Royal Cornwall Hospitals
NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 03 July 2025

Item Number: 9.2

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 will be reviewed by the Executive Leadership Team as part of its onward approval process to the Trust Board Of Directors. The report was presented to Quality Assurance Committee in May 2025 and it was noted that planned versus national hours had improved which had supported agency reduction and the phased approach to reduce roster template in the move to THP90 and THP 45. It was recommended for discussion at Trust Board

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	
Data Protection Impact Assessment completed?			x	

Recommendations:

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, heads 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, however, there are no concerns in relation to the clinical model and safety outcomes. Further support required to assess the impact of providing remote telemetry support has been requested from the national team.
- **Note the current position** with the neonatal nurse staffing position and CNST Year 6 actions and proposed way forward.
- **Note the non-recurrently** funded beds currently on Trauma, Phoenix and Zennor Ward
- **Note the current position** with a programme of work in relation to allied health care professionals across RCHT which will report into a June 2025, Executive Leadership Team meeting, and the June 2025, Quality Assurance Committee.
- **Note** the 8 recommendations supported by ELT and Committee below.

1. That the non-recurrently funded escalation spaces on Phoenix are considered to be funded substantively as part of the 2025/2026 operating planning round to enable lower cost delivery.

2. Note that both this and the June 2024 SNCT census results have identified a staffing deficit within the Trauma template which is currently funded non-recurrently and remains a cost pressure.

3. That a phased approach is taken to reduce down the rostered template in the Emergency Department to remove the corridor care and ADL posts if improvements continue to be seen and sustained in the application of THP 90-THP45. This has started week commencing THE 19 May 2025.

4. That should Eden Ward cease to have its day case bay bedded overnight, then the night template can be reduced by 1 health care support worker per night substantively.

5. Coronary Care Unit, Cardiac Investigation Unit, Acute Medical Unit, Roskear, Zennor, Wheal Prosper, Grenville, Gastro-liver unit, and Eden Ward repeat the tool in July 2025, due to changes in environment and case mix.

6. All wards to repeat SCNT in September 2025, to reflect seasonality and case mix changes following Trust reconfiguration to ward areas.

7. Seek support from the National Safer Staffing team on the calculation of remote cardiac telemetry.

8. That following the data collection process, series of professional judgement reviews and check and challenge, that 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. Situation / Executive Summary

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.

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. This remains unchanged in the current changes across NHS England.

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 (Appendix 1). 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.

Education was delivered last year across the Trust via the National Safer Staffing team – this year the Interim Associate Director of Nursing provided refresh training in the week preceding the audit and daily support and oversight was provided via the Clinical Matrons and Heads Of Nursing.

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).

There remains 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. Assessment

3.1 Changes since last establishment review:

The last nursing and establishment review paper was presented to the board in August 2024.

Changes since then:

- The Acute Frailty Unit has closed with patients now cared for across the Acute Medical and Frailty Unit and Zennor Ward, as part of the Acute Medical model transformation programme.

- 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, however, remains funded non-recurrently. The ward has been subject to an integrated improvement plan and has changed speciality due to the closure of the Frailty Unit on the 14 March 2025.

- The ward changes within Acute and Emergency Medicine have resulted in case mix changes on other medical wards for example, Wheal Prosper and Grenville; Grenville has had an increase in admissions of patients with eating disorders since the last review period.

- Roskear and Wellington Ward were both respiratory medicine during the census period.

- Cardiac Investigations Unit (CIU) admit primarily cardiology specialty patients and those awaiting cardiac surgery. The previous day case bay is now used as a 6 bedded inpatient area in addition to 2 radial lounges. This is now a permanent change in ward function.

- 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 providing elective surgical care.

- All escalation spaces were reviewed with 19 additional surge areas identified in January 2025 on Eden, Lowen, CIU, AMU, AFU, Zennor, Kerensa, Tintagel and Phoenix wards to support the introduction of the Total Hospital Protocol (THP90) to support urgent care performance and improve in day patient flow.

- The Emergency Department continue to have non-recurrently funded corridor and ADL escalation spaces.

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

- Trauma 1 and Trauma 2 currently has -16.48 WTE funded non - recurrently to support the template which was approved in the last review.

- Medical Unit Ward 2 at West Cornwall Hospital has a dual function in that it now has a Same Day Emergency Care area for clinical assessment and treatment as part of the Reform Frailty Programme (5 chairs and 1 trolley space, not a 6 bedded bay. This space closes overnight as part of its revised function.)

- St Josephs Ward at St Michaels Hospital has reduced its nurse template to support 6 day operating, with a total full year cost saving of £192 000. Following a consultation the theatres and wards shift patterns have been aligned to start times seen across other areas across the Trust.

- A Clinical Matron role is now part of the establishment in the Emergency Department in response to the Care Quality Commission Urgent and Emergency Care inspection and recommendation in May 2024.

- The process for agency nurse provision has been reviewed across the Trust. The introduction of a national pay cap and an additional level of approval by the Director of Nursing, Midwifery and AHPs or the Dual Chief Nursing Officer, has resulted in a significant reduction in the use of the agency nurse workforce across the Trust. In April 2024 agency nursing expenditure was £82 4973.00 which has reduced to £31 2238 in April 2025 (**Appendix 2**).

3.2 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:

Same Day Medical Assessment Unit

CQC Ref: CAS-476896-H8C1F4

Concern/Request details: **Received 15 July 2024**

Information was received from a whistleblower regarding same-sex accommodation breaches in the Same-Day Medical Assessment Unit (SDMA). They said that new guidelines have been issued to hold patients on the unit for 48 hours on trolleys in mixed-sex circumstances and had been advised not to report same-sex breaches as they would be ignored and answered with operational pressures.

CQC Ref: CAS-611666-L3S0N1

Concern/Request details: **11 November 2024**

Concerns were raised regarding SDMA being bedded overnight despite not having any medical cover and its usage being against its SOP. It was confirmed that SDMA does not form part of the Capacity Management Escalation Plan therefore it is not an escalation space. However, similar to the Emergency Department there are occasions when patients will queue out of SDMA. There was also assurance given that this area is it is sufficiently staffed with substantively if required to remain open overnight.

Same Day Medical Assessment/Newlyn Unit

CQC Ref: CAS-754348-J7N8V4

Concern/Request details: **06 February 2025**

Whistleblower concerns were raised regarding the use of SDMA and Newlyn Unit as escalation areas with overnight bedding of the unit in the absence of dedicated medical or substantive nursing coverage.

SDMA - when bedded overnight is sufficiently staffed with substantive nurse allocation, no clinical concerns have been escalated or reports of same sex accommodation breeches. Similarly, Newlyn had no safety concerns identified when used as an escalation area. There is an inclusion and exclusion-based criteria checklist for this area to ensure that there is minimal impact on next day elective activity or patient safety.

Acute Medical Unit 2

CQC Ref: CAS-503740-F5J1M1

Concern/Request details: **31 July 2024**

Concerns were raised by the CQC relating to observations of care on AMU2 these related to nutrition/hydration, care and the environment. Following an investigation, it was identified that there had been short term sickness which resulted in a slight nursing deficit. The team also confirmed that staff are undertaking extensive training in nutrition and hydration and there are designated domestic staff on the unit seven days a week.

Stroke Unit

CQC Ref: CAS-512283-J9F1D9

Concern/Request details: **07 August 2024**

A complaint was received from a relative about the poor availability of rehabilitation staff on the Stroke Unit. A detailed response was submitted to the CQC explaining the gaps in weekend cover, vacancies within the team at the time and explained a business case was under development including details of staffing levels that would be required based on the updated National Clinical Guidelines for Stroke which were published the previous year. It was noted that the gentleman was admitted on a Friday and was not seen by 2 of the 4 therapy professions until the Monday. This sat outside of the service they aim to deliver, in line with national guidance.

Acute Medical Unit

CQC Ref: CAS-573058-V5K2V1

Concern/Request details: **23 September 2024**

A concern was received regarding the positioning of a patient’s bed and chair in front of the fire exit and fire extinguisher in the bay. The CQC requested a copy of our standard operating procedure for boarding spaces, in particular the location of these spaces in relation to fire exits. A copy of the Standard Operating Procedure: Accommodating Additional Patients where a Bedspace is not available - Boarding and Temporary Escalation Space (TES) was submitted this has been endorsed by the Fire Officer, Authorised Engineer, and has been reviewed by the local fire authority.

Tintagel Ward

CQC Ref: CAS-756329-S5B3R3

Concern/Request details: **14 February 2025**

Concerns were received regarding care on Tintagel Ward related to covert administration of medication, delays in care, tea and medicine rounds. A copy of “The Medicines Policy Chapter 5: Preparation and Administration” was provided to the CQC to assure that this method of administration was in line with policy and confirmation that fill rates for staffing on this ward were in excess of 96% with Safe care escalation process Trust wide.

3.3. Other Internal Quality Concerns

Neonatal and Maternity skill mix and staffing levels remains a concern due to the inability to attract nurses/midwives with specialist skills. The majority of staff recruited are inexperienced requiring training and support from existing staff.

Therefore, the Neonatal staffing risk is extreme (16) due to high maternity leave, managed high sickness rates and the challenges of recruitment of a specialist workforce. This will directly impact the qualified in specialty (QIS) workforce which has a national requirement of 70%, in May 2025 - 32.8 % of the RCHT neonatal workforce is QIS.

However, the Neonatal Unit has only closed to the network three times in the last twelve months due to agreed mitigations which include daily review of staffing template, utilising ward leader, practice educator and clinical matrons clinically. There has also been executive approval to offer enhanced payment for bank hours and to keep the unit as safe as possible during this challenging period.

There has been ongoing collaboration and service improvements which include:

Partnership between Maternity regarding Neonatal Transitional care (TC) workforce. In the last year they have recruited to a band 7 lead role, band 4 nursery nurse and band 6 Midwifery specialists / Neonatal Nurses. The newly recruited Transitional care CSF will be monitoring and developing the competencies and education within the team.

Shift leader supported to complete ANNP apprenticeship to join medical rota after qualification in Sept 26 requiring additional study time and causing another decrease in available workforce.

Zennor Ward has undergone several changes over the last year, following the closure of the Acute Frailty Unit. Nursing staff were redeployed, a new substantive Ward Leader was appointed, and the ward now has a clear patient specialty identity. During their recent ward accreditation visit in April 2024, there was a slight improvement resulting in a bronze award.

The Acute Medical Unit (AMU) is still functioning as a medical ward however it is anticipated following the implementation of the second phase of the Acute Medical Model they will return to functioning as an acute AMU receiving the medical take direct. Staff in the run up to this have undertaken triage training. Low level quality concerns have remained, and focus continues completion of nursing assessments and the application of timely and effective handover processes.

The Trauma Units remain a concern, the vacant Clinical Matron post has part-time temporary cover. However there has been some improvement in their ward accreditation percentages, both wards remain at a bronze with Trauma 1 scoring 80% (December 2024) and increase from 70% (August 2024) and Trauma 2 – 74% (May 2025) from 76% (October 2024).

ASPIRE

Since January 2025 there has been a focus on RCHT ASPIRE Accreditation, this included the inpatient ward and outpatient departments with support to complete the implementation in the additional areas of theatres and maternity.

15 visits have been undertaken in the last 4 months. Seven inpatient wards are currently rated as white Grenville, Enhanced Post Operative Care Unit (EPOC), Polkerris, Fistral, Clic and Harlyn, Acute Medical Unit (AMU), Emergency Department (ED) and Marie Therese House. One of these areas, Fistral, Clic and Harlyn, is overdue a follow up assessment with their last assessment taking place November 24.

Overall, out of all the inpatient wards, there are a total of 4 inpatient wards who have not received an up-to-date assessment. Aside from Fistral, Clic and Harlyn, these have all previously been rated as bronze.

The themes of those rated white are:

- Safe Effective Rostering Fairly (SERF); All areas rated as white scored below 60%. SERF scores are affected by operational demands within departments such as additional beds requiring additional duties to be added to rosters. However, elements such as annual leave allocation, roster performance and approval time remain under the care groups direct control.

- Direct Care Time, although improved there remains an issue with some areas not submitting results consistently. 3 of the areas rated as white did not submit. The remaining areas that did submit, all but one area scored below 70%.

- Climate Survey: all areas, but one, failed to reach the 50% threshold for survey completion.

- QUESTT; the areas that submitted a QUESTT all scored below 80%, with the majority scoring below 50%.

- Documentation: all areas scored below 80% for the documentation audit.

- Environmental; although many questions feature in the low scoring questions, patient notes and workstations not being secured featured across most areas.

- Patient experience: low scoring includes patients knowing who the staff are caring for them and being aware of their discharge plan.

- Standards of care: there appears to be gaps in staff knowledge in relation to clinical school, the Nursing Midwifery and Allied Health Professional vision, and research activities.

3.4 Daily staffing assurance and meetings:

Outside of establishment reviews, each care group reviews their staffing levels and attends the once-a-day Trust wide Safe care staffing meetings to maintain safe staffing levels. Any deficit or areas of concern are escalated to the Associate Director of Acute Nursing, and if required to the Director of Nursing, Midwifery and AHPs or the Dual Chief Nursing Officer.

3.5 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.

However, the international recruitment pipeline has decreased due to lack of national funding. Optioneeriing workforce meetings were attended by all Care Groups since the last report.

This was a data driven exercise supported by the South West programme teams which enabled an in depth consideration of all workforce supply alternatives and exploration to find the best or preferred option There is a drive across the Trust to focus on the 'Grow your Own' initiative successfully implemented in Critical care and EPOC, to support Health Care Support Workers (HCSW) with funded apprenticeship routes into Registered Nurse Associate (band 4) or Registered Nurse roles.

3.6 Turnover and Current Vacancy Position:

Over the past twelve months, the Trust has seen its turnover remain static. In June 2024 annual turnover was 8.6% and in March 2025 it was 8.5%. The Trust has a Key Performance Indicator (KPI) of 7-11% and has maintained its performance within those parameters for the past year.

In March 2025, the Trust reported 73.61 band 5 registered nurse and +17.14 band 3 health care support worker whole time equivalent vacancies (WTE) this has reduced from 117 and 57.59 in June 2024.

3.7 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 for example norovirus and flu.

In March 2025, the Trust reported a sickness and absence position of 4.57% (Short term sickness 2.51% and long-term sickness 2.05%) compared to a June 2024 sickness position of 4.79% (short term 2.61% and long term 2.17%).

The Peripheral Site Care Group has the highest sickness levels at 6.01%, followed by Anaesthetist Critical Care and Theatres Care Group – 5.34% and Acute and Emergency Medicine – 5.11%.

3.8 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.

3.9 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 2 (there are four quartiles in total) both nationally and regionally. Meaning that our staffing resources on a daily basis sits in the lower half of the recorded hours for national and regional perspective. (Regional and national Peer median 8.6 Provider median 8.5) This is an improvement from the last report in May 2024 when we were in the lowest quartile.

- 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 3.4 Provider median 3.3)

- When both are combined, they sit within the lower part of quartile 2 for regional and national resource. (Regional and national Peer median 8.6 – 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 3.

3.10 Nursing Staff Cost Per Weighted Activity Unit (WAU):

On review of the most recent data within the system (2023/2024), RCHT remains within quartile 2 for WAU at £928 meaning on review that as an organisation we spend less than the peer median (£1,023) indicating that we are **more productive** in our nursing services than others. This is unchanged from the last report. This data can be found within **Appendix 4.**

3.11 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 the average monthly fill rates are over 95%, however, neonates and paediatrics have had several months of metrics that dropped below 93% since the last census that is below the Trust trajectory threshold.

3.12 Ward Leader Supervisory to Shift and On Costs:

All RNs and HCAs in inpatient areas have 21.5% headroom allowance Some care groups have assigned all, or part of, their 3.75% establishment headroom for sickness and 15% annual leave cover to temporary staffing lines. Others have included this headroom within some, or all, of their substantive staffing lines. Finance are going to discuss with Care

Groups a standardised approach. On costs for all wards and departments are set at the minimum of 21.5%.

3.13 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. Support was taken from the National Team in relation to interpretation of the Children and Young Peoples tool.

- Data collection was completed over 30 days within the time period of the 27 January to the 9 March 2025 (mainly Monday to Friday one weekend was undertaken), providing a robust six-week data set during this time.

- Training was provided to operational leaders by the national team last year and refresher sessions were delivered by the Interim Associate Director of Acute Nursing this year. 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.

3.14 Interpretation of the data:

Each Care Group was responsible for the calculation and oversight 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 detailed in their section within this report.

Following completion, this data and their professional judgement was presented to the Interim Associate Director of Acute Nursing, the Director of Nursing, Midwifery and AHPs and a senior finance manager 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 5** for each Care Group.

3.15 Operational Performance

Throughout the data collection period (27 January 2025 – 3 March 2025) the Trust continued to see increased operational demand. Additional surge spaces were identified for boarding (an additional patient above the ward template) these were a combination of beds and chairs. Where surge spaces were in use, this patient data has been captured within the tool to ensure the nursing demands of these patients was fully visible.

Across collection period, RCHT operational status was classified as OPEL 4 as 60% (63% weekdays and 50% weekends) OPEL 3 – 38% (37% weekdays and 42% weekends) and OPEL 2 – 2% (weekdays – 0% and weekends – 8%). During this period there were on average 98.64 patients with No Criteria to Reside at midnight.

3.16 Professional Judgement Outcomes following meetings with each Care Group.

AEM Care Group

- **Emergency Department (ED):** No recommended changes to current establishment. The non-recurrently funded roster to support corridor and ADL escalation space should cease when improvements in the Clinical Vision for Flow programme have been sustained for 3/12. In the interim the utilisation of the corridor space has been reviewed resulting in time shifting one RN shift from long day to twilight shift. There has also been a request to develop the role of the nurse associate within the department to increase in the template requirements and reduce band 5's. however, these are not included within this data collection.

- **AMU:** As part of the AMU "Getting it Right First Time" (GIFT) guidelines, a ratio of one registered nurse to six patients (1:6) is recommended – not including the nurse in charge. With the current staffing template on a day shift of 9+1 (AP) with a bed base of 54 patients this is achievable however with the 4 additional temporary boarding spaces makes a ratio of 1:6.4.

Overnight staffing is 8+1 (AP) (excluding the Nurse in charge) the ratio is 1: 6.75 patient. The 4 additional temporary boarding beds results in staffing radio of 1: 7.25.

If the AMU boarding beds were not utilised, they would have the correct staffing ratios during the day. The unit rosters a band 6 / 7 nurse to every shift ensuring senior clinical leadership is present 24 hours per day.

Therefore, it is recommended that there are no changes except to repeat the census in 3 months to review the impact of the Acute Medical Model phase 2 changes.

- **Coronary Care Unit CCU:** Recommended actions required for the next review is to ascertain the number of telemetry patients per day that are monitored by the CCU nurses, is there an increasing or decreasing trend and how many hours staff are required to work in the cardiac cath lab. Currently the unit does not meet national level 2 staffing criteria. Advice has been obtained from the Regional SNCT team to ascertain if there is scope within the SNCT process to measure remote telemetry hours. They advise that this is captured as additional activity and brought into the professional judgement conversations as these patients are captured in the CIU census. On review of the activity and SNCT data the request is to monitor and repeat census in 3 months, no current changes are required.

- **Cardiac Investigation Unit (CIU):** The unit function has changed significantly in the last 2 years. The day case bay is now an inpatient area and open 24/7 whereas previously closed over the weekend, with no increase in template staffing. Since the last census there has been ward reconfiguration to a cardiology only ward resulting in more 1b patients and increased length of stay through cardiac surgery waiters which previously were cared for on Roskear Ward. The current census reflects these changes, and it is recommended to repeat the census in in 3 months alongside length of stay data to determine whether changes to the weekend template are now required.

- **Roskear Ward:** Since the last census this ward is now primarily respiratory medicine and general medicine, noting that there is seasonal flux due to respiratory type illnesses it is recommended that the census should be repeated in 3 months' time.

- **Wellington Ward:** Previous report recommended to repeat in January 2025 to capture Winter data which has been completed via this census. No recommended changes at this time.

- **Phoenix Ward:** No recommended changes to current template. The unfunded beds will cease as part of the planned ward changes via the Planned Care Unit closure and reconfiguration of Phoenix Ward into the 21 bedded template of St Mawes.

- **Tintagel Ward:** There has been a sharp increase in acuity on the template reflected in the number of the chest wall pathway changes and care of all medical tracheostomy patients. They have skill mixed within current establishment to resulting in an increase in both band 4 and the band 6 posts. establishment. When fully recruited this will result in a band 6 on duty 24 hours a day, seven days a week. The review has supported these changes. No further recommended changes at this time.

- **Zennor Ward:** 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 however remains funded non-recurrently. The ward has been subject to an integrated improvement plan and has changed speciality due to the closure of the Frailty Unit on the 14 March 2025. Recommended to repeat the census in 3 months.

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

General Surgery and Cancer Care Group.

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

- **Emergency Surgical Unit (ESU):** The Same Day Surgical Assessment area was opened to provide clinical assessment and treatment from 7:00 – 22:30 for 5 days a week and 7:00 – 19:30- on this consists of 12 chairs within the ESU ward template. No recommended changes.

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

- **Planned Care Unit (PCU):** No recommended changes. Potentially closing to bring the patients nearer to the post-operative higher care unit and theatres. A staff consultation paper was presented at JCNC on the 13 May 2025. This proposes to redeploy 15.61 WTE – band 2-7 throughout the general, surgery and cancer care group. This will fill all vacancies leaving an excess of 1.06 to be redeployed Trust wide.

Specialist Services and Surgery Care Group.

- **Wheal Coates Ward:** No recommended changes. Next census needs to capture how may hours of care are provided to patients with tracheostomies, this additional activity is currently staffed via Kernowflex temporary workforce.

- **Gastro and Liver Unit (GLU):** No recommended changes – repeat census in 3 months.

- **Grenville Ward:** No recommended changes – repeat census in 3 months.

- **Wheal Prosper Ward:** No recommended changes – repeat census in 3 months following template changes.

Peripheral Sites and Trauma Care Group

- **Trauma 1:** Since the ward split in 2023 there has been a staffing deficit this was highlighted in the June 2024 paper with request to repeat census during the Winter to confirm the requirement to fund the uplift. This review confirms that there is both a registered and unregistered staffing deficit, request for Head of Nursing to review requirement ensuring that there is a ‘Grow your Own’ pathway utilising the role of the registered nurse associate.

- **Trauma 2:** Since the ward split in 2023 there has been a staffing deficit this was highlighted in the June 2024 paper with request to repeat census during the Winter to confirm the requirement to fund the uplift. This review confirms that there is both a registered and unregistered staffing deficit, request for Head of Nursing to review requirement ensuring that there is a ‘Grow your Own’ pathway utilising the role of the registered nurse associate.

- **Medical 1:** Following the last census in June 2024 there has been an increase of one health care assistant on nights provided from within the existing template – no additional funding was required. This has resulted in safer staffing levels for enhanced care patients and recommendation for no further changes following this census.

- **Medical 2:** One bay in Med 2 is now a same day emergency care area (excluded from this audit) – providing a facility for direct admission and assessment during the daytime. The previous SNCT found a staffing variance of -13.19 (Band 4-6 = 8.63 Band 2-4 = 5. This census identified a reduced deficit of -1.08 (Band 4-6 = -4.8 Band 2-4 = +1.2).

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

- **St Joseph's Ward:** No recommended changes however noting that breast surgery is moving to RCHT this may impact on the patient acuity staffing required. To be reviewed in next census.

Women's and Children's Care Group

- **Eden Ward:** No recommended changes, A deficit of 7.91 WTE was identified (Band 3-4 = +2.47 Band 5-6), due to the ongoing use of the day case area as an inpatient four bedded bay. Repeat in 3 months. An additional HCA is part of the roster 7 days per week due to the use of the Day Case Area overnight as part of the Trusts escalation plan. This could be removed should the Day Case Area not be used going forward.

- **Acute Paediatrics:** No recommended changes – it is recognised that the SNCT tool does not accurately calculate the Paediatric Assessment Area activity as was not designed to capture this data. The Head of Nursing has met with the National Lead for SNCT for Children and young person's lead to gain advice. This census will be repeated when the new tool is launched – provisional date July 2025.

3.16 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 in line with BAPAM nursing staffing requirements based on data from December 2024 - March 2025 due to lower activity on the unit but will not meet CNST Year 7 compliance due to the percentage of Qualified in Speciality (QIS) staff.

An action plan has been submitted for year 7 compliance which will include extra resource into education to support more staff to attend QIS training. With regards to nurse recruitment, there has been a successful recruitment drive with only 0.8 Band 5 vacancy remaining, however, most of these new recruits will not be QIS trained.

Maternity: Birthrate Plus (BR+), endorsed by the National Institute for Health and Care Excellence (NICE), is the nationally recognised tool for assessing and reviewing safe midwifery staffing levels in maternity services. It is commissioned biennially by the Dual Chief Nursing Officer / Deputy Chief Executive Officer. Maternity Services continue to operate within the establishment set by BR+, with the next full reassessment scheduled for 2027.

Following a comprehensive workforce review in December 2024, the maternity staffing risk was escalated and reopened as an extreme risk, rated 16. This escalation was due to ongoing concerns about safe service delivery, with an average of 34% of clinical midwifery staff unavailable to work clinically each month - primarily due to maternity leave. The risk score was calculated using retrospective staffing data from the past 24 months, alongside projected leave.

Subsequent mitigations have been implemented, including approval to over-recruit 10 WTE midwives within the existing staffing budget and the addition of 3 Kernowflex-only staff. As a result, the current risk rating has been reduced to 10. Further reduction to a score of 8 is anticipated with the development and implementation of a dedicated maternity recruitment and retention strategy, designed to support a sustainable workforce model.

The Enhanced Continuity of Carer (ECoC) model is currently funded at 6.4 WTE and is now fully staffed. This team focuses on providing targeted care for women and birthing people from areas of high deprivation, as well as those from Black and minority ethnic backgrounds, in alignment with national equity objectives.

Maternity staffing data, including current vacancy levels, emerging risks, and workforce concerns, is reported monthly to the Quality Assurance Committee (QAC) and the Trust Board via the Maternity and Neonatal Safety Report. As of this report, there are 5.67 WTE midwifery vacancies, which are posts approved specifically to accommodate anticipated maternity leave through over-recruitment and 0 vacancies for Maternity Support Workers.

Anaesthetics, Critical Care and Theatres Care Group (ACCT)

Enhanced Perioperative Care Unit (EPOC): No recommended changes – noting that there is now a nursing associate on every shift.

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.

For example, if Critical Care had 13 x L3 and 6 x 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.

Critical care has maximised the implementation of the registered nurse associate (RNA) at a ratio of 1 per 10 beds (2 per shift) as part of their successful 'Grow Our Own' pathway.

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 reduce 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.

3.17 Allied Health Care Professionals:

There is no mandate for Trusts to report specifically on the safety or effectiveness of the Allied Health Professional (AHP) 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 under-represented at Board level. Allied Health Professionals are an integral part of the RCHT workforce, often embedded in multidisciplinary teams and working to enable and deliver high quality care to patients.

Tools for determining demand and capacity and recommended staffing levels for AHP's are limited/not available. To date it has been left to individual Trusts to develop their own tools (if desired) to demonstrate "effective" staffing levels. This restricts the ability to benchmark services and give Board assurance as a whole regarding the most effective and safe use of the AHP workforce. A one size fits all approach would have limitations in a professional group that encompasses 14 diverse professions across many different areas of service delivery. However, a means of representing and reporting to the Board is needed, to support dialogue, accountability and quality within our Trust AHP workforce.

A joint paper outlining the current position for AHP's is being finalised with the Clinical Support Care Group and will be presented to a June 2025, Executive Leadership team meeting and June 2025, Quality Assurance Committee. It will contain proposals for approval for the current therapy redesign work.

Limitations – Nil identified.

4. 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. Further support required to assess the impact of providing remote telemetry support has been requested from the national team.

- **Note the current position** with the neonatal nurse staffing position and CNST Year 6 actions and proposed way forward.

- **Note the non-recurrently** funded beds currently on Trauma, Phoenix and Zennor Ward

- **Note the current position** with a programme of work in relation to allied health care professionals across RCHT which will report into a June Executive Leadership team meeting and the June Quality Assurance Committee.

- **Note** the 8 recommendations approved by ELT and Committee:

    1. That the non-recurrently funded escalation spaces on Phoenix are considered to be funded substantively as part of the 2025/2026 operating planning round to enable lower cost delivery.

    2. Note that both this and the June 2024 SNCT census results have identified a staffing deficit within the Trauma template which is currently funded non-recurrently and remains a cost pressure.

3. That a phased approach is taken to reduce down the rostered template in the Emergency Department to remove the corridor care and ADL posts if improvements continue to be seen and sustained in the application of THP 90-THP45. This has started week commencing 19 May 2025.

4. That should Eden Ward cease to have its day case bay bedded overnight then the night template can be reduced by 1 health care support worker per night substantively.

5. That Coronary Care Unit, Cardiac Investigation Unit, Acute Medical Unit, Roskear, Zennor, Wheal Prosper, Grenville, Gastro-liver unit, and Eden repeat the tool in July 2025, due to changes in environment and case mix.

6. All wards to repeat SCNT in September 2025, to reflect seasonality and case mix changes following Trust reconfiguration to ward areas.

7. Seek support from the National Safer Staffing team on the calculation of remote cardiac telemetry.

8. 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.

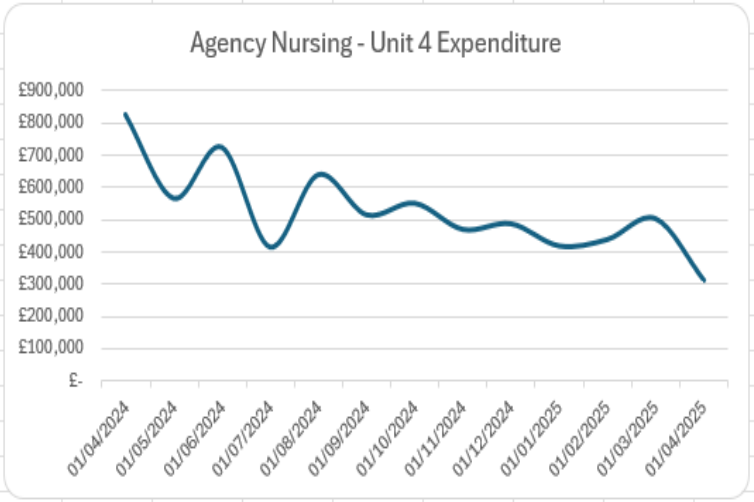
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Appendix 2.

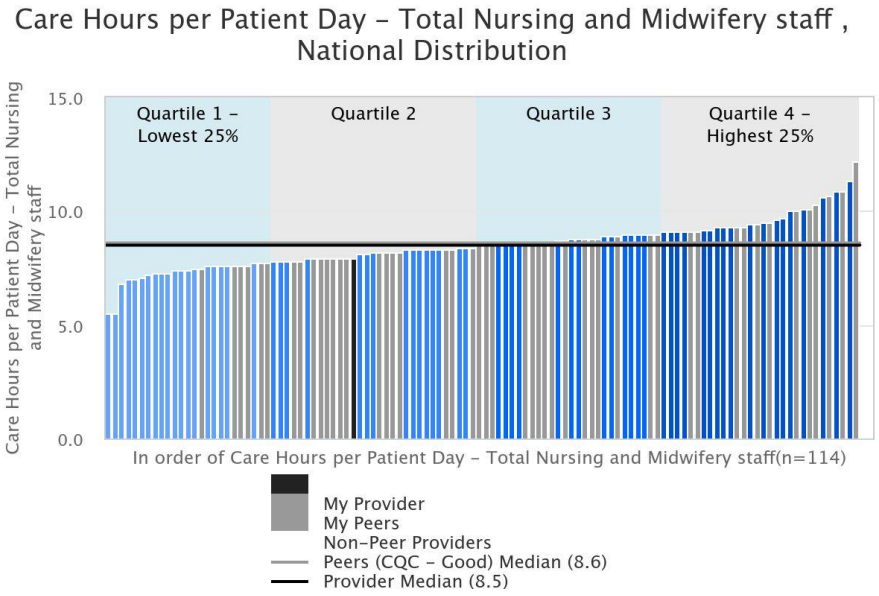
RCHT Agency Nurse Expenditure – April 2024 – April 2025.

Pay Category	Staff Category	Date	Value
Agency	Qualified Nursing	01/04/2024	£824,973.00
Agency	Qualified Nursing	01/05/2024	£565,699.00
Agency	Qualified Nursing	01/06/2024	£723,773.00
Agency	Qualified Nursing	01/07/2024	£414,653.00
Agency	Qualified Nursing	01/08/2024	£638,900.00
Agency	Qualified Nursing	01/09/2024	£514,638.00
Agency	Qualified Nursing	01/10/2024	£550,499.00
Agency	Qualified Nursing	01/11/2024	£469,422.00
Agency	Qualified Nursing	01/12/2024	£486,985.00
Agency	Qualified Nursing	01/01/2025	£418,270.00
Agency	Qualified Nursing	01/02/2025	£438,268.00
Agency	Qualified Nursing	01/03/2025	£502,719.00
Agency	Qualified Nursing	01/04/2025	£312,238.00

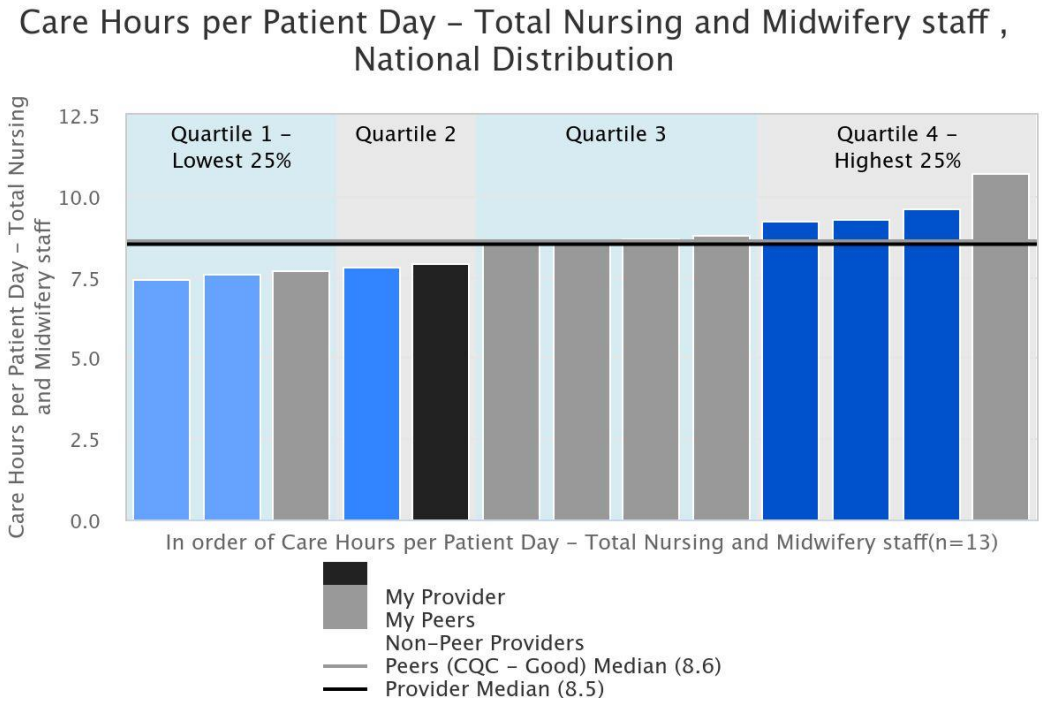


Appendix 3.

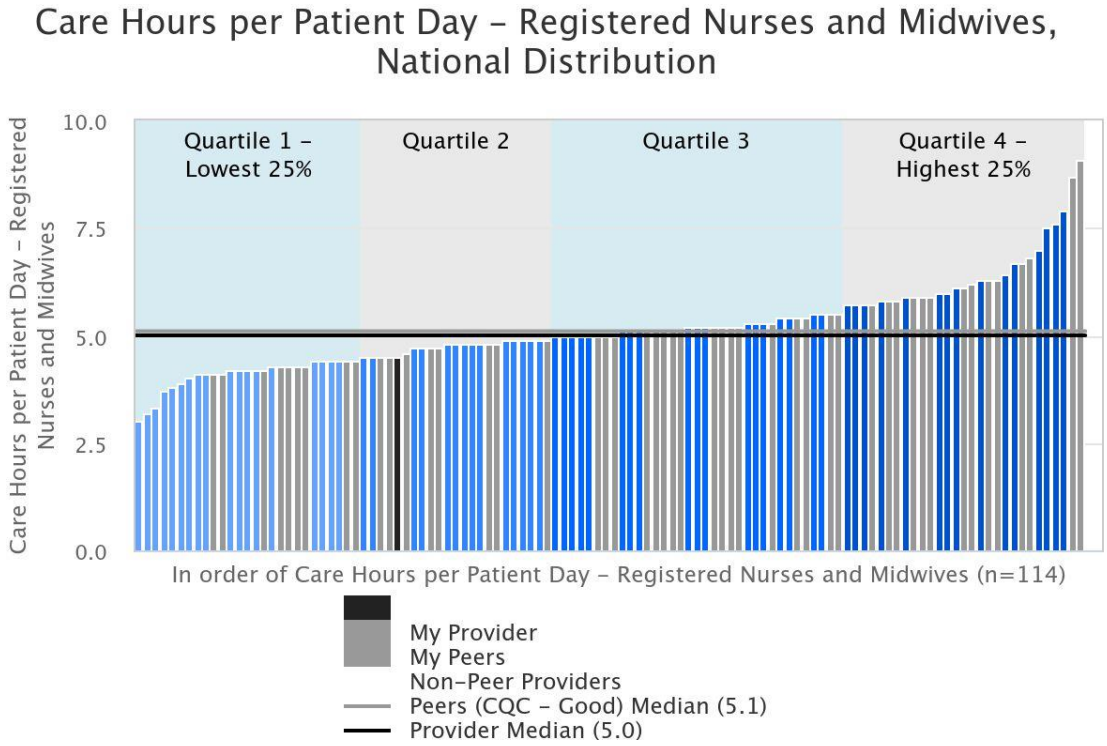
National Profile – Nursing and Midwifery staffing CHpPD:



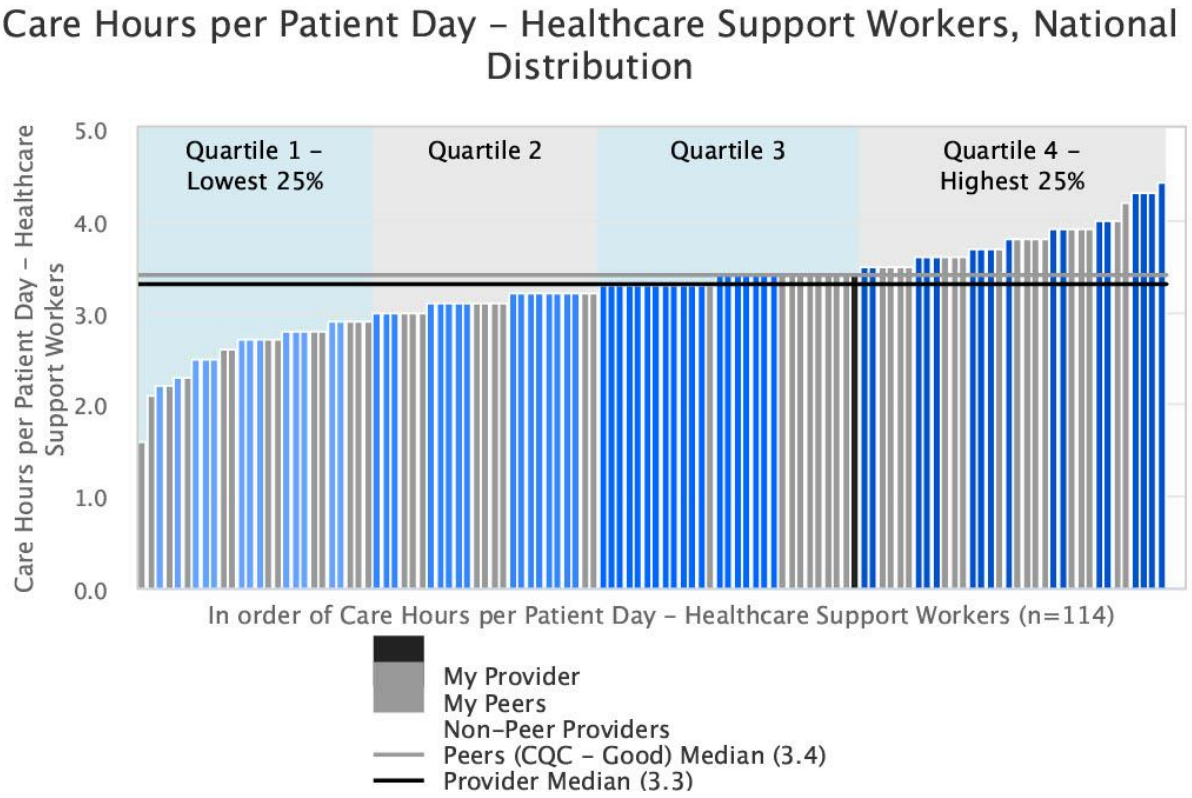
Regional Profile – Nursing and Midwifery staffing CHpPD:



National Profile Registered Nurses and Midwives CHpPD:

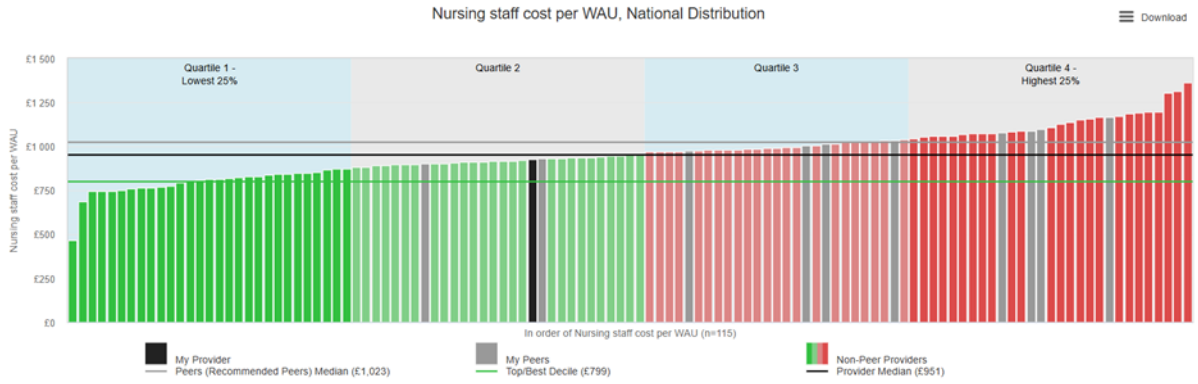


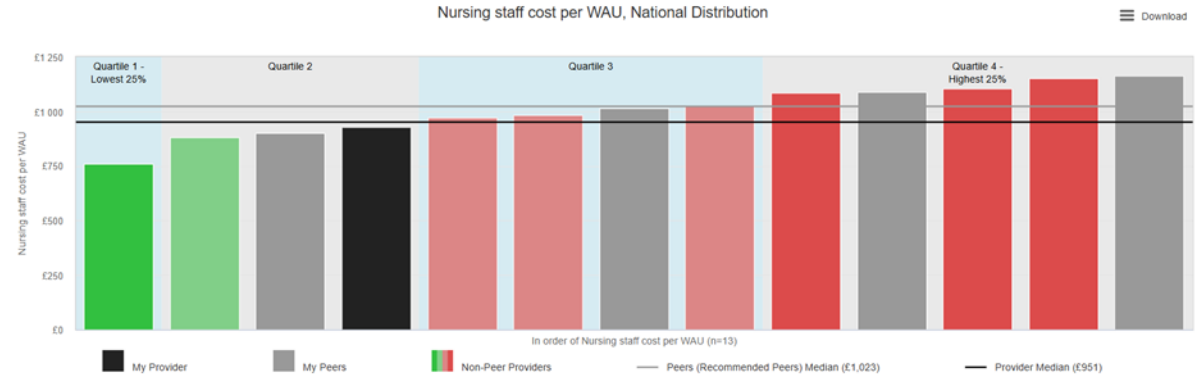
National Profile Health Care Support Workers CHpPD:



Appendix 4.

Nursing Staff cost per WAU National:





Appendix 5. Current budgeted establishment and the SNCT predictions

ACCT:

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
EPOC	13.70	3.91	17.61	13.92	1.55	15.47	+0.2	-2.36	-2.16
Critical Care	95.08	5.46	100.55						

Acute and Emergency Medicine:

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
AMU	62.89	61.13	124.02	68.50	26.64	95.14	-5.61	+34.49	+28.88
CCU	23.39	4.52	27.91	22.83	4.35	27.18	+0.56	+0.17	+0.73
CIU	14.57	4.46	19.03	28.68	11.15	39.83	-12.11	-6.69	-20.8
Roskear	20.45	19.36	39.81	20.06	19.27	39.33	+0.39	+0.09	+0.48
Wellington	28.35	16.46	44.81	32.62	14.65	47.27	-4.27	+1.81	-2.46
Phoenix	32.15	21.88	54.03	46.79	25.20	71.99	-14.64	-3.32	-17.96
Tintagel	22.87	32.82	55.69	25.89	46.02	71.91	-3.02	-13.2	-16.22
Zennor	18.46	15.44	33.9	32.38	32.38	64.75	-13.92	-16.94	-30.86

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
Kerensa	13.89	38.28	52.17	15.91	43.01	58.91	-2.02	-4.73	-6.93
ED	88.96	24.17	113.13	111.55	26.35	137.90	-22.59	-2.18	-24.77

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

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
Eden	17.0	13.07	30.07	27.38	10.6	37.98	-10.38	+2.47	-7.91
Fistral	19.11	7.62	26.74	14.8	7.5	22.3	+4.31	+0.12	+4.44
Polkerris	34.14	8.85	42.99	22.8	11.6	34.4	+11.34	-3.08	+8.59

General Surgery and Cancer:

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
Lowen	40.09	17.59	52.71	41.90	16.29	53.22	-1.81	+1.3	-0.51
ESU	19.05	14.33	33.38	23.1	8.99	32.12	-4.08	+5.44	+1.26

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
				3					
St Mawes	20.33	14.43	34.76	24.13	9.38	33.51	-3.8	+5.05	+1.25
Pendennis	20.98	13.59	34.57	26.51	10.31	36.82	-5.53	+3.28	-2.25
PCU	14.61	10.92	25.53	16.06	6.25	22.31	-1.45	+4.67	+3.22

Specialist Services and Surgery:

	Current Establishment			SNCT Predicted Requirement			Total Variance		
	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
Wheal Coates	16.41	16.41	32.82	21.86	8.5	30.7	-5.45	+7.91	+2.45
GLU	25.10	22.35	47.45	28.34	11.02	39.36	-3.24	+11.33	+8.09
Grenville	22.09	19.92	42.01	32.04	12.46	44.50	-9.95	+7.46	-2.49
Wheal Prosper	13.09	12.21	23.80	13.91	11.38	25.30	+0.82	-0.83	+1.50

Peripheral Sites and Trauma Care Group:

	Current Establishment	SNCT Predicted Requirement	Total Variance

	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE	Band 4-6	Band 2-3	Total WTE
Trauma 1	21.86	20.97	42.83	26.59	26.59	53.17	-4.73	-5.62	-10.35
Trauma 2	22.74	21.57	44.31	25.22	25.22	50.44	-2.48	-3.65	-6.13
Medical 1	17.41	21.88	38.29	21.19	21.19	42.37	-3.78	+0.69	-4.08
Medical 2	13.18	20.18	33.88	18.98	18.98	37.96	-5.8	+1.2	-4.6
MTH	13.68	13.67	27.35	13.28	13.28	26.55	+0.4	+0.39	+0.79
St Josephs	16.80	12.50	29.30 (30.57 with B7) New Template	19.68	13.12	32.8	-2.88	-0.62	-3.5