Nursing And Midwifery Task Group (NMTG)

Report and Recommendations

March 2020

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FOREWORD FROM SIR RICHARD BARNETT

It has been an absolute privilege to have chaired the Nursing and Midwifery Task Group (NMTG) over the last two years. I am completely humbled by the work of nurses and midwives and the amazing contribution they make to the lives of people across the life course every day in Northern Ireland (NI).

NI like the rest of the United Kingdom faces the challenges of rising demand which far exceeds the resources available. This reality as set out in 'System not Structures'[1] is putting enormous pressure on a system not designed to meet the changing needs of the population. There is growing consensus that for health and social care services to become sustainable, it cannot keep doing what it has always done. Without significant transformation, it is conceivable that the entire NI block grant would be needed to meet the demand being placed on health and social care. This is why I believe the transformation of nursing and midwifery services is essential to the stability and sustainability of the NI health and social care system.

During the course of the review I met with hundreds of nurses and midwives and their dedication, often in difficult circumstances, must be commended. Nursing and midwifery are the backbone of the NI health and social care system, and whilst those who lead nursing and midwifery are clearly committed to enhancing the professions contribution, it is crucial that nursing and midwifery are seen as an asset by all those involved in leading health and social care delivery. During the course of my review the Department of Health commitment to addressing the challenges facing nursing and midwifery is clearly evident through the provision of significant transformation funding of over £50million. This investment contributing to safe staffing, has enabled a significant growth in the numbers of undergraduate nursing and midwifery places and has enhanced a wider range of nursing specialisms and midwifery services. Clearly this level of investment needs to be sustained and the recommendations set out in this report will require the development of a costed implementation plan.

I believe an investment in nursing and midwifery is not only an investment in the lives of people who need care, but also in the NI economy. This report sets out an ambitious future agenda for nursing and midwifery which I believe will make a significant contribution to the transformation of health and social care, as set out in the *Health and Wellbeing 2026: Delivering Together* 2026 Vision. The recommendations in this report will facilitate the:-

1. Adoption of a population public health approach and put prevention and early intervention at the heart of nursing and midwifery practice.

2. Stabilisation of the nursing and midwifery workforce therefore ensuring safe and effective care.

3. Transformation of health and social care service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams (MDTs).

I want to thank all those who contributed to the formulation of the recommendations in this report. I believe if these recommendations are implemented, nurses and midwives can be confident that they will be able to deliver sound evidence based care, with the right numbers, at the right time, in the right place, by the right person with the right knowledge, and of course most importantly delivering the right experience for people, families and their communities.

Sir Richard Barnett
Chair of NMTG

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

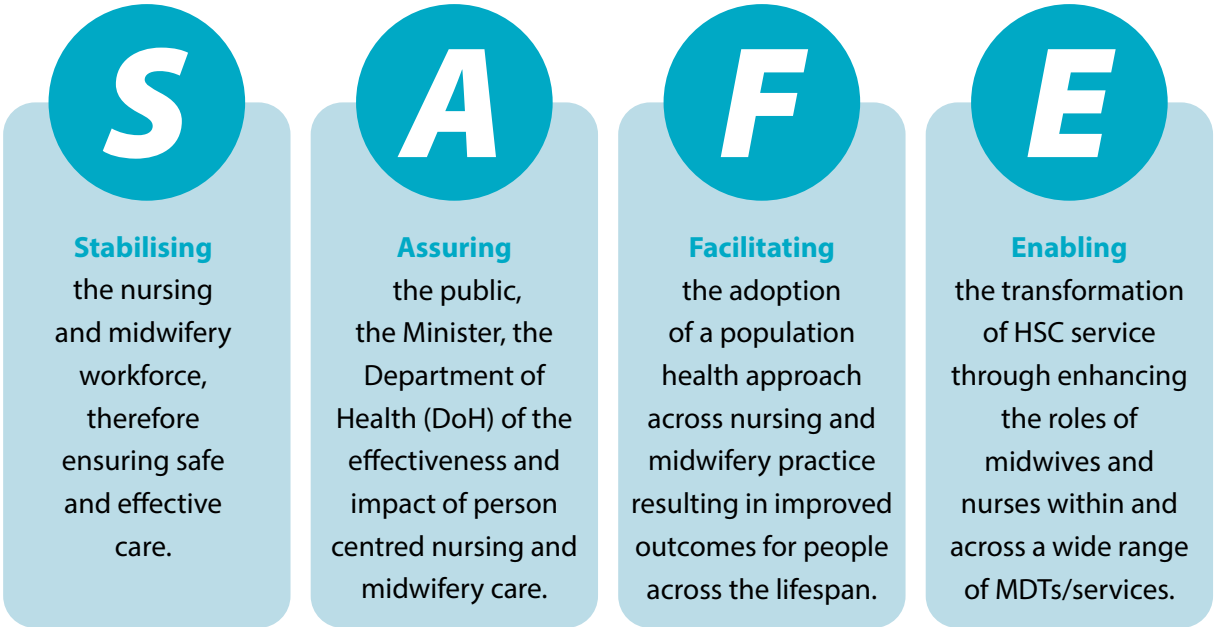
1. NMTG Context

The previous Health Minister, Michelle O'Neill established a NMTG independently chaired by Sir Richard Barnett. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured Health and Social Care (HSC) system over the next 10-15 years. The group were asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes.

2. NMTG Review Methodology

The review team adopted an outcome based accountability and co-production approach and set up three major workstreams to provide focus and concentrate the work on how the contribution of nursing and midwifery could be maximised to improve outcomes. Almost 1,000 participants from all branches of nursing, midwifery, including representatives from independent sectors and from other professions took part in over 36 events. The findings from these events were compared with a wide range of evidenced based literature and were used in the formulation of the report's recommendations.

In line with the terms of reference of the NMTG, the recommendations set out in this report provide a 10—15 year road map which will deliver ***S.A.F.E*** care through:-



3. NMTG Overview of Work Streams

The Nursing and Midwifery Workforce

This workstream focused on four core areas: building and sustaining safe stable teams; the scale of the workforce focusing particularly on the numbers of pre and post registration nurses and midwives; exploration of evidenced based options for the further development and/or introduction of new nursing and midwifery roles in order to improve outcomes; and the depth and breadth of nursing and midwifery leadership.

Long Term Conditions (LTC)

This workstream focused on identifying the contribution of nursing and midwifery across primary, community, acute, specialist nursing and midwifery services. To do this a number of long term conditions (LTC) were chosen to explore how the contribution of nursing and midwifery could be maximised, which included frailty, diabetes and respiratory conditions. These conditions ranked in the top for admissions to acute care and their prevalence in primary care and effect on pregnancy and the baby. In addition, two further sources of information were included: the findings from a review into the role of mental health nursing commissioned by the Chief Nursing Officer (CNO); and the findings from a focus group discussion with learning disability nursing. The LTC chosen were indicative and were used to help model the recommendations for nursing and midwifery now and in the future.

Population Health Work Stream

Maximising the contribution of nursing and midwifery in terms of improving population health outcomes was a core objective of the review. This workstream analysed a range of public health data, particularly data relating to the impact of deprivation, adverse childhood experience, mental health and lifestyle choices on health and wellbeing. As a result the workstream focused on the actions needed to not only 'make every contact count' (MECC) but those required to build a strong public health agenda within and across nursing and midwifery services.

4. NMTG Key Findings

Workforce Planning

Unsurprisingly the issues surrounding workforce predominated discussions. The report emphasises that nursing and midwifery as the single largest group (representing 34% of the health care workforce) is fundamental to the delivery of a sustainable health and social care system. Therefore investment in nursing and midwifery needs to be

commensurate with its role in providing care across the lifespan. Workforce data indicates that 94% of the workforce are female and 6% male, and almost 60% of the nursing workforce hold posts at Band 5 and midwives mainly at Band 6. This is over double the amount, when compared with other professions categorised as Band 5. Indeed with the exception of Band 6, when compared with other professions at Band 7 and above, nursing and midwifery has significantly lower number of clinicians at senior grade. Alongside workforce shortage the report identifies the lack of specialist and advanced clinical posts as a major concern, particularly the impact on delivering the ambition outlined in Deliver Together (2026). The report also highlights the increasing number of nurse and midwife vacancies, which have grown to an average of 12% (2,500 posts).

In addition, agency spend has risen from £9,852,129 in 2010/2011 to £51M in 2018/2019. Bank costs have also doubled from £30M in 2010/11 to £61M 2018/19. Clearly this is very concerning, not only in cost terms, but also its impact on the stability of the workforce. Therefore the report recommends the need for a five – ten year sustainable plan to increase the number of undergraduate places. It should be noted that the increase in the number of undergraduate places made possible by transformation funding provides a foundation for growth. This however needs to be sustained in order to keep pace with both population and workforce demographics. There was also a significant call for the introduction of legislation for safe staffing in order to safeguard patient care.

Postgraduate Education

In terms of postgraduate education the report highlights that in order to both retain and develop our nurses and midwives there is a need to restore and incrementally grow postgraduate training budgets. Over the last ten years the core postgraduate education budget in nursing and midwifery has progressively decreased from £10.8 million to £7.3 million. This reduction has been further compounded over this time period by an increase in postgraduate education costs and the increased costs associated with backfill for some of the training places. It is important to note however over the last two years these reductions have been offset by non-recurrent transformation funding. In the absence of sustained recurrent transformation funding and/or a restoration of core funding commensurate with the size of nursing and midwifery workforce, this will have significant implications for nursing and midwifery practice, career pathways, and wider health and social care reform.

Morale and Collective Leadership

The report also emphasises the need to address the morale of the profession, reduce bureaucracy and the unwarranted variation in the roles, teams and the structures of nursing and midwifery, from point of care to the boardroom. One of the core recurring messages that emerged from all those who participated in the workshops was a perspective that nurses and midwives do not feel valued as equal members of the MDTs. This was strongly linked to the fact that the vast majority of nurses are Band 5. This was further compounded by the lack of a systematic approach to workforce development and therefore opportunities for career or grade progression have been limited. A review of the roles and functions of nursing and midwifery leadership also showed significant variation in managerial infrastructure. The lack of dedicated investment has highlighted the need for bespoke leadership development. Across all of the workshops the issue of pay divergence with other professions and the rest of the UK was a recurring concern.

Public Health and Population Health

In relation to population health, there was a strong message that promoting health and wellbeing for the population of NI should be every nurse and midwife's business. Nurses and midwives felt their public health contribution had been compromised largely because of competing demands in their roles. It was also determined that the lack of dedicated and recognised public health nursing roles was also a compounding factor. The epidemiological and demographical realities over the next 10 – 15 years create a strategic imperative to maximise the contribution of nursing and midwifery in improving population health and wellbeing outcomes across all ages, all settings and all communities. The development of primary care Multi-disciplinary Teams (MDTs) creates a real opportunity to enhance the public health nursing roles, particularly in health visiting, mental health nursing and district nursing.

Socio-economic Value of Nursing and Midwifery

Whilst more bespoke work is needed on the socio-economic value of nursing and midwifery, we compared our findings with a wide range of evidence based literature. The report draws on a plethora of emerging evidence that correlates improved patient experience, and outcomes (reducing morbidity and mortality) with increased graduate nurse patient ratio. In addition, there is clear evidence that public health and early years nursing (Midwifery, Health Visitor, School Nursing, Paediatric and Family Nurse Partnership) contributes significantly to enabling the best start in life and in particular reducing risks associated with poor lifestyle choices and in promoting developmental, psychological and social wellbeing. Further evidence now shows that Specialist and Advanced Nurse Practitioners (ANPs) improve clinical care outcomes and provide a cost effective solution in augmenting the role of doctors.

5. Department of Health Transformation Programme

Since the launch of *Health and Wellbeing 2026: Delivering Together* the Department of Health (DOH) has made significant investment in a wide range of nursing and midwifery services with over £50M invested in three key critical areas:-

Workforce Stabilisation

An additional investment of £7M undergraduate education has enabled the highest number (1025) of nursing and midwifery training places commissioned in NI 2019/20. This represents an increase of 45% from 2015/16 and demonstrates the Department of Healths commitment to addressing the current shortages and growing the local nursing and midwifery workforce.

In 2016 the Department embarked on a regional international nursing recruitment campaign with the aim of bringing 622 overseas nurses by November 2020 to strengthen the local HSC workforce. Transformation investment into the Clinical Education Centre (CEC) has supported overseas nurses to meet the essential registration requirements to practice as a nurse in the U.K.

The Department launched its Delivering Care Policy (safe staffing) and has commissioned to date nine discreet phases which have resulted in an investment of over £15.2M.

Workforce Development

The post registration transformation investment of over £7.7 million has delivered significant educational opportunities for the nursing and midwifery professions, benefiting 1,965 participants over the last two years. Investment has enabled a wide range of programmes to be funded to build the clinical expertise and leadership capacity within the workforce. The investment has supported the strategic direction with a focus on community specialist practice programmes such as District Nursing, Health Visiting and School Nursing. Investment in the development of ANP roles in Primary Care, Emergency Care and Children's Nursing has been a significant achievement with the first Masters level ANP programme delivered in NI.

A range of other programmes, including bespoke quality improvement and leadership initiatives have been funded across mental health, learning disability, adult, children services and midwifery. Furthermore, investment has facilitated an innovative post registration nursing Master's programme for NI, designed to develop leadership skills in new nurses and support workforce retention. Additionally, transformation investment in a regional nursing and midwifery data transformation project is assisting the professions with implementing electronic record keeping and digitalisation.

Service Developments and Reforms

The Department has also invested £18M in nursing service developments across the life span. This has resulted in additional Health Visitors (HV) enabling a new ratio of 1 HV to every 180 children. In addition, a District Nursing Framework 2018-2026 was launched that has been designed to enable the delivery of 24 hour district nursing care no matter where you live. This has also enabled a new ratio of 8-10 whole time equivalent (WTE) per 10,000 of the population. Through the establishment of MDTs there has been additional investment in Neighbourhood Nursing teams and in ANP within Primary Care Teams.

6. NMTG Ambition

The recommendations proposed reflect a new vision/ambition to maximise the contribution of nursing and midwifery. It is the ambition that nursing and midwifery deliver the right evidence based care, with the right numbers, at the right time, in right place, by the right person with the right knowledge, and of course most importantly delivering the right experience and outcomes for persons, families and communities.

7. Recommendations

Before moving onto the recommendations of the report it is worth highlighting the recommendations also take account of the new mandatory Nursing and Midwifery Council (NMC) Future Nurse Future Midwife (FNFM) proficiency standards launched in May 2018 (Nursing) and November 2019 (Midwifery). These standards are set to revolutionise and modernise nursing and midwifery practice, and they are strongly focused on evidence based care, delivering population health, and patient and women centred care which will improve outcomes for people. The review team analysed all of the data from the workshops and following a literature review themed the recommendations under three core headings. The recommendations have been framed to reflect a new vision/ambition designed to maximise the contribution of nursing and midwifery.

7.1 Theme 1: Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes: Clearly nurses and midwives have a critical and collective leadership role to play across the lifespan in promoting health and well-being. It is within this context that the report is recommending:

7.1.1 The development of a new population health management programme for nursing and midwifery.

7.1.2 The creation of dedicated population/public health advanced nurse and midwife consultant roles across all of our HSC bodies.

7.1.3 To increase the number of school nurses, health visitors and expand the family nurse partnership programme across all of NI.

7.1.4 Recognising the demographic shifts, nursing needs to have joint and collective responsibility for the development, planning and leadership of older people services, including all nursing care services provided in the independent sectors.

7.2 Theme 2: Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice: Addressing the workforce challenges is strategically essential for the stabilisation of the nursing and midwifery workforce and health and social care delivery, therefore under this theme it is recommended we:

7.2.1 Sustain a minimum of 1000 undergraduate nurse and midwife placements per year for at least the next five years until we have reached a position of oversupply.

7.2.2 Establish a ring-fenced post education budget commensurate with both the size of the workforce and the HSC transformation agenda and as a minimum re-establish the previous investment of £10M.

7.2.3 Build and resource a new career framework for nursing and midwifery to ensure that within ten years we have advanced nurse, specialist midwife and nurses roles, as well as nurse and midwife consultant roles across all branches of nursing and midwifery.

7.2.4 Increase the number of clinical academic careers roles across all branches of nursing and midwifery.

7.2.5 Put Delivering Care Policy (safe) staffing on a statutory footing.

7.2.6 Develop arrangements for accelerated pay progression Band 5 to Band 6 grades similar to other professions. This in particular recognises that many Band 5 nurses after several years of practice acquire additional specialist knowledge and skills and take on additional responsibilities commensurate with Band 6 role as a senior clinical decision maker. Midwives become Band 6 within a year post registration.

7.2.7 Develop a person-centred practice policy framework for all nursing services and continue to develop woman and family centred midwifery services.

7.3 Theme 3: Doing the right things in the most effective way and working in partnership: The recommendations under this theme recognise the need for collective leadership and the development of integrated practice models within and across MDTs. For this to be fully realised there is a need to:

- **7.3.1** Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse/midwife leadership framework and investment in leadership training for nurses and midwives.
- **7.3.2** Invest in improvement science training and increase role of nursing and midwifery leadership in quality improvement initiatives.
- **7.3.3** Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness.
- **7.3.4** Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) new digital nurse leadership role in all HSC bodies.

8. NMTG High level Implementation Plan

In order to take forward these recommendations, a new nursing and midwifery strategy will need to be developed that is in line with *Health and Wellbeing 2026: Delivering Together* priorities. Indeed the Bengoa Report (October 2016) makes clear that system transformation is dependent on the modernisation of practice. Nursing and midwifery in line with the recommendations of this report will undergo significant practice reforms and clearly with a multi-disciplinary approach which is central to the delivering of better outcomes. The recommendations in this report will inevitably require legislative and ministerial approval and the development of a dedicated action plan. Clearly the recommendations will require additional significant investment over a 10-15 year period and this will be dependent on resources being released through service reconfiguration and/or efficiencies as well as securing new investment.


Registered Nurse
Health and Social Care
Registered Nurse
HSC Health and Social Care
HSC Health and Social Care

1

THE TASK

SECTION 1: THE TASK

On 25 October 2016, the then Minister of Health, Michelle O'Neill launched an ambitious 10 year approach to transforming health and social care ***Health and Wellbeing 2026: Delivering Together***[2]. This vision document, based on the findings of the Expert Panel report, led by Professor Rafael Bengoa, ***'Systems, not Structures: Changing Health and Social Care***, recognised that our society is getting older and people are living longer with long term health conditions. The vision document set out the necessary 'change' to deliver the world class health and social care services the people of NI deserve, acknowledging that current health and social care services were designed to meet the needs of a 20th century population, with a requirement for a programme of transformation implemented in a safe and sustainable way that meets the challenges of a 21st century population.

It was within this context and the many challenges facing nursing and midwifery that the Health Minister established a NMTG in 2017. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured HSC over the next 10-15 years. The group was asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes.

The Task Group reflected the current strategic mandates set out in:-

Health and Wellbeing 2026: Delivering Together

Particularly ensuring that the nursing and midwifery strategic direction mirrors the quadruple aim ambition:-

- people are supported to stay well in the first place
- people have access to safe, high quality care when they need it
- staff are empowered and supported to perform their roles - recognising that they are the most valuable resource available to the HSC organisations
- services are efficient and sustainable for the future

As detailed in *Health and Wellbeing 2026: Delivering Together*, the Task Group also sought to reflect the nursing and midwifery contribution to the 'change needed' in:

1. **Building capacity in communities and prevention** particularity in reducing health and social inequalities.
2. **Providing more support in primary care** and at home.
3. **Reforming our community and hospital services** so that our population receive evidence based care in the right place.
4. **Organising health and social care** by ensuring systems are co-designed, and are delivered in the most efficient and effective way.

The group also reflected the strategic objective reflected in;-

- Systems not Structures; Changing Health and Social Care – the Expert Panel Report
- Programme for Government (PfG) Framework 2016 - 2021[3] particularly on creating the condition for the people of NI to 'enjoy healthy active lives'
- Making Life Better – A Whole System Strategic Framework for Public Health 2013 – 2023[4]

The work of the Task Group was to be underpinned by a public health approach that promoted health and wellbeing. It was also expected to identify best practice and innovations in nursing and midwifery practice, embracing and building on work already undertaken across the UK and Ireland and further afield. The Task Group membership was to examine the socioeconomic value of nursing and midwifery and identify potential opportunities for the future. The NMTG was chaired by Sir Richard Barnett, and full membership of the Group is included at **Annex A.**

The 10-15 Year Road Ahead

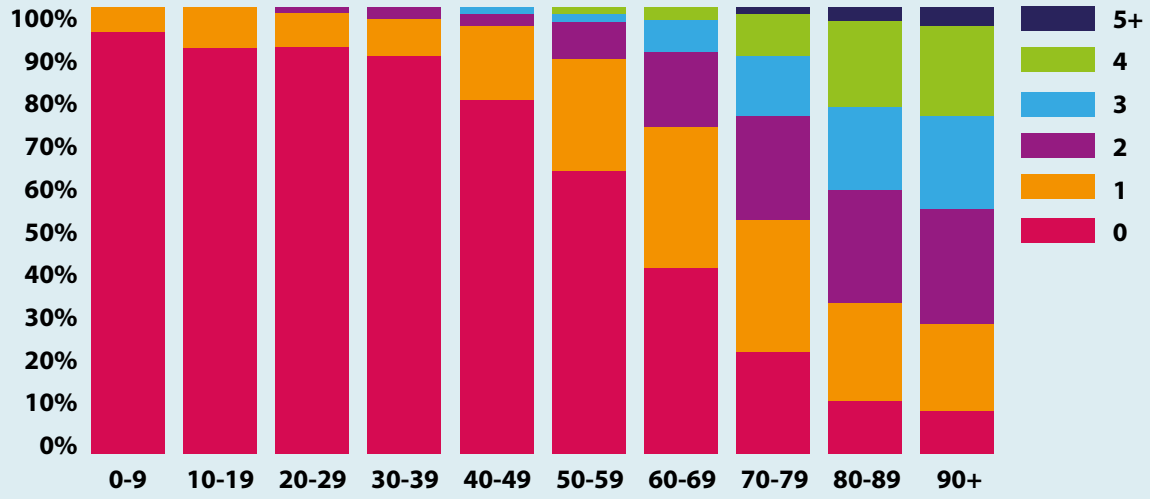
Looking forward over the next 10-15 years, NI like all the other countries of the UK and Ireland is facing a world where demographic realities and the pace of technological and social change will transform the relationship people have with health and social care.

The challenges outlined in **figure 1** will require a systemic, integrated and partnership approach across nursing and midwifery, the wider health and social care system and with the public.

Figure 1 - Reference NI NHS Conferdertion#NICON15

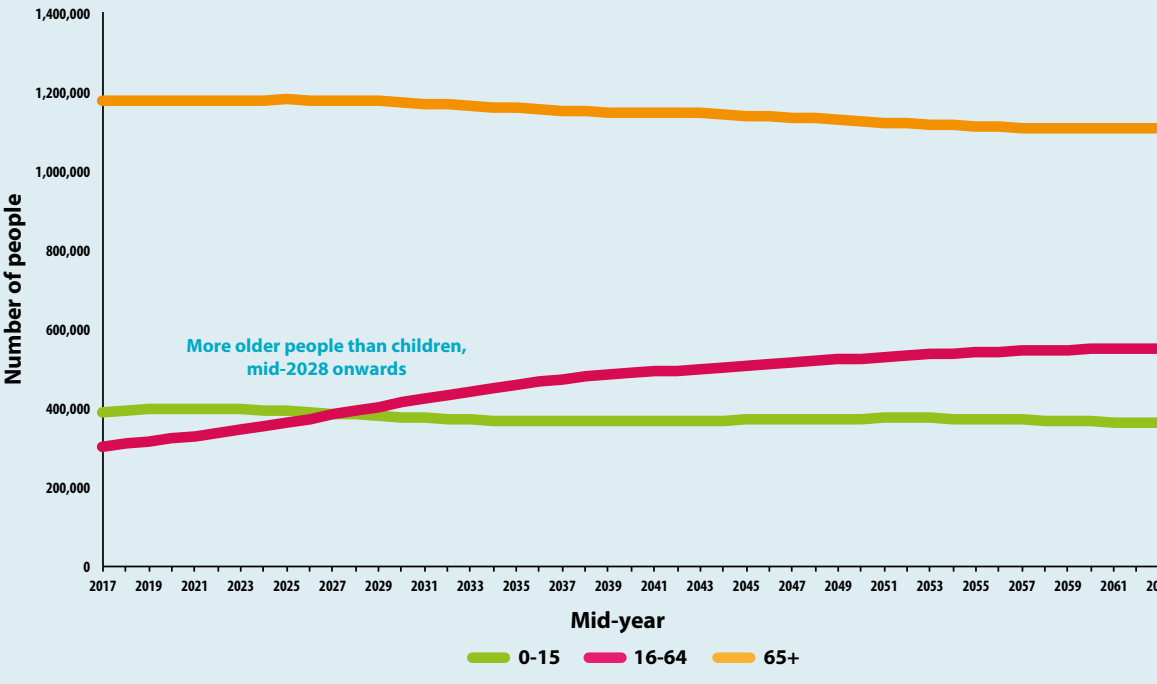
We know demand for services is arising largely as a result of an ageing population, many of who are living with complex needs and long-term conditions **(figure 2)**.

Figure 2 - Percentage of patients in each age band with the indicated number of morbidities



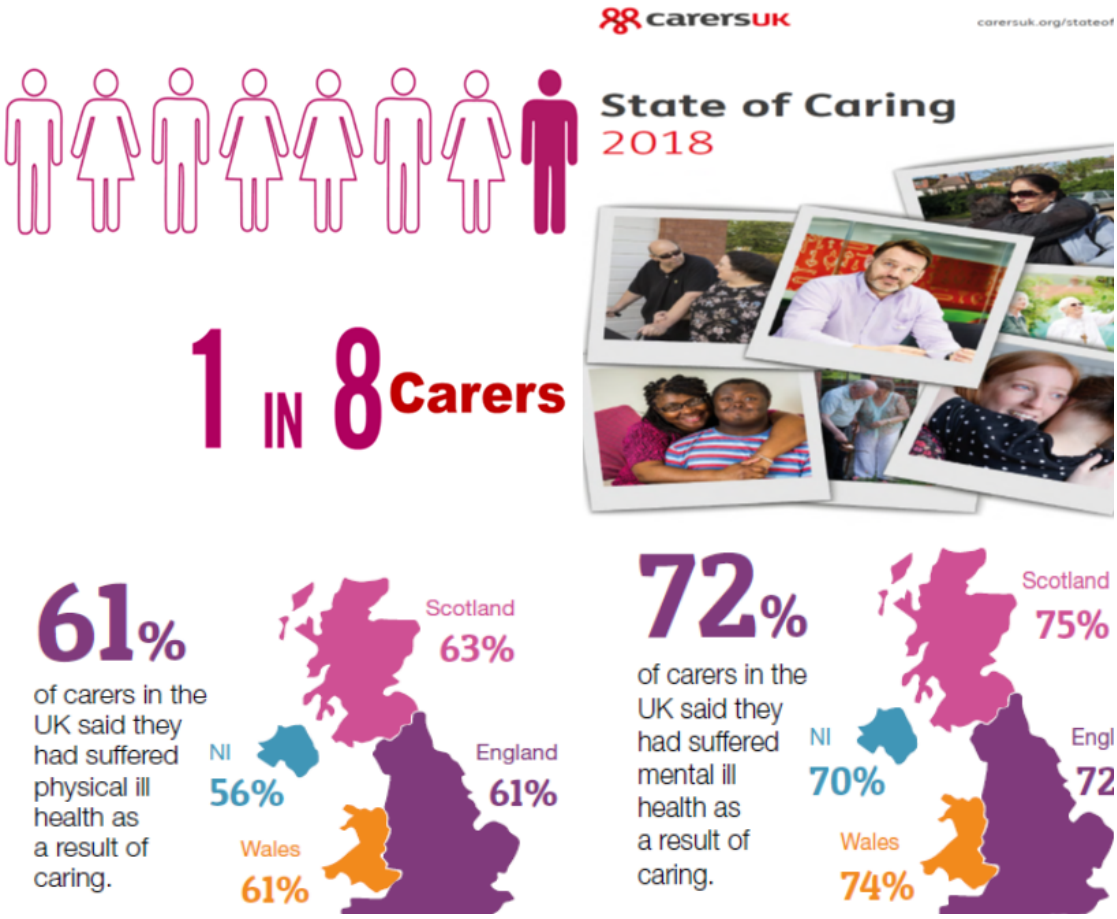
As set out in **figure 3** it is estimated by the year 2028 the population of older people in NI will be greater than the number of children. Indeed by 2023 the number of people over the age of 65 will make up 30% of the population and by 2061 it will grow to 50% of the population. The largest growth in the older person population will be those aged 85+. We also know this means there will be a commensurate rise in co-morbidities.

Figure 3 - Population by age group (mid-2017 to mid-2063)



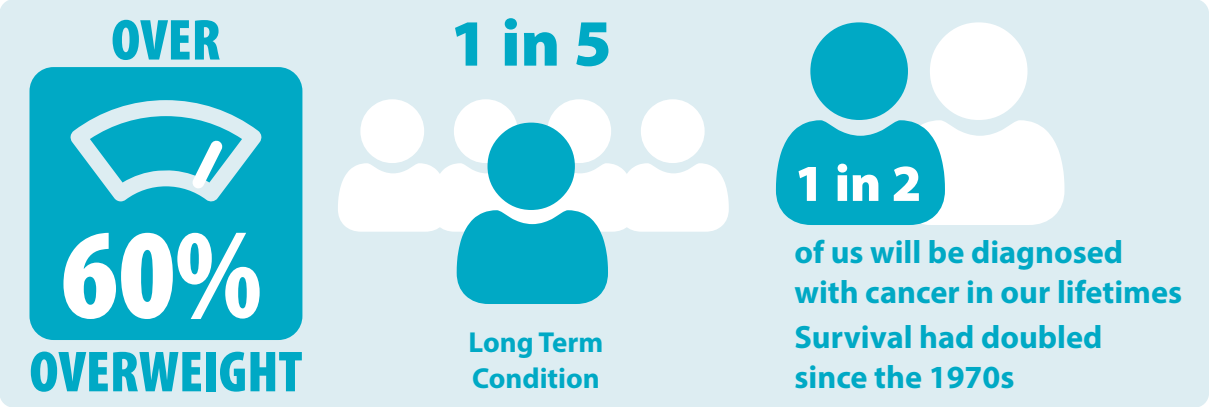
The reality behind these numbers also means that the numbers of people with dementia is estimated to increase from an average of 20,000 to 60,000 by 2051. It is also estimated that 1 in 8 adults are also carers. **(Figure 4)** It is anticipated the number of carers in NI is expected to rise from 220,000 to 400,000 by 2037, meaning that 1 in four adults in NI will be carers. Clearly we are increasingly becoming reliant on older people as informal carers, many who themselves will be vulnerable from poor health. Research by Carers UK (2018) found that in NI 61% of carers experienced poor physical health and 71% had experienced stress and depression as result of their caring role.

Figure 4 - State of Caring



We also know that 1 in 5 of our population now live with a long term condition, 1 in 2 of us will experience cancer and about 60% of us are overweight, this along with sedentary lifestyles and excessive drinking has created additional demand on the health and social care system. **(Figure 5)**

Figure 5 - Picture of Health Needs



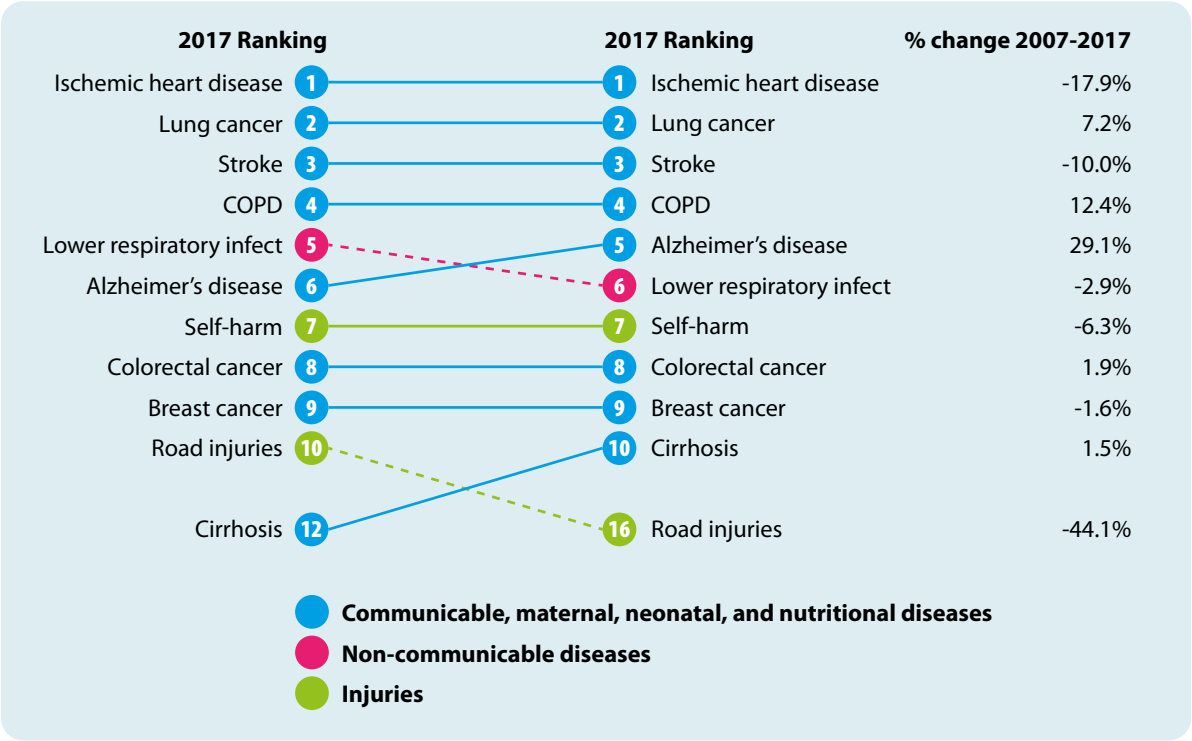
It is also regrettable as set out in **figure 6** that in NI life expectancy remains 7 years less for males and over 4 years less for females in the most deprived areas when compared with the least deprived areas of NI.

Figure 6 - Left Expectancy

Issue	Least Deprived	Most Deprived	Gap
Male Life Expectancy (2012-14)	81.1 years	74.1 years	7.0 Years
Female Life Expectancy (2012-14)	84.1 years	79.7 years	4.4 Years
Male Healthy Life Expectancy (2012-14)	63.4 years	51.2 years	12.2 Years
Female Healthy Life Expectancy (2012-14)	68.0 years	53.4 years	14.6 Years
Alcohol-related Deaths per 100,000 (2010-14)	7.9	33.0	318%
Alcohol-related Admissions per 100,000 (2012/13-2014/15)	318	1,600	403%
Smoking-related Deaths per 100,000 (2010-14)	111	255	129%
Self Harm Admissions to Hospital per 100,000 (2010/11-2014/15)	106	427	302%
Suicide Deaths per 100,000 (2010-14)	9.2	27.2	196%
Preventable Deaths per 100,000 (2010-14)	140	347	148%
Low Birth Weight (2015)	6.1%	7.8%	27%

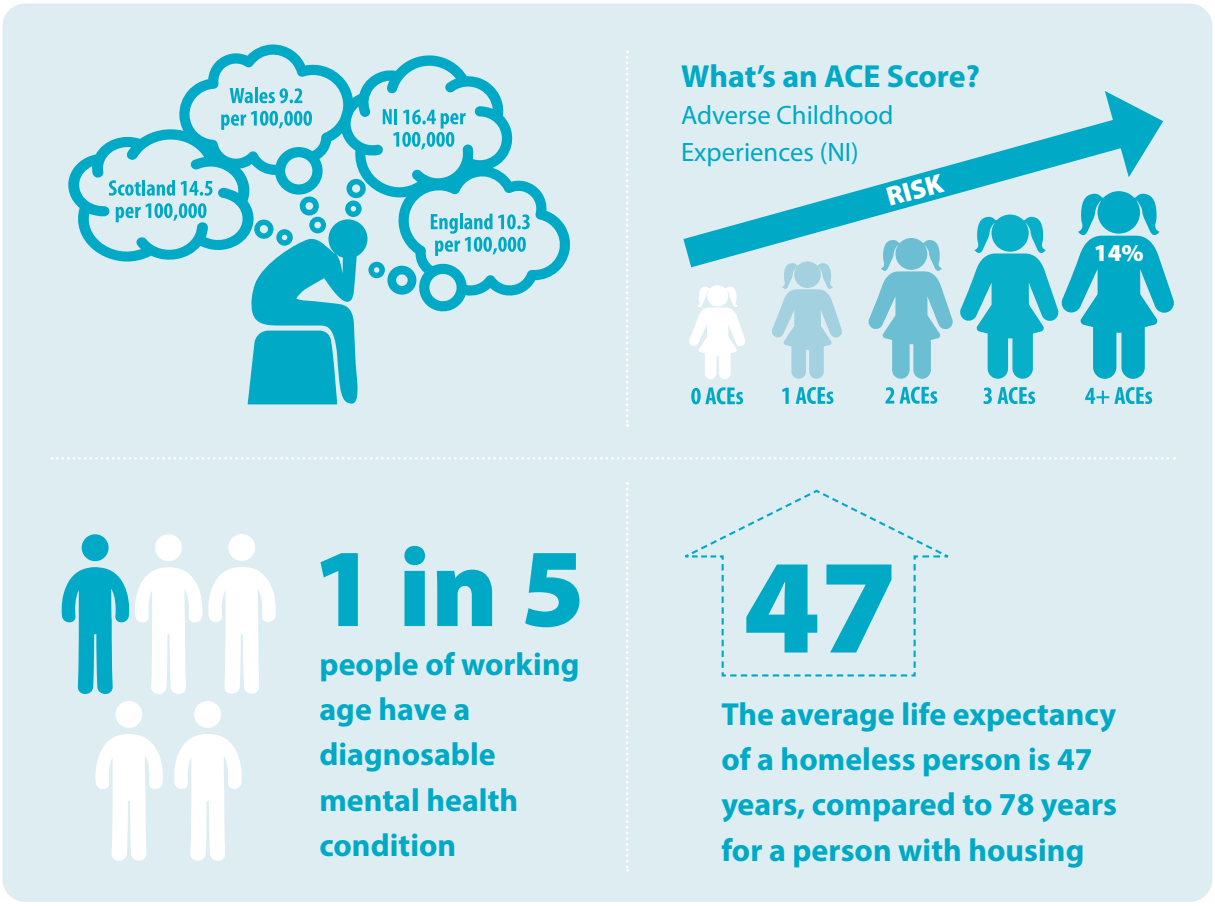
As set out in **figure 7** many of the causes of premature death are preventable through adopting healthier lifestyles.

Figure 7 - What causes the most premature death?



We also know that 1 in 5 **(figure 8)** people in NI will experience mental ill health. For people who experience serious mental ill health, research shows they live shorter lives by some 15- 20 years. Indeed research also shows if you experience homelessness your average life expectancy is 47 years. We know that around about 14% of Children and Young People (CYP) experience four or more Adverse Childhood Experience. Worryingly this means they are more likely to develop serious physical and mental health long term health conditions. This reality inevitably means the robust adoption of a population health approach and the fast tracking of innovation and implementation of evidence in order to prevent ill health, reduce the impact of health and social adversity, and enable people to live well and/or more independently with long term conditions. This means every nurse and midwife will have a critical role to play in promoting health and well-being and working in partnership with individuals, family, and their communities to address the wider social determinants of health.

Figure 8 - Profile of Mental Health Needs



Adopting a population health approach will enable nursing and midwifery to balance the intensive care needs of those in greatest need, with preventative health and social care intervention. This means health care will be driven by the utilisation of digital and data-driven technologies which will not only improve care outcomes but will enable the targeting of resources towards prevention and the early identification of risks.

Emerging and new personalised technologies (wearable devices) will change the way people will monitor and manage their health and will drive the personalisation of care and enable self-management/self-directed care. The expansion of remote care models, such as video consultations and symptom checkers, provided inside and outside the HSC system will also change the nature of the interaction with health care professionals. The advancement in genomics and precision medicine will improve the prevention, management and treatment of disease. Indeed the application of technologies, powered by health data will improve diagnostics, triage, reduce variation and increase efficiencies. Consequently new and emerging enabling technologies will radically change nursing and midwifery practice over the course of the next 10 -15 years. Such innovation unleashes the full potential of nurses and midwives to deliver more expert, personalised, and targeted health and social care in response to the changing demographic needs of the population of NI.

2

THE VALUE OF NURSING AND MIDWIFERY TO GLOBAL HEALTH

SECTION 2 – THE VALUE OF NURSING AND MIDWIFERY TO GLOBAL HEALTH

The value of nursing and midwifery is almost inestimable. Nurses and midwives make up nearly half of the global health workforce, with around 20 million nurses and 2 million midwives worldwide. Working in a wide variety of roles and in many different contexts, nurses are often the first and only health professionals people see for their health-care needs. Nursing and Midwifery is essential to meeting the challenges posed by demographic changes and rising health-care demands.[5] Also, nurses and midwives have a central role in universal health coverage (UHC). Nurse-led clinics could allow rapid and cost-effective expansion of services for non-communicable diseases, ANPs and Nurse Specialists could strengthen primary care, and nurses and midwives could be at the forefront of public health promotion and prevention campaigns and interventions.

It is within this context that nurses and midwives play a critical role in building communities that are resilient and capable of managing and responding to their own healthcare needs[6]. This is dependent upon a workforce which is both available and accessible to all. The professions of nursing and midwifery act as enablers to service delivery and many notable achievements have been made in this area. As the largest professional workforce they have the ability to transform how healthcare is both organised and delivered. It is important that nursing and midwifery is seen as a system asset and that policy makers and health and social care planners seek to optimise the potential that exists within the nursing and midwifery professions in order to improve the health of the population. This can be best achieved through evidence based policy development, effective collective leadership, strong professional governance and management.

In the United Kingdom, the nursing and midwifery workforce continues to develop practice and services, embracing new and emerging evidence to adapt to the changing environment and population needs. Change includes responding to an increasing complexity of care within differing models of service delivery, where safety, quality and service user experience are fundamental principles of professional practice[7]. As a result, significant gains have been made in increasing life expectancy and reducing many of the risk factors associated with mortality[8]. Crucially nursing and midwifery has a significant role particularly in the earlier years to address the wider social determinant of health.

In the words of Professor Marmot *"**Nurses are the most trusted group of people. Rightly so. Nurses and midwives treat individuals with compassion and care, and have great potential to improve the health of communities, through action on the social determinants of health."***

Recent inquiry has sought to define the economic value and impact of nursing and midwifery to society whilst recognising the challenges of providing such evidence, where value to the individual citizen is more often related to intangible psychological and emotional benefits that are difficult to measure quantitatively[9].

Studies globally from 2009 – 2011[10] have demonstrated that nurse staffing and missed care were significantly associated with increased mortality rates. A systematic review of these studies in 2016 asserted that the evidence points towards a higher proportion of registered nurses being associated with the most cost effective approach to provision of healthcare, when a wider consideration of societal benefits, such as averted lost productivity, could provide a substantial potential net economic benefit[11].

The World Health Organisation (WHO) Global Strategy on Human Resources for Health sets out an overwhelming case for robust workforce planning, investment in education and providing an environment conducive to the delivery of safe high quality health care. There is a clear alignment with *Health and Wellbeing 2026: Delivering Together* and the Health and Social Care (HSC) Workforce Strategy[12]. Whilst there are ongoing healthcare challenges presented by shortages of available workforces, addressing the health of a population should ensure healthcare resources are employed and deployed strategically. The report[13] argues for a "contemporary agenda with an unprecedented level of ambition. Better alignment to population needs, while improving cost-effectiveness depends on recognition that integrated and people-centred healthcare services can benefit from team-based care at the primary level". WHO asserts that a reshaped and transformative agenda through policy should provide a different type of healthcare worker with attention to expanded practice that enables appropriate utilisation of the workforce. The nursing scope of practice is highlighted as one which is flexible to populations and patient health needs, and has been particularly successful in delivering services to the most vulnerable and hard-to-reach populations[14].

Similarly, the midwifery scope of practice has the potential to provide 87% of the essential care needed for sexual, reproductive, maternal and newborn health services[15]. The 2014 Lancet series on the contribution of midwifery demonstrated the substantial health and wellbeing benefits for women, mothers and their infants when high-quality midwifery care was delivered[16]. The series recognised that the generation of further evidence of economic value was required; however that which existed established that midwifery care provided by educated and regulated practitioners was cost-effective, the return on investment similar to the cost per death averted for vaccination programmes.

Midwives make a critically important contribution to the quality and safety of maternity care providing skilled, knowledgeable, respectful and compassionate care for all women, newborn infants and their families. Their work is across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum and the early weeks of life including the woman's future reproductive health wellbeing and choices, as well as very early child development and the parent's transition to parenthood. The midwife is central to high quality maternity care, and the principle that 'all women need a midwife and some need a doctor too' is widely accepted.

Policies are in place with the aim of promoting woman centred care, continuity of care, greater choice of place and type of birth, reduction of unnecessary interventions, reduction of inequalities and improving safety. Recent policy on early years also underlines the importance of high quality maternity services.

Midwifery led settings are a cost-effective alternative to the prevailing model of obstetric led settings, increasing the agency of both women and midwives. A substantial body of evidence now exists to show that care provided by midwives in a continuity of care model, where the midwife is the lead professional in the planning, organisation and delivery of care throughout pregnancy, birth and postpartum period, contributes to high quality safe care. The recent Cochrane review (2016) has demonstrated that this model of care is associated with significant benefits for mothers and babies and has no identified adverse effects. Women experiencing this model of care are less likely to have an epidural, amniotomy or episiotomy; instrumental birth; have a premature birth; or experience fetal loss. They are more likely to have a spontaneous vaginal birth; to know the midwife who looks after them during labour and birth; express satisfaction with information, advice, explanation, preparation for childbirth and women who find services hard to access (due to social complexity), particularly value midwifery continuity of care.

A future leadership imperative is to continue to define and evidence the impact that the nursing and midwifery professions have on population health outcomes, developing and aligning service provision where the best use of registrant expertise is demonstrated.

3

THE AMBITION

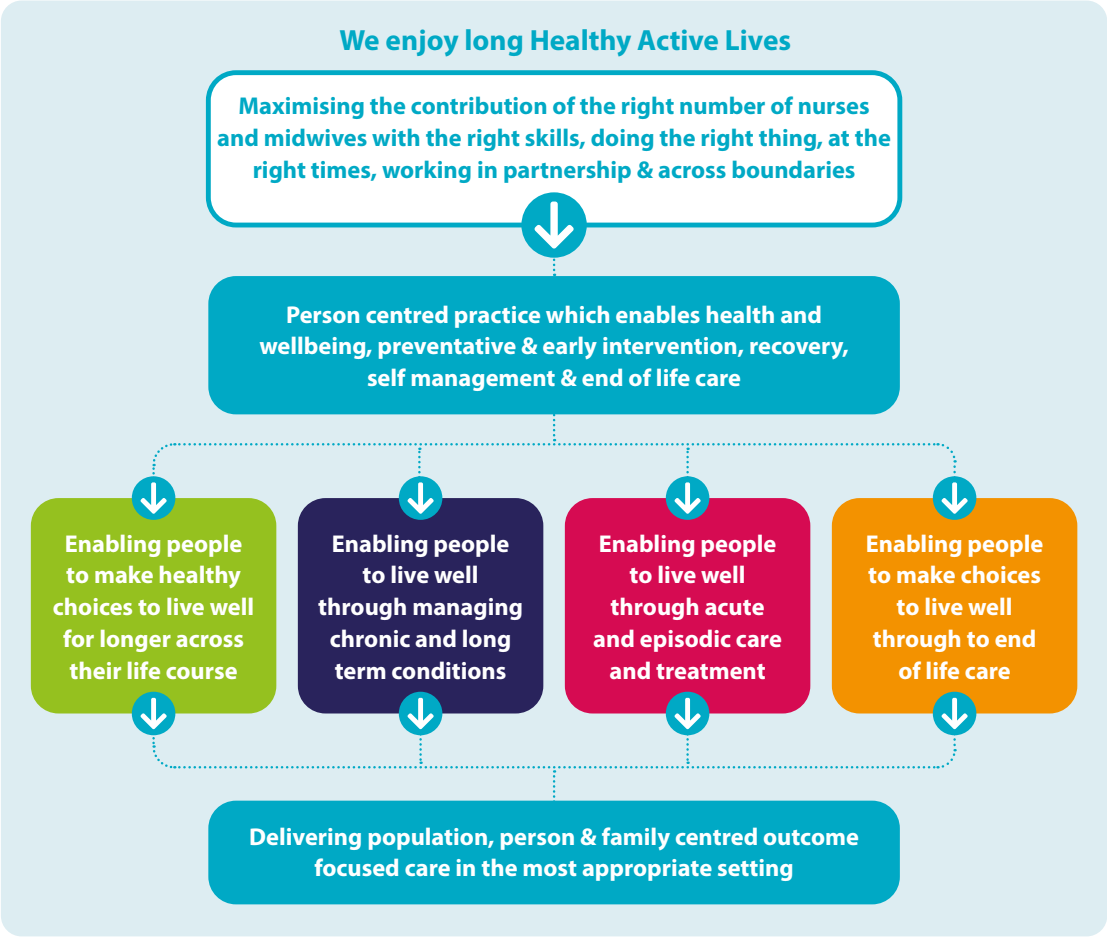
SECTION 3 – THE AMBITION

Nurses and midwives already make a significant contribution across the lifespan in partnering and empowering the people of NI to:-

- Enjoy healthy active lives,
- Recover, from ill health and in promoting self-management for those with pre-existing /long term conditions.
- Make person centred choices through effective end of life care.

This provides a crucial foundation on which to maximise the future contribution of nurses and midwives over the next 15 years. **Figure 9**: **Maximising the Contribution of Nurses and Midwives** below presents a strategic map of the future direction that will maximise the positive contribution of nursing and midwifery across health and social care.

Figure 9: Maximising the Contribution of Nurses and Midwives



We Enjoy Long Healthy Active Lives

The health aspiration outlined in the Executive's Draft Programme for Government (PfG) was the outcome ***'we enjoy long, healthy, active lives'.*** *Health and Wellbeing 2026: Delivering Together* outlined an ambitious roadmap reflecting the quadruple aim. In order to maximise the contribution of nurses and midwives, a part of that ambition is to strengthen the development of the professions that leads to every nurse and midwife understanding the importance of, and contributing to, public health approaches across the life course. Across all services and levels nurses and midwives will lead and contribute to understanding the needs of the population they serve, proactively co-designing solutions that prevent avoidable illness and improve health and social well-being outcomes based on population profiling and needs stratification.

Right Number of Nurses and Midwives with Right Skills, Doing Right Thing, At Right Times, In Right Places working in partnership and across boundaries

This ambition requires the development of knowledge, skills and abilities, to equip nurses and midwives to improve population outcomes. Central to this is the reform of nursing and midwifery education at pre-registration and post-registration levels including the intent to strengthen apprenticeship approaches and development of graduate entry models. A further enabler is the establishment of core standards for staffing levels across all midwifery and nursing services to ensure the right number of nurses and midwives are doing the right thing, in the right place, at the right time. Furthermore, this ambition can only be realised through the development of significant nursing and midwifery leaders for the future.

Person centred practice that enables health and wellbeing, preventative and early intervention, recovery, self-management, and end of life care

Visible leadership which is person-centred in word and deed, is central to the ambition and requires a commitment to a core set of values reflected in the practice of nurses and midwives at all levels from frontline to boardroom positions and across a range of career pathways. This approach recognises the need for collective leadership across education, practice, research and policy careers to support the future provision of person-centred health and social care.

Enabling people to make healthy choices and live well

Through the development of the nursing and midwifery workforce, the people of NI, irrespective of their age, personal circumstances and health status, will be enabled to make healthy choices and live well:

across their life course

whilst managing chronic and long term conditions

through acute and episodic care and treatment

and at the end of life

Delivering population, person and family centred outcome focussed care in the most appropriate setting

The ambition takes account of the vision for health and social care within NI which is to deliver world class health and social care services that are a safe and sustainable way to meet the challenges of a 21st century population. It recognises the challenges of achieving person-centred outcomes in the context of shared decision making and complexity of care delivery across diverse care environments.

In summary, this ambition will enable us to deliver person centred outcomes for patients, people, families, carers and staff which are aligned to the quadruple aim: improving the health of our people, ensuring sustainability of services, improving the quality and experience of care and supporting and empowering our staff.

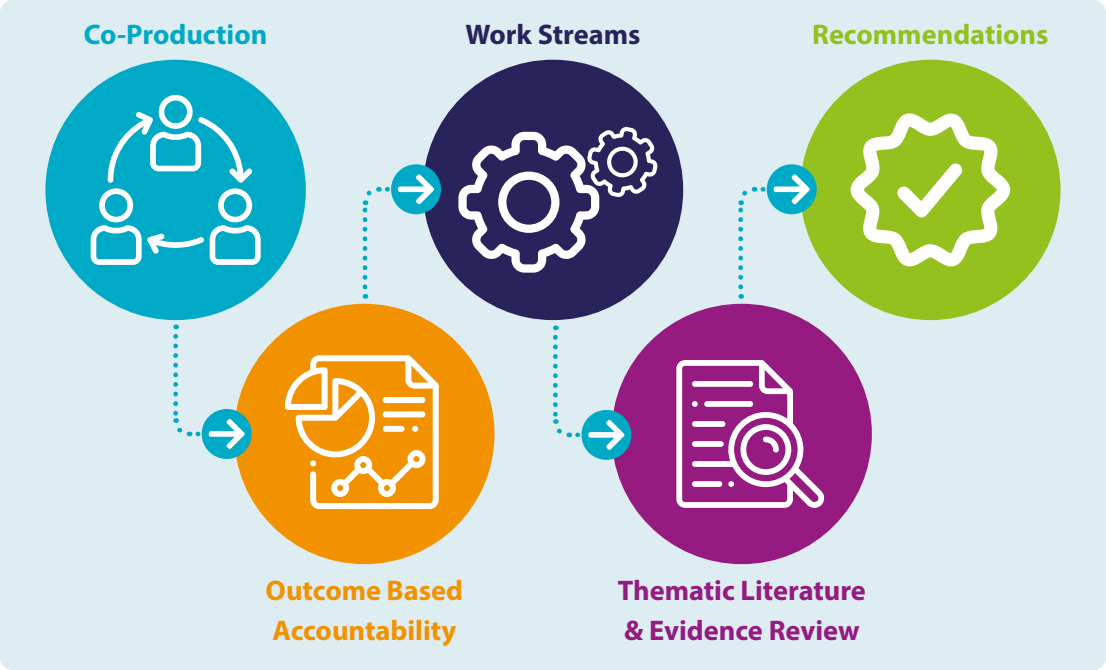
4

THE APPROACH

SECTION 4 – THE APPROACH

The core aim of the NMTG, as previously stated, was to develop a roadmap which would provide direction in achieving world class nursing and midwifery services in a reconfigured HSC over the next 10-15 years. The work of the Task Group was shaped by adopting a population health, evidenced based outcomes and life span approach. The approach has been shaped by the NMC Code of Conduct, NMC Future Nurse Proficiency Standards, NMC Education Standard's and UK CNO Enabling Professionalism. The work involved five key strands as outlined in **figure 10**, below.

Figure 10: Overview of the Approach



In order to create ownership across the midwifery and the nursing family a Co-Production model was adopted. This involved engaging midwives and nurses at all levels and across a wide range of services and settings, who through their engagement have contributed to the recommendations of this report.

In line with the Draft PfG, engagement events were modelled on the Outcomes Based Accountability (OBA) approach. This approach focuses on high level outcomes as the starting point of work rather than the end product, and works towards agreeing actions to achieve these outcomes. OBA supports a long term vision, allowing the Task Group to look ahead to the contribution of nursing and midwifery to population outcomes over the next 10-15 years.

As part of the OBA approach, three core workstreams were established to assist in the formulation of the recommendations in this report. These work streams were: nursing and midwifery workforce, long term conditions and population health presented in **figure 11**, below. This was achieved through group discussions that focused on:-

1. Lived and worked experience of staff.
2. Evidence of what works
3. What needs to change in order to deliver better outcomes?
4. How would we recognise success?

Across the three work-streams, the NMTG hosted over 36 events and had almost 1,000 participants from all branches of nursing and from midwifery, including independent sectors. Other professions also contributed to the work.

Figure 11: Overview of Nursing and Midwifery Group Attendee

	Worksteams	Number of Meetings	Ave Number of People Attending	Total
Stable Teams	3	8	25	200
Long Term Cond	3	9	25	225
Population Health	3	9	25	225
Learning Disability	1	1	25	25
Cancer Nurses Network	1	1	25	25
NIPEC Event	1	1	100	100
Practice Nurses	1	1	20	20
Mental Health Nurses	1	5	25	125
Leadership event	1	1	25	25
Total	15	36	32	970

- Estimated number of participants, calculated on basis on min 3 works streams 3 events per theme by average of 25 people attending)

Figure 12: Overview of Work Streams

Workforce

This workstream focused on four core areas: building and sustaining safe stable teams; the scale of the workforce focusing particularly on the numbers of pre and post registration nurses and midwives; exploration of evidence based options for the further development and/or introduction of new nursing and midwifery roles in order to improve outcomes; and the depth and breadth of nursing and midwifery leadership. Data in respect of workforce were drawn from the DoH Workforce Policy branch, and also from other work streams where workforce featured as part of discussion.

Long Term Conditions

This workstream focused on identifying the contribution of nursing across primary, community, acute and specialist nursing, and midwifery services. To do this a number of long term conditions were chosen to explore how the contribution of nursing and midwifery could be maximised, which included frailty, diabetes and respiratory conditions. These conditions ranked the top for admissions to acute care and their prevalence in primary care and for diabetes and respiratory conditions, their impact on pregnancy and the baby. In addition, two further sources of information were included: the findings from a review into the role of Mental Health Nursing commissioned by the CNO; and the findings from a focus group discussion with Learning Disability nursing.

Population Health

In light of the overall aim, population health was the third work stream. Having analysed data relating to key public health concerns, this workstream focused on healthy weight, mental health and emotional wellbeing and public health approaches in nursing and midwifery.

Data from the three work streams was collated and thematically analysed to draw out key areas that were further explored in the context of the existing evidence base. This resulted in nine themes which are presented in Section 7, page 81 and formed the foundation for the development of the recommendations outlined at page 85.

The final stage in the approach was the development and drafting of the report. This was an iterative process undertaken by a sub group of the NMTG and involved external expert review.

5

THE CURRENT PICTURE

SECTION 5: THE CURRENT PICTURE

Collectively the registered nurses, midwives and aligned support staff are the largest professional group in the HSC workforce, accounting for 34.4% of the total number of staff[17]. In this report we have presented evidence emphasising the value of nursing and midwifery. Within a challenging current context that often mitigates against the professions maximising their contribution. Nurses and midwives consistently demonstrate their contribution to the health and wellbeing of the population in NI, leading the way in delivering high quality, innovative person-centred care, contributing to the strategic objectives of transformation and co-production.

This section highlights some examples of nursing and midwifery practice excellence across NI, whilst contrasting some of the challenges for the current workforce.

Transformation of Nursing and Midwifery Service

Since the launch of *Health and Wellbeing 2026: Delivering Together* the Department has made significant investment in a wide range of nursing and midwifery services with over £50 million invested in three key critical areas:-

1. Workforce Stabilisation

An additional investment of £7 million undergraduate education has enabled the highest number (1025) of nursing and midwifery training places commissioned in NI 2019/20. This represents an increase of 45% from 2015/16 and demonstrated the Department's commitment to addressing the current shortages and growing our local nursing and midwifery workforce.

In 2016 the Department embarked on a regional International Nursing recruitment campaign with the aim of bringing 622 overseas nurses by November 2020 to strengthen the local HSC workforce. Transformation investment into the CEC has supported overseas nurses to meet the essential registration requirements to practice as a nurse in the U.K

The Department launched its Delivering Care Policy (safe staffing) and has commissioned to date nine discreet phases which has resulted in an investment of over £15.2M.

2. Workforce Development

The post registration transformation investment of over £7.7 Million has delivered significant educational opportunities for the nursing and midwifery professions, benefiting 1,965 participants over the last two years. Investment has enabled a wide range of programmes to be funded to build the clinical expertise and leadership capacity within the workforce. The investment has supported the strategic direction with a focus on community specialist practice programmes such as District Nursing, Health Visiting and School Nursing. Investment in the development of ANP roles in Primary Care, Emergency Care and Children's Nursing has been a significant achievement with the first Masters level ANP programme delivered in NI. A range of other programmes, including bespoke quality improvement and leadership initiatives have been funded across mental health, learning disability, adult, children services and midwifery. Furthermore, investment has facilitated an innovative post registration Nursing Masters programme for NI, designed to develop leadership skills in new nurses and support workforce retention. Additionally, transformation investment in a regional nursing and midwifery data transformation project is assisting the professions with implementing electronic record keeping and digitalisation.

3. Service Developments and Reforms

The Department has also invested £18M in nursing service developments across the life span. This has resulted in additional Health Visitors that has enabled a new ratio of 1 Health Visitor to every 180 children. In addition a District Nursing Framework 2018-2026 was launched that has been designed to enable the delivery of 24 hour district nursing care no matter where you live. This has also enabled a new ratio of 8-10 Whole Time Equivalent per 10,000 of the population. Through the establishment of Multi-Disciplinary Teams (MDTs) there has been additional investment in a Neighbourhood Nursing teams and in ANP within Primary Care Teams.

Examples of Nursing Improvement and Transformation

Across HSC Trusts nurses and midwives have been leading innovation and improvement across services. Examples include:

- A programme of work to prevent hospital admission for patients accommodated in a nursing home with a range of complex needs, including dementia, physical disability, and both chronic and terminal illness. A registered nurse worked with patients, relatives, staff, local GPs, allied health professionals, rapid response team and care managers to develop advanced care pathways. This initiative resulted in a significant reduction in decisions to admit patients from the nursing home to hospital.

- A donor transplant nurse having realised the number of kidneys transplanted from live donors was much lower in NI than the rest of the UK, embarked on a mission to streamline the process and worked with other colleagues to reduce the assessment time from two years to a one-day process. In doing so she has made it easier for people who wish to donate a kidney, improved the quality of life for patients, and ultimately saved lives.
- The first community-based fully integrated child and adolescent mental health service (CAMHS) for young people with intellectual disability established specialist teams within CAMHS, providing early intervention and holistic bio-psychosocial assessment through to high intensity intervention. This has improved referral pathways, the delivery of effective interventions, risk management, reduced the use of psychotropic medication and has demonstrated high levels of service user satisfaction.
- A telephone follow-up aftercare service for people who were being treated for head and neck cancer providing education and support for people and their families/ carers, empowered individuals to develop skills and confidence for self-surveillance and facilitated fast tracking to follow up services. This created a patient-led follow up service and reduced the requirement for a routine appointment follow up service.
- A pioneering nurse led initiative that provides treatment and care for patients who require intravenous therapies such as blood transfusions and intravenous antibiotics, now enables patients who would normally have been treated in an in-patient unit or out-patient department of major acute hospitals to be treated in their local communities.

Workforce Trends

The midwifery and nursing workforce make up approximately 34% of the health and social care workforce, making it the largest single professional group. Crucially midwifery and nursing are the backbone of health care and are therefore central to leading and delivering transformation across the entire life-course and across the health and social care system.

Currently the picture across health and social care is one of high vacancy and pressured work environments - registered nurse vacancy levels ranging from 8-10 %[18]. The shortfall of nurses and midwives in NI and across the UK, is reflective of the global position. The WHO predicts that by 2030 the global nursing deficit will be 7.6 million[19]**.** In a predominantly female profession, high levels of maternity leave is an ongoing workforce challenge, compounded by a shortage of available nurses and midwives to cover temporary posts. Consequently, heavy reliance on bank and agency support to maintain safe staffing levels has resulted in spiralling costs that could be invested more productively to benefit the workforce. High vacancy and pressured environments have consequently led to climbing sickness absence rates in the nursing and midwifery professions, **figure 13**.

Figure 13 - Health & Social Care Staff by Occupational Family (% WTE), March 2018

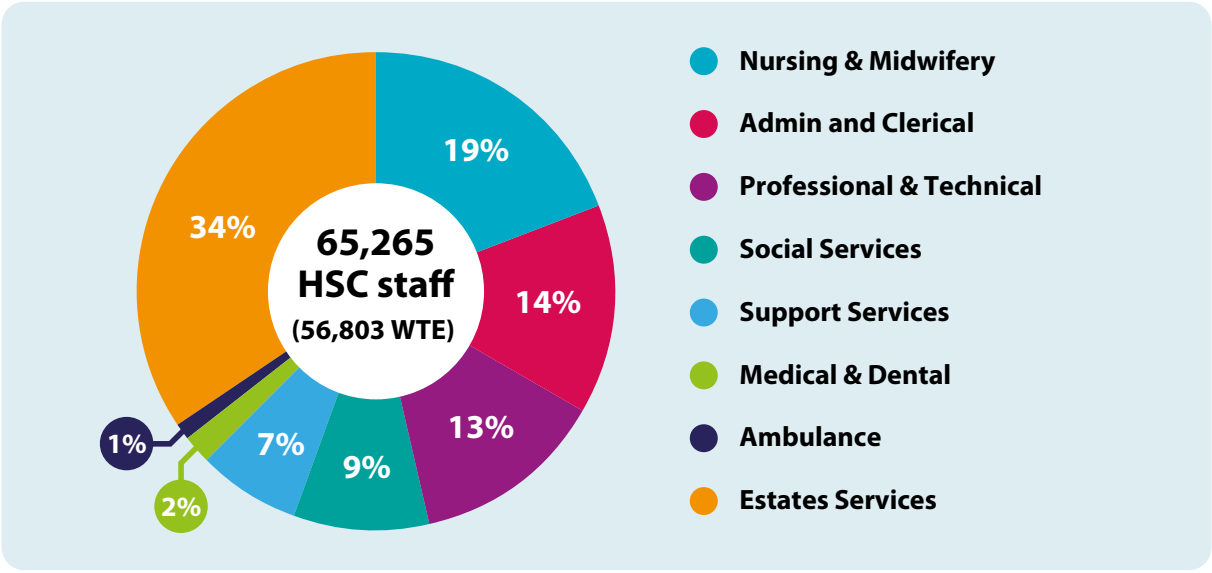
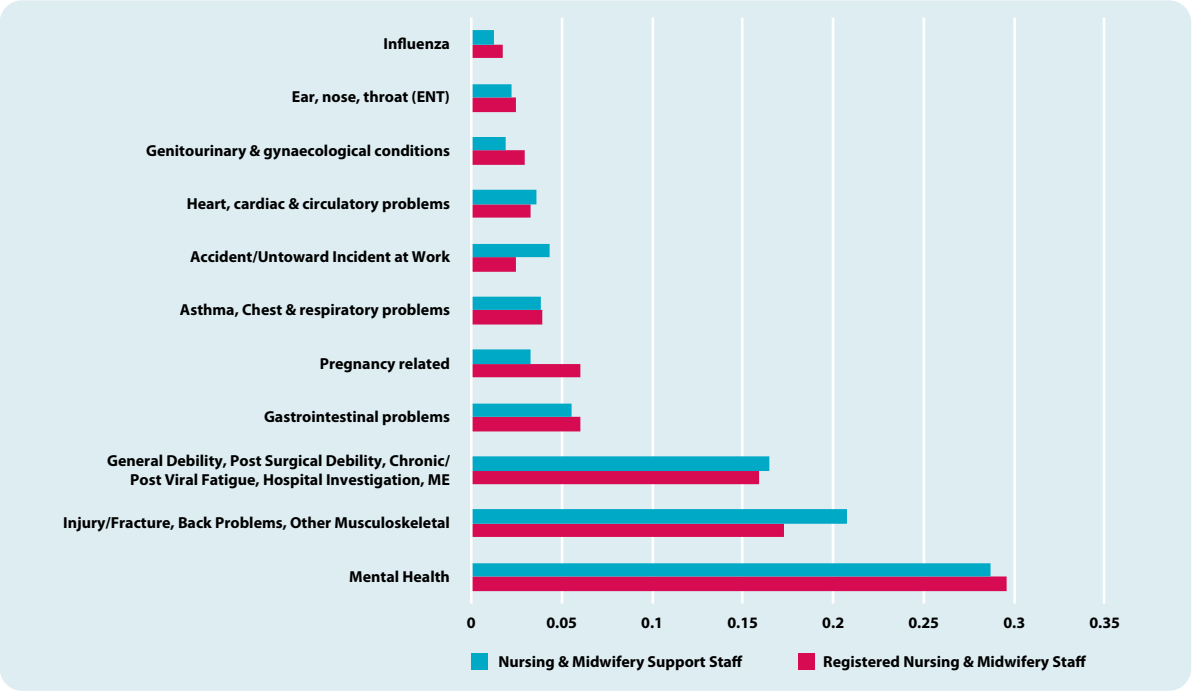


Figure 14 - Proportion of HSC Sickness Absence Hours Lost by Top 12 Absence Categories - 2018/19



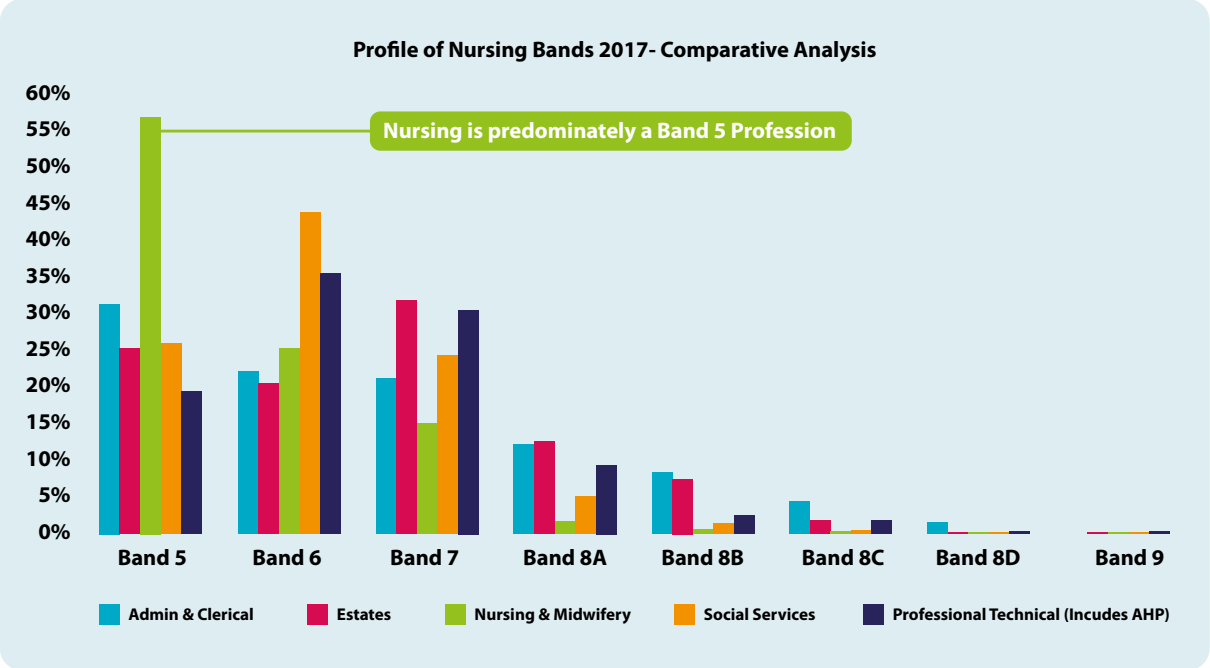
Between March 2016 and March 2017 the NMC reported a significant reduction in registrants[20]. The NMC surveyed those people who had left the register between June 2016 and May 2017. 4,544 former registrants responded citing working conditions as the top reason for leaving (44%). During the period 2008 to 2017 the nursing and midwifery workforce in NI increased by 7.8%. This has not kept pace with the increasing demand however, nor has it aligned with other professional groups.

Career Progression for Nurses and Midwives

The majority of health and social care professionals, with the exception of medicine, once graduated and registered with their regulatory body take up employment within the HSC enter the Agenda for Change (AfC) Pay Structure in Band 5 posts. Progression from the bottom of the pay band to the top of the pay band takes at least 7 years. HSC staff in NI have not received any pay uplift for 2017/2018. They are currently paid 1% less than National Health Service (NHS) staff in England and 2% less than Scotland. NHS staff in England have just accepted a pay deal that will see all staff at the top of each pay band receive a minimum of a 6.5% increase in pay over 3 years[21]. The pay structure is being simplified and the number of pay points are being reduced enabling staff to reach the top rate in each pay band sooner. NHS staff in Scotland are to receive 9% increase over three years and Wales are still in pay negotiations. The gap between NHS pay in NI and pay in the rest of UK is growing, making it difficult to recruit and retain an increasingly mobile workforce.

Furthermore, a higher percentage of roles carried out by registered nurses and midwives within the HSC are in lower pay bands than that of social services or professional technical. Over half of the qualified nursing workforce (56.8%) are in the lowest pay band (Band 5) and there are consistently lower percentages of registered nurse or midwife posts than social services or professional technical posts, across pay bands 6, 7, 8a. 8b, 8c and 8d as presented in **figure 15.** This pattern is also repeated in nursing and midwifery support posts across AfC Bands 1-4.

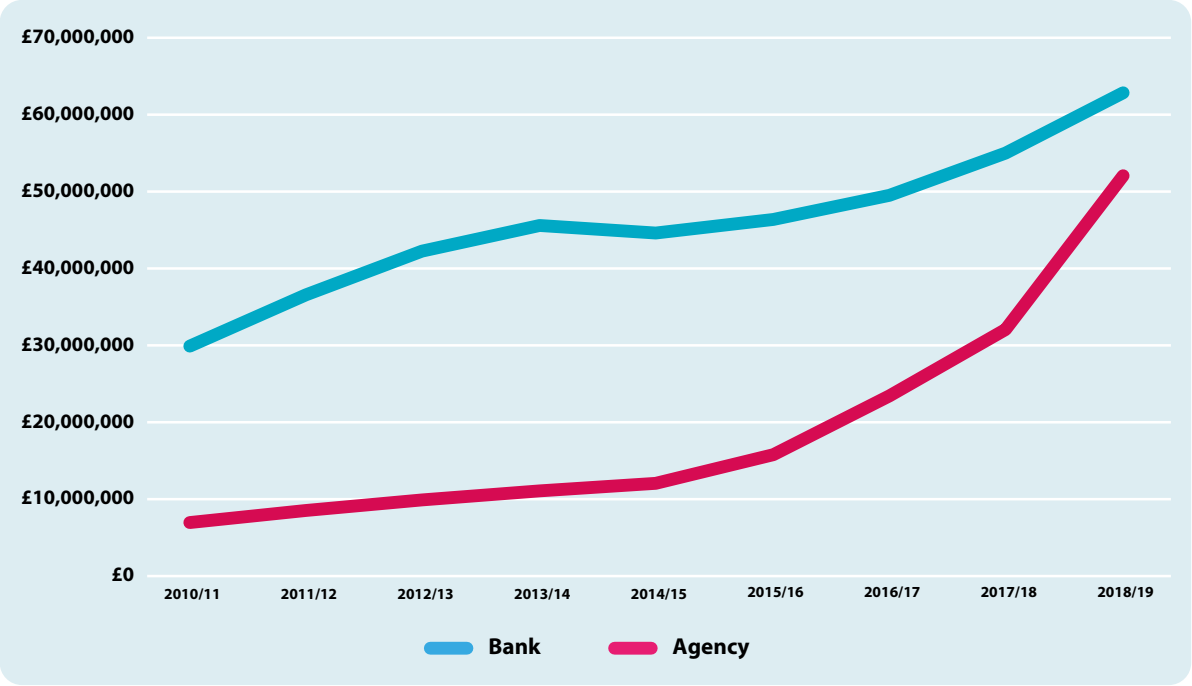
Figure 15 - Whole Time equivalent and % NI HSC Staff by Occupational Family & Pay Band 5-9 (March 17)



Impact on Nurses and Midwives

Within HSC organisations, the percentage of scheduled hours lost in the 2016/17 year due to sickness absence was around 6.6% and accounted for over £100 million[22] with mental ill health accounting for 30% of hours lost. HSC Staff surveys carried out in 2009[23], 2012[24] and 2015[25] report over 70% of nursing and midwifery staff working more than their contracted hours, with surveys consistently presenting increasing numbers of unpaid hours worked each week (59% working 1-5 hours, 13% 6-10 hours and 5% over 10 hours in 2015). The Royal College of Nursing (RCN)[26] reported that in 2017, shifts with one or more bank or agency nurse working was highest in NI cited at 50% compared with 45% in England, 40% in Wales and 38% in Scotland. A significant number of nursing staff respondents from NI (56%), also reported that they were unable to take sufficient breaks. **Figure 16** demonstrates a comparison between rising bank and agency costs across the nursing and midwifery workforce.

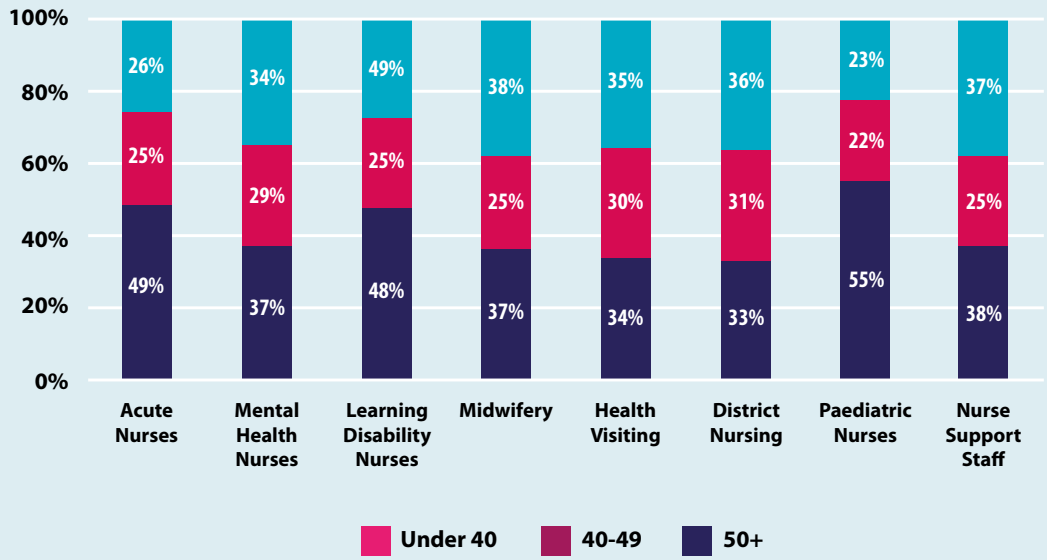
Figure 16 - Expenditure on Nursing & Midwifery bank and agency staff



In Source for **figure 16:** HRPTS. Figures exclude bank staff and staff on career breaks. 2010/2011 the HSC spent a total of £9,852,129 funding agency shifts across the service in NI. This has risen over the last 9 years to £51M in 2018/2019. Bank costs have also doubled from £30M in 2010/11 to £61M 2018/19. Clearly this is very concerning not only in cost terms but also its impact on the stability of the workforce.

The RCN reports that (across the 4 countries) that 65% of nursing staff are working on average almost one hour extra, of which 93% were not paid for. For nursing staff working outside the NHS across the UK this figure was 76%. This was highest in NI where 69% of respondents reported working additional unpaid time.

Figure 17 - Nursing and Midwifery Staff by Age Group (5 Head count) March 2018 Census



Furthermore as set out in **figure 17** over 32% of the Nursing and Midwifery workforce are over the age of 50, clearly this has significant implications for workforce planning and reinforces the need to raise the number of undergraduate places over the next five years to not only address current vacancies, but also to address potential retirements. There is therefore a need to develop a dynamic workforce model, which factors in need, demand, complexity, work-pattern flexibility, safe staffing, new ways of working, and staff leavers, in order to predict the number of nurses and midwifes in the next 5-10 years.

In summary, this paints a picture of a registered workforce under pressure and presents a compelling case for change in order to maximise the contribution of nursing and midwifery to improve the health of the population of NI.

Nursing and Midwifery in the Wider Context

Nurses and midwives are central to care and service provision for people with actual or potential health and social care problems across a range settings. As set out in **figure 17** nursing and midwifery has a long tradition of being an outward looking profession. Nurses and midwives have always proactively worked with other professionals (Doctors, Social Workers, AHPs) to deliver an integrated experience of care and improved outcomes. Within the context of *Health and Wellbeing 2026: Delivering Together* integrated working between professionals and across professional boundaries is an essential requirement for the transformation and the delivery of safe effective care.

As all professions examine, reform and transform their practice models, it is crucial as outlined in the Workforce Strategy that multi-professional and interdisciplinary practice adapts in response to our population needs. Whilst this means each profession must understand and respect the unique contribution of each other. It also creates opportunities to work together to develop new ways of working, for knowledge sharing and for the blending of skills (integrative practice models) across services and professions. Over the course of the next ten years nurses and midwives will play both core and enhanced roles in public health, primary care, acute, community and specialist care service. Therefore within the context of the HSC Collective Leadership Strategy (2017), nurses and midwives will take collective ownership for population health outcomes and in so doing will ensure that their distinct knowledge and skills complement the roles of other professions.

Promoting social justice is one of the foundational values of nursing and midwifery. Nurses and midwives are committed, therefore, at an individual, family and community level to work with others to address the health and social inequalities to improve outcomes among different population groups. This requires nurses and midwives to share responsibility for safeguarding, advocating and promoting the human rights for vulnerable people. Through strengthening community development approaches within nursing and midwifery, this will not only augment community planning approaches, but will create real opportunities for the development of assets, people and community based approaches to

health and social care reform. In so doing nurses and midwives make a positive partnership based contribution to creating the conditions for:-

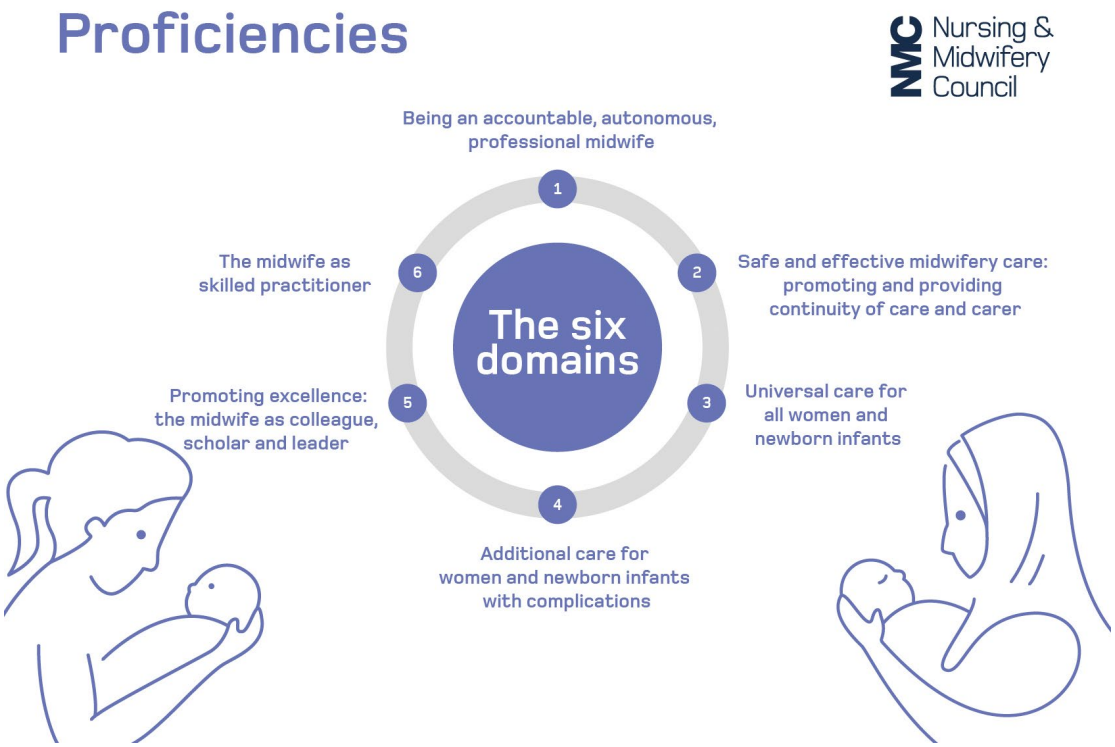
- a more equal society (PfG Outcome 3)
- people to *lead long, healthy and active lives* (PfG Outcome)
- a collaborative approach across sectors where we care for others and we help those in need (Progamme for Government Outcome 8)
- the delivery of high quality public services (PfG Outcome 11)
- Our children and young people the best start in life. (PfG Outcome 14)

Midwifery vignettes

In 2018 Lagan Valley Midwifery Led Unit (MLU) was named 'Best Maternity Unit' at the NI Positive Birth Conference. This is a Free Standing Midwife Led Unit (FMU) which promotes a positive childbirth philosophy and a calm and relaxing atmosphere. The midwives provide a fully integrated service caring for women in pregnancy, birth and beyond and the team is well established in the local community. In the previous year 92% of women who attended Lagan Valley MLU had a normal birth, 37% of these births were in water. The transfer rate to local Obstetric Units is 13%, subsequently 87% of women who start their labours in Lagan Valley MLU give birth there without the need for transfer. This reflects findings from the Birthplace UK study (2011).

The Belfast HSC Trust appointed a Specialist Midwife for Social Complexity and Perinatal Mental Health to increase the level of support and improve the coordination of care across the maternity and neonatal service. The role provides support to vulnerable mothers in pregnancy improving antenatal care services for these women, signposting and referring to appropriate agencies and services in order to enhance health, wellbeing and parenting preparation. This can reduce the associated risks including, the incidence of growth restricted babies; neonatal unit admissions due to drug/alcohol withdrawal symptoms; feeding problems; the associated increased incidence of intrauterine death and Sudden Infant Deaths amongst this group; adverse emotional behavioural and development outcomes associated with disturbed bonding processes with a vulnerable mother.

Future midwives in Northern Ireland will be educated to achieve the proficiencies illustrated below



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6

SHAPING THE FUTURE

SECTION 6: SHAPING THE FUTURE

Throughout the engagement process, a large amount of rich information was gathered from the perspective of nurses, midwives and support staff working at different levels from a wide range of sectors. Review of this information has generated nine themes that are presented in **figure 18**, below. This section will describe each theme and sub-themes within, highlighting the key messages and ideas articulated by workshop participants. The data gathered within the nine themes in a common structure are:

- ***Where We Are Now*** – providing a summary of strategic context and direction for the theme
- ***What We Heard*** – providing summary detail of the messages from staff and stakeholders who attended the workshops
- ***Where We Need to Be*** – providing a summary of the vision for the theme articulated by staff and stakeholders who attended the workshops

Each theme concludes with a summary of key messages that have informed the development of the recommendations for the Minister for Health, presented in Section 7.

Figure 18: Nine Themes from Engagement Events

Championing Person-centredness

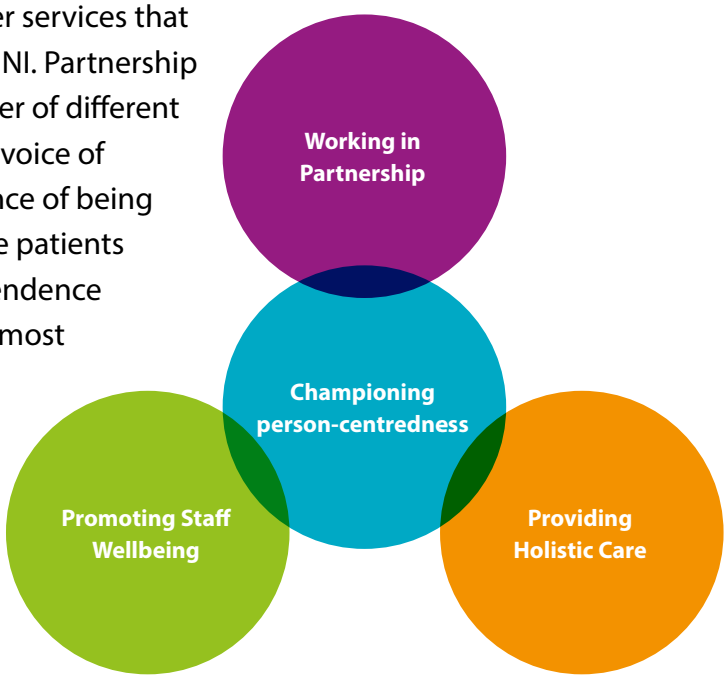
Create and promote a culture of appreciation in all directions.

Where we are now

The challenges in delivering quality care in practice, however, continue to be well recognised, and this debate has been fuelled by high profile inquiries and reviews suggesting that the experience of care is variable and often fails to meet the expected standard[27]. This has led to a commitment within the professions to reaffirm the importance of the fundamentals of care, emphasised in publications over the past 10 years[28], all of which highlight the challenges for nurses and midwives in providing sensitive and dignified care. There has, however, been consistent effort across the healthcare system within NI to develop person-centered practice in the nursing and midwifery professions, with a focus required for wider application and sustainability over time. This has been reflected in previous and current regional nursing and midwifery strategies and is now the clear policy direction as laid out in *Health and Wellbeing 2026: Delivering Together*.

What we heard

A consistent thread across many of the engagement events reflected person-centred care and its component parts. There was a strong emphasis on the desire to ***provide holistic care***, refocusing on the fundamentals of nursing and midwifery practice. This was in recognition of a perceived increasing shift towards a task orientated approach to care delivery that was being driven by workforce issues and demands to deliver services within highly pressurised environments. Closely aligned to this was a commitment to ***working in partnership*** to develop and deliver services that meet the needs of the population of NI. Partnership working was discussed from a number of different perspectives including: securing the voice of service users based on their experience of being in the system; and working alongside patients and their families to promote independence and develop pathways that ensured most appropriate place of care. Whilst effective partnerships within the multidisciplinary team to facilitate working across boundaries was referred to in the data, this was less evident in the context of delivering person-centred care.



Remove the blinkers, don't just focus on the immediate condition you are there to treat – look at the person as a whole.

There was also a focus on ***promoting staff well-being*** and creating workplace cultures that enabled people to flourish, which is an important aspect of person-centred practice.

Where we need to be

In NI we want nursing and midwifery to lead the way in creating the conditions that enable the development of person-centred cultures that will deliver on positive outcomes. In order to achieve this, there needs to be a shared understanding across the professions of person-centredness in its broadest sense and development of strategies that enable this to be operationalised across services and settings. The new Guide for Co-production in NI[29], will provide an impetus to move forward particularly working in partnership with the population of NI to achieve the best health and wellbeing outcomes.

Midwives have a long history of working in partnership with women, enabling their views and preferences and helping to strengthen their capabilities. Their focus on women centred care has long been central to the provision of safe, respectful, nurturing, empowering and equitable care, irrespective of social context and setting. Further development of midwife led models of care will continue to ensure that midwives are in a position to advocate for women within a complex system, coordinating care.

The benefits of championing person-centeredness for the nursing and midwifery workforce reach beyond impact to patients, clients and families. Emerging evidence indicates positive outcomes for staff well-being through proxy measures such as improved staff recruitment and retention. Furthermore, these outcomes are aligned to the quadruple aim with a particular focus on improving the quality and experience of care, supporting and empowering staff. Nurses and midwives are well placed to lead the development and implementation of approaches underpinned by co-production that will ensure a positive patient experience.

Key Messages:

- **A desire to refocus on the fundamentals of practice that enable a positive care experience for patients, families and staff**
- **The need to develop effective strategies that will deliver person-centred outcomes**
- **Co-production should be integral to working in partnership with people, families communities and within and across teams and services**

Providing Visible Leadership At All Levels

Where are we now

For some years, there has not been, a systematic or sustained approach to leadership and management training across the nursing and midwifery family in NI. The reality is that many staff stepping into their first leadership roles have not received any formal development or training.

Whilst the vast majority of HSC bodies have Executive Directors of Nursing, the scope of their strategic and operational responsibilities varies across the region. Inevitably this variation is reflected in the levels supporting the Executive Director of Nursing role, resulting in operational decisions about nursing being taken by other disciplines or professions. This includes decisions about adding or removing nursing and midwifery posts.

There are programmes currently focused on leadership development for Ward Sisters, Charge Nurses and Team Leaders and ad-hoc training in generic leadership programmes. From this positive starting position there are many opportunities to develop and grow leaders at levels through alternative approaches such as mentoring and coaching.

What we heard

Visible leadership was highlighted as essential to the delivery of safe and effective care. It is within this context that nurses and midwives stated they want to be 'well led' and 'empowered' by their leaders to influence the design and delivery of services. There was a strong sense that nurses and midwives had become increasingly 'micromanaged' and therefore nurses want existing leadership to create the conditions so that they can have more autonomy to act. Those attending the workshops were clear that they wanted this leadership to be more 'visible' and to 'take time' to appreciate and understand the realties for staff who were delivering direct care in clinical environments. The need for ***courageous leaders*** who would be ambassadors for the professions to challenge and remove the barriers to change was viewed as the enabler for nurses and midwives to do the 'job they trained to do'.

There was a sense that staff were often 'dropped' into senior roles without the necessary leadership training or support. Staff experience was often reliant on the leadership style and abilities of the person or people line managing their teams. Inevitably this led to variation in staff experience and the ability of team members to ***live out person-centred values***. As a result of decades of a general management approach to service delivery, staff perception was that nursing and midwifery leadership roles had become increasingly advisory with the consequences that a number of senior operational nursing leadership posts had been progressively disappearing. This was cited as having had a negative impact on the leadership capacity of the professions and the need to ***develop leadership skills for the future***.

Where do we need to be?

Within the context of the Collective Leadership Strategy[30] nurses and midwives are ready to be equal partners in policy, strategy, operational and professional leadership. Crucially within the collective leadership model, it will be important that the expertise of the nursing and midwifery professions is nurtured to ensure nurses and midwives are appropriately represented at all levels. Furthermore, it is imperative to ensure nurses and midwives at all levels are professionally led by senior nurse and midwife leaders, including staff working in social care and arm's length bodies. Furthermore, over the next decade the professions will be at the cutting edge of transformation, requiring nursing and midwifery to be equipped as current and future leaders from the front line to the boardroom, to maximise their contribution in improving peoples' experience of health and social care and the health and wellbeing of the population.

Key Messages:

- **Lack of a sustained approach to leadership development within nursing and midwifery**
- **Variation in HSC structures has resulted in other professions making operational decisions about nursing and midwifery care and resources.**
- **Nurses and midwives need to be equipped to lead the transformation of future services to enhance the health and well-being of the population.**

Improving Public Health

Public Health isn't just about children - our older population deserve support and help

Where we are now

Many of the previous reforms in health and social care have placed greater emphasis on development of services which impact on the present rather than investing in the future. Nurses and midwives have not yet had the capacity to influence more widely as the skills of population health assessment are not always recognised or valued by the professions and others[31]. Furthermore, the pressure and demands of work do little to promote good health and wellbeing in nurses and midwives. Improvements in this area are inextricably linked to capacity and support, along with remuneration and a stable workforce. *Health and Wellbeing 2026: Delivering Together* redresses that balance with a clear aim of investing in the future and in improving the health and wellbeing of the population.

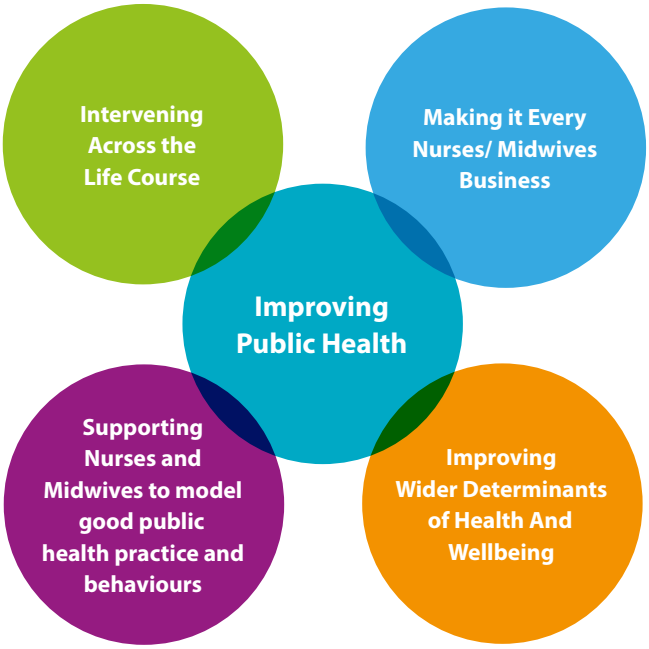
Currently, the significant emphasis for public health nursing is on children and health visiting, with little or no recognition or investment in the role of public health nurses more widely across the life course.

What nursing and midwifery brings to the future is a steadfast commitment to improving the health and wellbeing of individuals and communities at all ages and in all places. In response to increasing demands on nursing and midwifery services the focus on public health being everyone's business has weakened over the last decade, although the new NMC FNFM standards (2018 & 2019) emphasise public health. Whilst there are some small targeted public health nursing/midwifery initiatives in marginalised groups such as: MECC, Early Intervention Transformation Programme (EITP), and Family Nurse Partnerships and are starting to redress the balance in some small and focused areas of practice but they are not consistent across NI[32]. It is within this context that the pace of public health and population health nursing needs to be stepped up and maximised across the life course.

Recognise and promote the impact of every nurse / midwife from pre conception to older age and event moment between

We need to live the values we espouse and at times we will need help to do that

Who can make a difference to individual and population health through the social determinants of health



What we heard

Pregnancy and early years have a decisive impact on the health and well-being of mothers, children and families. The midwife has a vital part to play not only in helping to ensure the health of mother and baby, but in their future health and well-being and that of society as a whole. Pregnancy and early life lay the foundations for our individual health, well-being, cognitive development and emotional security – not just in childhood but also in adult life. What happens to children before they are born and in their early years profoundly affects their future health and well-being.

Midwives are crucial members of the public health workforce, well placed to help every child make the best start in life. Their health promotion and health protection activities improve maternity outcomes and long term health gains by addressing individual and social health determinants such as breastfeeding, smoking, drinking and their social and behavioural origins. The public health approach includes a commitment to the promotion of positive parenting and an acknowledgement of the importance of the parent's emotional well-being.

The promotion of health and wellbeing as ***every nurses' and midwives' business*** was a key message. It was recognised that the focus of public health and wellbeing practice early intervention; prevention and health promotion, promoting social inclusion and reducing inequalities in health and wellbeing. If nurses and midwives were to have the capacity and skills to maximise every contact they have with individuals and communities the impact on health and wellbeing could be significant. Furthermore, feedback reinforced that the influence of nurses and midwives to improve public health must be ***across the life course*** and in all places, including the young, those at working age and adults who are older, where we grow, where we work and where we live. Nurses and midwives recognised that they should ***model good public health practice and behaviours*** in maintaining their own health and wellbeing and promote a positive coaching approach. The data also reinforced the positioning of nurses and midwives as integral to where people work and live and as such can impact on every aspect of life. This is strengthened by the respect nurses and midwives are held in, yet they are often not afforded the time and capacity to influence beyond health and social care. There was a strongly held view that the relationship with communities has been lost in the pressure of service delivery reducing the ability of nurses and midwives to ***improve the wider determinants of health and wellbeing.***

Where do we need to be?

There is a significant role for the professions to impact on the health of the population. The main focus should be to facilitate the capability of nurses and midwives to avail of every opportunity to impact on individual and population health and wellbeing. The value and contribution of nurses and midwives to improving the health and wellbeing of the population of NI must therefore be supported and recognised. This will enable NI to rapidly move to the vision in *Health and Wellbeing 2026: Delivering Together* and nurses and midwives will be better prepared and supported to play their role in improving public health. Nurses and midwives should be facilitated to make the fullest contribution to public health across the life course and in all places working with other partners, such as local councils to improve the life changes for all.

To achieve this aim, the professions need to be appropriately prepared for their role in improving the health and wellbeing of the public at all levels within a public health career pathway. This will require roles for nurses and midwives that enable them to lead on population health approaches across the life span, including population health needs analysis, health and wellbeing improvement, health protection and providing public health practice within and across the system. One very important aspect of this vision is the need to support nurses and midwives to live the values of public health in both their professional and personal lives.

Key Messages:

- **Promoting health and wellbeing for the population of Northern Ireland should be every nurse and midwives' business**
- **Public health approaches should be normalised into nursing and midwifery practice to impact on all ages across settings and communities**
- **The need to develop population health management knowledge and skills to maximise the contribution of nursing and midwifery to health and wellbeing**

Staffing For Safe And Effective Care

Where we are now

It is timely and significant that the recent publication of the Health and Social Care Workforce Strategy by the DoH, takes a very detailed look at the workforce challenges facing health and social care in NI. The strategy sets out ambitious goals for a workforce that will match the requirements of a transformed system and which addresses the need to tackle the serious challenges with supply, recruitment and retention of staff. One of the key actions is to develop and sustainably fund an optimal workforce model for reconfigured health and social care services by 2026.

The implementation and progression of the Department's policy framework, *Delivering Care: Nurse Staffing in NI*, has served to highlight a stark disparity between actual staffing levels across a range of specialities and those staffing models identified for optimum delivery of safe and effective care.

The DoH has increased investment in pre-registration commissioning since 2016, following a five year downturn in training places between 2010-2015. In 2018/19 a further significant investment, supported by transformation funding, has financed a total of 1000 pre-registration places, which is at an all-time high.

International nurse recruitment is a current strategic short term measure to strengthen the existing workforce. A regional international campaign commenced in 2016 and is on track to deliver 622 nurses into NI by March 2020. Recruitment has yielded greater success in non-EU countries than in EU countries. The impact of the United Kingdom leaving the European Union in 2019, brings a further uncertain dimension to the current workforce challenges that could potentially exert a destabilising influence on the nursing and midwifery workforce, particularly on those workplaces in close proximity to the Republic of Ireland.

Evidence exists of enhancing contribution through role development, as nurses and midwives endeavour to embrace change and adapt their practice to meet service needs and demands. One such example is the development of ANP roles, the value of which is strategically endorsed in *Health and Wellbeing 2026: Delivering Together* and is gaining increasing recognition across primary and secondary care settings.

Within the unregistered nursing and midwifery workforce, roles have developed to provide additional support to the registered workforce, operating within the context of the delegation framework. In recognition of the valued contribution of this cohort of staff, the DoH, in 2018 mandated a suite of regional resources specifically to support nursing assistants and senior nursing assistants, including Standards and an Induction and Development Pathway.

What we heard

The urgent need to ***increase the numbers of registered nurses and midwives*** was a consistently strong and unanimous message. The presenting data painted a concerning picture of a pressurised, under resourced workforce, curtailing the capacity and capability of the nursing and midwifery professions to effectively deliver person-centred, safe and effective care. There was widespread recognition that sufficient resourcing of the workforce was a critical enabling success factor for safe staffing and improving outcomes for all. Increasing investment in pre-registration nursing and midwifery training was viewed as a key pivotal priority, for effective workforce planning in addressing the current workforce deficit.

It was clear from the evidence gathered that the ***providing support and reducing bureaucracy*** was highly valued and inextricably linked to the wellbeing and resilience of the nursing and midwifery workforce. Increased bureaucracy was cited as a significant barrier to enabling efficient functioning of the nursing and midwifery workforce, with frustrations expressed around data collection requirements, HRPTS and cumbersome electronic HR processes, which impede timely recruitment into vacant posts. Support was viewed as crucial for nurses and midwives in managerial and leadership roles, particularly with regard to recruitment processes, and managing sickness absence and also clinical support for newly registered staff.

There was a real desire and enthusiasm expressed to ***enhance nursing and midwifery contribution through the development of new roles*** within the professions. Opportunities to access, develop and resource new and innovative roles was viewed as essential for the preparedness of the future workforce, for example, the development of advanced nurse practitioner roles.

Furthermore, the value placed on the contribution of the non-registered workforce was also highlighted and viewed by registrants as a vitally important area for development, to maximise the impact of this group of staff, in supporting the delivery of safe and effective person-centred care.

Where do we need to be?

In order to achieve staffing for safe and effective care, we need to move to a desired position of having a sufficiently resourced and supported nursing and midwifery workforce in NI. This is crucial for maximising the contribution of the professions to deliver positive health and wellbeing outcomes for our population.

A range of supportive measures is needed at all levels to enable the workforce to function effectively and focus on delivering high quality nursing and midwifery care. Supportive models should be developed for newly qualified registrants joining the workforce and also for experienced registrants in managerial and leadership roles, with HR and administrative support for recruitment processes, absence management and data collection requirements.

We need to promote, develop and sufficiently resource enhanced roles to optimise the nursing and midwifery contribution to population health, and ensure readiness of the professions to meet current and future challenges and demands.

Key Messages:

- **A fundamental and pressing priority is the need to address workforce shortages and to strengthening the capacity of the nursing and midwifery workforce to deliver safe and effective care.**
- **The workforce should be supported to function effectively by reducing unnecessary bureaucracy**
- **Enhancing the development of new roles should be nurtured and progressed to optimise the contribution made by the professions across the life course.**
- **There is a need to ensure safe staffing levels are mandatory and funded**

Educating For The Future

Where are we now

Education and lifelong learning is fundamental to supporting nurses and midwives to meet challenges now and into the future. An educated, competent and motivated nursing and midwifery workforce is crucial to support UHC as a key imperative for improvement[33].

From April 2016, revalidation is the process that all nurses and midwives in the UK follow to maintain their registration with the NMC which includes a requirement to undertake CPD. The process of revalidation is aligned to The Code[34] which outlines professional standards of practice to ensure the safeguarding and general well-being of people. As previously cited, NMC has radically overhauling pre-registration nursing and midwifery standards and implementing a new education framework for the delivery of nursing and midwifery education and training in the UK. The NMC next piece of work will be on reforming post-registration standards.

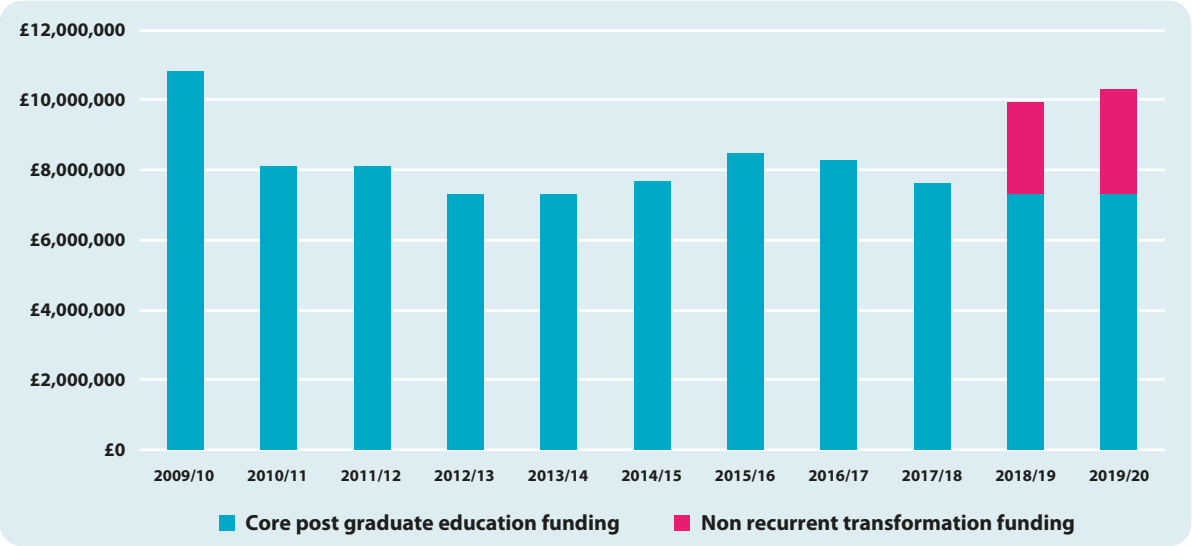
Within this context nurses continue to develop and expand their roles and responsibilities and exemplars of good practice are demonstrable across all settings in NI. Several programmes of work are already being taken forward at regional and national level to address a number of issues which have emerged regarding the current and future education of nurses and midwives. For example: development of Specialist midwife and Advance Nurse Practitioner (ANP) roles across a range of settings and consultant nurse and midwife roles. Much of this has been funded by redirecting resources from across the education budget and often resulted in deficits elsewhere. On occasions despite access to education there has also been lack of support for those wishing to pursue careers roles such as Clinical Academic Careers despite availability of PhD sponsorship.

Within the DoH, the CNO has responsibility for the post registration nursing and midwifery budget. On an annual basis a business case is developed to propose what is needed for the incoming year. This process is not sustainable as it is not possible to commission post registration programmes from universities and other education providers beyond the current annual and ad hoc basis. In terms of post-graduate education the report highlights that in order to both retain and develop our nurses and midwives there is a need to restore and incrementally grow postgraduate training budgets.

Over the last ten years **(figure 19)** the postgraduate education budget in nursing and midwifery has been progressively decreased from £10.8 million to £7.3 million. This reduction has been further compounded over this time period by an increase in post-graduate education costs and the increased costs associated with backfill for some of the training places. It is important to note however over the last two years these reductions have been

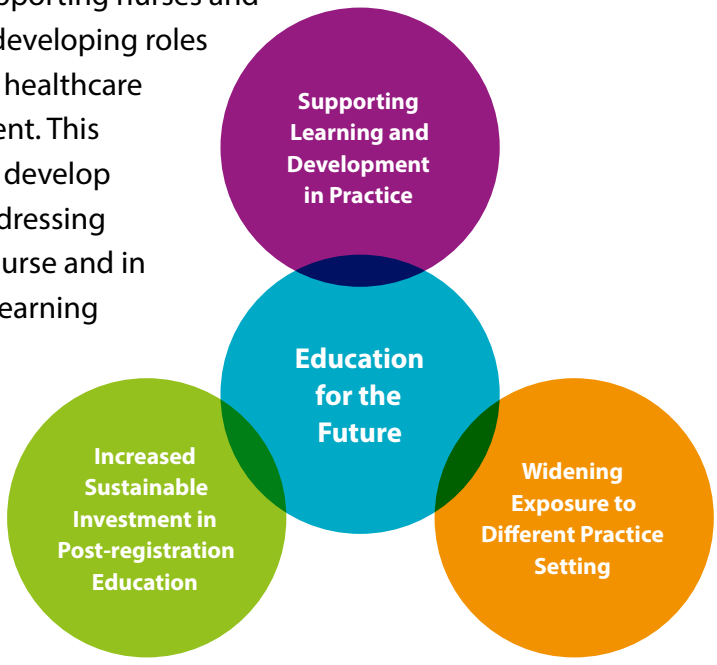
offset by non-recurrent transformation funding and an increase in both nurse and midwife student places. In the absence of sustained transformation funding and/or a restoration of recurrent funding commensurate with the size of nursing and midwifery workforce, this will have significant implications for nursing and midwifery practice career pathways and wider health and social care reform.

Figure 19 - Nursing & Midwifery Post Registration Education Investment Profile Source DOH



What we heard

Lifelong education and learning across a graduate workforce was highlighted as pivotal to maximising the potential for nurses and midwives to contribute to improving health and wellbeing of the population. Supporting nurses and midwives to take on innovative and developing roles was considered crucial for continued healthcare improvement and service development. This included the knowledge and skills to develop services outside hospital settings, addressing the needs of people across the life course and in particular those with comorbidities, learning disabilities, mental health needs and older people. Timely access to postgraduate education using blended learning approaches, where possible, delivered on a multi-professional flexible basis was identified as a fundamental driver for success.



Professional facilitation roles that support learning and development in practice such as preceptors, mentors and clinical educators, were viewed as enablers to learning and development in and outside of care environments. In particular, there was an expressed need to support new registrants in the immediate post qualifying period. Preceptors reported a feeling of being pressurised and found it difficult to spend time to focus on supporting newly qualified colleagues in the work place. Learning outside traditional boundaries through pre and post registration programmes within a multi-disciplinary context was considered a key component to ***widening exposure to difference practice settings***. Despite the current workforce challenges there was a real desire to ensure that the student nurse experiences in university and practice placements were positive and appropriate with a good level of support in a culture that encourages innovation and improvement.

A major concern was that qualified and experienced staff who were motivated to maintain and extend their skills and roles through Continuous Professional Development (CPD), were finding it difficult to access education. There was also widespread concern that postgraduate education was often inappropriate and inaccessible and that better outcomes could often be achieved through multidisciplinary training at a local level. There was a case made for ***increased and sustainable investment in post-registration education*** that would maximise the contribution of nurses and midwives into the future.

Where do we need to be?

The new proficiency standards for nursing and midwifery have been practice launched by the NMC. These standards are set to revolutionise and modernise nursing and midwifery practice, and they are strongly focused on delivering population health, and evidenced based interventions which will improve outcomes for people. The CNO has now established a Future Nurse Board to ensure NI becomes an exemplar of these standards. These standards will complement the direction of travel proposed in our report and indeed they have also been factored into the recommendations.

The recent Health and Social Care Committee, England, nursing workforce inquiry[35] has significant messages for all countries. It looked at the current and future scale of the shortfall of nursing staff and whether the Government and responsible bodies have effective plans to recruit, train and retain this vital workforce. The Committee heard a clear message that access to continuing professional development plays an important role in retention. Whilst it was noted that efforts are being made to retain staff, key recommendations included a reversal of cuts to nurses' CPD budgets; specific funding made available to support CPD for nurses working in the community; and access to continuing professional development needed to reflect skill shortages and patient needs. There is a need therefore, to ensure that the workforce is supported and developed to enable registrants and those contemplating a career in nursing or midwifery to lead service improvement and impact significantly on the delivery of person centred care.

Moving toward a future where nurses and midwives are at the forefront of service transformation requires a commitment to support the professions across their careers through progression and role expansion. There is a need to invest in post-registration education to ensure the right number nurses and midwives, with the right knowledge, skills and experience are working in the right place at the right time to improve the health and meet the needs of the population. Opportunities to undertake masters and doctoral programmes should be available, including the establishment of clinical academic careers. This should include establishing clinical academic posts for midwifery and each branch of nursing in all HSC organisations to strengthen the research and development capacity within nursing and midwifery teams. Cognisance should be taken of nurses working in lone roles, such as Practice Nurses. Furthermore there should be support for education in clinical practice available through a range of opportunities e.g. Clinical teaching, eLearning, Human Factors training, coupled with opportunities for Higher Education Institutions to plan for the development and delivery of programmes within a sustainable model which meets the emerging policy and strategy needs of the DoH.

Key Messages:

- **Continuous professional education and development is vital for safe effective practice and career development**
- **Within the current context and due to workforce constraints nurses and midwives are finding it increasingly difficult to access educational opportunities**
- **A sustainable funding and workforce model is required to support post-registration education to deliver on the transformational agenda**
- **Professional facilitation roles should be further enhanced to enable learning and development in a range of care environments.**

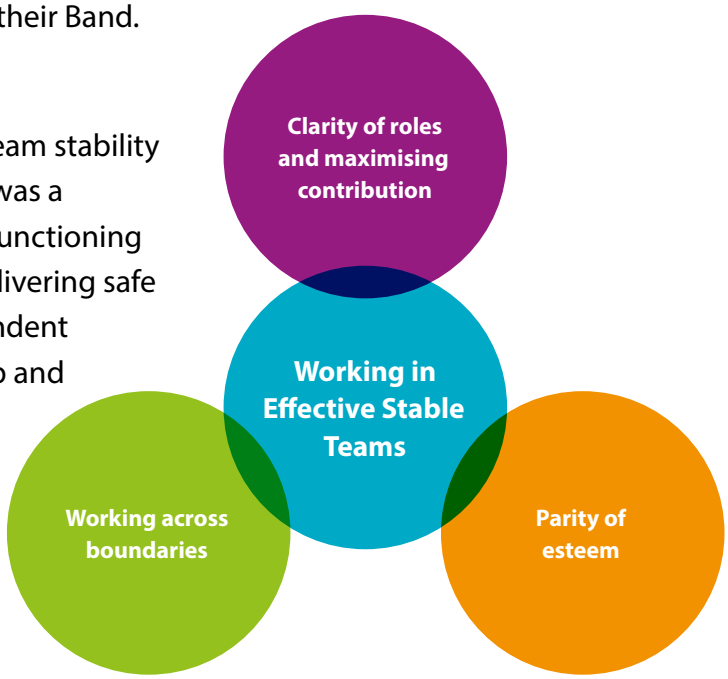
Working In Effective Stable Teams

Where we are now

Nurses and midwives are working across care settings in pressured environments which affects the stability of their teams. It is clear that working in teams that are short staffed has a negative impact on the professions, affecting their own safety and wellbeing, as well as eroding pride in their roles. Nurses and midwives serve as an around the clock surveillance system for early detection and prompt intervention when people's conditions deteriorate both in community practice and within hospitals. That surveillance system must be adequately resourced and communication systems must be excellent to ensure delivery of safe and effective care by stable teams. The context presented in section 5, reflects workforce trends including vacancy rates, recruitment and retention, and subsequent use of bank and agency staff that significantly challenge the establishment of effective teams.

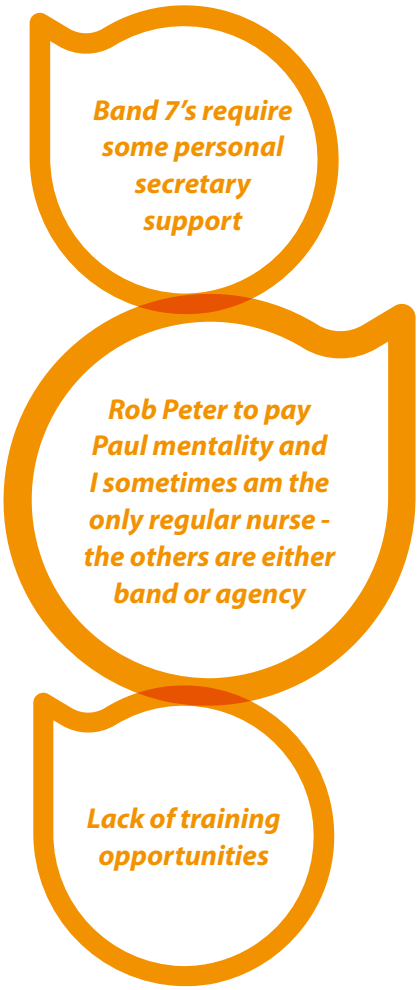
NI has much fewer opportunities for nurses and midwives above pay Band 5 than the rest of the United Kingdom. This lack of opportunity frustrates the professions in NI, as they feel there is very little opportunity for career progression, with no reward for midwives and those nurses who are working at the top of their Band.

What we heard



The need to strengthen and sustain team stability across all environments and settings was a resounding message. Effective team functioning was viewed as a crucial enabler to delivering safe and effective care with stability dependent on adequate staffing, good leadership and effective communication. Issues raised around this theme included the importance of regular team meetings, supervision and support, shift patterns and recruitment and retention. The reasons provided for this challenge were: frequent use of agency staff; delayed replacement of staff exiting the organisation; and a lack of opportunity for meaningful staff meetings. Staff identified that crisis management was the norm, where moving staff to areas under even more pressure was common practice. The reality was that nursing and midwifery staff were 'acting down' to plug gaps brought on by deficiencies in administrative support.

There was a need for ***clarity of roles that maximised the contribution*** of nursing and midwifery. Evidence was provided that nurses were expected to pick up on tasks and duties previously performed by other members of the multidisciplinary team. Staff also identified the lack of opportunity to experience different roles and regularly enquired about an internal transfer system for employees already in the HSC system enabling them to ***work across boundaries*** whilst avoiding a full application and recruitment process.



Nurses and midwives used the example of the advancement across AfC pay scales for other professions as an indicator of lack of ***parity of esteem***. This often played out in the effective functioning of teams; for example, AfC Band 5 nurses provided an example of mentoring new social workers who automatically progress to Band 6 pay scale after one year, whilst an experienced nurse remains at Band 5. This was counter-intuitive to an agenda that releases the potential of nurses and midwives and maximises their contribution within the system.

Where do we need to be?

Improving teamwork competency across nursing and midwifery could have enormous financial and quality care implications across the health and social care sector as a whole. Improving teamwork competency saves lives[36] and is marked as an international priority in discussions about restructuring nursing care provision[37]. Furthermore, in hospitals where nursing teamwork is rated as strong they report less missed patient care (Kalisch, Lee & Rochman 2010), fewer patient falls (Kalisch et al. 2007) and higher quality of work life impacting staff recruitment and retention (Brunetto et al. 2013)[38]. A direct correlation between teamwork, adequate staffing levels and job satisfaction has been evidenced[39]. Familiarity with team members, stability of the team, a shared common purpose among team members, as well as the right physical working environment that is conducive to staff engagement are all thought to characterise high performance teams.

The Department has invested in developing new roles in Advanced Nurse Practitioner (ANP) and it will be vital that employers ensure jobs are developed to match the skills of these very highly trained practitioners. In addition there needs to be encouragement and incentives for nurses to work at the top of their scope of practice. Nurses are the members of the inter-professional team which is available to the patient/client 7 days a week and 24 hours per day, so it makes sense to incentivise them to up-skill and work at the very top of their scope of practice. There is also a need for nurses especially out of hospital to operate in virtual, flexible and multiple teams, working across teams and agencies is a critical leadership skill.

Key Messages:

- **Workforce trends such as vacancy rate, use of bank and agency, and sickness absence rates are impacting on the establishment of effective stable teams**
- **There is a clear link between teamwork competency and the provision of safe and effective care**
- **There is a need to maximise the contribution of nurses and midwives within teams by incentivising them to work at the top of their scope of practice through appropriate career progression**

Maximising Digital Transformation

Where we are now

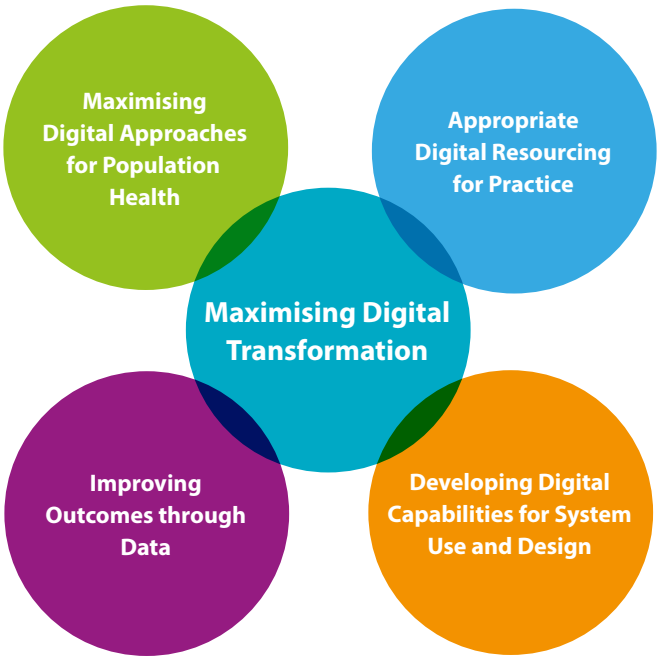
Technology systems in NI, with the notable exceptions of the Northern Ireland Electronic Care Record (NIECR) and the primary care system used by General Practitioners, are in the main unable to communicate with other technological systems between and across organisations. People in NI do not have electronic access to their health records; health records are mainly in paper format; innovation is slow to mainstream in practice and data requires more standardisation and structure. Where electronic records are operating, they tend to be in a form filing format, where there is limited ability to interrogate, report on or use the vast amount of information that nurses and midwives input to these systems every day.

> ***Encourage the role of technology to keep [those with mental health issues] connected with family and other members of the community e.g. WhatsApp***

Access to the internet and therefore infrastructure to support digital technologies can be difficult in some geographical localities of NI, particularly in rural areas. The abilities and skills to engage with, direct, develop and use digital technologies and data are not currently included in nursing and midwifery programmes across NI, neither at undergraduate or post-graduate levels.

Nurses and midwives often express the fact that they are not equipped with the necessary up-to-date hardware or software to do their jobs efficiently. They also often debate the utility of some of the systems currently deployed in NI citing that they are not intuitive to use, lack user-friendly interfaces (known as Application Programme Interfaces or APIs) and can be time consuming to complete, removing them from the opportunity to spend more time engaging with patients, women and their families.

This mirrors a recent UK-wide survey undertaken by the RCN, published in 2018[40] relating to the progress towards digital readiness for nursing to use health technologies in every day practice. This survey, whilst limited in the number that responded and therefore representative sampling, demonstrated messages about what nurses wanted in relation to technologies. Those nurses that responded sent a clear message that they wished to engage more in the development of health technologies, that current systems were not fit for purpose and that organisations needed to get the basics right in terms of provision of hardware and software to the registrant workforce, enabling them to do their job well.



What we heard

Necessary steps were identified by nurses and midwives for future digital maturity for health and social care services in NI. There was a repeated focus on ***appropriate digital resources to support practice*** through hardware and digital infrastructure for mobile and remote working across organisations. The ***development of digital capabilities for system use and design*** across all levels of the professions was also a strong theme that linked to ***understanding data*** from technological systems for the purposes of practice and ***outcome improvement***. From a future facing perspective, there was a clear message that systems design and opportunities to use technology to ***maximise digital approaches to population health*** should have nurses and midwives at the forefront, driving innovation. This included the use of digital approaches to support self-management of chronic conditions for the population of NI, both technologies currently available and those yet to be developed.

Where do we need to be?

NI has a strategy underpinning eHealth and technology[41] with a focus on developing both technologies to assist the public, health and social care service providers, and staff to use them. Real-time engagement about care and services with the public of NI through patient portals fostering the spirit of coproduction, a clear message from *Health and Wellbeing 2026: Delivering Together*; capture of data through remote monitoring systems; capture of data by the public themselves through fitness tracking equipment and health apps, could provide vital information about the health of our population and future opportunities to promote health and wellbeing. Nurses and midwives need to be appropriately equipped to track this data, understand utility for improvement and trend for bigger messages relating to population health and the impact of nursing interventions on health outcomes. In addition, a single system that communicates seamlessly across all sectors in NI is the ambition, through the Encompass programme of work currently being taken forward. Nurses and midwives understanding how to use this system and maximise the information flowing from it to improve outcomes for people should characterise the future.

Invest in technology infrastructure and training for nurses and midwives

The recent Wachter Review[42], commissioned to review and articulate the factors impacting the successful adoption of health information systems in care services in England, was tasked with providing a set of recommendations drawing on the key challenges, priorities and opportunities, messages resonating across all countries in the UK. In particular, there was a focus on the importance of developing digital leaders and clinician informaticians across organisations with appropriate resources and authority. Indeed recommendation 3 stated that efforts should be made to '*develop a workforce of trained clinician informaticians at the Trusts and give them appropriate resources and authority*'.

There is opportunity for nurses and midwives, therefore, to develop the required digital capabilities to enable quality improvement, appropriate data gathering – including decisions on that which should, and should not be gathered, data analysis, and engaging with technology driven healthcare to improve outcomes for populations[43]. Experienced nursing and midwifery roles are crucial to the implementation of interventions that are technology based[44], with significant opportunity to impact the implementation and design of digital health technologies because of their expert clinical workflow knowledge, decision making capacity and leadership role[45]. Nursing and midwifery leaders are also highly influential in the adoption of practice trends and should therefore seek to understand what digital providers offer including how these systems can assist or hinder nursing practice[46].

Key Messages:

- **Investment is needed for digital equipment and infrastructure to support its widespread use**
- **There is a need to build the skills and authority of nurses and midwives to lead the potential for future digital practice**
- **Digital systems need to be designed collaboratively with appropriately skilled registrants to ensure they are fit for nursing and midwifery practice**
- **Nurses and midwives need to be enabled to lead and engage with and influence the design of innovative digital health approaches for the population**

Recognising And Rewarding Excellence In Practice

Where we are now

In a UK-wide report, *Safe and Effective Staffing: The Real Picture*[47] four out of five Directors and Deputy Directors of Nursing indicated that their organisations ran on the good will of their staff to provide services. Nearly three in five (57%) of Directors and Deputy Directors of Nursing said that staff wellbeing declined over the past two years. In a similar report within HSC organisations in NI, 52% of nursing staff reported not having enough time to carry out all their tasks and duties and 28% reported that there were too few staff, feeling overwhelmed by workload[48].

In 2017, the Commissioner for Older People exercised his discretion to commence a statutory investigation into specific matters affecting older people, carrying out an investigation into the standards of care received by residents of Dunmurry Manor Nursing Home. His report of the findings of his investigation[49] set out 59 recommendations. These include a recommendation to ensure workforce plans are developed that take cognisance of nurse staffing requirements for the Independent Sector. He also recommended that a high level of staff turnover and use of agency should be considered a "red flag" issue for commissioners of care and the Regulation and Quality Improvement Authority (RQIA).

The DoH and the Northern Ireland Practice and Education Council (NIPEC)[50] have published a suite of documents to ensure a consistent approach across HSC Trusts regarding role, remit, function, training and education of Nursing Assistant and Senior Nursing Assistant roles undertaking delegated aspects of nursing care supervised by a registered nurse or midwife. This includes core elements of a job description for AfC Band 2 and 3 staff.

The DoH and NIPEC have also published an Interim Career Framework for Specialist Practice Roles[51], an Advanced Nursing Practice Framework[52] and Professional Guidance Supporting Consultant Nurse and Consultant Midwife Roles[53], distinguishing characteristics within components of practice between these roles. Alongside of these developments, nurses and midwives have consistently demonstrated their contribution to the health and wellbeing of the population in NI. There are cited examples, included in Section 5, of how they are leading the way in delivering high quality, innovative person-centred care, contributing to the strategic objectives of transformation and co-production.

Finally, NI has been collecting and demonstrating evidence on the contribution and impact of nursing and midwifery practice to person-centred health outcomes through the collection of Key Performance Indicators (KPIs) across a number of work programmes and

operational directorates. This initiative has been led collaboratively by the Public Health Agency and NIPEC since 2012 and is chaired by the CNO. Over the last 6 years since the work began, a wealth of data has been collected that has evidenced the positive impact of nurses and midwives on the health outcomes of people receiving health and social care services in NI. For further information on nursing and midwifery KPIS in NI please go to: http://www.nipec.hscni.net/work-and-projects/stds-of-pract-amg-nurs-mids/evidencing-care-kpi-for-nurs-mid-project/

What We Heard

Nurses and midwives across all care settings consistently reported feeling overstretched, resulting in patient care being compromised and care being left undone due to lack of time. Repeated concerns were raised about gaps in skill mix and a lack of corporate and professional infrastructure to support the professions. Participants at the workshops frequently reported that they felt the impact personally in terms of their own health and wellbeing and were concerned about work life balance, their own welfare and that of their colleagues. Morale was repeatedly described as "low", and regular statements were made relating to 'a simple thank you' from employers being appreciated by nurses and midwives. There was a clear message of the value of ***celebrating and rewarding success*** and promoting excellence in practice.

There was a consistent message about nurses and midwives being expected to take on the roles of other health and social care staff specifically administrative and domestic staff, Allied Healthcare Professionals, medical staff and social workers. The system was characterised by "too much bureaucracy", too much unnecessary paperwork and duplication of effort. This was further exacerbated by a lack of IT support and systems. There was strong consensus that these issues needed to be addressed in order to release time to ***maximising the value of nursing and midwifery*** care.

Many expressed concerns about the lower rates of pay earned by staff on AfC terms and conditions in NI. There was a generalised perception that the contribution of other health and social care professionals was being recognised in terms of AfC Banding, whilst the contribution made by nurses and midwives was not. There was a perceived lack of openness and transparency in relation to development opportunities and access to post-registration education and development programmes. Staff also cited occasions when they had been supported by their employer to complete specialist development programmes but were subsequently not employed, deployed, or in a position to utilise their specialist practice knowledge and skills in post following completion. There were also situations recounted of nurses utilising higher level skills beyond their AfC Job Band however were not remunerated at an appropriate level. This articulates a rationale for ***ensuring appropriate remuneration aligned to career progression for nurses and midwives***.

Issues relating to the ability of staff to provide appropriate levels of safety, quality and patient/ client experience were reinforced, such as: inadequate workforce planning, an increasing number of staff secured via agencies, and the stability of nursing and midwifery teams. These issues have been discussed in more detail in previous sections of this report. Shortages were more acutely felt in the Independent Sector and participants expressed dismay that workforce planning had consistently excluded the requirements of this sector.

Where do we need to be ?

Nurses and midwives need to feel valued and should be rewarded for advancing practice and being a significant contributor to the transformation agenda alongside other professions who are similarly acknowledged through career advancement and pay progression. Similarly, future services contracted out to be provided on behalf of the HSC by the Independent Sector HSC contracts must ensure that terms and conditions of employment for staff support a stable workforce.

A number of key policies and best practice documents from a professional and system perspective have painted a clear picture of the future in relation to recognition, enabling transformative leadership to achieve the overall aim within the current PfG aim of 'enjoying long, healthy and active lives'. Nurses and midwives are well placed to significantly contribute to improving the public health of the community, maximising transformation through person centred practice and improving quality and experience of care. The *Health and Social Care Workforce Strategy* identified two themes focused on actions in relation to promoting the health and wellbeing of the workforce and maintaining an effective work life balance.

Nurses and midwives should not suffer the unintended consequences of any service reform, particularly of administrative and support services that adversely impact on their ability to provide safe and effective care to patients and clients. Administrative processes that cause a duplication of effort placing an increasing burden on nurses and midwives need to be eradicated. Rather a system of streamlined information management and technology is required to support nurses and midwives to deliver person centred, safe and effective care. In shaping the future it is imperative for the professions to be able to evidence the impact of their practice which is key to maximising the contribution of nursing and midwifery to the population of NI.

Key Messages:

- **Action is required to improve the health and well-being and work-life balance of nursing and midwifery staff.**
- **In the interests of bringing stability to the nursing and midwifery workforce and reducing reliance temporary bank and agency staff, nurses and midwives pay in Northern Ireland should be commensurate with that in the other countries of the UK.**
- **The clinical infrastructure to support nursing and midwifery must be strengthened and critically involves reducing bureaucracy, streamlining information management and technology.**
- **HSC contracts for the independent and voluntary organisations must ensure that terms and conditions of employment for staff support a stable workforce in this sector.**
- **The future development of nursing and midwifery should be informed by the generation of evidence in practice and through the development of clinical academic careers.**

Leading Quality And Innovation

Where we are now

Health and Wellbeing 2026: Delivering Together sets out the road map for the development of a word class health and social care system. Any system that aspires to be world class must take a strong position on quality improvement. It is within this context that all health and social care professionals are required to fully integrate quality improvement into their work. This will mean improving our capacity to foster local innovation and to implement what works at scale. The NMC Code and Enabling Professionalism framework also articulates the requirement for nurses and midwives to continually learn and improve in practice. Through the Quality 2020 Strategy the IHI Improvement skills training suite, quality improvement capacity is being developed across nursing and midwifery services. There was also a deep recognition that QI training in nursing and midwifery is at an early stage of development and more needs to be done to build capacity across the nursing and midwifery workforce. In addition, the work of Regional Nursing Key Performance Indicator Advisory Group has increasingly introduced a culture of outcome measurement.
Again much more work is needed to ensure effective measurement of nursing and midwifery practice to become a systemic part of delivering routine care.

What we heard:

There was a recognition across all the workshops that to deliver care interventions based on evidence, nurses and midwives needed to be proactively supported to lead on quality and innovation.

Utilising and managing data to enable learning and improvement was linked to maximising the impact of nursing and midwifery practice across the life course.

This was clearly linked to the development of a supportive IT infrastructure to enable the capture and use of both experiential and clinical data and learn from and improve practice. Nurses and midwives expressed the need to ***engage in improvement and implementation science*** but there was recognition that nursing and midwifery as the largest professions still needed to build quality improvement capacity and capability, which would require sustained dedicated investment. There was an expectation that nurses and midwives should be ***leading and enabling innovation***. It was within this context that there was also a call for the system to recognise and value the opportunities for role enhancement across the professions. This was considered a critical enabler of services transformation and in improving population outcomes over the next 10 years.

Where do we need to be?

Nurses and midwives are critically positioned to provide the creative and innovative solutions for current and emerging health and social care challenges such as ageing population. We need to invest, therefore, in building improvement and implementation capability at undergraduate and postgraduate levels. Up until now, the potential for the professions to lead improvement science activities has not been fully realised. In their day-today practice nurses and midwives do not routinely receive opportunities to conduct research and contribute to improvement science (Taylor et al. 2010). The ability of the professions to seek the best research evidence, measure care outcomes and use empirical data to assess their current practice (Sherwood 2010) is dependent on the development of improvement science knowledge and skills. Crucially implementation science explores how the latest research and evidence can best be implemented to change healthcare policy and practice. This in turn assists the profession to translate evidence into practice and therefore improve care outcomes[54].

Value based approaches to quality improvement such as human factors and practice development are effective in bringing about cultural change and should also inform quality improvement and innovation. Understanding, applying and deploying such methods needs to be embedded across the HSC. Furthermore, in recognition that nurses and midwives play a key role in determining the quality of health and social care it is essential nurses and midwives are liberated through effective job planning to engage in quality improvement and in generating new ways of thinking, new ways of working and in new ways of utilising enabling technologies.

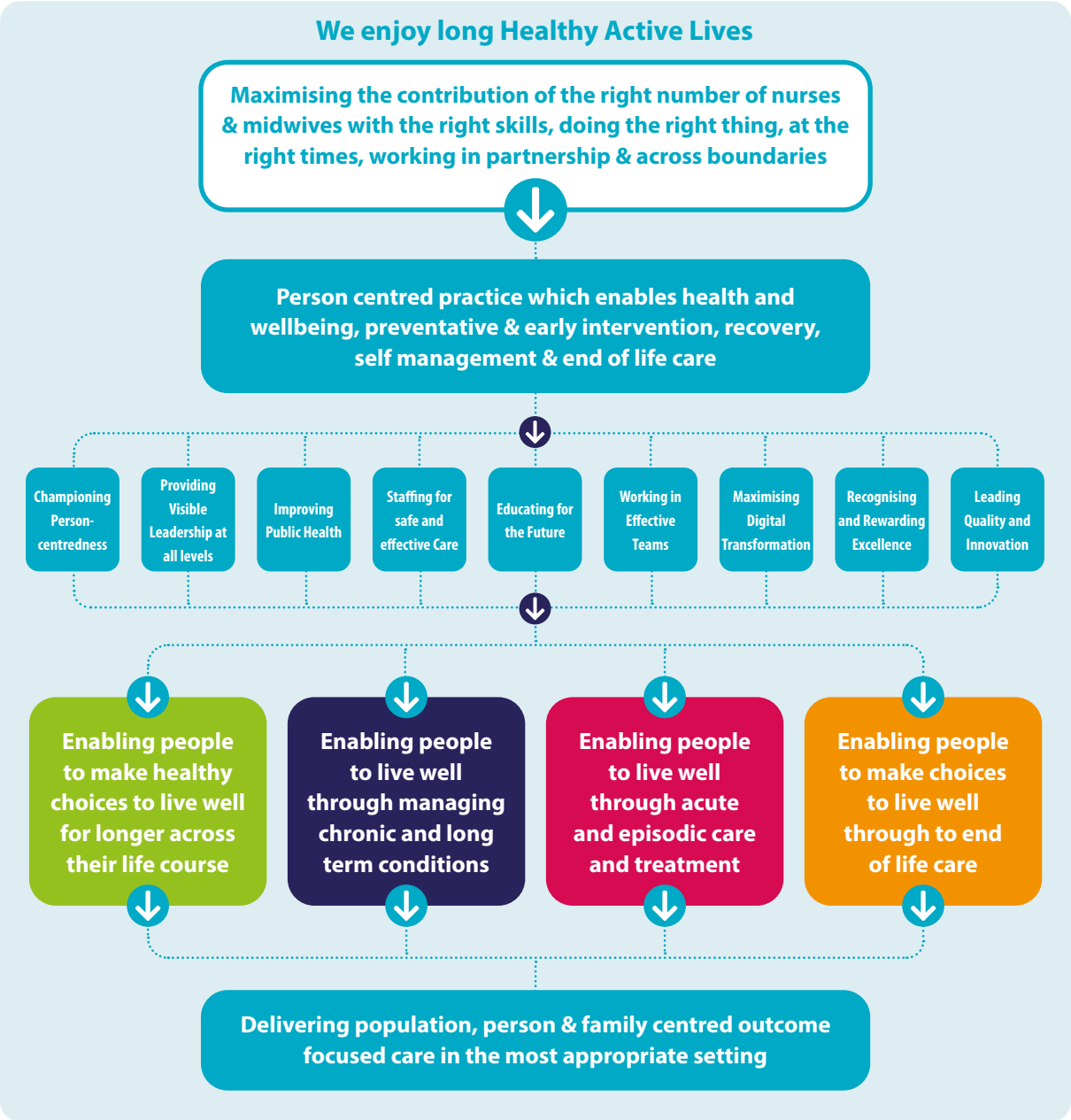
Key Messages

- **Nurses and midwives have the potential to significantly contribute to and to lead in the field of improvement science in healthcare.**
- **Opportunities need to be increased for nurses and midwives to be developed in a range of improvement and implementation science approaches.**
- **Nurses and midwives need to develop skills in gathering, collating and analysing data from across a range of professional and clinical systems for improving practice and driving innovation.**

7

THE WAY FORWARD - RECOMMENDATIONS

SECTION 7: THE WAY FORWARD – WORKING TO ACTION



Realising the Value of Nursing and Midwifery: - A Socio-Economic Perspective

In formulating the recommendations of this report it was important to consider the current and potential value of nursing and midwifery particularly in the context of enabling the population of NI to 'enjoy long healthy active lives'. It has been internationally recognised that the nurses and midwives undertake different roles in different circumstances, but they all share in the combination of knowledge, practical skills and values that has them well placed to meet the current and future needs of the population[55]. Whilst other professions share some or all of these features, the nursing and midwifery

contribution is unique because of its underpinning evidence base, the range and diversity of professional roles and the scale of the workforce. In reality the professions provide around the clock care, are often the first point of contact, and sometimes the only health professional engaging with people in the delivery of care and treatment. They are also an important part of the community, sharing its culture, strengths and vulnerabilities. Furthermore, nurses and midwives can shape and deliver effective interventions to meet the emerging needs of patients, families and local neighbourhoods. Whatever their particular role, they are guided by professional education, knowledge and their deep rooted person centred and humanitarian values.

Enabling people to make healthy choices to live well for longer across their life course.

Nursing and midwifery together spans the life course. When the family of midwives, health visitors, paediatric nurses, school nurses and Child and Adult Mental Health Services work collectively they are crucial to enabling the best start in life. The research shows that when this happens the costs associated with developmental delay, physical, social and mental health problems are significantly reduced[56]. Adverse Childhood Experience (ACE) research demonstrates that multiple ACEs is a major risk factor for many health conditions and represents risks for the next generation (e.g., violence, mental illness, substance use and long term physical health conditions)[57]. The research also shows that children and young people with four or more ACE's are more likely to develop serious long term health conditions, mental ill-health and significant levels of socio-economic disadvantage. Additionally, for early years, the contribution of midwifery has realised substantial health and wellbeing benefits for women, mothers and their infants when high-quality midwifery care is delivered and midwifery care provided by educated and regulated practitioners was found to be more than cost-effective.

Through the work of health visiting and early years nursing it is possible to reduce the cost of long term health conditions and to reduce intergenerational trauma and poor mental ill health. We know that mental ill health costs the NI Economy £3.5 billion[58]. Investing in prevention through enhanced early years and mental health nursing and midwifery roles could therefore significantly reduce the social and economic costs associated with poor mental health. An excellent example of this in practice is the family nurse partnership. A recent evaluation by demonstrated that it adds value through transforming the lives of children and their parents and breaking the intergenerational cycle of disadvantages[59].

Older people, whether in hospitals, care homes or in their own homes, who do not get enough opportunity to mobilise, are at increased risk of reduced bone mass and muscle strength, reduced mobility, increased dependence, confusion and demotivation[60].

These problems can be attributed to the phenomenon of what can be termed as 'deconditioning syndrome'. This affects well-being as well as physical function and could result in falls, constipation, incontinence, depression, swallowing problems, pneumonia and leads to demotivation, and general decline. We know that 10 days of bed rest in hospital leads to the equivalent of 10 years of ageing in the muscles of people over 80. Getting patients up and moving has been shown to reduce falls, improve patient experience and reduce length of stay by up to 1.5 days[61].

Enabling people to live well through acute and episodic care and treatment

As an evidence based profession nursing and midwifery delivers substantial socio-economic benefits[62]. Caird et al (2010), in their systematic literature review demonstrated that nurses and midwives working in a range of areas across the life span, collectively reduced costs by enabling people to be well. This included cost avoidance as result of the preventative roles undertaken by nurses and midwives. Research illustrates that prevention reduces costs, for example, falls by over £3,000[63], sepsis between £2,000 - £5,000[64], pneumonia by £2,000[65] and hospital acquired pressure ulcers between £2,000 -£3,000 per patient[66]. The estimated savings from preventing or delaying dementia for 1 year is £15,000 per person[67] on aggregate this data clearly presents an opportunity to increase productivity and reduce the cost of care failure through effective nursing and midwifery care.

In addition, research also shows preventing and effectively treating mental ill health has significant socio-economic benefit[68]. It is estimated that the cost of physical healthcare is around £2,000 extra when the patient is also mentally ill[69]. So if we treat a physically ill person for their mental illness we can expect to save up to £1000 a year on physical healthcare (due to the 50% recovery rate)[70]. It is also estimated that within two years of recovery following successful treatment, the employment rate for those with moderate/ severe mental health problems who recover is increased by 11.4 percentage points and by 4.3 percentage points for those with mild mental health problems. This means for every person who regains or retains employment an annual saving is made of £12,935 in terms of public expenditure[71].

A recent [72]systemic review of the literature on nurse skill mix, evidenced a correlation between higher numbers of registered [73]graduate nurses and lower risk of mortality: for every 10% increase in graduate nurses there was a 7% reduction in mortality rates. Research shows that [74]richer nurse skill mix (e.g., every 10-point increase in the percentage of professional nurses among all nursing personnel) was associated with lower odds of mortality (OR=0.89), lower odds of low hospital ratings from patients (OR=0.90) and lower odds of reports of poor quality (OR=0.89), poor safety grades (OR=0.85) and other poor outcomes (0.80<OR<0.93), after adjusting for patient and hospital factors.

Each 10 percentage point reduction in the proportion of professional nurses is associated with an 11% increase in the odds of death. Therefore a bedside care workforce with a greater proportion of professional nurses is associated with better outcomes for patients and nurses and thus saves money on terms of beds days and the cost associated with delayed recovery.

Enabling people to live well through managing chronic and long term conditions

Whilst more work is needed on establishing the socioeconomic value of nursing many studies show the beneficial impact of nursing and midwifery across different settings. The Institute of Education, University College London, in 2010 undertook a rapid systematic review of the socioeconomic value of nursing and midwifery.[75] They reviewed 32 international studies and concluded that interventions provided by specialist nurses or led by nurses were shown to have a beneficial impact on a range of outcomes for long-term conditions when compared with usual care.

Further individual studies show benefits from nurse-led care including reduced costs[76], higher patient satisfaction, shorter hospital admissions, better access to care, and fewer hospital-acquired infections[77]. Nurse-led interventions for chronic conditions such as diabetes have resulted in patients making more informed decisions about their care and being more likely to adhere to treatment. ANPs not only improved access to services and reduced waiting times, but also delivered the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up[78]. Similarly, an English study also showed that in a comparison of care effectiveness and cost effectiveness of general practitioners and ANPs in primary health care, outcome indicators were similar for nurses and doctors, but patients cared for by nurses were more satisfied[79].

There is evidence to suggest that person and community centred approaches that empower people to become partners in care create the conditions for self-management. Research by NESTA indicates that self-management approaches for people with particular long-term conditions could equate to net savings of around £2,000 per person reached per year, achievable within the first year of implementation[80]. This is now supported by international evidence that suggests changing the way in which patients and clinicians work (co-production) improved health outcomes across a range of long-term conditions, including diabetes, Chronic Obstructive Pulmonary Disease (COPD), hypertension, heart disease and asthma. Patients were less prone to exacerbation and demonstrated improvements in their core clinical indicators. As a result, there was a reduction in the cost of delivering healthcare of approximately seven per cent through decreasing Emergency Department (ED) attendances, reduced hospital admissions, reduced length of stay, and decreased patient attendances[81]. It was further hypothesized that implementing this approach in England could save the NHS £4.4 billion.

The Health Foundation publications on person-centred practice and self-management also suggest found that people who are supported to manage their own care more effectively are less likely to use emergency hospital services[82]. For example, people who take part in shared decision making are more likely to engage actively in their treatment plan, which results in better outcomes. The Foundation also found that self-management programmes can reduce health care utilisation. Several studies reported that self-management can reduce visits to health services by up to 80%. If implemented within NI, this would have significant impact on population health outcomes considering that one in five people live with a long-term condition. Across the life course nursing and midwifery are therefore uniquely placed to enable recovery and reduced costs associated with length of stay, acuity and adverse health care experience.

Recommendations

Enabling people to make choices to live well through end of life care

Whilst acknowledging there is a need for deeper and more rigorous socio-economic evaluation of the impact of nursing and midwifery, an attempt has been made to place recommendations in the context of the socioeconomic evidence. The recommendations are focused on four key areas presented below.

Maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

1. The development of a new population health management programme for nursing and midwifery.
2. The creation of dedicated population/public health midwife and advanced nurse and nurse and midwife consultant roles across all of our HSC bodies.
3. To increase the numbers of School Nurses, Health Visitors and expand the Family Nurse Partnership programme across all of NI.
4. Recognising the demographic skills, nursing needs to have joint and collective responsibility for the development, planning and leadership of older people services, including all nursing care services provided in the independent sectors.

Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice

5. Sustain a minimum of 1000 pre-registration nursing and midwifery places and increase in line with the needs of the population over the next five years.
6. Establish a ring-fenced post education budget commensurate with both the size of the workforce and the HSC transformation agenda and as minimum re-establish the previous investment of £10M.
7. Build and resource a new career framework for nursing and midwifery to ensure that within ten years we have advanced nurse, specialist midwife and nurse roles as well as nurse and midwife consultant roles across all branches of nursing and midwifery.
8. Increase the number of clinical academic careers roles across all midwifery and all branches of nursing.
9. Put Delivering Care Policy (safe staffing) on a statutory footing.
10. Develop arrangements for accelerated pay progression Band 5 to Band 6 grades similar to other professions. This in particular recognises that many Band 5 nurses after several years of practice acquire additional specialist knowledge and skills take on additional responsibilities commensurate with band 6 role as a senior clinical decision maker. Midwives currently move to Band 6 a year after registration.
11. Develop a person centred practice policy framework for all nursing and midwifery services.

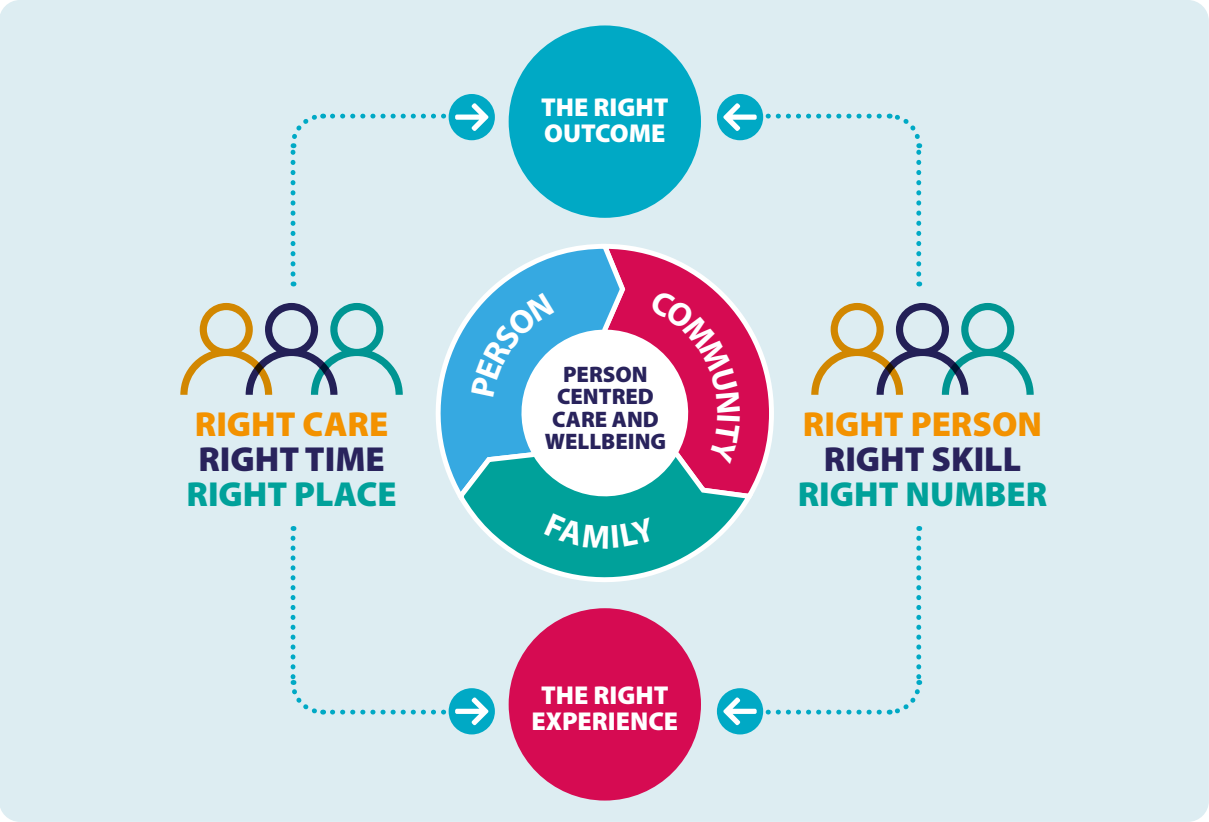
Doing the right thing in the most effective way – working in partnership

12. Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse/midwife leadership framework and investment in leadership training for nurses and midwives.
13. Invest in improvement science training and increase role of leadership in nursing and midwifery in quality improvement initiatives.
14. Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness.
15. Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) of a new digital nurse leadership roles in all HSC bodies.

Conclusion

The recommendations outlined above reflect a new vision/ambition **figure 20** to maximise the contribution of nursing and midwifery, which can be both used to guide decision making, but also to measure progress. It is our ambition that nursing and midwifery deliver the right evidence based care, with the right numbers, at the right time, in right place, by the right person with the right knowledge, and of course most importantly delivering the right experience for persons, families and communities.

Figure 20 - The Nursing and Midwifery Ambition



In order to take forward the recommendations outlined above, a new nursing and midwifery strategy will need to be developed that is in line with *Health and Wellbeing 2026: Delivering Together* priorities. Indeed the Bengoa Report (October 2016) makes clear that system transformation is dependent on the modernisation of practice. Nursing and Midwifery in line with the recommendation of this report will undergo significant practice reforms and clearly with a multi-disciplinary approach which is central to the delivering of better outcomes. The recommendations in this report will inevitably require legislative and ministerial approval and the development of a dedicated action plan. Clearly the recommendations will require additional significant investment over a 10-15 year period and this will be dependent on resources being released through service reconfiguration and/or efficiencies as well as securing new investment.

ANNEX A

Membership

The following members have been appointed to the Nursing and Midwifery Task Group:

- Chair – Sir Richard Barnett
- Expert panel – Bronagh Scott (NHS Wales)
- Education and research / person centred care – Prof Tanya McCance (UU)
- Public Health – Prof Viv Bennett (Public Health England)
- NIPEC – Angela McLernon
- RCN – Dr Janice Smyth
- Population Health Improvement – Dr Mary Hinds (PHA)
- Quality, Safety and Innovation – Dr Anne Kilgallen (DoH)
- Workforce and Education – Caroline Lee (CEC)
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Additional Support

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- Verena Wallace, DoH
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GLOSSARY

NMTG	Nursing Midwifery Task Group
DoH	Department of Health
LTC	Long Term Conditions
CNO	Chief Nursing Officer
HSCB	Health and Social Care Board
MECC	Making Every Contact Count
ANP	Advanced Nurse Practitioner
CEC	Clinical Education Centre
HV	Health Visitor
WTE	Whole Time Equivalent
MDT	Multi-disciplinary Team
NMC	Nursing Midwifery Council
UHC	Universal Health Coverage
CYP	Children and Young People
WHO	World Health Organisation
CAMHS	Child and Adolescent Mental Health Services
AfC	Agenda for Change
RCN	Royal College of Nursing
NHS	National Health Service
PfG	Programme for Government
MLU	Midwifery Led Unit
FMU	Free Standing Midwifery Led Unit
FNFM	Future Nurse Future Midwife
EITP	Early Intervention Transformation Programme

For Further Information Contact Nursing and Midwifery Directorate Department of Health
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Nursing and Midwifery Task Group

Next Steps Framework – A Three Phased Approach

2020 - 2026

1.0 IMPLEMENTATION CONTEXT:

This plan sets out the key actions required to deliver the recommendations of the NMTG and reflect a new vision / ambition to maximise the contribution of nursing and midwifery, which can be used to guide decision making and measure progress. The recommendations of the task group aim to create the conditions for nursing and midwifery services, to develop and be co-designed to deliver the right evidence based care, with the right numbers, at the right time, in the right place, by the right person, with the right knowledge, and of course most importantly delivering the right outcome and experience for people, families and their communities.

The actions in this plan have been prioritised and modelled on the NMTG '***SAFE'*** principle;-

S

Stabilising the nursing and midwifery workforce, therefore ensuring safe and effective care.

A

Assuring the public, the Minister, the Department of Health (DoH) of the effectiveness and impact of person centred nursing and midwifery care.

F

Facilitating the adoption of a population health approach across nursing and midwifery practice, resulting in improved outcomes for people across the lifespan.

E

Enabling the transformation of HSC service through enhancing the roles of nurses and midwives within and across a wide range of MDTs/services.

Whilst the primary aim of the NMTG was to develop a ten to fifteen year road map, this plan adopts a three phased approach aligned with strategic themes outlined in the NMTG report.

STRATEGIC THEME 1:

The adoption of a population health approach, through putting public health, prevention and early intervention at the heart of nursing and midwifery practice.

STRATEGIC THEME 2:

Stabilisation of nursing and midwifery workforce therefore ensuring safe and effective care.

STRATEGIC THEME 3:

Transformation of Health and Social Care Service through enhancing the roles that nurses and midwives will play within and across multi-disciplinary teams.

In line with the Minister's commitment, the plan has also been fully costed and a number of the recommendations have been identified for funding as set out in the 'New Decade, New Approach' Framework and Executive Commitment. These commitments will form part of phase one of the implementation of this plan. It is important to note the pace of implementation will be determined by the budget outcome for DoH, and all subsequent phases will require further strategic prioritisation and resource planning, this will also include the release of resources through efficiencies and transformation.

It is proposed that in 2026 this plan will be refreshed with a new five year strategic action plan, which at that stage, reflects population health needs, new political and policy mandates as well as new ways of working. The NMTG implementation plan and the development of a new Nursing and Midwifery Strategy will be overseen by the Chief Nursing Officer (CNO) in partnership with Central Nursing and Midwifery Advisory Committee (CNMAC) and in partnership with trade unions. Please note the actions outlined are indicative and may be subject to revision. In addition costs quoted in the following tables should be noted as indicative and accumulative.

2.0 STRATEGIC THEME 1

Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

*(*Recommendations identified for funding under 'New Decade,New Approach' and Executive Commitment)*

NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
			20/21	21/22	22/23	23/24	24/25	25/26
1. Put in place a new population health management programme for nursing and midwifery.	Develop a new public / population nursing & midwifery framework & develop a population health practice development programme.	Annually 1,000 nurses / midwives trained in Public Health Care.		£60K	£61K	£63K	£64K	£65K
2. The creation of dedicated Population/Public Health Advanced Nurse and Consultants roles for nurses and midwives across all of our HSC bodies.	*** Recruit a Regional Public/ Population Health Nurse /Midwife Consultant lead.**	16 WTE Public Health Practitioners resulting in improved public health outcomes.	**£70K**	**£102K**	**£104K**	**£106k**	**£108K**	**£110K**
	Strengthen Public Health Clinical Leadership Infrastructure in HSC Trust.			£426K	£434K	£443K	£452K	£461K
	Develop Public Health ANP/Midwife Programme / post.				£55K	£110K	£749K	£761K
3. Increase the number of school nurses, health visitors and expand the Family Nurse Partnership programme across all of NI.	Recruit additional Schools Nurses.	157 WTE Early Years nursing resulting in better outcomes for children young people & families.	£289K	£799K	£1.2M	£1.6M	£2.0M	£2.5M
	*** Implement Delivering Care Phase 4 Health Visiting.**			**£520K**	**£1.0M**	**£1.6M**	**£2.1M**	**£2.6M**
	Roll out Family Nurse Partnership.		£295K	£784K	£1.1M	£1.4M	£1.8M	£2.2M
4. Recognising the demographic trends, nursing should co - lead the development, planning and management of older people services including nursing care commissioned in the independent sectors.	Recruit Older Persons Nurse Consultant Leads in each HSC Trust.	30 WTE Older people nurses – resulting in improved health care across older people services.		£360K	£367K	£374K	£382K	£389K
	Enhance Community District & Specialist Nursing Home In-reach Services.		£248K	£505K	£773K	£1.1M	£1.3M	£1.4M
Total – Strategic Theme 1			**£902K**	**£3.6M**	**£5.1M**	**£6.8M**	**£9M**	**£10.5M**

3.0 STRATEGIC THEME 2

Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred care.

*(*Recommendation identified for funding under 'New Decade,New Approach' and Executive Commitment)*

			WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	20/21	21/22	22/23	23/24	24/25	25/26
1. Develop a person centred policy framework for all nursing & midwifery	Commission the development of Person Centred Digitalised Pathway.	6 WTE leads & new digitised person centred app.		£260K	£319K	£326K	£332K	£338K
2. Sustaining a minimum of 1000 under-graduate nurse & midwife placements for next five years until a position of oversupply is reached.	*** Maintain the undergraduate nursing and midwifery places at 1,000 per year and increase by 300 training places each year for next three years (additional 900 students between 2020 and 2023)**	1,300 student training places per year over the next three years cumulatively increasing to 3,900 students in training by 2023.	*£6.0M	*£11.4M	*£15.8M	£18.1M Review	£18.1M Review	£18.1M Review
3. Invest recurrently in nursing & midwifery post graduate education at a level commensurate with both the size of the workforce and the transformation agenda.	*** Increase post graduate nursing and midwifery education and training.**	Enable growth in specialist nurse training in line with HSC Transformation rising from £7.3M to £11.3M	**£2.7M**	**£4.0M**	**£4.1M**	**£4.2M**	**£4.3M**	**£4.3M**
4. Build & resource a new career framework so that within ten years there are Consultant Midwives & Advanced Nurses across all branches & across nursing specialities. **5. Increase the number of clinical academic roles in midwifery & all branches of nursing.**	Develop strategic plan which will systemically increase the number of Advance Nurse Practitioners, Consultant Nurses & Midwifes and Clinical Academic nurse/midwife roles.	120 WTE ANP in primary & community / secondary care 25 WTE Nurse/Midwifery Consultants. 25 WTE Clinical Academic posts.		£1.9M	£4.6M	£7.2M	£10M	£12.9M
6. Put Delivering Care Policy (normative (safe staffing) on a statutory footing. **(Please note Delivering Care Phase 4 costs covered by recommendation 3 above)**	***Implement Delivering Care Phases 2, 3, 5, & 7 and commission systems dynamic workforce modelling for the entire nursing and midwifery workforce.** Prepare submission for Minister Re:- Delivering Care Legalisation.	Additional 908 WTE nurses (phase, 2, 3, 5, & 7).	**£9.93M** **£100K**	**£19.4M** **£100K**	**£33.9M**	**£48.3M**	**£57.8M**	**£58.9M** **Review**
7. Develop arrangements for band 5-6 pay progression similar to other professions.	**Conduct a review to establish evidence of the cost and benefits of full implementation.**	To be agreed.						
Strategic Theme 2 Totals			**£18.8M**	**£37M**	**£58.7M**	**£78.1M**	**£91M**	**£94.7M**

4.0 STRATEGIC THEME 3

Doing the right things in the most effective way – working in partnership. Transformation of Health and Social Care Service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams.

*(*Recommendations identified for funding under 'New Decade, New Approach' and Executive Commitment)*

			WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	20/21	21/22	22/23	23/24	24/25	25/26
1. Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse leadership framework and investment in leadership training for nurses and midwives	Standardise Nursing & Midwifery Leadership Infrastructure. Strengthen senior clinical nurse & midwife leadership posts. Invest in an Aspiring Nurse and Midwife Leadership Training Programme.	36 WTE clinical leadership posts in midwifery & all branches of nursing. 48 Trainees.	£418K	£852K £160K	£1.3M	£1.8M £160K	£2.3M	£2.8M £160K
2. Invest in improvement science training and increase role of nursing and midwifery leadership in quality improvement initiatives.	Invest in Nurse and Midwife QI and Implementation Science Leads.	5 WTE Qi Leads.	**£353K**	**£360K**	**£367K**	**£374K**	**£382K**	**£389K**
3. Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness	Put in place a new nursing and midwifery quality assurance framework, and prepare a submission for minister on statutory requirements to underpin the framework.	Provides assurance and evidence of the impact of nursing and midwifery at policy and board levels	**Develop framework by 2022**					
4. Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) of a new digital nurse and midwife leadership role in all HSC bodies.	Establish a digital/innovation nurse/midwife network and appoint a regional digital and innovation nurse/midwife Lead and HSC digital nurse/midwife HSC Trust Leads.	6 WTE nurse / midwifery leads.	£438K	£447K	£456K	£465K	£474K	£484K
Strategic Theme 3 Totals			**£1.2M**	**£1.8M**	**£2.1M**	**£2.8M**	**£3.2M**	**£3.8M**

5.0 SUMMARY OF STRATEGIC THEME COSTS

	WHAT IT WILL COST AND BY WHEN					
	Phase 1		Phase 2		Phase 3	
	20/21	21/22	22/23	23/24	24/25	25/26
Strategic Theme 1 Totals	£902K	£3.6M	£5.1M	£6.8M	£9M	£10.5M
Strategic Theme 2 Totals	£18.8M	£37M	£58.7M	£78.1M	£91M	£94.7M
Strategic Theme 3 Totals	£1.2M	£1.8M	£2.1M	£2.8M	£3.2M	£3.8M
Grand Total	**£20.9M**	**£42.2M**	**£65.9M**	**£87.7M**	**£103.2M**	**£109M**

RECOMMENDATIONS IDENTIFIED FOR FUNDING NEW DECADE NEW APPROACH AGREEMENT AND EXECUTIVE COMMITMENT

	20/21	21/22	22/23	23/24	24/25	25/26
Delivering Care Phase 4 Health Visiting & Public Health Nursing	£70K	£622K	£1.1M	£1.7M	£2.2M	£2.7M
Increasing undergraduate places	£6.0M	£11.4M	£15.8M	£18.1M	£18.1M	£18.1M
Post Graduate Education	£2.7M	£4.0M	£4.1M	£4.2M	£4.3M	£4.3M
Implementing Delivering Care 2, 3, 5, & 7.	£9.93M	£20.1M	£33.9M	£48.3M	£57.8M	£58.9M

Recommendations Identified For Funding New Decade New Approach and Executive Commitment	£18.7M	£36.1M	£54.9M	£72.3M	£82.4M	£84M
Funding Gap	£2.2M	£6.0M	£11M	£15M	£20.8M	£25M

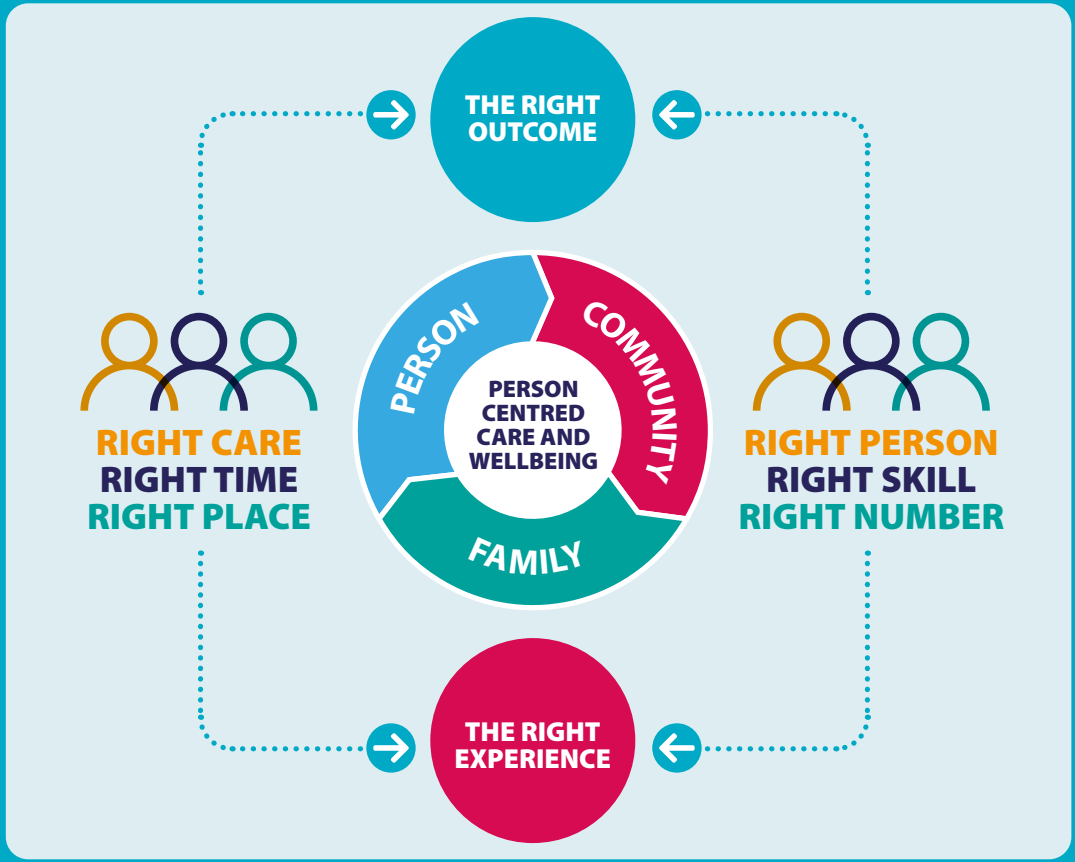
HOW GAP MIGHT BE FUNDED:

Between 2020 and 2026, in addition to those recommendation identified for funding under the 'New Decade New Approach' Agreement it is estimated that approximately an additional £25Millon would be required to fund the remaining NMTG recommendations over the next five years. The current nursing and midwifery agency spend is £51M (18/19), and assuming this could be incrementally converted into savings, then a proportion of this funding could be reinvested to cover the costs of the remaining recommendations.

MOVING AHEAD:

Our Ambition, Our Commitment:

Nursing and midwifery services dedicated to delivering person centred, evidenced based health and wellbeing care outcomes.



From the Chief Nursing Officer
Maria McIlgorm

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

VIA EMAIL:

Chief Executives, HSC Trusts, PHA and BSO
Executive Directors of Nursing, HSC Trusts and PHA

Department of Health
C5.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
[redacted]

Date: 21 April 2022

Dear Colleagues,

Launch of the Nursing and Midwifery Retention Report and Nursing and Midwifery Retention Initiative Implementation Framework

As you will be aware the Nursing and Midwifery Task Group (NMTG) Report identified the need to develop a Nursing and Midwifery workforce retention strategy as one of the recommendations aligned to the Workforce Stabilisation strategic theme.

Whilst the Workforce Stabilisation stream has already been progressed, the Department became aware of concerns that increasing pressures on frontline staff in the workplace had the potential to negatively impact staff retention. In response to this concern the Department commissioned an interim piece of work to determine if there were any immediate measures which could be put in place to mitigate these pressures on staff and thereby assist retention of the workforce.

The commissioned work was led by the Leadership Centre who conducted a survey between 20 December 2021 and 12 January 2022, to identify what immediate pressures the nursing and midwifery workforce were experiencing in their work place and how these might be addressed.

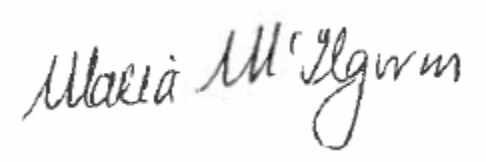
22% of the nursing and midwifery workforce in Northern Ireland responded and the information obtained from the survey are contained in the attached report. The supporting

implementation framework has been developed to assist with how the issues highlighted in the report will be addressed. You will note that the attached report identifies four key themes; Safe Staffing, Valuing Staff, Leadership and Good Working Conditions.

The Implementation Framework details 14 recommendations which have been aligned to the relevant work streams of NMTG implementation groups.

I would ask for your assistance and support to implement the recommendations at a local level to deliver this initiative to ensure that our nursing and midwifery workforce is supported in their workplace in whatever way you can.

Yours sincerely,



MARIA MCILGORM
Chief Nursing Officer

Northern Ireland Audit Office

Workforce planning for nurses and midwives

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
31 July 2020

N I A O

Northern Ireland Audit Office

Workforce planning for nurses and midwives

Published 31 July 2020

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of the Order.

K J Donnelly CB
Comptroller and Auditor General

Northern Ireland Audit Office
31 July 2020

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Abbreviations

CNO	Chief Nursing Officer
DoH	Department of Health
HSC	Health and Social Care
PHA	Public Health Agency
QUB	Queen's University Belfast
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RQIA	Regulation and Quality Improvement Authority
TYC	Transforming Your Care
UK	United Kingdom
UU	Ulster University
WTE	Whole Time Equivalent

Key Facts

2,754

The number of staffing vacancies in the HSC nursing and midwifery workforce group at December 2019 – including 2,114 registered nursing vacancies.

£115 million

The amount spent on temporary nursing and midwifery staff in 2018-19 – including £52 million spent on agency staff.

13.2%

The proportion of overall nursing and midwifery staff costs spent on temporary staff in 2018-19.

£1,700

The highest amount paid by three HSC Trusts in 2018-19 for single shifts worked by agency nurses on bank holidays

732

The reduction in nursing training places between 2011-12 and 2016-17 compared to previous levels.

11.5%

The proportion of HSC registered nursing posts vacant at December 2019.

1,210

The all-time high number of nursing training places commissioned in 2020-21.

Executive Summary

Executive Summary

Background

1. At March 2019, 66,800 people were employed in the Health and Social Care (HSC) sector. More than a third, almost 22,500, belonged to the nursing and midwifery workforce group. In 2018-19, the 16,000 registered nurses, 1,340 registered midwives, and 5,100 nursing support staff accounted for £870 million (almost a third) of the HSC sector's £2.7 billion staffing costs. As many as 3,500 nurses may also be employed in the independent care sector.

The demand for nurses and midwives is increasing

2. For some time, the demand placed on the local healthcare system has been increasing due to a growing population which is living longer and developing more long term conditions. Although the HSC registered nursing workforce has increased by 8.8 per cent between 2012 and 2019, this has been insufficient to meet the rising demand. Assuming similar delivery structures, workforce levels should have grown by over 23 per cent to match this increased level of demand.

3. The scale of increase in HSC nursing and midwifery staff vacancies illustrates the extent of current staffing pressures. Total vacancies have risen from 770 in 2013 to over 2,700 in December 2019, and now include 2,100 registered nursing vacancies. Between 2014 and 2019, the registered nursing vacancy rate increased from 3.2 per cent to 11.5 per cent.

4. In addition to the current 2,100 HSC nursing vacancies, 1,600 further nurses are required to ensure safe staffing levels. The shortage of nurses and a recurrent funding gap of almost £40 million have hampered efforts to recruit these staff.

The number of nursing training places was reduced in the face of wider financial pressures

5. Within the recently published HSC Workforce Strategy (*the 2026 Strategy*), the Department recognises the need to enhance its staffing information to support more effective workforce planning. Consequently, it has commenced work in this area. Improvements are necessary given shortcomings with current workforce data, for both HSC and independent sector vacancies.

6. Aside from the need for more robust data, some key previous workforce planning decisions have also contributed to the current staffing pressures. A Departmental nursing and midwifery workforce review covering 2009 to 2013 recommended making no changes to the number of pre-registration nursing training places then being commissioned. However, as this review did not formally consider the impact of the rising demand for care, it likely underestimated training requirements.

7. Following this review, the Department reduced the pre-registration training budget from an annual average of £30.1 million between 2008-09 and 2010-11, to £28.8 million between 2011-12 and 2016-17. As a result, 732 fewer nursing training places were commissioned during this period compared to 2009-10 levels. The annual number of midwifery places also never reached the recommended level of 70. The cuts were applied at a time when demand for care was continuing to rise. The Department told us that this decision was taken in the face of wider financial and affordability pressures. However, the significant and prolonged reduction in training places has had longer term consequences, including contributing to the rising vacancy levels and increased reliance on more expensive temporary staff. To try and address the considerable workforce gaps which have arisen, the Department has increased considerably the number of nursing and midwifery training places commissioned between 2017-18 and 2020-21.

8. Post-registration training helps nurses acquire new skills for specialist roles, and is particularly important in supporting initiatives aimed at transforming healthcare services. However, the post-registration budget allocation was also reduced from almost £9.5 million in 2008-09 and 2009-10, to an annual average of £8 million between 2010-11 and 2018-19. Although the Department acknowledges that the number of commissioned training programmes and places also reduced, a lack of detailed data means that the extent of the reduction cannot be quantified.

Actions are being taken to increase the supply of nurses and midwives

9. Whilst an updated workforce plan published in May 2016 confirmed that nursing and midwifery supply had not kept pace with demand, delays in implementing its recommendations meant that 129 fewer training places were commissioned in 2015-16 and 2016-17 compared with the numbers recommended. More positively, the Department has recently tried to address the clear staffing shortfalls through commissioning a signficant number of additional nursing and midwifery training places between 2017-18 and 2020-21, compared to recommended levels.

10. To try and further strengthen the local nursing workforce, the Department and Trusts launched an international recruitment campaign in May 2016, ultimately aimed at appointing 622 additional HSC nurses. At March 2020, the programme had secured 504 overseas staff, 458 of which currently remain in post. However, stringent requirements for achieving UK nursing registration, and visa criteria mean that substantial delays are common before nurses can commence HSC employment. Web-based interviews have recently been introduced to try and speed up the recruitment process, and the Department considers that the programme should still achieve the target of 622 staff, albeit by later than the initial March 2020 target date.

11. To date, it is unclear whether the actions taken will effectively align staffing supply with the rising demand. The Department will need to continually monitor the situation to consider what further longer term action might be necessary.

Agency costs for nurses have more than tripled since 2006-07

12. Against a background of inadequate workforce planning, rising demand for care, high vacancy levels, the need to provide safe staffing levels, and cover sickness and maternity absence, the Trusts' reliance on temporary nursing staff has been increasing dramatically. These staff (who are drawn from internal staff banks and agencies) incur higher costs than permanent staff, and are less likely to deliver satisfactory patient outcomes. Trust expenditure on temporary staff has risen from £14.6 million in 2006-07 to £115 million by 2018-19, and the increase in agency costs in this period, from £8.6 million to £52 million, has provided particularly poor value for money.

13. The workforce issues facing the Department and Trusts could be further heightened by the age profile of HSC nurses and midwives. The age profile has increased between 2009 and 2019, and currently 14 per cent of HSC nurses and 22 per cent of midwives are aged 55 and over.

Addressing the workforce challenges – the Department's 2026 strategy

14. Recognising the need to transform HSC services to cope with the growing demand for services, the Department launched *Transforming Your Care (TYC)* in December 2011, with the objective of moving more care into community settings. Whilst *TYC* required effective workforce planning to develop a suitably skilled staffing pool, the initiative had not made the degree of progress anticipated by 2014, nor did it outline any plans to develop a formal HSC workforce strategy.

15. The Department's revised ten year vision for care provided by the HSC sector (*Delivering Together*), which was launched in October 2016, committed to publishing an HSC-wide workforce strategy by May 2017. Issued in May 2018, this document (*the 2026 Strategy*) acknowledged the need to "*resolve fundamental problems with supply, recruitment and retention of the health and social care workforce*", and to address:

- high sickness absence;
- increasing spend on temporary staff;
- high vacancy rates;
- continuing lack of clarity over how the HSC would be configured sector by 2026; and
- the potential impact of Brexit on workforce supply.

16. The *2026 Strategy* ultimately aims to ensure that the reconfigured health system has the optimum number of people, skills and expertise to deliver treatment and care by 2026. However, as implementation of some of its 24 actions is already behind schedule, it will be important that key interim milestones are achieved by the December 2020 target date, including:

- establishing a regional HSC careers service;
- designing non-salary incentive programmes;
- establishing a rolling, prioritised workforce planning programme;
- progressing existing workforce planning recommendations; and
- introducing an optimum workforce model framework.

17. Achieving *the 2026 Strategy's* objectives will prove very challenging. If issues around training, recruitment and retention and vacancy levels are not effectively addressed, the HSC sector will likely face intolerable pressure. *The 2026 Strategy* acknowledges that the consequences of not achieving its objectives are "*grave*", and will result in:

- high agency expenditure increasing further;
- hospital waiting lists continuing to rise; and
- HSC services becoming unsustainable, and transformation of services becoming more difficult.

18. This report was completed before the outbreak of COVID-19. To ensure that audit work did not disrupt the efforts of severely stretched public bodies dealing with extremely challenging circumstances, the NIAO decided not to publish during the pandemic even though the report had been finalised. We also recognise that the demands associated with COVID-19 are likely to have future implications for workforce planning across the HSC sector.

Overall VFM conclusion

19. The Department and HSC Trusts face a range of significant challenges in ensuring that an appropriately resourced nursing and midwifery workforce is in place, including rising demand for care, increasing vacancy levels and international competition for staff set against a limited financial budget.

20. The decision to reduce training places to meet short-term financial pressures has had a significant long-term cost. The increasing reliance on agency nurses does not provide value for money.

21. The Department have taken important steps to respond to these challenges. The number of nursing and midwifery training places have been increased and an HSC-wide workforce strategy has been published. However, the scale of the staffing challenges which have developed mean that it faces an uphill task in developing a more sustainable workforce, and substantial efforts are still required if this crucial objective is to be achieved.

NIAO Recommendations

1. **The Department should ensure that enhanced data is gathered for HSC vacancies. In particular, it should: introduce more robust methodologies for gathering vacancy data; and routinely gather data on vacancies by nursing specialism, at Trust level, and on long-term vacancies. The Department should also explore if it is feasible to gather data which would facilitate more comprehensive benchmarking with the rest of the UK.**

2. **The Department should identify means to improve its intelligence on the independent sector's nursing workforce, to enable it to better understand the sector's staffing shortfalls and current and future needs, and factor these into workforce planning assumptions and projections.**

3. **Within both its annual commissioning of training places and longer-term workforce planning, the Department should clearly demonstrate how it has taken account of rising workloads, outflow of newly qualified staff, and implementing Delivering Care.**

4. **From 2020 onwards, the Department should monitor whether the increased number of nursing training places is strengthening the permanent HSC workforce and reducing vacancies and reliance on temporary staff. If notable progress is not being achieved, it should reassess if further increases in the number of training places are required.**

5. **The Department should routinely monitor data to identify the specific causal factors driving the increased reliance and expenditure on temporary staff, and consider how these can be addressed within longer-term workforce planning. This should include identifying the nursing specialisms and service areas most reliant on temporary staff, and expenditure being incurred on covering long-term vacancies.**

6. **Allied to the rising demand for care and high vacancy levels, the Department should consider whether workforce planning has taken sufficient account of the age profile of the nursing and midwifery workforce, and re-assess whether current projections will suitably address existing and longer-term staffing gaps.**

7. **Given the unremitting workload pressures facing the HSC sector, it is appropriate that the Department intends applying an increased focus on staff health and wellbeing. In implementing its proposed actions, it should seek to identify the main causal factors of sickness absence within the different HSC workforce groups, and consider what steps can be taken to address these to try and minimise absence levels.**

8. **The Department needs to robustly monitor developments to ensure that substantive progress is being achieved in implementing the actions, targets and milestones of both Delivering Together and the 2026 Strategy, and that effective liaison arrangements exist between those responsible for implementing transformation and for progressing workforce planning.**

9. **Regular monitoring should be undertaken to ensure that implementation of the strategy actions are progressing as envisaged, and that any concerns over progress are escalated upwards quickly. We recommend that the reference group provides formal and regular assurance reporting to the programme board.**

10. **The outcomes and benefits which the actions are expected to achieve should be clearly identified and quantified, and actual results regularly monitored against these. This will help inform interim strategy reviews which are planned for 2021 and 2024.**

11. **At this stage, the 24 actions generically address the HSC-wide workforce. The Department needs to assess how these can be translated into measures which will best address the differing needs and challenges of the various HSC professions. One key example of this will be designing appropriate non-salary incentive programmes.**

12. **Within performance management, the Department should seek to establish baselines for success in recruiting and retaining staff within the HSC sector, and measure subsequent performance against these.**

Part One:
Introduction and Background

Part One:
Introduction and Background

An overview of the Health and Social Care (HSC) workforce

1.1 Some 66,500 people are employed in the Health and Social Care (HSC) sector across eight different workforce groups[1]. Whilst these staff work in 16 different organisations, 93 per cent of them are employed in five HSC Trusts (Belfast, Northern, South Eastern, Southern and Western).

Nurses and midwives are the largest part of the HSC workforce

1.2 Nursing and midwifery is the largest group in the HSC workforce, with almost 22,500 staff (34 per cent), followed by administrative and clerical, which has just over 12,900 staff (19 per cent) **(Figure 1)**. The Department of Health (DoH or the Department) told us that a significant number of the administrative and clerical staff carry out work in direct support of clinical activity.

Figure 1: Nurses and midwives comprise one third of the HSC workforce

WORKFORCE GROUP	STAFF IN POST AT 31 MARCH 2019	% OF TOTAL STAFF
Nursing and midwifery[1]	22,493	34
Admin and Clerical	12,909	19
Professional and Technical	9,716	14
Social Services[2]	8,402	13
Support Services	6,549	10
Medical and Dental	4,480	7
Ambulance	1,219	2
Estate Services	727	1
TOTAL	**66,495**	

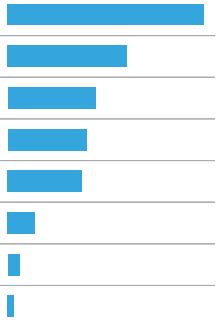
NOTES
[1] Figure includes nursing and midwifery support staff.
[2] Figure excludes domicillary support staff
Source: Department of Health

1.3 Nurses and midwives (including support staff) also account for the largest proportion of HSC staffing costs[2]. Of the total staffing costs of £2.69 billion in 2018-19, almost a third relates to nurses and midwives (£870 million)[3]. In comparison, the medical and dental workforce accounted for almost 20 per cent **(Figure 2)**.

1 Excluding domiciliary care workers and bank staff.
2 Including costs for bank, agency and locum staff.
3 These costs relate to the HSC Trusts only and are sourced from Trust finance returns.

Figure 2: Almost one third of staffing costs in the HSC sector relate to nurses and midwives

WORKFORCE GROUP	£ MILLION STAFF COSTS 2018-19
Nursing and midwifery	870
Medical and Dental	536
Social Services	394
Professional and Technical	353
Admin and Clerical	333
Support Services	123
Ambulance	53
Estate Services	30
TOTAL	**2,692**



Source: Department of Health and HSC Trusts

1.4 All HSC staff contribute to the HSC sector's efforts to try and achieve its aims and objectives. However, in addition to being the most significant staffing group in terms of both numbers and costs, nurses and midwives have the greatest contact time with patients and service users, and provide the widest range of services. At March 2019, this group comprised:

- just over 16,000 registered nurses (across four main fields of nursing practice[4]);
- 1,340 registered midwives (including students); and
- almost 5,100 nursing support staff.

1.5 The Department has overall responsibility for workforce planning in the HSC sector. For some time now, patient demand for care has been rising. To assess if the nursing and midwifery workforce is adequately resourced and skilled to deal with this, and whether further steps are necessary to ensure this is the case, the Department has published two key documents since 2016:

- *A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-25) (the 2015-25 Plan)* was published in May 2016. It set out both the proposed number of nursing and midwifery training places required until 2025, as well as considering wider workforce challenges. A similar review was previously completed for the Department which covered the period between 2009 and 2013 (*the 2009 Review*).

4 The four main areas of nursing practice are Adult, Children's, Mental Health and Learning Disability.

Part One:
Introduction and Background

- *The Health and Social Care Workforce Strategy (the 2026 Strategy)* was published in May 2018. It aims to address key staffing issues across the HSC workforce, including training, recruitment and retention which, if left unchecked, could lead to an already pressurised system becoming unsustainable. It sets out 3 objectives, 10 underlying themes and 24 proposed actions to be progressively implemented by 2026.

Scope of study

1.6 This study focuses on the management of the local nursing and midwifery workforce. We reviewed whether it is currently capable of dealing with increasing demand for care effectively and efficiently, whether sufficient steps are being taken to address key workforce challenges, and if workforce planning has been sufficiently robust. As previous estimates have indicated that the local independent care sector also employs up to 3,500 nurses[5], mainly across care homes and hospices, and there is a continued reliance on this sector by the HSC sector, we also assessed whether adequate consideration has been given to addressing its staffing needs.

1.7 We examined:

- key workforce trends, including staffing vacancy levels and reliance on temporary and agency staff;
- significant challenges facing the nursing and midwifery workforce, including: the growing demand for care; the age profile of the workforce; difficulties in recruiting and retaining staff; and the need to ensure safe nursing staffing levels across the different clinical settings; and
- how the Department and Trusts have responded to the workforce challenges, and whether workforce planning has ensured that an appropriately resourced and skilled workforce is in place which is capable of delivering care efficiently and effectively and coping with current and future demands.

Appendix 1 outlines our study methodology.

1.8 As effective workforce planning is also of significant importance across the wider HSC workforce, we will consider the merits of carrying out further reviews in the area within our forward work programme.

5 Estimate contained in `A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-2025)'.

Part Two:

The increasing demand for nurses and midwives and key pressures on the HSC sector

Part Two:
The increasing demand for nurses and midwives and key pressures on the HSC sector

Since 2012, the number of HSC registered nurses and support staff has increased, but the midwifery workforce has reduced

2.1 At March 2019, the HSC nursing and midwifery workforce group comprised 22,493 staff in post or 19,737 Whole Time Equivalent (WTE) staff, across three streams:

- registered nurses – 16,064 staff in post/14,222 WTEs;
- registered midwives – 1,341 staff in post/1,082 WTEs; and
- nursing and midwifery support staff – 5,088 staff in post/4,433 WTEs.

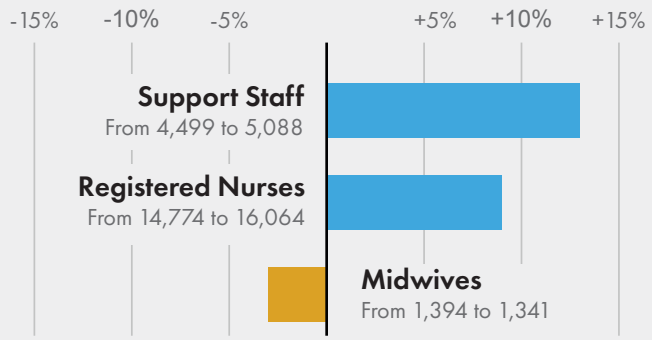
2.2 At this date, just over 71 per cent of staff in post were registered nurses, 23 per cent were nursing and midwifery support staff and 6 per cent were registered midwives. The variance between staff in post and WTEs illustrates that significant numbers of staff (37 per cent of HSC nurses and 63 per cent of midwives at March 2019) work part time to varying degrees. This is one of a range of factors which needs to be considered within workforce planning.

2.3 Between 2012 and 2019, the number of WTE HSC registered nurses has increased by 11.7 per cent. Whilst WTE nursing and midwifery support staff also increased by over 15 per cent over this period, the numbers of registered midwives reduced by 1.1 per cent. In terms of staff in post, the numbers of nurses and nursing and midwifery support staff increased by almost 9 per cent and 13 per cent respectively, but the number of midwives reduced by nearly 4 per cent **(Figure 3)**.

Figure 3: Staff in Post 2012-19

Between 2012 and 2019, the number of registered nurses and support staff in post increased, but the number of midwives in post decreased by almost 4%

CHANGE IN NUMBER OF STAFF IN POST BETWEEN 2012 AND 2019:



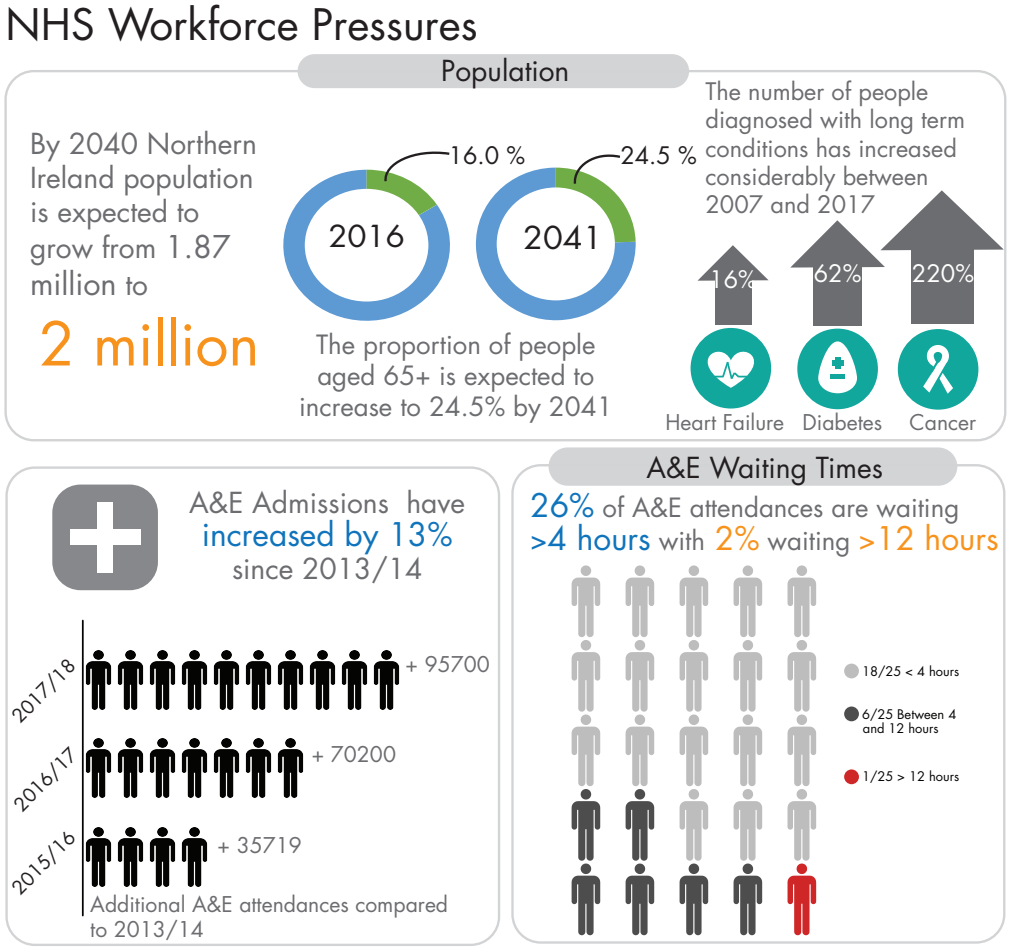
Source: Department of Health and HSC Trusts

2.4 Staffing costs currently held by the Department only relate to the overall workforce group, and are not disaggregated between the three staffing streams. Total staffing costs (including bank and agency staff) increased by almost 28 per cent from £680 million in 2011-12 to £870 million in 2018-19. In 2018-19, the Trusts spent £115 million on temporary nurses and midwives (13.2 per cent of total staffing costs).

The nursing and midwifery workforce has not grown sufficiently to keep pace with the rising demand for care

2.5 The number of HSC registered nursing staff in post has increased by 8.8 per cent between 2012 and 2019. However, this has been insufficient to keep pace with identified need. All available projections indicate that the demands on the HSC sector will continue to increase as the population continues to live longer and present with more complex needs. **Figure 4** sets out some of the pressures contributing to this increased demand, and also shows how these are placing the HSC workforce under growing pressure.

Figure 4: A range of factors are placing the HSC sector under considerable pressure



Part Two:
The increasing demand for nurses and midwives and key pressures on the HSC sector

2.6 These factors will continue to present considerable challenges across the HSC sector, but as the workforce group which has greatest contact with patients, the pressures will impact most significantly on nurses.

In the face of rising demand for care, vacancy levels have been increasing

2.7 Since 2012, we estimate that the number of registered nurses[6] required to deliver care in the HSC sector would have needed to rise by over 23 per cent[7], compared to the actual 8.8 per cent increase[8] to fill vacancies which were being actively recruited to at March 2019. As demand for care is increasing at a faster rate than available staffing levels, the Department has been unable to grow the workforce sufficiently to meet this, and the number of workforce vacancies has been sharply rising **(Figure 5)**.

2.8 When the *2009 Workforce Review (the 2009 Review)* was published, there were 397 vacancies across the nursing and midwifery workforce group. This subsequently rose to 725 in 2012, before reducing to 620 in 2014. Whilst some degree of staffing turnover and attrition will always be inevitable, there has subsequently been a steep upward trend in vacancies, and at December 2019, these had risen to just over 2,750. Some 2,114 of these are registered nursing vacancies **(Figure 5**). Whilst registered nurses comprise 71 per cent of the workforce group, they account for 77 per cent of vacancies.

2.9 Trends for the percentage of vacancies confirm that, whilst significant workforce gaps have developed across the three staffing streams, these are most acute amongst registered nurses. Between 2014 and 2019, registered nursing vacancies increased from 3.2 per cent to over 11.5 per cent. In this period, midwife vacancies also rose sharply from 1 per cent to 6.4 per cent. Nursing support staff vacancies increased from 2.5 per cent to 9.8 per cent **(Figure 5)**.

Vacancies have increased across all Trusts and all fields of nursing practice

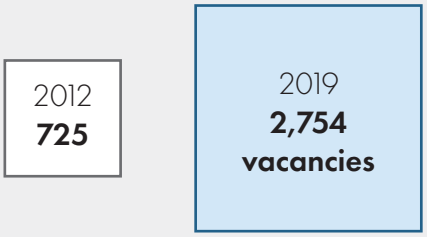
2.10 Vacancy numbers have increased very significantly in all Trusts since 2012, and the increase in vacancies has also impacted on all fields of nursing practice. Analysis by the Department in December 2019 suggested that the largest registered nursing staff group had a vacancy rate of 13 per cent and that almost 10 per cent of mental health and learning disability nursing posts were vacant **(Figure 5)**.

6 Based on staff in post analysis.
7 Our analysis of available data for staff in post and vacancies indicates that the staffing compliment increased from 15,219 to 18,225 between 2012 and March 2019.
8 This is based on an assumption that all active vacancies would be filled.

Figure 5: Nursing and midwifery vacancies

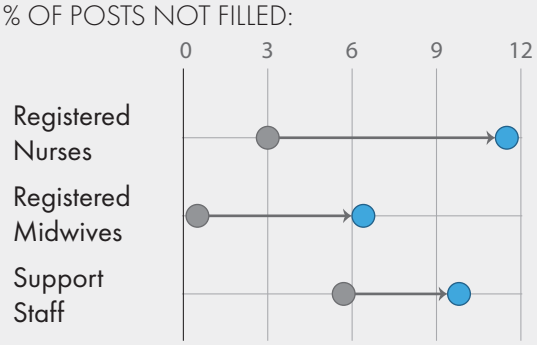
Whilst demand for care is expected to increase, staff vacancy rates have been rising. These increases have affected all Trusts and all fields of nursing practice.

The number of vacant nursing and midwife (including support staff) posts has increased significantly

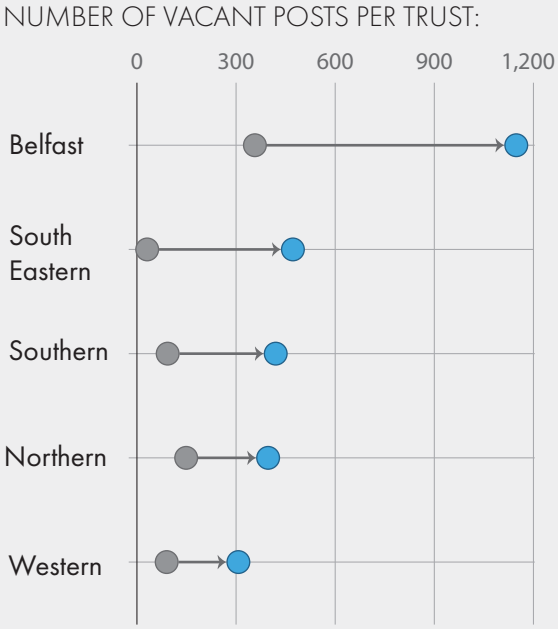


Significantly, the number of registered nursing vacancies increased from 445 to 2,114

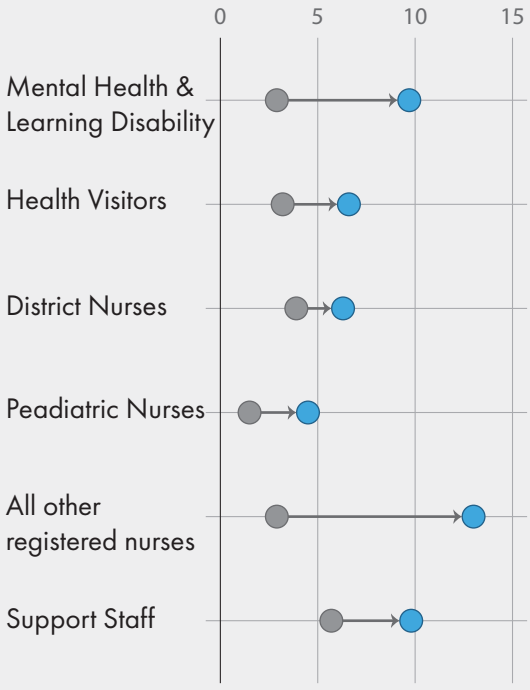
The percentage of vacant posts has also increased significantly between 2014 and 2019



The number of nursing and midwifery vacancies has increased across all Trusts between 2012 and 2019



The proportion of vacant posts has increased across all fields of nursing practice between 2012 and 2019



Source: Department of Health

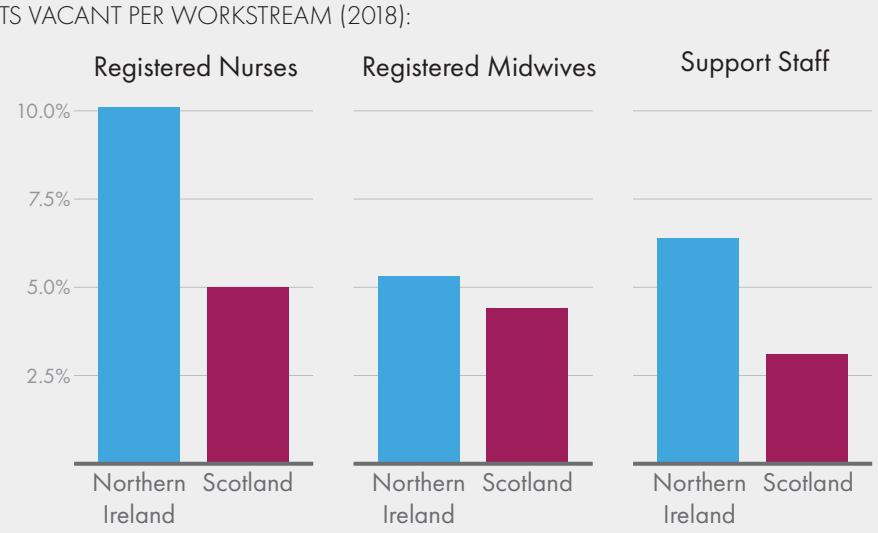
Part Two:
The increasing demand for nurses and midwives and key pressures on the HSC sector

HSC vacancy levels are significantly higher than in Scotland but closer to levels in England

2.11 At 2018, local vacancy levels were higher than in Scotland for all three staffing streams, and twice as high for nurses and nursing support staff **(Figure 6)**. The Department considers that whilst the data for Scotland appears similar to NI, some variation in definitions means that it is not definitively comparable. However, in our view, the available information illustrates that significant challenges are clearly apparent within the local HSC nursing and midwifery workforce.

Figure 6: Nursing and midwife vacancy rates in Northern Ireland and Scotland

Vacancy rates are higher in Northern Ireland in all three staff streams compared to Scotland



Source: NIAO analysis of HSC and Scottish data

2.12 Data produced by NHS Digital and NHS Improvement also indicates that, at December 2019, the vacancy rate for registered nurses in England stood at 10.7 per cent. This was marginally below the HSC vacancy rate of 11.5 per cent (paragraph 2.9).

The information available to the Department to monitor staffing vacancies is limited

2.13 Despite the potential impact of vacancies on the cost, quality and safety of services provided, we found shortcomings in the availaibity of monitoring data. Until March 2015, the Department conducted a formal twice yearly vacancy survey across the HSC Trusts, but it did not collect

data in 2016, as a new electronic recruitment system was being introduced. Whilst it re-commenced ad-hoc monitoring in 2017, we consider that limitations exist with this data:

- it may understate the true level of vacancies, as it only provides a `snapshot' of posts which the Trusts are actively recruiting to at a particular point in time. The Department told us that in circumstances where it is actively seeking to grow the overall workforce, some increase in vacancies will be inevitable.
- Trusts may not be categorising vacancies consistently; and
- vacancies may have been recorded differently under the previous manual arrangements and the recently introduced electronic system.

2.14 The Department has also not routinely monitored trends for long-term[9] vacancies since 2015. These bring particular challenges, including increased reliance and costs incurred on temporary staff. In 2015, 309 (30 per cent) of the 1,032 workforce group vacancies were long-term, 236 (76 per cent) of which were registered nursing vacancies.

2.15 The current *2026 Workforce Strategy (the 2026 Strategy)* has committed to examining where gaps exist in the data currently available, and aims to ensure that workforce trends and issues are more effectively monitored. This is important in the context of assisting workforce planning and managing wider workforce challenges which Parts Three and Four of this report consider.

NIAO Recommendation 1

The Department should ensure that enhanced data is gathered for HSC vacancies. In particular, it should: introduce more robust methodologies for gathering vacancy data; and routinely gather data on vacancies by fields of nursing practice, at Trust level, and on long-term vacancies. The Department should also explore if it is feasible to gather data which would facilitate more comprehensive benchmarking with the rest of the UK.

Whilst there is limited workforce data for the independent care sector, available evidence suggests that there are significant nursing shortages

2.16 It is widely acknowledged that the local independent care sector has assumed greater responsibility in recent years for delivering more complex aspects of care (including helping to implement *Delivering Together*[10]). However, longstanding difficulties have existed with obtaining accurate and reliable nursing workforce data for this sector. Employers are currently not required to disclose data, and the Department told us that some are reluctant to do so. On the basis of a UK-wide employment survey in 2013[11], *the 2015-25 Workforce Plan (the 2015-25 Plan)* estimated that the local independent sector employed between 2,731 and 3,475 nurses.

9 Posts which have been vacant for six months or longer.

10 *Delivering Together* was launched in October 2016. It is the Department's current ten year vision for transforming care services to better meet the needs of the increasing and ageing population.

11 Survey findings referred to by A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-25).

Part Two:
The increasing demand for nurses and midwives and key pressures on the HSC sector

2.17 Similar to the HSC sector, the local independent sector's need for registered nurses has been increasing, but it has also been experiencing difficulties in recruiting and retaining sufficient staff to meet demand. In 2015, a survey by the Royal College of Nursing (RCN)[12] indicated that the sector had an average nursing vacancy rate of just over 15 per cent.

2.18 The ongoing implementation of the Departmental policy *Delivering Care*[13] also has the potential to create significant challenges for the independent sector. Launched in March 2014, *Delivering Care* is the agreed local policy direction for formulating the development of safe staffing ranges for nursing and midwifery. This policy and implementation framework requires gathering the best evidence available and using a range of recognised workforce planning tools, as well as co-operating with a wide range of stakeholders.

2.19 As it is widely acknowledged that the HSC Trusts offer nurses more favourable terms and conditions, we consider that the need to fill the HSC posts identified through *Delivering Care* could further destabilise the independent sector's nursing workforce. In recent years, the RCN told us that the independent sector's workforce has already been depleted due to nurses leaving to work in the HSC sector. This is likely to have contributed to the high vacancy rate in the independent sector indicated by the RCN survey. In turn, this could result in the independent sector becoming increasingly reliant on agency nurses, which is likely to increase the cost to Trusts of care packages procured from the sector.

2.20 The workforce challenges facing the independent sector highlight the need for ongoing monitoring of its staffing requirements and shortfalls. However, to date, the absence of reliable workforce data has hampered the Department's ability to accurately quantify the sector's needs, and to factor these into workforce planning projections and the number of nursing training places which need to be commissioned. The Department told us that it required access to the independent sector's workforce data to address this issue, and that the sector has only recently agreed to start sharing this.

2.21 To bridge the information gaps, *the 2009 Review* and *the 2015-25 Plan* both recommended that a comprehensive baseline study of the independent sector nursing workforce be completed. However, the Department has not commissioned such a study. Instead, the Department's recent work to try and better understand the independent sector's workforce requirements has taken account of the RCN's analysis, and it has also recently commenced a phase of work within *Delivering Care* to identify the staffing levels required to deliver safe patient care in the sector. In our view, the historical absence of workforce data means that this could prove challenging.

2.22 The RCN told us that, over a number of years, it has been on public record in expressing concern that workforce planning for nurses in Northern Ireland has not appropriately embraced the independent care sector. The RCN considers that a more systematic approach to data collection and analysis is required in this area.

12 Care in Crisis: independent sector workforce survey in Northern Ireland.
13 Delivering Care: Nurse Staffing in Northern Ireland

NIAO Recommendation 2

The Department should identify means to improve its intelligence on the independent sector's nursing workforce, to enable it to better understand the sector's staffing shortfalls and current and future needs, and factor these into workforce planning assumptions and projections.

Implementation of Delivering Care is further increasing the demand for nurses

2.23 As paragraph 2.18 noted, the Department launched the *Delivering Care* Framework in March 2014 in order to identify the sufficient nursing staffing levels required across a range of nursing specialties to provide safe patient care, and to ensure that these staffing levels are put in place.

2.24 To date, work has been undertaken on eight phases of *Delivering Care*, each addressing different clinical settings[14]. The Chief Nursing Officer (CNO) commissions each phase of work, and implementation is being overseen by a central steering group, supported by a working group and expert reference group for each individual phase, led by the Public Health Agency (PHA):

- Each phase follows an agreed methodology and best available evidence to determine an appropriate staffing model.
- On completion of planning, each phase requires approval and sign off from the CNO.
- Funding is then required to implement the agreed staffing models of each phase, and the additional nurses then need to be recruited.

2.25 As it is ultimately aiming to enhance patient safety standards, it is important that good progress is achieved in implementing *Delivering Care*. However, for several reasons, progress has been slow:

- **Identifying staffing needs is complex** – a number of phases have taken longer than anticipated to progress due to complexities with developing staffing models and the innovative nature of the work.
- **The initiative has only been allocated limited funding** - to date, phase one (covering acute medical and surgical wards) has been allocated recurrent funding totalling £12.7 million. Whilst phases two, three and four have collectively received £3.2 million incremental funding, phases two to five currently have a total estimated recurrent funding gap of £38.9 million. Further progress is dependent on access to this funding, as well as an increase in the number of available trained nurses.

14 To date, Delivering Care has commenced work to consider nursing staffing requirements for Acute Medical & Surgical Wards, Type 1 Emergency Departments, District Nursing, Health Visiting, Mental Health, Neonatal Nursing, Primary Care and the Independent Care Sector.

Part Two:
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- **Limited progress has been achieved in recruiting the additional nurses required** – to date, 158 new nurses have been recruited across the first two phases. However, a total staffing shortfall of almost 1,600 currently remains across all phases which have commenced.

2.26 Together with the current 2,114 registered nursing vacancies (paragraph 2.8), the need for almost 1,600 additional staff to ensure safe staffing levels highlights that there is currently a very substantial nursing staffing deficit in the HSC sector. This could continue to increase given that further phases of *Delivering Care* are planned. Even if the funding required to fully implement the initiative is secured, the Trusts will likely continue to face challenges in recruiting the required staff, given the current local and global nursing shortage. A recent progress review of phase one confirmed that "*recruitment of staff continues to present regional challenges.*" The Department pointed out that this estimate of staffing shortfalls does not take account of changes which may arise from the ongoing implementation of the transformation agenda, and which may impact on nursing roles and how and where nurses work.

2.27 In the current environment, the Trusts remain heavily reliant on temporary staff to sustain both existing HSC operations and to take forward *Delivering Care*, despite the fact that the Francis Report[15] concluded that temporary cover is less likely to deliver satisfactory patient outcomes. For example, within the Adult acute medicine and Mental Health fields of nursing practice, almost 25 per cent of nurses at March 2018 were bank and agency staff[16].

The Department and Trusts face challenges in retaining newly qualified nurses and midwives but staff retention has recently improved

2.28 The problems experienced in Northern Ireland with recruiting sufficient numbers of nurses and midwives are symptomatic of wider international challenges. For some time, a global shortage of nurses and midwives has existed in developed countries. In 2016, the World Health Organisation estimated that this global shortage stood at approximately nine million staff.

2.29 Unsurprisingly, intense international competition for staff has developed. In 2014 and 2015, evidence suggested that a sizeable proportion of nurses and midwives were leaving Northern Ireland to work elsewhere shortly after completing training:

- In providing evidence to the Assembly Health Committee in April 2015, the RCN indicated that 20 to 30 per cent of locally trained nurses leave to work abroad for several years, before returning.
- A survey by Queen's University Belfast (QUB) in 2014 suggested that 21 per cent of its newly qualified nurses and midwives were employed outside Northern Ireland.

15 The Francis Report was published in February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

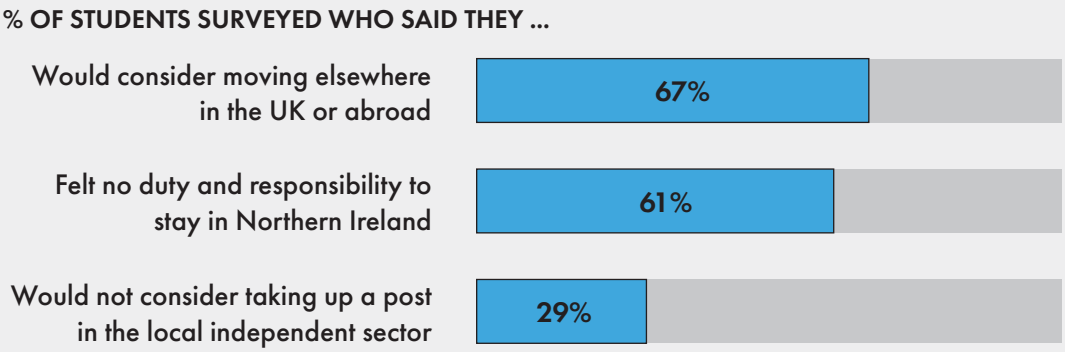
16 These are temporary nursing staff drawn from internal staff banks and external agencies.

2.30 *The 2015-25 Plan* acknowledged that the global shortage of nurses and midwives had resulted in countries including the US, Canada and Australia, offering generous salary and relocation packages and fast-tracked residency to try and recruit overseas staff. It also highlighted that NHS providers in England were aggressively targeting Northern Ireland to recruit staff, offering resettlement packages of up to £3,000.

2.31 A survey of final year nursing and midwifery students undertaken for the 2015-25 Plan also highlighted potential challenges with retaining staff. Whilst it is difficult to measure firm student intentions, 67 per cent of respondents stated that they would consider leaving to work elsewhere, and 61 per cent felt no duty to stay **(Figure 7)**.

Figure 7: Retaining newly qualified nurses and midwives

A survey of final year nursing and midwifery students highlighted that the Department and Trusts face significant challenges in retaining newly qualified nurses and midwives in Northern Ireland.



Source: 2015-25 Nursing and Midwifery Workforce Plan

2.32 More recently, evidence has emerged that the Department and Trusts have made some progress in retaining newly qualified staff. A key positive development is that, from 2016-17, the Department has recommended that all newly qualified nurses and midwives should be offered a permanant contract with HSC Trusts. Previously, financial restraints within HSC bodies had meant that this was not always the case. The Department also highlghted analysis which indicates that the proportion of newly qualified staff accepting employment outside of Northern Ireland had reduced from 13 per cent in 2014-15 to 4 per cent in 2016-17.

2.33 Nonetheless, any significant levels of staff outflow will present the Department with further difficulties in reducing both vacancy levels and reliance on temporary staff. Part Four of this report outlines the Department's intention to develop more effective staff recruitment and retention strategies. The *2015-25 Plan* has also sought to factor staff outflow into projections of the future number of nursing and midwifery pre-registration training places required. However, the significant reduction in nursing training places commissioned between 2010-11 and 2016-17 (paragraph 3.6), has also contributed to the current staffing shortfalls.

Part Three:

Ensuring the supply of nurses and midwives through workforce planning

Part Three:
Ensuring the supply of nurses and midwives through workforce planning

An adequate supply of student nurses and midwives is a crucial element of workforce planning

3.1 Effective long-term workforce planning is critical in identifying the numbers of nurses and midwives required to cope with current and future demand for care. Within this, it is important that an adequate supply of students is in place to address these factors, as well as retirements and cover for sickness and maternity absence. As **Figure 8** shows, the Department commissions both pre-registration and post-registration nursing and midwifery training and education for students in Northern Ireland from a range of providers.

Figure 8: The Department commissions training and education for nurses and midwives from a range of providers

Type of training/education	Background
Pre-registration (nursing and midwifery)	Training is commissioned from QUB, Ulster University (UU) and the Open University. From 2011, NI moved to three year degree level only programmes, incorporating the Nursing and Midwifery Council's 2010 requirements. Successful completion of this degree results in participants becoming registered nurses and midwives.
Post-registration (nursing and midwifery)	Post-registration education is commissioned from a range of education providers including QUB, UU, and the Open University. It enables nurses and midwives to acquire new skills for specialist and advanced roles including District Nursing, Health Visiting, Infection Prevention, Neonatal Care, Respiratory Disease and Diabetes. This training is crucial in improving population health outcomes and supporting the delivery of transformation initiatives.

Source: NIAO based on information provided by the Department of Health

A review of the nursing and midwifery workforce in 2009 underestimated the number of training places required

3.2 In the 2000s, the Department commissioned several nursing and midwifery workforce reviews, culminating in one which was completed in November 2009 (*the 2009 Review*). This covered the period up to 2013, but as it takes three years to obtain a nursing degree, it had implications for workforce planning up to 2016.

3.3 *The 2009 Review* projected[17] that the local nursing workforce would increase very marginally between 2008 and 2013, by 76 staff (0.5 per cent), from 14,860 to 14,936. On this basis, it concluded that no changes were required to the 814 pre-registration training places scheduled to be commissioned in 2011. As the Review forecast that the midwifery workforce would reduce by 90 staff (7 per cent) during this period from 1,278 to 1,188, it recommended increasing the number of annual midwifery training places from 50 to 70. This would have delivered an additional 100 midwives by 2016.

3.4 Workforce planning is a complex discipline, and in projecting future staffing needs we recognise that no scientific means exist for producing wholly correct estimates. However, in our view, there were limitations with *the 2009 Review's* projections. In particular, its recommendations were based exclusively on estimating the future size of the workforce. Whilst *the 2009 Review* acknowledged that other relevant issues existed, including rising demand for care, it did not factor these into its projections, as it concluded there was insufficient evidence to measure their likely impact. Given this, we consider that *the 2009 Review* under-estimated the number of nursing training places required. The Department told us that it was unable to provide an informed view on the robustness of the review's projections.

Despite evidence of staffing shortfalls, the number of nursing training places commissioned between 2010-11 and 2016-17 was significantly reduced, when the Department was faced with funding pressures

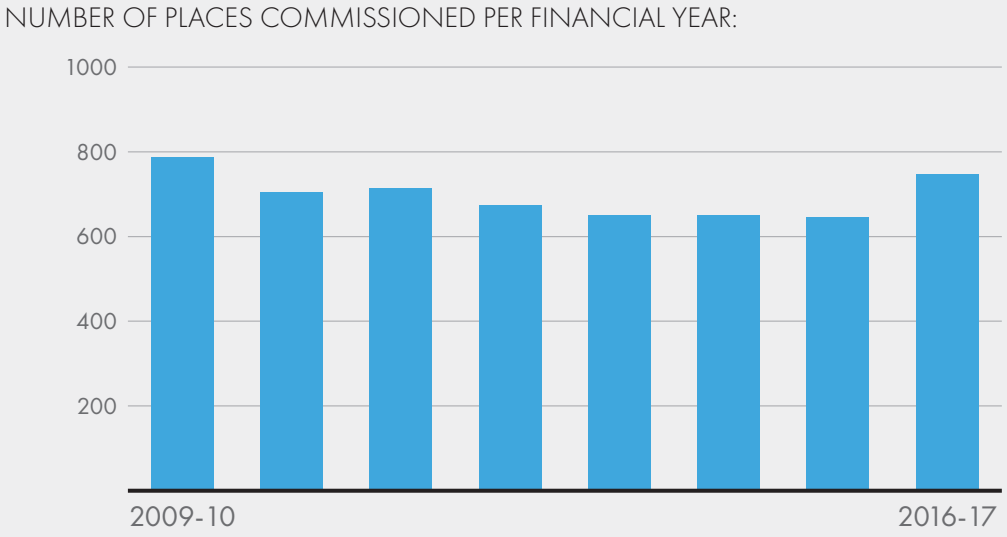
3.5 Fewer nursing and midwifery pre-registration training places were subsequently commissioned than *the 2009 Review* had recommended, mainly because the Department reduced the amount of funding allocated to the training budget. Between 2008-09 and 2010-11, the Department spent an annual average of £30.1 million on pre-registration training, but this fell to £28.8 million in the six years between 2011-12 and 2016-17. This represented a reduction of over 4 per cent. The Department told us that it had taken the difficult decision to reduce training levels in the face of wider financial pressures which had impacted on affordability.

3.6 **Figure 9** illustrates how the number of pre-registration nursing training places was considerably lower over the seven years between 2010-11 and 2016-17, compared to the 788 places commissioned in 2009-10. Significantly, the failure to maintain the 2009-10 training levels meant that 732 fewer nursing training places were commissioned over these seven years. Although the number of places increased from 646 to 746 between 2015-16 and 2016-17, this was still 42 fewer than in 2009-10.

17 Projections were based on both the numbers of qualified and student nurses and midwives.

Part Three:
Ensuring the supply of nurses and midwives through workforce planning

Figure 9: Nurse Training
Compared to the 788 places commissioned in 2009-10, the reduction in places over the following six years years resulted in 732 fewer places than if the 2009-10 rate had been maintained. Despite the increase in 2016-17 this still remained lower than 2009-10.



Source: Department of Health

3.7 During this period, demand for care was continuing to increase. Furthermore, the significant reduction in nursing training places was sustained over a prolonged period. We consider that this illustrates how the need to implement short term savings can have longer term consequences, as it must have contributed significantly to the increases in both nursing and midwifery vacancies (paragraph 2.8), and spend on bank and agency staff (paragraph 3.29) which have been apparent in recent years. The Department told us that a review commissioned by it which was completed in late 2015 had confirmed an acute shortage of Band 5 nurses, and that action was initiated shortly after this to address this.

3.8 The number of annual midwifery training places commissioned also never reached the 70 recommended by the *2009 Review* (paragraph 3.3) between 2009-10 and 2017-18. **(Figure 10)**.

Figure 10: Midwife Training
Fewer midwife training places have been commissioned than recommended over a significant period of time

Source: Department of Health

A revised workforce plan for 2015-2025 recommended increasing the number of nursing training places

3.9 The Department commissioned an updated workforce plan for nurses and midwives in December 2013. This work culminated in the publication of *the 2015-25 Plan* in May 2016[18]. Its primary focus was to forecast the number of pre and post registration training places required between 2015-16 and 2024-25, and develop an understanding of issues impacting on staff recruitment, retention and career progression.

3.10 *The 2015-25 Plan* acknowledged that the eight per cent increase in the nursing workforce since 2008 had been insufficient to keep pace with demand, and that a significant shortfall existed in the number of nurses available to fill vacant HSC and independent sector posts, with the same picture emerging for midwifery. It also highlighted the impact of the cuts applied to the pre-registration training budget.

18 An initial draft of the plan had been published in January 2016.

Part Three:
Ensuring the supply of nurses and midwives through workforce planning

3.11 To address staffing pressures, *the 2015-25 Plan* recommended commissioning almost 7,800 pre-registration nursing training places between 2015-16 and 2024-25. This represented an annual increase of 100 places compared to the average numbers commissioned between 2010-11 and 2014-15.

3.12 If the *2015-25 Plan's* recommendations are fully implemented, we acknowledge that a significant number of new nurses could enter the local workforce pool by 2028. However, the various factors which impact on workforce planning, such as staff turnover and attrition, make it difficult to quantify this. The proposals must also be viewed in the context that 732 fewer training places were commissioned between 2010-11 and 2016-17, compared to previous levels (paragraph 3.6).

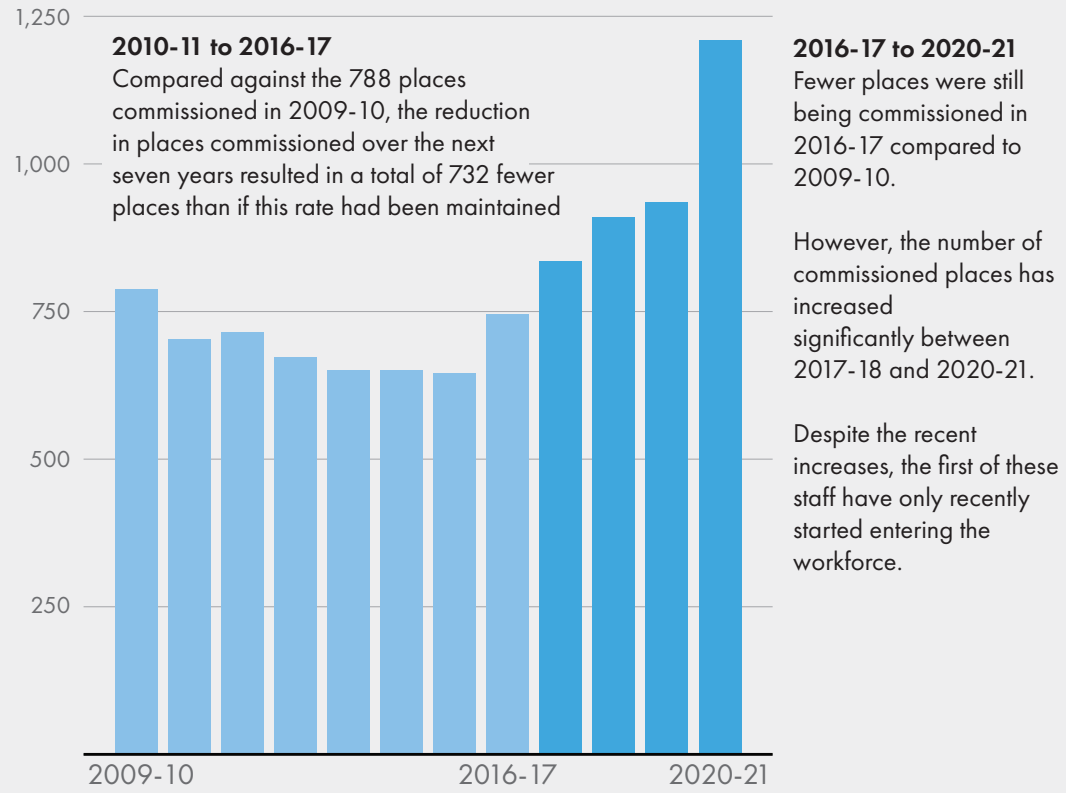
Whilst there were delays in implementing the plan's recommendations, the number of training places commissioned has recently signifcantly increased

3.13 In practice, there were some delays in implementing *the 2015-25 Plan's* recommendations. Whilst it was intended to cover the period between 2015-16 and 2024-25, it was not formally published until May 2016, and was therefore unavailable to inform commissioning for 2015-16 and 2016-17. In those two years, 1,392 pre-registration nursing training places were commissioned, which was 129 fewer than the 1,521 recommended for this period. In both years, the number of places remained below 2009-10 levels, although the 746 places in 2016-17 represented the highest number since 2009-10.

3.14 Since then, the Department has significantly increased nursing training levels, with a total of 3,895 places commissioned between 2017-18 and 2020-21 (an annual average of 974 places). In 2020-21 an all-time high level of 1,210 places were commissioned **(Figure 11)**. This indicates that the Department has started expanding pre-registration training to try and address the significant staffing shortfalls. However, as it takes three years for a registered nurse to complete training, the first of the increased number of trainees have only recently begun qualifying.

Figure 11: Nurse Training
Following a number of years where the number of nursing training places was significantly reduced, the Department has begun to increase the number of places commissioned.

NUMBER OF PLACES COMMISSIONED PER FINANCIAL YEAR:



Source: Department of Health

3.15 Consequently, it will be some time before the Department and Trusts can assess the degree to which the increased training levels are addressing both the workforce gaps and the rising demand for care. At an earlier stage of our fieldwork, the RCN told us that it was extremely difficult to be confident in the capacity of the *2015-25 Plan* to deliver its objective of ensuring that "*sufficient numbers of suitably qualified nurses and midwives are available and best placed to meet the health and care needs of the population in Northern Ireland over the next ten years*". However, the Department has highlighted that proposals within the New Deal, New Decade document have already resulted in substantial additional training places being commisioned in 2020-21 (paragraph 3.14), and that this has also proposed an additional 600 pre-registration places in 2021-22 and 2022-23, to help further strengthen the workforce in future years.

Part Three:
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3.16 The Department told us that *the 2015-25 Plan's* projections[19] had sought to take account of various factors, including rising and changing workloads, vacancy trends, maternity and adoption leave, sickness absence, and the implementation of *Delivering Care*. However, since the plan was developed, the available data indicates that vacancy rates have increased very significantly. Furthermore, it is apparent that a considerable number of additional staff are currently required to fill HSC nursing vacancies and implement the requirements identified by *Delivering Care* to achieve normative nursing levels (paragraph 2.25). Consequently, the substantial increase in training places commissioned may have to be sustained for a considerable period to better align workforce supply with demand.

NIAO Recommendation 3

Within both its annual commissioning of training places and longer-term workforce planning, the Department should clearly demonstrate how it has taken account of rising workloads, outflow of newly qualified staff, and implementing Delivering Care.

NIAO Recommendation 4

From 2020 onwards, the Department should monitor whether the increased number of nursing training places is strengthening the permanent HSC workforce and reducing vacancies and reliance on temporary staff. If notable progress is not being achieved, it should reassess if further increases in the number of training places are required.

3.17 As part of its efforts to address the considerable staffing challenges, the Department has made progress in recent years in ensuring that greater opportunities exist for current HSC staff (including nursing support staff) to progress into a registered nursing career, through increasingly funding pre-registration training by the Open University. Compared to 2015-16, when 25 places were commissioned, this has consistently increased each year, and in 2019-20, 120 places were commissioned. Whilst this initiative will not by itself fully address the current workforce deficits, it will assist the Department to some degree in trying to secure the required staffing levels.

3.18 *The 2015-25 Plan* also recommended that 530 midwifery pre-registration training places be commissioned between 2015-16 and 2024-25. The Department told us that these projections had been based on evidence then available including a birth rate in Northern Ireland which has been decreasing since 2012 and an apparent over-supply of midwives.

3.19 Currently, 22 per cent of midwives are currently aged over 55 and over 570 retirements are forecast to occur over the period of the *2015-25 Plan*. More recently, the Department has commissioned 275 midwifery training places between 2015-16 and 2018-19, and a futher 205 places in 2019-20 and 2020-21**(Figure 10)**. This is substantially higher than the training levels recommended by the *2015-25 Plan*. Similar to the registered nursing workforce, this means that the Department has recently taken action which aims to address the significant

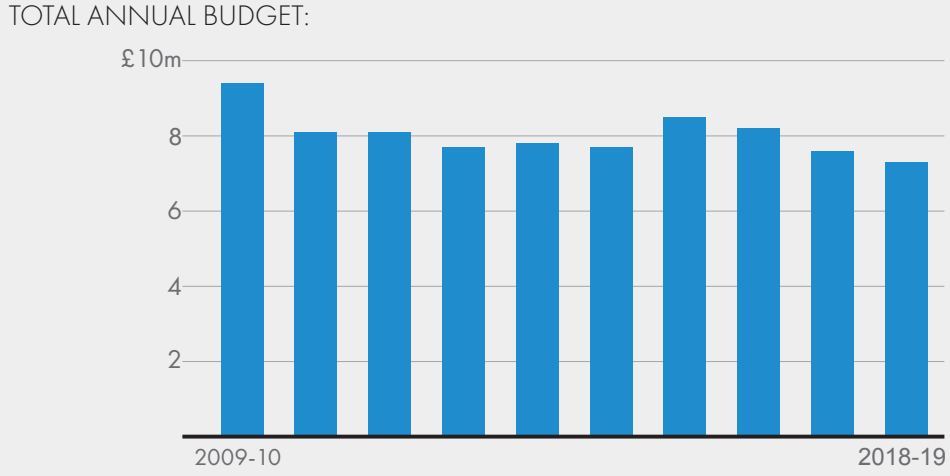
19 The plans projections were based on The Skills for Health Six Steps Methodology for Integrated Workforce Planning.

staffing gaps which have been developing. However, again, it will need to regularly review whether the workforce is sufficiently resourced to cope with patient demand.

The post-registration nursing training budget was significantly reduced but is progressively being restored to previous levels

3.20 The post-registration nursing training budget has also been progressively reduced. In 2008-09 and 2009-10, the Department allocated £9.5 million and £9.4 million respectively to the budget, but between 2010-11 and 2018-19, this has fluctuated between £7.3 million and £8.5 million, with an average of £7.9 million allocated. In 2018-19, the allocated budget fell to £7.3 million **(Figure 12)**.

Figure 12: Post-registration training budget
The post-registration training budget has been progressively reduced over the last decade, falling from £9.5 million in 2008-09 to £7.3 million in 2018-19



Source: Department of Health

3.21 The Department acknowledges that the reduced post-registration training budget has resulted in the number of commissioned programmes and places falling, but as data is only available from 2014-15, it is not possible to fully quantify the extent of this reduction. As **Figure 8** noted, post-registration training is particularly important in the context of equipping nurses to acquire new skills for specialist and advanced roles, and in helping deliver initiatives aimed at transforming healthcare services. The RCN told us that the cuts to the post-registration budget have had *"a devastating effect upon the specialist community workforce in Northern Ireland"*. It also told us that key nursing groups covered by post-registration training, including District Nursing, Health Visiting, School Nursing and Mental Health Nursing, were precisely the workforce groups which should have been expanding to help deliver transformation, instead of dis-investing in these.

Part Three:
Ensuring the supply of nurses and midwives through workforce planning

3.22 The Department highlighted that requirements for its various priorities are considered in the context of available funding, and that the local health and social care system is continuing to experience mounting pressures, with costs associated with maintaining existing service models continuing to increase at a pace which cannot be sustained. It pointed out that decisions on which programmes are commissioned are taken by its Education Commissioning Group who strive to establish how key strategic priorities can be met within the available budget. It highlighted that the availability of transformation funding in 2018-19 had permitted significant increases in training places across some of the strands of post-registration training, with specialist practice places increasing by 20 per cent from 98 to 118, and Advanced Nurse Practitioner places doubling from 16 to 32 since 2017-18. More recently, the Department has increased the post-registration training budget to £10 million in 2020-21, and intends further increasing it to £11.3 million in 2021-22, thereby restoring it to its previous highest level, subject to inflation.

3.23 In respect of District Nursing, *the 2015-25 Plan* recommended commissioning 340 training places between 2015-16 and 2024-25. Although this represented twice the numbers commissioned between 2008 and 2015, it is still notably lower than the 406 potential retirements over this period. The Department also told us that, in practice, the recommended annual 40 training places between 2015-16 and 2018-19 had not been filled, as Trusts had increasingly been unable to release nurses into the full-time training programme due to community nursing staff shortages. In our view, the level of projected retirements, combined with the inability to fill training places will likely lead to increasing staffing gaps in the local District Nursing workforce.

The Department is taking interim steps to strengthen the local nursing workforce

3.24 As well as commissioning the longer term 2015-25 Plan, the Department established a working group in May 2015 to assess the challenges which existed with recruiting and retaining nurses, particularly at Band 5 level[20].

3.25 When the group reported its findings in December 2015, it confirmed that there were insufficient Band 5 nurses to fill existing vacancies, largely because demand was outstripping supply. In our view, the reduction in pre-registration training must have contributed significantly to this situation. The group also identified concerns over newly qualified nurses leaving Northern Ireland to work elsewhere, highlighting that, in recent years, Trusts had been unable to offer all these nurses permanent contracts, due to funding constraints, and uncertainties arising from Trusts having to break even and operate in a one year budgeting cycle. The group recommended that steps be taken to address this situation. The department again highlighted that more recently, all students who had completed departmentally-commissioned courses had been offered permanent Band 5 posts within the HSC sector.

20 Band 5 is the level which newly qualified registered nurses enter the workforce.

3.26 To address another of the group's recommendations, the Department and Trusts launched an international nursing recruitment campaign in January 2016, with the overall objective of addressing nursing vacancies through appointing 622 additional staff by March 2020. At March 2020, the programme had secured 504 overseas staff, 458 of whom currently remain in post.

3.27 However, the initiative will take four years to fully deliver, which is a year longer than it takes a university nursing student to qualify. The RCN has attributed the lengthy time taken to appoint overseas nurses to the requirements for achieving UK nursing registration, including an English language test with a high failure rate, and a clinical skills test, as well as stringent visa criteria. The Department told us that the introduction of web-based Interviews had helped speed up recruitment and that the project is expected to achieve the target of 622 nurses, albeit by late 2020, although a variety of market and regulatory factors may impact on final numbers. Whilst the initiative has potential to help ease local staffing pressures, the 622 additional nurses envisaged will only partly address the staffing numbers required to fill current HSC vacancies and provide normative levels of nursing care (paragraph 2.25).

In response to increased demands, the Department's reliance and expenditure on temporary nursing staff has significantly increased

3.28 When workforce gaps arise, the Trusts use temporary staff to supplement their nursing and midwifery workforce. The temporary staff are drawn from both internal staff banks and external agencies. In addition to being more expensive than permanent staff, evidence suggests that using temporary staff to provide cover is less likely to deliver satisfactory patient outcomes[21].

3.29 Although using temporary staff to maintain service provision is sometimes unavoidable, reliance on this option has been escalating sharply for a sustained period:

- In 2006-07, the Trusts spent £14.6 million on temporary nurses and midwives. By 2011-12, this had increased to £45.2 million, and it has subsequently continued to rise, reaching £115 million in 2018-19.
- Between 2011-12 and 2018-19, the percentage of staff costs spent on bank and agency nurses and midwives increased from 6.6 per cent to 13.2 per cent. Furthermore, temporary staff costs rose by 154 per cent compared to just under 28 per cent for total staff costs **(Figure 13)**.

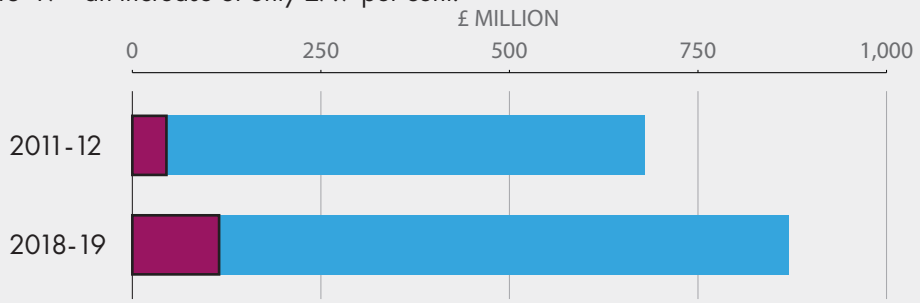
3.30 The vast majority of these costs relate to nursing rather than midwifery staff. Whilst more than £87 million was spent on temporary staff in 2017-18, the RCM told us that data obtained from the Department showed that only £1.5 million was spent on temporary midwives in 2017.

21 Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, February 2013.

Part Three:
Ensuring the supply of nurses and midwives through workforce planning

Figure 13: Between 2011-12 and 2018-19, costs of temporary nursing staff have increased by over 150 per cent

In contrast, total staff costs have increased from £680 million in 2011-12 to £870 million in 2018-19 - an increase of only 27.9 per cent.



Total expenditure incurred on **bank and agency staff** increased from £45 million in 2011-12 to £115 million in 2018-19: an increase of just over 150 per cent.
This increased expenditure accounted for a larger proportion of total spend over the period from 6.6 per cent in 2011-12 to13.2 per cent in 2018-19.

Source: Department of Health and HSC Trusts

3.31 Data on staffing costs was only available for Scotland. In 2018-19, temporary nursing and midwifery staff accounted for 13.2 per cent of staffing costs in Northern Ireland, compared to 8.8 per cent in Scotland in 2018[22]. Agency staff alone accounted for 6 per cent of local staffing costs, compared to only 1.2 per cent in Scotland.

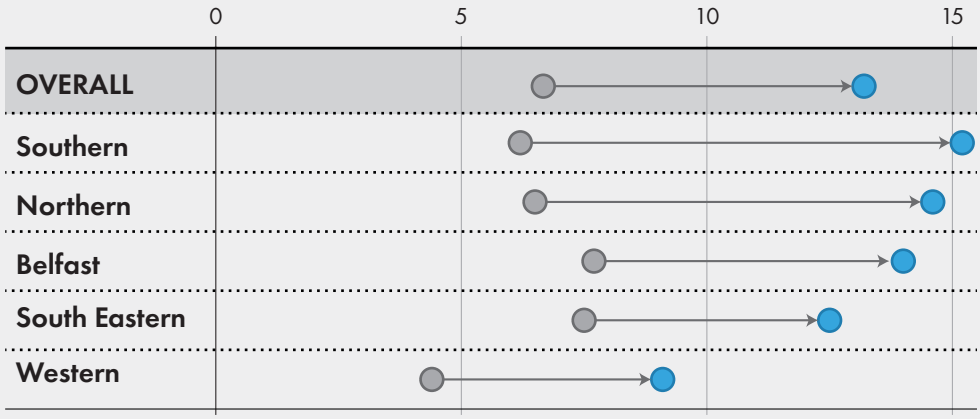
3.32 The increasing reliance on temporary staff has impacted on all Trusts, accounting for a significantly increasing percentage of total staffing costs since 2011-12 **(Figure 14)**.

22 Costs for Northern Ireland reflect both health and social care, whilst those for Scotland relate to health only.

Figure 14: Temporary Staff Costs

Between 2011-12 and 2018-19 the overall proportion of staff costs relating to temporary staff has increased across the system.

% OF STAFF COSTS USED ON TEMPORARY STAFF:



Source: Department of Health

3.33 Although the Department has overall responsibility for HSC workforce planning, it is not fully sighted on how the different factors are contributing to the rising reliance on temporary staff, as:

- the expenditure data it holds is not disaggregated across the three staffing streams;
- Trusts are not required to report why they have to engage temporary staff; and
- whilst Trusts gather data on temporary staff usage by nursing fields of practice, the Department does not routinely monitor this.

3.34 The Department told us that an existing protocol sets out when Trusts are permitted to engage short-term temporary nursing staff, and that each Trust has also developed guidance for employing agency staff. The Department also stated that the Trusts are committed to ensuring that temporary staff are only used as a means of providing cover for essential services and that approval to use such staff is required from a Trust Director. However, the escalation in costs clearly shows the need for more effective and strategic long-term workforce planning, for which the Department has lead responsibility.

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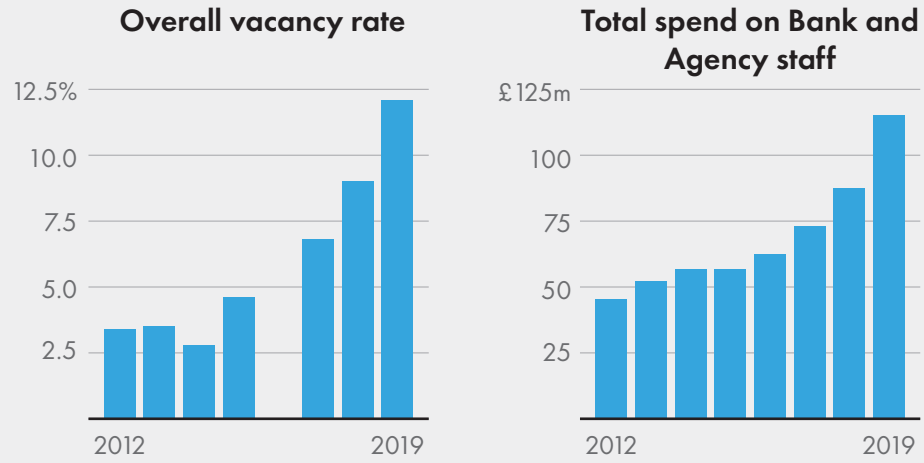
Ensuring the supply of nurses and midwives through workforce planning

3.35 **Figure 15** shows that when HSC nursing and midwifery vacancies increased from 3.4 per cent to 9 per cent between 2012 and 2018, temporary staff costs rose from £45.2 million to £87.3 million in a broadly similar period. However, there has not always been a straightforward link. Whilst vacancies increased from 2.8 per cent to 4.6 per cent between 2014 and 2015, temporary staffing costs remained virtually unchanged.

3.36 The Department told us that the increasing demand for care had been the main factor behind the rise in temporary staffing costs. However, underlying this, the difficulties in ensuring that staffing levels have kept pace with demand will, in our view, also have contributed to the rising vacancy levels and temporary staff costs. Other relevant influencing factors include sickness and maternity absence, the implementation of *Delivering Care*, work-life balance issues and even generational attitudes towards working choice and patterns.

Figure 15: Vacancy levels and temporary staff expenditure
Available evidence indicates that as nursing vacancies have been increasing spend on temporary staff has also been rising



Note: HSC vacancy rate data was not collected for 2016
Source: Department of Health and HSC Trusts

NIAO Recommendation 5

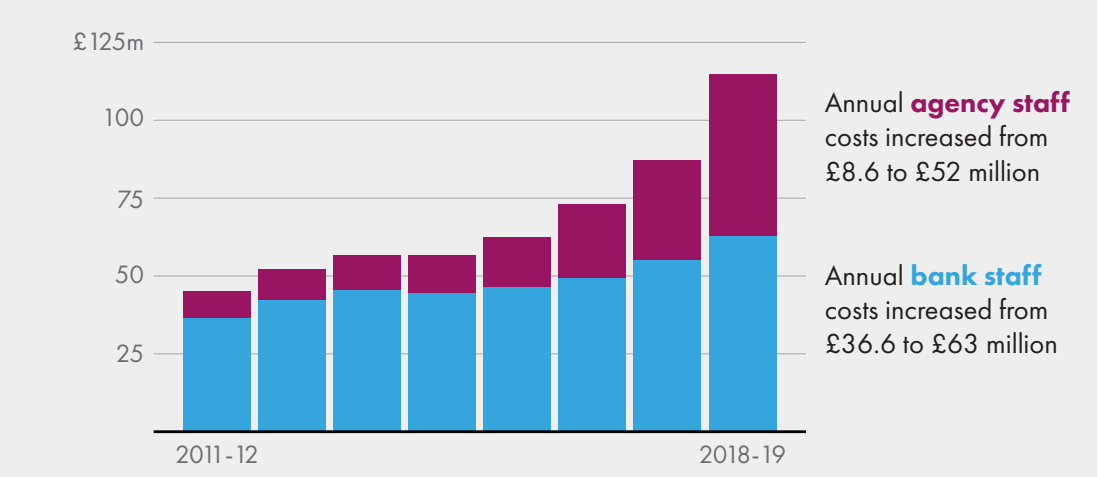
The Department should routinely monitor data to identify the specific causal factors driving the increased reliance and expenditure on temporary staff, and consider how these can be addressed within longer-term workforce planning. This should include identifying the nursing fields of practice and service areas most reliant on temporary staff, and expenditure being incurred on covering long-term vacancies.

Reliance on the most expensive and least favoured option of agency staff has risen very significantly

3.37 When Trusts need to engage temporary cover, using agency staff is more expensive than bank staff, and is also less likely to result in staff being deployed in less familiar clinical settings. However, the Trusts have become increasingly reliant on agency provision. In 2011-12, agency staff accounted for 19 per cent of temporary staffing costs, but by 2018-19, this had risen to 45 per cent. In this period, annual spend on agency staff rose by 502 per cent, from £8.6 million to £52 million **(Figure 16)**.

Figure 16: Agency and Bank staff costs

Overall expenditure on temporary staff has increased significantly between 2011-12 and 2018-19. Expenditure on Agency staff, which is a more expensive option than using bank staff and less likely to deliver strong patient outcomes, has increased by 500 per cent.



Source: Department of Health

3.38 The increasing expenditure on agency staff mirrors the findings of our recent follow-up review on locum doctors[23] and clearly does not provide good value for money. This is illustrated by the fact that three of the five Trusts[24] told us that, in 2018-19, they had paid hourly rates as high as £131 for non-contracted agency nurses and incurred costs of between £1,400 and £1,700 for single nursing shifts on bank holidays. As with the increased overall use of temporary staff, the growing reliance on the agency sector is likely attributable to several factors (paragraph 3.36).

3.39 In addition, the decision taken to reduce the number of training places (paragraphs 3.5 to 3.16) means that the growth of a strong internal HSC staff bank has been limited. In this respect, the RCN told us that measures introduced to save costs were now generating challenges which were becoming more expensive to address.

23 *Follow-up reviews in the Health and Social Care Sector: Locum Doctors and Patient Safety*, April 2019.

24 Belfast, South Eastern and Western HSC Trusts.

Part Three:
Ensuring the supply of nurses and midwives through workforce planning

3.40 Our recent report on locum doctors also highlighted how the strong financial and lifestyle incentives associated with agency employment can deter doctors from committing to a substantive post. These include having autonomy over where and when they work, and the potential to earn more than permanent staff. In our view, the increasing reliance on agency nurses suggests that a similar situation is emerging for nursing, and is presenting the HSC sector with increasing challenges in recruiting permanent staff.

3.41 The Department told us that the action it has taken in recent years to increase signifcantly the number of pre-registration nursing and midwifery training places demonstrates its sustained commitment to growing the HSC workforce. It also highlighted that the publication of *the 2026 Strategy* in May 2018 aims to support the overall long-term agenda to transform the delivery of health and social care in Northern Ireland.

The Department has not achieved a target to reduce reliance on temporary staff

3.42 In 2014, the Department attempted to reduce reliance on temporary staff through setting a target for that year to reduce the use of bank and agency nurses and midwives by 75 per cent. At this stage, it was envisaged that the target could be achieved through implementing *Delivering Care* and reducing vacancies and absenteeism. However, the Department told us that it had not proved possible to achieve this target against the background of rising HSC nursing vacancy levels, and recruitment challenges created by the global nursing shortage. In our view, the level of sickness absence amongst HSC nurses and midwives (paragraph 4.7) must also have contributed to this. The Department told us that any future targets in this area would need to be carefully researched and developed.

3.43 It also highlighted that there was clear evidence that rising agency costs were closely linked to the current configuration of services, meaning that transformation of these is a key priority. The Department is currently working with HSC employers on detailed proposals to reduce agency and locum spend, with an initial objective of reducing use of non-contracted agencies.

Stakeholders have expressed concerns over significant nursing staff shortages

3.44 Given the considerable difficulties with recruiting and retaining nurses, and the slow progress in implementing *Delivering Care*, stakeholders have unsurprisingly expressed concerns in recent years over local staffing levels. **Figure 17** summarises issues raised by the RCN to the Health Committee in April 2015, and by the Regulation and Quality Improvement Authority (RQIA)[25] to the Department in November 2017 (the first time RQIA had taken such action), following a series of inspections of local hospitals and nursing homes.

25 RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvement in the quality of those services.

Figure 17: RCN and RQIA have raised significant concerns about nursing staffing levels in Northern Ireland

Concerns raised by RCN	Concerns raised by RQIA
• staff shortages, with *"evidence of real concerns that patient safety is at risk"*. • significant nursing vacancies in the independent sector, with evidence of Trusts, who can offer better terms and conditions, poaching staff from the sector	• staffing levels were a problem in almost every area inspected. • reliance on agency and bank nursing staff due to a shortage of permanent staff, was impacting on the continuity of delivery of local nursing care. • nursing shortages were reducing staff morale, leading to higher sickness absence, and impacting on staff training, appraisal and supervision, which in some cases was leading to less effective patient care. • nursing shortages were a factor behind the closure of two local care homes, with the lack of beds in homes in that area potentially having a knock-on effect on hospital discharges.

Source: RCN and RQIA

3.45 The impact of nursing shortages has also been recorded in recent years on the corporate risk registers of all of the HSC Trusts excluding Belfast, with the Northern, South Eastern and Western Trusts having allocated this an `extreme' risk rating. This further highlights the scale of challenge facing the Department and Trusts in addressing the significant staffing gaps and shortfalls.

Part Four:
Addressing Key Workforce Challenges

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Addressing Key Workforce Challenges

4.1 Successful workforce planning requires consideration of wider issues than projecting the level of training places required. These include:

- addressing the age profile of the workforce;
- managing sickness absence;
- supporting transformation of healthcare services to cope with the rising demand for care, by ensuring the availability of sufficient numbers of staff with the right skills and expertise, and appropriate service reconfiguration; and
- assisting staff recruitment and retention through making the HSC an attractive employee destination.

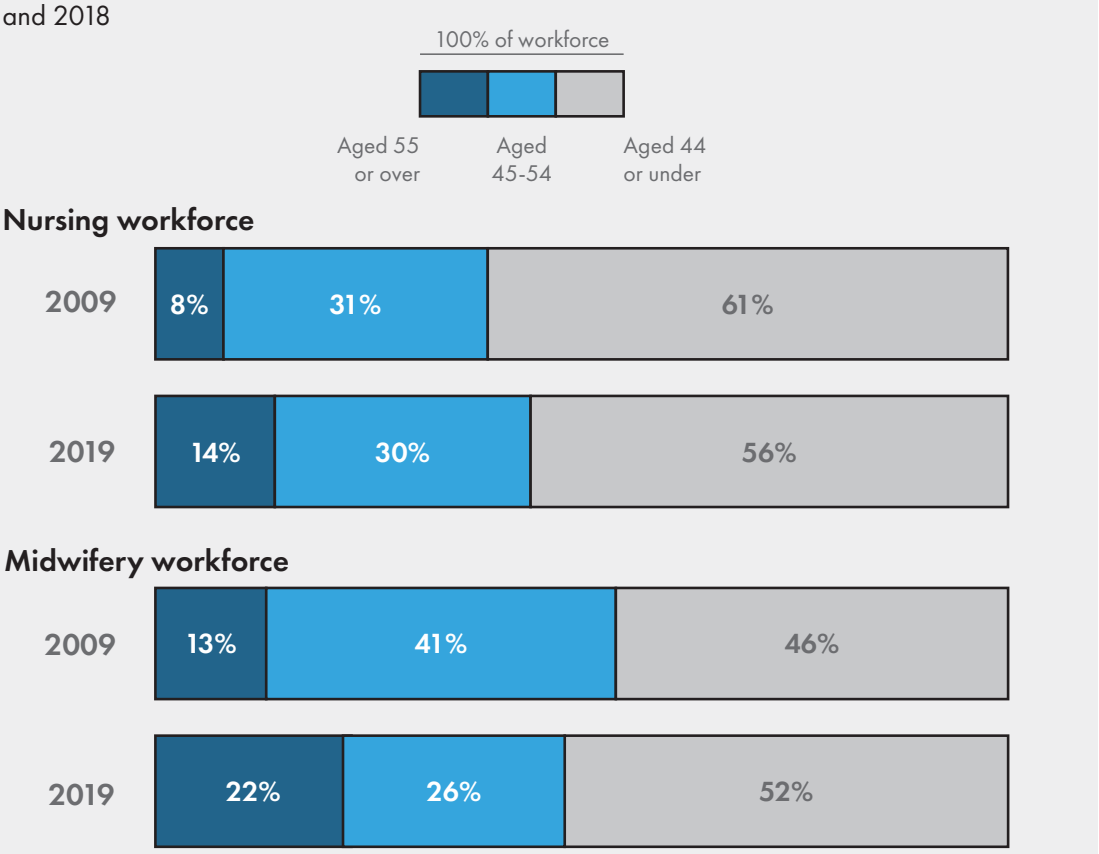
This part of the report considers these issues.

Substantial numbers of nurses and midwives could retire over the next ten years

4.2 Monitoring the workforce age profile helps identify likely retirement patterns and assist succession planning. In assessing this area, *the 2009 Review* highlighted potential future challenges in some front-line service areas where a disproportionately high percentage of the nursing and midwifery workforce was drawn from older age groups and where future retirements and attrition could prove problematic.

4.3 Despite this evidence, the Department, faced with financial pressures, subsequently reduced the number of pre-registration nursing training places commissioned between 2010-11 and 2016-17, and the age profile of local HSC nurses and midwives has continued to rise notably since then. Currently, 14 per cent of nurses and 22 per cent of midwives are aged 55 and over **(Figure 18)**.

Figure 18: Age profile of nursing and midwifery workforce group
The age profile of the nursing and midwifery workforce group has increased between 2009 and 2018



Source: Department of Health

4.4 Within such an age profile, significant numbers of impending retirements could potentially place an already stretched workforce under even greater pressure. However, forecasting retirement patterns is problematic for several reasons. For example, eligibility for retirement differs for specific grades and pension schemes, with midwives and some nursing staff being able to retire at 55. Employers are also now unable to specify a compulsory retirement age, and changes introduced following the Hutton Review of Public Sector Pensions[26] could result in staff working beyond their planned retirement age.

26 A review into the future of public sector pensions by an Independent Public Service Pensions Commission which was headed by Lord Hutton and which published its findings in October 2010.

Part Four:
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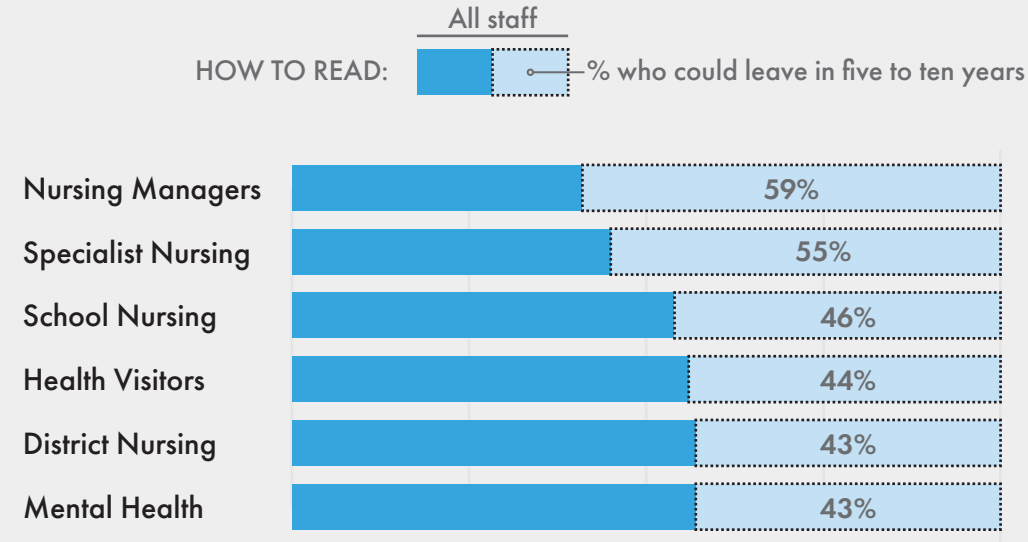
4.5 Despite these difficulties, *the 2015-25 Plan* forecast that over 40 per cent of staff in some key nursing fields of practice could retire or leave the service for other reasons over the next five to ten years **(Figure 19)**:

Figure 19: A significant proportion of staff in key fields of nursing practice and managerial positions could leave the HSC sector in the next five to ten years



Source: 2015-25 Nursing and Midwifery Workforce Plan

One Health Trust also told us that, within some of its nursing specialisms, there is evidence that a significant number of retirements is anticipated. The Department told us that the groups above contain relatively small numbers of staff which tend to have an older age group due to the level of experience required. It also highlighted that the current age profile of the groups does not provide signficant cause for concern.

4.6 In addition to nursing, 23 per cent of midwives are now aged over 55 and are therefore eligible to retire. The number of HSC midwives in post has also reduced between 2012 and 2018, and vacancy rates have risen notably in recent years (paragraphs 2.7 to 2.9).

NIAO Recommendation 6

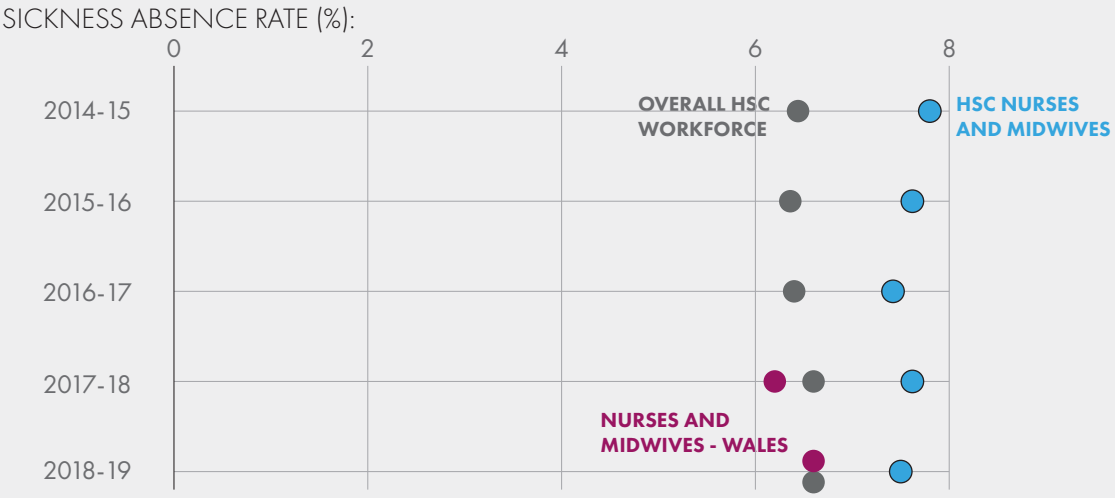
Allied to the rising demand for care and high vacancy levels, the Department should consider whether workforce planning has taken sufficient account of the age profile of the nursing and midwifery workforce, and re-assess whether current projections will suitably address existing and longer-term staffing gaps.

Nurses and midwives have relatively high sickness absence rates

4.7 In comparison to nurses and midwives in Wales[27] and the overall HSC workforce, HSC nurses and midwives have relatively high sickness absence levels. In 2012-13, this workforce group lost 6.6 per cent of working days due to sickness absence. Although a target to reduce this to 5 per cent was set in 2014, the sickness absence rate has instead increased to 7.5 per cent in 2018-19. This compares to 6.6 per cent for both the overall HSC workforce, and for nurses and midwives in Wales **(Figure 20)**. Sickness absence is therefore a further issue which needs to be considered within workforce planning.

Figure 20: Nurses and Midwives absence rates

Nurses and midwives have had relatively high levels of sickness absence compared to the overall HSC average in recent years. The most recent data also shows the rate is higher than in Wales



Source: Department of Health

4.8 The 2015 HSC staff survey results provided insights into possible contributory factors to the absence levels. Some 71 per cent of nurses stated that they regularly worked beyond their contracted hours, with 59 per cent claiming to have worked up to five additional unpaid hours each week. In addition, only 31 per cent believed that their employer was committed to facilitating a work-life balance. In respect of sickness absence among midwives, the RCM told us that its research identified high levels of emotional distress as a contributory factor. Together with its core sickness absence data, the results of the HSC staff survey provide the Department with important information which could help it identify the substantive issues which need to be addressed if sickness absence among nurses and midwives is to be reduced.

4.9 The combined effect of increasing vacancy levels and high sickness absence across a workforce of over 22,000 will have contributed to the current reliance on bank and agency

27 Wales was the only other part of the UK for which comparable data was available.

Part Four:
Addressing Key Workforce Challenges

staff. In the coming years, the Department is likely to face challenges in trying to minimise sickness absence among HSC nurses and midwives given the ageing workforce, more staff possibly having to work longer than anticipated, and the rising demand for care. Indeed, most of these factors apply across the wider HSC workforce.

4.10 Reducing the level of sickness absence among HSC nurses and midwives would clearly help improve workforce efficiency. To try and address this area, the recently published *2026 HSC Workforce Strategy (the 2026 Strategy)* proposes two actions to be implemented by 2021:

- developing an HSC staff health and wellbeing framework, with the aim of assisting staff to remain resilient, and physically and mentally well at work; and
- establishing sustainable occupational health services.

NIAO Recommendation 7

Given the unremitting workload pressures facing the HSC sector, it is appropriate that the Department intends applying an increased focus on staff health and wellbeing. In implementing its proposed actions, it should seek to identify the main causal factors of sickness absence within the different HSC workforce groups, and consider what steps can be taken to address these to try and minimise absence levels.

An HSC workforce strategy aligned to the transformation agenda was not published until 2018

4.11 For some time, it has been recognised that the HSC sector requires fundamental reorganisation to enable it to better cope with the growing numbers of people living longer, but with long-term conditions. To successfully facilitate such transformation, which involves relocating elements of care provision from hospitals to primary care and community settings, strong workforce planning is required to ensure the availability of appropriate numbers of staff with the right skills and expertise.

4.12 However, transforming care models and the associated workforce planning have both proved challenging and progress on both fronts has been fairly limited. Whilst the Department launched *Transforming Your Care (TYC)*[28] in December 2011, a review of HSC governance arrangements in 2014[29] found that the initiative had not made the degree of progress anticipated. In addition, despite progress in some areas of workforce planning, there had been no commitment within TYC to develop a formal HSC workforce strategy. In January 2016, the Department appointed an international expert panel[30] to advise on how transformation could be taken forward.

28 Transforming Your Care proposed a new model of care for the HSC sector in Northern Ireland.

29 The Right Time, the Right Place (December 2014).

30 The panel was chaired by Professor Rafael Bengoa.

4.13 Having considered the panel's findings[31], the Department launched `*Delivering Together*' in October 2016 as its revised ten year vision for future care delivery. Recognising the need for progress on workforce issues, *Delivering Together* committed to publishing an HSC wide workforce strategy by May 2017. In the event, *the Health and Social Care Workforce Strategy 2026* (*the 2026 Strategy*) was not published until May 2018. The Department told us that progress had been hampered by a number of events, including the suspension of the Assembly.

The *2026 Strategy* aims to address key workforce challenges and pressures, and there is a need to achieve progress in implementing its measures

4.14 *The 2026 Strategy* acknowledges the need to "*resolve fundamental problems with supply, recruitment and retention of the health and social care workforce*", as well as highlighting key challenges:

- high sickness absence;
- increasing spend on temporary staff;
- high HSC vacancy rates, particularly within nursing and midwifery;
- continuing lack of clarity over how the HSC sector would be configured by 2026; and
- the potential impact of Brexit on workforce supply.

4.15 By 2026, *the 2026 Strategy* aims to achieve three objectives:

- By **2019**, the Department and HSC providers will be able to monitor workforce trends and issues effectively, and take proactive action to address these before problems become more acute.
- By **2021**, health and social care in NI will be a fulfilling and rewarding place to work and train, and staff will feel valued and supported.
- By **2026**, the reconfigured health system will have the optimum number of people in place to deliver treatment and care and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.

Underlying these objectives are ten themes and 24 proposed actions.

4.16 As it is striving to assist the HSC sector successfully transform services, a number of *the 2026 Strategy's* measures are specifically aimed at equipping the workforce to deliver the care models envisaged by *Delivering* Together. This is important, given the limited progress previously achieved in realigning the workforce to help deliver *TYC*.

31 Systems, Not Structures – Changing Health and Social Care, October 2016.

Part Four:
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NIAO Recommendation 8

The Department needs to robustly monitor developments to ensure that substantive progress is being achieved in implementing the actions, targets and milestones of both *Delivering Together* and the *2026 Strategy*, and that effective liaison arrangements exist between those responsible for implementing transformation and for progressing workforce planning.

The Strategy aims to achieve 40 milestones by December 2020, but progress will require strong oversight and access to funding

4.17 When the *2026 Strategy* was published, the Department committed to establishing a number of groups to assist oversight and governance arrangements for its implementation phase **(Figure 21)**:

Figure 21: Proposed implementation arrangements for 2026 Strategy

Implementation Group	Responsibilities
Programme Board	Plan and formally monitor and manage implementation, with progress being "*informally reviewed periodically*".
Reference Group	Provide the programme board with advice and assurance on progress, and resolve any issues which arise.
Working Groups	Oversee delivery of ten individual strategy themes.
Performance Working Group	Develop relevant performance indicators, potentially including reductions in vacancy rates and temporary staff usage, and re-design the HSC staff survey to measure progress against intended outcomes.

4.18 At this stage, both the Programme Board and the Reference Group have been established and work is ongoing to finalise the working groups to take forward the strategy actions. Scoping work is also ongoing to determine the progress to date against each action, both at a local and regional level. The HSC staff survey has also been re-designed to help track progress in achieving the actions and the Programme Board has commenced work with the HSC to develop a suite of performance indicators which will provide the basis for measuring progress against all strategy themes, in line with outcome based accountability principles. Going forward, the Reference Group will have an important role in closely monitoring progress

on delivering the individual actions, and escalating any concerns upwards promptly to the Programme Board.

4.19 Whilst the Department has undertaken initial work to progress some strategy actions, we consider it important that implementation should now gather pace. An initial action plan has outlined 40 milestones which the Department aims to achieve by December 2020 for the *2026 Strategy's* 24 actions. In our view, achieving the following will be particularly important:

- improving workforce business intelligence by identifying gaps in workforce data;
- exploring workforce data systems to inform more evidence-based decision making;
- establishing a regional HSC careers service;
- designing non-salary incentive programmes;
- establishing a rolling, prioritised programme of workforce plans;
- progressing recommendations from existing workforce reviews; and
- introducing an optimum workforce model framework.

4.20 At this stage, the degree of funding required to implement *the 2026 Strategy* is unclear. Whilst the Department has acknowledged the need for "*more investment in people, and effective workforce engagement and planning*", it has also stated that it does not "*automatically assume that a certain amount of new money would be needed for it to succeed*".

4.21 Where new needs are identified, the Department has committed to making the best possible funding case. In this respect, it told us that the individual actions will be costed as they are taken forward. In our view, some of the actions might require substantial funding to be fully implemented, and if this is the case, there is no certainty that this will be made available in the context of competing financial priorities.

4.22 Consequently, the Department needs to assess which actions could potentially deliver the most significant longer-term savings and benefits, and provide the best returns on investment. For example, enhanced workforce planning and staff recruitment and retention initiatives may help reduce HSC vacancy levels and spend on temporary staff, whilst improved occupational health services could assist the Trusts in reducing sickness absence rates.

Part Four:
Addressing Key Workforce Challenges

There is a need to address staff recruitment and retention issues

4.23 Whilst *the 2009 Review* had initially flagged up the need for incentives to try and improve recruitment and retention for HSC nurses and midwives, the *2026 Strategy* acknowledged that further work is still required in this area. It proposes introducing non-salary incentive programmes for the different HSC professions by the end of 2020, to try and make the HSC sector an attractive choice of employee destination.

4.24 The RCM told us that its members viewed better development opportunities, more flexible working, and better support for staff as key factors for improving recruitment and retention for midwives. The survey of final year nursing and midwifery students undertaken for *the 2015-25 Plan* (paragraph 2.31) also highlighted factors which would encourage or discourage newly qualified staff from taking up employment in Northern Ireland **(Figure 22)**. In designing its incentive programmes we consider that the Department should take account of this available evidence.

Figure 22: Factors which would encourage or discourage local final year nursing students from working in Northern Ireland

Factors encouraging students to take up a post in NI	Factors discouraging students from taking up a post in NI
• being close to home • good promotion opportunities • a supportive employer • good preceptorship programme • job security • choice to work in area of interest • familiar with the system • permanent post • early advertisement of posts • a rotational placement scheme across the statutory and independent sectors if they could not obtain a post after completing training	• temporary contract • lack of staff on wards • unsupportive working environment • poor preceptorship programme • waiting lists for jobs • placed in unsuitable area • lack of opportunities to progress • working conditions putting registration at risk

Source: Nursing and Midwifery 2015-25 Workforce Plan

Achieving the Strategy's objectives will prove challenging

4.25 The RCN and RCM have both welcomed the publication of *the 2026 Strategy*. The RCN regards it as an honest assessment of the challenges facing the local nursing workforce. It considers that its proposed measures, if appropriately resourced, implemented and evaluated, will significantly improve workforce planning and benefit the nursing workforce. The RCM told us that it was pleased that specific workforce challenges including recruitment, retention and age profile have been highlighted as fundamental issues that need to be tackled.

4.26 However, the RCN considers that sustainable funding and effective workforce management will be required to achieve the strategy's vision, particularly in respect of supply, recruitment and retention of staff.

4.27 In our view, the *2026 Strategy* outlines a comprehensive range of measures which offer potential to address the serious workforce challenges which have developed. However, the scale of these challenges, and those which lie ahead, mean that the Department faces a very challenging task in fully achieving its objectives. If issues around training, recruitment and retention and high vacancy levels are not effectively tackled, an already strained system could potentially come under intolerable pressure trying to deal with the continually increasing demand for care. *The 2026 Strategy* itself acknowledges that the consequences of failing to achieve its objectives are "*grave*", as this will result in:

- high agency expenditure continuing to increase;
- hospital waiting lists continuing to rise; and
- HSC services becoming unsustainable, and the transformation of services becoming more difficult.

4.28 To enhance the prospect of *the 2026 Strategy* meeting its aims and objectives, we have made a number of recommendations.

NIAO Recommendation 9

Regular monitoring should be undertaken to ensure that implementation of the strategy actions are progressing as envisaged, and that any concerns over progress are escalated upwards quickly. We recommend that the reference group provides formal and regular assurance reporting to the programme board.

NIAO Recommendation 10

The outcomes and benefits which the actions are expected to achieve should be clearly identified and quantified, and actual results regularly monitored against these. This will help inform interim strategy reviews which are planned for 2021 and 2024.

Part Four:
Addressing Key Workforce Challenges

NIAO Recommendation 11

At this stage, the 24 actions generically address the HSC-wide workforce. The Department needs to assess how these can be translated into measures which will best address the differing needs and challenges of the various HSC professions. One key example of this will be designing appropriate non-salary incentive programmes.

NIAO Recommendation 12

Within performance management, the Department should seek to establish baselines for success in recruiting and retaining staff within the HSC sector, and measure subsequent performance against these.

Appendix

Appendix 1:
Study Methodology

(Paragraph 1.7)

In gathering evidence for this study we:

- reviewed key data, statistics and financial information related to workforce planning for nurses and midwives;
- analysed data and information relating to nursing and midwifery training;
- reviewed a range of strategy and policy documents which had been compiled by the Department, the Health and Social Care Board and the Public Health Agency (PHA);
- interviewed key staff from the Department, HSC Trusts and PHA; and
- engaged with the Royal College of Nursing and Royal College of Midwives (we also attempted to engage with the Independent Health and Care Providers but they were unable to facilitate this due to resourcing issues at the time).

NIAO Reports 2019 and 2020

Title	Date Published
2019	
Welfare Reforms in Northern Ireland	17 January 2019
Structural Maintenance of the Road Network	26 March 2019
Follow-up reviews in the Health and Social Care Sector: Locum Doctors and Patient Safety	9 April 2019
Making partnerships work: A good practice guide for public bodies	30 April 2019
Mental Health in the Criminal Justice System	14 May 2019
Management of the NI Direct Strategic Partner Project – helping to deliver Digital Transformation	14 June 2019
Local Government Auditor's Report 2019	19 June 2019
Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2018	26 July 2019
Major Capital Projects	8 December 2019
2020	
Injury on duty schemes for officers in the Police Service of Northern Ireland and the Northern Ireland Prison Service (Website only)	10 March 2020
Governance issues in Sport Northern Ireland	11 March 2020
Reducing Costs in the PSNI	28 April 2020
National Fraud Initiative	11 June 2020
The LandWeb Project: An Update	16 June 2020
Raising Concerns: A good practice guide for the Northern Ireland public sector	25 June 2020
Addiction Services in Northern Ireland	30 June 2020

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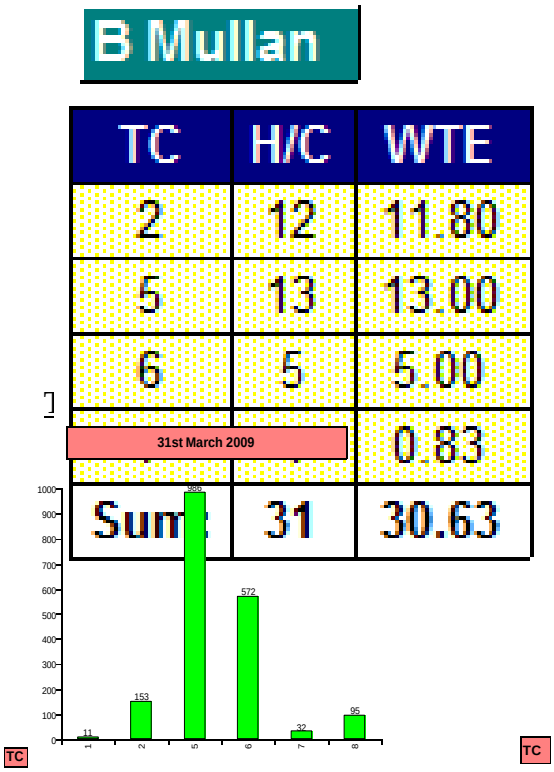
MENTAL HEALTH & LEARNING DISABILITY SERVICE GROUP WORKFORCE INFORMATION REPORT FOR PERIOD 01 APRIL 2008 TO 31 MARCH 2009

1.0 Staff in Post

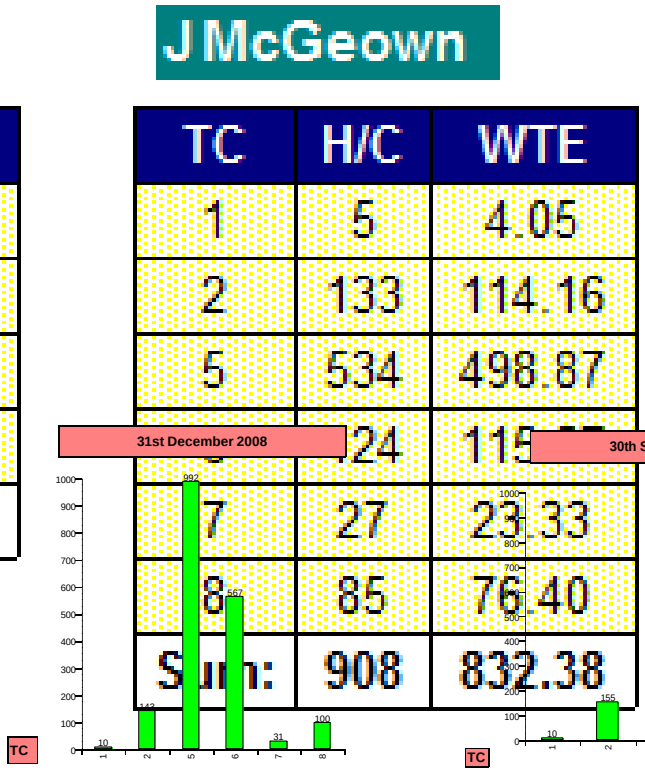
Tables 1a and 1b illustrate the number of staff in post by staff group, headcount (H/C) and whole time equivalent (WTE) greater than 0.03 as at 31th March 2009. Graphs 1-3 illustrate the number of staff in post as at 31st March 2009,31st December 2008 and 30th September 2008 respectively.
Staff with a WTE less than or equal to 0.03 refers to bank staff and staff on a career break, these are illustrated separately in tables 1c and 1d.
Please note there are 18 H/C, 16.17 WTE recorded in Table 1a that have been identified as discrepancies, that is their cost centres are either mapped to other service groups or have not been designated to a function/area. These staff have not been included in the function/area breakdowns.
Please note we are continuing to work with our finance colleagues to rectify this.

Staff Group	TC	H/C	WTE
Generic/Holding Code	1	11	9.52
Admin & Clerical	2	153	133.34
Nursing	5	986	907.69
Social Services	6	572	505.50
Professional & Technical	7	32	28.26
Medical & Dental	8	95	85.40
	Sum:	**1849**	**1,669.71**

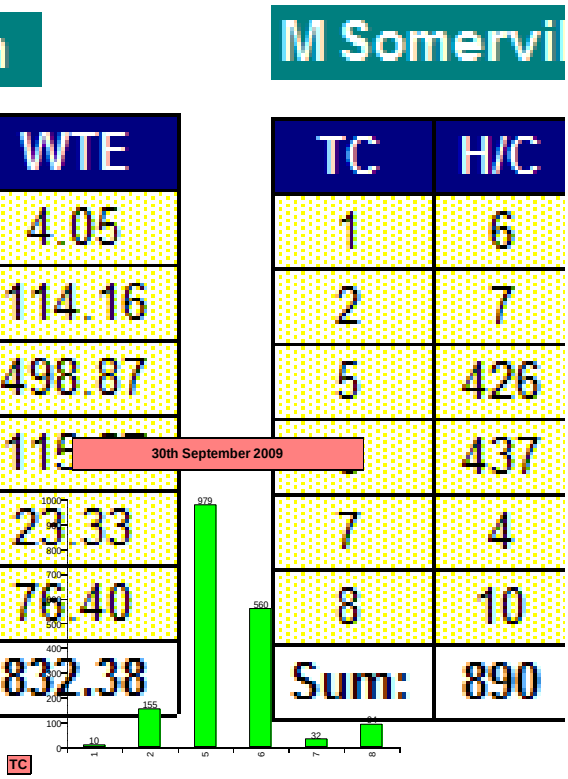
Table 1a Service Group



Graph 1



Graph 2



Graph 3

Table 1c illustrates the number of Bank Staff in post within each Function/Area by staff group. There are in total 33 Bank Staff.

J McGeown

TC	H/C	WTE
2	2	0.00
6	14	0.09
8	1	0.00
Sum:	17	0.09

M Somerville

TC	H/C	WTE
1	1	0.00
4	1	0.01
6	14	0.04
Sum:	16	0.05

Table 1c Function/Area

Table 1d illustrates the number of Staff on a Career Break Staff within each Function/Area by staff group, WTE and H/C with a WTE less than or equal to 0.03. There are in total 12 Staff on a Career Break

J McGeown

TC	H/C	WTE
2	1	0.03
5	2	1.03
6	3	0.05
Sum:	6	1.11

M Somerville

TC	H/C	WTE
1	1	0.03
5	2	0.04
6	3	0.09
Sum:	6	0.16

Table 1d Function/Area

2.0 Productivity Targets

The Trust has productivity targets set by the Region to meet in relation to Skill Mix (Nursing/AHP`s) , proportion of Admin & Clerical Staff, Turnover and Sickness Absence.

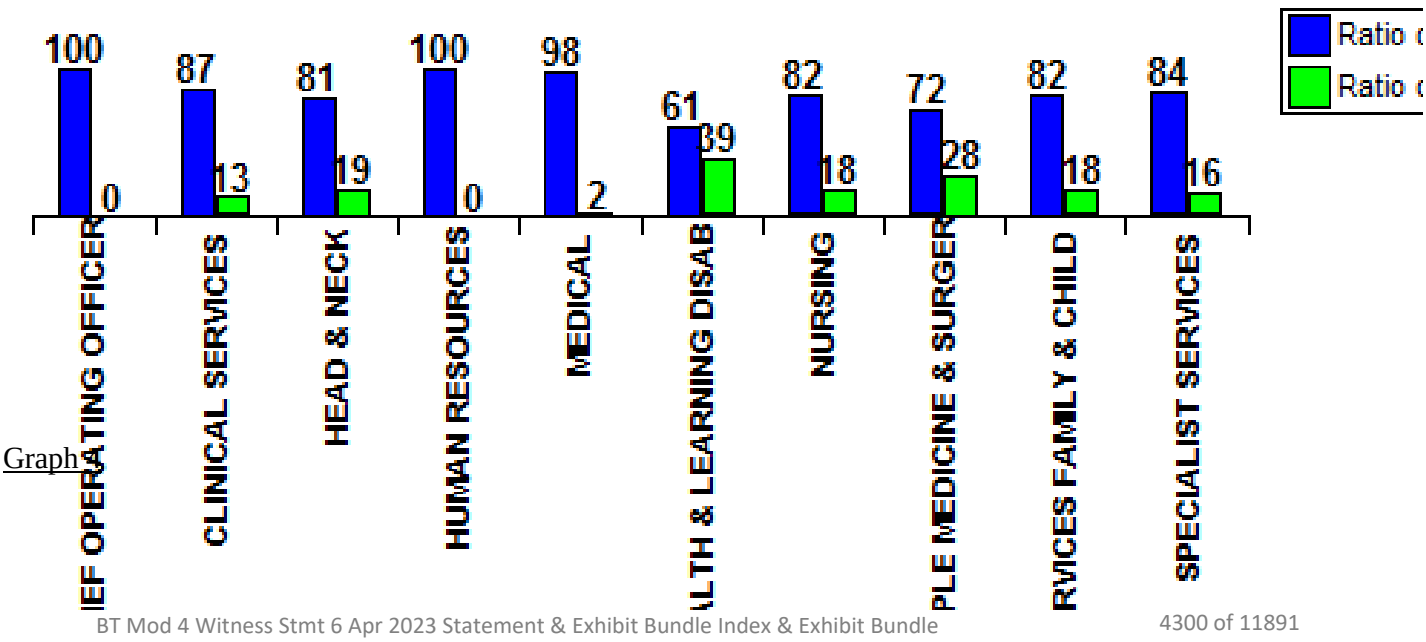
2.1 Skills Mix Nursing

Table 2a illustrates the Trusts Nursing ratio and Graph 4 illustrates the Nursing ratio by Service Group as at 31 March 2009. The Trust should ensure that, by March 2009, its ratio of qualified to unqualified nurses is reduced to 75:25 and to achieve the Trust Target of 74:26 by March 2011.

Trust Nursing Ratio at 31st March 2009

Ratio of Qual	:	Ratio of Un Qual
77	:	23

Table 2a



Graph

Table 2b illustrates the Nursing ratio of Mental Health & Learning Disability as at 31st March 2009

Mental Health & Learning Disability Nursing Ratio a		
Ratio of Qual	:	Ratio of Un Qual
61	:	39

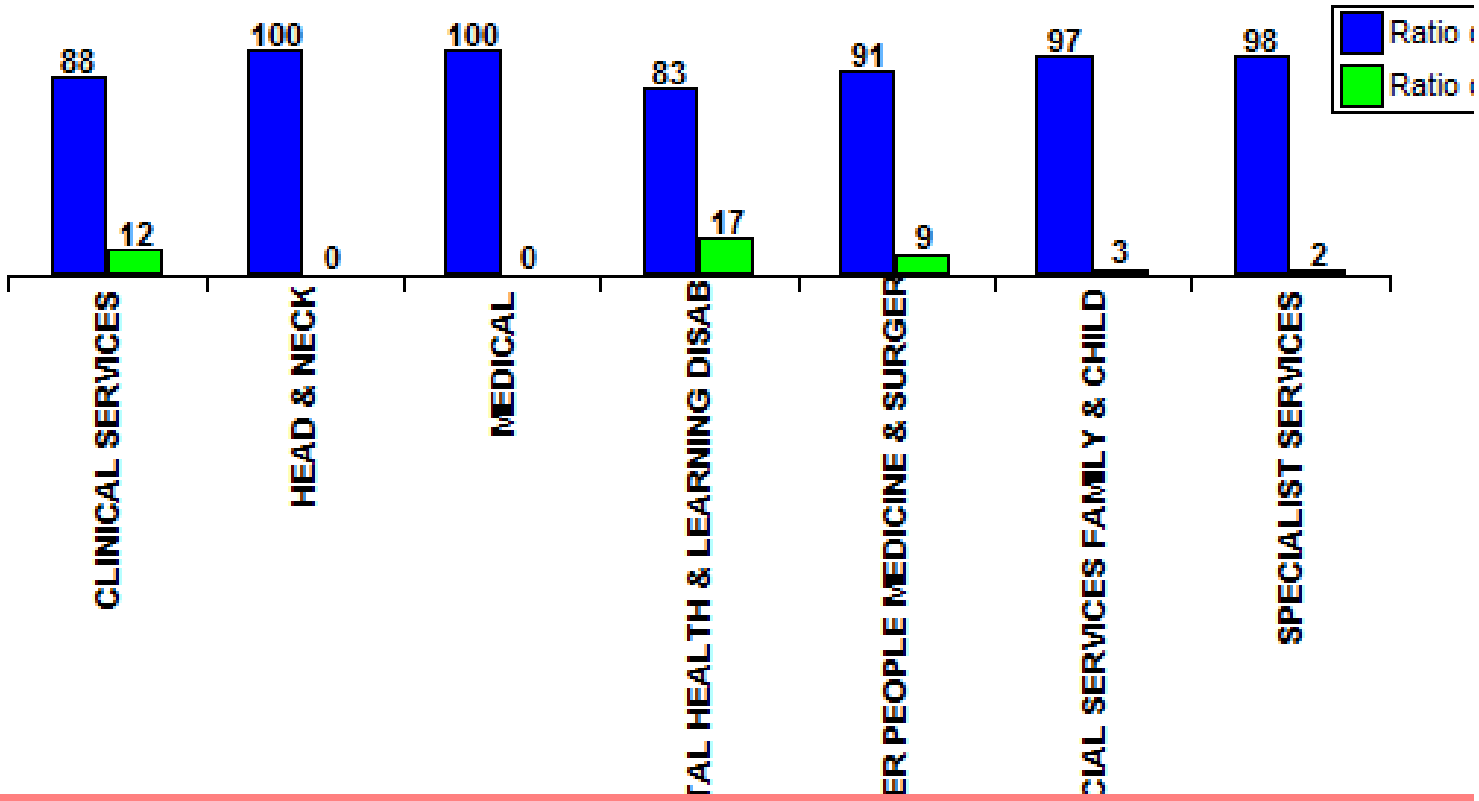
Table 2b

2.2 Skills Mix AHP`s

Table 2c illustrates the Trusts AHP ratio and Graph 5 illustrates the AHP ratio by Service Group as at 31 March 2009.The Trust should ensure that, by March 2009, its ratio of qualified to unqualified AHPs is reduced to 86:14 and to achieve the Trust Target of 84:16 by March 2011.

Trust AHP Ratio at 31st March 2009		
Ratio of Qual	:	Ratio of Un Qual
90	:	10

Table 2c



Mental Health & Learning Disability AHP Ratio at 31st March 200

Ratio of Qual	:	Ratio of Un Qual
83	:	17

Occup	Ratio of Un Qual
	0

AHP	Ratio of Qual	:	Ratio of Un-Qual
Clinical Psychology	100	:	0

AHP	Ratio of Qual	:	Ratio of Un Qual
Speech & Language	100	:	0

Table 2d

2.3 Proportion of Admin & Clerical Staff

The Trust should ensure that, by March 2009, the number of Admin and Clerical staff as a proportion of all Trust staff is reduced to 18.6%. Within the Trust 18.15% of all staff are Admin and Clerical. Within Mental Health & Learning Disability 8.17% of all staff are Admin and Clerical representing 4.48% of the total Admin and Clerical staff in the Trust.

2.4 Turnover

The priority for action target set for the Trust for the year 01 April 2008 to 31 March 2009 is to reduce Turnover by 5% compared to the 2007-08 percentage. This target excludes Administration and Clerical, Bank, Medics in Training and Temporary Staff. The cumulative turnover rate for the Trust excluding the above was 15.13% for 2007-08. Table 2e illustrates the Trust turnover rate for the 12 months to 31 March 2009.

Turnover	Target	Current % Turnov 08 - March
Excluding Admin & Clerical, Bank, Medics in Training and Temporary Staff	10.13%	6.87

The turnover figure for Mental Health & Learning Disability for the period 01 April 2008 to 31 March 2009 excluding Administration and Clerical, Bank, Medics in Training and Temporary Staff is 6.35%. The turnover figure for Mental Health & Learning Disability for the period 01 April 2008 to 31 March 2009 including Admin & Clerical but excluding Bank, Medics in Training and Temporary Staff is 6.11%.

Tables 2f and 2g illustrate the number of leavers and new starts respectively during March 2009 and over the period 1st April 2008 to 31st March 2009.

TC	No of Leavers Mar 09	WTE of Leavers Mar 09	No of Leavers April to Mar 09	WTE of Leave Mar
1			3	2.8
2			12	11.3
4			3	2.1
5	7	6.60	78	71.8
6	3	2.07	33	27.0
7			4	4.0
8	1	1.00	28	27.9
Sum:	11	9.67	161	147.

TC	No of New Starts Mar 09	WTE of New Starts Mar 09	No of New Starts April to Mar 09	WTE April t
1	1	1.00	2	1
2			8	7
5	7	6.85	72	6
6	6	5.53	31	2
7			2	1
8	2	2.00	31	3

Table 2g

The total number of leavers and starters during the period 01 April 2008 to 31 March 2009 is 181 and 148 respectively. To arrive at these figures, 19 (16.67wte) staff were removed as they were identified as 'movers' across the legacy sites. These staff where processed as leavers and subsequently placed back on the HRMS system as new starts.

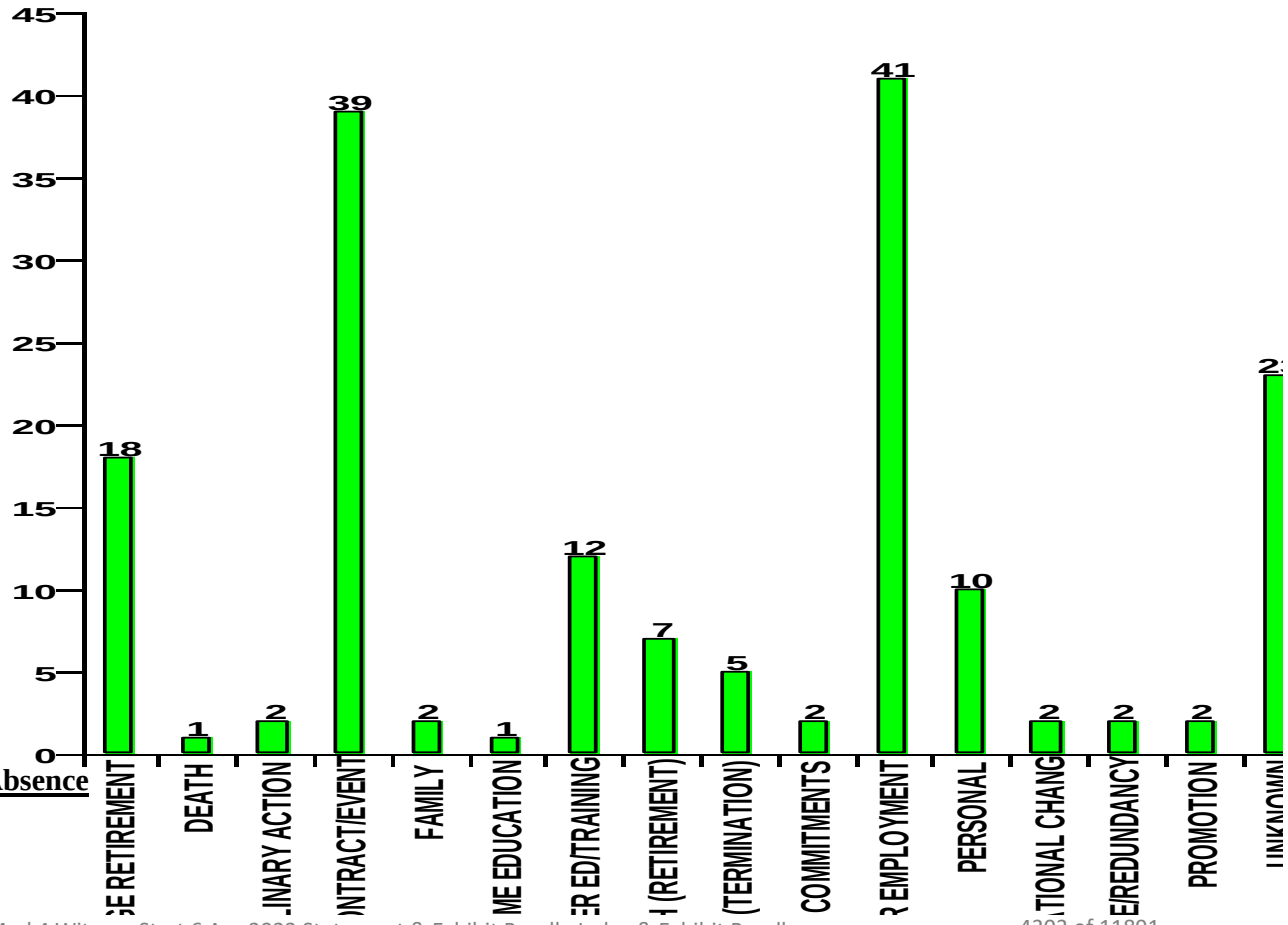
Table 2 h and Graph 6 illustrate the reasons for leaving during the period 1st April 2008 to 31st March 2009.

Reason Left Description	No of Staff
AGE RETIREMENT	18
DEATH	1
DISCIPLINARY ACTION	2
END FIXED TERM CONTRACT/EVENT	39
FAMILY	2
FULL TIME EDUCATION	1
FURTHER ED/TRAINING	12
ILL HEALTH (RETIREMENT)	7
ILL HEALTH (TERMINATION)	5
OTHER DOMESTIC COMMITMENTS	2
OTHER EMPLOYMENT	41
PERSONAL	10
PREMATURE/ORGANISATIONAL CHANG	2
PREMATURE/REDUNDANCY	2
PROMOTION	2
UNKNOWN	23
VOLUNTARY EARLY RETIREMENT	3
WIDOW/WIDOWER PENSION	1
Sum:	**173**

Table 2h

Graph 6

Sickness Absence



The Trust should ensure that, during 2008-09, levels of absenteeism are reduced to 10% below average 2006-07 levels in its legacy Trusts. The Trust absence target for April 2008-March 2009 is 5.9% working towards a regional target of 5.2% in 2010-11. The Trust actual end of year absence rate for April 2008-March 2009 is 5.79%. The locally agreed absence target for Mental Health & Learning Disability service group for the period 1 April 2008-31 March 2009 is 5.82 % and the actual end of year absence is 6.06%, 0.24% over target. Table 2i below illustrates performance for each quarter.

Mental Health & Learning Disability Service Group % Days Lost			
April-June 2008	**July-Sept 2008**	**Oct-Dec 2008**	**Jan-March 2009**
5.73%	**6.02%**	**6.73%**	**6.30%**

Table 2i

3.0 Vacancy Controls

The HRMS staff in post figures below exclude 9.52 wte for staff currently held under Generic codes. It is recognised that work needs to continue to address the discrepancies between HRMS staff in post and the general ledger staff in post.

	HRMS Staff in post WTE as at 31st March 2009	General Ledger WTE as at 31st March 2009	Funded Staffing Level as at 31st March 2009
Admin & Clerical	133.34	142.33	165.38
Nursing	907.69	894.38	1016.82
Social Services	505.50	471.75	547.91
PAMS & Prof & Tech	28.26	30.91	39.26
Medical & Dental	85.40	89.33	88.05
Grand Total	*** 1,669.71**	^1628.70	^1857.42

*Please note there are 0 WTE included in this figure which are research staff. These are excluded from Finance figures^. Within the Trust cost centres used for research account for 173.22 WTE on the General Ledger and 0 WTE on the Funded Staffing Level.

Table 8

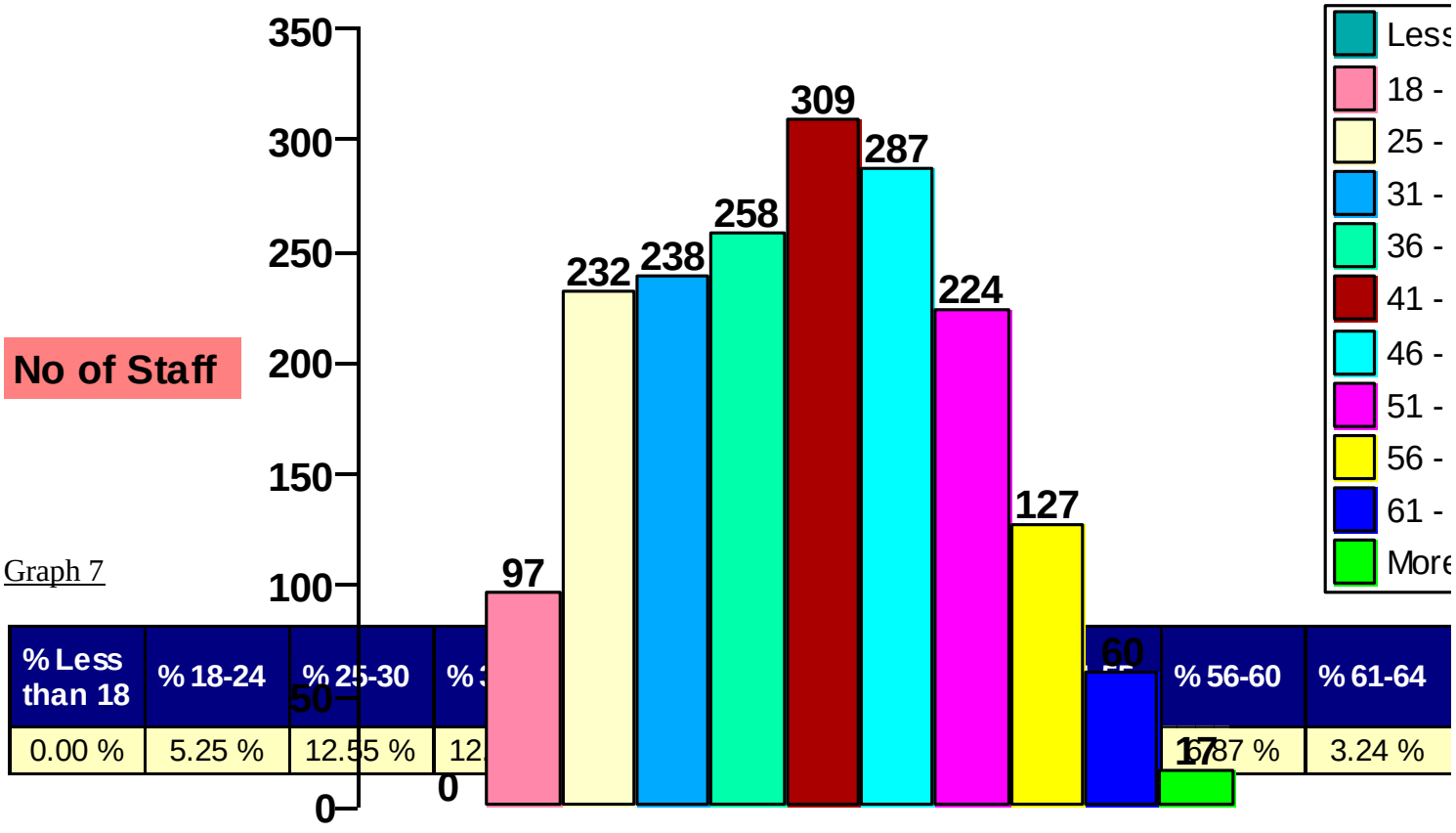
4.0 Agency Spend

Month	Monthly Spend £
*April/May '08**	212,926
June'08	164,752
July '08	176,585
August '08	241,832
September '08	334,326
October '08	211,862
November '08	146,139
December '08	206,116
January '09	206,139
February '09	245,506
March '09	173,226
Sum:	2,319,409

*figures provided from Finance are combined for April and May.
Please note funding for agency staff undertaking research is not included in the above table.

5.0 Age Profile

The age profile of the Service Group is illustrated in Graph 7 and table 5 below. The majority of staff fit in the 41-45 age range.



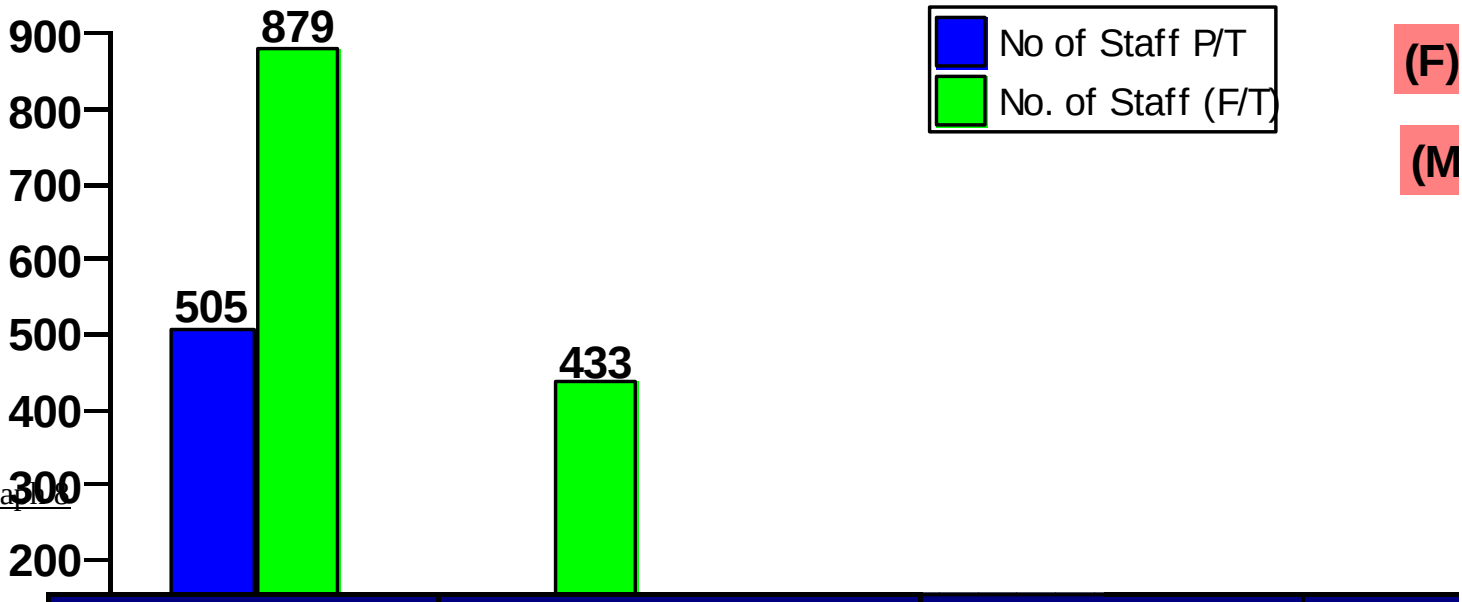
Graph 7

% Less than 18	% 18-24	% 25-30	% 31-35	% 36-40	% 41-45	% 46-50	% 51-55	% 56-60	% 61-64
0.00 %	5.25 %	12.55 %	12.					7.87 %	3.24 %

Table 5

6.0 Gender Makeup

The gender makeup of the Service Group is illustrated in Graph 8 and in Table 6 below



Graph 8

Sexcode	Full Time	Part Time	T
F	47.05 %	27.42 %	74
M	23.36 %	2.16 %	25
Sum:	70.42 %	29.58 %	10

Table

PROGRAMME TO INCREASE WORKFORCE PLANNING CAPACITY AND CAPABILITY FOR SERVICE MANAGERS

Belfast Health and Social Care Trust

WorkForce Planning & InformationTeam

TABLE OF CONTENTS

1. INTRODUCTION

1.1 Improved planning for the Healthcare Workforce is a top priority. At a regional level there is evidence from three major sources:

- The DHSSPS, 'A Healthier Future – A Twenty Year Vision for health and Wellbeing in Northern Ireland 2005 – 2025';
- Priorities for Action 2010/11
- Report by Professor John Appleby – 'Independent Review of Health and Social Care Services in Northern Ireland' August 2005.

And at a local level there is evidence from:

- Belfast Health & Social Care Trust New Directions
- Priorities for Action 2010/11
- Maximising Outcomes, Efficiencies and Resources (MORE)
- Lean
- Comprehensive Spending Review (CSR)

1.2 The DHSSPS in October 2007 commissioned 20 places on the Post graduate Certificate in Strategic Workforce Planning which was delivered by Thames Valley University in conjunction with National Workforce Projects. The latter is now known as Skills for Health. The course was successfully completed in January 2009 by four participants within the Trust. See appendix one for further details.

1.3 The course focused on an integrated six step methodology to workforce planning namely:-

Step one – define the plan

Step two – Mapping the forces for change - scenario planning

Step three – assessing demand

Step four – assessing supply

Step five – action planning

Step six – reviewing, adapting and implementing

Further detail is contained in appendix two.

1.4 Within the Belfast HSC Trust it is recognised that there is a need to establish better integration between service planning, financial planning and workforce planning in order to ensure continuing organisational fitness.

1.5 Most important of all at the point of delivering service to service users, effective workforce planning delivers:

- better quality of care – right skills, right place, right time;
- reduced risk – ensuring long term supply of staff;
- greater capacity – through optimum skill mix and productivity.

1.6 In order to increase the effectiveness of workforce planning across the organisation the HR Workforce Planning Team is developing a programme of learning and development through joint working which will run throughout 2009/10.

1.7 This draft paper sets out the proposal and recommendations for developing the skills and capacity for workforce planning across the organisation.

1.8 Evaluation of the programme will be carried out largely by the participants themselves although in order to ensure wider sharing of learning the group may wish to share the programme methodology and evaluations across the region.

2. DESCRIPTION OF THE PROGRAMME

Guiding Principle

2.1 'Workforce planning and development should be at the centre of an organisation's strategic and business planning for the future not, as too often at present, remote and disconnected from it.' (National Workforce Projects)

Definition

2.2 Workforce planning can be defined as a systemic process for identifying implementing and managing the competences and associated roles required to meet the service users' needs and the organisations' strategic goals within a set financial framework.

Key elements of the programme

2.3 The proposal addresses the needs of those involved in workforce planning and development at the following levels:

- board and senior managers responsible for strategic development;
- managers and team leaders leading operational management of workforce;
- technical staff providing data and analysis.

2.4 The proposal focuses on:

- increasing and improving capacity and capability in planning and managing the workforce within the Trust;
- developing a strategic workforce plan, particularly ensuring sustainability to support key programmes such as LEAN, MORE, and CSR;
- promoting workforce planning across the service groups through the introduction of the 'Integrated Service User Six Step Methodology Toolkit';
- improvements in data management and analysis;
- the need to address the implications of the ageing workforce and the need to make optimum use of the flexibility offered by the new NHS pension scheme;
- the management of workforce costs and skill mix.

2.5 The Trust will be able to evaluate progress by self-assessment against the workforce planning competencies developed by Skills for Health. 'The framework provides employers with a suite of competences that are necessary to carry out workforce planning to enable the delivery of safe and effective care to patients and the public. Knowing what these competences are will inform employers as to what skills and experience they need to encourage, develop and/or recruit within their organisation in order to most successfully plan the wider workforce'. *Skills for Health – UK Wide Workforce Planning Competence Framework.*

Benefits for participants

2.6 By participating in this programme the Trust will:

- develop a clear and up-to-date profile of workforce, activity and costs;
- be active in managing the existing workforce and addressing resource consequences, for example sickness absence, bank and agency usage, and costs of turnover;
- have sufficient information to plan and cost the learning and development needs of their employees so that appropriate use is made of available funding;
- be able to participate in evaluating the risk to service delivery arising from workforce supply difficulties;
- be proactive in their thinking about future workforce need so that they can create a more flexible workforce that can be reshaped over short timescales to meet the need of new models of service delivery.

Benefits for the Trust

2.7 The improved understanding of the workforce and the need to respond to service imperative will ensure a more focussed approach and more accurate information to underpin education commissioning arrangements with the DHSSPS and Higher Education partners.

2.8 Workforce planning and development will become part of normal organisational activity so that response to new service initiatives, and the modernisation agenda such as Unscheduled Care, Stroke Services and 'Maternity Matters', for example, will be timely and effective.

3. PARTNERS

3.1 The programme will be delivered by the HR Workforce Planning Team which comprises of:-

Mervyn Barkley – Co-Director Resourcing, Utilisation & Productivity

Stephanie Read – Senior HR Workforce Planning & Information Manager

Neil McDaid – HR Workforce Planning Manager

Angela Marner – Senior HR Workforce Planning Officer

3.2 The Team will make best use of available resources and develop collaborative partnerships within the Service Groups.

3.3 The Team will provide a facilitative and supportive role to each of the service groups working in the first instance with Laboratory Services, Estates Services and Human Resources with a view to setting up a Workforce Planning Subgroup in each of these areas.

3.4 The team will explore and research on-line existing workforce planning resources which can be tailored to meet the needs of the service group. For example

- the NHS Workforce Review Team produces reliable data and intelligence about the national workforce needed to deliver high quality, modern health and social care to meet change in demand;
- Skills For Health supports NHS organisations to achieve their workforce objectives and find solutions to the challenges that may prevent them from having the right people in the right healthcare roles in the future;
- The Regional Workforce Planning Network group, to share best practice, progress and future plans.

4. METHOD OF WORKING - A TAILORED APPROACH

4.1 The programme will address organisational need at the following levels:

- strategic - so that workforce planning is a key element of the Board agenda;
- operational - with managers being engaged in the process of determining the allocation and management of the workforce resource;
- technical - for those who need the appropriate skills and can access the necessary knowledge to fulfil the function.

Self Audit

4.2 Each participating service group will be able to assess its current workforce planning capacity and capability by self audit against the Skills for Health competency framework. This will highlight the gaps across the organisation and indicate the type and quantity of activity that will need to be built into the programme.

4.3 The programme will promote the use of the following:

- The "6 Steps" Workforce Planning Model developed by National Workforce Projects;
- a range of data sources such as the NHS Benchmarking Toolkit;
- integrated whole organisation workforce planning based on good practice in the region;
- the research evidence and suggested good practice provided by NHS Employers on the management of a mature workforce;
- skills expansion by local commissioning of the Post-Graduate certificate in Workforce Planning.
- workforce profiling using the Plymouth NHS Trust Workforce Profiling Toolkit.

5. OUTLINE OF PROGRAMME

5.1 The current thinking regarding the content of the programme of development is set out below.

Implementation of the Six Steps Workforce Planning Toolkit

5.2 The HR Workforce Planning Team have developed a number of one day workshops which are aimed at Service Managers who have a responsibility for Workforce Planning within their area of work. The objective of the workshop is to roll out across the whole organisation the use of the Skills for Health "6 Steps" Workforce Planning Toolkit. This requires every manager and budget holder to review and plan their future workforce over

a fixed timescale and this activity is carried up through the organisation and collated to build a workforce plan that is owned and will be driven by front line staff. Attached in Appendix three is the workshop objectives and dates.

Practical Workforce Planning Workshops

5.3 Additional workshops will be developed and delivered, tailored specifically to meet the needs of the service groups. The focus will be on the technical skills and practical requirements for introducing the '6 steps' toolkit and will link with the processes and tools developed by Skills for Health for example the NHS National Benchmarking toolkit, The workshop will focus on:

- creating the climate for improvement;
- the organisation and reporting processes required to support implementation;
- standardised planning templates and tools;
- links with service planning;
- feedback and review cycles.

6. RESOURCE IMPLICATIONS OF THE STRATEGY

6.1 Much of this strategy will be delivered through the expertise that exists within our HR Workforce Planning Team.

6.2 The elements of the plan that will require support are:

- commitment from Executive Team.
- release within Service Groups to attend Awareness Sessions and full day Workshops
- commissioning any additional Workforce Planning Certificate cohorts;
- evaluation of impact.

7. CONCLUSION

7.1 It is intended that this framework will ensure the Belfast Health and Social Care Trust is well placed to:

- improve services to patients;
- manage their human resource reliably and effectively;

- make a strong contribution to resource usage;
- support the development of a workforce able to implement the agenda for improvement outlined in the Trust's 'New Directions' document and in 'A Healthier Future – A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005 – 2025'.

8. RECOMMENDATIONS

Workforce Planning Steering Group

8.1 A Trust wide Workforce Planning Steering Group should be set up comprising of a member of each Service Group at Co-Director level or above.

8.2 The Steering Group will keep the programme under review as it progresses to ensure that it:

- Continues to meet participants' needs;
- Is amended in the light of any regional and or national developments
- Achieves the ultimate objective of collating a Workforce Plan for the Belfast Trust.

Postgraduate Certificate in Strategic Workforce Planning

8.3 Further places should be purchased on the Postgraduate Certificate in Strategic Workforce Planning and be made available to delegates from each of the Service Groups. This programme, which has been developed by National Workforce Projects, is accredited by Thames Valley University. The objectives and key features of the programme are to:

- connect and integrate the workforce planning function to service and financial planning;
- respond to the complex nature and planning required to deliver the plurality of service provision;
- move the focus away from short-term planning to medium and longer term strategic planning;
- enable consistency of approach in equipping organisations with workforce planning skills;
- raise the profile and improve perceptions of the role of workforce planning amongst planning colleagues.

Workshops on DHSPSS approach to Workforce Planning

8.4 Half day workshops should be developed in conjunction with the Department of Health to share the Department of Health's approach to workforce planning and how the outcomes of this influence education commissioning for Nursing, Midwifery and Allied Health Professions.

Appendix One:

Trust staff who have completed the Postgraduate Certificate in Strategic Workforce Planning

Name	Designation	Service Group
Mervyn Barkley	Co-Director Resourcing Utilisation & Productivity	Human Resources
Nicki Patterson	Acting Director of Nursing	Corporate Nursing
Stephanie Read	Senior HR Workforce Planning & Information Manager	Human Resources
Thomas Dempster	HR Manager Modernisation	Human Resources

Appendix Three

Title of Course: DEVELOPING YOUR WORKFORCE PLANNING SKILLS

Target Group: This course is suitable for those individuals who are responsible for drawing up a workforce plan within their area of work.

A**ims:** This course will provide managers with tools to support them in developing their short, medium and long term workforce plans.

Objectives: By the end of this course participants will be able to:

- Apply the six step workforce planning toolkit
- Develop scenario plans
- Describe and apply Lean methodology in the development of their workforce plan
- Identify the demand for and supply of staff required
- Identify methods and plans to bridge the gap
- Evaluate and review their workforce plan
- Draw up a workforce plan for the area of work

Duration: 1 day

Contact Person: Stephanie Read

Details: [redacted]

Dates & Times:

Dates	Times	Venue
24 June 2009	9.30am – 4.00pm	Betty Chambers
23 September 2009	9.30am – 4.00pm	Betty Chambers
18 November 2009	9.30am – 4.00pm	Betty Chambers
20 January 2010	9.30am – 4.00pm	Betty Chambers
24 March 2010	9.30am – 4.00pm	Betty Chambers

NURSING WORKFORCE PLANNING WORKSHOP

Programme

9.00	Introductions, Aims, Outline of session
9:15	Workforce Planning: Belfast Trust approach Introduction to six step framework
10.15	Central Nursing Workforce Planning to date (Step 1+Step 2)
11.00	Tea Break
11.15	Nursing Professional Workforce Planning demand Tools (Step 3) AUHUK, Telford
12:00	Workforce Supply (Step4)
12.30	LUNCH
1.15	Developing the action plan (Step 5)
2.15	Education
2.45	Being Person Centred & Managing Change
3.15	Tea
3.30	Implementing plan (Step 6) Performance Mgt 21st June
3.45	Attendance Management
4.15	Summary & Close

Belfast Health and Social Care Trust
caring supporting improving together

Nursing and Midwifery

Workforce Update and Action Plans

02 October 2020

Contents

Summary

The aim of the Report is to provide an update for the Executive team on the strategies adopted by the Central Nursing and Midwifery Team, led by the Executive Director of Nursing, for ensuring that sufficient numbers of suitably qualified nurses and midwives are available to provide safe, compassionate, person-centred care.

The report consists of

1) Workforce data, outlining both the funded staffing level and vacancy information by ward/team for each grade of nursing staff;
2) Backfill information (i.e. use of bank and agency) by Divisional Nurse by ward/team
   NB this information is only available for those wards/teams that are on electronic roster;
3) Divisional Nurse Workforce action plans.

It reflects the position at the end July 2020.

The workforce data and action plans have been provided by the respective Divisional Nurses and the backfill information has been generated centrally from the electronic roster. These contemporaneous reports and action plans are stored within a shared access site. They will be formally reviewed and updated each month by the Divisional Nurses and will be reported on at the bi-monthly Nursing and Midwifery Workforce Steering Group meetings.

Nursing Workforce Demand and Capacity

Demand for nurses has increased as a result of the implementation of the Delivering Care policy standards, which outlined the requirements to meet the normative nurse to bed and skill mix ratio in a range of specialties.

There is a local and national shortage of nurses and midwives. All Trusts within Northern Ireland have reported the same difficulty in recruiting sufficient staff to meet demand. The reliance on agencies (both contacted and off-contract) has increased significantly in the last 2 years, with 67% of agency expenditure in 2019/2020 related to off-contract agencies.

£m	**2018/19**	**2019/20**
Off-contract	10.0	25.9
On-contract	9.2	12.6
Totals	**19.2**	**38.5**
Off-contract %	**52%**	**67%**

The current turnover rate in nursing within BHSCT is 9.3%. This figure was 4.7% in 2017/18 and 7.17% in 2019/20. In addition to nurses, leaving post due to retirement, personal reasons, family commitments, relocation and promotion there is some evidence to suggest that BHSCT nurses are leaving substantive posts to undertake agency work with non-contracted agencies.

Nursing & Midwifery Vacancy Information

There were 1044 registrant vacancies (including 908 WTE Band 5 vacancies) and 338 WTE non-registrant vacancies in July 2020. The total number of vacancies in the nursing family is therefore 1379 WTE reflecting an 18.2% vacancy rate.

The Registrant and Non-Registrant Nurse and Midwife vacancies as reported by Divisional Nurses are tabulated below.

Divisions	Divisional Nurses	Total Funded Establishment	Reg	Un Reg	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total % Vacancy
Unscheduled Care	Olga O'Neill	1201.15	176.65	55.87	2.78	18.07	155.8	0	26.42	29.45	19.36%
Acute Care	Tara Clinton	1014.29	135.19	36.74	5.99	-18.8	148	0	-2.48	39.22	16.95%
Surgery	Geraldine Byers	753.67	77.93	23.7	15.29	23.14	39.5	0	23.7	0	13.48%
Cancer & Specialist Medicine	Lorna Bingham	283.92	32.08	1.88	0	2.12	29.96	0	0.73	1.15	11.96%
Older People's Services	Paula Forrest	294.55	28.92	11.4	0.03	4.21	24.68	0	3.97	7.43	13.69%
Community Health Nursing	Roisin McSwiggan	348.6	70.72	14.36	1.7	24.57	44.45	0	14.36	0	24.41%
Mental Health	Orla Tierney	585.99	97.2	58.13	17.03	30.35	49.82	0	58.13	0	26.51%
Children's & NISTAR	Fiona Moody	471.53	-36.71	-1.17	0.71	0.73	-38.15	-0.01	-0.22	-0.95	-8.04%
Trauma, Ortho & Rehab	Marion Mulholland	631.24	125.31	23.24	9	15.31	101	-1.16	3.78	19.46	23.35%
Children's Community	Nuala Toner	242.79	13.53	2.25	7.05	8.24	-1.76	-0.2	6.85	-4.6	6.42%
Maternity & Women's Health	Brenda Kelly	431.32	30.74	19.05	4.04	72.71	-46.01	2.12	6.05	13	12.04%
Learning Disability	Trish McKinney	305.38	45.97	79.1	2	6.7	37.27	0	79.1	0	40.96%
Total Vacancies		6564.43	797.53	324.6	65.62	187.35	544.56	0.75	220.39	104.16	17.10%

Increase in Undergraduate Nursing and Midwifery Training Places in N. Ireland

In 2019/2020, there were 1025 undergraduate training places across three Academic Education Institutions (AEIs) - Queens, Ulster and Open University. This number has increased year-on-year in the past 4 years. In March 2020, Health Minister Robin Swann confirmed a further increase of 300 undergraduate places to commence in September 2020. The total annual 1325 student places are apportioned across the adult, children's, mental health, learning disability and midwifery fields of practice as outlined below.

Programme	2019/20 Training Places	2020/21 Training Places	Additionality
Adult	660	860	200
Mental Health	130	180	50
Children's Nursing	95	115	20
Learning Disability	50	55	5
Midwifery (Direct Entry)	60	85	25
Midwifery (Short Programme)	30	30	-
Total	**1025**	**1325**	**300**

Positive experiences by nursing and midwifery students play a big role in determining employer destination of choice. BHSCT have increased practice placements to meet this increase of student numbers and to respond to the changing educational landscape with the launch of the NMC Educational Standards (NMC, 2018).

The Central Nursing Team are currently developing a proposal for a nursing apprenticeship model.

Nursing & Midwifery Recruitment

The Belfast Trust is engaged in a range of activities to enhance nursing and midwifery workforce recruitment and utilisation.

Local Recruitment

The Central Nursing and Midwifery Team (CNMT) continues to manage all recruitment activities for Adult Nursing (Bands 2, 3 and 5) and supports Divisions through the Nursing Workforce Recruitment Group. The team provides all administrative support to these recruitment exercises which has been successful in improving the pace of the recruitment process. The team:

- Administer the booking of recruitment panels and venues (partial booking) and forward all outcomes to Regional Recruitment Shared Service Centre (RRSSC).
- Inform candidates of the outcome of the interview on the day of interview and give feedback to unsuccessful candidates with encouragement to reapply.

In the 12-month period from April 2019 to March 2020 341 Band 5 nurses were recruited.
The recruitment campaign has continued throughout the Covid-19 pandemic. Virtual recruitment from the rolling Band 5 ad continues on a 4-6 weekly basis with 45 nurses recently appointed.

Despite the current challenges from Covid-19, 309 staff have been recruited since April 2020: 225 Band 5 nurses, 61 Band 3 staff and 22 Band 2 staff.

The workforce team collaborate with HR in a range of promotional activities linked with recruitment. The most recent initiative was the virtual recruitment exercise for Trauma, Orthopaedics and Rehabilitation using an extensive social media platform. The outcomes for this event are tabulated below.

Number of Registrations	109
Number who viewed YouTube video	82
Number who logged in to live event	30
Number who applied for posts	23
Number recruited (successful candidates)	11

International Recruitment

We are engaged in the Regional International Nurse Recruitment and this campaign has now restarted following the Covid-19 pandemic. BHSCT currently accepts 16 International Nurses per month and supports them through OSCEs. There has been a 100% pass rate to date. We are exploring strategies to increase both the number of nurses and their placement ward/department to address shortfalls in areas such as the perioperative environment. There are 500 international nurses currently ready to come to the UK and we plan to facilitate 250-300 within the Trust in the next 12 months.

Priorities for Recruitment

It is essential that there is a collaborative approach to the management of vacancies across the Trust. As a central nursing team we work to ensure that recruitment is in line with strategic priority

on a local level (for example the development of a new maternity hospital) and on a regional level (for example Health & Wellbeing 2026: Delivering Together). Cognisance is also taken of the increasing age of the nursing and midwifery population within specific fields of practice.

Moving forward there will be renewed vigour in targeting particular areas for recruitment. The Divisional Nurses have highlighted their priority areas for recruitment and these are listed below:

First Priority	Perioperative Department Respiratory Wards (RVH) Inpatient Learning Disability Urology Haematology Fractures Dementia Inpatient District Nursing Health Visiting Older People's Nursing
Second Priority	Critical Care Medical Specialties EMSU

A promotional campaign is planned that will showcase the exceptional work of the nursing and midwifery teams within BHSCT and there will be specific focus on the priority areas for recruitment. This campaign will be taken forward in collaboration with the HR team and follows the success of the recent virtual TOR recruitment exercise.

Developing Nursing Roles

The Central Nursing Workforce Team recognises the importance of innovating roles and functions in meeting health care's growing demand and supports the development of specialist and advanced nursing practice roles. Nurses in these roles use additional skills and knowledge to inform and further develop their practice.

The Central Nursing Team have participated in regional development of competency frameworks for Specialist Nurses, Advanced Nurse Practitioners (ANPs) and Consultant Nurses.

ANPs work at an advanced level using critical thinking, reflection and analysis to inform assessments, clinical judgement, complex reasoning and decisions. There are currently 9.52 WTE ANP posts within BHSCT and a further 16 WTE undergoing training.

	Paed ED	Paed Surgery	Paed Medicine	PICU/ NISTAR	Older People's	ED	Mental Health	Neonatal	Haematology	Acute Care at Home
Substantive Post	1	1	1	1	-	4.52	-	-	1	-
Trainee Post	2	-	1	2	2	3	4	1	-	1

Business Continuity

The Central Nursing Workforce Team adapt their team's services to support changes in the way patient care is delivered. As ward profiles change, the team work with respective Divisional Nurses to agree safe staffing levels and new ward rosters are uploaded.

Acuity/Dependency exercises are undertaken to analyse staffing levels and support the Divisional Nurses in triangulating staffing information.

The response from the Central Nursing Workforce Team to Covid-19 preparedness and planning has been analysed and reported and outlines the contribution that the Central Nursing Team made to the management of the pandemic.

The Central Nurse Bank extends operating hours to match demand, for example during winter pressures and this has continued since March 2020.

Central Nurse Bank

There has been a year-on-year increase in relation to the temporary nursing workforce requirement and backfill. In this report, expenditure for the period April-July 2020 is compared with the same period the previous year. This information is presented by Division and as a WTE figure in the respective sections of the report.

We are exploring the expansion of the nurse bank and the investment proposal will be tabled at Executive Team in October. We have extended hours of operation to ensure support for our colleagues in service who are managing the bed and patient flow pressures. There is a renewed focus on professional and educational support for our valuable bank nurse resource in relation to supervision, revalidation and appraisal and the outcomes of this project are being measured.

Roster Management

Maximising the resources that we have and using our data to its full potential is a priority for us as an organisation to inform improvement. The electronic roster system supports both these processes.

A number of workforce KPIs have been agreed and these will form part of a nursing workforce performance framework and will be reviewed at the bi-monthly Senior Nursing and Midwifery Workforce Steering Group (commencing November 2020).

The KPIs for roster management are

- Roster Approval Lead Time
- Additional duties hours and reasons for booking over funded establishment
- Planned vs Delivered Hours per Unit variance
- Percentage of actual clinical unavailability versus percentage of budgeted unavailability (Headroom)

Maximising the use of roster and adhering to the KPIs is predicted to have a positive impact on the use of the temporary nursing workforce.

In October 2020, the roster will move to a cloud-based system. It is expected (based on data from other Trusts where the system is currently in use) that the application that enables nurses to book shifts remotely using their smartphone will have a very positive impact on the uptake of shifts.

The Trust received limited assurance in the Internal Audit on Roster Governance (review period August 2019). A robust action plan to address the issues highlighted within the audit has been implemented and includes the aforementioned performance framework.

Conclusion

The central nursing workforce team works collaboratively and inter-professionally with colleagues to innovate and modernise, to reduce unnecessary costs and to build resilience and confidence. By using improvement methodologies and a collective leadership strategy, the team influences improvement in patient care.

In the year ahead the central nursing workforce team will collaborate with Trust colleagues (and in particular the Divisional Nurses) in the following activities that will form part of the Trust's Nursing Workforce Plan for 20/21:

1) **Targeted Recruitment Campaign for areas with greatest vacancies.**
   This approach has been agreed with the Divisional Nurses. We will tap into the particular expertise of HR colleagues in relation to branding and marketing to ensure success.
2) **Increase in the number of International Nurses recruited.**
   In 2020/21, INRs will be recruited for areas such as the perioperative environment. These areas were previously unable to avail of this talent pool, as the environment did not meet OSCE training requirements. We will support INRs to complete their OSCEs in ward-based areas and upon completion the nurses will transfer to theatre environments.
3) **Continued rollout of the Delivering Care programme.**
   The Delivering Care programme aims to support the provision of high quality care, which is safe and effective, in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialties. Our team will participate in all aspects of this initiative.
4) **Expansion of the Central Trust Bank**
   Integral to the delivery of safe, effective and compassionate care to our patients and clients is our workforce. In this regard, it is vitally important for the Trust to be able to place staff with the right skills and competencies in the right place at the right time. Moreover the Trust bank plays an instrumental role in ensuring that the professional registration and revalidation requirements associated with specific occupation groups are fulfilled and maintained accordingly. Increased focus on promoting the Trust bank as an attractive option for staff will reduce the dependence on non-contracted agencies. Expansion of the current nurse bank will enable rollout to other clinical and non-clinical areas and teams as appropriate
5) **Effective rostering**
   Launch of the Cloud-based e-roster system with remote booking app: it is expected (based on data form other Trusts where the system is currently in use) that the application that enables nurses to book shifts remotely using their smartphone will have a very positive impact on the uptake of shifts.
6) **Exploring the apprenticeship model for nursing.**
   Building on the success of the Open University programme the apprenticeship model will be explored further. Recruitment of Senior Nursing Assistants specifically to undertake the programme will be required and these students will be supported in-house to meet all training requirements.

7) **Supporting the modernisation agenda.**
   The team engage in reviews of services such as the Modernisation of Outpatient Service and the Perioperative workforce and identify opportunities for role development. The Central Nursing Workforce Team recognises the importance of innovating roles and functions in meeting healthcare's growing demand. There has been an increase in the number of trainee Advanced Nurse Practitioners supported to undertake the training programme in 2020/21.

Specific actions in relation to all of these plans are outlined in the following Central Nursing Workforce Action Plan.

Central Nursing Workforce Team Action Plan 2020-21

Ref No	Issues	Actions	Date for Completion Timescale	To be actioned by	Status at Sept 2020
	Current nursing vacancy rate is 18.2 % (n=1379). There are 908 Band 5 nursing vacancies and 338 non-registrant vacancies.	Ensure the number of candidates on active waiting lists exceeds the number of requisitions by 20%	**Oct 2020**	**SD**	
		Reduce the registrant vacancies by 20% by March 2021	**March 2021**	**SD/AP**	
		Total non-registrant vacancies to be reduced from 338 to <30 by Dec 2020	**Dec 2020**	**SD/AP**	
		Complete validation exercise of the BSO fortnightly vacancy report to ensure the info on vacancy numbers is in line with the central workforce info.	**Oct 2020**	**SD**	
		Collaborate with HR and BSO colleagues to expedite recruitment from waiting list into vacant posts.	**Oct 2020**	**SD**	
	There are 500 International Nurses ready to come to N Ireland. Previous restrictions on numbers for BHSCT do not apply.	Outline proposal to increase the number of INRs arriving each month from 10/12 to 24	**Sept 2020**	**SD**	
		Invest in additional resources to support the increased numbers	**Oct 2020**	**PF**	
		Recruit and support 200 INRs to become registrants within BHSCT by end March 2021	**March 2021**	**SD/AP/ Div. Nurses**	
	Complete the deployment of the Band 4 Transitional Students	Ensure effective deployment process through all elements of the process map	**Sept 2020**	**SD**	
		Communicate with those transitional students who did not engage in the process and encourage application to Band 5 registrant posts within BHSCT	**Sept 2020**	**SD**	
		Evaluate success of the strategy	**Sept 2020**	**SD**	
	The current talent pool does not meet the demand for nursing staff within BHSCT	Develop a proposal for a nursing apprenticeship model	**Dec 2020**	**SD/ PF**	

	The current roster product has become obsolete and will be replaced in Oct 2020 by a cloud-based system	Ensure safe and effective implementation of the new electronic roster system	**Oct 2020**	**PD**	
		Develop promotional campaign for launch of new system.	**Oct 2020**	**PD**	
		Rollout of Training Plan for staff who will be using the new system.	**Oct 2020**	**PD**	
		Maximise the efficiencies enabled by the end-user remote access application	**Dec 2020**	**PD**	
		Complete evaluation at end of first year	**Oct 2021**	**PD**	
	There is a requirement for all wards and departments to maximise the staffing resource we have available to us	Ensure that all functions of the electronic roster system are being effectively utilised through the implementation of a performance framework	**Sept 2020**	**PD/AP/Div. Nurses**	
		Identify 5 Key Performance Indicators for Workforce • Roster Approval Lead Time • Additional duties hours and reasons for booking over funded establishment • Planned Vs Delivered Hours (Net Hours) per Unit • Percentage of actual clinical unavailability versus percentage of budgeted unavailability (Headroom) • Bank and agency fill rate	**Sept 2020**	**PD**	
		Collect and report on baseline data	**Sept 2020**	**PD**	
		Bi-monthly Reporting Schedule to commence November 2020	**Nov 2020**	**PD**	
	The Internal Audit on Roster Governance (August 2019) received limited assurance	Develop an action plan to address all issues highlighted during the audit process	**Feb 2020**	**PD/AP**	
		Agree an implementation plan to address all issue	**May 2020**	**PD/AP**	
		Compile an evidence file for the audit team	**May 2020**	**PD**	
		Engage in communication process with the audit team	**May 2020**	**PD**	
		Meet with audit team for formal review of implementation plan	**Sept 2020**	**PD/AP**	
		Secure full assurance	**Oct 2020**	**PD/AP/Div. Nurses**	

	The register of bank-only staff is out-of-date	The register of bank-only staff will be validated to ensure that it reflects the list of staff who are available to work within BHSCT	**Sept 2020**	**MK/SD**	
	Investment in the bank-only staff is required to ensure that they feel that feel that they are a valued member of the Trust team	All bank-only staff will have an annual appraisal and a review of their training requirements.	**Dec 2020**	**MK/SD**	
		Professional requirements for all registrant bank-only staff will be met through twice-yearly supervision and professional revalidation every 3 years	**Dec 2020**	**MK/SD**	
		Identified peer vaccinators will provide flu vaccination for bank staff within the bank office	**Oct 2020**	**MK/SD**	
	The core operational hours of the central nurse bank do not meet the needs of service	Continue to have increased hours of operation as follows: Monday-Friday the bank office will operate from 0900 until 1900 and on Saturday and Sunday morning it will operate from 0900 until 1400.	**Ongoing**	**MK**	
	The central nurse bank and roster service is vulnerable because the substantive staff: agency staff ratio is disproportionately low	Articulate as a cost pressure the staff by grades and associated WTEs that have been historically recharged to Directorates each month	**Sept 2020**	**AP**	
		Commence substantive recruitment to these positions.	**Oct 2020**	**SD/AP**	
	Investment in the central nurse bank and roster services is required to enable expansion and development	Rework the business case to ensure that it reflects current Trust requirements	**Sept 2020**	**AP/SD/MK/PD**	
		Resubmit to Executive Team as an Investment Proposal	**Oct 2020**	**AP/PF**	
	Provision of support for Divisional Nurses in relation to nursing workforce issues	Weekly meetings to provide workforce support to Divisional Nurses. The agenda will include workforce methodology, roster compliance and action plans.	**Sept 2020**	**AP**	
		Promote the work of the workforce team as part of the Central Nursing Team through completion of the Page Tiger	**Sept 2020**	**AP/SD**	

	There must be workforce business continuity plans in place	Review and report on the Central Nursing Workforce Team's preparedness for and response to Covid-19 pandemic	**Sept 2020**	**SD/PF**	
	Assurance that resources are being effectively utilised is required given the £14m overspend on nursing in the year 2019/2020	Implementation of KPI reporting on a bi-monthly basis.	**Nov 2020**	**AP/Div. Nurses**	
		Completion of mid-year and end-year Delivering Care Monitoring Returns	**Ongoing**	**AP/Div. Nurses**	
		Ensure that workforce reports and action plans by Divisional Nurses are updated on a bi-monthly basis.	**Sept 2020**	**AP/Div. Nurses**	
		Provide data that is accurate, timely and specific e.g. recruitment reports, workforce KPI reports, backfill reports.	**Sept 2020**	**AP/SD/PD/MK**	
		Meet the objectives of the taskforce on roster governance.	**Dec 2020**	**AP/PD/Div. Nurses**	

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Overall Position

Divisions	Divisional Nurses	Total Funded Establishment	Reg	Un Reg	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total % Vacancy
Unscheduled Care	Olga O'Neill	1201.15	176.65	55.87	2.78	18.07	155.8	0	26.42	29.45	19.36%
Acute Care	Tara Clinton	1014.29	135.19	36.74	5.99	-18.8	148	0	-2.48	39.22	16.95%
Surgery	Geraldine Byers	753.67	77.93	23.7	15.29	23.14	39.5	0	23.7	0	13.48%
Cancer & Specialist Medicine	Lorna Bingham	283.92	32.08	1.88	0	2.12	29.96	0	0.73	1.15	11.96%
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Maternity & Women's Health	Brenda Kelly	431.32	30.74	19.05	4.04	72.71	-46.01	2.12	6.05	13	12.04%
Learning Disability	Trish McKinney	305.38	45.97	79.1	2	6.7	37.27	0	79.1	0	40.96%
Total Vacancies		6564.43	797.53	324.6	65.62	187.35	544.56	0.75	220.39	104.16	17.10%

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Unscheduled Care Workforce Information

Ward				Funded Establishment						Staff in Post					Variance					Telfords Updated Date	Total Vacancy %	Sickness %	Mat Leave %	COMMENTS
	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band2	Band 7	Band 6	Band 5	Band 3	Band 2					
Mater																								
ED				64.25	2	9.4	41.95	10.9	0	1.8	10.44	25.8	6.5	0.56	0.2	-1.04	16.15	4.4	-0.56		29.81	3.80%	3.90%	
Ward A	1.46	33	16	50.48	1	6	29.64	8.28	5.56	1	2.6	18.41	6.12	4	0	3.4	11.23	2.16	1.56	31/04/2020	36.35	10.10%	2.20%	
Ward B	1.35	35	16	47.5	1	4	28.49	8.45	5.56	1	3.8	25.43	8.69	3.6	0	0.2	3.06	-0.24	1.96	31/04/2020	10.48	7.40%	7.00%	
Ward C	1.35	18	18	27.92	1	3	13.4	6.86	3.26	0.87	2.87	10.52	6.71	4.5	0.13	0.13	2.88	0.15	-1.24	31/04/2020	7.34	3.40%	5.60%	
Ward D	1.35	30	16	38.74	1	5	19.85	9.89	3	1	5.09	15.54	9	1.68	0	-0.09	4.31	0.89	1.32	31/04/2020	16.60	13.00%	8.00%	
Ward E/SSU/CAU	1.35	21	16	47.84	1	6	23.52	12	5.32	1	5.8	10.6	12.8	3	0	0.2	12.92	-0.8	2.32	31/04/2020	30.60	13.20%	0.00%	
RVH																								
ED				141.09	8.45	16.67	75	36.22	4.75	8.91	13.22	87.72	25.44	0	-0.46	3.45	-12.72	10.78	4.75	29/05/2020	4.11	8.20%	3.40%	
Ward 2F CAU		12	10	51.53	2.48	8.1	21.76	19.19	0	1	6.29	16.58	11.4	0	1.48	1.81	5.18	7.79	0		31.55	6.60%	0.60%	
ACC				40.19	1	6	17.39	15.8	0	1	6	16.39	14.39	0	0	0	1	1.41	0		6.00	10.00%	6.90%	
Ward 5B	1.53	36	14	24.61	1.62	1.41	14.78	3.4	3.4	1.69	1	7.35	5.29	0.8	-0.07	0.41	7.43	-1.89	2.6	05/06/2020	34.46	12.30%	0.00%	
Cath Labs				43.91	6	22.03	12.33	1	2.55	4.5	17.82	10.08	1	2	1.5	4.21	2.25	0	0.55		19.38	4.60%	11.60%	
Ward 5C	1.17	24	24	33.97	1	1	22.07	6.06	3.84	2	2.44	19.48	6.6	3.24	-1	-1.44	2.59	-0.54	0.6	05/06/2020	0.62	6.20%	5.80%	
Ward 5D	2.43	20	20	48.49	1	3	33.95	6.47	4.07	1	2.99	26.06	5.27	1.12	0	0.01	7.89	1.2	2.95	05/06/2020	24.85	4.40%	6.20%	
Ward 5E	1.47	27	27	41.78	1	4	23.85	11.11	2.89	1	4	10.8	11.48	0	0	0	13.05	-0.37	2.89	05/06/2020	37.27	15.20%	6.40%	1 new start Aug
Ward 5F	1.47	27	27	41.78	1	4	22.78	11.11	2.89	1	3.64	15.92	8.91	2	0	0.36	6.86	2.2	0.89	05/06/2020	24.68	8.60%	4.80%	
Ward 6D	1.34	24	24	33.85	2	19.88	27.01	8.5	7.7	2	18	23.4	9.1	6	0	1.88	3.61	-0.6	1.7	05/06/2020	19.47	7.70%	0.00%	2 new starts Sept
Ward 6E/F		31+4	31+4	58.83	1	3	16.67	5.56	5.06	1	2.8	7.42	5.23	4.9	0	0.2	9.25	0.33	0.16	30/07/2020	16.90	7.30%	6.80%	
Ward 7A	1.46	18	18	31.29	1	3	16.67	5.56	5.06	1	2.8	7.42	5.23	4.9	0	0.2	9.25	0.33	0.16	30/07/2020	31.77	18.80%	4.20%	
Ward 7B	1.46	26	26	42.75	1	5.79	23.15	4.86	7.95	1	4.75	16.38	6.88	5.59	0	1.04	6.77	-2.02	2.36	30/07/2020	19.06	4.20%	7.60%	
Ward 7C	1.46	26	26	42.75	1	5.79	23.15	4.86	7.95	1	5	13.94	9.19	5.01	0	0.79	9.21	-4.33	2.94	30/07/2020	20.14	14.10%	0.00%	
Ward 7D	1.46	26	26	35.66	1	3	20.48	5.79	5.39	1	2	12.11	5.08	6.28	0	1	8.37	0.71	-0.89	30/07/2020	25.77	13.90%	0.00%	
BCH																								
8 North	1.35	21		29.81	1	3	18.52	2.89	4.4	1	2.7	11.2	2	2.98	0	0.3	7.32	0.89	1.42	30/03/2020	33.31	9.40%	9.60%	
8 South	1.35	23	23	31.47	1	3	19.72	3.12	4.63	1	3	11.81	3.12	4.81	0	0	7.91	0	-0.18	30/03/2020	24.56	15.00%	0.00%	
9 North	1.35	20	0	29.68	1	2	19.22	5.39	2.07	1	2	17.16	5.23	3.56	0	0	2.06	0.16	-1.49	30/03/2020	2.46	36.60%	9.20%	
7 North		25	closed	34.74	1	3	17.4	7.7	5.64	1	2.9	16.4	7.87	4.8	0	0.1	1	-0.17	-1.3		-1.07	12.30%	3.50%	
7 South		25	closed	35.37	1	3	16.7	8.67	6	1	3	12.37	9	5.26	0	0	4.33	-0.33	-0.33		10.38	16.90%	3.20%	
6 South		25	closed	34.62	1	3	16.5	8.76	5.36	1	2	15.5	5.65	5.12	0	1	1	3.11	3.11		23.74			
BCH Direct			closed	16.25	2	2.6	5.65	6	0	1	2.65	4	4.8	0	1	-0.05	1.65	1.2	1.2		30.77	0.00%	75.00%	
Specialist Nursing																								
Cystic Fibrosis																								
Respiratory																								
Totals				1201.15	45.55	159.67	641.6	244.4	114.3	42.77	141.6	485.79	217.98	85.71	2.78	18.07	155.81	26.42	29.45		571.36			

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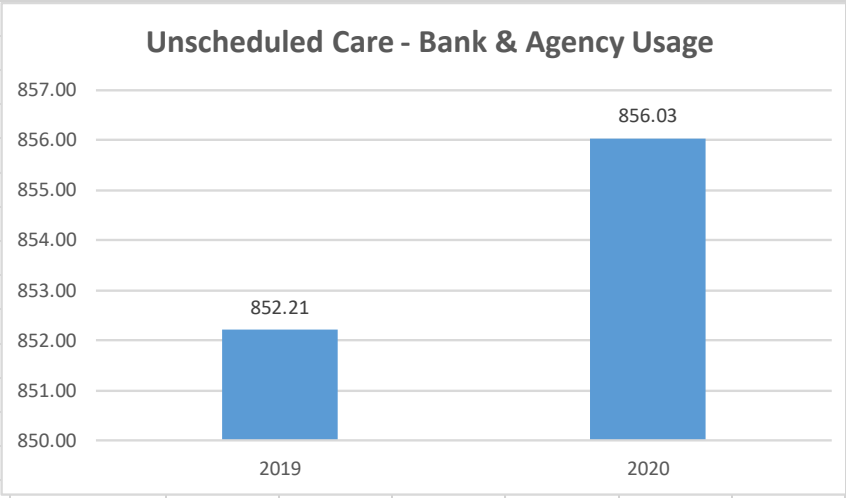
Unit	Unscheduled Care - Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
BCH 8 North	0	0	0	0	8.39	4.09	0.43	1.03
BCH 8 South	15.44	14.76	14.47	15.83	4.73	2.64	3.91	5.28
BCH 9 North	0	1.84	2.65	3.57	0	0	0	0
BCH Hospital at Night	2.78	3.21	2.34	2.68	2.03	1.48	1.89	1.16
BCH Patient Flow	0	0	0	0.09	0.51	0	0	0
BCH Phlebotomy	0.2	0.2	0.28	0.72	0.12	0.28	0.28	0.16
Cath Labs	0.08	0	0	0	0	0	0	0
Head Injury Liaison Service	0	0	0	0	0	0	0	0
MIH CCU	10.81	9.05	12.54	14.5	12.2	9.01	7.72	8.71
MIH ED	1.74	2.1	2.18	2.3	3.67	4.19	1.78	1.92
MIH ED ENP	0	0	0	0	0	0	0	0
MIH Patient Flow	0.34	0.16	0.16	0	0.16	0	0	0
MIH Ward B	10.81	8.54	8.41	9.5	12.63	9.45	5.79	5.11
MIH Ward D	18.13	19.89	19.04	19.25	19.48	23.11	15	20.51
MIH Ward E	8.41	9.48	9.79	11.02	16.35	16.78	16.16	17.81
MIH Ward F	3.04	3.06	3.7	6.24	4.9	9.22	6.65	4.94
Musgrave Custody	1.54	1.28	1.23	1.21	1.23	0.48	0.86	1.35
RVH CAU	7.21	10.05	9.68	11.57	9.87	5.66	6.24	4.68
RVH CPN's	0	0.2	0.48	0.24	0	0	0	0
RVH ED	15.93	16.03	13.24	17.49	9.05	8.2	15	17.66
RVH ED ACP's	0	0	0	0.13	0.27	0.13	0.13	0.07
RVH ED ENP's	0	0	0	0	0	0	0	0
RVH Patient Flow	0.14	0	0.23	0.22	0.5	0.8	0.32	0.64
RVH Phlebotomy	0.27	0.6	0.6	0.53	1.49	0.73	0.87	0.27
RVH Substance Misuse Nurses	0	0	0	0	0	0	0	0
RVH Ward 5B	7.12	7.95	7.23	6.23	3	3.38	5.08	4.29
RVH Ward 5C	0	2.4	3	1.31	0.53	0.38	1.45	2.25
RVH Ward 5D	0	0	3.13	2.34	2.37	2.33	5.11	5.18
RVH Ward 5E	10.49	15.96	16.86	15.67	23.06	25.09	22.96	28.31
RVH Ward 5F	17.57	18.3	18.22	14.41	18.92	15.69	17.43	19.23
RVH Ward 6D	10.61	8.79	12.03	10.17	14.96	16.73	14.89	13.2
RVH Ward 7A	10.5	8.12	9.22	8.9	8.98	7.66	10.29	8.91
RVH Ward 7B	15.24	15.56	16.26	16.82	17.34	13.96	16.15	16.51
RVH Ward 7C	11.94	19.54	21.64	21.44	19.77	15.27	14.58	15.59
RVH Ward 7D	12.65	12.05	14.2	12.91	12.77	10.55	11.65	12.07
Totals	**192.99**	**209.12**	**222.81**	**227.3**	**229.28**	**207.29**	**202.62**	**216.8**

Overall total	2019	2020
	852.21	**856.03**



	Action	Date for completion timescale	Status at 31 July 2020
Medical Specialties: MIH **FSL =** 134.08 **Vacancies** Band 6 x 0.40 WTE Band 5 X23.49 WTE Band 3X 0.85 WTE Band 2X 4.60 WTE Ward B = 10.48% Ward D = 19.44% Ward E = 30.6% **Specific areas of focus:** Nursing recruitment and retention is a priority for CAU/SSU, Respiratory and General Medicine. There are a total of 23.49 registered nurse vacancies, in addition to this there are: - Maternity leave Band 5 X 3.0 - Maternity leave Band 2/3 X 3.0 - Sickness Band 5/6 X4.0 - Sickness Band 2/3 X 4.0 This has impacted on core staff availability and therefore has resulted in use of bank and agency spend.	• Develop the Clinical Education Nurse role across MIH site • Develop an on-site fully equipped clinical education suite with simulation training. • Continue upskilling programme to support COVID/escalation	**October 2020**	
	Focus on reducing high cost agency spend by maximising own staff availability: • Offering increased hours • Offering overtime • Encouraging flexible working patterns • Cross site support (reviewing rotas on all wards and ensuring equity of cover with core staff) • Daily visible presence of lead nurses • Strict adherence to protocol for seeking off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
	• Review of E-roster involving Divisional Nurse, ward team, finance and central nursing workforce team to maximise effective use of staff and to retain senior staff. - Review Telford and Nurse to bed ratio for all wards taking into consideration side rooms - Training for newly appointed sisters/charge nurses and deputies. • Review impact of COVID on spend – realigning rosters and nurse to bed ratio to pre COVID state	**August 2020**	
	• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position within Mater site rotation programme when they graduate. • Transition students commencing permanent positions: - 1 Ward D - 1 Ward E	**September 2020**	

	• Recruitment drive: complete video blogs and bios to show the breath and diversity of the medical wards on the MIH site.	**September 2020**	
	• Open University Student Nurse training program for Senior Nursing Assistants: - 3 commencing year 1 - 2 year 2 - 2 year 3	**Ongoing**	
	• Resume the Mater site rotation programme and aim to scale and spread across other sites within 12 months. Ensure robust mentoring for new starts, ensuring they are well supported to carry out their role and will want to remain within our service area.	**October 2020**	
	• Monthly assurance meetings with the Divisional Nurse includes analysis of each Wards FSL Vs SIP, Bank and Agency spend, succession plans for replacement posts, service developments which impact on nursing workforce and proposals to develop new nursing roles.	**Ongoing**	
Respiratory: RVH BCH **Total vacancies: 50.88 WTE** **Specific areas of focus,** Ward 5E registered nurse vacancies = 45% 5F registered nurse vacancies = 39%	• Preparation of senior staff to participate in a virtual BHSCT recruitment exercise/jobs fair with a specific focus on respiratory nursing.	**October 2020**	
	• Appropriate use of overtime, extra hours, bank then agency. Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
	• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position within medical specialties. - 2 transition students = 5E, 5F - 1 international student = 5E	**Ongoing**	
	• Management of staffing across respiratory as a specialty: • Robust induction and training programme supported by Clinical nurse educator and Nursing Development Lead • Evaluate the impact and outcomes of cross-site cover (exploring opportunities as a result of staff displaced due to COVID) • Develop a rotational programme for respiratory nursing	**September 2020**	
	• Upskilling of all band 5/6 nursing staff to care for the acutely ill respiratory patient at ward level (airvo, NIV, CPAP, palliative care): • Bespoke education and training programme developed and supported by Nursing Development Lead, Clinical Nurse educator and specialist nursing teams	**Ongoing**	

	• Scope the development of progressive care beds and inclusion of this within a rotation programme.	**Ongoing**	
	• Escalation of nurse vacancies to workforce planning central nursing for active recruitment. • Create video blogs and bios to show the breadth and diversity of the respiratory specialties across the sites.	**September 2020**	
	• Ward staffing risk assessed monthly and risk register updated accordingly	**Monthly**	
Medical Specialties: RVH + BCH ➢ **Total vacancies:** **Specific areas of focus:** 7A registered nurse vacancies = 42% 7C registered nurse vacancies = 51% 7D registered nurse vacancies = 38%	• Escalation of nurse vacancies to workforce planning central nursing for active recruitment. • Create video blogs and bios to show the breadth and diversity of the respiratory specialties across the sites.	**September 2020**	
	• Promote a positive student nurse placement: - 2 transition student taking up posts in 6D	**Ongoing**	
	• Ward staffing risk assessed monthly and risk register updated accordingly	**Monthly**	
	• Band 6 workshops: building confidence in senior nurse role • Preparation of senior staff to participate in virtual BHSCT recruitment fair with medical specialties focus	**October 2020**	
	• Appointment of Clinical Nurse Educator.	**October 2020**	
	• Upskilling of all band 5/6 nursing staff to care for the acutely ill respiratory patient at ward level (care/insertion of PICC, TPN, care of patients on diabetic foot pathway, palliative care): • Bespoke education and training programme developed and supported by Nursing Development Lead, Clinical Nurse educator and specialist nursing teams	**December 2020**	
	• Promote medical specialties with students on placement.	**Ongoing**	
	• Appropriate use of overtime, extra hours, band then agency. Adherence to protocol for escalation to off contract agencies.	**Ongoing**	
Patient Flow: **FSL = 25.04 WTE** ➢ **Total vacancies** MIH = 1.0 B7 WTE **Areas of focus:**	• Recruitment via EOI withdrawn and looking at new ways of working • Impact of Covid on BCH activity may provide an interim option to ensure cover across all sites.	**August 2020**	
	• Cross site rotation of all patient flow team	**September 2020**	
	• FSL under review to ensure sustainable service provision. • Monthly meetings with Divisional accountant. • Using additional hours & bank staff in the first instance as opposed to overtime	**September 2020**	

Cross-site cover to ensure equity of service provision. Maternity leave x 2 WTE, sickness x 1.0 + trade union 0.4 WTE leave impacting on ability to adequately cover service without use of additional hours, overtime and bank.	• Monthly staff assurance meetings with Divisional Nurse and Service Manager: • Review of incidents • Review of staff in post • Review of bank, overtime spend • Staff in post-24.59	**Monthly**	
➢ **Phlebotomy** No vacancies **Area of focus:** Reviewing service availability and cross site working.	• MIH phlebotomy staff to be put onto E Rostering • MIH phlebotomy staff awarded a Band 3 and awaiting payment	**December 2020**	
	➢ Currently BCH Phlebotomy are helping RVH as wards have moved onto RVH site No vacancies	**Ongoing**	
	• RVH phlebotomy are looking at a change project of reducing the working day to provide an extended cover. • BCH phlebotomy staff x 2 are covering in RVH due to increased activity	**Ongoing**	
Cardiology: **MIH- Ward A CCU** **BCH- 9N CCU** **RVH- 5B, 5C, 5D, Cath Labs** FSL= 160.17 **Total vacancies:** Band 6 x 5.59 WTE Band 5 x 32.9 WTE Band 3 x 0 WTE Band 2 x 12.14 WTE **Vacancies per ward:** 5B = 34.46% 5C = 0.62% 5D = 29.72% Cath labs = 19.38% Ward A CCU = 36.35% **In addition to vacancies:**	• Enhance the knowledge, skills and competency based upskilling cardiology programme • Continue ILS and ALS skills training to support crash team on each site	**October 2020**	

	• Focus on reducing high cost agency spend by maximising own staff availability:
	  • Offering increased hours
	  • Offering overtime
	  • Encouraging flexible working patterns
	  • Cross site support (reviewing rotas on all wards and ensuring equity of cover with core staff)
	  • Continue Daily visible presence of lead nurses
	  • Strict adherence to protocol for seeking off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.
	  • Band 2 funding under review, aiming to reallocate to Band 3 and then recruit to these positions.
		Ongoing	

	• Review of E-roster involving Divisional Nurse, ward team, finance and central nursing workforce team to maximise effective use of staff and to retain senior staff. - Specific focus on KPIs: roster management	**Monthly**	

Maternity leave Band 5 x 9.0 Maternity leave Band 2/3 x 3 Sickness Band 5/6 x 9.0 Sickness Band 2/3 x 1.8 This has affected core staff availability and therefore has resulted in use of bank and agency spend. **Specific areas of focus:** Nursing recruitment and retention is a priority, predominantly in the MIH site. Review of cardiology services on MIH.	• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position within cardiology.	**Ongoing**	
	• Transition students taking up permanent positions: - 1 5B - 4 5C - 2 5D	**September 2020**	
	• Open University pathway for Senior Nursing Assistants facilitated and ongoing - 3 commencing year 1 - 2 year 2 - 2 year 3	**Ongoing**	
	Emergency Department + Emergency Care Village: RVH ➢ **Total vacancies:** ➢ **Specific areas of focus: New model of care – Urgent Treatment centre and the nursing model required to support this.** Continue RVH staff rotation across level 5C and 5D	• Resume the Mater site rotation programme and consider cross-site working within cardiology specialty. • Ensure robust mentoring for new starts, ensuring they are well supported to carry out their role and will want to remain within our	

		service area. **October 2020**	
	• Monthly assurance meetings with the Divisional Nurse includes analysis of each Wards FSL Vs SIP, Bank and Agency spend, succession plans for replacement posts, service developments which impact on nursing workforce and proposals to develop new nursing roles.	**Monthly**	
Emergency Department RVH ➢ **Total vacancies (4.11%):** Nurse Consultant: 8B x 1 WTE Lead Nurse: 8A x 1 WTE Band 7 x 2.14 WTE *(currently being covered by acting posts)* Band 6 x 11.15 WTE *(currently being covered by acting posts)* Band 5 x 0 Band 3 x 0 *(requires clarification)* **Specific areas of focus:** New model of care – Urgent Treatment centre and the nursing model required to support this.	➢ Recruitment of Emergency Nurse Consultant and Lead Nurse to strengthen clinical practice, leadership, research and development within the Emergency Care service.	**December 2020**	
	➢ Senior Nurse Recruitment (Band 6 & 7) there are a large number of nurses in acting posts due to vacancies and the uplifting band 5 posts (band 6 development programme) recruitment to substantive posts a priority to stabilise workforce.	**November 2020**	
	➢ Band 7 Development programme in order to strengthen clinical leadership, staff development and support.	**September 2020**	
	➢ To define model and nursing requirement for ED, Urgent treatment Centre and Emergency Care Village.	**September 2020**	
	➢ Emergency and Urgent Care Recruitment and Retention Strategy. This will explore staff wellbeing, training and education and work life balance. (in collaboration with ECV)	**December 2020**	
	➢ Band 7 Nursing Workforce and Governance. Ongoing work to improve governance in department	**April 2020**	
	➢ Ongoing support for Senior Nursing Assistants undertaking Open University Nurse Training - 1 year 1 - 2 year 2	**Ongoing**	
	➢ Clarification required regarding the allocation of demography monies Band 3 uplifted from 19.47 to 33 WTE	**September 2020**	
	➢ Focus on adherence to Roster policy and strict adherence to protocol for going to off contract agency and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
Emergency Care Village ➢ **Total vacancies (31.55%):** Band 7 x 0.24	➢ Emergency and Urgent Care Recruitment and Retention Strategy This will explore staff wellbeing, training and education and work life balance (in collaboration with ED).	**Ongoing**	
	➢ Appointment of band 7 clinical educator who will work closely with ED Educator in the development of staff	**February 2020**	

Band 6 x 1.8 WTE *(currently being covered by acting posts)* Band 5 x 5.45 (5.0 WTE commencing post September) Band 3 x 2.58	➢ Focus on adherence to roster policy and strict adherence to protocol for going to off contract agency and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
	➢ Ongoing support for Senior Nursing Assistants undertaking the Open University Nurse Training: - 1 year 1 - 2 year 2	**Ongoing**	
	• Ongoing focus on staff development: review of specific roles in relation to governance.	**September 2020**	
Emergency Department: MIH FSL = 64.25 **Total vacancies (27.94%):** ➢ Band 7 x 0.2 ➢ Band 6 x -1.04 ➢ Band 5 x 16.15 ➢ Band 3 x 4.4 ➢ Band 2 x -0.56 **Area of focus:** Nursing recruitment and retention is a priority for Mater ED with 19.15 vacancies, 15.31 being registered nurse vacancies.	• Service to maximise staff availability by: • Offering increased hours • Offering overtime • Encouraging staff flexibility	**Ongoing**	
	• Review of E-roster involving Divisional Nurse, ward team, finance and central nursing workforce team to maximise effective use of staff and to retain senior staff. - Focus on KPIs: roster management - Training for newly appointed sisters/charge nurses and deputies.	**Ongoing**	
	• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position within Mater site rotation programme when they graduate (no transition students at present as MIH was seen as a COVID site).	**Ongoing**	
	• Open University Nurse Training Program for Senior Nursing Assistants: • 1 commencing year 1 • 1 year 2	**Ongoing**	
	• Recruitment of: - Emergency Nurse practitioners x 2 - Advanced Clinical Practitioner trainee x 1 to further enhance the nursing skill set within the department.	**Commencing September 2020**	
	Utilise commissioned courses to enable staff development and maintain staff retention: • Nurse prescribing x 1 • Specialist practice x 3 • Minor injuries x 7 • On site clinical simulation training with the use of a portable simulation monitor.	**Ongoing**	

	• Resume the Mater site rotation programme and aim to roll out to other areas. • Ensure robust mentoring for new starts, ensuring they are well supported to carry out their role and will want to remain within service area.	**October 2020**	
	• Monthly assurance meetings with the Divisional Nurse includes analysis of each Wards FSL Vs SIP, Bank and Agency spend, succession plans for replacement posts, service developments which impact on nursing workforce and proposals to develop new nursing roles.	**Ongoing**	
Older People Services: **BCH – BCH Direct, 6S,7N,7S** **MIH – Ward C** **RVH – Stroke Unit 6E + F** FSL = 214.01 WTE **Vacancies:** Band 7 X 0.13 Band 6 x 3.01 WTE Band 5 x 15 WTE Band 3 x 5.56 WTE Band 2 X 3.7 WTE Maternity Leave and sickness impacts on staff availability Nursing recruitment and retention is a priority for Older People's Services (18.14 WTE RN vacancies across the inpatient areas). 7S = 10.38% 6S = 23.74% BCH Direct = 34.77%	Service to maximise staff availability by: • Offering increased hours • Offering overtime • Encouraging staff flexibility	**Ongoing**	
	Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in Older People's areas when they graduate (currently no transition students).	**Ongoing**	
	Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff.	**Complete**	
	Appropriate use of overtime, extra hours, bank then agency and strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessments and all of the above is considered.	**Ongoing**	
	• Ward staffing risk assessments updated monthly to ensure all control measures in place and the provision of safe, compassionate care for patients.	**Ongoing**	
	Promotion of Acute Care of the frail older person • Open University pathway for senior nursing assistants: - 1 year 1 - 1 year 2 • Development of older people's career pathway for nursing i.e. advanced nurse practitioners; additional specialist practice places secured through transformational funding. RN x1 ANP: RN x 3 Specialist Practice	**Ongoing**	
Stroke services	• Appointment of Clinical Nurse Educator for Stroke Unit.	**September 2020**	

➢ **Vacancies:** 2.5 WTE x Band 5 ➢ Reshaping Stroke Services Task and Finish Group, led by the HSCB, has been charged by the DoH with the design of and consultation on a service model for stroke services that capitalises on the opportunities to prevent stroke, reduce stroke associated death and disability and ensure high quality services that are fully sustainable.	• Hyper Acute Stroke Care requires a range of highly skilled staff, with access to diagnostic equipment 24 hours a day, seven days a week. In order to maintain a service that has 2 HASU nurses on duty per shift 6 x band 5 posts have been converted to band 6 HASU posts to allow 24/7 cover for critical patients, Lysis calls and Thrombectomy services. As activity increases from a regional perspective this will need to remain under review in light of reshaping and increasing the footprint.	**Completed**	
	• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in Stroke when they graduate. We have one transitional student who has been offered a position in Stroke services commencing September. • Co-production of a specific university course for Stroke nurses is being undertaken regionally and in partnership with UUJ and NIPEC. • Implementation of the Stroke Ambulatory Pathway is currently being funded at risk to provide a seven-day week service. This affords quicker access to the stroke unit for early diagnosis and intervention. Since the inception of this project/pilot the Stroke team have maintained their A status within the SSNAP ratings. An additional 10.88 WTE staff is being sought for recurrent funding from the DoH.	**Ongoing**	
	• Work with Department and Stroke Network to develop the workforce plan in line with the regional redesign of stroke services. • Agree funding with Department and commissioners for stroke ambulatory pathway as above.	**September 2020**	
Ambulatory Care Services: RVH **FSL=44.19** **VACANCIES (6%)** Band 5 x 3.35 WTE Band 4 x 1.0 WTE Band 3 x 0.55 WTE	• ACC service under review: impact on nurse staffing.	**September 2020**	
	• Monthly review of E-roster involving Service Manager, Lead Nurse Divisional Nurse, ward team, finance and central nursing workforce team to maximise effective use of staff • Appropriate use of overtime, extra hours, bank then agency, strict adherence to protocol for going off contract for agency nurses • Implementation and adherence to e-roster KPIs: - Staff awareness and training	**Ongoing**	
	• Band 4 discharge assistance awaiting start date	**October 2020**	

	• Open University Nurse Training Program for Senior Nursing Assistants:
	  • 1 commencing year 1
	  • 1 year 2
	  • 2 year 3 (due to 1 maternity leave)
	• Area accepting management students and therefore focusing on promoting a positive student nurse placement and encouraging these students to consider a permanent registered nurse position.
		Ongoing	

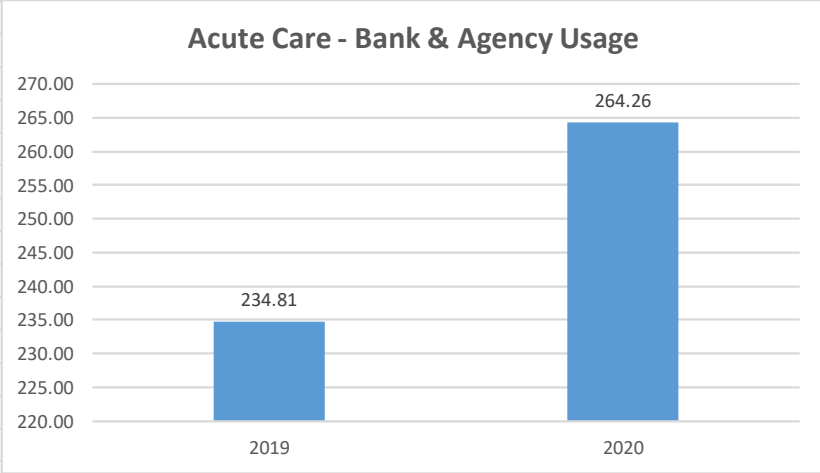
MAHI - STM - 102 - 4346

Acute Care Workforce Information

Ward				Funded Establishment								Staff in Post						Variance									
	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 8A	Band 7	Band 6	Band 5	Band 3	Band 2	Band 8A	Band 7	Band 6	Band 5	Band 3	Band 2	Band 8A	Band 7	Band 6	Band 5	Band 3	Band 2	Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
Periop																											
MIH DPU	N/A	N/A	N/A	23.5	0	1	2.11	15.64	2.75	2	0	1	3.1	14.86	2.75	1.75	0	0	-0.99	0.78	0	0.25	N/A	0%			
MIH Theatres	N/A	N/A	N/A	37.32	0	1	3.64	22.94	3.8	5.94	0	1	7.24	15.31	3.6	2.8	0	0	-3.6	7.63	0.2	3.14	N/A	20%			
Level 3 & EENT Theatres	N/A	N/A	N/A	160.16	0	10.1	14.98	85.62	7.45	41.56	1	8.41	25.05	43.64	7.5	33.85	-1	1.69	-10.07	41.98	-0.05	7.71	N/A	25%	7.40%	0.00%	
Level 3 Recovery	N/A	N/A	N/A	38.4	0	1	3	29.38	0	5	0	1	6.49	9.6	0	4	0	0	-3.49	19.78	0	1	N/A	45%			
Level 3 Anaes Nursing Service	N/A	N/A	N/A	17.78	0	0	17.78	0	0	0	0	0	17.99	0	0	0	0	0	-0.21	0	0	0	N/A	-1%			
BCH Tower Theatres	N/A	N/A	N/A	74.49	0	2.8	5.8	41.21	9.28	15.4	0	2.71	5.4	28.63	9.28	7.6	0	0.09	0.4	12.58	0	7.8	N/A	28%	4.50%	3.60%	
BCH Recovery/PACU	N/A	N/A	N/A	19.31	0	0.98	1	19.53	0.8	2	0	1	1	13.16	0	0	0	-0.02	0	6.37	0.8	2	N/A	47%	6.40%	0.00%	
BCH DPU	N/A	N/A	N/A	18.82	0	1	1	12.44	2.64	1.24	0	1	1	11.86	1.84	1	0	0	0	0.58	0.8	0.24	N/A	9%	20.90%	5.60%	
Endoscopy																											
Endoscopy BCH	N/A	N/A	N/A	30.79	0	1	1	25.87	0	2.92	0	1	0.8	17.76	0	1.58	0	0	0.2	8.11	0	1.34	N/A	31%	0.50%	0.00%	
SpEN	N/A	N/A	N/A	3	0	0	3	0	0	0	0	0	1	0	0	0	0	0	2	0	0	0	N/A	67%			None in TRF posts x 2 as transformational monies have now been halted at our request. Remaining SpEN x 1 is on sick leave
RVH Endoscopy	N/A	N/A	N/A	25.66	0	1	1	18.75	1.5	3.41	0	0.88	1	14.12	1.5	2.32	0	0.12	0	4.63	0	1.09	N/A	23%			
Nurse Endoscopists	N/A	N/A	N/A	2	0	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	N/A	0%			
SSP Nurses (BCS)	N/A	N/A	N/A	1.92	0	0	1.92	0	0	0	0	0	2.36	0	0	0	0	0	-0.44	0	0	0	N/A	-23%			
Critical Care & Trauma																											
RVH ICU/HDU	Level 3 beds - 1:1 Level 2 beds - 1:2	19 Level 3 beds; 8 Level 2 beds	19+8	214.47	0	9.14	92.28	83.52	16.62	10.16	0	9.79	90.88	58.84	15.36	6.59	0	-0.65	1.4	24.68	1.26	3.57	N/A	14%	8.50%	6.10%	Covid - Current Position x20 Level 3 beds; x8 Level 2 beds
BCH ICU/HDU	Level 3 beds - 1:1 Level 2 beds - 1:2	5 Level 3 beds; 4 Level 2 beds	5+4	47.16	0	2	21.01	18.15	4	1	0	2	22.14	13.73	1	1	0	0	-1.13	4.42	3	0	N/A	13%	8.70%	6.80%	BCH ICU, as from 14 July 2020 = 3+3 beds in HDU footprint and 4+3 beds in ICU footprint (+1 L3 bed in RICU; +1 L2 bed in PACU)
MIH ICU	Level 3 beds - 1:1 Level 2 beds - 1:2	3 Level 3 beds; 3 Level 2 beds	3+3	29.46	0	1	18.06	8.9	0.5	1	0	1	15.55	10.76	0.5	1.67	0	0	2.51	-1.86	0	-0.67	N/A	0%	13.20%	4.80%	Mater ICU, as from 14 July 2020 - 3+3 beds temporarily to BCH
Trauma Ward	2:9	8	0	23.79	0	2	7.7	8.8	2.64	3	0	2	7.7	8.8	2.64	0	0	0	0	0	0	3	2.9 NTBR Jan 2019	13%	4.00%	0.00%	Current position - 8 beds used by DOS Neurosurgery and IR Surgery
CC Outreach/Resus	N/A	N/A	N/A	15.46	0	7.62	0	0	0	0	0	7.43	0	0	0	0	0	0.19	0	0	0	0	N/A	1%	0.00%	0.00%	
Pain & Pre-Assessment																											
Acute & Chronic Pain	N/A	N/A	N/A	18.47	0	4.4	11.43	2.36	1.08	0	0	3.53	9.92	2	0	0	0	0.87	1.51	0.36	1.08	0	N/A	21%			Current position: Chronic Pain - Virtual Clinics
Pre-Assessment BCH & MIH	N/A	N/A	N/A	11.14	0	3	1	4.84	3.3	0	0	2	1.92	8.1	2.93	0	0	1	-0.92	-3.26	0.37	0	N/A	-25%			
Ambulatory/DSU																											
BCH DSU	1:4	26	21	12.74	0	1	1	7.24	2	1	0	1	2.8	10.88	3.96	1	0	0	-1.8	-3.64	-1.96	0	N/A	-58%	12.10%	0.00%	Additional staffing funded at risk but not reflected in budget Current Position: BCH DOS Open
RVH ACC	tbc	29+	29+	42.19	0												0	0	0	0	0	0	tbc	0%			Current Position: PTU - Elliott Dynes RVH DOS currently not working due to Covid arrangements: Discharge Lounge with Medicine; Escalation beds with Medicine.
Imaging																											
Imaging BCH	N/A	N/A	N/A	7.89	0	1	4.11	0.06	0	1.67	0	1	6.49	1	1.6	0	0	0	-2.38	-0.94	-1.6	1.67	N/A	-41%			Remodelling funding for IR as held in several budgets FSL should be increased when budget moves
Imaging RVH	N/A	N/A	N/A	16.89	0	2	11.61	3.28	0	1	0	1.9	16.52	0.6	2.85	0	0	0.1	-4.91	2.68	-2.85	1	N/A	-24%			
Neurosciences																											
Ward 4E	1.72	27	27	46.57	0	1	3	31.46	1.24	9.87	0	1	3	24.92	4	7.08	0	0	0	6.54	-2.76	2.79	NTB ratio is 1.72	14%	3.20%	3.70%	Funded for 27 beds, SIP based on 20 beds Currently 7 beds closed due to Covid = 20 beds open Ward 4E has fewer vacancies and based on current 20 beds we rotated 4 staff nurses to Ward 4F to cover for vacancies.
Ward 4F	1.82	27	21	49.15	0	1	3.6	33.77	2.23	8.55	0	1	2.8	17.17	3	5.26	0	0	0.8	16.6	-0.77	3.29	NTB ratio is 1.82	41%	9.00%	2.80%	Funded for 27 beds. SIP based on 21 beds, rotation of 4 Band 5 RGN from 4E to 4F Currently 6 beds closed due to staffing = 21 beds open
Specialist Nurses	N/A			25.76	2	11.6	12.61	0	0	0	1	9	10.31	0	0	0	1	2.6	2.3	0	0	0	N/A	23%			MND Band 7 interviews on hold
Totals				1014.29	2	68.64	243.6	473.8	61.83	116.7	2	62.65	262.46	325.74	64.31	77.5	0	5.99	-18.82	148	-2.48	39.22					

Unit	Acute Care - Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
BCH Day of Surgery	0.92	0.93	0.97	0.86	0.35	0.04	0.08	0
BCH DPU	0	0	0	0	0	0	0	0
BCH Endoscopy	0	0	0	0	0	0	0	0
BCH ICU/HDU	1.93	2.61	2.08	3.5	3.55	0	0	0
BCH Post-op Recovery	0.59	0.67	0.64	0.39	0.15	0	0.17	1.17
BCH Tower Theatres	3.56	3.83	3.6	3.26	0	1.11	0.93	1.49
CC Outreach	0.08	0	0.15	0	0.15	0	0	0
MIH ICU/HDU	1.1	1.24	0.72	1.58	1.59	1.72	1.65	2.03
RVH Anaesthetic Nurses	0.1	0.06	0.26	0.38	0.79	0.57	0.73	1
RVH Emergency Theatres	1.88	2.12	1.9	0.72	1.83	1.81	2.33	2.28
RVH Eyes & ENT Theatres	2.14	1.73	2.07	2.71	3.68	4.34	4.59	4.96
RVH Fracture Theatres	5.2	5.25	5.96	7.19	6.78	8.74	6.46	5.63
RVH ICU/HDU	6.87	7.65	8.56	9.52	12.62	9.81	9.99	10.79
RVH Major Trauma Ward	0	0	0	0	0	0	0	2.4
RVH Neuro Theatres	0.08	0.51	0.44	1.38	3.39	3.31	3.11	3.12
RVH Recovery	5.03	5.29	6.38	6.79	7.59	7.59	7.77	7.91
RVH Theatres 7-10	2.89	3.56	2.83	2.32	3.05	3.67	3.5	3.86
RVH Ward 4E	13.05	8.48	5.17	9.29	7.68	4.17	6.52	8.49
RVH Ward 4F	12.78	13.79	12.27	15	14.02	14.64	17.49	15.07
Totals	**58.2**	**57.72**	**54**	**64.89**	**67.22**	**61.52**	**65.32**	**70.2**

Overall total	2019	2020
	234.81	**264.26**



Acute Care Action Plan

Issues	Action	Timescale	Status at
Theatres and Recovery ➢ There are high levels of vacancies –**93.29 WTE 27%** funded vacancies within the ACCTSS peri-operative workforce currently. ***The priority areas for recruitment are Level 3 Theatres (RVH) and Recovery***. -**56.53 WTE 22%** ➢ The on-call rota and theatre over-runs impacts upon the availability of staff. ➢ Mater theatre team not yet on e-roster. ➢ Backfill is primarily provided by own staff/bank staff due to limited agency supply. ➢ Response to COVID19.	• Peri-operative Workforce Review group established and will meet quarterly, this incorporates all BHSCT Theatres.	Continue to review quarterly	
	• Development of a perioperative nursing workforce and recruitment action plan. The ACCTSS co-director is leading on peri-operative workforce plan for BHSCT.	Feb 21	
	• Previously there was an annual peri-operative specific recruitment day; this has been recently changed to reflect directorate areas. A virtual recruitment event has been proposed.	3 Months	
	• RVH Theatre lists continued including other specialities (renal transplants – 70 renal transplants April – June 20, urology & gynaecology). Upper GI & HPB surgery was managed initially in Cardiac theatres prior to moving to BCH in July 20. • An additional emergency list was established. • BCH, MIH, Cardiac & MPH theatres and DPU staff support ICU throughout COVID19 response. • Cross site working of theatre staff (MIH, BCH & MPH) continues to support surgery for P2 patients in RVH and BCH theatres. • BCH PACU is operational since July 20 following down of service in response to COVID19.	complete	
	• Alternative posts within the perioperative environment have been recruited to – 2 Operating Department Practitioners have been recruited.	Complete	
	• Retention Strategies – o Modernisation of Anaesthetic Nursing service; Learning & Development profile all nursing bands; Exit interviews - all staff – use of information ; Budget re-profile & consideration of Clinical Band 6 roles; SNA Band 3 development – New Recovery QCF programme and ongoing scrub programme. Review pay and conditions within remit e.g. car parking fees; AFC premium.	6 Months	

Issues	Action	Timescale	Status at
	○ Band 6 posts for theatres have been interviewed/recruited. (Senior Staff Nurse)	Complete	
	○ The NA band 2 QCF programme is on hold due to COVID -19, but will re-commence again in October 2020. There are 6 Band 2 NA currently on this programme. ○ MIH theatre team is currently on E Roster Managers list for implementation of E Rostering.	6 months	
	○ One full time Band 6 has been seconded by ACCTSS for 2 years to undertake the Children's & Young people Programme at QUB, this supports role development and succession planning within the peri-operative environment.	June 22	
	○ A Clinical Educator for ACCTSS Theatres has now been appointed.	Complete	
	○ A further 3 band 6 positions to be appointed to support the learning and development of staff across the 3 sites	6 months	
	○ The Nursing Education Seminar Room has now been installed with 6 PC's. This will enable a greater volume of nursing staff being able to access on-line learning opportunities.	Complete	
	• Pilot of a new role of band 2 Theatre Support Service Assistants undertaken – now in process of employing into this role with more band 3 stock controller posts.	6 months	
	• Review of student placements within peri-operative setting – theatres can facilitate more student placements. Student placements ceased in April/May 2020 due to COVID19 surge, 3 students will have placements in level 3 theatres at next allocation.	6 Months	

Issues	Action	Timescale	Status at
	• Review potential of management students coming to theatres for final placements. Level 3/EENT theatres has been re-audited for 7 students at any time, both PEF and CE included, however in the absence of a link lecturer QUB has requested all clinical areas require to be re-audited following COVID19 pandemic to assure appropriateness of placement area.	6 Months	
Intensive Care ➢ Experience of registrants is an issue: On BCH site 10 nurses (30%) < 1 year post-registration experience, on RVH, the number is 35 (21%) and on the Mater site, this figure is 3 (12%).	• Continue to develop and deliver Critical Care Skills Preparation Programme and include a PEER Support programme supported by Critical Care Clinical education team.	6 months	
	• Learning Needs Analysis – based on the professional development needs of individual staff (identified in Staff Development Reviews and Revalidation confirmation meetings) linked to National and Regional strategic drivers to assure commissioning of sufficient places on the post-registration degree level Critical Care Short Course across Critical Care Service to meet the GPICs standards of 50% or greater of registered nurses with a critical care qualification. Currently this stands around 60%.	6 months	
	• Critical Care RNs progress through a stepped nationally agreed competency framework – Step 1 (Foundation 12months long in-house delivered programme of clinical skills teaching and practice portfolio completion. This runs along a preceptorship programme for newly qualified RNs); Step 2&3 competencies are met whilst undertaking the Critical Care Short Course – this is a yearlong commissioned short course at QUB. RNs can apply through a selection process for a place on this programme after one year in Critical care and upon successful completion of step 1 competencies. 14 RNs are currently completing the 2019-2020 programme, despite the ongoing Covid challenges. 17 Critical Care Short Course places have been commissioned for 2020-2021.	6 months	

Issues	Action	Timescale	Status at
	• New staff nurses have the opportunity to meet with the Clinical Education team approximately every 8-12 weeks to provide support and enable discussion of any issues. There are also link education staff on each of the 3 sites to support new staff nurses. New staff attend the clinical skills workshops in Critical Care.	6 months	
	• FNFM brings opportunities to relax restrictions in pre-registration placement areas, current review of student placements in Critical Care is ongoing, and the exploration of placing first year students as a range of learning opportunities are in place to meet practice proficiencies.	6 months	
	• Band 6 staff Nurse/Deputy Sister Induction and Development Programme – based on the national newly released Step 4 Critical Care Leadership Competencies; • RN's have an opportunity to join the local Critical care Pressure Ulcer Prevention and Infection Prevention and Control Improvement Groups – and to become Link nurses in those areas; • Exploration of the development and piloting of Pain Management Link nurses in Critical Care with the Acute Pain Team; • Opportunities for Clinical Research secondments and CCOT secondments; • Critical Care staff in RICU have an opportunity for rotations into the NISTAR adult service.	Complete	
	• Explore/support one MSC programme a year in Critical Care practice / a management route - with support for those who wish to pursue an academic pathway.	1 Year	
	• There is a local induction for the Band 2 and Band 3 Nursing Assistants as well as the Trust wide induction and development programme based on the Regional standards.	Complete	
	➢ Increase number of 3rd year student placements to enhance recruitment opportunities and outcomes – 11 students for Critical Care (BCH, MIH, RICU) includes both 2nd and 3rd year students, at present no management – still in the planning phase with the PET	6 months	

Issues	Action	Timescale	Status at
	• Rotation across the 3 sites to ensure capacity, experience and to support the induction of new staff.	Complete	
➢ Need to build resilience among the nursing team.	• Focused work in this area to include support by the Clinical Educator, Bereavement Support initiatives, and resilience training.	6 Months	
➢ Response to COVID19	• Collaborated with Central nursing to implement nursing model within Critical Care/Nightingale during COVID19 pandemic. • Orientation, induction and training of nursing staff to support Critical Care. • Database of training compiled. • Debriefs with staff and learning collated from debriefs shared and implemented.	Complete	
Endoscopy ➢ Challenges covering lists in RVH and BCH due to reduced nurse staffing levels resulting from vacancies**, 9.97 WTE 16%**	• Continue to recruit to vacant posts.	6 Months	
	• Bank, agency and OT all utilised and kept under review.	6 Months	
➢ Increased complexity and workload.	• There is a band 6 Learning and Development role to facilitate the ongoing training & development of new and existing staff and senior health care assistants across endoscopy service; this has supported positive changes within the units.	Complete	
➢ Experience of nursing staff is an issue. 4 nurses on BCH site and 5 nurses on RVH site have <18m post-registration experience resulting is a dilution of skills. Additionally there are insufficient experienced staff to support the development of new staff. These issues affect the provision of cover	• Band 2 NA have been supported to upskill and there has been a recruitment programme to introduce band 3 senior health care assistants x 3 WTE to promote and build further resilience into the endoscopy service.	Complete	
	• Monitoring of list over-runs is ongoing which facilitates appropriate corrective action to be implemented in a timely manner. Real time data is available to provide the Clinical Lead and endoscopy senior management team with information to support improved utilisation of endoscopy lists.	3 Months	

Issues	Action	Timescale	Status at
for complex procedures such as ERCP & HALO.	• The learning and development band 6 practitioner supports with the training of all nursing staff to create and build upon an adaptable and flexible skill mix within the endoscopy service.	Complete	
Ambulatory Care ➢ DSU staff in process of returning to DSU following redeployment due to COVID19.	• DSU staff returned to day of surgery from COVID-19 re-deployment to BCH DSU. • PTU and DSU services independent of each other, BCH DSU managed by ACCTTS.	Complete	
	• RVH staff have returned to PTU & level 8N for Neurosurgery DOS and IR DC	3 months	
➢ Band 3 SNA to be recruited to DSU.	• To meet the demands of the current COVID-19 pandemic, the service has been reorganised to facilitate accommodate maximum number of patients in line with social distancing restrictions including staggered admission of patients and reconfiguration of the environment.	3 Months	
	• Access of Day of surgery facility to Hepatobiliary patients	6 Months	
	• Band 3 – 2 staff recruited, to commence employment September 2020.	complete	
➢ Service improvement projects undergoing.	A number of service improvement projects underway • Iron service pre-operative intervention in BCH DSU. • Angio service for patients with uterine fibroids.	complete	

Issues	Action	Timescale	Status at
Neurosciences ➢ 6 beds closed due to nurse staffing vacancies within neurosciences – ward 4F.	• Continue to review potential implementation of a Progressive Care Unit within neurosciences.	1 Year	
	• Beds in ward 4F remain closed due to limited staffing availability in the unit despite attempts to recruit to Neuro. 6 beds currently closed in ward 4E. This is due to IPC mechanisms for patients who are significantly immunocompromised.	6 Months	
	• The service continues to recruit staff into vacancies. A number of staff have left / retired. In January 2020, 17 band 5 nurses were upgraded to band 6 positions (through job change process).	complete	
	• There are extended roles for band 3 SNA which the service would like to explore further. These include NG feeding and trache care / suctioning.	1 Year	
	• The service has over recruited band 3 SNA positions. The band 3 SNA position provides additional support to patients in the neurology ward.	Complete	
Interventional Radiology ➢ The on-call rota and theatre over-runs impacts on the availability of staff. ➢ The acuity /Workload within RVH site is leading to staff moving to other sites. ➢ Team not yet on e-roster.	• With an increased number of consultant's sessions providing more timely response to emergency requests over runs of lists have decreased. • The utilisation of the 3rd room in RVH has significantly reduced late finish of cases.	Complete	
	• INR (stroke) team are covering on-call as a 1:4 rota (2 nurses per session and 7 sessions per week, this reduced to weekends only during Covid19 response. To be reviewed.	3 months	
	• RVH and BCH sites currently fully staffed with band 6 nurses supporting skill mix and staff numbers.	Complete	
	• IR nursing team on Eroster Manager list for implementation of Eroster in this area.	6 months	

Issues	Action	Timescale	Status at
Pain and Pre assessment ➢ Specialist skills required to deliver these specialist roles. Recruitment to specialist/new nursing roles – drain on ward staffing.	• Succession planning for further acute pain and pre-assessment nurses. • New nurses undertake a 6 month orientation and induction programme. • Induction booklet with competencies (questions and reflections built in) • After 2years plus in the service and if deemed ready • Non-medical Prescribing short course (degree/ or post-grad level)	6 Months	
	• Nurses new to pre-assessment will have an orientation and induction programme. This programme could be augmented by undertaking the M&K Pre-operative Assessment 3 x Day programme (£480), which would have to be financed through the service group. • Health Assessment stand alone Level 3 module is a module that could be commissioned and undertaken from one year plus in the Pre-assessment service. • Pre-assessment Nurses do not require to undertake non-medical prescribing they may require training in Patient Group directives available at CEC. • Band 6 Leadership development programme and RCN programmes may be relevant to the Pre-assessment nurses as part of their developmental learning needs.		
CCOT and Resuscitation Training Service	• Band 4 practitioners in resus to deliver training – this is working well and has supported service delivery. 2 Band 4 resuscitation service assistants have been recruited substantively in June 2020, both have been trained up to ILS level. The implementation of this role has supported the increase of staff trained in BLS and defibrillation both in community and acute settings. Resuscitation officers have been able to increase capacity for PILS & ILS.	complete	

MAHI - STM - 102 - 4356

Surgery Workforce Information

Ward				Funded Estlishment						Staff in Post					Variance					Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
	Agreed NTBR	Beds	Beds Open	Total funded estab	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2					
Mater																								
Ward F/ ESU Non Covid Ward		35	21	43.96	1	4.18	26.28	8.55	3.95	1	2.72	20.18	7.28	2.99	0	1.46	6.1	1.27	0.96		22%	9.40%	3.00%	Staff working in Level 7 BCH Interim surgical ward.
Macular Unit				21.13	6	2	10.2	3	0	5.72	1.72	11.08	3.64	0	0.28	0.28	-0.88	-0.64	0		-5%			Extending working hours to allow for patients to attend outside of normal hours. Spread of staff role to allow safe social distancing
RVH																								
Ward 5A		32	26	64.03	1	3	38.37	2.05	8.64	1	5	22.25	9	4.04	0	-2	16.12	-6.95	4.6	01-Jan-20	18%	6.00%	4.10%	1 B6 LTS, 3.0 ML, 2 B4 redeployed from AAA screening not included in figures
Ward 6A		26	22	43.43	2	4.78	22.28	6.94	5.56	2	4.6	14.46	5	2.36	0	0.18	7.82	1.94	3.2		30%	5.30%	0.00%	not included are an additional 2.64 registered off due to long term sickness/sheilding
Ward 6B		28	28	42	1	4	22.08	5.56	5.56	1	2.6	12.91	7.08	2.8	0	1.4	9.17	-1.52	2.76		28%	8.50%	5.90%	not included are an additional 4.0 registrants off due to sheilding and mat leave.
Ward 6C		26	27	43.43	1	3	26.5	6.52	6.41	1	3.85	20.2	5.66	3.39	0	-0.85	6.3	0.86	3.02		21%	8.20%	0.60%	Based on 26 bed telford & incl band 3 HK
Ward 2E		8	8	26.88	1	4.29	13.99	4.6	3	0	1.8	14.67	3	2.99	1	2.49	-0.68	1.6	0.01		16%	9.40%	7.70%	SIP includes Burns theatre, band 7 vacant from 01/07/2020
CSICU		18	18	92.98	5	31.3	48.4	0	9.28	5.8	27.21	36.71	0.8	6.12	-0.8	4.09	11.69	-0.8	3.16	19-Jul	19%	5.90%	3.00%	1 X B7 Clinical Educator, 1 x B7 + 3.2 wte LTS, 2.76 mat leave, 1.0 career break, 1.0 shielding
Cardiac Theatres				27.6	3	6	14.21	4.39		3	4	15.87	4.65	0	0	2	-1.66	-0.26	0		0%	6.00%	2.50%	2 x B5 shielding, 1 x B5 Maternity leave, 2 x B5 long term sick
Ward 28		8	8	14.76	1	1	8	3.27	1.49	1	1	6.72	2	0.56	0	0	1.28	1.27	0.93		24%	13.90%	0.00%	Ward 28 functioning with 4 inpt beds & providing ambulatory services also on ward
Eye Cas				8.68	2.6	1	6.3	0	0	2.6	1	5.86	0	0	0	0	0.44	0	0		5%	5.50%	0.00%	Operating referral only service to ensure safe spacing of patients and staff alike in limited clinic space
Opthalmology Day Unit				14.28	1	1	6.33	2.18	3.77						1	1	6.33	2.18	3.77		100%			Telford sbmitted to Nursing workforce team
Ward 4A (4b)		22	22	33.42	1	2.78	18.75	9.46	1.19	1	3.96	16.54	8.92	2.47	0	-1.18	2.21	0.54	-1.28		1%	23.50%	3.40%	Variance 7.64WTE9sickness/vacancy
Surgical Wd Level 8 Phase 2B		24	15												0	0	0	0	0					Ward relocated to L7 BCH
BCH																								
2 North (7N)		23	23	33.81	1	3.78	18.54	5.79	4.4	1	2.8	14.78	6.65	1.8	0	0.98	3.76	-0.86	2.6		19%	7.00%	1.60%	Staff working in Level 7 BCH Interim surgical ward.
2 South (7S)		24	24	36.14	1	3.78	20.33	9.99	0.88	1	1.96	12.44	7.4	0.88	0	1.82	7.89	2.59	0		34%	5.10%	1.90%	Staff working in Level 7 BCH Interim surgical ward.
3 South		30.71	24	40.83	1	3	24.97	7.27	4.59	1	3	10.42	7.19	0.64	0	0	14.55	0.08	3.95		46%			Ward moth balled. Staff redeployed to Ward 4A and 5 South
3 East				5.49		0.8	3.69	1		1	1	4.06	2.48	0	-1	-0.2	-0.37	-1.48	0		-56%			Team currently relocated to Gardiner Robb DPU
Ward 5 South		21	21	33.89	1	4.08	18.86	8.37	2.58	1	2	16.17	9.4	1.86	0	2.08	2.69	-1.03	0.72		13%	0.00%	0.00%	Combined staffing 3S and 5S staffing
Totals				626.74	30.6	83.77	348.08	88.94	61.3	30.12	70.22	255.3	90.15	32.9	0.48	13.55	92.76	-1.21	28.4					
OPD All Sites																								
RVH																				N/A				
Level 1				5.3	1	0	3.66	0.64	0						1	0	3.66	0.64	0		100%			
Level 6B /7				22.67	2	1.65	12.8	6.22	0						2	1.65	12.8	6.22	0		100%			
BCH																								
Wing ABC				24.15	1	1.75	13.77	9.66	0						1	1.75	13.77	9.66	0		108%			
Wing EF				6.44	1	0	3.26	2.18	0						1	0	3.26	2.18	0		100%			
Wing G				3	0	1	1	1	0						0	1	1	1	0		100%			
Chest Clinic				8.09	1	1.5	3.59	2	0						1	1.5	3.59	2	0		100%			
MIH																								
RGH Head Injury Nurse				1	1	0	0	0	0						1	0	0	0	0		100%			
BCH Enhanced recovery nurse				1	1	0	0	0	0	1.8	0	0	0	0	-0.8	0	0	0	0		-80%			.8 B7 in post secondement due to needs of service
Nutrition nurses				5	3	2	0	0	0	3	2	0	0	0	0	0	0	0	0		0%			
BCH Stoma Nures				1.6		1.6	0	0	0	1.6	0	0	0	0	-1.6	1.6	0	0	0		0%			
BCH Coloplast				2		2	0	0	0	2	0	0	0	0	-2	2	0	0	0		0%			
BCH Breast nurse				5.73	2.12	3.61	0	0	0						2.12	3.61	0	0	0		100%			
Mod Surgery				1.45	0	0	1.45	0	0						0	0	1.45	0	0		100%			
MIH Hepatology Nurse				1	1	0	0	0	0	1	1.8	0	0	0	0	-1.8	0	0	0		-180%			0.8 Mat cover B6 in post
MIH Stoma Nurse				0.8	0.8	0	0	0	0	0.8	0	0	0	0	0	0	0	0	0		0%			0.8 B7 stoma nurse retires July 2020. B6 temp post EOI to cover Summer period.
Urology Specialist Nurses				3	3	0	0	0	0						3	0	0	0	0		100%			
RVH GI Physiology				0.89		0.89	0	0	0						0	0.89	0	0	0		100%			
RVH Vasc spec nurse				3.17	1	2.17	0	0	0						1	2.17	0	0	0		100%			
Cardiac Spec Nurse				7.64	3.75	3.89	0	0	0						3.75	3.89	0	0	0		100%			
Thoracic spec nurse				3	1	2	0	0	0						1	2	0	0	0		100%			
Diabetic Nurse Specialists				8.93	3.11	5.82	0	0	0	7.56	5.74	0	0	0	-4.45	0.08	0	0	0		-49%			3.3WTE Shielding 0.6 LTS/ 3.4 Band 6 increased to Band 7 (Job re-evaluation)
RVH Fluoroscein Service				1	1		0	0	0						1	0	0	0	0		100%			
Glaucoma Service				3.85	2.85		0	1	0						2.85	0	0	1	0		100%			
RVH Contact lens service				1.8	1	0.8	0	0	0						1	0.8	0	0	0		100%			
Ophth ICATS				2.42	1.42		0	1	0						1.42	0	0	1	0		100%			
Ophth Pre Assessment				2		2	0	0	0						0	2	0	0	0		100%			
Totals				126.93	33.05	32.68	39.53	23.7	0	17.76	9.54	0	0	0	15.29	23.14	39.53	23.7	0					

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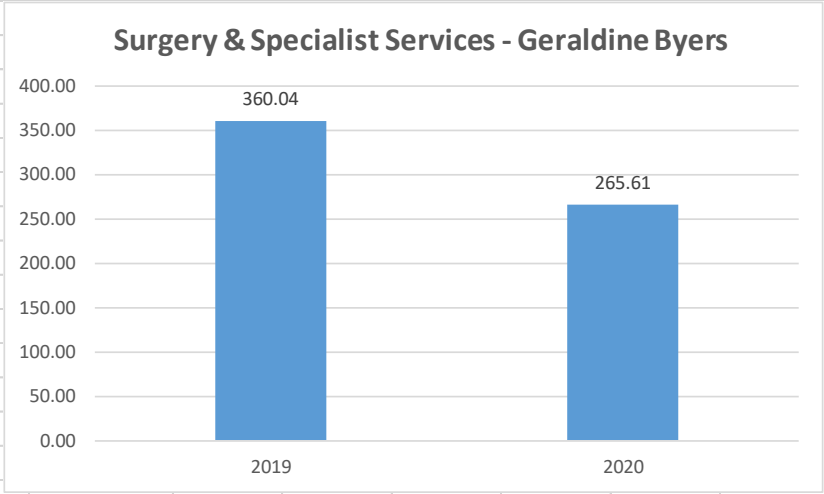
Division of Surgery and Specialist Services Backfill Information

Unit	Surgery & Specialist Services - Geraldine Byers							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
BCH 2 North	8.74	10.74	11.51	9.84	2.05	0	0	0
BCH 2 South	4.87	5.78	7.65	6.83	0.76	0	0	3.19
BCH Level 3 Urology	9.52	11.9	15.77	15.44	0.52	0	0	0
RVH Cardiac Theatres	0.81	0.59	0.51	0.3	0	0	0	0
RVH CS ICU/HDU	3.05	3.72	4.68	4.14	1.91	2.18	3.35	2.74
RVH Ward 2E (Burns Unit)	4.27	4.92	4.55	5.13	2.08	1.77	2.24	5.38
RVH Ward 28	4.61	5.2	4.03	3.91	2.54	3.18	3.46	4.58
RVH Ward 5A	5.39	5.08	4.69	6.48	8.17	12.03	11.53	11.94
RVH Ward 6A	15.86	12.31	15.96	13.04	14.52	13.9	13.08	14.43
RVH Ward 6B	10.61	9.59	13.81	14.32	13.75	15.82	14.54	14.22
RVH Ward 6C	15.02	14.94	15.39	14.54	12.74	16.4	20.07	16.54
RVH Level 8 Surigcal	0	0	0	0	0	0.37	1.97	1.32
Totals	**82.75**	**84.77**	**98.55**	**93.97**	**59.04**	**65.28**	**68.27**	**73.02**

Overall total	2019	2020
	360.04	**265.61**



Division of Surgery and Specialist Services Action Plan

REF NO	Issues	Action	Timescale	Status at 31 July 2020
	Urology ➢ There are high levels of vacancies – a total of 14.55 WTE registered nurse vacancies and 4.03 WTE nursing assistant vacancies within the urology ward team. This equates to 46% vacancies. The Urology nursing team are currently working across RVH Ward 4B, BCH Ward 5 South along with Gynae nursing colleagues to accommodate patients being admitted via emergency and elective pathways. This has afforded the team the opportunity to continue functioning, however without the support of the Gynae nursing team, this would be extremely challenging. The Urology Senior Nursing team are also having to provide support to other wards in RVH regarding the appropriate management	• Participation of the Urology team in the Directorate Jobs Fair in spring. The successful appointees have been contacted to ensure they still intend taking up appointment in Urology Service.	**Nov 2020**	
		• Appropriate use of overtime, extra hours, bank then agency Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
		• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in urology when they graduate	**Ongoing**	
		• Ensure that all Registrants in the Urology Ward Team and UDC undertake required training to enable them to fulfil the role of Practice Supervisor/ Practice Assessor roles for students while they are in their practice-learning environment.	**Oct 2020**	
		• Band 7 position is in the process of being recruited.	**Aug 2020**	
		• Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff.	**Completed March 2020**	
		• ASM for the Service is due to leave at the start of September. Recruitment for this position is ongoing.	**Sept 2020**	
		• Meeting between ASM and Divisional nurse to discuss options for how Urology service can be sustained in the coming months with current staffing levels.	**Aug 2020**	

	of Urology patients who are outlying in their wards. The team who were previously located in 3 East Urology Day Care are currently working in DPU, BCH. The Band 7 in UDC has tendered his resignation and is due to leave on 18th August 2020. The ASM for Urology is taking up a new position in Central Nursing at the start of September 2020.	• ASM in the process of uplifting current Band 2 Vacancies to Band 3s	**Sept 2020**	
REF NO	**Issues**	**Action**	**Timescale**	**Status at 31 July 2020**
	EMSU (Ward 6A/ 6B): • Nurse staffing deficit within wards 6A and 6B continue to be a significant challenge. • Currently there are 22.12 WTE registered nurse vacancies and 2.79 WTE nursing assistant vacancies across both wards. This equates to 30% and 28% vacancies respectively across the 2 wards. There has also been the establishment of a Surgical Ambulatory Service (SAmS) on RVH	• Divisional Nurse working with ASM, Finance and Bank office team to do analysis of agency expenditure and internal processes for requesting and authorising it. • EMSU team will introduce Safe Care – demonstration to be facilitated by Roster team in the coming weeks. • Strict adherence to Roster policy and assurance regarding KPIs to be requested of EMSU Senior nursing team and ASM. Monthly meetings to be held with ASM and Divisional Nurse. • KPI reported provided by Roster team from 1st September to be shared with and discussed with EMSU Senior Nursing team. This will highlight compliance with the KPIs for E Roster management with the ASM being required to account for the variance,	**End September 2020** **Sept 2020**	
		• Participation of the EMSU team in the Directorate Jobs Fair in spring.	**March 2020**	

	site incorporated into the Emergency Care Village. A number of staff from EMSU support the delivery of this service Mon-Fri 8am -6pm. • Surgical Assessment Service (SAmS) does not have Nursing staff funded to provide the service, therefor business case required to request additional funding for this model of service that has evolved from original IPT. • On a positive note, some staff who were redeployed to EMSU during Covid have expressed an interest in staying	• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in EMSU when they graduate. Two nurses who were transition students and working in EMSU during Covid have decided to remain in the Unit.	**Ongoing**	
		• Ensure that all Registrants in EMSU undertake required training to enable them to fulfil the role of Practice Supervisor/ Practice Assessor roles for students while they are in their practice-learning environment.	**Oct 2020**	
		• Divisional Nurse to support Service Manager and ASM in devising an IPT to request additional nursing resource for SAmS.	**Oct 2020**	
		• EMSU team to be requested to complete written proforma detailing reason for requests for Specials to ASM	**Aug 2020**	
		• Internal transfer policy will be initiated for staff who chose to redeploy to EMSU/ SAmS on a permanent basis • Two transition students have also chosen to remain in EMSU – 1 is allocated to 6A and 1 allocated to 6B.	**Oct 2020**	
	• Concerns regarding significant expenditure associated with off contract agency usage.	• Review of Roster with DN, ASM and E roster team manager. Agreed actions from this: ➢ ASM to undertake a review of changes to roster following approval. ➢ ASM to undertake a review to identify patterns as to when Specials are required. ➢ Strict adherence to authorisation of Specials. ➢ Band 7s to ensure off contract agency staff are not rostered where possible at weekends, nights, and public holidays. ➢ Roster manager to discuss possibility of a better rate for off contract agency staff. ➢ Safe Care model to be introduced in the Unit supported by Roster team. ➢ Safe Care model to be introduced in the Unit supported by Roster team. • All N/A vacancies to be filled ASAP and if required uplift from Band 2 to Band 3 posts.		

		• New Band 7's appointed to Ward 6A and 6B following retirement and reassignment of another Band 7.		
REF NO	**Issues**	**Action**	**Timescale**	**Status at 31 July 2020**
	Burns: ➢ Band 7 Ward Sister vacancy due to Band 7 having left the post recently to take up a post closer to home. ➢ Band 6 currently off on Maternity Leave and the other Band 6 has been appointed to a post in Community so expected to tender her resignation in the near future. ➢ Band 6 position in Burns Theatre has been advertised multiple times without successful appointment. Interviews being planned for most recent recruitment.	➢ Internal EOI advertised for Band 7 position for Burns Unit. ➢ Band 6 posts for the ward being advertised via EOI ➢ Interim plan for support from nursing staff Cardiac Theatres being explored (Band 6 who is returning from sick leave). ➢ On a day-to-day basis, support from Cardiac Theatres is being requested to support provision of Burns Theatres. ➢ Request from main theatre colleagues for support. ➢ A Band 6 from Cardiothoracic Ward has relocated to Ward 2E as an interim arrangement supported by the ASM for the area.	**Sept 2020**	
REF NO	**Issues**	**Action**	**Timescale**	**Status at 31 July 2020**
	Vascular: ➢ There are a total of 5.45WTE registered nurse vacancies and 3.88 WTE nursing assistant vacancies within vascular	• Participation of the vascular team in the Directorate Jobs Fair in spring.	**Spring 2020**	
		• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in Vascular when they graduate	**Ongoing**	
		• 1 Band 4 transition student has chosen to remain in 6C and another transition student is coming from 7C to 6C.		
		• Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff was scheduled to take	**October 2020**	

		place late March 2020 but was postponed because of Covid 19 Pandemic.		
		• Appropriate use of overtime, extra hours, bank then agency	**Ongoing**	
		• Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
		• Ensure that all Registrants in the Vascular Ward Team undertake required training to enable them to fulfil the role of Practice Supervisor/ Practice Assessor roles for students while they are in their practice-learning environment.	**Oct 2020**	
		• Explore the role of Clinical Educator for vascular /emergency surgery	**Sept 2020**	
	Cardiothoracic Surgery Ward 5A ➢ There are 16.12 WTE registered nurse vacancies and 2.3 WTE unregistered nursing assistant vacancies within Ward 5A. Currently there are 26 beds opened on the Ward.	• Participation of the cardiothoracic team in the Directorate Jobs Fair in spring.	**Spring 2020**	
		• Divisional Nurse to review Telford with ASM and Ward Sister in light of reduced number of beds being used	**Sept 2020**	
		• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in Cardiothoracic when they graduate.	**Ongoing**	
		• 1 Transition student is remaining in 5A.		
		• Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff was scheduled to take place late March 2020 but was postponed because of Covid 19 Pandemic.	**October 2020**	

		• Appropriate use of overtime, extra hours, bank then agency	**Ongoing**	
		• Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered	**Ongoing**	
		• Ensure that all Registrants in the Vascular Ward Team undertake required training to enable them to fulfil the role of Practice Supervisor/ Practice Assessor roles for students while they are in their practice-learning environment.	**Oct 2020**	
REF NO	**Issues**	**Action**	**Timescale**	**Status at 31 July 2020**
	CSICU ➢ There are a total of 14.98WTE registered nurse vacancies and 2.36 WTE unregistered nurse vacancies within CSICU	• Participation of the CSICU team in the Directorate Jobs Fair in spring.	**Spring 2020**	
		• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in CSICU when they graduate. No transition students remaining in CSICU as no placements in the unit during the height of Covid.	**Ongoing**	
		• Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff was scheduled to take place late March 2020 but was postponed because of Covid 19 Pandemic.	**Oct 2020**	
		• CSICU generally do not use Agency staff. Staff who have retired from their own team who have retired support by doing Bank shifts, however this has been significantly reduced during the Covid 19 pandemic due to a number of these staff shielding. A review of Bank staff will be actioned by the ASM for the area.	**Oct 2020**	
		• Ensure that all Registrants in CSICU undertake required training to enable them to fulfil the role of Practice Supervisor/ Practice Assessor roles for students while they are in their practice-learning environment.	**Oct 2020**	
		• Recent retirement of Band 7. Temporary Band 7 already was appointed in anticipation of this retirement.	**Aug 2020**	
REF NO	**Issues**	**Action**	**Timescale**	**Status at 31 July 2020**

	Ward 2 South There are a total of 8.71 WTE registered nurse vacancies and 2.59 WTE nursing assistant vacancies within 2 South. 1.0 WTE Band 6 is supporting the Enhanced Care pathway to support early, safe discharge of patients following complex Surgery.	• Participation of the 2 South team in the Directorate Jobs Fair in Spring	**March 2020**	
		• Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in 2 South when they graduate.	**Ongoing**	
		• Ensure that all Registrants in the 2 South Team undertake required training to enable them to fulfil the role of Practice Supervisor/ Practice Assessor roles for students while they are in their practice learning environment	**Oct 2020**	
		• Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff carried out in March 2020.	**March 2020**	
		• Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered	**Ongoing**	

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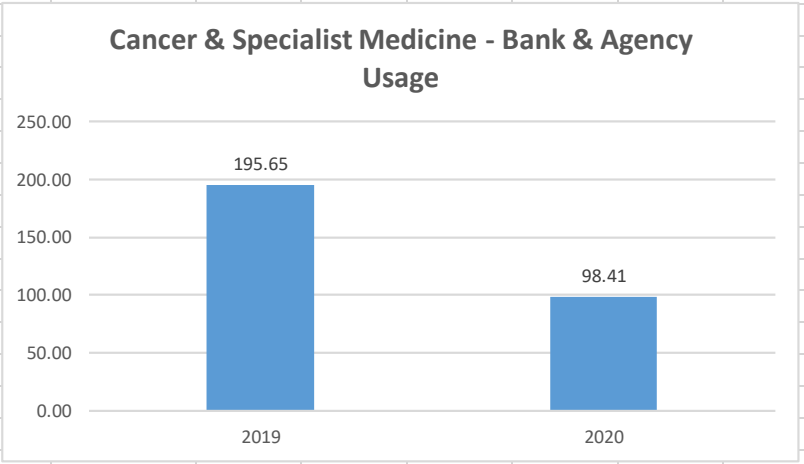
Cancer and Specialist Medicine Workforce Information

Ward	Funded Beds	Beds Open	Funded Establishment					Staff In Post					Variance					Total funded establishment	Total Staff In Post	Total Variance	% Sick Leave	% M/L
			Registered			Unreg		Registered			Unreg											
			Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2					
HAEMATOLOGY - Lisa Houlihan																						
6 North	20	12	1	2.36	25.29	5.34	3.05	1	1	13.15	5.60	4.79	0.00	1.36	12.14	-0.26	-1.74	37.04	25.54	11.50	10	4
10 North	28	28	1	20.74	23.68	5.44	4.66	1	17.62	22.48	5.20	4.13	0.00	3.12	1.20	0.24	0.53	55.52	50.43	5.09	12	0
BWS Haem			1	11.54	12.2	4.47	0.88	1	11.34	14.6	4.33	0.00	0.00	0.20	-2.40	0.14	0.88	30.09	31.27	-1.18	15	10
Apheresis			1	6.2	0	0	0	0.8	4.2	0	0.00	0.00	0.20	2.00	0.00	0.00	0.00	7.20	5.00	2.20	0	0
VTE Service			1	5	0	1	0	1	5	0	1	0	0.00	0.00	0.00	0.00	0.00	7.00	7.00	0.00	0	14
Haemophilia Centre			1	2.04	0	0.8	0	1	2.04	0	0	0	0.00	0.00	0.00	0.80	0.00	3.84	3.04	0.80	0	0
Warfarin Service													0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
NEPROLOGY and TRANSPLANT - Louise Crowe																						
11North	12	12	1	2	26.17	5.47	1.8	1	2	26.17	5.52	1.80	0.00	0.00	0.00	-0.05	0.00	36.44	36.49	-0.05		
11 South	13	11	1	2	24.28	7.99	0	1	2	21.6	7.36	0.00	0.00	0.00	2.68	0.63	0.00	35.27	31.96	3.31		
Neprology Specialist Nurse			5	0	0	0	0	6.09	0	0	0.00	0.00	-1.09	0.00	0.00	0.00	0.00	5.00	6.09	-1.09		
Dialysis Unit	40		2	4.37	32.14	17.4	0	2	4.37	28.41	16.82	0.00	0.00	0.00	3.73	0.58	0.00	55.91	51.60	4.31	8	14.42
Self Care HD			1.8	2.8	0	0	0	1.8	2.8	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.60	4.60	0.00		
Community PD			0.8	2.75	0	0	0	0.8	2.45	0	0.00	0.00	0.00	0.30	0.00	0.00	0.00	3.55	3.25	0.30		
Neprology OPD			1.68	3.1	2	2.67	0	1.61	2.6	2	2.92	0	0.07	0.50	0.00	-0.25	0.00	9.45	9.13	0.32		
Rheumatology - Louise Crowe																						
Rhem specialist nurses			3	0	0	0	0	3	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00	3.00	0.00	33	
Rhem liaison nurse			3	0	0	0	0	3	0	0	0	0	0.00	0.00	0.00	0.00	0.00	3.00	3.00	0.00		
Ward 3B MPH day			2	1	11.92	2.64	0	1	1	11.92	3.25	0	1.00	0.00	0.00	-0.61	0.00	17.56	17.17	0.39	27	17.1
Ward 3A MPH inpatient	18	18	1	1	11.32	2.42	4.28	1	1	11.17	2.97	4.28	0.00	0.00	0.15	-0.55	0.00	20.02	20.42	-0.40	9.5	5
Dermatology - Louise																						
Day Care 4 South			1	1	5.59	1	0	1	1	4.6	1	0	0.00	0.00	0.99	0.00	0.00	8.59	7.60	0.99		
Derm OPS Level 5 RVH			1.69	3.3	4.07	1	0.8	1	3.3	3.32	1.5	0.8	0.69	0.00	0.75	-0.50	0.00	10.86	9.92	0.94	3.98	
Derm OPD WD BCH			0.8	1	5.86	3	0	0.8	0	6.13	2.5	0	0.00	1.00	-0.27	0.50	0.00	10.66	9.43	1.23	16.88	9
Derm ICATS			2	0	0	0	0	2	0	0	0	0	0.00	0.00	0.00	0.00	0.00	2.00	2.00	0.00		
Oncology - Joanne Cullen																						
CC 2A	19	19	1	2	22.96	1.91	4.66	1	1.88	19.68	1.8	2.96	0.00	0.12	3.28	0.11	1.70	32.53	27.32	5.21	0	12
CC 2B			1	2	25.99	5.42	2.45	1	2	21.68	4.71	2.41	0.00	0.00	4.31	0.71	0.04	36.86	31.80	5.06	3	13
CC 3A			1	2	14.48	2.5	1	1	2	15.07	2.5	0.85	0.00	0.00	-0.59	0.00	0.15	20.98	21.42	-0.44	10	10
CC 3B	11	11	1	1	13.79	2.47	2.56	1	1	11.53	1.5	3.36	0.00	0.00	2.26	0.97	-0.80	20.82	18.39	2.43	9	0
AOHU			1	1	9.5	2.23	0	1	1	10.03	4.6	0	0.00	0.00	-0.53	-2.37	0.00	13.73	16.63	-2.90	11	4.2
Acute Oncology			2	0	0	0	0	2	0	0	0	0	0.00	0.00	0.00	0.00	0.00	2.00	2.00	0.00	0	50
Bridgewater Suite Onc			1	12.02	15.62	6.8	0	0.8	10.84	11.8	6.73	0.53	0.20	1.18	3.82	0.07	-0.53	35.44	30.70	4.74	10	20
BPS			0	0.97	2.35	2	0	0	0.8	3.38	2	0	0.00	0.17	-1.03	0.00	0.00	5.32	6.18	-0.86		
Radiotherapy OPD			1	1	3.68	1	0	1	1	2.79	1	0	0.00	0.00	0.89	0.00	0.00	6.68	5.79	0.89		
infusional services			1	7.51	0	0	0	1	3.5	0	0	0	0.00	4.01	0.00	0.00	0.00	8.51	4.50	4.01		
Total			43.77	101.7	292.9	84.97	26.14	42.7	87.74	261.5	84.81	25.91	1.07	13.96	31.38	0.16	0.23	549.47	502.7	46.8	.	.

Unit	Cancer & Specialist Medicine Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
BCH AOHU	2.6	1.76	1.81	1.58	3.35	3.32	2.9	0.89
BCH CC Ward 2A	6.04	4.64	4.73	4.43	2.67	1.12	1.29	2.35
BCH CC Ward 2B	10.39	8.5	7	8.51	3.28	2.97	1.17	2.57
BCH CC Ward 3A	1.46	1.65	1.52	1.96	0.56	0.52	0	0.55
BCH CC Ward 3B	2.87	2.98	2.24	2.38	0.59	0	0	0.07
BCH Dialysis Unit A and B (Renal)	4.41	2.94	4	3.72	2.95	1.77	2.37	2.61
BCH 4 South	0.02	0	0	0	0.21	0.26	0.43	0
BCH 6 North	0	11.96	13.54	11.95	5.94	6.13	3.81	4.49
BCH 10 North	4.79	4.56	4.62	2.94	1.76	0.75	1.71	2
BCH 11 North	8.64	0	7.15	5.14	6.08	6.98	4.4	5.66
BCH 11 South	5.62	6.97	5.84	7.79	1.66	1.74	1.87	2.66
Totals	**46.84**	**45.96**	**52.45**	**50.4**	**29.05**	**25.56**	**19.95**	**23.85**

Overall total	2019	2020
	195.65	**98.41**



<table>
<tr><th>Issues</th><th colspan="2">Action</th><th>Timescale</th><th>Status at 31 July 2020</th></tr>
<tr><td rowspan="5">Cancer and Specialist Medicine:
<u>3 Sites:</u>

All areas experiencing vacancies in Nursing workforce.

Current Divisional Vacancies
Total FSL 619 WTE

Band 6 x 13.96 WTE Vacancies
Band 5 x 31.38 WTE Vacancies
Band 3 x 4.75 WTE Vacancies
Band 2 X 3.30 WTE Vacancies

7% nursing vacancy across

Nursing recruitment and retention is a priority for Cancer and Specialist Medicine.

The main objective is to maintain safe staffing levels – right person undertaking right care in the right place.

Difficulty recruiting new staff.
Objective of DN and wider team to promote CSM as Division of choice when new staff being recruited.</td><td rowspan="5">ALL AREAS
Regular mitigation</td><td>Ensure system in place to monitor nurse sickness and maternity absence figures monthly.

• Directorate target 5.47% End of July 5.97%
• Teams call – keeping in touch with staff shielding.
• Close monitoring of staff shielding during Co-vid – all now returned to work.
• DN forwarded card to Co-vid positive staff.</td><td>Ongoing as part of DN assurance meeting with CDUs</td><td></td></tr>
<tr><td>Appropriate authorisation and use of overtime, extra hours, bank then agency and monitor compliance with workforce KPIs.</td><td>Ongoing work as new KPIs will be introduced.</td><td></td></tr>
<tr><td>Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.

<table>
<tr><th><u>Nursing</u></th><th>Staff</th><th>Agency</th><th>Bank</th><th>Total</th></tr>
<tr><td>Oncology</td><td>-634</td><td>144</td><td>107</td><td>-383</td></tr>
<tr><td>Rheumatology</td><td>-43</td><td>0</td><td>36</td><td>-7</td></tr>
<tr><td>Dermatology</td><td>-94</td><td>-1</td><td>10</td><td>-85</td></tr>
<tr><td>Haematology</td><td>-214</td><td>278</td><td>25</td><td>89</td></tr>
<tr><td>Palliative Care</td><td>-4</td><td>0</td><td>0</td><td>-4</td></tr>
<tr><td>Nephrology</td><td>-143</td><td>122</td><td>120</td><td>99</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Budgetary monitoring monthly</td></tr>
</table></td><td>Ongoing.
August 2020.</td><td></td></tr>
<tr><td>Service to maximise staff availability when required by:
• Offering increased hours
• Offering overtime
• Encouraging staff flexibility</td><td>Ongoing.
August 2020.</td><td></td></tr>
<tr><td>Review of E-roster/Telfords involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff.</td><td>COMPLETE 21/07/2020.</td><td></td></tr>
</table>

		Ward staffing risk assessments updated monthly to ensure all control measures in place and the provision of safe, compassionate care for patients. • 6N to update risk assessment and forward September 2020.	**Ongoing. September 2020.**	
Student Nurse placements		**Bed stock** 2A in CC reduced by 1 bed to 19 beds following return of AOHU to CC. 2B – 23 beds 3A – now BWS Onc treatment no in-patient beds now 20 chairs and 3 procedure/brachy beds. 3B – 11 beds 6N open with only 12 beds currently.(GI beds x 8 remain temporarily closed) as part of rebuilding services. 10N - 28beds 11N – 12 beds 11S – 11 beds MPH 3A – 13 beds + 5 currently for rapid access clinic. • Telfords reviewed as bed compliments changed during pandemic/service rebuilding. e.g. 6N re-opened with only 12 beds instead of 20 beds • Telfords reviewed as bed compliments changed during pandemic/service Ward 3a MPH – acuity to be reviewed in light of change in bed stock – 13 beds and 5 rapid access clinic beds.	**Review end of September 2020 as part of rebuilding plan**	
		Divisional Nurse collaborates with central nursing workforce team regularly.	**Ongoing September 2020**	
Open University		Specific recruitment event for Directorate 22nd February 2020. (71 successful)	**Complete 22/02/2020.**	
		CSM to work collectively with central nursing workforce and be actively involved in Trust recruitment drives. Providing panels members as required.	**Ongoing September 2020**	
		Explore live recruitment model for CSM areas of concern.	**September 2020.**	
		Promote positive student nurse placements to attract candidates to CSM. DN promoting CSM with students on walk rounds.	**Ongoing September 2020**	

		Establish focus groups with third year placement students, facilitated by NDLs/PEFS.	**Ongoing November 2020**	
		Review educational audits for Cancer and Specialist Medicine.	**October 2020**	
		DN to meet with PEF to review student placements and mentor register. (meeting set up October 2020) NDL monitoring FNFM training.	**October 2020**	
		Exit interviews to be encouraged and completed, NDLs to be involved in process. Themes to be reviewed.	**Ongoing November 2020**	
		Open University places – promoted and supported. Currently staff from CSM completing OU course.	**Ongoing September 2020**	
		Retention of transitional students. 8 retained and commencing August/September/October.	**Completed September 2020.**	
		Telfords reviewed as bed compliments changed during pandemic/service Ward 3a MPH – acuity to be reviewed in light of change in bed stock – 13 beds and 5 rapid access clinic beds.	**Completed July 2020. October 2020**	
		Transfer protocol promoted and continue to support staff who wish to transfer between sites and within Division.	**Ongoing July 2020**	
International recruitment		Work closely with central nursing workforce in placing international recruits and ensure OSCE training attended and successfully passed. Ensure mentor allocated and NDL provides support.	**Ongoing September 2020**	
Leadership support		All leavers offered to join bank as well as those staff retiring.	**Ongoing July 2020**	
		DN tea/coffee catch up with each Ward Sister to discuss development needs.	**Ongoing August 2020**	
Staff support		NDL role review as part of wider DN work in collaboration with central nursing workforce team	**December 2020**	

Nephrology – recruitment ongoing issue. DN and wider team to promote CSM as Division of choice when new staff being recruited through Trust ongoing recruitment or bespoke CSM recruitment. Ward 11N and 11 S (Transplant) Regional Dialysis Unit, Acute Dialysis Knock Breda Community Dialysis 11N-0 WTE x Band 5 Vacancies 11S -2.68 WTE RDU – 2.73WTE	**Nephrology Services**	Attract/recruit staff to Acute dialysis team in 11N and 11S transplant team.	**August 2020.**	
		Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position. <u>New starts</u> • 11 South -2.68 WTE Band 5 vacancies – 3 new starts imminent • 11 North-No vacancies • Dialysis Unit-3.73 WTE Band 5 vacancies – 1 new start imminent	**Ongoing**	
		8% sickness absence in the Dialysis Unit = 4 staff members on long-term sick leave • Recovering from COVID-19 related critical illness and being appropriately managed by OH • Underlying health condition and still shielding on the advice of GP. Referred to OH • Non-COVID-19 related illness and being appropriately managed by OH • Non-COVID-19 related illness and being appropriately managed by OH	**Ongoing August 2020**	
		Exit strategy for off contract agencies within Acute Dialysis due to HD skills deficit, arising from unfilled vacancies.	**Sept 2020**	
Haematology Ward 10N and 6N BWS Haematology **6N** 12.21WTE x Band 5 vacancies 0 WTE x Band 3 0 WTE Band 2 **10N** **3.12 Band 6 WTE vacancies** 1.20WTE x Band 5 vacancies 0.24 WTE x Band 3 0.53WTE Band 2	**Haematology services**	Ward 6N area of concern -12.14WTE Band 5 vacancies. (based on full complement of beds 26) Have been running prior to Co-vid on 20 beds and unused during Nightingale. Reopened July 2020 with only 12 beds. 8 beds temporarily closed in 6N due to reopening of services. Revised Telford agreed as part of re-establishment of services within BCH Tower.	**Sept 2020**	
		6N Band 6 x 2 advertised and interviews planned for 16th September to ensure senior decision making across rota.	**Sept 2020**	
		Ward staffing risk assessment updated each month by Ward Managers, overseen by ASM to ensure all control measures are in place focussing on management of absenteeism.	**Sept 2020**	

6N has experienced difficulty in recruiting over a sustained and lengthy period.		Service to maximise staff availability by: • Offering increased hours • Offering overtime • Appropriate use of overtime, extra hours, bank then agency	**Ongoing**	
		Strict adherence to protocol for going off contract for agency nurses.	**Ongoing**	
		Review of E-roster by E Roster Team involving Ward Sister and ASM, central nursing and DN to maximise effective use of staff and ensure appropriate surveillance of the system.	**21/07/2020**	
		International Nurse recruitment – 4 International nurses in 6N. Review in line with central nursing and HR when 3 yearly contract coming to end and secure extension for further 2 years.	**Ongoing**	
Issues	**Action**		**Timescale**	**Status at 31 July 2020**
Rheumatology and Dermatology Ward 3a and 3B in MPH Level 5 OPD Wing D BCH 4S BCH **3A** 0.15 WTE Band 5 vacancies 0.55 WTE Band 3 **3B** 0.61 WTE Band 3 vacancy **Level 5 OPD RVH** 0.75 Band 5 vacancies 0.50 WTE band 3 4S 0.99 WTE Band 5 vacancy Ward 4s remains temporarily closed and staff redeployed to MPH and RVH.	Rheumatology and Dermatology Services	Temporary Lead Nurse posts commenced to provide professional leadership and standardisation of protocols etc. and oversee implementation of action plan in collaboration with the ASM. (temporary for 6 months)		
		Band 7 post in 3b – out to advert to be interviewed in September.	**September 2020.**	

Wing D OPD re opened on 14/07/2020.				
Issues	**Action**		**Timescale**	**Status at 31 July 2020**
Oncology 15.06WTE Band 5 Vacancies 1.86WTE Band 3 1.96WTE Band 2 Cancer Centre new starts: CC2A 1 new start CC2B 3 new starts CC 3B 2 new starts	**Oncology Services**	Re-profiling of Band 5 posts x3 in CC to enable senior decision maker presence across rota. Interviews September 2020.	**September 2020.**	
		Oncology/Haematology Regional Stabilisation plan June 2020 – development of advanced nurse practitioner roles for BWS Haematology and AOHU Oncology.	**Ongoing**	
		Risk assessment updated to ensure all control measures in place and the provision of safe, compassionate care for patients and subsequently action plan updated accordingly with robust review process in place.	**Ongoing September 2020**	
		CNS workforce expansion plan (year 5) in progress.	**Ongoing September 2020**	

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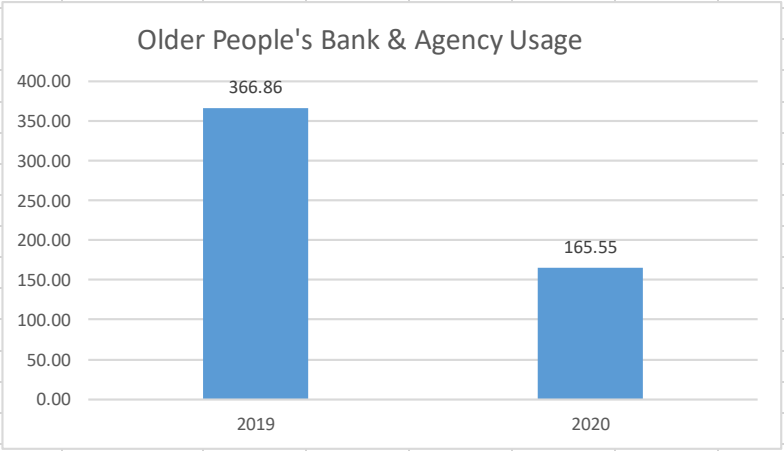
Older Peoples Services Workforce Information

Ward				Funded Establishment						Staff in Post					Variance					Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2					
Mater																								
Ward C	1.3 (currently1.5)	18	18	27.93	1	3	13.14	6.86	3.26	0.87	2.87	10.52	6.71	4.5	0.13	0.13	2.62	0.15	-1.24	01-Jun-20	6%			
RVH																								
Wards 6E/F	1.6 (currently with addation of HASU nurses 1.75)	31 and 4 assesment	31+4 assessment	65.2	2	5	27.01	8.5	7.7	2	5	23.73	9.1	6	0	0	3.28	-0.6	1.7		7%			
HASU					0	12.88	0	0	0	0	11.88	0	0	0	0	1	0	0	0					
Specialist Nurses					0	2	0	0	0	0	1.2	0	0	0	0	0.8	0	0	0					
BCH																								
6 South	1.3 (currently	25	Wards Current closed staff redeployed in service	34.61	1	3	16.5	8.76	5.36	1	3	16.54	5.65	5.12	0	0	-0.04	3.11	0.24		10%			
7 North	1.3 (Currently 1.4)	25		34.83	1	3	17.49	7.7	5.64	1	2.96	16.4	7.87	4.8	0	0.04	1.09	-0.17	0.84		5%			
7 South	1.3 (Currently	25		35.38	1	3	16.72	8.67	5.99	1	3	12.37	9	5.26	0	0	4.35	-0.33	0.73		13%			
BCH Direct				18.2	2.9	2.65	5.65	6	1	2	2.65	4	4.8	0	0.9	0	1.65	1.2	1		26%			
Musgrave																								
Meadowlands 1	1.3	24	20	26	1	3	13.9	7.71	3.88	2	2.85	9.95	6.84	1	-1	0.15	3.95	0.87	2.88	Jun-20	26%	11.20%	0.00%	
Meadowlands 2	1.3	24	20	26	1	3	13.9	6.73	3.88	1	2.91	12.2	7	2.6	0	0.09	2.89	-0.27	1.28	Jun-20	15%	12.60%	0.00%	
Knockbracken																								
Valencia		20	8	26.4	1	3	10.59	10.81	0	1	1	5.5	10.8		0	2	4.89	0.01	0		26%	11.40%	0.00%	
Totals				294.55	11.9	43.53	134.9	71.74	36.71	11.87	39.32	111.2	67.77	29.28	0.03	4.21	24.68	3.97	7.43					

Unit	Older People's Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
Acute Care at Home	0.00	0.44	0.36	0.88	0.00	1.86	1.49	1.24
BCH 1 South Direct	0.32	0.31	1.23	1.88	0.08	0.00	0.00	0.00
BCH 6 South	13.22	14.23	12.01	11.19	1.38	0.45	0.07	3.91
BCH 7 North	11.25	12.35	10.39	11.14	3.87	0.00	0.00	0.07
BCH 7 South	13.46	10.43	12.96	14.68	3.55	0.82	0.00	0.15
BCH Pre Assessment Unit	0.78	0.15	0.00	0.00	0.08	0.00	0.00	0.00
KHCP Dementia Inpatient Service	15.74	16.35	19.16	20.98	9.98	12.06	0.00	15.68
MIH Ward C	12.23	11.84	11.32	12.29	12.18	10.55	5.70	5.56
MPH Meadowlands 1	0.00	0.00	0.00	0.00	7.79	0.00	0.32	1.10
MPH Meadowlands 2	10.05	10.28	6.03	6.59	15.04	1.05	0.00	1.92
RVH Ward 6E/F (Stroke Unit)	14.24	13.78	16.73	15.59	14.13	11.96	10.04	11.47
Totals	**91.29**	**90.16**	**90.19**	**95.22**	**68.08**	**38.75**	**17.62**	**41.10**

Overall total	2019	2020
	366.86	**165.55**



Older People's Services Action Plan

Issues	Action		Timescale	Status at 31 July 2020
Older People Services: **5 Sites:** **BCH – BCH Direct, 6S,7N,7S** **MIH – Ward C** **RVH – Stroke Unit 6E&F** **MPH - Meadowlands 1&2** FSL 295.52 WTE Band 6 x 1.03 WTE Vacancies Band 5 x 20 WTE Vacancies Band 3 x 6.3 WTE Vacancies Band 2 X5.43 Nursing recruitment and retention is a priority for Older People's Services (20 WTE Band 5 vacancies across the inpatient areas). The nursing establishment in within Older peoples Wards are not in line with the Delivering Care standard	**ALL INPATIENT AREAS**	Service to maximise staff availability by: • Offering increased hours • Offering overtime • Encouraging staff flexibility	**Ongoing**	
		Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in Older People's areas when they graduate DN Meeting with PEF to review student placements and mentor register.	**Ongoing**	
		Review of E-roster involving DN, ward team, finance and central nursing workforce team to maximise effective use of staff.	**COMPLETE**	
		Appropriate use of overtime, extra hours, bank then agency Strict adherence to protocol for going off contract for agency nurses and only after appropriate risk assessment and all of the above is considered.	**Ongoing**	
		Ward staffing risk assessments updated monthly to ensure all control measures in place and the provision of safe, compassionate care for patients.	**Ongoing**	
		COE workforce plan; promotion of Acute Care of the older person • OU pathway for HCA staff; ONGOING • Development of older people's career pathway for nursing i.e. advanced nurse practitioners; additional specialist practice places secured through transformational funding. RN x1 ANP: RN x 3 Specialist Practice	**Ongoing**	
Issues	**Action**		**Timescale**	**Status at 31 July 2020**
Stroke Services (RVH)	**STROKE SERVICES**	Clinical Educator for Stroke Unit. Hyperacute Stroke Units require a range of highly skilled staff, with access to diagnostic equipment 24		

2.5 WTE x Band 5 Vacancies Reshaping Stroke Services Task and Finish Group, led by the HSCB, has been charged by the DoH with the design of and consultation on a service model for stroke services that capitalises on the opportunities to prevent stroke, reduce stroke associated death and disability and ensure high quality services that are fully sustainable.		hours a day, seven days a week. 6 x band 5 posts are being converted to HASU posts to allow 24/7 cover.		
		Focus on promoting a positive student nurse placement and encouraging these students to consider a registered nurse position in Stroke when they graduate.	**Ongoing**	
		Work with Department and stroke Network to develop the workforce plan in line with the regional redesign of stroke services . Agree funding with Department and commissioners for stroke ambulatory pathway	**Sept 2020**	
Meadowlands 6.51 WTE x Band 5 vacancies Decrease in staffing levels due to absenteeism. 10 beds currently closed in Meadowland 1 while review of service is underway	**REHABILITATION**	*Ongoing work to review Older People pathway and how that should be delivered and ongoing work to develop a frailty service.* Could potential leaded to changes in service delivery	**Sept 2020**	
		Ward staffing risk assessment updated each month by Ward Managers, overseen by ASM to ensure all control measures are in place focussing on management of absenteeism.	**Sept 2020**	
		Service to maximise staff availability by: • Offering increased hours • Offering overtime • Appropriate use of overtime, extra hours, bank then agency	**Ongoing**	
		Strict adherence to protocol for going off contract for agency nurses	**Ongoing**	
		Review of E-roster by E Roster Team involving Ward Sister and ASM, to maximise effective use of staff and ensure appropriate surveillance of the system.	**June 2020**	
		ASM and Ward Sisters training in management of E-Rostering	**Ongoing**	

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Community Nursing Workforce Information

Ward	Funded Establishment						Staff in Post					Variance					Telfords Updated Date	Total Vacancy %	COMMENTS
	Total funded establishment	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2			
Knockbreda	26.77	1	7	14.04	4.73		1	5	10.07	2.53		0	2	3.97	2.2	0	updating	31%	
Beech Hall	42.19	5	10.8	19.59	6.8		5	5	10.6	4.2		0	5.8	8.99	2.6	0	updating	41%	
Dundonald	28.45	1	7.8	14.91	4.74		1	7	11.4	3.6		0	0.8	3.51	1.14	0	updating	19%	
Shankill	28.2	2	6	13.8	6.4		1	5	9	5.8		1	1	4.8	0.6	0	updating	26%	
Bradbury	24.01	1	6	14.43	4.58		1	3	6.2	4.8		0	3	8.23	-0.22	0	updating	46%	
Arches	27.31	1	7.92	13.96	4.43		1	6	12.17	3.2		0	1.92	1.79	1.23	0	updating	18%	
Grove	30.27	1	7.4	15.3	6.57		0.5	5	11.8	6.8		0.5	2.4	3.5	-0.23	0	updating	20%	
Carlisle	28.01	1	7	13.44	6.6		1	4	11.3	5.6		0	3	2.14	1	0	updating	22%	Band 3 seconded to OU
Acute Care at Home	22	6	6	5	5		6	5	5	7		0	1	0	-2	0		-5%	
Community Nurse Inreach	6	1	5	0	0		0.8	4.8	0	0		0.2	0.2	0	0	0		7%	
Treatment Room Service	15.43	1	1	12	1.9		1	1	9.16	1.9		0	0	2.84	0	0	updating	18%	
Community Heart Failure Team	3	3	0	0	0		1	0	0	0	0	2	0	0	0	0	updating	67%	1 RN off on sick leave
Out of hours nursing team	35.67	1	6.88	10.38	17.41		1	5.53	6.2	9.26		0	1.35	4.18	8.15	0	updating	38%	
Continence team	10.76	1	4	3.3	2.14		1	3.9	2.8	2.14		0	0.1	0.5	0	0	updating	6%	
Pall & Onc Team	5	3	2	0	0		3	2	0	0		0	0	0	0	0		0%	
Community Diabetes Team	15.53	4	4	0	3.5		6	2	0	3.61		-2	2	0	-0.11	0		-1%	
Totals	348.6	33	88.8	150.2	74.8	0	31.3	64.23	105.7	60.44	0	1.7	24.57	44.45	14.36	0			

Community Nursing Services Action Plan

REF NO	Community Nursing Service ISSUES	ACTION	DATE FOR COMPLETION TIMESCALE	Status at 31 July 2020
	District Nursing Services District Nurse staffing has been highlighted as a major risk (red) on Trusts Principle & Directorate risk register **District Nursing day time hours Current vacancies** Band 7 x 0.5 wte Band 6 x 18.45 wte Band 5 x 23.87 wte Band 3 x 5.13 wte (this figure does not include the MDT Funding March 2020 5x Band 7, 2x Band 6 3x Band 5 **District Nursing Out of Hours Services Current vacancies** Current Vacancies across all Out of Hours District Nursing Services Band 6 x 0.74 wte vacant Band 5 x 4.23 wte vacant Band 3 x 9.19 wte vacant	**Short Term** • Monthly meeting held to review work pressures and staffing, skill mix, across 8 District Nursing Teams. Nursing Staff are requested to internally move across teams as necessary, ensuring delivery of service. Actioned by ASM • Business continuity (red) and kept under review. This includes CNIR assisting with administration of IV Therapies • Daily Telephone Liaison with Team Managers • Bank sourced for both Band 5, 3 & Band 6. Bank provision also monitored on weekly basis • Team Manager has reviewed District Nursing Sister caseloads in line with e-cat information. Where necessary caseloads have been divided to ensure an equitable workload within individual teams • Sickness absence monitored closely • Accommodation remains an issue in relation to the recruitment and retention of staff. Service Manager facilitating meetings to address this. **Action** Service Manager /Divisional Nurse Due Pandemic planning District Nursing day time covering shifts between 8am –8pm Out of Hours District Nursing covering between the hours of 8pm –8am Registered Nursing from Evening Service redeployed to nigh duty Senior Nursing Assistant redeployed to District Nursing Day Time and other areas	**March 18 to present on-going** **March 2020-to present ongoing**	

	District Nursing Recruitment 2020	**Band 7 MDT X 5** appointed and in post July 2020 **Band 6** staff ,11 interviewed 1 started in July 2020. 8 have start dates for August 2020. 2 to be appointed a All attended Community Nursing Induction Programme July 2020 **Band 5** Community Nursing commenced a trial rolling advert July 2020 34 staff shortlisted out of 36 Interviews arranged for August 2020 There is a need to continue to raise awareness with Universities and Secondary Care colleagues (evident through transfer requests) that newly qualified staff do not need hospital experience to work in the community. **Action;** Service Manager & ASM • Divisional Nurse to update ACOPS leadership Team and Executive Director of Nursing. **Action** Divisional Nurse **Medium / Long term** • Continue with Band 5 rolling advert for recruitment • Business Continuity reviewed and updated July 2020.	**On- going** **On-going**	

		• Review of AFC Banding is currently being taken forward for District Nurse Band 6, through Job Matching process. • Continue to seek opportunities to profile service regionally and nationally. Representation on regional groups- District Nursing Framework • Recommendations of Delivering care normative phase 3 agreed, • Funding given for West Belfast MDT • District Nursing phase 2 Modernisation and Workforce in progress. • Focus on shift patterns • Caseloads review to be aligned with GP federations • Focus on Key Worker for palliative and End of Life Care • IT Pilot of mobile working and staff diaries for allocation of calls in 2 teams Grove and Knockbreda • Other 6 District Nursing Teams using CAT caseload allocation Tool for allocating calls **Pandemic Planning for COVID 19** • Business continuity plan reviewed regularly • Social Distancing Measures put in place • Assurances of availability of PPE • Assurances staff using PPE as per DOH guidelines • Environmental Risk Assessments Completed • Community risked assessed in amber • Remote access for staff requested • All staff risk assessed • Return of shielding staff August 2020 • Liaison with Occupational Health regarding shielding Staff Risk Assessment	**on-going** **ongoing** **July 2019 ongoing** **March 2018** **On-going**	

		If business continuity moves to red high then • Divisional nurse to escalate to Service Director & Director of Nursing • .Closure to referrals from hospital & establishment of waiting list Communication to Hospital colleagues to be notified by Service Manager /ASM **Action** Divisional Nurse /Service Manager/ASM. **Team activities reviewed** • Current workload reviewed & prioritised at team level by caseload holder /team manager based on patient assessed need /dependency • New referrals triaged and prioritised for visit • Further Monitoring staff absence levels both short and long term and manage capacity within the team as per normal arrangements linking with all hospital /community /primary care teams as necessary. • Liaise with patient regarding time/day of visit postpone if necessary. • Liaise with profession specific core services if there is capacity to carry out patient visit. • Provide specific guidelines and policies to support core services	**On-going** **On-going**	

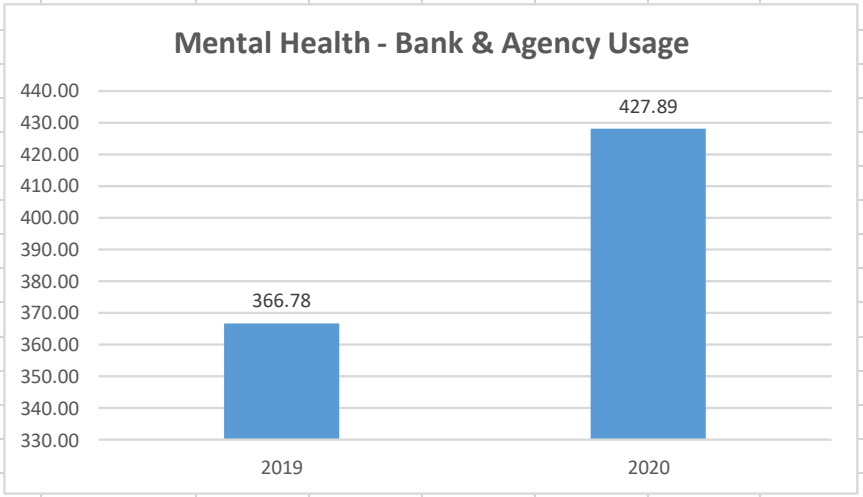
MAHI - STM - 102 - 4382

Mental Health Workforce Information

Ward	16% headroom inc Ward sr	Beds	Beds Open	Funded Estlishment						Staff in Post					Variance					Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
	Agreed NTBR			Total funded establishment	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2					
Knockbracken																								
Ward 1 (Shannon)	2.7	12	12	37.9	3	3	16.9	15	0	2	4	10.83	10.85	0	1	-1	6.07	4.15	0	Yes	27%	18.90%	0.80%	
Ward 2 (Shannon)	2	12	12	28	1	2	12	13	0	1	1	9.86	7	0	0	1	2.14	6	0	Yes	33%	13.60%	4.20%	
Ward 3 (Shannon)	1.5	10	10	18	1	2	5	10	0	1	1	4	4	0	0	1	1	6	0	Yes	44%	6.50%	0.00%	
Clare	1	20	14	26.5	1	1	9.5	14	0	1	2	5.94	11.52	0	0	-1	3.56	2.48	0	Yes	19%	5.40%	3.30%	
Neuro Behavioural Unit	1.5	12	2	21.62	1	1	9.62	10	0	1	1	4	4	0	0	0	5.62	6	0	Yes	54%	0.40%	0.00%	Ward Closing Actual NTBR maintained at 2.1
Mental Health BCH																								
Ward 1	1.4	14	14	23.37	1	3	14	4	0	1	2	11.6	5.07	0	0	1	2.4	-1.07	0	yes	10%	15.60%	3.50%	
Ward 2	1.2	20	20	27	1	3	16	7	0	1	2.16	17.35	6.4	0	0	0.84	-1.35	0.6	0	yes	0%	6.20%	8.90%	
Ward 3	1.2	20	20	27	1	3	16	7	0	1	2	17.21	8.08	0	0	1	-1.21	-1.08	0	yes	-5%	7.10%	3.40%	
Ward 4	4	6	6	26.5	1	3	18	4.5	0	1	3	15.56	6	0	0	0	2.44	-1.5	0	yes	4%	5.20%	0.00%	
Ward 5	1.2	20	20	27	1	3	16	7	0	1	2	16.97	5.45	0	0	1	-0.97	1.55	0	yes	6%	12.20%	5.30%	
Foster Green Site																								
Beechcroft	2.4	31	25	88.1	4	4	43.95	35.4	0	3	7	22.16	26.79	0	1	-3	21.79	8.61	0	in progress	32%			
Community																								
Community Mental Health				235	73.8	112.38	26.99	53.32	0	58.77	82.87	18.66	26.93		15.03	29.51	8.33	26.39	0	NA	34%			
Totals				585.99	89.8	140.38	203.96	180.2	0	72.77	110	154.14	122.09	0	17.03	30.35	49.82	58.13	0		22%			figures are for nursing not MDT

Unit	Mental HealthBank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
BCH AMHIC Ward 1 (MIH Ward L)	4.25	6.992	5.02	10.81	11.23	9.21	11.56	15.92
BCH AMHIC Ward 2 (MIH Ward J)	11.53	10.2	9.44	13.1	10.94	9.7	12.79	11.49
BCH AMHIC Ward 3 (KHCP Rathlin)	8.24	7.36	9.68	11.04	9.5	9.29	10.01	9.05
BCH AMHIC Ward 4 (KHCP Avoca)	7.23	8.51	8.68	10.34	12.05	7.08	8.56	8.35
BCH AMHIC Ward 5 (MIH Ward K)	4.14	4.1	5.96	6.16	10.93	8.02	9.24	9.97
Beechcroft 1 (Adolescent)	17.12	13.62	14.85	16.93	17.22	14.57	13.57	18.37
Beechcroft 2 (Children)	13.02	11.07	14.69	5.78	13.69	15.66	18.72	22.9
KHCP Clare Ward	5.79	4.68	4.39	4.65	2.67	5.31	5.59	1.37
KHCP MH Bed Flow	0.67	0.87	0.95	1.18	1.33	0.73	0.67	1.1
KHCP NRU/Innisfree	5.08	4.76	4.92	7.03	6.17	5.62	5.66	6.21
KHCP Shannon 1	1.1	2.62	5.29	4.74	2.06	2.04	2.8	3
KHCP Shannon 2	2.75	1.13	1.77	2.64	2.84	2.31	2.69	6.13
KHCP Shannon 3	1.95	2.93	2.76	3.88	0.96	1.48	1.71	2.3
Psychiatric Home Treatment House	0.81	0.75	0.55	0.69	0	0	0.05	0.33
Psychiatric Home Treatment Team	2.23	2.25	2.9	2.52	2.32	2.92	2.92	2.76
Unscheduled Care	1.4	1.62	1.13	1.54	1.11	1.03	0.85	1.26
Totals	**87.31**	**83.462**	**92.98**	**103**	**105.02**	**94.97**	**107.39**	**120.5**

Overall total	2019	2020
	366.78	**427.89**



Mental Health Nursing Action Plan

REF NO	Issues	Action	Timescale	**Status at 31 July 2020**
	Inpatient. Phase 5a delivering safe staff remains unfunded. All wards/ categories of care FSL falls below recommended safe staffing levels in regards to NTBR and skill mix resulting in high use of Bank / Agency staff. Poor compliance to e roster. E rosters not set against budget / FSL	Review of all e rosters across service against Delivering care recommendations	Sept 17th 2020	
		Review and reset rosters against FSL/ safe staffing recommendations	Sept 17th 2020	
		Rigorous oversight of e roster. Div. nurse, senior professional Nurse and NDL's have been given access to e- roster and training	August 2020	
		Introduction of e-roster KPI	Sept 2020	
		Ward sister access to create additional shifts suspended	August 2020	
		Continue recruitment, Band 5 rolling Add Adult and CAMHs. Bring recruitment under one advertisement	Ongoing	
		Continue to support staff through open university pre-registration nursing programme. 7 candidates commencing sept 20. 5 staff expected to complete October 20	Ongoing	
		Continue to provide positive student experience	Ongoing	
		Continue to provide comprehensive staff induction	Ongoing	
	Adult Mental Health Inpatient Unit. Delivering safe staffing not yet funded or implemented.	Position paper with Director SHWH & Finance for approval (see attached) in essence , to substantiate Band 5 positions to safe staffing recommendations and desist from using agency	Sept 20	

	Inadequate Limited vacancies but FSL Health roster set against 24% headroom , where as FSL set against historical 16% headroom Ward sister not supernumerary in FSL 26% RMN less than 2 years' experience. High sickness rate Ward 1 16.56 Ward2 6.67 Ward 3 9.65 Ward 4 7.25 Ward 5 9.21 6 staff on maternity leave 2 staff suspended Ongoing Regional bed pressures. July noted highest rate admissions / discharges Increased acuity/ complexity patient population resulting in higher levels of Special continuous observations prescribed. Approximately 1200 Nursing hours per week across unit.	Review and reset e-rosters	August 20	
		Rigorous oversight of e- roster Approval for off contract agency at director level	ongoing	
		Removed access from ward sister to create additional shift without oversight.	August 20	
		Continue rigorous attendance management	Ongoing	
		New service manager and ASM have received financial training modules	August 20	
		Band 7 ward sisters // CN to complete financial training.	Sept 20	
		Ongoing project to reduce continuous special observations in ward 4. Initial positive results noted	August 20	
		Morning Band 7 huddle , manage pressures/ staffing across unit	Jan 20	
		Early alert in situ and await DoH report/ recommendations of Task and Finish review re bed pressures	Sept 20	
	CAMHs Inpatient Beechcroft Staffing position remains on risk register. 32% Vacancy 21.79 Vacant Band 5 (£332,916 underspend YTD) 8.61 Vacant Band 3 (136,562 underspend YTD) Band 5 Agency spend £399,748 YTD	Risk assessment reviewed 17th August. Staffing to remain on risk register. Continue with Block booked off contract UK agency / replace with NI agency staff where possible. Reduce agency following new staff in post	Dec 20	
		Ongoing rolling band 5 advertisement and timely interviews 7 successful at recent interviews	Ongoing	
		All candidates on adult waiting list have been offered positions (1 accepted) Commence daily reporting special observation to quantify use.	August 20	

	High levels continuous special Observations across both wards			
	Delay refurbishment PICU Beechcroft.	Refurbishment and reconfiguration of PICU beds to commence September 2020. Delayed due to Covid Continue with 6 closed beds.	March 21	
	Knockbracken site: **Shannon Clinic** Absence levels High in wards 1 and 2 Ward 1 18.65% Ward 2 14.78% Ward 3 5.14% Financial position: underspend across unit -£51,369 Preliminary review against safe staffing levels indicates FSL too low NTBR and skill mix. Recommended skill mix will not likely be achievable with current workforce supply.	Rigorous adherence to attendance management protocols.	Ongoing	
		Recruit to vacant posts.	Nov 20	
		Review Rosters against Delivering Care recommendations	Oct 20	
	Clare Ward Absence 8.73% Vacancy- 3.56 WTE Band 5 2.48WTE band 3 Preliminary review against delivering safe staffing reveals incorrect skill mix and NTBR in FSL. Unlikely skill mix will be achievable within current workforce supply.	Rigorous adherence to attendance management protocols. Recruit to Vacant posts Review workforce against Delivering safe staffing recommendations	Oct 20	
	NRU Due for closure Oct 2020	Staff to be redeployed across service.	Dec 20	
	Community Mental Health Teams. 38 RN posts vacant across 42 teams. Number of vacancies created by expression of interest at band 7; Maternity Leave Long term sick leave Student mental Health – non recurrent funding	Monthly assurance meeting with Divisional Nurse / Service managers Band 5 / 6 accelerated nurse pathway with EDoN for consideration Substantiate EOI's were possible. Request priority for e roster roll out	Dec 20	

	Towards Zero suicide - non recurrent funding			
	Recovery Teams Band 6 Community Mental Health nurse Recruitment. Limited applicants, high DNA. 10 WTE band 6 Agency 10 WTE Band 6 Bank. Incorrect Interdisciplinary skill mix i.e. SW in Nursing posts	Currently undergoing service modernisation / restructure to amalgamate primary and recovery teams	Dec20	
		Continue with band 6 rolling add		
		Enlist assistance from Corporate Comms. re advertising campaign.		
		Develop rotation / work shadow opportunities.		
		Address Skill Mix as Nursing staff recruited. managers		
		Move to e roster when available / agreement with HR to run nursing absence reports when required		
		Monthly Monitoring meeting with Service Managers		
	Community and Partnership – addictions	Service manager to address a number of outstanding vacancies.		

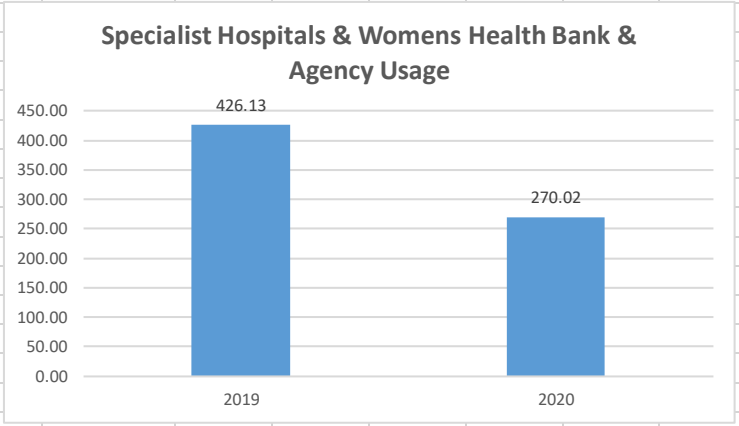
MAHI - STM - 102 - 4388

Trauma, Orthopaedics & Rehab Workforce Information

Ward				Funded Establishment							Staff in Post						Variance						Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2					
RVH																											
Ward 4A	1.57	22	0	35.55	1	3.54	20.37		5.32	5.32	1	0	9.24		4.84	3.77	0	3.54	11.13	0	0.48	1.55		47%			
Ward 4B	1.57	23	13	38.55	1	3.54	22.47		6.22	5.32	1	3.8	9.93		6.95	2.59	0	-0.26	12.54	0	-0.73	2.73		37%	8.40%	6.10%	
Ward 4C	1.57	23	23	37.05	1	3.54	21.42		5.77	6.32	1	2.8	13.2		5.43	1.02	0	0.74	8.22	0	0.34	5.3		39%	9.50%	5.80%	
Ward 4D	1 .80	22	22	41.8	1	3.54	24.06		5.33	7.87	1	4	16.01		5.23	2.88	0	-0.46	8.05	0	0.1	4.99		30%	8.80%	2.60%	
Fracture Clinic	N/A			31.95	1	3.4	19.45		5.5	2.6	1	3.7	13.17		5.69	1.8	0	-0.3	6.28	0	-0.19	0.8		21%	14.90%	0.00%	
Osteoporosis	N/A			4.73	1	0.53	3.2				1	0	3.2				0	0.53	0	0	0	0		11%			
Outcomes	N/A			2.81	1		1.81				0		1.8				1	0	0.01	0	0	0		36%			
Trauma Team	N/A			10.43	1	6.43			3		1	6.8			3		0	-0.37	0	0	0	0		-4%	26.90%	0.00%	
Musgrave																											
Withers 1A SCIU	1.5	23	23	33.21	1	3.81	18.19		6.21	4	1	3.81	17.89		6.07	4.87	0	0	0.3	0	0.14	-0.87		-1%	5.00%	0.00%	
Neurology	1.5	23	20	37.04	1	3.8	17.9		8.49	3.6	1	3.8	12.26	1	8.04	4.59	0	0	5.64	-1	0.45	-0.99		11%	11.60%	0.00%	
RABIU	1.8	23	20	50.41	1	4	22.32		11.51	10.58	1	3.8	14.26	1	12.61	9.2	0	0.2	8.06	-1	-1.1	1.38		15%	13.70%	0.00%	
POA	N/A	16 per	16 per day	14.13	1	5.47	4.14		2.6	1	1	4.47	4.51		2.6	1	0	1	-0.37	0	0	0		4%			
2B Paeds.	1 to 2 (some day	15	15	12.86	1	1	8.86		1	1	1	1	4.7		1	1	0	0	4.16	0	0	0		32%	0.00%	0.00%	
4A	1.25	20	20	25.4	1	2	15		4.5	2.9	1	1.8	12.53		3.84	2.56	0	0.2	2.47	0	0.66	0.34		14%	14.10%	3.70%	
4B	1.25	20	20	25.4	1	2	15		4.5	2.9	1	2	13.16		3.6	2.48	0	0	1.84	0	0.9	0.42		12%	15.00%	3.20%	
5A DOS	up to 35 patients	20 spaces	20	14.21	1	1	8.85		3.6	0	1	1	7.48		3.6	0	0	0	1.37	0	0	0		10%	6.30%	1.80%	
5B	1.25	20	20	25.9	1	2	15		4.5	2.9	0	2	13.16		3.39	2.95	1	0	1.84	0	1.11	-0.05		15%	25.60%	24.20%	
6A	1.25	20	20	25.26	1	2.82	14		3.56	3.7	1	2.82	11.6		3.54	2.76	0	0	2.4	0	0.02	0.94		13%	2.50%	0.00%	
6B ER	1.8	12	12	21.6	1	2	12.2		4.24	2.16	1	2	8.03		3.84	1.56	0	0	4.17	0	0.4	0.6		24%	20.50%	5.80%	
Theatres	N/A	10		73.02	2	9.76	34.91	15.97	2	6.28	2	8	26.52	15.23	2	6.8	2	1.76	8.39	0.84	0	0.52		19%	6.50%	3.70%	
Recovery	2.1	13		30.76	3	7.76	18			2	0	0.03	3.86		0	0.2	3	7.73	14.14	0	0	1.8		10%	12.50%	4.60%	
Specialist Nurses	N/A			9	6	3					4	2	0		0	0	2	1	0	0	0	0		33%			
OPD	N/A			23.9	1	3	16.15		4.75		1	3	15.74		3.55	0	0	0	0.41	0	1.2	0		7%			
Outcomes	N/A			6.27	0	4.11	2.16				0	4.11	2.16		0	0	0	0	0	0	0	0		0%			
Totals				631.24	31	82.05	335.46	15.97	92.6	70.45	24	66.74	234.4	17.23	88.82	52.03	9	15.31	101.1	-1.16	3.78	19.46					

Unit	Specialist Hospitals & Womens Health Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
MPH Neurology	7.91	8.89	7.73	10.31	6.64	5.14	6.02	9.15
MPH RABIU	18.69	15.7	16.88	17.29	19.96	14.15	12.51	14.14
MPH SCIU	1.15	1.31	1.62	0.76	0.63	0	0	0.37
MPH Ward 2A	0	0.96	0	0	0	0	0	0
MPH Ward 2B	0	0	0	0	0	0	0	0
MPH Ward 3A	0.98	1.18	1.76	2.58	1.5	1.74	1.15	1.51
MPH Ward 4A	3.31	3.91	2.69	3.1	1.06	2.3	2.02	1.28
MPH Ward 4B	3.2	3.15	2.88	2.08	2.6	2.75	2.17	2.79
MPH Ward 5A	0.98	0.61	0.4	0.12	0	0	0	0
MPH Ward 5B	1.17	1.75	0.35	1.78	2.1	0	0	0
MPH Ward 6A	2.49	1.63	1.47	1.36	0.77	0	0	0.21
MPH Ward 6B	0.37	0.51	0.53	0.31	0	0	0.44	0.24
MPH Withers 3B	0.49	0.74	0.72	0.54	0.05	0.07	0.88	0.99
RVH Fracture Clinic	3.88	3.43	4.35	3.11	3.56	2.83	2.01	1.81
RVH Fracture Trauma Coordinators	0	0	0	0	0	0	0.1	0
RVH Ward 4A	19.48	15.56	18.96	19.41	0	0	0	0
RVH Ward 4B	11.12	13.16	14.13	14.57	1.61	0	7.17	12.09
RVH Ward 4C	13.84	16.86	19.12	18.51	16.56	11.06	18.21	20.44
RVH Ward 4D	14.16	13.37	14.73	16.04	14.83	11.19	9.99	19.23
Totals	**103.22**	**102.72**	**108.32**	**111.87**	**71.87**	**51.23**	**62.67**	**84.25**

Overall total	2019	2020
	426.13	**270.02**



Trauma Orthopaedics and Rehabilitation services Action Plan

Nursing workforce report :Trauma Orthopaedics and Rehabilitation services updated 31 July 2020			
All areas experiencing band 5 vacancies **335.46 wte band 5 total FSL** 100.3 band 5 vacancies 30 % band 5 vacancy levels across the division Total 23% nursing vacancy across TOR The primary objective is to maintain safe staffing levels- right person undertaking the right care in the right place.	**Regular mitigation** • Ensure system in place to monitor nurse sickness and maternity absence figures monthly.	**Ongoing as part of monthly assurance meeting.**	
	• Ensure system in place to authorise appropriate use of overtime, extra hours, bank then agency and to monitor compliance with workforce KPIs.	**Ongoing work as new KPIs will be introduced**	
	ure there is strict adherence to protocol for going off contract for agency nurses and after appropriate risk assessment and all of the above is considered.	**Ongoing**	
	Assessment of bed stock • Jan 20 position 90 beds open on level 4 RVH and 2 wards in MPH changed to fracture wards 40 beds , 50 % band 5 nursing vacancies on level 4 RVH – workforce paper presented to executive team March 20 • COVID pandemic changes to services across TOR -elective services downturned and staff redeployed to other areas -beds in fractures level 4 reduced to 45 at the end of March 20 due to cancellation of elective surgeries- MPH running with 4 fracture wards 80 beds. • From June '20 level 4 fractures increased to 58 beds +4% nursing vacancies , however total variance 20% MPH Orthopaedics - one orthopaedic elective ward and 2 fracture wards one ward MPH closed at present due to ongoing estates works • July 2020, Level 4 T&O remain at 58 beds. When you compare the FSL vs SIP (without factoring in sickness and maternity) T&O are approx. 0.5wte over which is <1% of T&O FSL for 58 beds.	**Review end of September 2020 as part of rebuilding plan**	

	• July '20 RABIU - 3 beds remain closed due to high acuity and vacancies of 36% band 5. Review of risk assessments when new starts in post OCT '20 • Neurology band 5 vacancies remain high also 31% , however backfill using bank and agency has allowed beds to remain open could Joyce could you ask Paul to get numbers of backfill for month of JULY • ERU closed at present due to COVID redeployments and reduction in services vacancies remain high however 4 new starts awaiting dates post recruitment checks • Some Theatres and recovery MPH staff redeployed to RVH theatres at present only 2 lists running daily due to COVID	**Review end September 2020**	
All areas are reporting difficulty in recruiting new staff. The objective of the DN and wider nursing team is to promote TOR as a division of choice when new staff are being recruited.	• The DN continues to work closely with the Central nursing workforce team.	**Completed july'20 And ongoing**	
	• TOR is actively involved in the Trusts recruitment drives with good representation at recruitment exercises • TOR own recruitment event cancelled April 20 due to COVID pandemic .Online live recruitment event took place on June 25th '20 – 11 successful candidates at interview awaiting pre-employment checks • DN,Central nursing and ward staff encouraging transitional students to remain in areas on qualifying – 11 transitional students have accepted permanent jobs within TOR –awaiting pre-employment checks • Live recruitment event involved speakers from each of the services within TOR June'20 • This model was the first live recruitment event by the trust and will be used as a model for other areas	**Completed july'20**	
Acuity and Dependency	• TOR will provide panels for skype interviews on July '20 for live recruitment event interviews and June 20 for rolling Trust	**Completed End July '20**	
	• DN to work with Central nursing and the fracture wards to review their acuity and dependency • July '20 Level 4 Telfords reviewed as bed compliments changed during pandemic. 4D also reviewed due to higher acuity of spinal patients in Side rooms as receiving AGPs and 4D COVID amber zone • July '20 RABIU, Neurology and SCIU completing acuity tools and business case to be written for areas requiring higher nurse to bed ratios • MPH wards 4A/B, 6A, 5B Telfords reviewed and increased as nursing fracture patients (equates to level 4 RVH staffing) April '20	**Review Sept 2020 as rebuilding of services commences**	

International nursing recruitment	• International nurses recruited to level 4 RVH, RABIU and Neurology. Pre covid Plan in place to appointment to MPH then transfer to RVH when qualified and competent as level 4 was unable to provide further mentorship due to high vacancy levels, level 4 now able to accommodate further international nurses July 20. • Future plans to recruit international nurses for MPH theatres and recovery by providing first 3mths in MPH wards discussed with central nursing	**Review End Sept 2020**	
Area specific recruitment	• RABIU and Neuro-disability reviewed their skill mix and in additional to adult trained RNs they are employing RNs with learning disability and mental health backgrounds • Further Land D nurses joining team Sept 20 when pre-employment checks completed	**Ongoing reviewed July'20**	
Student nurse placements	• The DN has been meeting with Nursing Students during leadership walk rounds to promote all areas of the BHSCT but specifically TOR as an excellent clinical area to work. • There have been no reductions in student placements in TOR. • Staff to undertake FNFM online programme. This is to be included as part of new starts induction throughout TOR	**Review End Sept 2020**	
Open University places	• 3 individuals from MPH site are being supported to become band 5 RNs through the Open University course. • There are currently 3 individuals from RVH T&O being supported to become Band 5 RNs through the OU course with another member of staff commencing the OU course later this year. • This is being promoted as a route into Nursing within the division and the NDLs identify individuals who wish to be developed in this way	**Ongoing and review Sept 2020**	

Retention All areas have been reporting difficulty in retaining staff or that there will be difficulty retaining as a number of staff are approaching retirement or have gained jobs/promotions some within trust and some closer to where they wish to live in NI	Use of transfer protocol • TOR continues to supported individuals who wish to transfer within the division and between sites. • ERU staff undertaking programmed 2 weeks within ICU to assist with upskilling and induction	**Ongoing** **July '20**	
	• All staff who leave are offered bank contracts and those staff who are in the process of retiring are offered bank contracts.	**Ongoing** **July '20**	
Leadership support **(50-90% of staff managed by band 7)**	• DN in conjunction with SMs, ASMs and NDLs to explore ways to aide team building during pandemic as away days not possible at present.	**Review** **End December 2020**	
	• DN to schedule further catch-ups with the band 7s to support their development needs (coaching and supervision).	Review DEC '20	
Staff support	• Reviewing the role of the NDL as part of the wider DN work.	**Review End December 2020**	
	• DN to review with SMs and ASMs to consider whether a clinical educator would be of benefit.	**Review End December 2020**	
	• DN to review with SMs and ASMs and Ward Sisters and Charge Nurses whether a rotation programme, with rotation between theatres and the wards (including fractures on the RVH site) will be considered when the situation stabilises.	**Review End December 2020**	
New roles	• 2 x extended roles within theatres now in post band 7 specialist nurses. • Consider the use of further extended roles ,DN to review with SM and ASMs	**Review DEC'20**	
	• DN planning to work with SMs to consider the role of Advanced Nurse practitioner in TOR.	**Review End December 2020**	

Delivering Care Standard Orthopaedics on MPH and RABIU/Neuro disability and Spinal (MPH) did not receive funding under Delivering Care Standard **(normative nursing)**	• Orthopaedics are working at a Nursing Establishment for the Delivering Care standard but do not have the funding. At present working at higher NTB ratio, same as agreed with fracture wards on RVH site as currently nursing fracture patients , to return to agreed orthopaedic Telfords when working as orthopaedic wards July '20 • RABIU and Neurology are not working with normative nursing. - July '20 Neurology has completed acuity tool (DN, SM, ward charge nurse and central nursing met to review proposed Telford) RABIU / SCIU in process. Business case to be put forward to support Neurology's increased NTB ratio.	**Review End December 20**	
Use of Specials	• DN plans to review the use of specials in the fracture wards. • Paula Forrest to share work ongoing in COE to be considered by TOR. • Work ongoing through steering group to agree how to obtain figures and percentages	**Review End September 2020**	

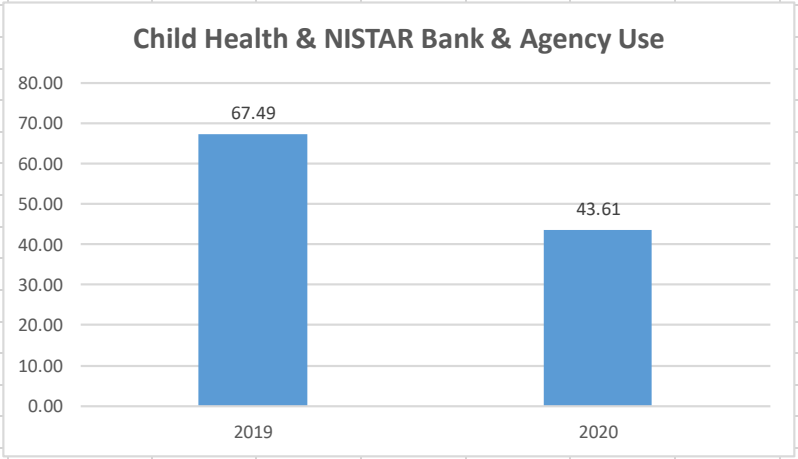
MAHI - STM - 102 - 4395

Children's Hospital & NISTAR Workforce Information

End of July 2020				Funded Establishment								Staff in Post							Variance							Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
Ward/ Dept	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2					
RBHSC																														
Allen Ward	1.8	18	16	33.52	0	1	3	21.47	0	8.05	0	0	1	2.5	17.67	0	9.78	0	0	0	-0.5	-3.8	0	1.73	0	By 17th July	-8%	0.00%	4.20%	
Belvoir Ward	2	9	9	18	0	1	1	11.8	0	4.2	0	0	1	1	9.67	0	5.67	0	0	0	0	-2.13	0	1.47	0	By 17th July	-4%	6.80%	0.00%	
ED				38.55	0	5.81	5.3	21.1	0	6.34	0	0	5.77	5.47	21.46	0	6.87	0	0	-0.04	0.17	0.36	0	0.53	0	By 17th July	3%	1.70%	3.60%	New Funding awarded for ED- additional triage rooms.
SSPAU	1.8	8	8	15	0	1	1	10	0	3	0	0	1	0.88	9.82	0	5.14	0	0	0	-0.12	-0.18	0	2.14	0	By 17th July	12%	3.00%	4.90%	
Haematology Ward inc OPD &DPU	2.8	10	10	36.27	0	2	7.6	21.22	0	5.45	0	0	1.8	6.4	17.1	0	4.44	0	0	-0.2	-1.2	-4.12	0	-1.01	0	By 17th July	-18%	2.50%	3.10%	
Outpatients				21.96	0	1	2	8.37	0	10	0.59	0	1	1.8	7.72	0	9.85	0.59	0	0	-0.2	-0.65	0	-0.15	0	By 17th July	-5%			
Clarke Clinic	2.4	8	8	19.73	0	1	2	14.42	0	2.31	0	0	1	2.76	12.08	0	0.88	0	0	0	0.76	-2.34	0	-1.43	0	By 17th July	-15%	3.40%	0.00%	
Barbour Ward	1.9	16	16	30.44	0	1	2.6	20	0	6.84	0	0	1	3.4	18.85	0	6.58	0	0	0	0.8	-1.15	0	-0.26	0	By 17th July	-2%	10.40%	5.00%	
Paul Ward	1.7	16	12	28.51	0	1	3	18.76	0	4	2.75	0	1	3.8	13.62	0	4.8	1.39	0	0	0.8	-5.14	0	0.8	-1.36	By 17th July	-17%	0.60%	5.10%	
Theatres & Recovery				46.69	0	3	2.72	33.9	0	7.48	0.59	0	3	2.32	30.72	0	5.48	1	0	0	-0.4	-3.18	0	-2	0.41	By 17th July	-11%			
Day Procedure (Knox)	1.3	10	0	13.04	0	1	1	8.33	0	2.71	0	0	1	1	5.95	0	3	0	0	0	0	-2.38	0	0.29	0	By 17th July	-16%	13.40%	0.00%	
PICU	7	12	12	84	0	5	17	58	0	3.93	0	0	3.92	17.5	44.95	0	2.8	0	0	-1.08	0.5	-13.05	0	-1.13	0	By 17th July	-18%	4.50%	5.40%	
Specialist Nurses				37.68	0	25.71	11.97	0	0	0	0	0	30.74	12.7	0	0	0	0	0	5.03	0.73	0	0	0	0	By 17th July	15%			
Rheumatology				2	0	1	0	1	0	0	0	0	1	0	0.66	0	0	0	0	0	0	-0.34	0	0	0	By 17th July	-17%			
Incontinence Nurses				0.55	0	0	0.55	0	0	0	0	0	0	0.18	0	0	0	0	0	0	-0.37	0	0	0	0	By 17th July	-67%			
Patient Flow				5.46	0	5.46	0	0	0	0	0	0	4.46	0	0	0	0	0	0	-1	0	0	0	0	0	By 17th July	-18%	1.10%	0.00%	
ANP - ED				3	3	0	0	0	0	0	0	1	0	0	0	0	0	0	-2	0	0	0	0	0	0	By 17th July	-67%			
ANP- Medical				2	2	0	0	0	0	0	0	1	0	0	0	0	0	0	-1	0	0	0	0	0	0	By 17th July	-50%			
ANP - Surgical				1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	By 17th July	0%			
Renal	1.6	3	3	3.49	0	1	0.8	1.69	0	0	0	0	1	0.8	1.64	0	0	0	0	0	0	-0.05	0	0	0	By 17th July	-1%			
Play Department				17.24	0	0	0	2.73	13.96	0	0	0	0	0	2.73	13.95	0	0	0	0	0	0	-0.01	0	0	By 17th July				
NISTAR																														
NISTAR(Paeds & Neonatal)				13.4	0	4	6.2	0	0.5	2.7	0	0	2	5.96	0	0.5	1.5	0	0	-2	-0.24	0	0	-1.2	0		-26%				
Totals		110	94	471.53	6	60.98	67.74	252.79	14.46	67.01	3.93	3	61.69	68.47	214.64	14.45	66.79	2.98	-3	0.71	0.73	-38.15	-0.01	-0.22	-0.95					

Unit	Child Health & NISTAR - Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
NISTAR	0	0	0	0	0.15	0.25	0.08	0
RBHSC Allen Ward	2.21	1.91	0.91	0.22	0.66	1.1	0.07	0.44
RBHSC Barbour Ward	1.07	2.56	1.46	1.29	1.62	1.28	0.95	1.56
RBHSC Belvoir Ward	0.95	1.03	1.14	1.51	2.75	1.45	1.01	1.61
RBHSC Childrens A&E	4.42	3.14	3.46	4.87	4.61	3.2	4.11	1.37
RBHSC Childrens Recovery	0.11	0.41	0.55	0.81	0	0	0	0.19
RBHSC Childrens Theatres	4.57	4.21	4.34	4.68	1.21	0.44	0.12	0.89
RBHSC Clarke Clinic	0.96	0.93	0.45	1.02	0.88	0.24	0.77	0.89
RBHSC Haematology	1.25	1.69	1.82	1.43	0.8	0.59	0.88	1.15
RBHSC Knox Ward	0	0	0	0	0.22	0	0	0.07
RBHSC Patient Flow	0	0	0.49	0.57	0.08	0.33	0.25	0.41
RBHSC Paul Ward	0.33	0.22	0.88	1.65	1.12	1.33	0.49	0.44
RBHSC PICU	0.6	0.5	0.41	0.46	0.08	0.46	0.42	0.59
Totals	16.47	16.6	15.91	18.51	14.18	10.67	9.15	9.61

Overall total	2019	2020
	67.49	**43.61**



Division of Child Health & NISTAR Action Plan

<table>
<tr><th></th><th>Issues</th><th>Action</th><th>Timescale</th><th>Status at 31 July 2020</th></tr>
<tr><td>1</td><td><u>Workforce Summary Position @ end of July 2020:</u>

8.7% vacancy rate at end of July across the Division.

Band 7 – 1 Vacancy in PICU (retirement) being recruited currently.

Band 5 Vacancies: 38.15 wte.

Band 3 Vacancies: 0.22

Across bands - there are a number of areas with vacancies some of which are new due to re-modelling of budgets.

Recruitment of potential new staff & students to the clinical areas.</td><td>-Two virtual Regional recruitment exercises happened in May and July 2020- yielding approximately 53 nurses- applications being progressed – some currently working as Band 4 transition students. There are further resignations and retirements pending in the next quarter and it is anticipated that all of the recruited posts will be needed to meet FSL. –

-Band 6 and 7 posts have been previously over recruited- PICU.

-A number of areas also have approval to over recruit Band 3 posts to support the workforce i.e. Medical wards, CHU and Paul ward.

-In the last Quarter, there were 44 Band 4 transition students on their final placement within RBHSC and as well as the normal placement objectives, they were provided with additional training sessions. All gave very positive feedback, with around 40 putting BHSCT as first choice during recruitment exercise.

Student placements have been reviewed and have been or will be increasing across areas, as per table below.

<table><tr><th></th><th>SLAIP Standards Student No.</th><th>FNFM Standards Student No.</th><th>Comments</th></tr></table></td><td>October 2020.</td><td></td></tr>
</table>

	Issues	Action	Timescale	Status at 31 July 2020

Allen Ward	6	6	0 (At capacity)
Barbour Ward	6	7	+1
Belvoir Ward	5	6	+1
RSC Haematology	5	6	+1
Clark Clinic	4	5	+1
DC & Knox Ward	2	3	+1
RSC ED	5	6	+1
Paul Ward	6	7	+1
PICU	8	7	-1 (At capacity)
Outpatients	3	4	+1
Specialist Nurses	4	5	+1
Theatres & Recovery	4	4	0 (At capacity)
SSPAU	0	3?	TBC- Autumn 2020
TOTALS	**58**	**69**	

Staff Unavailability
Maternity
Registrants - 10.9 wte
Non – Registrants – 3.0 wte

Sickness(LTS)
Registrants – 11.49 wte
Non- Registrants – 2.29 wte

Shielding- included in LTS above
Registrants **–** 7.25 wte
Non-Registrants – 2.69

Staff redeployed to Testing pods

- Backfill includes cover for additional COVID need i.e. Opening of second area in OPD for ED and additional nursing requirements. Telfords agreed and reviewed with Central Nursing Workforce team:
- Belvoir ward- 1st designated COVID ward – additional nurse needed on day shift/ night shift.
- SSPAU- 2nd COVID ward area - additional Band 5 on duty.
- Backfill also includes HCSW `specials` that are required for Trache bipap patients – these are increasing in numbers across a number of areas – Allen and Paul ward and this additional staffing reflected in the overspend accordingly. This

	Issues	Action	Timescale	Status at 31 July 2020
	Registrants – 1.0 wte **<u>Total unavailability including Vacancies</u>** Registrants – 68.79 (50.05 exc LTS) Non-Registrants – 8.21(3.21 exc LTS) **Backfill** Registrants – 52.8 wte Non-registrants – 5.38 wte	will be reviewed as part of the workforce meetings and consideration for requesting additional FSL. - Shielding figures and staff unavailability have varied across the months since COVID and where possible existing staff have been redeployed to areas of need.		
	Finance- Within the Division the financial position at end of July for nursing workforce is : £562 K underspend for nursing payroll £230 overspend for bank hours to cover maternity leave and vacancies. Giving total **underspend of £332K**	-Budgets are reviewed on monthly basis at Service area level. -Divisional team also meet with Accountant and review reports as part of SMT. Areas of concern are further discussed and remedial action taken if necessary. -Band 4 transitional students are also currently being funded out of existing FSL. -Redeployed staff on E roster also paid from Child Health budget. -Budgets need realigned to reflect COVID arrangements and additionality/ cost pressures.	**October 2020**	
2	**PICU** - Ensuring effective leadership and development of team based working.	- Band 7 posts in the unit have now increased to 5 wte, to allow senior cover across the week. This has proved effective but with some difficulties with team dynamics. - Band 7 team day had been planned but postponed due to COVID – will be revisited. - One Band 7 vacancy currently due to retirement and this is being recruited.	**October 2020**	
3	**ED/SSPAU** Budget has now been separated for ED and SSPAU.	- **SSPAU**- Band 6 and 7 have now been in post for over a year and the unit has recently moved to the refurbished new SSPAU. With the recent Band 5 recruitment SSPAU will get some more Band 5`s and will help with more stable workforce. Further consideration needed for FSL (15 wte) that may not meet all the requirements of the unit, particularly relating to winter pressures. Plan to measure acuity and review workforce modelling for the area.	**Review December 2020**	

	Issues	Action	Timescale	Status at 31 July 2020
	Age Appropriate Care Age limit has increased to 16 years as part of COVID actions and this has caused some difficulties with age appropriate care considerations and other patients within ED and the wider hospital.	- Increased age limit still in place. Training options for nursing teams being explored – management of adolescent drug/ alcohol abuse; mental health concerns; early pregnancy etc. - During COVID, a space was identified for adolescents that required inpatient treatment, in the pods in Barbour ward. However, this caused work force issues due to the unpredictability of demand but the area still needed to be staffed separately to the main ward, requiring minimum 2 nurses. As part of recovery work, clinicians and teams have requested that the age limit goes back to pre- COVID, allowing proper time to make suitable arrangements for this age group. This would include review of required nursing, medical and AHP workforce.		
4	**Children`s Haematology Unit** – Peer Review panel held with recommendations for additional staffing given – included Band 7s, 6, 5 and 3. Bring in line with National guidance and benchmarked against other CHU.	- Additional Band 3& 5 money in budget and posts being recruited to allow extended cover for Day care – from 8-8 Monday to Friday to have extra sessions 8-2 Saturday and Sunday. This has not been possible to date as have been unable to recruit the extra 2.26 wte Band 6`s needed to be on duty for chemotherapy treatment and funding still pending. It would be a requirement that there is a Band 6 on duty and so would not be sufficient to upskill existing Band 5`s as an interim measure. As per peer review and Cancer standards there needs to be a Band 6 on duty with the relevant experience in managing chemotherapy. Whilst Band 5`s will continue to develop those skills, they could not take charge without the senior clinical leadership. - Band 7 funding x 1.0 wte has been re-profiled to recruit Lead Nurse 8A – which was part of the recommendations. This post is currently being recruited and will be interviewed In September/ October 2020.	**October 2020**	

	Issues	Action	Timescale	Status at 31 July 2020
	NISTAR Vision paper – requirement for Education post and additional funding for Nurse led Team – Adult side.	- Service manager is preparing a Vision paper for Commissioners seeking funding for Band 7 Education post 0.5 wte with focus on Adult section of NISTAR but ability to work across the 3 areas. Funding request will also include Band 6 x 3 for nurse led service (Adults)		
5	**Bed closures** – have been required across a number of ward areas due to sickness/ absence/ vacancy.	- Risk assessments have been done for the ward areas where bed closures have been necessary. These are reviewed and updated on a monthly basis. All bed closures are discussed in advance with Divisional nurse and kept under review. **Allen ward** – Funded for 18 beds but only open to 16 for over a year. See detailed breakdown of current workforce (end of July position below) - **FSL** – 33.52 wte - **SIP** – 30.95 **Vacancies:** - Band 6 – 0.5 - Band 5- 3.8 (Over recruited Band 3 – 1.73 wte) **Staff Sickness/ absence** Shielding- Band 5 – 2.0 Maternity – Non Registrant – 1.0 wte **Backfill- per week** Registrants – 2.08 wte Non-Registrants- 0.29 = 2.37 wte **Total staff unavailable/ vacancies** – 7.3 wte- **21%** **Band staff recruited and pending –** 6 but 3 staff also leaving = 0.8 deficit Band 5. -Beds have been closed due to staffing levels, sickness and increasing acuity of patients. Acuity exercise has recently been completed and will be reviewed imminently. Training also being		

	Issues	Action	Timescale	Status at 31 July 2020
		reviewed to ensure sufficient staff available that can care for child on trache bipap. Currently the number of respiratory/airway patients who have a trache and/or require BiPAP/CPAP and may attend RBHSC for treatment are: • Tracheostomy (self-ventilating): 20 • Long term ventilation (trache & ventilation): 13 • Non-invasive ventilation (NIV): 38 • CPAP: 45 (these patients are usually managed as an outpatient). Currently within the hospital, we have 1 x LTV patient, 1 x trache patient and 1 x NIV patient who by the end of today will be nursed in Allen ward. Prior to the Covid-19 pandemic the respiratory team would routinely book a bed in Allen ward on a Sunday and Wednesday night to either commence a patient on NIV or to review ventilator settings to ensure patients aren't over or under ventilated. The average time for a patient to be discharged home with a new tracheostomy (self-ventilating) is approximately 6 weeks. On the other hand, a patient who requires long-term ventilation may mean a delayed discharge of approx. 8 months. Staff have seen an increase in the numbers and acuity of these children at ward level. There would normally be at least 1-2 patients with trache bipap across the wards each week, with further increases anticipated when schools resume. Currently these patients need to be nursed 1:1 due to AGP's and COVID. In normal times most of these patients have some sort chronic colonisation so normally cannot be nursed with other patients. **Paul ward** – Funded for 16 beds , open to 14 – initially due to one individual patient care consideration- as needed specialled and staffing levels did not permit- discharge was delayed. Beds have recently been closed again (open to 12) for 2-3 weeks due to staffing but 5 new starts are pending, which should help address. There are increased dependencies, including patient requiring 1:2 care as per neurosurgery protocol. Sufficient nurses rostered during day and use of Band 4 transitional students optimised for evening cover- Require 5		

	Issues	Action	Timescale	Status at 31 July 2020
		nurses on shift during day and 4 in evening but for some evenings and the full weekends there are only 3 nurses, which would not meet safe staffing levels. -FSL – 28.51 -SIP – 24.61 **Vacancies:** **-**Band 5- 5.14 (Over recruited Band 3 – 0.8) **Staff Sickness/ absence** **-Shielding**- None **- LTS** - None **-Maternity** – Registrants – 1.8 **- Essential study**- Burns & plastics (Band 6- induction) - 1.0 x 1 month – will be brought back early if bed closures impact on patient care/ service delivery. **Backfill- per week** Registrants – 1.17 wte- lost two permanent Band 5 staff, which impacted on staff available to do bank/ backfill. Next rota will have increased backfill. **Total staff unavailable/ vacancies** – 7.94 – 27% -Band staff recruited and pending NMC pin. • **Barbour ward** – Funded for 16 beds but may need to reduce to 14 for essential estates work (updating shower/ wash areas) - may need deferred due to bed pressures for side rooms.		
	Bed Closures (Cont`d)	- **CHU** – Funded to 10 beds but had only been open to 8 for some time, due to staffing. However, this has now been reviewed since estates work completed on unit and now open to 10 again.		

	Issues	Action	Timescale	Status at 31 July 2020
6	**Delivering Care for Children's Wards/Depts. to be rolled out Regionally**	- Await update from PHA following meetings 2018 with Lead nurses and raised with CNO by Executive Director of Nursing. - Divisional workforce meetings are convened 6 weekly; with smaller Service area, ones alternate months – across the 3 Services. These had been disrupted by COVID but have been set up again from September onwards. The meetings review current staffing, emerging staffing issues/ pressures; priorities for development for the Service/ Division and pending new funding/ IPTs etc.	**Review December 2020**	
7	Requirement to introduce a nursing workforce tool for Paediatrics. Increasing patient acuity across a number of ward areas: - Allen ward (Medical) - Barbour Ward (Surgical)	- Divisional Nurse visited Glasgow Children`s Hospital February 2019 to discuss their planning and development when new hospital opened and also review their patient acuity tool. - Work has been ongoing in conjunction with Workforce team in Central Nursing and the E Roster team to review patient acuity, after concerns were raised regarding increased acuity and staffing levels. The acuity results are due to be reviewed at end of September. -Work had been previously been done in Barbour ward and increased funding received because of demonstrated staffing pressures. Further work is now needed due to the age range of patients within the ward – from neonates to adolescents, as well as increasing acuity that the ward sister and nursing team have raised concerns about. Barbour ward will be part of the Team based working initiative and the clinical leads and ward sister will be provided with some coaching sessions in conjunction with HSC Leadership Centre to develop this programme.	**Review December 2020**	
8	Roster KPIs - Approval lead time (28 days) - Additional hours and booking over FSL (zero)	- All areas now on E roster apart from OPD. - Divisional Nurse attended E- roster update workshop August 2020 & other managers encouraged to do same. - Feedback and information from internal audit etc. has been shared widely with all the relevant nursing teams and	**October 2020**	

	Issues	Action	Timescale	Status at 31 July 2020
	- Planned Vs Delivered hours per WTE (<13 hours)	managers. Assurance sought and received around immediate remedial action being implemented for key actions. - It will be discussed in more detail at the monthly Sisters` meetings and Divisional Nurse Assurance meetings- to include assurance re the monthly checking process by ASMs. - E Roster reviewed monthly by Divisional nurse against the 3 KPIs and any discrepancies raised with team. - Some issues with FSL on E roster not matching actual FSL being addressed – Service areas need to ensure advise finance and E roster about any budget changes/ staff upgrades etc.		
9	**Workforce Developments** ➢ Advanced Nursing Practice development in line with Regional and strategic plans.	- The Division currently has 3 ANPs (Band 8a) and a 4th post is currently being recruited for PICU, to bring the area in line with other Paediatric Intensive Care Units. This has been brought in `at risk` but will be submitted as cost pressure for new monies. - A comprehensive recruitment and selection exercise has just been completed to recruit 5 trainee ANPs (Band 7) for ED, medicine and NISTAR/ PICU. The new recruits will take up post from September 2020 and in the first year will complete Non-medical prescribing course, if required as well as development of competencies across the 4 ANP domains. They will then commence MSc in ANP through UU. - A working group has been set up to ensure that there is a robust induction programme and clinical portfolio in place for the new trainees. This will also include ensuring the required level of supervision and mentorship is in place i.e. from Consultant and qualified ANP.	**Review October 2020**	
	➢ Specialist Nurses- RBHSC has a large number of Specialist nurses at Band 6 & 7 (37.68 wte FSL). Nurses work across a range of areas and so work is required around governance	- Regular meetings have been convened with Service Managers and ASMs from September 2020 to review the roles and consider job planning, supervision, training and governance arrangements. Support will be given for this process by the Workforce team, Central Nursing.	**January 2021**	

	Issues	Action	Timescale	Status at 31 July 2020
	for these posts – as further highlighted by unannounced RQIA inspection April 2019. ➢ Perioperative Workforce Review due to Regional shortage of staff in this area.	The division will be part of this work within the Trust and are providing the requested baseline information by end of August 2020. The work will include review of FSL, vacancies, recruitment and retention issues, as well as existing roles across Trust theatre areas and possible role development to bolster the workforce. **FSL in theatres and recovery**- 46.69 **Vacancies** – 5.58 **Sickness/ Absence** LTS Registrants – 3.2 Non-Registrants -2.0 Maternity- Registrants – 0.8 **Band 5 new starts** – pending 3. There are 3 theatres in the main RBHSC suite but cover is also provided for sessions in dental theatre and Imaging suite as well as sessions in cancer centre BCH. Additional staffing has been required due to COVID protocols, capacity has not been able to meet demand due to the turnover time, and so theatre access continues to be an issue for specialities. As with other theatre areas, RBHSC theatres have had some difficulties recruiting and retaining staff. The perioperative work is welcomed to help with that and particularly in preparation for a new hospital with additional theatres and demand.		
10	**New Children`s Hospital** - Requirement for maintenance of staffing levels to move to the new hospital with Services initially `as is` as per	- Development of workforce paper and plan to describe current service, service development that may be required over 5 years and staffing for the new hospital initially and at full commissioned capacity.	**December 2020**	

	Issues	Action	Timescale	Status at 31 July 2020
	Commissioners- whilst continuing to develop Services and roles within the current RBHSC to meet increasing demand & plan for the eventual use of the full capacity within the new hospital.	- Working in conjunction with Central nursing workforce team and the Executive Director of Nursing to ensure the plan continues to reflect the strategic direction for nursing. - Regular meetings with commissioners and MDT to discuss developing workforce plan. - Presentation of draft workforce plan in September 2020 to the Workforce planning project team.		

MAHI - STM - 102 - 4408

Children's Community Workforce Information

Ward				Funded Estlishment								Staff in Post							Variance							Telfords Updated Date	Total Vacancy %	COMMENTS
	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 8A	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2			
School Nursing				23.33	0	1	9	9.68	0	3.65	0	0	1	8.03	7.68	0	2.91	0	0	0	0.97	2	0	0.74	0		16%	SCPHN x 3.0wte
N.I.N.E.S				4.32	0	2	1	0.56	0	0.76	0	0	2	1	0.56	0	0.5	0	0	0	0	0	0	0.26	0		6%	
N&W C.C.N				41.84	2	4	8.12	9.85	2.87	15	0	2	4	8.67	8.31	2.87	8.34	0	0	0	-0.55	1.54	0	6.66	0		18%	
N&W Hype Project				1.3	0	1	0.5	0.8	1	3	1	0	1	0	0.8	1	2	1	0	0	0.5	0	0	1	0		115%	
N&W Working Womens Hlth. Proj.				2.38	1	0	2.79	0.5	0.8	1	0	1	0	2	0	0.8	0.5	0	0	0	0.79	0.5	0	0.5	0		75%	
Breastfeeding Peer Support Ser				3.01	0	1	0.67	0	0.67	0.67	0	0	1	0.67	0	0.67	0.67	0	0	0	0	0	0	0	0		0%	
Health Visiting MDT				9	1	0.5	6	0.5	0	1	0	0	0.5	6	0.5	0	1	0	1	0	0	0	0	0	0		11%	
Health Visiting				103.08	1	10	76.89	7.77	0	7.49	0	1	9.15	71.36	15.86	0	10.23	0	0	0.85	5.53	-8.09	0	-2.74	0		-4%	SCPHN x 9.0wte
Parenting Support Service (HV)				2.3	0	1.5	0	0	0.8	0	0	0	1.4	0	0	1	0	0	0	0.1	0	0	-0.2	0	0		-4%	
School Immunisation Team				11.26	0	1	0	8.58	0	1.68	0	0	1	0	8.13	0	1.12	0	0	0	0	0.45	0	0.56	0		9%	
Safeguarding Children's Team				6.5	1	6.5	0	0	0	0	0	1	4.5	0	0	0	0	0	0	2	0	0	0	0	0		31%	
Cch Management Team				5.5		5.5	0	0		0									0	5.5	0	0	0	0	0		100%	
Family Nurse Partnership				8	1	6	0	0	1	0	0	1	6.4	0	0	1	0	0	0	-0.4	0	0	0	0	0		-5%	
Forest Lodge				16.17		1	1	8.7		5.47		0	1	1	6.86	0	5.6	4.6	0	0	0	1.84	0	-0.13	-4.6		-18%	
N&W Willow Lodge				0		0	0	0		0									0	0	0	0	0	0	0		0%	
Childrens Therapeutic Support				0		0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0%	
Somerton Road/Muckamore				1		0	1	0		0			1	0			0		0	-1	1	0	0	0	0		0%	
S&E Childrens Dis Team (Inver)				3.8		0	3.8	0		0		0	0	3.8	0	0	0	0	0	0	0	0	0	0	0		0%	
Totals				242.79	7	41	110.77	46.94	7.14	39.72	1	6	33.95	102.53	48.7	7.34	32.87	5.6	1	7.05	8.24	-1.76	-0.2	6.85	-4.6			

Community Child Health Services Action Plan

REF NO	Issues	Action	Timescale	Status at 31 July 2020
	Health Visiting recruitment Funded posts –B6: 82.89wte plus 4.0WTE overfill posts, currently 11.61wte vacancies; this represents 14% of the total HV workforce, excluding sick leave, office-based staff, shielding and maternity leave. HV service anticipates a further 3 vacancies before the end of September 2020. This has a detrimental impact on the ability to deliver the HCHF programme as a universal service. This may delay early identification and recognition of developmental issues.	• There have been numerous recruitment advertisements since September 2019. 9 candidates have accepted posts from most recent advertisement. There is a further advertisement out at present on HSC Recruit. There are an additional 3.4 wte vacancies to fill following recruitment into offered posts		
		• Band 5 recruitment: There are 1.8wte current vacancies; however, both posts have been filled pending HR processes. B5 x 0.5 wte remains redeployed. • Within West Belfast, GPs have recruited staff to deliver the childhood vaccination programme, this has relieved significant pressure on the service to cover GP clinics within one part of the Trust • PHN x 1 is undertaking the Nightingale Leadership Programme		
		• There are 2 HCAs completing their first year of OU course. One further staff member has been successful in her application and will commence in Sept/Oct 2020. This encourages career progression and staff engagement	**Sept**	
		• The HV service continues to offer both flexible, shift patterns, home working where possible and compressed working hours, in keeping with Work-life Balance and requirements due to COVID and social distancing. Other workforce strategies include accommodating staff requests, as far as possible, in relation to their preferred base to work from, and a recent introduction of a database for staff to transfer bases/change working hours has proved successful.	**Sept**	

REF NO	Issues	Action	Timescale	Status at 31 July 2020
	Health Visiting Training	• 11 full time SCPHN places have been commissioned for 20/21; there will be an additional 3 full time students at a cost pressure to the Trust. A further 3 part-time SCPHN are commencing their 2nd year of training. • Mandatory training is on-going and database maintained		
	Public Health **Hype** **B6 0.5 wte vacant** **B5 0.8 wte** **NINES** **B7 2.0 wte** **B6 1.0 wte** **B5 0.56 wte** **B3 0.5** **BIHS** **B8A 1.0 wte** **B6 2.0 wte** **B5 0.5 wte vacant**	• The Hype Team have reset some service provision in partnership with other agencies. Risk assessments have been completed to carry out this work. A health questionnaire is completed for all service users. Home working continues were possible. Twelve applicants for the band 6 post will be shortlisted soon. • All new entrant screening to recommence in NINES with Health Assessments from Sept 2020. These will be carried out during home visits following the completion of health questionnaires. Testing for BBVs will be carried out during Health Assessments however; BCGs will not take place until clients are allowed to visit Bradbury. • Live TB cases will be followed up as a priority • New arrivals who are Pregnant will be fast tracked to maternity services. • All calls to BIHS triaged and essential visits being facilitated by staff with appropriate measures in place • Staff continue to respond to symptomatic Covid-19 service users and carry out testing within the homeless facilities. • GP sessions continue and involve telephone triage calls and essential visits with appropriate measures in place. • Screening clinics for those who inject drugs have recommenced on the 11th August with a reduced appointment systems in place to allow for appropriate Covid-19 measures • Hepatology Review clinics, Podiatry Psychotherapy and dental services. Once a permanent band 6 is in place the BIHS budget will be re profiled using the band 5 monies to create a band 7 post	**Sept 2020**	

	School Nursing **FSL** **B7- 1.0 WTE** **B6- 9.0 WTE** **B5 – 9.68 WTE** **B3 – 3.65 WTE**	• (1.99 WTE) Band 5 PHN vacancies ongoing recruitment and offer of increased hours to existing staff - bank use against current vacancies and within allocated budget • Band 6 x 2.0 WTE recruited – HR processes and NMC part 3 registration pending. • B3 undergoing OU nursing programme. - 2nd year.		
	Funding has been secured for 3 fully funded full time SCPHN school nursing places for 20/21- commencing in Sept 2020...	• 3 x SCPHN students commissioned for 20/21 academic year to support B6 workforce the securing of these places with add to the sustainability of the B6 SN workforce and facilitate career progression and succession planning.	**Sept 20**	
	Regional work is at an early stage to look at normative staffing within School Nursing however, within Trust, significant modernisation of the service has benefitted capacity and service delivery without diluting skilled practice.	• ASM engages regionally and is involved in the initial stages of the review of normative staffing within School Nursing. The current reconfigured staffing structure within BHSCT school nursing service has allowed Band 6 staff to delegate duties appropriately to the Band 3 and Band 5 workforce, developing capacity within the team for the full implementation of the HCHF programme with all work completed within the academic year .The increase in Band 5 staff has also allowed for expansion to the Band 6 role in assuming responsibility for safeguarding caseloads and holding • There has been recent additional regional funding secured from DOH/ transformational funding for school nursing programmes. Currently in planning phase. To include a student chat line and funding for school aged LAC assessments completion.	**June 20**	
		• Joint working between the school nursing and immunisation team enables B5 staff to work across both services at times of peak service delivery. This supportive partnership model works well.		
	Immunisation team The school immunisation team supports delivery of the school aged vaccination programme, including HPV and Flu vaccines. Due to Covid -This year's flu programme has an	. • BHSCT bank staff used successfully within budget to deliver school flu programme between Sept-Dec. • A supportive joint partnership model between the school nursing and immunisation team enables B5 staff to work across both services at times of peak service delivery.	**June 20**	

	increased target rate of 95% and has been extended to include year 8 children. FSL B7- 1.0 WTE B5- 8.58 WTE B3- 1.68 WTE			
REF NO	**Issues**	**Action**	**Timescale**	**Status at 31 July 2020**
	<u>Children's Community Nursing Service</u> **FSL-** B7- 4.0 WTE B6- 8.67 WTE B5- 9.85 WTE B4-3.54 WTE B3-14.0 WTE	• Currently recruiting B5 staff. • 1 x B5 internal transfer recruited due to start 1/6/18. • Appropriate use of BHSCT bank staff within budget. • Currently an increased Complexity of care needs within the special schools as schools return in Sept 20 with additional training and IPC requirements due to Covid precautions.		
		• CCN service continually review the complexities of care needs within the special schools and configuration of staff required to deliver care. • Band 3 -IIP investment for HCA staff to support care packages for children with highly complex health needs- recruited on a needs basis with child specific training .B3 HCA also support paediatric clinics in HWBC's including QB testing clinics for ADHD assessments and diagnosis. • Clinical Educator post B7 -1.0 WTE supports the training of staff and carers to deliver care for children with complex care needs.		
	Paediatric Epilepsy Nurse Specialist (PENS) – B7 1.0 WTE	• The PENS delivers nurse led clinics and holds responsibility for a caseload of children (0-19 years) with epilepsy, providing support and education to families, carers and education staff. • PENS is completing the initial QUB Health Assessment module 20/21 and will then complete nurse prescribing course 21/22.		
	Paediatric Continence Nurse Specialist – B7 1.0 WTE	• The PCNS provides specialist advice and support to children with continence problems and their families. This includes completing continence assessments as per NICE and regional guidelines ,		

		Continence education and support for families, education staff and carers, and developing toileting programmes and assessing the need for continence products.		
	Safeguarding Children Nurse Specialists (SCNS) 3.5 WTE in post (funding level 5.5 WTE). This is a Trust Wide Service **Significant increase in complexity of safeguarding cases**	• Safeguarding Nurse Specialist team currently has recently appointed a 1.0 WTE LAC Nurse Specialist. Awaiting confirmation of date to commence post. Currently advertising for Safeguarding Children Nurse Specialists to the team. Of the 3.5 WTE in post – 2.0 WTE are still on induction and due to the current restrictions because of the Pandemic – there are a number of aspects of the job, which have not been completed and cannot be signed off. Due to these factors and sickness levels within the team, as well as awaiting the appointment of 2.0 WTE staff, Safeguarding remains on the BHSCT Risk Register. Limited staff resources has had some negative impact on delivery of training. The safeguarding team work in partnership with social services colleagues to deliver trust wide safeguarding children training. Due to the current pandemic, this has been temporarily suspended. Named Nurse is to have a multi-professional meeting in order to discuss a proposed plan to re-instate this mandatory training. • Partnership working with regional named nurses and escalation of increasing risks discussed with Regional Nurse Consultant for safeguarding. Safeguarding supervision documentation for nurses under review as per as commissioned CNO. One to one case supervision is occurring under covid19 action plan – to staff who are new into post requiring their induction and for staff who have requested extra support, or where there has been an identified need for supervision to occur by the SCNS.	**September – December 2020**	
	Family Nurse Partnership	• 1.0 WTE Maternity leave – no plan to recruit for cover at present. • 0.8 WTE Band 7 acting up to temporary Band 8A (6 months EOI) beginning Sept 2020. • Discussion with PHA Regional FNP team has concluded that recruitment into vacant posts would not be necessary at present.		

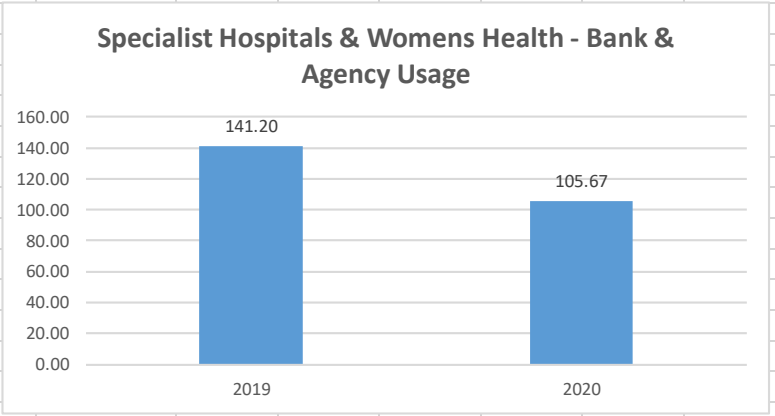
MAHI - STM - 102 - 4414

Maternity/Women's Health Workforce Information

Ward			Funded Establishment						Staff in Post						Variance						Total Funded	Total staff in	Total Variance	% Sick Leave	% M/L
			Registered				Unreg		Registered				Unreg												
Maternity	Funded Beds	Beds Open	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2					
MIH Midwifery Led Un	4	4	1.6	10.45	0	0	0	3.35	1	10.25	0	0	0	5.2	0.6	0.2	0	0	0	-1.85	15.4	16.45	-1.05		
RJMS Admissions Unit/EPPU			1	10	0	0	4	0.6	1	14.1	0	0	3.44	1.82	0	-4.1	0	0	0.56	-1.22	15.6	20.36	-4.76		
RJMS Day Obstetric Unit/FMU			3	4.82	0	0	2	1	2	4.95	1.8	0	1	1.88	1	-0.13	-1.8	0	1	-0.88	10.82	11.63	-0.81		
RJMS Delivery Suite/IC	15	15	11.44	89.53	0	8.41	4.64	13.05	11.3	54.14	9.5	0	1.82	9.4	0.14	35.39	-9.5	8.41	2.82	3.65	127.1	86.16	40.91		
RJMS johnston house	14	14	1	16.23	0	0	5.37	5.37	1	9.14	4.8	0	3.33	4.32	0	7.09	-4.8	0	2.04	1.05	27.97	22.59	5.38		
RJMS Obstetric Theatres			1	2.8	0	0	0	0	1	4.09	0	7.12	0	1.2	0	-1.29	0	-7.12	0	-1.2	3.8	13.41	-9.61		
RJMS Ward A	15	15	1	15.32	0	0	1.67	5.33	0.8	6.8	5.8	0	0.6	1.8	0.2	8.52	-5.8	0	1.07	3.53	23.32	15.8	7.52		
RJMS Ward E	20	20	1	18.24	0	0	4.39	8.38	1	11.76	6.8	0	3.47	3.46	0	6.48	-6.8	0	0.92	4.92	32.01	26.49	5.52		
Regional NNU	29	29	11.8	57.48	25.1	1.17	9.65	3	11.7	41.35	41.6	0.64	9.06	0	0.1	16.13	-16.49	0.53	0.59	3	108.2	104.3	3.86		
RJMS Antenatal Clinic/Mater ANC			3	18.45	0	1	5	7.28	1	17.25	0.82	0.7	7.52	3.98	2	1.2	-0.82	0.3	-2.5	3.3	34.73	31.27	3.46		
Community Midwife Team			1	27.5	0	0	0	0	1	21.9	0	0	0	1.4	0	5.6	0	0	0	-1.4	28.5	24.3	4.2		
Antenatal Education			1	2.5	0	0	0	0.4	1	4.88	0	0	0.43	0	0	-2.38	0	0	-0.4	0.4	3.9	6.31	-2.41		
Totals			37.84	273.32	25.1	10.58	36.72	47.76	33.8	200.6	71.1	8.46	30.67	34.5	4.04	72.71	-46.01	2.12	6.05	13.3	431.3	379.1	52.21	9.18%	3.91%
ENT																									
Wd29			36.44	1	2	24.34		6.7	2.4	0.91	2.4	23.98		6	2.87									8.40%	0.00%
Wd 31			12.39	1	1	6.76		2.24	1.49	0.77	1	3.71			0.91									14.50%	0.00%
SoD																									
GYNAE																									
5 South																	1	1.55		0.8				7.20%	1.70%
GUM																	1								
S&RH																1.18				0.3					
Bradbury																		0.6			0.5				

Unit	Specialist Hospitals & Womens Health -Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
BCH 5 South (Gynae)	3.43	4.05	5.6	5.09	0.2	0	1.79	5.69
Community Midwives North	0.6	0.49	0.23	0.36	1.06	0.34	0.27	0.26
Community Midwives South	0.05	0.1	0.2	0.15	0.7	0.85	0.65	0.7
Community Midwives West	0.05	0.3	0.4	0.45	0.58	0.4	0.88	0.75
MIH Midwifery Led Unit	1.78	1.89	2.04	3.12	0.89	0	1.85	2.15
RJMS Admissions Unit	1.83	2.06	2.17	2.17	1.85	1.35	1.88	2.68
RJMS Ante-natal Clinic	0.86	0.5	0.44	0.44	0.61	0.56	0.45	0.7
RJMS Ante-natal Education Team	0	0	0.35	0.56	0.06	0	0	0
RJMS Day Obstetric Unit	1.06	2.23	1.25	1.68	1.29	0.68	1.16	0.91
RJMS Delivery Suite	2.29	2.68	2.49	2.45	1.44	1.23	3.37	2.52
RJMS IOL Team	1.61	2.47	1.52	1.54	3.05	3.74	2.76	2.16
RJMS Johnston House	0.62	0.35	0.44	0.93	0.2	0.14	1.59	1.99
RJMS Midwifery Led Unit	0	0	0	0	0	0	0	0
RJMS Neonatal Unit	2.29	2.82	3.6	4.41	2.11	2.89	2.72	4.16
RJMS Night Coordinators	0.62	0.92	0.61	1.15	0.61	0.7	0.15	0.39
RJMS Night MCA	2	1.23	2.68	2.71	1.81	1.84	2	1.88
RJMS Obstetric Theatres	0.51	0.51	0.4	0.22	0.73	0.57	0.5	0.45
RJMS Ward A	0.59	0.85	0.54	1.35	1	0.22	0.88	0.45
RJMS Ward E	1.88	2.29	2.23	2.24	1.1	0.07	0.85	1.87
RVH ENT Recovery	0.61	0.89	1.18	1.75	0.81	0	0	0
RVH Eye Casualty	1.81	1.57	1.91	2.04	1.1	0.1	1.12	1.4
RVH Eye Casualty ENP	0	0	0	0	0	0	0	0
RVH Ward 29	5.46	5.87	4.85	7.24	3.32	3.8	3.37	2.32
RVH Ward 31	0	0	0	0	0	0	0	0
Totals	**29.95**	**34.07**	**35.13**	**42.05**	**24.52**	**19.48**	**28.24**	**33.43**

Overall total	2019	2020
	141.20	**105.67**



Specialist Hospitals and Women's Health Action Plan

Ref No	Issues	Action	Date for completion timescale	Status at 31 July 2020
3.	**Maternity & Neonatal Services** There are 18.0 wte Midwifery vacancies. There are currently no nursing vacancies in NNICU. Vacancy rate : 18% Sickness /absence rate : 9.18% Maternity Leave rate :3.91%	• Quarterly rolling programme of recruitment for midwifery staff and support roles for this area now reinstated. • 20 new start successful candidates interviewed w/c 12th June 2020 with posts offered and responses awaited. • Discussions in progress with Director of SHWH in relation to the over recruiting of Midwives if possible, in view of the outcomes required from Birth Rate Plus exercises for the new maternity hospital staffing for Midwifery. • Recruitment of Advanced Neonatal Nurse Practitioner trainees x 2 to commence training in Sept 20 with a view to appointment in Sept 21. • Bank usage continues across both professions. • Appropriate use of overtime and extra hours are monitored in line with e roster KPIs • RJMS do not utilise agency Nursing and Midwifery. • The Division has an approximate under spend of £400k in both Nursing and Midwifery.	**Dec 2020**	
		• Student Midwives who have been successful at interview for a Registered Midwife post will continue to be offered Band 3/4 posts until registration.	**July 2020**	
		• The age profile within the Midwifery team has been scoped and consideration needs to be given to over recruiting to offset potential vacancies as a result of retirements. • Number of Midwives over 55yrs at 31 March 2020: 71 Headcount (60.69 WTE)	**July 2020**	
		• Further progress of the succession planning strategy (e.g. New Horizons Project)	**Oct 2020**	

Ref No	Issues	Action	Date for completion timescale	Status at 31 July 2020
		• Development and appointment of an additional Lead Midwife 8a post in anticipation of Future Midwife training standards associated with Continuity of care models and the service relocation to the new Maternity hospital.	**Nov 20**	
		• Development of additional Specialist Midwifery roles at Band 7 level e.g. Haematology Midwifery Specialist.	**June 21**	
		• Participating successfully in the Trust internal rotation process.	**July 20**	
		• EPPC and Maternal Foetal Medicine surveillance posts are an area for concern in relation to succession planning. 5 x midwives facilitated to undertake third trimester ultrasound scanning training to equip possible candidates for future posts.	**Dec 20**	
		• Consultant Midwife and Practice Development staff meeting directly with QUB students.	**July 20**	
		• HoM /Consultant Midwife meeting with new starts x 4 times annually in the first year of employment to support and listen to concerns and issues identified.	**July 20**	
		• Commissioning and commencement of training of Advanced Neonatal Nurse Practitioner roles at Band 8a x 2.	**Sept 20**	
		•	**July 20**	
		• Voluntary Transfer Policy utilised successfully in this area.	**July 20**	
		• Twice-yearly rotational programme for midwives and support workers in operation.	**July 20**	
		• Continued commissioning of development courses for Midwifery e.g. examination of the newborn, ultrasound scanning, RCM leadership modules.	**July 20**	
		• x 1 midwife participating the Nightingale challenge	**Sept 20**	
		• Quarterly meetings with commissioners regarding activity and workforce planning.	**Sept 20**	

Ref No	Issues	Action	Date for completion timescale	Status at 31 July 2020
		• Development of a Nursing and Midwifery Workforce Model for the new Maternity Hospital following the completion of Birth Rate Plus phases 1 and 2.	**Dec 20**	
		• Implement retention strategies for midwifery as part of the Trust's Nursing and Midwifery Retention Plan e.g. Retire and Return.	**Sept 20**	
		• Continued implementation of Band 4 theatre scrub assistant role in Obstetric theatres	**Sept 21**	
4.	**<u>Nursing</u>** **Gynaecology & Sexual Health services** Vacancy rate :9.43% Sickness /absence rate : 9.84% Maternity Leave rate :0.97% **ENT /School of Dentistry Services** Vacancy rate : 9.62% Sickness/absence rate: 8.64% Maternity Leave rate :2.12%	• Participation in Trust recruitment activity for these areas. • Development of Nurse Lead Hysteroscopy service. • Development of band 5/6 Family Planning training post for succession planning and skill development purposes. • Consideration of Lead Nurse role for Gynae and Sexual Health services	**Sept 20** **Sept 21** **Feb 21**	
5.		• Participation in Trust recruitment activity for these areas. • Further collaboration with RBHSC colleagues to assist with recruitment for vacancies in Ward 31, Children's ENT services. • Consideration of Lead Nurse role for ENT and SoD services	**Dec 20**	

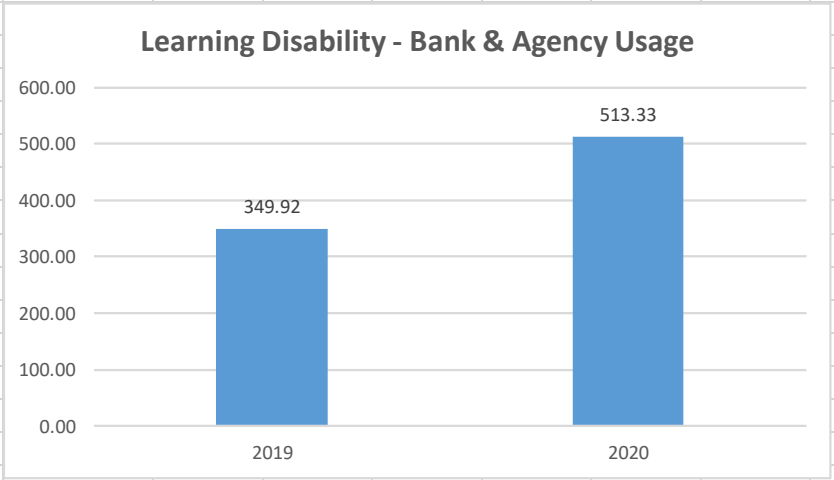
MAHI - STM - 102 - 4419

Learning Disability Workforce Information

Ward				Funded Establishment/nursing model						Staff in Post					Variance					Telfords Updated Date	Total Vacancy %	% Sick Leave	% Maternity Leave	COMMENTS
	Agreed NTBR	Beds	Beds Open	Total funded establishment	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2					
Muckamore																								
Cranfield 1		14	9		1	3.5	8	34.49	0	1	2.8	2.53	15.39	0	0	0.7	5.47	19.1	0	01-Jan-20	54%	7.30%	8.70%	band 6 inc 1.0wte on ML band 5 inc 1 band 4 transition studentband 3 inc 1.0wte on ML and 1.53wte on LTS
Cranfield 2		16	8		1	3.5	8	34.49	0	1	1	3.38	23.64	0	0	2.5	4.62	10.85	0	01-Jan-20	38%	18.80%	3.50%	1 band 6 is acting up as band 7 in sixmile band 5 inc 1.53 wte LTS band 3 inc1.0wte ML and 1.57 shielding and 2.79wte LTS
PICU		6	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0%			
Ardmore		33	11		1	3.5	11.23	44.56	0	1	2	5.8	31.3	0	0	1.5	5.43	13.26	0	01-Jan-20	33%	16.40%	5.60%	Band 5 inc 2.0wte band 4 transition students Band 3 2.0wte ML 2.0wte on career break 9.7 LTS
Sixmile		19	13		1	3.5	14.35	28.24	0	2	1	6	12.52	0	-1	2.5	8.35	15.72	0	01-Jan-20	54%	11.20%	2.20%	band 7 1.0 wte ML band 5 inc 2 band 4 transition students band 3 inc4.74wte shielding & LTS
Erne		9	9		1	3.5	8	40.22	0	1	0	4.6	29.35	0	0	3.5	3.4	10.87	0	01-Jan-20	34%	25.10%	2.50%	band 6 joining team in July 2020 Band 5 inc 2.0wte band 4 transition students band 3 inc).74 ML 1.96wte shielding & 5.79 LTS
RVH																								
Iveagh		6	6		1	1	15	18.5	0	1	5	6.8	9.2	0	0	-4	8.2	9.3	0	01-Jan-20	38%	5.80%	3.70%	HSCB agreed to reduce beds on permanent basis from 8 to 6
Community																								
Community L&D					6	8	1.8	0		3	8	0	0	0	3	0	1.8	0	0	01-Jan-20	30%			by Sept 2020 there should be an additional 4.0wte band 6
Totals				0	12	26.5	66.38	200.5	0	10	19.8	29.11	121.4	0	2	6.7	37.27	79.1	0					

Unit	Learning Disability Bank & Agency Usage							
	Apr-19	May-19	Jun-19	Jul-19	Apr-20	May-20	Jun-20	Jul-20
MAH Ardmore	14.93	13.77	14.69	14.4	24.91	22.55	21.7	22.27
MAH Cranfield 1	15	15.72	16.81	15.68	22.9	21.01	22.11	20.99
MAH Cranfield 2	11.25	8.81	8.01	11.57	18.65	18.48	20.53	20.13
MAH Iveagh	17.63	17.29	19.5	21.37	21.51	18.71	18.21	16.27
MAH Erne 1	13.65	11.16	13.48	13.45	22.9	26.46	26.38	27.33
MAH Sixmile	12.16	15.87	16.43	16.17	18.21	18.86	20.24	20.58
MAH Therapeutic Day Services	0.15	0.19	0.34	0.44	0.98	0.03	0.21	0.22
Totals	**84.77**	**82.81**	**89.26**	**93.08**	**130.06**	**126.1**	**129.38**	**127.8**

Overall total	2019	2020
	349.92	**513.33**



Learning Disability Action Plan

REF NO	Issues and position at End of August 2020	Action	Timescale	Status at Sept 2020
	Management of risk of immediate reduction to staffing levels due to the cessation of 15% incentive at the end of October 2020	In the event of an immediate reduction, we would refer to the MAH contingency plan to manage the site in the event of significant reduced staffing levels (overview below). • Use of day care staff • Requests to staff on annual leave • Requests recently retired staff • Use of agency staff • Communicate with other Trusts to assist. • Communicate with families.	**End October 2020**	
		Ward sisters/Charge Nurse and ASMs to discuss with staff	**End September 2020**	
	Staff Morale & Culture & Team work • Listening exercises have been held on site March 2020 to determine; • What motivates you to come into work? • What frustrates you about working here? • What ideas do you have to make things better? • Formal staff meetings held in partnership with trade union colleagues. Staff report that they are concerned about the ongoing safeguarding investigation and impact on the site, the future of the site, the management of challenging behaviour from patients, how incidents are followed up, the impact of COVID, the use of CCTV,	Plan further listening exercises with staff. Dates to be determined	**End October 2020**	
		Continue with formal staff meetings held in partnership with trade union colleagues *(also referenced in Rice report 2019/20)* Rolling calendar of meetings to be determined	**End September 2020**	
		Confirm dates for HR Team values sessions.	**End October 2020**	

<table>
<tr><th>REF NO</th><th>Issues and position at End of August 2020</th><th>Action</th><th>Timescale</th><th>Status at Sept 2020</th></tr>
<tr><td></td><td>some interpersonal issues between teams and perceptions as to how agency staff work.
We are working closely with HR to plan some sessions around values, team work, resilience and interpersonal working relationships on site
We promote good new stories on social media. In addition, we have linked in with our corporate comms team to make sure that good news stories are “pushed” out by the Belfast trust accounts (Facebook/twitter) in the main. We report false/inaccurate stories on twitter.
Clinical Improvement groups were established 2019 which were an opportunity for the MDT to reflect on specific concerns they may have as a team. These have been stood down due to COVID 19 but are in process of being reinstated.
Reflective practice sessions were in place from 2019 but stood down due to COVID-19</td><td>Continue to promote good news stories on social media and with Corporate Comms teams.</td><td>Ongoing</td><td></td></tr>
<tr><td></td><td></td><td>Re-instate reflective practice sessions</td><td>End October 2020</td><td></td></tr>
<tr><td></td><td></td><td>Re-instate clinical Improvement groups(also referenced in Rice report 2019/20)</td><td>End October 2020</td><td></td></tr>
<tr><td></td><td>Staffing levels & stabilising the workforce (recruitment)
The nursing model was developed in conjunction with a Telford exercise to identify the staffing requirement to manage the existing patient population in MAH. See example below for Week
<table>
<tr><th></th><th>Patient nos</th><th colspan="3">Plan</th></tr>
<tr><th></th><th></th><th>Reg</th><th>Non Reg</th><th>Total</th></tr>
<tr><td>Cranfield 1</td><td>9</td><td>8.96</td><td>26.13</td><td>35.09</td></tr>
<tr><td>Cranfield 2</td><td>8</td><td>8.96</td><td>34.35</td><td>43.31</td></tr>
<tr><td>Ardmore</td><td>10</td><td>8.96</td><td>35.47</td><td>44.43</td></tr>
<tr><td>Sixmile</td><td>12</td><td>16.24</td><td>16.8</td><td>33.04</td></tr>
<tr><td>Erne</td><td>8</td><td>8.96</td><td>37.7</td><td>46.67</td></tr>
</table></td><td>Continue all efforts to recruit registrants and SNAs. Continue to have a specific rolling advert for registrants and Senior nurse assistants. A further 6.0wte SNA posts have been offered August 2020.</td><td>Ongoing</td><td></td></tr>
<tr><td></td><td></td><td>Work with central nursing to develop ideas to support recruitment efforts and market MAH and LD services as a potential employer</td><td>End September 2020</td><td></td></tr>
<tr><td></td><td></td><td>Recruit band 6 Deputy ward sister posts (also referenced in Rice report 2019/20)</td><td>End November 2020</td><td></td></tr>
</table>

REF NO	Issues and position at End of August 2020	Action	Timescale	Status at Sept 2020
	Total **47** **52.08** **150.45** **202.53** of 17th August 2020. 1. Observations are reviewed at PiPA and then the nursing model is reviewed weekly and reported on to senior management and stakeholders in DoH. 2. The OOH Co-Ordinator reviews rosters for the following day and then there are daily conversations between the ward sisters/charge nurses and ASMs where there are gaps staff are asked to move to those areas of need. Staff allocation sheets are maintained to make sure there is equitable movement. 3. Current substantive staffing position in MAH. Correct on 27/08/2020	Fully recruit to the OoH co-ordinators posts to cover weekends (also referenced in Rice report 2019/20) Ensure the agency nurses are fully integrated into ward teams (also referenced in Rice report 2019/20) All agency staff should complete their competency framework Monthly meetings with Attendance management team regarding long term cases	**End November 2020** **End November 2020** **End October 2020**	

	Staff in post		
	Reg	**Non Reg**	
CF1	6.59	14.38	Inc 2 SL and 1 ML
CF2	5.39	22.95	Inc 6.22 SL and 1 ML
Ardmore	5.64	26.65	Inc 5.12 SL and 2.83 ML
Sixmile	7	11.31	Inc 3.53 SL
Erne	6.2	31.79	Inc 4.78 SL and 0.74 ML
Total	**30.82**	**107.08**	

REF NO	Issues and position at End of August 2020	Action	Timescale	Status at Sept 2020
	4. Back fill against the model is generally higher than 90% across the site. 5. Work is underway with e roster team to review all rosters to ensure safe rostering of staff. 6. Work in partnership with Nurse bank to ensure sustainable levels of block booked bank and agency staff. 7. Currently circa 50 block booked agency staff who have been here longer than 6 months. 8. Agreed SLA for further 12 months with Direct Health care nurse agency for up to 50 wte registrant staff (to maintain stability coming into Winter 2020/21). 9. Continue to work to integrate the agency staff into teams.			
	Stabilisation of Management/Leadership Staff **Collective Leadership team** 1. Permanent Co-Director appointed and took up post April 2020. 2. Previous Interim Co-Director has been promoted to Interim Director. Her portfolio includes Learning Disability Services. This has provided a level of continuity and support for the team. 3. Permanent Divisional Social Worker in post for circa 3 years. 4. Permanent Clinical Director in post. 5. Interim Divisional Nurse in post for 11 months. **MAH Senior Management team** 1. There are 3 fully funded Assistant manager posts. All 3 posts are now recruited to. 1 post the post holder has been in post for circa 2 years. 1 post holder had previously held a temporary post as ASM since January 2020 but was successful in getting the permanent post. A third post has been offered and the new person starts November 2020. 2. We have successfully appointed a day care manager and a deputy day care manager.	Interim Divisional Nurse position requires permanent recruitment.	**To be determined**	

<table>
<tr><th>REF NO</th><th>Issues and position at End of August 2020</th><th>Action</th><th>Timescale</th><th>Status at Sept 2020</th></tr>
<tr><td></td><td>3. All Clinical Areas have a permanent band 7 appointed since December 2019.</td><td></td><td></td><td></td></tr>
<tr><td></td><td>Staffing requirements & resettlement
<table>
<tr><th></th><th colspan="2">End Aug</th><th colspan="2">End Sept</th><th colspan="2">End Oct</th><th colspan="2">End Nov</th></tr>
<tr><th>Ward</th><th>Inpt Nos</th><th>Trial Leave</th><th>Inpt Nos.</th><th>Trial Leave</th><th>Inpt Nos</th><th>Trial Leave</th><th>Inpt Nos</th><th>Trial Leave</th></tr>
<tr><td>Cranfield 1</td><td>9</td><td>0</td><td>9</td><td>0</td><td>9</td><td>0</td><td>9</td><td>0</td></tr>
<tr><td>Cranfield 2</td><td>8</td><td>0</td><td>8</td><td>0</td><td>8</td><td>0</td><td>8</td><td>0</td></tr>
<tr><td>Ardmore</td><td>10</td><td>1</td><td>8</td><td>3</td><td>7</td><td>4</td><td>6</td><td>5</td></tr>
<tr><td>Sixmile</td><td>12</td><td>2</td><td>12</td><td>2</td><td>12</td><td>2</td><td>11</td><td>3</td></tr>
<tr><td>Erne</td><td>8</td><td>1</td><td>7</td><td>2</td><td>7</td><td>2</td><td>7</td><td>2</td></tr>
<tr><td>Total</td><td>47</td><td>4</td><td>44</td><td>7</td><td>43</td><td>8</td><td>41</td><td>10</td></tr>
</table>
Predicted patient population July to November 2020
1. Resettling these 6 patients successfully this will reduce our staffing requirement at MAH by approximately 15.0 wte band 3 Senior nurse assistants.</td><td>Successful resettlement of 6 patients

Resettlement oversight group established (also referenced in Rice report 2019/20)

Plans are required for remaining 41 patients on site, including those patients/family members who have repeatedly indicated that they do not wish to leave MAH</td><td>End November 2020

End September 2020

End September 2020</td><td></td></tr>
</table>

REF NO	Issues and position at End of August 2020	Action	Timescale	Status at Sept 2020
	2. Resettling these 6 patients may allow for an opportunity to review the living arrangements on site to reduce the number of clinical environments to be staffed.			
	Managerial/Leadership Support & Communication • Further increased visibility of Senior Management on site. • Ward Sisters, Deputy Ward Sisters, are available on each of the wards usually daily. • There are senior nurses who provide cover in the OoH. At weekends, the ward sisters and Deputy Ward sisters identify who is senior nurse on site. • This is supported by a robust Senior Manager/Senior Nurse on call system • ASMs are based on the wards. • The SM is based on site visits clinical areas on average 3-4 times a week. • The DN is based on site, undertakes a weekly team call, and visits clinical areas 1 x weekly/fortnightly. • From October 2019, Staff briefings were held every 2 months. The Director responsible for MAH, the Co-Director and the DN. led these. These were stood down due to COVID • The DN has been visible on site until COVID, has had a team call with our nurses and has requested another Team call to talk and engage with staff. • Trade Union colleagues' re- established their office on site and are on site 1x weekly to meet staff. • Planned Exec DoN meeting with MAH staff August 2020.	Planned Leadership walks rounds/team meetings. *(also referenced in Rice report 2019/20)*	**End November 2020**	
		Further date for Exec DoN to meet with MAH staff to be determined before end December 2020.	**End December 2020**	
		Re-instate staff briefings & communication *(also referenced in Rice report 2019/20)*	**End October 2020**	
		Re-instate Newsletter.	**End September 2020**	
	Learning and Development • We have a permanent NDL for Learning Disability who supports practice development on site.	Integrate QI into all areas of MAH	**Ongoing**	

<table>
<tr><th>REF NO</th><th>Issues and position at End of August 2020</th><th>Action</th><th>Timescale</th><th>Status at Sept 2020</th></tr>
<tr><td></td><td>

We are proving opportunities to develop in Quality improvement and a team are undertaking a QI project supported by SQB.
There are opportunities to develop skills for example: MAPA trainers, ILS trainers, Peer vaccinators, Positive behaviour work.
New roles have been piloted and are in process of evaluation: for example: Behavioural support staff.
Students are placed in all clinical areas supported by their mentors and sign off mentors. We are also getting ready to implement the new Future Nurse Future Midwife standards. The Practice education facilitator is regularly on site and we have completed in the early part of 2020 our educational audits. Feedback from students is largely positive.
We are active members of the QUB partnership chaired by Head of School Prof L Marsh. There will be a Joint appointment for LD nursing advertised in coming months.
We are also supporting 3 OU Year 2 student nurses and are accommodating a further 7 OU students (5 LD pathway, 1 MH and 1 Adult pathway commencing Sept/Oct 2020)

</td><td>Fully evaluate the role of behavioural support and determine commissioning of same. This is the responsibility of the psychology department</td><td>End December 2020</td><td></td></tr>
<tr><td></td><td></td><td>Implement the new Future Nurse Future Midwife standards.</td><td>End December 2020</td><td></td></tr>
<tr><td></td><td></td><td>Promote and support the joint appointment for LD nursing. This is the responsibility of QUB to progress but we have had input</td><td>End November 2020</td><td></td></tr>
<tr><td></td><td></td><td>Continue to support OU progression.</td><td>Ongoing</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td><u>Leavers</u>

1. Exit questionnaires undertaken with leavers. Highest reason for leaving is determined as location of work closer to home.
2. HRPTS data would indicate that the number of leavers has been reduced this year in comparison to last. This data refers to all leavers.

<table>
<tr><td>Count of MAH Turnover</td><td>Apr-18</td><td>Mar-19</td><td>Leavers</td><td>Turnover %</td></tr>
<tr><td>2018/2019</td><td>496</td><td>480</td><td>78</td><td>15.98%</td></tr>
</table>
</td><td>Continue to monitor exit questionnaires.</td><td>Ongoing</td><td></td></tr>
</table>

REF NO	Issues and position at End of August 2020	Action	Timescale	Status at Sept 2020
	<table><tr><td>Count of MAH Turnover</td><td>Apr-19</td><td>Mar-20</td><td>Leavers</td><td>Turnover</td></tr><tr><td>2019/2020</td><td>479</td><td>470</td><td>80</td><td>16.86%</td></tr></table> <table><tr><td>Count of MAH Turnover</td><td>Apr-20</td><td>Jun-20</td><td>Leavers</td><td>Rolling Turnover %</td></tr><tr><td>2020/2021</td><td>464</td><td>458</td><td>6</td><td>1.30%</td></tr></table>			
	Future workforce planning 1. Communication from the current Health Minister has determined that MAH will not be closing. However, there still needs to be clear direction about what the future plan is for MAH/LD services. 2. Senior team involved in strategic meetings 3. Workshop planned by BHSCT senior management team to determine vision and direction for the service. 4. Work planned to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care. 5. Senior nursing team involved in phase 9 of Delivering care.	Senior team involved in strategic meetings. Clear direction about what the future plan is for MAH/LD services. The future management for MAH is a departmental decision.	**End December 2020**	
		Workshop planned by BHSCT senior management team to determine vision and direction for the service by end of October 2020	**End October 2020**	
		Work planned to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care. Meeting to be held with RQIA by end of Sept 2020.	**End September 2020**	
		Senior nursing team involved in phase 9 of Delivering care *(also referenced in Rice report 2019/20) Telfords have been requested by 25th September 2020*	**End September 2020**	

Belfast Health and Social Care Trust
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Belfast Trust Nursing Workforce Strategy 2021/22 to 2025/26	
Purpose	• *An effective workforce is key to the Trust's success in delivering high quality, safe compassionate care.* • *The Trust has developed a nursing workforce strategy, focusing primarily on the next five years, in an effort to address its unsustainable nursing vacancy position.* • *The strategy outlines the current and anticipated future vacancy levels within band 5 and 6 nursing, and proposes a number of initiatives aimed at significantly reducing the vacancy rate as soon as possible over the next five years.* • *The strategy also explores ways in which the Trust can improve the management of its nursing workforce with a focus on sickness absence, recruitment and retention, and a review of roles and responsibilities to help optimise the use of the entire workforce.*
Corporate Objective	• To secure and maintain safe and effective nursing workforce levels to meet service needs
Key areas for consideration	• **Key Proposals** The key proposal to effect a substantial reduction in nurse vacancies is the recruitment of 1,000 additional international nurses over the next two financial years. Based on current assumptions around new investment, trainee numbers and staff turnover, this should allow a reduction in the vacancy level from 18% to around 5.5% by the end of 2022/23. This will generate additional costs of around £15m before accounting for any additional funding from DOH as part of the new regional international nurse recruitment (INR) business case. A number of strategies and initiatives are also being developed to improve recruitment, retention and roster and backfill management and to reduce sickness absence. In addition, further work will be done to review

	nursing skill mix and explore the potential for new roles to support/replace registered nurses in order to reduce nurse vacancy rates where possible and optimise the use of the entire workforce. This will allow the Trust to be able to safely staff wards, theatres and other departments and deliver contracted levels of activity. • **Financial Considerations** Even assuming a contribution of approximately £3.6m from DOH (currently unconfirmed), the recruitment of 1,000 international nurses will result in an overspend of £11.4m over the next two years. The Trust is seeking non-recurrent funding from DOH but in the absence of funding would argue that the investment over the next two years will be offset by reductions in off-contract agency expenditure. Recurrently, the Trust's vacancy rate will be significantly reduced which will allow the Trust to contain nursing workforce spend within budget. • **Risks and Assumptions** The five year strategy assumes limited new investment in services and associated workforce (1.5% per year). **Further investment above this level, for example to tackle waiting times or implement new service developments, would increase the anticipated vacancy levels.** Assumptions have been made around the share of the region's graduate trainee posts that will be appointed in the Belfast Trust over the next five years. Any change in this will impact on the projected vacancy levels. The Trust would argue that in light of the relative workforce positions across the region, the proportion of graduates allocated to Belfast should be increased which would reduce the requirement for international nurses.
The Ask	• DoH are asked to ratify the proposals included in this workforce strategy which has been approved by the Board of the Belfast Trust. • DoH are asked to fund additional international recruitment nurses above the numbers included in the regional business case over the next two years. The total **non-recurrent** funding requirement for the Belfast Trust is approximately £15m (£5.5m in 2021/22 and £9.5m in

	2022/23) before any contribution as part of the regional business case.
Next Steps	• Given the gravity of the Trust's nursing vacancy position, the Trust believes it has no option but to proceed to implementation of its strategy. At this stage, the Trust is proceeding at financial risk on the basis that a non-recurrent overspend associated with international nurse recruitment is preferable to ongoing overspending on premium cost agency. • The Trusts is developing detailed proposals and action plans with clear aims, targets and timescales to implement the strategy. Detailed updates against these action plans will be presented at the September Trust Board and will be available for review by DOH on request.

Belfast Health and Social Care Trust

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Nursing Workforce Strategy 2021/22 to 2025/26

June 2021

Executive Summary

A well-staffed and motivated workforce is key to the Trust's success in providing a safe, effective and compassionate health and social care service. Furthermore, increasing our workforce capacity will be crucial in rebuilding and stabilising our health and social care system after COVID.

The COVID-19 pandemic exacerbated what was already a serious nursing workforce issue in the Belfast Trust. The Trust has an average nurse vacancy rate of 18%, although this average masks considerably higher rates in our band 5 nursing category where the vacancy rate averages 24%, and in individual wards and specialties. The nurse vacancy rate has grown year on year from 9% in 2015/16. At the same time, sickness absence rates amongst nurses have risen, putting additional pressure on the Trust's depleted workforce.

In response to the rising vacancy rates across NI, DOH began to gradually increase the annual number of graduate training places in 2018/19. However, this will not deliver any material improvement in the vacancy rate until 2023/24 when the impact of the additional 300 places introduced in 2020/21 is realised. In the meantime, the Trust is likely to face an ongoing vacancy rate of at least 18% which is not sustainable. Operationally, services are finding it increasingly more challenging to provide safe levels of care and are relying on unacceptably high levels of temporary staff. Vacancy rates have already impacted on the level of service provided in theatres. Financially, high levels of backfill and limited supply mean that the Trust is relying on increasing levels of off-contract agency staff who can cost up to 3 or 4 times more than Trust nurses.

This paper explores the various ways in which the Trust can reduce its registered nursing vacancy rate in the short, medium and longer term, taking account of any known future workforce pressures, including the need to tackle Northern Ireland's unacceptable waiting times.

The Trust believes that the only real means of increasing the number of nurses in the short term is through an increase in international nurse recruitment (INR), building on recent success in that area. The Trust has developed a proposal in relation to INR which builds up the number of nurses recruited per month to 60 to recruit 1,000 new nurses before the end of 2022/23. This would be sufficient to reduce the gross vacancy rate after sickness to around 5.5% by the end of 2022/23. This is more in line with the aims outlined in the NHS Plan which recommended a 5% vacancy target. Current bank staff usage would be sufficient to address the residual vacancy albeit subject to availability of cover at specialty level. The vacancy rate will reduce further to around 4% in 2024/25 to reflect the increase in graduate trainees available for appointment from September 2023.

In the longer term the Trust believes that it will be important to have access to a sustainable local workforce market, with sufficient numbers of graduate trainees coming out every year to replenish staff lost through turnover and to meet any growth in nursing workforce requirements for example to roll out the 'Delivering Care' agenda and to address current excessive waiting times. The Trust would recommend that the additional 300 places per year commissioned between 2020/21 and 2022/23 should be maintained in order to facilitate additional capacity to address waiting lists beyond 2025/26. Changes in the way nurse undergraduates are funded could provide opportunities for increasing places within the existing resource given the financial pressures in the HSC system.

Notwithstanding any initiatives aimed at recruiting additional nurses, the Trust recognises the need to improve the management of its nursing workforce, and several initiatives will be implemented aimed at attracting, recruiting and retaining staff, reducing sickness absence, optimising roster management and improving the management of backfill with a particular focus on eliminating the use of off-contract agency staff.

The Trust also recognises the need to look objectively and innovatively at care pathways and tasks in order to maximise our current workforce/skill mix and ensure that all roles within the nursing family are utilised within the existing policy guidance whilst at the same time providing new job and career opportunities to those in our local communities, creating wealth in society. However, it is acknowledged that new roles will require appropriate system approvals and the development of training programmes, and as such this work is not likely to have a significant impact on registered nursing vacancy gaps in the short to medium term.

In summary, the Trust's aim is to increase its nursing workforce to reduce its gross vacancy rate from 18% to a more reasonable/manageable level of 5% or less. A range of solutions are proposed to deliver this aim, the key elements being:

- An increase in international nurse recruitment from 15 per month in 2019/20 to 60 per month by 2022/23. In total, this should deliver an additional 1000 nurses by the end of 2022/23 (subject to any particular recruitment difficulties associated with COVID), reducing the vacancy rate to 5% after accounting for unfunded sickness levels

  The Trust would envisage continuing to use an appropriate level of bank nursing, primarily to cover short term absences due to sickness, maternity or other short term vacancies pending recruitment for example, which is acknowledged to be the primary purpose of the nurse bank.

- In the longer term, the Trust proposes that trainee numbers are at least maintained at the 2021/22 to 2022/23 levels of 1325 per year. These levels would be sufficient to meet staff turnover in the Trust and, subject to a regional evaluation of nurse vacancies, should provide sufficient nurses to be able to increase activity to help reduce NI waiting times.

The Trust will also implement a number of focused task and finish groups to improve recruitment, and retention and to develop new roles to support nurses, and there will be a renewed focus on reducing staff sickness absence levels.

The current strategy will require a total investment of around £15m in 2021/22 and 2022/23, relating to the recruitment of additional nurses. It is hoped that around £3.6m of funding will be secured through the regional international nursing business case. The Trust is requesting additional non-recurrent funding of £11.5m over the next two financial years to meet the residual costs. However, in the event that non-recurrent funding is not provided the Trust believes that the overspend associated with international nurse recruit is preferable to the anticipated overspend associated with the premium costs of agency nurse usage which is inevitable if the current vacancy rate is not addressed. In the absence of additional international recruits the Trust does not believe there are any options to avoid agency spend whilst maintaining safe nursing levels.

Strategy Aims

Aim:

To identify the nursing workforce gap for the Belfast Trust over the next five years, evaluate a range of options to address gaps in the short and medium term and develop a plan to reduce the nurse vacancy rate to 5% or less in the shortest possible time. This will help the Trust provide safe levels of care across its wards and departments and ensure optimal use of funded beds and theatres.

Stabilising the nursing and midwifery workforce, therefore ensuring safe and effective care, and ensuring a sustainable nurse workforce plan for the longer term to meet staff turnover and enable the Trust to meet required increases in workforce capacity associated with service growth.

Scope:

The paper will focus on the gap in relation to registered band 5 and 6 nurses where vacancy levels are greatest.

Strategic Context

This nursing workforce strategy has been produced by colleagues across the Trust with key input from the directorates of nursing and HR. The strategy is expected to align to 'Health and Social Care Workforce Strategy 2026: Delivering for Our People' which was published in 2018. The Workforce Strategy was developed by the Department of Health and wider health and social care bodies in close co-operation with trade unions and other organisations and involved significant engagement with the workforce. The Strategy document included a detailed look at the problems and challenges across the whole health and social care workforce in Northern Ireland, and set the objectives and actions to ensure that Northern Ireland could meet its HSC workforce needs and the needs of its workforce.

The Strategy showed that whilst overall workforce numbers had been increasing in the years leading to its publication in 2018, there was still a need for additional people. At that time, the HSC vacancy rate (of posts being actively filled) was deemed to be around 5% but a drilling down into this figure highlighted key areas of concern, including within nursing, midwifery and medical staffing.

Introduction and Background

Nursing accounts for around 35% of the Trust's total workforce budget, comprising approximately 5700 registered nurses and 1900 unregistered nurses/nursing assistants. The Trust relies on a significant intake of new nurse graduates each year to address staff turnover which is approximately 10% for registered nurses.

Between 2010/11 and 2016/17, the number of new nurse undergraduate places commissioned by DOH fell by 732 to an annual trainee complement of 800 per year in 2016/17. At the same time, the Trust's registered nurse requirement has been rising by an average of almost 2% per year as a result of the implementation of the Delivering Care policy standards, which outlined the requirements to meet the normative nurse to bed and skill mix ratio in a range of specialties, and other service investments, including transformation. As a consequence, the Trust vacancy rate for registered nurses increased from 9% in 2015/16 to 18% in 2019/20.

Whilst the annual numbers of trainees has increased since 2016/17, increases in funded establishment mean that we have not seen the benefit of those increases. A net gain is expected as a result of the additional 300 trainee places commissioned in 2020/21 but it will take three years before we see the impact of the Belfast Trust's share of those graduates on the ground. In the meantime, it is envisaged that, without action, the vacancy rate will grow, with additional concern being raised about the impact of COVID on staff retention and competing demands for nursing from the independent sector.

The current vacancy rate of 18% represents a significant risk in terms of safe, effective and compassionate care and staff wellbeing.

Whilst vacancies have resulted in bed closures at times, the impact of the excessive vacancy rate is most marked in theatres where it is more difficult to secure backfill. By way of illustration, the Trust expects to be delivering 80% of its funded operating lists by the end of June 2021 (currently 77%). This is a deterioration in the pre-COVID position when the Trust benefitted from approximately ten additional theatre nurses through a contract with an English Trust; this ceased as a result of COVID. The current staffing deficit is 73 WTE based on funded staffing levels (which include 22% headroom for leave/sickness etc), taking account of long term sick leave and maternity leave and available backfill including additional hours and agency. The Trust is funded for 322 weekly sessions, 260 of which can be delivered with the current resource. Therefore, the Trust is experiencing a gap of 62 sessions per week as a result of staffing shortfalls. Whilst every speciality is different, the complex nature of BHSCT work means that we deliver an average 1.5 operations per session. Consequently, the current gap of 62 sessions per week represents 'lost' capacity of 93 patients per week or 4,650 patients per annum.

The risk to service provision associated with our high vacancy rate was very much highlighted in 2020/21 during COVID-19. Vacancy levels rose above the 18% due to COVID-19 related absence which took a further 5% or so of our staff out of our workforce at any one time, and at the same time access to external backfill fell. This, combined with occupancy levels well in excess of the 80% seen in the best performing healthcare systems in the world, meant that there was no slack in the system in terms of beds, and more importantly staff, when the pandemic hit. As a result, the Trust was forced to downturn some services in order to redirect staff to care for COVID-19 patients.

It is important to note that the current 18% vacancy rate is the average for all registered nurse grades; however, within the 18%, rates are low for senior nursing posts and much higher for band 5s for example (24%) as shown below. As a result, the focus of the Trust's workforce strategy is to address the vacancies at band 5 entry level and band 6.

Nursing	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Jan-21
FSL	6874	6949	7171	7436	7571	7635
WTEs	6176	6214	6235	6162	6201	6363
Gross vacs %	10%	11%	13%	17%	18%	17%

Band 5	12%	12%	14%	19%	24%	
Band 6	2%	10%	13%	16%	13%	

It is also important to note that vacancy rates vary between specialities, with some specialties such as learning disability, district nursing, health visiting and mental health experiencing much higher vacancy rates as shown in the table below.

Band 5 and 6 Gross Vacancies at January 2021

Category	Vacancies %
Adult*	(19%)
Child Health (incl health visitors)	(7%)
Children's	(0%)
District Nursing	(22%)
Learning Disability	(72%)
Maternity	(5%)
Mental Health	(20%)
Neonatal	(5%)
Totals	**(19%)**

*Adult includes areas such as occupational health, risk and governance, education, tissue viability, infection control and labs where vacancy rates tend to be lower.

The 18% vacancy rate equates to a current shortfall of over 900 band 5 and 6 nurses which will grow by approximately 400 every year as a result of turnover and potentially up to 100 more for workforce growth associated with Delivering care or service developments. In addition to this, sickness absence is currently around 4% higher than funded sickness absence levels meaning a further 160 band 5/6 posts require backfilling at any one time. In the context of an expected intake of around 300 new graduates next year it is easy to see why the vacancy rate is growing year on year.

Over the last few years, whilst the appointment of international nurses through the regional INR initiative has had some impact on nursing levels, the Trust has addressed its gross vacancy position primarily through the use of temporary staff from the Trust bank or from external nurse agencies. Although the use of bank staff has been maintained at around £22m, the rising vacancy rate has resulted in an increasing reliance on agency staff and in the last two years the proportion of off-contract premium cost agency staff has risen substantially. Yet despite this increased use of temporary backfill, the Trust is only backfilling approximately 60% of its vacancies meaning that its **net** vacancy rate in the last few financial years is unacceptably high at around 8%. We note that the NHS Plan suggests a target 5% **gross** vacancy rate in its strategic plan.

Staff surveys and feedback consistently cite safe staffing levels as the highest risk and the greatest concern for staff.

Post-COVID there appears to be little chance of our vacancy rates subsiding and indeed we do not know what impact COVID-19 will have on our future staffing position. We may see a need for new services and associated staffing related to the longer term health effects of COVID-19. Furthermore, if the HSC wants to tackle its unacceptable waiting times, significant investment will be required across a range of staffing groups which will require early planning in terms of additional nursing training places.

It should be recognised that further additional investment in Delivering Care or the introduction of new services which have a nursing requirement will impact on the projections made in this paper. At this stage the Trust has only included confirmed investments; as a result, the substantial nursing requirements associated with future potential investments in No More Silos, Cancer Strategy or other service developments not yet approved and funded, will not be included. Crucially, the

projected requirements do not allow for any additional nurses to address waiting times. This is discussed in more detail below

Financial Impact of Current Backfill Arrangements

The magnitude of our vacancy and absence rates means that despite growing a substantial and effective nurse bank over the last few years (with annual spend of circa £22m), the Trust has had to use considerable and increasing levels of agency nursing. Moreover, in the last two years in particular, the use of off-contract agency staff has grown exponentially. These staff can cost up to three times more than HSC staff which has put further pressure on our restricted finances. In 2019/20, agency spend across all staff categories was £250m for the region. The Belfast Trust share of the £250m spend was £87m, which in part reflects the relative vacancy rates across Trusts in the region where for example our nurse vacancy rate is two to three times higher than other Trusts. The £87m included medical agency costs of £24m and nursing costs of £38m. Of the nursing total, almost two thirds (£27m) related to off contract agency, in stark contrast to 2015/16 where off-contract nurse agency spend was minimal, again reflective of the increased vacancy position. In broad terms, around £15m of off contract nursing costs are an avoidable cost pressure to the Trust if other alternatives were available.

Further details on agency spend and a detailed analysis of the nurse vacancy rate and backfill for band 5 and 6 nurses between 2015/16 and 2019/20 is provided in Appendix 1.

The Trust has commenced work to try to eliminate or at least significantly reduce the use of off contract agency spend, including initiatives to improve roster management and attract more staff on to the nurse bank. However, realistically off contract agency usage and the associated unnecessary costs will be unavoidable unless nursing vacancies reduce significantly.

Anticipated Additional Nursing Requirements 2021/22 to 2025/26

In order to determine the vacancy gap and resultant nursing workforce need over the next five years, the Trust has undertaken a detailed review of the current and future nursing workforce position, based on current budget and actual nursing numbers and adjusting for new investments, turnover, sickness absence and anticipated new recruits including graduates and international nurses. Estimates are based on a combination of historic trends and planned changes linked to focused initiatives.

The forecast band 5/6 vacancy position for 2021/22, before accounting for any planned changes is shown below. This indicates that the Trust is facing a vacancy rate of 22% in 2021/22 after reflecting current sickness absence levels. On the assumption that 2019/20 backfill levels can be sustained, the Trust would expect a net vacancy rate, after available backfill, of circa 9%.

2021/22 Opening Position	Totals
Starting FSL	4,804
Delivering Care new posts	28
NMS/other known investments	0
New Posts @ 1.5% p.a.	72
Staffing Requirement	**4,904**
Actual opening WTE	3,871
Del Care B7 posts (B6 leavers)	(21)
Leavers @ 10.5% p.a.	(407)
New starts	136
New NI Graduates	275
New OU Graduates**	25
Estimated Funded International Nurses	120
Expected Actual Staff in Post	**4,000**
Expected Gross Vacancies	**(904)**
	19%
WTE Sickness absence above rostered/funded levels	**(160)**
Vacancies including unfunded sickness absence	**(1,064)**
	22%
Additional hours/overtime based on 19/20 levels	45
Expected bank availability (19/20 levels)	296
Net Vacancies after bank/overtime	**(723)**
	15%
Agency (based on 19/20 levels)	281
Residual net vacancies	**(442)**
	9%

The gross vacancy by programmes of care is provided in Appendix 2. A short commentary explaining the basis of calculations is also provided.

9% is not an acceptable level for net vacancies in the context of safe, effective and compassionate care and the over-reliance on off-contract agency staff in arriving at the 9% is also unacceptable in the context of the Trust's financial obligations.

Urgent action is required to reduce the gross vacancy level to more acceptable level, akin to the target set out in the NHS plan.

Options for Addressing Shortfalls over the next 5 years

It is recognised that the Trust will need a range of immediate, short term and longer term measures to reduce risk and stabilise the workforce. Whilst reducing the current vacancy levels is a priority, it is also important that the Trust has the best possible staffing and expertise levels in place to meet

the needs of users. It is also crucial that the Trust is a rewarding and fulfilling place to work and that the Trust invests in the wellbeing of the workforce, empowering and supporting staff to do what they do best.

Therefore alongside the recruitment of additional nurses, a series of other workforce management initiatives will be implemented as part of the workforce strategy.

International Nurse Recruitment (INR)

The Trust believes that the only real means of significantly increasing the number of nurses to reduce vacancies is through international nurse recruitment. An international nurse recruitment campaign, led by DOH, commenced in 2016 as a short-term measure to help maintain safe staffing levels at that time but the current contract expires within the next month. A regional business case is currently in development to commence a new campaign.

The Trust recruited over 250 nurses through the current campaign and, along with other Trusts, is bidding for additional places as part of the regional business case.

The overriding benefit of recruiting more international nurses to address the Trust's vacancy rate is that well-trained and experienced nurses are immediately available subject to a short induction period. Other benefits are:

- there has been considerable success in recruiting international nurses over the last six months following a slow start to the programme - over the last year, 123 international nurses have been recruited with 113 of those recruited during the period January 2021 to April 2021, reflecting a significant upwards trend.
- retention amongst INRs is excellent – of the 252 nurses recruited by the Belfast Trust to April 2021, 243 remain in post
- The programme is supported by DOH and funding will be available to fund a number of new staff over the next five years subject to approval of the regional business case
- International nurse recruitment numbers can be reduced, ceased or increased (subject to management capacity) almost immediately which will allow the Trust to be flexible if circumstances change
- The recruitment, induction and staff welfare requirements associated with large numbers of new recruits is manageable with moderate investment

A new framework for delivery of the new international nursing campaign is being evaluated and is hoped to be in place in June subject to approval of the business case. The Trust understands that funding is a limiting factor in terms of the numbers of international nurses that DOH will approve. Regardless of the number finally approved, the Belfast Trust would argue strongly that we should receive a disproportionately high proportion with associated funding, given our relative nursing numbers compared with other Trusts (Belfast employs 32% of the nursing workforce across the HSC) and more importantly the vacancy rate in Belfast Trust which we understand to be substantially higher than other Trusts.

The Trust proposes recruiting 1000 new international nurses between April 2021 and March 2023. This would reduce the band 5/6 nursing vacancy level to around 5.5% after accounting for sickness absence. From 2023/24, the increase in graduate numbers should allow the Trust to meet its staff turnover without relying on INR recruitment and the vacancy level in 2025/26 would reduce to around 4% on average.

If NI graduate trainee numbers return to 1025 from 2023/24, the vacancy rate would begin to rise over a number of years so this will be kept under review and necessary action taken.

Resources Required

The cost of recruiting international nurses, to include recruitment and registration fees, induction, accommodation and initial training is approximately £14,000 per nurse. Further investment in Trust staffing is required within HR and nursing to support the nurses following appointment. Investment in 1,000 international nurses by the end of 2022/23 would therefore cost around £15m, comprising over £14m to cover the cost of recruiting, training and providing short term accommodation for the nurses, and around £0.9m for Trust nursing and HR support required to manage, induct and support the nurses.

	2021/22 £'000	2022/23 £'000
Number of additional nurses per year	***360***	***640***
Nurse Recruitment Costs- fees, training, accommodation etc	5,112	9,087
INR admin and support costs - Nursing Directorate	278	371
INR admin and support costs - HR Directorate	96	129
Total Cost	**5,486**	**9,587**
Anticipated Funding	(1,795)	(1,825)
Net Cost	**3,692**	**7,762**

The Trust is assuming that DOH will provide funding for 120 INR nurses per year for the two years (240 across the five years covered by the business case) including some contribution towards infrastructure costs, as part of the regional business case which would reduce the cost to the Trust by around £1.8m per year.

The Trust is therefore requesting non-recurrent funding of almost £11.5m over the next two years to facilitate recruitment of up to 60 international nurses per month up to a total of 1,000 nurses over the next two financial years to address its vacancies. Recurrently, this should help the Trust eliminate off contract agency staffing which is costing the Trust £23m per year for band 5 and 6 registered nurses (based on 2019/20 levels). The premium associated with off-contract agency costs is assumed to be at least 100% of the HSC cost so it could be assumed that at least £11m could be saved per year if off contract nurse agency usage was eliminated. Taking account of the fact that INR will not address issues in all specialities (such as learning disability), £11m per year may be an overestimate; however, it is expected that the £11.5m associated with 1000 new nurses will be more than offset by a reduction in off-contract agency costs over the two years. Furthermore, the cost of the INRs is non-recurrent, but cost reductions associated with the reduction in off contract agency costs will be recurrent.

In the event that DoH does not provide non-recurrent funding, the Trust would continue at risk on the basis that international nurses are preferable to continued use of temporary external staff in terms of safe staffing levels and staff morale over the longer term, and whilst the Trust does not have the funding to cover the cost of INR recruitment the resulting overspend would be less than the cost of backfilling vacancies with off contract agency staff. Recurrently, the Trust's nursing costs should return to below funded levels when premium cost backfill is eliminated which is essential to long term financial stability.

In the event that the trust is required to address the £11.5m within existing resources, the Trust is proposing that some of the costs, for example costs associated with providing accommodation, training and welfare support, could be funded from charitable funds, specifically from the fund established to support staff post-COVID.

The workforce strategy assumes that no additional INRs will be required beyond 2022/23. Further work is needed to determine the longer regional requirement for nursing, taking account of vacancy levels across all Trusts and planned service expansion including waiting list management requirements etc. This exercise may indicate a need to continue INR in Belfast beyond 2022/23 to meet new service needs.

Improved Management of Workforce and Backfill

As part of its nursing workforce strategy, work has commenced in relation to the following

- Improved sickness absence management- HR pilot commencing Spring 2021
- Improved roster management and monitoring- led by central nursing
- Improved management of bank and agency staff- led by deputy director of nursing
- More expeditious and targeted recruitment- led by HR
- Improved retention including expansion of return to work
- Scoping all undergraduate placements within BHSCT to enable the increase in pre-registration training places in QUB and UU
- maximising the number of placements available for funded Open University students, particularly in hard to recruit areas, to supporting career progression for nursing assistants as part of our investment in our people and to enhance our registered nursing workforce
- Supporting career progression and developing additional entry routes into nursing

Action plans with planned outcomes and clear timescales are being developed to articulate the various work programmes to deliver the above and progress against those action plans will be shared with the Trust Board in September 2021.

Resources Required

The Trust has recently approved investment of circa £320k per annum to extend the Trust's nurse bank service, particularly out of hours. This will provide better oversight on backfill arrangements across the Trust, ensuring that the Trust is able to place staff with the right skills and competencies in the right place. Bank office staff will provide assurance in relation to the appropriate induction of staff and adherence to statutory mandatory training requirements. They will also provide a monitoring role to identify opportunities for improved roster management and backfill management to ensure the best use of the Trust's resources aligned to the Belfast Trust quality management system.

The Trust is confident that this additional £300k will be more than offset by a reduction in high cost agency staff and is not requesting funding from commissioners.

It is envisaged that with the successful reduction in vacancies over the next two to three years, demand for bank nursing staff will reduce. Bank office staffing will be kept under review and as workload reduces, staff will be redeployed to other roles or used to establish or expand Trust admin, social work or medical bank office services.

Development of New Roles

The Trust, led by the Deputy Director of Nursing, is currently exploring a number of new roles aimed at supporting registered nurses, to determine if and how this might reduce the overall requirements for registered nurses. Key risks and challenges, including any legislative issues and the impact on the regionally agreed Delivering Care policy standard, will be explored as part of the evaluation. It is crucial that any new roles are evidence based with clarity on outcomes of what new roles will contribute so the Trust will reflect learning and experience of similar workforce initiatives elsewhere in the UK as part of this work.

Examples of existing support roles within the nursing family are the housekeeper, scrub assistant, play specialist, phlebotomist, and dementia companion roles; however, the Trust believes there are further opportunities. Crucially, the current roles do not replace the need of registered nurses; rather, they are to provide support within the nursing family, patient safety and experience.

The Trust will continue to review its existing nursing skill mix and roles to ensure we are maximising our existing workforce to enable us to identify the best fit in terms of contributing to integrated care to meet the needs of people across organisations and settings.

A detailed action plan highlighting the key areas of focus in relation to new roles will be implemented over the next year as part of the implementation of the nursing workforce strategy. The work streams within this plan are aimed at:

- maximising the Trust's current workforce/skill mix and ensuring all roles within the nursing family are utilised within the existing policy guidance
- optimising delegation within nursing to ensure the most appropriate use of skills within a health and social care team to achieve person-centred outcomes and improve safety and quality of care and services

Key areas for development and review have been identified as perioperative, outpatients, mental health and learning disability services. New models of care, including the relative benefits of an enhanced social care model in learning disability, will be considered and evaluated.

The Trust believes that the development of new roles as part of a revised skill mix (which would need to be reflected in Delivering Care ratios) warrants further consideration at a regional level. As discussed above the introduction of new roles could improve job satisfaction for registered nurses whilst creating opportunities for unregistered staff.

Unlike NHS England, there is currently little or no apprenticeship activity within HSC organisations in part due to the fact that current policy within NI excludes public sector organisations from drawing down funding from DfE or apprenticeship programmes. The Trust would like to explore the potential for apprenticeships further and believes it would provide opportunities for staff, particularly unregistered staff, to develop their careers and for the Trust to introduce new roles and/or training programmes in conjunction with further education colleges.

Perioperative career pathway being progressed by BHSCT and regionally

A perioperative workforce strategy group was established by the Interim Director of Acute Services in the Belfast Trust in August 2020, the purpose of which was to ensure the provision of a skilled workforce to meet current and future service demand. The key aims were to review current roles within the perioperative setting, identify alternative roles to be developed, develop a recruitment strategy, review existing training opportunities and actions required to meet the changing needs of the service, develop core competencies, education and learning requirements and to implement a Trust wide training program. The Trust is also represented regionally on two groups, phase 1b Delivering care which aims to support the provision of high quality care through the development of appropriate staffing models and a perioperative career pathway development group led by NIPEC.

It is hoped that as well as ensuring a sustainable, appropriate and effective perioperative workforce, the introduction of new roles and changes in skill mix arising out of this work might improve recruitment to the perioperative setting and help address the current vacancy position.

The perioperative workforce already includes a number of non-nursing roles such as theatre support services assistants, nursing assistants, theatre housekeepers and ward sister support officer, which are aimed at freeing up the time of registered staff to allow them to concentrate on direct patient care duties and contribute to improved theatre utilisation by reducing theatre turnaround time between each patient. There are also currently twelve HSCWs within ACCTSS as part of the perioperative team undertaking the role of scrub practitioner whose roles include providing skilled assistance to the surgeon in the operating theatre within the sterile field and the setting up of surgical instrumentation for use during a surgical procedure or intervention. Work is underway to develop this role further to expand the scope of procedures the scrub practitioner could perform. The range of cases delegated to the role of the scrub practitioner needs to be advised by local policy and based on a risk assessment linked to the complexity of the case. The expansion of this role would supplement the perioperative team. These roles could allow changes to skill mix which could reduce the requirements for and therefore vacancy levels within registered nursing.

A detailed action plan is being developed by the perioperative workforce strategy group to:

- finalise training needs to increase number of scrub assistants
- develop a programme for band 3 HCSW scrub practitioners to further develop their role to undertake more complex cases
- progress recruitment of additional support roles and train accordingly
- agree career pathway for non-registered staff and qualifications, experience and skills required for each role
- agree career pathway for registered staff to include leadership roles.
- review current ratio of registered to non-registered staffing

The action plan, which will be submitted in June 2021, will articulate the expected outcomes and timescales for delivery. This will sit alongside regional perioperative work including new investment in perioperative services through Delivering Care.

Long Term Workforce Management Strategy

The requirements identified in this paper relate primarily to the delivery of current service provision levels with a moderate increase in needs based on historic trends. **It excludes any additional nursing requirements associated with the reduction of waiting times** over the next few years which is a

Trust and regional priority. Addressing our unacceptable waiting times will require significant financial and staffing resources, including additional nursing. These nurses will be in addition to the requirements identified in this paper and will need to be considered in the regional planning of nursing and other trainee places to ensure that we are in a position to increase capacity as soon as we can when the funding becomes available. It is recognised that fully addressing the current waiting times will require considerable investment in staff and money and that HSC infrastructure and finances will dictate the period over which this could be achieved. Further detail on this issue is included in Appendix 3.

The Trust is aware that the Chief Nursing Officer has commissioned a piece of work to look at a longer term nursing workforce plan which will incorporate the nursing requirements associated with addressing waiting times.

If additional trainees are required, funding is likely to be a constraining factor given the financial outlook for the HSC over the next few years. Changes in the way nurse graduate trainees are funded could provide opportunities for increasing places within the existing resource given the financial pressures in the HSC system. A number of options around the funding of fees and/or bursaries are provided in Appendix 4.

Summary and Recommendations

It is clear from the detailed review of the nursing workforce and vacancy position that a combination of strategies and initiatives are needed to deliver a sustainable workforce which makes best use of its staffing resource, including improved roster management, better staff retention and more targeted recruitment in hard to fill areas. Sickness absence must remain a priority of focus, building on successes within the Trust and elsewhere, and addressing the increasing numbers of agency nurses, particularly from off-contract agencies will also be a priority to ensure the Trust makes the best use of its limited financial resources. In the longer term, the number of trainees must be sufficient to meet staff turnover and to address growth in the demand of nurses as a result of service expansion including additional work to reduce waiting times and new developments to meet demographic growth or new service need. This may involve increasing trainee places alongside the development of new roles to support nursing.

In terms of making a material impact on the current band 5 and 6 nurse vacancy level in the short term, the only realistic solution appears to be to substantially increase the number of international nurses recruited. The Trust's preferred option in this regard would be to increase the monthly intake to 60 in as short a time as possible until the gross vacancy rate is reduced to around 1%, bearing in mind that sickness levels are currently around 4% above funded levels. This would bring vacancy levels on the ground to 5% in line with the aims of the NHS Plan. These residual vacancies, relating in the main to short term absence, would be covered by temporary bank staff in line with the Trust's aims for a bank nurse workforce.

The Trust will require non-recurrent investment of around £11.5m over the next two financial years to enable it to recruit a thousand additional nurses, assuming that the Trust receives approximately £3.5m as part of the regional international nursing business case. This would reduce the vacancy rate to 5.5% by the end of 2022/23, falling further to around 4% by 2025/26 when new graduate numbers take effect.

The anticipated nursing workforce position for band 5 and 6 nurses over the next five years is summarised below.

	2021/22	2022/23	2023/24	2024/25	2025/26
Starting FSL	4,804	4,904	5,045	5,121	5,198
Delivering Care new posts	28	0	0	0	0
Specific investments	0	68	0	0	0
New Posts @ 1.5% p.a.	72	74	76	77	78
Staffing Requirement	**4,904**	**5,045**	**5,121**	**5,198**	**5,276**
Actual opening WTE	3,871	4,316	4,941	5,035	5,179
Del Care B7 posts (B6 leavers)	(21)				
Leavers @ 10.5% p.a.	(407)	(405)	(427)	(426)	(454)
New starts	137	128	128	128	128
New NI Graduates	275	308	363	402	402
New OU Graduates**	25	30	30	40	40
Estimated Funded International Nurses	120	120	0	0	0
Expected Actual Staff in Post	**4,001**	**4,496**	**5,035**	**5,179**	**5,296**
Expected Gross Vacancies	**(903)**	**(549)**	**(85)**	**(18)**	**20**
	19%	11%	2%	0%	0%
WTE Sickness absence above funded levels	**(160)**	**(180)**	**(201)**	**(207)**	**(212)**
Vacancies incl. unfunded sickness absence	**(1,063)**	**(729)**	**(287)**	**(225)**	**(192)**
	22%	**14%**	**6%**	**4%**	**4%**
Proposed additional INRs	315	445	0	0	0
Net vacancies after INRs	(748)	(284)	(287)	(225)	(192)
Net Vacancy rate before backfill	15%	6%	6%	4%	4%

This projected position assumes that:

- 1,000 additional international nurses are recruited between April 2021 and 2022/23
- Nurse turnover is reduced from the current rate of 10.5% to 9.5% in 2022/23 and to 8.5% in 2023/24
- The Belfast Trust is able to recruit one third of DoH graduate trainees over the period 2021/22 to 2025/26
- Investment in new band 5/6 nursing does not exceed 1.5% (approximately 80 posts), excluding posts associated with the new maternity hospital

Further detail on the vacancy rate by programme of care is provided in Appendix 5. It should be noted that whilst the overall vacancy is reduced to 4% over the period, the vacancy rate between specialties will vary based on projections which reflect historic patterns. The Trust will ensure that recruitment is managed and nurses are deployed effectively to match new appointments to vacancies across the full range of specialties. Vacancies across wards and specialties will be closely monitored to identify areas with vacancy rates above the average and targeted action taken to address.

Limitations of Workforce Strategy and Plan

It is important to note that the current strategy is aimed at addressing the current workforce vacancy position to include an annual 1.5% increase in nursing requirements to meet investments to cover both Delivering Care and service developments. Additional nurses would be required for investment above this level, for example to address waiting lists or to implement regional strategies such as No More Silos or the Cancer Strategy. In addition to Delivering Care, The Nursing and Midwifery Task Group Implementation Framework (March, 2020) aims to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured Health and Social Care (HSC) system over the next 10-15 years. This is also likely to result in increased workforce needs beyond the levels assumed in this strategy.

Appendix 3

Addressing Waiting Times – Additional Nursing Requirements

Reducing waiting times to acceptable levels is perhaps the greatest priority for the Belfast Trust. Northern Ireland waiting times were already significantly longer than the rest of the UK pre-COVID and have risen considerably as a result of the downturn in elective care during the pandemic. In December 2020, in the Belfast Trust alone, there were over 112,000 patients waiting for an outpatient appointment, 54,000 of who were waiting more than a year with 4,000 of those waiting more than three years. At the same time, over 46,000 inpatients/daycases were waiting for an appointment, with 27,000 of those waiting more than a year and 4,500 of those waiting over 3 years.

Between 2011/12 and 2016/17 the Trust had made a significant impact in terms of addressing its long waiting lists. Between 2011/12 and 2014/15, HSCB had allocated significant non-recurrent funding to Trusts to meet a series of Departmental waiting time targets. During that period, the Belfast Trust spent £154m in tackling waiting times of which £129m was spent in the IS (£31m of which was outside NI) and £25m on in-house initiatives. By the end of that period, the Trust had managed to reduce waiting times significantly across most of our specialties and were largely meeting the 9 and 13 week targets. However, annual funding fell to around £6m per year in 2015/16 and 2016/17 and has reduced significantly each year since. Almost all of the funding allocated during the period was non-recurrent. A relatively small amount of recurrent investment followed but was limited to a handful of specialties, the most material being orthopaedics. Since many of the Trust's specialties had considerable underlying capacity/demand gaps, as soon as the non-recurrent funding ceased, waiting times began to grow again and have continued to grow to their current levels.

Having a clear plan to reduce waiting times to acceptable levels is absolutely crucial but it is recognised that that will require investment of multiple hundreds of thousands of pounds, hundreds more staff, additional beds and additional infrastructure including new theatres. There will be two elements to recovery, the first in addressing the substantial backlog and then developing robust plans to address the recurrent capacity gaps where the existing annual supply is insufficient to meet annual demand.

Money is only one issue and obviously a key one given Trust underlying deficits. However, we recognise that our main limiting factor currently is staffing and that means that in-house solutions will not be available in the short to medium term whilst we recruit more medical, nursing and AHP staff. Rather, we will rely heavily on the IS both in and outside NI. The impact of the pandemic on waiting lists across the UK means that capacity that might have been available to us previously in other UK or ROI organisations will be in high demand.

The Trust is embarking on a high level exercise, building on the regional waiting list work carried out by HSCB, to try to identify the magnitude of the recurrent capacity gap, the associated staffing and infrastructure requirements and the resultant revenue and capital costs. We believe that significant recurrent investment will be required but that we will not be able to use much of that for four to five years until we build up the required staffing and infrastructure. Funding will be required in the interim to fund the new training places required though DOH, with appropriate engagement with education providers etc, and capital will be needed to build new theatres for example.

In tandem with this work, the Trust will continue to seek and exploit any and all productivity opportunities in both inpatients/daycases and outpatients, the latter building on work being developed through our outpatients modernisation programme.

Belfast Health and Social Care Trust

Draft for Discussion

Adult Social and Primary Care

Modernisation (Continuous Improvement) Board

Workforce Development and Equality

Joan Peden
4th June 2013

① Introduction

The Adult Social and Primary Care (ASPC) Directorate has one of the largest workforces within the Trust with 4,822 headcount and 3,591.46 wte.

The ASPC Directorate, as set out within the Trust Vision and Corporate Plan, has underway significant transformational service change programmes within its broad range of services.

The establishment of the ASPC Modernisation (Continuous Improvement) Board is to provide for a strategic overview of the following broad areas of work :-

- Adult Social Care Reform
- Community Service Improvement
- Community Integration and Resettlement
- Hospital Modernisation
- Integrated Urgent Care Pathway (Integrated Care Partnerships)
- Proactive Management of Long-term Conditions
- Workforce Development
- Service User and Staff Involvement
- Equality

within

- Older People Services
- Learning Disability
- Mental Health
- Physical and Sensory Disability
- Administrative and Clerical Support Service

② Workforce and Equality Issues Integrated within Programmes of Work

Within the ASPC Directorate service change and modernisation is well established and underway within Older People Services, Learning Disability, Mental Health and the other services.

The Trust has in place a number of underpinning procedures, policies and practices that are key enablers to the service and workforce change and modernisation. These are being applied (mostly need to be applied in all) within the workstreams in place. In summary these include :-

- Good Practice Guide on Communication and Consultation
- Trust Consultation Scheme
- Trust Equality Scheme
- Organisational Framework on the Management of Staff Affected by Organisational Change and Staff Redeployment Scheme

It is important that the workforce and equality issues are integrated and dealt with within the workstreams that are in place or to be established.

The Continuous Improvement Plans (CIPs) provide for the identification of workforce and equality issues.

It is recommended the CIPs are reviewed to identify and prioritise the workforce and equality issues.

It is further recommended where the projects have significant workforce or equality issues associated with them a Senior HR Manager / Business Partner is also a member of the workstream.

③ Workforce Development / Plan

A strategic overview on workforce issues and development is required from an overall Directorate perspective. A methodology that will enable the identification of the workforce implications of service change in regard to 'Right People with the Right Skills and Competencies in the Right Plan at the Right Time to Ensure the Right Outcome for the Service User' is an integrated workforce planning model.

The model applied within the Belfast Trust on Workforce Planning has been the six step approach to Workforce Planning as detailed below :-

The Integrated Service Centred Six Step Methodology

Step 1 : Defining the Plan
Step 2 : Visioning the Future / Mapping Service Change
Step 3 : Assessing the Required Workforce
Step 4 : Identifying Workforce Availability
Step 5 : Developing an Action Plan
Step 6 : Implement, Monitor and Refresh

This integrated six step model has been agreed as the Regional approach to workforce planning on TYC. If agreed it would probably be detailed as over-leaf :-

Project Monitoring Template

Project Name	The development of an integrated Workforce Plan for the Adult and Social Primary Care Directorate. This will be determine and undertaken on a service area basis, eg. Older People, Learning Disability, Mental Health in order to determine the overall Workforce Plan incorporating development and the full range of workforce issues, resources, skills, roles and numbers to meet the vision
Project Lead	To be effective this needs to be service lead. A Project lead within each area supported by other service representatives. A Senior HR Manager will be appointed as support lead supported by Workforce Planning and Information staff
Project Aim and Description	To ensure all the workforce issues associated with continuous improvement within the Directorate are identified in order to inform the resources, skills, roles and development issues to meet and deliver the future service needs of the Adult and Social Primary Care Directorate
Project Product and Outputs	➢ ASPC Directorate Workforce Plan ➢ Service based workstreams Workforce Plans ➢ A description of the numbers, skills, roles, development issues of the workforce required to deliver the…..
Key Actions and Timescales	➢ Development of Project Plans ➢ Identification of Leads ➢ Awareness Training on six-step model ➢ Service X Service Approach ➢ Decisions
Risk and Constraints	Competing Priorities
Project Completion Date	To be determined

6. APPENDIX ONE

Belfast Health and Social Care Trust

Terms of Reference

Adult Social and Primary Care Directorate
Steering Group
on the
Development of an Integrated Workforce Plan

1) Project Aim

To determine an overall Directorate Workforce Plan for which describes, identifies and sets out the key workforce issues, associated with the Service plans within the Directorate, including future Service needs of the Directorate

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles
- Workforce trends and requirements, turnover, recruitment
- Training requirements

Project Description

A broad description of the Integrated Workforce Plan is as follows :-

- Overview of Directorate
  - Vision
  - Values
  - Priorities and Plans
  - Description of Workforce and Workforce Trends and Issues 2013

- Service by Service Review
  - Define the Plan / Purpose / Scope
  - Visioning the Future / Mapping the Service Change
  - Application of the Six Step Model
  - Assessing the required workforce
  - Identifying Workforce availability
  - Development an Action Plan
  - Implementation Plan
  - Overview for Directorate
  - Conclusion and Implementation and Monitoring Plan and Arrangements

2) Role and Responsibilities

- To oversee the development of the Workforce Plan in accordance with the Project Plan
- To report to and update the Modernisation Board on Progress

3) Membership

3.1 Chair

The Chair of the Steering Group will be Joan Peden : Co-Director, Human Resources and Adult Social and Primary Care HR Business Partner

3.2 Members

4) Timescale

As set out with the Project Plan

5) Frequency of Meeting

ADULT SOCIAL & PRIMARY CARE
DIRECTORATE INTEGRATED WORKFORCE PLAN
APRIL 2015 – MARCH 2020

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Contents

- Terms of Reference
- Directorate strategic context
- Methodology
- Key findings
- Action Plan
- Conclusions
- Next steps

Terms of Reference

To determine an overall Directorate integrated workforce plan that sets out the key workforce issues associated with the service plans within the directorate, including the future needs of the Directorate in terms of:-

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- Workforce trends
- Training requirements

Vision statement

“ We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community”

Strategic Context

Departmental, Regional & Local Policy Direction	**> Quality 20/20 > Savings Plans > Nursing Normative Staffing > TYC > Social Work Strategy > Regional Workforce Reviews > New Directions 2**
Performance & accountability	**➢ Directorate Balance Scorecard ➢ > Management Plan & scorecard**
Strategic Reform & Modernisation Programme	**> Service change > 19 modernisation projects > 2 workforce service reviews**
Workforce / Development	**> Second largest Directorate 4639 headcount, 3906.10 wte > Nurse Revalidation > NISCC Registration > Recruitment & Retention**
Funding	**> Effective and Efficient > £150 million pay > £142 million non pay > £7,522,000 savings**

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Range of Service Areas

Mental Health

- CAMHS including Home Treatment, Early Intervention Team, Acute MH Hospital
- Recovery including Community MH Teams, Eating Disorder Service, MH & Deafness Early Intervention
- Primary Mental Health Care including Psychological therapies, Self-harm Team, addictions & trauma support.
- Acute including Home Treatment, Acute MH Hospital and day treatment services

Learning Disability

"Social Inclusion & Independence"

- Supported Living & Day Opportunities
- Community Treatment & Support Services
- Muckamore Abbey Hospital
- Iveagh Children's Unit

Range of Service Areas

Older People Services & Physical & Sensory Disability

"Supporting people to maintain independence, inclusion within family and community, protection for vulnerable people"

- **South & East Belfast Locality & Older People wards, BCH**
- **Intermediate Care, Mental Health and Dementia Inpatient and Outreach Services.**
- **North & West Belfast Locality and Stroke Services, RVH/ Mater**

Psychology Services

"Enhancing and enabling psychological health and wellbeing"

- **Adult Psychologoical Services including physical health and mental health problems**
- **Neuro-Disability Psychological Services including adults with learning disability, acquired brain injury and neuropsychological problems**
- **Children's Psychological Services including children's disability services, paediatric psychology & therapeutic services for looked after children**

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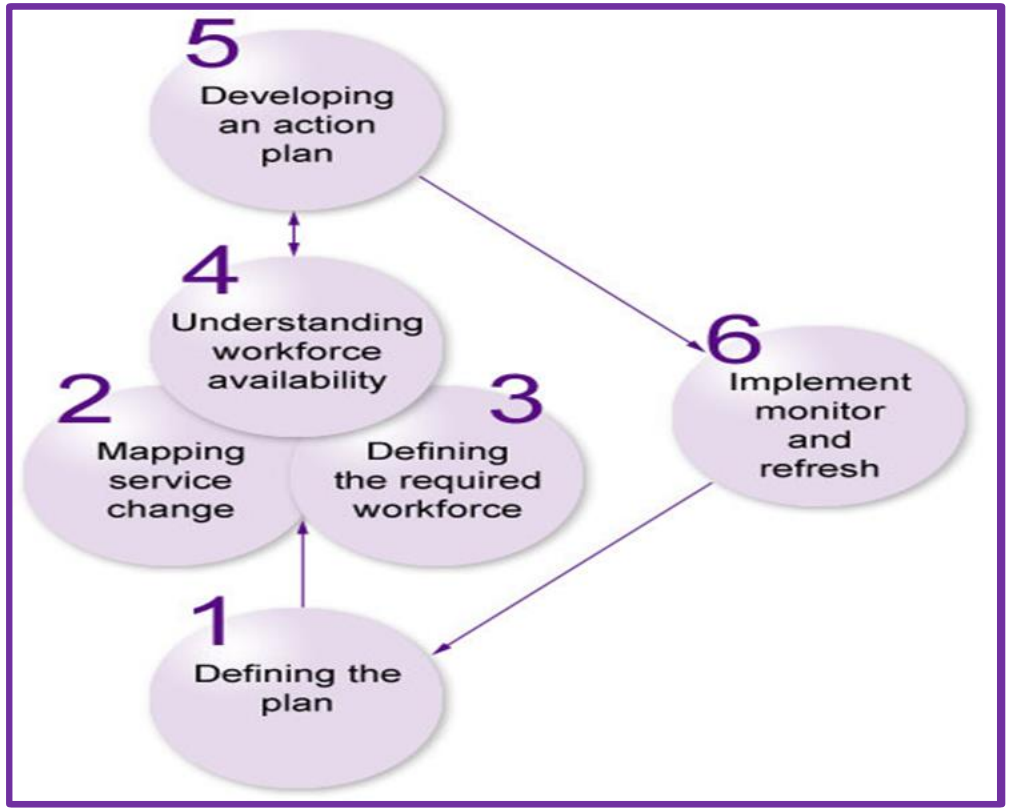
Methodology



Caveats and Considerations

- Document is fluid and subject to change
- Projections are indicative and will change over time
- HRPTS
- Framework for monitoring & review

1 Defining the plan

DRIVERS For Change

- Bamford, Cavendish, Berwick, Donaldson, Keogh
- Transforming Your Care
- Quality 2020
- Excellence & Choice Strategic Reform & Modernisation
- Regional Social Work Strategy
- RQIA Reviews
- Adult Safeguarding
- Mental Health Capacity Bill
- Delivering Care: Nurse Staffing in Northern Ireland
- Recruitment & Retention
- Regional & Local Workforce Reviews
- Succession Planning : Growing our People Today for Tomorrow
- Agency Expenditure
- Pension Reforms

2 Mapping service change

Mental Health Services

- Reprovision of services in community settings
- Rehabilitation & Recovery Services
- CAMHS Review
- Day Opportunities Review
- New Mental Health Hospital

Learning Disability Services

- Muckamore Abbey Resettlement
- Community Treatment & Support Services
- Day Opportunities Review

2 Mapping service change

Older People Services

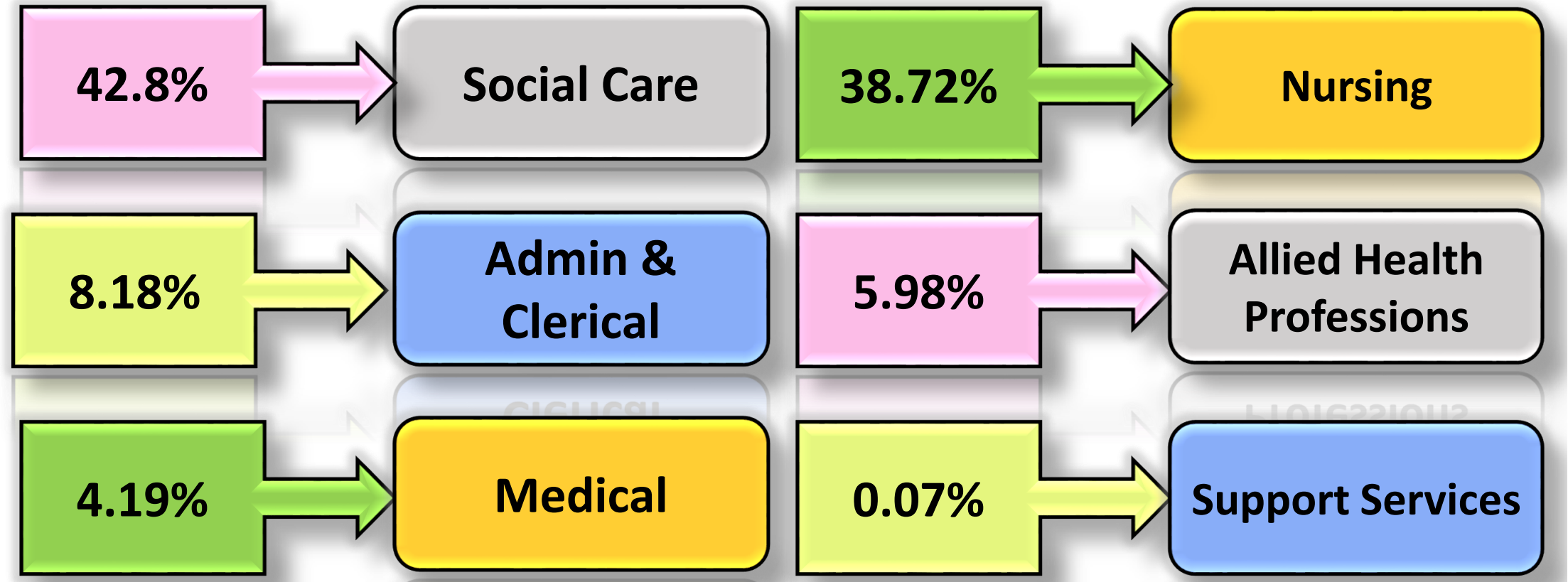
- Statutory Residential Care
- Supported Living
- Reablement
- Acute Care At Home
- BCH Direct
- District Nursing Review
- Social Care Review
- Social Care Rapid Response
- Physical & Sensory disability services
- Sleep-Ins
- Admin review

Psychology Services

- Provision of Trust wide life-span autism diagnostic and intervention services
- Increase access to Psychological services across the Trust
- New model of service delivery for children's emotional, behavioural and mental health services

3 Defining the required workforce

Workforce Intelligence



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3 Defining the required workforce

Workforce Intelligence

Grade Mix Set to change to improve agency spend	Skill Mix set to change to meet nursing normative staffing levels	Social Care Workforce Review	District Nursing Workforce Review
Succession Planning : Growing our People Today for Tomorrow	Systems and new ways of working	NISCC Registration for domiciliary and day care workforce	Recruitment & Retention Strategy
Supporting the Shift Left	Savings Target £7,522,000	Workforce Budget year ending March 2015 £150 million	Nurse Revalidation
Impact of new technology	New skills	Highest Admin & clerical agency expenditure	Agency Expenditure £5.5 million

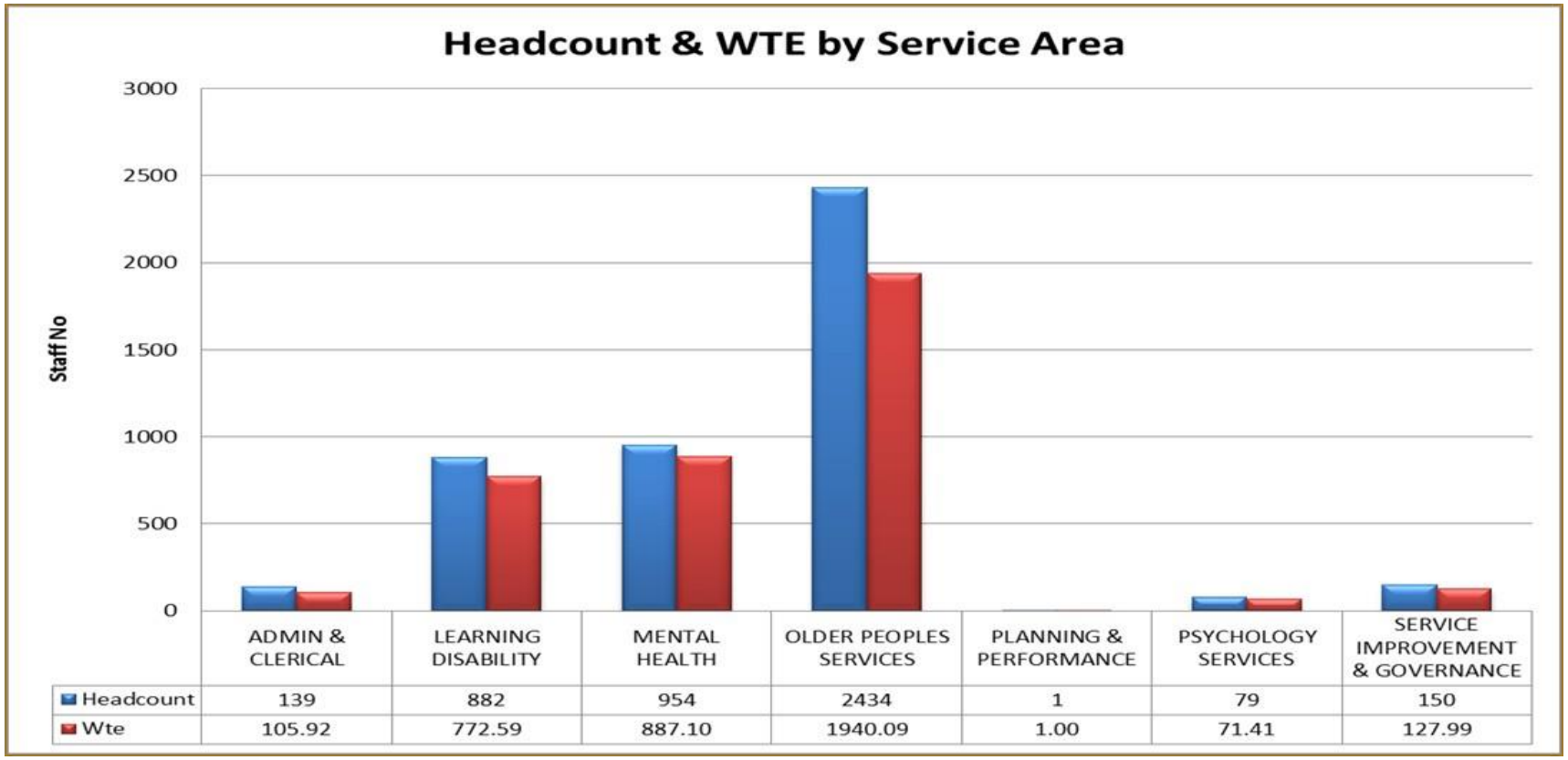
Workforce Projections

WTE is projected to reduce by an indicative 24.4 wte

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in post 31st March	4639	4647.21	4622.81	4566.41	4546.01
Average No. of Leavers	-321.4	-321.4	-321.4	-321.4	-321.4
Average No. of Starters	+299	+299	+299	+299	+299
Learning Disability Reviews	-46				
Mental Health Reviews	-28	-2	-34	-2	-2
Older People Reviews	+24				
Admin & Clerical Reviews	+80.61				
Total **Indicative** Projected staff in post 1st April	4647.21	4622.81	4566.41	4546.01	4521.61
Net Variance	+8.21	-24.4	-56.4	-20.4	-24.4

4 Understanding workforce availability

Key Workforce Findings



	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PLANNING & PERFORMANCE	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE
Headcount	139	882	954	2434	1	79	150
Wte	105.92	772.59	887.10	1940.09	1.00	71.41	127.99

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4 Understanding workforce availability

Key Workforce Findings

50% of staff employed in Older People Services

20% of staff employed in Learning Disability Services

23% of staff employed in Mental Health Services

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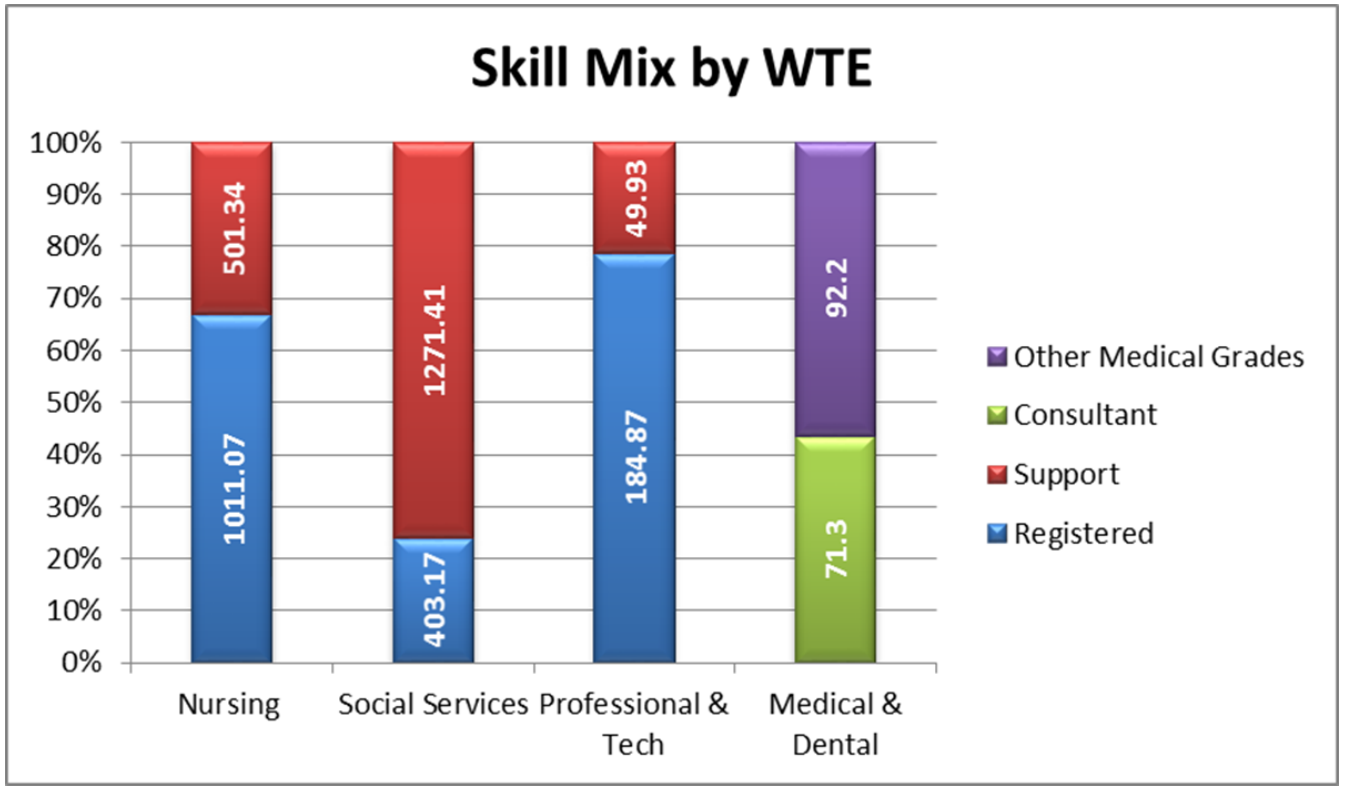
4 Understanding workforce availability

Key Workforce Findings – Skill Mix



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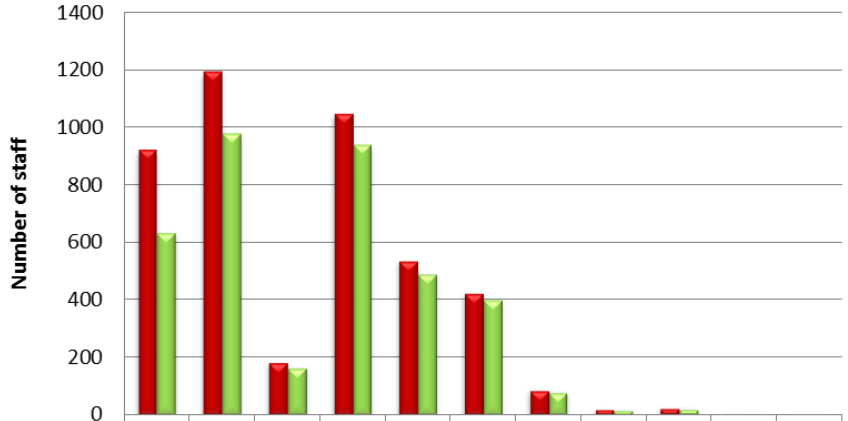
4 Understanding workforce availability

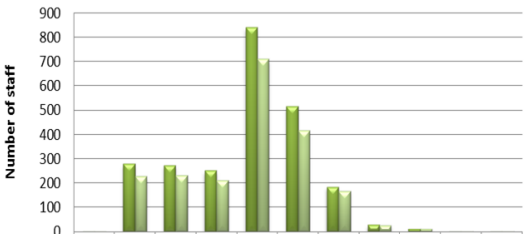
Key Workforce Findings – Grade Mix

Adult Social & Primary Care Directorate



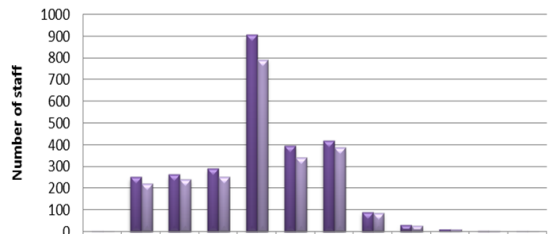
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
H/count	924	1193	184	1048	535	423	87	20	25	6	1
WTE	634.4	979.8	166.5	940.5	489.7	401.9	81.19	18.20	22.59	5.60	1.00

Specialist Hospitals and Womens Health Directorate



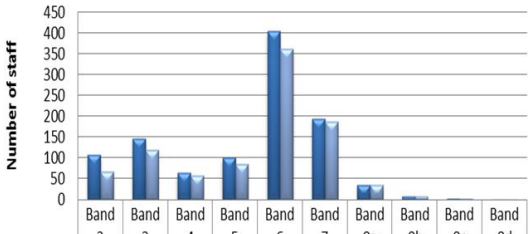
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
H/count	2	278	274	251	841	515	184	29	12	3	2
WTE	2.00	226.6	231.1	209.7	709.8	417.7	168.0	27.33	12.00	3.00	2.00

Surgery and Specialists Services Directorate



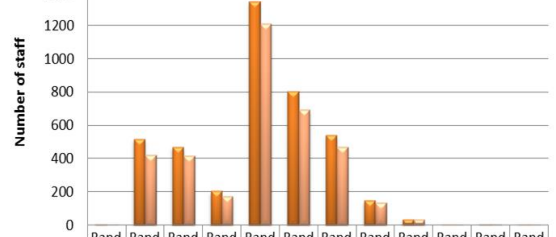
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
H/count	1	251	263	290	907	396	418	90	31	11	5	1
WTE	0.16	219.7	241.4	252.2	791.2	342.7	386.3	87.43	29.34	10.60	5.00	1.00

Children's Community Services Directorate Band Profile



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
H/Count	107	147	64	100	404	193	36	9	3	1
Wte	68.08	119.47	56.98	85.89	361.87	186.13	36.00	9.00	3.00	1.00

Acute & Unscheduled Care Directorate



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
H/count	7	519	470	206	1346	805	543	149	36	5	6	1
WTE	2.48	422.4	415.3	174.5	1209.	694.3	471.7	134.1	34.35	4.93	6.00	1.00

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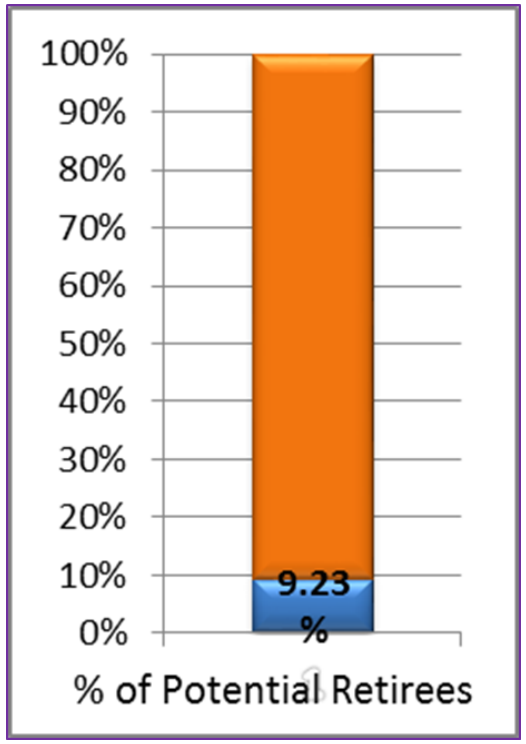
4 Understanding workforce availability

Key Workforce Findings – Turnover & Potential Retirement Profile



Pension changes

State pension

HSC pension

People working longer

Trust turnover at Sept 14 was 4.88%

Directorate turnover was 5.84%

Mental health service area turnover rate at 31 March 15 was 9.67%

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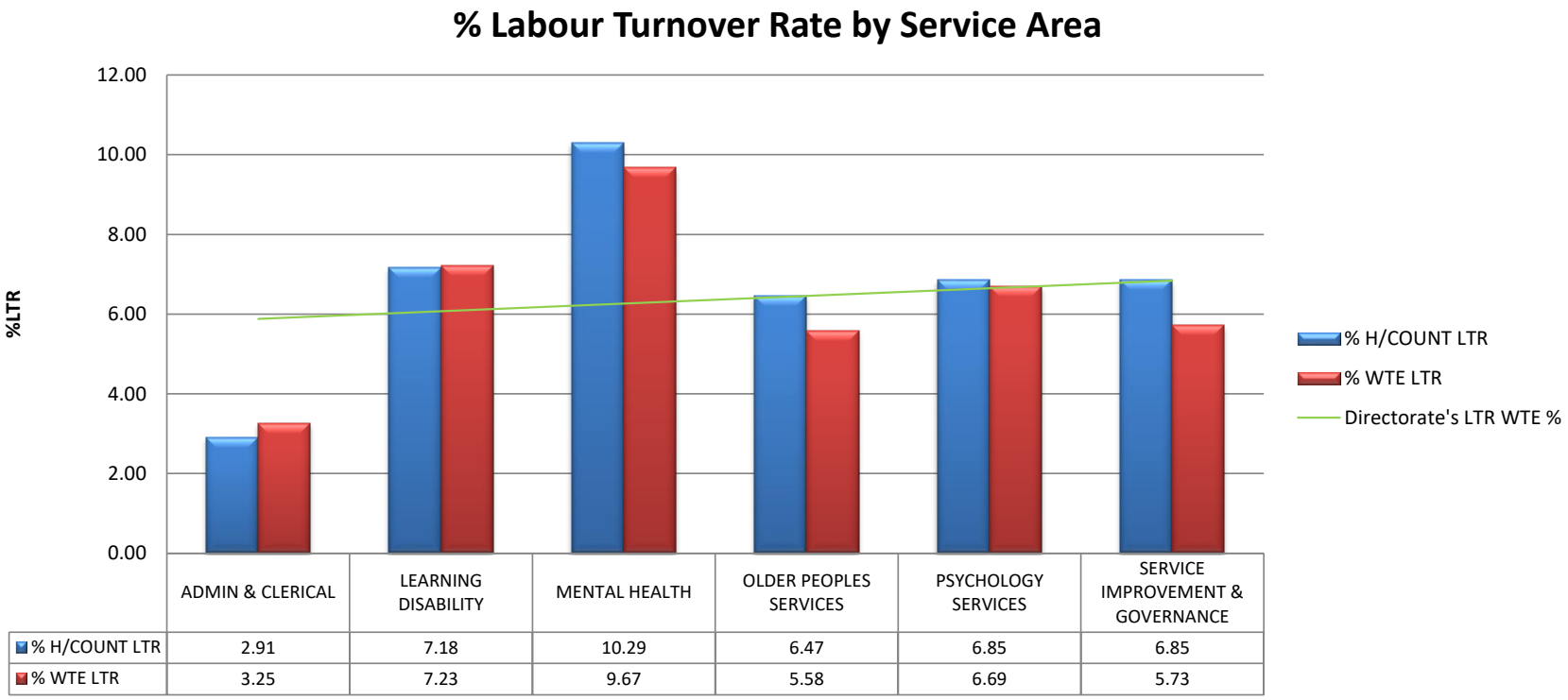
4 Understanding workforce availability

Key Workforce Findings – Turnover



	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE
% H/COUNT LTR	2.91	7.18	10.29	6.47	6.85	6.85
% WTE LTR	3.25	7.23	9.67	5.58	6.69	5.73

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Workforce Findings – Reasons for Leaving

REASON FOR LEAVING	2014-2015 H/C	2014-2015 WTE
Death	4	3.34
Disciplinary action	4	3.25
End fixed term contract	15	12.35
External Secondee Out	1	0.8
Ill Health Retirement	17	14.76
Ill Health Termination	34	20.37
Medical Rotation	41	39.2
Resignation	104	72.32
Retirement	96	76.83
Transfer to other HSC Org	17	15.8
VER - Actuarilly Reduced	10	8.82
GRAND TOTAL	**343**	**267.84**

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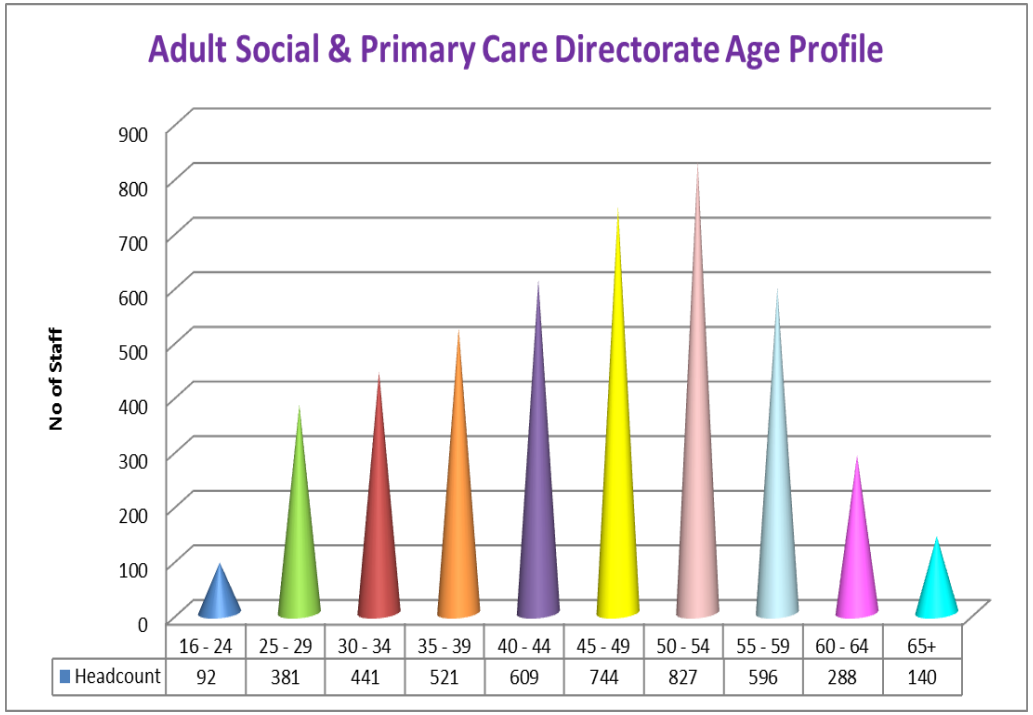
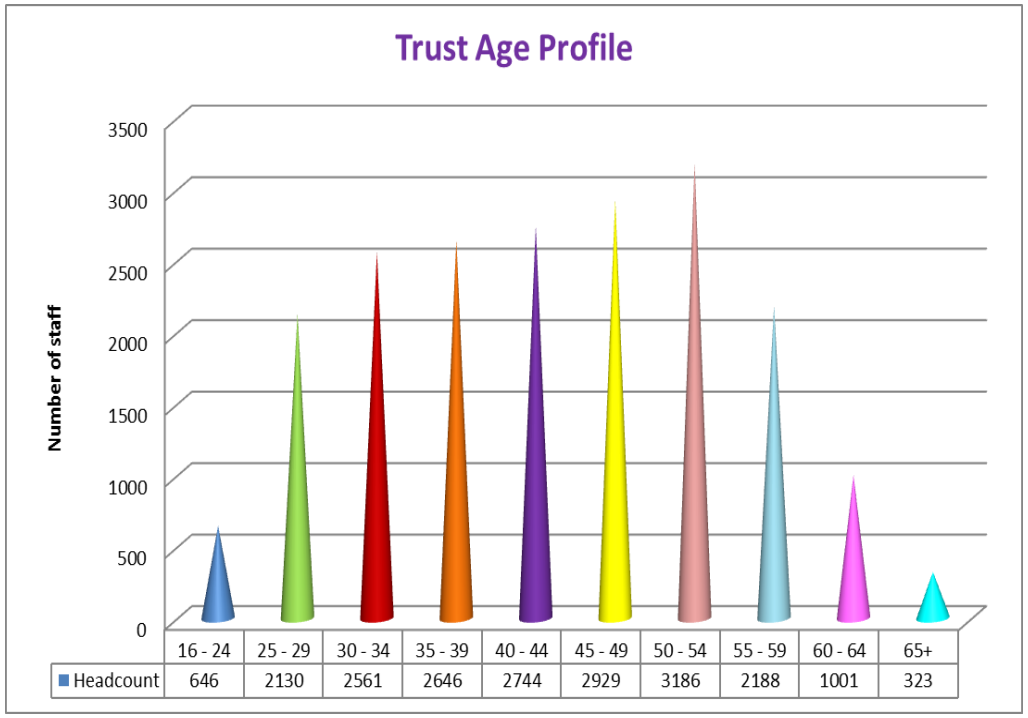
4 Understanding workforce availability

Key Workforce Findings Age profile





18% in the Directorate are aged 50 – 54 and compares to 16% Trust wide
13 % in the Directorate are aged 55 – 59 compared to 11% Trust wide
6% in the Directorate are aged 60 – 64 compared to 5% Trust wide
3% are aged 65+ compared to 2% Trust wide

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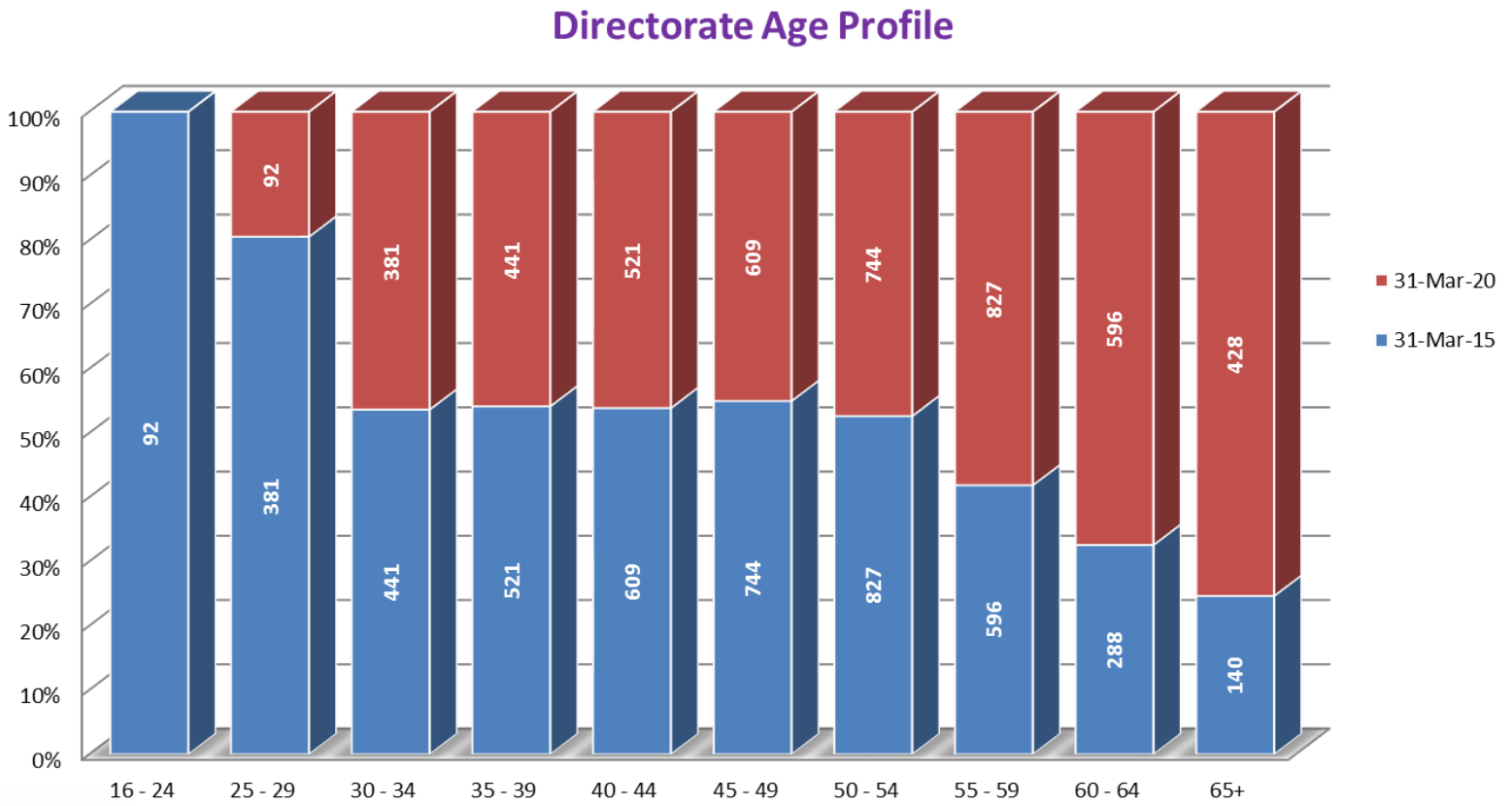
Key Workforce Findings – Age profile



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4 Understanding workforce availability

The case for succession planning - 120 senior staff aged 55+

Mental Health	Learning Disability	Older People Services	Psychology	Admin & Clerical
• **36 staff** • Medical • Nursing • Social Care • Professions Allied to health • Senior Manager	• **16 staff** • Senior Manager • Medical • Nursing • Social Care • Professions allied to health	• **60 staff** • Senior Manager • Medical • Nursing • Social Care • Professions allied to health	• **5 staff** • Professions allied to health	• **3 staff** • Senior Manager

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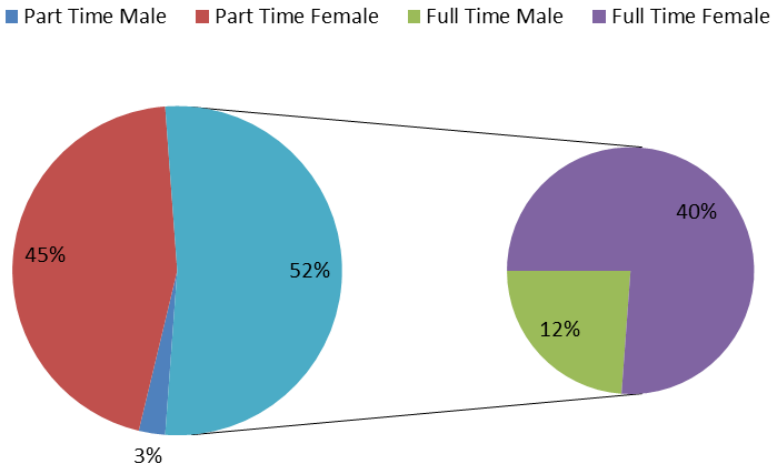
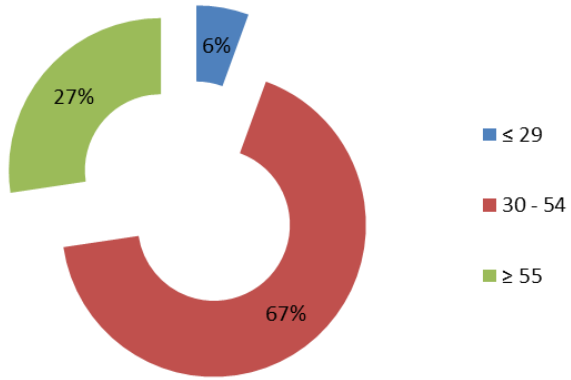
Key Workforce Findings – Gender & working profile

% Working Time by Gender



% Part time Staff by Age Range



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Key Workforce Findings – Sickness Absence

Sickness Absence	April 11 to March 12	April 12 to March 13	April 13 to March 14	April 14 to March 15	April 15 to Dec 15
TARGET BY MARCH	6.01%	5.31%	5.00%	6.71%	
Overall Absence %	6.39%	6.78%	7.4%	7.59%	6.81%
Variance	+0.38%	+1.47%	+2.4%	+0.88%	

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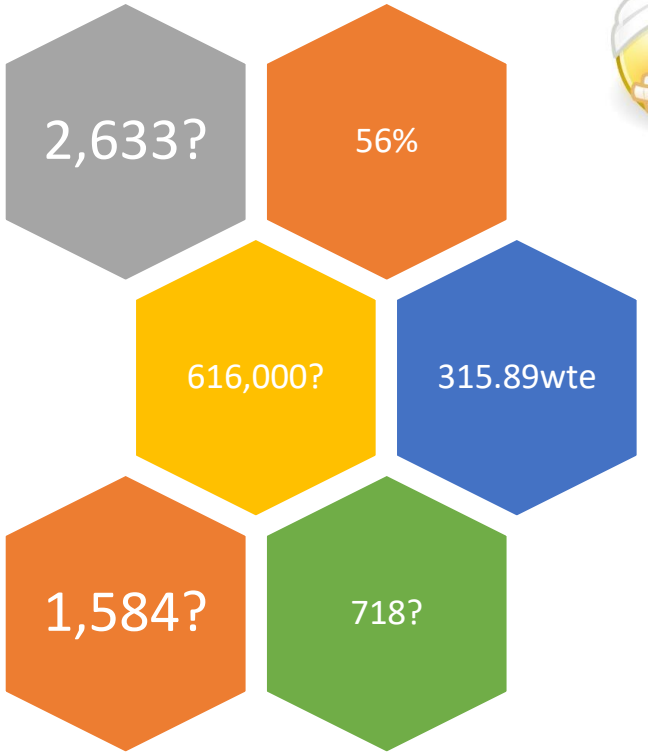
Key Workforce Findings – Sickness Absence

Top 8 Reasons For Absence	H/count
General Debility	960
Stress	331
Vomiting	245
Influenza	237
Back ache/pain	181
Other Chest and Respiratory	190
Grief/Bereavement	134
Post-surgical Debility	95



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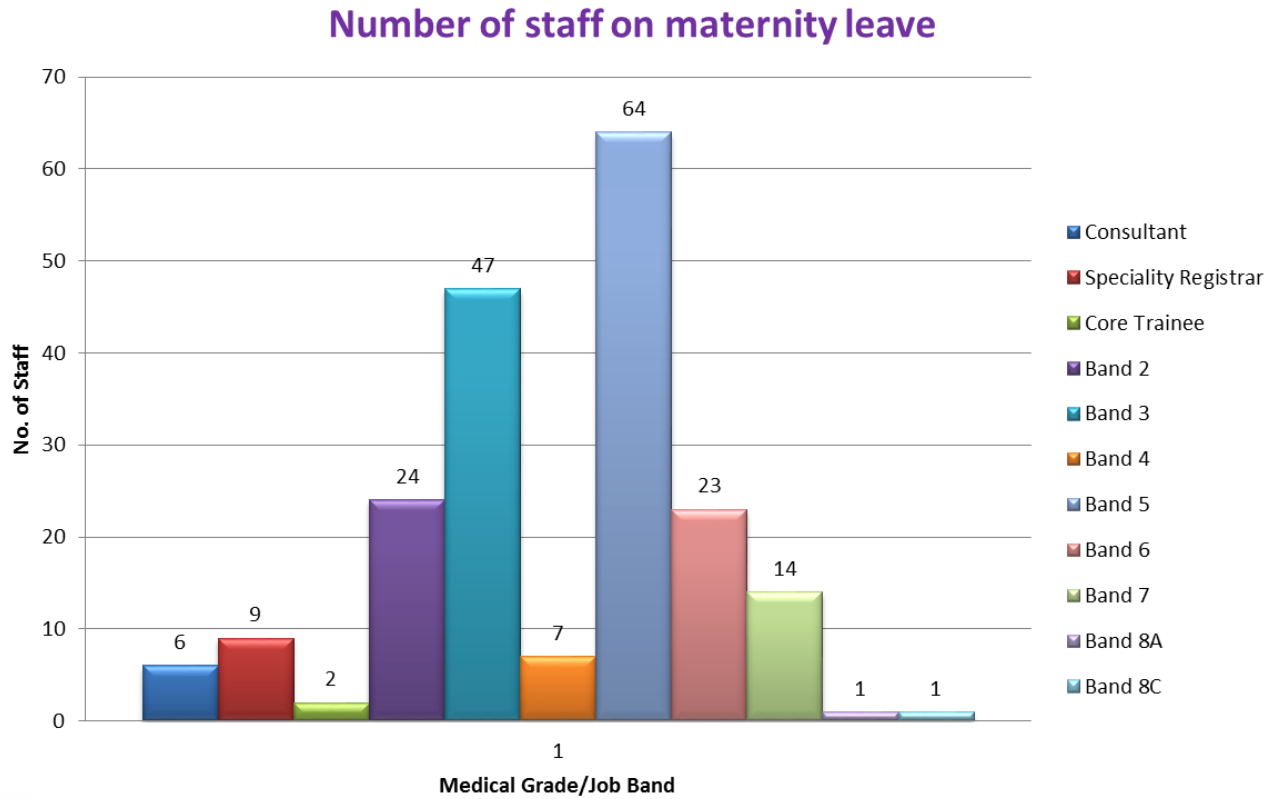
Key Workforce Findings - Maternity



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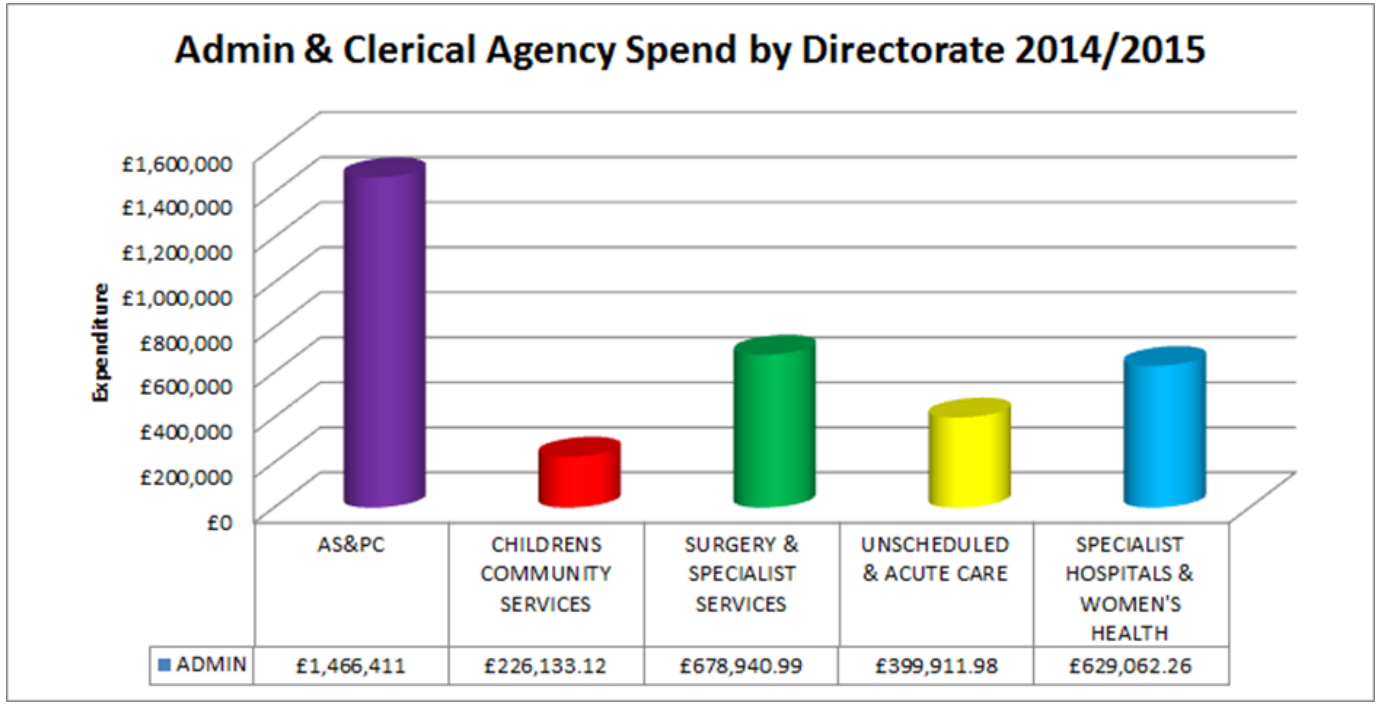
Key Workforce Findings – Agency Spend



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5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
1. Reform and proposed modernisation projects	➢ To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan, identify and map out the workforce implementation issues and actions. ➢ To apply the Trust's Framework on the Management of Staff affected by organisational change.	Co-Directors / Senior Managers
2. Workforce Reviews	➢ To complete and implement the local workforce reviews on: • Social Care Review. • District Nursing Review. • Admin Review (Older People Services). • Agency Staffing Reduction.	Co-Directors / Senior Managers Senior Mgrs
3. WTE's	To track movement and/or changes in WTE.	Workforce Planning Team

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
4. Skill Mix	➢ To track and monitor shifts in skill mix primarily within: • Nursing. • Social Care.	Workforce Planning Team
5. Grade Mix	➢ To track and keep under review any grade mix change.	Workforce Planning Team
6. Changing Roles and Responsibilities	➢ To identify and meet the development needs of changing roles and responsibilities.	Senior Managers / HR / Professional Leads
7. New Roles	➢ To support the development and implementation of new roles, eg. Consultation, change process and associated banding.	Senior Managers/ HR / Professional Leads

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
8. Professional Issues	➢ To support the implementation of the Revalidation process for nurses. ➢ To support the registration process within the Social Care Workforce.	Senior Managers / HR / Professional Leads
9. Recruitment & Retention Strategies and Actions	➢ To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas. ➢ To review and monitor reasons for leaving to inform action.	Senior Leads / HR
10. Local Induction	➢ To review local induction arrangements.	Senior Managers / HR

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
11. Succession Planning	➢ To take targeted action to provide succession planning development opportunities in identified groups and areas including: • Coaching. • Staff Development Review Process (PCF/PDP). • Growing Our People Today for Tomorrow: either bespoke or part of Trust-wide programme. • To undertake further analysis, eg. Survey or interviews to inform further actions.	Senior Managers / Modernisation & Workforce Planning Team
12. Improving Health and Wellbeing and Engagement within Directorate	➢ To develop bespoke health and wellbeing and engagement action plan for the Directorate. ➢ Consistent application of attendance management toolkit and Trust policy. ➢ Review underlying reasons for absence (root cause) and bespoke programme in place.	Co-Directors / Senior Managers / HR

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
12. Improving Health and Wellbeing and Engagement within Directorate	➢ Increase awareness and knowledge of local 'BWell' and regional 'Choose Well' programmes. ➢ Increase Directorate representatives at the Health and Wellbeing and Engagement Forum. ➢ Support the development of Employee Advocates. ➢ Support the development of Engaging Managers. ➢ Support 'Living the Values' of the Trust within the Directorate.	Co-Directors / Senior Managers / HR
13. Technology	➢ To continue to improve access, knowledge and skills in the use of new technology. ➢ To embrace and utilise technology to support new ways for working.	Co-Directors / Senior Managers

Conclusions

- Increasing impact of Community Planning
- Succession Planning increasingly important
- Recruitment & Retention Issues
- Workforce Projections are indicative
- High levels of sickness absence
- Workforce Plan is a live document

Next Steps

- Implement Directorate wide Action Plan
- Review and evaluate progress against Action Plan
- Services to carry out workforce plan reviews
- Service Area Action plans to be implemented
- Workforce Plan to be shared
- Update and review Workforce Plan on an annual basis

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YOU

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Adult Social & Primary Care Directorate

Integrated Workforce Plan

April 2015 – March 2020

FOREWORD

The Belfast Health and Social Care Trust delivers integrated health and social care to 340,000 citizens in Belfast and part of the Borough of Castlereagh. It also provides a range of Regional Specialist Services to all of Northern Ireland. The Trust employs over 20,000 staff and has a transient bank / agency workforce of around 8,000 staff at any one time.

The Adult Social and Primary Care Directorate (hereafter referred to as the Directorate) is the second largest Directorate in the Trust with 4639 staff and 3906.10wte providing Services in over 50 locations.

It is vital that the Directorate workforce in the Belfast Trust is skilled and trained with the ability to be flexible, innovative and adaptive to future changes in Service delivery models whilst maintaining the vision that:-

"We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community"

Our vision is underpinned by our values and principles which are at the core of everything that we do to support and assist our Service users.

- Services should be person centered (ie. Service users will have their rights respected and be supported to keep control of their lives).
- Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs.
- Everyone has the right to experience community living.
- Everyone has the right to experience the same level of Service provided by the Trust, regardless of location.
- Services will be planned, implemented and evaluated in partnership with users and carers.
- Service improvement and modernisation will be based on best practice.
- Staff will be supported in their professional and personal development.
- Services will be delivered in an efficient and effective manner within available resources.

We recognise our workforce is paramount to delivering high quality care and realising our vision and objectives. In order to achieve our vision and goals, managing, planning and developing our workforce to ensure that it is able to deliver high quality health and social care for both now and the foreseeable future is integral to the success of the Directorate.

To this end, as part of the Directorate's Modernisation Agenda I commissioned the development of an Integrated Workforce Plan to describe, identify and set out the key workforce issues associated with the Service Plans within the Directorate, including the future workforce Service needs of the Directorate.

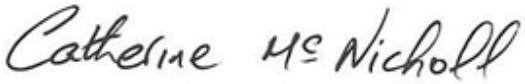
This Workforce Plan therefore:-

- Sets out clearly the Directorates plan for future direction and the required workforce between 2015 and 2020;
- Explains the context and processes on which these decisions have been made;
- Provides aggregated workforce intelligence and trend analysis;
- Highlights key trends and emerging themes from the wider health and social care system that may have implications for Service delivery in future years;
- Identifies a range of key actions on workforce issues;

The Action Plan contained within this document aims to lay the foundation for the further development of a competent, compassionate, caring, supporting, confident, and innovative workforce for the future.

I would like to express my sincere thanks to the members of the Directorate's Modernisation Board and Workforce Planning Steering Committee who committed their time, energy and expertise to the development of this Workforce Plan I would also like to thank all of the individuals across the Directorate and from the corporate Directorates, Finance and Human Resources who have provided us with support, evidence and information and the wide range of stakeholder representatives who contributed to and participated in various meetings, workshops, focus groups and interviews during this process.

This Workforce Plan is the first Directorate wide workforce plan across the organisation and will be a key indicator of our progress towards meeting our challenging objectives and I look forward to reviewing, monitoring and evaluating progress at each milestone.



Mrs Catherine McNicholl
Director of Adult Social & Primary Care

Executive Summary

1. Introduction

The purpose of the Integrated Workforce Plan is to describe, identify and set out the key workforce issues associated with the Service Plans within the Directorate, including the future needs of the Directorate in terms of:-

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles
- Workforce trends and requirements, turnover and recruitment
- Training requirements

It is important to note a number of other significant workforce reviews were already commissioned and underway within the Directorate, namely the 'Older People's Services Social Work and Social Care Modernisation and Workforce Review[1]' and 'District Nursing Workforce Review[2]'.

1.1 Range of Services

Currently there are four Service Group areas within the Directorate and the focus of the Integrated Workforce Plan :-

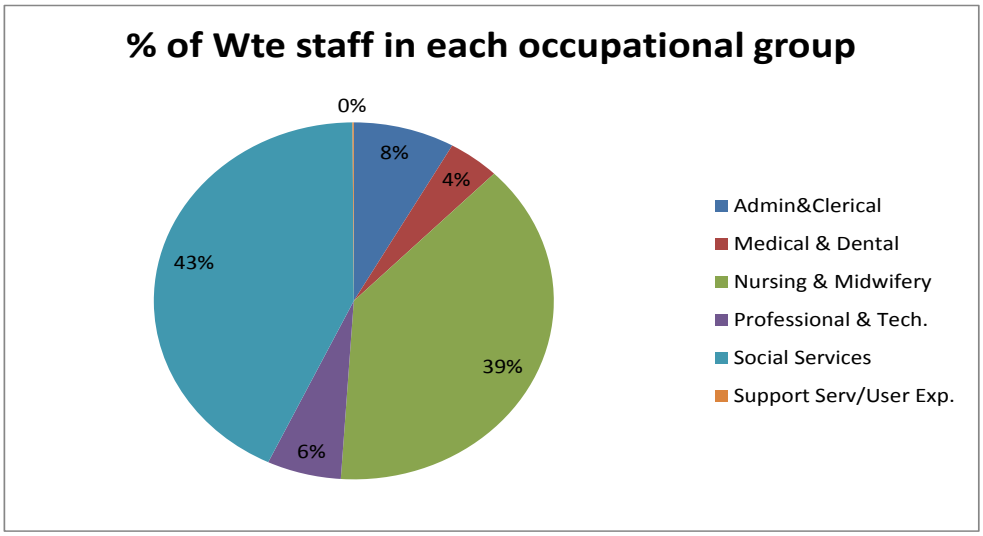
- Mental Health Services
- Learning Disability Services
- Older People and Physical and Sensory Disability Services
- Psychology Services

These are supported by a range of other Services including administration, planning and performance, Service improvements and governance.

1.2 The Workforce

The Directorate, the second largest in the Trust, employed at 31st March 2015, 4,639 headcount or 3,906.10 whole time equivalent (wte) across each of the occupational family groups as illustrated in the charts over:-

[1] Older People's Services Social Work and Social Care Modernisation and Workforce Review – September 2015
[2] District Nursing Modernisation and Workforce Review 2014/15 – Final Draft



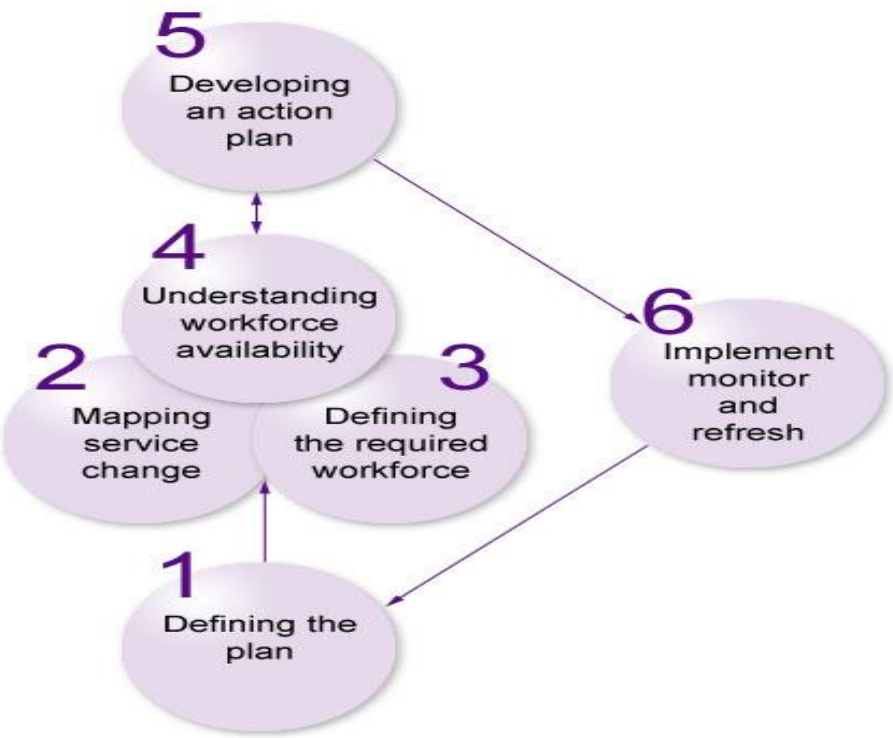
Occupational Group	Headcount	WTE
Admin & Clerical	380	318.62
Medical	192	163.50
Nursing	1,688	1,512.41
Allied Health Professions	263	234.8
Social Work & Social Care	2,113	1,674.18
Ancillary & General	3	2.6
Grand Total	**4,639**	**3,906.10**

1.3 Service Change

The Directorate has set out an ambitious strategic reform and modernisation programme to support the improvement in the delivery of Services and an improvement in the Service user experience. This is to be achieved within the financial envelope available which has an associated efficiency savings target of £7,522,000 in the first year of this plan 2015/2016. To support the delivery of this Service change 19 reform and modernisation projects are currently underway.

2. Methodology

The skills for Health Six Step Methodology to Integrated Workforce Planning has been applied to support the development of this Workforce Plan.



3. Six Step Approach

3.1 Defining the Plan

The primary purpose of the plan is to ensure we have the right people, with the right skills and competencies in the right place at the right time to ensure the right outcome for the Service Users.

There are a number of key drivers for change, including Transforming Your Care, 2015/16 Savings Plan, a number of Reviews including Donaldson[3], Bamford[4], Berwick[5], Cavendish[6], Keogh[7], and Nursing Normative Staffing levels, Regional Workforce Reviews and the introduction of New Technology.

[3] The Right Time Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland
[4] The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007
[5] A Promise to Learn : A Commitment to Act: by the National Advisory Group on the Safety of Patients in England
[6] The Cavendish Report : An investigation into what can be done to ensure that all people using Services are treated with care and compassion by Healthcare Assistants and Support Workers in the NHS and Social Care settings
[7] Review into the quality of care and treatment provided by 14 Hospital Trusts in England:Overview Report

The scope of the Plan focus' on :-

Mental Health Services :	In Patient
	Recovery / Rehabilitation
	Children Adolescent Mental Health Services (CAHMS)
	Primary Care Partnerships
Learning Disability :	Hospital Services
	Day Care Services
	Community Treatment and Support
Older People Services :	Statutory Residential Care
	Supported Living
	Reablement Services
	COPD and Respiratory Services
	Acute care at Home
	Review of District Nursing
	Review of Social Work and Social Care
	Self-Directed Support
	Stroke Services
	Unscheduled Care
	Social care Rapid Response
	Physical and Sensory Disability Services
	Psychology
	Admin and Clerical
Psychology Services :	Adult Psychology Services
	Neuro-Disability Psychology Services
	Children's Psychology Services

3.2 Mapping the Service Change

The implications of Transforming Your Care and the transition of Service delivery from predominantly acute based to community based settings is key to mapping the Service change required.

As outlined above in the Services provided, the Directorate is significantly involved in the provision of home, near to home, community based and hospital Services.

There are a wide range of proposed Service reforms and modernisation programmes within each of the Service Group areas. In summary these include:-

Mental Health Services

- New Mental Health Inpatient Unit (scheduled to open 2017);
- Retraction from long-stay Mental Health Wards and reprovision within Community settings;
- Rehabilitation and Recovery Services to be restructured to meet the requirements of patients as outlined in Bamford : Equal Lives;
- The outcome of the Department Review on CAMHS;
- Review of Day Centre Care Provision;

Learning Disability Services

- Resettlement of Learning Disability clients from Muckamore Abbey Hospital;
- Review of Learning Disability Day Care Services;
- Community Treatment and Support;

Older Peoples Services

- Older People Statutory Residential Care;
- Supported Living;
- Reablement;
- COPD and Respiratory Services;
- Acute Care at Home;
- Review of District Nursing and Social Work workforce;
- Stroke Services;
- Unscheduled Care;
- Social Care Rapid Response;
- Physical and Sensory Disability Services;
- Sleep-ins;

Psychology Services

- Provision of trust-wide life-span autism diagnostic and intervention Services.
- Increase access to psychological Services across the Trust.
- New model of Service delivery for Children's emotional, behavioural and mental health Services across the Trust.

Workforce Budget

The Directorates Workforce budget for the year ending 31st March 2015 was £150 million and non-pay was £140 million.

Agency Expenditure

The total level of Agency expenditure by the Directorate at the end of 31st March 2015 was £5,508,633, 21% of the total Trust expenditure on Agency.

3.3 Defining the Workforce

Workforce change is expected to support enhanced Community Services with an associated shift of resource from acute to community care. This will require re-training and redeployment of associated staff in each of the occupational family groupings.

Information is contained within the Plan on the WTE's, skill mix and grade mix both current and projected and defines the workforce within:-

- Mental Health Services
- Learning Disability Services
- Older People Services
- Psychology Services

Across all Service group areas during the course of the workforce plan significant change will be required within each job family.

Social Work and Social Care Workforce

This is currently the largest workforce group (43%) within the Directorate and during the course of this plan much work is required to rebalance the workforce within the Acute Hospital setting and across the Integrated Care Teams within Older People Services bringing about changes in skill mix and potential new roles to improve the Hospital Discharge process for example. The introduction of Self Directed Support will have a significant impact and we will need to ensure all social care staff are registered with the Northern Ireland Social Care Council (NISCC) as Health Minister Simon Hamilton wants Northern Ireland to lead the way across the UK in ensuring social care workers in domiciliary and day care are registered.

Nursing Workforce

In relation to the nursing workforce, which makes up 38% of the Directorate's total workforce, will be faced with changes to skill mix as normative staffing is rolled out, new roles will be required in the community, Nursing Revalidation will be introduced and Phase 2 of Delivering Care will become available which will focus on mental health and district nursing. A programme of work will also be required to promote and attract new graduates into a Care of the Elderly career pathway and investment to support our Ward manages to participate in leadership, management, staff development and audit is also required.

Medical Workforce

Whilst this workforce group, which accounts for 4% of the Directorate's workforce is set to remain relatively stable during the course of this plan, focused efforts to recruit and retain doctors within the Care of the Elderly Programme of Care is required. Participation in the Regional Workforce planning by Medical Speciality will also be required with Psychiatry scheduled to commence July to December 2015.

Administration and Clerical Workforce

This workforce makes up 8% of the Directorate's total workforce and during the course of this plan it is anticipated that it will increase, as a significant recruitment programme takes place to reduce agency usage with an associated reduction in spend. This staff group will also be deployed to the multidisciplinary teams and new skills will be required and technologies are set to be reviewed including 'Big Hand' the use of mobile devices and voice recognition.

3.4 Understanding Workforce Availability

To understand the workforce that is available, it is necessary to consider and analyse the trends amongst the existing workforce. Set out below are some high level workforce trends across the Directorate with comparisons drawn across the Trust.

Workforce Trends

Projection for Retirements: over the course of the Plan the Directorate has a potential retirement profile of 9.23%. It is projected 428 staff may retire i.e. those currently aged 60+. 37 staff within Mental Health Services, 58 within Learning Disability, 290 within Older People Services, 144 are Band 2 Domicilliary Care Workers and 26 are Band 3 District Nursing Support Workers.

Age Profile : the Directorate age profile identifies a systemic need for succession planning. 120 staff aged 55+ are in band 7 and above positions. This compares to a total of 709 staff aged 55+ in band 7 and above positions across the Trust.

Turnover : at September 2014 the Directorate turnover rate was 5.84% which compares to 4.88% across the Trust. Mental Health Service Group Area had the highest turnover rate of 9.67% at 31 March 2015.

Sickness Absence : the overall absence rate for the Directorate for the 12 months ending 31st March 2015 was 7.59% and is the highest it has ever been since the establishment of the Belfast Trust.

Gender Profile : 85% of the workforce are female which compares to 78% across the Trust.

18% of the total male workforce in the Directorate are in band 7 or above positions which compares to 13% across the Trust.

12% of the total female workforce in the Directorate are in band 7 or above positions which compares to 13% across the Trust.

Working Pattern profile : 48% of the Directorate workforce work part time which compares to 41% across the Trust.

27% of the Directorate's part time workforce are aged 55+ which compares to 20% across the Trust.

Length of Service : 63% of the workforce have 10+ years continuous Service.

3.5 Developing an Action Plan

In order to realise the benefits of this workforce plan an Action Plan is required to monitor progress and to ensure the plan is continually reviewed and updated to maintain its currency. The one constant in our health and social care sector is the need to change, to ensure our Services are the best they can be and fit for the future within an ever increasing ageing population, presenting with more complex needs. The demographics amongst our workforce are also changing and the key areas identified below for inclusion in the Action Plan at this stage are indicative and set to change over the course of the plan:-

Overview of Workforce Profile

Whole Time equivalents (WTE)
Over the course of the plan the WTE is projected to reduce by an indicative 24.4wte. It is important to note however, that workforce projections are set to evolve as projects and consultations progress. The projections to date are therefore indicative and speculative and subject to review.

Skill Mix
Over the course of the plan the skill mix amongst the Social Work workforce is projected to change within the Integrated Care Teams. Currently the Workforce Review[8][8] recommends a shift towards a higher professionally qualified workforce and this will be further reviewed and considered within the Trust.

Within the nursing workforce the skill mix is set to also change as they work to introduce normative staffing levels.

Grade Mix
The Social Care workforce is projected to change; to rebalance the integrated care teams and a shift of band 4 staff from the Community to the Hospital setting is projected[9]. Administration and Clerical numbers within band 2, 3 and 4 will increase owing to the move to recruit to substantive posts and reduce agency expenditure.

Changing Roles and Responsibilities
Throughout the course of the plan as Service areas implement the new models of Service delivery, for example Menal Health Inpatient Unit, changes to existing roles and responsibilities will take effect and these changes will need to be captured for the purposes of updating and monitoring progress.

[8] Older People's Services Social Work and Social Care Modernisation and Workforce Review – September 2015
[9] As 8 above

New Roles

New roles have been identified and developed within the Acute Care At Home Team and as the Social Care Workforce Review moves towards implementation, new roles within the proposed 'Older Persons Care and Placement & Review Team' will also be developed.

Workforce Trends and requirements, turnover and recruitment

To ensure the currency of the workforce plan it is necessary to continually review and monitor the movements amongst the workforce, examining and analysing trends and identifying areas experiencing difficulties in recruiting and or retaining staff. A programme to promote Care of the Elderly as an attractive career pathway for nursing staff is to be developed as it is recognised that this is a difficult to recruit to area. A Recruitment and Retention Strategy for the appointment of Geriatricians will also be developed in line with the Regional Workforce plan in this area.

Training requirements

New skills will be required to support the shift from Acute to Community, and the utilisation of new technologies, e.g. Big Hand, Voice Recognition, and telehealth. Making the best use of systems and technology across all areas and developing the skills and knowledge base required to do so.

A local induction for newly qualified staff in particular those appointed as a result of the 'One Stop Shop' Recruitment Fair in June and those within administration and clerical will be required.

Compliance under statutory and mandatory training obligations will be necessary to ensure we have a competent workforce in place with the required skills and competences to fulfil their roles.

Succession Planning : Growing our People Today for Tomorrow. Due to the potential number of staff who may retire in senior management positions a succession plan will be needed to safeguard the Service.

This workforce plan sets out the key workforce challenges for the Adult Social and Primary Care Directorate over the course of the next five years, April 2015 to March 2020. The challenges facing the Directorate cannot be underestimated as it works to care, support and improve together, ensuring the right people with the right skills and competences, are in the right place, at the right time, to ensure the right outcome for the Service user.

The plan is divided into two sections. Section 1 of the plan sets out the macro Directorate wide workforce challenges and Section 2 considers the challenges at a micro Service area level.

High Level Action Plan

Adult Social and Primary Care Integrated Workforce Plan

Key Area	Action	Lead	Timescale / Update March 17
1. Reform and Proposed Modernisation Projects	To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan, identify, map out the workforce implementation issues and actions To apply the Trust's Framework on the Management of Staff affected by organisational change	Co-Directors / Senior Managers	
2. Workforce Reviews	To complete and implement the local workforce reviews on : ▪ Social Care Review ▪ District Nursing Review ▪ Admin Review (Older People Services) ▪ Agency Staffing Reduction	Co-Directors / Senior Managers	
3. WTE's	To track movement and/or changes in WTE	Modernisation & Workforce Planning Team	
4. Skill Mix	To track and monitor shifts in skill mix primarily within : ▪ Nursing ▪ Social Care	Modernisation & Workforce Planning Team	
5. Grade Mix	To track and keep under review any grade mix change	Modernisation & Workforce Planning Team	
6. Changing Roles and Responsibilities	To identify and meet the development needs of changing roles and responsibilities	Senior Managers / Human Resources / Professional Leads	

7. New Roles	To support the development and implementation of new roles, eg. Consultation, change process and associated banding	Senior Managers / Human Resources / Professional Leads	
8. Professional Issues	To support the implementation of the revalidation process for nurses To support the registration process within the Social Care Workforce	Senior Managers / Human Resources / Professional Leads	
9. Recruitment and Retention Strategies and Actions	To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas To review and monitor reasons for leaving to inform action	Senior Leads / Human Resources	
10. Local Induction	To review local induction arrangements	Senior Managers / Human Resources	
11. Succession Planning	To take targeted action to provide successional planning development opportunities in identified groups and areas including : ▪ Coaching ▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme ▪ To undertake further analysis, eg. survey or interviews to inform further action	Senior Managers / Workforce Planning Team	
12. Improving Health and Wellbeing and Engagement within Directorate	To develop bespoke health and wellbeing and engagement action plan for the Directorate Consistent application of attendance management toolkit and Trust policy	Co-Directors / Senior Managers / Human Resources	

	Review underlying reasons for absence (root cause) and bespoke programme in place Increase awareness and knowledge of local 'B'Well' and Regional 'Choose Well' programmes Increase Directorate representatives at the Health and Wellbeing and Engagement Forum Support the development of Employee advocates Support the development of Engaging Managers Support Living the Values of the Trust within the Directorate		
13. Technology	To continue to improve access, knowledge and skills in the use of new technology To embrace and utilise technology to support new ways of working	Co-Directors / Senior Managers	

Contents

SECTION 1

1.1 INTRODUCTION

In May 2014, the Director of Adult Social and Primary Care commissioned the development of an integrated workforce plan for the Directorate as one of the key work streams of the Directorate's Modernisation Board. A Directorate Workforce Planning Steering Group was established as a result, the membership of the group is set out in Annex A and the Terms of Reference are set out in appendix 1.

A range of significant workforce reviews were already commissioned, some of which have been completed.

Commissioned Work Streams:

- A review of our District Nursing Workforce;
- A review of our Social Work and Social Care Workforce;
- Development of our new purpose built Mental Health Inpatient unit;
- Resettlement project in Muckamore Abbey Hospital;
- Development of Reablement Services;
- Stroke Services;
- BCH Direct;
- Acute Care at Home

All of the above workforce reviews will supplement the Plan however this document will be the overarching document addressing the many issues currently facing the workforce. This document sets out the strategic workforce implications for the Directorate over the next five years.

1.1.1 The Format of the Document

Section 1 Sets out the Directorate overview, the Services provided, a description of the current workforce, the Terms of Reference of the Workforce Planning Steering Group, the Six Step Methodology, Guiding Principles applied, the purpose and the scope of the Workforce Plan, the drivers for change and ownership of the Plan. It then covers the key stages of the Six Step Model including mapping Service change, defining the required workforce, understanding workforce availability, developing an action plan and implementation and monitoring arrangements.

Section 2 Sets out a micro level Workforce Plan for four Services Areas.

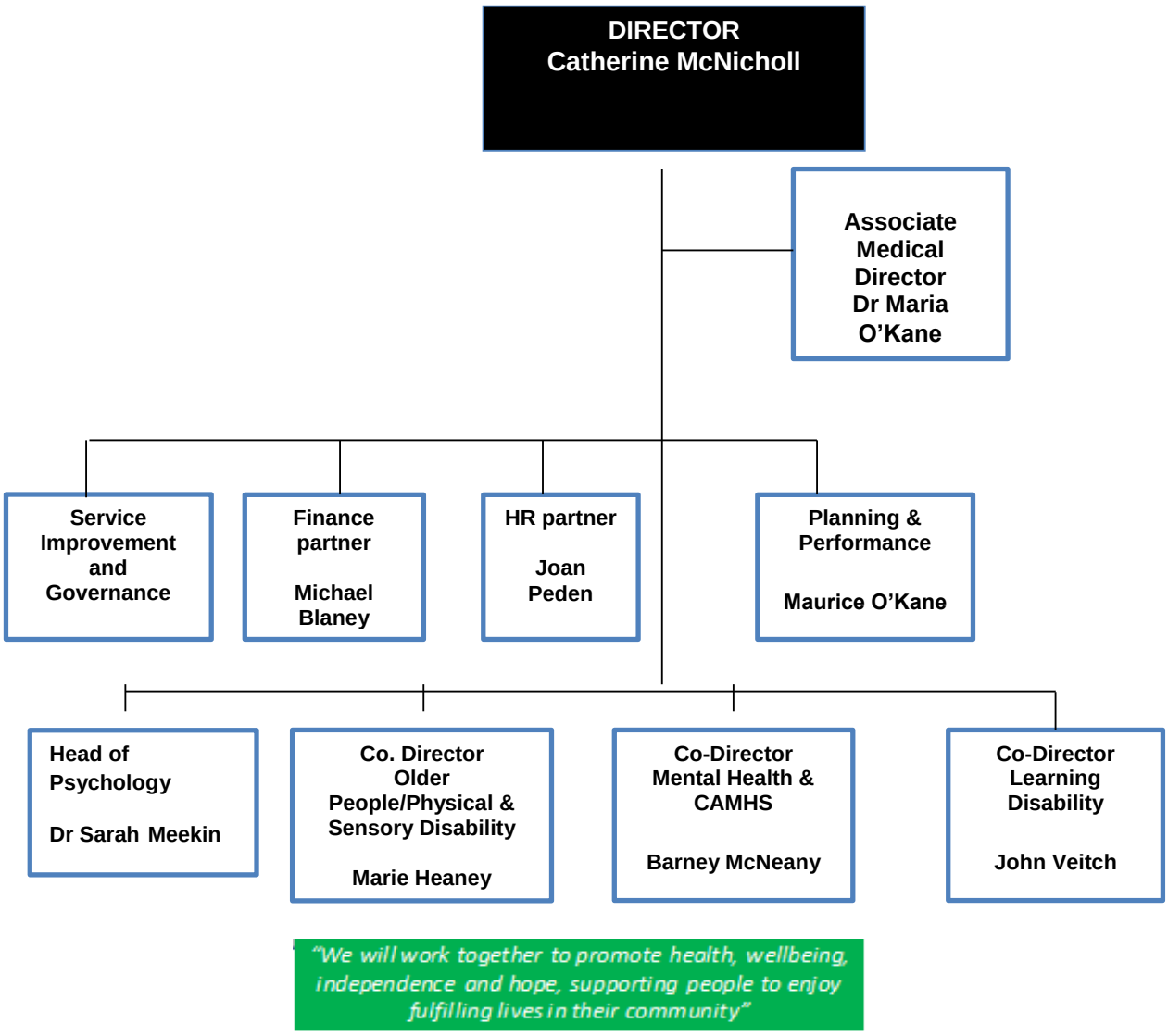
Section 3 Sets out the Summary of findings.

1.1.2 The Range of Services within the Directorate

Currently there are four Service Group areas within the Directorate:-

- Mental Health
- Learning Disability
- Older People and Physical Disability
- Psychology Services

These are supported by a range of other Services, including Admin Services, Planning and Performance, Service Improvement and Governance and Business Partner Services from Finance and Human Resources. The organisational structure of the Directorate is illustrated below.



The Directorate has grown and evolved and is committed to continue to provide a modern, responsive patient and client centred Service in the areas below.

- Mental Health – "Recovery"
  Within Mental Health there are four separate Service areas including:-
  - Primary Mental Health Care (including Psychological Therapies, Self-harm Team, Addictions and Trauma Support);

- Community Mental Health Services : comprising of - 4 geographical Community Mental Health Teams, Primary Mental Health Teams, One Point of referral, Early Interventions, Mental Health and Deafness, Community Forensics, Huntington Team, Perinatal Service, Community Support Team, 342 Ormeau Road and Weavers Hill (Supported Living), Resettlement Team;
- Acute (including Home Treatment, Acute Mental Health Hospital and Day Treatment Services;
- Children and Adolescents Mental Health Service (CAMHS), (including Home Treatment, Early Intervention Team, Beechcroft, Acute Mental Health Hospital).

Learning Disability – *"Social Inclusion and Independence"*
Within Learning Disability there are a range of Service areas including:-

- Supported Living and Day Opportunities;
- Community Treatment and Support;
- Muckamore Abbey Hospital;
- Iveagh Children's Unit.

Older People Services – *"Supporting people to maintain independence, inclusion within family and community, protection for vulnerable people"*
Within Older People Services there are a range of Service areas including:-

- South and East Belfast Locality and Older Peoples wards, Belfast City Hospital;
- Intermediate Care, Mental Health and Dementia Inpatient and Outreach Services;
- North and West Belfast Locality and Stroke Services, Royal Victoria Hospital/Mater Hospital.

Physical & Sensory Disability Services – *"Inclusion, Independence and Personalised Services"*

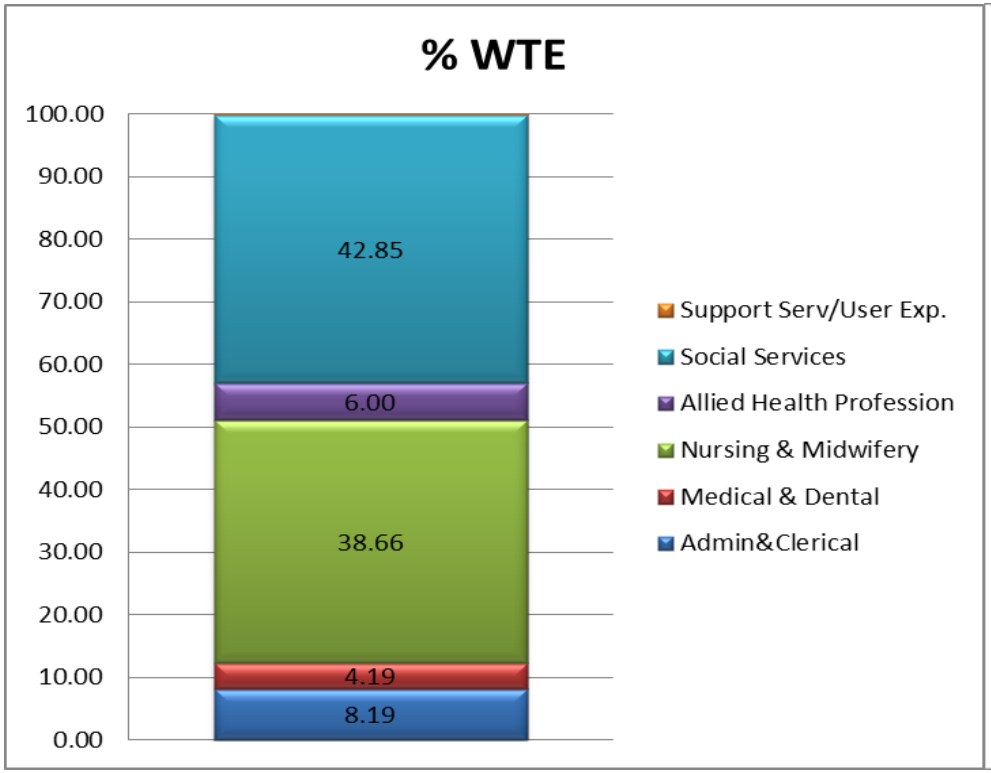
- Social Work Teams;
- Care Management Teams;
- Supported Living & Day Opportunities;
- Sensory Support Team;
- Community Brain Injury Team;
- Community Emergency Response Team.

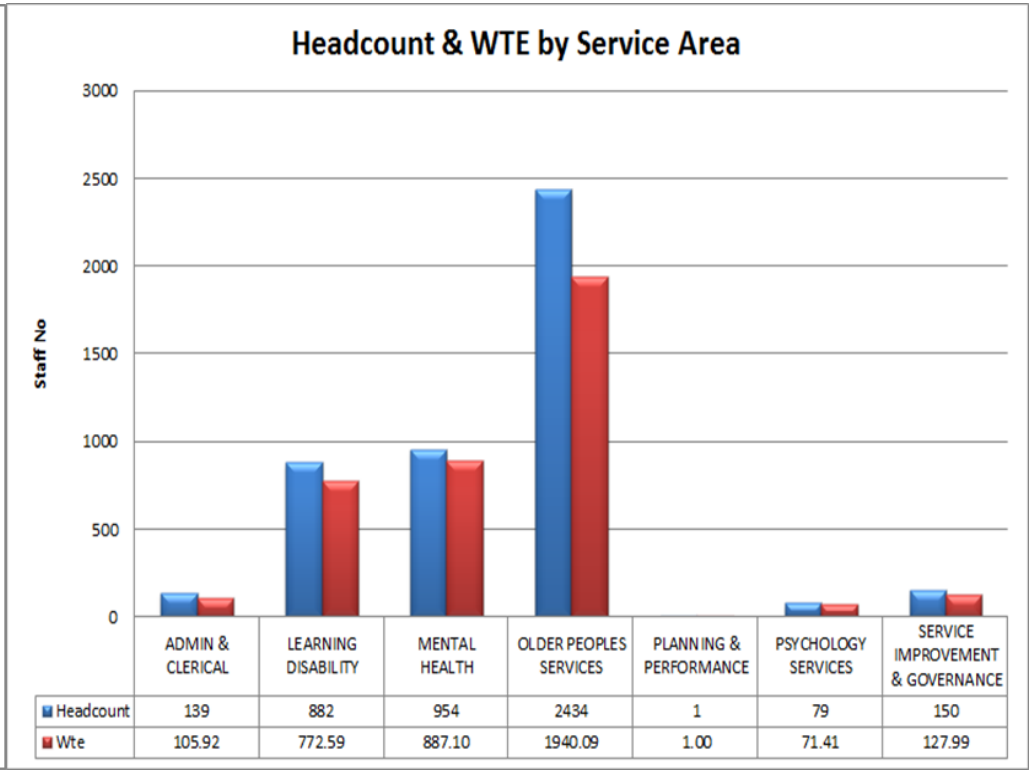
Psychology Services – *"Enhancing and enabling psychological health and wellbeing"*
Within Psychology Services there are a range of Service areas including:-

- Neuro-Disability Psychological Services (including adults with learning disability, acquired brain injury and neuropsychological problems);
- Children's Psychological Services (including Children's Disability Services, Paediatric Psychology and Therapeutic Services).
-

1.1.3 The Current Workforce

The Directorate, the second largest in the Trust, employed at 31st March 2015, 4,639 headcount or 3,906.10 whole time equivalent (wte) across each of the occupational family groups as illustrated in the graphs below.

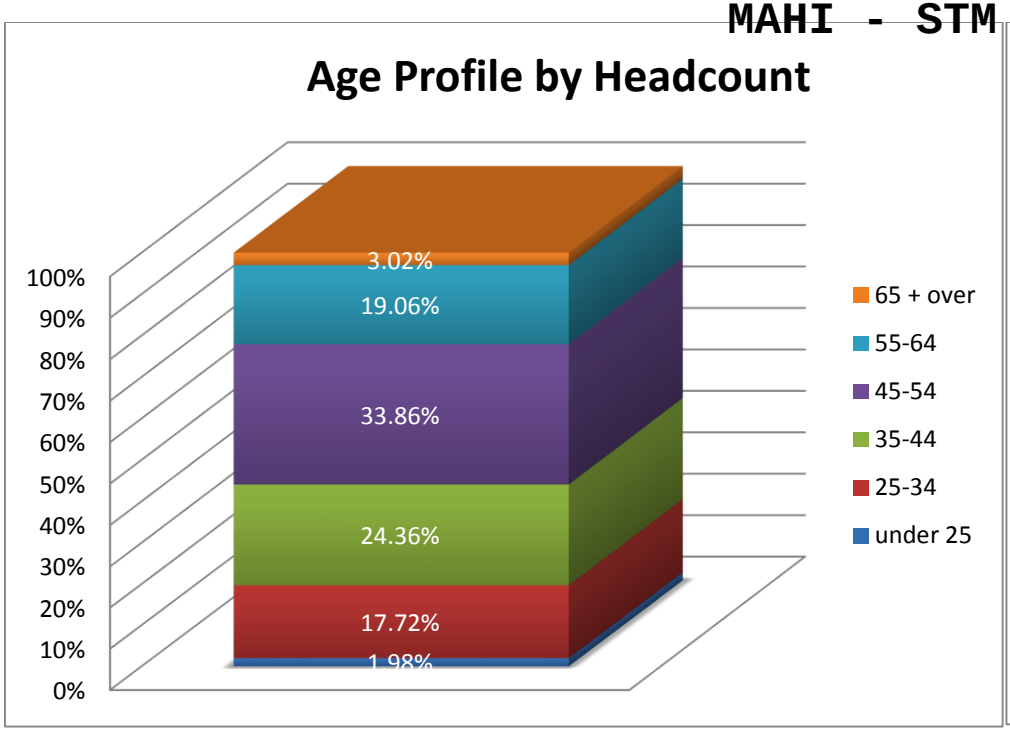


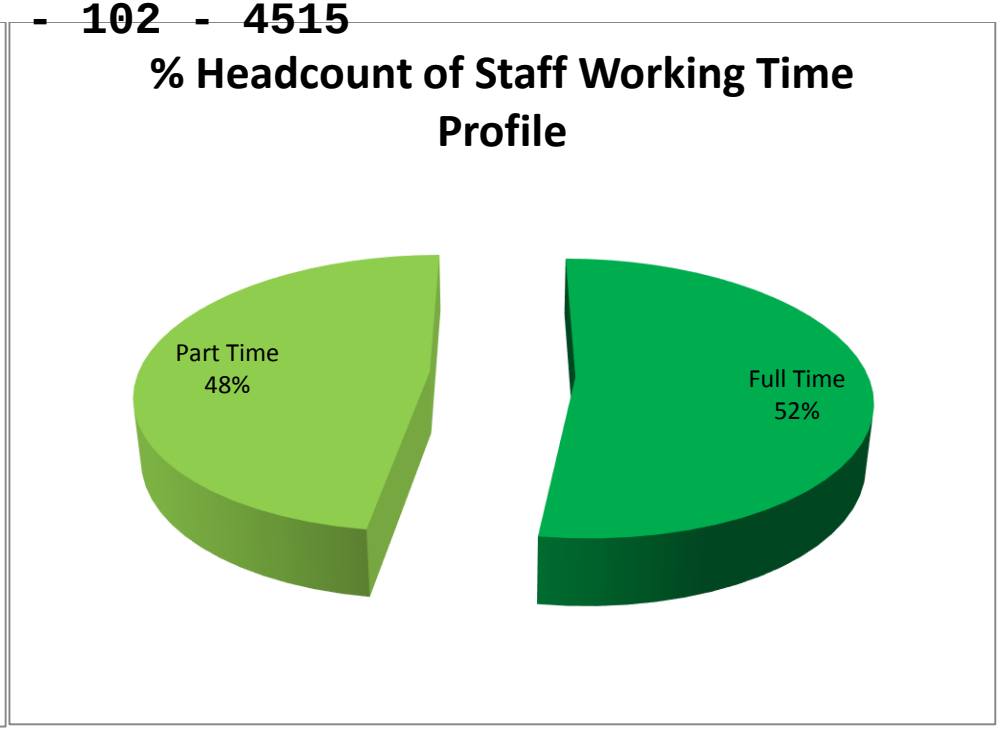


Social work & Social Care workforce is the largest staff group within the Directorate accounting for 42.85% of the total workforce.

Admin & Clerical staff accounts for 8.19% of the Directorate's workforce which equates to 10% of the Admin and Clerical workforce within the Trust.

- Older peoples Services Division employs the largest number of staff within the Directorate at 50%;
- Mental Health employs 22%;
- Learning Disability 20%.

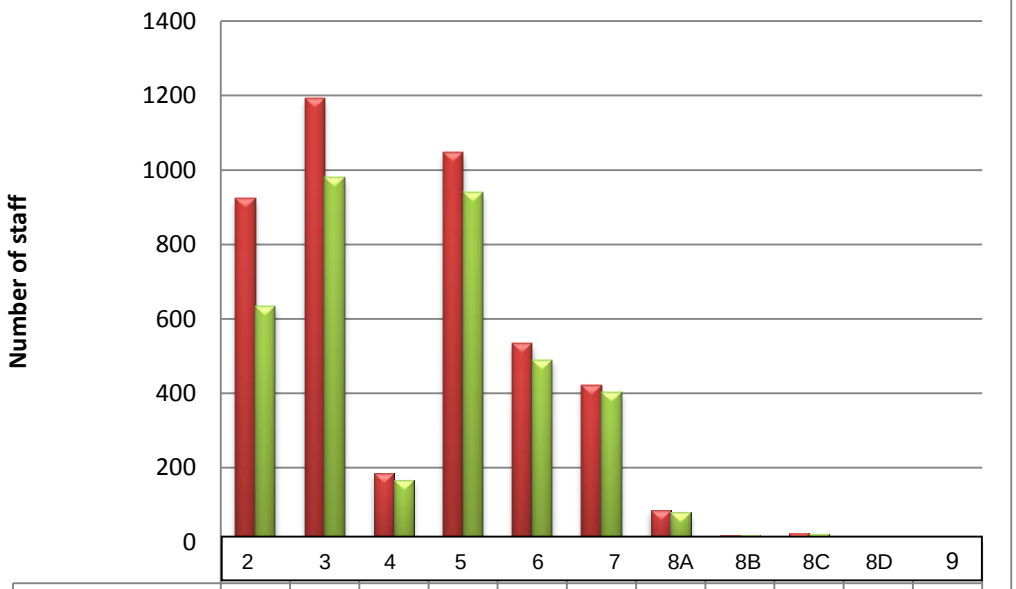




The age profile of the Directorate highlights a large number of staff 33.86% will fall into the over 55 age bracket over the course of the plan and further analysis has indicated there are 32 staff currently in senior posts, 16 at 8A, 7 at 8B, 4 at 8C and 5 at 8D which indicates the need to invest in Succession Planning within the Directorate.

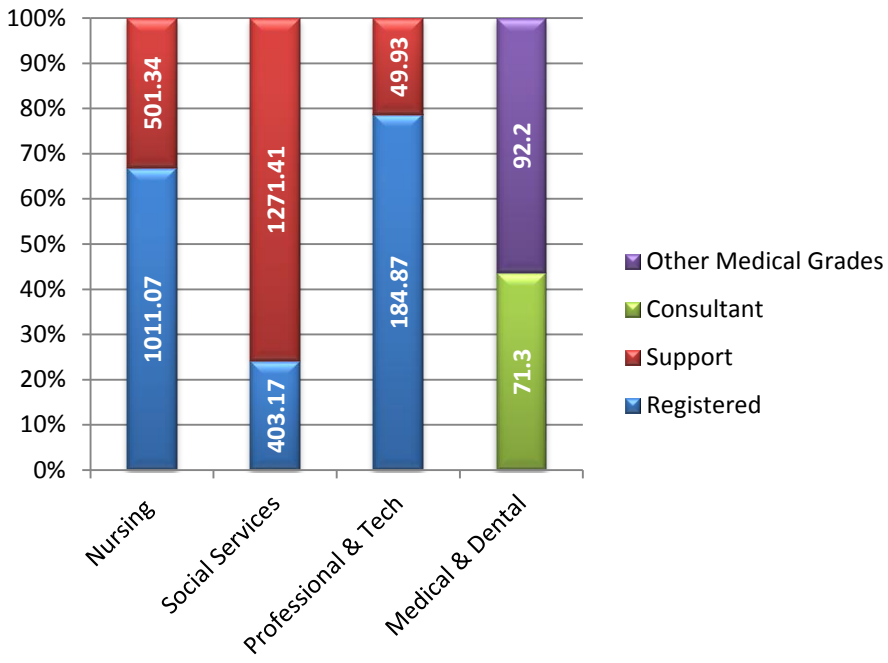
48% of the total headcount work part time, compared to 42% across the Trust; and of those 94% are female and 6% are male. The domiciliary care workforce make up the majority, 28% of the part time workforce. The part time workforce also indicates that the workforce are availing of the wide range of work life balance options available to staff. During the course of the last financial year a total of 214 work life balance applications were made and 211 of those were approved.

Band Profile



	2	3	4	5	6	7	8A	8B	8C	8D	9
Sum of H/count	924	1193	184	1048	535	423	87	20	25	6	1
Sum of wte	634.4	979.8	166.5	940.5	489.7	401.9	81.19	18.20	22.59	5.60	1.00

Skill Mix by WTE



The Directorate has a diverse range of staff across its grading structure with the highest number of staff working at a band 3 (25%). During the course of the last financial year Band 2 Domiciliary Care staff were moved to contracted hours contracts as opposed to zero hours contracts as a result of recognising the need to improve the delivery of Service to our Older People population in terms of continuity and flexibility of Service. A regional Domiciliary Care Workforce group have been tasked with developing a regional workforce plan within the Older People Programme of Care.

Skill mix is an important factor in ensuring we have the right people, with the right skills and competences delivering the right care. Within the Directorate the skill mix ratios are:-

- Nursing and midwifery 65:35
- Social Services skill mix ratio is 22:78
- Professional & technical skill mix ratio is 77:23
- Medical staffing skill mix ratio is 44:56

1.1.4 The Range of Services within the Directorate

The Directorate has set out an ambitious strategic direction and plan of health and social care reform and modernisation as set out within its Directorate Plan. This includes four key themes:-

Safety & Excellence
Partnership
Continuous Improvement
People & Resources

1.1.5 The Patient / Client

At the core of the Directorates vision is the Patient and Client Experience. Sir Liam Donaldson in his December 2014 report[10] identifies 'At the epicenter of our complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make their experience, the outcome of their condition, their treatment, and their safety as good as it gets'.

> 'Research shows that staff satisfaction and patient experience are closely linked – patients receive better care when staff are engaged and well led'.
> Sir Liam Donaldson

Workforce planning is a key component of setting the direction of travel for the Directorate over the next five years and this document has been developed using the Skills for Health Six step approach to workforce planning methodology. The Directorate recognises the need for change, as the impacts of demographic changes and a shrinking labour market are increasingly understood. Not only will the needs of our patients and clients continue to change and demand for our Services increase, but the workforce profile and characteristics of our staff will also change as our own workforce ages.

1.1.6 Terms of Reference

The terms of reference set out the project aim to determine an overall Directorate Workforce Plan which describes, identifies and sets out the key workforce issues, associated with the Service plans within the Directorate, including future Service needs of the Directorate.

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles

[10] The Right Time, the Right Place : http://www.dhsspsni.gov.uk/ldreport270115.htm

- Workforce trends and requirements, turnover, recruitment
- Service integration across the Directorate/Organisation
- Statutory and legislative changes
- Working patterns
- Partnership working
- Service delivery
- Demographic changes

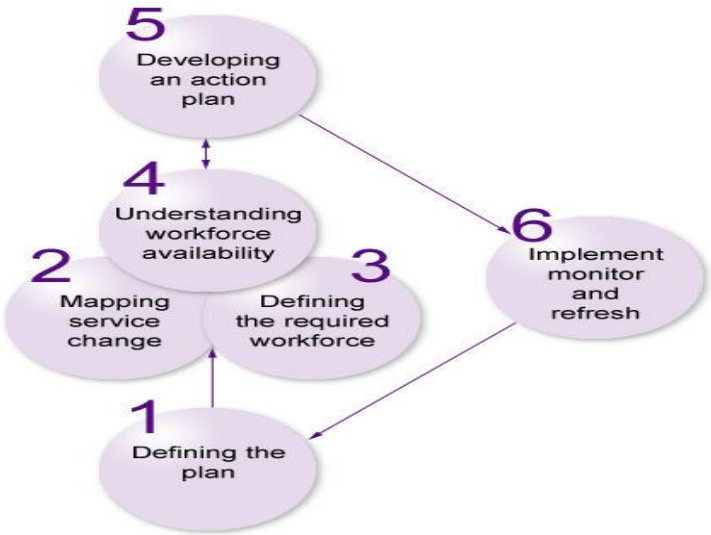
1.2 SIX STEP METHODOLOGY TO INTEGRATED WORKFORCE PLANNING

Within Health and Social Care, workforce planning has traditionally been viewed as a number crunching exercise. The Skills for Health approach to workforce planning however provides a clear methodology, fit for purpose and fit for the workforce planning requirements of the 21st Century. The Department of Health's Nursing & Midwifery Workforce Review document December 2014[11], defines workforce planning 'at its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, within the correct budget, delivering Services to provide the best possible patient and client care.'

Shirley Rogers, Director of Health Workforce in the Scottish Government during her visit to the NI Health Committee on 10 June 2015 stated "I would certainly put workforce planning at the top of my job description in terms of the things that we absolutely have to get right. Our approach has been that workforce planning is a bedrock thing from which you can vision, as opposed to a second-order thing that you come to when you get to it, because you cannot do without it."

The Skills for Health Six Step Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this Workforce Plan and figure 1 illustrates the six steps and how they are interrelated.

Figure 1 : Six Step Methodology



[11] Evolving & Transforming to Deliver Excellence in Care – A workforce Plan for Nursing & Midwifery in Northern Ireland (2015-2025)

This high-level stepped approach has been the back bone in developing this workforce plan and has helped Service managers in their decision-making to support the establishment of information on the supply and demand dynamics relevant to their workforce, whilst also recognising uncertainty in that the decisions made today may change tomorrow as the nature of health and social care in Northern Ireland is fluid and ever changing.

The new Minister for Health Simon Hamilton during his visit to the Trust in June stated:-

> "We must all play our part in finding solutions. We are all part of the one team. We all want a world class health and social care sector. I am placing the opportunity for change firmly with frontline staff".

1.3 GUIDING PRINCIPLES OF THE DEVELOPMENT OF THIS WORKFORCE PLAN

The following principles were employed to guide the development of this workforce plan:-

Guiding Principles

- ✓ The plan will focus on an integrated approach with the patient / client in the centre;
- ✓ Service Managers, Human Resources, Finance and Performance and Planning personnel will also be central to supporting the development of the plan going forward;
- ✓ The whole of the Directorate's workforce will be taken into account, including the numbers, skills and skill mix required;
- ✓ The plan will take account of the demographics, health, and social care needs of the patient and client population;
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required;
- ✓ Stakeholder engagement should be employed throughout the whole process of implementation.

1.4 STEP 1 : DEFINING THE PLAN

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single Service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

1.4.1 Purpose

The primary purpose of this plan is to ensure we have the right people, with the right skills and competences, in the right place at the right time to ensure the right outcome for the Service user.

The Plan will ensure:-

- A clear understanding of the future direction of directorate Services;
- An integration with Service and financial strategies;
- A base of realistic and affordable assumptions;
- Short and medium term changes to Service are taken account of;
- Engagement with all stakeholders;
- Equality Impact screening;
- Public consultation where necessary;
- A link to commissioning plans;
- Organisational / Strategic changes across the Trust;
- The provision of an evidence base.

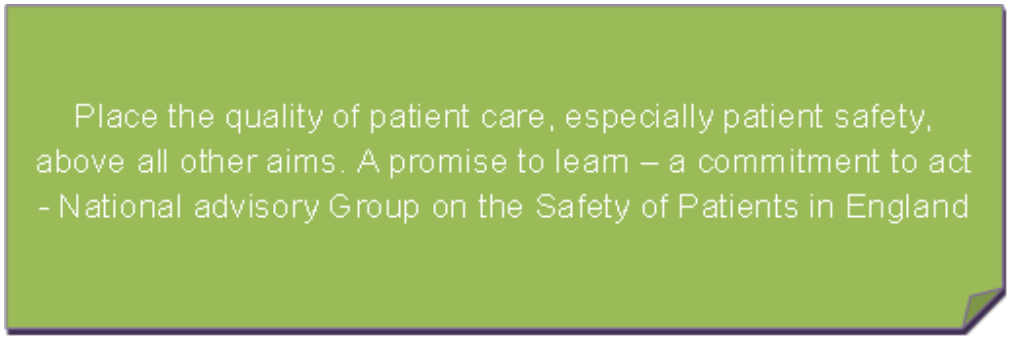
1.4.2 Drivers for Change

Public expectations of health and social care are changing and patients and carers expect high-quality services to be delivered close to their homes. The demand on our services is set to increase, with people living longer, with more complex needs, the workforce for the future will undoubtedly require retraining, new skills not least with the speed and introduction of new technologies and potentially the introduction of new roles. The demands for the services provided by the Directorate will become greater as the health and social care landscape in Northern Ireland continues to evolve, as the shift from acute to community healthcare services grows. There are many drivers for change particularly with the recent onus on quality and patient safety which has been highlighted in a range of regional and national strategies and reports including:-

- ❖ Transforming Your Care – A Review of Health & Social Care in Northern Ireland December 2011;
- ❖ 15/16 Savings Plans;
- ❖ The Right Time, The Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland December 2014 Donaldson Review 2014;
- ❖ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013;

- The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007;
- The Cavendish Report 2013 – an investigation into what can be done to ensure that all people using Services are treated with care and compassion by healthcare assistants and support workers in the NHS and social care settings;
- The Berwick Report – A Promise to Learn a Commitment to Act – Improving the Safety of Patients in England August 2013;
- Review into the quality of care and treatment provided by 14 hospital Trusts in England: Overview report Professor Sir Bruce Keogh KBE;
- Normative staffing levels;
- Anticipated Mental Capacity Bill;
- Regional workforce reviews in medical and nursing and midwifery;
- Improving & Safeguarding Social Wellbeing – A strategy for Social Work in Northern Ireland 2012 - 2022;
- Pension Reform
- Delivering Care:Nurse Staffing in Northern Ireland (2015)
- Quality 2020 – A 10-year quality vision for health and social care in Northern Ireland
- Introduction of new technology eg. Human Resources Payroll Travel & Subsistence System (HRPTS) and Community Information System (CIS).

The drivers outlined above are not an exhaustive list and there will be those that will impact on individual Services. Regardless of the source of the drivers it is essential that the impact is assessed and the requirements are factored into the model of Service delivery and the resources needed to meet the expected demands and targets.



1.4.3 Scope

This workforce plan is developed as a first step approach in supporting the Directorate meet its challenges. The Scope of the plan will focus on the workforce requirements for the delivery of Directorate Services which includes:-

1.4.3.1 Mental Health Services

Approximately 250,000 adults and 45,000 children and young people have a mental health need at any one time in Northern Ireland. This represents 1 in 6 of the population. There is a greater incidence of mental health in Northern Ireland than in the rest of the UK by 25%. It is estimated that 20% of young people are suffering ‘significant mental health problems’ by their 18th birthday.

In-Patient

The period covered by this plan will see the provision of a new inpatient mental health Service which meets the needs of the patients and Service users. This will include a new Mental Health unit which will be built on the Belfast City Hospital site and is expected to be completed during 2017.

Recovery / Rehabilitation

The rehabilitation / recovery Services will be restructured to meet the requirements, as outlined in Bamford "Equal Lives (2005)", to ensure that patients are provided with the Services they require and not limited by what is currently available. Opportunities to have Services provided in the community will be the first option / preference.

Children's Adolescent Mental Health Services (CAMHS)

A review of the CAMHS has identified the need for additional Services including inpatient provision; a primary mental health team in the community covering the Belfast & South Eastern Trusts and the development of the Crisis Assessment Intervention Team (CAIT).

The Personality Disorder Service will be reviewed as part of the Regional review into this Service. This review will help to inform the direction and model of the future Service delivery.

1.4.3.2 Learning Disability

Learning Disabilities affect about 1.5 million people in the UK and in Northern Ireland there is a population of approximately 26,500 people with a learning disability, of whom half are aged between 0-19 years. It is projected that the number of people with a learning disability will increase by one per cent each year over the next 15 years, and that children and older adults with complex physical needs will both be large areas of growth. The increased support needs of this population will require an associated growth in service provision to meet their complex physical health needs.

An estimated 26% of people with a learning disability are admitted to hospital, compared to 14% of the general population (National Patient Safety Agency 2004). Services can range from emergency care provision, outpatient appointments and day procedures, through to the need for surgical intervention and repeated lengthy admissions due to complex health needs. As a result of the demographic changes highlighted previously the Trust should work towards the implementation of the recommendations included in the Review of Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings, which are outlined later. In addition to the above and following the Bamford Review in 2005 it has been agreed regionally that all patients, where possible, should be resettled and given the opportunity to live in the community. This will have a direct impact on both the hospital and the community learning disability Services.

1.4.3.3 Older People's Services including Physical and Sensory Disability Services

There will be significant change to how we deliver our Services in the future to ensure that we meet the demands and requirements of TYC. This will include meeting commissioning specifications regarding Frail Elderly, Respiratory, Diabetes, Stroke and End of Life Care; the need to provide more opportunities to older people and their carers for self-directed support and an increase in the choices available to older people for independent living through additional supported living schemes.

The Directorate must ensure that it complies with statutory functions, including the review of the social work and social care workforce to ensure the necessary skills mix, capacity and appropriate organisational arrangements, are in place, to meet the requirements of delegated statutory functions.

There is also a need to review the Homecare Management Support structure to ensure it meets the requirements of the regulatory bodies. The Directorate is developing a Trust-wide Acute Care at Home programme. A focus will be to improve performance and efficiency across all hospital sites through improving patient flow and the management of complex delayed discharge pathways. The Directorate will need to ensure the safe, effective and timely discharge for patients receiving Inpatient Care within the Dementia Inpatient Service.

There will be a review of the day care opportunities within physical & sensory disability Services and the Directorate will link in with the regional workforce planning group on the development of a workforce plan for our domiciliary care workforce.

1.4.3.4 Psychology

A review of access to Psychological Services across the Trust will be undertaken to identify where these can be increased. The Directorate will work to ensure the provision of Trust-wide life-span autism diagnostic and intervention Services.

1.4.4 Ownership

The Workforce Planning Steering Group, Chaired by the HR Co-director was established to develop this Integrated Workforce Plan for the Directorate's Modernisation Board. This workforce plan is owned by the Directorate and will be continually reviewed, updated and evaluated to maintain its relevance and to reflect the ever changing health and social care environment today and in the future.

Workforce data has been obtained from our Human Resources, Payroll, Travel and Subsistence (HRPTS) System for the years ending 31st March 2014 and 2015 respectively and trend analysis identified using workforce data from our previous Human Resources Management System (HRMS). For the purposes of trend analysis consideration has been given to the period April 2011 to March 2015.

A range of methods were employed between April 2014 and March 2015 to meet the project aim and objectives including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups and interviews with stakeholders within the Directorate and reviewing relevant policies and strategies to identify proposed capital and Service developments or changes over the next five years.

The findings have been used to inform and shape the content and Action Plan and consideration has also been given to our Trust values:

The Trust and the Directorate has developed a strong focus on values, attitudes and behaviours of staff as focus for ensuring that individuals are living the Trust Values. This plan will seek to ensure the adequate supply of staff with the right skills, values and behaviours in the right numbers to deliver safe, effective high quality care. This is of the most significant importance to the Directorate and the Trust.

1.5 STEP 2 : MAPPING SERVICE CHANGE

This is the first of three interrelated steps. This is the process of Service redesign in response to patient choice, changes in models of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from Service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

1.5.1 Population and Health Profile

Northern Ireland has the fastest growing population of any country within the UK (DHSSPS, 2013a). The Northern Ireland Statistics and Research Agency (NISRA, 2013) projected the population to rise from 1.79 million in 2010 to nearly 2 million in 2025 (an increase of almost 8%).

There are 430,763 children and young people, under the age of 18 in Northern Ireland (PHA, 2014) and the number of people aged 65 and over is forecast to increase by 42%, from 260,000 to 370,000. Significantly, though, the number of people of working age is only projected to increase by 1.4%, from 1,109,000 to 1,124,000, by 2025. Over the same period, the number of people aged 85 and over will increase by 25,000 to 55,000.

These statistics bear relevance to the population the Directorate serves.

- 26,500 people are living with a learning disability, and half are aged between 0-19 years
- 250,000 adults and 45,000 children and young people have a mental health need at any one time in Northern Ireland
- 20,000 older people are living in Northern Ireland with Dementia

Former Health Minister, Mr. Jim Wells said “Enabling people to live well with dementia is one of the greatest challenges that we face in health and social care at present and into the future. It is recognised that we need to work together to improve the understanding of dementia in wider society, and reduce stigma and isolation.

The Hemsworth Court scheme is a great example of what can be achieved for people with dementia and their carers to support them to live as part of the community for as long as possible. The facilities are state of the art and provide a safe and secure environment for people with dementia”.

The Dementia Strategy (DHSSPS, 2011e) indicates that levels of dementia are projected to increase to 60,000 by 2051 from 19,000 in 2010. Between 17-21% of the population have a physical disability, and around 37% of households include at least one person with a disability (NISRA).

High levels of mental health problems, self-harm, suicide and alcohol and drug abuse are reported in the homeless population and an estimated 2/3 of prisoners have mental health problems (PHA, 2014). *Transforming Your Care* (DHSSPS, 2011b) highlighted that 24% of women and 17% of men in NI have a mental health problem – over 20% higher than the rates in England or Scotland. The Framework for Mental Health and Wellbeing Northern Ireland (DHSSPS, 2011d) highlights that 10-20% of older people (aged 65 years or over) suffer from serious mental health problems.

1.5.2 Financial Challenges

The Trust continues to face significant financial challenges and must work towards delivering the efficiencies required to meet the financial funding available. The implications of the efficiency challenges that face not only the Directorate workforce over the next five years will be significant, particularly in relation to meeting existing commitments; irrespective of any modernisation and reform.

A key financial objective with the TYC reforms is to ensure that financial resources appropriately reflect the proposed new Service models across all areas of care. This was described in *Transforming Your Care* as a shift left. The *Transforming Your Care* report highlights the intention to shift approximately 5% (£83m) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme commencing. In order to effect this shift of care and funding out of hospital Services and into the primary / community setting, the HSCB will commission Services to be delivered in a different way.

The Directorate in the first year of this workforce plan has identified the following in its savings plans for 2015/2016:-

- Proposed reprovision of statutory Elderly Person's Home, in line with client choices.
- Proposed retraction from long-stay Mental Health ward and reprovision within community settings.
- Proposed closure of Acute Day Treatment Service, with essential components of the Service carried out by the Home Treatment team.
- Proposed reprovision of Adult Mental Health Day Centre Services, centralising the provision of Mental Health day Services, with the remaining provision focused on those most in need for the duration that those individuals require a statutory Service.
- Proposed review of Day Services provided in the community and voluntary sector
- Proposed review of Beechcroft in the context of the regional requirements.
- Proposed review of directly managed Learning Disability Day Centres within the Trust taking account of locations.
- Proposed review of respite care within Learning Disability Services. Respite Services for approx. 350 clients would be reviewed.
- Reduction in Administration Costs.
- Staff Productivity-reduction in overtime and agency costs.

1.5.2.1 Workforce Budget

The Directorate's workforce budget for the year ending 31st March 2015 was £150million, and non-pay was £140million, making its workforce it's most expensive resource. The Directorate did breakeven and will continue to focus on managing its budget for the duration of this plan. The savings plan target for the Directorate for the current 2015/16 financial year is £7,522,000 broken down by £1,781,000 for Revenue & Expenditure and £5,740,000 for workforce modernisation.

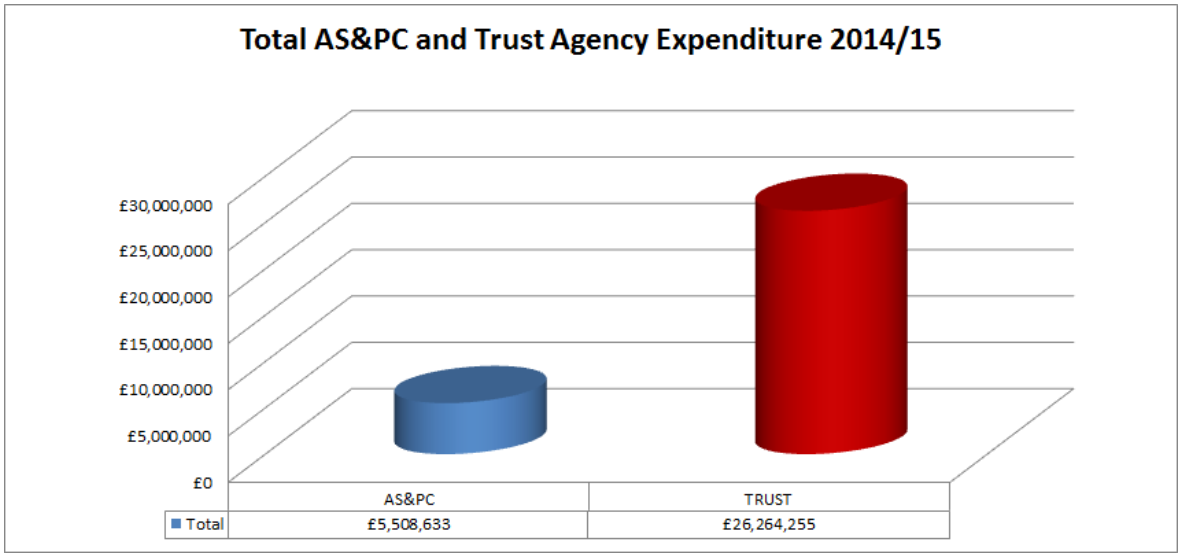
1.5.2.2 Agency Expenditure

The total level of Agency expenditure by occupational family group within the Directorate for the 12 months to 31st March 2015, was £5,508,633[12] as illustrated in Table 1 below:-

Table 1 : Agency Expenditure

FAMILY GROUP	AGENCY SPEND FOR THE 11 MONTHS TO 31st March 2015
ADMIN & CLERICAL	£1,466,411
ANCILLARY	£19,061
ALLIED HEALTH PROFESSIONS	£127,336
SOCIAL SERVICES	£1,263,150
NURSING	£1,524,174
MEDICAL	£1,108,501
TOTAL	**£5,508,633**

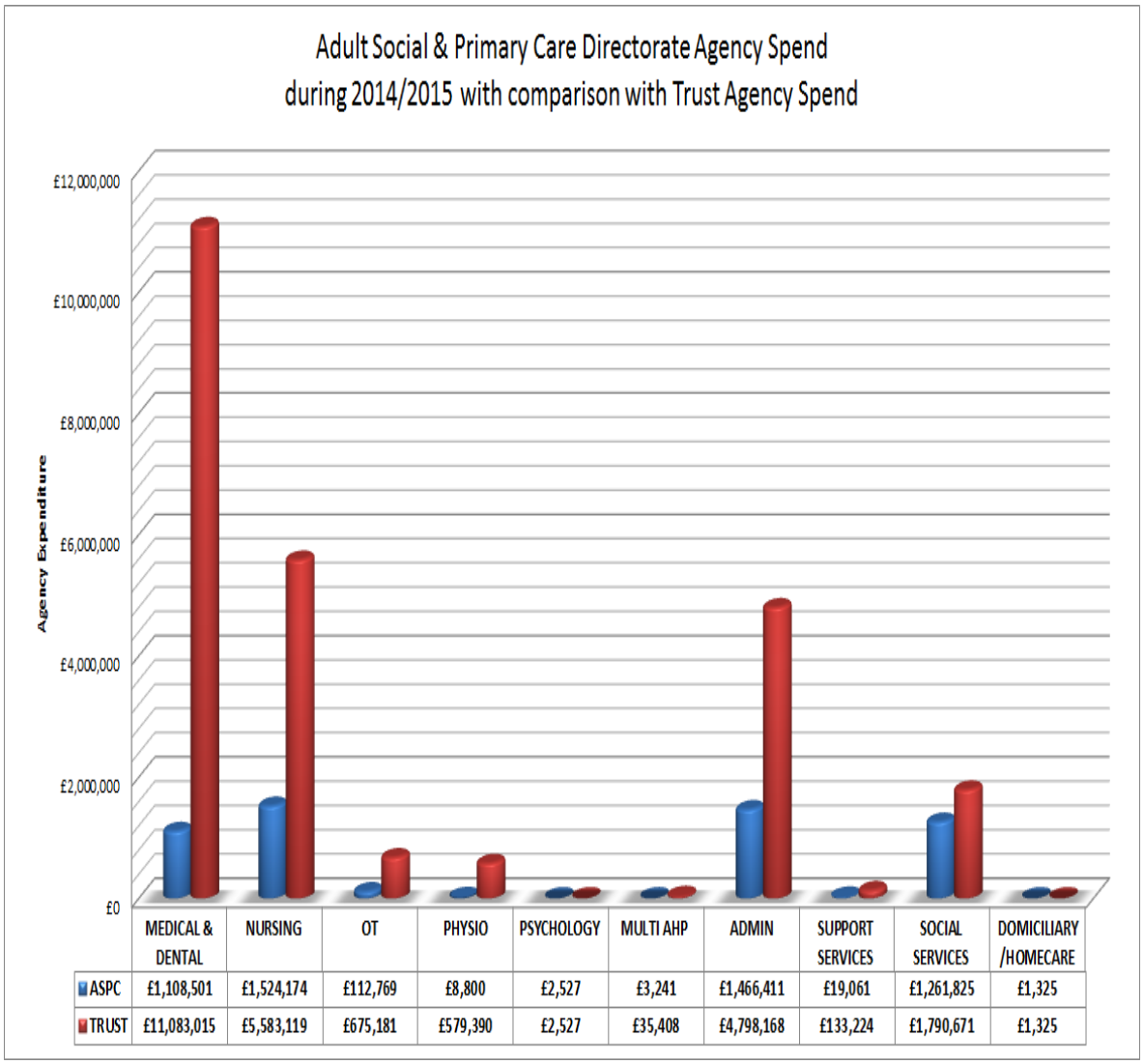
This represents 3.7% of the total salaries and wages budget for the Directorate. When the total Agency expenditure across the Trust is considered £26,264,255 the Directorate was accountable for 21% of that total expenditure as illustrated in the Graph below.



[12] Management Accounts Agency report as at 31 March 2015

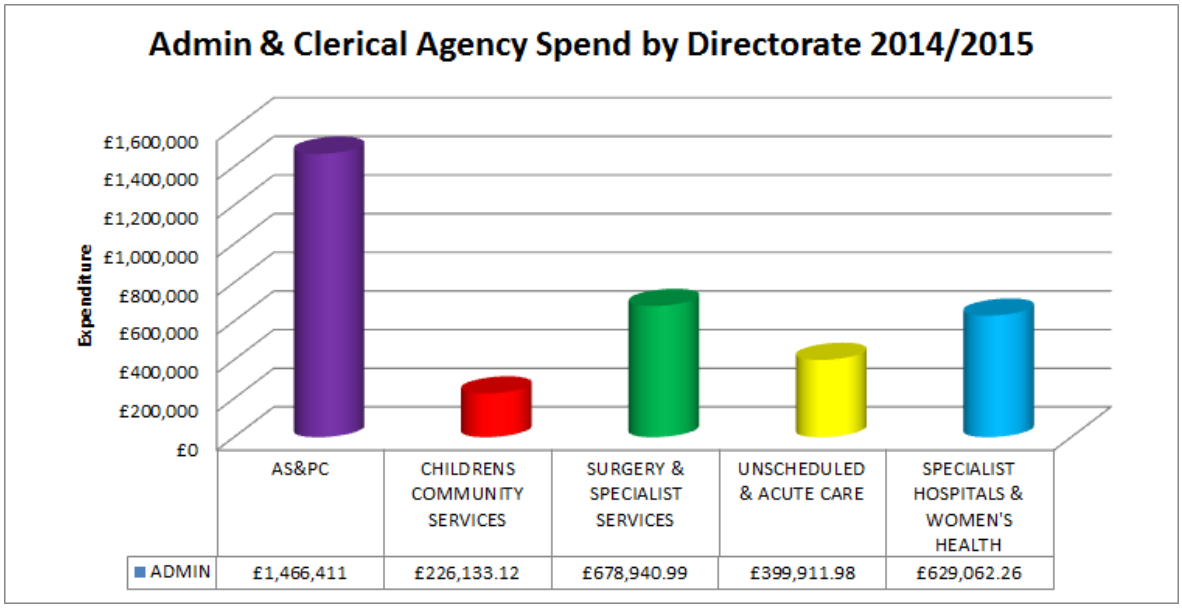
The graphs below highlight and compare the level of agency usage, across the clinical Directorates in the Trust, for those occupational groups with the highest levels of expenditure.

The graph below compares the level of agency expenditure within the Directorate to that of the Trust for 2014/15. This information is broken down further in this section to compare expenditure with the other clinical directorates within the Trust.

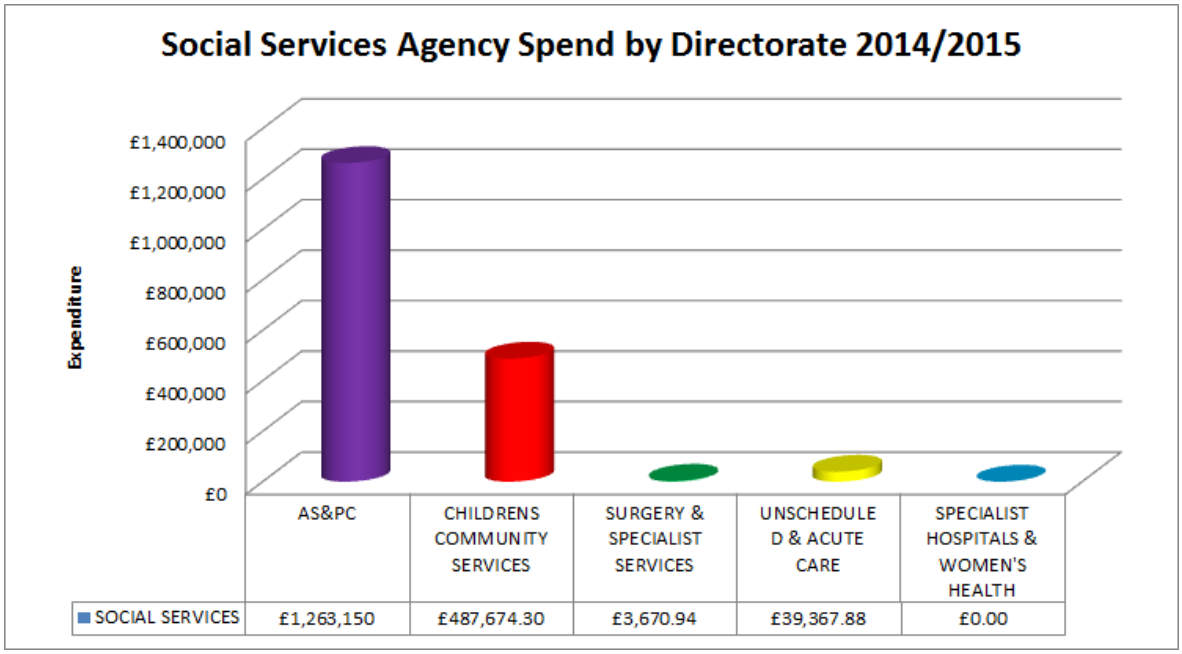


	MEDICAL & DENTAL	NURSING	OT	PHYSIO	PSYCHOLOGY	MULTI AHP	ADMIN	SUPPORT SERVICES	SOCIAL SERVICES	DOMICILIARY /HOMECARE
ASPC	£1,108,501	£1,524,174	£112,769	£8,800	£2,527	£3,241	£1,466,411	£19,061	£1,261,825	£1,325
TRUST	£11,083,015	£5,583,119	£675,181	£579,390	£2,527	£35,408	£4,798,168	£133,224	£1,790,671	£1,325

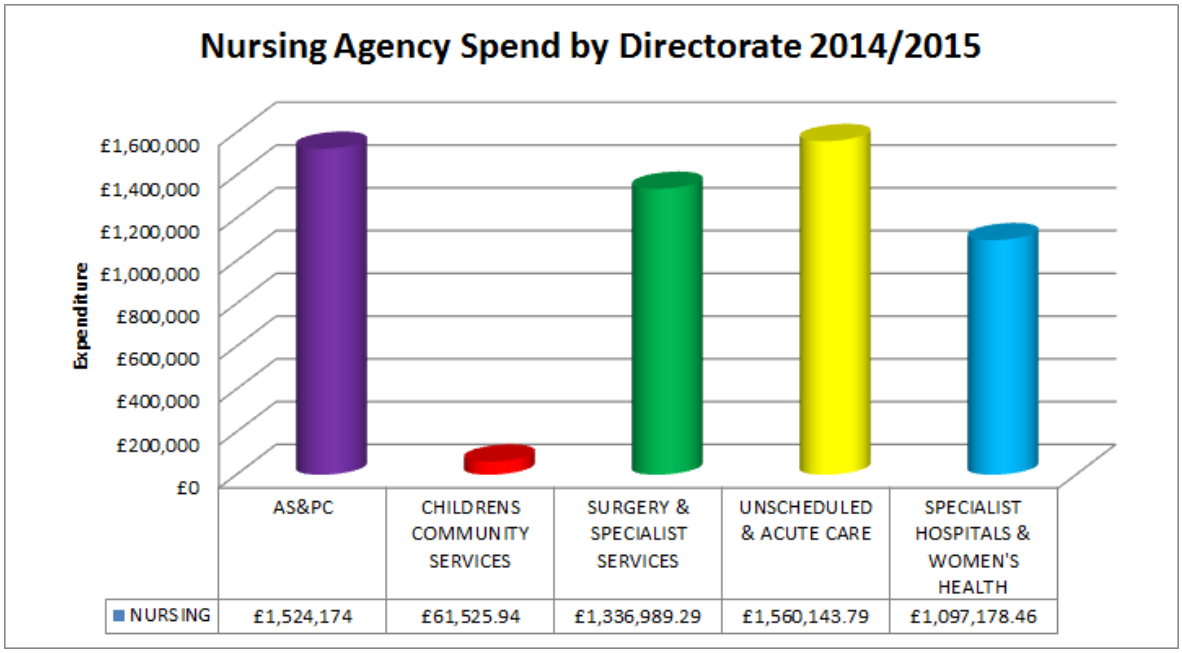
The Directorate had the highest level of agency expenditure for admin & clerical staff when compared to the other clinical Directorates as illustrated in the graph overleaf. The level of expenditure, within the Directorate, was approximately £1.45m for the year, which was over 43% of the total agency expenditure for this occupational group within the clinical directorates. This expenditure accounted for over 30% of the Trust's total spend on admin & clerical agency staff.



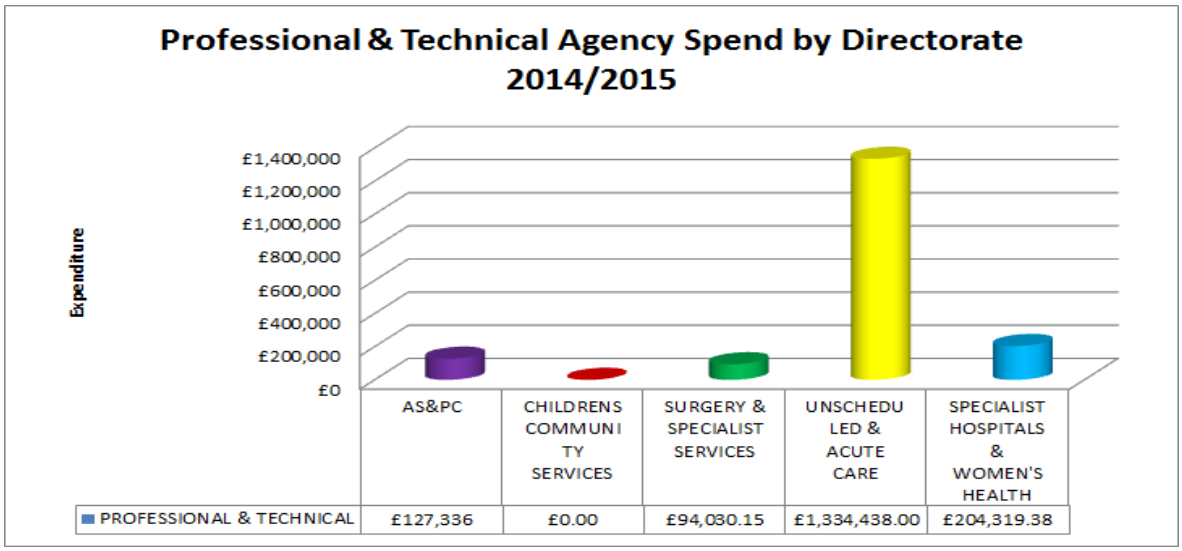
Social Service agency expenditure which includes both social work and social care within the Directorate (£1.26m) was higher than the other clinical directorates combined (£0.53m). This is not unexpected given that the Directorate employs the majority of social Services staff and therefore has greater responsibility for this functional area when compared to the other directorates.



Amongst the clinical directorates Unscheduled and Acute Care were the largest users of agency nursing staff during the year as illustrated in the graph overleaf. The Directorate, which was the second biggest user of agency nursing staff, accounted for over 27% of the total clinical directorates' agency nursing spend.



The graph below highlights the very low level of agency usage amongst Professional and Technical staff in the Directorate, accounting for only 7% of the expenditure in this area.



Within the Directorate a tight level of vacancy control is maintained, allowing resources to be used where they are most needed and assisting with financial controls and the modernisation programme.

1.6 STEP 3 : DEFINING THE REQUIRED WORKFORCE

This step involves mapping the new Service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of

1.6.1 Workforce Projections

More significant workforce change is expected to support enhanced community Services; with an associated shift of resource from acute to community care. This will result in re-training and re-deployment of associated staff in each of the occupational family groupings within the Directorate:-

- Social Services
- Nursing
- Medical
- Ancillary
- Allied Health Professions
- Administration & Clerical

1.6.2 Social Services Workforce

The Social Services workforce makes up the greatest proportion of the Directorate's workforce at 42.8% or 2113 headcount and 1674.58wte as illustrated in Table 2 below.

Table 2

Service Area	Skill Mix	H/Count	WTE
Learning Disability	Qualified Social Worker	70	65.89
	Social Care Support	8	5.47
	Social Work Support	373	317.88
Learning Dis Total		451	3891.24
Mental Health	Other AHP	4	3.80
	Qualified Social Worker	93	88.80
	Social Care Support	16	12.01
	Social Work Support	62	51.65
Mental Health total		175	156.26
Older Peoples Services	Qualified Social Worker	248	219.92
	Social Care	8	7.80
	Social Care Support	815	573.69
	Social Work Support	413	325.17
Older People total		1484	1126.58
Psychology Services	Qualified Social Worker	2	1.50
	Social Work Support	1	1.00
Psychology total		3	2.50
Grand total		2113	1674.58

Note the 4 Other AHP staff are counsellors held on the system against a Social Services job code & personnel area

There are no set guidelines as to what the skill mix registered to non-registered social worker should be. Within the Directorate however the ratio is 35 qualified social worker to 65 support.

The social care workforce is made up of social care managers at band 7 and the social care support workforce is largely made up of Home Helps / Domiciliary Care staff in Band 2. Table 3 below illustrates the makeup of the Social Care workforce by band, the majority of which, 75% are band 2.

Table 3

Social Care Workforce	H/count	WTE
Band 7	9	8.8
Band 5	37	34.65
Band 4	33	30.51
Band 3	143	103.31
Band 2	629	425.03
TOTAL	**851**	**602.36**

A regional domicilary care workforce plan is currently being developed and the recommendations from this piece of work will need to be considered in terms of the impact on our current workforce. Demand for this service will also need to be considered in light of recent announcements regarding the reduction in Independent Nursing Home placements.

Within Social Services consideration will need to be given to the integrated approach of the Social Worker from the hospital to the community setting and vice versa creating the pathway for greater continuity of care for the Service users. The impact of this on discharge planning would be a key performance indicator.

Much work has already taken place with the Social Work and Social Care Modernisation Workforce Review 2014/15 and key recommendations have been made in relation to strengthening the capacity of the workforce and Service in order to meet the current and future social care needs, in line with both Trust and Regional Strategic direction. This is particularly with regards to the streamlining of the social care and social work function in Integrated Care Teams, the development of new teams and roles in relation to hospital Social Work and the review of care home residents.

The Social Care Review has made several recommendations for both the Hospital Social Work and Integrated Care teams, which are outlined below.

Hospital Social Work

- There is a need for Social Work to redefine its professional standards, to set its vision for the future and to refine its role within the hospital context. This review advocates, that moving forward, this could be best achieved under a single line of management and accountability. To that end it is recommended that Hospital Social Work is managed under a unified professional and operational line of accountability, in the form of a single Assistant Service Manager who is a professionally qualified Social Worker.

- It is anticipated that an increased skills mix of Band 4 Social Care Assessors will be required across the Hospital Social Work Service to manage non-complex social care cases. These staff will be resourced within current funding levels, as it is envisaged that they will replace posts currently being filled by Band 6 Social Workers.

- Governance arrangements in relation to the Hospital Social Work Service are to be strengthened. This is to be achieved through the implementation of agreed standards and audit tools for professionally qualified staff and the introduction of operating, recording and audit standards for Band 4 Social Care staff.

- A 7 day Hospital Social Work Service is to be developed for the acute and unscheduled care sectors across Belfast City Hospital, Royal Hospitals, Mater Hospital, Ulster Hospital and Musgrave Park Hospital.

Integrated Care Teams

In relation to Social Care and Social Work in Integrated Care Teams, the review makes the following recommendations:

- It is proposed that the management and review of long term placements, is moved from the Integrated Care Team structures to a discrete Older Person's Care and Placement Review Team. This will enable the service area to ring fence resources to maximise the care and protection of our most vulnerable service users.
- A Band 7 Senior Case Manager should be created across the Service area and aligned to each Integrated Care Team. The Senior Case Manager will hold a small discrete caseload of high end complex cases and lead on practice development across the team. The Senior Case Manager will also act as a Designated Officer.

- The Care Management function should be integrated into the core Band 6 Social Worker role in the Integrated Care Teams. To that end, the review recommends streamlining the five current roles and job titles into four roles of *Senior Case Manager, Social Work Lead, Social Worker and Social Care Co-ordinator* under a unified line management structure accountable to the Team Leader.

- The review is proposing that the skill mix within teams should re-orientate towards a ratio of 75% Social Workers and 25% non-professional staff.

- For those service users who are identified as requiring an assessment of need, all initial assessments and comprehensive assessments of social care needs within ICT's should be carried out by a professionally qualified Social Worker. This will enable Social Care staff, in Integrated Care Team's, to be more holistic and prevention focused in the assessment of Older People.

Generic Recommendations

- The review recommends the development and implementation of a case load analysis tool to support practitioners and managers to analyse both the breadth and complexity of work, and also the activity and demands of caseloads.

- It is recommended that eNISAT tools should be fully utilised by Social Care and Social Work staff across the Service area, in both hospitals and integrated care teams.

The Social Care Workforce in relation to demand, going forward will also need to consider the impact of the Social Care Strategy and confirm the best option from the review going forward.

Health Minister Simon Hamilton stated at the health and Social Care Board Adult Safeguarding event to mark World Elder Abuse Day on 18 June:-

"More than 23,000 social care workers, including social workers, are already registered with the Northern Ireland Social Care Council (NISCC). It is my intention that compulsory registration will be introduced for the remaining groups of social care workers in domiciliary and day care." "This will bring an estimated 12,000 additional workers onto the NISCC Register. Details regarding the timeline are to be confirmed but it is hoped to progress roll out this year. This will mean Northern Ireland will be leading the way across the UK. Social care workers provide care and support for some of the most vulnerable people in our society. Many work unsupervised in people's homes. Registration will give greater confidence and assurance to Service users, their families and the wider public that those entrusted to provide this care are suitable and safe to do so."[1]

1.6.2.1 Social Services Workforce Summary

In summary the social care workforce during the course of the plan faces considerable change particularly in relation to rebalancing the workforce across the Integrated Care Teams which is likely to mean new roles and revised skill mix in this area. The Domiciliary care workforce also faces significant change particularly in relation to the outcome of the Regional Domiciliary Care Review that is currently underway. The introduction of the Self Directed Support Model will have a significant impact and will be monitored during the course of the plan and work will need to commence to ensure all social care staff are registered with the Northern Ireland Social Care Council in line with the agreed timeline.

1.6.3 Nursing Workforce

There are currently 1688 headcount and 1512.41wte nursing staff within the Directorate as illustrated in Table 4 below.

Table 4

Service area	Skill mix	H/count	Wte
LEARNING DISABILITY	Nurse Support	217	184.42
	Qualified Nurse	186	173.06
LEARNING DISABILITY Total		**403**	**357.49**
MENTAL HEALTH	Nurse Support	139	132.97
	Qualified Nurse	415	397.26
MENTAL HEALTH Total		**554**	**530.23**
OLDER PEOPLES SERVICES	Nurse Support	236	183.95
	Qualified Nurse	491	436.74
OLDER PEOPLES SERVICES Total		**727**	**620.69**
PSYCHOLOGY SERVICES	Qualified Nurse	2	2.00
PSYCHOLOGY SERVICES Total		**2**	**2.00**
SERVICE IMPROVEMENT & GOVERNANCE	Qualified Nurse	2	2.00
SERVICE IMPROVEMENT & GOVERNANCE Total		**2**	**2.00**
Grand Total		**1688**	**1512.41**

Currently based on Human Resources Payroll Travel & Subsistence System (HRPTS) within our Older People Services the ratio based on wte is 70:30, within Mental Health it is 75:25 and within Learning Disability it is 48:52.

Demand for nursing in the Directorate is likely to increase based on recommendations contained in *Delivering Care: A Framework for Nursing and Midwifery Workforce* (DHSSPS, 2013b). The Nursing and Midwifery Leaders in Northern Ireland have defined skill mix for an adult hospital-based general medical or surgical care setting as 70:30 and at the same time recognises some flexibility within the stated skill mix in any given area will be tolerated, to maximise the use of support staff, where higher levels of dependency and lower levels of acuity exist and there is evidence to demonstrate that safe, effective, person-centred care is being provided. The skill mix should not, however, fall below 65:35, registered : unregistered staff.

During the course of this plan Phase 2 of Delivering Care will become available and considers Mental Health and District Nursing. Of those held on HRPTS against a District Nursing job code the ratio is 67:33. The District Nursing Review will need to be considered given the recognised increase in the number of education commissions in this area and the introduction of the Home Treatment Service, linked with BCH direct. This may mean a corresponding increase in the number of new District Nursing graduates recruited over the course of the plan.

The Delivering Care:A Framework for Nursing and Midwifery Workforce document also highlights that 'skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to 'fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as a nurse leader for the ward.'[13]

The Directorate will need to consider the numbers to be identified amongst its existing workforce to undertake specialist practice community programmes.

13 Delivering care: Nursing staffing in Northern Ireland Two: Using the Framework for medical and surgical care settings pg 3.

The review of the District Nursing Workforce[14] has highlighted a total of six recommendations including:-

- A consistent and equitable service over the 24hour period 7 days a week. District Nurses should be aligned to General Practitioners and also geographically zoned.
- Extension of the Acute Care At Home Team to 7 days for all professionals (currently just nursing and physiotherapy) and the Clinical Nurse In Reach to be aligned to the team as the hospital facing element.
- Amalgamate evening, night, twilight, and out of hours elements of the 24 hours Nursing Team.
- Develop referral pathways and communication systems with Acute Care At Home Teams and other interfacing teams.
- Standardisation City Wide
- Clinical support teams re-integrated back into District Nursing Teams.

1.6.3.1 Nursing Workforce Summary

In summary the Nursing workforce requires significant change in relation to supporting the 'shift left', new roles are likely to be required in the community and there will be skill mix changes to meet the requirements of normative staffing. Older Peoples Services in particular have a programme of work to promote and attract new graduates into a Care of the Elderly career pathway and investment is required to support our Ward Managers to participate in leadership, management, staff development and audit.

1.6.4 Medical Workforce

Northern Ireland Medical and Dental Training Agency NIMDTA have reduced the number of training posts in Psychiatric Medicine and the Directorate will need to review this to ensure they recruit and retain sufficient medical staff in this area over the course of this plan. As the focus moves to treatment in the community for mental health clients the Directorate will need to identify from their current supply how this demand for Service can be met. In August 2014, 2013 and 2012 there were 53 which compares to 57 in August 2009, 56 in August 2010 and 54 in August 2011, a gradual decrease of 4 over the course of the last six years.

The Kings Fund Report on Workforce Planning in the NHS April 2015 highlighted that the Centre for Workforce Intelligence identified two key indicators of pressures in the psychiatry workforce namely:-

- There is a high vacancy rate in psychiatry consultant posts (6.3%) (Health Education England 2015).
- Nearly one in five doctors undertaking core psychiatry training in 2014 did not progress into higher speciality training.

Within Psychiatry whilst we do not have the same level of vacancy at consultant level we are experiencing difficulties at trainee level and are nine trainees short which has now become a trend that is affecting patient provision.

[14] District Nursing Modernisation and Workforce Review 2014/15 Final Draft

Within Care of the Elderly it is recognised that there is a national shortage of adequately trained doctors and the Directorate has advertised repeatedly without success. It may now be relevant to consider recruitment campaigns internationally.

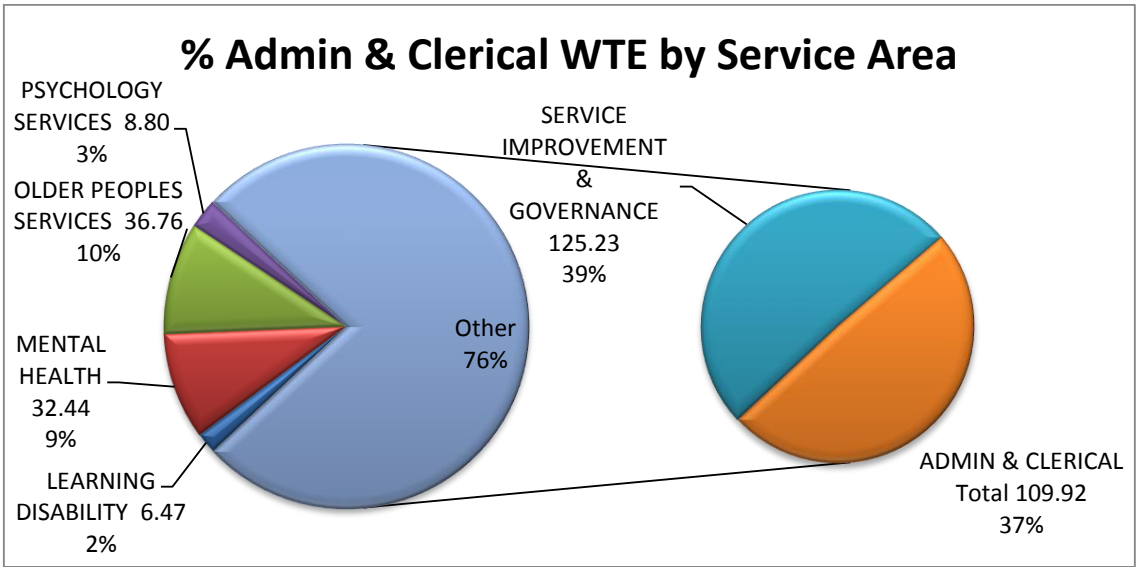
Across the region there is also a programme of workforce planning by speciality being undertaken with Geriatrics currently underway and Psychiatry scheduled to commence during July to December 2015. The Directorate will be required to participate in this process and the outcome of each will need to be incorporated into this local Directorate workforce plan going forward.

1.6.4.1 Medical Workforce Summary

In summary the medical workforce during the course of this plan is set to remain relatively stable with concentrated efforts on recruitment within Care of the Elderly.

1.6.5 Administration and Clerical Workforce

During the course of the year ending 31 March 2015 a decision was taken to move the administration and clerical staff from a centralised source to each of the functional areas. The graph below illustrates the distribution of the staff by Service area at 31 March 2015, with the majority of staff 39% in Service Improvement and Governance.



Going forward the administration and clerical workforce will be reviewed across the organisation and within the Directorate in the first quarter of this current financial year further changes have been made. Learning Disability Services now have 45.29 wte admin staff, and Mental Health Services have 107.02 wte staff.

Through agency expenditure 80.61 wte agency staff are currently in post in the Directorate and given this high agency usage and expenditure plans are in place to recruit to 44.92wte posts i.e 22.67 wte band 2, 49.12wte band 3 and 8.82 wte band 4. A further review of the remaining 35.69wte will take place during the course of this plan.

It is therefore anticipated that there will be a significant reduction in agency expenditure amongst this staff group within the Directorate as substantive appointments are made.

The deployment of this staff group to the multidisciplinary teams will require news skills and learning and a review of technologies including 'Big Hand' laptops and voice recognition will be undertaken during 2016/17.

1.6.5.1 Administration and Clerical Summary

In summary the Administration and Clerical workforce is set to see further changes during the course of this plan with more staff becoming part of the multidisciplinary team and perhaps also becoming a more stable workforce with the significant recruitment programme set to take place to reduce agency spend.

1.6.6 Acute Care At Home Workforce

A new Acute Care at Home Team is currently being established. This is a community based multidisciplinary team which will work in an innovative integrated way with Primary Care to meet the growing needs of Older People, carers and the Community. This dedicated team will add to existing Services in providing comprehensive and rapid specialist assessment, advice and intervention to those elderly people in most need of help and provide an appropriate alternative to hospital admission.

Table 5 below provides a breakdown of the additional new roles that are currently being recruited.

Table 5

Occupational Group	Job Role	Band	No. of posts
Nursing			
	Co-ordinator	8A	1
	Nurse Practitioner	7	4
	District sister / Charge Nurse	6	4
	Acute Nurse	5	3
	Healthcare Support / Rehabilitation Assistant	3	5
Allied Health Professions	Occupational Therapist	6	1
	Physiotherapist	6	3
Admin & Clerical	Information Manager	4	2
	Administrative Support	3	1
TOTAL			**24**

1.6.7 Sleep-ins

The Directorate Services have a number of residential settings where staff are required to sleep-in. Following the outcome of a recent case in respect of sleep-ins and working time compliance Trusts regionally are assessing this practice with a view to considering alternative options to meet compliance. This is to ensure that there are sufficient staff on duty to deal with emergency situations should they arise during the night. The practice now needs to be reviewed in light of the challenge raised by trade unions in connection with the legality of this way of covering work and potential breaches of the Working Time Directive.

Currently where staff undertake sleep-in duties they are paid an allowance of £30 per night while sleeping on the premises. However, if during this period they are called to undertake work this is remunerated at their current hourly rate. These periods are not counted towards their normal working week.

The cost of sleep-ins to the Trust was over £400,000 for the year of which £235,000 was attributed within the Directorate.

The review into sleep-ins is on-going, but it is likely that Services who use sleep-ins will have to cease this practice and the likelihood is that a move to waking nights will be required moving forward. There will be implications for the Service with this outcome, in terms of requiring additional financial and staffing resources.

1.6.8 Workforce Projections

Throughout the course of this plan our **workforce projections** are set to evolve as projects and consultations progress and this in turn will have an impact on the workforce going forward. The projections to date, detailed below, are therefore **indicative** and **speculative** and **subject to review** and are based on the following:-

- Average number of leavers calculated on the average in the previous five years April 2011 – March 2016.
- Average number of new starters calculated on the average in the previous three years April 2013 – March 2016.
- A **speculative** reduction within Learning Disability as a result of the reviews currently being undertaken.
- A **speculative** reduction within Mental Health Services as a result of the reviews currently being undertaken and the opening of the new Inpatient Unit.
- An increase in staffing owing to the introduction of the Acute Care At Home Team.
- An increase in staffing owing to the recruitment of administration and clerical staff.

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in post 31 March	4639	4715	4787	4761	4767
Average No. of Leavers (Headcount) *	-302	-318	-318	-318	-318
Average No. of Starters (Headcount)*	378	326	326	326	326
Learning Disability Reviews		-29			
Mental Health Reviews	-6	-22	-34	-2	-2
Older People Reviews	67	50			
Admin & Clerical Reviews	16	65			
Total **Indicative** Projected staff in post 1 April	4715	4787	4761	4767	4773
Net Variance	76	72	-26	6	6

Table 6

* Information for 2015/16 are actual figures

Graph 1 overleaf demonstrates a trend line indicating marginal changes to the workforce in terms of headcount. As at 01 April 2016, 4715 will be in post with a projected 4,773 in post as at 31 March 2020 an indicative increase of 58 over the course of this five year workforce plan.

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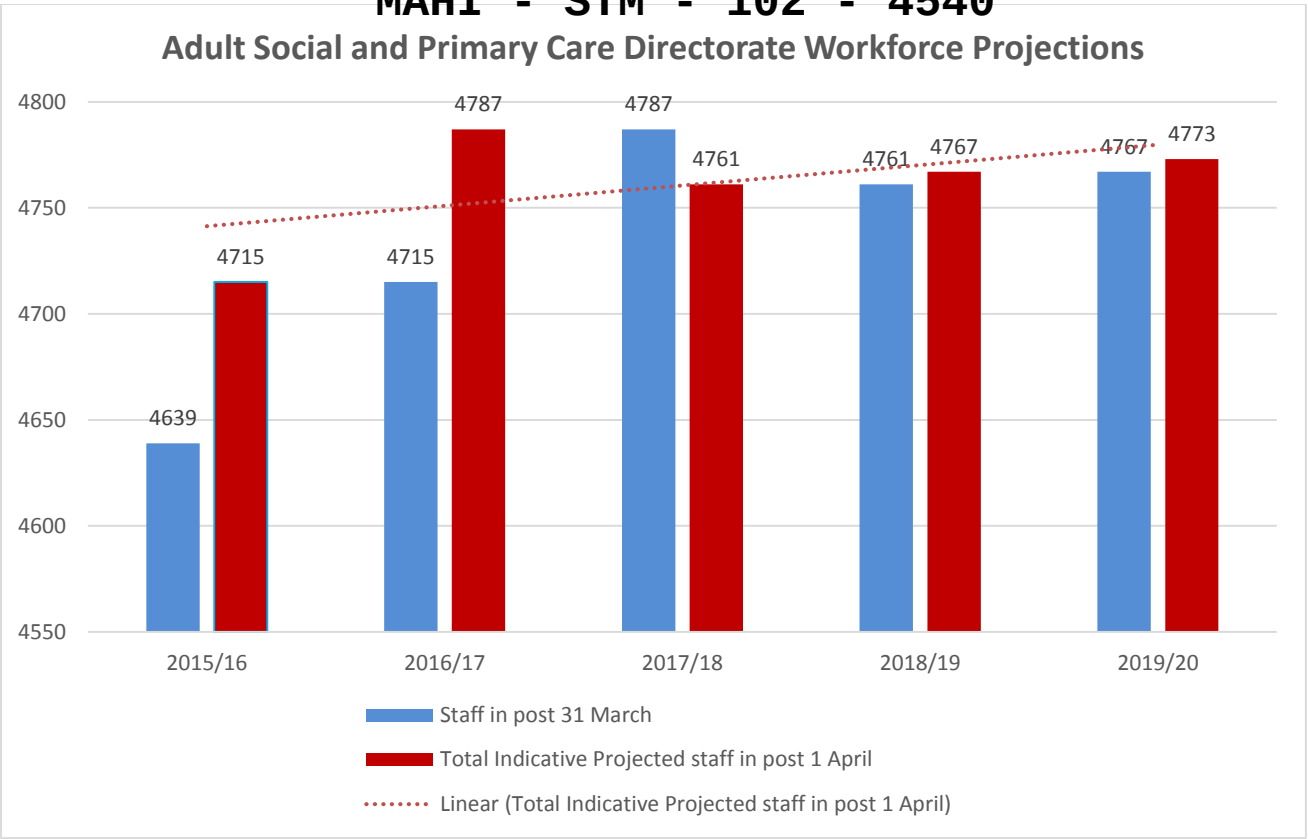


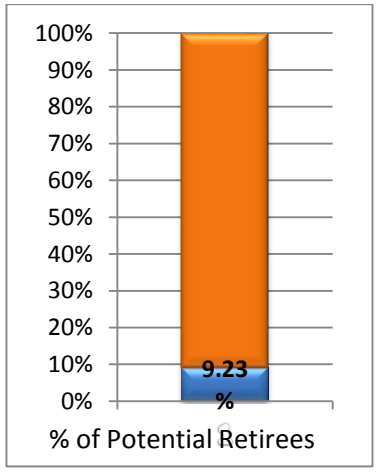
Graph 1

1.6.8.1 Projections for Retirement

Table 7 below identifies the % projections for potential retirements during the course of the plan and is based on the assumption that those over the age of 60 today will retire in the next five years. Therefore 9.23% of the Directorate's workforce or 428 staff will retire.

Table 7

Age Range	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE	**Grand Total**
16 - 24		32	19	39	1	1	92
25 - 29	16	106	99	145	8	7	381
30 - 34	16	107	116	167	21	14	441
35 - 39	17	116	118	240	12	18	521
40 - 44	14	109	150	307	13	16	609
45 - 49	25	136	153	396	8	26	744
50 - 54	17	151	186	441	8	24	828
55 - 59	17	67	76	409	6	21	596
60 - 64	12	45	28	190	1	12	288
65+	5	13.00	9	100	1	12	140
% of Potential Retirees	12.23	6.58	3.88	11.91	2.53	16.00	9.23



The Directorate has a potential retirement profile of 9.23%. This equates to 428 headcount and 310.48 wte. This means that the number of individuals who may exit the organisation on the basis of retirement currently is significantly greater than in previous years when an average of 65 headcount and 54.42wte retired in the previous five years which compares to an average projection of 86 headcount and 62.1 wte in the five years to March 2020. During the year ending 31 March 2015, 96 headcount and 76.83 wte retired which was a significant increase when compared to the previous year when 60 headcount and 53.26 wte retired.

The impact of the pension reforms however may mean for a considerable number of staff who have not yet reached the age of 60 are more likely to remain in the work place for longer when compared to those who are in the 60+ age bracket today.

The introduction of the Voluntary Exit Scheme (VES) in this current financial year will also have an impact as applications to support voluntary exit must be associated with our 2015/16 Financial Reform and Efficiency Plans.

1.6.8.1 Special Classes

Special Class status is a historical provision awarded to certain professions, which, subject to qualifying criteria being met, allows a member to retire at age 55 without a reduction to their benefits. It was abolished for all new entrants to the NHS Pension scheme after 6 March 1995 and for those previously holding the status, who have a break in pensionable employment of any one period of five years or more. It applies to Nurses, Physiotherapists, Midwives, Health Visitors, Nurse Auxiliaries and Occupational Health Nurses. Within the Directorate there are currently 85 staff who may potentially qualify who are nurses with 20 years or more Service.

1.6.8.2 Mental Health Officer Status (MHO)

MHO status is a historical provision that was introduced to compensate members caring for patients suffering from mental health disorders. MHO status was abolished for all new entrants to the NHS Pension Scheme after 6 March 1995, and for those previously holding the status, who have a break in pensionable employment of any one period of five years or more. MHO status does not apply in the 2008 Section or the 2015 Pension Scheme. Those who do qualify and who have 20 years MHO membership can retire from age 55, without any reduction to benefits, providing they are still in pensionable MHO employment on the day before they retire. Unlike Special Classes MHO members can count each complete year of MHO membership, after building up 20 years, as 2 years for benefit purposes, and this is known as 'doubling'. Within the Directorate there are currently 250 staff who may potentially qualify with 20 years or more Service. Over the course of the year to 31 March 2016, 7 nursing staff retired at the age of 55, 5 within Mental Health services and 2 within Learning Disability. This compares to a total of 5 nurses who retired at age 55 across the other clinical directorates.

1.6.9 Hot Spot Areas

The main *Hot Spot Areas* and key factors which will have an impact on the workforce projections over the next five years are presented below:

1.6.9.1 Recruitment

During the course of the financial year, ending 31st March 2015, a total of 375 new staff have been appointed to the Directorate. This compares to 468 in 2013/14 and 456 in 2012/13. A total of 231 ad requisitions were processed, broken down by occupational group as shown in table 8 below.

Table 8

OCCUPATIONAL GROUP	NO. OF AD REQUISITIONS	NO. OF APPLICANTS
Admin & Clerical	16	630
Nursing	123	4566
Medical	11	28
Social Care	77	2826
AHP	4	21
TOTAL	**231**	**8071**

It is worth noting, from the general Band 5 Adult Nursing advertisement a total of 2116 applications were received and of those only 28 cited Older People as a preference area to work in.

It is recognised that our growing and ageing population with multiple long term conditions will require more staff to care for our older population. Based on the statistics above it is important the Directorate invest in promoting, the care of the elderly nursing, as an attractive area to work in for prospective new graduate recruits. This has been identified as an area of risk by Older People Services and an Action Plan is in place.

In recent months the impact of additional recruiting in Unscheduled Care has exacerbated problems in Older People Services and an Action Plan is currently being drafted to address the recruitment difficulties. The fact that we are going out to recruit additional staff for acute care at home and for district nursing as indicated above will also add to this challenge. Overseas recruitment may be necessary as well as the need to speed up recruitment processes at all stages, to reduce time from vacancy arising to getting new staff on the ward. The Directorate participated in the Trust's 'One Stop Shop' Recruitment Fair on 6 June where 27 recruitment panels interviewed 311 potential employees and 271 were offered positions subject to the necessary pre-employment checks. The Directorate appointed 27 staff nurses to Learning Disability, 14 Permanent and 13 Temporary and 38 successful applicants have indicated Care of the elderly as a first, second or third preference area to work. The Directorate are continuing to work with Corporate Nursing and Human Resources to complete the recruitment process and induct the new staff. This exercise will undoubtedly help to improve the situation. In addition a previous recruitment exercise earlier in the year secured a further 8 permanent appointments in Learning Disability and within Mental Health a waiting list with 21 successful candidates recorded has been established.

1.6.9.2 Graduate Recruitment for nursing staff

Currently recruitment for new graduates is carried out Trust-wide for Band 5 newly qualified staff in January and June with adhoc recruitment taking place for band 6 and above during the course of the year as and when the need arises. Table 9 overleaf demonstrates that the number of pre-registration nursing and midwifery places commissioned has fallen in recent years from 790 in 2008/2009 to 685 in 2014/2015.

Table 9 – Nursing & Midwifery pre-registration Training Commissions

Branch	Pre-Registration Commissioned Places by Year						
	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Adult	525	535	471	471	444	444	444
Adult OU	0	18	0	9	9	7	9
Mental Health OU	36	18	18	9	9	18	16
Children's	55	60	60	60	55	55	55
Mental Health	99	99	99	99	96	96	96
Learning disability	15	30	30	30	30	30	30
Midwifery D/Entry	30	30	30	30	35	35	35
Midwifery, Additional Registration	32	35	35	35	25	25	0
Totals	**792**	**825**	**743**	**743**	**703**	**710**	**685**
Year of completion	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**

Prior to the recruitment event in June the Directorate recruited a total of 122 headcount, 119.48 wte newly qualified staff as illustrated in Table 10 below.

Table 10

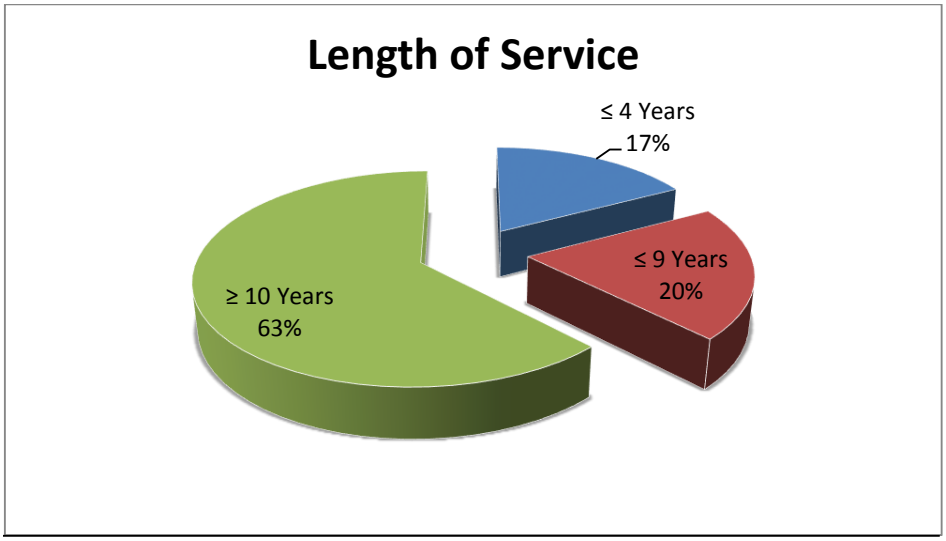
Occupational Group and Job	H/count	Wte
ALLIED HEALTH PROFESSIONS	**15**	**15**
7A75 OCCUPATIONAL THERAPIST (5) X005	10	10
7B35 ASSISTANT PSYCHOLOGIST (5) X005	4	4
7S45 OCCUP THERAPY - SUPPORT (5) X005	1	1
NURSING	**94**	**91.7**
5A15 ACUTE NURSE (5) X005	31	30.6
5A45 DISTRICT NURSE (5) X005	17	16.4
5A55 TREAT ROOM/PRACTICE NURSE (5) X005	1	0.5
5A65 MENTAL HEALTH NURSE (5) X005	29	28.8
5A75 LEARNING DISABILITY NURSE (5) X005	16	15.4
SOCIAL SERVICES	**12**	**11.78**
6A35 PHYS DIS/SENS IMPR SOC WR (5) X005	1	1
6S25 ELDERLY SOCIAL WORKER SUPP (5) X005	6	5.58
6S35 PHYS DIS/SENS IMPAIR SUPP (5) X005	2	1.8933
6S55 LEARNING DIS SOC WR SUPP (5) X005	1	1.3067
6S95 COMMUNITY SOCIAL CARE SUPP (5) X005	2	2
Grand Total	**122**	**119.48**

31 Acute nurse appointments were made from the 491 students due to complete in 2014/15, 29 mental health nurses from the 99 students and 16 from the 30 students in Learning Disability. Perhaps further analysis could be undertaken to ascertain the numbers across the region particularly in regard to mental health and learning disability as the trust appointed 29% and 53% respectively of those new graduates available to the Region.

It is worth noting however that there is an upward trend of newly qualified staff taking up posts outside Northern Ireland, as reported in the Nursing and Midwifery Workforce Plan[15] 'a survey conducted by Queen's University, Belfast in 2012 demonstrates an increasing trend (currently 21%) for newly qualified nurses and midwives being employed outside Northern Ireland following completion of their programmes'.

1.6.9.3 Retention

Within the Directorate 63% of the staff have 10 years or more continuous Service, 20% have 5 – 9 years' Service and 17% have less than five years' Service as illustrated in the chart below.



Of those staff with less than 5 years' Service 295 belong to Nursing and 284 are within social Services. The Directorate recognises retention amongst nursing staff within older people Services as a concern and have identified the following:-

- Possible deficits in how staff are inducted and mentored.
- Recognition of the need to engage more with staff who leave the Service to ascertain their reasons for leaving.
- Need to engage more directly and more often with nursing teams to get feedback and ensure their solutions are facilitated.
- Sisters /Charge nurses not being facilitated to be off the rota to undertake management /staff development work /audit
- Under uptake of our ward sisters of development programmes

Older People Services have identified in their objectives for 15/16 to over recruit and release band 7 staff as this will be more cost effective than off contract agency and increasing absenteeism.

[15] As 11 above Evolving & Transforming to Deliver Excellence in Care

1.6.10 Role Redesign

This requires consideration of who is best placed to carry out the task. Within Social Services depending on the Option chosen it is likely that roles will be redesigned to improve the Hospital Discharge Process. Within Mental Health, undergraduates now do undertake a module in cognitive behaviour therapy which supports the modernisation agenda within this area and the treatment plans provided for Service users. Within Community Learning Disability the pool of potential applicants will be extended to attract individuals from an OT or Social Services background for example into Behaviour Practitioner roles which would have traditionally been only available for Nursing staff to apply.

Throughout the Directorate it will be necessary to ensure staff are well equipped with the right training, knowledge and skills to work in both the Acute and Community settings across a range of professional and support roles.

1.6.11 Professional Issues

The Nursing & Midwifery Review identified that the range of professional issues listed below will have a significant impact on the nursing and midwifery workforce:

- Revised NMC Code of Conduct
- Changes to Revalidation
- NMC Pre-Registration Standards
- NMC Standards for Learning and Assessment in Practice
- Advanced and Specialist Practice roles
- Preceptorship
- Mentorship and practice training in community settings
- Supervision Standards

The new Code of Practice for Nurses and Midwives became effective from 31st March 2015, and reflects the world in which we live and work today, and changing roles and expectations of nurses and midwives. It is structured around four themes namely:-

- prioritise people,
- practise effectively,
- preserve safety and
- promote professionalism and trust.

Developed in collaboration with many who care about good nursing and midwifery, the Code can be used by nurses and midwives as a way of reinforcing their professionalism. Failure to comply with the Code may bring their fitness to practise into question.

Revalidation is a process that all nurses and midwives will need to engage with to demonstrate that they practise safely and effectively throughout their career. It is easy, straightforward and will help nurses and midwives develop as professionals. It is anticipated that the revalidation process will commence in October 2015 and will begin with those whose current registration is due to expire in April 2016. Within the Directorate there are currently 105 nursing staff who fall into this category.

The directorate will need to ensure that all nursing staff are engaged in this process and working on developing their portfolios together with a process of renewal every three years. They also need to ensure all nursing staff have a registered NMC online account.

1.6.12 Career Development and Specialisation

The Directorate will need to consider how they will promote and support the proposal identified in the Nursing & Midwifery Review 2015 to 2025 to introduce a rotation model for student and newly qualified nurses and midwives, across the hospital, community and independent sectors as well as the partnership graduate programme between the statutory and Independent/Private sector whereby the nurse would undertake a number of modules at Masters level while spending equal time between sectors.

> *Transforming Your Care* (DHSSPS, 2011b), and the shift from predominantly hospital based care to the community and the increasing role of the independent sector highlights the importance for student nurses to experience hospital, community and the independent sector during their training. Consequently, this will prevent a limitation on experience in these sectors and increase workforce flexibility.

This may also be considered as an approach to develop the flexible workforce across the Directorate and indeed in readiness for the first cohort of such under and post graduate students.

1.6.13 Technology and Technical Skill Demands

Changes in technology continue and the Directorate needs to embrace these changes in order to realise the benefits that they will bring in terms of more efficient and effective working.

Already facilities such as video conferencing, digital dictation, e-learning, electronic prescribing, use of I-Pads and remote/home working are starting to become a reality for many of our workforce. It is difficult to comprehend how much technology might have changed by the end of this workforce planning period. However, in order to gain maximum benefit from future technological change the Directorate will require a workforce with increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

> Communication, IT and Business skills are key skills for the future workforce and access to a wide range of training and development to achieve competencies should be included in staff development programmes. The requisite training and development to acquire these skills is necessary at all levels of care delivery.

The introduction of new technologies will change the way health care is delivered in the future and will improve the level of Services provided to our Service users. Service users will be able to provide essential health information, such as blood pressure readings, through the new technologies, to Trust staff, without the need to leave their home. However the introduction of new technologies will require training for the staff delivering the Services and possibly the Service users and/or their carers.

1.7 STEP 4 : UNDERSTANDING WORKFORCE AVAILABILITY

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to Service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

1.7.1 Workforce Figures (based on HRPTS data at 31st March 2015)

Workforce data and information in relation to the overall workforce within the Directorate and wider Trust has been downloaded from Human Resources, Payroll, Travel and Subsistence System (HRPTS). This system was introduced in the Trust in November 2013 and deployed to all staff at band 6 and above in March last year. The HRPTS data is continually updated and managed locally by each manager on the system.

The figures included within this workforce plan are reported as they have been recorded on HRPTS. To allow meaningful analysis, Trust bank staff and staff on career breaks have been excluded. Where staff have more than one post in the same organisational unit, or even within a different organisational unit, each post will have been counted in the 'Staff in Post' headcount, but the whole-time equivalent (WTE) will reflect the proportion of standard hours that are worked in each post. Staff who are temporarily absent from their position, for example due to sick leave, have been included in the analysis.

The data obtained for the purpose of this Workforce Plan includes a breakdown of the current workforce figures, inter alia, by:

- **Occupational Group;**
- **Service area (eg. Mental Health, Learning Disability, Psychology, Older People Services);**
- **Age;**
- **Gender;**
- **Headcount (HC) and Whole Time Equivalents (WTEs);**
- **Full-time or part-time status.**

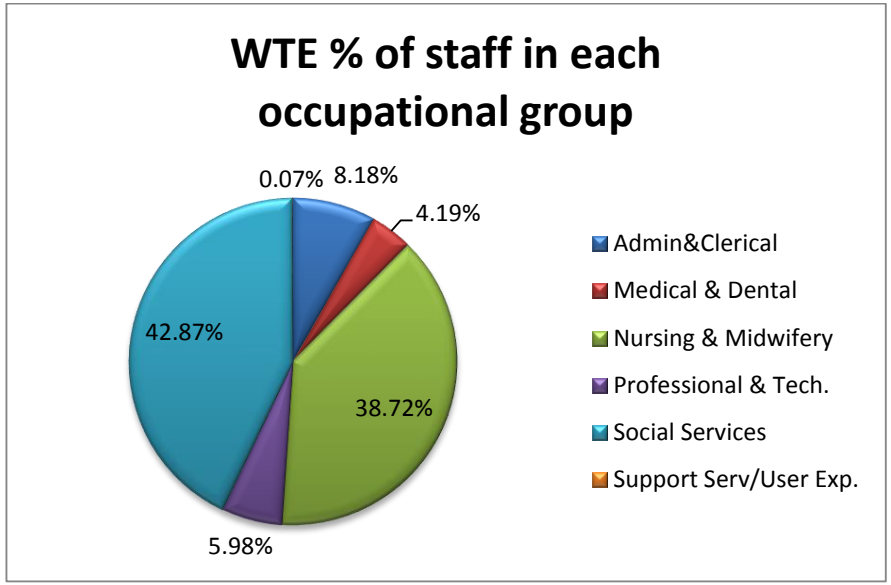
1.7.1.1 HRPTS

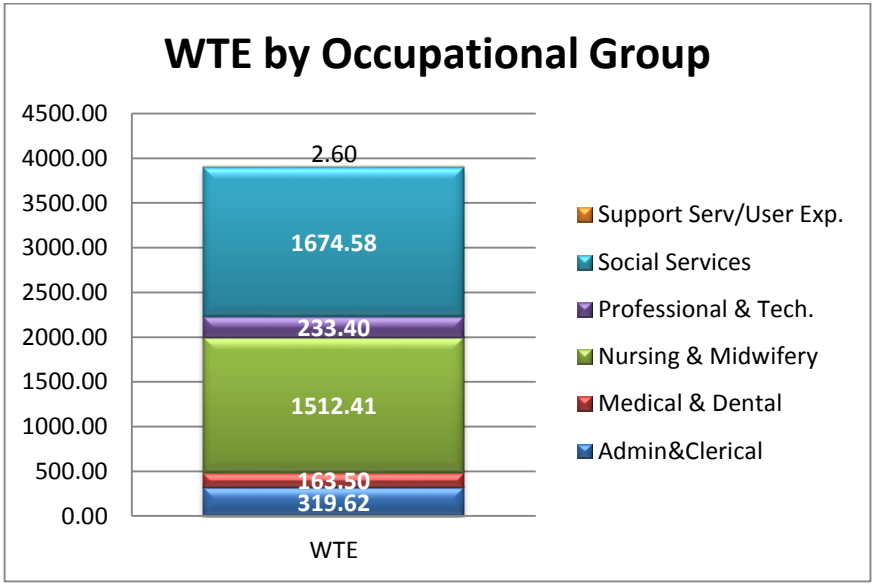
During the course of this plan all managers within the directorate will be provided with training on their own Manager self-Service management information reports. This will help to build the capacity and capability across the directorate and achieve benefits realisation as well as support managers in making their business decisions in relation to workforce planning. A suite of 23 Manager Self Service Reports are available and include for example, headcount, absence analysis, joiners, leavers, movers, work life balance, vacancies and learning participants and cancellations.

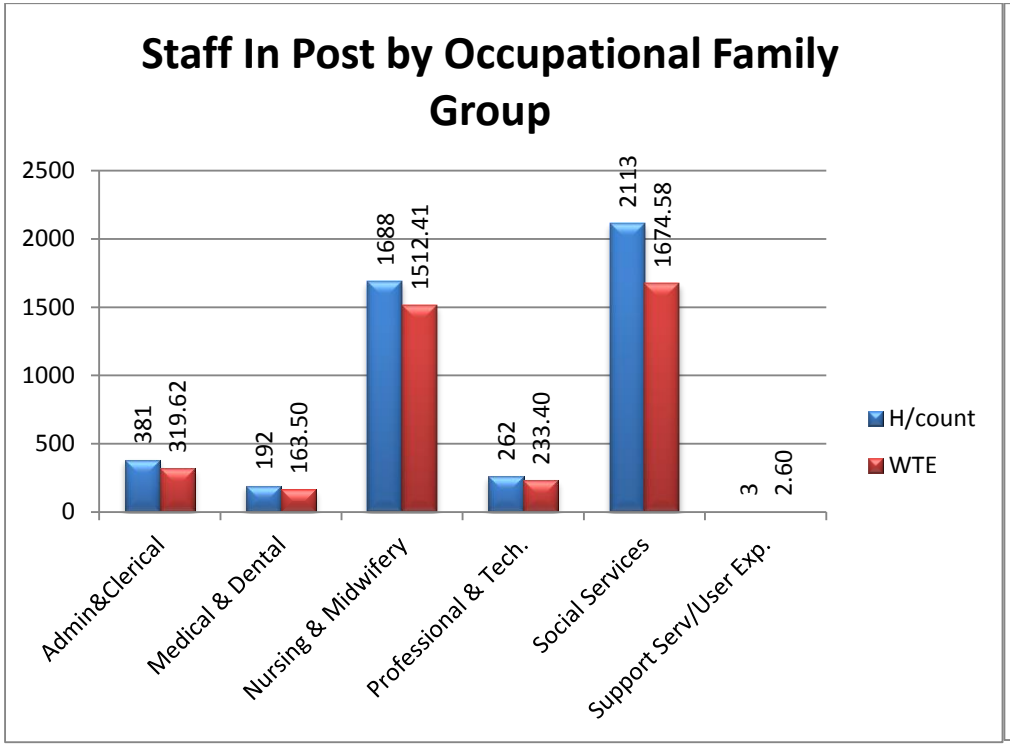
The data relating to the directorate workforce available on HRPTS provides a reasonable baseline demonstrating the numbers presently employed within the Directorate, across each family group as demonstrated in the workforce profiles below. The workforce information is based on staff in post as at 31 March 2015.

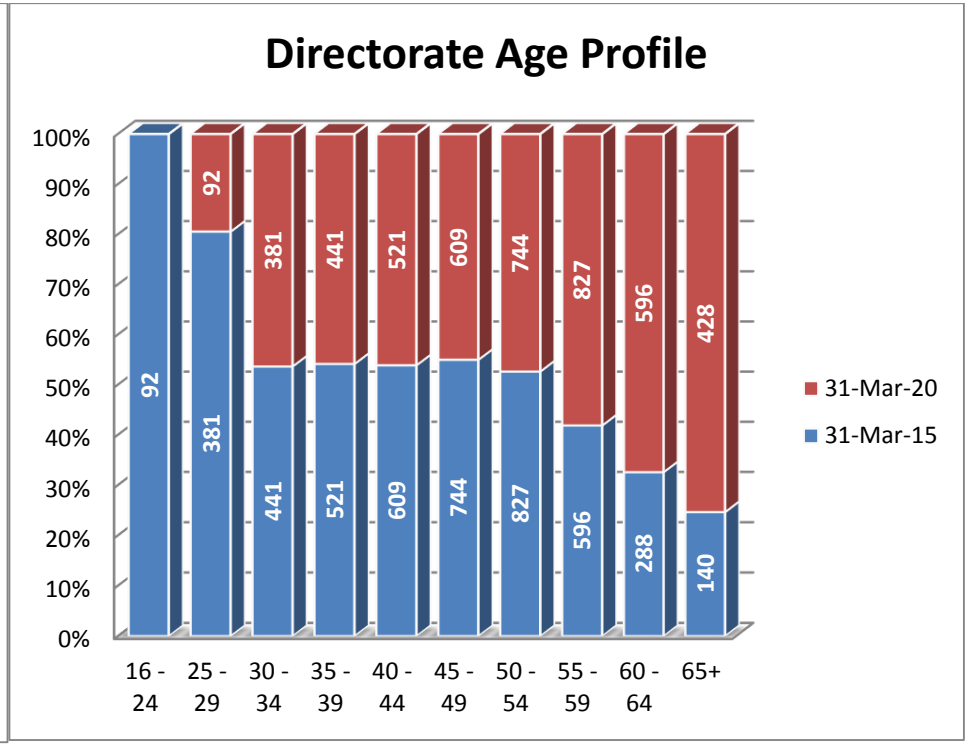
1.7.2 Directorate Workforce Profile

The Directorate employs 4639 or 3906.1 Whole Time Equivalent (WTE) staff (excluding Trust wide bank staff and career breaks) with a comprehensive range of skills and knowledge geared towards meeting the needs of patients and clients.









The majority of the Directorate's workforce is employed within Social Services 42.87% and whilst this is set to remain, over the course of the plan there should be a move from the acute to community in all areas, with staff being redeployed accordingly.

It is accepted that we have an ageing workforce and over the course of the next five years the likelihood is that more staff will be working longer and a larger proportion of the Directorate's workforce will be aged 55+. The Directorate will need to ensure it is age aware and has in place measures to ensure age diversity is promoted.

1.7.2.1 Skill Mix

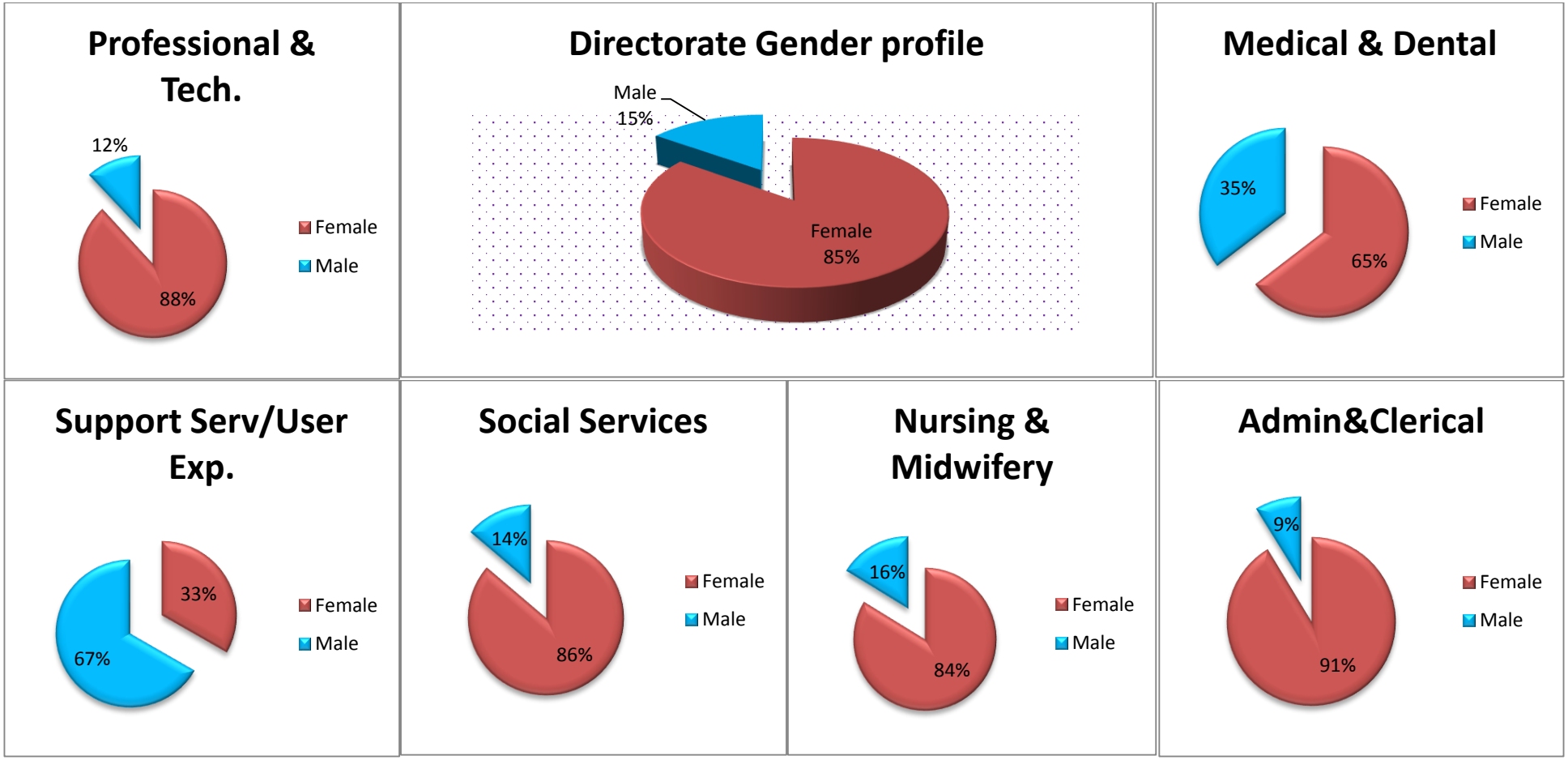
Table 11 below highlights the skill mix ratios amongst the clinical workforce groups and this is set to change particularly within nursing as normative staffing levels are introduced over the next five years.

Table 11

Combined Grades in each Family Group	Headcount	WTE	Ratio WTE	Projected Ratio	
Medical			**44:56**		
Consultant	84	71.30			
All other grades	99	92.20			
Nursing			**67:33**	**Nursing**	
Qualified Nurse	1096	1011.07		Acute Medicine	70:30
Nurse Support	592	501.34		Mental Health	TBC 2016/17
				District Nursing	TBC 2016/17
Social Services					
Social Work			**35:65**		
Qualified Social Worker	400	376.11			
Social Work Support	834	695.70			
Social Care			**1:99**		
Social Care	8	7.80			
Social Care Support	819	593.56			
Allied Health Professions					
Clinical Psychology	86	78.08	**84:16**		
Psychology Assistant	16	15.01			
OT	84	78.45	**92:8**		
OT Support	7	6.96			
Other AHP	34	28.34	**50:50**		
Multi AHP Support	36	27.96			
Ancillary					
Ancillary	3	2.60			
Admin & Clerical					
Admin & Clerical	377	319.62			
Grand Total	**4575**	**3906.10**			

1.7.2.2 Gender Profile

Within the Directorate the gender profile is 85% female and 15% male as illustrated in the pie charts below by Directorate and occupational group. Of the total Directorate workforce 3,941 are female and 698 are male this compares to 15,862 females and 4,502 males within the Trust 78% and 22% respectively.



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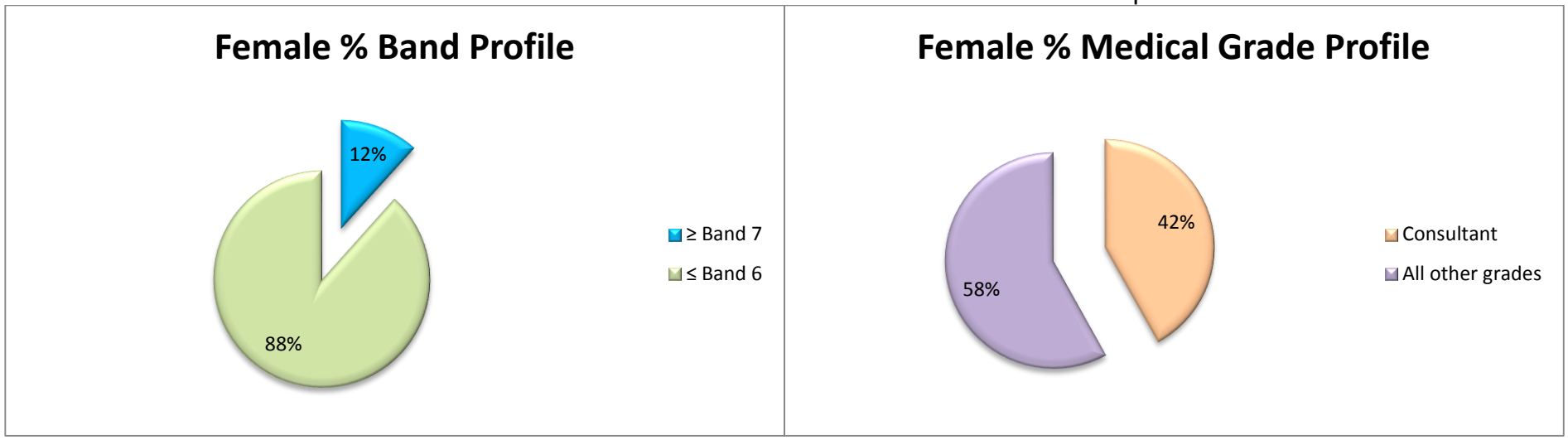
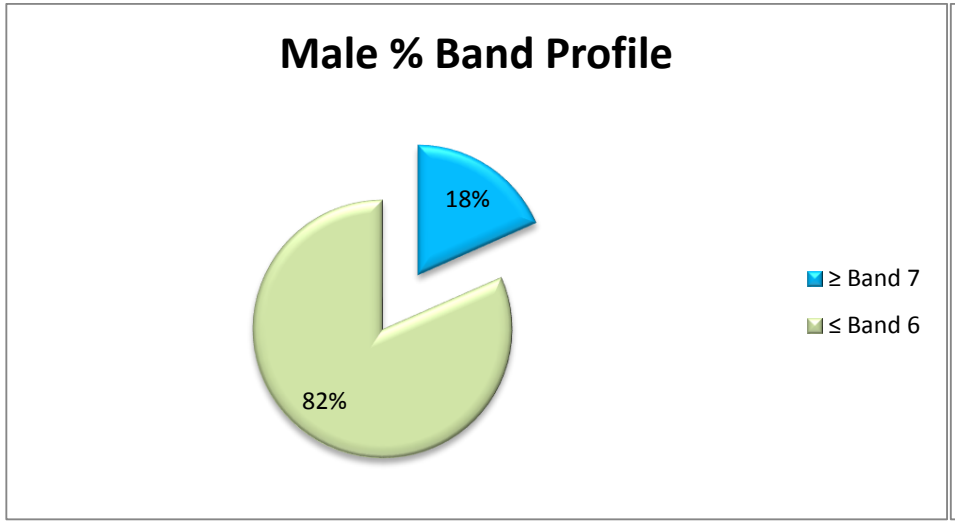
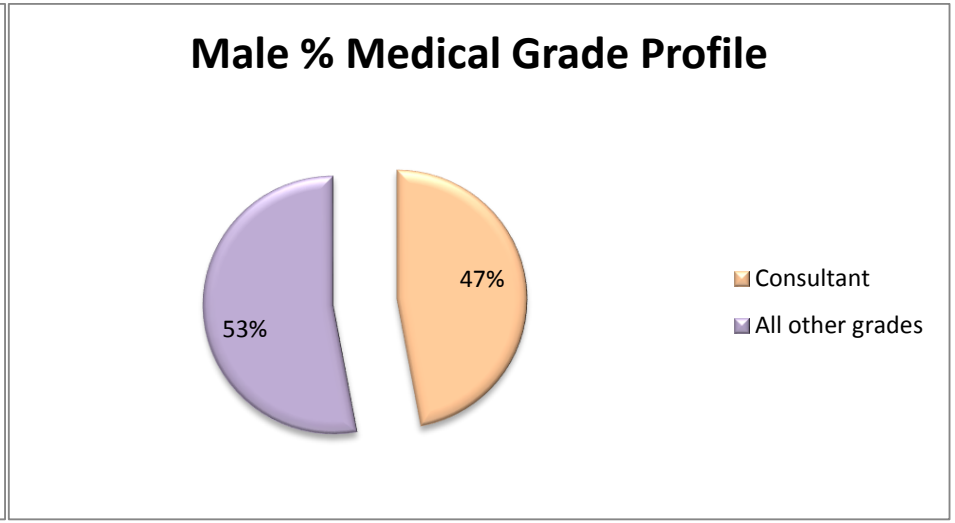
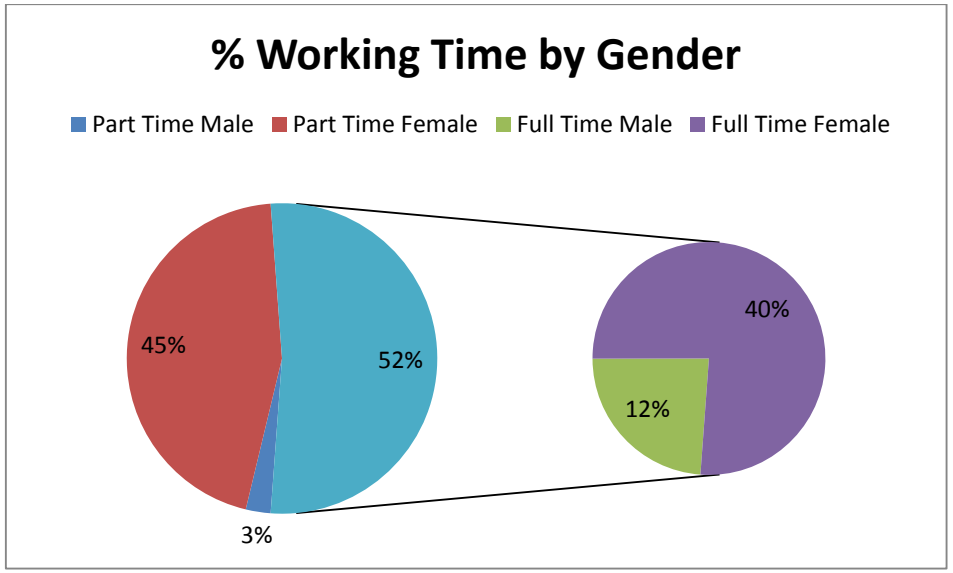
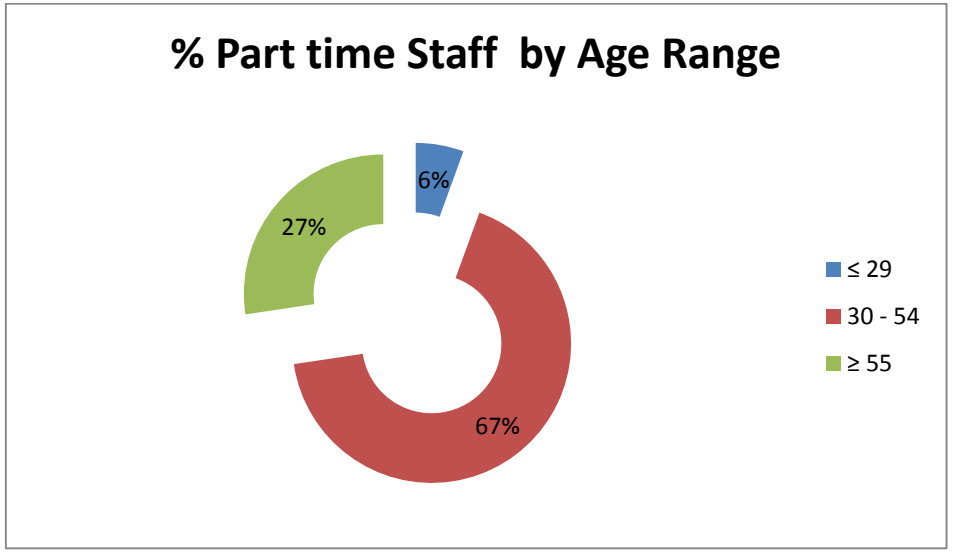
When considering the gender profile and band profile there is a greater proportion of males in band 7 or above positions, 18%, than the proportion of females,12% and this again is reflected amongst the medical workforce and their grade profile as illustrated in the pie charts below. 42% of the female medical workforce are consultants which compares to 47% of the male medical workforce. This is comparable to the Unscheduled Care Directorate who also have 17% of their male workforce in Band 7 or above positions or Trust wide 16%.











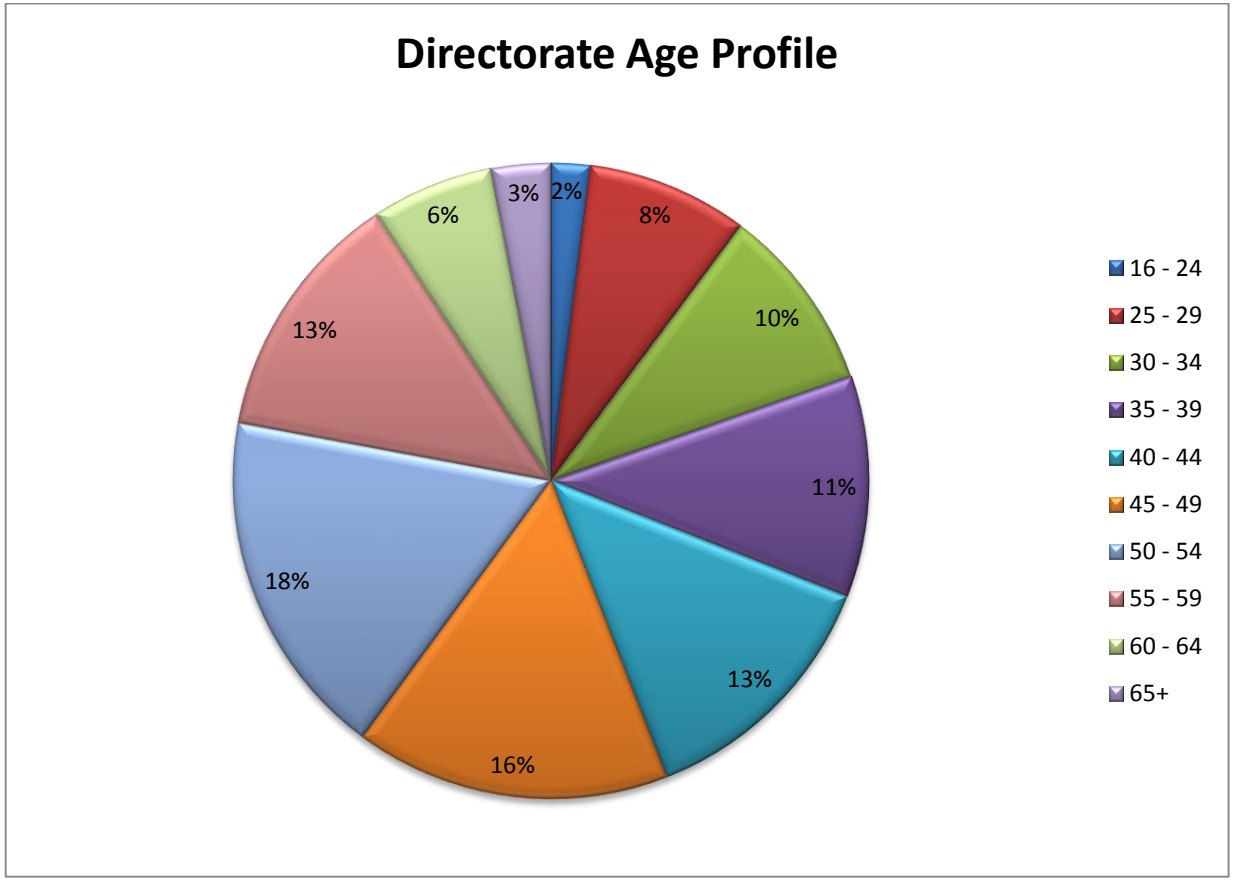
48% (2211) of the total headcount of staff within the Directorate work part time and of those 2091 are female and 120 are male, 95% and 5% respectively. Of the 52% (2428) of the workforce who work full time 1850 or 76% are female and 578 or 24% are male.

Of all those working part time 6% are age 29 or younger, 67% are between the age of 30 – 54 and 27% are 55 or over. It may be over the course of the next five years that the number of part time staff increases as more wish to avail of flexible working options and this may also become more evident with the introduction of shared parental leave.

An increase within the older workforce may also become apparent as the population ages it may be the case that greater numbers of the workforce wish to reduce their hours to look after elderly parents for example. It is likely over the course of this plan that more staff will be recruited to support the move to more Services being offered 24 hours 7 days a week and more staff working fewer hours to meet work life balance requirements.

1.7.2.3 Age Analysis

As the population demographic is aging so too is our workforce as demonstrated in the pie chart below. 40% of the Directorate's workforce is aged 50+ and as indicated earlier it is likely that more staff will work longer.



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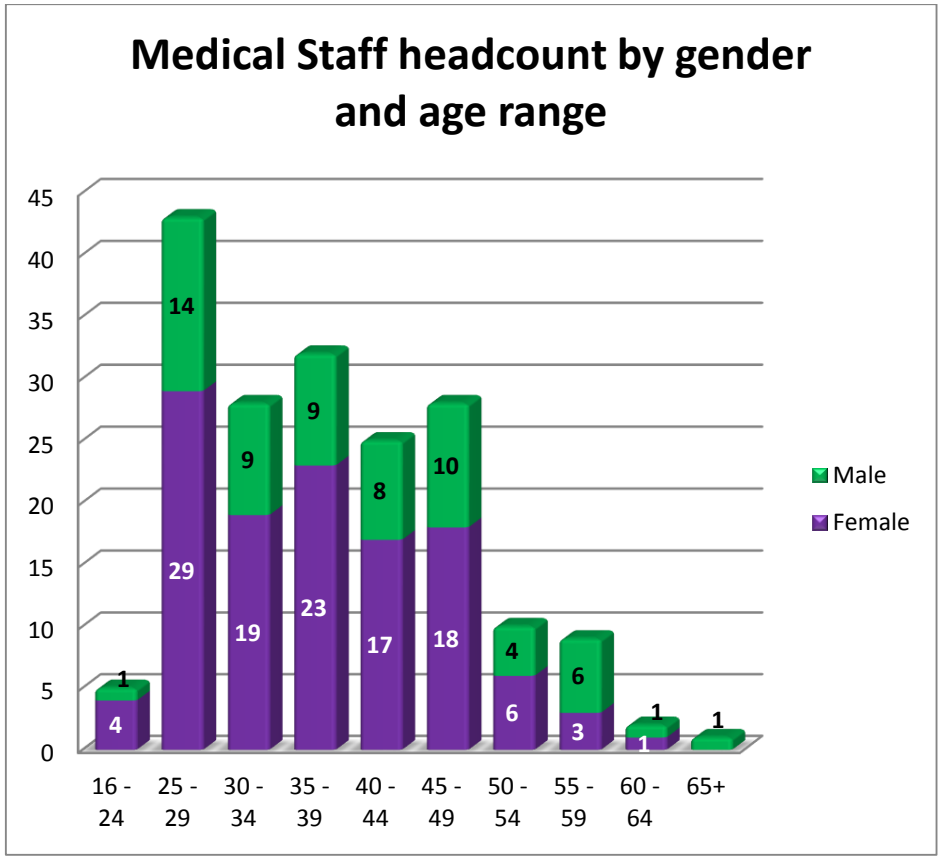
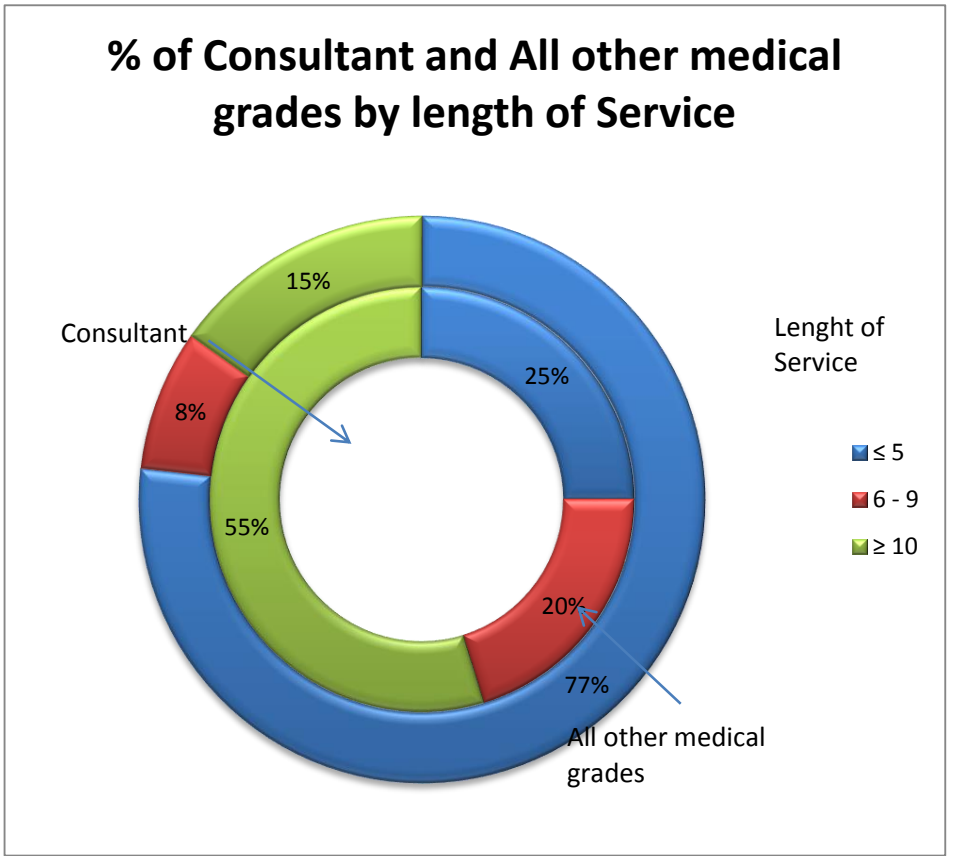




The Medical workforce is a relatively young workforce with the majority of staff falling within the 25 – 29 age bracket. The average age of a Consultant within the Directorate is 37 years and 7 months and 55% of the consultant workforce has 10 or more years' Service. This compares to the average age of 46 years and 7 months of a Consultant across the Trust.

In terms of the number of staff within the Directorate who are aged 55 or over there are 1024 or 799.1 wte. Of those 120 are in band 7 or above positions as highlighted in Table 12 below. 83 are in the range 55 – 59, 31 aged 60 – 64 and 6 are, 65 or over.

Table 12

Age Range	Band	H/count	WTE
55 - 59	7	50	48.01
	8A	11	10.53
	8B	6	4.60
	8C	2	1.29
	8D	5	5.00
	Medical Staff	9	5.68
55 - 59 Total		**83**	**75.11**
60 - 64	7	21	18.86
	8A	5	3.80
	8B	1	1.00
	8C	2	1.80
	Medical Staff	2	2.00
60 - 64 Total		**31**	**27.46**
65+	7	4	3.23
	Medical Staff	2	0.30
65+ Total		**6**	**3.53**
Grand Total		**120**	**106.10**

A further breakdown is provided by Service Group Area in Table 13 overleaf.

Table 13

Service area	AGE RANGE	BAND	H/count	Wte
LEARNING DISABILITY	55-59	Medical Staff	1.00	1.00
		7	6.00	6.00
		8a	3.00	3.00
		8d	2.00	2.00
	60-64	7	2.00	2.00
		8a	2.00	1.00
LEARNING DISABILITY Total			**16.00**	**15.00**
MENTAL HEALTH	>=65	Medical Staff	1.00	0.30
		7	1.00	1.00
		8a	1.00	1.00
	55-59	Medical Staff	8.00	4.68
		7	11.00	10.80
		8a	2.00	1.53
		8b	2.00	1.00
		8d	1.00	1.00
	60-64	Medical Staff	1.00	1.00
		7	5.00	5.00
		8a	2.00	1.80
		8c	1.00	1.00
MENTAL HEALTH Total			**36.00**	**30.11**
OLDER PEOPLES SERVICES	>=65	Medical Staff	1.00	0.00
		7	2.00	1.23
	55-59	7	32.00	30.21
		8a	4.00	4.00
		8b	3.00	2.60
		8d	1.00	1.00
	60-64	Medical Staff	1.00	1.00
		7	14.00	11.86
		8a	1.00	1.00
		8b	1.00	1.00
OLDER PEOPLES SERVICES Total			**60.00**	**53.91**
PSYCHOLOGY SERVICES	55-59	7	1.00	1.00
		8c	2.00	1.29
		8d	1.00	1.00
	60-64	8c	1.00	0.80
PSYCHOLOGY SERVICES Total			**5.00**	**4.09**
ADMIN & CLERICAL	55-59	8a	3.00	3.00
ADMIN & CLERICAL SERVICES Total			**3.00**	**3.00**
Grand Total			**120.00**	**106.10**

Succession planning will need to be addressed during the course of the plan particularly in light of the number of staff considered to be in high level senior positions. The Trust has in place a Succession Planning Model “Growing Our People Today for Tomorrow”. To date five staff from the Directorate have participated in the Succession Planning programmes. Given the identified issues for the systemic need to invest in Succession Planning within the Directorate, this is a key action measure for the Action Plan.

1.7.2.4 Turnover

Turnover is considered a key workforce measure considering the number of staff who leave in a period as a percentage of the number of staff employed during the same period. The formula used within the Trust is:

$$\frac{\text{Number of leavers in period}}{\text{Average number of staff employed in period}} \times 100$$

The average number of staff in the period is taken at the start of the period added to the number working at the end of the period and the total divided by two.

Whilst there is no set level at which point employee turnover starts to have a negative impact on an organisation's performance some key issues for consideration include:-

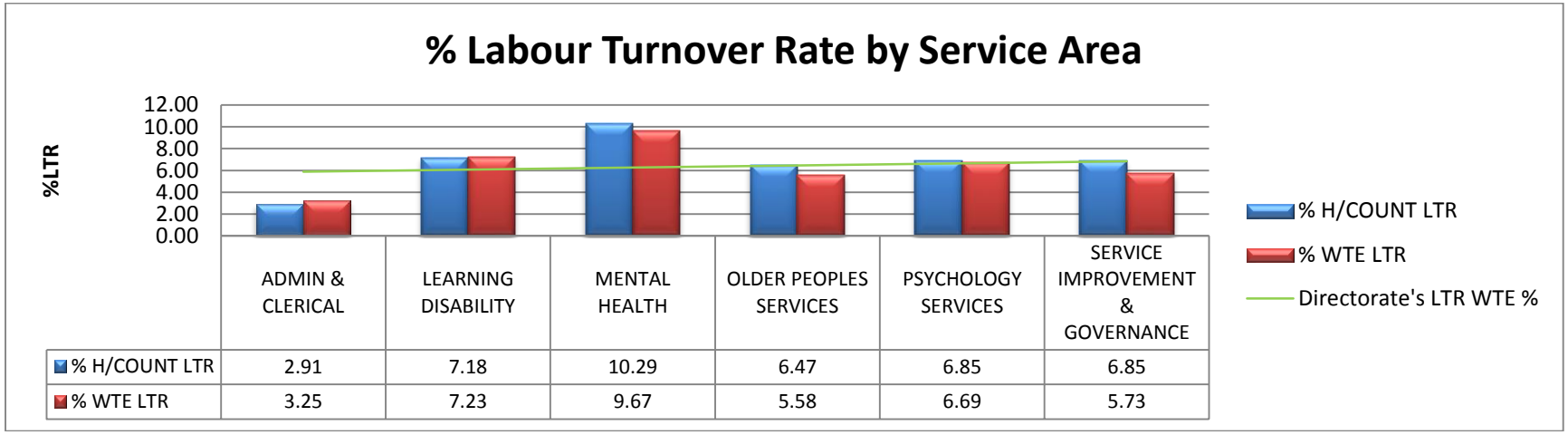
- The reason why people are leaving
- The average length of time taken to recruit
- The average length of time taken to train a new recruit
- The grade of people leaving
- The area in which the people are leaving

Over the course of the twelve month period ending 30 September 2014 the Trust's overall turnover rate was 4.88% which compares to 5.84% within the Directorate.

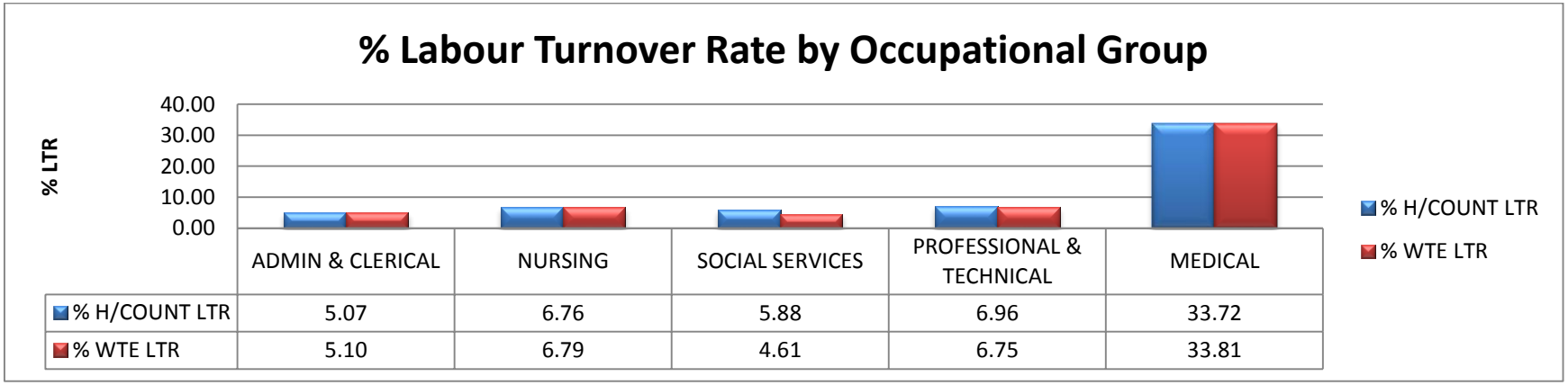
Table 14 below indicates the number of leavers from the Directorate over the past five years and notably the number of leavers has remained relatively static.

Table 14

Number of Leavers			
Year	H/count	WTE	+/- from previous year wte
2010/11	309	273.04	
2011/12	330	287.44	14.4
2012/13	316	268.79	-18.65
2013/14	309	272.76	3.97
2014/15	343	267.84	-4.92



	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE
% H/COUNT LTR	2.91	7.18	10.29	6.47	6.85	6.85
% WTE LTR	3.25	7.23	9.67	5.58	6.69	5.73



	ADMIN & CLERICAL	NURSING	SOCIAL SERVICES	PROFESSIONAL & TECHNICAL	MEDICAL
% H/COUNT LTR	5.07	6.76	5.88	6.96	33.72
% WTE LTR	5.10	6.79	4.61	6.75	33.81

Perhaps more important is the reason why employees are leaving and Table 15 highlights the reasons why people have left the Directorate over the past five years.

Table 15

REASON FOR LEAVING	2010-2011		2011-2012		2012-2013		2013-2014		2014-2015	
	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
Age Retirement	58	50.02	64	52.17	73	61.34	35	31.78		
Caring for children					1	0.53				
Completion of training			1	1						
Death	4	3.31	2	2	2	2	3	1.99	4	3.34
Disciplinary action	4	3.07	5	4.74	3	3	3	3	4	3.25
End fixed term contract	62	60.8	63	62.06	64	61.9	48	46.36	15	12.35
External Secondee Out							1	1	1	0.8
Family	1	1	1	0.53						
Full time education	1	1			2	1.33	4	3.8		
Further education/training	8	7.08	13	9.54	1	1	2	2		
Ill Health Retirement	18	15.36	19	16.85	12	9.86	9	7.38	17	14.76
Ill Health Termination	27	20.75	28	22.58	22	17.96	20	15.74	34	20.37
Medical Rotation							13	12.6	41	39.2
Other Employment	60	55.21	81	70	51	44.84	15	12.97		
Personal	20	15.79	15	14.13	10	8.03	3	2.08		
Premature/Efficiency	2	2								
Premature/redundancy	1	1	2	2						
Promotion	1	1	4	3.65	8	7.5	6	4.86		
Redeployment					5	4.53				
Resignation							106	91.13	104	72.32
Retirement							25	21.48	96	76.83
Secondment	2	1.5	1	1	1	1	1	1		
Transfer			1	0.5	17	15.6	8	6.99		
Transfer to other HSC Org							2	2	17	15.8
Unknown	32	27.39	13	9.78	21	18.16	3	2.8		
Voluntary Early Retirement (Abated)			3	2.59	1	0.61	1	1		
Voluntary Early Retirement	8	6.76	14	12.32	3	2.62				
VER - Actuarilly Reduced							1	0.8	10	8.82
Voluntary Redundancy					9	6.98				
GRAND TOTAL	**309**	**273.04**	**330**	**287.44**	**316**	**275.21**	**309**	**272.76**	**343**	**267.84**

It should be noted, whilst sickness absence remains a major concern within the Directorate, considerable efforts have been made to address the issue and the year ending 31st March 2015 demonstrates the highest number of ill health terminations over the past five years.

1.7.2.5 Sickness Absence

The overall sickness absence rate for the Directorate for the twelve months ending 31st March 2015 was 7.59% and is the highest it has ever been since the establishment of the Belfast Trust, as demonstrated in Table 16 below. Also included is the current year to 31 December 2015, highlighting 6.81% for the nine months.

ASPC sickness absence rates

SICKNESS ABSENCE	Apr 11 - Mar 12	Apr 12 - Mar 13	Apr 13 - Mar 14	Apr 14 - Mar 15	Apr 15 - 31 Dec 15
TARGET BY MARCH %	**6.01**	**5.31**	**5.00**	**6.71**	**7.40**
OVERALL ABSENCE % FOR Social & Primary Care Services	6.39	6.78	7.46	7.59	6.81

Table 16

It should be noted that following the implementation of HRPTS, sickness absence from 2013/14 to 2014/15, has been recorded by managers in hours on Manager self-Service.181 different reasons why staff were off sick have been recorded during the course of the year. Table 17 demonstrates the top eight reasons with stress being cited as the second reason and back ache/pain as the fifth highest.

REASON FOR ABSENCE	H/C	HRS LOST
General Debility	960	102,457
Stress	331	96,450
Vomiting	245	23,598
Influenza	237	8,590
Back ache/pain	181	27,711
Other Chest and Respiratory	190	13,474
Grief/Bereavement	134	22,458
Post-Surgical Debility	95	25,619

Table 17

The total number of staff who were absent due to sickness over the course of the year ending 31st March 2015 was 2,633 which equates to 56% of the Directorate's total workforce. A total of almost 616,000 hours were lost, which equates to 315.89 wte or 8.1% of the workforce were absent for the full year. Of the 2,633 staff who were absent during the year, 1,584 were absent on 1 occasion, 718 on 2 occasions, 227 on 3 occasions, 83 on 4 occasions, 16 on 5 occasions, 4 on 6 occasions and 1 on 7 occasions.

The Directorate has taken steps to improve levels of attendance. There has been an increase in training for Managers / Supervisors in the management of absence, more consistent application of the Management of Absence Policy, more focus on the management of long-term absence and the referral of cases to Case Manager.

The Trust has recently launched its focus on Health and well-being strategy and action plan and as part of this renewed approach to Health and Wellbeing, a series of mandatory 1.5hour Attendance Management workshops will take place for all managers within the Directorate in September 15. The purpose of the workshops is to "walk through" the new Manager's Toolkit for Managing Sickness Absence, which is designed to provide practical support and advice for line managers, ensuring consistent and fair application of the Managing Attendance Protocol.

The Toolkit includes 2 new requirements from Managers:

1. Implementation of attendance management meetings where staff have unacceptable attendance.
2. Completion of a quarterly return to the Co-Director and HR in relation to management actions where all staff reaching trigger points / long term sickness leave.

A letter from the HR Director to all staff highlighting the new focus on Health and Wellbeing and Attendance Management was issued on the Hub on 22 May, and provided to all managers to discuss at team meetings and return to work interviews.

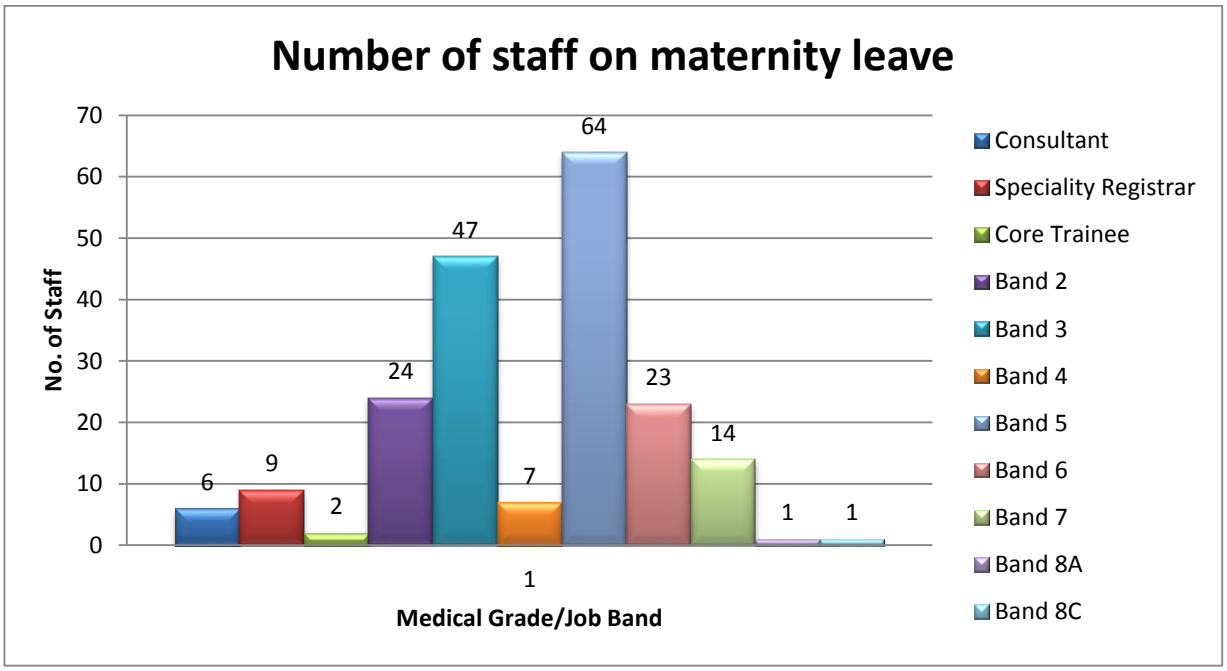
In addition, more detailed analysis on the reasons for sickness absence within the Directorate will take place over July and August, to ensure any relevant support / interventions can be considered in line with the 2015/16 Health and Wellbeing Action Plan.

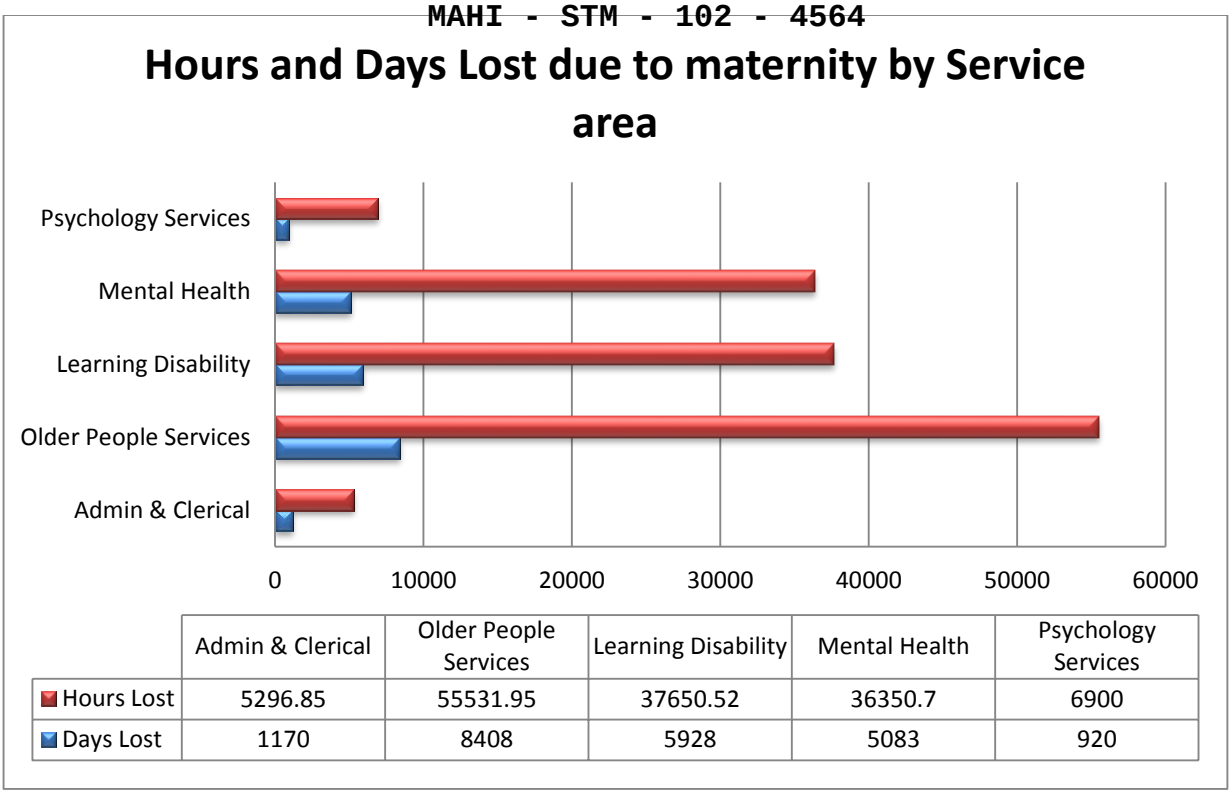
HR and Occupational Health will be launching a FAQ guide for all employees in the Autumn in relation to sickness absence, in addition to delivering bespoke training sessions for employees regarding their responsibilities under the Managing Attendance Protocol.

The HR Directorate will be implementing the Health and Wellbeing Action Plan within the Directorate, benchmarking will also take place with additional similar Service providers from other Organisations to identify any best practices the Directorate can undertake to reduce its absence cost.

1.7.2.6 Maternity Absence

During the course of the year ending 31 March 2015 there were a total of 198 staff off on maternity leave with a total of 149,432.52 hours and 22,492 days lost to the Service as illustrated in the graphs below. The average age of those off on maternity leave was 33.33 years.





	Admin & Clerical	Older People Services	Learning Disability	Mental Health	Psychology Services
Hours Lost	5296.85	55531.95	37650.52	36350.7	6900
Days Lost	1170	8408	5928	5083	920

In the previous year a total of 202 staff had time off owing to maternity leave with 23,825 days lost and 149,278.7 hours. It is anticipated therefore during the course of the next five years that this level of absence owing to maternity leave is set to continue.

Of the 198 staff who had time off due to maternity, 95 also had time off during the year owing to sickness as illustrated in Table 18 overleaf.

Reason for Absence	Number of Staff
General Debility	30
Other pregnancy rela	9
Back ache/pain	5
Morning sickness	5
Vomiting	5
Influenza	4
Post Natal	4
Stress	4
Diarrhoea	3
Other chest and resp	3
Ante Natal	2
Depression	2
Gastroenteritis	2
Oth ear/nose/throat	2
Road Traffic Accidnt	2
Urinary tract infect	2
Accident-work relatd	1
Grief/Bereavement	1
Hypertensive disease	1
Inj to foot or ankle	1
Inj to shoulder/arm	1
Migraine	1
Other inj/fracture	1
Other musculoskeleta	1
Sinusitis	1
Sore throat	1
Stress-Work Related	1

Table 18

During the course of the plan those off on maternity leave could be monitored to ascertain the length of time off due to sickness and if the sickness occurs before or after the period of maternity leave. This analysis would support the review and impact on backfill.

Table 19 below indicates the number of staff off on maternity leave across each of the clinical directorates for comparison purposes.

Staff on Maternity Leave for Period 1 April 2014 – 31 March 2015	Headcount	Hours Lost	Days Lost
Acute & Unscheduled Care	384	285,964.49	42,869
Surgery & Specialist Services	237	190,260.93	27,803
Adult Social & Primary Care	198	150,572.52	22,644
Specialist Hospitals & Womens Health	189	130,491.75	19,588
Childrens Community services	76	54,515.3	8,018
Grand Total	**1084**	**811,804.99**	**120,922**

Table 19

1.8 Step 5 : Developing an Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned Services, even if this means some further Service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change.

The main major developments for the Directorate over the next five years will be focused around the implementation of Transforming Your Care and the move from Acute to Community based Services. In relation to the Action Plan required to implement and deliver this workforce plan, below in Table 20 are the key elements required going forward. As expected with any major reform and modernisation programme, timescales below are indicative and set to change as they are subject to communication, consultation and due process.

Table 20	**Action Plan for Adult Social and Primary Care 2015 to 2020**		
Service Area	**Action**	**Person Responsible**	**Timescale**
Learning Disability	Completion of MAH Resettlement project, including the redeployment of affected staff	Esther Rafferty	31 March 2016
Learning Disability	Review of community Day Centres and the redeployment of affected staff	Neil Kelly	31 March 2016
Learning Disability	Reduction in the sickness absence rate within the Service area from 9.03% to 8.03%	John Veitch	31 March 2016
Learning Disability	Confirmation on future direction of Iveagh linked with CAMHS and implementation of outcomes	Esther Rafferty	31 March 2020
Learning Disability	Confirmation of the required workforce going forward within all areas	John Veitch	31 March 2016
Mental Health	Relocation of DGU & redeployment of affected staff	Mel Carney	31 March 2016
Mental Health	Completion of CAMHS review and implementation of outcomes	Billie Hughes	31 March 2020
Mental Health	Proposed opening of the new Inpatient Mental Health Unit	Mel Carney	31 March 2018
Mental Health	Proposed review of Approved Social Worker Role to be completed by March 2016	Mary O'Brien	31 March 2016
Mental Health	Proposed review of the need for Eating Disorder Services	Peter Bohill	31 March 2018
Mental Health	Proposed review of the provision of Day Services	Peter Bohill	31 March 2016
Mental Health	Implement the outcome of the Criminal Justice Service Review as it impacts on Unscheduled Care Court Service	Mel Carney	31 March 2017
Mental Health	Reduction in the sickness absence rate within the Service area from 7.8% to 6.8%	Barney McNeany	31 March 2016
Mental Health	Confirmation of the required workforce going forward within all areas	Barney McNeany	31 March 2016

Older Peoples Services	Implement outcome of district nursing review	Gabby Tinsley	31 March 2020
Older Peoples Services	Roll out Keith Hurst toolkit to all relevant areas	Bridget Denvir	31 March 2016
Older Peoples Services	Implement outcome of Social Work & Social Care Review	Katie Campbell	31 March 2020
Older Peoples Services	Extend BCH Direct in conjunction with IMPACT developments	Catherine Collins	31 March 2016
Older Peoples Services	Promotion of Care of the Elderly as an attractive area to work	Marie Heaney	Ongoing
Older Peoples Services	Introduction of Acute Care At Home Service	Gabby Tinsley	31 March 2016
Older Peoples Services	Complete merger of Reablement & Social Care Rapid Response – Katie Campbell	Katie Campbell	31 December 2015
Older Peoples Services	Proposed review of Adult Physical Sensory Disability Day Opportunities	Bernie Kelly	31 March 2016
Older Peoples Services	Proposed review of Domiciliary Care Workforce linked to development of regional workforce plan	Marie Heaney	31 December 2015
Older Peoples Services	Reduction in the sickness absence rate within the Service area from 10.37% to 9.37%	Marie Heaney	31 March 2016
Older Peoples Services	Confirmation of the required workforce going forward within all areas	Marie Heaney	31 March 2016
Directorate	Reduction of Sickness Absence by 1%	ALL	31 March 2016
Directorate	Implementation of Attendance management Toolkit to reduce sickness absence including health and well-being at work strategy	ALL	31 March 2016
Directorate	Implementation of Nurse Revalidation process	ALL	Ongoing
Directorate	Implementation of Normative Staffing	ALL	Ongoing
Directorate	Implementation of Recruitment & Retention Strategies particularly in hotspot areas older people Services and medical staff	ALL	Ongoing
Directorate	Implementation of NISCC Registration for all Social Care Workers in domiciliary and day care	ALL	Ongoing
Directorate	Ensure statutory and mandatory training compliance	ALL	Ongoing
Directorate	Develop and implement Succession Planning Strategy – Growing our People Today for Tomorrow	ALL	31 March 2016

Directorate	Implement Induction Programme for all new recruits	ALL	Ongoing
Directorate	Promote age awareness and age diversity as more staff remain in the workplace longer	ALL	Ongoing
Directorate	Promote Living the Values and Behaviours	ALL	Ongoing
Directorate	Develop new roles to support the 'shift left'	ALL	Ongoing
Directorate	Develop the Workforce Plan detailing the required workforce going forward in terms of WTE's Grades, Band, Skill Mix and costings	ALL	Ongoing

1.8.1 Pressure Points Identified for Supply and Demand

A number of key areas have been identified within Directorate that need to be considered to ensure supply and demand measures can be met. Many challenges are likely to arise within the next five to ten years as a result of various dynamics within the workforce. These include the following:

- The numbers and the health and well-being of staff, particularly those aged 55 or older and in the front-line Service areas;
- The numbers of staff aged 45 – 54 years who will start to retire within the next five to ten years (or who may otherwise be more liable to leave the Service for other reasons), particularly in the front-line Service areas;
- The impact and cost of Normative Staffing;
- The impact and cost of new models of Service delivery. Productivity gains and efficiency savings are becoming increasingly difficult to achieve, with long term demand drivers likely to significantly outweigh improvements in productivity;
- The impact of new technology and the need to develop new skills to fully utilise the resource;
- A global shortage of nurses and geriatricians and other countries competing for newly qualified or existing staff, offering more attractive terms and conditions;
- The impact of *Delivering Care: Nurse Staffing in Northern Ireland*. The Framework is being developed using a phased approach to include nursing and midwifery workforce ranges across hospital and community settings in all programmes of care;
- The impact key policies, strategies and Service developments will have on specific Service areas, such as, district nursing, specialist nursing, mental health nursing (eg. Transforming Your Care, Bamford Action Plan, Dementia Strategy, Donaldson Review);
- The impact of the new Mental Health In-patient unit with single room patient accommodation and difficulties associated with observations and assessments;
- The impact of other professions e.g. medical workforce and the difficulties in recruiting to ED Departments and General Practice;
- Future of workplace – Nurse Consultants and Advanced Practice Nurses;
- The need to develop new skills for the autonomous practitioner to support the shift left from acute to community across all staff groups.
- The need to develop capacity and capability to develop robust workforce plans to meet the growing changing needs of the population, resulting in an engaged workforce with the required skills, knowledge, competencies, behaviours and values;
- Recruitment and Retention difficulties resulting in inappropriate grade and skill mix;
- A systemic need for succession planning.

SECTION 2

2.1 MENTAL HEALTH SERVICES

This section of the plan will highlight workforce planning issues associated with the provision of Services within mental health. The Trust's mental health teams provide Services to the population of Belfast and across the region through Adult Inpatient Services, Recovery/Rehabilitation, CAMHS and Primary Care Partnerships. Mental health Services are provided by a workforce of 954 staff, details and an analysis of which are provided later in this section.

Mental health Services are separated into four distinct Service areas:-

- In-patient Service, which has 86 beds located on two sites the Mater and Knockbracken sites
- CAMHS, which is located at Beechcroft, has 33 beds
- Primary Care Services, which includes the mental health therapy Hubs, the Court Diversion Scheme and the Eating Disorder Service
- Community Mental Health Services : comprising of - 4 geographical Community Mental Health Teams, Primary Mental Health Teams, One Point of referral, Early Interventions, Mental Health and Deafness, Community Forensics, Huntingtons Team, Perinatal Service, Community Support Team, 342 Ormeau Road and Weavers Hill (Supported Living), Resettlement Team.

2.1.1 The Drivers

- There is a drive to shift from acute to community mental healthcare Services and deliver a person centred approach.

This has been highlighted in a range of recent regional reports including: The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007, Transforming Your Care – A Review of Health & Social Care in Northern Ireland December 2011. This shift from acute Service provision to one which is more community based is likely to impact on the resources needed to deliver these Services safely. This focus to become person centred and deliver Services in the community is reflected within Adult Social & Primary Care values and principles.

Services should be person centred (i.e. Service users will have their rights respected and be supported to keep control of their lives)

- There is drive to provide for patient safety and high quality Services.

This has been highlighted in a range of recent national and regional strategies and reports including Quality 2020 (DHSSPS, 2011c);The Francis Report (2013); The Cavendish Review (2013); The Keogh Report (2013) and The Berwick Report (2013).

- Anticipated Mental Capacity Bill

The draft Mental Capacity Bill will introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a physical or mental illness) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision for themselves.

The bill will work to ensuring that an individual's capacity to make decisions about their health, care and personal welfare is respected. Appropriate safeguards are also included to ensure that an individual's best interests are respected where their capacity is comprised. This is again in line with the person centred approach.

2.1.2 The Future Models of Service Delivery

Services will be planned, implemented and evaluated in partnership with users and carers

2.1.2.1 In-Patient Services

Table 1 illustrates the changing provision of inpatient mental health Services within the Belfast Trust.

Mental Health Inpatient Services			
	Previous Inpatient bed provision prior to 2013	**Current Inpatient bed provision – since 2013**	**Planned Inpatient bed provision - 2017**
	Avoca 16	Avoca 9	BCH 80
	Rathlin 24	Rathlin 24	
	Windsor 35	Mater 53	
	Mater 55		
Total	**130**	**86**	**80**

Table 1

The preferred model of Service delivery will be the centralisation of inpatients facility on the Belfast City Hospital site. There will be a total of 80 inpatient beds, including 6 Psychiatric Intensive Care Beds located in the new psychiatric unit. The number of beds has been reduced, by 50, from 130, which were located at three sites, Knockbracken HealthCare Park, the Mater Infirmorum Hospital and the Belfast City Hospital. The implications for the workforce of this change are provided later in this section.

2.1.2.2 In-Patient Recovery Services

There will be a total of 54 recovery beds within the Trust, which will be a reduction from the current position of 110 beds. In future recovery Services will be based in the Shannon Clinic (34 beds), with a further 20 beds in Clare Ward, low secure unit. There will be a review of the Neuro-Rehabilitation Unit (NRU) to identify the need for these Services and how they can be best met in the future. The outcome of this review, when completed, will be incorporated into the plan. In meeting the recommendations set out in the Bamford Review the patients, whose Services are provided in the Dorothy Gardner Unit, will have these provided in the community from 1 February 2016. Currently there are 10 patients being cared for in the unit, with another 5 in a phased discharge process.

Where possible staff will be given the opportunity of following the patients and provide the care in a community setting.

The care of the patients residing in the community will continue to be managed by 5 teams split geographically in addition to the Clozapine and Lithium Service.

2.1.2.3 CAMHS

A review of the CAMHS has identified the need for additional resources including inpatient provision; a primary mental health team in the community covering the Belfast & South Eastern Trusts and the further development of the Crisis Assessment & Intensive Intervention Team (CAIIT).

The Service is currently awaiting the outcome of the Acute CAMHS review to outline a clear commissioning statement and the role of Beechcroft within the stepped care model. There will be 33 beds available for the CAMHS, comprising of 18 beds for adolescents and 15 beds for children.

The development of a one point of referral system for the whole of the CAMHS will be completed during the course of this workforce plan. The CAIIT will develop and provide an alternative to hospital admission and respond to A&E Central point of referral. The Crisis Assessment and Intensive Intervention Team which provides an alternative to acute intervention will be expanded and provide a Service to the South Eastern Trust.

The Personality Disorder Service will be reviewed as part of the Regional review into this Service. Recommendations coming from the review will be incorporated into this workforce plan, as and when it is concluded.

2.1.2.4 Primary Care Partnerships – Referral Hub

Following a successful pilot in 2013 the local Commissioning Groups have made a commitment to the establishment of Mental Health Talking Therapy Hubs across Belfast. Currently there are two Hubs in operation for east and west Belfast. The aim of the Hub will be early intervention when someone is referred by their GP with a mental health problem and they will be triaged by the Co-ordinator (Band 7) and where necessary will be referred on for assistance. There is a one week target for making the initial contact with the individual. The Hubs will enable emotional well-being and mental health care to be co-ordinated by providing an all-inclusive approach from a variety of partners. The Services to be provided to patients will include; counselling; cognitive behaviour therapy; facilitated self-help; life coaching and signposting to other support Services e.g. fitness centres.
During the course of this plan the Trust will be establishing a Mental Health Hub in north and south Belfast. In total there will be four Talking Therapy Hubs across the Trust and it is anticipated that it will take up to 2 years for full implementation of this project. This Service will be delivered in partnership with external agencies which will assist in the provision of Services, such as life coaching skills, cognitive therapy and Gyms.

2.1.2.5 Day Centre Provision

Given the underutilisation of the Services spread over the locations the proposal is to centralise Trust day Services from the two centres to one. This project is currently at the public consultation stage with a closing date of 26th November 2015. Once this has been completed there will be a review to determine if a more central location would be more suitable than either of the two centres that are currently open.

2.1.2.6 Court Diversion Scheme

The current court diversion scheme, whereby a dedicated Service is provided to the court Service is no longer sustainable in its current format and will need to change. The existing Mental Health Court Diversion Scheme has been integrated into the 24 hour Unscheduled Care Mental Health Team. At this stage there are no additional resources being put into the Service. This position may change following the completion of the Criminal Justice Service review, which is currently underway. The outcome of this review will impact on the future provision of this Service and will help the Service to plan the way forward.

2.1.2.7 Eating Disorders Day Treatment Service

Currently there is no funding available to develop this Service; however, early developmental work has been carried out to highlight the cost of extra contractual referrals as high cost cases are transferred to England/Scotland. This revenue could be redirected to Day Treatment Services within the Belfast Trust thus making it a more patient centred Service.

The RQIA have conducted a Regional Review into the treatment of eating disorders and the Service is awaiting the outcome of this review to inform its future Service provision.

The local Commissioning Group have confirmed that they will provide recurring funding for a Band 5 to provide an early intervention Service relating to eating disorders.

2.1.2.8 Addiction Services

The Health & Social Care Board are looking to expand the Substance Misuse Liaison Service. This Service provides early intervention and protection of substance misuse related conditions within the general hospital setting. There will be 3 additional posts available for this Service with effect from April 2016.

2.1.2.9 Mental Health – Recovery

2.1.2.9.1 Resettlement Team

This Team was set up to work with Service users who had effectively lived in hospital for the most of their lives who have now been resettled back into the community. The resettlement process is now in its latter stages and the focus of this team is moving towards working with those individuals who require an intensive community rehabilitation Service. There has been significant investment in the Service with more to follow. Investment to date has seen the team increase its staffing levels with the addition of 1 x band 6 OT, 1 x band 6 S/W, 1 band 6 CPN and 3 x band 3 support workers. These posts are in the recruitment process at present. There will be further appointments made of 1x band 7 S/W, 3 x band 3 support workers, 1 x band 7 Psychologist, 1 x band 5 OT in the next six months. This Team will be renamed the Community Rehabilitation Team.

2.1.2.9.2 Adult Safeguarding

The responsibility for the discharge of Adult Safeguarding sits with the Associate Director for S/W for Mental Health and CAMHS with the operational responsibility delegated to the Principle S/W for Mental Health and CAMHS. There has been a significant rise in Adult Safeguarding Referrals in recent months following an assertive awareness campaign. The rise in referrals has necessitated the increase in the workforce within this area with the additionality of 2 x band 7 S/W. 1.5 of these posts are a current cost pressure within the Service area.

2.1.2.9.3 Implementing Recovery through Organisational Change

This was an eighteen month project which concluded in Oct of 2014, the Service area took on three specific challenges from a list of ten as part of the implementation of the project, one of these challenges was to set up a Recovery College, which would deliver co-produced and co-delivered courses open to Service users, carers, family and staff. The programme are currently recruiting 1 x Band 7 Co-ordinator as a cost pressure and it is anticipated that further recruitment of band 4 and 5 staff will be required within the next two years, numbers of which to be agreed as the College develops.

One of the other Challenges was entitled “Transforming the Workforce”, this is targeted at employing peer staff within the programme i.e. staff who have live experience of mental health difficulties. Three staff have been employed to date, these where vacant band 3 posts. It is envisaged that any further band 3 posts within the programme will be considered for peer staff. This will be utilisation of current resources rather than additional posts.

2.1.3 The Workforce required to Deliver the Future Services

This section identifies the resources that the Mental Health Services will need to deliver its Services in the future as highlighted earlier.

The changes that are due to take place throughout the Directorate over the course of the period covered by this plan will result in changes to the workforce. New models of Service delivery, the demands of TYC and the need to ensure that high quality cost effective Services are delivered will have an impact on the resources that are required going forward. These will reflect the needs of the Services in the future and in some areas will mean a radical departure from what is currently in place.

2.1.3.1 Projected Workforce

Table 2 outlines the projected workforce in mental health Services which is based on the starting workforce at the beginning of the plan and the average number of leavers and new starts. Also included are the known workforce changes in relation to the projects currently underway or planned to be completed during the course of this plan. The plan projects an increase in the workforce in the Service area by 22 staff, which is due to the fact that on average there were more starters than leavers over the last 5 years impacting on the projected workforce.

Mental Health Services Workforce Projections 2015/2020

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in Post at 31 March	954	960	957	942	959
Average No. of Leavers *	-74	-76	-76	-76	-76
Average No. of starters *	86	95	95	95	95
Reviews	-6	-22	-34	-2	-2
Total indicative projected staff in post 1 April	960	957	942	959	976
Net Variance	6	-3	-15	17	17

* figures for 2015/16 are actual figures

Table 1

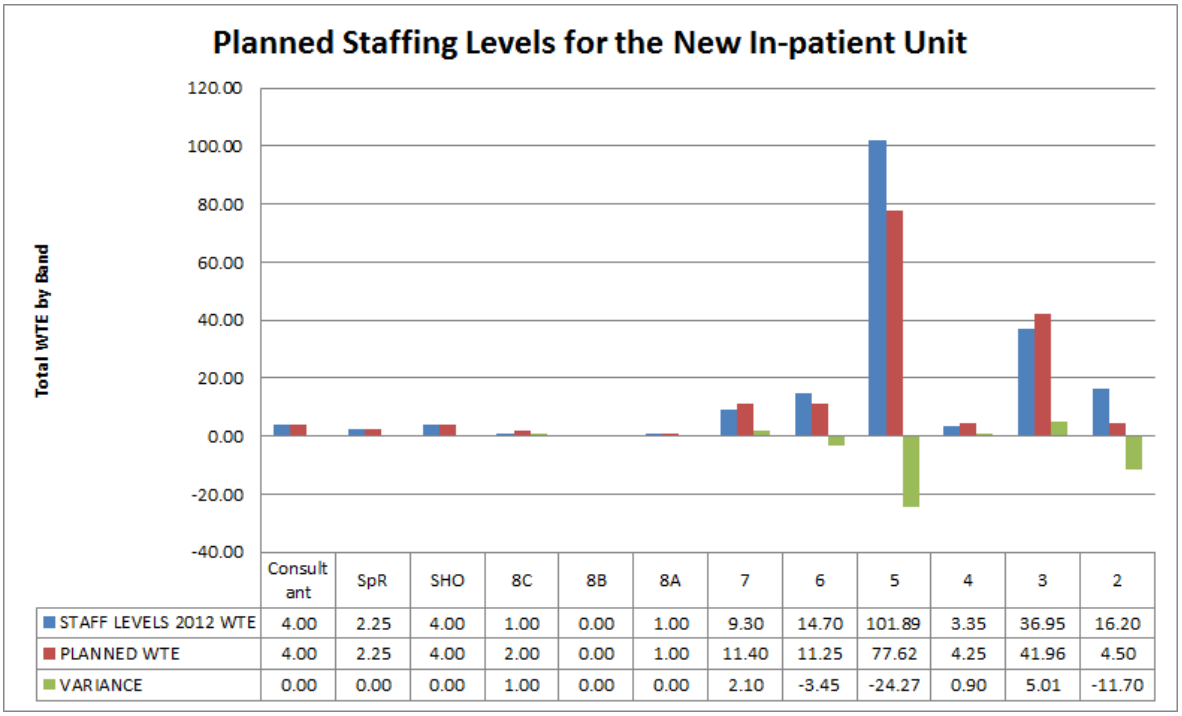
The resources identified by Service area are based on the need to deliver Services as they are currently planned. These may be subject to change to accommodate changes that arise during the period of the plan, but are not yet identified.

Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs

2.1.3.2 In-Patient Unit

Following the completion of the new in-patient unit, scheduled for August 2017, being built on the Belfast City Hospital site there will be capacity for 80 patients to be treated within the Trust. Graph 1 highlights the resources required in the new in-patient unit and compares these to the resources that were previously required to provide the Services. In the new unit all patients will have their care provided in individual rooms. The move to individual rooms, as opposed to wards is a progression of the Trust's approach to care provision in the future. It provides the patient with the privacy of their own room, which provides a place to go if they are stressed, thereby helping to reduce stress levels and assisting patient care. The individual rooms are more secure, providing greater protection of the patient's possessions.

There will be implications for the staff as it may take more time to check on patients in their own rooms as it would have on the wards, but this has been factored into the staffing requirements needed to provide the Service.



	Consultant	SpR	SHO	8C	8B	8A	7	6	5	4	3	2
STAFF LEVELS 2012 WTE	4.00	2.25	4.00	1.00	0.00	1.00	9.30	14.70	101.89	3.35	36.95	16.20
PLANNED WTE	4.00	2.25	4.00	2.00	0.00	1.00	11.40	11.25	77.62	4.25	41.96	4.50
VARIANCE	0.00	0.00	0.00	1.00	0.00	0.00	2.10	-3.45	-24.27	0.90	5.01	-11.70

Graph 1

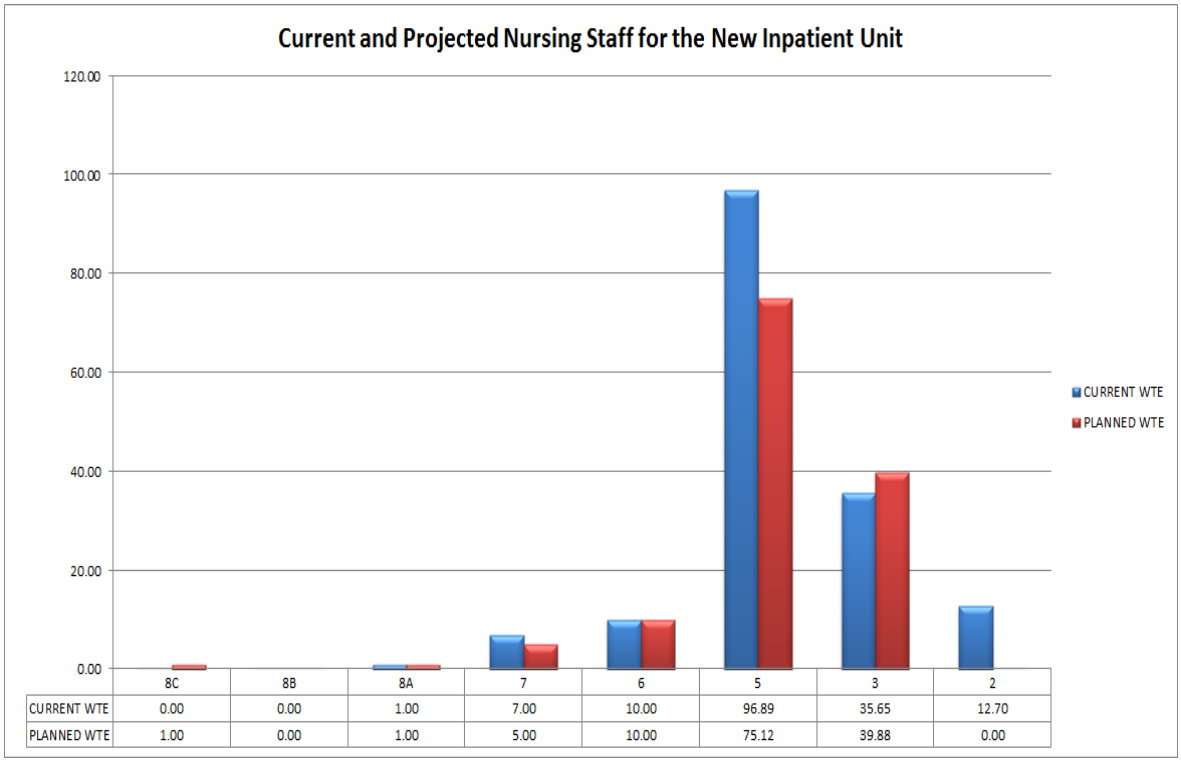
It is expected that there will be a decrease in the total number of staff required to provide the Services in the new in-patient unit than was needed before. Overall, including all bands of staff, the number of staff will reduce from 194.64 wte to 164.23 wte.

There will be an increase of Band 8c managers from 1 to 2 and there will also be a slight increase in the number of Band 7 staff by 1.0 wte; however there will be a significant reduction in Band 5 staff by 24.27 wte, which is due to the reduction in the number of patients that will be treated in the new unit. The table also appears to show a significant decrease in the number of Band 2 staff needed in the new unit from 16.2 to 4.5 wte; however this is due to the regrading of the nursing support staff following the Agenda for Change review of their banding. Some of those staff who have been regraded will be included in the Band 3 staff numbers in the new unit.

The new Mental Health In-patient Unit will see an overall reduction of 31.24 wte nursing staff, when compared to the resources needed in the previous facilities. The skill mix will however remain unaltered at 70:30 registered to support staff.

Nursing Skill Mix	Current WTE	Planned WTE
Registered	114.89	92.12
Support	48.35	39.88
Total	**163.24**	**132.00**

Table 3



Graph 2

2.1.3.2 Recovery – Community

Through the continued progress achieved under TYC more patients/Service users will be provided with the opportunity to return to the community. To ensure that the new model of Service delivery is achieved the resources required are identified in table 4.

Staff Required	Number of Staff Required
Team Leaders	8.0
Social Workers	16.0
Community Psychiatric Nurses	22.0
Occupational Therapist (Band 7)	1.0
Occupational Therapist	4.0
Psychologist	4.0
Dual Diagnosis Worker	1.0
Phlebotomists	2.0
Band 3 Support Staff	16.0
Band 7 Practitioners	6.0
Full Weight Psychiatrist	1.0
Band 6 Nurse	1.0
Care Co-ord. Band 7	2.0
Clinical Services Manager	1.0

Table 4

2.1.3.4 Primary Care Services

The Hubs, which have been outlined earlier in this plan will meet weekly and will require the Trust staff highlighted in the table 5 to deliver the Services. In addition to the Trust employees the Services will be provided by a number of local private, community and voluntary organisations.

Staff Requirements for Therapy Hubs	
Band	**Required**
Band 7	4.0 WTE
Band 4	1.0 WTE
Band 3	2.8 WTE

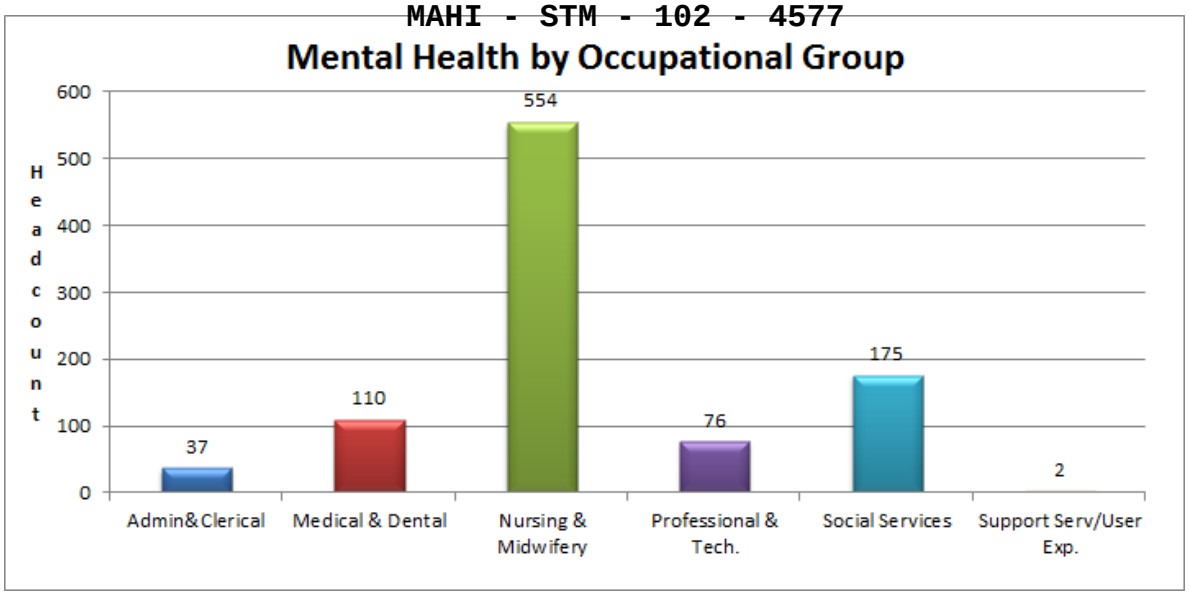
Table 5

There will be a review of Day Care Services undertaken, by the Service area, during 2015/16 and the recommendations coming out of this review will be used to plan the future provision of Services within Day Care.

2.1.4 Workforce Supply

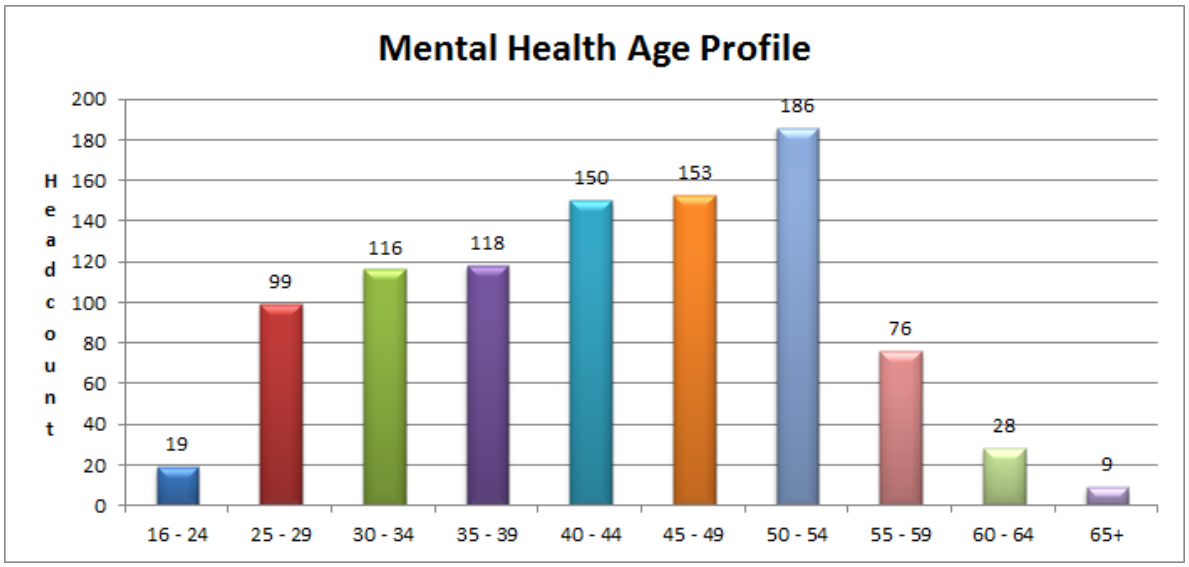
The workforce that has been identified in this workforce plan will in the main be made up from the existing workforce, with the need, in some areas, for reskilling or new staff. This section of the report looks at the resources that are currently available within Mental Health Services, which is the second largest of the Service areas within the Directorate and is based on the staff in post at 31 March 2015.

Graph 3 highlights that over half of the workforce (58%), within Mental Health is made up of nursing staff, and 22% are social Services staff.



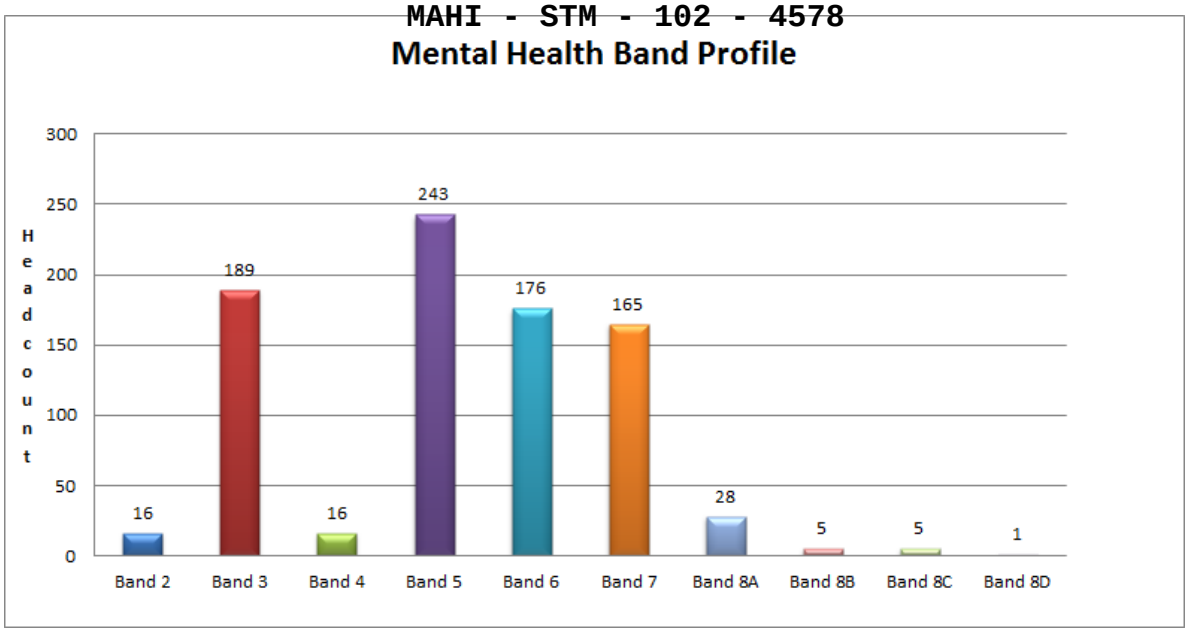
Graph 3

The age profile of staff working in Mental Health Services is provided in the graph 4. There is a fairly even distribution of staff across the age ranges, with the largest group of staff aged between 50 and 54, which has almost 20% of the workforce within the Service area.



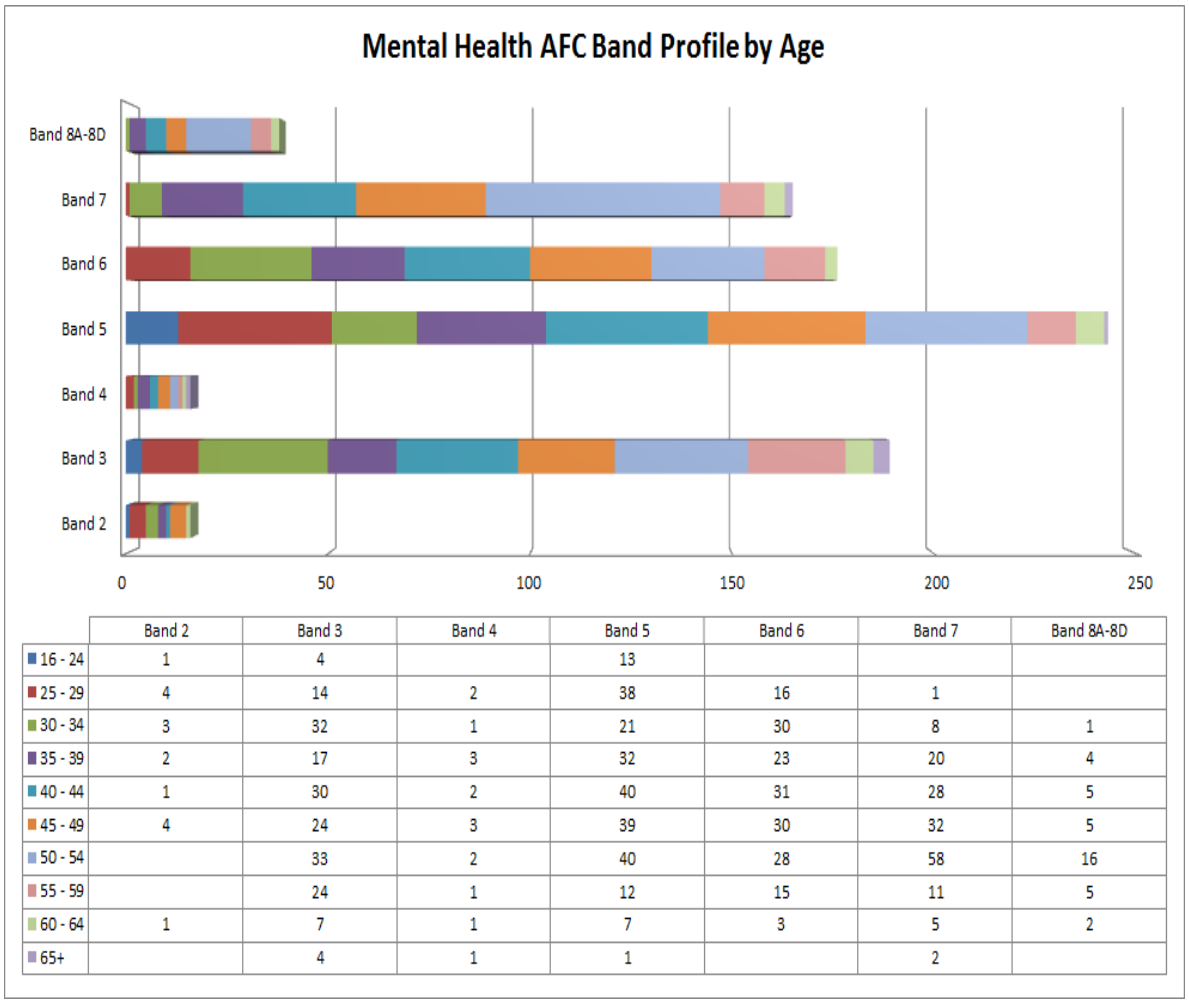
Graph 4

Within the Service area, staff who are aged 55 and above, account for approximately 12% of the total workforce, which is less than the Directorate figure of 22%. An area of concern is that over 31% of the workforce is over 50 and may have the option to retire in 5 years and only 25% are under the age of 35.



Graph 5

Graph 6 looks at possible links between bands and the age profile for the Service area to identify any issues that may have to be addressed as part of this workforce plan.



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A-8D
16 - 24	1	4		13			
25 - 29	4	14	2	38	16	1	
30 - 34	3	32	1	21	30	8	1
35 - 39	2	17	3	32	23	20	4
40 - 44	1	30	2	40	31	28	5
45 - 49	4	24	3	39	30	32	5
50 - 54		33	2	40	28	58	16
55 - 59		24	1	12	15	11	5
60 - 64	1	7	1	7	3	5	2
65+		4	1	1		2	

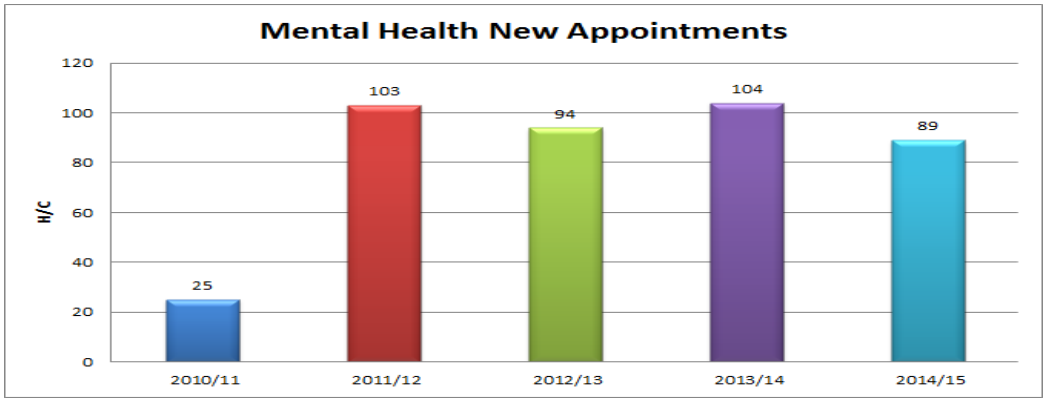
Graph 6

At Band 7 manager level 11% of the staff are aged 55 or older, however, there is three times this number between the ages of 50 and 54. The indication, based upon the current age profile, is that 46% of the total staff at this grade will be 55 or over by 2020, which may have implications for succession planning and the potential loss of skills.

It is also worth highlighting the age profile of the staff in senior management positions within the Mental Health Service area. There is a total of 38 senior managers, from 8A to 8D, of these 7 are aged 55 and over, which is approximately 18% of the total senior managers. If we include the age group 50-54 in these figures there are 23 managers who account for approx. 61% of the total number of senior managers in the Mental Health Service area. Succession planning will be required for this group of staff as with the Band 7 staff above.

2.1.4.1 Recruitment

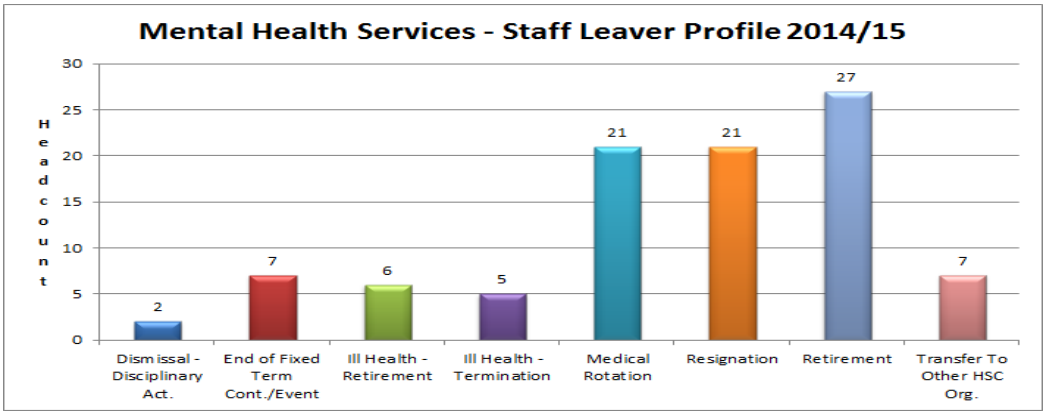
Graph 7 shows that 415 staff have been appointed to positions within the Mental Health Service area, over the last 5 years**.**



Graph 7

During this period 146 Band 5 staff have been appointed across the Service area, which has the highest number of new appointments. Band 6 staff, with 99, has the second highest total of staff appointments within the Service area. There has been 15 Band 8a and above staff appointed to the Mental Health Service area.

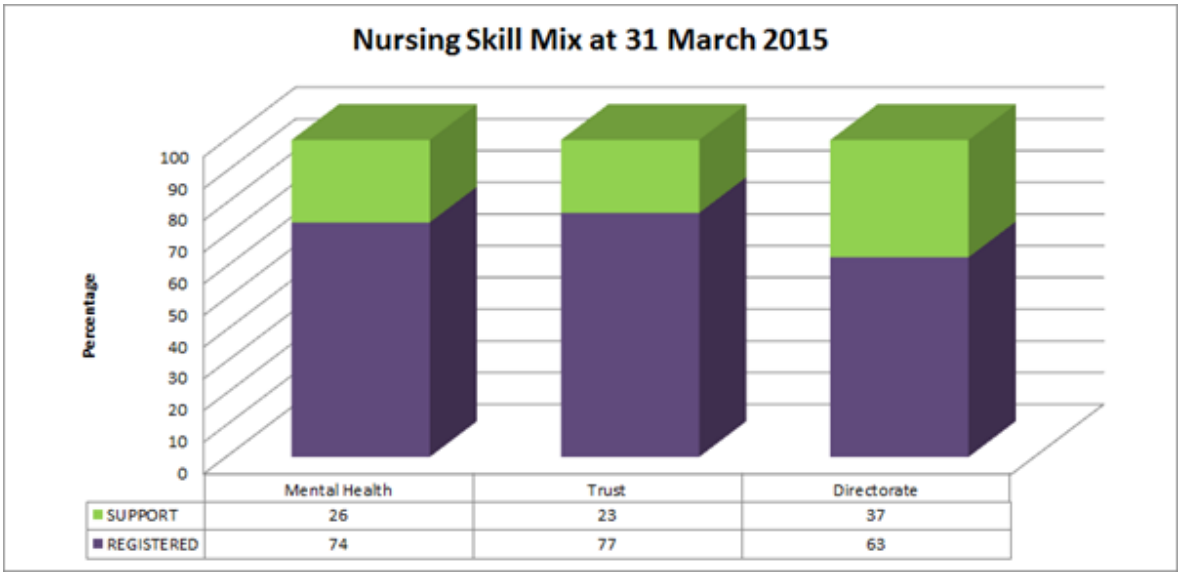
Graph 8 illustrates the reasons recorded for staff leaving the Mental Health Services between 1st April 2014 and 31st March 2015. During this period 96 staff from the Service area left the Trust with resignation and retirement accounting for 50% of the reasons recorded. Ill-health was recorded for almost 11% of the total number of leavers. Staff leaving to go to another health care organisation was recorded against only 7 staff (7%). Included in the total number of leavers is 37 staff that were on temporary contracts, the majority of whom, 21, were on medical rotation.



Graph 8

2.1.4.2 Skill Mix

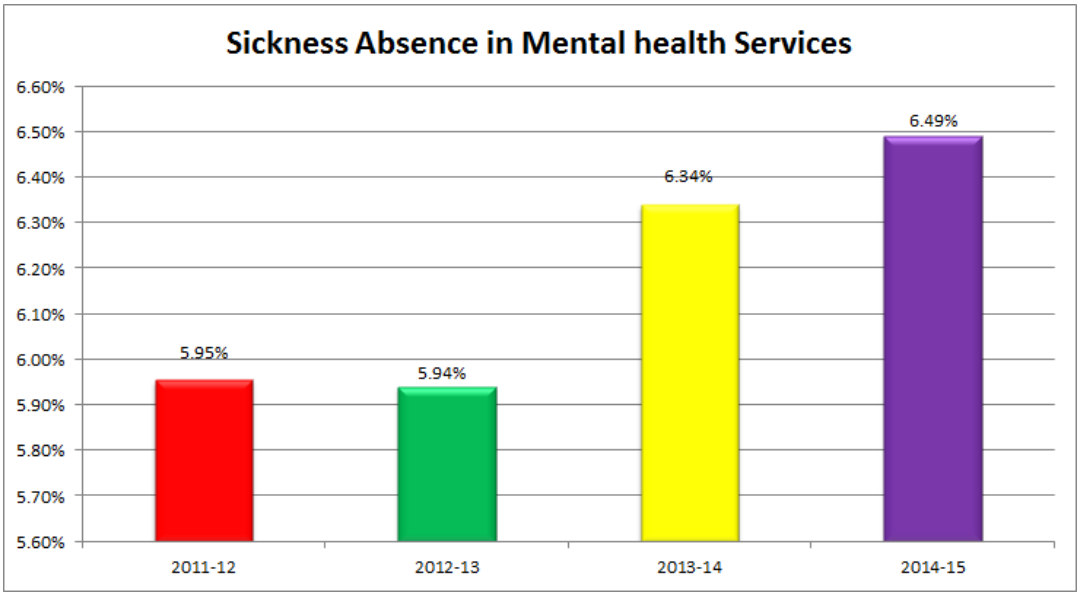
Graph 9 provides the skill mix in nursing staff within Mental Health Services. Currently, in Mental Health Services the nursing skill mix is 74:26 Registered to Non-registered staff. The ratio of qualified nurses in mental health Services is lower than that for the Trust as a whole which is 77:23. It is not anticipated that there will be significant changes across this Service area during the period of this workforce plan.



Graph 9

2.1.4.3 Sickness Absence

The levels of sickness absence within Mental Health Services, for the period 1st April 2011 to 31st March 2015, are illustrated in Graph 10. Over this period the level of absenteeism due to sickness has risen by approximately 0.54%. In the 12 months to 31st March 2015, a total 18,000 days (126,000 hours) were lost due to sickness within the Service, this equates to 81 WTE staff being absent for a year. This level of absence will have impacted on the level of expenditure on agency staff.



Graph 10

In the period from 1st April 2014 to 31st March 2015, the main reasons recorded against sickness absence were, General Debility; Stress; Depression, Grief/Bereavement and Back Ache, which in total accounted for approximately 59,380 hours of sickness absence. These reasons accounted for approximately 47% of the total sickness recorded for that year. General Debility was recorded against 18,855 hours, 15% of the total sickness for the Service area and was the number 1 reason for sickness absence.

During the period 1st April 2014 to 31st March 2015, the Service area lost a total of 5745 hours due to work related stress. Table 5 provides the cost associated with this absence, based on the mid point of the band recorded in this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

Mental Health Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
3	963.74	8799
5	1654.5	20218
6	1354.5	20670
7	450	8199
8A	375	8115
Total	**5744.74**	**66001**

Table 5

2.1.4.4 Agency Expenditure

Agency expenditure within Mental Health Services amounted to £550,000 for the year 2014/2015. Expenditure on admin & clerical staff, at £290,000, was the highest closely followed by medical and dental agency staff at £225,000.

This comparatively lower level of expenditure reflects that mental health had a lower level of sickness than other areas in the Directorate as well as a lower number of vacant posts during the year reducing the need for agency expenditure.

MENTAL HEALTH Comparison of Agency Expenditure with sickness Levels and Vacant Posts 2014/2015	
Sickness Absence Hours	132,005.06
Number of staff Lost due to Sickness Absence	80.7 WTE
Agency Expenditure	£554,991
Vacant Posts	156

Table 6

2.1.5 Summary

There are many changes, within mental health Services that have been identified and will take place during the next five years. These changes vary in terms of the scope and size of the project ranging from the completion of the new Inpatient Unit during 2017 to the reorganisation of the Court Diversion scheme. There are other changes which, the Service is confident will take place over the next five years, but clarity as to the direction of travel has still to be obtained. In some cases the outcome may identify a variation of an existing

Service such as the Court Diversion Scheme, whilst for others the review may lead to the introduction of a new Service such as a scheme for people with eating disorders. These projects are awaiting the outcome of reviews, both internal and external to the Trust. These will impact on the Services that are provided within the Service area.

It is not anticipated that the current projects and those that are in the planning stage will have a significant impact on the overall workforce resources needed to deliver the Services. However it will only be when each review is completed that the full workforce implications will be known and these will be incorporated into the workforce plan during the reviews, which take place over the next 5 years.

The management team will need to address the issue of the level of sickness absenteeism within the Service, including the time lost due to work related stress. Availing of the support of the Attendance Management team within HR will assist the management team when addressing these issues. Reviewing the use of agency staff across all family groups and in particular admin & clerical should also be carried out to identify issues and remedial action.

2.1.6 Action Plan

The development of the workforce plan has identified actions required to be undertaken by the Service. These have been highlighted in the table below. As we proceed through the period covered by this plan more actions will be identified and will be added to the list during the reviews.

Table 18 Action Plan for Mental Health Services 2015 to 2020

Service Area	Action	Person Responsible	Timescale
Mental Health	Closure of DGU & redeployment of affected staff	Mel Carney	31 March 2016
Mental Health	Completion of CAMHS review and implementation of outcomes	Billie Hughes	31 March 2020
Mental Health	Opening of the new Inpatient Mental Health Unit	Mel Carney	31 March 2018
Mental Health	Review of Approved Social Worker Role to be completed by March 2016	Mary O'Brien	31 March 2016
Mental Health	Review of the need for Eating Disorder Services	Peter Bohill	31 March 2018
Mental Health	Review of the provision of Day Services	Peter Bohill	31 March 2016
Mental Health	Implement the outcome of the Criminal Justice Service Review as it impacts on Unscheduled Care Court Service	Mel Carney	31 March 2017
Mental Health	Reduction in the sickness absence rate within the Service area from 6.49% to 5.49%	Barney McNeany	31 March 2016
Mental Health	Confirmation of the required workforce going forward within all areas	Barney McNeany	31 March 2016
Mental Health	Develop and implement succession planning strategy – Growing our People Today for Tomorrow	Barney McNeany	31 March 2017
Mental Health	Implement Induction programme for all new recruits	Barney McNeany	31 March 2016
Mental Health	Promote age awareness and age diversity as more staff remain in the workplace	Barney McNeany	31 March 2016
Mental Health	Ensure statutory and mandatory training compliance	Barney McNeany	31 March 2016

2.2 LEARNING DISABILITY

This section of the plan will highlight workforce issues associated with the provision of Services within Learning Disability. Learning Disability teams provide both a regional Service and a local Service to the population of Belfast. Services can range from emergency care provision, outpatient appointments and day procedures, and repeated lengthy admissions due to complex mental health and behavioural needs. These Services are provided by a workforce of 896 staff, details and an analysis of which are provided later in this section.

The learning disability Services are separated into three Service areas:-

- In-patient Service for adults and children, located on two sites the Muckamore Abbey Hospital (MAH) and the Iveagh Unit;
- Residential Supported Living and Day opportunities, which currently provide over 750 day care places;
- Community Treatment and Support Service.

> ***"We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community"***

2.2.1 The Drivers

2.2.1.1 Hospital Services

- There is a drive to shift from acute to community healthcare Services consistent with a person centred approach and accompanied by a hospital model
- Deliver a modern acute inpatient Service

This has been highlighted in a range of recent regional reports including: The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007, Transforming Your Care – A Review of Health & Social Care in Northern Ireland December 2011. This shift from acute Service provision to one which is more community based is likely to impact on the resources needed to deliver these Services safely. This focus is currently demonstrated in the resettlement project currently underway at Muckamore Abbey Hospital, which will see all long stay patients resettled into the community.

- There is drive to provide for patient safety and high quality Services.

This has been highlighted in a range of recent national and regional strategies and reports including Quality 2020 (DHSSPS, 2011c); The Francis Report (2013); The Cavendish Review (2013); The Winterbourne View Report (DH, 2013); The Keogh Report (2013) and The Berwick Report (2013)

> ***Services should be person centred (i.e. Service users will have their rights respected and be supported to keep control of their lives)***

The children and adolescent Service, provided at the Iveagh Unit in Belfast, will be unaffected by the above resettlement exercise and will continue to provide the current level of Service provision.

2.2.1.2 Day Care Services

Health & Social Care Board recommendations for future day opportunities provision in Northern Ireland which give clear direction to increase the amount of day opportunities provided by the voluntary and private sectors will result in a reduced number of adults with a learning disability attending Trust day centres.

Traditionally the Trust has provided day care to people with a learning disability mostly within Trust learning disability day centres. As recommended by Bamford and included in the HSCB recommendations the Services are looking to increase the amount of day support and day opportunities provided outside of our day centres and within local communities. This will involve greater use of the voluntary and private sector as well as other departments and agencies such as DEL, DARD, DSD, Education and Belfast City Council. The implications of this change in emphasis will mean that the Trust will propose to reduce the number of its day centres. This will have a knock on effect in relation to the use of voluntary and charitable providers and the staffing requirements needed in this area.

The aim of this proposal is to reduce the number of statutory day places provided in our day centres and, as per policy direction, increase our partnerships with other sectors regarding day opportunities for adults with a learning disability. This will result in those with complex needs getting a specialist Service with the possibility of those who can avail of a wide range of Services having these provided by other agencies. This will happen through the assessed needs of our clients in a person centred manner. Presently 'A Consultation on the Delivery of Learning Disability Day Services for People Living in Belfast' is due to close on 26 November 2015.

We are also reviewing our residential and supported living services. This may result in our residential provision moving to a supported living model which may involve the provision of Services by the voluntary and private sectors.

Our review, which is due for completion by 31 March 2016, could result in Belfast Trust considering to no longer be the provider of residential services for adults with a learning disability with a move to supported housing. This review could also result in a move by the Trust to reduce direct service provision regarding supported living services which will have an impact on our staffing levels.

2.2.1.3 Community Treatment & Support

The community treatment and support service will, like other service areas within this Directorate, have to deal with the challenges presented by demographic change. This will mean an increase in both the number of people requiring our services and the degree of complexity that the Trust will be required to treat and support.

We will also be expected to develop Services to meet the requirement to reduce the number of hospital admissions in the future; to reduce the incidence of delayed discharges from hospital and promote greater use and carer involvement.

2.2.1.4 Adult Safeguarding

Adult safeguarding is a growing area of demand in learning disability services, particularly large scale complex investigations in group care settings which require skilled and experienced staff and make heavy demands on staff resources. In addition, the new regional safeguarding policy widens the scope of the Trust's safeguarding responsibilities to people who would not always meet access criteria for the Trust's service areas. This could create additional demand.

2.2.1.5 Social Work Strategy

The regional social work strategy is a 10 year plan which has three central themes, strengthening the capacity of the social work workforce, improving social work services and building leadership and trust in the profession. All of these areas have significant workforce implications for the Trust.

2.2.1.6 Approved Social Worker

The Trust is currently struggling to meet the demands of providing ASW services. There are considerable problems with workload issues and availability of sufficient numbers of qualified staff. A review has recently been undertaken and the findings of this review will be incorporated into the plan during the monitoring process.

2.2.1.7 Anticipated Mental Capacity Bill

The draft Mental Capacity Bill will introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a learning disability, physical or mental illness) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision for themselves.

The bill will work to ensure that an individual's capacity to make decisions about their health, care and personal welfare is respected. Appropriate safeguards are also included to ensure that an individual's best interests are respected where their capacity is comprised. This is again in line with the person centred approach.

While the bill's impact is to a great extent unknown at this stage, there will certainly be a significant requirement for initial and ongoing training, a significant increase in requirements for formal capacity assessments, formal best interests decision making and applications for legal authority to carry out certain actions. In addition, the Trust will need to set up and staff its own formal authorisation mechanisms.

2.2.2 What our Services will look like

During the period covered by this workforce plan there will be changes to the Services delivered by the learning disability teams. These changes are highlighted in this section. It is worth noting that some of these projects are at different stages of development.

Services will be planned, implemented and evaluated in partnership with users and carers

2.2.2.1 Hospital Services

Upon completion of the community integration project which is anticipated in December 2016, MAH aims to; in agreement with the HSCB; introduce a phased approach to the modernisation of the core hospital. It is anticipated that the remaining core wards will have approximately 50 beds which will provide assessment and treatment, Psychiatric Intensive care and regional low secure forensic Services.

The hospital will no longer have long stay beds on the site with patients completing treatment and active discharge planning back to community placements. Wards previously used for care of long stay patients will be closed and decommissioned on a phased basis, leaving only the newly built “core” wards.

A day Services facility will also be retained providing therapeutic, support and treatment Services to the acute in patient wards. Iveagh Children’s inpatient Services will continue to provide tier 4 inpatient Services and with HSCB approval aim to develop an enhanced outreach Service to support community placements and avoid potential admissions.

2.2.2.2 Supported Living and Residential Provision

The Trust will strive to ensure all our clients have suitable living arrangements based on the assessed need of the individual. To achieve this, the Trust will review how Services are delivered in order to ensure the best outcome for our clients. This will result in the Trust enhancing and developing partnerships with the voluntary and private sectors while reducing statutory provision, but maintaining a well-motivated workforce able to meet the assessed needs of our client group.

The new Service will ensure our clients get the best, most effective, inclusive Service possible, this model will have enhanced involvement by the voluntary and private sector which will be closely monitored by Trust staff. The Trust will continue to support and monitor the same number of clients who receive day opportunities, residential and supported living Services involving an increase in the use of other sectors in accordance with the regional model.

2.2.2.3 Community Treatment & Support

The model of delivery identified for the community treatment and support Services will include five teams, a care management team and four multi-disciplinary community based teams. In addition the Trust provides an Intensive Support Service; a Psychological Therapies Service; a Forensic Psychology Service; a Safeguarding Service and a Health Facilitation Team.

2.2.3 The Workforce Required to Deliver the Services in the Future

The changes that are due to take place throughout the Directorate over the course of the period covered by this plan will result in significant changes to the workforce. New models of Service delivery, the demands of TYC and need to ensure that high quality cost effective Services are delivered will have an impact on the resources that are required going forward.

Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs

This section of the workforce plan identifies the resources that the Learning Disability Services will need to deliver its Services in the future. The changing landscape of the area in which Learning Disability Services operate will undoubtedly impact on the delivery of future Services. This may require different resources to those delivering the current Services, which will include the competency of the workforce as well as the number of staff required to deliver high quality Services in the future.

2.2.3.1 Workforce projections

Table 1 illustrates the projected changing workforce in Learning Disability Services which is based on the starting workforce and the average number of leavers and new starts over the last three years. Also included are the known workforce changes in relation to the projects currently underway or planned to be completed during the course of this plan. The plan projects an increase in the workforce in the Service area by 73 staff.

Learning Disability Services Workforce Projections 2015/2020

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in Post at 31st March	896	938	924	939	954
Average No. of Leavers *	-53	-72	-72	-72	-72
Average No. of starters *	95	87	87	87	87
Reviews		-29			
Total indicative projected staff in post 1st April	938	924	939	954	969
Net Variance	42	-14	15	15	15

* figures for 2015/16 are actual figures

Table 1

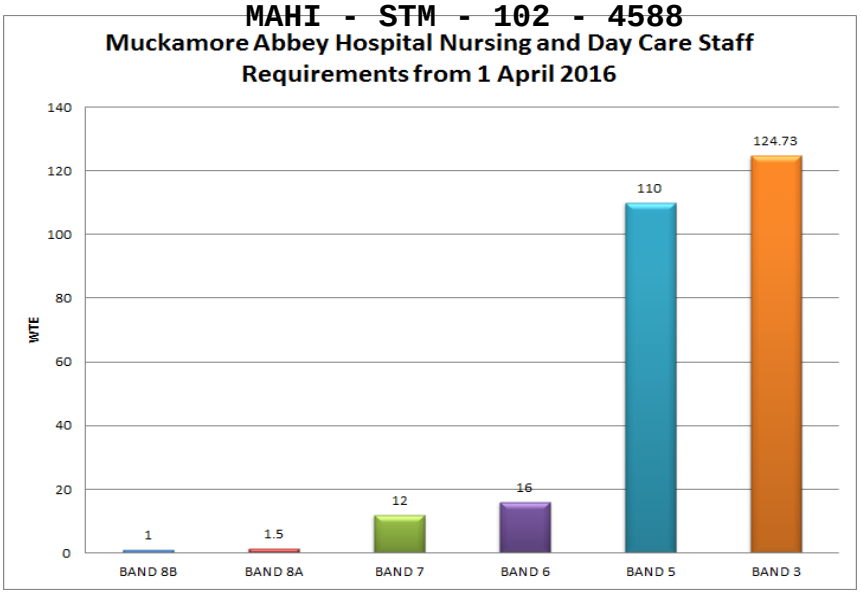
2.2.3.2 In-patient – Muckamore Abbey Hospital

The change in the model of Service delivery to a modern acute inpatient assessment and treatment Service with associated intensive care unit will require a revised level of resources to reflect the changes in patient profiles and acuity. A robust multi-disciplinary team will be required to deliver treatment and interventions to ensure as short a period in hospital care as possible. The current resource needs to address multi professional deficits. The proposed retraction plan for nursing staff does not address the normative staffing, skill mix and ratios needed or safeguarding requirements that will be a feature of acute tier 4 inpatient services.

A revised nursing plan will increase the number of band 7, 6, and 5 registrants – with a reduction in band 3 healthcare support workers.

It must be noted that representation must be pursued to increase the number of pre-registration students to address projected retirements from the Service over the next 5 – 10 years with anticipated turnover of registrants being over 40%.

The staffing model proposed needs to address the Trusts recurrent cost pressure of supervision requirements for those admitted for inpatient care thus reducing the reliance on the use of bank staff or agency.



Graph 1

2.2.3.2.1 Medical workforce

There is also the need to review the input and bandings of all specialist services, including the medical staffing compliment. The Trust is exploring whether the resource would be better placed in "owning" Trusts taking into account the current Service commissioning arrangements to the Northern and South Eastern Trust community Services.

2.2.3.3 Community Services – Residential, Supported Living and Day Opportunities

Management of Learning Disability Services envisage a reduction in staff as the Residential Supporting Living and Day Opportunity model rolls out across day care, residential and supported living services over the next five years from 487 staff currently, to 441.8 wte, a reduction of 45.2wte. This reduction in staff will impact on staff at Band 3, Band 5, Band 6 and Band 7 as the proposed new model of service delivery is developed.

Band	Existing Staff WTE	Required Staff WTE
BAND 3	216	194.4
BAND 4	7	7
BAND 5	142	127.8
BAND 6	57	51.3
BAND 7	37	33.3
BAND 8A	9	9.0
BAND 8B	3	3.0
BAND 8D	2	2.0
MEDICAL STAFF	14	14.0
Total	**487**	441.8

Table 2

Table 2 confirms the impact that the proposed changes to the current model of Service delivery will have on the workforce within Learning Disability Community Services.

2.2.3.4 Sleep-ins within Learning Disability Residential and Supported Living

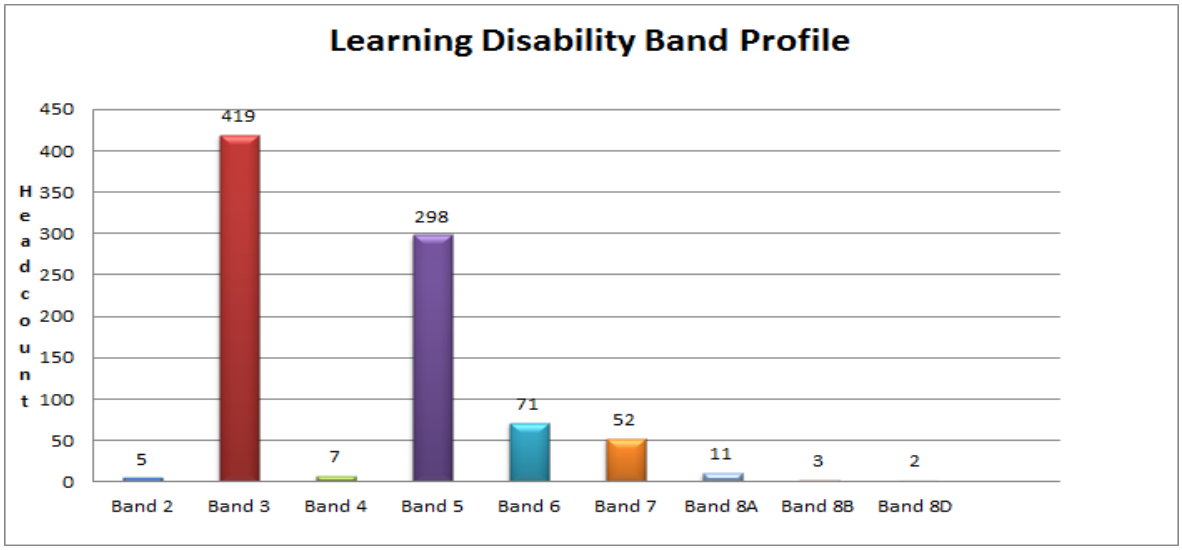
Currently sleep-ins, within the Trust residential and supported living Services, are provided by staff ranging from Band 3 to Band 7. This Service is currently provided to supplement the waking staff who are on duty, in the event they are required in an emergency. In Learning Disability Services eight of the units have a need to use sleep ins. This practice is currently under review across the Trust and the outcome of this review will impact on the delivery of Services in residential homes in Learning Disability Services. Should sleep-ins cease in the future, there will be an additional cost pressure for the Service in that staff will be engaged in waking nights, which will be more expensive than the current rate paid for sleep-ins.

There will also be a need for additional staff because of the need to adhere to the Working Time Directive. This prevents staff from working more than 48 hours, including the overnight hours that would have previously been covered by sleep-ins, which did not count towards working time.

2.2.4 Current Workforce

This section of the plan looks at the resources that are currently available within Learning Disability Services, which has almost 900 staff, covering the inpatient units at Muckamore and the Iveagh unit in Belfast and the community Services. The information provided in this section is based on the staff in post as at 31st March 2015.

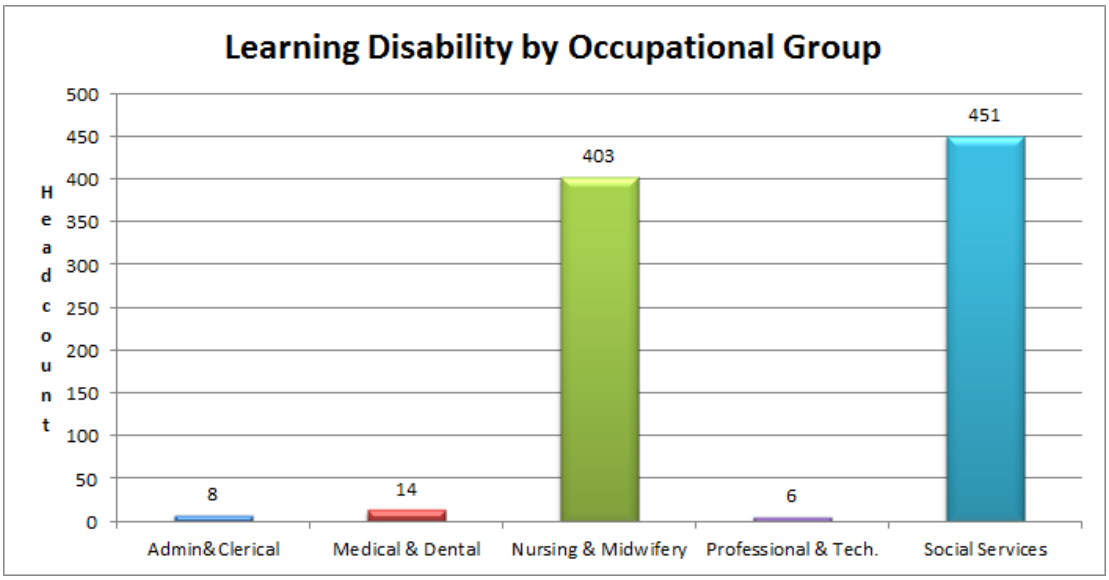
Graph 2 highlights the fact that the majority of the staff are employed at Band 3 and Band 5, with support staff accounting for almost half of the Service's workforce. Given the transformation in the Service delivery, more patients cared for in the community, it is anticipated more support staff will be employed. However the changing focus of Service at MAH is away from long stay patients to one of providing a treatment and assessment function. The implications of this are already being evidenced by the reduction in the number of support staff required on this site.



Graph 2

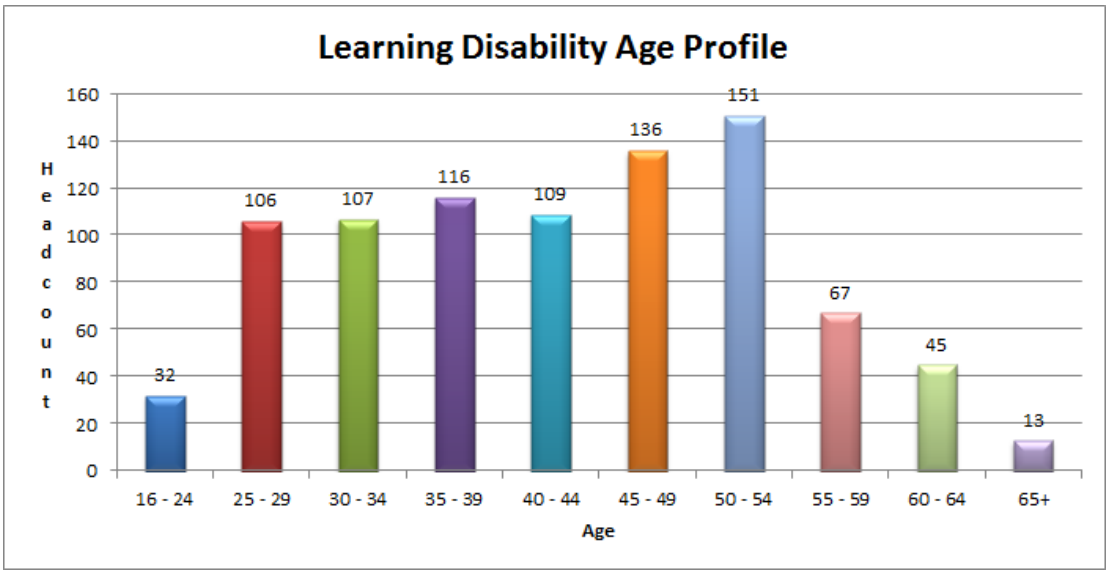
The management at MAH have included in their plan a need for fewer Band 3 support staff and an increase in Band 5 nursing staff.

Graph 3 illustrates that social Service staff make up over 50% of the total workforce within the Service area. This section of staff accounts for approximately 21% of the total social Service staff within the Directorate.



Graph 3

The age profile for the Learning Disability Service, in graph 4, highlights that 125 members of staff (14%) are above the age of 55. By the end of the period covered by this workforce plan another 151 members of staff will fall into this category, which based on current staffing levels would mean by 2020 31% of the workforce within the Service area will be aged 55+.



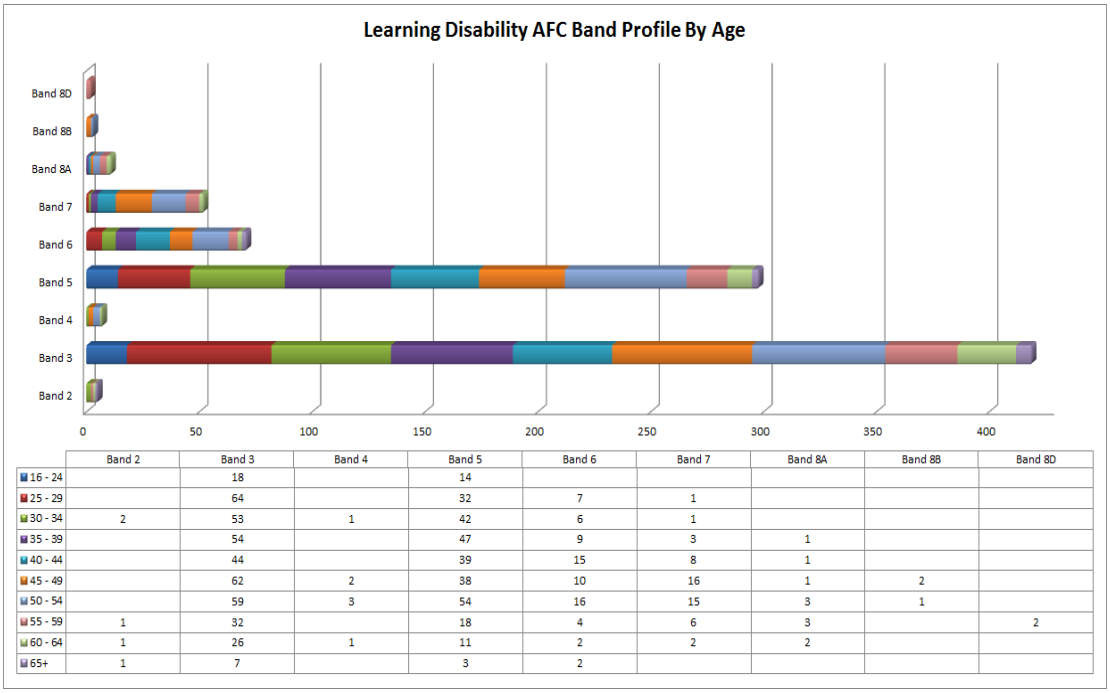
Graph 4

The age profile highlights a fairly even distribution across the Service with the exception of the 16-24 age range, which is significantly lower than the other with the exception of staff aged 65+.

Staff in the 50-54 age group account for 17% of the Service workforce; across the Trust 14.8% of the staff are found in the same age group. A significant number of the staff in this age group will be in a position to retire by the end of the period covered by this plan, including nursing and staff with Mental Health Officer status.

Graph 5 highlights the age profile of the staff and the impact it will have on the different grades of staff. At Band 7 manager level 13% of the staff at this grade are aged 55 or older, however, there is twice this number between the ages of 50 and 54. The indication is that 44% of the total staff at this grade will be 55 or over by 2020, which may have implications for succession planning and potential loss of skills and knowledge.

There is 71 staff at Band 6 within the Service area. Within this band of staff 8 are aged 55 and above. However there is a further 16 staff in the 50-54 age group and when added to the older age groups this gives a total of 34% of the total Band 6 staff aged 50 and above. Again this may require succession planning to be put in place or at least to address the potential loss of skills and experience.

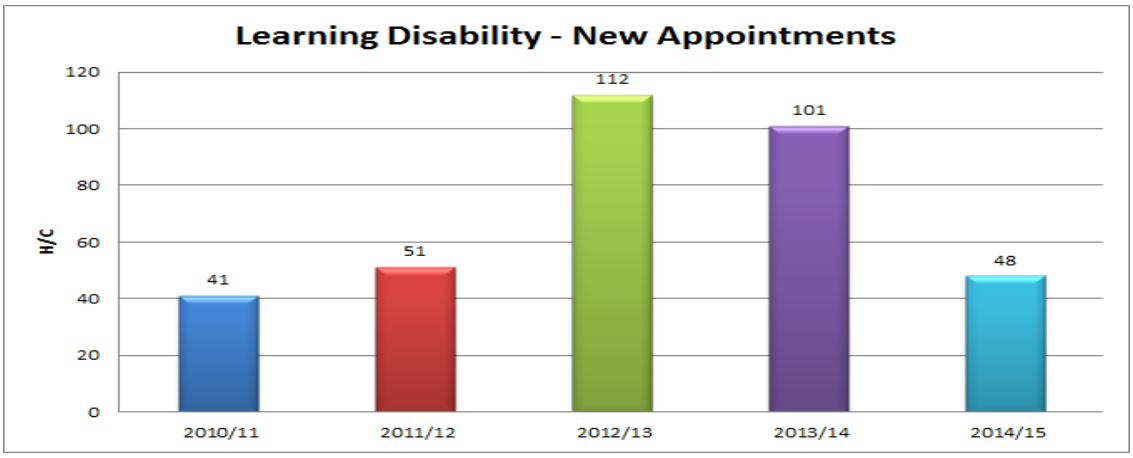


	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8D
16 - 24		18		14					
25 - 29		64		32	7	1			
30 - 34	2	53	1	42	6	1			
35 - 39		54		47	9	3	1		
40 - 44		44		39	15	8	1		
45 - 49		62	2	38	10	16	1	2	
50 - 54		59	3	54	16	15	3	1	
55 - 59	1	32		18	4	6	3		2
60 - 64	1	26	1	11	2	2	2		
65+	1	7		3	2				

Graph 5

2.2.4.1 Recruitment

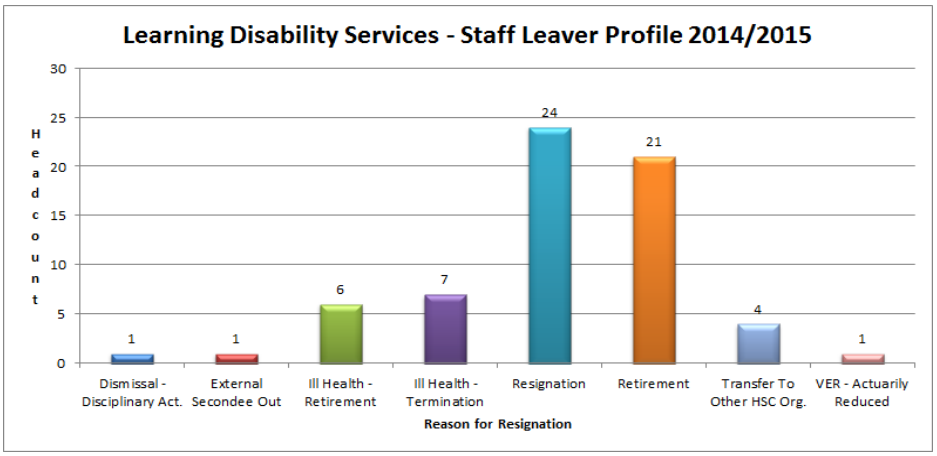
Graph 6 illustrates the total number of new appointments in Learning Disability Services over the last 5 years.



Graph 6

Over the last 5 years 353 staff have been appointed to positions within the Learning Disability Service area. These include appointments for staff to new and replacement posts. During this period 160 Band 3 staff have been appointed across the Service area, which has the highest number of new employees. Band 5 staff, with 113, has the second highest total of staff appointments. There has been 14 Band 8a and Band 8b staff appointed to the Learning Disability Service Group.

Graph 7 illustrates the reasons recorded for staff leaving the Learning Disability Services between 1st April 2014 and 31st March 2015.

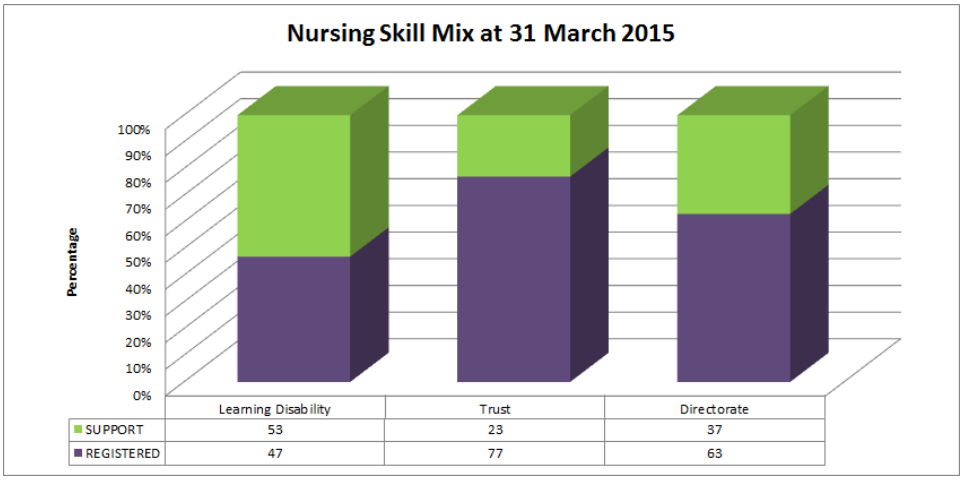


Graph 7

During this period 65 staff from within the Service area left the Trust. Resignation and retirement accounted for approximately 69% of the reasons recorded for staff leaving. Ill-health was recorded for almost 20% of the total number of leavers. Staff leaving to go to another health care organisation was recorded against only 4 staff (6%). Included in the total number of leavers is 14 staff that were on temporary contracts.

2.2.4.2 Skill Mix

Graph 8 compares the nursing skill mix in Learning Disability Services with that of the Trust and the Directorate. Currently, in Learning Disability the nursing skill mix is 47:53 Qualified to Non-Qualified staff. It is not anticipated that there will be significant changes across this Services area during this workforce plan. However there will be small areas of change for example at the MAH site where the number of registered nursing staff will decrease slightly, which when coupled with a large decrease in support staff will change the skill mix on this site.

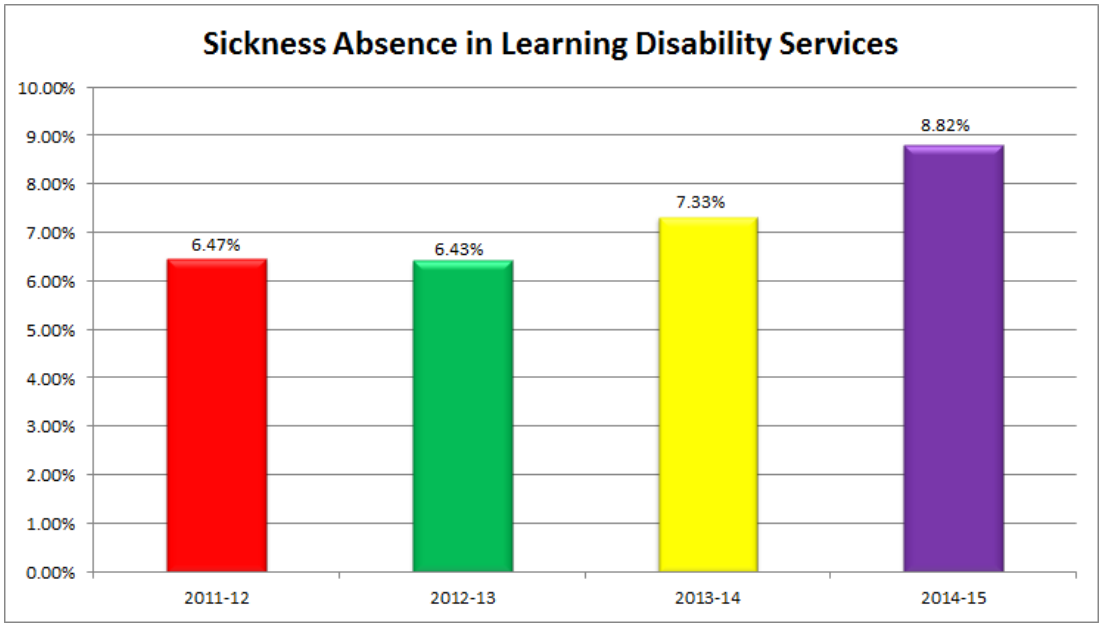


Graph 8

As mentioned earlier, in this plan, the changing needs of the patients at MAH will impact on the nursing skill mix. However it would be expected that as the resettlement project is completed more support staff will be required to provide the Services to the same patients in a community setting. To date 15 support staff have been redeployed from MAH into community areas.

2.2.4.3 Sickness

The levels of sickness absence within Learning Disability Services, for the period 1st April 2011 to 31st March 2015, are illustrated in graph 9. Over the last 4 years the level of absenteeism due to sickness has risen by 2.35%. In the 12 months to 31 March 2015, a total 21,500 days (142,000 hours) were lost due to sickness within the Service, which equates to 97 WTE staff being absent from work for the year.



Graph 9

The main reasons recorded against sickness absence were, Stress; General Debility; Post-Surgical Debility, Back ache and Depression, which in total accounted for approximately 71,364 hours of sickness absence. The reasons outlined above accounted for approximately 50% of the total sickness recorded for that year. Stress, which was the number 1 reason for sickness absence, was recorded against 26,000 hours, 18.3%, of the total sickness for the Service area.

Over the period 1st April 2014 to 31st March 2015, the Service area lost a total of 5465 hours due to work related stress. Table 3 provides the cost associated with this absence, based on the salary of the Bands recorded for this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

Learning Disability Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
3	2555.21	23329
5	2460	30061
7	450	8199
Total	**5465.21**	**61589**

Table 3

2.2.4.3 Agency Expenditure

Learning Disability Services spent approximately £890,000 on agency staff during 2014/15. There was over £400,000 spent on social Services staff; over £200,000 on admin & clerical agency staff and approximately £190,000 on nursing agency staff.

The level of agency expenditure can be explained in part due to the fact that learning disability Services had considerably more vacant posts during the year with 241 vacancies, which was the highest in the Directorate. Table 4 compares the agency expenditure with sickness absence and vacant posts.

Comparison of Agency Expenditure with sickness Levels and Vacant Posts 2014/2015	
	LEARNING DISBAILITY
Sickness Absence Hours	131363.1
Number of staff Lost due Sickness Absence	67.37
Agency Expenditure	£849,806.75
Vacant Posts	241

Table 4

2.2.5 Summary

There are several projects that will impact on the workforce within Learning Disability, which have been identified during the development of this workforce plan. The completion of the MAH Resettlement project will see the transformation from a hospital where the majority of patients were long stay to a facility with no long stay patients, providing an assessment and treatment Service. The plan has also identified that a review of Day centres will be undertaken and the identification of the future model of service delivery is due for March 2016. This may involve greater use of the voluntary and charitable sector in the provision of Services. These projects will impact both on the Service users and the workforce and an important consideration will be to minimise the impact on both groups. The completion of these projects is unlikely to have a significant impact on the workforce resources needed within Learning Disability Services.

Like many Services, Learning Disability uses sleep-ins and this use is currently being reviewed by the Trust across all Services. The outcome of this review will have implications for the Service as the status quo will not remain. All Services will have to find an alternative method through which to provide their Services, which will probably require additional resources in workforce and financial terms.

The level of sickness absence and agency expenditure is high in this area. These are two areas that will require attention and action by the management team to reduce the levels of absence and expenditure. In connection with the sickness absence the Attendance Management Team within HR are available to provide support and assist in addressing this issue.

2.2.6 Action Plan

The development of the workforce plan has identified actions required to be undertaken by the Service. These have been highlighted in the table below. As we proceed through the period covered by this plan more actions will be identified and will be added to the list during the reviews.

Table 18 Action Plan for Learning Disability Services 2015 to 2020			
Service Area	**Action**	**Person Responsible**	**Timescale**
Learning Disability	Completion of MAH Resettlement project, including the redeployment of affected staff	Esther Rafferty	31 March 2016
Learning Disability	Re-configuration of day opportunities provision and the potential redeployment of affected staff	Neil Kelly	31 March 2016
Learning Disability	Reduction in the sickness absence rate within the Service area from 8.82% to 7.82%	John Veitch	31 March 2016
Learning Disability	Confirmation on future direction of Iveagh linked with CAMHS and implementation of outcomes	Esther Rafferty	31 March 2020
Learning Disability	Confirmation of the required workforce going forward within all areas	John Veitch	31 March 2016
Learning Disability	Develop and implement succession planning strategy – Growing our People Today for Tomorrow	John Veitch	31 March 2017
Learning Disability	Implement Induction programme for all new recruits	John Veitch	31 March 2016
Learning Disability	Promote age awareness and age diversity as more staff remain in the workplace	John Veitch	31 March 2016
Learning Disability	Ensure statutory and mandatory training compliance	John Veitch	31 March 2016

2.3 Older Peoples Services including Physical and Sensory Disability

2.3.1 Introduction

Older Peoples Services is the largest section within the Adult Social and Primary Care Directorate. This Service area contains the largest number of staff within the Directorate with 2,434 providing the Services. It has the highest number of social care staff, 1,484 in the Trust.

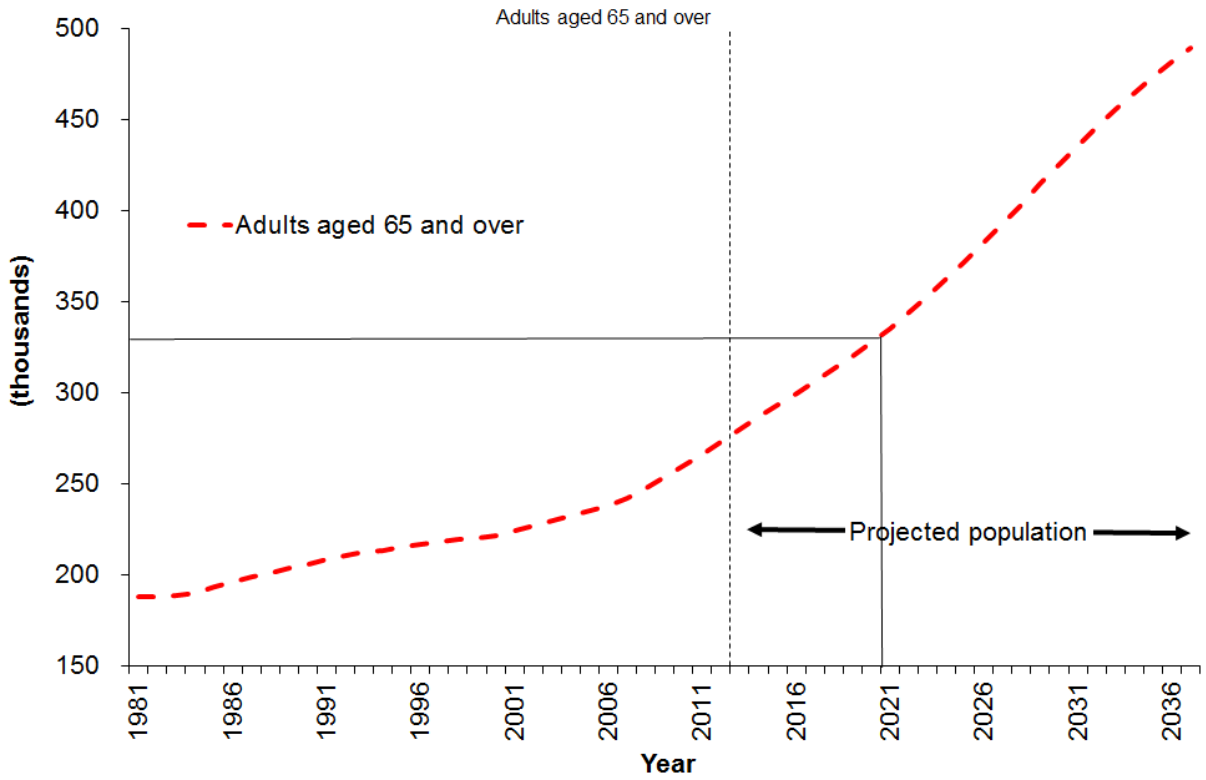
The Service is organised into five teams which are outlined below:

- Complex Discharge Unit
- South & East Belfast Locality & Older People's Wards BCH
- Provider Services North & West Belfast Locality & Older People's Wards RVH/Mater
- Physical & Sensory Disability Service
- Intermediate Care & Mental Health Services, Residential, Day Care and Domiciliary Services (S&E Locality) & Gateway Adult Protection

2.3.2 The Drivers

2.3.2.1 Responding to population needs

We have an ageing population who may place additional and more complex demands on the Trust's Services, which will be a major driver for this Service area. The graph below illustrates the projected population for those who will be over 65, which is expected to be over 327,000, by 2020 (NISRA 2010).



The Belfast Trust contains 7 out of the top 10 most deprived areas in Northern Ireland. Deprivation impacts on health issues and disease prevalence e.g. COPD, Heart Disease, Cancer, Asthma and Diabetes. North, West and East Belfast have the lowest life expectancy in Northern Ireland and some of the highest chronic disease prevalence in Northern Ireland.

2.3.2.2 Transforming Your Care (TYC)

There will be significant changes as to how we deliver our Services in the future to ensure that we meet the demands and requirements of TYC. This will include meeting commissioning specifications regarding Frail, acute, Elderly, Respiratory, Diabetes, Stroke and End of Life Care; the need to provide more opportunities to older people and their carers for self-directed support and an increase in the choices available to older people for independent living through additional supported living schemes.

2.3.2.3 Complying with statutory functions

We need to ensure we meet the requirements of delegated statutory functions and that we are fit to meet the demands placed on the Service in the future. This will include the registration of all Domiciliary and Day Care Workers. Following the announcement by the Health Minister to introduce compulsory registration of all social care workers practising in Domiciliary care, Day Care and supported living Services the Trust will have to work to achieve this by a possible deadline of 31st December 2016.

2.3.2.4 Responding to Regional Reviews / Initiatives

2.3.2.4.1 Provision of Residential Services

The outcome of the regional review into the provision of residential Services will help to inform the Trust's approach to its residential care Services.

2.3.2.4.2 Reablement Service

Reablement is a regional initiative which has been developed in response to the Transforming Your Care (TYC) agenda. The initiative dictates that all clients who are referred for social care input, and meet Reablement criteria, should have a period of Reablement care, needs assessed and care planned by an OT and delivered by trained Reablement Support Workers following client specific Intervention Plans. Care is delivered using the 'hands off' Reablement model. The Reablement Service will be fundamentally different from a standard domiciliary care Service in that the re-ablement support worker will not just meet the day to day needs of the older person but will actively help them to achieve maximum independence at the earliest opportunity. It is designed to enable older people to regain the skills and confidence they may have lost as a result of poor health or as a consequence of having spent a period of time in hospital or residential care.

2.3.2.4.3 Domiciliary Care

A regional workforce review is currently underway. The purpose of the group that has been established to oversee the project is to carry out a workforce review of domiciliary care which will inform planning to ensure the availability of a workforce to meet future demand and redesigned Services. One of the objectives of the review is to produce a Workforce Plan in early 2016. The outcome of the regional review into the provision of Domiciliary Care Services will help to inform the Trust's approach to its residential care Services.

2.3.2.4.4 Responding to Trust Reviews

There are reviews currently underway which will highlight areas where change may be necessary. The outcomes of these reviews, once they are completed, will be included in the workforce plan. It may not be possible to include this information in the first year of the plan, but will be factored into the plan during the monitoring and reviews of the plan.

2.3.2.4.5 Review of Supported Living

A review of the provision of supported living is to be undertaken by the Trust, the outcome of this review will impact on the resources needed to deliver the Services in the future and will require close monitoring to ensure the Trust is prepared for the changes and challenges this may present.

One of the challenges in relation to supported living, which will help to promote the client's independence, is the fact that clients are not as familiar with this model of care.

2.3.2.5 Stroke Services

Stroke Services are currently undergoing a significant change project with the introduction of Early Supported Discharge (ESD). The main driver for this change is that the evidence shows that patient outcomes are improved when patients are discharged to undergo rehabilitation in their own homes, as soon as they are medically fit, as opposed to in a hospital setting.

2.3.2.6 Review of Social Workers

The aim of the project is to review and modernise the social work and social care and care management workforce within Older Peoples Services, in order to be best placed to meet the requirements and key objectives of "Transforming Your Care" and the NI Social work Strategy (Improving and Safeguarding Social Wellbeing – A Strategy for Social Work in Northern Ireland 2012 – 2022).

The review will consider staffing levels, WTE's, skill mix, grade mix, ways of working, changing roles and responsibilities, new roles and also current and emerging workforce trends and requirements, turnover, recruitment and training.

2.3.2.7 Review of District Nursing

The challenges facing nurses and midwives during this period of transition include a growing number of older people and other vulnerable groups requiring nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; the associated drive to prevent hospital admissions and to ensure end of life care at home; the advent of telehealth and telemedicine; the requirement for advanced physical assessments and non-medical prescribing; the increase in the delivery of nurse led Services and measuring the quality of care received by patients in a world of 7 day/24 hour community Service delivery.

The development of TYC health functions such as management of acute respiratory illness, stroke, and urgent unscheduled care will be increasingly managed in community setting as opposed to hospital admissions. As such having access to wrap around district nursing Services to support informal carers or provide services such as domiciliary care packages to these being cared for at home rather in hospital.

2.3.2.8 Review of Unscheduled Care

The RQIA requirements, including those highlighted following the Inspection in Unscheduled Care (July 2014), found that there were significant challenges being experienced by older people within the Belfast Trust. Frail older people, attending the emergency department, can result in multiple assessments and transfers and may lead to deterioration in their condition.

To help reduce the risk of deterioration in the person's condition and to alleviate the pressure on the emergency department at the RGH a Service dedicated to assessing the needs of frail elderly people rather than their attendance at the RGH has been developed. The new unit based at the BCH site will be opened to provide a new Service to frail older people, which will provide Services from 9.00am to 9.00pm. Older patients will attend the new unit rather than attending the Emergency Department at the RGH. It is expected this will relieve pressures on the E.D. and provide a more efficient Service to the older patients.

Older People who need urgent assessment rather than emergency care can wait for several hours, after services have been contacted, before they are brought by ambulance to hospital. Many older people admitted via RVH Emergency Department may wait for several hours before transfer to a bed, usually in the Acute Medical Unit. If beds in Acute Medical Unit are not available they will be transferred as an outlier to another ward area. Following assessment in Acute Medical Unit the patient may be referred to the care of a Geriatrician but can wait for a period of days before transfer to a specialist Geriatric bed in either BCH or Musgrave Park Hospital. Transfers between hospitals frequently occur in the evening period and many patients were often being cared for outside locations that were designed to deliver the care required.

2.3.2.9 Acute Care at Home

The Acute Care at Home Team (ACHT) is being established, through the support of the Belfast Integrated Care Partnerships, to support older people to manage unexpected illness in their own home instead of being admitted to hospital. This team of skilled health professionals will treat the patient and manage their care at home during an acute period of illness.

Should hospital admission be necessary, the ACHT will coordinate with staff at emergency departments and acute medical units to discharge patients as soon as possible. The team will also organise the individually tailored package of care each patient will need, to be as independent as possible.

2.3.2.10 COPD and Respiratory Services

There are approximately 8,500 patients with COPD in the Belfast Trust, for which there is no cure. Respiratory disease is one of the main causes of emergency hospital admission. There is a need for investment in the existing COPD Services to move towards a model, located in the community, which will provide greater promotion of prevention, self-care, management of the condition in the community and the avoidance of unnecessary hospital admission. The delivery of a fully coordinated and joined up approach, involving all the relevant health and social care providers, will be essential for the health and wellbeing of the Service users and reduce the burden on already overstretched emergency departments.

2.3.2.11 Sleep-ins

Currently, sleep-ins are provided by staff ranging from Band 3 to Band 7. Sleep-ins are required within the Service to ensure that care is provided, in residential settings, in an efficient and economical way. Older people Services make use of sleep-ins to a significant extent and are the biggest user of this facility within the Directorate.

2.3.3 What Older People Services will look like

As demonstrated through the drivers there are a number of changes within this Service area, many of which are directed at moving Services away from the acute setting and more into the community as indicated in the Transforming Your Care agenda. These Services are at different stages of progression from the planning stage to those that are well under way in their development path, but all are due to be completed within the timescale of this workforce plan. This section of the plan describes what the Services will look like.

Services will be planned, implemented and evaluated in partnership with users and carers

2.3.3.1 Reablement and Social Care Rapid Response Services

The Reablement Service has recently merged with the Social Care Rapid Response Service. In the future Services will be provided using the re-ablement approach i.e. promoting independence in the Service user. It is envisaged that those assessed as being suitable for a period of re-ablement will have had their maximum independence restored within 6 weeks. The Reablement Service will be provided over a seven day week and may reduce need for Services such as homecare.

2.3.3.2 Supported Living

This Service is being reviewed. One of the tasks that needs to be undertaken is that the Trust needs to raise awareness of the concept of supported living for older people as a model of care, as well as proposals for better promoting the facilities within their area.

The Trust needs to explore the possibility of taking on an element of risk sharing with the housing associations. Risk sharing may in fact act as an added incentive for the Trusts to better promote their supported living facilities. This would be assisted through more joint planning between the Trusts and housing associations before decisions are made to commission new facilities.

2.3.3.3 Social Work and Social Care

This Service is being reviewed. The review will consider the roles and functions of social work and social care within the hospital setting and within the integrated care teams with a view to developing a range of responsive multi-disciplinary community Services for older people with a range of complex health and social care needs.

The development of TYC health functions such as management of acute respiratory illness, stroke, and urgent unscheduled care will be increasingly managed in community settings as opposed to hospital admissions. There is a need for community teams to be able to deliver

a range of practical, social and environmental supports in a personalised flexible manner whilst at the same time standardising access to Service and managing resources through Regional Eligibility Criteria.

The hospital discharge agenda and attendant pressures continue to test community systems and responses. Transitions of care from acute hospital to community settings, for frail elder older people, require sound planning and safe and effective reliable discharge pathways. There is a pressing need for a clear access and referral process for hospital discharges to community, and 'in reach' or 'outreach' approaches to provide seven day access to community Services.

A number of options have been identified as a result of the review including no change to current Service provision; creating additional Band 6 posts to each ICT; maintaining the current model with the standardisation of staffing levels across the ICTs or streamlining care management into social work/social care roles and creating new roles such as Senior Social Worker Case Manager.

2.3.3.4 District Nursing

This Service is being reviewed. Many health tasks provided in hospital today are the community district nursing tasks of tomorrow.

There will be eight Integrated Care Teams (ICTs) that will provide an enhanced range of Services, which stabilises and cares for their patients to prevent admission and to facilitate early discharge from hospital. Key task for ICT's will be timely assessment of need along the continuum from prevention, support and enablement, towards complex and long term case management provision of home based care as alternative to institutional or hospital care, management of risk , end of life care, capacity, consent mental capacity decision making . This may involve greater involvement in comprehensive geriatric assessment at home, and development of district nursing as members of the multi-disciplinary assessment.

These enhanced Services will be provided on a trust wide basis 24 hours a day, 7 days per week. This new model of Service delivery will provide rapid access to the Community Urgent Care Team.

The preferred model will also include an Acute Care at Home Team, which will provide support to District Nursing patients between 11.00pm and 8.00am seven days per week. This Service will also manage the hyper-acute patients at home for a period of up to 72 hours. Rapid access to assessment/clinical investigations and social care Services will be delivered by this team.

2.3.3.5 Unscheduled Care

The BCH Direct Service which was set up in 2014 to provide a more effective and safer Service to older people and to help alleviate the pressure on the emergency department at the RGH will be reviewed over the next 12 months. The Service has had a significant impact on caring for older people and the review will look to identify how this can be best developed to meet the needs of the future.

2.3.3.6 Self-Directed Support

Self-directed support provides Service users with the opportunity to manage their care in a way that best suits their needs. The Service users have control over the way their support is provided and as much control as they wish over their own budget. This option is available to everyone who is assessed as being in need of social care support.

The Trust wants to significantly increase the uptake on this resource as approximately only 4% of care is provided through this route. It is anticipated that following the appointment of a Project Officer there will be significant uptake in the Services available.

2.3.3.7 Complex Discharges

The Service area's new Community Complex Discharge Team (CCDT) has been operational from June 2014. The key objectives of the team have been to improve performance and efficiency across all hospital sites through improving patient flow and the management of complex delayed discharge pathways. The team works collaboratively across all teams and sites to improve interface pathways and has an oversight and responsibility for progressing and challenging causes for delay and defining future Service developments to meet patient needs.

The team is responsible for gathering and providing information to all levels of the organisation on complex delayed discharges. It provides a link for both internal and external Trusts in relation to expediting complex discharges. The CCDT manages patient flow from acute to community Services and within and across community Services and will challenge where necessary performance and decision-making on discharge pathways to ensure the safe and efficient discharge of patients.

The impact of the Service is currently being reviewed and there is a possibility that there will be recommendations for increasing some community Services i.e. Reablement/Domiciliary Packages. Work is currently underway to combine and extend the two hubs into 1 as well as providing the Service 7 days per week.

2.3.3.8 Supported Housing Development – Dementia

The development of a supported housing Service for brain injury will be developed in west Belfast. It is expected the development will commence in March 2015 and take 12-18 months to complete.

2.3.3.9 Physical & Sensory Disability Service

The growing demands on the Service, to meet hospital discharge targets will impact on the Physical and Sensory Disability Service. These demands will include care packages having to be ready within a short timeframe, meeting the needs of the growing ageing population which correlates with increasing ill health, a rise in Korsakoff's Service users (alcohol related), the potential impact of Mental Capacity Bill and a rise in adult safeguarding referrals since new Gateway Model in Older People Services and PSD commenced support for carers.

2.3.3.10 COPD and Respiratory

The expansion of current Services to include the development of additional community based respiratory Services, will be supported by ICP arrangements and funded by the Belfast Local Commissioning Group. The existing team will be expanded to specialist GP, nursing and physiotherapy staff and will become the ICP Respiratory Team.

The expanded Services will include improved support for patient's at home, thereby helping the patient and their carer to better manage their condition at home. If hospital admission is necessary the length of stay will be reduced as the joined up package of care will help to avoid readmission. Services will be provided 7 days per week in the community, meaning that patients can be discharged at the weekend and support and advice will be provided out of hours. The development of these expanded Services will also be supported by a new home oxygen Service.

The Service will also provide greater support in the area of self-care. New education programmes will be provided for newly diagnosed COPD patients. These will be provided by voluntary and community organisations, in addition to quicker access to rehabilitation programmes in the community and improved access to quit smoking Services.

2.3.3.11 Stroke Services

Following the merger of the stroke wards on the BCH and RVH sites and the need to deliver on TYC, the future focus for the stroke Service has shifted away from hospital based Services. There is a need to develop an appropriate model and structure for Services to be delivered in the community to enable stroke patients to be cared for at home. Increased availability of stroke Services for patients living at home and in the community will support more people across Belfast. This will assist more patients to be discharged from hospital at the earliest opportunity and receive specialist rehabilitation at home.

Work is now underway, through Belfast ICPs, to improve the management of Transient Ischaemic Attacks (TIAs) and to enhance the level of rehabilitation support available to stroke survivors. This will include Service provision 7 days per week, and those at greatest risk of a stroke following a TIA are seen within 24 hours. There will be enhanced input from Allied Health Professionals such as Physiotherapists, Occupational Therapists and Speech and Language Therapists, in both hospital and in the community to improve quality of life and reduce the need for long term care.

2.3.3.12 Acute Care at Home

The Acute Care at Home Team (ACHT) is being piloted, through the support of the Belfast ICPs. This team of skilled health professionals will treat the patient and manage their care at home during an acute period of illness. Should hospital admission be necessary, the ACHT will coordinate with staff at emergency departments and acute medical units to discharge patients as soon as possible.

This Service will be available 24 hours a day, 7 days per week and 365 days a year. It will help to protect the independence of frail older people; reduce the potential onset of confusion that can be caused by going to hospital and promote a quicker recovery. The team will also organise the individually tailored package of care each patient will need, to be as independent as possible.

2.3.4 Sleep-ins

As previously stated the practice of using sleep-ins is currently under review across the Trust and the outcome of this review will impact on the delivery of Services in residential homes in Older People Services. Should sleep-ins cease in the future, which is likely, there will be an additional cost pressure for the Service in that staff will be engaged in waking nights, which will be more expensive than the current rate (£30) paid for sleep-ins.

2.3.5 What will be the Required Workforce

The changes to the Services that are due to take place throughout the Directorate over the course of the period covered by this plan will result changes to the workforce. New models of Service delivery, the demands of TYC and the need to ensure that high quality cost effective Services are delivered will have an impact on the resources that are required going forward. These will reflect the needs of the Services in the future and in some areas will mean a radical departure from what is currently in place.

Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs

The required workforce identified in this workforce plan will be made up from the existing workforce, with the need, in some areas, for reskilling or the recruitment of new staff. This section of the report looks at the resources that are currently available within Older People's Services, which is the largest of the Service areas within the Directorate. When the preferred option from the Social Work and District Nursing Reviews have been confirmed these will be incorporated into the plan.

Table 1 below highlights the projected changing workforce in Older People Services which is based on the starting workforce and the average number of leavers and new starts. Also included are the known workforce changes in relation to the projects currently underway or planned to commence during the course of this plan, which projects an increase in the workforce of 34 staff.

Older People and Physical & Sensory Disability Services Workforce Projections 2015/2020

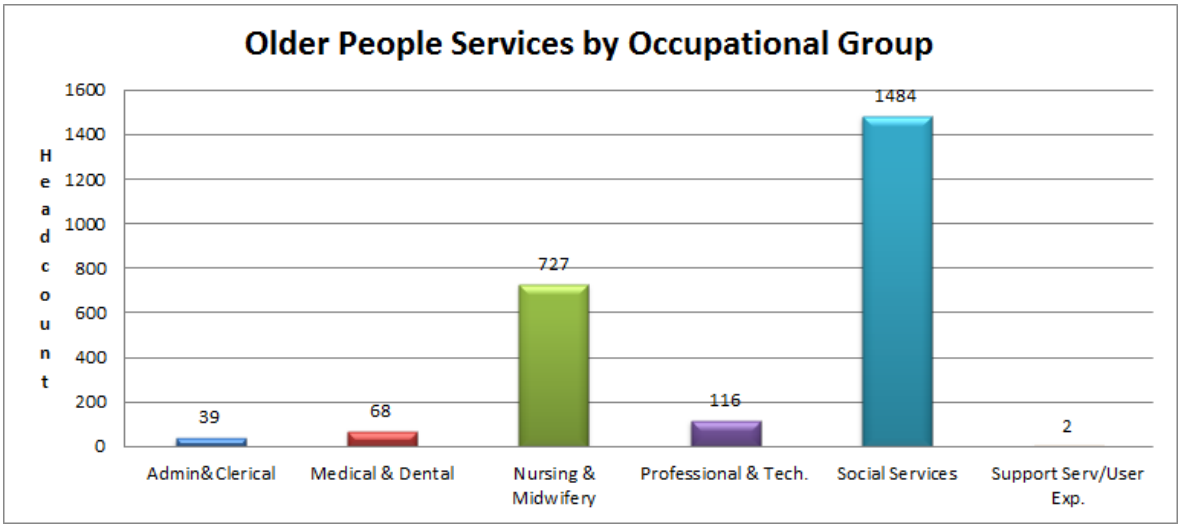
	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in Post at 31st March	2514	2598	2623	2598	2573
Average No. of Leavers *	-164	-165	-165	-165	-165
Average No. of starters *	181	140	140	140	140
Reviews	67	50			
Total indicative projected staff in post 1st April	2598	2623	2598	2573	2548
Net Variance	84	25	-25	-25	-25

* figures for 2015/16 are actual figures

Table 1

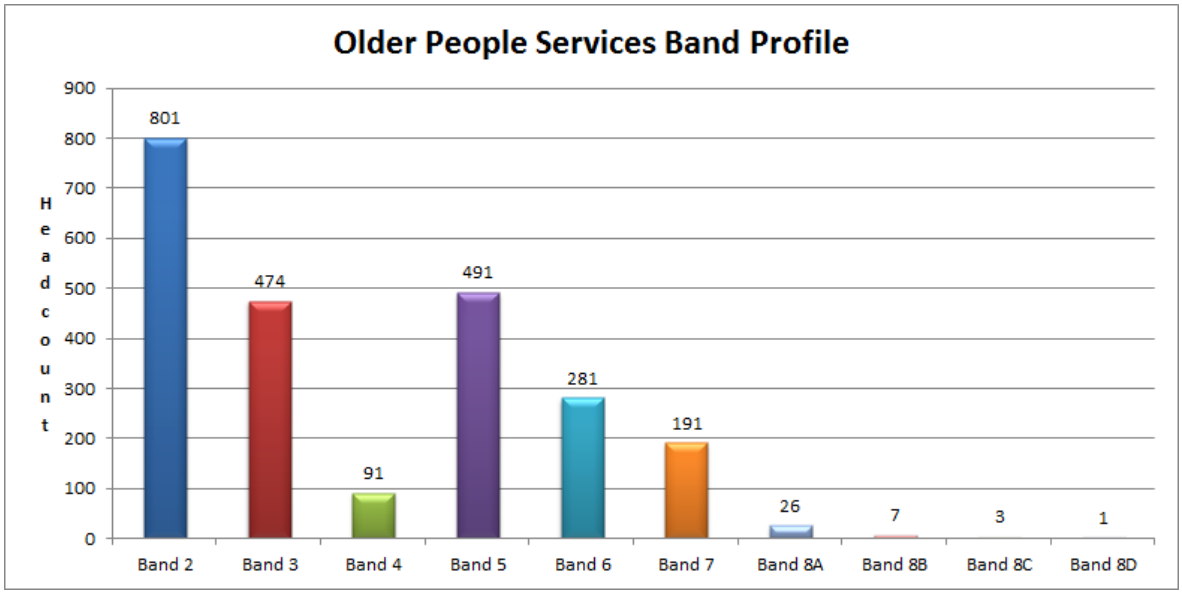
2.3.6 The Current Workforce

The information provided in the graphs below gives detail on the staff profile of the current workforce in Older People Services. Social Services staff make up approx. 61% of the total workforce in the Service area. In comparison to the social Services staff across the Trust, Older People Services, account for almost 50% of this group of staff.



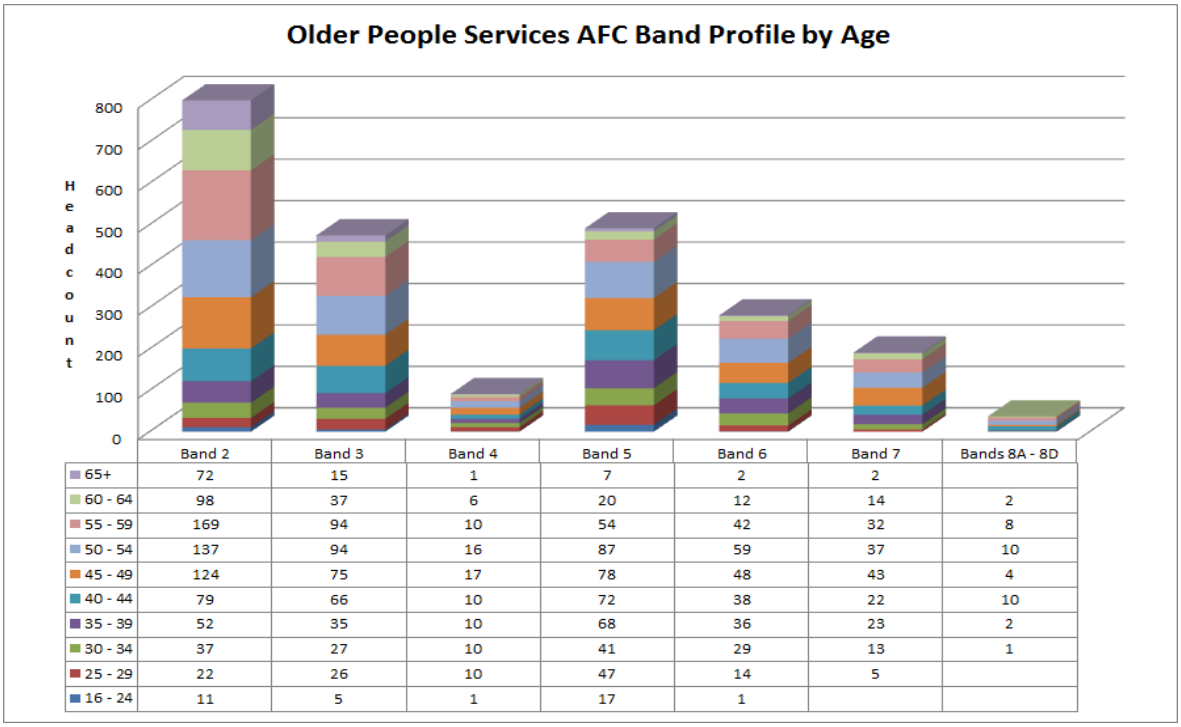
Graph 1

Graph 2 highlights that support staff, Bands 2 – 4, account for 58% of the staff within the Service area.



Graph 2

There is within Older People Services 697 staff who are aged 55 and over. This age group currently makes up 29% of the workforce within the Service area. By the end of the 5 year period, an additional 441 staff will fall into this category, giving a total of 1140 staff (47%), who will be over the age of 55. Across the Trust there is 3492 staff aged 55 or over, equating to approximately 17.5% of the Trust's total workforce. There is 351 staff under the age of 35, which equates to 14% of the Service's workforce.



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Bands 8A - 8D
65+	72	15	1	7	2	2	
60 - 64	98	37	6	20	12	14	2
55 - 59	169	94	10	54	42	32	8
50 - 54	137	94	16	87	59	37	10
45 - 49	124	75	17	78	48	43	4
40 - 44	79	66	10	72	38	22	10
35 - 39	52	35	10	68	36	23	2
30 - 34	37	27	10	41	29	13	1
25 - 29	22	26	10	47	14	5	
16 - 24	11	5	1	17	1		

Graph 3

Graph 3 highlights the age profile for Older Peoples Services broken down by band of staff. There is a total of 37 staff at bands 8A- 8D and of these 20 are aged 50 and over. Whilst this may not have a major impact on the efficient functioning of the Service during the initial period of the workforce plan; it is clear that preparation for the loss of these skills and experience must be given consideration.

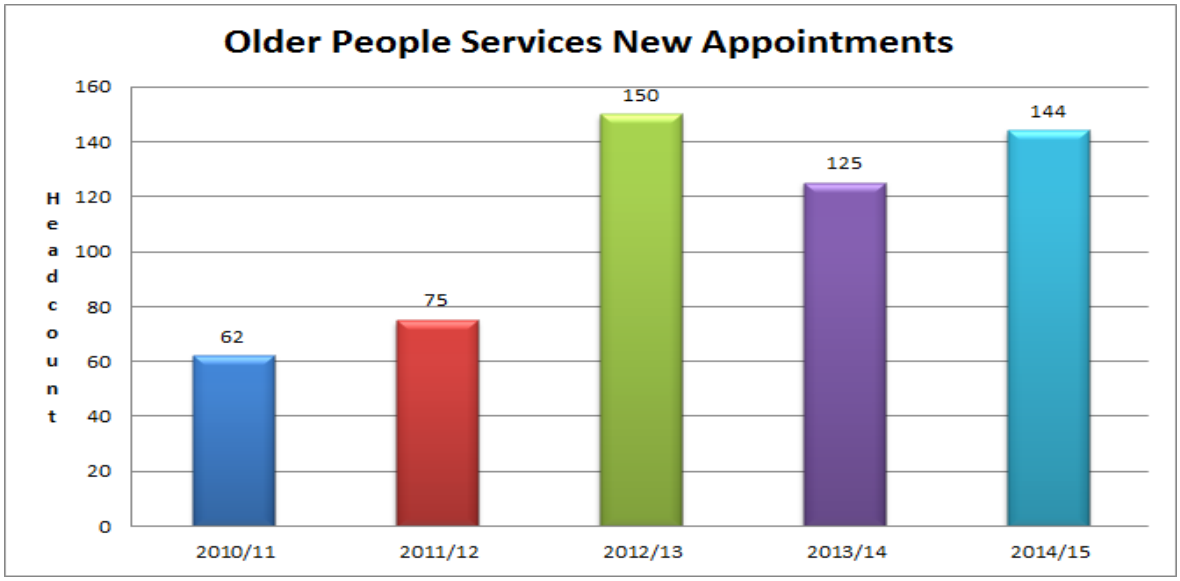
Staff at Band 7 level, within the Service area, have a total complement of 184 and 85 of these 46% are aged 50 and above. By the end of the 5 year period covered by the plan and additional 43 staff will fall into this age category, which will account for 70% of the total Band 7 workforce in Older Peoples Services. Within Older Peoples Services the majority of staff are employed at Bands 2 and 3, which make up a total of 54% of the workforce for the Service area.

There is a total of 801 staff at Band 2 and of these 42% are aged 55 and over. By the end of the next 5 years there will be an additional 137 staff in this age category, based on the current age profile of the staff.

Band 3 staff, of which there are 474, account for 20% of the total staff within the Service area. There is 146 Band 3 staff who are aged 55 and over, which is 31% of the total band 3 staff within the Service area. Based on the current age profile for the Service there will be an additional 94 Band 3 staff who will fall into this category within 5 years.

2.3.6.1 Recruitment

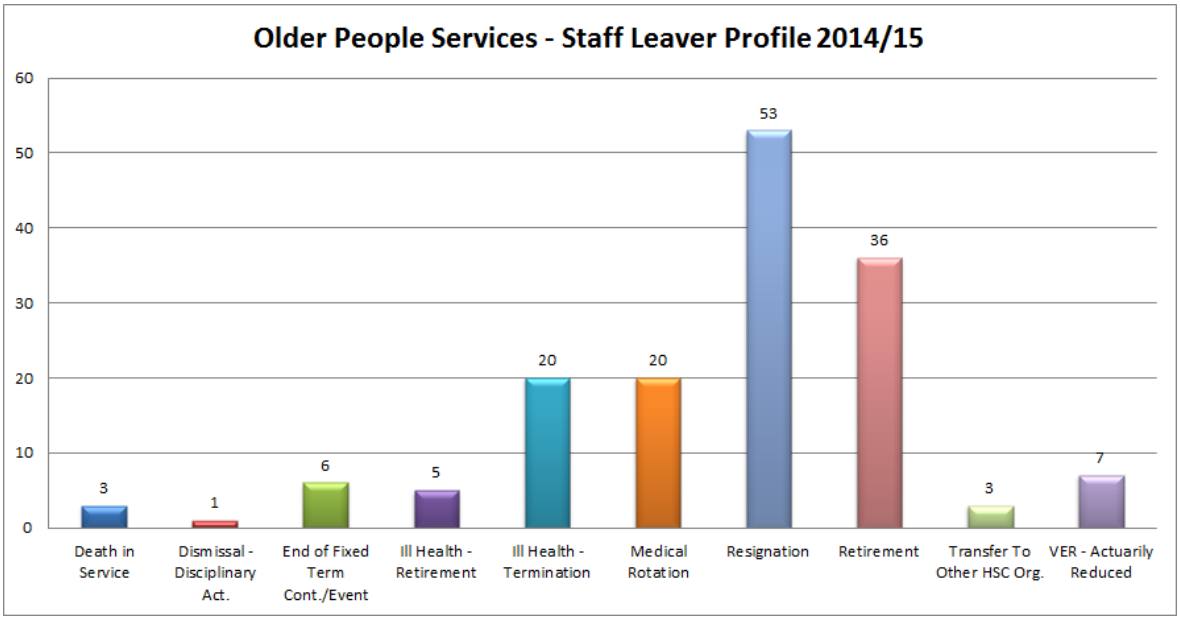
The chart below illustrates the total number of number new appointments in Older People's Services over the last 5 years.



Graph 4

Over the last 5 years 556 staff have been appointed to positions within the Older People's Service area, this includes internal and external appointments. During this period 154 Band 5 staff have been appointed across the Service area, which has the highest number of new employees. Band 3 staff, with 100, has the second highest total of staff appointments within the Service area. There has also been 74 Band 7 appointed to Older People's Services. In the last year 33 staff were appointed to new posts and of these 21 were in support roles, the majority of which are based in the community.

The graph below illustrates the reasons recorded for staff leaving the Trust from Older People's Services between 1 April 2014 and 31 March 2015.

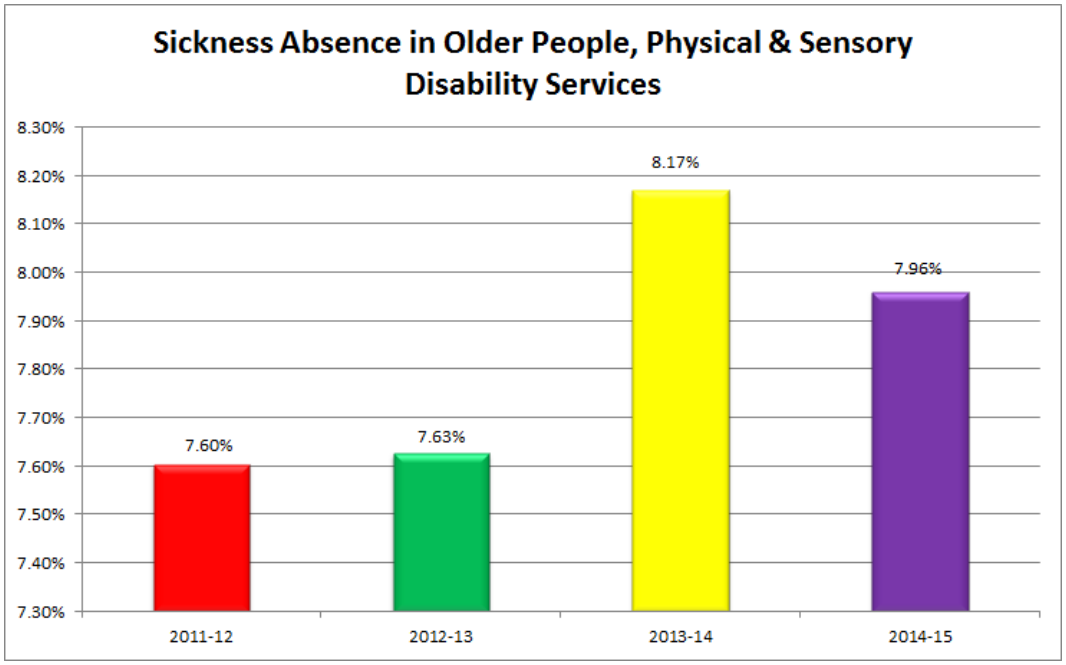


Graph 5

During the period 154 staff left the Service area. Resignation and retirement accounted for approximately 58% of the reasons recorded for staff leaving. Ill-health was recorded for almost 16% of the total number of leavers. Staff leaving to go to another health care organisation was recorded against only 3 staff (2 %), however as there is a high number of staff who have recorded resignation, with no additional details.

2.3.6.2 Sickness Absence

The levels of sickness absence within Older Peoples Services, for the period 1 April 2011 to 31 March 2015, are illustrated in graph 6. Over this period the level of absenteeism due to sickness has risen by 0.36%. In the 12 months to 31 March 2015, a total 43,700 days (260,000 hours) were lost due to sickness within the Service, this equates to 197 WTE staff being absent for a year.



Graph 6

The main reasons recorded against sickness absence, in the Service area were, General Debility; Depression; Stress; Post-Surgical Debility and Back Ache, which in total combined for approximately 139,155 hours of sickness absence. The reasons outlined above accounted for over 53% of the total sickness recorded for that year. General Debility, which was the number 1 reason for sickness absence, was recorded against 61,000 hours, 23.5% of the total sickness for the Service area.

It is not surprising that there will be a higher number of hours of sickness absence in this Service area, due to the higher staffing levels. However, this does not readily explain why General Debility accounts for twice as much sickness absence in this area, in percentage terms, when compared to Mental Health and Learning Disability Services. The number of hours recorded for General Debility in Older People's Services is almost five times the hours recorded in the two other main Service areas.

The only other reason, in the top four, common to the three areas is Stress. Again Older People's Services account for the highest number of hours recorded against this reason, approximately 32,900. The incidence of stress recorded absence in this area (12.6%) is higher, than that of Mental Health at 11.9%, but lower than Learning Disability at 18.3% of the total recorded sickness for their Service areas.

Over the last year the Service area lost a total of 7063 hours due to work related stress. The table below provides the cost associated with this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

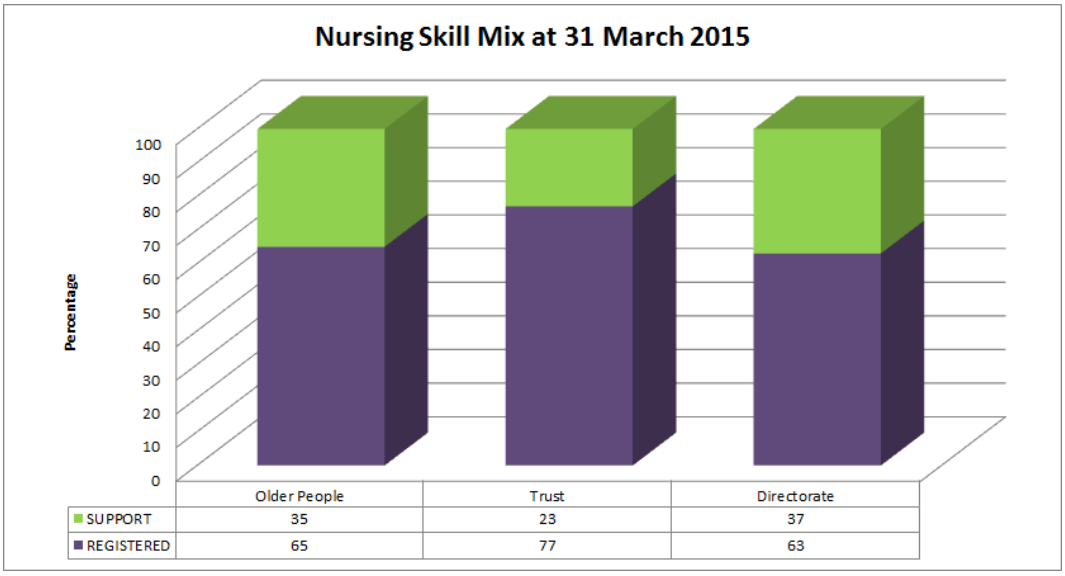
Older People and Physical & Sensory Disability Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
2	1176.4	9305
3	2268.54	20712
5	2712	33141
6	260.9	3981
7	645	11752
Total	**7062.84**	**78891**

Table 2

2.3.6.3 Skill Mix

Graph 7 highlights the nursing skill mix within the Older Peoples Services at 31st March 2015.



Graph 7

The nursing skill mix within the Older People Services is 65:35 (Registered: Non-Registered). Whilst there have been changes in some function areas, the new BCH Direct unit and the further development of the Reablement Service, there would not be any expectation of a significant change in the skill mix for the Service area as a whole. It is not anticipated that other areas within this Service area will experiencing changes that will impact significantly on the nursing skill mix.

2.3.6.4 Agency Expenditure

Older Peoples Services had the highest level of agency expenditure within the Directorate at £2.4 million. It also has the highest number of staff, within the Directorate, which may be a contributory factor in its use of agency staff. This coincides with the area having the highest number of hours lost due to sickness absence. The Service area accounted for almost twice the level of agency expenditure that mental health and learning disability had combined.

Within the Service area expenditure on nursing agency £1.26 million and social Services with £860,000 were the highest. Older people's Services had lower levels of expenditure on admin & clerical staff than either mental health or learning disability.

Older Peoples Services Comparison of Agency Expenditure with sickness Levels and Vacant Posts 2014/2015	
Sickness Absence Hours	316111.74
Number of staff Lost due Sickness Absence	162.11 WTE
Agency Expenditure	£2,405,629.54
Vacant Posts	180

Table 3

2.3.7 Summary

Old People Services is the largest function area within the Directorate. It is also the service area that will experience the greatest amount of change during the next five years. There are several key issues that are impacting on the Service area including, the changing demographics of the region; the requirements of TYC for example the review of Stroke Services and the establishment of the Acute Care at Home Service; the need to adapt to the outcomes of regional reviews e.g. the introduction of the Reablement Service and the outcomes of the Trust's own reviews into Services e.g. District Nursing and Social Care workforces.

The changes required to address these 4 key areas have resulted in a number of projects that are currently underway such as the merger of the Reablement and Social Care Rapid Response Service and those that are in the planning stage such as the review of the Unscheduled Care Services based at BCH; the reviews of Social Work and District Nursing staff and the greater emphasis on providing more opportunities to Service users for self-directed support. When the reviews that are currently underway across the region and within the Service area have been completed they too will have an impact on the Service and consequently the workforce resources necessary to deliver their outcomes.

It is projected that over the course of the next 5 years there will be a projected reduction in the staff levels by over 100, within the Service area, through the implementation of the identified projects. There will be further projects identified as the Service area progresses through the next 5 years that are not yet known. As these requirements of these projects are identified the workforce implications will be determined and these will be incorporated into this plan as part of the review process.

In addition to these individual projects the Service area will have to address the issues of agency expenditure, sleep-ins and staff absenteeism. Assistance from the Attendance Management Team is available for Service managers to help address the challenge presented by the high level of sickness absenteeism. Agency expenditure, within the Service area, is the highest in the Directorate at over £2.4m and needs to be addressed by the management team. Sleep-ins will present a significant challenge to the service area. The review currently underway across the Trust regarding sleep-ins will identify the course of action to be taken by the Service area address this issue, which will probably mean the need for additional resources.

2.3.8 Action Plan

The development of the workforce plan has identified actions required to be undertaken by the Service. These have been highlighted in the table below. As we proceed through the period covered by this plan more actions will be identified and will be added to the list during the reviews.

Table 18	Action Plan for Older People Services 2015 to 2020		
Service Area	**Action**	**Person Responsible**	**Timescale**
Older Peoples Services	Implement outcome of District Nursing Review	Bridget Denvir / Gabby Tinsley	31 March 2020
Older Peoples Services	Roll out Keith Hurst toolkit to all relevant areas	Bridget Denvir	31 March 2016
Older Peoples Services	Implement outcome of Social Work & Social Care Review	Jillian Martin	31 March 2020
Older Peoples Services	Extend BCH Direct in conjunction with IMPACT developments	Catherine Collins	31 March 2016
Older Peoples Services	Promotion of Care of the Elderly as an attractive area to work	Marie Heaney	Ongoing
Older Peoples Services	Introduction of Acute Care At Home Service	Gabby Tinsley	31 March 2016
Older Peoples Services	Complete merger of Reablement & Social Care Rapid Response	Katie Campbell	31 December 2015
Older Peoples Services	Review of Adult Physical Sensory Disability Day Opportunities	Bernie Kelly	31 March 2016
Older Peoples Services	Review of Domiciliary Care Workforce linked to development of regional workforce plan	Marie Heaney	31 December 2015
Older Peoples Services	Reduction in the sickness absence rate within the Service area from 7.96% to 6.96%	Marie Heaney	31 March 2016
Older Peoples Services	Confirmation of the required workforce going forward within all areas	Marie Heaney	31 March 2016
Older Peoples Services	Develop and implement succession planning strategy – Growing our People Today for Tomorrow	Marie Heaney	31 March 2017
Older Peoples Services	Implement Induction programme for all new recruits	Marie Heaney	31 March 2016
Older Peoples Services	Promote age awareness and age diversity as more staff remain in the workplace	Marie Heaney	31 March 2016
Older Peoples Services	Ensure statutory and mandatory training compliance	Marie Heaney	31 March 2016

2.4 Psychology Services

2.4.1 Introduction

Psychology is the smallest of all the Service areas with 79 members of staff however this Service is a core component to the delivery of Services across the whole Directorate. The Service contributes to reviews across the Directorate to ensure the best use of limited psychological resources and responds to training needs across the Directorate by establishing training programmes as required.

2.4.2 Drivers

2.4.2.1 Engagement with Services users, carers, community and voluntary groups

Psychological Services have identified the need to improve Service user and carer involvement in design and delivery of psychological Services. The Service area have also recognised the need to increase support and partnership with community and voluntary groups.

2.4.2.2 Strategy for the Development of Psychological Therapy Services DHPSS NI (2010)

This strategy followed on from Delivering the Bamford Vision –Action Plan (2009-11). The strategy recognises that Services need to be redesigned around the needs of individuals. The strategy identifies that improving provision of psychological therapies can help individuals and families by providing early psychological interventions. One of the recommendations from the strategy was that “Trusts should re-design mental health and learning disability Services around a stepped care model with access to psychological therapy Services at all levels

2.4.2.3 Respond to DHPSS Ministerial Targets

There is a ministerial target that has been in place from April 2012 that no patient waits longer than 13 weeks for psychological therapies.

2.4.3 What Psychology Services will deliver in the Future

Psychology Services will work to provide trust-wide life-span autism diagnostic and intervention Services. This will be achieved through the further development and expansion of autism Services to the adult community.

Psychology Services will work to increase access to psychological Services across the trust. The Service will **c**ontinue to work with Mental Health PCP and DOH and Trust Mental Health Services to develop models of increasing access to psychological therapies.

The Service will expand the development and availability of consultation & training and supervision to community providers e.g. suicide prevention groups.

Develop model for delivery of psychological support using principles of self-care to those diagnosed with long term health conditions in partnership with community & voluntary sectors and other trust colleagues.

In partnership with DOH/PHA and trust physical health and mental health colleagues, develop a model for the delivery of a “psychological medicine” framework within the acute Services in BHSCT, referencing liaison mental health Services, liaison alcohol Services and clinical health psychology Services.

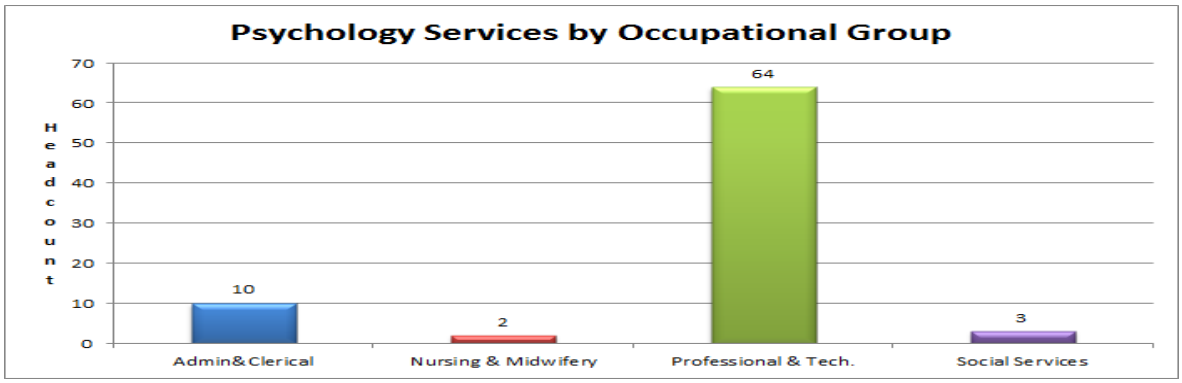
In partnership with mental health CAMHS Services and Children's Services directorate the Service will deliver a new model of delivery of Children's Emotional, Behavioural and Mental Health Services across the Trust.

2.4.4 The Workforce required to deliver the Future Services

The Service is engaged in various projects across the directorate, which will identify the resources that will be required to meet the demands on the Service.

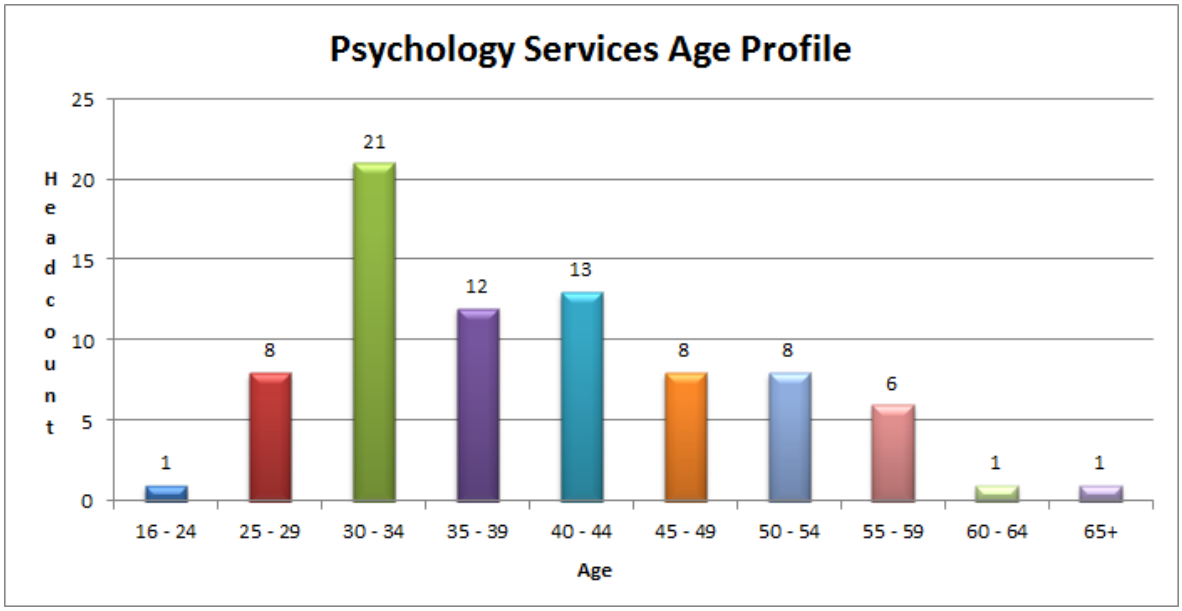
2.4.5 Workforce Supply

The information provided in this section is based on available data as at 31st March 2015. There is a total of 79 staff who work in Psychology Services, which provides a Service right across the Directorate. Unsurprisingly the majority of staff are from the Professional and Technical Occupational Group indeed 81% of staff in this group are registered Psychologists.



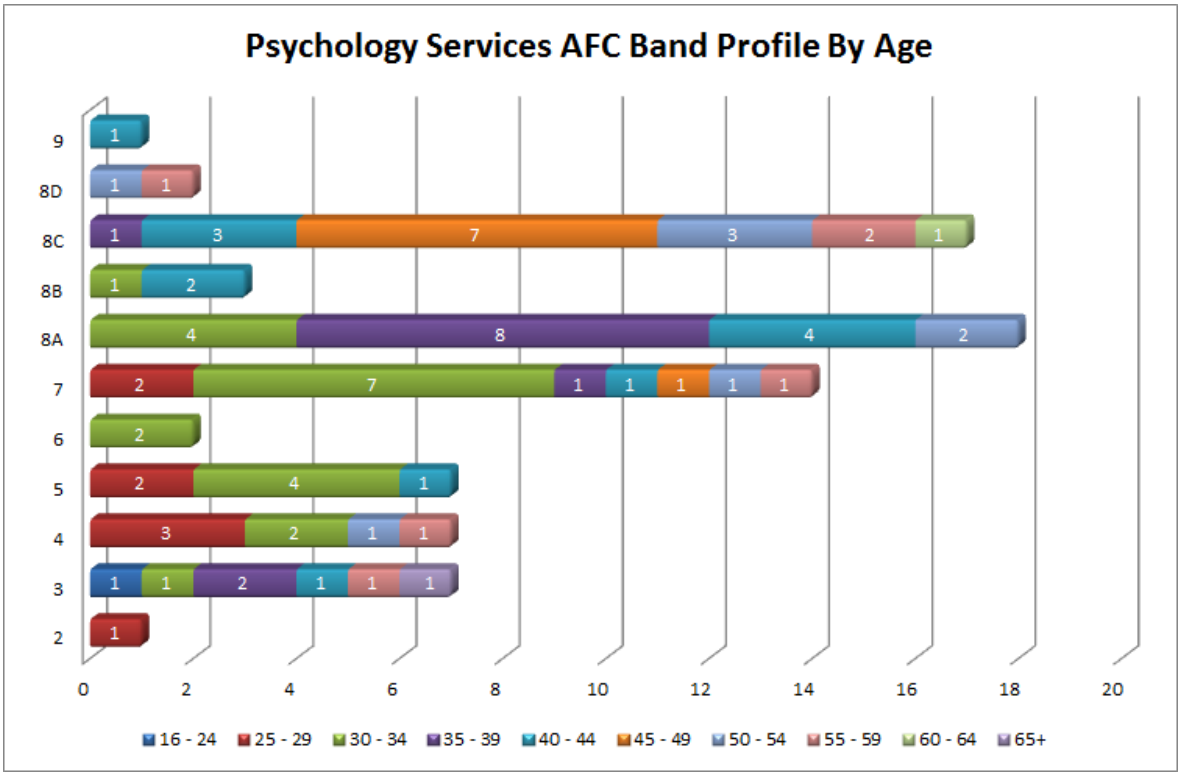
Graph 1

Graph 2 illustrates the age profile for the Service area and as can be seen there is a fairly even distribution of age ranges amongst all the staff with the possible exception of the number of staff in the 30-34 age group.



Graph 2

Graph 3 considers the age profile of the staff and the impact it will have on the different grades of staff. Unlike the other Service areas within the Directorate Psychology Services age profile indicates a greater number of staff in the younger age groups. At bands 8A to 8D level 10% of the staff at this grade is aged 55 or older, with a further 10 %of staff at this grade between the ages of 50 and 54. The indication is that 20% of the total staff at this grade will be 55 or over by 2020, which may have implications for succession planning and potential loss of skills and knowledge. Within the Service area 40 of the staff, 51%, are at Band 8A to Band 8D.

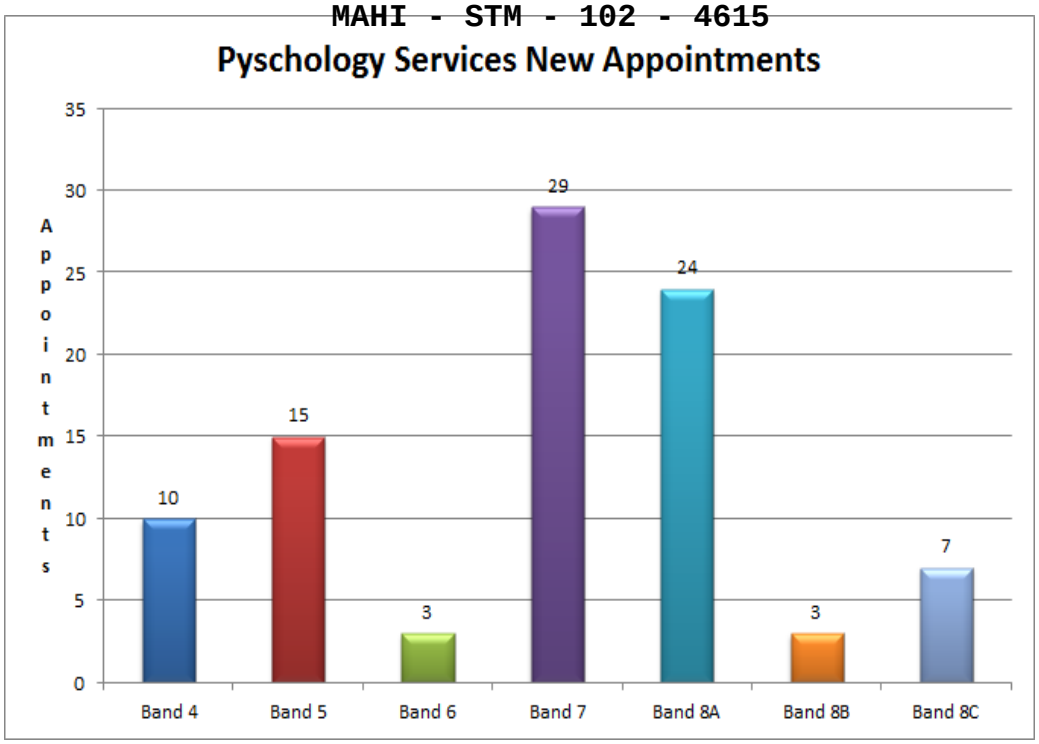


Graph 3

2.4.5.1 Recruitment

In the five year period up to 31 March 2015 there were 91 appointments made to Psychology Services.

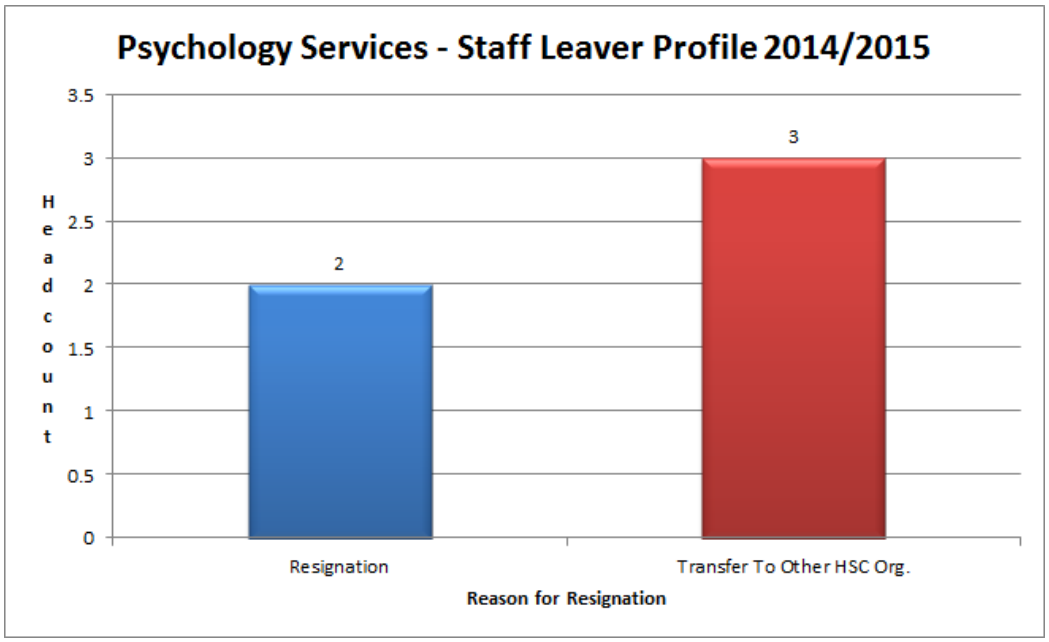
Over the last 5 years 91 staff have been appointed to positions within the Psychology Service area. During this period 29 Band 7 staff (31%) have been appointed across the Service area, which has the highest number of new appointments. Band 8A staff, with 24 (26%), has the second highest total of staff appointments within the Service area. There has been 10 Band 8 staff appointed to Psychology Services.



Graph 4

During the last 12 months four staff were appointed to new posts, including 3 qualified members of staff and 1 support staff.

Graph 5 illustrates the reasons recorded for staff leaving the Psychology Services between 1st April 2014 and 31st March 2015. During this period 5 staff left the Service area.



Graph 5

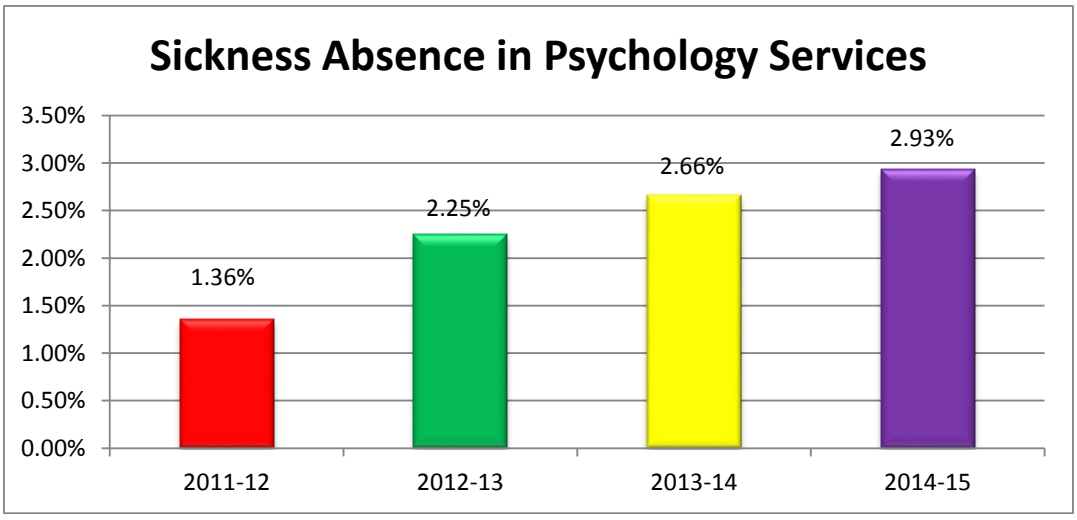
2.4.5.2 Skill Mix

Graph 6 below highlights the skill mix for Psychology Services.

Graph 6

2.4.5.3 Sickness Absence

Graph 7 reflects the level of sickness absenteeism in Psychology Services between 1st April 2011 and 31st March 2015. As can be clearly seen the trend is in an upward direction. By 31st March 2015 the level of absenteeism was over twice the rate as that at 31st March 2012. In total there were 559 days lost due to sickness in the last year, which equates to 2.5 WTE staff.



Graph 7

In the period up to 31st March 2015 there was approximately 4,000 hours (2.4 wte staff) lost within the Service due to sickness absenteeism. The four most common reasons recorded for these absences are Disc problems, 720 hours; Post-surgical Debility, 698 hours; Vertigo, 332 hours and work related Stress, 1012 hours. Over the last year the Service area lost a total of 1012 hours due to work related stress. Table 2 over provides the cost associated with this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

Psychology Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
3	600	5478
7	412.5	7516
Total	**1012.5**	**12994**

Table 2

2.4. Summary

The Psychology Service is a small, but key Service within the Directorate. Services are provided across the other three key areas within the Directorate. As a consequence of this role the Service responds to the demands of the other Service areas and delivers Services accordingly. Planning for the future is more challenging because of this as the management team need to be aware of the demands of the main Service users, before they can fully identify and plan their own Service initiatives and changes.

Sickness absence within the Service has almost doubled and assistance is available from the Attendance Management Team in HR to address any areas of concern relating to this issue.

3. Summary of key Findings

The Directorate, like every clinical Directorate is a care provider and vitally dependent on its staff who are required to be in the right place, at the right time, with the right skills, delivering the right care to the right Service users. Workforce planning is therefore vital to ensure we have a clear plan of how the current workforce can meet the challenges ahead and at the same time continue to put the patient first every time all of the time.

This Workforce Plan is very much a working document that will evolve over time and be continuously reviewed, updated and monitored as the Directorate adjusts over the course of time to the challenges it faces. Getting the balance between the workforce demand and supply is in itself a key challenge and undoubtedly workforce planning is a hugely complex exercise.

A number of key findings have been identified throughout the document and include:-

- A continued focus on high quality service provision to improve the Service User experience.
- A greater focus on delivering Services at home, near to home, or in community based settings.
- Our workforce will require greater skills in the use of technology to enhance both their working environment and the Service User experience.
- Our workforce is ageing and a focus on their health and well being will be required to support staff working longer.
- New roles will need to be developed to support staff moving from the acute to the community.
- New ways of working to support more Services being delivered 24 hours a day, 7 days a week.
- A greater focus on managing attendance.
- The importance of workforce intelligence and good quality data to support the review, and update of this workforce plan and to aid business decision making.
- A focus on the required workforce going forward in terms of WTE's, Grade and skill mix requirements.
- A renewed focus on registering our social care workforce with NISCC to give greater confidence and assurance to Services Users, that those providing their care are suitable and safe to do so.

Overall this Workforce Plan is linked directly to the strategic vision and priorities of the Directorate. The ongoing development of the workforce to ensure it is flexible, skilled and trained to deliver different models and patterns of care will be an area of focus over the next five years, ensuring that we maintain a positive attitude as we care, support and improve together.

4. References

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http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf TYC

http://www.nidirect.gov.uk/transforming-your-care-tyc TYC

http://www.dhsspsni.gov.uk/swstrategy.pdf

5. Annexes

Annex A

Membership of the Workforce Planning Steering Committee

Joan Peden, Co-Director of HR
Monica Molloy – Senior HR Manager Modernisation & WFP
Stephanie Read – Senior HR Manager Modernisation & WFP
Neil McDaid – HR Manager Modernisation & WFP
John Veitch – Co-Director Learning Disability
Barney McNeaney – Co-Director Mental Health
Marie Heaney – Co-Director Older People Services
Bridget Denvir – District Nursing Review
Neil Kelly – Learning Disability Community
Jillian Martin - Social Services Review
Damien Maguire – NIPSA
Roberta Magee - Unison

Annex B

Membership of the Workforce Modernisation Board

Catherine McNicholl (Chair)**,** Adult Social & Primary Care Director
Joan Peden, Co-Director of HR, BHSCT
John Veitch, Co-Director Learning Disability Services
Barney McNeaney, Co-Director Mental Health Services
Marie Heaney, Co-Director Older People and Physical & Sensory Disability Services
Michael Blaney, Finance Partner
Maurice O'Kane, Performance & Service Planning
Roberta Magee – Unison
Joe Lynch – Unison
David Kerr – RCN
Damien Maguire - NIPSA

6. APPENDIX ONE

Belfast Health and Social Care Trust

Terms of Reference

Adult Social and Primary Care Directorate
Steering Group
on the
Development of an Integrated Workforce Plan

1) Project Aim

To determine an overall Directorate Workforce Plan for which describes, identifies and sets out the key workforce issues, associated with the Service plans within the Directorate, including future Service needs of the Directorate

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles
- Workforce trends and requirements, turnover, recruitment
- Training requirements

Project Description

A broad description of the Integrated Workforce Plan is as follows :-

- Overview of Directorate
  - Vision
  - Values
  - Priorities and Plans
  - Description of Workforce and Workforce Trends and Issues 2013

- Service by Service Review
  - Define the Plan / Purpose / Scope
  - Visioning the Future / Mapping the Service Change
  - Application of the Six Step Model
  - Assessing the required workforce
  - Identifying Workforce availability
  - Development an Action Plan
  - Implementation Plan
  - Overview for Directorate
  - Conclusion and Implementation and Monitoring Plan and Arrangements

2) Role and Responsibilities

- To oversee the development of the Workforce Plan in accordance with the Project Plan
- To report to and update the Modernisation Board on Progress

3) Membership

3.1 Chair

The Chair of the Steering Group will be Joan Peden : Co-Director, Human Resources and Adult Social and Primary Care HR Business Partner

3.2 Members

4) Timescale

As set out with the Project Plan

5) Frequency of Meeting

Belfast Health and Social Care Trust

caring supporting improving together

Adult Social & Primary Care Directorate

Monitoring Report on Integrated Workforce Plan

April 2015 – March 2020

Update as at 31 March 2017

Introduction

This monitoring report provides an update on key elements of the workforce plan for Adult Social and Primary Care, which was signed off by the then Director, Catherine McNicholl in 2016. This report provides an update for senior managers within the Directorate covering a number of key areas including workforce information, broken down by service area and by band; skill mix and reasons for staff leaving the Directorate. Information is also provided on the major staff reviews that are ongoing in the Directorate and other areas, which were felt would be beneficial if they were included in this update.

The key Highlights of the Monitoring Report include:

- 22 live projects within the Directorate at 31 March 2017
- Agency expenditure on admin staff has increased
- There has been a small decrease in the overall workforce
- The largest increase in staff was at Band 6
- There have been 11 new roles introduced into the Directorate
- Approximately 1900 social care staff have registered with NISCC
- Sickness absence has increased to 7.72%
- Collective Leadership structures are currently being developed within the Directorate

A template, to reflect the key areas of focus from the plan, was agreed with the Directorate's senior management team and this is the template used by the Modernisation and Workforce Planning Team in this monitoring report. The period covered by this report is the 12 months to 31 March 2017.

Key Area	Action	Lead	Update March 2017
1. Reform and Proposed Modernisation Projects	To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan; identify and map out the workforce implementation issues and necessary actions To apply the Trust's Framework on the Management of Staff affected by organisational change	Co-Directors / Senior Managers	There were 22 live modernisation projects across the Directorate, at the 31 March 2017, as summarised in the table below.

Project Title	No.
Older People Services – Live Projects	**13**
Admin Review	1
Social Care Workforce Review	1
Domiciliary Care Services – Review of service delivery	1
District Nursing Review	1
Temporary Closure of Meadowlands	1
Future developments of dementia (EMI Services) – Review of service delivery model	1
Physical and Sensory Disability Services – Review of Day Care	1
Change of Working Pattern for Community Diabetes Nursing Service	1
Review of Community Rehabilitation Services (Older People Services)	1
Reprovision of Services at Ballyowen EMI Unit	1
Review of Elderly People's Homes	1
Stroke Services – Extended Working Week	1
Unscheduled Care Pathway Project - Community Unscheduled Care Workforce Group	1
Mental Health – Live Projects	**6**
Development of new Mental Health Inpatient Unit - workforce issues	1
Mental Health Day Opportunity Review	1
Neurobehavioural Rehabilitation Unit (NRU) – Resettlement of Patients	1
Redesigning the single point of access - Community Mental Health	1
Integration of Primary and Recovery Mental Health Teams	1
Mental Health Community Rehab extended working	1
Learning Disability – Live Projects	**3**
Muckamore Resettlement Workforce Project	1
Review of Day Opportunities in Learning Disability	1
Review the need for an extended working day/on-call facility in LD Community Treatment and Support Services	1
Grand Total	**22**

Key Area	Action	Lead	Update March 2017
2. Workforce Reviews	To complete and implement the local workforce reviews in the following areas	Co-Directors / Senior Managers	
	Social Care Review	Katie Campbell	A Steering group was established to oversee the implementation of the recommendations of the review. The new team structures have been developed for the service, which have indicated significant changes to the current structure. The proposals, which required the redeployment of XXXX staff, were equality screened. It was necessary to have a selection process to align staff to their new positions and this process took place in February. The plan is to complete the redeployment of all staff by September 2017.
	District Nursing Review	Gabby Tinsley	A Steering group has been established to implement the recommendations of the review. Phase 1 has been completed, but phase 2 will not commence until a service lead is in post to take project forward.
	Admin Review (Older People Services)	Marie Heaney	The report has been completed. The Admin. Manager (Band 7) has been appointed who is charged with the responsibility of implementing the recommendations of the report. These include the introduction of new structures and the harmonisation of administration practices and processes across the service.
	Agency Staffing Reduction		During the 12 months 1 April to 31 March 2017, 32 admin staff were appointed to the Directorate and there were 27 leavers. It should be noted that 3 admin staff appointed in this period left within the same reporting year. The level of expenditure, on agency admin staff, was up by £431,102 (21.4%) for the year when compared to the same period in 2015/16, to a total of £2,014,000. Overall there was an increase in the number of admin & clerical staff employed in the Directorate, with 32 new appointments, 28 at Bands 2 to 4 and 25 staff who left the Directorate, 20 of whom were employed at Bands 2 to 4.

			Over the same period, there was an increase in sickness absence amongst admin & clerical staff from 4.8% to 5.3%.

Key Area	Action	Lead	Update March 2017
3. WTE's	To track movement and/or changes in WTE	Modernisation & Workforce Planning Team	Overall, during the monitoring period, the workforce decreased by 27 staff (2.64 WTE). The reason the WTE has only decreased slightly compared to the headcount is due to existing staff increasing their hours during the past 12 months (170 staff increased their hours by a total of 39.72 WTE compared with 152 staff who decreased their hours by 27.86 WTE. (+11.86 WTE) The only increase in staff occurred in Children & Learning Disability Services, by 4 headcount (10.67 WTE). The biggest change occurred within Care of the Elderly, which had a decrease of 13 headcount, but experienced an increase in WTE by 3.22. This is due to new staff coming into the service area with a higher WTE than the staff who left the service area who had a lower WTE. The Admin sub division has substantially decreased headcount from 31 March 2015 due to restructuring of the organisational units. The majority of these admin staff were moved to the Care of the Elderly division now positioned under Paula Weir.

Staff in Post by Service Area

Organizational Unit	31 March 2015 HC	31 March 2015 WTE	31 March 2016 HC	31 March 2016 WTE	31 March 2017 HC	31 March 2017 WTE
ADMIN SUBDIV	140	106.9	20	19.8	16	16
CARE OF THE ELDERLY DIV	2514	1940.1	2480	2018.47	2467	2021.69
CHILDREN & LEARNING DISABILITY DIV	882	772.6	930	818.66	934	829.33
MENTAL HEALTH & CAMHS DIV	954	887.1	1023	961.70	1010	949.99
PSYCHOLOGICAL SERVICES DIV	79	71.41	84	77.54	83	77.51
Grand Total	**4639**	**3906.1**	**4537**	**3897.18**	**4510**	**3894.54**

Key Area	Action	Lead	Update March 2017
4. Skill Mix	To track and monitor shifts in skill mix primarily within : ▪ Nursing ▪ Social Care	Modernisation & Workforce Planning Team	There has been a change in the nursing skill mix during the year ending 31 March 2017, changing from 66:34 to 65:35 qualified to support staff. This is due to a decrease in qualified nursing staff compared to nursing support staff, -29 Headcount, -23.12 WTE. As at 31st March 2017, there were 108 vacant positions in Nursing within the Directorate. The majority are at Band 5 level, 39, followed by 38 Band 3s, 23 Band 6s, 7 Band 7s and 1 Band 8B. These vacant positions have all been progressed with requisitions through to Recruitment. There has also been a change in the social care skill mix, from 21:79 in March 2016 to 22:78 qualified to support staff, as at 31 March 2017. This change is due to an increase in the number of qualified social workers and a decrease in Social Care support staff. Social Care support staff have decreased each year since 31 March 2015. (-100 HC/-38.92WTE overall)

Skill Mix									
	31 March 2015			31 March 2016			31 March 2017		
Nursing Skill Mix	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**
Qualified Nursing	1096	1011.07	65	1115	1034.85	66	1086	1011.73	65
Nursing Support	592	501.34	35	579	494.59	34	579	498.85	35
Total	**1688**	**1512.41**	**100**	**1694**	**1529.44**	**100**	**1665**	**1510.59**	**100**
Social Care Skill Mix									
Qualified Social Work Staff	441	403.71	21	418	394.38	21	449	424.44	22
Social Care Support	1672	1271.41	79	1611	1255.51	79	1572	1232.49	78
Total	**2113**	**1675.12**	**100**	**2029**	**1649.89**	**100**	**2021**	**1656.93**	**100**

Key Area	Action	Lead	Update March 2017
5. Grade Mix	To track and keep under review any grade mix change	Modernisation & Workforce Planning Team	The biggest change in the Directorate grade mix is seen at Band 5 level where there has been a decrease of 22 (17.49 WTE). The majority of these staff were from the Nursing & Midwifery occupational group, 20 (15.73 WTE). The percentage of Nursing staff who left the Directorate is higher in comparison to the figure for the Trust as a whole. 30% of leavers in the Directorate were Nursing staff compared to 20% Trust wide. The largest increase in the Directorate was at Band 6, which increased by 20 staff (21 WTE). The biggest increase in these Band 6 staff came from the Social Services occupational group, 16 (15.93 WTE).

ASPC Staff in post by Agenda for Change Band Profile						
Band	**31 March 2015**		**31 March 2016**		**31 March 2017**	
	HC	**WTE**	**HC**	**WTE**	**HC**	**WTE**
Band 2	924	634.4	739	517.68	706	497.18
Band 3	1193	979.8	1289	1058.69	1305	1080.06
Band 4	184	166.5	168	150.03	165	149.36
Band 5	1048	940.5	1036	945.71	1014	928.22
Band 6	535	489.7	525	488.14	545	509.14
Band 7	423	401.9	447	430.80	445	428.04
Band 8a	87	81.19	89	83.58	93	88.0
Band 8b	20	18.20	21	20.00	22	20.72
Band 8c	25	22.59	26	23.1	27	24.83
Band 8d+	7	6.6	7	6.6	6	5.6
TOTAL	**4446**	**3741.38**	**4347**	**3724.35**	**4510***	**3894.54***

**There are 182 NON AFC Staff, 163.40WTE in the Adult, Social & Primary Care Directorate*

Key Area	Action	Lead	Update March 2017
6. Changing Roles and Responsibilities	To identify and meet the development needs of changing roles and responsibilities Development of Collective Leadership model	Senior Managers / Human Resources / Professional Leads Director/ Co-Directors/ Human Resources	Under the Changed Job Process, there was 1 application for 3 post holders. The Directorate has engaged in the development of its collective leadership structure. The structures, which were not yet complete by the date of this update, are based on Divisions, i.e. Older People; Mental Health and Learning Disability, representing the service areas within the Directorate. The Chairperson will be a member of medical staff. The divisions will be organised into Care Delivery Units. Leadership at this level will be provided by senior

			clinical expert(s), supported by experienced Senior Managers. The Draft structures are included in Appendix 1.
7. New Roles	To support the development and implementation of new roles, eg. Consultation, change process and associated banding	Senior Managers / Human Resources / Professional Leads	There have been 11 new roles introduced into the Directorate. These are: • Night Co-ordinator (Band 7) – Mental Health Services • Primary Care Partnership Hub Practitioner (Band 6) – Mental Health Services. • Driver - Acute Care At Home Team (Band 2) • Deputy Manager, Residential Homes for People with Dementia (Band 6) • Administration Service Manager (Band 7) • Acting Head of Learning Disability Services (Band 8C) • Peer Support Worker: Mental Health (Band 3) • Social Care Co-ordinator (Band 4) • Dementia Nurse, Dementia Inpatient/Outreach Service (Band 6) • Triage/Discharge Assistant (Band 4) • Care Review and Support Practitioner (Band 6): CReST The new roles that have been created within the Directorate have all been assessed by the Pay Modernisation Team within HR

Key Area	Action	Lead	Update March 2017
8. Professional Issues	To support the implementation of the revalidation process for nurses To support the registration process within the Social Care Workforce	Senior Managers / Human Resources / Professional Leads	During the course of the next 6 months a total of 554 nursing staff will be required to participate in revalidation as shown in the table below. The information is based on HRTPS as at 31 March 2017. Both social work and social care staff are now required to register with the Northern Ireland Social Care Council (NISCC). There was approximately 2000 social care staff to be registered by 31 March 2017. By the end of the year approximately 150 staff, who had still to

			register with NISCC. The reasons for this include staff on sick leave career break and other leave. The Mental Capacity Bill passed into law in 2016. The impact the Bill will have on the Service is still unclear as many of the issues that will affect the service are likely to be modified dependent on the guidance to the Act. Over the last 6 years, there has been significant growth in the amount of adult safeguarding work being undertaken. During the last year, the Trust had 36% of the total number of regional referrals (3069), of which 2984 were to the ASPC Directorate. The new adult safeguarding policy and procedures will have a major impact on the Directorate. There will be greater expectation in relation to prevention work, with no additional funding being provided. The new policy will see the creation of a single point of contact for referrals; new definitions on the management of adults at risk of harm, who do not meet the current threshold for protection, which will lead to additional work within the services. Designated Adult Protection Officers must be qualified social workers at Band 7 or above who will require extensive training on the new policy. It has been identified that there will be considerable costs associated with the implementation of the new policy and procedures.

Nursing Registration

Month Registration due to expire	Number of staff
Lapsed Registrations	5*
March 2017	1
April 2017	37
May 2017	31
June 2017	37
July 2017	68
August 2017	28
September 2017	352

*3 members of staff were on a career break, 1 was on long term sick leave and 1 is carrying out trade union duties full time.

Key Area	Action	Lead	Update March 2017
9. Recruitment and Retention Strategies and Actions	To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas	Senior Leads / Human Resources	There were 221 requisitions raised to fill vacant posts. There were 98 for nursing and 88 for social services positions. Older People services had 76 requisitions for vacant posts; Mental Health Services had 51 and Learning Disability had 49 requisitions. There was also a Directorate wide recruitment fayre for Nurses and Social Workers, which took place on Saturday 14 May 2016; over 268 individuals attended with 192 individuals successful on the day. Twenty Social Worker appointments were made and 30 appointments were made to Nursing posts, subject to pre-employment checks. A waiting list has been established. There was 24 Staff Nurses Band 5 appointed to Learning Disability services and 6 in Mental Health.
	To review and monitor reasons for leaving to inform action		An analysis of the need to undertake another Recruitment fayre in 2017 is currently being carried out. During the year, The Mod & WFP and the Retained Recruitment Teams have worked with the managers at MAH to devise a plan to address the staffing issues, linked to the patient resettlement process. These delays were due to difficulties experienced by

			external organisations linked to the building of suitable new premises into which patients can be resettled. There is no significant change in either the number of staff leaving the Directorate nor the reasons for their leaving. The Trust Nursing Voluntary Internal Transfer Policy went live in June 2016 and as at 31 January 2017 has received 112 internal transfer requests. Nine of these requests came from Adult Social & Primary Care staff. Twenty-two staff made requests to transfer into the Adult Social & Primary Care Directorate Do we know what area they wanted to move into?(Emailed Margaret Devlin 28/07 to find out). It was the only Directorate to receive more requests into the Directorate than out. When comparing the list of Directorate new starts against leavers, excluding temporary staff, 15 had started and subsequently left in the same reporting period. Ten of these staff belonged to the Nursing & Midwifery occupational group. Seven were Band 5 (6.6 WTE) and 3 were Band 3 staff (2.8 WTE). Their reasons for leaving were mostly Resignation. Of the 15 staff, 8 left from the Care of the Elderly services, 4 from Mental Health, and 3 from Children & Learning Disability. There were 32 leavers in the reporting period at Band 7 level, 29.64 WTE. (9.7% of all leavers) 15 left under 'Resignation', 14 left due to Retirement, 2 under Ill Health Retirement and 1 Ill Health termination.

Reasons for Leaving the Directorate

Reason for Leaving	2015/16 HC	2015/16 WTE	2016/17 HC	2016/17 WTE
Resignation	123	101.51	136	107.73
Retirement	61	50.13	78	67.72
Medical Rotation	54	52.5	40	38.69
Ill Health - Termination	23	17	30	22.98
Ill Health - Retirement	16	13.5	14	11.08
Transfer To Other HSC Org.	14	13.1	9	6.68
End of Fixed Term Cont/Event	5	4.8	5	4.6
VER	2	2	5	3.68
Death in Service	1	1	1	1
Dismissal - Disciplinary Act.	1	0.8	2	2
External Secondee Out			1	1
Grand Total	**300**	**256.34**	**321**	**267.16**

Key Area	Action	Lead	Update March 2017
10. Local Induction	To review local induction arrangements	Senior Managers / Human Resources	A local induction programme is in place in all of the service areas within the Directorate. It has been used for new starts appointed following the Recruitment Fayre on 14 May 2016. The programmes have been updated following feedback from previous participants.

Key Area	Action	Lead	Update March 2017

11. Succession Planning	To take targeted action to provide succession planning development opportunities in identified groups and areas including: ▪ Coaching ▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme ▪ To undertake further analysis, eg. survey or interviews to inform further action	Senior Managers / Workforce Planning Team	A succession plan has been developed for the Trust, which is based on which Tier the staff member is as opposed to Bands. The highlights for the ASPC Directorate are that: There are 112 staff in Tiers 2 to 5. The Directorate accounts for almost 21% of the total staff at these levels within the Trust. There are 8 staff at Tier 3; 32 at Tier 4 and 71 at Tier 5. Currently 2 members of staff, at Tiers 4 and 5, are undertaking the Succession Planning Course.

Key Area	Action	Lead	Update March 2017
12. Improving Health and Wellbeing and Engagement within Directorate	To reduce the level of sickness absence within the Directorate by 1%	Co-Directors / Senior Managers / Human Resources	The level of sickness absence rose from 7.07% at 31 March 2016 to 7.72% at 31 March 2017 and the target for the end of the year was 6.71%. The absence rate is 1.28% above the Trust rate. On average 20 days were lost per employee due to sickness absence. Over 25,000 days were lost due to mental health illnesses. Return to Work interviews were completed on 46% of occasions.

	To develop a bespoke health and wellbeing and engagement action plan for the Directorate. Consistent application of attendance management toolkit and Trust policy. Review underlying reasons for absence (root cause) and bespoke programme in place to address issues. Increase awareness and knowledge of local 'B'Well' and regional 'Choose Well' programmes. Increase Directorate representatives at the Health and Wellbeing Steering Group. Support Living the Values of the Trust within the Directorate.		A Trust Wide Steering Group has been established and the Directorate is represented on this group. The Attendance Management Team had completed an exercise to review the causes of absence across the Trust in the latter part of 2015 and ASPC were involved in this exercise. The Directorate has a representative on the "B"Well Group. Eighty-seven teams have held workshops on values up to the end of March 2017.
Key Area	**Action**	**Lead**	**Update March 2017**
13. Technology	To continue to improve access, knowledge and skills in the use of new technology To embrace and utilise technology to support new ways of working	Co-Directors / Senior Managers	During the year to 31 March 2017, the number of staff registered to use HRPTS increased from 2310 to 4771. There was a request for 2878 password resets, which are due to staff locking themselves out of the system or forgetting their password. The roll out of Community Information System - PARIS is almost complete and at the end of the year Psychology were the last major team to complete this exercise. Generally, within the service there is a move away from manual/ paper records. Staff Plan has been

			rolled out within the Older People Service. Currently the system is of limited use with the biggest benefit being the reporting mechanism. There are issues with scheduling which makes the system labour intensive for the Co-ordinators.

Appendix 1

Leadership Structures

Learning Disability Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - Divisional Nurse (new)
  - Carer Consultant (new)

The team collectively reports to the ASPC Director and professional reporting lines remain unchanged

Mental Health Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - Divisional Nurse (new)
  - Service User Consultant (existing role)

The team will collectively report to the ASPC Director. Professional reporting lines remain unchanged

Older People's & Physical Disability Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - 2 Divisional Nurses (new) for Community and Hospital
  - Service User Consultant (new)

The team will collectively report to the ASPC Director. Professional reporting lines remain unchanged

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Adult Social & Primary Care Directorate

Monitoring Report on Integrated Workforce Plan

April 2015 – March 2020

Update as at 31 March 2018

Introduction

This monitoring report provides an update on key elements of the workforce plan for Adult Social and Primary Care, which was signed off by the then Director, Catherine McNicholl in 2016. This report provides an update for senior managers within the Directorate covering a number of key areas including workforce information, broken down by service area and by band; skill mix and reasons for staff leaving the Directorate. Information is also provided on the major staff reviews that are ongoing in the Directorate and other areas, which were felt would be beneficial if they were included in this update.

The key Highlights of the Monitoring Report include:

- 16 live projects within the Directorate at 31 March 2018
- Small increase in expenditure on admin agency staff
- There has been no significant change to the overall workforce
- The largest increase in staff was at Band 6
- There have been 19 new roles introduced into the Directorate
- Over 2,000 social care staff have registered with NISCC
- Sickness absence has increased to 8.31%
- Collective Leadership structures are currently being developed within the Directorate

A template, to reflect the key areas of focus from the plan, was agreed with the Directorate's senior management team and this is the template used by the Modernisation and Workforce Planning Team in this monitoring report. The period covered by this report is the 12 months to 31 March 2018.

Key Area	Action	Lead	Update March 2018
1. Reform and Proposed Modernisation Projects	To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan; identify and map out the workforce implementation issues and necessary actions To apply the Trust's Framework on the Management of Staff affected by organisational change	Co-Directors / Senior Managers	There were 15 live modernisation projects and 1 TUPE exercise, which is included below, across the Directorate, at the 31 March 2018, as summarised in the table below.

Project Title	No.
Older People Services - Live Project	**9**
Stroke Services on RGH site phase 2	1
Guaranteed Hours for Domiciliary Home Care Service South & East/North & West & Regional UNISON Partnership Prog Phase 2	1
Change of Working Pattern for Community Diabetes Nursing Service	1
Reprovision of Ballyowen EMI	1
District Nursing HR Workforce Task and Finish Group	1
Extended working week	1
ASPC Social Care Workforce Review	1
Review of EMI Day Care	1
Transport Service Improvement Project	1
Mental Health - Live Projects	**4**
Development of new Mental Health Inpatient Unit- workforce issues	1
Neurobehavioral Rehabilitation Unit (NRU)	1
Mental Health Community Rehab extended working	1
TUPE - LIFELINE	1
Learning Disability - Live Projects	**3**
Muckamore Resettlement Workforce Project	1
Review of Day Centres Physical Disability	1
Review the need for an extended working day/on-call facility in LD Community Treatments and Support Services	1
Grand Total	**16**

Key Area	Action	Lead	Update March 2018
2. Workforce Reviews	To complete and implement the local workforce reviews in the following areas	Co-Directors / Senior Managers	
	Social Care Review	Katie Campbell	A Steering group was established to oversee the implementation of the recommendations of the review. The new team structures have been developed for the service, which have indicated significant changes to the current structure. The proposals, which required the redeployment of 17 staff, were equality screened. It was necessary to have a selection process to align staff to their new positions and this process took place in February 2017. The plan was to complete the redeployment of all staff by September 2017 and this happened. Two staff opted to leave the service through the Voluntary Exit Scheme.
	Agency Staffing Reduction		During the period 1 April 2017 to 31 March 2018, 32 admin staff were appointed to the Directorate and there were 27 leavers. It should be noted that 3 admin staff appointed in this period left within the same reporting year. The level of expenditure, on agency admin staff, was £2.079m, which is an increase of £65,000 on the previous year. This represents a slow down in the expenditure on admin agency which had an increase in excess of £400,000 during the previous year.. The rate of sickness absence for the year, amongst admin staff was 6.41%, up from 5.3% for the previous year. However, this does represent a significant decrease from the start of the period when the absence rate amongst admin staff was 14.43%.

Key Area	Action	Lead	Update March 2018
3. WTE's	To track movement and/or changes in WTE	Modernisation & Workforce Planning Team	Overall, during the monitoring period, the workforce increased by 3 staff (14.88 WTE), indicating that staff are taking on more working hours. The only decrease in staff occurred in Care of the Elderly Services, by 16 headcount (6.09 WTE). The biggest change occurred within Psychological Services, which had an increase of 9 headcount and an increase in WTE by 7.47.

Staff in Post by Service Area

	31 March 2015		31 March 2016		31 March 2017		31 March 2018	
Organizational Unit	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**
ADMIN SUBDIV	140	106.9	20	19.8	16	16	23	21.6
CARE OF THE ELDERLY DIV	2514	1940.1	2480	2018.47	2467	2021.69	2448	2015.6
CHILDREN & LEARNING DISABILITY DIV	882	772.6	930	818.66	934	829.33	935	827.26
MENTAL HEALTH & CAMHS DIV	954	887.1	1023	961.70	1010	949.99	1015	959.98
PSYCHOLOGICAL SERVICES DIV	79	71.41	84	77.54	83	77.51	92	84.98
Grand Total	**4639**	**3906.1**	**4537**	**3897.18**	**4510**	**3894.54**	**4513**	**3909.42**

Key Area	Action	Lead	Update March 2018
4. Skill Mix	To track and monitor shifts in skill mix primarily within : ▪ Nursing ▪ Social Care	Modernisation & Workforce Planning Team	There has been a change in the nursing skill mix from the previous year, which was 65:35 qualified to support staff to 64:36 at 31 March 2018. This is due to the headcount of qualified nursing staff decreasing by 53, and support increasing headcount by 3. There has also been a change in the social care skill mix, from 22:78 in March 2017 to 23:77 qualified to support staff, as at 31

			March 2018. This change is due to an increase in the number of qualified social workers by 20 headcount and a decrease in Social Care support staff by 5. Social Care support staff have decreased each year since 31 March 2015. (-105 HC (-36.26 WTE) overall)

Skill Mix												
	31 March 2015			31 March 2016			31 March 2017			31 March 2018		
Nursing Skill Mix	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**
Qualified Nursing	1096	1011.07	65	1115	1034.85	66	1086	1011.73	65	1033	962.61	64
Nursing Support	592	501.34	35	579	494.59	34	579	498.85	35	582	503.88	36
Total	**1688**	**1512.41**	**100**	**1694**	**1529.44**	**100**	**1665**	**1510.59**	**100**	**1615**	**1466.49**	**100**
Social Care Skill Mix												
Qualified Social Work Staff	441	403.71	21	418	394.38	21	449	424.44	22	469	440.01	23
Social Care Support	1672	1271.41	79	1611	1255.51	79	1572	1232.49	78	1567	1235.15	77
Total	**2113**	**1675.12**	**100**	**2029**	**1649.89**	**100**	**2021**	**1656.93**	**100**	**2036**	**1675.16**	**100**

Key Area	Action	Lead	Update March 2018
5. Grade Mix	To track and keep under review any grade mix change	Modernisation & Workforce Planning Team	The biggest change in the Directorate grade mix is seen at Band 5 level where there has been a decrease of 74 (71.01 WTE). The majority of these staff were from the Nursing & Midwifery occupational group, 62 (62.08 WTE). The largest increase in the Directorate was at Band 6, which increased by 58 staff (56.82 WTE). The biggest increase in these Band 6 staff came from the Social Services occupational group, 30 (26.83 WTE).

ASPC Staff in post by Agenda for Change Band Profile								
Band	**31 March 2015**		**31 March 2016**		**31 March 2017**		**31 March 2018**	
	HC	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**
Band 2	924	634.4	739	517.68	706	497.18	661	465.07
Band 3	1193	979.8	1289	1058.69	1305	1080.06	1343	1114.28
Band 4	184	166.5	168	150.03	165	149.36	177	162.18
Band 5	1048	940.5	1036	945.71	1014	928.22	940	857.21
Band 6	535	489.7	525	488.14	545	509.14	603	565.96
Band 7	423	401.9	447	430.80	445	428.04	443	424.95
Band 8a	87	81.19	89	83.58	93	88.0	105	98.18
Band 8b	20	18.20	21	20.00	22	20.72	24	24.20
Band 8c	25	22.59	26	23.1	27	24.83	28	26.71
Band 8d+	7	6.6	7	6.6	6	5.6	5	4.60
TOTAL	**4446**	**3741.38**	**4347**	**3724.35**	**4510***	**3894.54***	**4513***	**3909.42**

**There are 184 NON AFC Staff, 166.09WTE in the Adult, Social & Primary Care Directorate*

Key Area	Action	Lead	Update March 2018
6. Changing Roles and Responsibilities	To identify and meet the development needs of changing roles and responsibilities Development of Collective Leadership model	Senior Managers / Human Resources / Professional Leads Director/ Co-Directors/ Human Resources	Under the Changed Job Process, there were 9 change job applications. The new Divisional structures have been confirmed within the Directorate. These are attached in appendix 1 of this update.
7. New Roles	To support the development and implementation of new roles, eg. Consultation, change process and associated banding	Senior Managers / Human Resources / Professional Leads	There have been 19 new roles introduced into the Directorate. Examples of these include, Falls Prevention & Management Co-ordinator Band 7; Programme and Project Leader (Education, Communications & PR) Band 5;

			Case Finding Research and Development Practitioner Band 7 and Co-Production Manager - Connected Community Care Band 7 The new roles that have been created within the Directorate have all been assessed by the Pay Modernisation Team within HR.

Key Area	Action	Lead	Update March 2018
8. Professional Issues	To support the implementation of the revalidation process for nurses To support the registration process within the Social Care Workforce	Senior Managers / Human Resources / Professional Leads	During the course of the next 6 months a total of 361 nursing staff will be required to participate in revalidation as shown in the table below. The information is based on HRTPS as at 31 March 2018. Both social work and social care staff are now required to register with the Northern Ireland Social Care Council (NISCC). At the 31 March 2018 over 2,000 social care staff are registered with NISCC. There are 5 staff whose, registrations have lapsed. The reasons for this include staff on sick leave, career break and other leave.

Nursing Registration	
Month Registration due to expire	**Number of staff**
Lapsed Registrations	**4**
April 2018	3
May 2018	0
June 2018	1
July 2018	3
August 2018	2
September 2018	348

Key Area	Action	Lead	Update March 2018
9. Recruitment and Retention Strategies and Actions	To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas To review and monitor reasons for leaving to inform action	Senior Leads / Human Resources	There were 722 requisitions raised to fill vacant posts in the Directorate, of these 328 were for Nursing and 266 for Social services positions. Older People services had 398 requisitions for vacant posts; Mental Health Services had 134 and Learning Disability had 166 requisitions, Psychological Services 24. During the year, 22 nursing staff left the Directorate to go to another Directorate within the Trust. This included 15 qualified nursing staff and 7 support staff. Six of the movers went to Specialist Hospitals and Women's Health, Surgery & Specialist Services and Unscheduled & Acute Care with the remaining 4 staff moving to Children's Community Services. When comparing the list of Directorate new starts against leavers, excluding temporary staff, 17 had started and subsequently left in the same reporting period. Sixteen of these staff had permanent contracts and 1 was on a temporary contract. Seven staff were from the Nursing & Midwifery occupational group and 9 were from Social Services. Of the 17 staff, 9 left from the Care of the Elderly services, 4 from Mental Health, and 4 from Children & Learning Disability. The highest proportion of leavers were Band 5, 108 staff (99.33 WTE), followed by Band 3 staff, 93 (77.30 WTE). During the year, 180 (165.07 WTE) Nursing staff left the Directorate, accounting for over 50% of all leavers, compared to 18% of all leavers Trust wide. Within Social Services 117 (86.60 WTE) staff left the Directorate, accounting for 33% of all leavers compared to 9% of leavers Trust wide. There were 78 leavers in the reporting period at Band 5 level, 72.53 WTE. (39.4%) which left under 'Resignation'.

Reasons for Leaving the Directorate

Reason for Leaving	2015/16		2016/17		2017/2018	
	HC	WTE	HC	WTE	HC	WTE
Resignation	123	101.51	136	107.73	198	174.04
Retirement	61	50.13	78	67.72	77	66.64
Ill Health - Termination	23	17	30	22.98	36	24.51
Ill Health - Retirement	16	13.5	14	11.08	17	12.49
Transfer To Other HSC Org.	14	13.1	9	6.68	15	12.27
End of Fixed Term Cont/Event	5	4.8	5	4.6	1	0.20
VER	2	2	5	3.68	2	1.59
Death in Service	1	1	1	1	6	5.11
Dismissal - Disciplinary Act.	1	0.8	2	2	2	1.88
External Seconded Out			1	1	1	1.00
Grand Total	**246**	**203.84**	**281**	**228.47**	**355**	**299.73**

Key Area	Action	Lead	Update March 2018
10. Local Induction	To review local induction arrangements	Senior Managers / Human Resources	A local induction programme is in place in all of the service areas within the Directorate. It has been used for new starts appointed since May 2016.
11. Succession Planning	To take targeted action to provide succession planning development opportunities in identified groups and areas including: ▪ Coaching ▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme	Senior Managers / Workforce Planning Team	A succession plan has been developed for the Trust, which is based on which Tier the staff member is as opposed to Bands. The highlights for the ASPC Directorate are that: A Succession Plan is also being developed for the ASPC Directorate, which will be available during the summer of 2018. This will hopefully provide a catalyst for the Directorate to review its approach to succession planning with a view to putting in place a plan to ensure that there is minimal impact on service provision when key staff leave the Directorate.

	▪ To undertake further analysis, e.g. survey or interviews to inform further action		

Key Area	Action	Lead	Update March 2018
12. Improving Health and Wellbeing and Engagement within Directorate	To reduce the level of sickness absence within the Directorate by 1% To develop a bespoke health and wellbeing and engagement action plan for the Directorate. Consistent application of attendance management toolkit and Trust policy. Review underlying reasons for absence (root cause) and bespoke programme in place to address issues. Increase awareness and knowledge of local 'B'Well' and regional 'Choose Well' programmes. Increase Directorate representatives at the Health and Wellbeing Steering Group. Support Living the Values of the Trust within the Directorate.	Co-Directors / Senior Managers / Human Resources	The level of sickness absence rose from 7.72% at 31 March 2017 to 8.31% at 31 March 2018 and the target for the end of the year was 7.33%. The absence rate is 1.50% above the Trust rate. On average 21 days were lost per employee due to sickness absence. Over 26,000 days were lost due to mental health illnesses. The Attendance Management Team continues to support managers within ASPC to address the issues associated with high levels of staff absenteeism. The Directorate has a representative on the Trust's "B"Well Group. A Trust Wide Steering Group has been established and the Directorate is represented on this group. Thirty-six teams held Values workshops up to the end of March 2018. This more than any other Directorate during the same period.

Exit Interviews	In 2016 the Modernisation & Workforce Planning Team started to encourage staff who were due to leave the Trust, to complete the HRPTS Exit Interview Questionnaire. Each month an email is sent to upcoming leavers to request this questionnaire be completed to assist with Succession Planning.	Human Resources	From 1 April 2017 – 31 March 2018, 32 staff from the Directorate completed an Exit Interview. Sixteen staff who completed the Exit Interview were leaving due to 'Retirement'. 7 staff cited 'Better location/travel' as a main reason for leaving. Thirty of those who completed the Exit Interview answered 'Yes' when asked if they would recommend Belfast Trust as a good place to work.
Key Area	**Action**	**Lead**	**Update March 2018**
13. Technology	To continue to improve access, knowledge and skills in the use of new technology To embrace and utilise technology to support new ways of working	Co-Directors / Senior Managers	As at 31 March 2018, 4783 staff, across the Directorate, had been given a user ID to enable them to access the HRPTS. Generally, within the service there is a move away from manual/ paper records. Staff Plan has been rolled out within the Older People Service. Currently the system is of limited use with the biggest benefit being the reporting mechanism. There are issues with scheduling which makes the system labour intensive for the Co-ordinators.

Appendix 1

Leadership Structures

Learning Disability Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - Divisional Nurse (new)
  - Carer Consultant (new)

The team collectively reports to the ASPC Director and professional reporting lines remain unchanged

Mental Health Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - Divisional Nurse (new)
  - Service User Consultant (existing role)

The team will collectively report to the ASPC Director. Professional reporting lines remain unchanged

Older People's & Physical Disability Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - 2 Divisional Nurses (new) for 1 Community and 1 Hospital
  - Service User Consultant (new)

The team will collectively report to the ASPC Director. Professional reporting lines remain unchanged

Key Area	Action	Lead	Update March 2017
11. Succession Planning	To take targeted action to provide succession planning development opportunities in identified groups and areas including: ▪ Coaching ▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme ▪ To undertake further analysis, e.g. survey or interviews to inform further action	Senior Managers / Workforce Planning Team	A succession plan has been developed for the Trust, which is based on which Tier the staff member is as opposed to Bands. The highlights for the ASPC Directorate are that: A Succession Plan is also being developed for the ASPC Directorate, which will be available during the summer of 2018. This will hopefully provide a catalyst for the Directorate to review its approach to succession planning with a view to putting in place a plan to ensure that there is minimal impact on service provision when key staff leave the Directorate.

Belfast Health and Social Care Trust

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Adult Social & Primary Care Directorate

Monitoring Report on Integrated Workforce Plan

April 2015 – March 2020

Update as at 31 March 2019

Introduction

This monitoring report provides an update on key elements of the workforce plan for Adult Social and Primary Care, which was signed off by the then Director, Catherine McNicholl in 2016. This report provides an update for senior managers within the Directorate covering a number of key areas including workforce information, broken down by service area and by band; skill mix and reasons for staff leaving the Directorate. Information is also provided on the major staff reviews that are ongoing in the Directorate and other areas, which were felt would be beneficial if they were included in this update.

The key Highlights of the Monitoring Report include:

- 9 live projects within the Directorate at 31 March 2019
- Significant increase in expenditure on admin agency staff
- The workforce is at its highest level since 2015
- The largest increase in staff was at Band 3
- There have been 17 new roles introduced into the Directorate
- 107 social care staff registrations with NISCC had lapsed
- Sickness absence has decreased from 8.31% to 7.98%
- Collective Leadership structures have been completed for the Directorate

A template, to reflect the key areas of focus from the plan, was agreed with the Directorate's senior management team and this is the template used by the Modernisation and Workforce Planning Team in this monitoring report. The period covered by this report is the 12 months to 31 March 2019.

Key Area	Action	Lead	Update March 2018
1. Reform and Proposed Modernisation Projects	To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan; identify and map out the workforce implementation issues and necessary actions To apply the Trust's Framework on the Management of Staff affected by organisational change	Co-Directors / Senior Managers	There were 8 live modernisation projects and 1 TUPE exercise, which is included below, across the Directorate, at the 31 March 2019, as summarised in the table below.

Project Title	**Number Live of Projects**
Older People and Sensory & Physical Disability - Live Projects	
Community Discharge Hub	1
Stroke Services – Phase 2	1
Review of Day Centres – Physical Disability	1
Community Diabetes Service – Standardisation of processes and Change of Work Pattern	1
Transport Service Improvement Project	1
Mental Health Services – Live Projects	
New Mental Health Inpatient Centre	1
Closure of Neurobehavioural Rehabilitation Unit	1
Relocation of PACCS Team	1
Hospital Enhanced Liaison Psychiatry Service	1
Total	**9**

Completed Projects

During the year, 13 projects were completed and a breakdown of the areas is provided below:

Older people services	8
Mental Health Services	2*
Learning Disability Services	3
Total	**13**

* One of the projects was a TUPE exercise

Key Area	Action	Lead	Update March 2018
2. Workforce Reviews	To complete and implement the local workforce reviews in the following areas	Co-Directors / Senior Managers	
	Home Care Review	Katie Campbell	A Steering group was established to oversee a review of the delivery of the Home Care service. Initially the review will focus on the working patterns of staff and the banding of the staff currently in post. There are 44 different contracted hours, currently worked by the Home care staff and the review will investigate the possibility of reducing this number to 4 preferred levels of contracted hours. The review will also consider the banding of staff as there is a suggestion that our ability to recruit staff is impacted by the current band 2 level for home care staff.
	Agency Staffing Reduction		During the period 1 April 2018 to 31 March 2019, 49 admin staff were appointed to the Directorate and there were 21 leavers. The level of expenditure, on agency admin staff, was £2.7m, which is an increase of over £600,000 (28%) on the previous year. This represents a significant increase in the expenditure on admin agency staff, which had an increase of £65,000 during the previous year. The rate of sickness absence for the year, amongst admin staff, was 5.8%, down from 6.4% for the previous year.
3. WTE's	To track movement and/or changes in WTE	Modernisation & Workforce Planning Team	Overall, during the monitoring period, the workforce increased by 99 staff (75.71 WTE). The only decrease in staff occurred in Children & Learning Disability services, by 32 headcount (35.9 WTE).

			The biggest change occurred within Mental Health & CAMHS Services, which had an increase of 75 headcount and an increase in WTE by 50.2.

Staff in Post by Service Area

	31-Mar-15		31-Mar-16		31-Mar-17		31-Mar-18		31-Mar-19	
Organizational Unit	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**
ADMIN SUBDIV	140	106.9	20	19.8	16	16	23	21.6	17	17
CARE OF THE ELDERLY DIV	2514	1940.1	2480	2018.47	2467	2021.69	2448	2015.6	2501	2072.54
CHILDREN & LEARNING DISABILITY DIV	882	772.6	930	818.66	934	829.33	935	827.26	903	791.36
MENTAL HEALTH & CAMHS DIV	954	887.1	1023	961.7	1010	949.99	1015	959.98	1090	1010.18
PSYCHOLOGICAL SERVICES DIV	79	71.41	84	77.54	83	77.51	92	84.98	101	94.05
Grand Total	**4639**	**3906.1**	**4537**	**3897.18**	**4510**	**3894.54**	**4513**	**3909.42**	**4612**	**3985.13**

Key Area	Action	Lead	Update March 2018
4. Skill Mix	To track and monitor shifts in skill mix primarily within : ▪ Nursing ▪ Social Care	Modernisation & Workforce Planning Team	The skill mix for nursing staff at the 31 March 2019 was 62:38. This represents a significant change in the nursing skill mix from the previous year, which was 64:36 qualified to support staff. This is the third year in a row that the proportion of qualified nursing staff has decreased. This is due to a decrease in the number of qualified nursing by 26 and corresponds to an increase in support staff by 32. There has also been a change in the social care skill mix, from 23:77 in March 2018 to 25:75 qualified to support staff, as at 31 March 2019. This change is due to an increase in the number of qualified social workers by 51 headcount and a decrease in Social Care support staff by 28. This continues the change in the skill mix that has recorded since 2015. Social Care support staff have decreased each year since 31 March 2015 by 133 Headcount and 54.12 WTE overall.

Skill Mix

	31-Mar-15			31-Mar-16			31-Mar-17			31-Mar-18			31-Mar-19		
Nursing Skill Mix	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**	**HC**	**WTE**	**%**
Qualified Nursing	1096	1011.07	65	1115	1034.85	66	1086	1011.73	65	1033	962.61	64	1007	937.31	62
Nursing Support	592	501.34	35	579	494.59	34	579	498.85	35	582	503.88	36	614	527.48	38
Total	**1688**	**1512.41**	**100**	**1694**	**1529.44**	**100**	**1665**	**1510.59**	**100**	**1615**	**1466.49**	**100**	**1621**	**1464.79**	**100**
Social Care Skill Mix															
Qualified Social Work Staff	441	403.71	21	418	394.38	21	449	424.44	22	469	440.01	23	520	477.97	25
Social Care Support	1672	1271.41	79	1611	1255.51	79	1572	1232.49	78	1567	1235.15	77	1539	1217.29	75
Total	**2113**	**1675.12**	**100**	**2029**	**1649.89**	**100**	**2021**	**1656.93**	**100**	**2036**	**1675.16**	**100**	**2059**	**1695.26**	**100**

*Includes Lifeline Staff

Key Area	Action	Lead	Update March 2018
5. Grade Mix	To track and keep under review any grade mix change	Modernisation & Workforce Planning Team	The biggest change in the Directorate grade mix is seen at Band 3 level where there has been an increase of 50 (43.32 WTE). The largest decrease in the Directorate was at Band 2, which decreased by 31 staff (24.37 WTE).

ASPC Staff in post by Agenda for Change Band Profile

*Band	31-Mar-15		31-Mar-16		31-Mar-17		31-Mar-18		31-Mar-19	
	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Band 2	924	634.4	739	517.7	706	497.18	661	465.07	630	440.7
Band 3	1193	979.8	1289	1059	1305	1080.06	1343	1114.28	1393	1157.6
Band 4	184	166.5	168	150	165	149.36	177	162.18	178	166.53
Band 5	1048	940.5	1036	945.7	1014	928.22	940	857.21	964	870.17
Band 6	535	489.7	525	488.1	545	509.14	603	565.96	612	572.43
Band 7	423	401.9	447	430.8	445	428.04	443	424.95	444	421.4
Band 8a	87	81.19	89	83.58	93	88	105	98.18	121	111.59
Band 8b	20	18.2	21	20	22	20.72	24	24.2	28	27.2
Band 8c	25	22.59	26	23.1	27	24.83	28	26.71	37	34.27
Band 8d+	7	6.6	7	6.6	6	5.6	5	4.6	4	3.6
TOTAL	**4446**	**3741.4**	**4347**	**3724**	**4510**	**3894.54**	**4513**	**3909.42**	**4411**	**3805.49**

Key Area	Action	Lead	Update March 2018
6. Changing Roles and Responsibilities	Development of Collective Leadership model	Director/ Co-Directors/ Human Resources	The Divisional structures have been confirmed for the Directorate and are attached in appendix 1.

7. New Roles	To identify and meet the development needs of changing roles and responsibilities To support the development and implementation of new roles, e.g. Consultation, change process and associated banding	Senior Managers / Human Resources / Professional Leads	Under the Changed Job Process, there were 6 change job applications. There have been 17 new roles introduced into the Directorate. Examples of these include, Community & Crisis Counsellor – Lifeline Band 5; Head of Audit & IT – Band 7; Delirium Prevention Co-ordinator – Band 7; Lead Clinical Pharmacist, Acute Care at Home Team Band 8A; Care Consultant Learning Disability – Band 7. Lead Child Psychotherapist – Band 8B. The changed and new roles that have been created within the Directorate have all been assessed by the Pay Modernisation Team within HR.
8. Professional Issues	To support the implementation of the revalidation process for nurses To support the registration process within the Social Care Workforce	Senior Managers / Human Resources / Professional Leads	As at 30 June 2019, there were 5 members of staff, whose revalidation had lapsed. This information is based on HRTPS as at 31 March 2019. Both social work and social care staff are required to register with the Northern Ireland Social Care Council (NISCC). At the 31 March 2019, according to the information held on HRPTS, the NISCC registration of 107 staff had lapsed.

Nursing Registration	
Month Registration due to expire	**Number of staff**
Lapsed Registrations at 31 March 2019	**0**
April 2019	1
May 2019	1
June 2019	3

Key Area	Action	Lead	Update March 2018
9. Recruitment and Retention Strategies and Actions	To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas	Senior Leads / Human Resources	There were 837 requisitions raised to fill vacant posts in the Directorate, of these 331 were for Nursing and 289 for Social services positions. Older People services had 427 requisitions for vacant posts; Mental Health Services had 232 and Learning Disability had 148 requisitions, Psychological Services 30. There were 228 leavers from the Directorate, which is the lowest number of leavers in the last 4 years. The number of new staff who subsequently left the Directorate during year was 3. This compares to 17 for the previous year The highest proportion of leavers were Band 3, 61 staff (52.22 WTE), followed by Band 5 staff, 50 (44.57 WTE). During the year, 78 (70.84 WTE) Nursing staff left the Directorate, accounting for over 34% of all leavers, compared to 30% of all leavers Trust wide. This represents a significant decrease from the previous year. Within Social Services 97 (75.88 WTE) staff left the Directorate, accounting for 42% of all leavers compared to 9% of leavers Trust wide. During the year, 34 nursing staff applied to transfer from the Directorate to go to another Directorate within the Trust. Twenty-four nursing staff actually transferred during the year. During the same period, 15 nursing staff transferred into the ASPC Directorate.
	To review and monitor reasons for leaving to inform action		Over 50% (116) of leavers are recorded as resigning, which is the most common reason stated for leaving. The next most common reason was retirement with 16% (36) followed closely by ill-health retirement with 13% (29) of all leavers.

Reasons for Leaving the Directorate

	2015/16		2016/17		2017/2018		2018/2019	
Reason for Leaving	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Resignation	123	101.51	136	107.73	198	174.04	116	102.79
Retirement	61	50.13	78	67.72	77	66.64	36	28.89
Ill Health - Termination	23	17	30	22.98	36	24.51	29	21.16
Ill Health - Retirement	16	13.5	14	11.08	17	12.49	17	14.84
Transfer To Other HSC Org.	14	13.1	9	6.68	15	12.27	20	18.65
End of Fixed Term Cont./Event	5	4.8	5	4.6	1	0.2		
VER	2	2	5	3.68	2	1.59	4	3.3
Death in Service	1	1	1	1	6	5.11	4	2.95
Dismissal - Disciplinary Act.	1	0.8	2	2	2	1.88		
Mutually agreed Resignation Scheme							2	1.8
External Seconded Out			1	1	1	1		
Grand Total	246	203.84	281	228.47	355	299.73	228	194.38

Key Area	Action	Lead	Update March 2018
10. Local Induction	To review local induction arrangements	Senior Managers / Human Resources	A local induction programme is in place in all of the service areas within the Directorate. It has been used for new starts appointed since May 2016.
11. Succession Planning	To take targeted action to provide succession planning development opportunities in identified groups and areas including: ▪ Coaching ▪ Identification of critical posts	Senior Managers / Workforce Planning Team	A Succession Plan was sent to the Directorate in March 2018, which highlighted the following: There were 275 staff at Tiers 2 to 6. Care of the Elderly was the largest service area with 115 staff at these Tiers, closely followed by Mental Health and CAMHS with 96 staff. Children and Learning

	▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme ▪ To undertake further analysis, e.g. survey or interviews to inform further action		Disability had 44 staff and Psychology services had 15. There is 156 staff at Tier 6 and 149 of these staff are Band 7 staff. A Framework for use in the identification of critical posts has been developed by the Modernisation & Workforce Planning Team, which is being rolled out to the Directorates.

Key Area	Action	Lead	Update March 2018
12. Improving Health and Wellbeing and Engagement within Directorate	To reduce the level of sickness absence within the Directorate by 1% To develop a bespoke health and wellbeing and engagement action plan for the Directorate. Consistent application of attendance management toolkit and Trust policy.	Co-Directors / Senior Managers / Human Resources	The level of sickness absence fell from 8.31% at 31 March 2018 to 7.93% at 31 March 2019 and the target for the end of the year was 7.89%. The absence rate is 1.60% above the Trust rate. On average 22 days were lost per employee due to sickness absence, up 1 on the previous year. Over 200,000 hours were lost due to mental health illnesses and accounted for 36% of all absences compared to 33% for the Trust. Over 117, 000 hours were lost due Musculoskeletal injuries, within the Directorate, which accounted for half of all absences for this reason across the Trust The Attendance Management Team continues to support managers within ASPC to address the

	Review underlying reasons for absence (root cause) and bespoke programme in place to address issues. Increase awareness and knowledge of local “B’Well” and regional ‘Choose Well’ programmes. Increase Directorate representatives at the Health and Wellbeing Steering Group. Support Living the Values of the Trust within the Directorate.		issues associated with high levels of staff absenteeism. The Directorate has a representative on the Trust’s “B’Well” Group. A Trust Wide Steering Group has been established and the Directorate is represented on this group. Forty-five Team Values workshops were held in the year ending 31 March 2018. This more than any other Directorate during the same period.
Exit Interviews	In 2016, the Modernisation & Workforce Planning Team started to encourage staff who were due to leave the Trust, to complete the HRPTS Exit Interview Questionnaire. Each month an email is sent to upcoming leavers to request this questionnaire be completed to assist with Succession Planning.	Human Resources	From 1 April 2018 – 31 March 2019, 28 staff from the Directorate completed an Exit Interview. Five staff cited ‘Better location/travel’ as a main reason for leaving, 4 left due to improved work life balance opportunities and 2 cited better development opportunities. 176 staff were asked to complete the Exit Questionnaire, but only 28 did so.

Key Area	Action	Lead	Update March 2018
13. Technology	To continue to improve access, knowledge and skills in the use of new technology	Co-Directors / Senior Managers	As at 31 March 2019, 4723 staff, across the Directorate, had been given a user ID to enable them to access the HRPTS and 3792 staff had logged on to the system. Of the staff who have not logged on to the system, 731 are employed in social services and 673 of this group are at Bands 2 to 4. It may be worth the Directorate exploring the possibility for this group of staff to be give home access to the ESS only on the HRPTS system.

Appendix 1

Leadership Structures

Learning Disability Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - Divisional Nurse (new)
  - Carer Consultant (new)

The team collectively reports to the ASPC Director and professional reporting lines remain unchanged

Mental Health Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - Divisional Nurse (new)
  - Service User Consultant (existing role)

The team will collectively report to the ASPC Director. Professional reporting lines remain unchanged

Older People's & Physical Disability Services

- The proposed Divisional Leadership Team comprises:
  - Chair of Division (new role)
  - Co-Director (existing role)
  - Divisional Social Worker (new)
  - 2 Divisional Nurses (new) for 1 Community and 1 Hospital
  - Service User Consultant (new)

The team will collectively report to the ASPC Director. Professional reporting lines remain unchanged

Key Area	Action	Lead	Update March 2017
11. Succession Planning	To take targeted action to provide succession planning development opportunities in identified groups and areas including: ▪ Coaching ▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme ▪ To undertake further analysis, e.g. survey or interviews to inform further action	Senior Managers / Workforce Planning Team	A succession plan has been developed for the Trust, which is based on which Tier the staff member is as opposed to Bands. The highlights for the ASPC Directorate are that: A Succession Plan is also being developed for the ASPC Directorate, which will be available during the summer of 2018. This will hopefully provide a catalyst for the Directorate to review its approach to succession planning with a view to putting in place a plan to ensure that there is minimal impact on service provision when key staff leave the Directorate.

Muckamore Abbey Hospital Resettlement Programme – Update Report January 2014

Project Aim

The Muckamore Abbey Hospital (MAH) Resettlement Project is part of the regional Community Integration Programme. This programme has been established to improve the life of those with learning disabilities by providing a range of services that will support personal choice. This will be a move away from a service-led to a needs-led approach to the delivery of services. This regional programme will be a move away from current hospital based to community based services; and will involve the resettlement of 239 long stay patients, who reside at Longstone Hospital in the Southern HSC Trust; at Muckamore Abbey Hospital (MAH) in the Belfast HSC Trust and Lakeview in the Western HSC Trust.

The MAH Resettlement project has been concerned with the resettlement of 182 patients residing at the hospital into the community prior to 31 March 2015. At 10 January 2014 there were 64 patients still to be resettled from MAH. Each patient is assessed regarding their suitability for resettlement and an appropriate care package put in place. However in the event that a patient, for whatever reason, is deemed not yet ready for resettlement they will be moved to another ward; until such time as the patient is ready to be resettled.

Patients currently living at MAH will be resettled into the Belfast, Northern, South Eastern and Southern Trust areas. In order to achieve this, a structured project approach is being followed to coordinate the resettlement of those who no longer require assessment and treatment from the hospital setting. There will be a much stronger emphasis on person-centred identification of needs and more creative commissioning of services. The resettlement of the patients from MAH will lead to the closure of 8 wards before the 31 March 2015.

Management of project

A workforce Strategy Steering Group, Chaired by John Veitch (Co-director Learning Disability services), has been established to manage the employment issues related to this project. There is representation from the Northern and South Eastern Trusts, as well as the main trade unions on the Group. The HR lead is Joan Peden.

A workforce planning sub-group has also been set up to identify the workforce resources required to provide services to the hospital after the completion of the resettlement project in 2015. This group is comprised of representatives from the various staff groups and trade unions affected by the project and reports back to the workforce Strategy Steering Group. HR is represented on this group by Neil McDaid.

Staff briefings are held every six months to update all affected staff of the current position, in relation to the resettlement project, and this is led by the Project Manager, Esther Rafferty. Monica Molloy and Neil McDaid have attended these sessions to address any HR issues that arise as part of this process.

What has been achieved to date

It was agreed at the start of this project that the resettlement and consequently the closure of the wards would be handled on a phase basis. The schedule of ward closures was shared with the Steering Group, the trade unions and the staff. It was always accepted that whilst the project had a planned approach to the ward closures, this would always be subject to change dependent on which ward the patients were resettled from earliest.

Throughout this process the planned closure of wards has changed and this is outlined below:

Ward	Original Planned date for Closure	Current Status	Planned Closure
Finglass	31 March 2012	Closed 30 Sept 2012	
Oldstone	31 March 2012	Open	31 March 2015
Erne	30 Sept 2013	Merge with Ennis 31/12/2013	31 March 2014
Ennis	30 Sept 2013	Merge with Erne 31/12/2013	31 March 2014
Killead	31 March 2013	Closed	
Moylena	31 March 2014	Open	31 March 2015
Greenan	31 March 2014	Open	30 Sept 2014
Rathmullan	31 March 2015	Closed 30 Sept 2013	

Day Support services to reduce by 33% by 31 March 2015

It has been possible for some wards to be closed ahead of schedule because the patients on those wards have had care packages put in place enabling them to move out of the hospital, back into the community. However there are wards which are still open after their original date of closure because it has not been possible to finalise care packages that would enable all the patients to move into the community.

Affected Staff

The resettlement project has impacted on most areas on the MAH site and has affected all staff groups. The MAH site will remain open and will provide an assessment and treatment service from 2015. The staff currently employed on those wards that are not due for closure are deemed not to be affected by this project and will therefore not feature in any redeployment exercise.

However staff employed on the wards and Day Support area, identified above, are affected. The details of the numbers and Grades of affected staff are provided in appendix 1. There are Approximately 307 (265.61 WTE) staff affected by this project with the largest groups of staff being Nursing; PCSS; Admin & Clerical; social services staff and Estates. There are other groups of staff, including Transport; Physiotherapy; Occupational Therapy and Medics, who provide services on the MAH site who may be affected, but their numbers are very low.

Challenges

There are several challenges facing the managers responsible for managing this project including the geographical location of the MAH. There will be very few opportunities to be redeployed on the site. Many of the affected staff live in the local area and travelling to Belfast is not appealing to them. For some this would require two buses to get to Belfast city centre.

The majority of PCSS staff requiring redeployment (approx. 33 headcount) are Band 2, unlike the majority of staff in comparable positions in the Belfast Trust area who are Band 1. Even if posts can be identified, the likelihood is that they will be at a lower band, which will mean pay protection will have to be applied, which will have an impact on the section's budget.

Nursing staff who need redeployed (approx. 28 WTE) are mainly Band 3 Learning Disability Nurses. In additional to the geographical issue outlined before they are specialised nurses and as such do not use many of the general nursing support skills expected in a Band 3.

What has been done to date

The workforce Planning Steering Group has been established with John Veitch as the Chair. The Steering Group set up a workforce planning sub-group to identify the workforce needed on the MAH site to deliver the services post 2015 and to work through the issues associated with this task. The workforce planning sub-group has identified the number of affected staff who will need to be redeployed as a result of this project. This redeployment process is adhering to the Trust's Protocol on the Management of Staff Affected by Organisational Change.

PCSS – following encouragement from HR PCSS set up their own internal job scrutiny and posts are held within the Directorate and offered to staff based at MAH in the first instance. Attached in appendix 2 is a list of the posts that have been offered to PCSS staff at MAH as part of the redeployment exercise. Staff have been redeployed on site in the first instance, but there were only limited vacancies, which were taken by those staff in the first phase of the project.

Managers from PCSS have held staff briefings and one to one meetings with their staff to explore the options available to them. To date 10 staff have been redeployed on site and 5 have been redeployed at different locations within the Trust.

Nursing – managers have held one to one meetings with nursing staff, with Band 3 nursing support staff being the most affected. The Project Lead (Esther Rafferty) had put in place a block on permanent recruitment of affected bands of staff in 2012 in preparation for the redeployment of staff; and only recruited temporary staff. To date thirteen Band 3 nursing support staff have been redeployed on site. However there will still be a significant shortage of posts on the MAH site for Band 3 staff.

Arrangements are being put in place with other sections within the Adult Social & Primary Care and other directorates to offer suitable posts to affected staff before they are advertised externally. Limited opportunities for the redeployment of staff should arise during the year. In the six months from April to September 2013 there was 29 Band 3 nursing support staff that left the Trust. During the same period in 2012 there was 44 Band 3 nursing support staff that left the Trust. If the same number of vacant posts were available during the same period in 2014 there would be sufficient posts to enable the redeployment of affected staff.

Other Trusts - In addition to the above HR staff met with counterparts from the Northern and South Eastern Trusts to explore the possibility of getting assistance with regard to this exercise. Both Trusts have agreed to forward all vacancies, prior to external advertisement, to the Belfast for consideration by affected staff at MAH.

The mechanisms and procedures relating to this process have been agreed with the two Trusts and the trade unions. Given that all Trusts are in a difficult position in terms of financial pressures and the need to make savings the options were restricted.

Options

Redeployment

The managers of the two staff groups with the largest numbers of affected staff are exploring every option to ensure that all staff are redeployed, including opportunities in other areas of work such as Admin & Clerical etc. Throughout the remaining period of this project all suitable vacant posts will be made available to staff. The various Directorates are working hard to try to overcome these challenges. As previously mentioned the geographical location of the hospital makes the challenge of redeploying affected staff even more difficult.

Natural Wastage

A small number of affected staff have indicated that they intend to resign or retire at the end of the project, but these will account for very few staff.

Northern & South Eastern Trusts

We will continue to work with our colleagues in other Trusts to ensure that we can maximise any opportunities that may arise between now and when the project is due for completion in March 2015. Currently there are limitations to this as both Trusts have their own staffing/redeployment issues and the trade union view that they have to address these before they can assist the Belfast Trust in this project.

The process has been agreed and resources have been identified to provide support to affected staff to ensure they are able to respond to the opportunities that are presented, by the Northern & South Eastern Trusts.

VER/VR

Consideration needs to be given to make available, to affected staff, Voluntary Early Retirement (VER)/ Voluntary Redundancy (VR), in the likelihood that not all affected staff will be able to be redeployed. PCSS have prepared a business case in support of VER/VR, should monies become available during the current financial year. This, in all probability, will be required in the next financial year given the challenges associated with the redeployment of the staff at MAH.

Currently there is a total 16 Band 2 and Band 1 PCSS staff over the age of 50 and who are contributing to the HSC Superannuation Scheme and therefore would meet the criteria to be able to apply for VER.

Appendix 1

MAH Affected Staff by Age and Grade at 30 September 2013

	Age Range (WTE)										
Grade	**20 - 24**	**25 - 29**	**30 - 34**	**35 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65+**	**Total**
ACUTE NURSE (5)	1	1									2
ACUTE NURSE SUPPORT (3)	8.76	6			1.53		1	1			18.29
ADMIN & CLERICAL (2)				0.87							0.87
ADMIN & CLERICAL (3)				0.53							0.53
BUILDER (3)								1			1
CATERER (2)		2.33	2.09		2	4	1.67				12.09
DOMESTIC SERVICES (1)		1.67									1.67
DOMESTIC SERVICES (2)	1.22		1.32	0.87	0.59	3.73	1.87	1.63	2.7	2.27	16.2
ELECTRICIAN (4)					1			1			2
JOINER (4)						1	1				2
LABOURER (2)						1		1		1	3
LAUNDRY WORKER (1)		0.8		0.5	3.55	1.02	2.54	0.67		1	10.08
LEARNING DIS SOC WR SUPP (5)		2	3	2.6	1.99	2	2		2	1	16.59
LEARNING DIS SOC WR SUPP (6)							1	1	1		3
LEARNING DISABILITY NRS SUP(2)							1				1
LEARNING DISABILITY NRS SUP(3)	7.58	13.66	10.94	5.93	10.65	10.4	17.69	8.05	6.39	2	93.29
LEARNING DISABILITY NURSE (5)	4	5.8	5.48	4.54	5.03	7.11	15.23	7.69	2.31	0.4	57.59
LEARNING DISABILITY NURSE (6)		1	1	1	3	2					8
LEARNING DISABILITY NURSE (7)						5		1		1	7
MENTAL HEALTH SOC WR SUPP (5)		0.8	1								1.8
MULTI SKILLED SUPPORT (2)					1						1
OCCUPATIONAL THERAPIST (5)											1
PAEDIATRIC NURSE SUPPORT (3)		1.61									1.61
PAINTER (3)						1					1
PLUMBER (4)								1			1
PORTER (1)								1			1
SEWING ROOM (2)								1			1
SOCIAL WORK MANAGER (7)						1					1
Total	**22.56**	**36.67**	**24.83**	**16.84**	**30.34**	**39.26**	**45**	**27.04**	**14.4**	**8.67**	**265.61**