

Some trusts spend substantially more on ward staffing than others even after allowing for specialty mix, ward size, London Weighting and time spent on other duties.

A few trusts review the way their wards are staffed in a way that is both systematic and sensitive to patients' needs but the majority could learn from their example.

ward staffing

Many trusts are making good use of the staff they have in post though some could improve this with better scheduling and management.

Outcome measures need to be adopted nationally to demonstrate any relationship between the quality of care and ward staffing resources.

Hospitals employ a significant number of specialist nurses but their impact on ward staffing and care is unclear and needs evaluating.

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Introduction and background

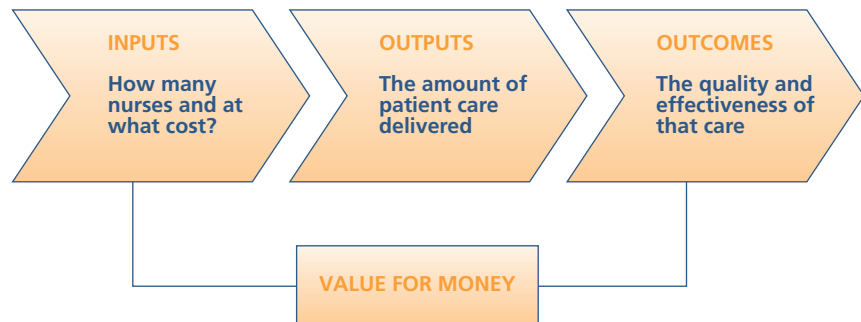
1. Staffing the wards is by far the largest single budget item for an acute trust and the quality of care that is delivered has a major impact on health outcomes. The Audit Commission's 1991 report on nursing identified that there was considerable scope for improvement in the efficiency and effectiveness with which nurses were deployed.^I Few trusts appeared to use systematic methods for reviewing ward establishments or matching staff to workload. The report also noted that many hospitals did not pay enough attention to assessing the quality of nursing and that standards were often not monitored even when they were set.
2. In the ten years since that report was published, significant changes have affected the provision of nursing care on wards. Some changes were already apparent at the time of the report, such as reductions in the supply of nurses, Project 2000 (a major change in nurse education) and changes to management arising from the 1991 NHS reforms. Other factors, such as the reduction in junior doctors' hours and changes in patterns of healthcare delivery, including shortened lengths of stay for patients in hospital and the increasing use of nurses in providing specialist care, have also had an impact on the way that wards are staffed. A review, then, is timely and ward staffing was chosen as one of the first four topics in the Audit Commission's Acute Hospital Portfolio. Ward staffing rather than 'nursing' is reviewed as this reflects the much larger contribution to patient care of non-registered staff. These include healthcare assistants and clinical support workers who have replaced student nurses who are now largely supernumerary.
3. Another factor affecting both the costs and the quality of care delivered by staff on the wards is the use of bank and agency staff. The Audit Commission has recently published a national report^{II} examining their use, the quality of their work, their costs and management arrangements. This review of ward staffing, while including the costs of bank and agency staff in looking at ward costs, focuses as well on the effectiveness of the permanent staff and the outcomes of ward care as a whole.
4. Demonstrating value for money in ward staffing involves assessing the resources and staffing levels against the amount of patient care delivered and the outcomes – the effectiveness or quality of the work that is done [EXHIBIT 1, overleaf].

I Audit Commission (1991), *The Virtue of Patients: Making the Best Use of Ward Nursing Resources*.

II Audit Commission (2001), *Brief Encounters*.

EXHIBIT 1

Demonstrating value for money



Source: Audit Commission

5. Measuring the inputs for ward staffing, that is, the number and cost of staff on each ward, is relatively straightforward. The outputs, in terms of the volume of patient care, are much more complex. This is because nurses at some trusts have taken on extra responsibilities and some support workers serve meals or carry out other domestic tasks. These differences are likely to become more pronounced if trusts continue, rightly, to challenge role boundaries between different types of staff. Measuring the outcomes of care, in terms of clinical risk or quality, remains the most problematic task, despite advances made since 1991. Many trusts have been addressing the need for more consistent reporting of clinical incidents and there are some good examples of standards being set and monitored.

6. The Audit Commission collected data from almost all trusts in England and Wales in 2000. This review uses those data to answer three questions:

- How much do trusts spend on ward staffing and how can differences be explained?
- Is there any evidence that resources can be used more efficiently and effectively in the delivery of patient care?
- Does the level of resources relate to clinical risk or the quality of the care delivered?

The findings are divided into three sections that aim to answer these questions and that cover respectively expenditure, efficiency and clinical risk.

Findings

Even after all these adjustments, substantial differences remain in the amount that individual trusts spend on ward staffing.

Expenditure on ward staffing

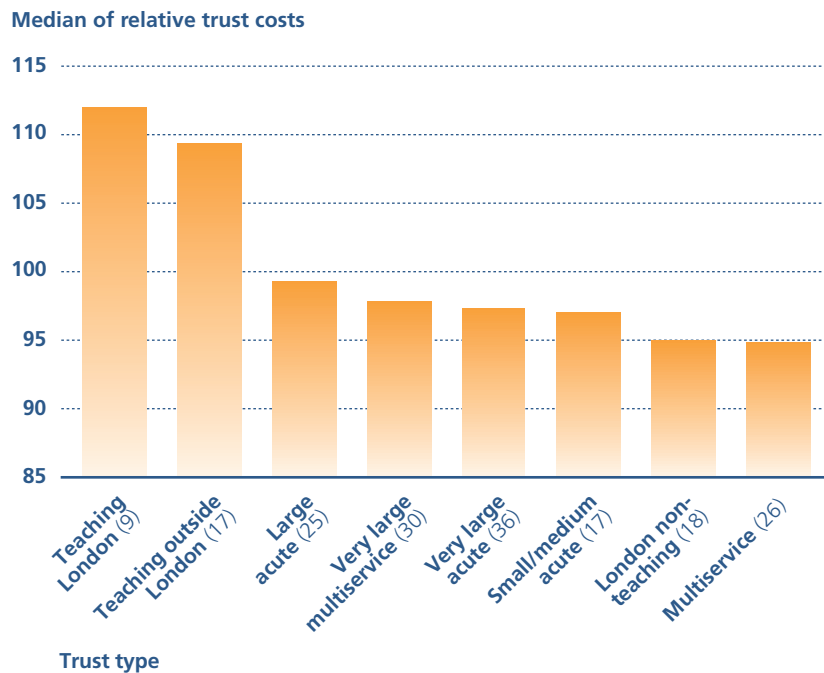
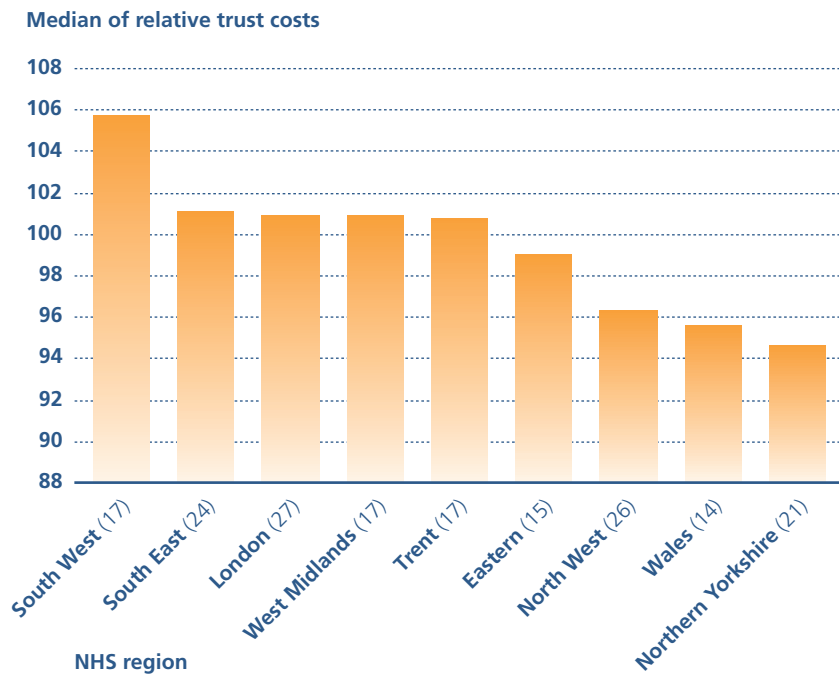
7. Interpreting information on the amount of money spent on ward staffing is a complex task because:
 - trusts have different mixes of types of wards and of patients;
 - wards are different sizes and large wards tend to cost less per bed on average;
 - staff are organised differently; and
 - accounting systems are not standardised.
8. The data collected as part of the survey have been adjusted to take account of some of these factors so that better comparisons can be made:
 - Each ward is compared with similar wards. It is classified as one of 60 different types according to the main specialties it covers. The database created by the Audit Commission includes data from over 3,600 wards;
 - Adjustments have been made for the economies of scale from which larger wards benefit. This recognises that, in the short or medium term, trusts can do little about the physical size of wards;
 - Where staff included in ward establishments also run outpatient clinics an allowance for the cost of their time has been deducted from ward costs;
 - The extra cost of employing staff in London has been deducted.
9. Wards are compared according to the cost of each available bed. Although it is likely to be more useful to express the cost of each occupied bed, the quality of data relating to occupancy in the survey was insufficiently robust to allow this. The data do however, show generally high occupancy levels so it is reasonable to assume that most wards were operating at, or close to, their maximum capacity. In practice, therefore, costs per available bed will vary little from cost per occupied bed. Adjustments were made for beds that were not occupied as a result of closure, either temporary or routine, as in the weekend closure of beds in five-day wards. Once all the adjustments have been made to the cost of a particular ward, the resulting figure can be compared with the average cost for other similar wards to produce the relative cost of that ward. For a more detailed description of the methodology see Appendix 1.
10. Even after all these adjustments, substantial differences remain in the amount that individual trusts spend on ward staffing. There are some patterns in these variations, including differences between the NHS regions, and some types of trust spend less than others, perhaps reflecting traditional resourcing patterns. Trusts in the South West Region spend more than average on ward staffing, whereas those in the Northern and Yorkshire Region spend less. After adjusting for London Weighting, trusts

in the London NHS Region spend almost exactly the average (average relative trust cost ratio is 100.9 compared with the overall average of 100), but this disguises the disparity between the capital’s relatively high-spending teaching hospitals (112) and its lower spending non-teaching hospitals (95) [EXHIBIT 2]. Although, in part, this may reflect case-mix differences over and above those already taken into account by comparing like specialties, case-mix is unlikely to explain the substantial difference.

EXHIBIT 2

Average relative costs by NHS region and trust type

Some NHS regions and trust types spend more or less than the average.



Notes: Costs are adjusted and standardised for the mix of ward types in each trust. The national average cost = 100. Numbers of trusts in each region/type of trusts is shown in brackets. Specialist trusts have been excluded. See Appendix 1 for detailed description of methodology.

Source: Audit Commission

11. Other factors that have not been taken into account but which might explain some of the individual differences include the condition of the local labour market; ward and hospital layout; and socio-economic factors that can affect both workforce and workload. It is not clear how much trusts have assessed the impact of these factors when setting ward establishments.

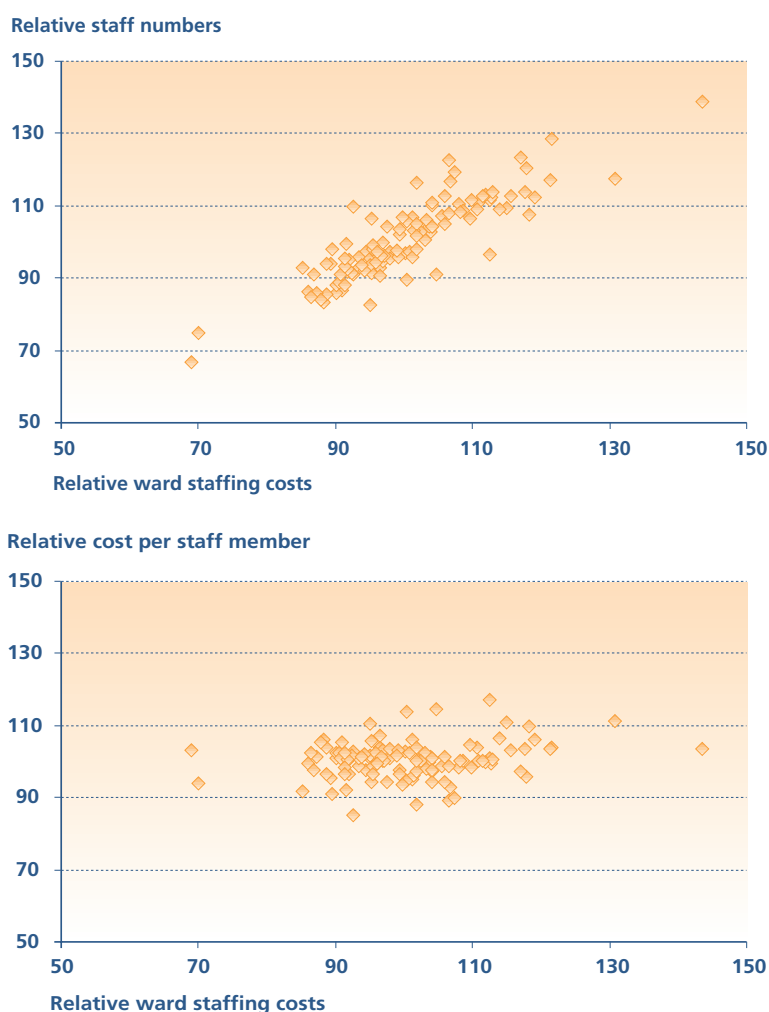
Numbers or grade mix?

12. The relative costs reflect both the number of ward staff and their grade mix. Some have suggested that high costs due to grade mix are justifiable if they can be shown to deliver better quality. On the other hand, high costs may also be due to higher than average numbers of staff, after allowing for specialty, ward size and other duties. The data show that overall costs are strongly associated with staff numbers but not with the average cost per staff member, which is an indicator of grade mix [EXHIBIT 3]. In other words, trusts that spend more on ward staffing tend to employ more staff per bed rather than fewer, more expensive staff. These trusts need to establish whether higher numbers of staff mean a better service for patients.

EXHIBIT 3

The relationship of trusts' ward staffing costs to the number of staff and the cost per staff member

There is strong correlation between relative staff costs and staff numbers, but not with relative costs per staff member, so trusts spending more on ward staffing tend to employ more staff per bed.



Note: The costs and staff numbers are all adjusted and standardised so that the average = 100 (see Appendix 1).

Source: Audit Commission

The allocation of resources within trusts

13. Whatever the overall level of resources allocated to ward staffing by trusts, individual wards should, in theory, receive an appropriate share of the available resources. This does not mean that they should all receive the same or even a fixed amount for each bed – different types of wards need different numbers and grades of staff, according to the needs of their patients.

14. The Audit Commission survey has determined average costs per bed for each specialty. While these do not constitute a norm or correct allocation, they are a useful comparative tool. In all trusts, individual wards receive more or less relative to these national averages and so for each ward a ‘relative’ cost can be derived showing whether it is more or less expensive than the average. The range of these relative costs provides a measure of the consistency of allocation within a trust. In some trusts, the degree of variation is large and wards are substantially over- or under-funded compared to similar wards in other trusts [EXHIBIT 4]. In many trusts it appears that one specialty or directorate is over- or under-funded compared to the others.

15. A high level of consistency within a trust implies good planning and management, while wide variation between relative ward costs indicates that a systematic review of ward establishments is needed. Staffing establishments may have been set historically. There may have been incremental changes but no fundamental review for many years. The rapid pace of change in healthcare means that all ward establishments need to be reassessed every two or three years to ensure that they meet current patient needs. This could improve ward care, even without the increase in numbers of nurses promised in the NHS Plans for both England and Wales^{I II} [BOX A, overleaf].

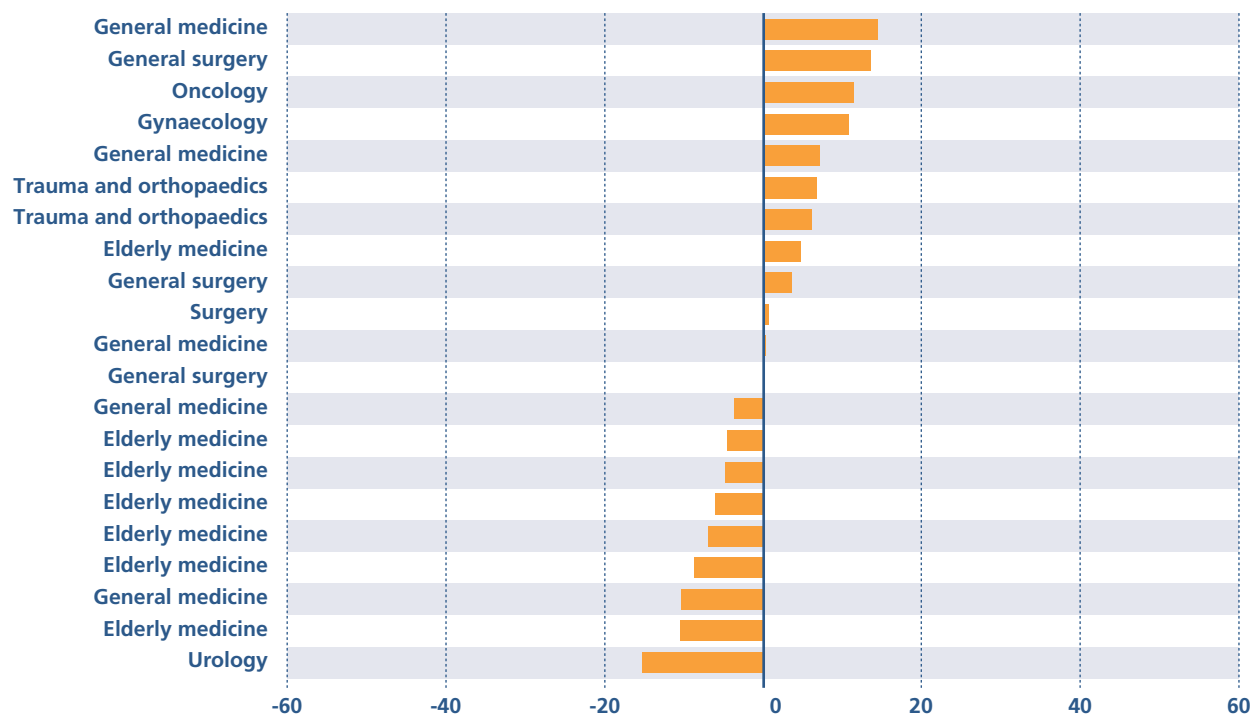
I National Assembly for Wales, (January 2001), *Improving Health in Wales*.

II Department of Health, (July 2000), *NHS Plan*.

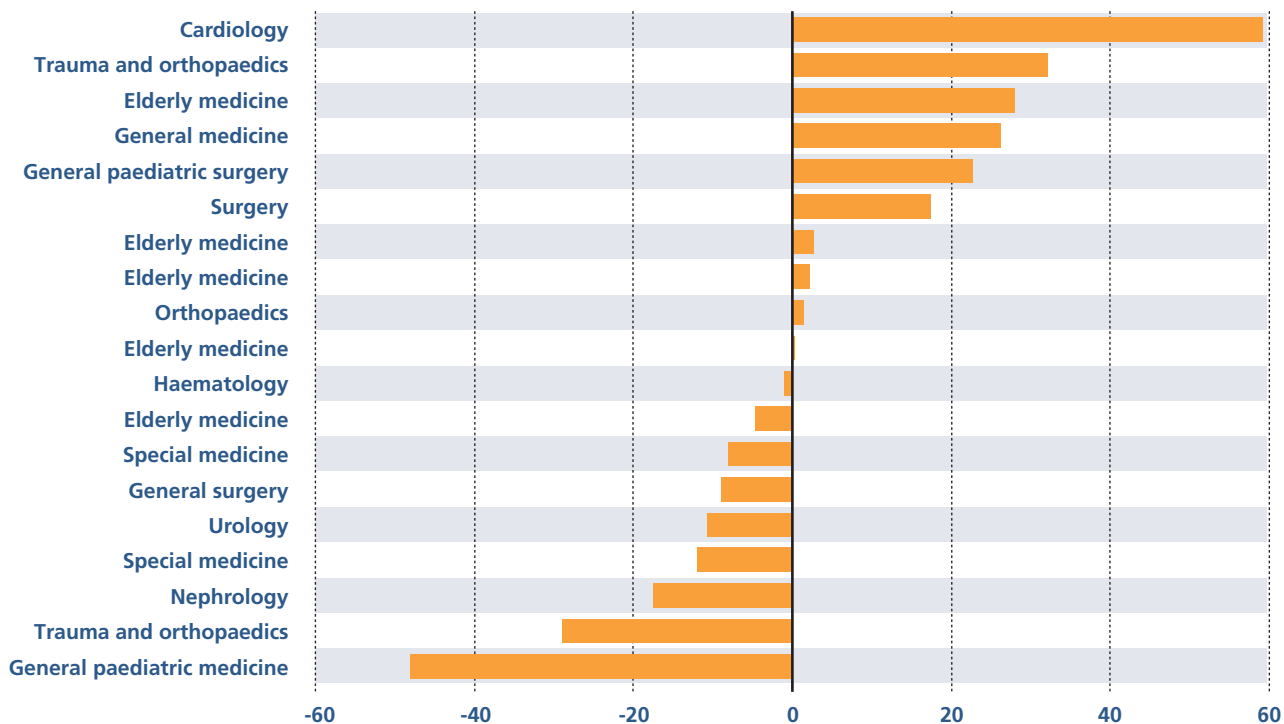
EXHIBIT 4

The allocation of resources within trusts

In trust A, a reasonably consistent allocation of resources has been achieved.



In trust B there is a more uneven allocation of ward costs.



Note: In both charts, the values are the percentage difference from national average for each ward type.

Source: Audit Commission

BOX A

Setting appropriate establishments

Workload measurement

Some trusts have used systems to measure workload and to set establishments. Various methods have been developed from the 1960s onwards and these were reviewed by the Audit Commission in 1992.¹ All have advantages and disadvantages. Those that measure the dependency of patients or analyse nurse activity are good at involving staff and can be useful in making adjustments for local factors. For the purposes of establishment setting, they can be used retrospectively and for a short period. They all involve an element of professional judgement that is inevitably limited by the experiences of those making the judgements.

Benchmarking

Benchmark data, such as those collected in this review, can also be useful in setting establishments. By providing inter-trust comparisons they challenge accepted historical staffing patterns within trusts. Simply imposing benchmarks as 'norms' will almost certainly be viewed with suspicion by staff. A combination of both benchmarking and consultation or workload measurement will help to determine establishments that are both rationally based and fair.

Summary of the principles for effective establishment setting

Arrangements should be:

- Simple – not too time consuming;
- Transparent – all staff must be able to see how staffing levels are determined;
- Integrated – into the management structure so that real change to budgets results from their use;
- Benchmarked – against other trusts so as not to perpetuate accepted historic staffing levels; and
- Linked to outcomes – establishment setting should be linked to measured outcomes on the ward.

¹ Audit Commission (1992), *Caring Systems: A Handbook for Managers of Nursing and Project Managers*.

On average, trusts employ the equivalent of 26 ... specialist nurses.

The role of non-ward-based nurses

16. Information was collected about the number of specialist nurses who are employed by or work within a trust and are involved in in-patient care but are not part of ward establishments. Community liaison nurses, tissue viability nurses and stomatherapists are examples. It is possible that trusts that employ more of these types of nurses might have fewer ward-based nurses. No relationship was found however. On average, trusts employ the equivalent of 26 whole time equivalent (WTE) specialist nurses. Many of these nurses have new roles that did not exist 10 years ago: some have taken on responsibilities previously carried out by medical staff. This raises a number of questions for policymakers and trust managers:

- what is the impact of these nurses on the quality and outcomes of ward care;
- what impact have these nurses had on other nurses' roles – have their roles become more restricted, and, if so, are they content; and
- what will be the effect of the further expansion of roles envisaged by the NHS plan?

Are ward staff used efficiently?

17. Deploying ward staff to maximise hours at the patient's bedside requires good management. Rosters and shifts must be well planned, sickness absence minimised and study-leave used appropriately. To measure how well trusts are achieving these aims requires an understanding of the proportion of contract hours that should be available to patients.

18. Annual leave entitlement is fixed and accounts for 13.5 per cent of registered nurse contract hours. Unregistered staff sometimes have less annual leave, which may only account for 11.5 per cent of contract hours. The majority of wards have a minimum of 50 per cent registered staff and so annual leave levels will vary between 12.5 and 13.5 per cent. If rosters are well planned, annual leave will be evenly spread to avoid the need for costly temporary staff.

19. The national average level for sickness absence for ward staff is 5.5 per cent. Nurses, of course, take other types of leave of which maternity leave is perhaps the most significant. Given normal fertility rates, this should account for no more than a further 1 per cent.

20. The survey asked trusts how much, if any, allowance was made for study leave in their establishments. For those trusts that made an allowance the average was 2 per cent. If annual leave entitlements, sickness absence and study leave are added together, the percentage of contract hours for these reasons should be between 21 and 22 per cent [TABLE 1, overleaf].

Trusts with a low level of hours worked need to ensure that they understand the reasons for the missing hours...

TABLE 1

Leave allowances

Percentage contract hours lost due to

Annual leave	12.5 – 13.5
Sickness absence	5.5
Maternity leave	1
Study leave	2
Total hours lost	21-22

21. Data were collected on the shifts actually worked on each ward by each grade, and on the length of the shifts, excluding unpaid breaks over a period of four weeks. This was then compared with the total number of contracted hours. The hours worked as a percentage of contracted hours was calculated for each trust as an average of its individual ward results.

22. The median for all trusts of 76.7 per cent [EXHIBIT 5] is below the 78–79 per cent expected if all hours are accounted for. This means that there is scope for the majority of trusts to improve their utilisation of ward staff. Poor utilisation may be due to high levels of sickness absence or study leave, or to poor deployment and roster design, all of which are unacceptable. Action can be taken to remedy these problems. Trusts with a low level of hours worked need to ensure that they understand the reasons for the missing hours and they must do everything possible to reduce them.

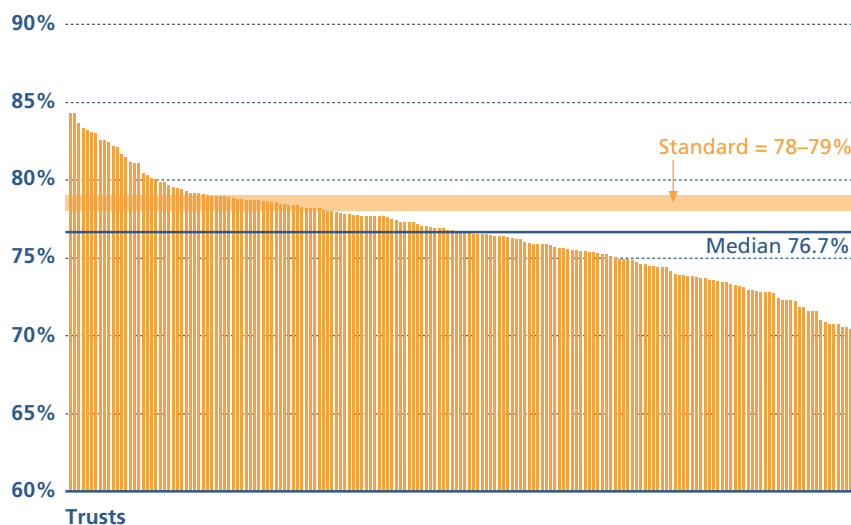
23. The level of reported sickness for registered nurses was collected separately in the survey for each trust as a whole. There was, however, no correlation between the percentage of contracted hours worked and the level of sickness absence for each trust. This may suggest that some sickness absence goes unreported or unrecorded.

24. Some trusts achieved higher than 79 per cent. This could be due to low levels of annual leave, study leave or sickness absence. Since the overall level of annual leave is fixed, low levels in one month have to be counterbalanced by high levels in another. The same is true for study leave, although the impact is lower. High utilisation in the sample month that has been achieved for these reasons will lead to low utilisation in other months. This is not good practice, although high utilisation due to low levels of sickness absence is an indication of good practice.

EXHIBIT 5

The proportion of contracted ward staff hours that are worked on the wards

Trusts should achieve 78–79 per cent after allowing for annual leave, study leave and the national average for sickness absence and maternity leave.



Note: Permanent staff only.

Source: Audit Commission

25. Shift overlap was not taken into account in these calculations because the appropriateness of the amount of time that overlaps is wholly dependent on the way it is used. This may vary greatly between the wards within a trust as well as between trusts, and while it needs to be monitored carefully at individual trusts, it does not lend itself to national comparison.

Shift patterns

26. The last ten years have seen difficulties in the recruitment and retention of nurses, and trusts have been encouraged to offer flexible shift patterns to enable staff to work at times that fit in with other commitments. Ward managers have been given more freedom to arrange shifts to suit both the nature of the work in their particular specialty and the preferences of their ward staff. Analysis of data collected for assessing the utilisation of ward staff shows the extent to which variable shift times have been introduced [BOX B, overleaf].

BOX B

Evidence on shift patterns

Issue	Evidence
Are flexible shift patterns in wide use?	Only 1 in 10 wards has more than 20% of its hours worked as non-standard shifts. These wards were spread evenly through 106 trusts (just over 50% of trusts).
Are there regional variations?	Only 1 in 10 of the trusts in London had wards with more than 20% of the hours worked as non-standard shifts. This compared to 6 in 10 of the trusts outside London.
Is there wide use of the two long shifts per day pattern?	In contrast, while overall only 7% of wards in our sample have changed to a two long shift pattern, 50% of these are in London hospitals.

Note: Precise start and finish times for shifts varied a little between trusts but standard shifts were defined as Early, Late, Night, Long day, Half day.

Clinical risk

27. It might be assumed that spending more on ward staffing delivers a better standard of care. Health outcomes would therefore be demonstrably better in those trusts that spend more on ward staffing. However, measuring the quality of care that ward staff deliver is not straightforward. It is hard to identify care outcomes that are solely the result of the care delivered by the ward staff. Even when such outcome measures are agreed, comparisons require the use of consistent and uniform methods for measurement and recording. Although it was recognised that collecting clinical risk data is difficult, and in some cases unreliable, it was included as part of the Audit Commission survey because:

- it is important to see how many trusts could supply the data when asked;
- it identifies those trusts that need to improve their clinical risk information systems; and
- it encourages the development of more consistent methods.

28. Data were collected in five areas of clinical risk: complaints; pressure ulcers; patient accidents; staff accidents and ward audits [BOX C]. Allowances were made for trusts that could not provide data in the exact form required but that could provide some information. Attempts were also made to collect information in the form usually available within trusts, so, for example, information on pressure ulcers was collected at trust level but accident data at ward level. Despite this, several trusts were not able to supply the data [BOX D].

BOX C

The five areas in which data were collected

Indicator	Definition	Rationale
Formal complaints	Complaints about ward staffing if available, but all complaints if not.	Measure of patient dissatisfaction.
Pressure ulcers	Trust incidence if available, but point prevalence if not.	Pressure ulcers are preventable and cause pain and suffering. They increase length of stay in hospital.
Patient accidents	All accidents recorded by wards.	Some accidents are avoidable and can cause injury, slow rehabilitation and an increase in the length of stay.
Staff accidents	All accidents recorded by wards.	May be related to staff numbers but may also be affected by equipment provision and effective management.
Audits	Number carried out at ward level.	Are a proxy measure of the learning culture and the quality focus of the wards.

BOX D

Trusts unable to supply data

	Percentage unable to supply data	Comment
Formal complaints	3	A further 16% could only provide total numbers of complaints – they did not separate those about ward care. These were compared separately by the Audit Commission.
Pressure ulcers	17	50% could only provide a prevalence measure – not incidence.
Patient accidents	1.5	
Staff accidents	1	
Ward audits	0	

29. No relationship was found between the relative amount spent on ward staffing and a composite score based on the five measures above. This does not give a definitive answer to the issue of the relationship between the cost and quality of ward staffing because of shortcomings in the clinical risk data already mentioned and because differences in performance may reflect quality of measurement and reporting as much as the quality of the care. Linking inputs to outcomes is essential in demonstrating value for money (Exhibit 1) and determining appropriate staffing levels. Further work is necessary to improve measurement and to understand the variations.

30. Minimising clinical risk means not only ensuring adequate staffing levels but also creating well-trained and well-managed staff. Effective management means having the appropriate monitoring systems in place. Trusts that have a culture that encourages staff to record accidents and mistakes without the fear of blame will be able to identify danger areas and address them. It may be that staffing levels need to be reviewed in areas where the number of adverse incidents is high. When clear definitions for clinical incidents are available so that numbers can be compared like for like between trusts, then good performance can be easily identified. Learning from this good performance can then be shared.

Conclusions

- Some trusts spend more on ward staffing than others even after allowing for ward size and specialty mix. Some patterns do emerge with trusts in some NHS Regions and some types of trusts spending more than others. This is likely to be due to historical resourcing allocations.
- Many trusts have wide disparity in the funding of their individual wards relative to other trusts and there is scope to improve the allocation of funds within trusts. Trusts should review individual ward budgets regularly. A method that takes account of both changes in local workload and national averages is most likely to produce reasonable results.
- A substantial number of non ward-based nurses are now employed in trusts. It is not clear what their impact is on the outcomes of ward care and on the roles of ward-based nurses. This issue needs further research.
- There is room for improvement in the efficiency with which some trusts deploy their staff to increase the utilisation of the staff they have in post.
- Trusts cannot demonstrate a link between the amount spent on ward staffing and the quality of care they deliver. Trusts that spend more on ward staffing may deliver better quality care but that cannot be effectively demonstrated within the constraints of the existing outcome data.
- Clearly-defined outcome measures are required so that ward staff can demonstrate the value of the care that they deliver. These should be defined nationally so that trusts can compare their performance. Examples include the grade of pressure ulcers that should be included in incidence reports and which patient and staff accidents should be included in a clinical incident report.
- Unless and until trusts that spend more can demonstrate a clear link with the quality of care that is delivered, movement towards a more even allocation of resources seems reasonable both for patients and staff.

Appendix 1

Explanation of the calculation of relative ward costs

Step 1 – Select wards

For each trust a minimum sample of 20 acute wards is taken (or all wards for trusts with fewer than 20 relevant wards). Post-natal, intensive and continuing care wards were excluded. A total sample of more than 3,600 wards covering all trusts in England and Wales was included.

Worked example

Trust sample of wards

Ward A – Medicine

Ward B – Medicine

Ward C – Cardiology

Ward D – Surgery

Etc

Step 2 – Collect data for each ward

For each ward included, details of costs and the specialty of the patients admitted for a two-month period were collected. For the purpose of the analysis, the specialty of the ward was determined systematically from the classification of individual patient episodes. Where more than 75 per cent of the episodes were within a single specialty, the ward was classified under that specialty; the more mixed the episodes, the more general the classification.

Step 3 – Calculate actual cost per bed

For each ward the costs of:

- London Allowance (if applicable); and
- Time spent manning outpatient clinics

are deducted from the total staff cost of the ward.

The remaining costs are divided by the number of available beds. Adjustments are made for the number of days that beds are closed either temporarily or routinely, as in weekend closure of beds in 5-day wards.

Available beds rather than occupied beds were used because:

- The data on occupied beds were not accurate enough; and
- The pressure on beds means that the number of available and occupied beds is likely to be very similar.

Worked example

Ward C – Cardiology (annual costs)

Total cost	£560,000
London weighting	0
Cost of time spent in clinics	£20,000
Bed days lost to closure	0
Costs used in calculation	£540,000
Number of beds	20
Cost per bed	$£540,000/20 = £27,030$

Step 4 – Calculating relative cost per bed

In this step, the actual costs per bed for a given ward are compared to the predicted average costs per bed of a ward of that type and size. This provides a relative cost for that ward. The actual cost for all wards of that type from step 3 is plotted against the number of beds in the ward. The trend line formed is used to predict the average costs for a ward of the same type and size of wards.

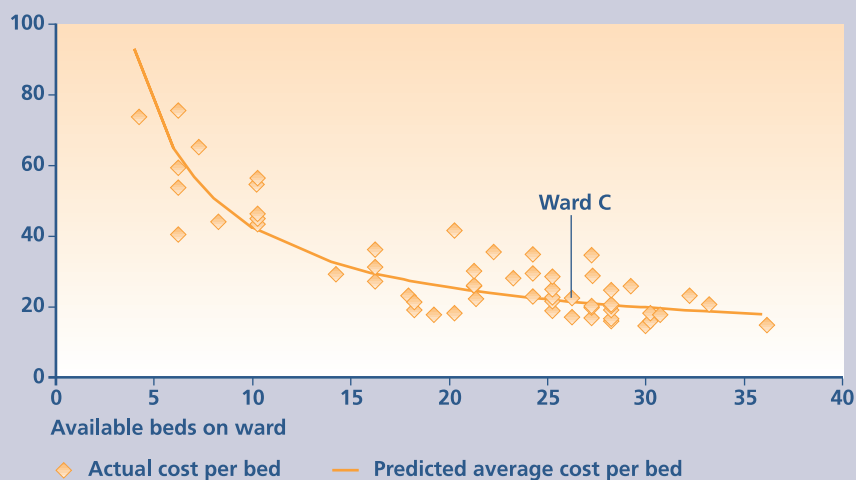
The relative cost for a particular ward is calculated by dividing its actual cost per bed from step 3 by the predicted average cost per bed and multiplying by 100.

Worked example

Ward C – Cardiology (annual costs)

The chart shows the range of costs for Cardiology wards.

Ward staffing cost (£000s pa) per bed



Worked example (cont)

Taking ward C as an example, the figure is calculated as:

Adjusted cost per bed for ward C	£27,030
Predicted average cost per bed for Cardiology ward of 20 beds	£25,500
The relative cost of ward C	$£27,030/£25,500 \times 100 = 106$

Step 5 Calculating relative trust cost

The relative costs of each ward in the trust sample are averaged to calculate relative trust cost for the trust as a whole.

Worked example

Sample of wards

Ward	Relative ward cost	Ward	Relative ward cost
A	102	K	92
B	108	L	105
C	106	M	101
D	98	N	102
E	115	O	92
F	96	P	94
G	95	Q	112
H	99	R	120
I	104	S	105
J	110	T	104
		Total	2060

Average relative ward costs = $2060/20 = 103$

Relative trust cost = 103



acute hospital PORTFOLIO

The Acute Hospital Portfolio is a collection of audits that are available for auditors to undertake at acute trusts, according to local priorities. They focus on key service areas or resources within the trust that are of concern to trust managers and patients. Each year the Audit Commission selects up to four topics from the Portfolio to survey across all trusts. There are three main stages to the survey work carried out in sequence.



The data collection and diagnostic work are the core of the survey and each trust receives from its auditor a tailored assessment of its performance based on the data collected. In-depth audit work is then carried out at only a minority of trusts – those that demonstrably need it. The survey is repeated for each topic within four years so that progress can be monitored both at individual trusts and nationally. A maximum of 16 topics is currently envisaged to allow coverage of all the key issues and service areas.

This review reports the results from the survey of ward staffing. This is one of the first four topics in the Portfolio. Similar reviews have already been produced for each of the other three topics this year: Accident and Emergency, Catering and Day Surgery, and next year: Medicines Management, Medical Staffing, Radiology and Supplies and Procurement.

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