Appendix i

An Independent Nursing Review and Assessment of staffing levels and safe patient care at Axminster Community Hospital, as commissioned by the Executive Team, Northern Devon Healthcare NHS Trust

Author: **Rhiannon Jones (RN, DipN, PGDip, MSc)**

Date: **4th January 2015**

Contents

1.0 Biographical Details:

The author is a Registered Nurse with 26 years' post-registration experience in acute and community settings. She has current registration with the Nursing & Midwifery Council. She is an adult nurse, who specialised in gerontology and general medicine.

She is a Florence Nightingale Scholar who has undertaken international travel to explore the concepts of Collaborative Care and advances in care of the elderly in Canada and Boston, US.

She has published articles in Nursing Journals on the topics of patient self medication and the prevention and management of inpatient falls. Her Masters dissertation focused on staff sickness absence, for which she achieved a merit.

She has held a number of diverse senior management and leadership positions, to include General Manager for Community Services, with responsibility for 21 Community Hospitals and District Nursing Services across Gwent with a population base of 600,000.

The past five years have been spent in Corporate Nursing, with substantive employment as an Assistant Director of Nursing in a large, successful, integrated Health Board in Wales. Her present portfolio encompasses safety, quality and patient experience. Within this role she regularly deputises for the Executive Director of Nursing.

The author has no affiliation to Northern Devon Healthcare NHS Trust.

2.0 Introduction:

In December 2014 the author was formally commissioned by the Executive Team, Northern Devon Healthcare NHS Trust to conduct an independent, professional nursing assessment regarding the proposal, executed by the Board, to temporarily close Axminster Community Hospital and transfer services to Seaton Community Hospital.

The full Terms of Reference can be found in **Appendix 1** but, in essence, they direct the reviewer to explore staffing levels and patient safety at Axminster Community Hospital, specifically:

- The staffing levels and their alignment to Best Practice Guidance;
- HR reports and Key Performance Indicators relating to patient outcomes;
- Risk Assessment processes and Board reporting – *Ward to Board*.

The report aims to provide an independent overview of the staffing ratios for Axminster Community Hospital in terms of:

- Safety for patients and staff
- Compliance with regulation and best practice

The above are the predominant cited factors for the Trust proposition to temporarily transfer services from Axminster to Seaton.

3.0 Methodology:

The methodology for the independent assessment concentrated on:

- **Document reviews** - examination of Board Reports and KPI data;
- **Detailed Literature Review** and internet searches;
- **Telephone interviews**.

The review was conducted during late December 2014 and early January 2015.

Due to time constraints and geographical barriers site visits were not feasible or practical.

4.0 Background:

Northern Devon Healthcare NHS Trust operates across 1,300 square miles providing care and treatment for people from Axminster to Bude and from Exmouth to Lynton. The Trust offers both acute and community services through North Devon District Hospital, a network of 17 Community

Hospitals and nine community health and social care teams, across Torridge, North Devon, East Devon, Exeter and Mid Devon.

Devon is the third largest county in the Country, however it is also one of the most sparsely populated, with a population density well below national and regional averages. Rurality can present issues associated with accessibility for patients as well as staff recruitment and retention challenges.

For the independent review, two Community Hospitals are the focus namely: Axminster and Seaton, with Axminster the centre of attention.

The Trust is contracted by Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) to provide high quality and safe acute and community care for the population served. Northern, Eastern and Western Devon Clinical Commissioning Group is responsible for £1.1bn of health care funding. It replaced Primary Care Trusts and was authorised to commission health care services from 1 April 2013. The CCG is one of two clinical commissioning groups in Devon. As its name suggests, it is founded on three localities supporting the Northern, Eastern and Western parts of Devon.

Axminster and Seaton Community Hospitals provide services which include inpatient care, for which there are ten commissioned beds in both community hospitals, and some day case activity vis-a-vis virtual in-patient care.

In October 2014 the Trust Board announced its intention to temporarily transfer beds from Axminster Hospital to Seaton Community Hospital, based on escalating concerns about the provision of safe patient services, predominantly attributable to nursing staffing issues.

The Trust outlined its concerns as follows:

- That the inpatient services in Seaton and Axminster Hospitals were no longer sufficiently clinically resilient to offer a safe service to both communities in their current configuration, particularly heading into winter when service demand increases.

- In acknowledging the risk in October 2014, the Board announced its intention to temporarily transfer inpatient beds from Axminster to Seaton as of 6 January 2015.

They cited that:

"In both hospitals for the majority of every 24 hour period, there is only one registered nurse on duty at any one time. Whilst there are no

concerns with the quality of care offered in either hospital, the lack of registered nurse support puts undue pressure on the service.

It was the view of the senior clinicians of the Northern Devon Healthcare Trust that a risk exists around running an inpatient service at both hospitals with only one registered general nurse on shift. This nurse is not only responsible for the inpatients, but the security of the building and the other staff. This means they are not able to take breaks or leave the ward or hospital. In the longer term it also means they work without peer support or challenge from other nurses, which they feel poses a greater risk to patient care in the healthcare environment post-Francis and Mid Staffordshire".

Following public communication events, arranged post the decision, it became apparent that there was considerable antipathy towards the Board decision and public confusion as to the rationale for the pronouncement. The Board therefore halted its temporary plan and embarked on a formal consultation exercise for the month of December, to include the commissioning of an independent nursing review.

5.0 The independent, professional nursing review:

5.1 Document review

A range of data was requested from the Trust to inform the review, namely:

- A profile of Axminster & Seaton Community Hospitals;
- Staffing establishment reports for the two Community Hospitals;
- HR reports re: sickness absence rates (against target), attrition, vacancy factor, Bank & Agency utilisation, Appraisal compliance;
- Staff experience data - satisfaction survey results;
- Training compliance, specifically mandatory and statutory training;
- Quality & patient safety data: patient satisfaction, complaints, SI's & clinical incident data wider Trust data for comparisons;
- Financial reports;
- Risk Assessments and Risk Register relating to Axminster;
- Bi-annual Board Reports re: Staffing Levels;
- Any formal reports to the Board or sub-committees which identify the quality and safety concerns within the Community Hospitals.

5.2 Literature Review and Internet Search

The literature review and internet search has been comprehensive and concentrated on NHS England publications. This was particularly important in the context of the reviewer being Wales-based, where there is a different model of health care and staffing provision.

The review has predominantly focused on the evidence base for staffing levels but also incorporated drivers for the provision of safe, high quality patient care, to include;

- High profile enquiries such as Francis & Keogh;
- The Strategy for Nursing (DoH);
- The National Quality Board;
- Professional College Guidance; specifically the Royal College of Nursing
- NICE Guidance
- The Safe Staffing Alliance
- The Keith Hurst Staffing model
- The Community Hospitals Association
- The concept of professional isolation
- Workforce planning and attrition in nursing

5.3 Telephone interviews

A range of staff, from Managers to Clinicians, were interviewed via telephone. An interview *checklist* was prepared to structure the discussions, which can be found in **Appendix 2**.

The following individuals kindly made themselves available for an in-depth telephone discussion:

Name:	Designation:
Kevin Marsh	Executive Director of Nursing
Steve Hudson	Divisional General Manager
Dr Chris Bowman	Clinical Director
Tina Naldrett	Associate Director of Nursing
Anne Cameron	Deputy General Manager
Cathy Weeks	Matron
Pauline White	Deputy Matron
Chris Entwhistle	Deputy Matron

6.0 Trust Data/Document review:

A substantial amount of information, as requested by the reviewer, was kindly and efficiently provided by:

- Darryn Allcorn, Interim Director of Workforce and Organisational Development
- Steve Hudson, Divisional General Manager
- Gemma Steele, Fundraising & Communications Assistant
- Tina Naldrett, Associate Director of Nursing

Much of the data informed the reviewer and was deemed essential to provide a personal overview of the Trust (for which there was no previous knowledge) and, more specifically, Axminster and Seaton Hospitals.

6.1 Workforce data

6.1.1 Sickness, Training Compliance & Appraisals

Data	Target	Findings	Commentary
Sickness (Dec '13 – Nov '14)	3%	Axminster = 2.57% Seaton = 2.86%	In Nov '14 Axminsters' absence rate peaked to **7.51**% There are 10 periods between the two Community Hospitals where the sickness rates are above the target.
Training compliance	variable	Axminster has 50% overall compliance with statutory and mandatory training (9 out of 18 areas are on/above target). Seaton has 61% overall compliance with statutory and mandatory training (11 out of 18 areas are on/above target).	Resuscitation compliance is as low as 42.3% in Axminster Hospital. This could be deemed to be a particular issue not least in light of a significant SI in another of the Trust's Community Hospitals. These overall compliance rates are well below target and present a risk.
Appraisals	85%	Axminster = 80% Seaton = 73.1%	Both Hospitals are below target.

			Regular and meaningful staff appraisals are critical for an efficient, effective and engaged workforce to secure excellent patient experience and positive staff experience. In the annual NDHT Staff Survey (2013) 53% of Community Hospital respondents said their appraisal did not help them to improve their job & 30% stated that they didn't feel valued by the organisation as a result of their appraisal.

6.1.2 Funded Establishment

Hospital	Establishment		
	Funded	Actual	Variance
Seaton	21.31	19.48	-1.83 (-8.6%)
Axminster	21.51	18.72	- 2.79 (-13%)

It should be noted that a variance of -13% for a small Hospital (10 beds) would be significant in terms of day to day impact.

6.1.3 Vacancy Factor/Leavers

Hospital	Leavers as a % of FTE
Seaton	6.76%
Axminster	22.86%

Average Staff Turnover (UK) is cited as 6%. Axminster's turnover rate is significantly higher than the UK average and >3 times that of Seaton. This could indicate that the workforce is more stable in Seaton Community Hospital.

6.1.4 Agency utilisation & spend (Oct '14)

Seaton	RN 0.85 HCA 1.24	£8,073
Axminster	RN 2.41 HCA 3.42	£22,797

Many Trusts and Health Boards across the UK operate a zero Agency policy which, whilst predominantly cost-driven, recognises the potential negative impact of casual workers on the continuity of patient care, patient throughput and overall patient experience.

Bank & Agency utilisation measures the proportion of nursing staff on duty who are agency or bank staff. Frequent use of temporary staff may be indicative of wider workforce issues and may impact on the cost effectiveness and efficiency of the nursing workforce, as temporary staff can be less familiar with the care environment. There is a particular risk within small Community Hospitals when using Registered Agency Nurses due to the professional isolation and impact on continuity of care.

6.2 Quality and patient safety

The Annual Staff Survey and the Friends & Family Test have been analysed to try and extrapolate any meaningful data to inform the review, however the response rates are relatively small and are generalised via the Community Hospital Directorate. The data is not considered to be statistically significant, albeit there are some interesting results that could warrant further, future analysis and triangulation by the Trust.

Below are some examples:

50% of respondents feel that they are involved in decisions about service changes.

54% would recommend their organisation as a place to work.

84% are satisfied with the quality of care given.

85% are likely or extremely likely to recommend the organisation for care and treatment.

In terms of patient outcomes and nursing-sensitive indicators, this is work in progress, which was evident from a discussion with the Executive Director of Nursing. A Nursing Dashboard is in use, which covers fall rates, Health Care Acquired Infections, Hospital Acquired Pressure Ulcers etc. The reports are analysed and discussed at the Trust Quality Forum, chaired by the Head of Quality & Safety. There have been no infection outbreaks, Serious Incidents or thematic issues from complaints identified for either Seaton or Axminster Community Hospitals.

6.3 Staffing profile

- Skill mix ratio

Following a review of Community Hospitals Staffing commissioned by the Clinical Commissioning Group in 2013, it was agreed that the establishments within Community Hospitals should have a baseline of 1:8 RN per patient ratio and a skill mix of 50:50%.

It is evident from this establishment review that neither Seaton nor Axminster Hospitals are compliant with this standard, with Axminster having the greater non-compliance and therefore risk, due to turnover and sickness absence peaks.

Hospital	**Funded establishment**	**Skill mix**	**Actual establishment**	**Skill mix**
Axminster	21.51	46:54%	18.72	41:59%
Seaton	21.31	45:55%	19.48	42:58%

It is patent that historical legacies of separate Community Hospital provision and past management, together with their associated staffing, presents a challenge for the Devon commissioners and providers in terms of current consistency. The Care Quality Commission firmly places responsibility with the service provider (NDHT) for ensuring patient safety and good quality care through the provision of adequate staffing.

- Registered Nurse per Bed

The Hospitals operate, for the majority of shifts, with one Registered Nurse supported by Health Care Assistants. For 10 beds this is outwith the standard set by the CCG (2013) but also means that the Registered Nurse is operating in professional isolation, referred to as *'lone working'* within the Trust Consultation Document.

It is important to recognise that staffing ratios are just one component of a complex arena that must be taken into account when determining safe staffing levels. Other important constituents are:

Patient acuity

Patient dependency

The environment of care

The competencies and experience of the team

Leadership and management

Multidisciplinary Team engagement

- Supervisory status

The Ward Leaders (Deputy Matrons) are rostered to have 2 management days per week but the deputy matrons have identified that due to staffing deficits they are rarely able to secure protected management and leadership time, having to be rostered to undertake clinical work and direct patient care, often as the only registrant on duty.

6.4 Ward to Board reporting and risk management

In line with the Chief Nursing Officer's publication " How to ensure the right people, with the right skills, are in the right place at the right time" and as part of the Government response to the Francis report, all Trusts in England are required to ensure their inpatient wards are safely staffed at all times, day and night. As part of the commitment to openness and transparency details of planned and actual nursing shifts for each ward are now published on every Trust website and collectively on NHS Choices. Boards have to review compliance to safe staffing levels a minimum of bi-annually.

There is a professional, moral and legal duty of care to ensure staffing levels are adequate. Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments. This right is enshrined within the National Health Service (NHS) Constitution, and the NHS Act 1999 makes explicit the Board's corporate accountability for quality.

Nurses' responsibilities regarding safe staffing are stipulated by the Nursing and Midwifery Council (NMC), covering every registered nurse in the UK. And in England, demonstrating sufficient staffing is one of the six essential standards that *all* health care providers (both within and outside of the NHS) must meet to comply with Care Quality Commission (CQC) regulation.

A number of reports have been forwarded to the reviewer which demonstrate that compliance to staffing levels across the Trust have been formally reported to the Board. In addition, concerns about the Community Hospitals infrastructure and inconsistent staffing have also been formally reported, as have Serious Incident reports relating to Community Hospitals (for example: Moretonhampstead Community Hospital).

Concerns in relation to Axminster Hospital have clearly been escalating and whilst there do not appear to be any discernible/identifiable patient safety incidents or mortality impact, the staffing deficits are substantial,

exacerbated by the small nature of the Community Hospital environments.

An Impact Assessment (**appendix 3**) has been completed, which does explore creative solutions to address the staffing gaps on a day to day basis. Whilst this is natural and appropriate in the short term it would not be deemed to be fitting or sustainable in the medium or longer term. The professional concerns appear to have reached a 'tipping point' in October 2014, with the advent of more leavers, the inability to recruit and exacerbated by increased sickness absence in November.

The staffing issues across the Community Hospitals Directorate are confirmed as being included in the Directorate Risk Profile.

7.0 Literature Review/Internet Search

The following section provides an overview of relevant literature associated with safe staffing levels. It must be pointed out that there is currently no nationally agreed or accepted ratio for staffing levels in Community Hospitals.

The RCN (2010) have stated that staffing levels have always been an issue. "What is the optimal level and mix of nurses required to deliver quality care as cost-effectively as possible?" is a perennial question.

In the absence of an agreed national standard it is reasonable and appropriate to apply best evidence available and professional judgement, whilst taking into account the inter-related factors identified on page 12 of this report.

Many Trusts in England appear to be using a range of guidance and models to determine appropriate staffing levels for Community Hospitals, to include:

- NICE
- RCN
- Safer Staffing Alliance
- Hurst (AUKUH)
- Professional judgement

As part of the National Quality Board mandate to ensuring safer staffing levels, Trusts have been directed to an evidence-based acuity audit using the "Safer Nursing Toolkit ". This audit enables nurses to assess patient acuity and dependency to ensure that nursing establishments reflect patients' needs. The audit, alongside the senior nurses' professional judgment, determines the optimum staffing levels for each ward. The 'Safer Nursing Toolkit' is being incrementally adopted throughout Northern Devon Healthcare NHS Trust, as confirmed by the Associate Director of Nursing.

There is a comprehensive and growing body of research and evidence indicating that nurse staffing levels has a significant impact in terms of patient outcomes.

There is a strong correlation between nurse staffing levels, the quality of nursing care, and patient outcomes. This includes measures such as patient length of stay, complication rates, failure to rescue and mortality rates.

Whilst this review focuses on NHS England and UK literature it is worth noting that a number of health systems around the world have introduced

mandatory minimum staffing ratios such as a minimum of one nurse to five patients in California, and at least five nurses per twenty patients in Victoria, Australia (RCN, 2010).

Settings where there is high nurse to patient ratios are strongly associated with improved patient outcomes. Kane et al (2007) highlighted an international meta-study with data from hundreds of thousands of patients, estimated that each additional full time nurse per patient day saved five lives per 1,000 medical patients, and six per 1,000 surgical patients.

Evidence suggests that when ratios exceed eight patients per nurse, the risks to patient safety increase significantly. For example, surgical patients in English hospitals exceeding this ratio experienced a 20 per cent or more increase in the odds of death (Rafferty et al, 2007).

As the need for nursing care depends on a wide variety of factors, it is difficult to determine an optimal level of staffing necessary to deliver good quality care which can be applied generically. There are conflicting views, outlined in the literature, as to whether a minimum standard is appropriate. However, work undertaken by the esteemed Safe Staffing Alliance (2013) identifies that "*Under no circumstances is it safe to care for patients in need of hospital treatment with a ratio of more than eight patients per registered nurse during the day time on general acute wards, including those specialising in care for older people."* The RCN (2013) have highlighted that whilst the conclusions of the Safe Staffing Alliance definitively show that more than eight patients per registered nurse is an unacceptable risk, this does not imply that a ratio of fewer than eight patients per nurse can be considered safe. This is because ratios alone are not sufficient or a panacea. In terms of standards for care of older people, the RCN have purported a ratio of 1 Registered Nurse to 7 patients, with a 65:35% skill mix ratio (RCN, 2012). This is in recognition of the complex needs for the specialised care of older people.

In a survey by Ball and Pike (2009) cited by the RCN (2010), two-fifths of nurses in the UK reported that care was compromised at least once a week due to short staffing.

The survey found that NHS nurses who regularly report that patient care is compromised are working on wards with twice as many patients per RN as those who report care is never compromised. On average wards that have a ratio of no more than six patients per RN on duty rarely or never report that care is compromised due to short staffing. A ratio of eight or more patients per RN is associated with patient care on a ward regularly

being compromised by short staffing (from once or twice a week to every shift).

7.1 High profile enquiries

The focus on nursing and staffing, as a key determinant of the quality of care experienced by patients, has become increasingly prominent over recent years, with several high profile public enquiries highlighting the importance of ensuring appropriate nurse staffing capacity and capability.

The serious short comings associated with the quality of patient care at Mid Staffordshire NHS Foundation Trust are well known and publicised.

For the purposes of this review they are summarised as the Francis Report is, without doubt, the most influential inquiry to impact on the setting of standards for staffing in recent times.

The Francis review was prompted by unusually high reported mortality rates between 2005 and 2008 in Mid Staffordshire. Following an initial investigation and independent inquiry, a public inquiry was commissioned, led by Robert Francis QC. The public inquiry, published in 2013, identified significant shortcomings in leadership, workforce planning, and nurse staffing levels.

Francis identified that financially motivated reconfigurations resulted in many serious cases of understaffing and he noted that "the numbers had always been tight, and declined during the period with which the inquiry [was] concerned" (Francis R, 2013). The workforce also suffered from skill mix dilution, as a ratio of 60 per cent registered to 40 percent unregistered nursing staff fell to a 50:50 split, with intentions to further reduce the proportion of registered nurses (Francis R, 2010).

The final report of the Mid Staffordshire Public Inquiry made a number of recommendations relating to staffing levels, including that NICE be commissioned to develop nationally validated workforce tools, that Trusts be required to risk assess any changes to workforce configurations, and that Trusts consult nursing directors on the impact on patient safety of proposed staffing changes (Francis R, 2013). NICE have now published their guidance and Trusts in England report to their Boards six monthly on staffing level compliance against standards. The NICE guidance is reviewed later in this report.

A similar set of contributory factors were identified repeatedly in high profile care crises. The Healthcare Commission in its investigation reports on outbreaks of *C. Difficile* at Stoke Mandeville Hospital and at Maidstone

and Tunbridge Wells reveal a number of similarities between the Trusts. Both had undergone difficult organisational mergers (which impinged on systems for clinical governance and risk assessment), were pre-occupied with finances, had poor environments, and had very high bed occupancy levels. And, as at Mid Staffordshire, financial pressures led to the Trusts reducing further already low numbers of nurses. The effect in all three cases, apparent from patient and staff comments, was that too frequently basic nursing care was not provided, putting patients' safety and lives at risk.

Building on the findings of the Mid Staffordshire Public Inquiry, the Prime Minister commissioned a review by Professor Sir Bruce Keogh, the NHS Medical Director for England, into 14 Trusts that were consistently high outliers on two measures of relative mortality rates, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator). While the review did not find any failings on the scale of those that occurred at Mid Staffordshire, it did identify a number of significant causes for concern, notably, "inadequate numbers of nursing staff in a number of ward areas, particularly out of hours, at night and at the weekend...compounded by an over-reliance on unregistered support staff and temporary staff" (Keogh B, 2013). In some cases, "there were insufficient nursing establishments, whilst in others there were differences between the funded nursing establishments and the actual numbers of registered nurses and support staff available to provide care on a shift by shift basis". The final report of the Keogh Mortality Review recommended the ambition that "nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by Trust Boards".

7.2 The Royal College of Nursing

The above mentioned high profile reviews focus predominantly on patient outcomes but short staffing compromises care both directly and indirectly and is well known to impact on staff too.

Recurrent short staffing results in increased staff stress and reduced staff wellbeing, leading to higher sickness absence (needing more bank and agency cover), and more staff leaving. The impact of inadequate staffing has been repeatedly highlighted, year on year, as a matter for urgent attention by the Royal College of Nursing.

A large scale survey of RCN members exploring nurse wellbeing found that on average nurses score more poorly on the Health and Safety Executive (HSE) stress exposure scale than the benchmark average. Nurses with the worst stress scores were more likely to have lower job satisfaction, and were most likely to want to leave their jobs. This

downward spiral is not only costly to the individual nurses caught in the cycle, but is costly to the health service in terms of:

- sickness absence costs
- turnover costs
- ill-health retirement
- agency and bank cover

The Chartered Institute of Personnel and Development's absence management survey estimates that 10 million working days a year are lost to the NHS due to sickness absence at a total cost of £1.7 billion a year. On average sickness absence in the NHS in England varies between 4-4.7 per cent depending on the time of year. Interestingly the highest levels of sickness absence are recorded in specialties such as elderly and general medicine, which have lowest levels of RN staffing relative to patients (RCN 2010).

7.3 The National Quality Board: "how to ensure the right people, with the right skills, are in the right place, at the right time"

In 2013 the National Quality Board, sponsored by the Chief Nursing Officer for England, published the above titled guidance to support organisations to make the right decisions and create a supportive environment where staff are able to provide compassionate care. It set out the expectations for commissioners and providers for getting nursing staffing right in order to ensure the delivery of high quality care and the best possible outcomes for patients.

This publication does not define staffing ratios per se. It highlights the complexity of determining safe staffing levels and stresses that there is no single formula or ratio that calculates the right answer. The report states that getting the right number of staff with the right skills and competencies is not something that should be mandated or secured nationally, stressing this is a local determination.

7.4 NICE: Staff Staffing Guideline 1 (2014)

The Department of Health & NHS England commissioned NICE to develop evidence-based guidelines on safe staffing following the publication of the Francis Report (2013), The Keogh Review (2013), the Cavendish review (2013) and the Berwick Report (2013).

The guideline makes recommendations on safe staffing levels for nursing in adult inpatient wards in acute settings. It identifies that there is no single nursing staff-to-patient ratio that can be applied across a whole range of wards to safely meet patient needs. It does identify a range of factors that should be systematically assessed at a local level to determine staffing establishments, these include:

- Patient factors
- Ward factors
- Nursing staff factors

The guideline does recommend that a Registered Nurse should care for less than 8 patients in a shift and this excludes the nurse in charge.

The RCN in its publication 'Safe Staffing for Older People's Wards" (2012) highlight that the complexity and intensity of care needs for older people means that nurses need to exercise a high level of knowledge, skill, competence and compassion yet there is an unmistakable imbalance of resources and a dilution of skill mix for this vulnerable group.

7.5 Keith Hurst modelling

Keith Hurst is a respected national authority on the relationship between staffing and patient outcomes. He has been studying evidence-based staffing levels for many years and from 2006 has evolved his work to include the importance of patient dependency and acuity to determine appropriate staffing levels. In 2008 he published work on a major UK staffing study which aimed to overcome weaknesses in patient classification models and workload assessment tools. His work built on the Association of UK University Hospitals (AUKUH) ward staffing multipliers, which are work-based, nurse-to-patient ratios. The modelling is now widely used across the UK, complimented by acuity tools.

7.6 Professional Isolation

The Northern Devon Healthcare NHS Trust have highlighted concerns about 'lone working' within their consultation document, as a significant factor affecting staff. In defining this, the author has explored the concept of lone working and the literature associated with the concept of isolation, geographically and professionally. This is important in the context of the prescribed staffing levels for Axminster and Seaton, where the actual establishment means that there is often only one Registered Nurse on duty per shift. This professional isolation is further exacerbated by the geographical nature of the Community Hospitals, where they are often single-ward buildings with a significant distance apart.

An integrative review by Martha Williams (2009) sought to critique and analyse empirical and theoretical literature on the concept of rural professional isolation. Her research focused on the shortage of nurses in rural communities and the challenges to recruiting and retaining nurses where professional isolation has been cited as an inhibitor to a stable workforce. Professional isolation has been defined as being distanced from

peer support, professionally working alone characterised by sole practitioners working in very small teams in non-urban locations. The evidence is strong in that professional isolation has been cited as a barrier to recruitment, retention, competence and continuing professional development.

7.8 Vacancies & attrition

Effective recruitment and retention of an educated, skilled, caring and compassionate workforce is critical for delivering high quality, safe, effective care and support for people who need it.

The challenge is to ensure that the nursing workforce has the right number of people with the right skills, knowledge and behaviours to consistently provide high quality, compassionate and appropriate care, in order to achieve the aims and expectations of the Trust Board, Government, the profession and, importantly, the public.

With the NHS already struggling to ensure it has safe staffing levels in place, the challenge is likely to grow over the next five to ten years as growing demand for nursing care outstrips a stagnating or declining supply of registered nurses. Current workforce models have identified a high likelihood of a significant nursing shortage, and urgent action will need to be taken to secure the future ability to provide safe levels of staffing in the England health service.

The national shortage of Registered Nurses has been articulated by the Royal College of Nursing. According to workforce data and projections, the health system in England will be experiencing a deepening national nursing shortage. While it is difficult to pinpoint the difference between supply and demand at any given point, the RCN believes there is growing evidence that employers are starting to experience serious challenges in recruiting staff in the right numbers and with the right skills to meet demand.

NHS Employers published a paper outlining the results of an NHS Registered Nurse Supply and Demand Survey conducted in May 2014. Some of the main points of the survey are identified below:

90 NHS organisations took part, of which:

- *39% have 1 – 50 hard to fill nurse vacancies*
- *36% have 50 – 100*
- *8% have 100 plus*
- *There is a 10% vacancy rate on average – i.e. posts not permanently occupied.*

- *45% have actively recruited outside UK in last 12 months (Spain, Portugal and Ireland being most popular)*
- *51% are considering overseas recruitment in next 12 months*
- *60 of the organisations surveyed are planning to increase nursing establishments*
- *Hard to fill band 5 medical nurses have been reported by 20% of the organisations surveyed.*

Formal Turnover rates are based on the number of starters recruited into the department/Trust and the number of staff who exit the organisation. Staff who leave to another role through either promotion or into a different department or division are generally not included in the published turnover rates. Turnover measures use data on annual joiners and leavers to provide a stability index (defined as the percentage of staff in the organisation for at least a year). Average length of service can also be used as a proxy. High workforce turnover may result in frequent uncovered vacancies and inefficiencies in workforce expenditure, and may also be indicative of a poor working environment.

It is difficult to determine the ideal turnover rate, it can be good and bad. If it is too high it could be disruptive and costly but at the same time could save money and improve quality depending on the performance of individuals who leave. If it is too low then an organisation may not be attracting new recruits with new ideas and creativity. NHS Wales & Scotland have cited that an average, satisfactory turnover rate is about 6%.

Northern Devon Healthcare NHS Trust have identified issues with recruitment and this is particularly evident for some of their Community Hospitals.

This picture is supported by the Royal College of Nursing who believe that a key cause of inadequate staffing levels is under capacity in the workforce, with a great many vacant posts across the system. The RCN undertook a survey in early 2013 of around 2,000 ward sisters and found that 69 per cent reported a difference between the total funded establishment and the number of staff actually employed in post. Of these, 52 per cent reported that actual staffing complements were slightly under the funded establishment and 34 per cent reported they were significantly under the funded establishment. Reasons for understaffing included cuts to posts (reported by 27 per cent of respondents) and vacancy freezes (25 per cent), but difficulty recruiting was found to be by far the most significant cause, reported by 53 per cent of respondents (RCN, 2013).

8.0 Telephone interviews

A range of staff from Clinicians to Managers, employed by Northern Devon Healthcare NHS Trust, were engaged in an individual telephone discussion, using a pre-prepared framework to enable a semi-structured interview.

All interviewees were professional, engaging, well-informed and helpful.

It was striking that, without exception, there was significant professional concern being expressed about the viability of services and the sustainability medium to longer term, because of the '*dire*' staffing position.

A day-to-day challenge, and pressure, was articulated by clinicians who are faced with regular staffing deficits that are deteriorating. One individual cited that they have sleep deprivation worrying about staff cover. This is a situation that is intolerable.

The resilience, professionalism and commitment of the nursing teams across Seaton and Axminster Community Hospitals were articulated strongly. This was particularly the case when discussing the impact of the current staffing situation against key performance indicators and patient safety incidents (of which there appear to be few adverse events). The expressed view is that the tenacity and commitment of the nurses is tantamount to the provision of high quality care. The nursing teams have demonstrated high flexibility, regularly being asked to transfer to other units to provide cover and amend their rostered shifts. Whilst this is laudable it is not sustainable and will undoubtedly have a discernible future impact on staff morale and resilience.

There was an evident frustration amongst some of the interviewees regarding the potential risks to patient safety and staff experience, exacerbated by a perceived delay in making and taking a decision to ensure safer services. The consultation proposals appear to be strongly supported despite a palpable pride and passion regarding the provision of care within Axminster.

9.0 Findings

The summary of findings is aligned to the Terms of Reference for the independent nursing review.

- The Care Quality Commission firmly places responsibility with the service provider (NDHT) for ensuring patient safety and good quality care through the provision of adequate staffing. The Northern Devon Healthcare NHS Trust is clearly executing its responsibility to ensure high quality care and patient safety, following reported clinical and managerial concerns, which have been escalating, about the viability of two of its Community Hospitals, namely Axminster & Seaton.

- The Trust declared that its preferred option is to temporarily transfer inpatient services from Axminster to neighbouring Seaton Hospital. This decision appears congruent with decisions made about other Community Hospitals within the catchment. Albeit other decommissioning (temporary or otherwise) has been aligned to published intent by the Clinical Commissioning Group (for example Stroke Services).

- The Trust did not anticipate the strength of public feeling and antipathy towards its decision and has acknowledged that it failed to formally consult on its intention.

- Senior Clinical Leaders and Managers are extremely concerned about the quality and safety for patients and staff welfare, in light of on-going and increasing staffing gaps, exacerbated by recruitment difficulties and sickness absence.

- There are no nationally recognised minimum safe staffing levels for Community Hospitals. That said, with the age profile and co-morbidities of the majority of patients within the Community Hospitals, their acuity and related dependency it is deemed reasonable to apply the NICE Guidance, RCN Guidance and Safer Staffing Alliance recommendations to Community Hospitals. Providing care for older people requires skill and time. This patient group often have the most complex and intense care needs.

- Axminster and Seaton Hospitals operate, for the majority of shifts, with one Registered Nurse supported by Health Care Assistants. For 10 beds this is outwith the standard set by the Clinical

Commissioning Group (2013) but also means that the Registered Nurse is operating in professional isolation, referred to as *'lone working'* within the Trust Consultation Document.

- Professional isolation has been defined as being distanced from peer support, professionally working alone characterised by sole practitioners working in very small teams in non-urban locations. The evidence is strong in that professional isolation has been cited as a barrier to recruitment, retention, competence and continuing professional development.

- In terms of Statutory/Mandatory Training Axminster has 50% overall compliance with statutory and mandatory training (9 out of 18 areas are on/above target). Seaton has 61% overall compliance with statutory and mandatory training (11 out of 18 areas are on/above target). These levels could be deemed to be unacceptable.

- The nurse-to-patient ratios in place across Axminster and Seaton Hospitals do not comply with standards espoused by the Safer Staffing Alliance (2013) which identifies that "*Under no circumstances is it safe to care for patients in need of hospital treatment with a ratio of more than eight patients per registered nurse during the day time on general acute wards, including those specialising in care for older people."* The ratios are also non-compliant to the recently published NICE Guidance (2014) of 1 RN to 8 patients and the standards published by the RCN for the care of older people (2012) which purported a standard of 1 RN to 7 patients.

- The Skill Mix ratio at Axminster and Seaton Hospitals, based on funded establishment and actual establishment, are well below a minimum range of 50:50% (cited in the Francis Review) and set as a standard by the CCG (2013), presenting potential risk to patient safety and staff welfare.

- The Ward Managers are frequently counted in the staffing numbers providing direct patient care, meaning they do not have their 'management/leadership' time.

- Agency expenditure in Axminster Hospital during October was £22,797. Reliance on casual staff can have an adverse effect on patient care.

- Over the rolling year, leavers as a percentage of the Full Time Establishment at Axminster is 22.86%. The average UK turnover rate has been cited as 6%. The Trust is experiencing difficulties in recruitment, despite proactive measures, which is reflective of the national picture of published nursing shortages.

- Based on the data review, Seaton Hospital appears more stable than Axminster, from a workforce perspective, albeit there are evident staffing challenges present in both Hospitals affecting clinical resilience and safety.

- Sickness absence in both Axminster and Seaton Hospitals, for the past year, is below the 3% target. This however belies the peaks in absence which hit a high of 7.51% in November in Axminster.

- There does not appear to have been any adverse patient events in Axminster or Seaton Hospitals despite the significant staffing pressures which are more prevalent in Axminster Hospital. This is testament to the commitment and resilience of the nursing teams.

10.0 Conclusion

In October 2014 the Northern Devon Healthcare NHS Trust Board announced its intention to temporarily transfer beds from Axminster Hospital to Seaton Community Hospital, based on escalating concerns about the provision of safe patient services predominantly attributable to staffing issues.

Following public communication events, arranged post the decision, it became apparent that there was considerable antipathy towards the Board decision and public confusion as to the rationale for the pronouncement. The Board therefore halted its plan and embarked on a formal consultation exercise for the month of December, to include the commissioning of an independent nursing review.

In December 2014 a review was formally commissioned by the Executive Team, Northern Devon Healthcare NHS Trust to conduct an independent, professional nursing assessment regarding the preferred option identified in the consultation, executed by the Board, which proposed temporarily transferring Axminster Community Hospital inpatient services to Seaton Community Hospital.

The assessment included a review of Trust Board documents and data, telephone interviews and a comprehensive literature review regarding methodology for safe staffing.

There is a dearth of guidance relating to safe staffing within Community Hospitals but safe staffing levels are an essential pre-requisite to delivering quality patient care. There is a wealth of research across health systems, worldwide, showing the direct correlation between higher levels of nurse staffing and:

- Improved patient outcomes;
- Improved recruitment and retention;
- Economic benefits to employers and communities.

Staffing ratios are just one component of a complex arena that must be taken into account when determining safe staffing levels. Other important constituents are: patient acuity, patient dependency, the environment of care, the competencies and experience of the team, leadership and management, and multidisciplinary team engagement.

A number of reports and documents, prepared by NDHT, have been reviewed which demonstrate the escalating concerns and professional

anxiety regarding the sustainability of services within Axminster and Seaton Hospitals.

The reviewer concludes that Northern Devon Healthcare NHS Trust has attempted to address serious, significant and escalating professional concerns about safe staffing in Community Hospitals. Their preferred option - to temporarily transfer services from Axminster Community Hospital to Seaton Community Hospital - appears reasonable. It is based on the evidence available, clinical and managerial concern and it is clear, in the opinion of the reviewer, that best practice guidance and Trust data has been appropriately used to inform decision making.

11.0 Appendices

Appendix 1

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Terms of Reference

External Assessment of NDHT decision about safe staffing and viability of safe patient care at 10 bedded community inpatient hospitals (Axminster)

This report is required within the timeframe of the wider consultation process, the Board will use it to consider their options when they meet week commencing 5 January 2015.

Looking at the following areas, has NDHT been objective in its decision making re patient safety at Axminster Hospital

- Was the setting of nursing safe staffing levels in accordance with national picture?
- Are these nursing staffing levels in accordance with similar Trusts/Provision?
- Are these nursing staffing levels robust across all community hospitals in the Trust? Do they benchmark with one another? Do they benchmark the Trusts other inpatient nursing provision?
- Does the decision for Axminster reflect the same triggers and decision making which has been applied to other recent patient safety decisions in Ilfracombe and Crediton.
- Has appropriate consideration and objectivity been given to the following
    - Lone working for registered nurses
    - Patient safety and harm events and impact upon quality indicators
    - Proportion of temporary staffing use
    - Impact of service/staffing constraints on patient outcomes, for example how does temporary staffing affect patient flow and discharge planning for patient pathways

- Has appropriate medical cover been assessed as part of the overall assessment? Does the level of medical management and overview support safe patient care?
- Have the Trusts data sets and "soft intelligence" been used objectively to inform Executive and Board decisions re risks

associated with safe staffing and patient safety at Axminster (and in the community hospitals?)

- Is the clinical leadership message getting from ward to Board effectively?

Appendix 2

Framework for Telephone Discussions

General:

- Introductions & confirmation of role and responsibilities
- Purpose of the independent review (Terms of Reference)
- Confidentiality
- Naming in report – acceptance/agreement?

Overview:

1. Overview of Axminster & Seaton Community Hospitals
2. Outline the speciality for each Hospital
3. Geography & geographical layout
4. Innovation (eg Productive Ward series)

Activity and performance:

1. ALOS
2. % Occupancy
3. Turnover interval/throughput
4. Budgetary position

Nursing establishments:

1. Staffing levels
2. Skill mix ratio
3. Supervisory status of Ward Leader
4. Casual worker utilisation (Bank & Agency use)
5. Absentee rates
6. Staff turnover and length of service
7. Compliance to staffing baseline
8. Exit questionnaires
9. Budgetary position

Clinical Teams:

1. Medical Model
2. Allied Health Professionals
3. Ward Clerk provision
4. Other? (to include morale)

Safety & Quality (Clinical Governance)

1. Key Performance Indicators

2. Nursing Metrics
3. Patient Experience surveys
4. Staff Experience surveys
5. Risk Profile & escalation processes
6. Continuing Professional Development – opportunities and compliance to training

Appendix 3 – Staffing Impact Assessment

Proforma for reviewing safe staffing

A useful tool as a prerequisite to escalating concerns

for completion by Matron

A useful tool/prompt to ensure al reasonable efforts have been explored when safe staffing may be impacted upon.

This tool assists you when thinking about continuity of service and safe staffing; we have other tools for escalation of acuity and enhanced care need.

Complete all sections, with a narrative/explanation, not just a yes/no please

Risk assessment re: Axminster Hospital, 10 bedded inpatient ward staffing from

Area to explore	Outcome
Can matron base themselves in this unit, if covering more than one, for a period to support?	Realistically, for a short time period only: days not weeks. However this risk assessment covers a period of weeks/months. Also 'base themselves' will not help in terms of whether a trained nurse is needed or not with such small nos. – it would mean being one of the numbers on the shift. Therefore this would impact practically on other work: eg HR investigations/hearings/ SIRI investigations, SEAs, and leadership support to other sites. There would also be an impact on matron's walk rounds, attendance at 1-1s, and all other forums/committees where matron representation is expected.
Has the roster been scrutinised by the band 7 and 8 to ensure all efforts made to achieve effective cover? Is all non-clinical time essential Consider this across period of time	Yes. Rosters are scrutinised by both the band 7 and 8 prior to approval. Study leave is minimal but will be checked to see the necessity of the sessions for next month by Band 7.

causing concerns	
Have part time staff been asked if they want additional shifts?	Yes. Part-time staff regularly work additional shifts. All staff frequently change shifts, work split duties, stay on late.
Has annual leave been reviewed, right amount of people off?	Yes This particular week we have no annual leave Every month rotas are approved by firstly the ward manager, and then the matron before issuing to staff. The amount of AL being taken is always considered and reasons for any discrepancies explored by the matron.
Have all shifts vacant, been referred to NHSP and if required unlocked to agency?	Yes. Fill rate by NHSP is not good for RNs or HCAs. There are no RNs on NHSP that pick up shifts at Axminster and very few HCAs. If the shifts are unlocked to agency as soon as they go on the system then we have a better fill rate, but if left to the agreed time frame then we have poor fillage rate
Have lines of work been requested?	Yes. At present we are using 2 long line RNs and we are trying to arrange some long line HCAs for the New Year. None are able to be supplied by NHSP so have now requested agency if available.
Have neighbouring teams been asked if they can assist? Community hospitals and community?	Seaton, Sidmouth, Exmouth Community Hospitals are both below normal staffing levels
Has the Director of Nursing been asked if other Trusts can assist us? (Assistant Directors can assist you with this)	No.

Is sickness being actively managed, what is the %. Describe process at the moment for active cases? Also indicate if the % has increased during this period of concern? Clarify if any of this sickness Manual Handling, or stress related?	Yes. We have one RN on long term sick 1 HCA long term sick who will be retiring probably in January We have two other HCAs retiring end December No other current sickness issues at present. All staffs sickness being managed as policy recent meeting with Marjorie Mullins to go through sickness issues all up to date. None of these issues are for stress or manual handling issues Latest data: Annual Leave for this week - 0% Sickness RNs 5.7% (which is just 1 nurse) HCAs 2.4%
Have those on maternity leave been approached to see if they would like to be paid annual leave and return early from extended leave attached to maternity leave?	None on maternity leave at present. One RN going on maternity leave end January beginning of February 2015
If anyone is on special leave, could this be reviewed as Restricted practice?	Not applicable.
Could band 7 on site clinical lead do one additional day a week clinical?	Band 7 already adapts clinical time vs. managerial time to cover clinical shifts. She always puts patients first and stays late or comes in early to undertake her managerial work, band 8 taken work from her to help.

	Not sure when she last had a complete managerial day
Is there anyone seeking redeployment that could help?	Unaware of any individuals – HR to advise.
Can any non-essential training be moved to a time when staffing less concerning?	Possibly in the short-term (eg;1 month) but for any longer would have detrimental effect on: 1. Quality and safety % compliance with training
Can bed base reduction be considered, have conversations happened with managers re this possibility ?	No. I would suggest this is not possible in a 10-bedded area. Any reduction in beds would still require same nos. of RNs therefore no benefit.
Can colleagues from other departments assist, ie MIU and outpatinets?	We only have 3 part time HCAs which cover outpatients clinics in Seaton Sidmouth and Axminster, if these staff were taken from clinics then clinics would have to be cancelled
Have you spoken to the operational manager about reducing admissions for a short period until safe staffing possible?	No. I would suggest this is not possible in a 10-bedded area. Any reduction in beds would still require same nos. of RNs therefore no benefit. Reduction in admissions would be possible, however, this would result in very small nos. of patients which would help with the low HCA numbers but not the RNs
Can you inform us here if the skill mix as well as the numbers are being achieved?	Morning shift should be x 1 RN and 2 HCA. Late shift 1 RN and 2 HCAs Nights 1 RN and 2 HCAs On January

If skill mix diluted , please specify how frequently this is occurring	off duty only 1 or 0 HCAs able to be rostered. From 5/1/15 when we were expecting the temporary closure of beds the problem the problem reaches crisis point with some days having no HCAs to roster on duty. It is not acceptable to plan to run unit with x1 RN on every shift or a shift with no ward HCAs working. It raises safety and governance issues as well as workload and is against NICE guidance.
What proportion of temporary staffing would you be using to cover the rota during this period of concern. In % against overall staff on ward in a week.	During the 2 week period of the rota commencing 5/1/15, there are 5 shifts currently uncovered without any RN rostered. This is because there is no annual leave this week in subsequent weeks this number will be higher. This would result in agency staff working alone – if the shifts were successfully covered - and possible handing over to other agency staff. This is happening at present with our 2 long line RNs who have been working, which is not acceptable to plan to do this – only in exceptional circumstances. We also have 32 HCA shifts not covered which will means on most shifts there will only be 1 ward HCA on duty.
During period of concern is any of the patient safety or patient experience data raising concerns in relation to sustaining quality and safety.	No actual concerns currently, but with the acuity and dependency of the patients nursed at Axminster there is a risk to sustaining quality and safety with the predicted staffing levels available.

Any rise in complaint or concerns being raised by relatives/visitors/carers?	No
Any safeguarding issues being raised?	No

Options/Recommendations:

1. Lines of work covered by Agency to cover shortfall. (Short-term only acceptable with lone working and governance risk, also risk of being unable to obtain sufficient staff.)
2. For temporary bed closure to go ahead as planned, if this does not happen and staff do not go from Axminster to other units Exmouth, Sidmouth, Rapid Response, Community, SAS out patients all these services will be affected and these units will also be at risk.
3. Reduction in bed base at Sidmouth to release staff to cover Axminster. (Risks of lone RN working if reduce to 10)