

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

CLINICAL MANAGEMENT BOARD – 24 APRIL 2009

REVIEW OF WARD STAFFING LEVELS AND SKILL-MIX 2008/09

EXECUTIVE SUMMARY

1. INTRODUCTION

This report outlines the 2008/09 review which has included all 49 ward areas across the Trust including A+E, ECC and CDU, Medicine, HCOOP, Specialty Medicine, Oncology, Child Health, Surgery, Head & Neck, T+O, RVUIR, and Gynaecology.

The purpose of this paper is to:

- Present comparisons with national and local benchmarks
- Present the findings from the review
- Provide a current picture of turnover and recruitment to vacancies
- Present recommendations
- Propose priorities for investment in ward-staffing and outline further work to be undertaken to understand the level of investment required
- Link any investment to new and more productive ways of working

2. FINDINGS

All 49 wards in the directorates involved were reviewed for staffing levels and skill-mix (ratio of Registered Nurses to Healthcare Assistants/support staff). The review found that EKHUFT ward staffing levels are generally average but the costs are around £1m below the average nursing costs in comparison with 38 other large acute hospitals in England (***Audit Commission Ward Nurse Staffing Benchmarking Review 2009***) with grade mix in the lower quartile. Nurse per bed ratio is below our 3 closest neighbouring acute trusts, although according to Dr Foster data (2009) our HSMR is lowest (***Nursing Times April 2009 (Appendix 2)***).

Last year the 2007/08 ward staffing review undertaken across 37 wards within Medicine, HCOOP, Surgery, T+O and Vascular & Urology resulted in the investment of £2.1m into ward establishments which was used to fund 67.1wte additional band 5 nurses across these wards. Recruitment to these additional posts is complete but with additional turnover there remains a vacancy factor across nursing of 6.8% although it is slightly lower across the wards (4.79%).

The A+Es, ECC, neuro rehabilitation, oncology, renal ward, gynaecology and child health were not reviewed last year but were included in 2008/09 review.

Overall, the review found that in February 2009 the impact of current vacancy levels, sickness and maternity/paternity leave for all areas resulted in 84.8% of total funded establishment available for work. The use of temporary staff (NHS-P) partially closed this gap. The supply of temporary staff is consistent and has improved over 2008/9; however a number of specialist wards and departments continue to experience a poor supply of temporary staff. In addition, the trust has used an agency supplier over the winter period as a contingency to manage a significant number of additional beds.

Skill-mix varies across all 49 wards and not necessarily in relation to the acuity or complexity of patient needs. 22 of the 49 wards have a skill-mix less than the RCN recommendations (65:35 skill-mix). A high proportion of these are around 55:45.

Two methods of modelling ward establishments were used:

- Nurse per Occupied Bed Method (Hurst 2008), a reliable validated tool
- Association of United Kingdom University Hospitals (AUKUH) tool for measurement of patient dependency and nursing workload.

Both methods demonstrated that many wards have current establishments which are below those required which suggests that despite investment last year, staffing levels have not kept pace with current activity, throughput and length of stay.

The review suggests that there is a large short-fall in establishment for A&E. It has been difficult to find current national benchmarking data as the Audit commission survey did not include A&E. In the light of Healthcare Commission report into Mid-Staffordshire, further work will be required to benchmark the A+E establishments to understand the level of investment required.

3. RECRUITMENT AND VACANCY MANAGEMENT

Current turnover rate of registered nurses is 9%, a reduction from 10% last year. This may indicate greater stability within the workforce. Recruitment has relied on newly qualified nurses, recruiting experienced band 5 nurses remains a challenge. Co-ordinated recruitment to the 67 wte additional band 5 posts, following investment last year, has now been achieved and ward vacancies have reduced significantly from 12% last year 4.79% due to recruitment initiatives and improved vacancy management.

Month	Total vacancy wards	Non registered staff (wte)	Registered staff (wte)	% vacancy
March 09	49.92	42.36	7.56	4.79

The reduction in vacancies has been largely achieved through site based co-ordination of recruitment, open events, group recruitment initiatives, dedicated resourcing team support and the implementation of a vacancy tracker enabling improved vacancy management at directorate level.

The increased demand for temporary staff since September 2008 has been largely met through NHSP but has required the use of agency to fill shortfalls. The nursing pool has provided further flexibility on the KCH site and the feasibility of using this approach to increase supply across sites requires further work.

4. FUTURE STAFFING MODELS

The future challenges facing the organisation will be keeping pace with demand for services and commitment to provide high quality services with excellence in patient experience. Improvements in patient safety, patient experience and efficiency will largely be reliant on having the optimum numbers of skilled nursing staff and excellence in clinical leadership at ward level.

The roll-out of 'productive ward' is having a profound impact on the way that ward teams organise their systems and processes of care; they can 'release time to care for patients' by removing activities and tasks which do not add value to patient experience. The continued challenges facing ward teams include the need to:

- Optimise care-pathway and reduce length of stay in hospital
- Optimise patient safety and reduce any avoidable harm events
- Optimise patient experience including addressing any issues associated with mixed-sex accommodation; ensuring that patients feel part of their care decisions which includes information-giving; and improving patient reported outcomes of care.

- Moving to 'real-time' bed management system and system of electronic rostering.

The strategic approach to future ward staffing models will require:

- Career-pathway development for registered nurses with better career-progression from band 5 to band 6 roles;
- Role development for band 6, 7, and 8a post-holders to focus on the development of advanced knowledge and skills to complement the clinical team and to ensure better, faster, and effective decision-making through-out the care pathway and specifically on admission and discharge/transfer.
- Career-pathway development for support staff with better career-progression for band 2 to band 3; and for the development of band 4 associate practitioner role in ward areas with wider skill-set including support skills to nursing, therapies and potentially to medical staff.
- Increase ward clerk capacity and capability during afternoons and evenings with appropriate skills to run an effective real-time approach to bed management using PAS system
- Modelling of ward staffing scenarios for moving to 28 bedded wards with 50% single ensuite rooms as part of estates plan.

Ward based clinical teams will require expert clinical leadership with strong emphasis on leading for excellence in customer care and patient safety. Clinical models of care will change over the next five years with distinctive changes to the way that emergency and elective pathways are organised with more emphasis on:

- ambulatory and short-stay care with emphasis on nurse-managed discharge
- high acuity patients with complex needs requiring 'managed care' approach with possibility of hand-over to community matrons in community services to co-ordinate and manage rehabilitation
- telephone follow-up of patients with chronic conditions by either/combination of nurses, therapists or pharmacists

5. RECOMMENDATIONS

The recommendations are based on the detailed analysis from the review as outlined in the main body of the report

1) Improving the use of the current resource

- a) Introduce the formal recognition of the senior staff nurse role for individuals who meet the criteria on pay band 5;
- b) Agree method of managing vacancy factor (across whole directorate) to recruit to maternity leave (in individual wards);
- c) Implement electronic rostering and monitor efficiency and effectiveness
Explore feasibility of implementing the nursing pool across all 3 sites.
- d) Aim for vacancy factor <2% of total establishment; explore options for optimising recruitment and retention including return to practise and selective overseas recruitment for hard to recruit specialist areas.

2. Proposed areas for investment

- e) Investment into ward clerk posts to provide evening cover across wards in the region of 0.5wte per ward with sharing across wards.
- f) Alter skill-mix to provide improved career progression and focus on better training and preparation for senior ward staff to lead in a changed system. Conversion of a band 5 post to band 6 on each ward to provide improved leadership and management and support to the ward manager role. This would apply across 44 wards.

- g) Further investment of band 5 posts into two medical wards and the Urology ward where current levels are well below national average.
- h) Explore the case for additional staffing required in T&O as part of capacity review
- i) Conversion of some band 2 posts to band 5 posts across nine of the medical wards to improve skill-mix
- j) Investment into the Paediatric wards to provide combination of additional registered nurses and support staff with enhanced skills to improve staffing levels whilst acknowledging current high skill-mix.
- k) Implement ward based Associate Practitioner (Band 4) role to create a more flexible and competent workforce.
- l) Investigate case to understand the level of investment required in the A+E departments and roles required alongside service improvement modelling for patient flow through A+E, CDU and the short stay areas.
- m) Plan for a flexible resource for staffing additional beds at WHH primarily to support Cambridge J ward which accommodates 11 additional beds daily during winter pressures.

As part of ongoing review of ward staffing ward establishments will be reviewed annually to ensure that they are fit for purpose. Changes to ward configurations in year will require review and re-evaluation of establishment in year to ensure safe and effective care.

The investments described will require funding in the region of £1m. It is proposed that the trust considers funding investments from successful achievement of CQUINs which hold a value of £1.9 million for 2009/10. It is proposed that case for investment will go through normal business planning processes and will be managed across the trust on behalf of directorates with their agreement.

CMB Members are asked to discuss and approve the direction of travel and the priorities identified for development and investment.

Julie Pearce
Director of Nursing, Midwifery & Quality

Helen O'Keefe
Associate Director of Nursing

20 April 2009.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

CLINICAL MANAGEMENT BOARD - 24 April 2009

REVIEW OF WARD STAFFING LEVELS AND SKILL-MIX 2008/09

1. INTRODUCTION

Following the review of ward staffing which was reported to CMB in March 2008 it was agreed that further work be undertaken to review ward establishments annually to ensure that they are fit for purpose.

This report outlines the 2008/09 review which has included all 49 ward areas across the Trust including;

- A+E, ECC and CDU
- Medicine
- HCOOP
- Specialty Medicine
- Oncology
- Child Health
- Surgery
- Head & Neck
- T+O
- Renal
- Vascular
- Urology
- Gynaecology

The report recommends further investment in ward staffing for 2009/10 to promote a high quality workforce reflecting the needs of patients, a stronger role for clinical leadership and management, improved administrative support to wards and greater emphasis on a pathway approach in implementing new roles.

Any investment proposed should go through the normal business case process.

2. BACKGROUND

In 2007/08 a structured review of ward staffing levels and skill-mix was undertaken across 37 wards within Medicine, HCOOP, Surgery, T+O and Vascular & Urology. The review was reported to CMB on 14 March 2008 and recommended a level of investment in ward staffing with further work to be undertaken to review again in 2008/09. The 2007/08 review resulted in the investment of £2.1m into ward establishments which was used to fund 67.1wte additional Band 5 posts across these wards.

The impact of low staffing levels is well documented and the Health and Social Care Act (2008) code of practice on the prevention and control of healthcare associated infections highlights the need for sufficient staff to be available to care for patients safely. US researchers have found that higher nurse staffing levels correlate with improved patient satisfaction particularly in relation to discharge instructions, communication about treatment and care, and about medications (Harvard School of Public Health 2008).

Ward staffing levels and skill-mix have been regularly reviewed as part of the annual business planning cycle. The methodology used to support this work involved a combination of the 'staffing costers' and professional judgements. The financial modelling tool 'staffing costers' (developed by EKHUT) has enabled ward managers and matrons to define the numbers of nurses by band per shift required to manage the workload on an average shift, taking into account shift times, and periods of shift overlap.

The financial model allows for assumptions to be used for calculating the nurse establishment as a whole time equivalent (wte) which generates the number of wte nurses by pay band. The calculation assumes percentage allowances to take into account annual leave and 4 days study leave (18%), sickness (3 %), with no allowance for maternity/paternity leave. This gives an additional average allowance of allowance of 21%.

The model provides a systematic way of calculating staffing establishments but does not take account of patient acuity, dependency and associated nursing workload. The case mix and dependency will have changed as a result of the efficiency and productivity gains produced by managing increased activity through reduction in length of stay, improvements in managing the system, and increases in day case and ambulatory care.

Following the investment into ward staffing in 2008/09 the average skill-mix and staff : bed ratio was uplifted to improved levels. (Staff per bed ratio is calculated to include the whole ward establishment including registered and non registered staff). The following table outlines the impact on the directorates that benefited from the investment.

Table 1: Impact of investment of 67 wte Band 5 nurses on skill-mix and staff : bed ratio

Directorate	Average skill-mix 2007/08	Average skill-mix 2008/09	Average staff:bed ratio 2007/08	Average staff:bed ratio 2008/09
Medical wards	55 / 45	56 / 44	1.14	1.19
Coronary Care	78 / 24	76 / 24	2.22	2.2
Stroke	51 / 49	63 / 37	1.19	1.52
Rehabilitation	48 / 52	53 / 47	1.10	1.18
Surgery	53 / 47	60/40	1.09	1.28
T+O	53 / 47	57 / 43	1.12	1.17
Renal and Urology	53 / 47	62 / 38	1.06	1.23

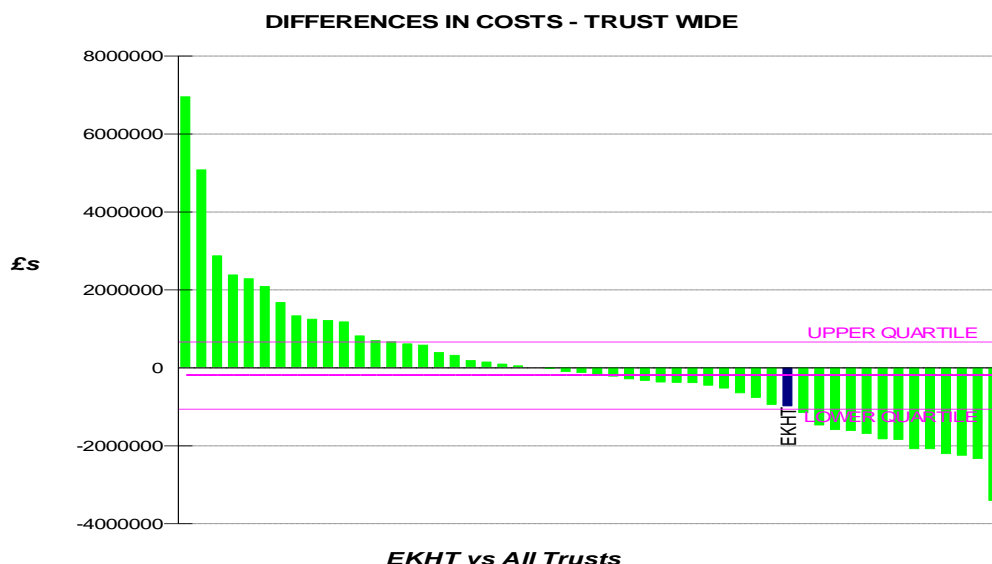
The A+Es, Emergency Care Centre (ECC), neuro rehab, oncology, renal, gynaecology, and child health did not receive investment last year but were included in this 2008/09 review.

3. NATIONAL AND LOCAL COMPARITORS

There are no national targets or guidelines for the numbers of nurses required (except in a few specialist areas such as intensive care). The range of methodologies available for assessing nursing requirements are not precise due to variability of need and so comparison with national benchmarks can prove a valuable aid for trusts in setting staffing numbers.

The Acute Hospitals Portfolio has twice collected and fed back data to all acute trusts in England and Wales. This exercise was repeated on a voluntary basis in 2008/09 and more than 50 trusts have signed up to take part. Participating organisations completed data submissions giving details of staffing and costs for the months of May and June 2008 and to date 38 trusts have taken part.

In 2008/09 EKHUFT nurse staffing levels in whole time equivalents (WTE) are average but are near the lowest quartile in relation to spend on ward staffing with expenditure over £1m below average. **Figure 7** gives a visual representation with EKHUFT highlighted in blue.



The Audit Commission (Ward Nurse Staffing Benchmarking Review 2009) report also concludes (Appendix 1) that:

- Grade mix is in the lower quartile.
- Staffing levels are particularly low for the children's wards.
- For the majority of surgery and medical wards the percentage of qualified nursing staff is lower than average.
- 88% of the nursing establishment were in post which is in the lower quartile which may be an indicator of vacancy and turnover levels.
- Expenditure on temporary staff is in the lower quartile indicating efficient management of leave.
- Relatively few temporary staff were employed in the sample period and overall costs are low, indicating that staff may be under some pressure.
- The trust allowance of 21% for all types of absence is average
- Maternity leave absence was in the upper quartile
- Sickness levels were average

At this time recruitment to the additional 67 wte band 5s from the 07/08 review was not complete which elevated the vacancy factor.

The latest statistical research by Dr Foster concludes that the more nurses an acute trust has per bed improves mortality rates and reduces length of stay. On reviewing 147 trusts with A+E units the model shows that by far the strongest indicator of a trust's performance is the number of qualified staff including nurses and doctors. Analysis suggests trusts with a low nurse to bed ratio were around twice as likely as those with a high nurse to bed ratio to have a high HSMR rating (Appendix 2).

EKHUFT is not shown in the ranking due to data problems but subsequently submitted data for EKHUFT ranks us 97th out of 147 trusts placing us between Ipswich Hospital NHS Trust and The George Eliot Hospital NHS Trust. This shows that our nurse per bed ratio is below our three closest neighbouring acute trusts but our HSMR is lower than all of them indicating there are other variables involved.

	Nurse per bed	Staff per bed	HSMR status
East Kent Hospitals University NHS Foundation Trust	1.51	2.77	Low

It should be noted that the calculation used by Dr Foster for nurse per bed takes the total nursing numbers which includes all registered nurses in the trust, including non ward based nurses and does not include healthcare assistant numbers.

4. CURRENT WARD ESTABLISHMENTS

The review was undertaken by Lead Nurses and facilitated by the Associate Director of Nursing (Workforce development, Education & Training) with support from the Director of Nursing, Midwifery & Quality, Workforce Information and Directorate finance leads.

Current funded ward establishments within A+E + CDU, Medicine, HCOOP, Specialty Medicine, Oncology, Child Health, Surgery, Head & Neck, T+O, Renal, Vascular, Urology and Gynaecology were reviewed in January 2009 to determine budgeted establishments which were then agreed by ward managers. Skill-mix and staff : bed ratio was calculated for each ward. The following table gives an outline summary for each directorate. Ward staffing numbers include all support staff, including ward clerks.

Table 2: Summary of staffing profile by directorate at end December 2008

Directorate	Funded est WTE	Average skill-mix RN:HCA	Average staff:bed ratio
A+E and CDU	295.20	69 / 31	NA
Medical (including neuro rehab)	419.59	56 / 44	1.19
Coronary Care	64.4	76 / 24	2.2
Stroke	101.92	63 / 37	1.52
Rehabilitation	87.48	53 / 47	1.18
Surgery and Head + Neck	133.23	60/40	1.28
T+O	172.25	57 / 43	1.17
Renal, Vascular, Urology	122.22	62 / 38	1.23
Oncology	20.95	74 / 26	1.49
Gynaecology	49.13	58 / 42	1.63
Paediatrics	67.99	88/12	1.2
Total	1534.38		

The information presented in this form has limited value on its own but does give a staffing profile at the time of the review by directorate. The main observations are that skill-mix is low across medicine, rehabilitation, T+O, surgery and gynaecology when compared with the recommendations made by the Royal College of Nursing for 65:35 (Registered nurses : support staff) skill-mix for general medical and surgical wards.

Vacancies

The current turnover rate of registered nurses is 9%, a reduction from 10% last year. A national study (NOHPRB 2006) reported national turnover at 9.8% with South East Trusts reporting a higher level of 12.8%. The current turnover of support staff, including healthcare assistants is 14%, a reduction from 15% last year. Nationally reported turnover in 2006 was 11.8% with South East Trusts reporting a higher level of 15.3%.

The Audit Commission review (Ward Nurse Staffing Benchmarking Review 2008/09) findings that 88% of the nursing establishment were in post ranks EKHUFT in the lower quartile. Proportion of band 2s in post was in upper quartile performance but the proportion of band 5s in post was below average.

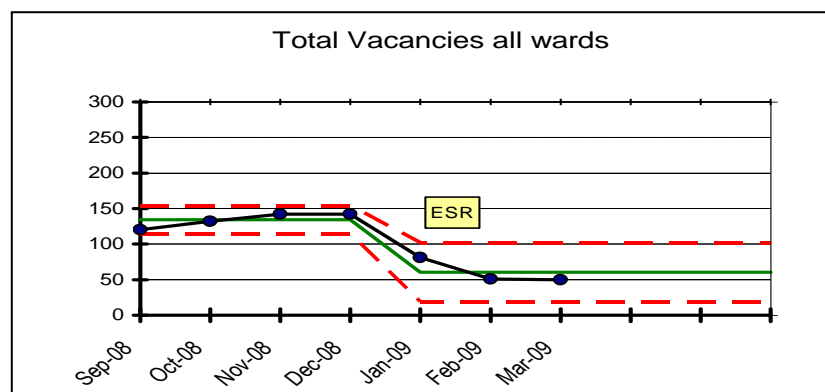
During the sample period recruitment to the additional 67 wte band 5s from the 07/08 review was not complete which elevated the vacancy factor as these additional posts were included in the total ward establishments..

A vacancy tracking system has been implemented for nursing posts since September 2008 which enables directorates to proactively monitor and manage vacancies more effectively. From September to December 2008 this was based on 'live' reported data from ward managers on current vacancies. However, due to inconsistencies in reporting the accuracy of this data was unreliable and so this system has been further developed using workforce information data linked to ESR to avoid duplication of effort in recording vacancies, improve reliability and enable improved vacancy management. Table 3 shows the reduction in the number of vacancies on wards since January 2009.

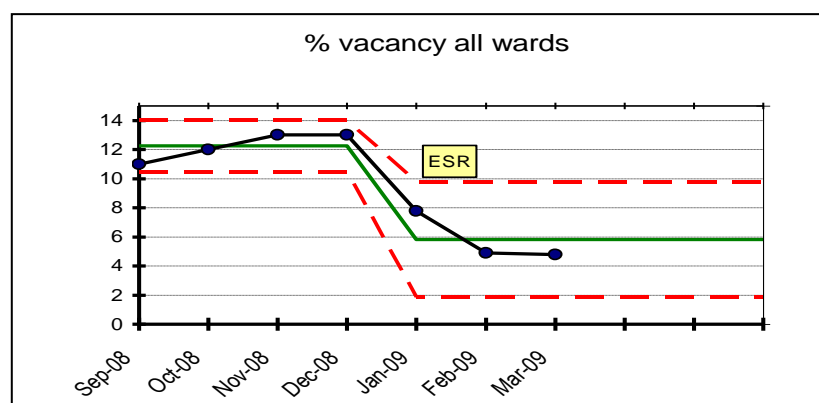
Table 3: Vacancies for all nursing posts and wards only

Months	Total vacancies	Total Reg nurse vacancies	Total Non registered vacancies	% vacancy all nursing posts	Total Vacancies all wards	Non registered vacancies all wards	Reg nurse vacancies all wards	% vacancy all wards
Jan-09	224.81	123.59	101.22	7.96	81.04	61.47	19.57	7.78
Feb-09	193.66	107.65	86.01	6.82	50.99	44.16	6.83	4.9
Mar-09	192.06	105.4	86.66	6.8	49.92	42.36	7.56	4.79

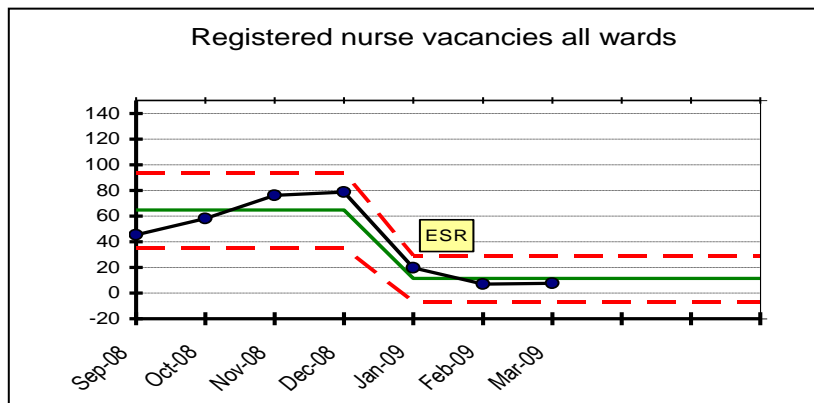
Represented as a trend, the step change seen below relates to the change to using ESR data from January 2009. A+C staff are excluded from the ESR data which now refers to ward staffing nurse vacancies only. This may partially explain the improvement in vacancy levels but there does appear to be an underlying reduction in ward vacancies due to recent recruitment of 95 staff through group recruitment exercises. **Figure 1** uses an SPC (statistical process control chart) to show the vacancy trend for ward staffing:



From September to December the higher number of reported vacancies from ward managers may have been due to inconsistency in the application of reporting criteria. From February 2009 the % vacancies for wards is 5% (against an overall 6.8% for nursing and midwifery including non ward areas). **Figure 2** shows the trend in % vacancy for all wards:

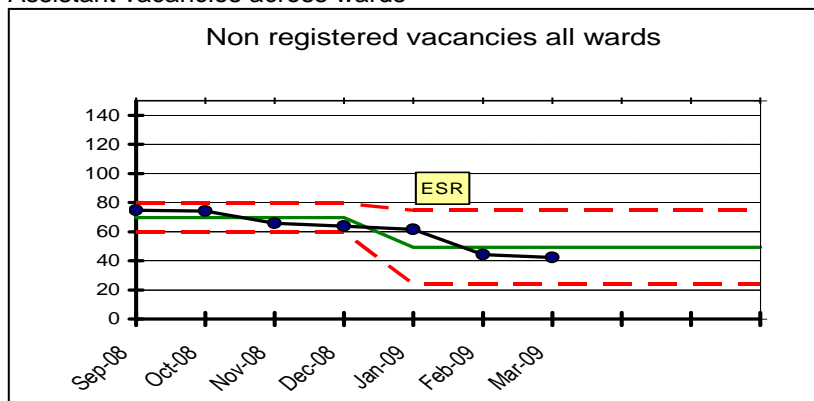


Recent recruitment initiatives have reduced the numbers of vacancies for both registered nurses and healthcare assistants. However, it remains a challenge to keep pace with current turnover to continue to close the vacancy gap whilst attracting the right calibre of staff. **Figure 3** shows the trend in Registered nurse vacancies across wards.



The ESR data used since January 2009 underplays the number of registered ward nurse vacancies by around 15 WTE due to anomalies around the establishment for thrombolysis nurses.

Healthcare assistant turnover is higher than for registered nurses but vacancy levels are falling due to improved recruitment approaches including site based co-ordination of recruitment and dedicated resourcing team support. **Figure 4** shows the trend in Healthcare Assistant vacancies across wards



ESR data will continue to be used to ensure consistency, avoid duplication of effort and to avoid ward managers being asked to report this separately.

Long term sickness and Maternity / Paternity leave

The level of long-term sickness and maternity/paternity leave varies across directorates. Ward managers are required to manage staffing within the budget or funded establishment. The level of temporary staff allowed to cover the gaps will vary depending on the period of time the staff have been absent due to long-term sickness or maternity leave. In areas where a high proportion of ward staff are not available for work the risk falls on the individual ward rather than being managed across the directorate. The absence associated with maternity/paternity leave is significant and there is no allowance made for this within the ward establishments.

The 1534.38 wte funded establishment across the wards involved in this staffing review is only around 54% of the total nursing establishment as the review did not cover maternity, theatres, intensive care, renal satellite units, outpatients, radiology or specialist nurses. Workforce data for the whole nursing establishment of 2840.05 wte shows that the impact of current vacancy levels, sickness and maternity/paternity leave for all areas means that only 84.8% of funded establishments are actually available for work. The 15.1% of establishment not available for work represents around 430 wte staff which represents around 7890 shifts per month or 1820 per week. For ward managers this requires managing the shortfall within the % establishment available for work. This shortfall is partly met with NHSP temporary staff but sometimes means study leave is cancelled and staff are obliged to undertake mandatory training and professional development in their own time.

Table 4: Profile of total funded trust nursing and midwifery establishment, vacancies, sickness and maternity/paternity leave at February 2009

Total establishment (WTE) as at end Feb 09	WTEs	% funded establishment	Totals
Funded establishment	2840.05		84.81%
Vacancies	193.66	6.81%	15.19%
Sickness	135.77	4.78%	
Maternity/paternity leave	102.7	3.6%	

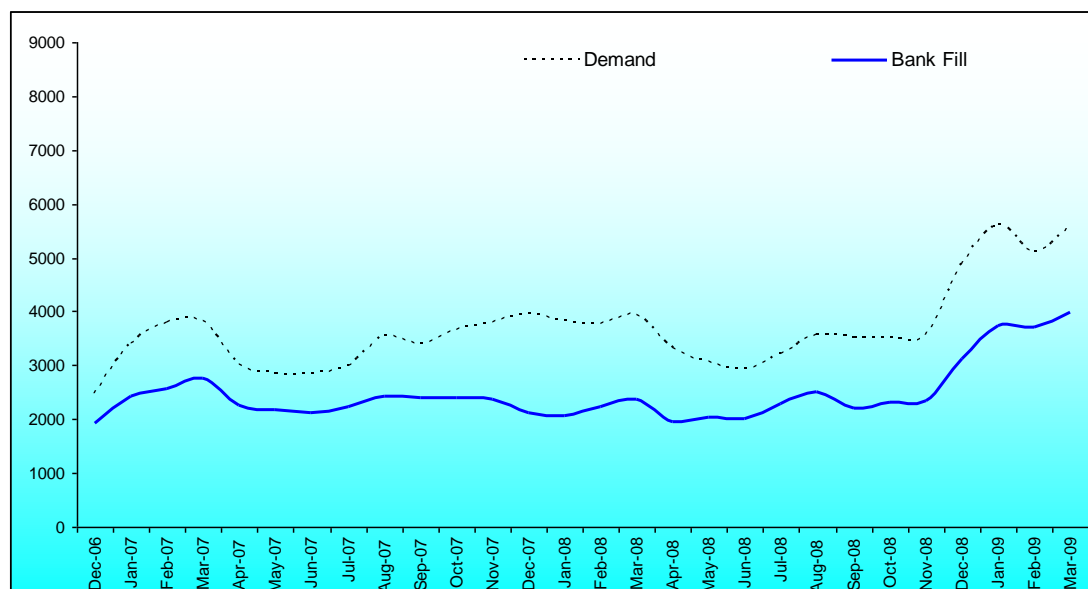
Temporary staff usage

The level of temporary staff usage across directorates is managed with appropriate controls and is monitored in relation to total ward staffing expenditure. The current use of temporary staff through NHS-P provides between 400 and 600 shifts per week and is fairly consistent in delivering a fill rate of around 65%. 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 especially in filling gaps at short notice.

The profile of demand and availability of temporary staff to cover shifts suggests that the reliance on temporary staff to bridge the gap between funded establishment and staff available for work is too high and presents a significant risk to ward teams and patients. This is particularly apparent when fill rates fall to only 50% of those requested although the fill rate achieved over this winter (66%) is an improvement on winter 2008 (53%) despite an increase in demand. This increase in demand is due to increased use of additional beds and increasing patient dependency. In certain specialist areas e.g A+E, CDU and intensive care NHS-P fill rates are poorer than for wards due to the difficulty in sourcing temporary staff with the required skills.

The demand for temporary staff cover has increased since November 2008 due to the impact of additional beds and this has been partially met by agency cover. This ongoing arrangement is being managed within appropriate controls but has resulted in increased expenditure on temporary staffing to ensure patient safety.

Figure 5: Picture of NHS-P demand (shifts requested) and number of shifts filled since December 2006



Additional beds

Flexibility in capacity is provided by the use of significant numbers of additional beds across the 3 main sites particularly during winter pressures. The escalation plan for the use of these beds takes account of patient acuity and infection control criteria in order to optimise patient

safety. However, these beds are not funded and current staffing levels do not allow a high degree of flexibility particularly on wards where there are high levels of long term sickness and maternity leave therefore a combination of methods is used to provide staffing cover including:

- Moving staff to wards with additional beds
- Staff undertaking additional shifts
- Use of temporary staffing through NHS-P

. The additional beds are used in planned areas to ensure a safe environment for care but this does place the burden of responsibility on the same wards which does put staff under pressure. For example, Cambridge J ward regularly had up to 17 extra beds daily until January when this was reduced to 11 following the movement of curtain tracking to implement 4 bedded bays. Further realignment of bed numbers is planned within medicine at the WHH to allow the distribution of risk associated with additional beds across a greater number of wards.

The numbers of additional beds in use varies but is higher in winter months. Data on numbers of additional beds occupied daily at midnight collected by bed bureau is represented below:

Table 5: Profile of additional beds occupied at midnight from September 2008 to March 2009.

	Sept	Oct	Nov	Dec	Jan	Feb	March
WHH	592	366	633	677	1238	1136	1090
QEQM	46	112	418	673	1067	684	555
KCH	39	113	58	125	112	26	95
Grand total OBDs							9855

On a daily basis this equates to a range between 1 to 60 beds at the WHH, 0 to 48 beds at QEQM, and 0 to 19 beds at KCH.

These 9855 occupied bed days over the seven month period (212 days) represents an additional average 46.48 OBD daily. If a new ward establishment was planned to accommodate this activity, using the Hurst model for a medical ward, an additional 59.2 wte staff would be required.

Flexible staffing and the Nursing pool

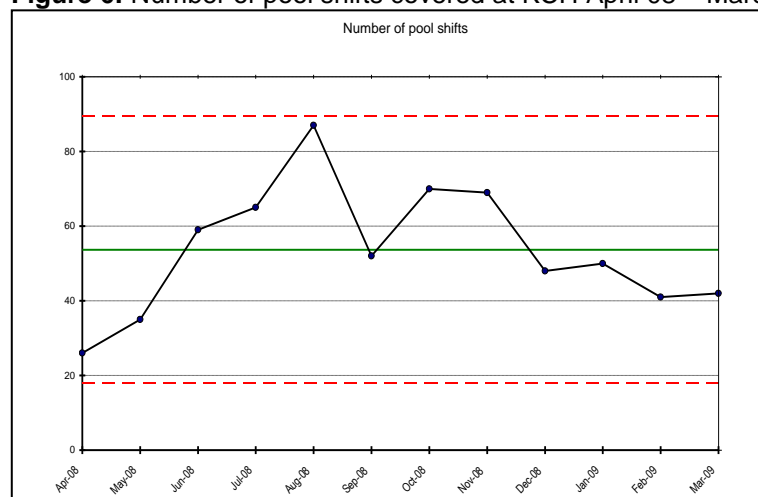
Employed staff are currently able to undertake additional hours by:

- working overtime on their own ward
- working shifts as part of the nursing pool where they are deployed to the ward of greatest need
- working through NHS-P

Over a recent 8 week period from 15.2.09 to 5.4.09 35% (1629) of NHS-P shifts were undertaken by staff who are employed by EKHUFT and also work additional shifts through NHS-P (multi post holders). The remaining 65% (2939) were undertaken by 'bank only' staff.

The nursing pool was implemented one year ago at KCH and is managed by the Matrons. Staff who are deployed from the pool are paid at grade and it is resourced from non recurrent savings from vacancies. A web enabled tool has commenced testing at KCH which will enable monitoring and reporting of bookings which will support roll-out across other sites. Although only a small number of shifts have been covered in this way it has proved to be a useful additional flexible resource and has provided cover to the other sites when required.

Figure 6: Number of pool shifts covered at KCH April 08 – March 09



Most pool shifts are undertaken by registered nurses. There is a financial incentive for substantively employed nurses with more than three years experience, who work part time, to work additional hours through the pool rather than NHS-P as NHS-P shifts are paid at point 3 of band 5. The financial incentive to substantive employees who work full time are even greater if they work additional hours through the pool as overtime. It is not clear why more nurses do not opt for pool shifts and further work to explore the feasibility of implementation across WHH and QEQM is required.

Recruitment and retention

The general approach is to recruit to vacancies rather than anticipating vacancies by factoring in turnover and this is compounded by posts taking almost 4 months to fill. The implementation of Stepchange Recruitment Tracking Software is anticipated to streamline the process and this is currently undergoing implementation across directorates.

A proposal for implementation of a process for recruitment to maternity leave absence funded from actual vacancies is planned across directorates in order to provide catch up with vacancy management and improve available staffing levels.

There has been a reduction in healthcare assistant vacancies which has been achieved through a combination of approaches including:

- Co-ordination of advertising, shortlisting and interviewing of healthcare assistants by a senior nurse lead for each site.
- Local recruitment open events held at weekends which appear to be successful in recruiting large numbers. 32 healthcare assistants were recruited to vacancies at the WHH from an open day held in November 2008, and a further 30 following a KCH open day in February.
- Since October 2008 the resourcing team have provided some short term dedicated support for nursing recruitment which has reduced the time taken to fill vacancies for group recruitment exercises.

Recruitment of registered nurses is more challenging, particularly to posts which require some previous experience and the majority of suitable applicants are internal. Co-ordinated group recruitment of newly qualified nurses each February (30 nurses in February 2009) and September ensures that all are offered posts within the Trust but this is insufficient to fill all vacancies. Additional challenges are faced with loss of staff to primary care based services which are currently providing opportunities for promotion for Band 5 nurses. The open days held have tended to attract healthcare assistants rather than nurses and more creative approaches have to be used to improve successful recruitment of quality applicants:

- A programme of supporting individuals wishing to return to nursing is planned in collaboration with the University of Greenwich. The approach will be to employ as healthcare assistants to promote their commitment to the organisation and to

formalise the support provided. Course costs will be borne not by individuals (which is the norm) but will be funded from the education contract budget.

- Overseas recruitment will be explored in collaboration with NHS-P who hold the national contract.
- A recently completed short film promoting nursing in the Trust will be used on the website and at open events.
- Involvement in national recruitment events

It is recommended that the ability to recruit to anticipated vacancies by factoring in turnover will further reduce the vacancy factor across ward staffing. In addition, the ability to manage maternity leave absence by recruiting to the combined vacancy factor at directorate level will mean a reduction in reliance on temporary staffing, reduction in vacancies, and an improvement in available staffing levels.

5. MEASUREMENT OF ACUITY / DEPENDENCY AND 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, care of patients requiring parenteral or enteral nutrition, management of central venous lines, tracheostomy care, complex medication regimes including oral and intravenous therapy, neurological assessment, monitoring and observation.

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 of 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 time allocated during their final period of practice learning. With around 150 student nurses alone undertaking this assessment within EKHUT annually this represents a significant workload that is also absorbed at ward level.

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.

The Nurse per Occupied Bed (NPOB) formulae (Hurst 2008) were applied to the main specialties. These formulae 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 22 specialties and all wards were benchmarked against the most appropriate 'fit'.

The dimensions of patient dependency and acuity are important variables in determining nursing workload and an acuity-dependency tool was applied (AUKUH, 2007) to study current nursing workload in all wards and to calculate ward establishment. This then was compared with the findings using the Hurst formulae to synthesize the information from both approaches to support the rationale for investment where there are gaps when mapped against current ward establishments.

The Association of United Kingdom University Hospitals (AUKUH) Acuity Dependency tool was applied to all wards. Data was collected on every patient on participating wards at 15.00, daily Monday to Friday for 20 days and quality control was provided by senior nurses. (The AUKUH tool was adapted for use in the Paediatric wards in order to test the reliability of the application of the RCN model and current nursing workload).

The findings from using the two approaches provide useful comparisons and are represented by Directorate (Appendix 3) and by gap analysis of application of the Hurst model (Appendix 4).

5.1 A+E and CDU

Specialty	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix
ECC	KCH	18	3	83.23	54.5	1.07 (1.26%)	NA 21.84	NA	68/32
CDU					29.8				
					total 84.2				
A+E	QE	25	3	106.83	94.7	27.37 (20.3%)	NA 33	NA	68/32
CDU	39.5								
	total 134.2								
A+E	WHH	25	3	105.14	92.9	27.26 (20.5%)	NA 38.68	NA	70/30
CDU	39.5								
	WHH				Total 132.4				

The application of the Hurst model for A+E departments required collection of average daily totals of minor patients, trolley patients and resus patients over a 2 week period to calculate required staffing. The result was combined with the result of applying the Hurst model to the CDUs to give a total staffing requirement. Although there was a close correlation between the ward establishment calculated when applying the Hurst model and existing staffing at KCH, there was a gap when it was applied to WHH and QEQM.

The acuity dependency tool was then used to assess nursing workload only in the CDUs as there is no validated tool available for A+Es currently. This demonstrated a higher nursing workload at the WHH than at QEQM. All CDUs received investment last year but the A+Es were not included in the 2007/08 review.

The 2008/09 Audit Commission review did not include A+Es and in the light of the Mid Staffordshire report in the interests of patient safety it is recommended that separate modelling work is undertaken to understand the level of investment required, to include benchmarking with other trusts across SEC SHA region. It will also be important to review what proportion of investment needs to be allocated for Paediatric or dual qualified nurses to provide cover for the shifts where 25% of patients are children.

5.2 Medicine and Neuro rehabilitation

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Treble	KCH	18	0	24.9	22.7	-2.2	22.96	-1.94	53/46	
Cambridge K	WHH	22	1	28.79	27.7	-1.09	28.72	-0.07	50/50	5.85
Oxford	WHH	14	1	21.73	21.5	-0.23	*18.62	-3.11	64/36	
Deal	QE	20	3	24.75	25.2	0.45 (1.78%)	31.82	7.07 (22.2%)	60/40	

St Margarets	QE	20	0	23.83	25.2	1.37 (5.4%)	23.8	-0.03	56/44	1.6
Invicta	KCH	24	1	27.71	30.2	2.49 (8.24%)	*30.88	3.17 (10.2%)	56/44	
Bethersden	WHH	26	2	29.35	32.7	3.35 (10.2%)	32.32	2.97 (9.1%)	60/40	
Minster	QE	29	2	33.47	36.5	3.93 (10.7%)	37.79	4.32 (11.4%)	54/46	
Cambridge M1	WHH	22	1	24.32	27.7	3.32 (11.9%)	29.85	5.53 (18.5%)	55/45	
Cambridge M2	WHH	23	2	25.53	29	3.47 (11.9%)	29.27	3.74 (12.7%)	57/43	
St Lawrence	KCH	32	2	35.38	40.3	4.92 (12.2%)	37.87	2.49 (6.5%)	52/48	
Neuro rehab	BHD	22		26.94	31.4	4.46 (14.2%)	25.97	-0.97	51/49	
Mount McMaster	KCH	26	0.4	33.09	39	5.91 (15.1%)	31.04	-2.05	56/44	0.2
Sandwich Bay	QE	29	2	32.79	42.8	10.01 (23.3%)	37	4.21 (11.3%)	59/41	
Cambridge J	WHH	23	2	27.01	35.2	8.19 (30%)	31.71	4.7 (14.8%)	58/42	6.92

* During the period of nursing workload assessment (AUKUH tool) bed numbers were reduced on Oxford (12 beds) and Invicta (19 beds) so results were extrapolated to provide estimated nursing workload according to usual bed numbers.

There was a close correlation between the ward establishment calculated when applying the Hurst model and the acuity dependency tool for nine wards, and a gap when compared to current ward establishments. For three wards there was a close correlation between the two methods and actual establishment, and for three wards there was little correlation which may be due to normal variations in nursing workload over the period of data collection. On Cambridge J the additional nursing workload generated by additional beds (equivalent to 6.92 wte) is in addition to the already significant gap seen.

Skill-mix is below 60:40 in twelve wards and below 55:45 in five wards, an improvement on last year but remaining below recommended RCN levels.

The 2008/09 audit commission review found that within medicine including HCOOP, Stroke, Rehabilitation and Oncology wards whilst WTE per bed is average, cost per WTE is in the lower quartile indicating a weak grade mix.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 15 wards
- Increasing the establishment of Cambridge J to provide a flexible resource for the additional 11 beds used during winter pressures
- Investment of additional band 5s into Mount McMaster and Sandwich Bay
- Conversion of a band 2 post to band 5 in all other wards with a skill-mix less than 60:40 (9 wards)

5.3 Coronary Care

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Taylor	KCH	6	1	17.16	17	-0.16	12.75	-4.41	86/14	1.37
CCU	QE	10	0.4	22.23	28.4	6.17 (21.7%)	21.71	-0.52	70/30	0.32
CCU	WHH	7+6	2	*25.03	32.1	7.07 (22%)	26.4	1.37 (5.18%)	73/27	

* 0.61wte Cardioversion nurse not included as not ward based

There does not appear to be a correlation between the ward establishment calculated when applying the Hurst model and the acuity dependency tool for the coronary care units at WHH and QEQM but there is a reasonable fit for Taylor ward.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 3 units

5.4 Stroke

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds - wte
Kingston	KCH	23	3	35.83	37.4	1.57 (4.1%)	39	3.17 (8.1%)	60/40	4.52
Richard Stevens	WHH	24	3	35.84	38.6	2.76 (7.15%)	38.1	2.26 (5.9%)	62/38	
Fordwich	QE	20	3	30.25	33.8	3.55 (10.5%)	32.18	1.93 (5.99%)	67/33	1.56

The current funded establishments include 5.67wte Band 6 thrombolysis nurses for each stroke unit. This takes the staff:bed ratio close to 1.5 as recommended. The skill mix is more variable but no less than 60:40.

It is arguable to include the 5.67wte in the ward numbers as they have to be available to leave the ward to administer thrombolysis in A+E and provide 1:1 care for the first 24 hours. This role is not reflected in the Hurst model and it assumes the funded establishment is all ward based.

In applying the Hurst tool 6 beds were included as 'acute' beds. The closest tool is defined as a critical care area which gives a ratio of 2.84 for these 6 beds. The acuity + dependency results give a picture of variable workload across the Units but both methods correlate consistently with the existing establishments.

Two of the units accommodated extra beds during the 20 day period of nursing workload assessment which represents a significant additional workload when converted into wte required. Kingston ward had extra beds up on most days and the dependency of these patients converted into an additional 4.52 wte nurses required.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 3 units
- Developing enhanced roles within the non registered workforce

5.5 Rehabilitation

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix
Cambridge L	WHH	18	2	24.58	25.7	1.12 (4.3%)	25.28	0.7 (2.7%)	52/48
St Augustines	QE	29	3	33.55	41.4	7.85 (18.9%)	38.65	5.1 (13.1%)	52/48
Harbeldown	KCH	27	3	29.35	38.6	9.25 (23.9%)	38.24	8.89 (23.2%)	54/46

There was a close correlation between the calculated establishments when applying both the Hurst model and the acuity dependency tool and a gap when comparing to existing establishments which is most evident for St Augustines and Harbeldown. Average skill mix remains the lowest across the rehab wards when compared to the rest of the medical wards.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 3 wards
- Developing enhanced roles within the non registered workforce

5.6 Surgery and H&N

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Rotary	WHH	9+10dc	1	29.44	22.5	-6.94	18.51	-10.93	60/40	
CSF	QE	16+2dc	0	*23.7	25.2	1.5 (5.9%)	19.36	-4.34	60/40	2.84
CSM	QE	18+2dc	0.4	25.3	28.1	2.8 (9.9%)	21.73	-3.57	67/33	1.5
Kings B	WHH	27	3	*31.68	39.8	8.12 (20.4%)	32.52	0.84 (2.58%)	53/46	
Kings A2	WHH	20	1.5	23.11	29.5	6.39 (21.6%)	25.17	2.06 (8.1%)	60/40	

* CSF- 6.1wte covers CAL and pre-admission so not included in the ward establishment
 Kings B - 2.0wte covers CAL so not included so not included in the ward establishment

The calculated establishment for all surgical wards derived by applying the acuity dependency tool is below that indicated by the Hurst NPOB model. For Rotary ward the acuity dependency tool does not take account of the 495 ward attenders during the 20 days of data collection.

The 2008/09 audit commission review found that across all surgical areas including ENT, Urology, surgical specialties, Trauma + Orthopaedics, and Gynaecology, whilst WTE per bed is above average, cost per WTE is in the lower quartile indicating a poor grade mix. Surgical occupancy was in the upper quartile.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 5 wards
- Developing enhanced roles within the non registered workforce

5.7 T+O

Ward	Site	No. bed	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Kings C2	WH	24	0.4	30.57	35.4	4.83 (13.6%)	24.46	-6.11	63/36	
Quex	QE	19	0.5	23.61	28	4.39 (15.6%)	20.93	-2.68	58/42	1.69
Kings C1	WH	27	2	31.7	41.8	10.1 (24.1%)	30.47	-1.23	54/46	
Seabathing	QE	23	0.5	26.83	35.6	8.77 (24.6%)	27.3	0.47 (1.72%)	57/43	1.11
Kings D1	WH	25	2	28.29	38.7	10.41 (26.8%)	35.98	7.69 (21.3%)	52/48	
Bishopstone	QE	28	2	31.25	43.3	12.05 (27.8%)	37.84	6.59 (17.4%)	57/43	

In all wards there is a correlation between the results of applying both the Hurst model and acuity dependency tool but this is only close for two wards. It is not clear why the approaches did not match more closely but the wards did report a lower than average nursing workload during the assessment period. Two wards had additional beds regularly. The establishments of Kings D1 and Bishopstone are significantly lower than when applying both methods and in the case of Kings D1 this is in addition to a poor skill-mix.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 6 wards
- Developing enhanced roles within the non registered workforce
- Investment of additional band 5s to be included in business case for capacity planning

5.8 Renal, vascular and Urology

Ward	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Marlowe	29+6dc	0	57.14	63.3	6.16 (9.73%)	37.32	-19.82	64/36	3.72
Kent	22+6dc	2	30.51	37.1	6.59 (17.7%)	33.02	2.51 (7.6%)	62/38	2.7
Clarke	30+6dc	3	34.57	48.9	14.33 (29.3%)	*33.93	-0.64	60/40	

* During the period of nursing workload assessment (AUKUH tool) bed numbers were reduced on Clarke (24 beds) due to refurbishment works so results were extrapolated to provide estimated nursing workload according to usual bed numbers.

There is no correlation between the calculated establishments when applying the Hurst model and the acuity dependency tool. The acuity dependency tool did not effectively capture the complexity of nursing associated with dialysis patients on Marlowe nor take account of the throughput on Clarke ward.

Clarke ward also accommodates additional day case ambulatory patients on two days per week which are not reflected in the AUKUH model as they do not occupy beds.

Recommendations include:

- Conversion of a band 5 post to band 6 in all 3 wards
- Developing enhanced roles within the non registered workforce
- Investment of additional band 5 establishment into Clarke ward and/or exploring the feasibility of some redistribution of the establishment across the directorate

5.9 Oncology

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix
Braebourne	KCH	14	0	20.95	20.8	-0.15	23.76	2.81 (11.8%)	74/26

The calculated establishments when applying the Hurst model and the acuity dependency tool are not dissimilar.

Recommendations include:

- Conversion of a band 5 post to band 6

5.10 Gynaecology

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Birchington	QE	19	0	*29.82	24.7	-5.12	19.46	-10.36	62/38	1.24
Kennington	WH	11	0	*19.31	14.3	-5.01	10.22	-9.09	55/45	2.54

* Birchington - 3.25wte covers pre-assessment & EPU clinics so not included in the ward establishment

There is a correlation in the calculated establishments derived when applying the Hurst model and the acuity dependency tool but this does not take account of ward attenders or the volume of throughput associated with these wards.

Kennington - 3.6wte covers pre-assessment & EPU clinics, and RVHF clinics so not included in the ward establishment

Recommendations include:

- Conversion of a band 5 post to band 6 in both wards
- Developing enhanced roles within the non registered workforce

5.11 Paediatrics

Ward	Site	No. beds	Inc wte for 08/09	Funded wte current	RCN tool	Gap (%) current funded establishment and RCN tool	Adapted AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix
Rainbow	QE	24	0	30.15	34.3	4.15 (12%)	31	0.85 (2.74%)	89/11
Padua	WH	32	0	37.84	44.5	6.66 (14.9%)	43	5.16 (12%)	87/13

Padua has 30 in patient beds, 2 high dependency cubicles and 4 ambulatory beds. Rainbow has 23 in patient beds, 1 high dependency cubicle and 4 ambulatory beds. The Hurst model for paediatric wards is validated only in surgical settings within teaching hospitals and therefore does not take account of the complex case mix of mixed medical and surgical patients, adolescents with mental health issues, and behavioural and learning disability problems of these two wards.

The RCN recommends staffing levels of:

- 1:1 or 1:2 trained nurse per patient ratios (depending on acuity) for high dependency
- 1:3 ratio for children under 3 years
- 1:4 ratio for day shifts
- 1:5 ratios for night shifts

The application of this model calculates staffing levels higher than currently exist. The gap would be wider if non clinical roles e.g. Playleader, ward clerk and Matron were not included in the ward establishment.

The AUKUH tool, designed for adults, was adapted for application to Padua and Rainbow ward and calculated establishments were again higher than currently exist. Occupancy levels reflect seasonal variations with higher numbers of admissions due to respiratory illnesses in winter often requiring more intensive nursing, and in summer more admissions due to minor trauma and fractures requiring less intensive nursing. Therefore there may be opportunities for innovation in the use of the nursing resource by the introduction of annualised hours contracts to provide additional staffing to cope with demand during winter months.

The NSF for children and young people requirement that by 2010 every A+E should have a paediatric area staffed by paediatric nurses presents a further dimension for consideration.

The 2008/09 audit commission review found that staffing levels are the lowest in the comparator group (total of 30 wards) but that skill-mix is higher on both wards than the sample average of 78/22. The occupancy on the children's wards is in the top 25% of trusts.

Recommendations include:

- Investment into non registered staff and some additional band 5s
- Developing enhanced roles within the non registered workforce

Neonatal Intensive Care

The neonatal intensive care units provide 25 cots at the WHH (7 intensive care, 2 high dependency, and 16 special care) and 14 cots at QE (2 high dependency and 12 special care). The British Association of Perinatal Medicine (BAPM 2001) recommends guidelines of:

- 1:1 trained nurses per patient ratio for intensive care
- 1:2 for high dependency care
- 1:4 for special care

Calculated establishments when applying these guidelines results 74.75wte (actual 58.33) for WHH and 28.75wte (actual 20.34) for QEQM.

The 2008/09 audit commission review did not include SCBUs and compared the WHH NICU with only one other. Staffing costs and grade mix was similar in both. In order to further test current establishment the NICUs will participate in a national benchmarking exercise to contribute to the development of a validated Hurst tool.

6. CONCLUSIONS

1. All 49 wards, including the A+Es, CDUs and ECC reviewed for staffing levels and skill-mix.
 2. These 49 wards were benchmarked against 38 other trusts as part of the Audit Commission Acute Hospital Portfolio (Ward Nurse Staffing Benchmarking Review 2008/09)). The main findings from data submitted for May and June 2008 were:
 - a. The trust's nurse staffing levels are average but the costs are over £1m below the average nursing costs
 - b. Grade mix is in the lower quartile
 - c. Staffing levels are particularly low for the children's wards
 - d. For the majority of surgery and medical wards the percentage of qualified nursing staff is lower than average
 - e. 88% of the nursing establishment in post is in the lower quartile. (At this time recruitment to the additional 67 wte band 5s from the 07/08 review was not complete which elevated the vacancy factor. The vacancy factor is now 6.8% meaning an improvement to 93.2% in post).
 - f. Expenditure on temporary staff is in the lower quartile indicating efficient management of leave
3. EKHUT is ranked 97th out of 147 for nurse per bed ratio, below our 3 closest neighbouring acute trusts, although HSMR is lower than all of them (Dr Foster 2009).
 4. The impact of current vacancy levels, sickness and maternity/paternity leave for all areas resulted in only 84.8% of funded establishments available for work in February 2009. The use of temporary staff (NHS-P) partially closed this gap but supply is fairly consistent and an agency supplier has been used this winter to ensure patient safety when winter pressures require the use of significant numbers of additional beds.
 5. Total average vacancy levels across the 49 wards is 5% against 6.8% across all nursing + midwifery. Registered nurse vacancies represent 15% and healthcare assistants 85% of ward vacancies. Improved co-ordination of Healthcare assistant recruitment has significantly reduced the actual numbers of vacancies since September 2008.
 6. Recruitment of sufficiently experienced band 5 nurses remains a challenge. Co-ordinated recruitment to the 67 wte additional band 5 posts, following investment last year, has now been achieved and current turnover rate of registered nurses is 9%, a reduction from 10% last year. This may indicate greater stability within the workforce.
 7. Skill-mix varied across all 49 wards and not necessarily in relation to the acuity or complexity of patient needs. 22 of the 49 wards had a skill-mix less than the RCN recommendations (65:35 skill-mix).
 8. Calculation of establishments using the Nurse per Occupied Bed (Hurst 2008) method suggested that in 38 out of 49 wards current establishments are based on a lower staff per bed ratio suggesting that despite investment last year staffing levels have not kept pace with current activity, throughput and length of stay.
 9. Calculation of establishments using the AUKUH (2007) method of calculating establishments taking account of nursing workload associated with patient acuity and dependency demonstrated that 25 out of 46 wards have current establishments which are lower than those recommended by the tool. This tool was not suitable for use within A+E departments.
 10. Comparison of establishment generated by using both Hurst (2008) and AUKUH (2007) suggests there is good correlation between the approaches for CDU, stroke, rehab wards, most medical wards, oncology, gynaecology, and paediatric wards.

11. Comparison of establishment generated by using both approaches applied to ward areas with a combination of in-patient, day case and outpatient activity (coronary care, surgery, head + neck, and renal, vascular & Urology) resulted in a poor fit between approaches.
12. The current establishments do not allow ward managers any protected time for management activity including leadership of quality improvement activity related to patient experience and standards.

As part of ongoing review of ward staffing:

1. Patient acuity and dependency will be measured in all ward areas for at least two periods of time each year to monitor any changes in activity and LOS and impact on nursing work-load.
2. Ward establishments will be reviewed annually to ensure that they are fit for purpose.
3. Investment in ward staffing establishments will be linked to improvements in quality, patient safety and patient experience monitored through ward and directorate-based metrics.
4. Changes to ward configurations in year will require review and re-evaluation of establishment in year to ensure safe and effective care.
5. Provision of adequate isolation facilities for patients with known infections places additional nursing workload. Increasing the number of side rooms as part of the estates strategy will also have implications on the way that patients are monitored and the use of technology against current Hurst recommendations that an additional 6% nurse staffing is required when patients are nursed in single rooms.

7. FUTURE STAFFING MODELS

The challenges facing the organisation in keeping pace with demand for services includes achievement of access targets, patient choice and plurality of providers, and meeting the challenges of a growing and ageing population. Our commitment to providing the highest quality services, maintaining and improving patient safety and improving efficiency are largely reliant on having optimum numbers of skilled nursing staff in post who are motivated and proud to work for the organisation.

The peninsula position of the trust presents additional challenges in relation to recruitment of experienced staff externally and we largely develop our own staff to be the next generation of leaders particularly at ward level. As services develop across the health economy it is essential for appropriate provision of promotional opportunities within acute services in order for us to compete as an employer for the most talented staff.

In order to build sustainability in ward staffing in 2009/10 to promote a high quality workforce reflecting the needs of patients, greater emphasis should be placed on a pathway approach in implementing new roles, a stronger role for clinical leadership and management, and better administrative support to release nursing time. Future models for ward staffing will need to explore new ways of working and new roles and will need to reflect the direction set out in The NHS Next Stage Review: A High Quality Workforce (DH 2008). Ward teams will require a job family approach which may include roles which require lower level clinical skills in combination with administrative skills coupled with an excellent customer care approach and communication abilities.

Efficiencies

Continued review of the ward staffing resource will be required in line with the capacity review of elective and emergency services. Profiling elective activity around peak emergency activity will require consideration of the staffing model required to provide a flexible staffing resource. A combination of solutions may be appropriate including taking more annual leave at off peak times, annualised hours, and efficiencies to be gained by the electronic rostering tool soon to be implemented. There may also be benefits in staffing an additional medical ward during winter pressures to improve the patient experience and reduce dependency on temporary staffing.

The benefits of systems improvement work including the Productive ward programme which focuses on reduction of waste and release of nursing time to increase time spent on direct patient care is linked to ward level quality metrics. These allow empowerment of ward staff to

manage improvements in MRSA infections, falls, C,Diff, pressure sore prevalence, staff absence, mixed sex accommodation, direct care time and patient feedback. The descriptors around these metrics are being further developed to ensure consistency of performance measurement.

Improvements in administrative support to wards and clinical teams will be required to enable nurses to deliver care against increasing expectations, increasing patient acuity and dependency, increased complexity of drug administration regimes, and a continued drive to reduce length of stay and promote patient recovery in shortened time periods. The ward clerk is a key role for front-of-house communication on wards, managing telephone inquiries, providing information for clinical teams, conveying relevant patient information, receiving visitors and ensuring that clinical staff are able to focus on providing patient care. In order to further improve direct care time for clinical staff there is a need to develop ward clerk provision to provide a shared resource of evening cover across wards to enable improved customer service models to be developed as well as improving accuracy of timely capture of patient data on PAS. These functions currently fall under the responsibility of the ward nurses whose role would be better refocused on delivery of patient care.

A stronger role for clinical leadership and management

Under Agenda for Change former E grade posts rebanded as Band 5s has obscured the experience and seniority of some post holders. This may act to reduce the incentive for post holders to continue to develop their knowledge and skills as their experience is recognised as less visible as was evident previously. The loss of this career development opportunity means the service may not be able to maximise the benefits to patients that this experienced group of nurses has the potential to provide.

Ward Managers, Matrons and Lead nurses have identified a need to formally recognise the role of the Senior Staff nurse to reward existing experienced nurses, provide an aspirational role within the nursing structure, and promote motivation and succession planning into the Band 6 role. It is anticipated that this formal recognition of the Senior Staff Nurse role will promote clinical leadership and further support the provision of high quality services to our patients.

Expanding opportunities at band 6 for experienced clinical nurses will ensure that acute services retain the most experienced staff and enable better career pathways into extended, advanced and autonomous roles. This will address the Audit Commission findings that grade mix is in the lower quartile. The band 6 role on the ward is largely focused on high level clinical expertise, supporting the band 7 in the ward manager role, role modelling for junior staff, supervision of learners including new staff, students and non registered staff. There are opportunities to refocus the band 6 role on implementation of initiatives to improve patient flow by improving pathway management, discharge planning, nurse initiated discharge. Their clinical expertise could also be utilised to improve record keeping and accuracy of recording treatment to support clinical coding in optimising income generation.

With an ageing nursing workforce it is essential that succession planning includes the recognition and value of existing clinical experience and encourages relevant post holders to continue to build on their experience. Promoting development of the workforce in this way will support the delivery of high quality, safe, effective care, will improve retention and may also improve recruitment into Band 5 posts.

Greater emphasis on pathway approach in implementing new roles

The transition to degree level registration for nursing by 2012 may mean that in future there are less nurses but who are better prepared to lead teams and meet the challenges of a changed system.

The changing nature of service delivery suggests that there will be the requirement for different configurations of professionals and support staff in future. Skills for Health anticipate that there will be a major expansion in the number of people required to work at Assistant and Associate Practitioner level. The Associate Practitioner role operates at Band 4 and provides a care role situated between the registered practitioner and the assistant level role. Some of

their remit involves them delivering protocol-based clinical care that had previously been within the remit of registered professionals. It is a role which is relevant for many professions and areas where it has already been successfully introduced nationally include Mental Health, GP practices, Critical Care, Emergency Care, Radiology, Breast Screening and Pathology.

Preparation for the role is based on completion of a Foundation degree whilst working as a trainee. Trainees are paid a percentage of the Band 4 salary whilst training and the SHA provides salary support of £8429 per annum to provide backfill for course attendance.

An Associate Practitioner who has the required knowledge and skills is able to undertake a range of activities including intravenous cannulation, collecting patients from theatre, provision of enteral nutrition, insertion of nasogastric tubes, gastric aspiration, participating in administration of medications to patients, removing clips and drains, co-ordinating discharge arrangements. They could provide continuity of care for elective pathways and improve patients' experience by providing streamlined care, and release nursing time for those activities that can not be delegated.

Around 25 trainees are in post currently within theatres, radiology, audiology, therapies, fracture clinic, oncology, and outpatients. The first ward based role focusing on skills to support the patient pathway for joint replacement surgery is due to be implemented in May this year. 32 places have been commissioned for September 2009. This cohort is to commence in post in September 2009 whilst undertaking the Foundation degree at Canterbury Christchurch University. The first cohort should be focused initially within elective services, ambulatory care and rehabilitation wards to include Surgery, Head + Neck, T+O, Vascular, Urology, Gynaecology, Paediatrics, Stroke and Rehabilitation wards.

Utilising ward staffing resources more effectively

Currently any monthly under spend on nursing budgets is given up as non recurrent savings. This means that it is not possible to recruit to posts that are not vacant when staff are on maternity leave. If these posts can be recruited to there would be less reliance on temporary staff to fill the gaps and a reduction in the demand on NHS-P. Small amounts of vacancy currently not recruited to results in under spend on ward budgets. Creative recruitment to this vacancy factor across directorates or sites could provide a flexible resource of staff to respond to fluctuating demand and reduce reliance on temporary staffing and deliver improved care to patients.

8, RECOMMENDATIONS

Priority areas for development and investment in 2009 / 2010 are:

Improving use of the current resource

- n) Introduction of formal recognition of the senior staff nurse role for individuals who meet the criteria.
- o) Agreement on methods of utilising ward staffing budget more flexibly and effectively to deliver safe, effective care to patients including managing the absence created by maternity leave by recruiting to this using current vacancy level across individual directorates.
- p) Efficient and effective rostering practices will be monitored through the implementation of the electronic roster.
- q) Explore feasibility of implementing the nursing pool across all sites.
- r) Further recruitment initiatives as part of the strategy to reduce the vacancy factor including exploring overseas recruitment options, and attracting those returning to nursing.

Proposed areas for investment

- s) Investment into ward clerk posts to provide evening cover across wards in the region of 0.5wte per ward.
- t) Alteration of skill-mix to provide improved career progression and focus on better preparing nurses to lead in a changed system. Conversion of a band 5 post to band 6 on each ward to provide improved leadership and management and support to the ward manager role. This would apply across 44 wards.

- u) Some further investment of band 5 posts into two medical wards and the Urology ward. Additional band 5 establishment should also be included in the business case for capacity planning within T+O.
- v) Conversion of some band 2 posts to band 5 posts across nine of the medical wards to improve skill-mix
- w) Investment into the Paediatric wards to provide additional support staff with enhanced skills to improve staffing levels but address current high skill-mix.
- x) Implementation of the ward based Associate Practitioner (Band 4) role to create a more flexible and competent workforce. Support staff will be required for facilitation of work based assessment.
- y) Further immediate work to understand the level of investment required in the A+E departments and roles required alongside service improvement modelling for patient flow through A+E, CDU and the short stay areas.
- z) A flexible resource for staffing additional beds at WHH primarily to support Cambridge J ward which accommodates 11 additional beds daily during winter pressures. Hurst model calculation of required establishment for this additional capacity would be 13.8 wte (8.28:5.52 skill-mix).

Some indicative costs associated with some of the proposed areas for investment are shown in **Table 6: Indicative costs associated with some of the proposed areas for investment**

Proposal	Area	Approximate cost per wte	No. posts (wte)	Total cost
Investment into ward clerk posts (mid point band 2 0.5wte each ward)	All 44 wards	£17,528	22	£385,616
Reband mid point band 5 (plain time) to next appropriate point (bottom of scale) on band 6 payscale (plain time)	All 44 wards	£1,646	44	£72,424
Mid point band 5 (plain time)	3 wards	£28,202	3	£84,606
Reband mid point band 2 (plain time) to bottom of scale on band 5 pay scale (plain time)	9 wards	£7752	9	£69,768
Band 4 (bottom point) plain time	2 Paediatric wards	£21,645	4	£86,580
Funding additional 13.8wte establishment for 11 additional beds <ul style="list-style-type: none"> • Mid point band 5 (plain time) • Mid point band 2 (plain time) 	Cambridge J	£28,202	8.28	£233,512
		£18,035	5.52	£99,553
			Total	£1,032,059

Costs exclude Cost of Living Supplement. Costs uplifted by 2.4% for 09/10 pay award but do not include extra duty payments for out of hours enhancements.

CMB Members are asked to note and support the approach taken to review staffing levels and support the conclusions.

Julie Pearce
Director of Nursing, Midwifery & Quality

Helen O'Keefe
Associate Director of Nursing

Main conclusions

Staffing numbers and costs

11 Overall, the Trust's nurse staffing levels in whole time equivalents (WTE) are average when compared to the other trusts in the database. However, the costs of nursing staff are over £1 million below the average nursing costs. These indicators refer to the data for all 47 wards submitted for analysis.

12 Analysis by specialty areas shows that staffing levels and costs are above average for medical wards and surgical wards. However, staffing levels are particularly low for the children's wards and in critical care.

13 The Trust employs 103 specialist nurses that work across the Trust in specialist areas (they are not specifically ward based). We have provided a separate pack containing this chart and charts that compare the different types of specialist nurses such as breast care, continence, diabetes, falls, gynaecology etc.

Grade mix

14 The Trust's grade mix, expressed as cost per WTE is low; it is near the bottom 25 per cent of trusts (lower quartile). It is in lower quartile in surgery, medicine and critical care, but for the children's wards it is high.

15 Analysis of the ward tool shows that for the majority of surgery and medical wards, the percentage of qualified nursing staff is lower than average (ward pack separately provided).

Temporary staff

16 The Trust's expenditure on temporary staff in all specialty areas is low, in the bottom 25 per cent of trusts, indicating efficient management of leave. The total allowance for all types of leave is in line with other trusts.

Occupancy levels

17 The Trust's occupancy level was 85 per cent, in line with the other trusts. Breakdown into the specialty areas shows that it was high (top 25 per cent of trusts) for surgical and children's wards; for medical wards and critical care the occupancy was average.

Establishment levels

18 Of the Trust's nursing establishment, 88 per cent were in post, which is in the bottom 25 per cent of trusts, and may be an indicator of vacancy and turnover levels that need to be addressed. All four specialty areas (medicine, surgery, critical care and paediatrics) were in or near the lower quartile. Given that relatively few temporary staff were employed during the sample period and that overall costs are low, staff may be under some pressure.

Average cost by band

19 The cost per band for bands 2, 3, and 5 was average in the comparator group, but the cost per bands 6 and 7 were high (in the top 25 per cent of trusts). The cost for band 8 was in the lower quartile.

Inpatient Survey: nursing related questions

20 We compared the Trust's score on nursing related questions from the Healthcare Commission's 2007 Inpatient Survey with the scores of the other Trusts in the database. At 56 per cent the response rate was low. The charts relating to these indicators have been separately provided to the Trust. The

Trust's performance was around average for most indicators. It scored particularly well (top 25 per cent of trusts) on the question relating to washing and cleaning hands between touching patients.

21 However, the Trust compared poorly (bottom 25 per cent of trusts) on the following indicators:

- perception on the numbers of nursing staff on duty;
- information provision about the patient's condition or treatment;
- help to control pain;
- response time to call button;
- waiting time to admission;
- patients' experience of mixed gender sleeping areas; and
- supporting patients with their meals.

The way forward

22 We suggest that the Trust reviews the following indicators in more details and addresses the findings:

- the low grade mix in some areas;
- the low staffing levels on the children's wards and critical care;
- low in post figures where recruitment has not been finalised; and
- national inpatient survey scores on issues highlighted in paragraph 21 above.

Figure 7: Differences in staffing numbers showing overall nurse staffing levels as average

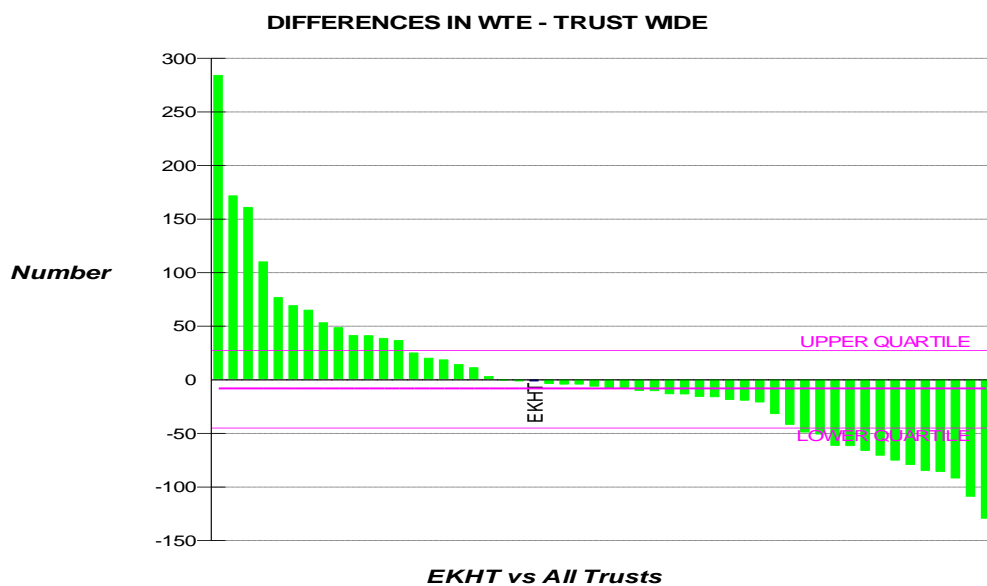


Figure 8: Differences in staffing costs showing EKHT near lower quartile

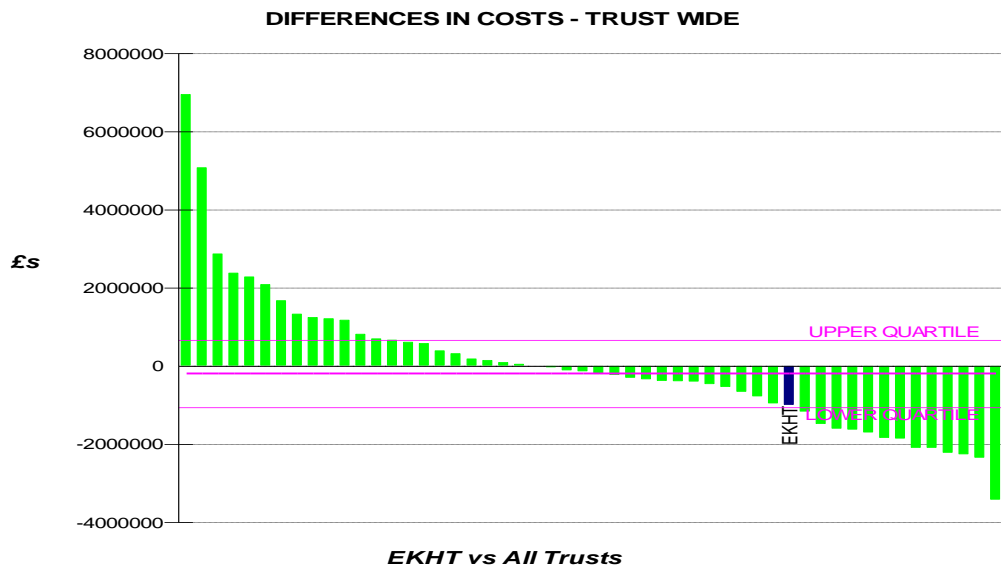
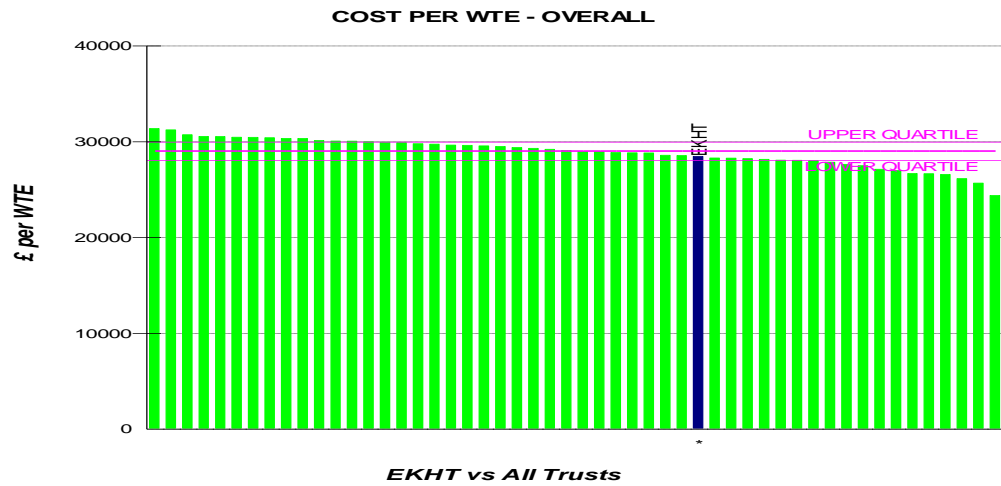


Figure 9: Cost per wte overall showing grade mix near the lower quartile



Appendix 3: Gap analysis of current ward establishments by directorate

Directorate	Ward	Specialty	No. beds	Increase wte for 09/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
A+E	A+E, CDU QEQM	Emergency admissions	25	3	106.83	94.7	27.37 (20.3%)	33		68/32	
A+E		CDU									
A+E	A+E, CDU WHH	Emergency admissions	25	3	105.14	92.9	27.26 (20.5%)	38.68		70/30	
A+E		CDU									
A+E	ECC + CDU KCH	Emergency admissions	18	3	83.23	54.5	1.07 (1.26%)	21.84		68/32	
A+E		CDU									
Medicine	Deal	Endocrinology	20	3	24.75	25.2	0.45 (1.78%)	31.82	7.07 (22.2%)	60/40	
Medicine	St Margarets	Gastroenterology	20	0	23.83	25.2	1.37 (5.4%)	23.8	-0.03	56/44	1.6
Medicine	Cambridge K	Cardiology	22	1	28.79	27.7	-1.09	28.72	-0.07	50/50	5.85
Medicine	Cambridge M1	Endocrinology	22	1	24.32	27.7	3.32 (11.9%)	29.85	5.53 (18.5%)	55/45	
Medicine	Cambridge M2	Gastroenterology	23	2	25.53	29	3.47 (11.9%)	29.27	3.74 (12.7%)	57/43	
Medicine	Oxford	Infectious Disease	14	1	21.73	21.5	-0.23	18.62	-3.11	64/36	
Medicine	St Lawrence	General	32	2	35.38	40.3	4.92 (12.2%)	37.87	2.49 (6.5%)	52/48	
Medicine	Treble	General	18	0	24.9	22.7	-2.2	22.96	-1.94	53/46	
Medicine	Sandwich Bay	Respiratory	29	2	32.79	42.8	10.01 (23.3%)	37	4.21 (11.3%)	59/41	
Medicine	Cambridge J	Respiratory	23	2	27.01	35.2	8.19 (30%)	31.71	4.7 (14.8%)	58/42	6.92
Medicine	Mount McMaster	Respiratory	26	0.4	33.09	39	5.91 (15.1%)	31.04	-2.05	56/44	0.2
Medicine	Minster	Short stay	29	2	33.47	36.5	3.93 (10.7%)	37.79	4.32 (11.4%)	54/46	
Medicine	Bethersden	Short stay	26	2	29.35	32.7	3.35 (10.2%)	32.32	2.97 (9.1%)	60/40	
Medicine	Invicta	Short stay	24	1	27.71	30.2	2.49 (8.24%)	30.88	3.17 (10.2%)	56/44	
Medicine	CCU QEQM	Coronary Care	10	0.4	22.23	28.4	6.17 (21.7%)	21.71	-0.52	70/30	0.32
Medicine	CCU WHH	Coronary Care	7+6	2	25.03	32.1	7.07 (22%)	26.4	1.37 (5.18%)	73/27	

Medicine	Taylor	Coronary Care	6	1	17.16	17	-0.16	12.75	-4.41	86/14	1.37
HCOOP + IC	Fordwich	Stroke Unit	20	3	30.25	33.8	3.55 (10.5%)	32.18	1.93 (5.99%)	67/33	1.56
HCOOP + IC	Richard Stevens	Stroke Unit	24	3	35.84	38.6	2.76 (7.15%)	38.1	2.26 (5.9%)	62/38	
HCOOP + IC	Kingston	Stroke Unit	23	3	35.83	37.4	1.57 (4.1%)	39	3.17 (8.1%)	60/40	4.52
HCOOP + IC	St Augustines	Rehabilitation	29	3	33.55	41.4	7.85 ((18.9%)	38.65	5.1 (13.1%)	52/48	
HCOOP + IC	Cambridge L	Rehabilitation	18	2	24.58	25.7	1.12 (4.3%)	25.28	0.7 (2.7%)	52/48	
HCOOP + IC	Harbeldown	Rehabilitation	27	3	29.35	38.6	9.25 (23.9%)	38.24	8.89 (23.2%)	54/46	
Specialty Medicine	Neuro rehab	Neuro rehab	22		26.94	31.4	4.46 (14.2%)	25.97	-0.97	51/49	
CCHHD	Braebourne	Oncology	14		20.95	20.8	-0.15	23.76	2.81 (11.8%)	74/26	
Child Health	Padua	Paediatric	32		37.84	NA		43	5.16 (12%)	87/13	
Child Health	Rainbow	Paediatric	24		30.15	NA		31	0.85 (2.74%)	89/11	
Surgery	CSF	Surgery	16+2dc	0	23.7	25.2	1.5 (5.9%)	19.36	-4.34	60/40	2.84
Surgery	CSM	Surgery	18+2dc	0.4	25.3	28.1	2.8 (9.9%)	21.73	-3.57	67/33	1.5
Surgery	Kings A2	Surgery	20	1.5	23.11	29.5	6.39 (21.6%)	25.17	2.06 (8.1%)	60/40	
Surgery	Kings B	Surgery	27	3	31.68	39.8	8.12 (20.4%)	32.52	0.84 (2.58%)	53/46	
Head + Neck	Rotary	Head & Neck	9+10dc	1	29.44	22.5	-6.94	18.51	-10.93	60/40	
T+O	Bishopstone	T+ O	28	2	31.25	43.3	12.05 (27.8%)	37.84	6.59 (17.4%)	57/43	
T+O	Quex	T+ O	19	0.5	23.61	28	4.39 (15.6%)	20.93	-2.68	58/42	1.69
T+O	Seabathing	T+ O	23	0.5	26.83	35.6	8.77 (24.6%)	27.3	0.47 (1.72%)	57/43	1.11
T+O	Kings C1	T+ O	27	2	31.7	41.8	10.1 (24.1%)	30.47	-1.23	54/46	
T+O	Kings D1	T+ O	25	2	28.29	38.7	10.41 (26.8%)	35.98	7.69 (21.3%)	52/48	
T+O	Kings C2	T+ O	24	0.4	30.57	35.4	4.83 (13.6%)	24.46	-6.11	63/36	
RVIRU	Clarke	Urology	30+6dc	3	34.57	48.9	14.33 29.3%	33.93	-0.64	60/40	
RVIRU	Kent	Vascular	22+6dc	2	30.51	37.1	6.59 (17.7%)	33.02	2.51 (7.6%)	62/38	2.7
RVIRU	Marlowe	Renal	29+6dc		57.14	63.3	6.16 (9.73%)	37.32	-19.82	64/36	3.72
Womens Health	Birchington	Gynaecology	19		29.82	24.7	-5.12	19.46	-10.36	62/38	1.24
Womens Health	Kennington	Gynaecology	11		19.31	14.3	-5.01	10.22	-9.09	55/45	2.54

67.1 1534.38

Appendix 4: Gap analysis of current ward establishments against Hurst model

Directorate	Ward	Specialty	No. beds	Increase wte for 09/09	Funded wte current	Hurst NPOB tool	Gap (%) current funded establishment and Hurst NPOB	AUKUH Acuity dependency	Gap (%) current funded establishment and acuity	Skill mix	Extra beds
Child Health	Padua	Paediatric	32		37.84	NA		43	5.16 (12%)	87/13	
Child Health	Rainbow	Paediatric	24		30.15	NA		31	0.85 (2.74%)	89/11	
Head + Neck	Rotary	Head & Neck	9+10dc	1	29.44	22.5	-6.94	18.51	-10.93	60/40	
Womens Health	Birchington	Gynaecology	19		29.82	24.7	-5.12	19.46	-10.36	62/38	1.24
Womens Health	Kennington	Gynaecology	11		19.31	14.3	-5.01	10.22	-9.09	55/45	2.54
Medicine	Treble	General	18	0	24.9	22.7	-2.2	22.96	-1.94	53/46	
Medicine	Cambridge K	Cardiology	22	1	28.79	27.7	-1.09	28.72	-0.07	50/50	5.85
Medicine	Oxford	Infectious Disease	14	1	21.73	21.5	-0.23	18.62	-3.11	64/36	
Medicine	Taylor	Coronary Care	6	1	17.16	17	-0.16	12.75	-4.41	86/14	1.37
CCHHD	Braebourne	Oncology	14		20.95	20.8	-0.15	23.76	2.81 (11.8%)	74/26	
A+E	ECC + CDU KCH	Emergency admissions			83.23	54.5				68/32	
A+E		CDU	18	3		29.8	1.07 (1.26%)	21.84			
Medicine	Deal	Endocrinology	20	3	24.75	25.2	0.45 (1.78%)	31.82	7.07 (22.2%)	60/40	
HCOOP + IC	Kingston	Stroke Unit	23	3	35.83	37.4	1.57 (4.1%)	39	3.17 (8.1%)	60/40	4.52
HCOOP + IC	Cambridge L	Rehabilitation	18	2	24.58	25.7	1.12 (4.3%)	25.28	0.7 (2.7%)	52/48	
Medicine	St Margarets	Gastroenterology	20	0	23.83	25.2	1.37 (5.4%)	23.8	-0.03	56/44	1.6
Surgery	CSF	Surgery	16+2dc	0	23.7	25.2	1.5 (5.9%)	19.36	-4.34	60/40	2.84
HCOOP + IC	Richard Stevens	Stroke Unit	24	3	35.84	38.6	2.76 (7.15%)	38.1	2.26 (5.9%)	62/38	
Medicine	Invicta	Short stay	24	1	27.71	30.2	2.49 (8.24%)	30.88	3.17 (10.2%)	56/44	
RVIRU	Marlowe	Renal	29+6dc		57.14	63.3	6.16 (9.73%)	37.32	-19.82	64/36	3.72
Surgery	CSM	Surgery	18+2dc	0.4	25.3	28.1	2.8 (9.9%)	21.73	-3.57	67/33	1.5
Medicine	Bethersden	Short stay	26	2	29.35	32.7	3.35 (10.2%)	32.32	2.97 (9.1%)	60/40	
HCOOP + IC	Fordwich	Stroke Unit	20	3	30.25	33.8	3.55 (10.5%)	32.18	1.93 (5.99%)	67/33	1.56

Medicine	Minster	Short stay	29	2	33.47	36.5	3.93 (10.7%)	37.79	4.32 (11.4%)	54/46	
Medicine	Cambridge M1	Endocrinology	22	1	24.32	27.7	3.32 (11.9%)	29.85	5.53 (18.5%)	55/45	
Medicine	Cambridge M2	Gastroenterology	23	2	25.53	29	3.47 (11.9%)	29.27	3.74 (12.7%)	57/43	
Medicine	St Lawrence	General	32	2	35.38	40.3	4.92 (12.2%)	37.87	2.49 (6.5%)	52/48	
T+O	Kings C2	T+ O	24	0.4	30.57	35.4	4.83 (13.6%)	24.46	-6.11	63/36	
Specialty Medicine	Neuro rehab	Neuro rehab	22		26.94	31.4	4.46 (14.2%)	25.97	-0.97	51/49	
Medicine	Mount McMaster	Respiratory	26	0.4	33.09	39	5.91 (15.1%)	31.04	-2.05	56/44	0.2
T+O	Quex	T+ O	19	0.5	23.61	28	4.39 (15.6%)	20.93	-2.68	58/42	1.69
RVIRU	Kent	Vascular	22+6dc	2	30.51	37.1	6.59 (17.7%)	33.02	2.51 (7.6%)	62/38	2.7
HCOOP + IC	St Augustines	Rehabilitation	29	3	33.55	41.4	7.85 (18.9%)	38.65	5.1 (13.1%)	52/48	
A+E	A+E, CDU QEQM	Emergency admissions			106.83	94.7				68/32	
A+E		CDU	25	3		39.5	27.37 (20.3%)	33			
Surgery	Kings B	Surgery	27	3	31.68	39.8	8.12 (20.4%)	32.52	0.84 (2.58%)	53/46	
A+E	A+E, CDU WHH	Emergency admissions			105.14	92.9				70/30	
A+E		CDU	25	3		39.5	27.26 (20.5%)	38.68			
Surgery	Kings A2	Surgery	20	1.5	23.11	29.5	6.39 (21.6%)	25.17	2.06 (8.1%)	60/40	
Medicine	CCU QEQM	Coronary Care	10	0.4	22.23	28.4	6.17 (21.7%)	21.71	-0.52	70/30	0.32
Medicine	CCU WHH	Coronary Care	7+6	2	25.03	32.1	7.07 (22%)	26.4	1.37 (5.18%)	73/27	
Medicine	Sandwich Bay	Respiratory	29	2	32.79	42.8	10.01 (23.3%)	37	4.21 (11.3%)	59/41	
HCOOP + IC	Harbeldown	Rehabilitation	27	3	29.35	38.6	9.25 (23.9%)	38.24	8.89 (23.2%)	54/46	
T+O	Kings C1	T+ O	27	2	31.7	41.8	10.1 (24.1%)	30.47	-1.23	54/46	
T+O	Seabathing	T+ O	23	0.5	26.83	35.6	8.77 (24.6%)	27.3	0.47 (1.72%)	57/43	1.11
T+O	Kings D1	T+ O	25	2	28.29	38.7	10.41 (26.8%)	35.98	7.69 (21.3%)	52/48	
T+O	Bishopstone	T+ O	28	2	31.25	43.3	12.05 (27.8%)	37.84	6.59 (17.4%)	57/43	
RVIRU	Clarke	Urology	30+6dc	3	34.57	48.9	14.33 29.3%	33.93	-0.64	60/40	
Medicine	Cambridge J	Respiratory	23	2	27.01	35.2	8.19 (30%)	31.71	4.7 (14.8%)	58/42	6.92