses from Portugal in February 2014 and 25 from Italy who commenced work in September 2014 to provide a dedicated resource ahead of the increased demand anticipated in winter 2014/15.

- Enabling newly qualified nurses to work through NHS Professionals during the Preceptorship period on the ward where they hold a substantive post three months after qualification since 2010/11.
- Reduction of pay from agenda for change spine point 3 to 1 for 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 the last review has been sustained with the average achievement of % time clinically effective (time worked) across all wards, within E-Rostering for October 2014 at 74.59% against 70.37%in December 2012. 27 of the 45 wards achieved more than the optimum 75%, against only 9 in December 2012, which demonstrates significant 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 October are over 100% at QEQM and WHH and over 95% across K&C

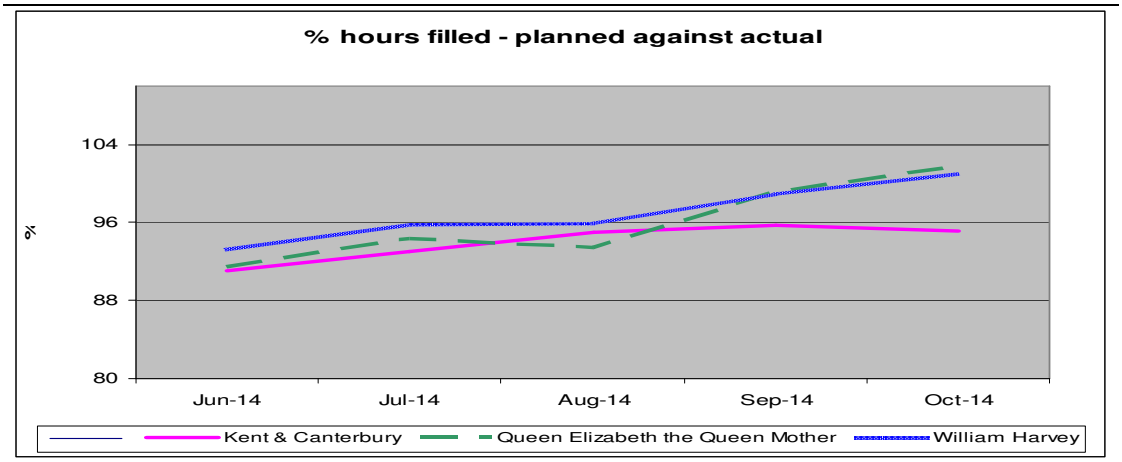
It should be possible to fill 100% of hours if:

- 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 has been seen over the first 6 months of reporting, shown in figure 14. 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 although further work is required at K&C.

Figure 14. % hours filled planned against actual 2014/15

% Hours filled - planned against actual 2014/15						
Hospital site	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Kent & Canterbury	92	91.08	93.05	94.97	95.65	95.14
Queen Elizabeth the Queen Mother	94	91.34	94.26	93.37	99.09	101.80
William Harvey	93	93.16	95.66	95.82	98.83	100.93



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 NHSP. Reporting of January, February and March fill rates will need to include shifts required to staff funded winter contingency beds as well as those that are filled as required when additional beds are used on an ad hoc basis.

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

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

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

Table 1. Methodologies used to evaluate specialties

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

Theatres	Association for Perioperative Practice (2008)

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 has been 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 20 day 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 have significantly higher calculated establishments required using this method than they have currently. 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 will commence 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 any previous review 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.
- 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	Comments
CDUs	CDU WHH	CDU	72.35	67.80	67.40	21.65	The SNCT does not capture bed utilisation and high turnover of patients
		Cambridge M1				25.14	
	CDU, QEQM		39.56	44.10	45.10	34.60	
	ECC	CDU	56.07	37.3	27.00		PJ reflects junior doctor feedback to the Deanery of insufficent staff to take bloods but this work could be undertaken by staff other than nursing
		ECC		46.1	NA		
Medical	Harvey ward		25.65	28.60	24.60	26.64	Alignment for most wards except Cambridge J and Deal where current establishments are below that suggested by all 3 modelling methods. Oxford ward establishment reflects higher requirement for single rooms.
	Treble ward		28.24	30.20	24.20	23.49	
	Mount McMaster		29.19	31.20	33.70	26.78	
	Invicta		29.06	31.00	33.70	28.89	
	Cambridge J		39.87	46.10	44.80	48.37	
	Cambridge K		34.91	31.20	38.10	35.43	
	Cambridge M2		27.26	28.60	29.20	28.11	
	Oxford		24.02	26.00	20.50	20.63	
	Minster Ward		32.44	33.70	32.60	35.97	
	Sandwich Bay		28.18	29.70	30.30	29.83	
	St Margarets		27.19	30.70	31.50	29.47	
	Deal		32.55	38.70	38.10	38.24	
Stroke	Kingston		40.11	42.30	42.1*	34.61	Alignment for Fordwich (*SEC Network Stroke model) but less so for Kingston and RSU. SNCT does not capture stroke thrombolysis nursing work outside the ward.
	Richard Stevens		41.39	42.60	44.8*	38.10	
	Fordwich Ward		37.99	34.20	38.05*	33.00	
Frailty	Harbledown		34.24	31.80	32.20	32.92	Alignment across both wards but higher PJ for Cambridge L reflects additional beds in use
	Cambridge L		33.10	34.90	29.30	31.23	
Coronary Care	CCU WHH		32.04	30.00	32.71	21.09	Alignment with PJ in all wards and Hurst for WHH &QE. Additional staff for pPCI at WHH brings nursing workload in line with actual. Increased K&C establishment reflects higher cost of staffing small wards.
	CCU QEQM		23.15	22.00	26.52	22.08	
	Taylor KCH		16.16	12.20	7.70	9.85	
Renal & Oncology	Marlowe		52.70	52.7	54.7	46.62	Alignment across both wards. Increased Brabourne establishment reflects higher cost of staffing small wards.
	Brabourne		16.77	14.7	15.12	10.58	
Gynaecology	Kennington ward		21.60	20.90	16.83	13.86	Alignment with PJ but less so with Hurst and SNCT due to not able to capture outpatient and dasy attender activity.
	Birchington		28.71	27.5	22.95	20.50	
Paediatrics	Padua		45.59	47.9	50.9*		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 1:4 overnight (*RCN guidance).
	Rainbow		38.54	42.5	45.9*		
Surgical	Clarke		43.06	44.6	44.7	39.01	Alignment for most wards except Rotary due to SNCT capturing inpatient and trolley activity but not outpatient/ activity. Higher PJ on Cheerful Sparrows wards reflects the additional bed use in the end bay on each ward which is staffed on an ad hoc basis.
	Kent		32.28	26.40	24.90	22.74	
	Kings A2		24.64	28.30	24.90	25.09	
	Kings B		33.95	34.60	33.60	30.97	
	Rotary		34.21	32.6	19.90	19.19	
	Cheerful Sp M		28.49	31.5	27.00	25.66	
	Cheerful Sp F		30.31	32.8	29.50	27.71	
Trauma & Orthopaedic	Kings D		52.97	53.60	53.00	50.03	Alignment for mosts wards except Kings C1 where SNCT & PJ suggest higher workload than funded establishment allows for. However, the ward has 4.0 WTE dedicated Therapy staff
	Kings C1		34.50	38.80	35.20	39.03	
	Kings C2		34.97	30.00	31.90	29.22	
	Bishopstone		33.55	32.0	29.60	33.40	
	Seabathing		34.44	33.7	34.10	33.96	
	Quex		25.34	26.9	26.30	23.37	

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 October 2014 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 6 wards. The E-Rostering system is able to demonstrate that current funded establishments allow for no more than 8 patients per nurse on day shifts on all wards. 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 – E-Rostering system

Ward	Ratio patients to RN - day shifts	Ratio patients to RN - night shifts
Kingston	4.1	7.3
Harvey ward	7.0	9.8
Treble ward	5.6	8.6
Mount McMaster	7.4	11.1
Invicta	5.9	11.5
Taylor KCH	1.9	2.4
Harbledown	5.5	11.0
CDU WHH	4.1	6.1
Richard Stevens Unit	5.3	10.0
Cambridge J	6.4	14.8
Cambridge K	5.8	13.7
Cambridge M2	4.9	9.8
Cambridge L	4.8	13.0
Oxford	4.1	10.2
CCU WHH	2.1	2.9
CDU, QEQM	3.7	7.6
Minster Ward	5.4	11.4
Fordwich Ward	3.1	6.4
Sandwich Bay	5.2	12.6
St Margarets	6.3	13.8
Deal	4.7	16.5
CCU QEQM	3.3	6.4
Marlowe	3.2	9.0
Brabourne	2.8	3.8
Kennington ward	3.6	8.8
Birchington	4.0	8.2
Clarke	5.7	18.6
Kent	4.1	10.1
Kings A2	5.7	11.1
Kings B	6.6	11.4
Kings D male(1)	5.5	12.0
Kings D female (2)		
Kings C1	6.1	12.4
Kings C2	5.9	14.4
Rotary	3.0	8.6
Cheerful Sp Male	4.8	9.8
Cheerful Sp Female	4.2	10.0
Bishopstone	5.3	11.9
Seabathing		
Quex	5.3	10.0

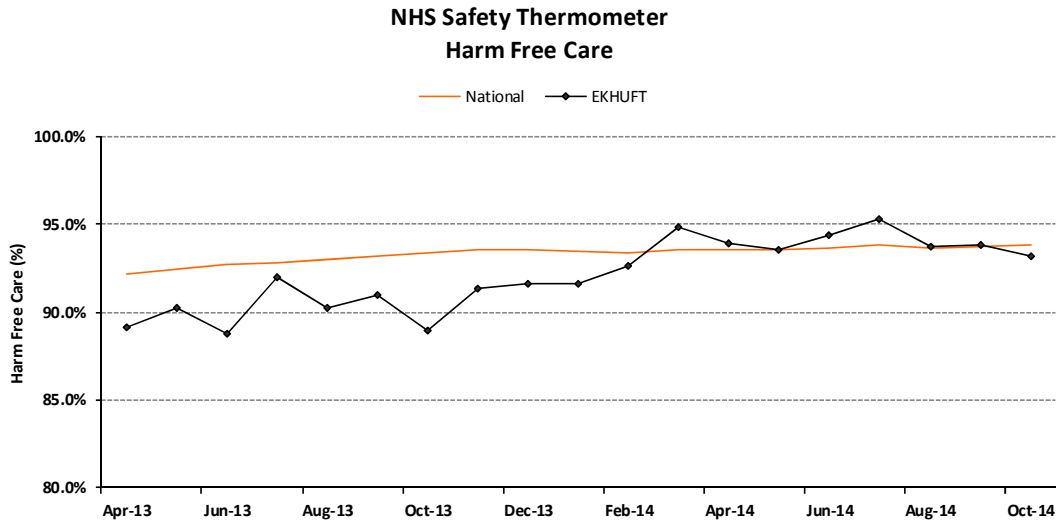
The Safer Staffing Alliance do not support that it is acceptable to have higher ratios of patients per registered nurse at night but many Trusts, whilst meeting the 8:1 on day shifts, report ratios of 12:1 at night. The ratio of 18:1 on Clarke ward reflects the exclusion of the registered nurse on a 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

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

During 2013/14 the Trust improved against and exceeded the national average by year end by achieving 94.87% Harm Free Care for our patients against the 93.6% national average. Figure 17 shows that the Trust has sustained the improvement made in 2013/14 and average Harm Free Care in 2014/15, year to date, has improved to 0.3% above national average;

Figure 17. Harm free care performance against national average ((Apr-13 to Oct-14)



Most wards (34 out of 45) demonstrated average Harm Free Care (acquired in hospital) for 100% patients in October 2014 and only 1 ward was <95%.

11. ANALYSIS OF SPECIALTIES

11.1 Medical wards

- Vacancy levels were particularly high on Cambridge J due to the recent increase from 28 to 34 funded beds. Recruitment was underway at the time of the review but some posts were not yet recruited to. In January 2015 the vacancies had reduced to 6.0 WTE.
- Sickness levels exceeded 6% on 5 wards in October.
- Effective rostering is seen on most wards except where sickness levels are high.
- Triangulation of evidence based tools suggests that here is alignment for most wards except Cambridge J and Deal where current establishments are below that suggested by all 3 modelling methods. Oxford ward establishment reflects higher requirement for single rooms. Both Cambridge J and Deal wards exceeded an average 13 patients per registered nurse on nights during October.
- Three wards show a low % fill of actual against planned hours filled – MountMcMaster due to the creation of optional shifts to cover additional beds that remained unfilled, Oxford due to high sickness and Deal due to high vacancies.
- Only one ward fell below 90% 100% Harm Free Care (new harms only) during October.
- 3 wards fall below 90% of patients recommending to Friends and Family. The lowest two are Cambridge J and Deal

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Harvey ward	19	0	25.65	25.65	96.4%	7.23	1.00	73.10	55/45	1.35	28.60	24.60	26.64		4321	98.64	91.90	123.55	93.69	123.70	94.70%	missed Oct submission
Treble ward	18	0	27.78	28.24	107.6%	3.49	1.00	75.80	55/45	1.56	30.20	24.20	23.49		6434	87.29	84.30	103.67	101.61	103.51	100.00%	98.00%
Mnt McMaster	24	2	28.47	29.19	92.8%	3.98	0.40	78.80	50/50	1.21	31.20	33.70	26.78	0.27	9372	92.70	100.91	79.89	100.00	102.69	100.00%	97.00%
Invicta	24	0	28.56	29.06	97.3%	7.05	0.00	76.30	58/42	1.21	31.00	33.70	28.89		8701	91.26	99.19	81.04	96.77	138.98	95.80%	91.00%
Cambridge J	34	0	39.04	39.87	76.4%	8.88	0.71	72.80	59/41	1.17	46.10	44.80	48.37		11093	111.26	103.00	188.80	110.90	104.57	100.00%	86.00%
Cambridge K	28	0	34.13	34.91	86.9%	0.7	0.00	81.30	60/40	1.40	31.20	38.10	35.43		10181	91.63	85.03	107.78	100.71	95.79	96.40%	94.00%
Cambridge M2	20	0	26.61	27.26	103.8%	3.19	2.00	65.90	58/42	1.36	28.60	29.20	28.11		7592	91.61	106.74	93.73	94.89	98.97	100.00%	91.00%
Oxford	14	0	23.61	24.02	100.4%	7.04	1.92	64.40	62/38	1.17	26.00	20.50	20.63		5108	105.45	106.87	139.04	66.20	77.42	87.50%	94.00%
Minster Ward	23	0	31.57	32.44	112.5%	7.09	0.00	69.10	48/52	1.41	33.70	32.60	35.97		8801	52.34	94.41	106.70	104.67	80.47	100.00%	89.00%
Sandwich Bay	21	0	27.75	28.18	86.9%	0.97	0.00	81.40	55/45	1.34	29.70	30.30	29.83		8592	97.06	110.32	153.67	88.39	96.98	100.00%	94.00%
St Margarets	22	3	26.54	27.19	97.6%	2.77	3.20	70.50	62/38	1.23	30.70	31.50	29.47	3.64	8505	54.33	89.59	120.73	88.47	182.04	100.00%	100.00%
Deal	28	0	32.03	32.55	85.5%	2.28	0.00	87.30	56/44	1.16	38.70	38.10	38.24		8966	139.12	112.90	108.17	94.35	68.23	96.40%	86.00%

Conclusion:
Generally establishments are satisfactory, enabling teams to provide high levels of harm free care and good FFT results. Some investment may be required for Cambridge J and Deal ward.

11.2 Clinical Decision Units

- Vacancy levels and sickness are more significant at K&C than the other sites
- There is some alignment of Professional Judgement and Hurst for WHH and QE. Both sites are experiencing an evolving model of care to an acute assessment model but this is taking time to establish and embed and in reality the additional beds at WHH are in use and the 25 beds at QE have not been reduced to accommodate a planned acute assessment model.
- The ECC shares the establishment for the CDU but professional judgement suggests that current staffing levels need to be explored further. PJ reflects junior doctor feedback to the Deanery of insufficent staff to take bloods but this work could be undertaken by staff other than nursing
- The SNCT does not capture the bed utilisation and the high turnover of patients which is a feature of CDUs. It should be noted that although the SNCT captures the nursing workload of patient care needs it does not take account of the additional workload of admitting, transferring and discharging the high numbers of patients turned over in each 24 hour period. Bed utilisation will be included in the next review.
- NHS England has excluded CDUs from the assessment of % fill of actual against planned hours currently. However, these areas are included in internal reporting and WHH achieves >85%. QE falls below 80% at night for RN shifts due to creation of optional shifts to cover additional beds that remained unfilled.
- All sites achieved >96% Harm Free Care (new harms only) during October.
- WHH and QE fall below 90% of patients recommending to Friends and Family.

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
CDU WHH	14	11	71.24	72.35	92.1%	3.56	2.00	70.40	64/36	2.26	67.80	67.40	21.65	5.65	11222	29.54	116.47	87.86	90.34	101.61	100.00%	80.00%
	18	0											25.14		6097							
CDU QEQM	25	6	38.86	39.56	106.6%	5.08	1.00	73.10	62/38	1.58	44.10	45.10	34.60	5.11	12602	109.81	98.28	89.54	79.66	100.51	96.80%	82.00%
CDU K&C	18	**0**	56.07	57.07	86.0%	6.50%	1.90	71.1	76/24.		37.30	27.00			9934						100.00%	86.00%
ECC K&C	NA	**0**									46.10	NA										

Conclusion:
Generally establishments are satisfactory. Further exploration of recruitment, retention and turnover is required to support gaps in staffing.

11.3 Coronary Care

- Vacancy levels are proportionally high on Taylor ward at K&C
- Sickness levels are relatively high across all 3 units and is reflected in poor roster effectiveness (% time worked) particularly at K&C and QE
- Professional judgement shows a close correlation with current in all units but acuity and dependency (SNCT) determines significantly lower required establishments at WHH and K&C. The reason is that the SNCT does not capture pPCI nursing work outside the ward.and the 5.64 wte pPCI band 6 nurses included in the budgeted establishment account for this difference. The higher K&C establishment reflects higher cost of staffing small wards
- All units achieve >80% fill of actual against planned hours
- All units achieved 100% Harm Free Care (new harms only) during October.

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Taylor KCH	5	2	16.16	16.16	80.9%	5.76	0.00	70.60	91/9	3.23	12.20	7.70	9.85	1.16	3185	117.15	80.49		100.39		100.00%	100.00%
CCU WHH	11	2	31.91	32.04	96.7%	6.52	0.00	76.90	81/19	2.91	30.00	32.71	21.09	0.67	2945	86.54	93.58	107.93	90.39	80.29	100.00%	88.00%
CCU QEQM	12	0	23.00	23.15	96.6%	4.61	0.60	70.50	69/31	1.92	22.00	26.52	22.08		3371	88.21	89.50	94.98	103.63	94.03	100.00%	98.00%

Conclusion:
Establishments are satisfactory. Taylor ward due to small ward size appears over-staffed and all areas will need to be reviewed over the next few months to capture average acuity. Both these issues will need to feed into the clinical strategy workforce stream.

11.4 Stroke

- Vacancy levels are low on Kingston and Fordwich but higher on RSU.
- Both Kingston and Fordwich have contingency beds which represent significant additional staffing requirement as determined by the SNCT. This is partially met through NHSP and staff working overtime shifts. Both these wards have higher sickness levels than RSU.
- Roster effectiveness (% time worked) is lower on both Kingston and RSU due to high sickness and high vacancy levels respectively.
- There is alignment between current establishments and Professional Judgement. The SNCT does not capture stroke thrombolysis nursing work outside the ward but when this element is accounted for there is alignment with current establishments.
- All ward establishments are near the Hurst recommended level of 1.9 for stroke units but in the absence of a model specifically for Hype-acute stroke units (HASU) the SEC Cardiovascular Clinical Network standard was applied which recommends a staffing ratio of 2.9 WTE per bed for HASUs and 1.35 WTE per bed for stroke ward beds. Application of this model determines slightly higher establishments than current actual.
- RSU and Kingston show <80% fill of actual against planned hours filled largely due to high sickness and vacancy respectively
- All 3 units achieved >95% Harm Free Care (new harms only) during October.
- Only Kingston (88%) fell below 100% of patients recommending to Friends and Family.

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	SEC Network	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Kingston	22	5	39.44	40.11	95.6%	6.69	1.81	68.40	60/40	1.82	42.30	42.10	34.61	2.41	6167	100.97	90.86	76.80	97.15	85.62	100.00%	88.00%
Richard Stevens Unit	24	0	40.78	41.39	91.5%	3.37		68.80	53/47	1.72	42.60	44.80	38.10		7345	88.16	78.95	122.21	77.23	101.82	100.00%	100.00%
Fordwich Ward	19	4	37.02	37.99	97.8%	4.61	1.00	75.90	54/46	1.99	34.20	38.05	33.00	3.84	6807	108.99	100.34	125.97	104.95	91.78	95.50%	100.00%

Conclusion:
K&C and WHH stroke units require investment to meet the SEC network standards. 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.

11.5 Acute Frailty

- Cambridge L is over-established due to planned staffing to cover contingency beds.
- Sickness levels are low and effective rostering is seen on both wards.
- There is close alignment between current establishments and Professional Judgement, Hurst and SNCT
- Both wards show >80% fill of actual against planned hours
- Both wards achieved 100% Harm Free Care (new harms only) during October.
- Cambridge L achieved 100%, and Harbeldown 83%, of patients recommending to Friends and Family.

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Harbledown	24	3	33.67	34.24	96.3%	4.06	1.00	73.20	53/47	1.42	31.80	32.20	32.92	0.35	8582	94.99	100.74	94.75	101.61	87.16	100.00%	83.00%
Cambridge L	21	5	32.30	33.10	108.7%	1.89	1.38	74.20	57/43	1.27	34.90	29.30	31.23	5.27	5978	113.21	87.62	129.38	97.05	119.85	100.00%	100.00%

Conclusion:
The beds on Cambridge L should be funded on a permanent basis to support the consistency of use. This will need to be reviewed as part of a demand and capacity review by the division.

11.6 Surgery

- Vacancy levels are significant across several wards
- Sickness levels are higher across wards where there are contingency beds and lower roster effectiveness (% time worked) is reflected across these wards
- Most wards show alignment of current establishments with Professional Judgement, Hurst and SNCT except Rotary due to SNCT capturing inpatient and trolley activity but not outpatient/ activity.
- All wards except CSF show >80% fill of actual against planned hours filled
- All wards except Rotary show 100% Harm Free Care (new harms only) during October.
- All wards except Kings B show above 90% of patients recommending to Friends and Family.

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Clarke	36+6	2	41.60	43.06	93.6%	2.23	0.80	78.00	56/44	1.19	44.60	44.70	39.01	0.79	9674	73.89	89.24	113.88	97.80	101.57	100.00%	96.00%
Kent	20+6	5	31.03	32.28	96.0%	4.2	0.00	80.60	57/43	1.61	26.40	24.90	22.74	0.25	8536	81.66	101.02	89.84	95.58	97.47	100.00%	95.00%
Kings A2	20	0	24.16	24.64	92.2%	1.48	0.00	80.80	55/45	1.23	28.30	24.90	25.09		8189	93.75	110.08	102.05	87.09	136.79	100.00%	92.00%
Kings B	27	0	32.57	33.95	93.9%	1.06	1.80	73.10	53/47	1.25	34.60	33.60	30.97		12406	92.97	98.84	112.77	115.04	133.52	100.00%	86.00%
Rotary	16	0	33.93	34.21	98.0%	0.21	1.60	73.40	53/47	2.13	32.60	19.90	19.19		5683	85.08	113.20	103.97	94.65	87.10	93.80%	95.00%
Cheerful Sp M	18	8	28.49	28.49	88.6%	6.16	0.00	76.20	55/45	1.58	31.50	27.00	25.66	2.79	9017	104.40	109.49	154.76	95.83	80.98	100.00%	92.00%
Cheerful Sp F	20	8	30.28	30.31	103.5%	4.89	1.00	70.00	55/45	1.51	32.80	29.50	27.71	3.51	9403	110.97	134.24	138.83	111.21	65.48	95.00%	92.00%

Conclusion:
Establishments are generally satisfactory but consideration should be made to properly establish the additional beds on both cheerful sparrows wards as they are frequently used and it is challenging to provide a consistent approach to making resources available.

11.7 Trauma and Orthopaedics

- Vacancy levels are particularly high on Seabathing where sickness levels are also high. Sickness is also extremely high on Kings C1 and Quex ward and this is reflected in lower roster effectiveness (% time worked)
- Kings D has contingency beds which represent significant additional staffing requirement as determined by the SNCT. This is partially met through NHSP and staff working overtime shifts. These additional beds are funded from January 2015.
- There is alignment between current establishments, Professional Judgement, Hurst and the SNCT for all wards except Kings C1 where both Professional Judgement and the SNCT determine higher required establishments. However it should be noted that this ward has 4.0 wte dedicated Therapy staff.
- Kings D and Quex show <80% fill of actual against planned hours filled largely due to additional shifts required to staff contingency beds not always being filled.
- All wards except Seabathing achieved 100% Harm Free Care (new harms only) during October.
- All wards except Kings D female show above 90% of patients recommending to Friends and Family.

			Funded establishment			Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Kings D M(1)	39	4	52.09	52.97	90.5%	0.5	1.64	78.00	56/44	1.35	53.60	53.00	50.03	2.45	9975	101.97	94.44	141.75	78.56	101.75	100.00%	95.00%
Kings D F(2)															6401	97.10					100.00%	89.00%
Kings C1	27	0	33.05	34.50	85.4%	10.26	0.00	74.90	49/51	1.27	38.80	35.20	39.03		8227	92.04	102.48	123.27	105.54	85.48	100.00%	92.00%
Kings C2	24	0	33.51	34.97	89.7%	0.12	1.80	75.80	56/44	1.45	30.00	31.90	29.22		9348	77.67	83.51	121.48	80.65	83.49	100.00%	96.00%
Bishopstone	22	0	32.06	33.55	96.1%	0.67	0.00	83.60	45/54	1.52	32.00	29.60	33.40		6904	86.31	112.12	93.89	106.89	90.36	100.00%	96.00%
Seabathing	26	0	32.96	34.44	77.5%	5.46	0.00		50/50	1.32	33.70	34.10	33.96		9167	89.2					95.70%	92.00%
Quex	19	1	24.33	25.34	91.5%	8.42	0.00	77.00	65/35	1.33	26.90	26.30	23.37	0.10	6775	62.70	78.08	182.28	105.81	68.71	100.00%	94.00%

Conclusion:
Establishments are generally satisfactory. Kings D will require further review and may need investment in the future. Kings C1 based on nursing workload and acuity will require a small investment to bring levels to Hurst and closer to SNCT and professional judgement.

11.8 Renal and Haematology/oncology

- Vacancy levels are particularly high on Marlowe but sickness is low and roster effectiveness is achieved at over 76%
- Poor roster effectiveness is seen on Braebourne due to high maternity leave which is not completely recruited to
- Both wards have current establishments above those recommended by Hurst for renal (1.71) and Oncology wards (1.82). Professional judgement determines similar staffing levels to current in both wards but acuity and dependency (SNCT) determines lower levels than actual.
- Marlowe shows <80% fill of actual against planned hours filled largely due to vacancy levels.
- Both wards achieve excellent % Harm Free Care (new harms only) during October and 100% patients recommend to Friends and Family.

			Funded establishment		Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Marlowe	29 +6	4	52.70	83.7%	2.44	1.00	76.70	63.37	1.81	52.7	54.7	46.62	0.15	12047	96.30	102.03	74.73	80.10	94.79	96.40%	100.00%
Brabourne	8	0	16.77	114.3%	0.65	3.00	61.60	83/17	2.09	14.7	15.12	10.58		2880	72.68	99.10	90.84	96.77	N/A	100.00%	100.00%

Conclusion:
Establishments are generally satisfactory. High vacancies on Marlowe ward may require an innovative approach to resolve and succession planning for the retiring ward manager is planned.

11.9 Gynaecology

- Vacancy levels and sickness are high on Kennington but both wards achieve good roster effectiveness
- Both wards are above the Hurst recommended level for Gynaecology wards but the establishments include staff to provide early pregnancy assessment clinics as well as inpatient beds.
- Professional judgement determines similar staffing levels to current in both wards but acuity and dependency (SNCT) determines lower levels than actual as the tool does not allow capture of outpatient activity
- Both wards have contingency beds and both show <80% fill of actual against planned hours at night largely due to the creation of additional shifts within E-Rostering which are not always filled.
- Both wards achieve excellent % Harm Free Care (new harms only) during October and >90% patients recommend to Friends and Family.

			Funded establishment		Attendance			Evaluation methods								Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Kennington	11+2	4	21.60	85.5%	5.30	0.67	77.70	55/45	1.96	20.90	16.83	13.86	2.67	4635	105.54	141.51	104.15	57.93	140.00	100.00%	94.00%
Birchington	15	4	28.71	98.4%	1.44	1.00	76.60	63/37	1.91	27.5	22.95	20.50	3.54	6174	109.32	90.44	146.66	92.05	68.18	94.70%	92.00%

Conclusion:
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. The division should explore the possible alignment of breast services with gynaecology to create wards that deal with women's needs. This will need to be explored as part of the clinical strategy and would align skills and competencies of staff more effectively than the current medical / HCOOP outliers occupying the additional beds on these wards.

11.10 Paediatrics

- The paediatric wards have seen investment of almost £800K since the previous review and have recruited to all additional posts.
- Vacancy levels and sickness are low on both wards but roster effectiveness could be improved on Padua ward
- Following the CQC review it was identified that there was shortfall in Paediatric staff outside designated paediatric areas. This is reflected in higher required staffing levels according to Professional Judgement and the RCN tool. On Padua the increase is due to providing cover to channel day unit Mon – Fri and additional requirements in outpatients. On Rainbow the increase is due to additional requirements to cover outpatients, and an increase in requirements overnight to support the RCN ratio of 1:4. This has been calculated assuming an average occupancy level of 80% during the day and 65-70% at night. The actual occupancy is lower than this.
- Both wards achieved 100% Harm Free Care (new harms only) during October.

		Funded establishment			Attendance			Evaluation methods					Average filled hours - actual v planned Oct 14 Shift fill - DAY		Average filled hours - actual v planned Oct 14 Shift fill - NIGHT		Quality
Ward	Beds Funded	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	RCN	Occupancy Oct 14 (%)	(%) RNs	(%) Support staff	(%) RNs	(%) Support staff	Harm free care (new harms only) Oct 14
Padua	28	45.45	45.59	98.7%	2.31	1.00	69.80	75/25	NA	47.9	50.9*	55.28	94.95	91.76	101.74	84.21	100.00%
Rainbow	20	38.54	38.54	99.0%	0.82	1.00	78.50	73/27	NA	42.5	45.9*	51.33	97.17	122.23	94.90		100.00%

Conclusion:
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.

11.11 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. However there remains a significant vacancy factor despite innovative recruitment of newly qualified and also inexperienced nurses and there is some reliance on temporary staff to fill gaps in staffing which is reflected in the % filled hours at the WHH site.
- The recent demand for critical care services at QEQM have seen the unfunded 9th bed being utilised on a routine basis, which has proved challenging to provide the appropriate level of nurse to bed ratio. Recruitment has also been slow at QEQM as well. Unfortunately this means each of the three critical care units is not able to consistently have a supervisory shift leader as recommended by the ICS. The reason being for this is the difficulty critical care in general has faced in recruiting suitable nurses which is also reflected nationally at present balanced with an increased demand for critical care services.
- 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.
- 100% Harm Free Care was achieved in all units in October

			Funded establishment			Attendance			Evaluation methods			Shift fill - DAY		Shift fill - NIGHT		Quality Indicators	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Occupancy Oct 14 (%)	Average filled hours - actual v planned Oct 14 (%) RNs	Average filled hours - actual v planned Oct 14 (%) Support staff	Average filled hours - actual v planned Oct 14 (%) RNs	Average filled hours - actual v planned Oct 14 (%) Support staff	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
ITU WHH	11	0	63.79	63.79	91.9%	1.97	1.00	77.00	83/17	5.8	82.92	128.62	135.62	133.98	246.15	100.00%	n/a
ITU QE	8	1	47.05	47.05	94.3%	4.66	0.00	81.10	91/9	5.8	80.66	94.76	101.91	107.01		100.00%	n/a
ITU KCH	8	2	39.16	39.16	96.8%	5.15	2.76	68.30	92/8	4.9	101.25	92.65	180.36	96.62	151.28	100.00%	n/a

Conclusion:
Available staffing is below the Intensive Care Society standard due to vacancies and the use of additional beds and this will need to be addressed as part of the clinical strategy.

11.12 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. NICE guidance is due to be published in February 2015 and this will inform future reviews along with a detailed evaluation against Birth-rate Plus.

One element of Birth-rate Plus, Midwife to birth ratio, is currently monitored monhtly. 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 clinical roles only and excludes midwives engaged in management or specialty work. Recent research suggests that a ratio of 1.29.5 may now be more relevant today.

The median Midwife to birth ratio for 2013/14 was 28.0 and the average 28.2. In 2014/15 the average is 29.4 and the median 29.94 at November. 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.

Midwifery 2014/15 year to date staffing vs. ratio position with the median and average staffing level:

Month	Staff In Post		Total Births		Ratio
Apr -14	242.35		652		32.28
May- 14	242.45		611		30.24
Jun-14	246.25		592		28.85
Jul-14	240.83		613		30.54
Aug-14	237.63		587		29.64
Sept-14	245.98		587		28.64
Oct-14	245.48		636		31.09
Nov-14	253.16		547		25.93
		Total	**4,825**		**Median 29.94**
					Average 29.40

Conclusion:

A full structural review including the implementation of a new community service model is expected to be completed by the summer of 2015, following which the full formal BR+ assessment will be undertaken in Sept 2015. The Trust is running on an overall provision of a 1:28 midwifery staffing ratio importantly noting that the workforce is disproportionately balanced in favour of the community at present where by the national gold standard is a ratio of 1:98 yet the current trust position is an

average ratio of 1:80 indicating that there are around 20 wte midwives working in the community more than would be predicted for a service of this size thus leaving potential gaps in provision elsewhere. Community service provision remodelling will form part of the service reconfiguration after which the new service model and BR+ assessment should be finalised no later than September 2015.

11.13 Theatres

Theatre complexes operate on all 3 main sites:

1. WHH
    - Main theatre 24 hour services of CEPOD & C section – 24 hour service
    - Day Unit
2. K&C
    - Main theatre with on call from 18.00 to 08.00 and on call for CEPOD – 24 hour service
    - Day Unit
    - Ophthalmic Suite
3. QE
    - Main the theatre 24 hour service of C section (24 hour service) and on call from 23.00 to 08.00 for CEPOD
    - Day Unit

The AFPP guidance for staffing each operating theatre is currently met and requires for each theatre:

- 1 x anaesthetic assistant
- 2 x scrub practitioners
- 1 x circulating support worker
- 1 x recovery practitioner

- Good roster effectiveness is seen across most theatre areas despite fairly high sickness levels around 5%
- There are significant vacancies at WHH and K&C

Investment into theatre staffing was agreed around 2010, which enabled elective services across main and day surgery theatres (all specialities) to deliver activity for 50 weeks of the year rather than the previously funded 40 – 48 weeks. Although AFPP guidance for theatres is met, due the size and diversity of the theatre complexes the following require exploration in order to ensure patient safety in line with the service extending to 7 day working:

- The management roles at weekends – Additional requirement to ensure availability of the Theatre Coordinator role on Saturday and Sunday at QE and WHH. The surgical division is currently developing a business case to address this.
- The out of hours recovery: - the AFPP guidance allows for this area but current staffing prevents full utilisation of theatres (CEPOD/ Trauma). The surgical division recognises this restriction and is working on the requirements to reflect demand.

The main challenges are:

1. High vacancies at WHH and K&C. The role of theatre practitioner is fulfilled by both registered nurses and operating department practitioners and there is a 50/50 split of the numbers of staff in these professional groups.
2. The current age profile of the current workforce suggest that a third of staff are eligible for retirement in the next 5 years.
3. Potential increased activity and expansion of services in the private sector locally (KIMS, Benenden and the new hospital on the WHH site) will create an unprecedented demand for new staff.
4. Elective and emergency demand to meet the NHS standards and working towards extending the working week to 6 days (including Saturday) as part of the plan to reduce weekend and overtime payment therefore making the service meet the needs of our community – as weekend theatre lists are in high demand. Activity is increasing at an average of over 10% per year. It is expected that extended days and 7 day working will be necessary within two years to meet the demand with a staffing increase required of up to 30%.
5. Workforce development. A workforce plan has been drafted to include maximising the student ODP numbers the trust supports to 20 per year and increasing the associate practitioner band 4 work force to 10 per site.

	Funded establishment				Staff in post								
Theatres	**Funded Establishment (WTE)**	**TP (WTE)**	**Ass Pract band 4 (WTE)**	**TA/HCA (WTE)**	**Staff in Post (WTE)**	**TP (WTE)**	**Ass Pract band 4 (WTE)**	**Support worker (WTE)**	**Proportion staff in post (%)**	**Skill mix**	**Sickness Oct 14 (%)**	**Maternity leave (WTE at 31.10.14 (WTE)**	**E-Rostering effectiveness Oct 14 (% time worked)**
WHH	169.57	112.21	3	52.79	159.24	105.75	2	49.98	93.91%	1 12/19	4.90%	Day unit ward - 4.8%,	Day Unit theatres - 76.7% Day Unit ward 74.4% Main theatres - Anaesthetic 81.3% Main theatres- Recovery 82.3%
QEQM	135.74	90.6	2	41.81	132.63	88.38	2	40.92	97.71%	67/33	5.90%	Day unit theatres - 3.6% day unit ward 6.6%	Day Unit theatres - 69.3% Day Unit ward 75.5% Main theatres 70.8%
K&C	105.23	76.52	0	24.11	95.42	70.27	1	22.55	90.68%	73/27	5.70%	0	KC Theatres - 76.2 ophthalmic suite K&C - not live on rota Day Unit (All) 72.0%

11.14 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). Posts were fully recruited to, however, demand within the emergency departments has increased since 2013 with a 6% increase in attendance.

NICE will publish a consultation on national guidance, based on an initial scoping exercise, in January 2015 and guidance will be published in May 2015. The guideline will consider a range of patient, environmental and staffing factors that may impact on safe nursing staff requirements at the A&E department level. This will include attendance rates and patterns, including likely 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.

For the purpose of this October 2014 review the departments were reviewed using currently available methodologies:

1. 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 is 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.

2. Professional judgement on how many staff are required on each shift was applied and this indicated that additional staff are required.

Emergency Depts	Funded Establishment (WTE)	RN (WTE)	Tech band 3 (WTE)	HCA band 2 (WTE)	Staff in Post (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	E-Rostering effectiveness Oct 14 (%time worked)	Professional Judgement	BEST	Bank & Agency expenditure month 7
WHH	77.64	51.8	14.3	11.54	73.12	94.17	9.93%	65.1	87.6	57.4	141,855
QEQM	74.03	50.3	14.7	9.03	64.96	87.74	4.50%	76.7	83.1	Incomplete	11,111

Evaluation of staffing was inconclusive but highlighted that:

- Vacancy levels are more significant at QE than at WHH. Alternative staff groups i.e. paramedics are being considered for employment within the EDs as they have a suitable skill set to compliment the nursing and medical teams.
- Sickness levels are particularly high at the WHH at 9.93% and this is currently being robustly managed
- Agency expenditure at the WHH was extremely high in October

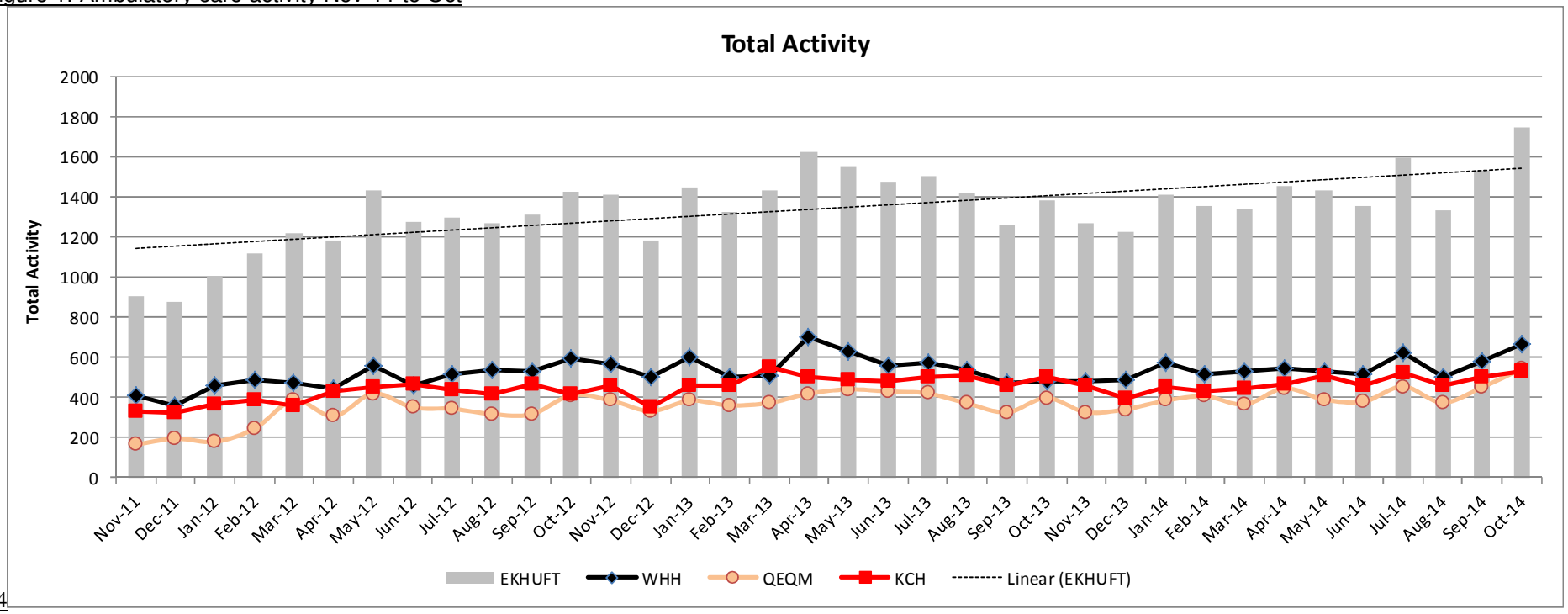
Further work is required to undertake a full review against NICE guidance. Professional Judgement is that current funded establishments do not fully provide for the following areas of priority:

- 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

11.15 Ambulatory Care

Ambulatory care is provided from Monday to Friday on all 3 main sites and an 08.00 – 14.00 DVT service is provided at the WHH and QEQM. Activity includes elective day cases, outpatient review clinics, ward attenders and emergency inpatients on all 3 sites and rehabilitation and HCOOP outpatient clinics at K&C and QEQM. Activity has grown around 35% over the last 3 years, shown in figure 1.

Figure 1. Ambulatory care activity Nov-11 to Oct



14

A 6 week pilot of 'hot' ambulatory care from 08.00 – 20.00 7 days a week was undertaken from 1st October 2014 at QEQM. Patients triaged in A+E were diverted to ambulatory care if deemed appropriate and this led to admission avoidance for nearly 300 patients. Patients included A+E walk-ins, GP referrals into A+E and patients who had already been admitted to CDU who were 'pulled' into the ambulatory unit. The urgent care physician also took direct referrals from GP's. This pilot was undertaken in addition to current activity and was resourced by nursing overtime and additional hours undertaken by medical staff. Following completion of the pilot the service has reverted back to existing provision.

A pilot has been set up at the WHH to provide a hot ambulatory service but within existing hours due to lack of additional staffing resource.

Additional resource of around £200K has now been secured from winter funding monies to extend WHH opening hours to 8pm and allow 7 day working at both WHH and QEQM for emergency ambulatory care. Funding will cease on 31st March 2015. The funding will provide an additional 4.0 WTE nursing support (50/50 skill mix) plus 1.0 WTE admin support on both the WHH and QEQM. Recruitment is underway but the challenge will be to fill the posts in order to deliver the extended service. Current establishments have not changed since 2011 and professional judgement reveals that an additional 6.0 WTE staff are required to meet the current demand. The additional funding provided to deliver the extended service meets the professional judgement of what is required but it is considered that further investment may be required to increase the baseline establishment.

WARD ESTABLISHMENT REVIEW OCTOBER 2014 BoD 03/15

Ambulatory Care	Funded Establishment (WTE)	RN (WTE)	Ass Pract band 4 (WTE)	HCA (WTE)	Staff in Post (WTE)	RN (WTE)	Ass Pract band 4 (WTE)	Support worker (WTE)	Proportion staff in post (%)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	Prof judgment - current service	Prof Judgement - to extend service	Total	Potential Investment
WHH	12.28	6.60	1.00	3.20	11.28	6.60	0.00	3.20	91.86%	4.9	0.00	85.2	54/46	14.2	3.9	18.1	5.82
QEQM	14.81	8.68		3.60	15.57	9.44	0.00	3.60	105.13%	4	0.75	77.2	59/41	18.9	3.4	22.3	7.49
K&C	14.38	6.80	2.00	2.73	14.08	6.80	2.00	2.44	97.91%	11.8	0.00	80.7	47/53	14.9	NA	NA	NA
														6.01			**13.31**

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. Most of the impact of the agreed investment of £2.9m is seen in this staffing review and 88% of posts are now recruited to. Recruitment has been 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 the investment into ward staffing is almost fully realised and has increased WTE per bed across most areas.
4. Average skill mix is similar to the previous review but the impact of associate practitioners is reflected in a slightly reduced skill mix in medical and CCU wards where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies.
5. Registered nurse vacancies in wards are currently 37.66 wte which is 13 wte lower than at the previous staffing review. Healthcare assistant vacancies have increased by 10 wte to 36.44 wte.
6. 56 newly qualified nurses commenced employment in September 2014 and a further 45 are expected to commence in April 2015.
7. Overseas recruitment of EU nurses continues. 50% turnover has been seen in the 52 nurses recruited over the last 2 years. A further 41 EU nurses will commence between October and November 2014 and another 16 in January 2015.
8. Excellent progress is being made towards achieving and sustaining the target 4% registered nurse and 5% HCA sickness aimed for following the staffing investment. Registered nurse sickness was below 3% and HCA sickness 5% in September 2014.
9. In October 2014 there was a total of 41 wte (2.53%) 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.
10. Overall turnover increased in registered nurses and midwives from 9.5% in 2012 to 11.2% during 2013/14 and was slightly above national and local averages. The turnover of healthcare assistants was stable at 10.6% and is below national and local averages.
11. The use of temporary staff through NHS-Professionals and agency continues to rise, and is deployed to fill gaps due to vacancies, long term sickness, some maternity leave and to support safe staffing for additional beds. The proportion of shifts filled by agency has increased to 24% from 19% since April 2014.
12. The improvement in roster quality seen in the last review has been sustained with the average achievement of % time clinically effective (% time worked) across all wards, within E-Rostering for October 2014 at 74.51% against 70.37%in December 2012.
13. 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 6 months of reporting and aggregated fill rates in October are over 100% at QEQM and WHH and over 95% across K&C.
14. The average ratio of patients per registered nurse in October 2014 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 6 wards. The E-Rostering system is able to demonstrate that current funded establishments allow for no more than 8 patients per nurse on day shifts on all wards. Further work is underway to explore how to achieve live reporting of staffing status including patient acuity/dependency and patients per registered nurse.

15. Most wards (34 out of 45) demonstrated average Harm Free Care (acquired in hospital) of 100% patients in October 2014 and only 1 ward was <95%.
16. 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 may be required for Cambridge J and Deal ward.
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 and all areas will need to be reviewed over the next few months to capture average acuity. Both these issues will need to feed into the clinical strategy workforce stream.
Stroke	K&C and WHH stroke units require investment to meet the SEC network standards. 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 should be funded on a permanent basis to support the consistency of use. This will need to be reviewed as part of a demand and capacity review by the division.
Surgery	Establishments are generally satisfactory but consideration should be made to properly establish the additional beds on both cheerful sparrows wards as they are frequently used and it is challenging to provide a consistent approach to making resources available.
T& O	Establishments are generally satisfactory. Kings D will require further review and may need investment in the future. Kings C1 based on nursing workload and acuity will require a small investment 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. The division should explore the possible alignment of breast services with gynaecology to create wards that deal with women's needs. This will need to be explored as part of the clinical strategy and would align skills and competencies of staff more effectively than the current medical / HCOOP outliers occupying the additional beds on these wards.
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.
Critical Care	Available staffing is below the Intensive Care Society standard due to vacancies and the use of additional beds and this will need to be addressed as part of the clinical strategy.
Midwifery	The average Midwife to birth ratio in the first 8 months of 2014/15 is 1:29.40. A Maternity structural review and implementation of a new community service model is planned in 2015/16.
Theatres	Staffing reflects AFPP guidance but to enable full utilisation of theatres at weekends further theatre co-ordinator and recovery staff are required.
Emergency Departments	

The review is inconclusive. Professional Judgement suggests that current staffing levels appear sub optimal but further review will be undertaken against the recently published NICE ED staffing tool.

Ambulatory Care

Recent investment to extend the service to 7 day working during winter has been made but professional judgement suggests that additional staff are required to meet current demand due to the increase in activity seen over the last three years.

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

6. Evaluate the impact of the investment into ward staffing;
   - Achieve full implementation of additional posts taking place across 2014/15.
   - Evaluate impact of the investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety.
   - Consider further phased investment for wards where evidence suggests more staff are required to keep pace with acuity and dependency of patients.
   - Consider extending funding of contingency beds beyond the winter period.

7. Optimise the use of existing resources;
   - Further reduce the vacancy levels for registered nurses by implementation of a robust plan to recruit 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.

8. Improve clinical leadership and supervision of quality of care (next phase of agreed investment);
   - Implement the supervisory element of the ward manager role and evaluate the benefits through the ward manager accountability framework.
   - Implement the plan for all ward managers to undertake the clinical leadership programme over the next three years.

9. 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

10. 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 46 wards as at Oct 2014, proportion of staff in post, adjusted establishment incorporating the separate bank line.

				Funded establishment				Staff in post					Bank line				
Ward	Specialty	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	RN (WTE)	Ass Pract band 4 (WTE)	HCA (WTE)	Staff in Post (WTE)	RN (WTE)	Ass Pract band 4 (WTE)	Support worker (WTE)	Proportion staff in post (%)	Separate bank line (£000s)	RN Adjusted Bank (WTE)	SW Adjusted Bank (WTE)	Total Adjusted (WTE)	Full Establishment (WTE)
Kingston	Stroke	**22**	**5**	39.44	23.85	0.92	13.87	37.71	24.44	0.92	11.55	95.6%	20.90	0.67	0.00	0.67	**40.11**
Harvey ward	Neuro rehab	**19**	**0**	25.65	13.80	0.00	10.85	24.73	13.80	0.00	9.93	96.4%	0.00	0.00	0.00	0.00	**25.65**
Treble ward	Neurology	**18**	**0**	27.78	15.44	1.00	10.43	29.88	17.64	1.00	10.33	107.6%	14.20	0.46	0.00	0.46	**28.24**
Mount McMaster	Gastro	**24**	**2**	28.47	14.00	0.00	12.57	26.42	13.60	0.00	10.92	92.8%	22.40	0.72	0.00	0.72	**29.19**
Invicta	Respiratory	**24**	**0**	28.56	16.35	0.00	10.50	27.78	17.60	0.00	8.47	97.3%	15.50	0.50	0.00	0.50	**29.06**
Taylor KCH	Cardiac Care	**5**	**2**	16.16	14.33	0.00	0.66	13.08	11.91	0.00	0.00	80.9%	0.00	0.00	0.00	0.00	**16.16**
Harbledown	Acute frailty	**24**	**3**	33.67	17.59	0.00	14.26	32.41	17.80	0.00	13.79	96.3%	17.70	0.57	0.00	0.57	**34.24**
ECC	CDU	**18**	**0**	56.07	42.89	0.00	11.18	48.22	36.04	0.00	10.18	86.00%	0.00	0.00	0.00	0.00	**56.07**
	ECC	NA	**0**														
CDU WHH	CDU	**14**	**11**	71.24	45.45	0.00	22.20	65.64	45.32	0.00	16.72	92.1%	34.70	1.11	0.00	1.11	**72.35**
	Cambridge M1	**18**	**0**														
Richard Stevens Unit	Stroke	**24**	**0**	40.78	21.46	2.00	13.82	37.31	21.25	2.00	12.56	91.5%	19.10	0.61	0.00	0.61	**41.39**
Cambridge J	Respiratory	**34**	**0**	39.04	22.64	0.00	14.90	29.81	17.96	0.00	10.35	76.4%	26.00	0.83	0.00	0.83	**39.87**
Cambridge K	Cardiology	**28**	**0**	34.13	19.96	1.00	11.67	29.66	18.29	1.00	8.87	86.9%	24.30	0.78	0.00	0.78	**34.91**
Cambridge M2	Gastro	**20**	**0**	26.61	15.18	0.00	9.93	27.63	16.47	0.00	9.67	103.8%	20.30	0.65	0.00	0.65	**27.26**
Cambridge L	Acute frailty	**21**	**5**	32.30	18.11	0.80	11.89	35.11	21.33	0.80	11.47	108.7%	24.90	0.80	0.00	0.80	**33.10**
Oxford	Infectious dis	**14**	**0**	23.61	14.36	0.00	7.75	23.70	15.09	0.00	7.61	100.4%	12.80	0.41	0.00	0.41	**24.02**
CCU WHH	Cardiac Care	**11**	**2**	31.91	25.41	1.00	4.00	30.86	24.36	1.00	4.00	96.7%	4.00	0.13	0.00	0.13	**32.04**
CDU, QEQM	Emrgncy med	**25**	**6**	38.86	23.95	0.00	12.17	41.44	25.20	0.00	13.50	106.6%	21.90	0.70	0.00	0.70	**39.56**
Minster Ward	Cardiology	**23**	**0**	31.57	15.03	1.97	13.07	35.52	17.40	0.00	15.62	112.5%	27.20	0.87	0.00	0.87	**32.44**
Fordwich Ward	Stroke	**19**	**4**	37.02	19.82	2.00	12.01	36.19	21.64	2.00	11.05	97.8%	30.30	0.97	0.00	0.97	**37.99**
Sandwich Bay	Respiratory	**21**	**0**	27.75	15.41	1.00	9.54	24.11	14.20	1.00	7.41	86.9%	13.30	0.43	0.00	0.43	**28.18**
St Margarets	Gastro	**22**	**3**	26.54	16.08	0.00	9.46	25.90	15.40	1.80	8.20	97.6%	20.30	0.65	0.00	0.65	**27.19**
Deal	Endocrinology	**28**	**0**	32.03	17.61	1.00	11.72	27.40	15.60	2.00	8.33	85.5%	16.30	0.52	0.00	0.52	**32.55**
CCU QEQM	Cardiac Care	**12**	**0**	23.00	15.51	0.00	6.46	22.21	14.34	0.00	6.85	96.6%	4.80	0.15	0.00	0.15	**23.15**
Marlowe	Nephrology	**29 +6**	**4**	52.70	33.26	0.50	17.14	44.09	30.22	0.00	12.07	83.7%	0.00	0.00	0.00	0.00	**52.70**
Brabourne	Oncology	**8**	**0**	16.77	13.97	0.00	2.00	19.17	15.17	0.00	2.80	114.3%	0.00	0.00	0.00	0.00	**16.77**
Kennington ward	Gynae	**11+2**	**4**	21.60	11.90	0.00	7.70	18.47	10.87	0.00	6.60	85.5%	0.00	0.00	0.00	0.00	**21.60**
Birchington	Gynae	**15**	**4**	28.71	18.13	1.00	7.58	28.25	17.85	1.00	7.40	98.4%	0.00	0.00	0.00	0.00	**28.71**
Neonatal ITU	NICU	**7**	**0**	64.00	56.54	2.35	2.61	59.37	54.77	0.00	2.60	92.8%	0.00	0.00	0.00	0.00	**64.00**
Padua	Paediatric	**28**	**0**	45.45	34.35	1.20	7.98	44.87	36.39	0.00	7.68	98.7%	4.50	0.14	0.00	0.14	**45.59**
Rainbow	Paediatric	**20**	**0**	38.54	28.34	1.40	7.80	38.17	29.50	0.00	7.67	99.0%	0.00	0.00	0.00	0.00	**38.54**
Clarke	Urology	**36+6**	**2**	41.60	23.20	2.00	13.90	38.93	22.56	1.00	11.57	93.6%	28.10	0.00	1.46	1.46	**43.06**
Kent	Vascular	**20+6**	**5**	31.03	17.80	1.00	9.73	29.80	17.47	1.00	9.33	96.0%	24.10	0.00	1.25	1.25	**32.28**
Kings A2	Gen Surg	**20**	**0**	24.16	13.31	0.00	9.85	22.28	9.80	0.00	9.48	92.2%	9.30	0.00	0.48	0.48	**24.64**
Kings B	Colorect Surg	**27**	**0**	32.57	17.21	0.00	12.83	30.58	15.86	0.00	12.19	93.9%	26.50	0.00	1.38	1.38	**33.95**
Kings D male(1)	T+O	**39**	**4**	52.09	28.95	0.00	20.30	47.15	23.85	0.00	21.01	90.5%	16.90	0.00	0.88	0.88	**52.97**
Kings D female (2)																	
Kings C1	T+O eld trauma	**27**	**0**	33.05	16.14	0.00	14.40	28.23	14.15	0.00	13.48	85.4%	27.90	0.00	1.45	1.45	**34.50**
Kings C2	T+O elective	**24**	**0**	33.51	18.41	0.00	13.60	30.07	16.93	1.00	11.13	89.7%	28.00	0.00	1.46	1.46	**34.97**
Rotary	Max fax / ENT	**16**	**0**	33.93	17.68	0.00	10.31	33.24	17.28	0.00	10.31	98.0%	8.70	0.28	0.00	0.28	**34.21**
Cheerful Sp Male	Colorect Surg	**18**	**8**	28.49	15.53	1.00	10.96	25.25	13.25	1.00	9.00	88.6%	0.00	0.00	0.00	0.00	**28.49**
Cheerful Sp Female	Gen Surg	**20**	**8**	30.28	16.53	0.00	11.15	31.33	16.40	1.00	13.93	103.5%	0.50	0.00	0.03	0.03	**30.31**
Bishopstone	T+O eld trauma	**22**	**0**	32.06	14.34	1.00	14.92	30.80	14.33	1.00	13.87	96.1%	28.60	0.00	1.49	1.49	**33.55**
Seabathing	T+O trauma	**26**	**0**	32.96	16.29	1.00	14.17	25.56	14.47	1.00	8.63	77.5%	28.40	0.00	1.48	1.48	**34.44**
Quex	T+O elective	**19**	**1**	24.33	15.71	0.00	4.73	22.25	14.33	2.00	4.93	91.5%	19.40	0.00	1.01	1.01	**25.34**
ITU WHH	Critical care	**11**	**0**	63.79	53.03	0.00	4.40	58.61	47.02	0.00	6.00	91.9%	0.00	0.00	0.00	0.00	**63.79**
ITU QE	Critical care	**8**	**1**	47.05	42.93	0.00	3.12	44.37	40.57	0.00	3.12	94.3%	0.00	0.00	0.00	0.00	**47.05**
ITU KCH	Critical care	**8**	**2**	39.16	36.06	1.00	1.00	37.91	34.81	1.00	1.00	96.8%	0.00	0.00	0.00	0.00	**39.16**
				1620.02	**1023.84**	**26.14**	**477.09**	**1521.47**	**984.53**	**24.52**	**433.18**	**93.92%**	**641.80**	**12.95**	**12.38**	**25.33**	**1645.35**

Appendix 2: Modelling methods applied to adjusted funded establishments for the 46 wards.

					Attendance			Evaluation methods										Shift fill - DAY		Shift fill - NIGHT		Nurse Sensitive Quality Indicators		
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	Full Establishment (WTE)	Sickness Oct 14 (%)	Maternity leave (WTE at 31.10.14 (WTE)	E-Rostering effectiveness (% time worked)	Skill mix	wte:bed	Prof judgment	Hurst NPOB	SNCT	SNCT (contingency beds)	Total vital signs obs (VitalPAC)	Occupancy Oct 14 (%)	Ratio of patients per RN Oct 14 Days	Ratio of patients per RN Oct 14 Nights	Average filled hours - actual v planned Oct 14 (%) RNs	Average filled hours - actual v planned Oct 14 (%) Support staff	Average filled hours - actual v planned Oct 14 (%) RNs	Average filled hours - actual v planned Oct 14 (%) Support staff	Harm free care (Safety Thermometer) Oct 14	Harm free care (new harms only) Oct 14	Friends & Family Test (% who would recommend) Oct 14
Kingston	22	5	39.44	40.11	6.69	1.81	68.40	60/40	1.82	42.30	42.1*	34.61	2.41	6167	100.97	4.1	7.3	90.86	76.80	97.15	85.62	95.50%	100.00%	88.00%
Harvey ward	19	0	25.65	25.65	7.23	1.00	73.10	55/45	1.35	28.60	24.60	26.64		4321	98.64	7.0	9.8	91.90	123.55	93.69	123.70	84.20%	94.70%	missed Oct submission
Treble ward	18	0	27.78	28.24	3.49	1.00	75.80	55/45	1.56	30.20	24.20	23.49		6434	87.29	5.6	8.6	84.30	103.67	101.61	103.51	100.00%	100.00%	98.00%
Mount McMaster	24	2	28.47	29.19	3.98	0.40	78.80	50/50	1.21	31.20	33.70	26.78	0.27	9372	92.70	7.4	11.1	100.91	79.89	100.00	102.69	81.00%	100.00%	97.00%
Invicta	24	0	28.56	29.06	7.05	0.00	76.30	58/42	1.21	31.00	33.70	28.89		8701	91.26	5.9	11.5	99.19	81.04	96.77	138.98	95.80%	95.80%	91.00%
Taylor KCH	5	2	16.16	16.16	5.76	0.00	70.60	91/9	3.23	12.20	7.70	9.85	1.16	3185	117.15	1.9	2.4	80.49		100.39		100.00%	100.00%	100.00%
Harbledown	24	3	33.67	34.24	4.06	1.00	73.20	53/47	1.42	31.80	32.20	32.92	0.35	8582	94.99	5.5	11.0	100.74	94.75	101.61	87.16	100.00%	100.00%	83.00%
ECC	18	0	56.07	56.07	6.50%	1.90	71.1	76/24.		37.3	27.00			9934								100.00%	100.00%	86.00%
	NA	0								46.1	NA													
CDU WHH	14	11	71.24	72.35	3.56	2.00	70.40	64/36	2.26	67.80	67.40	21.65	5.65	11222	29.54	4.1	6.1	116.47	87.86	90.34	101.61	100.00%	100.00%	80.00%
	18	0										25.14		6097										
Richard Stevens Unit	24	0	40.78	41.39	3.37	0.00	68.80	53/47	1.72	42.60	44.8*	38.10		7345	88.16	5.3	10.0	78.95	122.21	77.23	101.82	95.50%	100.00%	100.00%
Cambridge J	34	0	39.04	39.87	8.88	0.71	72.80	59/41	1.17	46.10	44.80	48.37		11093	111.26	6.4	14.8	103.00	188.80	110.90	104.57	90.30%	100.00%	86.00%
Cambridge K	28	0	34.13	34.91	0.7	0.00	81.30	60/40	1.40	31.20	38.10	35.43		10181	91.63	5.8	13.7	85.03	107.78	100.71	95.79	89.30%	96.40%	94.00%
Cambridge M2	20	0	26.61	27.26	3.19	2.00	65.90	58/42	1.36	28.60	29.20	28.11		7592	91.61	4.9	9.8	106.74	93.73	94.89	98.97	100.00%	100.00%	91.00%
Cambridge L	21	5	32.30	33.10	1.89	1.38	74.20	57/43	1.27	34.90	29.30	31.23	5.27	5978	113.21	4.8	13.0	87.62	129.38	97.05	119.85	69.20%	100.00%	100.00%
Oxford	14	0	23.61	24.02	7.04	1.92	64.40	62/38	1.17	26.00	20.50	20.63		5108	105.45	4.1	10.2	106.87	139.04	66.20	77.42	75.00%	87.50%	94.00%
CCU WHH	11	2	31.91	32.04	6.52	0.00	76.90	81/19	2.91	30.00	32.71	21.09	0.67	2945	86.54	2.1	2.9	93.58	107.93	90.39	80.29	100.00%	100.00%	88.00%
CDU, QEQM	25	6	38.86	39.56	5.08	1.00	73.10	62/38	1.58	44.10	45.10	34.60	5.11	12602	109.81	3.7	7.6	98.28	89.54	79.66	100.51	96.80%	96.80%	82.00%
Minster Ward	23	0	31.57	32.44	7.09	0.00	69.10	48/52	1.41	33.70	32.60	35.97		8801	52.34	5.4	11.4	94.41	106.70	104.67	80.47	100.00%	100.00%	89.00%
Fordwich Ward	19	4	37.02	37.99	4.61	1.00	75.90	54/46	1.99	34.20	38.05*	33.00	3.84	6807	108.99	3.1	6.4	100.34	125.97	104.95	91.78	81.80%	95.50%	100.00%
Sandwich Bay	21	0	27.75	28.18	0.97	0.00	81.40	55/45	1.34	29.70	30.30	29.83		8592	97.06	5.2	12.6	110.32	153.67	88.39	96.98	95.20%	100.00%	94.00%
St Margarets	22	3	26.54	27.19	2.77	3.20	70.50	62/38	1.23	30.70	31.50	29.47	3.64	8505	54.33	6.3	13.8	89.59	120.73	88.47	182.04	96.00%	100.00%	100.00%
Deal	28	0	32.03	32.55	2.28	0.00	87.30	56/44	1.16	38.70	38.10	38.24		8966	139.12	4.7	16.5	112.90	108.17	94.35	68.23	71.40%	96.40%	86.00%
CCU QEQM	12	0	23.00	23.15	4.61	0.60	70.50	69/31	1.92	22.00	26.52	22.08		3371	88.21	3.3	6.4	89.50	94.98	103.63	94.03	100.00%	100.00%	98.00%
Marlowe	29 +6	4	52.70	52.70	2.44	1.00	76.70	63/37	1.81	52.7	54.7	46.62	0.15	12047	96.30	3.2	9.0	102.03	74.73	80.10	94.79	89.30%	96.40%	100.00%
Brabourne	8	0	16.77	16.77	0.65	3.00	61.60	83/17	2.09	14.7	15.12	10.58		2880	72.68	2.8	3.8	99.10	90.84	96.77	N/A	100.00%	100.00%	100.00%
Kennington ward	11+2	4	21.60	21.60	5.30	0.67	77.70	55/45	1.96	20.90	16.83	13.86	2.67	4635	105.54	3.6	8.8	141.51	104.15	57.93	140.00	100.00%	100.00%	94.00%
Birchington	15	4	28.71	28.71	1.44	1.00	76.60	63/37	1.91	27.5	22.95	20.50	3.54	6174	109.32	4.0	8.2	90.44	146.66	92.05	68.18	94.70%	94.70%	92.00%
Neonatal ITU	7	0	64.00	64.00	4.77	0.00	74.70															100.00%	100.00%	n/a
Padua	28	0	45.45	45.59	2.31	1.00	69.80	75/25	NA	47.9	50.9*				55.28			94.95	91.76	101.74	84.21	100.00%	100.00%	n/a
Rainbow	20	0	38.54	38.54	0.82	1.00	78.50	73/27	NA	46.7	45.9*				51.33			97.17	122.23	94.90		100.00%	100.00%	n/a
Clarke	36+6	2	41.60	43.06	2.23	0.80	78.00	56/44	1.19	44.6	44.7	39.01	0.79	9674	73.89	5.7	18.6	89.24	113.88	97.80	101.57	96.20%	100.00%	96.00%
Kent	20+6	5	31.03	32.28	4.2	0.00	80.60	57/43	1.61	26.40	24.90	22.74	0.25	8536	81.66	4.1	10.1	101.02	89.84	95.58	97.47	61.50%	100.00%	95.00%
Kings A2	20	0	24.16	24.64	1.48	0.00	80.80	55/45	1.23	28.30	24.90	25.09		8189	93.75	5.7	11.1	110.08	102.05	87.09	136.79	94.70%	100.00%	92.00%
Kings B	27	0	32.57	33.95	1.06	1.80	73.10	53/47	1.25	34.60	33.60	30.97		12406	92.97	6.6	11.4	98.84	112.77	115.04	133.52	100.00%	100.00%	86.00%
Kings D male(1)	39	4	52.09	52.97	0.5	1.64	78.00	56/44	1.35	53.60	53.00	50.03	2.45	9975	101.97	5.5	12.0	94.44	141.75	78.56	101.75	100.00%	100.00%	95.00%
Kings D female (2)														6401	97.10							100.00%	100.00%	89.00%
Kings C1	27	0	33.05	34.50	10.26	0.00	74.90	49/51	1.27	38.80	35.20	39.03		8227	92.04	6.1	12.4	102.48	123.27	105.54	85.48	95.80%	100.00%	92.00%
Kings C2	24	0	33.51	34.97	0.12	1.80	75.80	56/44	1.45	30.00	31.90	29.22		9348	77.67	5.9	14.4	83.51	121.48	80.65	83.49	100.00%	100.00%	96.00%
Rotary	16	0	33.93	34.21	0.21	1.60	73.40	53/47	2.13	32.6	19.90	19.19		5683	85.08	3.0	8.6	113.20	103.97	94.65	87.10	93.80%	93.80%	95.00%
Cheerful Sp Male	18	8	28.49	28.49	6.16	0.00	76.20	55/45	1.58	31.5	27.00	25.66	2.79	9017	104.40	4.8	9.8	109.49	154.76	95.83	80.98	100.00%	100.00%	92.00%
Cheerful Sp Female	20	8	30.28	30.31	4.89	1.00	70.00	55/45	1.51	32.8	29.50	27.71	3.51	9403	110.97	4.2	10.0	134.24	138.83	111.21	65.48	85.00%	95.00%	92.00%
Bishopstone	22	0	32.06	33.55	0.67	0.00	83.60	45/54	1.52	32.0	29.60	33.40		6904	86.31	5.3	11.9	112.12	93.89	106.89	90.36	100.00%	100.00%	96.00%
Seabathing	26	0	32.96	34.44	5.46	0.00		50/50	1.32	33.7	34.10	33.96		9167	89.2							73.90%	95.70%	92.00%
Quex	19	1	24.33	25.34	8.42	0.00	77.00	65/35	1.33	26.9	26.30	23.37	0.10	6775	62.70	5.3	10.0	78.08	182.28	105.81	68.71	100.00%	100.00%	94.00%
ITU WHH	11	0	63.79	63.79	1.97	1.00	77.00	83/17	5.8						82.92			128.62	135.62	133.98	246.15	83.30%	100.00%	n/a
ITU QE	8	1	47.05	47.05	4.66	0.00	81.10	91/9	5.8						80.66			94.76	101.91	107.01		85.70%	100.00%	n/a
ITU KCH	8	2	39.16	39.16	5.15	2.76	68.30	92/8	4.9						101.25			92.65	180.36	96.62	151.28	100.00%	100.00%	n/a
			1620.02	1645.35		40.99	74.52%																	