North Bristol NHS
NHS Trust

Report to:	Trust Board	**Agenda item:**	**10**
Date of Meeting:	30 October 2014		

Report Title:	Safe Nurse Staffing – 6 Monthly Assurance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		**X**	
Prepared by:	Jan Lynn, Deputy Director of Nursing (Part A) Lisa Marshall, Deputy Director of Midwifery (Part B)			
Executive Sponsor (presenting):	Sue Jones, Director of Nursing and Quality			
Appendices (list if applicable):	[List appendices or state none]			

Recommendation:
The Trust Board is asked to note this report the assurance regarding actions already underway and actions planned to ensure staffing levels are safe, effectively monitored and published openly

Executive Summary:

Further to the Government response to the Francis report the National Quality Board (NQB) published 'How to ensure the right people with the right skills are in the right place at the right time' in November 2013. The NQB guidance set 10 expectations, 9 of which were for acute Trusts.

Within the NQB guidance the Director of Nursing is responsible for providing the Trust Board with assurance around Safe Nurse Staffing which includes six monthly reports on safe staffing and monthly updates on Workforce Information. This is the fourth of such six monthly reports.

Further to the NQB guidance, NICE has also published its first guidance on safe staffing for nursing in adult inpatient wards in acute hospitals (July 2014). The NICE guidance also makes recommendations about the factors that should be systematically assessed at ward level to determine the nursing staff establishment, recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met and recommends monitoring staffing levels and taking action to ensure safe care by adjusting staffing numbers as required.

This report provides assurance against the relevant NQB expectations and NICE recommendations; it details what is currently in place to meet the expectations and recommendations and the plans in place to address any gaps.

Section 2 of this report specifically covers safe Maternity Unit staffing. There has been investment in Midwifery staffing to address acuity, and the number of unit closures in the last year. The Midwife to Birth ratio now benchmarks similar to other units in the South West.

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1. Purpose

The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing,

2. Background

Further to the Robert Francis report, the National Quality Board has published guidance[1] that sets out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients.

NICE has also published its first guidance 'Safe staffing for nursing in adult inpatient wards in acute hospital' (July 2014) and intends to produce further staffing levels guidance for Midwifery and Acute Admissions inpatient wards. NICE recommends that their guidance is read alongside that of the NQB guidance.

Both the NQB and NICE guidance do not set defined staffing ratios with a single ratio or formula. NICE state that *'There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward has to determine its nursing staffing requirements to ensure safe care*.' They do, however, recommend the use of an evidence based tool to determine the average number of nurses required.

The guidance also refers to the 'Safe Care Alliance' publication of a maximum of 1:8 Registered Nurses (RN) to patients' ratio and NICE recommends that we should *'take into account that there is evidence of increased harm associated with a RN caring for more than 8 patients during the day shifts.'*
Within NBT, the establishments have been set using evidence based tools, professional judgement, and the contribution of the wider multi professional team and acuity and dependency will be routinely monitored together with key performance indicators. Previous reviews have been undertaken which included the Shelford acuity/dependency Tool in January 2014 (Frenchay and old Southmead Hospitals).

With regard to the benchmarking of skill mix ratios, the plan is to meet the requirement of:
1 RN to 8 patients on a day shift and also to have all inpatient wards working to a minimum skill mix of an average RN/HCA ratio of 60/40.

Presently there are 2 wards which do not reach the required RN ratio of 1:8 on a day shift and 11 wards which do not reach the required average 60/40 split of RN/HCA (table 1).

WARDS	%RN/HCA (60/40%)	RN:8 Pts
Gate 6b - Neuro	65/35	1:5
Gate 7a - Neuro	56/44	1:5
Gate 7b - Neuro/Trauma	63/37	1:5
Gate 8a - Medicine/Renal	66/44	1:6
Gate 8b - Renal	59/41	1:4
Gate 9a - CoE acute	59/41	1:6
Gate 9b – Medicine Complex Care	59/41	1:6
Gate 25a - Neuro/Trauma	65/35	1:5

[1] How to ensure the right people with the right skills are in the right place at the right time, NQB, November 2013

Gate 25b - MSK Trauma	55/45	1:6
Gate 26a - MSK Ortho	59/41	1:6
Gate 26b - Surgical Admissions/Trauma	65/35	1:5
Gate 27a - Cardiology/CCU	69/31	1:5
Gate 27b - Respiratory/Isolation Suite	63/37	1:4
Gate 28a – Medicine Complex Care	56/44	1:5
Gate 28b – Medicine Complex Care	51/49	1:6
Gate 31a&b - Acute Assessment Unit	67/33	1:5
Gate 32a - Short stay Med	58/42	1:5
Gate 32b - Medicine	58/42	1:5
Gate 33a - Burns and Plastics	75/25	1:5
Gate 33b - Vascular surgery	64/36	1:5
Gate 34a - Colorectal surgery	70/30	1:5
Gate 34b – Urology surgery	65/35	1:5
Rosa Burden Unit – Neuro Psychiatry	67/33	1:5
Cotswold – Gynaecology	80/20	1:8
Elgar 3 - CoE Rehab	50/50	1:10
Elgar 4 - CoE Rehab	50/50	1:10

(Table 1)

The Director and Deputy Director of Nursing are working with the Heads of Nursing to review the wards ratios to meet the requirements as stated above. Each Directorate management team is presently reviewing their ward skill mix using both quantative and qualitative data (including these benchmarks) to build a case for any changes in skill mix to be put forward as part of their Business Planning and Budget setting process.

By the time of this report we will just have completed another Shelford acuity/dependency Tool review and the results will be examined at the October Nursing and Midwifery Governance Committee (NMGC).

Demonstrating sufficient staffing is one of the essential standards that all health care providers must meet in order to be compliant with CQC requirements and we have been required to publish staffing data since April 2014. The data which we have been providing has been:

- Six monthly Trust Board report re: Safe staffing
- Board level report detailing planned and actual staffing for the previous month.
- Monthly report published on the Trust's website and uploaded onto NHS Choices website
- Nursing/Midwifery staffing levels each shift (planned and actual) displayed at ward level.

Boards must, at any point in time, be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care. All NHS Trusts are accountable to the NHS Trust Development Agency (TDA) and, as stated in the Accountability Framework 2014-15, will be expected to provide the NHS TDA with assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk.

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This report will provide assurance against the NQB guidance and expectations for acute Trusts and NICE recommendations, the purpose of which is to ensure that high quality care can be delivered and the best outcomes can be achieved for patients.
All but one expectation (Expectation 10) is targeted at healthcare providers and there is overlap between some of the expectations. See below (Figure 1).

National Quality Board 10 Expectations
Accountability and Responsibility 1. The Board take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. 2. Processes are in place to enable staffing establishments to be met on a shift by shift basis
Evidence Based Decision Making 3. Evidence based tools are used to inform staffing capacity and capability
Supporting & Fostering a Professional Environment 4. Clinical & Managerial Leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns 5. A multi professional approach is taken when setting nursing, midwifery and care staffing establishments 6. Nurses and midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
Openness & Transparency 7. Boards receive monthly updates on workforce information and staffing capacity and capability is discussed at a public board meeting at least every six month on the basis of a full nursing & midwifery establishment review. 8. NHS providers clearly display information about the nurse's midwives and care staff present on every ward, department or service on each shift.
Planning for Future Workforce Requirements 9. Providers of NHS services take an active role in securing staff in line with their workforce requirements.
The Role of Commissioners 10. Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time.

(Figure 1. National Quality Board expectations Nov 2013)

3 General Factors Influencing Nurse Staffing

The national picture influencing the increased requirement for healthcare and, therefore, nurses is well documented and includes:

- The ageing population's impact on inpatient dependency and acuity.
- Rapid throughput and shorter inpatient-stays but of a greater complexity and acuity. Patients with low acuity are no longer found within our acute wards
- Decreasing RN direct-care time and the corresponding rise in support worker direct care time
- New roles within the workplace; e.g. Band 4 Assistant Practitioner
- Change in the nursing skill mix e.g. Housekeeper, Supervisory Sister
- The Francis report
- New technologies and treatments
- Changes to pathway delivery i.e. integrated care models
- National Performance measures and CQUIN
- Public expectations regarding quality
- Financial position

3.1 Nurse Staffing and Nurse Outcomes

The impact of nursing, midwifery and care staffing on the quality of care experienced by patients and on patient outcomes and experience has been well documented, with studies linking low staffing levels to poorer patient outcomes and increased mortality rates. Recent reviews by Sir Bruce Keogh and Don Berwick reinforced this with examples of where poor outcomes have been linked to poor nurse to patient ratios. For example, in Professor Sir Bruce Keogh's review, a positive correlation was found between inpatient to staff ratios and higher Hospital Standardised Mortality Ratios (HSMRs), (Keogh, 2013).

4 Staffing in the new Brunel Building

The nursing establishments for the Brunel Building were set before this guidance was published and used the best available evidence at the time, including RCN guidance[2] (2003; 2012), Audit Commission 2008 benchmarking and professional judgement. Cost per bed day, Nurse WTE per bed, ratios of registered to unregistered nurses were all used to set staffing levels against patient pathways and expected care needs. The previous Director of Nursing set this out in a document outlining the rationale and benefits (Building our future 2010).

The Non-Medical Clinical Workforce (NMCW) theme chaired by the Director of Nursing, led the development and implementation of a non-medical clinical workforce for the Brunel building. The work included implementing standardised nursing shifts, a 12 hour shift with a short 6 hour shift to make up the hours over each month. Shift standardisation was introduced to ensure an affordable workforce, with continuity of care for patients. As agreed as part of the change, the 12hr shift patterns are presently being evaluated by the Wellbeing Lead to determine how successful this has been for staff. A task and finish group is leading this work.

A new Matron leadership structure and Supervisory Ward Sisters has been implemented and additional roles such as Assistant Practitioners, Housekeepers, Ward Administrators and additional Receptionists are all in place.

Since moving to the new Brunel Building in May 2014 the ward nursing teams have found it very challenging working in a completely new environment with their new teams which included new staff to the organisation. This was also in the context of problems with the new Building and working closely with other important groups of staff who also had changed their ways of working e.g. Facilities.

To support these issues the Deputy Director of Nursing has been working closely with the Ward Sisters using the 'Productive Ward' methodology to facilitate improved ways of working and efficiencies to release time to care for patients.

Part of this work has been to review the new role of the Housekeeper which has not yet brought about the benefits for the ward team as first envisaged. A recent 'activity follow through' (time and motion) review of this role has demonstrated that most of the Housekeeper's time is spent undertaking the tasks that were previously undertaken by Domestic catering staff. In relation to nurse staffing this is having a direct impact, as the funding for these roles came from the nursing skill mix. This review will be presented to the Strategic Workforce Committee at their October meeting to discuss a way forward.

[2] Scott C., 2003, Setting safe nurse staffing levels, An exploration of the issues, Royal College of Nursing
Hayes N., Ball J., 2012, Safe staffing for older people's wards, Royal College of Nursing

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Unfortunately this has led to Wards overstaffing against their original planned/funded numbers leading to overspends, as there is a view from the Ward Sisters that there are not enough staff on duty to manage the increased number of patients on the ward than in the old Hospital wards.

There has also been concern with managing patients at risk of falls with 75% single rooms and the number of 'Specials' being booked are above plan in relation to the ward budgets. Different ways of managing patients at high risk of falls is being explored.

To mitigate against the overspends at ward level, the Heads of Nursing are critically reviewing their ward establishments and agreeing funded staffing levels with their Ward Sisters. A 'Specialling' Policy is also in the process of being developed to provide a robust process for assessing the requirement for additional staff and a robust approval process to authorise any booking through NBT Xtra. The Trust Falls group has an Action Plan in place to reduce the number of falls and the Dementia Matron is piloting different ways of working with patients that had cognitive impairment to reduce the risks of falls and dependency on 'Specials'.

Whilst making the transition into the Brunel environment concern about sufficient planned staffing levels to provide safe staffing has been raised by the Heads of Nursing. Some Directorates have already had business cases approved for additional investment in nursing, for example Theatres and Neurology. Directorate management teams with similar potential shortfalls will use the Business planning and Budget setting process to submit evidence based business cases. The Shelford acuity/dependency Tool and other nursing metrics will assist in this process.

5 Meeting the NQB Expectations and NICE recommendations

5.1 Accountability & Responsibility

Key actions that are in place are:

- Staffing levels 'planned and actual' for each ward, are reviewed on a shift by shift basis and at the daily 'Patient Flow and Leadership' meetings which are managed by a Directorate Matron or Head of Nursing. The accountability for ward staffing levels is with the Ward Sisters and Matrons who raise concerns to the Heads of Nursing and Deputy/Director of Nursing, if required.
- Systems for monthly assurance and reporting are in place using nursing metrics, for example QUESTT data.
- A staffing establishment review is undertaken six monthly using the Safe Care Tool (Shelford), an evidence based acuity and dependency tool. The staffing establishment is approved by the Director of Nursing.

Key actions that are being progressed are:

- Standardised processes are being developed to assist in decision-making regarding ward staffing levels on shift by shift basis. This includes a 'Specialling' Policy to support good patient assessment and appropriate action to support patients.
- As part of the revised Eroster implementation an Escalation Policy for addressing staff shortages on a shift by shift basis will be developed. This will also capture any Wards which identify 'Red Flags' as recommended by NICE. Examples of 'Red Flags' on wards (NICE), would be delays or omissions with vital signs or medications and less than 2 RNs present on a ward during the shift.

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- The Shelford Tool will be completed this month and will be reviewed by the Nursing and Midwifery Governance Committee before being presented to Trust Board.

5.2 Evidence Based Decision Making

Key actions that are in place are:

- Use of evidence based tools to determine staffing levels is part of the staffing establishment review. This includes the ratio of RN to Health Care Assistant (HCA) and Shelford Tool to determine acuity and dependency requirements.
- Scrutiny/Triangulation of results of tools are used in conjunction with professional judgement and local knowledge. The Ward Sisters, Matrons and Heads of Nursing review their skill mix and use nursing metrics to support any decision making.
- Daily reviews of actual staff available in comparison to planned staffing levels is reviewed and recorded at ward level by the Ward Sisters. This data is collated and reported monthly on Board reports, NBT Website and NHS Choices for the public.

Key actions that are being progressed are:

- E-rostering is being further developed to support all these requirements to enable robust 'live' reporting and monitoring of staffing levels. This has been rolled out since September 2014 and should reach all wards by the end of the year. This enhanced system also includes a 'Safe Care' acuity and dependency tool which has the functionality to support more immediate staffing deployment.
- The revised E-rostering system will also provide the ability to fulfil the NICE recommendations with regard to identifying 'red flags' at ward level where there are concerns with staffing levels. This will be supported by an Escalation Policy which supports the deployment of staff to provide safe staffing levels across the Trust.

5.3 Supporting & Fostering a Professional Environment

Key actions that are in place are:

- Ensuring that the organisational culture supports staff and ensures that staff are able to raise concerns/ speak up (NBT Whistleblowing Policy 2013)
- The NBT incident reporting system eAIMs is widely used to support escalation of concerns and facilitate risk management.
- Regular analysis of incident data to identify and respond to trends in relation to safe staffing. Monthly Directorate level data is presently sent to the Heads of Nursing directly from Risk Management.

Key actions that are being progressed are:

- Incident reporting eAIMs Is presently being revised to include improved guidance for staff completing incident forms with concerns about staffing levels.

Graph 1 (below) reflects the total number of 'staffing' incidents since April 2013 each month. It is interesting to note the apparent seasonal trend around peak holiday periods and it is envisaged that when the revised eRostering package is rolled out this will improve the annual leave management with the use of 'autoroster' which pre-populates shifts to provide adequate cover.

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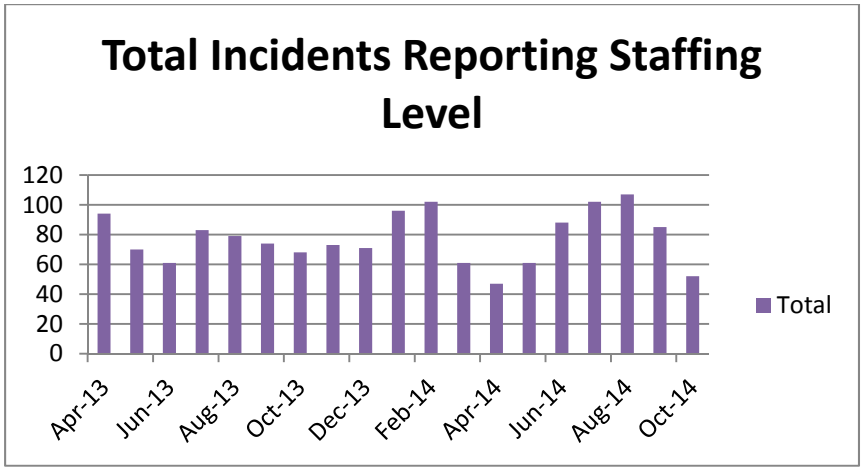


Graph 1 - Total number of staffing levels incidents

6 Openness and Transparency

Key actions that are in place are:

- Monthly updates on inpatient staffing 'planned and actual' are made available to the Public on our Website and NHS Choices
- Information about the ward nurses and care staff working on each shift is displayed and accessible to the public

Key actions that are being progressed are:

- A ward nurse staffing establishment review will be undertaken using evidence based methodologies. Directorates will use this data to inform any potential shortfalls in staffing levels via the Business Planning process. These will need to be approved by the Director of Nursing and considered by the Trust Board.

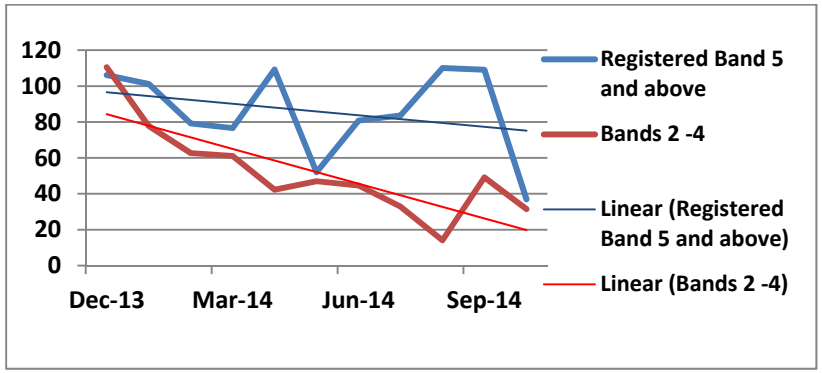
7 Planning for future workforce requirements

A plan to recruit the staff required to fill current vacancies, to manage turnover and to recruit the staff that will result from the investment is in place and is actively being managed.
The Recruitment Plan includes:

- Targeted individual recruitment plans to attract recruits to our 'hot spot' areas where the vacancy rate is high e.g. AAU and Theatres.
- Supporting centralised recruitment and Assessment Centres to recruit to NBT values
- Increase capacity to support Return to Nursing Practice Students from UWE
- Increase opportunities for apprenticeships and our Pre-Nursing Programme (part of the national pilot).
- Retention strategies proposed from the work of the Wellbeing Lead.

The Recruitment Plan is having a positive effect in relation to a reduced number of nursing vacancies, RNs and HCAs. (Graph 2) below.

Census data Nursing Vacancy Level Tracking WTE from 1 Dec 13 – 1 Oct 2014



Graph 2

The overall trend lines of both RNs and Bands 2-4 have been reducing month on month.

8 The Role of Commissioners

The guidance sets out clear and specific expectations of commissioners for pro-actively seeking assurance that providers have sufficient nursing and care staffing capacity and capability to deliver the outcomes and quality standards.

We maintain a constant dialogue with Commissioners about any issues relating to safety and staffing levels. We have in place processes to ensure a Medical/Nurse Director review of Cost Improvement Programmes, assessed for impact on quality via Quality Impact Assessments.

9 Recommendations

The Board is asked to note that the Trust has systems & processes in place that either meet or will meet the 10 NQB expectations and NICE guidance.

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Section 2, Maternity Unit Safe Staffing

1. **Purpose**

To report safe staffing review within the maternity service

2. **Background**

2013-2014

Midwifery staffing, April 2013-March 2014 and March 2014-September 2014 was funded for 187 whole time equivalent (wte) midwives providing clinical care,

5.6 wte of the 187 wte were providing specialist roles and 7.3 wte were providing a sonography service, with 1.6 wte in training for the sonography service. The sonography midwives are not included in the calculation for the birth ratios. Staffing has been reviewed and is set at a skill mix ratio of 80:20 trained to maternity support worker,

The total births in 2013 were 6201 giving a midwife to birth ratio of 1:35 against the recommended ratio of 1:29.5

Unit closures can occur either when there are insufficient beds, or when there are insufficient midwives to provide 1:1 care during labour. This is managed by arranging suitable transfers to other local units. Data collected around unit closures showed a recurrent trend in insufficient staffing able to provide 1:1 care in labour. With a significant increase in hours closed to 264.5 in September 2014.

Community midwifery staffing has been reviewed and is set at a skill mix ratio of 80:20 trained to maternity support worker.

The community midwives work to a midwife to caseload average ratio of 1:100 women and work with Maternity support workers to provide care. There is no clerical support within these teams.

Table 1

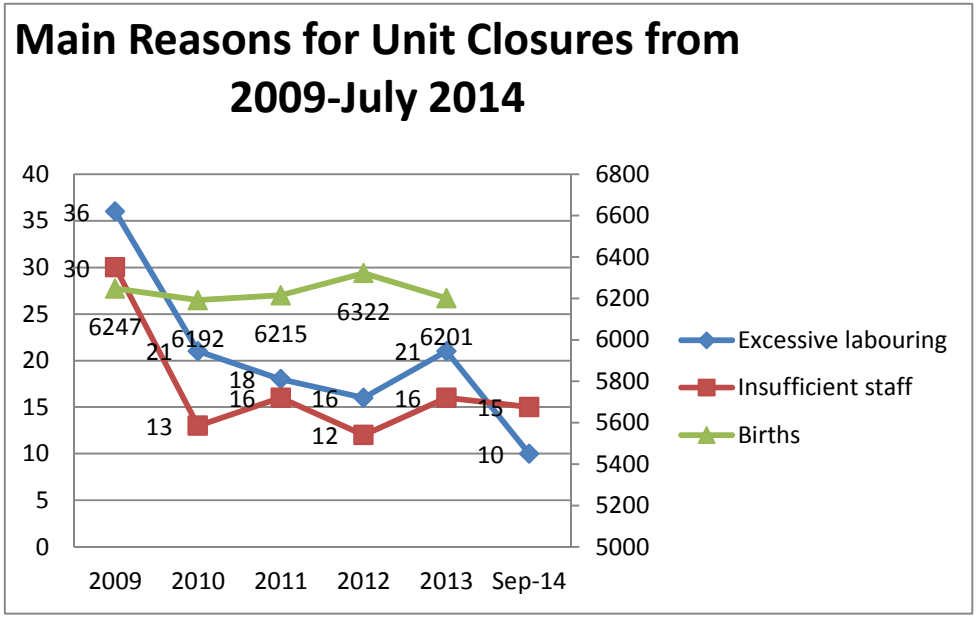
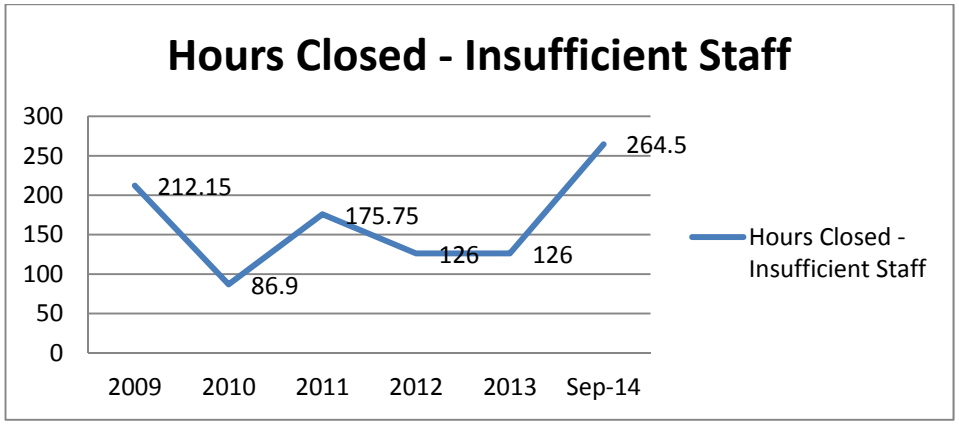


Table 2



3. **Report**

To validate the closure data and to ensure safe staffing the Directorate purchased the **Birthrate Intrapartum Acuity® System (BRIPAS)**
Data has been collated consistently since W/C 14th July 2014. During this time it has demonstrated that 66% of the time there were recordings where staffing levels were less than the acuity and 33% where staffing levels met the acuity.

A further break down of the 66%, shows that 61% of this time, the unit was up to 3 midwives short for the acuity and 39% of the time we were more than 3 midwives short for the acuity

BRIPAS is a 'predictive/prospective' tool which enables assessment of real time workforce planning within the delivery suite using clinical indicators. Acuity is a measure of the intensity of need arising from the number and clinical status of women and the infants during labour and delivery.

Enabling health care workers to classify women admitted to the delivery suite in order to identify the acuity or demand and allocate the appropriate ratio of midwife time to meet staffing standards. It is informed by clinical indicators and enables a more proactive and prospective approach to management of risk factors and better use of staffing within the delivery suite, as well as informing workforce planning within the wider midwifery service. BRIPAS is based on the Birthrate Plus® tool which is a recognised workforce tool cited by national bodies such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The BRIPAS showed a deficit in staffing within the unit and a shortfall in midwifery staffing of 30 wte. This was supported by the closure data in Tables 1 and 2.
The data was presented to the Director of Nursing and the Chief Executive in September 2014 who acknowledged the risk being held within Women and Children's and the recurrent closures and inability to provide 1:1 care to all women.

The Director of Nursing reviewed the data and with agreement from the Chief Executive approval was given to increase midwifery staffing levels by 10 wte.

The increase in staffing improves the midwife to birth ratio to 1:32, these staff will be in post and working independently by November 2nd 2014.

To achieve the recommended midwife to birth ratio of 1:29.5, the midwifery establishment would need to be increased to 208 wte. This would require a further 20 wte to be employed.

Consultant presence on the delivery suite is recommended as 168hrs per week with >5000 deliveries. NBT currently has 74hrs of consultant presence.

CNST requires trusts to be working towards this standard, it has been difficult to achieve nationally. Benchmarking nationally

against units with >6000 deliveries demonstrates that our number of consultant hours on delivery suite is on the low side (UHBristol 80hrs) However there is only one unit achieving 168hrs cover (St Mary's, Manchester), and we consistently demonstrate that we deliver a safe service..

Reference: Safer Childbirth standards (Royal College of Obstetricians and Gynaecologists et al 2007) and Standards for Maternity Care (RCOG 2008).

The Maternity Department train in a multi-professional model, using PROMPT training, developed at Southmead Hospital. The training has supported safe emergency care despite increased acuity in the caseload.

1:1 care in labour is currently achieved for 80% of labouring women and this has impacted on appropriate care in labour and patient satisfaction. We expect this to improve with the newly appointed midwives.

All midwives have personal development opportunities, having an annual appraisal and open access to a Supervisor of midwives (SOM), who also meets with them annually. Each SoM currently has a caseload of 1:19; this will improve to the NMC recommendation of 1:15 with a new SOM joining the team following completion of training by December 2014.

There is a formal development programme for transition from Band 6 to 7, this programme is in place on the delivery suite and community setting and is commencing in the ward areas by December 2014.

All band 5 midwives have a named preceptor and follow a preceptorship package. On completion of the first year they transition to Band 6 and then proceed through the first AFC gateway on completion of competencies outlined in the Band 6 job description.

There is a robust clinical governance process and the maternity dashboard looking at outcomes is reviewed monthly and detailed audits and case review is implemented using dashboard data, to ensure quality and safety of service.

4. Summary

Maternity acute unit staffing has been at an unacceptable level to provide 1:1 care in labour for the increased acuity of the women using the service.

An evidence based tool has been used to measure acuity and appropriate staffing requirements and there has been an agreed initial increase of 10 wte midwives to support the service delivery.

A Strategic review of current working models and skill mix is required to identify the potential requirement to further increase numbers of midwives following full analysis of working models, to achieve midwife to birth ratio of 1:29.5

The previous review of community midwifery services has ensured the caseload ratio of 1:100 with an 80:20 ratio of trained to support staff is in line with recommendations. Clerical support is an identified area needing review.

Staff at all grades are provided with emergency skills and drills training and have personal development discussed at annual appraisals, and for midwives also an annual review with their

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Supervisor of Midwives. Personal development programmes and preceptorship packages are embedded within the Directorate.

5. Recommendations

- Strategic review of current working models to assess future levels of staffing and skill mix
- Review of clerical support in the community setting
- Ongoing audit of 1:1 care in labour
- Ongoing use of BRIPAS to inform staffing requirements in relation to acuity

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Benchmarking Against Other Trusts

Maternity Unit	Births	Consultant Presence	Midwife:Birth Ratio
Queens Hospital, Romford	7050	98 hours	1:29
Plymouth	4500	98 hours	1:32
UHB	5500	80 hours	1:33
Royal Gloucester	6500	76 hours	1:33
NBT	6300	74 hours	1:35
Birmingham	5700	60 hours	1:28
Nottingham City Hospital	5700	40 hours	1:30
Royal Derby	6100	84 hours	1:27
St Mary's Manchester	8200	112 hours (168)	1:28
Chelsea & Westminster	5800	102 hours	1:30