Royal Cornwall Hospitals NHS Trust

**Meeting:** Trust Board In Public

**Date of Meeting**: 03 September 2026

**Item Number:** Item Number

**Title of Report**: Bi-Annual Safe Nursing Staffing Review Board Report – Part One - The Report

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## Purpose of the Report:

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

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

## Consultation:

This report has been developed through the individual Ward and Divisional reviews undertaken over the last three months with Ward Leaders, Clinical Matrons and Heads of Nursing. The report and all the recommendations have been reviewed and endorsed for approval the Executive Leadership Team and the Quality Assurance Committee in August.

## Key Risks (please tick one or more):

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

**Reputational** ☒ **Legal / Regulatory** ☒

## Impact:

| Assessment | Yes | No | N/A | Summarise any adverse impacts identified |
|---|---|---|---|---|
| **Equality Impact Assessment completed?** | | X | | |
| **Quality Impact** | | X | | |

| Assessment | Yes | No | N/A | Summarise any adverse impacts identified |
|---|---|---|---|---|
| **Assessment completed?** | | | | |
| **Data Protection Impact Assessment completed?** | | X | | |

## Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

| Considerations | Summary of considerations (if one or more does not apply state 'not applicable') |
|---|---|
| **Health and wellbeing of the population, including inequalities and wellbeing** | Safe staffing impacts positively on the health and wellbeing of the population including inequalities and wellbeing. |
| **Quality of services provided or arranged by RCHT, including inequalities in benefits from those services** | Safe staffing impacts positively on the quality of services provided by RCHT and the experience of our patients and staff |
| **Sustainable and efficient use of NHS resources by RCHT** | This report provides broad assurance in this that the Trust benchmarks positively in use of resources and has identified areas where we need to progress improvement in relation to nationally recognised safe staffing guidelines. |

## Recommendation(s):

## **The** Board **is recommended to:**

- **Receive for assurance** the content of the Bi-Annual Safe Staffing Review Board Report which has been reviewed and endorsed by the Executive Leadership Team and Quality Assurance Committee.

- **Approve t**he 13 case recommendations along with the further professional recommendations outlined in the report which have been endorsed by the Executive Leadership Team and Quality Assurance Committee.

# Bi-Annual Safe Nursing Staffing Review

## 1. Situation / Executive Summary

1.1 The report has been reviewed and endorsed by the Executive Leadership Team and Quality Assurance Committee and is presented to the Trust Board for approval.

1.2 The review draws on the Safer Nursing Care Tool where appropriate, national staffing standards and guidance, professional judgement, quality indicators, Ward to Board metrics, roster data, workforce indicators and regulatory intelligence.

1.3 Overall, the report demonstrates broad assurance that the Trust is aligned to the National Quality Board expectations of having the right staff, with the right skills, in the right place at the right time. It also confirms that, where full compliance with national or specialty-specific requirements cannot yet be evidenced, clear recommendations and improvement actions have been identified.

1.4 The review identifies a number of areas of assurance, including strong registered nurse and support staff fill rates at Trust level, with broad fill rates attained above 80% during the review period, an improving nursing vacancy trajectory, appropriate use of SNCT and professional judgement, evidence of compliance with many relevant national standards, and a clear governance route through Executive Leadership Team, Quality Assurance Committee and Trust Board. The report also highlights positive benchmarking in nursing productivity, with RCHT remaining in quartile 2 for nursing cost per Weighted Activity Unit compared with peers.

1.5 The core recommendations are to approve the 13 ward/unit specific case recommendations, including roster reviews, budget realignment, transfer of identified funding, and targeted business case development where templates are underfunded or need to be reset.

1.6 The Board is also asked to approve the wider professional recommendations, including strengthening incident reporting for sub-optimal staffing, relaunching the Red Flag process, improving SNCT validation and application, developing divisional position statements and improvement plans where national guidance is only partially met, and ensuring nursing workforce plans respond to current and future service requirements.

1.7 Further work is required to ensure ward leaders are consistently enabled to deliver their supervisory leadership function. The review identifies that some ward and unit leaders do not currently have the Trust standard of 37.5 hours supervisory time embedded within templates, and that a significant proportion of available supervisory time has been lost through backfilling clinical shifts and sickness absence. Divisions should therefore reset expectations with ward leaders and roster approvers, ensure supervisory time is protected wherever possible, and develop clear plans for wards and units below the 37.5-hour standard to achieve compliance.

1.8 The report is also clear that nursing appraisal compliance requires focused improvement. Current appraisal performance is rated red and is below expected levels, with variation across wards and units. Each Division should develop an improvement delivery plan to increase appraisal compliance, supported by protected leadership time, clear monitoring through divisional governance, and

escalation where improvement is not sustained. This is critical to ensuring staff development, competence, retention, morale and safe delivery of care.

1.9 Professional Nurse Advocate provision is below national requirements. The Trust requires 32 PNAs by ward/team coverage, or 42.43 by the 1:20 registered nurse ratio, against current provision of 17. A Trust-wide plan is being developed to increase PNA capacity and support compliance.

In summary, the review provides substantial assurance that safe staffing is being reviewed through a robust and nationally aligned process, while also identifying areas where further action is required. The key priorities are to deliver the agreed ward-based recommendations, strengthen compliance with national and specialty guidance, protect ward leader supervisory time, improve appraisal rates, and maintain oversight through divisional and corporate governance until the next bi-annual safe staffing review which commences in September.

## 2. Background

2.1 The Department of Health and NHS England commissioned NICE to develop evidence-based guidelines on safe staffing for nursing (NICE 2014); this followed several high-profile reports ( Francis, 2013, Keogh, 2013, Cavendish, 2013, Berwick, 2013) which linked nurse staffing and competence to patient outcomes.

2.2 The Royal Cornwall Hospitals NHS Trust Board has the accountability to ensure the organisation has the right culture, leadership and skills in place for safe, sustainable and productive staff. It is expected to deliver the right staff, with the right skills at the right place and time, in accordance with the National Quality Board Standards 2016 (Figure 1).

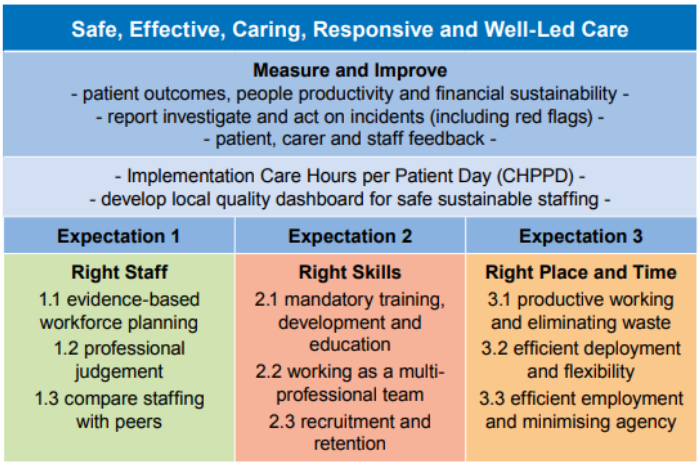



Figure 1. National Quality Board Standards

**Daily Operational Management and Process**

2.3 Outside of establishment reviews, each Division reviews their staffing levels and attends the once-a-day Trust wide Safer Care Nursing staffing meetings to maintain safe staffing levels. The accountability of this meeting is allocated to a rotation of the Divisional Head of Nursing who support the hospitals team of Clinical Matrons.

2.4 Any deficit or areas of concern are escalated to the Associate Director of Acute Nursing and AHPs, and if required to the Acting Chief Nurse.

2.5 **Bi-Annual Safe Staffing Review Process**

2.5.1 The bi-annual safe nurse staffing review is coordinated and led by senior members of the nursing leadership team and uses a triangulated approach in their safe staffing processes in accordance with NHS Improvement (2018) principles of safe staffing as seen in Figure 2.




Figure 2. Principles of Safe Staffing

2.5.2 The Safer Nursing Care Tool (The Shelford Group, 2023) enables evidence-based assessment of patient acuity and dependency, using staffing multipliers to align nursing establishments with need. It is triangulated with quality indicators, Ward to Board metrics, AMaT audit data and professional judgement (Saville et al, 2023). Findings are reviewed by the Acting Chief Nurse and senior multi-professional colleagues to agree recommendations, outcomes, learning and future key lines of enquiry.

2.5.3 Outcomes of the safe staffing reviews have been agreed by the Acting Chief Nurse and a panel of professional leads in nursing, finance and rostering as well as the divisional stakeholders.

2.5.4 These outcomes are categorised as:

- **No Roster Changes.**
- **Recommendation for change; roster review / adjustment (Cost Neutral).**
- **Recommendation for change; a case to increase roster establishment.**
- **All can be + / - with Recommendations for next assessment.**

2.5.5 The results from these safe staffing reviews, contributes to this the Trust Board report on Safe Staffing within Nursing.

2.5.6 The paper outlines ward/unit establishment is in relation to the 30-day census data collection of acuity and dependency period of 16th March 2026 to 24 April 2026.

2.5.7 The assessment will refer to high level Trust wide / Divisional level information and data.

2.5.8 Where recommendations are for a change; the specific wards/units' relevant information will be provided to support the clinical reasoning for the case for change to ultimately support the delivery of safe nursing staffing.

2.5.9 The last report which was presented to Trust Board was on the review period of the 15 September 2025 to 24 October 2025.

2.5.10 There were 7 recommendations from this review/report of which were reviewed within this safe staffing review and an update is seen in Part 2 Appendices Information Pack (Appendix 2).

## 3. Assessment

It is noted that this paper covers the 28 wards/units within that Trust that are identified in Part 2 Appendices Information Pack – Appendix 3.

### 3.1 Operational changes since the last data collection

#### 3.1.1 Patient Pathways

- West Cornwall Hospital (WCH) Medical Wards 1/2 – Clinical Assessment Treatment Unit (CATU): Relaunched bed protection for CATU pathways which resulted in increased direct admissions.

- Roskear – Change of Specialty: The ward switched from being a mixed Cardio-respiratory to a Respiratory / General Medical Ward.

- St Mawes – Change of footprint: St Mawes switched ward footprint with Phoenix Ward resulting in an increase of beds from 24 to 32. Surgical Teams on this ward and Planned Care Unit (PCU) were amalgamated to support a new staffing template of this complex footprint.

#### 3.1.2 Escalation Areas

- Eden Ward – Day case Area: This clinical area in unfunded out of hours in line with other escalation areas and is opened and subsequently has the provision to convert six day-case spaces into bedded care for up to 4 patients.

- Discharge Lounge: This clinical area in unfunded out of hours and is opened and subsequently has the provision for bedded care for up to 9 patients.

- Phoenix Ward: This clinical area is funded 24hr and is open and subsequently has the provision for bedded care for up to 5 patients which has been in use since the last assessment, and it is **recommended to move the budget into the wards substantive budget.**

- Medical Day Unit (MDU): This clinical area is unfunded 24hrs a day opened and subsequently has the provision for bedded care for up to 13 patients.

- PCU: This clinical area is unfunded 24hrs a day opened and subsequently has the provision for bedded care for up to 13 patients.

### 3.2 High Level Overview of National Quality Board Standards

3.2.1 **Expectation 1: Right Staff (Part 2 Appendices Information Pack – Appendix 4).**

#### 3.2.1.1 Fill rates of Registered Nurses (Monitored through RCHT – Ward to Board Dashboard)

In April 2026 the fill rate for registered nurses was 98.4% in the whole trust. With the average range over a 6-month period of 94% to 100%

(Source: RCHT – Ward to Board Dashboard)

On reviewing this on each ward, with an exception base level of 80%; 3 wards/units fell below this base level.

St Josephs Ward had the highest fill rate of 88% with the lowest of 78%. There were no concerns in regards an average of 88.2% supporting a recommendation later in this paper to move funding.

Marie Therese House in November 2025 had a fill rate of 79% and since that time has increased each month to 93%.

The Critical Care Unit over the last 6-months ranged from 67% to 73%. Critical Care is a 19 bedded unit which supports a patient with both Level 2 and Level 3 care. The template fluctuates to reflect the acuity and dependency of the patients on the unit allowing them to flexibly provide the right level of staffing for the unit.

#### 3.2.1.2 Fill rates of Support Staff (Monitored through RCHT – Ward to Board Dashboard)

In April 2026 the fill rate for support staff was 97.4% in the whole Trust.

With the range over a 6-month period of 93% - 97%.

(Source: RCHT – Ward to Board Dashboard).

On reviewing this on each ward with an exception base level of 80%; 6 wards/units fell below this base level.

CCU, CCU both have lower numbers of HCA within their template which results in significant swings in fill rate based on percentage. CCU record one month at 76% and CIU have 4 episodes under 80% with the lowest at 70% with no concerns raised.

Wheal Prosper has at 3 points been under 80% with the lowest being at 73%. Like CIU and CCU the ward has a lower number of HCAs, but this was balanced will a higher than 100% fill rate in Registered Nurses to balance the risk.

St Josephs had the highest fill rate of 84% with the lowest of 59% supporting their variable activity levels. There were no concerns in regards an average of 79% supporting a recommendation later in this paper to move funding.

GLU had two episodes under 80% both at 79% in November 2025 and March 2026 respectively.

Wellington had one episode under 80% at 73% rill rate in February 2026 with no concerns.

#### 3.2.1.3 Agency Usage:

On reviewing the agency usage over preceding months to April it remains static level with 76.3 WTE use in the month of April 2026 (Qualified nursing agency).

#### 3.2.1.4 Care Hours Per Patient Day (CHPPD):

The Trust benchmarks registered and non-registered CHPPD (Care Hours Per Patient Day) through the national Model Health System. CHPPD is calculated by dividing registered and unregistered hours worked over 24 hours by the number of inpatients at midnight, enabling comparison across organisations. It supports local and national monitoring of workforce deployment, quality, performance, patient outcomes and productivity.

**Outcome of benchmarking with peers: Registered Nursing and Midwifery** – The Trust sits within the quartile 2 (There are four quartiles). Meaning that our staffing resources daily sits in the lower half of the recorded hours. (Provider median 4.8 and Peer Median 4.6.

**Outcome of benchmarking with peers: Healthcare Support Workers** – The Trust sits within the quartile 2. Meaning that our staffing resources daily sits in the lower half of the recorded hours. (Provider median 4.6 and Peer Median 3.8.

#### 3.2.1.5 Weighted Activity Unit (WAU):

Cost per WAU is the Model Hospital's headline productivity measure, comparing Trust costs with activity output. The national average is £3,500 for non-specialist Acute Trusts.

Costs above £3,500 suggest higher-than-average spend per unit of output; costs below £3,500 suggest lower-than-average spend.

Cost per WAU can also be analysed by cost component, including nursing.

The latest system data (2024/2025) shows RCHT remains in quartile 2 for WAU, with a nursing median of £951 against a peer median of £979, indicating comparatively greater nursing productivity.

### 3.2.2 Expectation 2: Right Skills (Part 2 Appendices Information Pack – Appendix 5)

#### 3.2.2.1 Appraisals within Nursing:

Appraisal compliance is 66.2%, rated **RED**, with a declining trend below the lower control level, indicating instability in performance. Compliance remains affected by reduced supervisory time and competing priorities, creating

resource constraints. Across reviewed wards/units, compliance ranged from 0% to 100%. Appraisals are essential for learning and development planning; therefore**, it is recommended each Division should develop an improvement delivery plan to support compliance.**

#### 3.2.2.2 Statutory and Essential Training:

The compliance is at 82.27% rated **AMBER** for the month of April 2026. Within the wards / units review the range was from 65.84% to 94.26%. Review indicated contributing factors for non-compliance includes operational release constraints and accessibility issues.

#### 3.2.2.3 Ward Team Permanent Staff Stability Index:

Team stability is measured through ESR over a rolling 12 months, using permanent staff only and excluding fixed-term, temporary, bank and locum staff. It compares current permanent headcount with those employed at the start of the period. Across reviewed units, stability is 87.01%, rated **AMBER**, with a range of 58.82% to 100%.

#### 3.2.2.4 Nurses in posts against establishment:

In April 2026 the Nursing vacancy WTE was 209.19 with an improving trajectory based on the last 12 months. With the last 12month prior to this being 241.8.

### 3.2.3 Expectation 3: Right Place, Right Time (Part 2 Appendices Information Pack – Appendix 6)

#### 3.2.3.1 Skill Mix:

There are **no concerns** with the skill mix of the wards reviewed. As a Trust we have a 57% / 43% ratio of Registrants to Non-Registrants. There is warranted variation between wards/units due to the acuity / dependency of patients on the differing wards/units.

#### 3.2.3.2 Staffing Incidents:

Sub-optimal staffing must be recorded on Datix, which requires users to select a main and subcategory and will soon be replaced by Radar Healthcare. Between 1 October 2025 and 31 March 2026, only 14 incidents were recorded as ‘Inadequate Staffing’ across the Trust, raising **concerns** about reporting effectiveness.

A wider keyword search for staffing themes produced over 1,400 results, with no means to analyse by professional discipline. With Radar Healthcare replacing Datix, it is **recommended that system configuration is reviewed to accurately record future sub-optimal staffing incidents by discipline.**

Discussions with Ward Leaders, Clinical Matrons and Heads of Nursing identified under-reporting, so incident reporting should be promoted across clinical teams. There is also a **concern** that the Trust does not follow NICE guidance or use Safecare Live to report, monitor and respond to staffing Red Flags in adult inpatient wards. It is therefore **recommended that the Trust**

**relaunch the Red Flag process to strengthen safe staffing.**

### 3.2.4 Regulatory Interest and Quality Concerns

#### 3.2.4.1 CQC Inspections

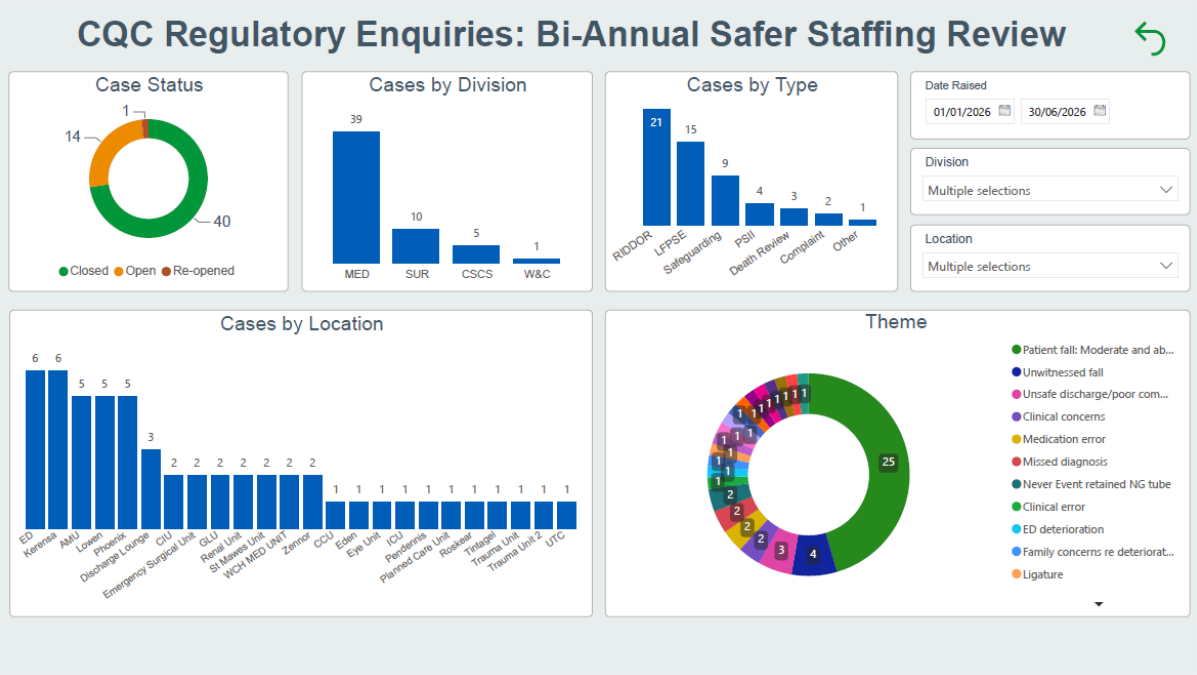
Since the last establishment paper, the Trust received the final CQC report for the March 2026 surgical assessment at West Cornwall Hospital, with no regulation breaches identified.

Royal Cornwall Hospitals NHS Trust remains rated **Requires Improvement**. West Cornwall Hospital remains rated **Good**, and its surgical services improved from Requires Improvement to **Good**.

#### 3.2.4.2 CQC Regulatory Enquires

The Trust receives routine regulatory enquiries from the Care Quality Commission (CQC) as part of their continuous engagement model to build a full quality picture over time.

3.2.4.3 Between 1 January 2026 to30 June 2026 the Trust received 55 case enquiries relevant to the Safer Staffing report. The below dashboard provides an overview of the case status, locations and themes, with individual drill-down reports for areas with 3 or more enquiries provided in Part 2 Appendices Information Pack (Appendix 7).




3.2.4.4 High-level commentary shows Medicine wards/departments had the most enquiries, with admission areas (ED and AMU) among the highest. Patient falls were a significant theme, appearing in 29 of 55 cases, and remained prominent in departments with more than three enquiries, as detailed in the appendices.

### 3.3 High Level Overview of Safe Staffing Review

#### 3.3.1 Evidence based tools and data – SNCT Calculation Recommendations

3.3.1.1 High Level – Trust Wide Variance in registrant nursing workforce

Across the 28 wards where the SNCT was appropriate to use.

| Funded WTE Registrants Band 4 - 6 | | SNCT Predicted Requirement | | Variance |
|---|---|---|---|---|
| 714.98 | - | 704.33 | = | +10.65 |

3.3.1.2 High Level – Trust Wide Variance in non-registrants' workforce

Across the 28 wards where the SNCT was appropriate to use.

| Funded WTE Non-registrants Band 2-3 | | SNCT Predicted Requirement | | Variance |
|---|---|---|---|---|
| 528.9 | - | 563.59 | = | -34.69 |

3.3.1.3 High Level – Trust Wide Overall Variance Nursing Staffing

Across the 28 wards where the SNCT was appropriate to use.

| Funded WTE Band 2-6 | | SNCT Predicted Requirement | | Variance |
|---|---|---|---|---|
| 1243.88 | - | 1267.92 | = | -24.04 |

3.3.1.4 A full breakdown by ward of SNCT calculations can be found in Part 2 Appendices Information Pack (Appendix 8).

#### 3.3.2 Outcomes

**3.3.2.1 Ward to Board**

Ward to Board (Part 2 Appendices Information Pack – Appendix 9) is monitored at ward, speciality and divisional levels and reported through the Quality Assurance Committee. Trust-wide patient outcome themes by exception include Hospital Acquired Pressure Ulcers (> Category 2), concerns in admission areas (ED and AMU pathways), ward-based trauma care, and device-related pressure damage in Critical Care. Falls per 1,000 bed days and falls causing severe or moderate harm remain a concern, with incidence rising across all Divisions except Surgery. This is triangulated with

CQC enquiry findings in section 3.2.4.3.

#### 3.3.2.2 AMaT (Audit Management and Tracking) Quality Indicators

The Trust reviewed several outcome and quality indicators as part of this review, with full detail in Part 2 Appendices Information Pack (Part 2 Appendices Information Pack – Appendix 10). Key concerns include Trust-wide Delirium Assessment Recognition compliance, ranging from 26.8% to 50.3%. Given the known link between delirium and falls risk, lower-performing wards include Roskear, Wellington, Zennor, Wheal Prosper, GLU, Kerensa and AMU. Compliance with CAUTI-related KPIs is also a concern and may contribute to falls through sub-optimal care across several wards.

#### 3.3.2.3 Ward Accreditation – Aspire

3.3.2.3.1 The overall picture for the ASPIRE Accreditation found that there are 20 wards who are improving, 1 maintaining its performance and 8 in decline.

3.3.2.3.2 Areas in declined with a White rating are those assessed more at risk which are AMU, Wellington, followed by those who are rated as bronze. Full breakdown can be seen in Part 2 Appendices Information Pack – (Appendix 11).

3.3.2.3.3 Elements of Aspire that remain a focus of improvement are documentation and SERF Scores (Safe Effective Rostered Fairly Tool).

3.3.2.3.4 The SERF is related to safer staffing in several metrics and specifically unfilled roster, agency usage % and additional duties. On the SERF dashboard (Part 2 Appendices Information Pack – Appendix 12) the wards of concern are highlighted to be AMU, ED, EPOC, GLU, Critical Care, Phoenix, St Micheals Ward, Trauma, Zennor. This triangulation with the other content of the report confirms concerns and further supports specific recommendations which are later made on: EPOC, Critical Care, Phoenix, St Micheals Ward, Trauma, Zennor.

### 3.3.3 Professional Judgement

#### 3.3.3.1 National Staffing Guidelines

3.3.3.2 There are several national guidelines that were referred to during this review. For ease of access please see a full list in Part 2 Appendices Information Pack (Appendix 13). Through the review we assessed if we were:

- **Compliant.**
- **Partially Compliant.**
- **Not-complaint.**

3.3.3.3 11 Wards/Unit identified guidance. We are fully compliant with 6 and partially compliant with 5.

3.3.3.4 **Emergency Department** The speciality has a specific SNCT tool which has been used and applied to respond to the complexities of an Emergency Department. This tool has been used.

**We meet the standards / guidance in full.**

**3.3.3.5 AMU (Inc. MRATS)**

GIRFT (2023) Six to Help Fix: Acute Medicine guidance for improving in-hospital flow provides guidance that:

- Nurse to Patient ratio is a minimum of 1:6.
- The shift is led by supernumerary registered senior nurse on shift.

**We meet the standards / guidance in full.**

**3.3.3.6 Phoenix Ward (Inc. HASU)**

National Clinical Guideline for Stroke (2023) provide guidance that:

- Hyper-acute Stroke required 2.9 WTE per HASU bed with an 80:20 skill mix split.
- Acute Stroke / Rehabilitation requires 1.35 WTE per ASU bed with a 65:35 skill mix split.

**We meet the standards / guidance in full.**

**3.3.3.7 Coronary Care Unit (CCU)**

Whilst there is no specific guidance for Coronary Care, as a dedicated Level 2 Unit the Guidelines for the Provision of Intensive Care Service V3 or (GPICS) is applicable stating:

- Level 2 patients must have a minimum registered nurse: patient ratio of 1:2 to deliver direct care.
- Additional there needs to be a mechanism to review need on a shift-by-shift basis looking at additional components such as single side rooms/ outbreak situations/ patient needs.

**We meet the standards / guidance partially.**

**3.3.3.8 Wellington Ward (Inc. Respiratory Higher Care)**

Respiratory Medicine GIRFT Programme National Speciality Report 2021 provide guidance that:

- Nurse to Patient ratio is mandated 1:2 for patients on Non-Invasive Ventilation (NIV).
- Nurse to Patient ratio at a minimum of 1:4 for other RSU patients.

**We meet the standards / guidance partially.**

#### 3.3.3.9 Wheal Prosper

The speciality has a specific SNCT tool which has been used and apply to ward/units with increased side rooms to respond to the complexities of delivery of care in a single side room area. This tool has been used.

**We meet the standards / guidance in full.**

#### 3.3.3.10 Marie Therese House (MTH)

The UK Rehabilitation Outcomes Collaborative (UK ROC) https://www.ukroc.org/ukroc provides the national clinical registry for specialist rehabilitation. MTH is defined as a UKROC Level 2b service and reviewing the nursing resource / establishment and roster template against the criteria we are above the basic calculation with allowance made for single room facilities, environment and the minimum registered nursing numbers.

In addition, the single room environment has a specific SNCT tool which has been used and applied.

**We meet the standards / guidance in full.**

#### 3.3.3.11 Critical Care Unit

There is minimal set standard which are guidance in the Guidelines for the Provision of Intensive Care Service V3 or (GPICS) which are:

- Level 3 patients must have a minimum registered nurse: patient ratio of 1:1. Level 2 patients must have a minimum registered nurse: patient ratio of 1:2.
- Each ICU must have an identified intensive care matron/lead nurse dedicated solely to managing intensive care.
- The matron must hold the same specialist intensive care nurse educational standards as direct care staff providing care to critically ill patients and families.
- There must be a clinical shift leader, who is not allocated a patient, 24/7.
- All clinical shift leaders must have completed or be working towards completion of CC3N Step 4 Competencies and hold a post-registration critical care award.
- ICUs with more than 10 beds, and each additional 10 beds thereafter, and/or ICUs with large numbers of single rooms, additional infection prevention control requirements or a wide geographical unit footprint, must have at least one additional enhanced critical care nurse who is not allocated a patient.
- There must be no more than 20% of registered nurses from bank/agency, who are NOT substantively employed by the unit, on any one shift.

- Each ICU must have dedicated professional nurse advocates (PNAs) within the establishment, who are given designated time to deliver the role.

- A minimum of 50% of registered intensive care nurses must be in possession of a post-registration critical care award.

- Each ICU must have a dedicated supernumerary clinical educator; the ratio must equate to a minimum of 1 WTE per 75 registered nurses and non-registered healthcare support workers.

**We meet the standards / guidance partially.**

#### 3.3.3.12 Enhanced Perioperative Care

Guidance on Establishing and Delivering Enhanced Perioperative Care Services 2020 highlights several standards:

- Nurses should incorporate the skills required in sufficient numbers

- At least 1 registered nurse per shift should hold or be working towards a postgraduate qualification relevant to EPC or have significant experience in Critical Care or Acute Care.

- There should be access to a clinical nurse educator (with appropriate competencies) on site.

**We meet the standards / guidance in full.**

#### 3.3.3.13 Paediatric Wards (Fistral / Polkerris)

The NQB have guidance called Safe, sustainable and productive staffing An improvement resource for children and young people's inpatient wards in acute trusts 2018 of which the bi-annual safe staffing review process covers all elements. In addition, in Defining Staffing Levels for Children and Young People's Services RCN UK Standards 2025 highlight standard recommendations:

- Children under 2 years: minimum 1 Registered Children's Nurse (RCN) to 3 children (1:3).

- Children aged 2 years and over: minimum 1 Registered Children's Nurse to 4 children (1:4).

- A Band 6 or above Nurse in Charge should be supernumerary and not included in the staffing numbers used to calculate direct patient care.

- Staff have specialist competencies relevant to the patient population (For RCHT HDU and oncology).

**We meet the standards / guidance partially.**

#### 3.3.3.14 Lowen

There are two supportive guidance papers for Lowen. Haematological cancers: improving outcomes NICE NG47 and Guidance to Accompany the FACT - JACIE International Standards for Immune Effector Cells, Third Edition 2025. These highlight standard recommendations:

- The level of staffing required for neutropenic patients is equivalent to that in a high dependency unit (1:2 referenced from Guidelines for the Provision of Intensive Care Service V3).

- Standard B 3.6.4: There shall be a nurse/recipient ratio satisfactory to manage the severity of the recipient's clinical status. The intent of this standard is to acknowledge that nursing needs of a recipient, vary based on the severity or acuity of recipient's clinical status. The clinical unit should be staffed so that if several recipients require periods of >1 nurse/patient there will be adequate numbers of trained staff available. Sufficient flexibility shall exist within the pool of trained staff to meet intensive recipient needs when they occur.

**We meet the standards / guidance partially.**

3.3.3.15 The guidelines highlighted above are complex and detailed. Where it has been identified we cannot evidence that we meet with the standards and guidance in full it is **recommended that each Division submit a position statement, risk assessment and improvement plan to the Nursing, Midwifery and Allied Health Care, Professional Workforce Group**.

### 3.3.4 Application of Operational Nursing

#### 3.3.4.1 Senior Nurse Cover

Throughout the review it is noted a good awareness and assurance of having either the Ward Leader or deputy on duty across the seven-day period. However poor practice was noted regarding ‘time shifting’ hours which is covered in commentary below.

#### 3.3.4.2 Funded Supervisory Time in Templates

Ward Leaders should have 37.5 hours’ standard supervisory time at RCHT to lead teams, monitor care standards, manage performance and improve patient safety. ESU, Pendennis, EPOC, Polkerris and Fistral fall short of this standard. In several areas, supervisory time was ‘time shifted’ from the five-day template to compressed hour patterns, reducing coverage across the week. It is therefore **recommended that each Division reset this standard with Ward Leaders and roster approvers, and develop plans for wards/units below 37.5 hours to achieve compliance with this standard.**

In addition, it was noted that through this review the Trust fell significantly short of the provision of supervisory time. Losing a total of 13,378 hours or 1783 short 7.5 hour days due to backfilling clinical shifts or sickness absence (Part 2 Appendices Information Pack – Appendix 14, shows full breakdown). This equates to approximately 45% of templated supervisory time in templates lost across all areas. This would have impacted on the delivery of performance.

#### 3.3.4.3 Access to Professional Nurse Advocates

NHS England provides guidance in Professional nurse advocate A-EQUIP model: a model of clinical supervision for nurses 2024, of a ratio of at least one PNA per clinical team/ward is needed.

To achieve this, they suggest at least 1:20 registered nurses should be trained. Our assessment against these standards is based on 28 areas using SNCT plus 4 non-SNCT areas. Therefore:

Total of 32 clinical team/wards = 32 PNAs required or:

848.77 WTE = 42.43 PNAs on a 1:20 ratio.

At the Royal Cornwall Hospitals NHS Trust, we have 17 PNAs.

Therefore, the Trust is below the national requirement for Professional Nurse Advocate provision. A Trust-wide plan is being developed to increase PNA capacity and support compliance with the recommended establishment.

#### 3.3.4.4 Roster Uplift Standardisation

The application of uplift or headroom is applied to effective shifts on a ward / unit's roster/template. The standard application of 21.5% is applied to the core calculation to ensure safe patient care levels and service provision when colleagues are away for such things as annual leave, professional development and as a buffer against short-term sick leave or unexpected personal emergencies.

During the review, rosters were reviewed and concerns were noted in the following areas where the roster uplift is not as standard. ESU 21%, St Mawes 21.08%, Fistral 20.77%, and Polkerris 13.76%. All of which results in a cost pressure and overspend during the time highlighted above. Therefore, it is **recommended the Chief Nurse has an allocated budget to resolve SNCT minor issues and that is reported through the bi-annual staff safe staffing review report how it has been allocated and for the Paediatrics Wards this need to be part of the wider assessment and business case review for the underfunded templates.**

### 3.3.5 Outcome of Ward Based Safe Staffing Review – By Exception

### 3.3.6 Outcomes by category (Full Summary in Part 2 Appendices Information Pack – Appendix 15)

#### 3.3.6.1 No Roster Changes

18 of the 28 wards/units using SNCT are recommended as No Roster Changes and Safe with recommendation to repeat the Bi-annual Safe Staffing Review in September 2026.

0 of the 4 wards/units not using the SNCT reached this outcome.

#### 3.3.6.2 Recommendation for change; roster review / adjustment (Cost Neutral)

3 of the 28 wards/units using the SNCT are recommended for change with a roster review / adjustment that is cost neutral.

3 of the 4 wards/units not using the SNCT reached this outcome.

##### 3.3.6.2.1 Case 1: Pheonix Ward (Inc. Hyper Acute Stroke Unit)

Summary: **Recommendation to move the funded money from escalate beds into wards substantive budget.**

Clinical Reasoning in Safe Staffing Review: Headlines.

| | |
|---|---|
| Right Staff | No exceptions to report |
| Right Skills | Supports rationale to equip substantive staff with training to deliver speciality-based care. |
| Right Place and Time | Supports investing in substantive staff |
| Evidence Based Tools and Data | No exceptions to report |
| Outcome | There are no related concerns to the care delivered on the ward in relation to this recommendation, but the bed resources are linked to reduced mortality in stroke. |
| Professional Judgement | Escalation beds have been identified as required as part of a system review in the stroke pathway and they are already funded. |

##### 3.3.6.2.2 Case 2: Zennor Ward

Summary: **Recommendation to endorse the work up of plans move of ward to support the better management of Enhanced Therapeutic Observations of Care (ETOC) patients and release the space for the new UTC.**

| | |
|---|---|
| Right Staff | Increased demand on template to ward layout |
| Right Skills | No exceptions to report |
| Right Place and Time | Layout and patient group results in increased requirement to deliver ETOC |

| | |
|---|---|
| Evidence Based Tools and Data | SNCT results show a variance of -16.06 WTE Band 4-6 and -20.74 WTE Band 2-3 |
| Outcome | Patient outcomes noted are 2 HAPU (>Category2), and 1 fall with severe or moderate harm in last 12 months. Falls static and high at 10.28 falls per 100 bed days and poor VTE compliance on the ward. Good IPC rates and average compliance of 93% with catheter acre, 90%-line care but good hand hygiene at 100% |
| Professional Judgement | The nightingale footprint of the ward is challenging for the ward to care for with the number of ETOC patients |

#### 3.3.6.2.3 Case 3: SMH – St Joseph's Ward

Summary: **Recommendation to endorse the transfer of funds from budget by reducing template, which is assessed as having excess, to fund Case 7/8.**

| | |
|---|---|
| Right Staff | The ward is unaffected by the vacancy rate of 4.53 WTE |
| Right Skills | No exceptions to report |
| Right Place and Time | No exceptions to report |
| Evidence Based Tools and Data | The ward had a variance of +17.49 WTE |
| Outcome | Patient outcomes noted are 0 HAPU (>Category2), and 0 fall with severe or moderate harm in last 12 months. Falls static and high at 4.34 falls per 100 bed days and good VTE compliance on the ward. Good IPC rates and average compliance of 93% with catheter acre, 90%-line care but good hand hygiene at 100% |
| Professional Judgement | Due to the services and number of patients through the ward and reduction in activity on certain days a reduction is possible |

#### 3.3.6.2.4 Case 4: WCH – Urgent Treatment Centre (UTC)

Summary: **Recommendation to endorse roster review to support UTC service at WCH.**

| | |
|---|---|
| Right Staff | The UTC service needs a full review of provision and associated workforce plan that supports service delivery |
| Right Skills | Once a review happens this needs to support a training needs analysis of the Unit |
| Right Place and Time | The template needs to support the expectation of service services and correct the mismatch |
| Evidence Based Tools and Data | There is no SNCT model therefore it will be constructed through consensus of demand and capacity |
| Outcome | Concerns regarding service delivery noted regarding accessibility of service hours |
| Professional Judgement | Need for triangulated approach of all the above |

#### 3.3.6.2.5 Case 5: SMH – St Micheals Ward

Summary: **Recommendation to endorse the transfer of funds from budget by reducing template, which is assessed as having excess, to fund Case 7/8.**

| | |
|---|---|
| Right Staff | The ward is unaffected by the vacancy rate of 5.76 WTE |
| Right Skills | No exceptions to report |
| Right Place and Time | No exceptions to report |
| Evidence Based Tools and Data | SNCT is not appropriate for this unit and requires a review of demand but there is surplus based on first review of demand against establishment |
| Outcome | There are no concerns based on the day case function / OPD unit |

| | |
|---|---|
| Professional Judgement | Due to the services and number of patients through the ward/OPD and reduction in activity on certain days a reduction is possible |

#### 3.3.6.2.6 Case 6: Critical Care Unit

Summary: **Recommendation to endorse a template review to support the ability to comply with National Standards.**

| | |
|---|---|
| Right Staff | Fill rates are consistently recorded below 80% |
| Right Skills | Concerns regarding not meet educational standards in GPICs with high vacancies 20.23 WTE and ongoing agency use |
| Right Place and Time | No exception concerns |
| Evidence Based Tools and Data | SNCT is not a recognised tool for Critical Care and therefore a full template review against standards and demands is essential |
| Outcome | Patient outcomes noted are 1 HAPU (>Category2) but with several <Category2 device related incidents, and 0 fall with severe or moderate harm in last 12 months. With good compliance in Safety metrics of catheter care 93.3%, line care 100% and 95.4 Hand Hygiene. |
| Professional Judgement | Concerns raised that the unit is not meeting the national guidance of GPICS |

### 3.3.6.3 Recommendation for change; a case to increase roster establishment/budget

6 of the 28 wards/units using the SNCT are recommended for change with a case to increase roster establishment.

1 of the 4 wards/units not using the SNCT reached this outcome.

#### 3.3.6.3.1 Case 7: ESU

Summary: **Recommendation endorse the Division to create a review of services using existing funding for proposal to reset wards supervisory time to 37.5hrs**

| | |
|---|---|
| Right Staff | The Unit only has 23 hours against the standard of 37.5 hours |
| Right Skills | The unit has low appraisal compliance77.4%, good training compliance 90.74% with a stability of workforce at 84% |
| Right Place and Time | No concerns with skill mix but the reduction in supervisory and only achieving 68% in 6 months has an impact on the unit |
| Evidence Based Tools and Data | SNCT results show a variance of -0.76 WTE Band 4-6 and +4.74WTE Band 2-3 |
| Outcome | The unit has an Aspire outcome of Bronze with patient outcomes noted are 1 HAPU (>Category2), and 0 fall with severe or moderate harm in last 12 months and a low falls per 100 bed days of 3.64. With good compliance in Safety metrics of catheter care 94.1%, line care 100% and 95% Hand Hygiene. |
| Professional Judgement | As our surgical admissions area we need to support the unit like our medical admissions with the leader having the trust standard of 37.5hrs supervisory |

#### 3.3.6.3.2 Case 8: Pendennis

Summary: **Recommendation endorse the Division to create a review of services using existing funding for proposal to reset wards supervisory time to 37.5hrs.**

| | |
|---|---|
| Right Staff | The Unit only has 23 hours against the standard of 37.5 hours |
| Right Skills | The unit has low appraisal compliance 58.8%, good training compliance 91.44% with a stability of workforce at 85.71% |
| Right Place and Time | No concerns with skill mix but the reduction in supervisory and only achieving 54% in 6 months has an impact on the unit |

| | |
|---|---|
| Evidence Based Tools and Data | SNCT results show a variance of -1.65 WTE Band 4-6 and -1.95 WTE Band 2-3 |
| Outcome | The unit has an Aspire outcome of Silver with patient outcomes noted are 1 HAPU (>Category2), and 3 falls with severe or moderate harm in last 12 months and a low falls per 100 bed days of 2.94. With good compliance in Safety metrics of catheter care 93.3%, line care 100% and 95% Hand Hygiene. |
| Professional Judgement | Pendennis is a busy high acuity ward with a rich skill mix that needs the leader to have the trust standard of 37.5hrs supervisory |

#### 3.3.6.3.3 Case 9: Trauma 1

Summary: **Recommendation endorse the Division to create a review of services using existing funding for proposal to close gap of shortfall needed to correct budget for template and consider business case for remaining (Linked to Case 3 and 5).**

| | |
|---|---|
| Right Staff | No concerns about fill rates to existing template which a proportion is unfunded |
| Right Skills | The unit has low appraisal compliance 64.7%, low training compliance 76.09% with a stability of workforce at 76% which is low |
| Right Place and Time | Some roster review required with compliance to supervisory shifts that are set according to template |
| Evidence Based Tools and Data | SNCT results show a variance of -3.47 WTE Band 4-6 and -2.0 WTE Band 2-3<br><br>This is against a template which is not fully funded currently. There is a shortfall of 2.74 Band 5 and 2.73 |
| Outcome | The unit has an Aspire outcome of Bronze on a decreasing trend with patient outcomes noted are 2 HAPU (>Category2), and 1 fall with severe or moderate harm in last 12 months and a low falls per 100 bed days of 1.16. With |

| | |
|---|---|
| | good compliance in Safety metrics of catheter care 97.7%, line care 100% and 100% Hand Hygiene. |
| Professional Judgement | No professional judgment as exceptions |

#### 3.3.6.3.4 Case 10: Trauma 2

Summary: **Recommendation endorse the Division to create a review of services using existing funding for proposal to close gap of shortfall needed to correct budget for template and consider business case for remaining (Linked to Case 3 and 5).**

| | |
|---|---|
| Right Staff | No concerns about fill rates to existing template which a proportion in unfunded. |
| Right Skills | The unit has good appraisal compliance 95.5%, low training compliance 84.08% with a stability of workforce at 100%. |
| Right Place and Time | Some roster review required with compliance to supervisory shifts that are set according to template. |
| Evidence Based Tools and Data | SNCT results show a variance of -5.01 WTE Band 4-6 and -5.37 WTE Band 2-3.<br><br>This is against a template which is not fully funded currently. There is a shortfall of 4.00 Band 5. |
| Outcome | The unit has an Aspire outcome of Bronze on a decreasing trend with patient outcomes noted are 2 HAPU (>Category2), and 0 falls with severe or moderate harm in last 12 months and a low falls per 100 bed days of 5.83. With good compliance in Safety metrics of catheter care 93.3%, line care 100% and 95% Hand Hygiene. |
| Professional Judgement | No professional judgment as exceptions. |

#### 3.3.6.3.5 Case 11: Fistral

Summary: **Recommendation to endorse the Division to review ongoing shortfall in funding in budget to fund the template with a business case which is an ongoing overspend. In addition, endorse the Acting Chief Nurse to move uplift from ward supervisory time in other areas to this roster to become compliant with national standards within Paediatrics. This has been agreed by both relevant Divisional Directors.**

| | |
|---|---|
| Right Staff | There are significant shortfalls with this roster template and the funded establishment. The template is not fully funded with in addition some shifts not having 21.5% uplift. The template is only funded at 27hrs of supervisory time for the ward leader. |
| Right Skills | The unit has good appraisal compliance 97.1%, low training compliance 69.42% with a stability of workforce at 90% |
| Right Place and Time | No concerns with skill mix but the reduction in supervisory and only achieving 66% in 6 months has an impact on the unit |
| Evidence Based Tools and Data | SNCT results show a variance of +7.06 WTE Band 4-6 and -0.79 WTE Band 2-3<br><br>This is against a template which is not fully funded currently. |
| Outcome | The unit has an Aspire outcome of Bronze on an increasing trend with no patient outcomes concerns but it is noted that we are not meeting national standards set out regarding nurse in charge status clinically co-ordinating the shift or until recruitment having adequate numbers of Registered Children's Nurses. |
| Professional Judgement | Fistral is a busy high acuity ward with a rich skill mix that needs the leader to have the trust standard of 37.5hrs supervisory |

### 3.3.6.3.6 Case 12: Polkerris

Summary: **Recommendation to endorse the Division to review ongoing shortfall in funding in budget to fund the template with a business case which is an ongoing overspend. In addition, endorse the Acting Chief Nurse to move uplift from ward supervisory time in other areas to this roster to become compliant with national standards within Paediatrics. This has been agreed by both Divisional Directors.**

| | |
|---|---|
| Right Staff | There are significant shortfalls with this roster template and the funded establishment. The template is not fully funded with in addition some shifts not having 21.5% uplift. The template is only funded at 27hrs of supervisory time for the ward leader. |
| Right Skills | The unit has good appraisal compliance 0%, low training compliance 69.90% with a stability of workforce at 97.3%. |
| Right Place and Time | No concerns with skill mix but the reduction in supervisory and only achieving 86% in 6 months has an impact on the unit. |
| Evidence Based Tools and Data | SNCT results show a variance of +10.19 WTE Band 4-6 and -3.35 WTE Band 2-3.<br><br>This is against a template which is not fully funded currently. |
| Outcome | The unit has an Aspire outcome of White on a decreasing trend with no patient outcomes concerns with only concern regarding line care dipping in compliance at 88%. Also noted that we are not meeting national standards set out regarding nurse in charge status clinically co-ordinating the shift or until recruitment having adequate numbers of Registered Children's Nurses. |
| Professional Judgement | Polkerris is a busy high acuity ward with a rich skill mix that needs the leader to have the trust standard of 37.5hrs supervisory |

#### 3.3.6.3.7 Case 13: EPOC

Summary: **Recommendation to endorse Division to return removed funding from this budget for required Monday service.**

| | |
|---|---|
| Right Staff | There is a concern that the units funding was moved without Acting Chief Nurses approval. This resulted in the service on Monday being unfunded and a cost pressure when required. |
| Right Skills | No concerns |
| Right Place and Time | Monday's demand is not funded |
| Evidence Based Tools and Data | SNCT not appropriate to use and use consensus based on demand |
| Outcome | No Exceptions |
| Professional Judgement | The funding needs to be returned as part of bi-annual safe staffing review. |

### 3.3.6.4 Other Recommendations for next assessment:

3.3.6.4.1 Trust Wide: Promotion of Incident Reporting of Sub-optimal Staffing on Incident Management System.

3.3.6.4.2 Trust Wide: Acting Chief Nurse is allocated a budget to resolve SNCT minor issues and that it is reported through the bi-annual safe staffing review report how it has been allocated.

3.3.6.4.3 Trust Wide: Senior Nurse Refresher Training in SNCT for improved validation and practical application of tool.

3.3.6.4.4 Trust Wide: Workforce Development plans for Registered Nurse Associates.

3.3.6.4.5 Trust Wide: Relaunch the Red Flag process to strengthen safe staffing.

3.3.6.4.6 Trust Wide: Where National Guidelines are not meet as highlighted in this paper each Division submit a position statement, risk assessment and improvement plan to the Professional Workforce Group.

3.3.6.4.7 Trust Wide: Each Division works on an improvement delivery plan to support compliance with appraisals.

3.3.6.4.8 Emergency Department: Ongoing review of Template against changing Capacity and Demand.

3.3.6.4.9 CCU: SOP for Flexing Staffing According to Acuity and Dependency in the Coronary Care Unit.

3.3.6.4.10 GLU/Grenville/AMU: Focus improvement works with a Care Pathway and Care Plan for the Care of the Adult Patient with Eating Disorders.

3.3.6.4.11 Wellington: SOP for Flexing Staffing According to Acuity and Dependency in Respiratory Higher Care.

3.3.6.4.12 Lowen: SOP for Flexing Staffing Allocation on Ward – Nurses Allocation by Acuity and Dependency on Lowen Ward.

3.3.6.4.13 Lowen: Divisional enquiry on long term delivery plan for Advice Line.

3.3.6.4.14 Lowen: Create supportive development plan for Assistant Practitioners to work at top of license on ward.

3.3.6.4.15 New KLOE for monitor to further understand nursing impact:

- WCH – Med 2: ETOC Requirement overnight.
- CCU: Lost nursing time for PPCI pathway, Telemetry Demand.
- CIU: Lost time to off ward activity.
- GLU: Bed days (Eating Disorder Patients).
- Grenville: Bed days (Eating Disorder Patients).
- St Mawes: Medical Outliers.
- Wheal Coates: Tracheostomy Patients.
- Fistral: Bed days (Eating Disorder Patients).
- Polkerris: Admission Profiling on PAU, Audit NiC Compliance and Supervisory Status.
- Lowen: Number of Neutropenic patients.

3.3.6.4.16 A full overview of multiple KLOE is supplied in Part 2 Appendices Information Pack (Appendix 16) for reference and to support further triangulation.

## 4. Risk

Following completion of the Bi-annual Safe Staffing Review in Nursing several key risks have emerged for acknowledgement. These are:

**Trust Wide Safe Staffing:**

- There is a risk of sub-optimal patient, colleague and organisational outcomes.
- This is caused by sub-optimal levels or skill mix or deployment of nursing resources.

- This is controlled by the co-ordinate bi-annual safe staffing review and the recommendations of the review.

**Compliance with Principles and Practices of the SNCT Tool:**

- There is a risk that the validity of the outcome of the SNCT calculation could in inaccurate.

- This is caused by poor application of the tool when assessing acuity and dependency and errors in application of the calculator.

- This is controlled by all nurses who complete the SNCT collection will be retrained ready for census in September 2026. Collector limited to three colleagues on ward to apply consistency. Improved verification processes agreed at Ward and Divisional Levels. New Bi-annual Safe Staffing Ward Level Report template includes confirmation of verification of process and tool calculation.

**Sub-optimal Compliance with National Staffing Standards / Guidelines:**

- There is a potential and unknown risk to our outcomes at a patient, colleague and organisational level.

- This is caused by non-compliance or partial compliance against National Standards / Guidelines.

- This is controlled by the recommendation that Division will submit a review paper to clinical cabinet of any non-compliance, with associated risk assessment and improvement plan.

**Professional Nurse Advocacy (PNA):**

- There is a risk to the delivery of restorative clinical supervision and nurse led and enacted quality improvement.

- This is caused by sub-optimal number of PNAs across the organisation and not having one per ward / clinical team.

- This is controlled by other opportunities to grow and learn as a profession and a commitment to train more.

**Ward Leader Clinical Visibility:**

- There is a risk to ward leadership, care standards, delivery of performance and patient safety onwards.

- This is caused by the practice of ‘time shifting’ supervisory hours into compressed working patterns.

- This is controlled by divisions resetting the standard with ward leaders and those partially and fully approving the rosters.

## 5. Accountability

The Divisional Heads of Nursing will be accountable to lead the implementation of actions associated within their Divisions.

The Associate Director of Acute Nursing and AHPs has responsibility for the co-ordination of the Bi-annual Safe Staffing Review process and the training of colleagues in the clinical application of the SNCT.

The responsible accountable Executive Director for safe nursing staffing is the Acting Chief Nursing Officer.

## 6. Recommendations

### **The** Board **is recommended to:**

- **Receive for assurance** the content of the Bi-Annual Safe Staffing Review Board Report which has been reviewed and endorsed by the Executive Leadership Team and Quality Assurance Committee.

- **Approve t**he 13 case recommendations along with the further professional recommendations outlined in the report which have been endorsed by the Executive Leadership Team and Quality Assurance Committee.

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