Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board In Public

Date of Meeting: 05 September 2024

Item Number: 09.2

Title of Report: Safer Staffing Bi-Annual Report

Executive Director Lead: Kim O'Keeffe, Dual Chief Nursing Officer / Deputy Chief Executive RCHT

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Purpose of the Report:

Decision ☒ **Discussion** ☒ **Assurance** ☒ **Information** ☒

The report is provided to enable the Board to discharge its accountability in continuing the culture of safe, sustainable, and productive nursing and midwifery staffing, and its responsibility for ensuring that there are proactive, robust, and consistent processes in place for the measurement of safe staffing requirements.

Consultation:

The report has been reviewed and endorsed for approval by the Executive Leadership Team 7 August and the Quality Assurance Committee on 28 August 2024.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	
Quality Impact Assessment completed?			x	

	Yes	No	N/A	Summarise any adverse impacts identified
Data Protection Impact Assessment completed?			x	

Recommendation(s):

The Board is recommended to:

- **Note** that the current report provides a range of data and information that provides assurance to the Executive Leadership team and Board of Directors that nursing and midwifery staffing has been safe across the three RCHT sites.
- **Note** for assurance that national guidance on undertaking the review has been followed and has been robust and engaged ward leaders, clinical matrons, head of nursing with the right level of overview and scrutiny by the corporate nursing team.
- **Note** the inclusion of the national "Model Hospital" data in relation to regional and national performance for Care Hours per Patient Day (CHpPD) and Weighted Activity Unit (WAU).
- **Note** the current position with the Coronary Care Unit not meeting level 2 staffing ratios and there are no concerns in relation to the clinical model and safety outcomes.
- **Note** the current position with the neonatal nurse staffing position and CNST Year 6 actions and proposed way forward.
- **Note** the current position with a programme of work in relation to allied health care professionals across RCHT and CFT which will be available for review at the next review period.
- **Note** the management recommendations and actions:
  - 3 ward internal shift changes that can be facilitated through internal ward changes.
  - A review is undertaken prior to the next SCNT of the variation in ward leader supervisory time to shift and make recommendations.
  - That non-recurrently funded escalation spaces on Zennor, Phoenix and Frailty are considered to be funded substantively as part of the 2025/2026 operating planning round to enable lower cost delivery.
  - The temporary increase to the Trauma Unit template needs to continue to be evaluated in the next review and should a further SCNT review support this, be considered for substantive funding in the 2025 /2026 operational planning round to enable lower cost delivery. Noting the separation of the unit into 2 units; following leadership, safety and quality concerns.

- That Zennor, Frailty. Lowen, Coronary Care, EPOC and Pendennis repeat the tool in September 2024, due to changes in environment and case mix.
- All wards to repeat SCNT in January 2025, to reflect seasonality and winter case mix changes.
- Seek support from the national safer staffing team on the calculation of patient footfall and dependency through the Paediatric Assessment Unit.
- Separate nursing establishments at St Micheals Hospital wards to ensure clear visibility of assigned nursing workforce before next SNCT review.
- Separate the acute paediatric nursing establishments to ensure clear visibility of the assigned nursing workforce before the next SNCT review.
- That following the data collection process, professional judgement reviews and check and challenge, there are no other material changes to establishments following this review at this time.

Bi- Annual Nursing and Midwifery Safer Staffing Report June 2024.

1. Introduction:

The purpose of this paper is to provide clear and credible assurance to the Trust Board, enabling them to discharge their accountability regarding the continued culture of safe, sustainable, and pro-active nursing and midwifery staffing. As evidenced throughout this paper there is a clear, robust, and consistent process in place for the measurement of safe staffing requirements.

The paper outlines the current ward/unit establishment and, following a 30 day data collection of patient acuity and dependency, what the predicted staffing requirements are using a nationally recognised validated tool.

The report was endorsed at the Executive Leadership team meeting 7th August and all the recommendations endorsed for further review and consideration at the Quality Assurance Committee.

2. Background:

There is a statutory requirement as defined by the National Quality Board (2016) and NHS England (2018) to ensure that NHS Provider organisations have processes in place to ensure safe nurse staffing across its departments. It is paramount that as an organisation there are staff with the “Right skills in the Right Place at the Right time,”. This is evidenced in both research and academic literature as having a direct correlation on the safety and quality of care provided to patients.

The patient acuity and dependency data was collected across inpatient clinical areas using the updated and validated Safer Nursing Care Tool (SNCT) from the Shelford Group. The Trust purchased the licences from the Shelford Group for inpatient areas, assessment units, Children’s and Young Person’s areas and the Emergency Department. These purchases are approved by the Dual Chief Nursing Officer.

The tool provides a research-based prediction on the required amount of registered and non-registered nursing hours needed for a department using the acuity and dependency of the patient’s data collected over a 30-day period.

This is the first time that this updated version of the tool has been applied at Royal Cornwall Hospitals Trust (RCHT). See Appendix 1 for the patient criteria. The tool was updated at the end of 2023 to include a separate category for those patients who required enhanced care, they also provided a separate calculator for departments who had a bed base of 75% or above of single side rooms.

Education was delivered across the Trust via the National Safer Staffing team, all those attending were required to achieve a satisfactory pass via written assessment at the end of the training.

Whilst the SNCT gives a predicted number of staff hours required, this cannot be used in isolation. Professional judgement must be applied to increase confidence and validity of the recommended staffing levels as elements due to environment, staff skill and external demands are unable to be captured by the tool.

Nationally the allocation of band 4 staff into registered or non-registered workforce remains ambiguous, which is mirrored locally at RCHT. This is due to some staff holding active registration (Registered Nursing Associates) with the Nursing and Midwifery Council (NMC) and others being unregistered (Assistant Practitioners). Currently there is no national guidance as to where these workers should be placed. Hence it was decided locally they would remain in the registered split in line with the previous reviews here at RCHT. This will be reviewed when any further national guidance is available.

In the review, the Trust has also benchmarked against the national and regional performance for registered and non-registered CHpPD (Care Hours per Patient Day) through the national Model Hospital platform.

3. Changes since last establishment review:

The last nursing and establishment review paper was presented to the board in June 2023. Since then:

- Discharge Coordinators have been implemented in the inpatient areas. They support nursing staff with the planning of patient discharges, liaising with families, community services and social/ charity care to support safe, effective and timely discharges for our patients and release time to care.

- As recommended in the June 2023 review, the Trauma Unit has now spilt into two independent inpatient wards (Trauma 1 and Trauma 2). Staffing has been spilt from the original establishment to support patient care. This has meant that there is a temporary unfunded increase to establishment due to the requirements of staff as two clinical areas instead of one.

- Zennor Ward received an uplift in nursing workforce to support the unestablished increase in beds from 21 to 27 inpatient beds. This is being recruited to substantively but remains unfunded substantively. The ward has been subject to an integrated improvement plan and has changed speciality to Elder Care during the last 3 months.

- Changes within the surgical wards include St Mawes becoming a ring fenced elective ward and Pendennis is now an outlying ward for medicine as well as for elective care.

- A Care Group reconfiguration was completed in early 2024 with the dissolution of the Urgent Emergency and Eldercare Care Group and the movement of some services into the Specialist Services and Surgery Care Group and the remaining merging with Specialist Medicine to become Acute and Emergency Medicine Care Group.

- Boarding spaces are continuing to be utilised in ward areas to support operational pressures.

- The Emergency Department is continuing to recruit to their non funded corridor and ADL escalation spaces which are currently funded non-recurrently.

- Phoenix Ward has 5 beds escalation beds funded non-recurrently as part of the Trust winter plan since the last review

- Lowen Ward has moved into its new location and ward configuration which has seen an increase in side room capacity.

4. Regulatory Interest and Internal Quality Concerns

Since the last establishment paper, the Trust has received regulatory interest from the Care Quality Commission (CQC) for the areas below:

- Tintagel Ward – concerns were raised to the CQC in relation to the ward leadership and standards of care through a whistleblower. These were answered by the Trust with requested evidence. There are no internal concerns in relation to the ward which has continued to thrive under a change in leadership 18 months ago.

- Emergency Department – The CQC undertook a responsive review in urgent care including the Emergency Department. The draft report is awaited. No safety concerns were raised during the visit. The informal feedback received was positive, but some comments were made in relation to capacity in nurse leadership, this is under review within the Care Group and will be triangulated once the drafty report is received.

- Zennor Ward - Concerns were raised in relation to patient safety and quality of nursing care on Zennor Ward – a comprehensive integrated improvement plan had already been implemented by the Trust in November 2023 following the ward triggering on ASPIRE ward accreditation and the ward to board. encompassing the clinical care and development of the individual leaders. The CQC visited Zennor Ward in July 2024 and noted positive improvements since these actions had been taken. At the time of this report the Trust is awaiting the draft report.

Other Internal Quality Concerns

- The Trauma Unit triggered on ASPIRE Ward Accreditation and through a series of formal complaints in relation to professional behaviour, documentation, communication and fundamentals of care. At the request of the Dual Chief Nursing Officer, a quality review was undertaken by the Interim Director of Nursing, Midwifery and Allied Health Care Professionals and Associate Director Of Acute Nursing with the Head Of Nursing and Clinical Matron for the area, with a number of additional actions agreed to their accreditation plan. The unit is currently awaiting a further accreditation visit to assess progress.

5. Daily staffing assurance and meetings:

Outside of the establishment reviews, twice daily staffing meetings are conducted to maintain safe staffing numbers. Since the last review, these have been reviewed and processes have been updated. The changes have been positively evaluated by the teams and has freed up time to care and for Clinical Matrons to be more visible in the clinical areas, has enhanced autonomy for ward leaders with roster management and delivered efficiencies in managing the nursing workforce across the 3 sites.

6. The Nursing Workforce at RCHT:

The Trust's ability to provide great care to our patients is dependent on having a well-rounded, motivated workforce who are stable and knowledgeable. Over the past few years, RCHT has seen its workforce become more multicultural with the continued drive of both international and national recruitment. This helps to support the reduction of vacant band 5 and above roles. There is currently a national shortage of Registered Nurses (RN) which will not be mitigated by domestic training for the near future. Whilst the plan to recruit from outside the United Kingdom (UK) continues, this has been reduced in 2024, as no central funding has been made available from National Health England (NHSE), to support associated costs of relocation, visas and registration process with the NMC, meaning this would need to be found from within RCHT funds.

RCHT continues to promote the use of Registered Nursing Associates (RNA) (Band 4). Since the last review, they have been introduced into areas such as Intensive Care and the Emergency Department. The Trust continues to extend their skill competencies in line with NMC guidance. Whilst there is a drive to increase the skill set for RNAs across the Trust, such as intravenous medication, there needs to be robust training packages for these skills to ensure patient safety. The band 4 RNA cannot replace an RN, but there is clear acknowledgement that they can complement and enhance patient experience, care, safety and further enable job satisfaction, confidence and competency.

In line with the national movement in 2023, RCHT increased the banding for the majority of its Health Care Support Workers (HCSWs) from band 2 to 3. For those who did not already possess the required skills or hold an appropriate qualification, they were given a 12 month period to complete a clinical skills framework or revert back to a band 2 role, noting this role would then not be able to undertake the extended skills. Some posts were retained at a band 2 for staff who did not wish to move to band 3 or for those who were "new to care" as initial training roles. If an individual HCSW role does require a specific skills set not found in the framework, local variance can be applied.

7. Turnover and Current Vacancy Position:

Over the past twelve months, the Trust has seen its turnover reduce. In June 2023 annual turnover was 9.4%. This has continued to reduce and in June 2024 is 8.6%. The Trust has a Key Performance Indicator (KPI) of 7-11% and has maintained its performance within those parameters for the past year.

In June 2024, the Trust reported a 117 Whole Time Equivalent (WTE) Band 5 Registered Nursing vacancies and 57.59 WTE Health Care Support Worker vacancies which is an improved trajectory from February 2024, 139 WTE RN and 102 WTE HCSW. Further work is needed to close down the vacancy factor across both groups.

8. Sickness and Absence:

Sickness and absence has remained relatively static over the 12 months. The Trust has seen a decrease in long term sickness but fluctuation in short term sickness in season changes, for example, seasonal illness or increased COVID prevalence.

In June 2024, the Trust reported a sickness and absence position of 4.79% (Short term sickness 2.61% and long-term sickness 2.17%) compared to a June 2023 sickness position of 5.03% (short term 2.41% and long term 2.63%).

9. National and Regional Benchmarking:

The information used to bench mark the Trust against its peers is from “The Model Hospital system”. Providers submit their local information which is then collated and modelled against both peer and national providers, allowing organisations to draw comparisons of various aspects of activity and outcomes.

9.1. Care Hours per Patient Day (CHpPD):

The Trust is able to benchmark itself against the national and regional performance for registered and non-registered CHpPD (Care Hours per Patient Day) through the national Model Hospital platform. Organisations submit the amount of registered and unregistered hours worked over 24 hours and the number of patients in beds at midnight. This is then divided to give the number of CHpPD, allowing comparison across organisations. This is used as a local and national measure for workforce deployment in inpatient settings and is used to support deployment and as a metric for quality, performance, patient outcomes and productivity.

- Registered CHpPD for the organisation sits within the quartile 1 (there are four quartiles in total) both nationally and regionally. Meaning that our staffing resources on a daily basis sits in the lower part of the recorded hours for national and regional perspective. (Regional and national Peer median 4.9 Provider median 5.0)

- Unregistered CHpPD for the organisation sits within the top of quartile 3 nationally and regionally. Meaning that our unregistered resource on a daily basis sits towards the top of the recorded hours for national and regional perspective. (Regional and national Peer median 3.6 Provider median 3.4)

- When both are combined, they sit within the upper part of quartile 2 for regional and national resource. (Regional and national Peer median 8.4 – Provider median 8.5)

- It should be noted that there is no submission within the model hospital health system for band 4 workers at RCHT, meaning that all band 4 workforce have been recorded under the unregistered workforce.

- Model Hospital data is not live, and therefore the data for this period is not yet available. was not available . It does show that the organisation is performing in-line or slightly better than regional and national peers for CHpPD. This data can be found within Appendix 2:

9.2. Nursing Staff Cost Per Weighted Activity Unit (WAU):

The WAU metric is in essence a productivity measurement used in the Model Hospital system. It allows the reviewer to note an organisation's associated costs compared to the amount of output (WAU Produced). For example, a higher than average nursing staff cost per WAU is indicative of an organisation who spends more on their nursing staff per its activity than a typical organisation.

On review of the most recent data within the system, RCHT is noted as being within quartile 2 for WAU (£914) meaning on review that as an organisation we spend less than the peer median (£929) indicating that we are more productive in our nursing services than others. This data can be found within Appendix 3.

9.3 Actual Versus Planned hours:

The Trust reports nationally monthly on the actual versus planned nursing hours within departments. On review of the data for the past 12 months for RN and HCSW neither metric has dropped below 93% which is above the Trust trajectory threshold.

9.4 Ward Leader Supervisory to Shift and On Costs:

The review has highlighted variation there is variation about supervisory to shift built into departmental rosters this ranges from 60-100% of time across the Care Groups. It is therefore recommended that this is reviewed prior to the next data collection. On costs for departments are set with a minimum of 21.5% which is just below the national profile of 22%, this is not mandated guidance.

10. Data Collection through the SNCT :

Collection of data relating to staffing numbers and patient classification has been formulated through attaining the elements below:

- Data collection has been undertaken using the national Safer Nursing Care Tool (SNCT) from the Shelford Group for adult inpatients, in areas such as the Emergency Department, Acute Medical Unit, and paediatric wards, where a specific version of the tool was applied.
    - Data collection was completed over 30 days (mainly Monday to Friday one weekend was undertaken), providing a robust six-week data set during this time.
    - Refresher training was provided to operational leaders by the national team. This was then cascaded throughout the care groups.
    - In line with the requirements, the data collection is completed at the same time daily (14:00). Ward staff were required to input each individual patient's acuity and dependency score against set parameters.

- For an added level of scrutiny, independent peer reviews were completed to ensure the validity of the results was high. These were allocated from outside of the Care Group.

11. Interpretation of the data:

Each Care Group was responsible for the calculation of their own data – the six week average of patient numbers were entered into the tool, along with the spilt of registered to non-registered staff required on shift. The tool then produced the Whole Time Equivalent (WTE) required for the department based on the data.

To allow the Care Group to apply their professional judgement to WTE predicted, the factors below were also considered:

- Current establishment.
- Prior SNCT establishment prediction.
- Past 12 months Ward to Board data for the department.
- Complaints and patient experience data.
- Prior six months audit results and actions.
- Incidents reports of suboptimal staffing.
- Current and prior ASPIRE rating with associated actions.
- Direct Care Time Audit results.
- Environmental factors.

Specialist areas such as Intensive Care, Neonatal Unit and Theatres have also provided narrative following their own reviews via validated tools / guidance.

Once complied, this data and their professional judgement was presented to the Interim Director of Nursing, Midwifery and AHPs and to the Associate Director of Acute Nursing for further scrutiny and oversight by the relevant Head Of Nursing with their nursing and roster teams.

A breakdown of the current budgeted establishment and the SNCT predictions can be found in Appendix 4 for each Care Group.

Operational Performance

Throughout the data collection period the Trust continued to see increased operational demand meaning that both boarding (an additional patient above the ward template) and TES areas were in operation. Where boarding beds were in use, this patient data has been captured within the tool to ensure the nursing demands of these patients was fully visible.

Across the 30 day collection period, RCHT operational status was classified as OPEL 4 meaning that the organisation was under high pressure. This is the highest level of OPEL levels, detonating increased demand, stress and risk to patient care.

12. Professional Judgement Outcomes

Professional Judgement following meeting with AEM Care Group

- **Emergency Department (ED):** No recommended changes to current establishment, noting the change in patient cohort over the review period.

- **AMU:** One recommended change to current establishment noting the positive improvements that have been seen within the unit. The unit now rosters a band 6 / 7 nurse to every shift ensuring senior clinical leadership is present 24 hours per day. As part of the AMU "Getting it Right First Time" (GIFT) guidelines, a ratio of one nurse to six patients is recommended – not including the nurse in charge, however, currently this is only achieved with the nurse in charge taking a patient caseload. The Care Group will review this internally to determine whether this can be achieved through a skill mix review.

- **Coronary Care Unit CCU:** One recommended change to review in September to ascertain the length of time off ward and number of Cath Laboratory cases conducted by the CCU nursing team. After this there may be a requirement to increase staffing numbers. Currently the unit does not meet national level 2 staffing criteria. However, on review of the activity and SNCT prediction the request is to monitor and review if required.

- **Cardiac Investigation Unit (CIU):** No recommended changes

- **Roskear Ward:** No recommended changes given the lower number of patients requiring enhanced care. Re-assess during the winter period review to capture seasonal illness changes and interdependencies of case mixes across Roskear and Wellington Ward.

- **Wellington Ward:** One recommended change. Repeat SNCT in January 2025 to **understand** if the demand and capacity remains the same in the winter period. Care Group asked to consider review of template to see if twilight shift could be incorporated to support night-time requirement and help support reduction in falls. This would be through internal skill mixing.

- **Phoenix Ward:** One recommended change. Recruit substantively into the unfunded beds as it is unlikely that these will be removed. The ward currently supports these beds through the use of temporary and agency staff. This needs picked up through the 2025/2026 operational planning process.

- **Tintagel Ward:** No recommended changes.

- **Zennor Ward:** One recommended change to repeat SCNT in 3 months' time to assess ongoing impact of change in specialty.

- **Kerensa Ward:** No recommended changes.

- **Acute Frailty Unit:** One recommended change; further review in September 2024, and if the deficit remains consider increasing the template. There is no national guidance for staffing of acute frailty units. The unit was originally set up to function as an SDEC, currently the unit operate as highbred model of SDEC and AFU this is believed to have affected the validity of the data from the SNCT. Currently the unit has no substantive lead despite attempts to recruit and is heavily supported by the clinical matron for, ward leadership.

General Surgery and Cancer Care Group.

- **Lowen Ward:** One recommended change. Between the funded budgeted establishment and the SNCT predicted requirements, there is a positive balance of 13.33 WTE. Caution must be noted on this positive balance as SNCT only advocates for the use of the single room multiplier tool if the bed base is above 75% singles rooms. Lowen is 50%; if the calculation of aggregated to 50% singles rooms, then Lowen ward is in a negative balance of 1.27 WTE. Repeat in SCNT in winter months.

- **Emergency Surgical Unit (ESU):** No recommended change. ESU currently supports the provision of a trolley bay which is not factored into the budgeted establishment along with the Same Day Surgical Area (SDSA), which in times of pressure remains open overnight to support organisational flow.

- **Pendennis Ward:** Two recommended changes. Repeat SCNT in September 2024, due to change in case mix at ward level. Pendennis Ward is an outlier in terms of ward to board performance seeing an increase in patients falls and pressure ulcers. The ward continues to support patients from outside speciality and is currently awaiting the start of their new ward leader. It is there requested that Pendennis' template is increased temporarily to accommodate a 3rd Health Care Support Worker on night shift with re-evaluate at next data collection.

  The Care Group will look to achieve this through skill mix review across areas.

- **Planned Care Unit (PCU):** No recommended changes.

Specialist Services and Surgery Care Group.

- **Wheal Coates Ward:** No recommended changes.

- **Gastro and Liver Unit (GLU):** No recommended changes.

- **Grenville Ward:** No recommended changes.

- **Wheal Prosper Ward:** No recommended changes.

Peripheral Sites and Trauma Care Group

- **Trauma 1:** One recommended change. The current template since the ward spilt into two is currently unfunded. This needs to be reviewed as part of the 2025 / 2026 operational planning process if the SCNT tool process continues to endorse this uplift in the winter review.

- **Trauma 2:** One recommended change. The current template since the ward spilt into two is currently unfunded. This needs to be reviewed as part of the 2025 / 2026 operational planning process if the SCNT tool process continues to endorse this uplift in the winter review.

- **Medical 1:** One recommended change to be made, to consider reduction of HCSW in the day to allow for a twilight shift during the peak nighttime hours. This will be undertaken within existing establishment.

- **Medical 2:** No changes currently, further data collection required to understand if this was an isolated increase – where CHpPD is increased temporary staff have been utilised to ensure safe provision of patient care and staff safety.

- **Maire Theresa House:** No changes recommended.

- **St Joseph's Ward:** One recommended change recommended in that the establishment to be spilt for other clinical areas within SMH for total transparency.

Women's and Children's Care Group

- **Eden Ward:** No recommended changes

- **Acute Paediatrics:** One recommended change. Between the funded budgeted establishment and the SNCT predicted requirements, there is a positive balance of 11.71 WTE (Fistral and Polkerris wards). Currently all acute paediatric rosters are held under one establishment making interpretation of the data challenging. In line with national guidance there is always at least one paediatric nurse on all shifts to support children's care.

  During the data collection period, there were no children who required the support of the paediatric high dependency area which again is staffed from within this template as such there was a large positive balance on Polkerris ward.

  As part of the data collection numbers for attendance within the PAU department were attempted however this was abandoned due to inability to confidently track, this will be revisited at the next collection following discussion and review with the National SCNT team.

Areas below are outside the SNCT review:

Neonatal Unit: The Neonatal Unit is not covered within the SNCT metrics. Staffing should be based on BAPM Neonatal Standards. Currently the nursing template at RCHT is not in line with BAPAM nursing staffing requirements and will not meet CNST Year 6 compliance when benchmarked against activity using the national workforce tool. For the neonatal

nursing calculation, the Trust must comply with 6.07 WTE per post, which significantly affects establishment calculation (25% uplift vs Trust standard 21.5% uplift). This has to be signed off by the ODN network to ensure compliance against the standard.

A case to increase nursing staffing levels to meet these recommendations is being undertaken by the Care Group which sits outside the scope of this paper and regular updates will be provided through the CNST Year 6 updates in the Maternity and Neonatal Safety report to the Trust Board. However, this will be updated on actions taken at the next SNCT review paper.

Maternity: No recommended changes**.** Birth Rate Plus (BR+) is endorsed by the National Institute for Clinical Excellence (NICE) as a tool for the assessment and review of safe midwifery staffing for maternity services and is commissioned bi-annually by the Dual Chief Nursing Officer **/** Deputy Chief Executive Officer.

The Maternity Services received their most BR+ recent report on the 22 July 2024. The report progressing through Care Group governance and Trust Board reporting requirements. Of note the report highlights the increase in complexity and acuity of our women and birthing people. In 2021 65.2% of women and birthing people were in categories 4 and 5, most complex, by 2024 70.6% were placed in these categories. Overall, the results from the BR+ review highlight a positive variance in staffing of 0.28WTE when an uplift of 21.5% is applied however it should be noted that 24% uplift is being discussed nationally and already implemented in some units. It is therefore lightly that this will be mandated in the future.

Following a workforce review which concluded in July 2023, maternity staff are now confidently redeployed to areas where there is increased acuity, resulting in a safe and stable workforce. There were two consultations undertaken in late 2022 within the community midwifery setting to ensure safe staffing.

The recommendation for Maternity Continuity of Carer (MCOC) for women requiring extra nurturing (WREN) is funded at 6.4 WTE to support existing teams. This team has an emphasis on caring for women and birthing people living in areas of high deprivation and those from a black or ethnic minority backgrounds. Recruitment is currently underway; the service will roll out as Midwives are recruited.

A monthly update on maternity staffing including concerns and risks, alongside current vacancy rates is provided to Quality Assurance Committee (QAC) and Trust Board via the Maternity and Neonatal Safety Report. At the time of writing there are no midwifery vacancies within the maternity services with a waiting list

Anaesthetics, Critical Care and Theatres Care Group (ACCT)

Enhanced Perioperative Care Unit (EPOC): One recommended change: EPOC undertook its first SNCT data collection for this review. However, the credibility of the data is in question due to the closure of 3 of the 7 beds for 3 weeks of the data collection due to estate works. It is therefore recommended that a further data collection is conducted in late summer/Autum.

Critical Care Unit: No recommended changes. Critical Care activity and the associated nursing workload are dynamic and can vary significantly throughout a shift. Emergency

admissions and patient deterioration are not predictable, and therefore the number of nurses on shift should safely allow for flexibility to respond to changes in patients' clinical conditions and unit activity and demands.

The nurse staffing standards published in the Guidelines for the Provision of Intensive Care (GPICS) version 2:1 (2022) cite the Core Standards for Intensive Care Units and in the Adult Critical Care Clinical Reference Group Service Specification provide standards for nurse staffing ratios to ensure a positive impact on both quality of care and safety for critically ill patients.

- **Level 3 patients** (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum **1:1** to deliver direct care

- **Level 2 patients** (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum **1:2** to deliver direct care

- **PLUS,** a Clinical Co-ordinator (this person **is not** rostered to deliver direct patient care to a specific patient) 24/7 5

- **Units with greater than 10 beds** will require additional registered nursing staff (this person **is not** rostered to deliver direct patient care to a specific patient) over and above the clinical coordinator to enable the delivery of safe care. The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g., multiple single rooms). Consideration needs also be given during events such as infection outbreak

- An example of this would be 30/05/2024 Critical Care 13 L3 and 6 L2 = 18 RN per shift (made up of 16 RN and 2 RNA).

On recent review of Safe Care Stats, at commencement of shift with - hours (not GPICS compliant) is currently 1/3 of all shifts recorded. There are a small number of shifts in which the hours match exactly (this means GPICs compliant for the patients we have, but no admitting capacity within GPICS). The majority of shifts now have excess hours. The majority of those are <5 hours which does not equal an admitting nurse within GPICs but is a vast improvement on our previous position and a sign of our overall increased safety and move towards meeting the national guidance for Critical Care.

Theatres: No recommended changes. There is no national benchmarking tool for the use in perioperative practice. Guidance is sought via The Association of Perioperative Practice (AfPP).

"Two practitioners are recommended for a list of major surgery unless there is only one case. Two practitioners are recommended for a list of minor surgery that demands a quick throughput or has several cases on it such as for an elective day surgery list."

Within the Trust theatre staffing is set as follows:

- **All elective theatres require.**

Two registered and one unregistered members of staff, plus an anaesthetic practitioner (may drop to one registered if only one case if necessary but an unregistered added).

- **All emergency theatres require.**

Two Registered and two unregistered staff (minimum 2:1), plus a minimum of one anaesthetic practitioner.

- **Recovery Unit**

Ratio of one to one care until patient able to maintain safe airway then move to a ratio of one registered member of staff to two patients. In addition to this there is a designated individual in care and a non-registered staff member to act as porter/housekeeper.

Allied Health Care Professionals:

Demonstrating safe and effective staffing levels is one of the essential quality and safety standards required to comply with the Care Quality Commission (CQC) regulation 18 standard. This requirement is captured within the NHS constitution 2015, and Health Act 2009, which make explicit the Board's corporate accountability for quality.

In 2016, the National Quality Board detailed the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well led care on a sustainable basis.

This assurance model has been adopted by Nursing and Midwifery workforces nationally, with organisations completing annual safe staffing establishment reviews with the published findings presented to executive boards.

At present, there is no mandate for Trusts to report specifically on the safety or effectiveness of the Allied Health Professional workforce. Attempts to standardise Allied Health Professional workforce reporting have been undertaken nationally since 2016 but failed to produce meaningful outcomes. Consequently, the Allied Health Professional Workforce has historically been a blind spot at board level.

This is a similar story in terms of e-job planning for AHP's, it is not a mandated requirement to have e-job plans for AHP's, it is a Long Term Plan (NHS, 2018) commitment for all clinical staff to be deployed utilising either an electronic job plan or roster – both Trusts utilise a roster System. The lack of e-job plans means that genuine Clinical Capacity for an individual / team / service is not known.

There is a renewed enthusiasm from the Office of the National Chief AHP to gain traction in this work nationally, to be able to set expected "Effective" AHP staffing levels in NHS settings – to see meaningful national roll out of any such tool realistically however is years off.

To date it has been left to individual Trusts to develop their own tools (if desired) to demonstrate "Effective" staffing levels – unfortunately, this then means they have reduced use outside of that Trust as it reflects their referral / pathway / criteria patterns.

There are a variety of tools available Nationally to demonstrate aspects of Demand and Capacity but none that reflect the range of pathways within a service or the range of presentations that patients are referred to a service i.e. there are tools that can show the number of new patient slots you need to meet referral demand but they do not demonstrate the capacity you need after the initial assessment for ongoing care and support.

To date AHP service pathway demand and capacity work has not been undertaken in CFT or RCHT. A programme of work has commenced to develop a consistent tool that allows AHP Teams across CFT and RCHT to:

- Be able to accurately articulate their genuine clinical capacity (patient facing time).
- Be able to clearly define the demand on their service throughout their pathway reflecting a range of patient presentations and journeys.
- Identify and demonstrate (with evidence), any significant difference in demand and capacity and seek solutions.
- Provide regular assurance to both Trust boards regarding the level of AHP staffing in each Trust, escalating any significant risks by exception through appropriate Directorates / Care Groups current processes.

  Outputs of this work will be available for the next review period.

Limitations:

This was the first time the SNCT process was undertaken in RCHT with the embedded enhanced care and side room specific tools. The SNCT was undertaken in the paediatric areas for the first time and there was some local learning to support embedded practice which will help to assure at the next review with support from the national SCNT.

Recommendations:

- Note that the current report provides a range of data and information that provides assurance to the Executive Leadership team and Board of Directors that nursing and midwifery staffing has been safe across the three RCHT sites.
- **Note** for assurance that national guidance on undertaking the review has been followed and has been robust and engaged ward leaders, clinical matrons, head of nursing with the right level of overview and scrutiny by the corporate nursing team.
- **Note** the inclusion of the national “Model Hospital” data in relation to regional and national performance for Care Hours per Patient Day (CHpPD) and Weighted Activity Unit (WAU).
- **Note** the current position with the Coronary Care Unit not meeting level 2 staffing ratios and there are no concerns in relation to the clinical model and safety outcomes.
- **Note** the current position with the neonatal nurse staffing position and CNST Yr 6 actions and proposed way forward.
- **Note** the current position with a programme of work in relation to allied health care professionals across RCHT and CFT which will be available for review at the next review period.
-

- **Note** the management recommendations and actions:
  - 3 ward internal shift changes that can we facilitated through internal ward changes.
  - A review is undertaken prior to the next SCNT of the variation in ward leader supervisory to shift and make recommendations.
  - That non-recurrently funded escalation spaces on Zennor, Phoenix and Frailty are considered to be funded substantively as part of the 2025/26 operating planning round to enable lower cost delivery.
  - The temporary increase to the Trauma template needs to continue to be evaluated in the next review and should a further SCNT review support this be considered for substantive funding in the 2025 / 2026 operational planning round to enable lower cost delivery.
  - That Zennor, Frailty. Lowen, Coronary Care, EPOC and Pendennis repeat the tool in September 2024, due to changes in environment and case mix.
  - All wards to repeat SCNT in January 2025, to reflect seasonality and winter case mix changes.
  - Seek support from the national safer staffing team on the calculation of patient footfall and dependency through the Paediatric Assessment Unit.
  - Separate nursing establishments at St Micheals Hospital wards to ensure clear visibility of assigned nursing workforce before next SNCT review.
  - Separate the acute paediatric nursing establishments to ensure clear visibility of the assigned nursing workforce before the next SNCT review.
  - That following the data collection process and professional judgement reviews and check and challenge there are no other material changes to establishments following this review at this time.

Appendix 1.

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: - Patients at risk of a compromised airway - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains - Severe infection or sepsis - New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.

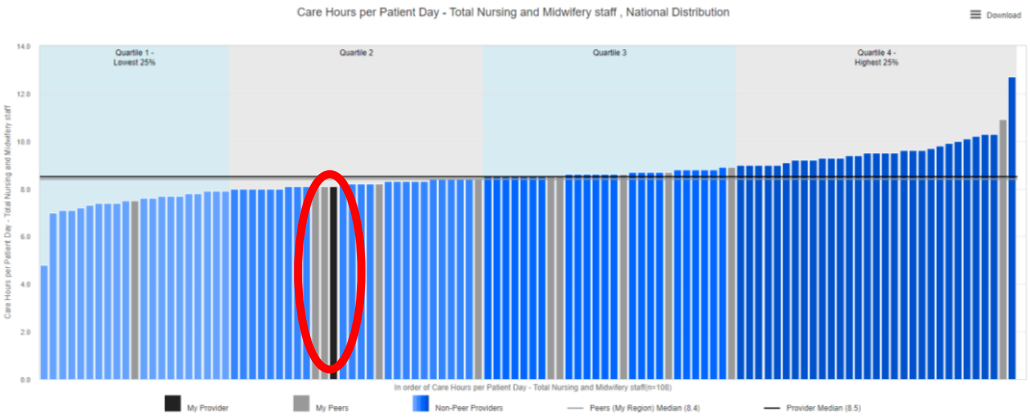
Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: - Greater than 50% oxygen continuously - Requiring close observation due to acute deterioration and needing advanced organ support - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium - CNS depression of airway and protective reflexes - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

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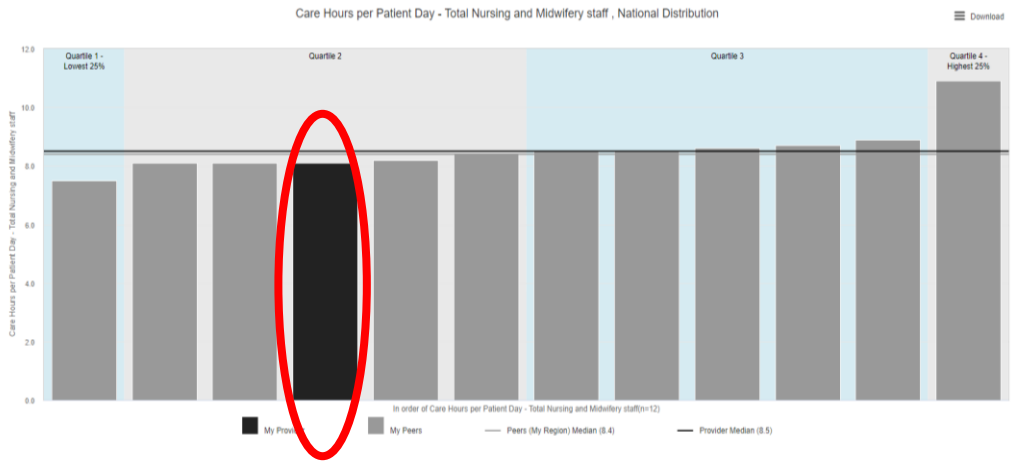
Published October 2023

Appendix 2.

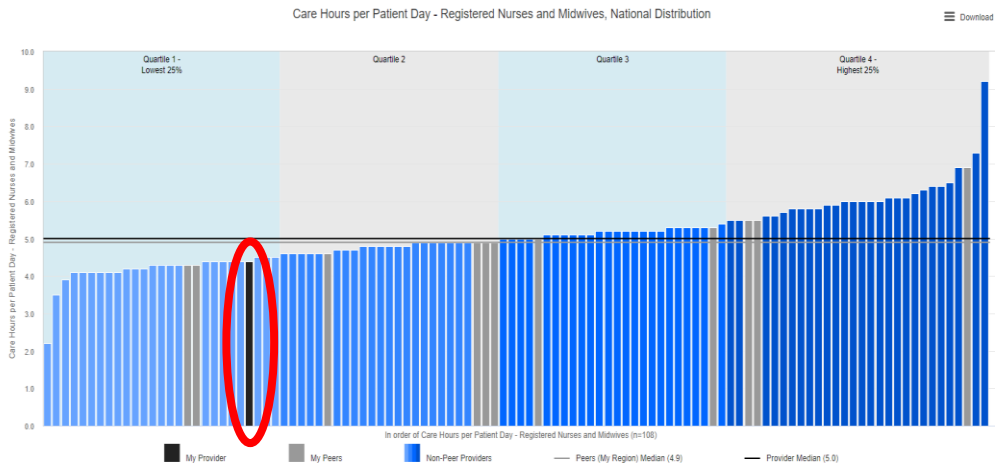
National Profile – Nursing and Midwifery staffing CHpPD:



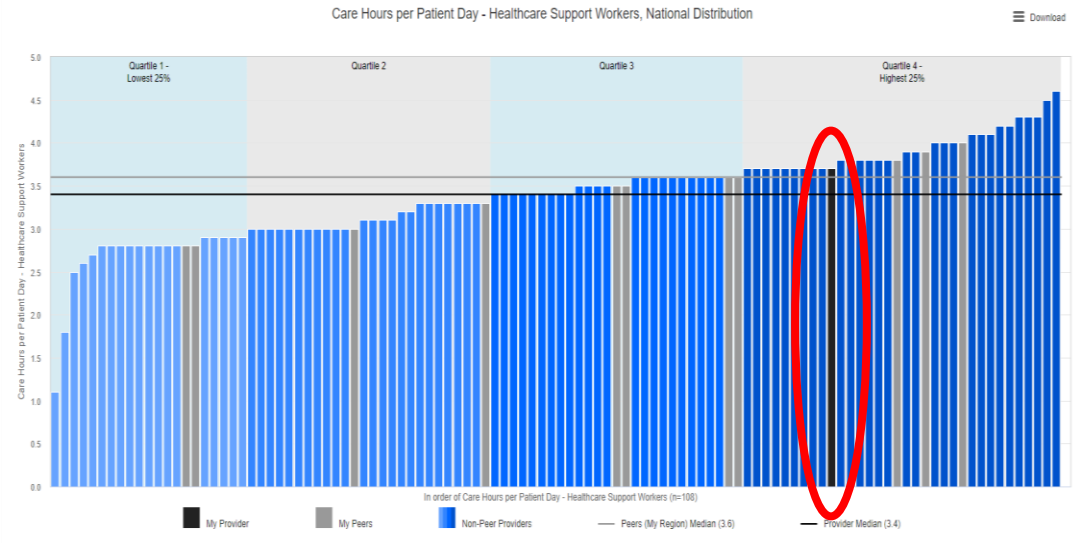
Regional Profile – Nursing and Midwifery staffing CHpPD:



National Profile Registered Nurses and Midwives CHpPD

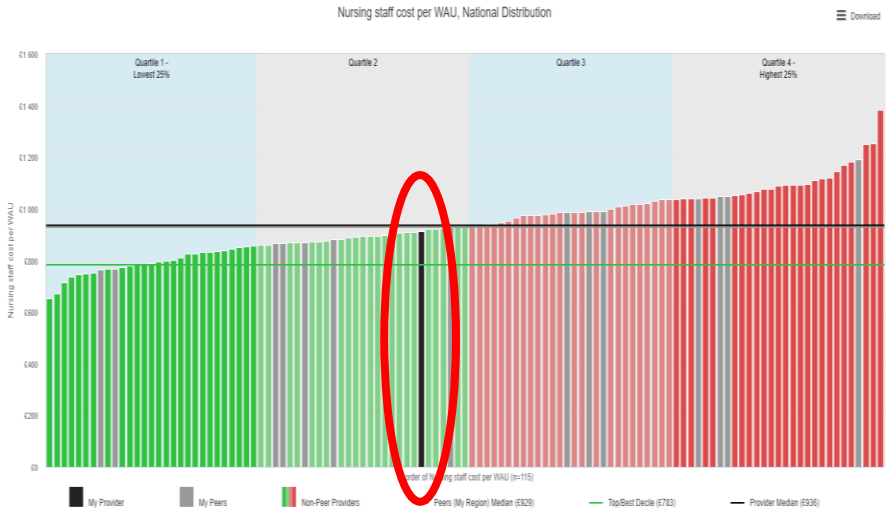


National Profile Health Care Support Workers CHpPD:

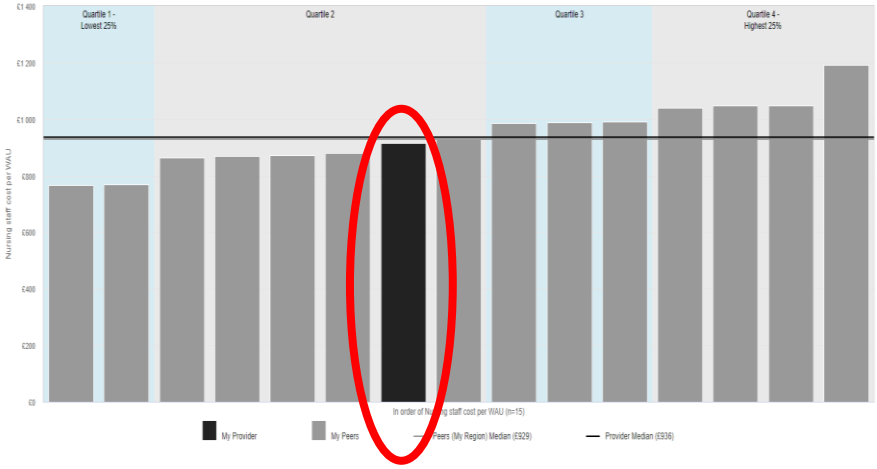

Care Hours per Patient Day - Healthcare Support Workers, National Distribution
Download
Quartile 1 - Lowest 25%
Quartile 2
Quartile 3
Quartile 4 - Highest 25%
Care Hours per Patient Day - Healthcare Support Workers
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
In order of Care Hours per Patient Day - Healthcare Support Workers (n=108)
My Provider
My Peers
Non-Peer Providers
Peers (My Region) Median (3.6)
Provider Median (3.4)

Appendix 3.

Nursing Staff cost per WAU National:



Nursing staff cost per WAU Regional:



Appendix 4. Current establishments and SNCT predictions

Acute and Emergency Medicine:

	Current Establishment		SNCT Predicted Requirement		Variance
	Band 4-6	Band 2-4	Band 4-6	Band 2-4	
AMU	48.36	49.22	63.2	34	**0.38**
CCU	23.39	4.52	18.03	3.43	**6.44**
CIU	14.57	4.46	17.32	5.17	**-3.46**
Roskear	20.45	19.36	16.58	15.93	**7.3**
Wellington	31.08	13.73	33.19	14.91	**-3.29**
Phoenix	28.7	15.54	36.56	19.68	**-12**
Tinatgel	22.87	32.82	19.29	27.76	**8.63**
Zennor	22.8	20.56	21.89	21.03	**0.44**
AFU	20.63	19.14	30.94	28.56	**-19.73**

	Current Establishment		SNCT Predicted Requirement		Variance
	Registered	Non Registered	Registered	Non Registered	
ED	101.19	20.68	122.67	25.54	**-26.34**

Women's, Children's and HIV Care Group:

	Current Establishment		SNCT Predicted Requirement		Variance
	Band 4-6	Band 2-4	Band 4-6	Band 2-4	
Eden	17	13.07	23.81	9.56	**-3.39**
Fistral	20.54	4.76	18.9	9.6	**-3.2**
Polkerris	27.88	8.83	15.1	7.7	**14.91**

	Current Establishment		SNCT Predicted Requirement		Variance
	Band 4-6	Band 2-4	Band 4-6	Band 2-4	
Lowen	29.34	11.4	35.88	18.2	**13.33**
ESU	22.54	9.87	24.04	9.35	**-1.27**
St Mawes	21.3	14.59	33.31	12.57	**-8.99**
Pendennis	18.81	14.86	30.3	11.78	**-8.41**
PCU	15.61	10	16.62	6.46	**2.53**

NB - Lowen is calculated in a normal SNCT model as side rooms do not equate to 75% of bed stock, however of aggregation to 50% beds they are calculated to -1.27 WTE.

Specialist Services and Surgery Care Group:

	Current Establishment		SNCT Predicted Requirement		Variance
	Band 4-6	Band 2-4	Band 4-6	Band 2-4	
Wheal Coates	16.41	16.41	21.11	8.21	**3.51**
GLU	25.14	22.35	34.14	13.36	**2.77**
Grenville	19.17	21.87	25.33	9.76	**6.59**
Wheal Propser	11.94	13.33	13.82	6.26	**5.19**

Peripheral Sites and Trauma Care Group:

	Current Establishment		SNCT Predicted Requirement		Variance
	Band 4-6	Band 2-4	Band 4-6	Band 2-4	
Trauma 1	21.86	22.46	22.71	27.76	**-6.15**
Trauma 2	21.86	22.46	22.65	27.68	**-6.01**
Medical 1	18.2	20.09	20.78	20.78	**-3.27**
Medical 2	17.24	20.84	25.87	25.84	**-13.19**
MTH	14.76	12.68	13.28	13.28	**0.88**
St Josephs	18.58	12.89	17.19	12.5	**1.78**