Department of
Health, Social Services and Public Safety
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Delivering Care: Nurse Staffing in Northern Ireland

Section 1: Strategic Direction and Rationale for general and specialist medical and surgical adult in-hospital care settings

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

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Revised Final Draft March 2014

Preface

A message from the Minister for Health and Public Safety

I am delighted to introduce, *Delivering Care: Nurse Staffing in Northern Ireland*. The document focuses on General and Specialist Medical and Surgical Adult In-hospital Care Settings and is the first in a series which will in time cover all care settings.

This document is a further step in the modernisation of Health Services within Northern Ireland and it is the first time we will measure the inputs of Nurse Staffing against the outputs of Key Performance Indicators of good quality care and patient experience.

Whether a commissioner or a provider of care, you must draw upon this policy document to assist you to understand the environment of care and how that environment demands the application of a particular range of nurse staffing.

The people of Northern Ireland are rightly demanding that they and their relatives are cared for by a workforce which has sufficient nurses, with the right skills, in the right place to ensure the delivery of a compassionate, person centred, safe and effective service which we can be proud of.

My goal has always been to have a world class nursing workforce able to provide world class care and I believe this document better prepares us to ensure that continues to happen.

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report[1] (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

This document focuses particularly on medical and surgical units and is the first in a series which will expand to cover a range of major specialties across all programmes of care. As nurses we all have a duty to ensure staffing levels are appropriate and adequate, to provide a high standard of practice and care at all times under the responsibilities outlined within the code of the Nursing and Midwifery Council. This Framework is intended to support Ward Sisters/Charge Nurses, professional and general managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth and in developing new services. Staffing can never be viewed in a vacuum and there is no one perfect tool to define what the staffing profile should be in any particular unit, so it is vital that a number of elements are taken account of such as, the activity within the unit, the requirement to support annual leave, statutory learning and professional regulatory activity, the mix of skill within the workforce, timely recruitment to vacant posts and other factors which might impact on workforce planning, such as the length of stay of patients and the environment. In addition to these elements there must also be an understanding of Key Performance Indicators (KPIs) such as the clinical indicators of good quality care and patient experience. This document should not be viewed in isolation and it will become part of a Nursing KPI Dashboard where the workforce will be one element viewed alongside Clinical Indicators and Patient Experience Indicators. I believe a triangulated approach looking not only at the inputs required to deliver Person Centred Care but also interrogating the outputs which are the quality indicators and the patient experience are essential to improving care within Northern Ireland.

Delivering Care sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that I recognise is all the more important as we move through one of the most difficult periods in the history of the Health and Social Care sector in Northern Ireland. The publication of this first piece, in a series of work on staffing ranges, is intended to promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments when commissioning new services to ensure safe, effective, person centred care.

The timing of this framework coincides with the implementation of *Transforming Your Care,* the review of Health and Social Care in Northern Ireland*,* which sets out

[1] Scottish Executive Health Department (2004a) *Nursing and Midwifery Workload & Workforce Planning Project.* Edinburgh: SEHD.

a range of proposals for the future of services in the region; concluding that there is an unassailable case for change and strategic reform. The Nursing and Midwifery workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

I would like to express my sincere thanks to the members of the Steering Group and Working Group who committed their time energy and expertise in the development of this framework document.

I would also like to thank all of the key stakeholders across the Health and Social Care system who took part in the various consultations and workshops during the development of the Framework. A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for the significant project management, co-ordination, facilitation, and contribution to drafting of documents provided during the development of the framework.

Finally, I would like to thank Professor James Buchan, School of Health, Queen Margaret University, Edinburgh, for reviewing the documents and providing valuable feedback to support the final production and publication of Sections 1 and 2 of the Framework.

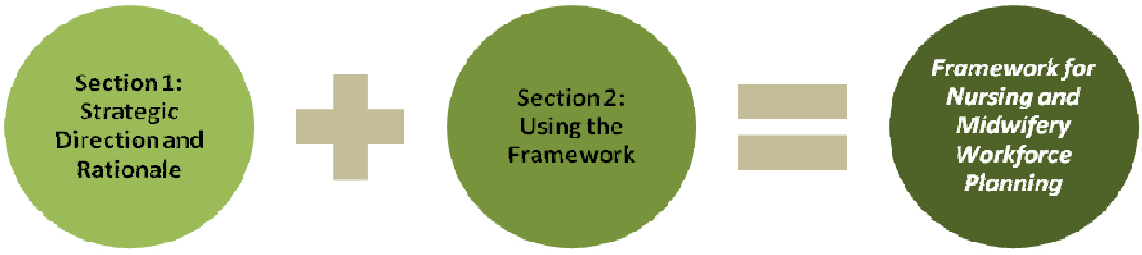
This document should now be shared with Health and Social Care Trust Boards and mechanisms established to ensure workforce planning processes are in place throughout Northern Ireland to support safe, effective, person centred care.

Chief Nursing Officer

Delivering Care: Nurse Staffing in Northern Ireland.

The framework is made up of the following constituent elements:

And is made up of two complimentary documents:



GLOSSARY OF TERMS

Term	Meaning
Hospital Care	The utilisation of a hospital bed during an episode of in-patient treatment or care
Regional Services	Specialist services which are provided from one or two hospital sites for people throughout the region
Framework	This document describes a series of steps which incorporate a number of elements that impact on workforce planning such as nursing: bed ratios, Planned and Unplanned Absence Allowance and influencing factors which can be used to describe the optimum workforce required to support safe, effective, person centred care.
Ward	A group of hospital beds, with associated treatment facilities, managed as a single unit. A ward may function for the full 24 hour period in a 7 day week or within a variation of this pattern. This includes for example: day procedure units, elective surgical units, short stay wards.
Professional Regulatory Requirements	Activity within nursing and midwifery roles which is a professional regulatory requirement, but not necessarily an element of direct care provision. This includes: compliance with standards set by the regulatory body, supervision, and compliance with governance arrangements.
Classification of Clinical Care Settings	
Medicine	A general medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions. This includes, for example: acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
Specialist Medicine	A specialist medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated. This includes, for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.
Surgery	A general surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery. This includes, for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
Specialist Surgery	A specialist surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated. This includes, for example: neurosurgery, plastics, cardiac and head and neck surgery.

EXECUTIVE SUMMARY

Delivering Care: Nurse Staffing in Northern Ireland has been developed to support the strategic vision identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[2]. This framework will inform the Public Health Agency's duties detailed in the Health and Social Care Framework, the Department of Health Social Services and Public Safety Commissioning Directions and Health and Social Care Board Commissioning Plan.

The framework should inform Health and Social Care Trusts and Commissioners –

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

The framework documents incorporate a range of sections that will address a variety of settings across hospital and community care. It should be noted that elements of Section 1 will have relevance to a number of settings and subsequent phases, such as Planned and Unplanned Absence Allowance, Influencing Factors and the requirement to triangulate workforce planning processes with quality information such as Key Performance Indicators (KPIs). In addition, it is anticipated that midwifery staffing levels will be reviewed by the Project Groups as part of the evolving Project Plan.

This framework is based on the best evidence available including a range of recognised workforce planning tools, and has been produced in consultation with a wide range of stakeholders including commissioners and service providers, nurse managers, front-line staff and personal and public involvement, professional and staff side organisations. A core element is the development of a staffing range. This approach has been taken in preference to the simple application of an absolute number or ratio, as individual ward staffing is influenced by a range of factors all of which must be considered.

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries[3]***.***

The first phase of publication of the framework includes two sections relevant to nurse staffing levels in the first instance:

Section 1: Strategic Direction and Rationale

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

[2] Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.
[3] Please see pages 1 - 3 of this document.

The document is a brief summary of the elements of the framework, how they were agreed and how they might be applied in the context of the changing healthcare settings nurses work in currently.

Section 2: Using the Framework for Medical and Surgical Care Settings

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a particular clinical setting. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

The products of the *Delivering Care* Project aim to provide all staff, but particularly nurses, both in front line practice, management and commissioning with a framework which will assist workforce planning processes and support constructive conversations about nurse staffing levels in Trusts.

It is anticipated that Health and Social Care Trusts will take account of the recommended staffing ranges contained in this document when developing:

- Proposals to meet the objectives within Transforming Your Care
- New proposals for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

Over the last number of years changing patterns of service delivery, modernisation of care pathways, increased use of technology, increased patient acuity and higher throughput levels in wards have resulted in changes to staffing levels in Northern Ireland.

The outcome has been a combination of investment in new services and efficiencies in existing services. Executive Directors of Nursing have worked throughout this period of change to ensure staffing levels are maintained at a level that enables the provision of safe, effective person centred care.

This framework will provide a policy context to assist Trusts and commissioners to plan more effectively particularly during this time of transition. Commissioners will as a result, have a regional framework within which they can agree and set consistent ranges for nursing workforce requirements for Health and Social Care Trusts in Northern Ireland.

SECTION 1: STRATEGIC DIRECTION AND RATIONALE

1.0 INTRODUCTION

1.1 The subject of nurse staffing in hospital wards and community settings has been a topic of debate and discussion for a number of years. Ensuring appropriate staffing has been referenced in inquiries and investigations, shown in research evidence and is viewed by patients and their carers as a key element in influencing the quality of care.

1.2 The Independent Inquiry into the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust[4] highlighted the need for appropriate staffing levels to support safe, effective, person centred care.

Speaking at the publication of his final report, Robert Francis QC said:

> *"The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care."*
>
> *"The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff."*
>
> *"People must always come before numbers. Individual patients and their treatment are what really matters.....This is what must be remembered by all those who design and implement policy for the NHS."*

2.0 BACKGROUND AND CONTEXT

2.1 There are a number of drivers which have informed the development of the *Delivering Care f*ramework. They include:

Regional Policy and Strategy

2.2 A number of key strategic documents underpinned the development of this framework including:

Transforming Your Care

The strategic review of Health and Social Care (HSC): *Transforming Your Care*[5] sets out the direction of travel for HSC services in Northern Ireland over the next five years. This is supported by the Commissioning Plan[6], which details year on year service provision, priorities and standards that services must meet. The implications of the changes to services in the next five years are significant, particularly in the development of new service models and the response the workforce will be required to make in support of these changes. Examples include:

- A reduction in length of stay for patients in hospital environments resulting in a higher concentration of acutely ill older patients with complex co-existing long term conditions, who require more care and treatment and therefore more intensive nursing care
- Changing Hospital services, more care being provided in patients/clients own homes, community and domiciliary settings
- Technology increasingly used in support of care delivery

[4] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, HMSO.
[5] Department of Health Social Services and Public Safety/Health and Social Care Board. (2011). *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.
[6] Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB.

› Greater emphasis on the prevention of ill health.

Quality 2020

HSC service provision in Northern Ireland is underpinned by the three key components of: safety, effectiveness and patient/client focus as defined through *Quality 2020*[7]. *Quality 2020* refers to 'Strengthening the Workforce', as one of its strategic goals, elements of which include the continuous need to develop the knowledge and skills of the HSC workforce, measured through improved outcomes for patients and clients.

The People's Priorities

Nurses and midwives are the largest staff group in the HSC system providing general and specialist care and treatment in all HSC environments. Nurses and midwives are central to the provision of quality care and are highly valued by the public in Northern Ireland, a view expressed in the Patient Client Council report: *The People's Priorities*[8] which identified the protection of front-line staff, particularly nurses, as the top priority for the HSC organisations.

A Partnership for Care

The need to develop a framework to support effective workforce planning was identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[9] and as part of the Health and Social Care Board (HSCB)/Public Health Agency (PHA) Commissioning plan 2011/12[10].

Evidence Base Related to Staffing Levels and Patient Outcomes

2.3 Significant research has been undertaken into the issues of both nurse staffing levels and skill mix, thereby providing a wide literature base in relation to the association between lower numbers of registered nurses and significant reduction of the quality of patient outcomes[11]. Examples include:

› Fewer registered nurses, increased workload, and changing nursing teams in care environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units in a mixed method study combining longitudinal data (5 years) and primary data collection[12].

› Features of the hospital work environment, such as better staffing ratios of patients to nurses, nurse involvement in decision making, and positive doctor-nurse relations, are associated with improved patient outcomes, including mortality and patient satisfaction[13].

[7] Department of Health Social Services and Public Safety. (2011). *Quality 2020, A 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland*. Belfast, DHSSPS.
[8] Patient Client Council. (2010). *'The People's Priorities. A View from Patients, Service Users, Carers, and Communities on Future Priorities for Health and Social Care in Northern Ireland'*. Belfast, PCC.
[9] Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.
[10] Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB. Available for download at: http://www.hscboard.hscni.net/publications/Commissioning%20Plans/490%20Commissioning%20Plan%202011-2012%20-%20PDF%20993KB.pdf
[11] Flynn, M. and McKeown, M. (2009). 'Nurse staffing levels revisited: a consideration of key issues in nurse staffing levels and skill mix research'. *Journal of Nursing Management*. 17, 759 – 766.
[12] Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., Aisbett, K. (2011). Nursing staffing, Nursing workload, the work environment and patient outcomes. *Applied Nursing Research*. 24(4), pp 244 – 255.
[13] Aiken, L.H., et al. (2011). Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal*. 344, e1717.

- Links have been demonstrated between lower numbers of registered nurses and increased length of stay and associated cost.[14]
- The Health Care Commission following an investigation into links between nursing workforce and patient outcomes concluded that staffing levels appeared to be based on traditional and/or costs constraints rather that patient need or outcomes.[15]

Evidence from Public Inquiries

2.4 As previously mentioned, a number of public inquiries have highlighted the need for appropriate staffing levels in health and care settings. Examples include:

Mid Staffordshire NHS Foundation Trust

The recommendations of the Francis Inquiry[1617] identified the importance of including nursing staff at all levels in discussions related to standards of care and the resources required to deliver safe and effective, person centred care. Referring to the long term failures of the Trust, Robert Francis QC stated: *'The quality of nursing during that period suggested that staffing levels had been acknowledged to have been too low as long ago as 1998.'*[18]

Public Inquiry into the Outbreak of Clostridium Difficile

The *Public Inquiry into the Outbreak of Clostridium Difficile*[19] raised a number of issues in relation to the ability of the organisation to provide safe and effective standards of care regarding infection prevention and control, linked to historic staffing levels. The Final Report stated: *'Underfunding within nursing and domestic services had been a particular difficulty for many years, and had been raised frequently with the Northern Health and Social Services Board, the main commissioner of services in the Trust.'*[20]

NHS Review

The NHS review into the quality of care and treatment provided by 14 hospital trusts in England[21] by Professor Sir Bruce Keogh recommended that '*nurse staffing levels and skill mix'* should *'appropriately reflect the caseload and the severity of illness of the patients they are caring for.'* This recommendation was made in light of the fact that the review teams found inadequate numbers of nursing staff in a number of ward areas, which was compounded by an over-reliance on unregistered support staff and temporary staff.

[14] Cho, S.H., et al (2003). The effects of Nurse Staffing on Adverse Events: Morbidity, Mortality and Medical Costs. *Nursing research.* 52, pp 71-79.
[15] Health Care Commission. (2005). *Ward Staffing*. London, Health Care Commission.
[16] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.
[17] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London, TSO
[18] *Op Cit*, n 16, page 396.
[19] Hine, D. (2011). *Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals.* Available for download at: http://www.cdiffinquiry.org
[20] *Ibid*, page 76.
[21] Keogh, B. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Available for download at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Why Develop a Range?

2.5 It was anticipated from the outset of this work that the process of developing staffing ranges would be progressed in a phased approach to address other areas of clinical practice such as: emergency department, district nursing, health visiting, mental health and learning disability care settings.

Aim

2.6 The overarching aim of the work was:

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 specialities.

Scope and Objectives

2.7 The scope of Phase 1 was to: *Develop a staffing ranges framework related to general and specialist adult hospital medical and surgical care settings.*

2.8 Objectives were designed to enable completion of a framework and achieve the required outcomes of Phase 1 which included: the production of a regional descriptor of a range of staffing levels for general and specialist medical and surgical adult care hospital settings; development of a list of factors which influence or impact upon the appropriate staffing range for defined general and specialist adult hospital medical and surgical care settings; a format of presentation for a framework which would include user guidance. A summary of the process used to develop the framework can be found at Appendix 1, page 19 of this document.

Range not Ratio?

2.9 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio[22]. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.

2.10 It is anticipated that on occasion nurse staffing may be outside the policy range. In such cases the Executive Director of Nursing must provide assurances about the quality of nursing care to these patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.

2.11 It is expected that HSC Trusts will take account of the staffing ranges contained in this framework in developing proposals to meet the objectives within *Transforming Your Care*, in supporting new proposals for additional resources and when developing efficiency and productivity plans.

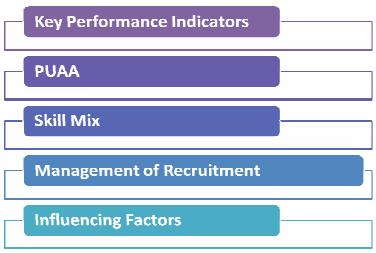
[22] Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies if wrongly calibrated, coupled with relative inflexibility.

2.12 In addition, commissioners will be able to use the framework within which they can agree and set consistent ranges for nursing workforce requirements for providers of health and social care in Northern Ireland.

ASSUMPTIONS OF THE FRAMEWORK

3.0 Introduction

3.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.



3.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.

ASSUMPTION 1:
ASSURANCE OF SAFETY, QUALITY AND EXPERIENCE THROUGH KEY PERFORMANCE INDICATORS

3.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of this document supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.

3.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

Organisational: absence rates within nursing and midwifery teams; normative staffing ranges which will include vacancy rates.

Safe and Effective Care: incidence of pressure ulcers, falls, omitted or delayed medications.

Patient Experience: consistent delivery of nursing/midwifery care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

It is recognised that such quality information, which is being continuously monitored, will demonstrate the efficacy of staffing levels in a particular clinical area. Where the

staffing complement meets the demand of the service being provided, quality indicators should demonstrate that safe, effective, person centred care is being delivered. Should quality indicators begin to fall below the accepted level of achievement, staffing levels should be reviewed as one of the lines of enquiry of attributable causes.

ASSUMPTION 2:
PLANNED AND UNPLANNED ABSENCE ALLOWANCE

3.5 Planned and Unplanned Absence Allowance (PUAA) refers to periods of absence from work, which can be described as anticipated and, therefore, must be factored into the workforce planning process. This comprises annual leave, sickness[23], and mandatory study leave. It was necessary, therefore, when describing nurse or midwifery[24] staffing to agree an allowance which could be factored in to any subsequently developed range.

Rationale

3.6 Telford (1979)[25] remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom. This methodology recognises the need for 'allowances and amendments for sickness, absence, holidays, in-service training and nursing education'[26] in any method of effective workforce planning.

3.7 In 2006, the Royal College of Nursing recommended a PUAA of 25%[27]. Similarly, the Healthcare Commission recommended a minimum of 24% in 2005[28], prior to the implementation of Agenda for Change[29].

3.8 Other professions have reflected a requirement to build in allowances for planned and unplanned leave. For example, the medical profession referred to the necessity of 'supporting professional activities' within the Consultant Contract Framework (2003)[30]. *Professional activities* were identified as: training, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local governance activities. Leave is also directed to be built into weekly job planning for consultant teams, including an average of 10 days per year of professional activity[31]. It should be noted that sickness absence was not accounted for within the Consultant Contract framework.

3.9 In 2002, the Auditor General for Scotland[32] identified a requirement for Planned and Unplanned Leave Allowance to be taken into account within nursing workforce planning processes, outlined in **Table 1**, page 7.

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[23] 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
[24] It should be noteds that this element of the assumptions of the framework is applicable to nursing and midwifery.
[25] Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.
[26] *Ibid*, page 2 of the referenced document.
[27] Royal College of Nursing Policy Unit. (2006). *Setting Appropriate Ward Nurse Staffing levels in NHS Acute Trusts*. London, RCN.
[28] Health care Commission. (2005). *Ward Staffing*. London, Health Care Commission.
[29] Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf
[30] Department of Health, Social Service and Public Safety. (2003) *Consultant Contract Framework*. Available for download at: http://www.dhsspsni.gov.uk/scu-consultantcontract.pdf
[31] Department of Health, Social Service and Public Safety. (2008). *Regional Guidance on Job Planning for Medical and Dental Consultants in Northern Ireland*. Available for download at: http://www.dhsspsni.gov.uk/regional-guidance-on-job-planning-for-medical-and-dental-consultants-in-northern-ireland.pdf Page 15 - 16.
[32] Audit Scotland. (2002). *Planning ward nursing – legacy or design?* Edinburgh, Auditor General.

Table 1:

Planned and Unplanned Absence Allowance, Auditor General Scotland[41].

Year	Annual Leave:	Sick Leave:	Study Leave:	Total Allowance
2002	13.5%	5.5%	3%	22%

Annual Leave

3.10 The implementation of Agenda for Change[33] provided an increase from 25 to 33 days' leave for staff with a service record of 10 years or over. This substantial increase would, therefore, require that the allowance for annual leave calculated within PUAA is increased from that adopted in 2002. A reduction in the number of public holidays from 12 to 10 provided an overall net increase of 16%.

3.11 For the purposes of the framework, annual leave is calculated at the mid point of the Agenda for Change[34] leave allocation, which is 29 days + 10 days public holidays = 39 days. There are 260 working days per year for a full time/37.5hr person. This equates to 39/260 = **15%.**

Sickness Absence

3.12 *Priorities for Action*[35] outlined the regional target for 'absenteeism' in 2011 at 5.2%. The 5% level set within the PUAA is below this regional target recognising the need for continuous improvement in this area.

Mandatory Study Leave

3.13 In response to the increased intensity and complexity of patient care and the need to support the continuing provision of safe, effective, person centred care, mandatory training needs have significantly increased for the nursing and midwifery workforce in the last 10 years from 2002. This includes regulatory requirements such as: meeting the Nursing and Midwifery Council (NMC) Standards for Learning and Assessment in Practice[36], statutory midwifery supervision and the Chief Nursing Officer's standards for supervision in nursing[37], as well as a range of clinical competencies which are required to comply with national and regional policy or standards. Examples of the types of training required for all staff and professional staff and associated hours required are outlined in **Table 2**, page 9. There is a regulatory requirement for professional updating, elements of which may be undertaken in a registrant's own time. As more robust revalidation models are progressed in light of the Francis Inquiry[38], it is essential that PUAA can accommodate this.

3.14 The nursing and midwifery workforce has a high percentage of individuals that choose part-time working arrangements - 56% full time, 44% part time[39]. Training must be provided on the basis of headcount as opposed to Whole Time Equivalents, which considerably increases the overall number of staff requiring training.

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[33] Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf
[34] The NHS Staff Council. (2012). *NHS terms and conditions of service handbook*. Available for download at: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf
[35] Department of Health, Social Service and Public Safety. (2010). *Priorities for Action 2010 - 2011*. Belfast DHSSPSNI.
[36] Nursing and Midwifery Council. (2010). *Standards for Pre-registration Nursing Education*. London, NMC.
[37] Chief Nursing Officer for Northern Ireland. (2007). *Standards for Supervision in Nursing*. Belfast, DHSSPSNI.
[38] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.
[39] *Ibid*.

Future Allowances

3.15 It was therefore proposed that the average level applied in 2002 of 22% should be reviewed to reflect the changes to annual leave allowances, and statutory and mandatory training requirements for professional and non-professional staff within a ward team.

3.16 The revised allowances, stipulated at **Table 3**, below, have been agreed by the Nursing and Midwifery Leaders in Northern Ireland, using those defined by the Auditor General (2002)[40] as a starting point, taking into consideration the elements mentioned in paragraphs 3.10 – 3.14, page 7. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods. The ranges incorporate a Planned and Unplanned Absence Allowance of 24%.

Table 3: Comparative Planned and Unplanned Absence Allowances

Year	Annual Leave:	Sick Leave:	Study Leave:	Total Allowance
2002	13.5%	5.5%	3%	22%
2013	15%	5%	4%	24%

3.17 This agreement should enable discussions between commissioners and service providers to take place in relation to workforce planning for the future.

3.18 It should be noted that an agreement was reached through the *Delivering Care* Project Groups, that Planned and Unplanned Absence Allowance should not include absence for maternity leave. The Nursing and Midwifery Leaders in Northern Ireland recognise that Maternity Leave is a particular challenge for service providers due to the predominance of females in the workforce.

[40] Audit Scotland. (2002). *Planning ward nursing – legacy or design?* Edinburgh, Auditor General.

TABLE 2

EXAMPLES OF STATUTORY[41] AND MANDATORY[42] TRAINING FOR NURSING AND MIDWIFERY STAFF[43]

	Annual commitment (average in hours)	One off commitment (average in hours)	
Core skills – all staff*			
Equality, diversity and human rights	-	7.5	To include complaints handling
Fire Safety	2	-	
Health and Safety	2.5	3.75	To include COSHH / waste management
Infection prevention and control	3.75	-	
Moving and handling	3.75	-	
Safeguarding adults	3.75	-	Increased training required as per role and responsibility
Safeguarding children	3.75	-	Increased training required as per role and responsibility
Resuscitation	3.75	-	Basic life support to Advanced Life Support dependent on need
Information governance	-	3.75	To include record keeping, data protection etc.
Statutory and mandatory training for nursing and midwifery			
Clinical policy and guidelines updates	7.5	-	MUST nutrition tools / tissue viability / NEWS / haemovigilance etc.
Nursing / Midwifery specific training	15	-	Includes statutory supervision & obstetric emergencies for midwives / mentorship etc. for nurses
Clinical skills	11.25		Includes end of life care / violence and aggression etc.
New equipment / technologies	7.5		New equipment training needs including Point of Care Testing
Total	**64.5**	**15**	

79.5 hours / 7.5 hours per day = 10.6 days per year

10.6 days / 260 working days per year = **4.07% allocation for training**

*Ref: UK Core Skills and Training Framework, Skills for Health 2012

[41] **Statutory Training:** is training that an organisation is legally required to provide, as defined in law (and consequently a legal paper can be referenced), or where a statutory body has instructed organisations to provide training on the basis of legislation.

[42] **Mandatory Training:** is a training requirement that has been determined by an organisation (i.e. in policy). Mandatory training is concerned with minimising risk, providing assurance against policies, and ensuring that the organisation meets external standards, for example: Zero Tolerance Violence and Aggression training.

[43] It should be noted that unregistered staff do not attend training which is in place as a result of a professional or regulatory requirement.

ASSUMPTION 3:
SKILL MIX

3.19 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[44], a skill mix comprising a higher level of unregistered staff may be appropriate. A level of skill mix will be determined regionally for a variety of care settings by the Nursing and Midwifery Leaders in Northern Ireland, based on best available evidence such as recognised workforce planning tools, related to the care setting under consideration. The skill mix relevant to a particular setting will be included within the subsequent '*Using the Framework for..*' sections. To reference the skill mix for general and specialist medical and surgical adult hospital care settings, please see page 3 of Section 2.

3.20 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 nurse leader for the ward.*'[45][46]

3.21 An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

ASSUMPTION 4:
MANAGEMENT OF RECRUITMENT

3.22 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.

3.23 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

- Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
- Avoidance of overuse of temporary staff, for example, bank and agency staff
- Matching of staff skill and band mix to patient acuity and dependency within approved guidelines[47]
- Timely and ongoing review of risk assessments linked to service reconfigurations.

[44] For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.
[45] Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.
[46] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.
[47] For information related to skill mix for medicine and surgery, please see *Delivering Care* Section 2, page 3.

ASSUMPTION 5: INFLUENCING FACTORS

3.24 It is acknowledged that workforce planning for nursing staff is both complex and diverse[48]. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation[49] is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:

- Workforce
- Environment and Support
- Activity
- Professional Regulatory Requirements.

3.25 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a care setting. Further information on factors which influence workforce planning in medical and surgical settings can be found in Section 2, pages 7 - 13.

NURSE STAFFING RANGES

4.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery

MEDICINE

4.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.

4.2 A **specialist medical care setting** is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated, including for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example: Medical Assessment Units.

4.3 In some general ward areas, existing ***in both medical and surgical settings***, a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24 bed general respiratory ward. As models of care for general medicine move towards specialisms, the number of specialist beds may increase. Where this occurs, a number of calculations will need to be made on two or more cohorts of patients to determine an overall appropriate nursing/bed ratio.

4.4 **Figure 1,** page 12, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and

[48] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 6.
[49] *Ibid.*

lower end of the specialist range (1.3). The range stipulated includes an allowance of 24% for PUAA.

Figure 1: Nurse Staffing Range for General and Specialist Medicine.

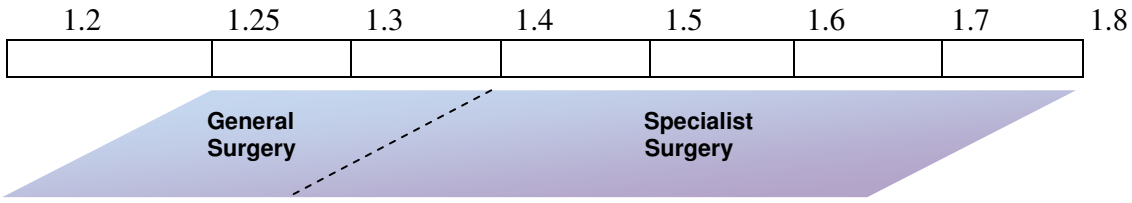
SURGERY

4.5 A **general surgical care setting** is defined as comprising adult surgical patients admitted for elective or emergency surgery, including for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.

4.6 A **specialist surgical care setting** is defined as, comprising adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated, including for example: neurosurgery, plastics, cardiac and head and neck surgery.

4.7 **Figure 2** below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for PUAA. For further information as to how the ranges were described and agreed, please go to page 19 of this document.

Figure 2: Nurse Staffing Range for General and Specialist Surgery.



4.8 Providing an example: The Ward Sister of a 24 bed medical ward has used a Telford Exercise, coupled with the use of influencing factors to determine that her ward should be staffed at 1.3 on the nursing: bed range.

This equates to: 24 x 1.3 = 31.2 Whole Time Equivalents (WTE) to provide safe, effective person centred nursing care.

Adding in the requirement for the 100% (1 WTE) allocation of Ward Sister time for supervision/ management responsibilities, this equates to a Funded Establishment of 32.2 WTE, in this example.

With a skill mix of 70:30 this allows for:

- 21.84 WTE registered staff (0.7 x 31.2)
- 9.36 WTE unregistered staff (0.3 x 31.2)
- 1.0 WTE Ward Sister.

ILLUSTRATIVE EXAMPLE

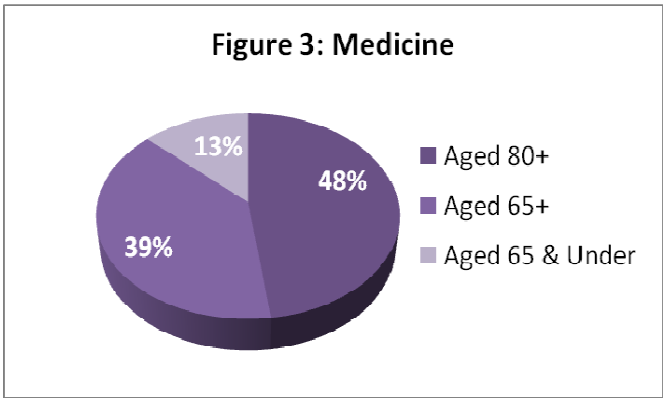
The illustration contained within pages 13 - 16 highlights a snapshot of the activity in an *actual* medical ward in Northern Ireland.

Along with an overview of activity within the snapshot, the numbers of staff that the range for general medical settings represents are described. It is also worthy of note that in addition to the demonstrated workload element, there are a number of activities which are part of the professional role of nursing staff, which are not outlined within the illustration, including, for example: professional supervision, preceptorship, or mentorship of pre-registration students. For further information, refer to the *Influencing Factors* section of the framework outlined within Section 2, and, para. 3.13, page 7, of this document.

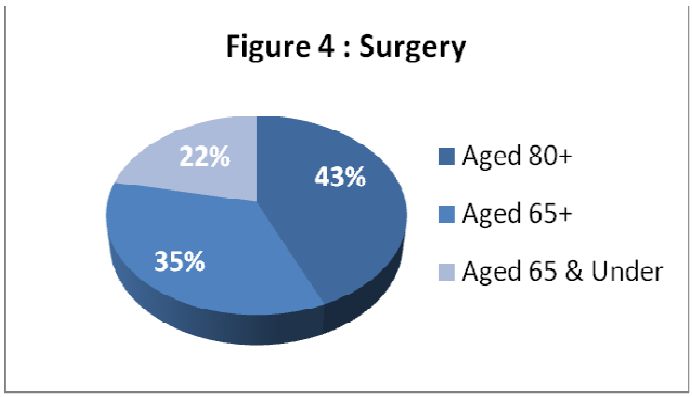
This illustration depicts an adult general medical ward, with 24 beds divided between 1 x 4 bedded bays, 2 x 6 bedded bays and 8 single rooms. The profile below provides a picture of the type of person nurses are currently caring for in hospital-based care. **Figures 3 and 4,** also below, demonstrate the age demographics of people within acute care services, from a snapshot of a medical and surgical ward in a Trust in Northern Ireland.

Patient Profile

John's story is typical of someone who is being cared for within adult hospital-based acute medical services in Northern Ireland. John is 81 years old. He lives on his own and has recently been experiencing difficulty breathing. 17 years ago, he suffered a number of small strokes from which he fully recovered and he now remains on medication to prevent further deterioration. Two years ago he had his right kidney removed because a malignant tumour had been found. He is usually independent, but suffers from severe pain from osteoarthritis in both knees which means he walks with a stick. His mobility is quite limited as a result and recently he has been increasingly unsteady.

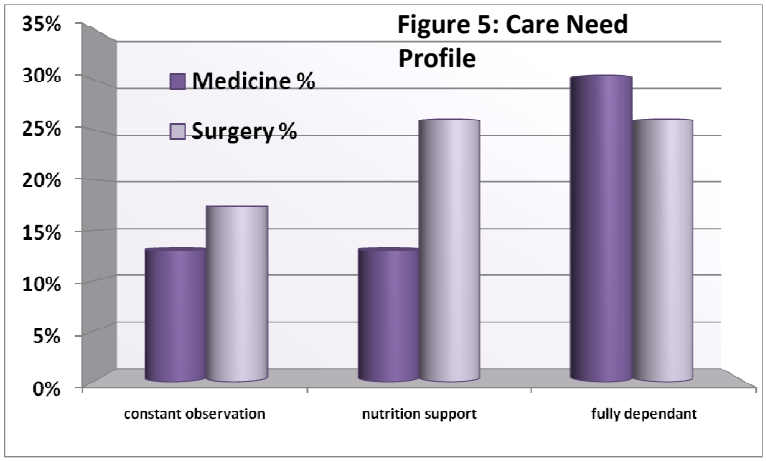


John's daughter, who lives 20 miles away from him, has told staff that she thinks he has fallen at home when on his own because of bruises and cuts on his face and limbs. She also feels he has not been eating sufficiently at home. When he reaches the ward, he is tired and distressed, and makes it clear to staff he does not want to be in hospital. The change of environment along with an abnormal blood chemistry and increasing shortness of breath means he becomes disorientated and confused, requiring constant observation. His breathlessness is diagnosed as being a symptom of congestive cardiac failure, for which he receives an intravenous drug which increases his urinary



output. This intervention has the effect of John wanting to walk to the toilet frequently. He also requires a number of investigations outside of the ward area all of which he has to be accompanied by one member of staff because he is at high risk of falling or accident. His lethargy means he has no interest in eating, is unable to take care of himself, and needs assistance to eat, drink and wash.

Figure 5, below, presents a profile of some of the types of care needs that the people identified in **Figures 3 and 4**, page 13, present with during an episode of care in hospital. The graphs correspond to percentages of the total number of people in a medical or surgical care setting. Nurses are caring for an increasingly significant number of people, who are like ***John***, with multiple care needs, unable to care for themselves and requiring a high level of support. It should be noted that this is not exhaustive of the totality of care provided.

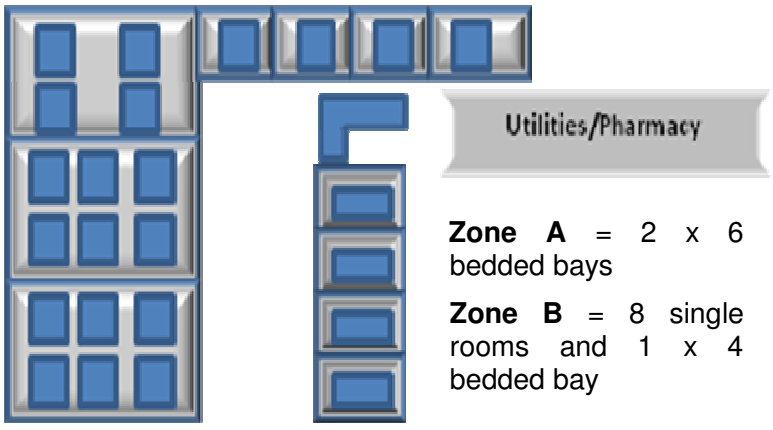


It should be noted that the profile of people being admitted for care within general/specialist medical and surgical settings is changing all the time.

Northern Ireland has a population of approximately 1.8 million people and is the fastest growing population in the UK. The number of people over 85 years old is predicted to increase by 19.6% by 2014, and those over 75 years increasing by 40% by 2020. More people are living longer, with long term conditions and disabilities, which can be further complicated by more than one condition in some cases[50] and a requirement for complex drug regimen.

A recent audit of practice carried out in a HSC Trust in 2013 demonstrated that 73% of people in an acute medical ward required Intravenous medications (IVs). This percentage equated to a total of 96 doses required in a 24 hour period, which require two registered nursing staff to check, prepare and administer per HSC Trust policy, with an average preparation and administration time of 9 minutes per patient per dose. This represents 29 hours of time spent by registered nurses in the management and administration of complex drug regimes in a 24 hour period.

Diagram 1: Ward Layout.



Environment

Diagram 1, right, depicts a typical ward layout. This environment of care means nurse staffing is divided into two teams Zone A

[50] Department of Health Social Services and Public Safety/Health and Social Care Board. (2011). *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.

and Zone B. The design of the ward environment is an important element in the consideration of staffing complements. A number of factors relating to the care environment may impact on the ability of the nursing team to deliver safe, effective, person centred care such as: vision, travel distances to supplies and utilities, creating cohorts of beds and use of technology.

For example, direct lines of vision for nursing staff into the patients' room(s) from a corridor are essential to allow for maximum patient observation, which requires large vision panels. Beds should be clustered in appropriate groups to maximise staff efficiency and to reduce travel distance to supplies and utilities. In addition, provision of decentralised staff bases in all ward environments provides uninterrupted lines of sight to patients and also allows the patients to see staff.

Appropriate location of storage for clinical supplies, equipment and consumables, including the location of utilities can positively influence productivity of nursing staff. This can be further enhanced by the provision of local daily supplies dedicated to bed clusters thereby reducing the travel distance within a ward.

This also applies to the location of departmental adjacencies such as xray and diagnostics particularly important when nursing or midwifery staff are required to escorting patients to other clinical areas/settings for diagnostics/ interventions/treatments.

Staffing Profile

Table 4 below, presents the required staffing complement that cares for the people outlined in the patient profile in **Figures 3 - 5**, pages 13 - 14.

Table 4: Staffing Complement

	Mon	Tues	Wed	Thu	Fri	Sat	Sun
Morning							
Registered	5	5	5	5	5	4	4
Band 3	1	1	1	1	1	1	1
Band 2	2	2	2	2	2	1	1
Afternoons							
Registered	5	5	5	5	5	4	4
Band 3	1	1	1	1	1	1	1
Band 2	1	1	2	2	1	1	1
Evening							
Registered	4	4	4	4	4	4	4
Band 3							
Band 2	1	1	1	1	1	1	1
Night Duty							
Registered	3	3	3	3	3	3	3
Band 3							
Band 2	1	1	1	1	1	1	1

This equates to a nursing:bed ratio of 1.3 and a skill mix of 70:30% registered/unregistered staff. Not included in calculations in this illustration is 1 WTE (100%) allowance for leadership and management /supervisory responsibilities of the Ward Sister/Charge Nurse and 24% Planned and Unplanned Absence Allowance.

5.0 IMPLEMENTING AND MONITORING THE FRAMEWORK

5.1 HSC Trusts will be monitored in relation to implementation of *Delivering Care: Nurse Staffing in Northern Ireland* year-on-year through the indicators of performance measures across Health and Social Care. In addition, staffing levels will also be monitored through the Chief Nursing Officer's Professional Assurance Framework. Nursing Key Performance Indicators (KPIs) currently being developed in Northern Ireland should assist in providing feedback related to the quality of care within care settings. This should provide useful information about the quality of care particularly in relation to those settings which have been benchmarked with the framework. In addition to KPIs and other indicators related to the nursing workforce, this information should assist in determining the efficacy of the framework and the way in which it is being used.

6.0 CONCLUSION

6.1 This document sets out the strategic direction and rationale for the development of a framework to support nurse workforce planning in Northern Ireland, beginning with general and specialist acute adult hospital medical and surgical care settings.

6.2 The framework should be used by HSC Trusts to take account of the recommended staffing ranges when developing:

- Proposals to meet the objectives within *Transforming Your Care*
- New bids for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

6.3 It will inform both the Health and Social Care Trusts and commissioners:

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

6.4 Commissioners will, as a result, have a regional framework in which they can agree and set consistent ranges for nursing workforce requirements for HSC Trusts in Northern Ireland.

Appendices

Appendix 1 - METHODOLOGY OVERVIEW AND PROCESS SUMMARY

Methodology Overview

The work undertaken by the Steering Group of this project took place from May 2011 to September 2012. Membership and Terms of Reference of the Steering Group are included at Appendix 2, page 21. A Working Group was also established, Membership and Terms of Reference included at Appendix 3, page 22.

At the outset of the project, it was recognised that determining appropriate staffing ranges was a complex process, dependent on a variety of factors, including the complexity of illness; level of co-morbidities; case mix; throughput; length of stay; and geographical layout of the environment. During 2009/10, a 'task and finish' group, supported by the Department of Health Social Services and Public Safety (DHSSPS), took forward work to scope a range of nursing/bed ratios for a number of general and specialist, medical and surgical areas within the acute care sector. The work of this group informed the approach used within the project.

The Steering Group agreed and implemented a project plan for Phase 1 to achieve the aim and objectives, which included a work programme encompassing the following components:

- Two time-limited literature reviews were conducted to determine:
  a. Methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally
  b. Available evidence-based staffing ranges or ratios which have been developed for adult hospital medical and surgical specialties
- A range of interviews were conducted with HSC Trust partners to gather information in relation to staffing ranges work which had been taken forward
- Using the work completed by the DHSSPS in 2010, a Glossary of Terms was agreed
- Development and agreement of a suite of factors within four domains, which should support nurses to determine where, along a continuum available within a staffing range, the needs of the people they care for may be met safely and effectively
- Information from available national expertise was gathered to inform the work of the Project.

Process Summary

Two time-limited literature reviews were undertaken to inform the work of the project. The first was conducted by the Business Services Organisation, Clinical Education Centre, and reviewed methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally. The conclusions from this review were that existing knowledge and practice in relation to staffing ratios and workforce planning remained relevant. In addition, there has been the recent development in England of an electronic tool to assist workforce planning – the Safer Nursing Care Tool[51]. The second literature review focused on available evidence-based staffing ranges or ratios, which have been developed for adult hospital medical and surgical specialties. This review, carried out by the PHA, confirmed that little work had been reported in relation to evidence-based staffing ranges/ratios for particular adult hospital medical and surgical specialties.

Between May and July 2011, a NIPEC Senior Professional Officer, undertook a number of face-to-face interviews with the nursing and midwifery workforce leads in each of the five HSC Trusts. These interviews informed the project by facilitating the revisiting and refreshing of data captured during the 2009/10 task and finish exercise, and identified a list of factors which could influence the point within a staffing range at which a nursing team might be set. In

[51] Information regarding the Safer Nursing Care Tool is available for download at: http://www.institute.nhs.uk/quality_and_value/introduction/safer_nursing_care_tool.html

addition, work to establish agreed staffing ranges for general adult hospital medical and surgical care settings was supported. During the completion of this work, it became apparent that it would be helpful to agree staffing ranges for specialist medical and surgical care settings, to support the generalist ranges, given that many general clinical settings currently exist with cohorts of beds dedicated to other types of services in specialist care.

The ranges for the data refreshing exercise provided a continuum measurement from which a range might be set, based on existing staffing complements within Northern Ireland. It should be noted that HSC Trust organisations had previously reviewed funded establishments based on a range of workforce planning tools including Telford[52] and the Association of United Kingdom University Hospitals[53]. Given that Planned and Unplanned Absence Allowances (PUAA) were included in historical funding within legacy Health and Personal Social Services Boards of between 18% to 23%, ranges were set to reflect the recommended 24% PUAA (please see page 14 of this document).

Following this exercise, the Working Group agreed a list of core influencing factors, set within four domains, from which definitions of terms and impact were developed.

Throughout the progress of the project work, a number of sources of expertise were available to the Steering and Working Groups, both regionally and nationally. In particular, contact was made with the Institute for Innovation and Improvement in relation to the Safer Nursing Care Tool, and the Central Manchester University Hospitals National Health Service (NHS) Foundation Trust in relation to the development of a simplified version of an electronic nursing workforce planning tool. The learning from these exercises informed the approach to the staffing ranges, which were agreed regionally and which constitute an element of this phase of the Framework.

The outcomes achieved by the completion of Phase 1 of the Project were:

i. A relevant Glossary of Terms

ii. Definition of staffing ranges in relation to general and specialist adult hospital medical and surgical care settings

iii. Definition of a Planned and Unplanned Leave Allowance

iv. Definition of a number of Influencing Factors, which impact upon the delivery of safe and effective care, and which determine the ratio within a staffing range at which a nursing team might be set.

It should be noted that, whilst the overarching aim of this project encompassed nursing and midwifery staff, the first two documents, Sections 1 and 2 were directed towards nursing staff only, due to the areas for which staffing ranges have been defined. It is acknowledged, however, that there are elements of Section 1 which will have relevance to midwifery settings, such as Planned and Unplanned Absence Allowance and Influencing Factors.

[52] Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.
[53] Association of UK University Hospitals (2009) *Patient Care Portfolio. AUKUH acuity/dependency tool: implementation resource pack*, London: AUKUH. Tool and related literature are available for download from www.aukuh.org.uk

APPENDIX 2 - MEMBERSHIP OF STEERING GROUP

Representation for	Representative
PHA	Pat Cullen, Director of Nursing and Allied Health Professions, Chair, from April 2012 to present day. Mary Hinds, Director of Nursing and Allied Health Professions, Chair from April 2011 – April 2012.
HSC Trust Executive Directors of Nursing	Alan Corry-Finn, Executive Director of Nursing, WHSCT.
Human Resources	Myra Weir, Assistant Director of Human Resources (from April 12), SEHSCT.
HSC Trust Nursing and Midwifery Workforce Leads	Nicki Patterson, Co-Director of Nursing (Workforce) replaced by Allison Hume (August 2013).
PHA	Siobhan McIntyre, Regional Lead Nurse Consultant, Chair of Working Group.
DHSSPS	Kathy Fodey, Nursing Officer, Workforce replaced by Caroline Lee (September 2013).
Regional Partnership Forum	Rita Devlin, Senior Professional Development Officer (RCN).
HSCB	Paul Turley, Assistant Director Commissioning, (non-registrant).
Patient Client Council	Maeve Hully, Chief Executive.
NIPEC	Maura Devlin, Interim Chief Executive (to August 2011) Glynis Henry, Chief Executive (from Sep 2011).
NIPEC	Angela Drury, Senior Professional Officer (Lead Officer).

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Steering Group are as follows:

TOR1 To agree a project plan, timescales and methodology for the project
TOR2 To contribute to the achievement of the project aims and objectives
TOR3 To undertake ongoing monitoring of the project against the planned activity
TOR4 To receive progress reports from the Project Lead and agree actions arising
TOR5 To contribute to the final report for submission to the PHA
TOR6 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project
TOR7 To approve appropriate communiqués for wider dissemination
TOR8 To review the impact of the tool 12 months after development and implementation.

Membership of Steering Group is non-transferrable, other than in exceptional circumstances and with prior agreement of the Chair.

APPENDIX 3 - MEMBERSHIP OF THE WORKING GROUP

Organisation	Representative
PHA	Chair – Siobhan McIntyre, Regional Lead Nurse Consultant.
NIPEC	Angela Drury, Senior Professional Officer NIPEC (Lead Officer).
DHSSPS	Kathy Fodey, Nursing Officer, Workforce replaced by Caroline Lee (September 2013)
DHSSPS	Mary Maguire, Health Estates replaced by Gillian Kelly (June 2013).
SHSCT	Glynis Henry, Assistant Director of Nursing (Workforce Lead) until August 2011, replaced by Lynn Fee (February 2012).
NHSCT	Allison Hume, Assistant Director of Nursing (Workforce Lead).
SEHSCT	Caroline Lee, Assistant Director of Nursing (Workforce Lead) replaced by Sharon McRoberts (September 2013).
WHSCT	Brendan McGrath, Assistant Director of Nursing (Workforce Lead).
BHSCT	Nicki Patterson, Co-Director Nursing (Workforce Lead) replaced by Moira Mannion (August 2013).

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Working Group are as follows:

TOR1 To contribute to the achievement of the project aims and objectives.

TOR2 To participate in the agreement and testing of a tool to define staffing ranges in general and specialist adult medical and surgical hospital care settings.

TOR3 To participate in the amendment and testing of the tool in other general and specialist hospital care settings.

TOR4 To participate in the amendment and testing of the tool in mental health and learning disability inpatient and community care settings.

TOR5 To contribute to reports offered to the Steering Group.

TOR6 To contribute to the interim and final reports for submission to the PHA.

TOR7 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project.

TOR8 To approve appropriate communiqués for wider dissemination.

TOR9 To review the impact of the tool 12 months after development and implementation.

APPENDIX 4 - ABBREVIATIONS

Abbreviation	Meaning
BHSCT	Belfast Health and Social Care Trust
DHSSPS	Department of Health, Social Services and Public Safety
FE	Funded Establishment
HCSW	Health Care Support Worker
HSC	Health and Social Care
HSCB	Health and Social Care Board
KPI	Key Performance Indicator
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
PHA	Public Health Agency
RCN	Royal College of Nursing
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Delivering Care: Nurse Staffing in Northern Ireland

Section 2: Using the Framework for general and specialist medical and surgical adult in-hospital care settings

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a medical and surgical care settings. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

CONTENTS

Final Draft March 2014

Preface

A message from the Minister for Health and Public Safety

I am delighted to introduce, *Delivering Care: Nurse Staffing in Northern Ireland*. The document focuses on General and Specialist Medical and Surgical Adult In-hospital Care Settings and is the first in a series which will in time cover all care settings.

This document is a further step in the modernisation of Health Services within Northern Ireland and it is the first time we will measure the inputs of Nurse Staffing against the outputs of Key Performance Indicators of good quality care and patient experience.

Whether a commissioner or a provider of care, you must draw upon this policy document to assist you to understand the environment of care and how that environment demands the application of a particular range of nurse staffing.

The people of Northern Ireland are rightly demanding that they and their relatives are cared for by a workforce which has sufficient nurses, with the right skills, in the right place to ensure the delivery of a compassionate, person centred, safe and effective service which we can be proud of.

My goal has always been to have a world class nursing workforce able to provide world class care and I believe this document better prepares us to ensure that continues to happen.

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report[1] (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

This document focuses particularly on medical and surgical units and is the first in a series which will expand to cover a range of major specialties across all programmes of care. As nurses we all have a duty to ensure staffing levels are appropriate and adequate, to provide a high standard of practice and care at all times under the responsibilities outlined within the code of the Nursing and Midwifery Council. This Framework is intended to support Ward Sisters/Charge Nurses, professional and general managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth and in developing new services. Staffing can never be viewed in a vacuum and there is no one perfect tool to define what the staffing profile should be in any particular unit, so it is vital that a number of elements are taken account of such as, the activity within the unit, the requirement to support annual leave, statutory learning and professional regulatory activity, the mix of skill within the workforce, timely recruitment to vacant posts and other factors which might impact on workforce planning, such as the length of stay of patients and the environment. In addition to these elements there must also be an understanding of Key Performance Indicators (KPIs) such as the clinical indicators of good quality care and patient experience. This document should not be viewed in isolation and it will become part of a Nursing KPI Dashboard where the workforce will be one element viewed alongside Clinical Indicators and Patient Experience Indicators. I believe a triangulated approach looking not only at the inputs required to deliver Person Centred Care but also interrogating the outputs which are the quality indicators and the patient experience are essential to improving care within Northern Ireland.

Delivering Care sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that I recognise is all the more important as we move through one of the most difficult periods in the history of the Health and Social Care sector in Northern Ireland. The publication of this first piece, in a series of work on staffing ranges, is intended to promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments when commissioning new services to ensure safe, effective, person centred care.

The timing of this framework coincides with the implementation of *Transforming Your Care,* the review of Health and Social Care in Northern Ireland*,* which sets out a range of proposals for the future of services in the region; concluding that there is an unassailable case for change and strategic reform. The Nursing and Midwifery

[1] Scottish Executive Health Department (2004a) *Nursing and Midwifery Workload & Workforce Planning Project.* Edinburgh: SEHD.

workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

I would like to express my sincere thanks to the members of the Steering Group and Working Group who committed their time energy and expertise in the development of this framework document.

I would also like to thank all of the key stakeholders across the Health and Social Care system who took part in the various consultations and workshops during the development of the Framework. A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for the significant project management, co-ordination, facilitation, and contribution to drafting of documents provided during the development of the framework.

Finally, I would like to thank Professor James Buchan, School of Health, Queen Margaret University, Edinburgh, for reviewing the documents and providing valuable feedback to support the final production and publication of Sections 1 and 2 of the Framework.

This document should now be shared with Health and Social Care Trust Boards and mechanisms established to ensure workforce planning processes are in place throughout Northern Ireland to support safe, effective, person centred care.

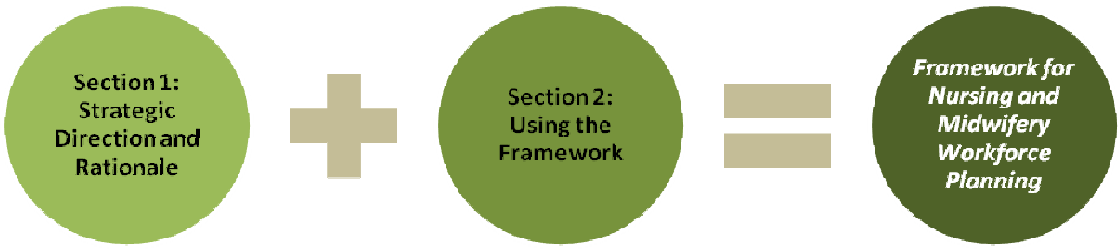
Chief Nursing Officer

The framework is made up of the following constituent elements:

Assumptions of the Framework

Nurse Staffing Ranges

And is made up of two complimentary documents:



GLOSSARY OF TERMS

Term	Meaning
Hospital Care	The utilisation of a hospital bed during an episode of in-patient treatment or care
Regional Services	Specialist services which are provided from one or two hospital sites for people throughout the region
Framework	This document describes a series of steps which incorporate a number of elements that impact on workforce planning such as nursing: bed ratios, Planned and Unplanned Absence Allowance and influencing factors which can be used to describe the optimum workforce required to support safe, effective, person centred care.
Ward	A group of hospital beds, with associated treatment facilities, managed as a single unit. A ward may function for the full 24 hour period in a 7 day week or within a variation of this pattern. This includes for example: day procedure units, elective surgical units, short stay wards.
Professional Regulatory Requirements	Activity within nursing and midwifery roles which is a professional regulatory requirement, but not necessarily an element of direct care provision. This includes: compliance with standards set by the regulatory body, supervision, and compliance with governance arrangements.
Classification of Clinical Care Settings	
Medicine	A general medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions. This includes, for example: acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
Specialist Medicine	A specialist medicine care setting is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated. This includes, for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.
Surgery	A general surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery. This includes, for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
Specialist Surgery	A specialist surgery care setting is defined as comprising: adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated. This includes, for example: neurosurgery, plastics, cardiac and head and neck surgery.

EXECUTIVE SUMMARY

Delivering Care: Nurse Staffing in Northern Ireland has been developed to support the strategic vision identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[2]. This framework will inform the Public Health Agency's duties detailed in the Health and Social Care Framework, the Department of Health Social Services and Public Safety Commissioning Directions and Health and Social Care Board Commissioning Plan.

The framework should inform Health and Social Care Trusts and Commissioners –

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments and when commissioning new services to provide safe, effective, person centred care
- To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

The framework documents incorporate a range of sections that will address a variety of settings across hospital and community care. It should be noted that elements of Section 1 will have relevance to a number of settings and subsequent phases, such as Planned and Unplanned Absence Allowance, Influencing Factors and the requirement to triangulate workforce planning processes with quality information such as Key Performance Indicators (KPIs). In addition, it is anticipated that midwifery staffing levels will be reviewed by the Project Groups as part of the evolving Project Plan.

This framework is based on the best evidence available including a range of recognised workforce planning tools, and has been produced in consultation with a wide range of stakeholders including commissioners and service providers, nurse managers, front-line staff and personal and public involvement, professional and staff side organisations. A core element is the development of a staffing range. This approach has been taken in preference to the simple application of an absolute number or ratio, as individual ward staffing is influenced by a range of factors all of which must be considered.

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries[3]***.***

The first phase of publication of the framework includes two sections relevant to nurse staffing levels in the first instance:

Section 1: Strategic Direction and Rationale

This Section sets out the policy context and rationale for the work of the *Delivering Care* Project in Northern Ireland and includes the following elements:

- Background, context and strategic drivers for developing staffing ranges
- Assumptions of the framework
- Nurse Staffing ranges.

[2] Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

[3] Please see pages 1 - 3 of this document.

The document is a brief summary of the elements of the framework, how they were agreed and how they might be applied in the context of the changing healthcare settings nurses work in currently.

Section 2: Using the Framework for Medical and Surgical Care Settings

This Section sets out how the elements of the framework might be used practically by Ward Sisters, Charge Nurses, general and professional managers to facilitate constructive conversations around nurse staffing ranges for a particular clinical setting. It includes the following elements:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

The products of the *Delivering Care* Project aim to provide all staff, but particularly nurses, both in front line practice, management and commissioning with a framework which will assist workforce planning processes and support constructive conversations about nurse staffing levels in Trusts.

It is anticipated that Health and Social Care Trusts will take account of the recommended staffing ranges contained in this document when developing:

- Proposals to meet the objectives within Transforming Your Care
- New proposals for additional resources to support service innovation and reform
- Developing efficiency and productivity plans for current services.

Over the last number of years changing patterns of service delivery, modernisation of care pathways, increased use of technology, increased patient acuity and higher throughput levels in wards have resulted in changes to staffing levels in Northern Ireland.

The outcome has been a combination of investment in new services and efficiencies in existing services. Executive Directors of Nursing have worked throughout this period of change to ensure staffing levels are maintained at a level that enables the provision of safe, effective person centred care.

This framework will provide a policy context to assist Trusts and commissioners to plan more effectively particularly during this time of transition. Commissioners will as a result, have a regional framework within which they can agree and set consistent ranges for nursing workforce requirements for Health and Social Care Trusts in Northern Ireland.

SECTION TWO: USING THE FRAMEWORK FOR MEDICAL AND SURGICAL CARE SETTINGS

1.0 INTRODUCTION

1.1 This document is the second section of *Delivering Care: Nurse Staffing in Northern Ireland.* It is designed to assist all staff, but particularly nurses, both in front line practice, management and commissioning, in the process of nursing workforce planning.

1.2 This section contains the following elements of the framework:

- Nurse staffing ranges for general and specialist medical and surgical adult care hospital settings
- Factors which influence the point within a staffing range which is appropriate for an individual service or care setting
- Guidance on 'How to Use' the framework.

1.3 For further information relating to the background, context and process of the work surrounding the development of the framework please refer to Section 1 of *Delivering Care*.

Range not Ratio?

1.4 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio[4]. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.

1.5 It is anticipated that on occasion nurse staffing may be outside the normal range. In such cases the Executive Director of Nursing must provide assurances about the quality of nursing care to these patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.

1.6 It is expected that HSC Trusts will take account of the recommended staffing ranges contained in this framework in developing proposals to meet the objectives within *Transforming Your Care*, in supporting new proposals for additional resources and when developing efficiency and productivity plans.

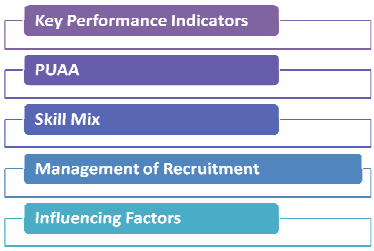
1.7 In addition, commissioners will be able to use the framework within which they can agree and set consistent ranges for nursing workforce requirements for providers of health and social care in Northern Ireland.

[4] Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies if wrongly calibrated, coupled with relative inflexibility.

ASSUMPTIONS OF THE FRAMEWORK

2.0 Introduction

2.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.



2.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.

ASSUMPTION 1:
ASSURANCE OF SAFETY, QUALITY AND EXPERIENCE THROUGH KEY PERFORMANCE INDICATORS

2.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of Section 1, supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.

2.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

Organisational: absence rates within nursing and midwifery teams; normative staffing ranges which will include vacancy rates.

Safe and Effective Care: incidence of pressure ulcers, falls, omitted or delayed medications.

Patient Experience: consistent delivery of nursing/midwifery care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

It is recognised that such quality information, which is being continuously monitored, will demonstrate the efficacy of staffing levels in a particular clinical area. Where the staffing complement meets the demand of the service being provided, quality indicators should demonstrate that safe, effective, person centred care is being delivered. Should quality indicators begin to fall below the accepted level of

achievement, staffing levels should be reviewed as one of the lines of enquiry of attributable causes.

ASSUMPTION 2:
PLANNED AND UNPLANNED ABSENCE ALLOWANCE

2.5 The ranges incorporate a Planned and Unplanned Absence Allowance of 24%. This allowance refers to periods of anticipated absence from work and should, therefore, be factored into the workforce planning process. This includes annual leave, sickness[5], and mandatory study leave. This element is further defined in *Section 1* of the framework, page 6. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods.

ASSUMPTION 3:
SKILL MIX

2.6 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[6], a skill mix comprising a higher level of unregistered staff may be appropriate.

2.7 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 registered:unregistered staff, based on best available evidence such as recognised workforce planning tools, related to this care setting. 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.

2.8 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 nurse leader for the ward.*'[7][8]

An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

[5] 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
[6] For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.
[7] Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.
[8] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.

ASSUMPTION 4:
MANAGEMENT OF RECRUITMENT

2.9 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.

2.10 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

- Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
- Avoidance of overuse of temporary staff, for example, bank and agency staff
- Matching of staff skill and band mix to patient acuity and dependency within approved guidelines[9]
- Timely and ongoing review of risk assessments linked to service reconfigurations.

ASSUMPTION 5:
INFLUENCING FACTORS

2.11 It is acknowledged that workforce planning for nursing staff is both complex and diverse[10]. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation[11] is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:

- Workforce
- Environment and Support
- Activity
- Professional Regulatory Requirements

2.12 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a medical or surgical setting. The tables contained at pages 7 - 13 outline the Influencing Factors within the four identified domains, including the following descriptions:

- A definition of what the factor means in terms of using the framework
- An indication of how the factor impacts on staffing ranges, with related guidance
- A list of helpful resources in relation to the factors described.

[9] For information related to skill mix please see assumption 3, page 3.
[10] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 6.
[11] *Ibid*.

5.4 The Influencing Factors should be used to inform service providers, commissioners, and Ward Sisters/Charge Nurses to set or review the point at which a facility falls within the continuum of a nurse staffing range. The factors presented will be used to influence the point at which a facility falls within the continuum.

5.5 Two practical examples of how the Influencing Factors might be used to guide workforce planning are included in this document at pages 15 - 16 and 19 - 20 of this document.

NURSE STAFFING RANGES

3.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery

MEDICINE

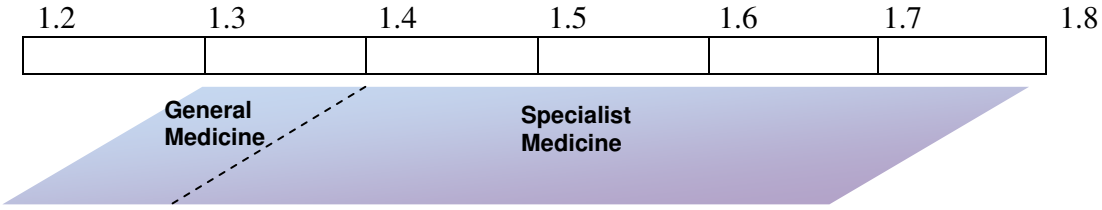
3.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.

3.2 A **specialist medical care setting** is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated, including for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example, Medical Assessment Units.

3.3 In some general ward areas, existing ***in both medical and surgical settings,*** a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24-bed general respiratory ward. As models of care for general medicine move towards specialisms, the number of specialist beds may increase. Where this occurs, a number of calculations will need to be made on two or more cohorts of patients to determine an overall appropriate nursing/bed ratio.

3.4 **Figure 1**, below, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care*, *Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care*, *Section 1*.

Figure 1: Nurse Staffing Range for General and Specialist Medicine.



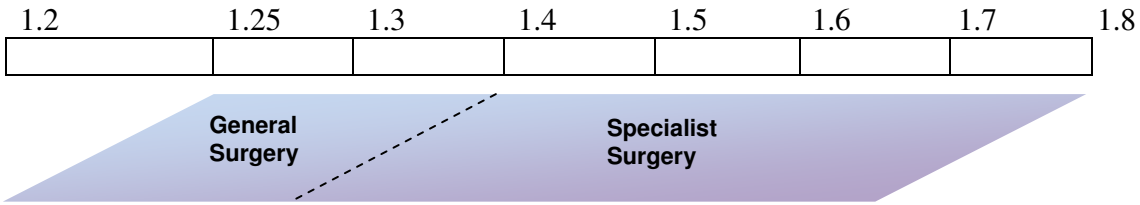
SURGERY

3.5 A **general surgical care setting** is defined as comprising adult surgical patients admitted for elective or emergency surgery, including for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.

3.6 A **specialist surgical care setting** is defined as, comprising adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated, including for example: neurosurgery, plastics, cardiac and head and neck surgery.

3.7 **Figure 2**, below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care*, *Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care*, *Section 1*.

Figure 2: Nurse Staffing Range for General and Specialist Surgery.



3.8 Providing an example: The Ward Sister of a 24 bed medical ward has used a Telford Exercise, coupled with the use of influencing factors to determine that her ward should be staffed at 1.3 on the nursing: bed range.

This equates to: 24 x 1.3 = 31.2 Whole Time Equivalents (WTE) to provide safe, effective person centred nursing care.

Adding in the requirement for the 100% (1 WTE) allocation of Ward Sister time for supervision/ management responsibilities, this equates to a Funded Establishment of 32.2 WTE, in this example.

With a skill mix of 70:30 this allows for:

- 21.84 WTE registered staff (0.7 x 31.2)
- 9.36 WTE unregistered staff (0.3 x 31.2)
- 1.0 WTE Ward Sister.

WORKFORCE

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	Rosters provide a structured process of matching available staff, and their skills, to the variations in workload to ensure patient safety. Within a roster system, the arrangement of start and finish times known as 'shifts', plus the sequence of working days available per staff members' contract over an agreed period of time, ensure that available numbers of staff are deployed to manage the workload demands.	Optimal rostering of staff supports effective management of the staffing resource available to a manager to deliver on the workload demands of a ward or department. An imbalance in the numbers and skills of staff available to meet the care demands of patients can present greater risks to patient safety. Appropriate shift patterns are key factors in delivering safe and effective care, and maintaining staff morale.
Planned and Unplanned Absence Allowance	Periods of absence from work, which are expected or unexpected and, therefore, factored into the workforce planning process. This includes sickness (both short and long term, with long term defined as 20 days or over and up to six months), study leave, as a minimum for mandatory training, non clinical working, e.g. management time.	Planned and Unplanned Absence Allowance acknowledges that staff have particular requirements and rights that render them unavailable to be rostered. This allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.
Ward Sister's/ Charge Nurse's time	An agreed 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 nurse leader for the ward.	The absence of an agreed allowance of time for Ward Sisters and Charge Nurses to address the management and supervisory responsibilities of their role can result in such essential responsibilities being neglected and failure to provide leadership at ward level. Currently, a ward sister/charge nurse manages a staffing complement in excess of 32 staff with associated appraisal, supervision, regulatory, human resource responsibilities and budgetary management including salaries and wages and goods and services.
Skill mix	The percentage ratio of registered to unregistered nursing staff working within an individual care setting.	An inappropriate skill mix can result in a mismatch of duties and responsibilities to roles. This can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources.

Management of Recruitment	Due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained. Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements: › Maintenance of staffing levels, which support the delivery of safe and effective, person centred care › Avoidance of overuse of temporary staff, for example, bank and agency staff › Matching of staff skill and band mix to patient acuity and dependency within approved guidelines › Timely and ongoing review of risk assessments linked to service reconfigurations.	Vacancy rates must continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills.
Management of absenteeism/ sickness	The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable.	Effective approaches to the management of periods of staff absence support the continuity of services, provision of safe and effective person centred care, patient safety and good staff morale.
Competence skill set to work flexibly	The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of demands.	The absence of a core set of transferable skills can limit the capacity of staff to meet a broad range of demands in a given department. To ensure that the essential clinical skills are developed within a team demands careful identification of learning needs and development opportunities for all staff.

Helpful Resources:

The HSC Trust Roster Policy should provide information on appropriate rostering practice.

Planned and Unplanned Absence Allowance Guidance at page 6 of *Delivering Care*: *Section 1*.

RCN Publication: *Making the business case for ward sisters/ team leaders to be supervisory to practice*:
http://www.rcn.org.uk/__data/assets/pdf_file/0005/414536/004188.pdf

Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN.
http://www.rcn.org.uk/__data/assets/pdf_file/0009/287784/003312.pdf

ACTIVITY

Term Used	What does this mean?	Impact?
Ward Attendees	Persons who attend a clinical setting for a planned or unplanned visit to seek advice, review or treatment e.g. wound review following surgery.	Ward attendees must be captured as a workload indicator at all times. Incremental growth in ward attendances can place increasing demands on ward nursing teams, without appropriate increases in staffing levels to manage same, and could potentially become an unfunded service development if not appropriately managed.
% Bed Occupancy	A measurement of the percentage of time that beds are occupied, measured at midnight. Day cases and ward attendees are excluded from the calculation. **Average Daily Occupied Beds** **---------- x 100** **Average Daily Available Beds**	Capturing bed occupancy at 12.00 midnight only can result in substantial activity and workload being omitted. Comparing bed occupancy at 12.00 midday and 12.00 midnight can provide valuable management information. The Government's Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals, average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions[12].
Throughput	Is the average number of patients per bed during a calendar month. This can include deaths, discharges and transfers to other wards. Day Cases and ward attendees are excluded from the calculation. **Total Inpatients** **----------** **Average Number of Available Beds**	With managed shorter lengths of stay in many hospital beds, throughput is an important workload indicator in the service. In settings where the admissions rate is high e.g. Acute Medical Admissions Units have a high, volume of people being admitted to the care setting, therefore, a high throughput, there is a requirement for higher numbers of staff to support the ongoing care needs.
Patient Dependency/ Acuity	An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	Appropriate workload measurement tools can lead to appropriate staffing levels for wards and departments, thus supporting safe and effective care.
Length of Stay	A measurement of the average length of time spent in hospital. Day Cases and ward attendees are excluded from the calculation. **Average Daily Number of Occupied Beds x Days in Year** **----------** **Total Inpatients**	The trend in Health and Social Care services has been towards shorter lengths of stay. This also results in more complex discharge processes, as people are provided with ongoing treatment and care in the community setting. These factors ultimately contribute to an increase in the throughput and a resultant increase in the workload demand for staff.

Seasonal Variations	Patients commonly present with a range of conditions and chronic illnesses which may be dependent on the time of the year, or become exacerbated at certain times of the year. This provides a particular case mix of conditions and/or increased volume of admissions which may require more intensive nursing input due to the critical nature of the care required.	Seasonal variations are likely to present a greater workload burden on nursing staff. It is important that increased workload demands are supported by appropriate staffing levels.
Specialities/ Case Mix	The range and variation of patients' health conditions managed in a particular clinical setting	A broader range of specialties and case mix being managed in a care setting presents a greater demand on the nursing team in terms of knowledge, skills and complexity.
Number of Beds	The actual number of beds in a clinical setting.	The number of beds and design of a ward environment can have an impact on the efficiency of a ward or department. There would appear to be an optimal number of beds per ward to maximise efficiencies.
Assessment of Risk	Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care[13]. This includes, risk to people in their care, members of staff and other members of the public.	By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. Time is required from the nursing team for this activity to carry out ongoing risk assessments for people within their care environments.
Incremental Service Improvements / Development	This is activity concerned with testing ideas, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users. (Department of Health, 2008)[14].	Incremental service improvements are designed to implement improvements in patient care and/or outcomes. This can result in improved working conditions for staff. Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale.

[12] Department of Health (2000). *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services.* London, DoH.
[13] Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.
[14] Department of Health (2008). *Making the difference: The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS.* London, DoH.

ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	The support provided within a clinical area by Information Technology and other mechanised systems and sufficient equipment maintained and stored appropriately which may assist registrants in caring for people.	Access to available software which links to a range of data systems can enable efficient transfer of information, which assists at many stages of the patient care pathway. Efficient systems may reduce workload requirement and conversely, inefficient systems may add to the workload e.g. staff spending time sourcing equipment.
Geographical Layout/ Room Structure	The arrangement of the physical clinical environment, including whether or not there are single roomed facilities. The physical arrangement of a clinical setting has an impact on workforce planning, in that it may require greater numbers of staff where there are areas of poor visibility or require staff to work in discrete teams.	A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements. Where single rooms restrict visibility and therefore compromise clinical and care observations this will have an impact on staffing levels in wards.
Ward Size	The 'average' 24-bedded[15] clinical area can be constructed of 24 beds, configured within a mixture of multiple bed areas and/or single rooms.	In clinical settings where the bed complement is substantially smaller, nursing: bed ratios will be significantly higher to support the provision of safe and effective care on a 24 hour basis. Similarly, where a ward is significantly larger than 24 beds, there will be a requirement for appropriate levels of senior staff to support the provision of safe and effective care on a 24 hour basis.
Departmental Adjacencies in relation to Areas for Patient Transfer	The physical distance required to be covered when escorting patients to and from other service areas, e.g. radiology, theatre(s). Where there is likely to be a significant number of patients requiring a nurse escort*, the workforce planning impact needs to be taken into account in determining staffing levels to support safe, effective person centred care.	Nursing staff may be required to escort patients to diagnostic testing/theatre, thus removing the member of staff from the team and the team ability to share the workload.
Supportive Staff Infrastructure	The support provided within a clinical area by other members of staff, who are not registrants or within the family of nursing e.g. administration or housekeeping staff.	There are a range of tasks which can be completed by individuals who are not identified as working within the family of nursing e.g. administrative staff, housekeeping staff.

Escorting refers to the professional role of attending to a patient when in transit from one care environment to another (i.e. the patient requires care).

[15] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 24. The 'average' NHS ward has 24 beds.

PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	This is activity which is linked with care delivery but is not a direct element of the process of care delivery, e.g. multi-professional case meetings.	The level of this activity and requirements for delivery of such can impact on the workload of nursing teams. This requires definition as to what elements are present within the nursing workload and how much time is expended on them.
Compliance with professional regulatory standards	This is activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a clinical environment, such as those for learning and assessment in practice/mentorship. This may include ongoing monitoring of these standards.	High ward activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards.
Supervision	This is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety. (NIPEC, 2007)	An element of the time required to train nurses and those within the family of nursing is included in the Planned and Unplanned Absence Allowance of 24%.
Accountability and governance requirements	The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services. Governance has been defined as 'systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community, and partner organisations' (DoH Integrated Governance Handbook 2006). Accountability embodies three key attributes: • recognisably high standards of care • transparent responsibility and accountability for those standards • a constant dynamic of improvement.	In order to provide safe, effective, person centred care, appropriate staffing levels are required to impact positively upon the professions' ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators. This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires the time of the team to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care.

References and Helpful Resources:

Department of Health (2006). *Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations.* Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf

Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS.

Northern Ireland Practice and Education Council (2007). *The Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS*. Belfast, NIPEC.

Department of Health Social Services and Public Safety. (2011). *Framework Document*. Available for download at: http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

http://www.nmc-uk.org/Publications/Standards/

6.0 HOW TO USE THIS FRAMEWORK

6.1 This framework has been designed to promote a shared understanding of workforce planning principles associated with nurse staffing levels to provide safe effective, person centred care. As Trusts reform and modernise their services, the nurse staffing ranges and planned and unplanned absence allowance outlined in this document must be taken into account prior to releasing funding from nurse staffing for efficiency/productivity savings.

6.2 Use of the framework will inform both HSC Trusts and the Commissioner for a range of purposes, some of which are presented below:

HSC Trusts

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing establishments, and when commissioning new services, to provide safe, effective, person centred care.
- › To support general and professional managers in presenting clearly the need for investment in nurse staffing, within changing service profiles, particularly in response to incremental service growth.
- › As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

Commissioner

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing proposals for commissioning general and specialist services to provide safe, effective, person centred care.
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

6.3 Commissioners will as a result have a regional framework in which they can agree and set consistent ranges for nursing workforce requirements for HSC Trusts in Northern Ireland.

6.4 Pages 15 - 20 contain a number of practical examples illustrating how to use the Framework to assist nursing workforce planning processes. There is also a worked example of a 'Telford Exercise' at page 17, using the Telford model of nursing workforce planning, which remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom[16].

[16] Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.

Scenario No. 1

Preparing for a Discussion

A Ward Sister has been in post for 4 years in an acute adult in-hospital medical care setting in Northern Ireland Health and Social Care Trust (NIHSCT). During this time, the acuity and dependency of the patients her team cares for had increased, along with increased bed occupancy and decreased length of stay. The number of part-time staff within her team complement has also increased significantly.

Sister decides to use *Delivering Care* to have an informed, evidence-based discussion with her Line Manager, about the nurse staffing requirement for her ward to support the provision of safe and effective person centred care.

Steps for discussion:

1. This ward is an acute adult in-hospital medical care setting. Using the Staffing Range for medicine, the lower end of the ratios is 1.3.
2. Sister undertakes a 'Telford' exercise (please see page 17) using her own professional judgement and information from the day-to-day running of the ward, identifying when staff are required to manage optimally the service provided.
3. Sister then looks at the Influencing Factors, pages 7 - 13. Through reading the information, she realises that:
   - it would be helpful to have in place an e-rostering system to assist with the optimum management of the staffing resource
   - the sickness absence rate in the ward she manages is currently 6.5% excluding maternity leave.
4. In order to prepare for the discussion with her line manager, Sister contacts a colleague who contacted her recently to raise awareness regarding the implementation of the e-rostering system within NIHSCT. She is informed that her ward will be included in year two of implementation. She also has a discussion with colleagues within Human Resources and Occupational Health departments to identify if there are any further steps she might take to best manage the sickness absence rate in her ward team.
5. Having identified these areas for action, Sister has several other issues for discussion with her line manager arising from the Influencing Factors:
   - a review of the skill mix within the ward is required as currently it is 68:32 and not the recommended 70:30 registered: unregistered staff
   - the significant increase in part-time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements
   - shorter lengths of stay have increased the workload for nursing staff, particularly in relation to complex discharge planning
   - verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Meeting with Ward Sister and Line Manager.

Sister begins the meeting with her Line Manager by talking about the action she has taken in relation to the e-rostering system and enhanced management of sickness/absence rates in her ward as a starting point when considering the staffing complement. Having discussed these issues, the Line Manager identifies a number of other approaches which might help Sister to review the processes within the ward she manages, such as the Productive Ward[17], or Lean Thinking[18]. Sister agrees that further work could be done within the ward team, in relation to streamlining some of the processes.

She outlines that the ward, being an acute adult in-hospital medical care setting, starts at a ratio of 1.3, using the staffing range for medicine within *Delivering Care Section 2*. The 'Telford' exercise indicated that the complement of staff required was within the lower end of the range; the skill mix required, however, was 70:30, higher than what was currently included in Sister's Funded Establishment (FE). She also identifies that the significant increase in part time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements.

She also discusses that shorter lengths of patient stay have increased the workload for nursing staff, particularly in relation to complex discharge planning, and verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Sister and her Line Manager consult with the Assistant Director for Nursing and Midwifery Workforce within the Trust, to reach an agreement that the point within the range at which the FE currently falls: 1.3 is appropriate; there is, however, a question in relation to the skill mix of the FE. There are currently 24 beds in the ward.

This equates to 1.3 x 24 = 31.2 WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

31.2 x 0.7 = 21.84 registered

31.2 x 0.3 = 9.36 unregistered

Sister currently has 21.2 registered staff and 10.2 unregistered staff members as part of her team.

She agrees with her Line Manager and Assistant Director of Nursing and Midwifery Workforce that an additional 0.64 WTE registered staff should be added to her staff complement and 0.84 WTE unregistered staff be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Ward Sister leadership/supervisory role at the agreed set level of 100 % WTE of a Band 7; this brings the total funded establishment to be calculated at 32.2 WTE.

[17] The Productive Ward focuses on improving ward processes and environment to help nurses and therapists spend more time on patient care, thereby improving patient safety and efficiency. For further information, please go to: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

[18] Lean thinking is an approach which is about getting the right things to the right place, at the right time, in the right quantities, whilst minimising waste and being flexible and open to change. For further information, please go to: http://www.institute.nhs.uk/quality_and_value/lean_thinking/lean_thinking.html

Example Outline of a 'Telford' Exercise

Please note: the 'Telford' exercise outlined within these pages demonstrates the use of one workforce planning tool which involves a degree of professional judgement. A number of workforce planning tools exist, which use a range of different approaches to the activity, some of which have been referred to in *Delivering Care, Section 1*.

1. Define the length of the shift patterns over a 25 hour period, which includes one hour in total for handover (two half hour periods). For example: that the morning shift is 5 hours long, afternoon shift is 5 hours long, evening shift is 4 hours and night shift 11 hours. These hours are recorded in column **B** in **Table 1,** page 18.
2. Identify the number of registered and unregistered staff required for each shift based on professional judgement; regarding appropriate numbers to provide safe, effective, person centred care.
3. Add up the number of staff for each band to reach a total for the week for each shift – see column **A.**
4. Calculate the number of hours required for each staff group by multiplying columns **A** and **B** to reach the answer located in column **C.**
5. Add all the hours up in column C to provide a total number of staff hours. Multiply this number by 1.24 to add the required 24% Planned and Unplanned Absence Allowance.
6. Divide this number by 37.5 to reach the number of Whole Time Equivalents (WTE) required to staff the ward.
7. You will see from the three columns to the far right of Table 1, it is also possible to calculate numbers by band and therefore calculate skill mix using the same method of:

   Sub-total of hours x 1.24 / 37.5 = Number of WTEs

8. This example provides a total of 31.51 WTEs of all bands. This includes 22.25 of registered staff and 9.26 of unregistered staff. To calculate the skill mix:

   $$\frac{\text{Total number of registered staff}}{\text{Total number of staff}} = 70.6\%$$

   $$\frac{\text{Total number of unregistered staff}}{\text{Total number of staff}} = 29.4\%$$

9. Finally, to calculate the nursing to bed ratio, divide the total staff complement by the number of beds:

   $$\frac{31.51}{24} = 1.31 \text{ nursing: bed ratio}$$

10. It should be noted that these calculations do not include the allocated 100% of a Ward Sister's/Charge Nurse's time to fulfil his/her leadership/supervisory role within the care setting. Adding this allocated time brings the Funded Establishment to 32.51

Table 1

	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Total for week A	hours per shift B		Weekly hours per shift per level C	Registered	Band 3	Band 2
Morning														
Registered	5	5	5	5	5	4	4	**34**	**5**		**165.00**	165.00		
Band 3	1	1	1	1	1	1	1	**7**	**5**		**35.00**		35.00	
Band 2	2	2	2	2	2	1	1	**12**	**5**		**60.00**			60.00
Afternoon														
Registered	5	5	5	5	5	4	4	**33**	**5**		**165.00**	165.00		
Band 3	1	1	1	1	1	1	1	**7**	**5**		**35.00**		35.00	
Band 2	1	1	2	2	1	1	1	**10**	**5**		**45.00**			45.00
Evening														
Registered	4	4	4	4	4	4	4	**28**	**4**		**112.00**	112.00		
Band 3	0	0	0	0	0	0	0	**0**	**4**		**0.00**		0.00	
Band 2	1	1	1	1	1	1	1	**7**	**4**		**28.00**			28.00
Night Duty														
Registered	3	3	3	3	3	3	3	**21**	**11**		**231.00**	231.00		
Band 3								**0**	**11**		**0.00**		0.00	
Band 2	1	1	1	1	1	1	1	**7**	**11**		**77.00**			77.00
										Sub total	953.00	673.00	70.00	210.00
										add 24%	228.72	161.52	16.80	50.40
										Total	1194.12	834.52	86.80	260.40
										WTE	**31.51**	22.25	2.31	6.94
								Total WTE			**31.51**	**22.25**		**9.25**
								Nursing To Bed Ratio			**1.31**			
									Total Beds	**24**				
Totals									**Skill Mix %**			**70.62**		**29.38**

Scenario 2

Preparing for a Discussion

The Assistant Director (AD) for Acute Services, Northern Ireland Health and Social Care Trust (NIHSCT), has been informed that one of the wards within his service group, an acute adult in-hospital general surgical care setting, will be closing 2 beds in the next financial year due to some of the surgical interventions previously carried out as in-patient procedures now being undertaken as day surgery admissions. In addition, two beds currently used for patients returning from surgery and staffed outside of the upper limits of the specialist end of the staffing ranges, are being stepped down to general surgical beds. The care of those patients will be moving to a newly configured unit located elsewhere in the Trust. The AD is aware that this will have an effect on the staffing complement within this ward and decides to use *Delivering Care Part 1* to have an informed, evidence-based discussion with the Lead Nurse for surgery and the Charge Nurse responsible for the ward.
Steps for discussion:

1. The Charge Nurse's ward is an acute adult in-hospital general surgical care setting. There are currently 26 beds, the staffing ratio currently set at 1.25 for 24 of the beds and 2.5 for two of the beds. The Funded Establishment (FE) in his clinical setting is 36.2 Whole Time Equivalents (WTE) with a skill mix of 70:30, registered:unregistered staff.
2. Using the staffing range for surgery, the lower end of the ratios is 1.25. It is likely that this will be applied to all 24 beds, following the service redesign and reconfiguration of bed usage.
3. The AD calculates that this would provide a FE of 30 WTE. Whilst reading through the framework document, he notes that there are a number of areas which need to be considered during the meeting with the Lead Nurse for surgery and the Charge Nurse. He raises the potential use of the framework to guide discussions with the Lead Nurse, and encourages her to have a conversation with the Charge Nurse to think about areas of preparation in advance of the meeting. He also contacts the NIHSCT Nursing and Midwifery workforce lead, to explore possibilities for reconfiguration of the ward team staffing complement using the Delivering Care Framework. Following that discussion, he asks the Workforce Lead to attend the meeting with the Lead Nurse for surgery and Charge Nurse.
4. The Lead Nurse for surgery and Charge Nurse discuss the framework document in order to prepare for the meeting. The Charge Nurse subsequently agrees to carry out a 'Telford' exercise (please see page 17) to estimate the likely need for staff at particular times of the week when the service in his ward area becomes particularly busy.
5. They also consider the Influencing Factors, pages 7 - 13. Through reading the information, they realise that:
    - 3 recently registered staff have joined the team in the last month; they need development of their skill set in relation to the type of service being provided in the ward, and a period of preceptorship
    - Over the last two years, the length of stay of patients in the ward has been decreasing and the throughput increasing
    - The geographical layout of the ward has always presented a difficulty for

- Staff have reported that Key Performance Indicator (KPI) scores collected for nursing and midwifery organisationally have recently fallen compared with previous scores across three out of the five measurements within AHSC Trust. Staff have also reported that there is difficulty in getting time to conduct audits for KPI measurement.

Meeting with Assistant Director for Acute Services NIHSCT, Assistant Director Nursing and Midwifery Workforce NIHSCT, Lead Nurse for surgery and Charge Nurse.

The AD begins the meeting by offering an opportunity to the Lead Nurse for surgery and Charge Nurse to present their thinking in relation to identified areas for discussion from *Delivering Care Part 1*. In terms of the geographical layout of the ward, Charge Nurse has identified a need to review the storage systems. The Lead Nurse has offered the opportunity to work with him to implement the Productive Ward[19], which has successfully helped other areas review ward-based systems and increase efficiency for the ward team.

Charge Nurse outlines the results of the 'Telford' exercise, which indicated that the complement of staff required was within the lower end of the range for general surgery. He acknowledges that the skill mix at which the ward operates is 70:30. The Lead Nurse and Charge Nurse discuss the impact of the decreased length of stay and increased throughput, coupled with a registered staff complement that has a proportion of recently registered staff, who are still within the requirements for induction and preceptorship. The impact of this increased workload on staff is demonstrated through the evidence provided in the falling KPI scores and anecdotal evidence that staff are finding it difficult to find time to collect audit information.

After much debate during the meeting, it is agreed to review the 'Telford' exercise, providing additional staff numbers at busy times in the working week to allow for the extra workload identified. It is agreed that this should be reviewed again in 6 months' time, during which staff will have been provided with some of the required development to build confidence/new competence to provide the service, thus reducing the requirement for extra staffing. When the 'Telford' exercise is repeated, the range is calculated at 1.3. It is also agreed that Charge Nurse will retain the existing Band 6 staff team members, who will not be redeployed in the first instance, to support the development of the ward team.

This equates to 1.3 x 24 = 31.2 WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

31.2 x 0.7 = 21.84 registered

31.2 x 0.3 = 9.36 unregistered

Charge Nurse currently has 24.5 registered staff and 10.5 unregistered staff members as part of his team.

He agrees with those attending the meeting that 2.66 WTE registered staff and 1.14 WTE unregistered staff should be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Charge Nurse leadership/supervisory role at the agreed set level of 100% WTE of a Band 7, this brings the total funded establishment to be calculated at 32.2 WTE.

[19] *Op cit*, n 17.

ABBREVIATIONS

Abbreviation	Meaning
BHSCT	Belfast Health and Social Care Trust
DHSSPS	Department of Health, Social Services and Public Safety
FE	Funded Establishment
HCSW	Health Care Support Worker
HSC	Health and Social Care
HSCB	Health and Social Care Board
KPI	Key Performance Indicator
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
PHA	Public Health Agency
RCN	Royal College of Nursing
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent

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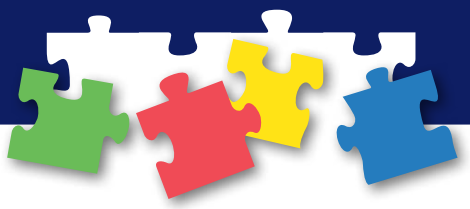
AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

A Partnership for Care

Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015

Contents



A Message from the Minister

As Minister for Health and Social Care I have had many opportunities to witness first hand the immense impact that nurses, midwives and support workers have on the delivery of care across a range of settings. Traditionally nurses and midwives are seen as the guardians of care, working closely with patients/clients and their families twenty four hours a day, leading, managing and working in teams, advocating for patients and facilitating change and reform. It is this central role that is so vital to our health and social care system.

Nurses and midwives teach, support and nurture the professionals of tomorrow and remind us of the importance of the person, the patient and community that must be central to our services.

All of us, whether as patients or staff, want to be treated courteously, with dignity, respect, sensitivity and compassion. How we work and interact can have a real impact upon the experience of those who use our services, creating an environment where we can all take pride in the services that we offer. A considerable amount of progress has been made with the launch in 2008 of the patient experience standards, but we cannot be complacent, which is why I am delighted to see the needs of patients/clients reflected throughout this strategy.

I recognise that in health and social care our staff are the most important resource. While no one can deny that the current economic climate will present difficult choices and decisions I am optimistic that through working in partnership we will face these challenges together to improve the health and well being of the population in Northern Ireland.

Michael McGimpsey, MLA
Minister for Health, Social Services and Public Safety

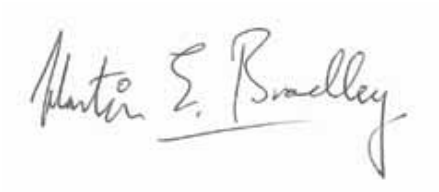
Foreword by Chief Nursing Officer

Whatever your role within the family of nursing and midwifery this strategy is for you, it sets out our priorities for the next five years as we progress with drive and enthusiasm to achieve our vision of working in partnerships to meet the health and social care needs of our population.

In my role as Chief Nursing Officer I am fortunate to be able to spend time with members of the nursing and midwifery family throughout Northern Ireland observing the excellent work they do caring for patients and clients.

As nurses, midwives and support workers what we do affects every single person in our community. We welcome life, help people to make healthy choices, support those with a disability or chronic disease, and care for those who are terminally ill. In the past few years we have seen fundamental changes to the way our health and social care services work, with the establishment of the new Trusts, the Health and Social Care Board, Public Health Agency, Business Services Organisation and Patient Client Council. These organisational changes are designed to put the patient/client at the centre of our services and secure good health for the whole population.

The next five to ten years will bring an ever greater pace of change, and difficult choices – rather than wait passively for the tough choices to emerge, we must look ahead, act now and prepare for the future.



Martin Bradley
Chief Nursing Officer

Our Strategy

This strategy is the culmination of a range of work which has been undertaken in Northern Ireland in response to the Modernising Nursing Careers agenda and supports the Midwifery 2020 initiative. It has been developed in consultation with members of the nursing and midwifery family and patient representatives through a series of engagement workshops. Its development has been overseen by a steering group chaired by the Chief Nursing Officer.

This strategy has been developed under the four strategic themes of:

- **Promoting Person Centred Cultures**
- **Delivering Safe and Effective Care**
- **Maximising Resources for Success and**
- **Supporting Learning and Development.**

Based on the information obtained during the engagement workshops three key perspectives have been identified under each of the strategic themes. These will be used as lenses through which to view the strategy and achieve the vision. Each of the key perspectives is articulated at strategic, organisational and individual level to ensure that every nurse, midwife and support worker has a place in this strategy and can clearly see what it means for them.

Strategy Development

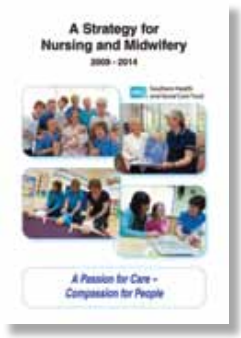
Trust Strategies

Reflected within the strategy are the themes contained within each of the five Health and Social Care Trust nursing and midwifery strategies which have been published during 2008/09, namely

Western Trust - Nursing ...Making a Difference – 2008 – 2012

Northern Trust – Our Futures, our journey – 2008 – 2012

South Eastern Trust – Nursing and Midwifery Strategy 2008 – 2011



Southern Trust – A passion for care – compassion for people 2009 - 2014

Belfast Trust – Striking the balance – 2009 – 2012

This strategy should be seen as a high level road map to guide the family of nursing and midwifery over the next five years. It is based on the principle that the contribution of every nurse, midwife and support worker is valued and has a part to play in ensuring the delivery of high quality safe and effective care to patients/clients. The strategic themes capture both the enduring values of nursing and midwifery as well a vision for the future.

This strategy will generate local action plans from each of the HSC Trusts, the Public Health Agency and DHSSPS and will also be adopted by the independent and voluntary and community sector.

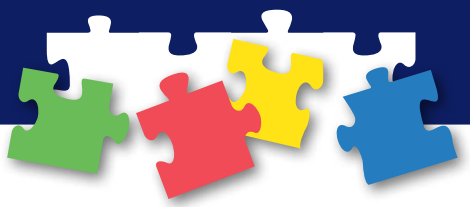
The Strategic and Policy Context

It is an exciting and challenging time to be part of the nursing and midwifery family in Northern Ireland. The restoration of devolved government and the implementation of the Review of Public Administration have reshaped organisational and management structures. Throughout this unprecedented period of change the delivery of safe, high quality, effective and compassionate care has relied upon the family of nurses and midwives working across a diverse and wide range of settings with the aim of providing person centred care 24 hours a day 365 days of the year.

In addition to improved social conditions and public health successes, new drugs and technologies have contributed to the population living longer with people increasingly living with one or more chronic condition. Many of these conditions, such as cardiovascular disease, cancer, diabetes and chronic respiratory disease are linked by common preventable risk factors. Smoking, prolonged unhealthy nutrition, physical inactivity, and excess alcohol use are major causes of ill health within the population. As members of integrated, multidisciplinary teams nurses and midwives have important roles to play in working with patients/clients and their families in the prevention, treatment and management of chronic diseases from preschool through to old age.

The establishment of the new Public Health Agency, Health and Social Care Board and the Patient Client Council in April 2009 was driven by the need to improve the health and wellbeing of the people of Northern Ireland and reduce inequalities; as such the health and social care system should be proactive in working towards, anticipating and preventing health and social care problems rather than merely reacting to them. To achieve this there will be an increased focus on anticipatory care that crosses organisational boundaries. A self care approach will be adopted which will allow people with long term conditions to have access to improved information, education and support, as well as new technology aimed at enhancing home-based care. Similarly, health and social care organisations, local government and the independent, voluntary and community sectors will work together to ensure the person is placed at the centre of decision making processes and that safe and effective care services are increasingly delivered in the individuals home.

Changes in demographic trends and the aging population mean that increasingly more of the nursing workforce is employed in the independent / voluntary and community sectors. The review of the nursing and midwifery workforce conducted in September 2008 indicated that between 2000 and 3000 qualified nurses are currently employed within these sectors. It is therefore important that we recognise the knowledge; skills and experiences attained within these settings and cultivate a highly skilled and flexible workforce for the future.



The monitoring and inspection of the availability of health and social care services, including those within the independent sector is undertaken in Northern Ireland by the Regional Quality Inspection Authority (RQIA) who examine all aspects of the care provided and work to ensure public confidence in these services. In addition with the transfer of duties from the Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009, RQIA undertakes a range of responsibilities for people with a mental illness and those with a learning disability.

In Northern Ireland a range of policy initiatives, launched since 2002, have reflected the changing context of Health and Social Care and set the direction for future service delivery, namely:

- Developing Better Services: Modernising hospitals and Reforming Structures;
- Investing for Health;
- A Healthier Future: A Twenty Year Vision for Health and Wellbeing;
- Caring for People Beyond Tomorrow;
- The Review of Public Administration;
- Changing the Culture;
- The Bamford Review;
- Patient Client Experience Standards.

A summary of these documents is attached at **Appendix 1**

These policy documents and initiatives reflect the changing face of health and social care in Northern Ireland. Nurses and midwives must embrace the future opportunities and challenges that the professions face and exercise the direction outlined in this strategy to help shape the future.

Nursing and Midwifery in Northern Ireland

Nurses and Midwives are registered with the Nursing and Midwifery Council, with nursing subdivided into the four areas of adult, mental health, learning disability and care of children.

Pre–Registration Education

The students of today are the registrants of tomorrow. Effective educational programmes and mentorship will support and develop nurses and midwives for the future.

In Northern Ireland pre registration education is delivered by Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. Further information on these courses can be found on the relevant websites outlined below.

Queens University
www.qub.ac.uk/schools/SchoolofNursingandMidwifery

University of Ulster
www.science.ulster.ac.uk/nursing

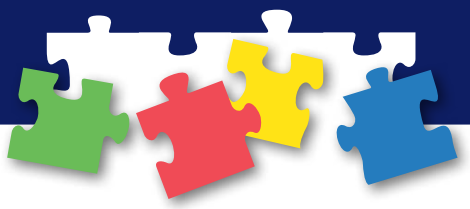
Open University
www3.open.ac.uk/study/undergraduate/health-and-social-care/nursing/index.htm

Post Registration Practice

Consolidation period Post Registration - Guidance from the NMC recommends that all new registrants be afforded protected time in their first year of practice with the support of a preceptor. For midwives this period of consolidation culminates in a review process at which the progression from AfC band 5 to AfC band 6 takes place.

Career Progression

Following the consolidation period some practitioners will choose to specialise in a particular area of practice, whereas others will maintain a wider general focus. Both routes are of equal value. As nurses and midwives progress in their careers they will amass a portfolio of knowledge, skills and attributes with an emphasis on advanced decision making, advanced clinical skills, research, leadership and management.



Healthcare Support Workers

Health Care Support Workers are an important and valued part of our workforce and they play a key role in the delivery of safe and effective care across a range of settings.

In considering the roles and responsibilites of support workers there is more work required to obtain consensus on a number of areas including a common title for support workers at AfC bands 2 and 3, establishing a common level of educational attainment for entry into posts, new roles such as the maternity support worker and learning and development opportunities consistent with and supportive of the Knowledge and Skills Framework.

This will offer opportunities within the needs of service to further careers at a pace appropriate to abilities, skills and aspirations with the potential to progress to pre registration education.

Work in this area will be undertaken as part of the Central Nursing and Midwifery Advisory Committee (CNMAC) workforce planning and development and modernisation subgroup.

Our Vision

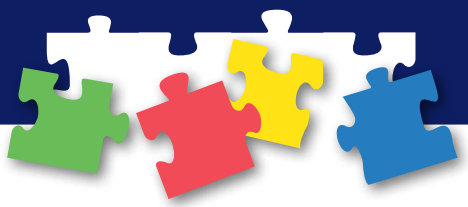
A Partnership For Care

To achieve this vision we will maximise the effectiveness of the nursing and midwifery contribution to improving health and social wellbeing and tackling inequalities for the popluation of Northern Ireland.

To support this vision nurses, midwives and support workers will:

- have the patient and families as their primary concern, reducing inequalities and working in partnership with individuals, communities and the public for improved health and social outcomes;
- work with other professional groups, agencies, patients and communities to maximise the use of everyone's talents and skills;
- be accountable, skilled and flexible, always striving to work effectively and efficiently to provide safe, accessible and equitable care acting as the patient/client advocate;
- practise in an atmosphere of continual learning and development, demonstrating their commitment to continuous quality improvement and an ability to learn from experiences and accredited sources of evidence and contributing to that evidence.

Our Values



The underpinning values of the nursing and midwifery family are the principles and beliefs that guide the choices and daily practice of individuals. These are relevant to any system, care setting or career structure. For nurses and midwives these principles are embodied within the Nursing and Midwifery Council Code: Standards of Conduct Performance and Ethics (2008). These values articulate the manner in which they work and the passion they have for care. These need to be at the core of our practice and support person centred care.

The family of nursing and midwifery will:

- treat people with **care and compassion**, with **dignity and respect** and with **impartiality**;
- work in **partnership and collaboration** with patients, clients, carers and colleagues in the interests of providing high quality care;
- be **accountable** for their actions;
- provide **leadership** to ensure safe and effective care;
- maintain **ongoing competence** throughout their working careers.

These vision and values statements are an integral part of the ways of working, regardless of the setting. Every member of the nursing and midwifery family has a personal responsibility to express these values in the way they interact with patients and clients and each other. These values should underpin every professional decision and are reflected throughout this strategy.

The Strategy for Nursing and Midwifery

A Partnership for Care

Promoting Person Centred Cultures

> Being person centred requires the formation of therapeutic relationships between professionals, patients/clients and others significant to them in their lives and that these relationships are built on mutual trust, understanding and a sharing of collective knowledge
> ***(McCormack & McCance, 2006)***

Through the development of Person Centred Cultures the nursing and midwifery family aim to ensure that the patient/client is an equal partner with the nurse/midwife. Assessing, identifying options for and delivering the most appropriate care for the individual. This involves sharing information on all aspects of the patient/client needs and available services. This requires mutual respect and courtesy.

Effective care, values the rights and needs of individuals and is accessible, responsive and promotes health and wellbeing.

To achieve this we will focus on three key perspectives:

- **ENSURING PERSONAL AND PUBLIC INVOLVEMENT**
- **IMPROVING THE PATIENT/ CLIENT EXPERIENCE**
- **WORKING TOGETHER FOR POSITIVE OUTCOMES**

ENSURING PERSONAL AND PUBLIC INVOLVEMENT (PPI)

Engagement with individuals and communities should be an integral part of service planning, commissioning and delivery. It means discussing with those who use our services and the public: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.
(HSC circular (SQSD) 29/07)

At a Strategic Level

- The Director of Nursing in the Public Health Agency (PHA) and the Directorate of Nursing and Midwifery within DHSSPS, in conjunction with the Patient and Client Council, will ensure the voice of the citizen is heard by supporting the involvement of patients and the public in shaping health policy and influencing service redesign leading to a partnership approach to better health.

- The commitment to PPI will be reflected in the leadership and accountability arrangements within HSC organisations. The nursing and midwifery elements of involvement will be coordinated and monitored by the Director of Nursing within the Public Health Agency in conjunction with the Trust Directors of Nursing, in line with regional strategy.

At an Organisational Level

- Directors of Nursing will adopt a systematic approach to PPI that links corporate decision making to local communities.

- Directors of Nursing will work with PPI leads to ensure a co-ordinated and equitable approach to involvement across the HSC and where relevant the independent, community and voluntary sectors.

At an Individual Level

- Each nurse and midwife will recognise that PPI is part of their responsibilities and demonstrate an individual contribution at their performance review.

- Nurses, midwives and support staff will use every opportunity to put patients, clients and the public in the lead for managing their care through a process of shared decision making.

"If the acquisition of PPI knowledge and skills becomes part of everyone's personal development plans, it will enhance practice, service and also inculcate a sense of ownership of the PPI agenda." (*Nurses and PPI, 2009)*

IMPROVING THE PATIENT/CLIENT EXPERIENCE

Patients and clients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained. This principle should be supported by all health and social care organisations and professional bodies, enabling staff to provide a quality service.
(Improving the Patient and Client Experience, 2008)

At a Strategic Level

- The Chief Nursing Officer (CNO) in partnership with the Director of Nursing at the PHA will oversee the regional implementation and monitoring of the "Improving the Patient and Client Experience" standards.
- A regional working group will develop appropriate measurement methodology that will generate evidence of achievement against the patient and client experience standards.

At an Organisational Level

- Directors of Nursing will ensure that organisational policies have due regard to the implementation of the patient and client experience standards.
- Directors of Nursing, ward sisters and their senior teams will act as inspirational role models providing visible leadership throughout their organisations acting on identified aspects of poor practice.

At an Individual Level

- Nurses and midwives will demonstrate through their behaviour, their role as advocates of quality care through the implementation of the patient and client experience standards and adherence to their code of conduct.
- Nurses, midwives and support staff will proactively seek and act upon a range of feedback to evaluate the impact of the patient and client experience standards.

"Good quality care is everyone's business; it requires champions in the boardroom and at the bedside." (*M Bradley, 2008)*

WORKING TOGETHER FOR POSITIVE OUTCOMES

Health and social care is a complex business; collaborative working, coordination and teamwork are necessary to achieve the positive outcomes nurses and midwives seek for patients and clients.

At a Strategic Level

- Nurses and midwives will work collaboratively within a multi-agency environment to put public health and social well being at the core of the health and social care system.

- The family of nursing and midwifery will secure an integrated and person centred approach to the development of services, within the existing and developing service frameworks.

At an Organisational Level

- Effective commissioning requires effective population needs assessment. Directors of Nursing will support nurses and midwives to work in partnership with community groups, statutory and voluntary agencies to compile and/or contribute to health and social care profiles of local populations to inform the commissioning process.

- Directors of Nursing will work collaboratively to enhance and sustain effective environments that value and support the contribution of nurses and midwives working together with a range of disciplines to achieve positive outcomes.

At an Individual Level

- Nurses and midwives will work in partnership with their patients and clients, in therapeutic relationships, supporting them to make informed choices about their care and treatment.

- Nurses, midwives and support staff will work closely with and value the contributions of the multi-disciplinary team, actively seeking positive outcomes for patients/clients.

"Understand the contribution that effective interdisciplinary team working makes to the delivery of safe and high-quality care.....work with colleagues in ways that best serve the interests of patients."
(GMC,Tomorrow's doctors, 2009)

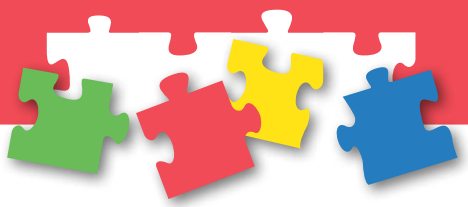
Delivering Safe and Effective Care

> The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.
> ***(Quality Standards for Health and Social Care, 2006)***

The delivery of safe and effective care is the responsibility of all staff within the health and social care system including the independent, voluntary and community sectors. Nurses and midwives must recognise their personal responsibility and accountability for the delivery of evidenced based care. They will do this through competent decision making and the effective identification and management of risk, recognising and acting on areas of poor practice to ensure the best outcomes for patients and clients.

To achvieve this the family of nursing and midwifery will focus on three key perspectives:

- **BEING ACCOUNTABLE FOR CARE**
- **MANAGING RISK**
- **DELIVERING EVIDENCE BASED CARE**



BEING ACCOUNTABLE FOR CARE

Accountability is integral to professional practice. Nurses and midwives make decisions that effect patient/client care in a wide variety of circumstances and environments based on professional knowledge, judgement and skills. Accepting responsibility and being accountable for such decisions is an essential part of delivering safe and effective care.

At a Strategic Level

- The CNMAC will work with the CNO and senior colleagues to develop a regional accountability framework for nurses and midwives.
- The Local Supervising Authority Midwifery Officer at the PHA will act as a point of contact for supervisors of midwives and provide leadership, support and guidance on a range of matters.

At an Organisational Level

- Directors of Nursing will exercise their executive power and influence from ward to board, acting in the best interests of patients and clients.
- Directors of Nursing will monitor the implementation and maintenance of supervision processes against the regional standards through the annual report submitted to the CNO.
- Midwifery supervision is a statutory function. Supervisors of midwifery will provide a mechanism of support and guidance which will protect women and babies by actively promoting safe standards of care.

At an Individual Level

- Nurses and midwives will demonstrate through their actions understanding of their accountability to patients/clients, employers and the Nursing and Midwifery Council.
- Nurses, midwives and support staff will take ownership for quality care, holding themselves and others to account for the highest standards of care, acting to escalate concerns and address poor standards.

"As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions."
(Nursing & Midwifery Council, 2008)

MANAGING RISK

To ensure the delivery of safe and effective care nurses and midwives must be able to manage risk, embrace accountability, and meet the demands of governance. By adopting an anticipatory approach nurses and midwives can act proactively to minimise risk and provide a high quality service that meets patient/client needs and act on lessons learnt to drive improvements in the quality and safety of services ensuring that practice is informed and improved.

At a Strategic Level

- The Director of Nursing at the PHA will lead on a regional approach to learning from incidents, accidents and reviews including the establishment of a Regional Adverse Incident and Learning (RAIL) system.
- The Directorate of Nursing and Midwifery within DHSSPS will ensure that learning outcomes are fed back into all training and development activities to maximise the learning and reduce the risk of reoccurrence.

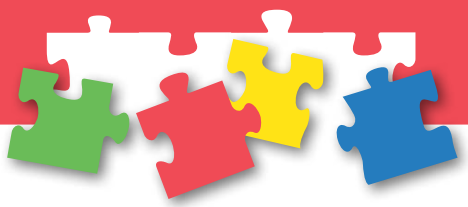
At an Organisational Level

- Directors of Nursing will exercise their executive power and influence informing, advising and assisting colleagues at board level to understand how strategic decisions may affect the quality and safety of patient care and the wider patient experience.
- Directors of Nursing will provide active leadership within a governance framework to enable risk to be assessed and managed effectively.

At an Individual Level

- Nurses, midwives and support staff will have access to and work within established risk management policies and processes.
- Nurses and midwives will be able to comprehensively assess and proactively respond to service users' individual needs and identified risks within their sphere of practice.

"…..Hospitals should do the sick no harm."
(F Nightingale, 1820 – 1910)



DELIVERING EVIDENCED BASED CARE

As professionals nurses and midwives must be able to demonstrate the effective integration of evidence, including research findings, into their clinical decision making processes to ensure the delivery of safe and effective care. Evidence based care must therefore be a core component of contemporary nursing and midwifery practice.

At a Strategic Level

- The nursing and midwifery directorate within DHSSPS will ensure professional expertise is fully integrated into decision making processes at policy level.
- The CNMAC Research and Development subgroup will provide leadership and strategic direction for nursing and midwifery research and development in order to improve patient/client experience and outcomes.

At an Organisational Level

- Directors of Nursing will ensure the dissemination of evidenced based policies, procedures, standards and guidelines for nursing and midwifery practice. These will be supported by a dynamic programme of audit to monitor practice and highlight concerns at an early stage.
- Directors of Nursing will support practitioners to develop research expertise and utilise these skills within the healthcare settings.

At an Individual Level

- Nursing and midwifery decisions will be made through a process of critical analysis, characterised by compassion, respect and dignity.
- Nurses and midwives will utilise practice development, research and benchmarking to integrate evidence based care into their practice and will contribute to the development of that evidence.

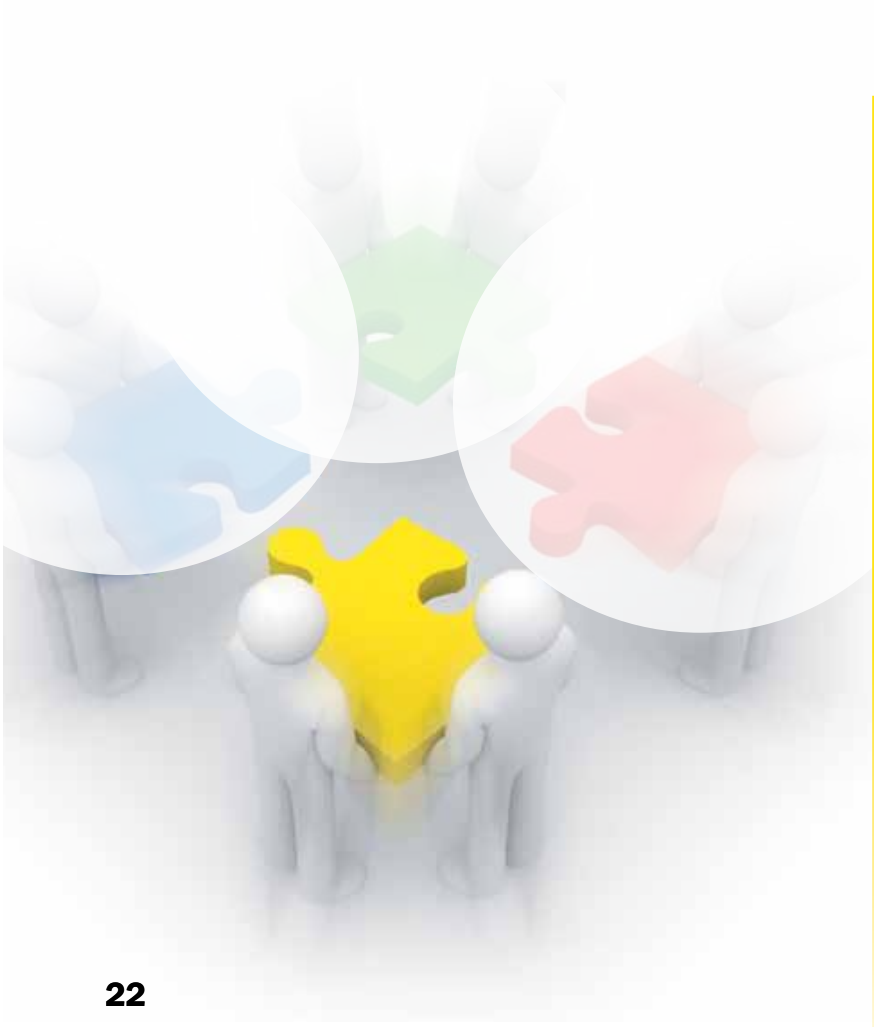
"The translation of discoveries into interventions that deliver benefits for patients and the public requires the involvement of many different disciplines." *(A Shared Vision for UK Health Research, 2010)*

Maximising Resources for Success

> Nursing innovations are key to improvement and progress in health systems worldwide.
> ***(International Council for Nurses, 2009)***

Individuals and organisations need to ensure that public resources are fully utilised and focused to meet the needs of patients and clients, providing and improving health and social care.

This strategy encourages entrepreneurship and innovation balanced with the need to maintain the safety of patients and clients. It recognises that nurses and midwives need to take appropriate actions to maximise the available resources and respond to the needs of patients and clients to ensure the best possible outcomes.



To achieve this the family of nursing and midwifery will focus on three key perspectives:

- **RESPONDING TO NEED**
- **IMPROVING OUTCOMES THROUGH INNOVATION**
- **WORKFORCE PLANNING**

RESPONDING TO NEED

Nurses and midwives are ideally placed to assist in identifying the needs of their patients and clients and to develop new and innovative ways to deliver quality care across a range of settings. New and expanding roles require additional skills and competencies building upon the solid foundations of existing practice and placing patients and clients at the centre of care.

At a Strategic Level

- The changing context of health care delivery will require the focused review of nursing and midwifery practice areas to ensure they are fit for purpose and meeting the needs of patients and clients.

- The CNO and Director of Nursing at the PHA will champion the development of new and innovative ways of delivering high quality, compassionate care.

At an Organisational Level

- Directors of Nursing will adopt the use of service improvement methodologies to design systems and processes which respond to the needs of patients/clients, avoid duplication and maximise the use of resources.

- Directors of Nursing will lead on the assessment of need and development of enhanced roles for nurses and midwives which improve the patient/client experience.

At an Individual Level

- Nurses, midwives and support staff will recognise their unique contribution to improving the health and wellbeing of the population and will work with others to meet the needs of patients/clients.

- Nurses, midwives and support staff will strive to protect and secure optimum independence and self determination for each individual patient/client and their family.

"Every system is designed to achieve exactly the results it gets....if you don't like the results, change the system."
(Don Berwick, Institute of Health care Improvement, 1996)

Maximising Resources for Success

IMPROVING OUTCOMES THROUGH INNOVATION

Those who deliver care are best placed to make improvements in that care. In Northern Ireland nurses and midwives are at the forefront of service re-design, pushing the boundaries and challenging traditional practices. The adoption of a transformational leadership approach will encourage innovation in the development of nurse, midwife and healthcare support roles which harness and develop individual talents to improve outcomes for patients and clients.

At a Strategic Level

- The Directorate of Nursing and Midwifery within DHSSPS will support initiatives such as the Florence Nightingale foundation travel scholarship to enhance nursing and midwifery practice, service delivery and improve patient/client care.
- The Directorate of Nursing and Midwifery within DHSSPS and the Research and Development Office of the PHA will promote access to research opportunities to enhance practice and ultimately improve outcomes for patients and clients.

At an Organisational Level

- Directors of Nursing will promote a “can do” culture within organisations supporting ward sisters/charge nurses/team leaders, individuals and teams to challenge traditional practices to improve patient client care.
- Directors of Nursing will encourage staff to celebrate and share validated innovations and research findings and where appropriate adopt and sustain new ways of working for the benefits of patients/clients.

At an Individual Level

- Nurses, midwives and support staff will identify opportunities for practice/ service improvements and communicate these to line managers.
- Nurses, midwives and support staff will spread and embed innovation and research findings to improve outcomes for patients and clients.

“Society and the health care system will value nurses and midwives not only as clinicians, but also as managers, teachers, researchers, activists, thinkers and policy-makers.”
(Commission on the Future of Nursing and Midwifery in England, 2009)

WORKFORCE PLANNING

The management of people and finance go hand in hand. To maximise resources and ensure best possible outcomes for patients and clients the nursing and midwifery family will ensure the right people are in the right place with the right skills at the right time. Effective workforce planning leads to the recruitment and retention of a flexible, responsive and high performing workforce who can meet the needs of service delivery.

At a Strategic Level

- The CNO will task CNMAC to establish a regional workforce planning, development and modernisation subgroup which will advise DHSSPS on a Northern Ireland wide approach to the effective management of supply and demand within the nursing and midwifery professions.

- The Director of Nursing at the PHA in collaboration with Directors of Nursing will build a workforce planning toolkit to ensure the right people with the right skills in the right job. This will include assessment of population health needs, knowledge of current nursing and midwifery staff, their skill-mix, and data on other healthcare professionals.

At an Organisational Level

- Directors of Nursing will be proactive in identifying future nursing and midwifery workforce requirements. This intelligence will influence workforce commissioning to ensure the future needs of patients and clients are met.

- Directors of Nursing will focus on the values and worth of nursing and midwifery, highlighting the strengths and advocating the professions as top careers for the future.

At an Individual Level

- Nurses, midwives and support staff will recognise their skill sets both transferable and specialist to enable them to move flexibly between different environments of care.

- Nurses, midwives and support staff will work with and support one another to help achieve a balance between work and personal life.

"Effective workforce planning in nursing has a profound impact on patient care – directly effecting factors such as mortality and failure to rescue."
(Professor Anne Marie Rafferty, 2009)

Supporting Learning and Development

> Lifelong learning and development for staff in the Health and Social Care is key to delivering a modern patient and client focused service. It is important that DHSSPS, working with its partners and related sectors, develops and equips staff with the skills they need to support changes and improvements in patient and client care.
> ***(DHSSPS, Workforce Learning Strategy 2009 – 11)***

Nurses, midwives and their support staff can only deliver high quality care if they maintain and develop their knowledge and skills, working together respecting one another and communicating effectively. Given the pace of change in the delivery of health care and the rise in public expectations the principles and values of lifelong learning are increasingly important to all members of the nursing and midwifery family.

This strategy will ensure that within supportive culture, learning and development will continue to contribute to a knowledgeable and dynamic workforce, supported by strong and visible leadership at all levels.

To achieve this the family of nursing and midwifery will focus on three key perspectives:

- **PROMOTING A LEARNING CULTURE**
- **DEVELOPING THE WORKFORCE**
- **DEVELOPING LEADERSHIP**

PROMOTING A LEARNING CULTURE

A culture of learning does not necessarily develop spontaneously; it has to be nurtured, supported and developed over a period of time. Within a culture of learning the family of nursing and midwifery will create, acquire and transfer knowledge enabling staff to reflect upon practice and with new knowledge and insights improve outcomes for patients and clients.

At a Strategic Level

- Based on the learning needs analysis of nursing and midwifery the Education Commissioning Group will work in partnership with service and education providers to commission courses and development opportunities based on the needs of patient/clients. The impact of this learning will be evaluated to determine its bearing on practice.

- The CNO in association with NIPEC will adopt a regional approach to knowledge management through the practice and quality development database which will spark innovation, operational improvement and enhanced care.

At an Organisational Level

- Directors of Nursing will embrace the principles of a learning organisation ensuring that a learning and development action plan is implemented in each organisation and its impact evaluated.

- Directors of Nursing will promote fair and equitable access to learning and development. This will support the Knowledge and Skills Framework and the appraisal/personal development process to meet training needs and demonstrate learning outcomes.

At an Individual Level

- Nurses, midwives and support staff will take responsibility for their personal development and career plan maximising formal, informal and experiential learning opportunities.

- Nurses, midwives and support staff will actively participate in practice development opportunities and share the learning with others to improve outcomes for patients and clients.

"In a learning organisation people continually expand their capacity to create the results they truly desire, new and expansive patterns of thinking are nurtured, collective aspiration is set free, and people are continually learning to see the whole together." (*Peter Senge, 1990)*

Supporting Learning and Development

DEVELOPING THE WORKFORCE

Within health and social care the workforce is the greatest resource and asset. In a context of continuing change and developments in people's health and social care needs, advancing technology and rising public expectations the pattern of practice and the organization of care delivery creates both challenges and opportunities for nurses, midwives and support staff in working towards improvements in care.

At a Strategic Level

- The CNMAC workforce planning, development and modernisation subgroup will review the outcomes of the Modernising Nursing Careers and Midwifery 2020 initiatives and advise on new ways of working including the role of nurse consultants and health care support workers.
- Building on the work already undertaken in the development of a post registration career framework we will adopt a skills escalator approach to support flexible career paths.

At an Organisational Level

- Directors of Nursing will encourage and promote confidence in staff to develop new skills and knowledge supporting the development of new roles which will improve patient/client care.
- Directors of Nursing will embed the practice education coordinator and facilitator roles, to support learners in practice.

At an Individual Level

- Nurses, midwives and support staff will engage in continuing development that will enhance practice and meet career aspirations.
- Nurses and midwives will facilitate the professional and personal development of others, demonstrating leadership, reflective practice, supervision, quality improvement and teaching skills.

"Health care provision requires that practitioners possess the knowledge and skills to respond and adapt to current and future health care priorities and needs." (*WHO, Strategic Directions for Nursing and Midwifery, 2002)*

DEVELOPING LEADERSHIP

Leadership in nursing and midwifery is crucial to the quality of patient/ client care and to the development of the professions. Leaders need to be confident, competent, well motivated, self aware, and socially skilled. They need to be team players who are able to work with others across professional and organisational boundaries. In short good leaders make positive, tangible changes to the delivery of care.

At a Strategic Level

- The CNO working with the Director of Nursing at the PHA will provide professional leadership to the family of nursing and midwifery, working closely with statutory bodies, professional and staff associations, HSC Trusts and the voluntary and independent sectors.

- Nursing and midwifery will adopt a succession planning approach to leadership development, identifying and nurturing leaders of the future in a commitment to ensure continuous, seamless leadership transition.

At an Organisational Level

- Directors of Nursing will provide strategic leadership and act as role models to ensure safe and sustainable services.

- Ward Sisters, Charge Nurses and Team Leaders will provide leadership to frontline teams ensuring the delivery of safe, effective compassionate care.

At an Individual Level

- Nurses, midwives and support staff will set an example of excellence for others.

- Each nurse and midwife will be prepared to lead and be accountable for improvements in patient care.

"The ability of midwives to be strategic leaders in service, policy and higher education requires that these roles are there to start with; and that midwives have the expertise, credibility and leadership skills to represent the profession and its contributions." (*Delivering high quality midwifery care, 2009)*

Where do we go from here

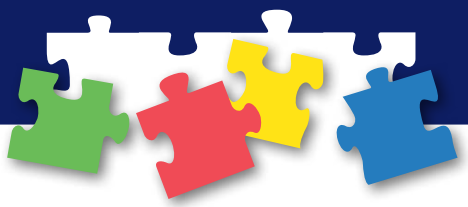
This strategy outlines a strategic vision for the family of nursing and midwifery in Northern Ireland. Each of our strategic themes of Prompting Person Centred Cultures, Delivering Safe and Effective Care, Maximising Resources for Success and Supporting Learning and Development have identified three perspectives through which together we will achieve our vision.

At an individual level each nurse, midwife and support worker has a responsibility to embrace the perspectives expressed in this strategy.

At an organisational level Executive Directors of Nursing will develop action plans that will bring forward the implementation of this strategy and its key perspectives.

At a strategic level the CNO and the Director of Nursing in the PHA will support and monitor the progress of this strategy.

Appendix 1 – Summary of Policy Documents



Developing Better Services; Modernising Hospitals and Reforming Structures - published in June 2002 this document contained a range of proposals for modernising acute hospital services, building on the recommendations from the Acute Hospitals Review Group report of 2000. The key areas addressed were the future configuration of hospital services; future organisational structures and workforce. These issues have subsequently been largely subsumed by the Review of Public Administration and the introduction of Agenda for Change.

Investing for Health – also published in 2002 this document presented a cross-departmental, multi-sectoral framework for action to improve health and wellbeing in Northern Ireland by setting out how the Northern Ireland Executive plans to achieve its aim of 'working for a healthier people'.

The strategy recognises the important contribution made by members of statutory and non-statutory groups and identifies the principles and values that should guide future action to improve health highlighting the cost of poor health to the individual, families and to the economy.

A review of the investing for health strategy is underway and is due to be concluded by mid 2010.

A Healthier Future - this regional strategy for health and wellbeing was published in December 2004.The strategy is a vision for health and wellbeing in Northern Ireland over the next twenty years and intends to give the direction of travel for health and social services.

The strategy places a strong emphasis on:

- promoting public health;
- engagement with people and communities to improve health and wellbeing;
- the development of responsive and integrated services which will aim to treat people in communities rather than in hospital;
- new, more effective and efficient ways of working through multi-disciplinary teams;
- measures to improve the quality of services; and
- flexible plans, appropriate organisational structures and effective, efficient processes to support implementation of the strategy.

Appendix 1 – Summary of Policy Documents

In April 2009, the Minister launched the new Public Health Agency. This saw a range of functions in Health and Social Care brought together to focus on improving the health and wellbeing of everyone in Northern Ireland. This restructuring is an opportunity to create a system for health and social care services and health promotion that can deliver more effectively on the vision, strategic themes and policy directions set out in A Healthier Future.

Caring for People Beyond Tomorrow published in October 2005 is a primary health and social care strategic framework for individuals, families and communities in Northern Ireland. This strategy sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

Key aspects of the Strategic Framework are:

- A service focused on providing comprehensive person centred care;
- A first point of contact that is readily accessible and responsive to meet people's needs day or night;
- A co-ordinated, integrated service employing a team approach with multi-agency linkages;
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered;
- A focus on prevention, health education and effective self-care.

The Review of Public Administration (RPA) was launched by the Northern Ireland Executive in June 2002 with the final outcome announced by the Secretary of State in November 2005. Its purpose was to review Northern Ireland's system of public administration with a view to putting in place modern, accountable and effective arrangements for public service delivery in Northern Ireland. It allowed for joined up thinking and the promotion of key cross cutting values such as efficiency, equality, accountability and co-terminosity.

Within Health and Social Care there were two major phases for implementation of the RPA. The first phase involved the establishment of the 5 new integrated HSC Trusts and the retention of the NI Ambulance Trust with effect from 1 April 2007. The second phase completed in April 2009 witnessed the establishment of a Health and Social Care Board, a new Public Health Agency and a Patient Client Council to replace the previous four boards and health and social services council structure.

Changing the Culture published in 2006, sets out a three year action plan to minimise Healthcare Acquired Infections. The key areas within the document are as follows:

- Organisation and culture;
- Education, training and practices;
- Governance, accountability and audit;
- Surveillance;
- Patient and public partnerships.

Since the publication of this document a range of activities have been undertaken, including a full review of the action plan entitled Changing the Culture 2010.

The Bamford Review published in 2007 is a series of eleven reports which outline a strategic direction for Northern Ireland to modernise and reform mental health and learning disability policy and service provision. The reports set out a clear vision on how an excellent service for those with mental health and or learning disabilities and their families can be provided, with the service user experience at the heart of any improvement.

The Bamford Action Plan (2009 – 2011) sets out the governments commitment to improving mental health and wellbeing of the population of Northern Ireland and to driving service improvement for those with a mental health need or a learning disability.

Improving the Patient, Client Experience Standards published in 2008, sets out the five standards relating to respect, attitude, behaviour, communication, privacy and dignity describing what the public should expect from staff in the health service.

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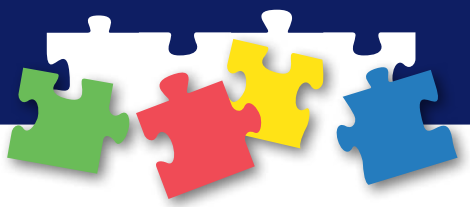

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Nursing And Midwifery Task Group (NMTG)

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

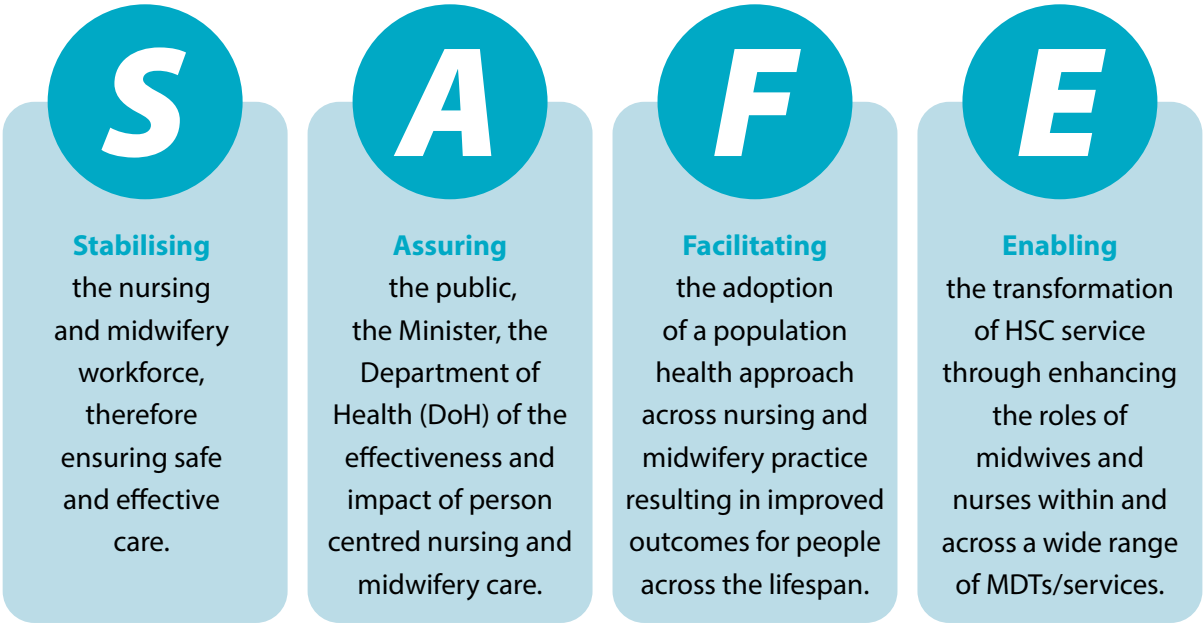
1. NMTG Context

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.

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

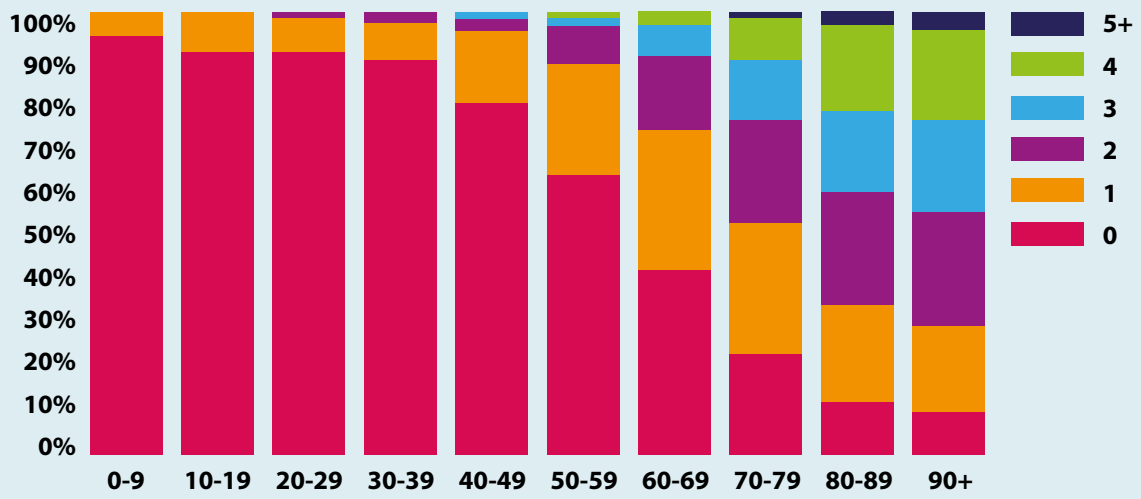
Looking forward over the next 10-15 years, NI like all the other countries of the UK and Ireland is facing a world where demographic realities and the pace of technological and social change will transform the relationship people have with health and social care.

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

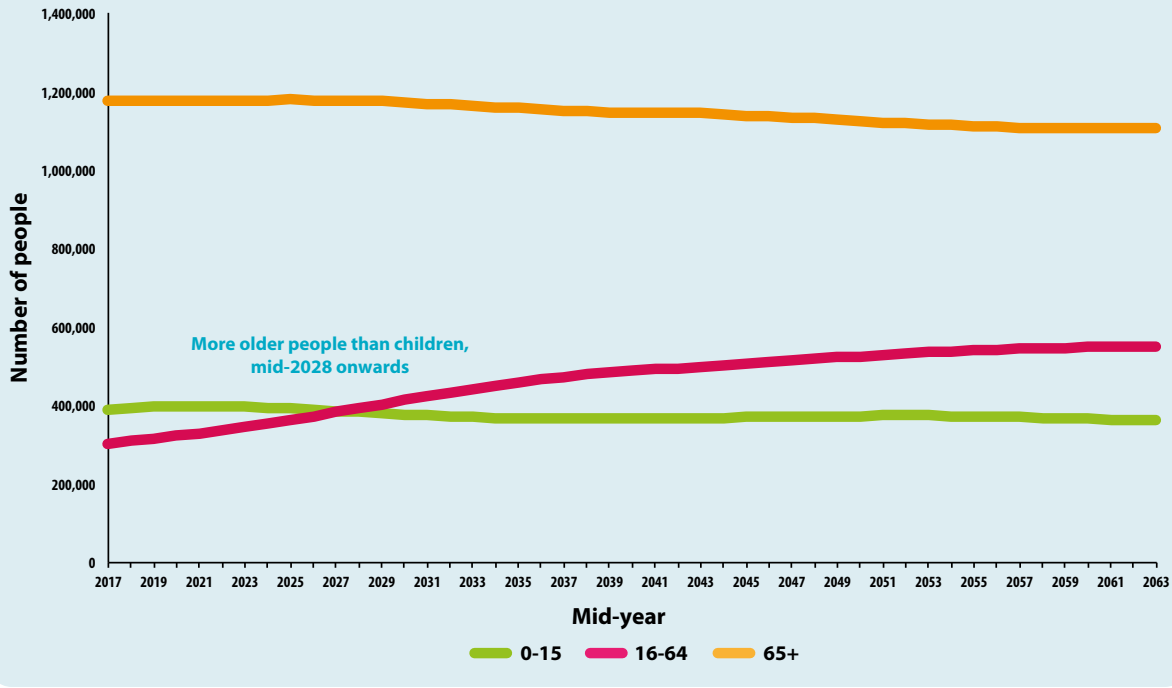
We know demand for services is arising largely as a result of an ageing population, many of who are living with complex needs and long-term conditions **(figure 2)**.

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



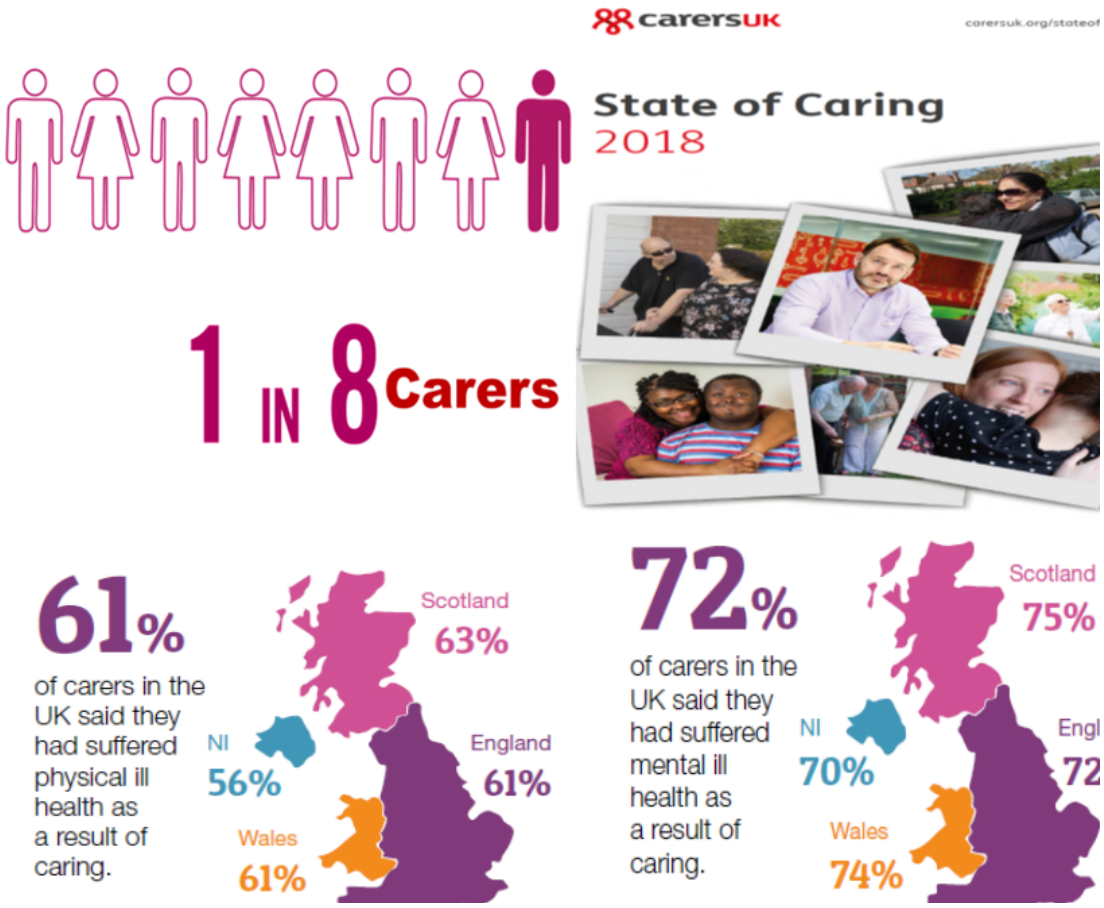
As set out in **figure 3** it is estimated by the year 2028 the population of older people in NI will be greater than the number of children. Indeed by 2023 the number of people over the age of 65 will make up 30% of the population and by 2061 it will grow to 50% of the population. The largest growth 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)



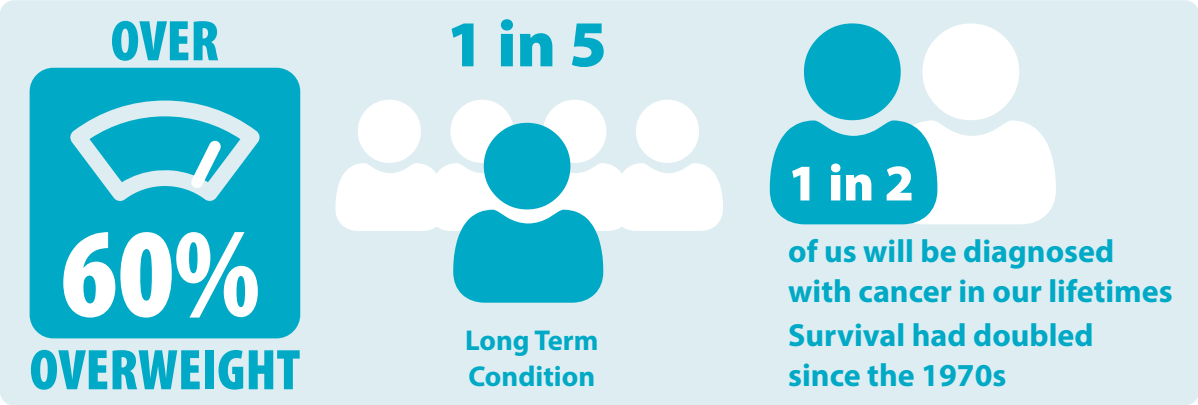
The reality behind these numbers also means that the numbers of people with dementia is estimated to increase from an average of 20,000 to 60,000 by 2051. It is also estimated that 1 in 8 adults are also carers. **(Figure 4)** It is anticipated the number of carers in NI is expected to rise from 220,000 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



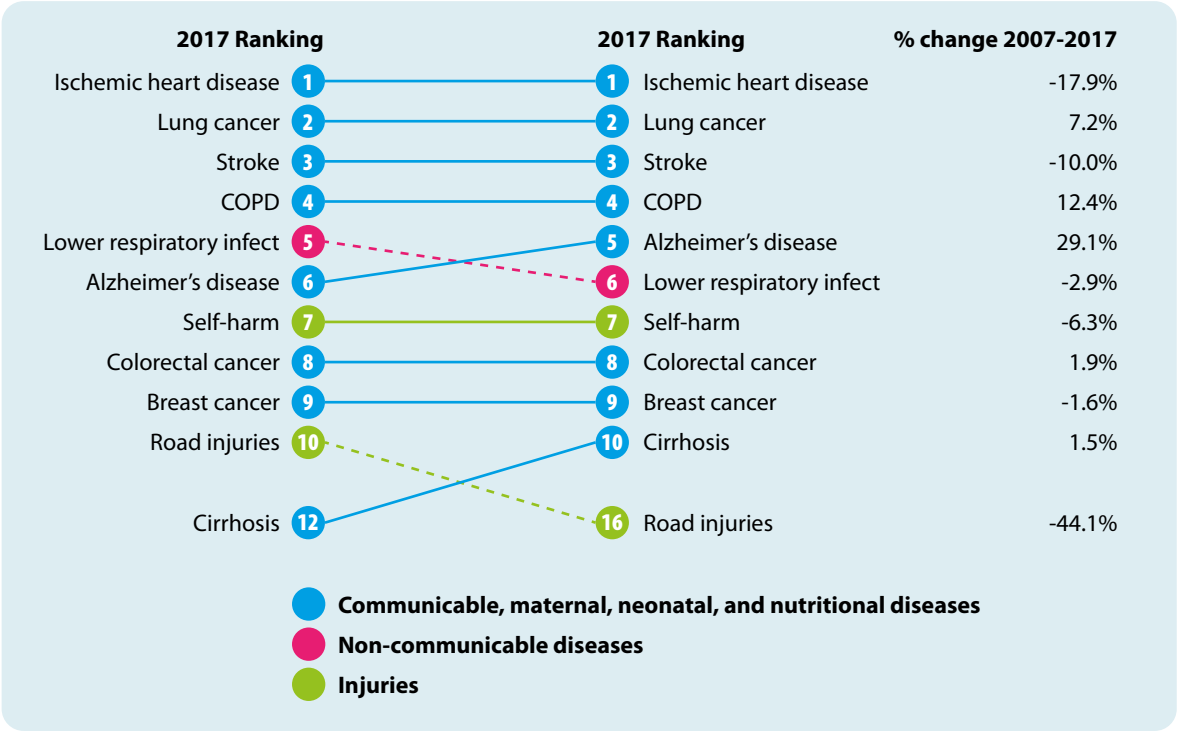
It is also regrettable as set out in **figure 6** that in NI life expectancy remains 7 years less for males and over 4 years less for females in the most deprived areas when compared with the least deprived areas of NI.

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%

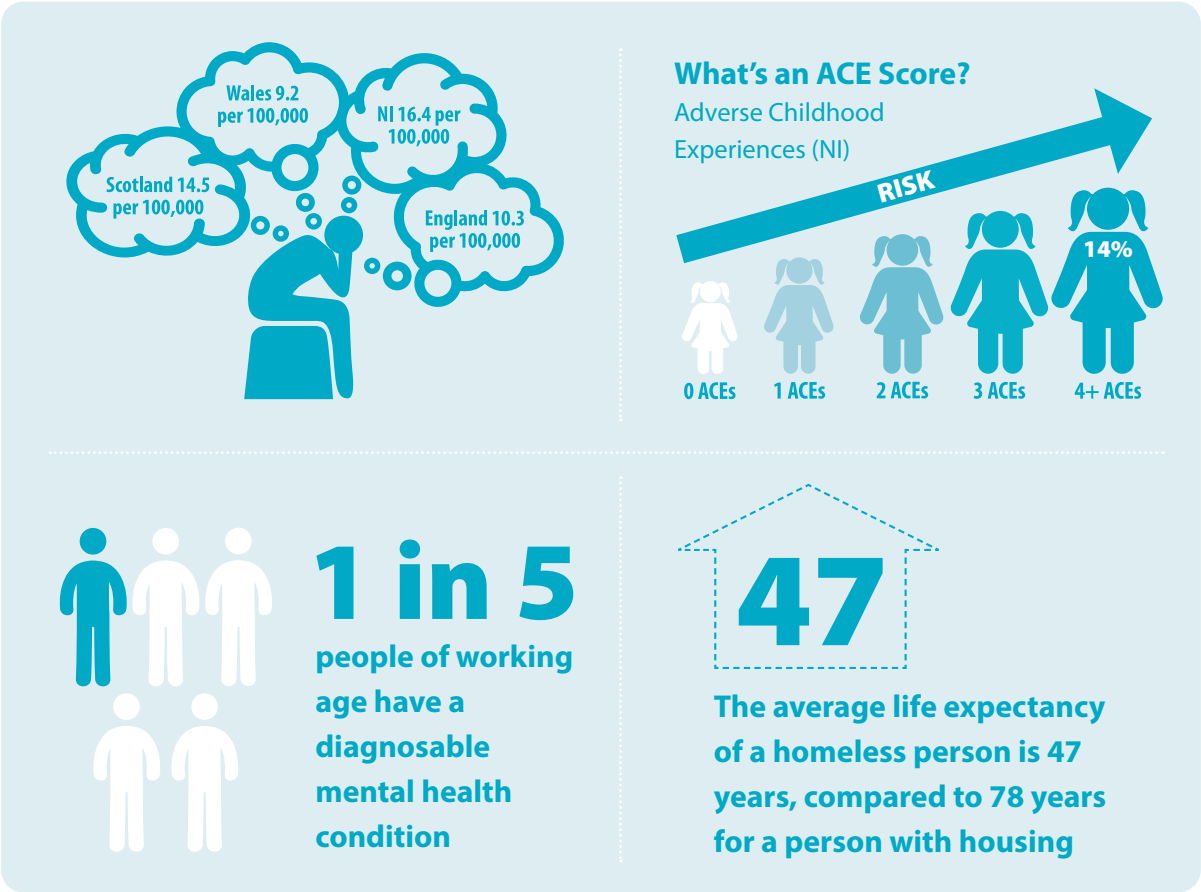
As set out in **figure 7** many of the causes of premature death are preventable through adopting healthier lifestyles.

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.

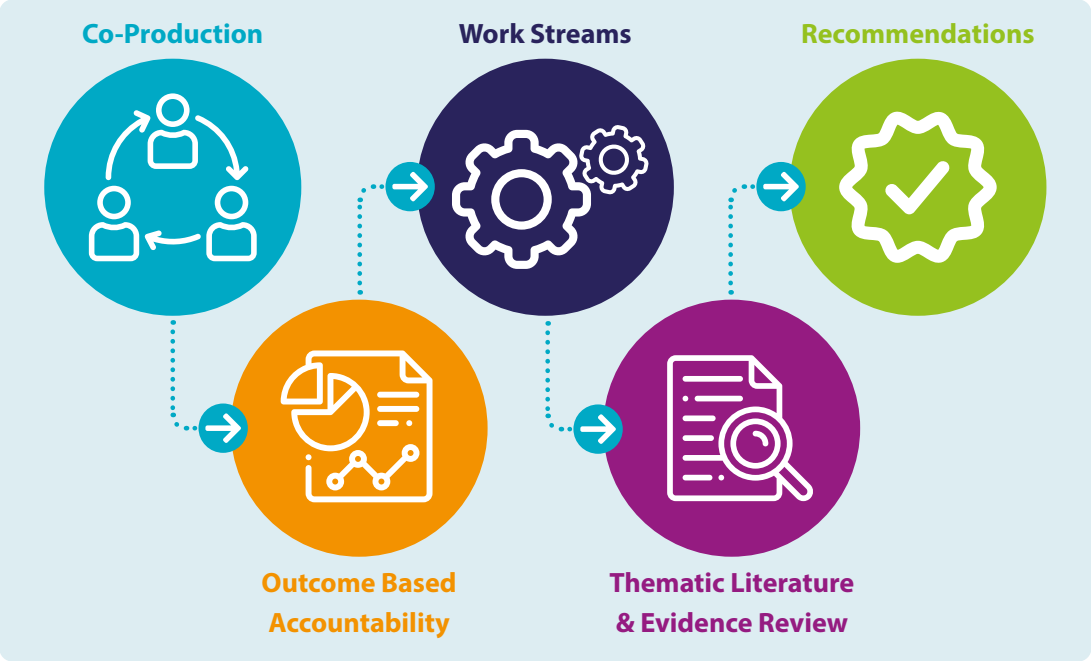
4

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

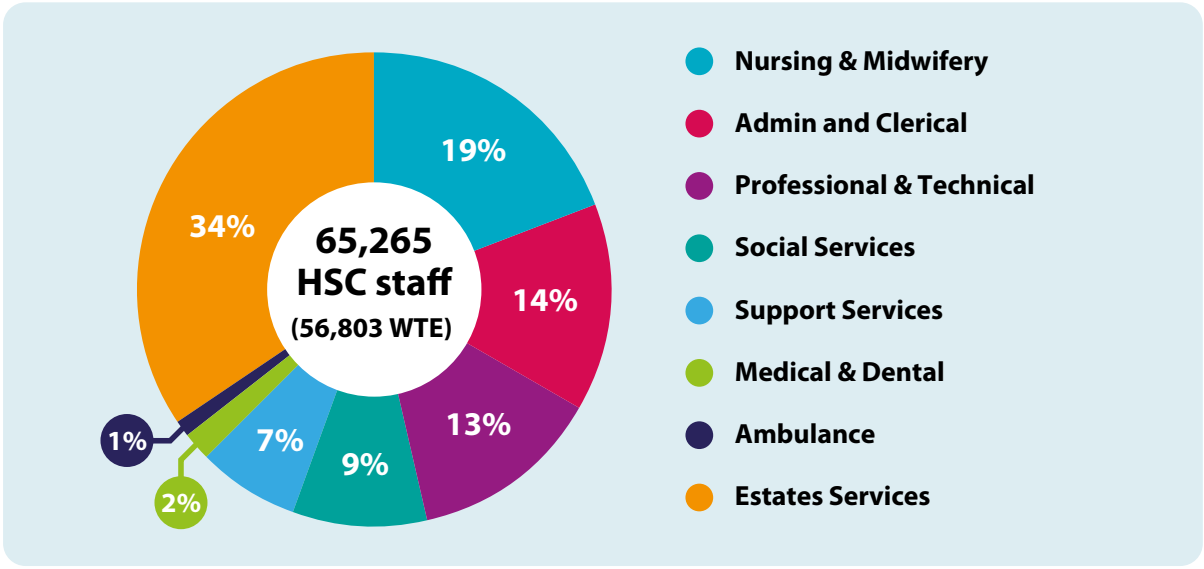
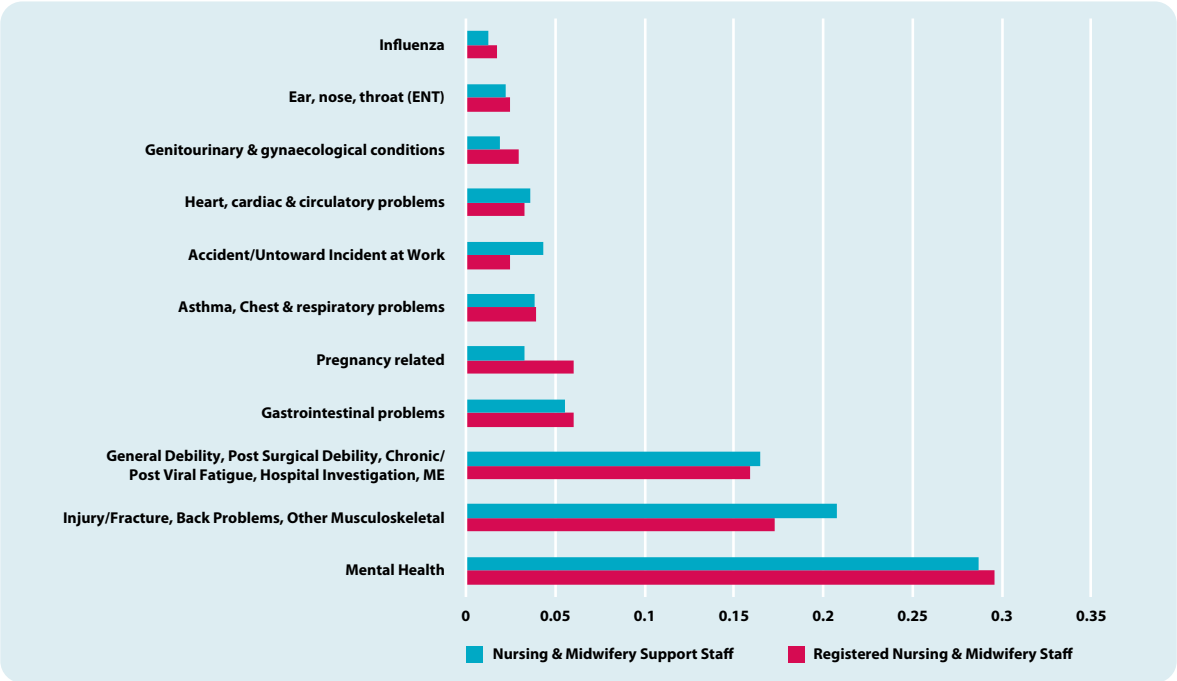


Figure 14 - Proportion of HSC Sickness Absence Hours Lost by Top 12 Absence Categories - 2018/19



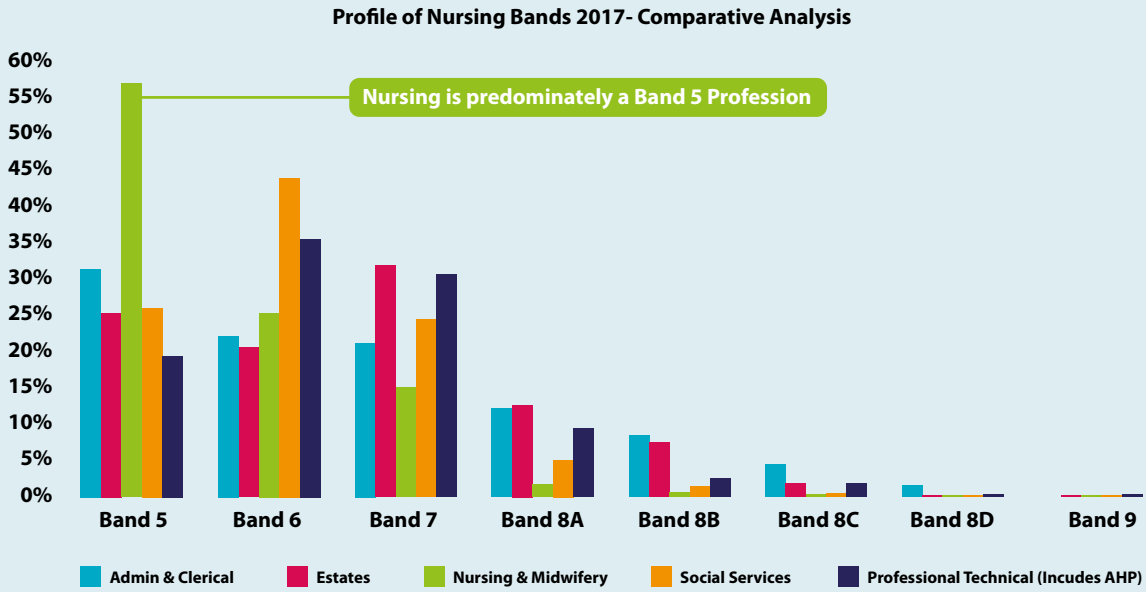
Between March 2016 and March 2017 the NMC reported a significant reduction in registrants[20]. The NMC surveyed those people who had left the register between June 2016 and May 2017. 4,544 former registrants responded citing working conditions as the top reason for leaving (44%). During the period 2008 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.

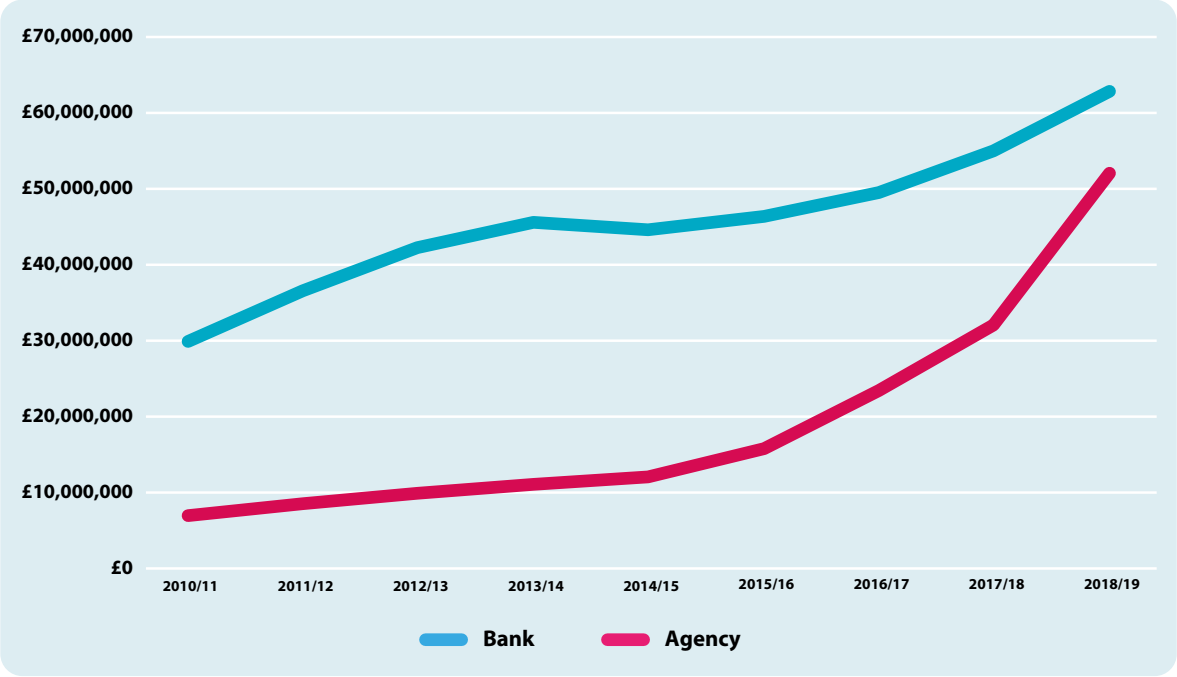
Figure 15 - Whole Time equivalent and % NI HSC Staff by Occupational Family & Pay Band 5-9 (March 17)



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.

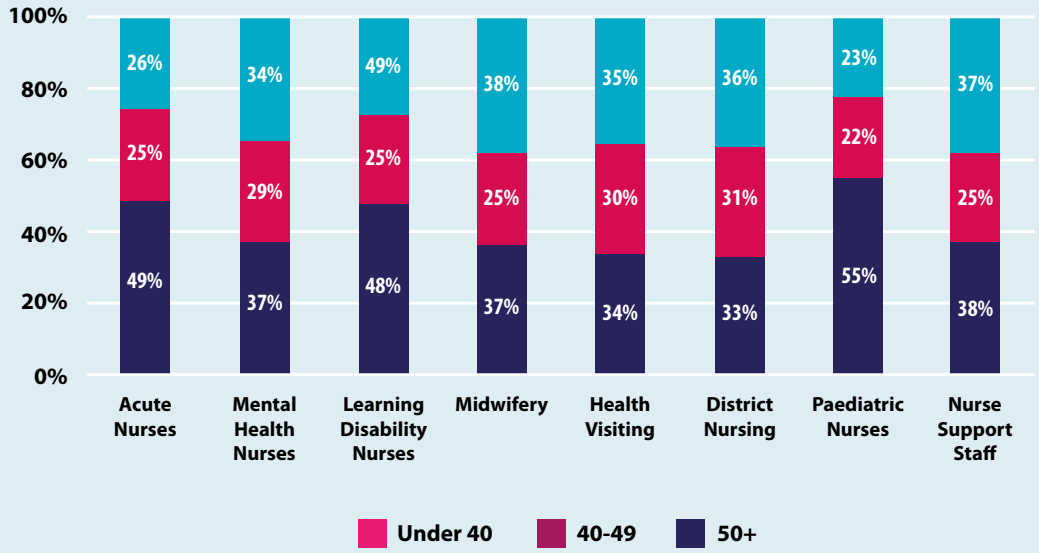
Figure 16 - Expenditure on Nursing & Midwifery bank and agency staff



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:-

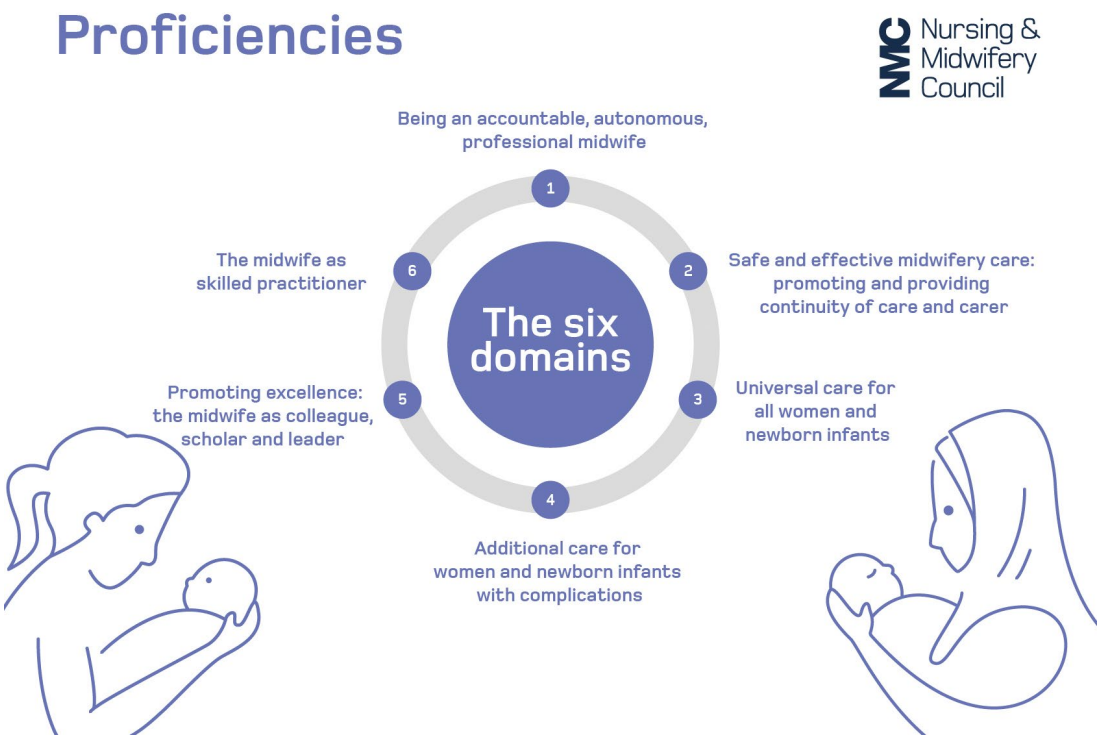
- a more equal society (PfG Outcome 3)
- people to *lead long, healthy and active lives* (PfG Outcome)
- a collaborative approach across sectors where we care for others and we help those in need (Progamme for Government Outcome 8)
- the delivery of high quality public services (PfG Outcome 11)
- Our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



This diagram is reproduced and reprinted with permission with thanks to the Nursing and Midwifery Council 2019

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

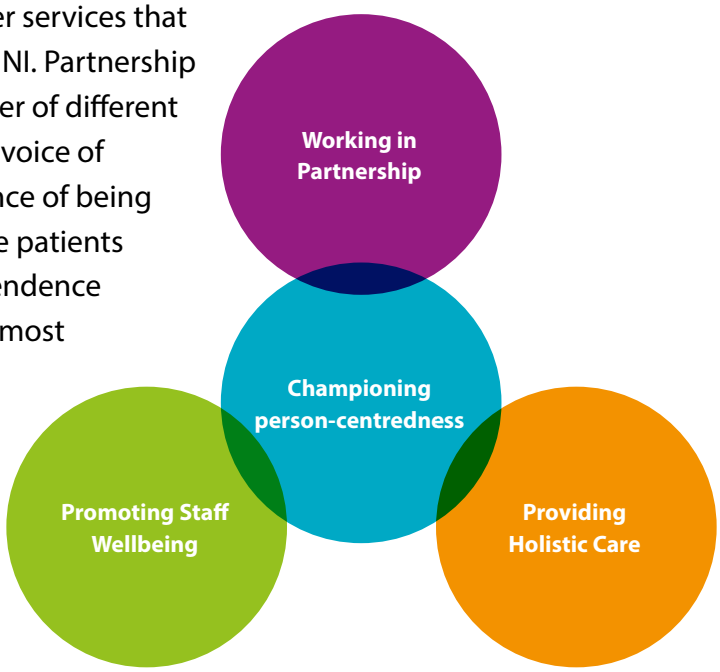
Create and promote a culture of appreciation in all directions.

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.

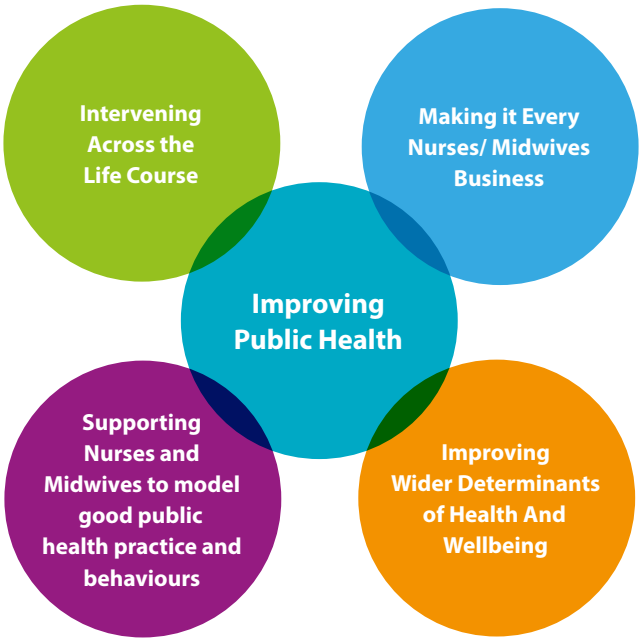
Currently, the significant emphasis for public health nursing is on children and health visiting, with little or no recognition or investment in the role of public health nurses more widely across the life course.

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.

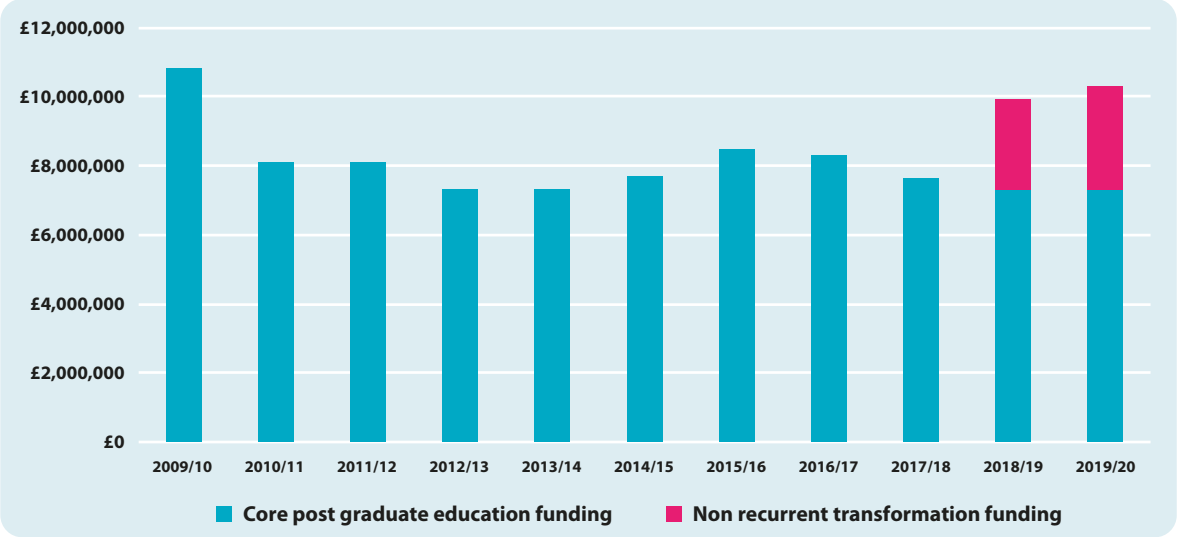
Within this context nurses continue to develop and expand their roles and responsibilities and exemplars of good practice are demonstrable across all settings in NI. Several programmes of work are already being taken forward at regional and national level to address a number of issues which have emerged 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

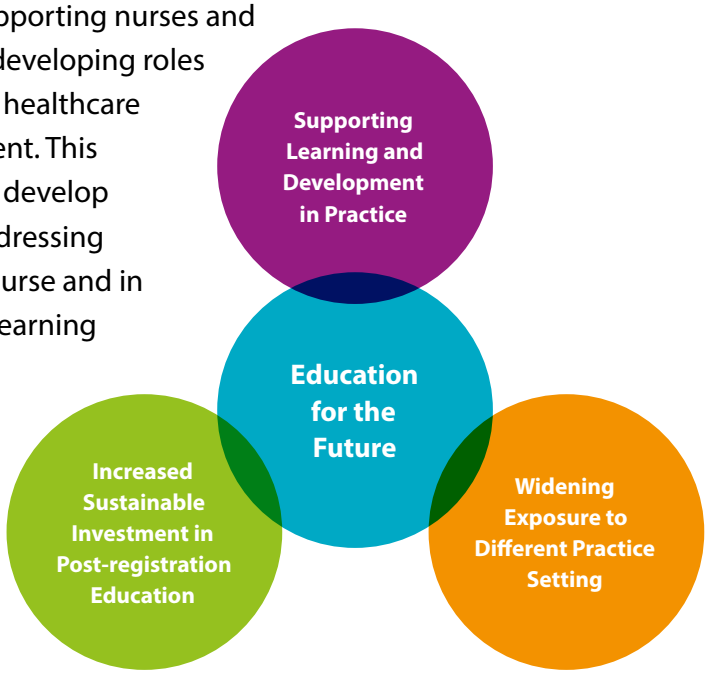
offset by non-recurrent transformation funding and an increase in both nurse and midwife student places. In the absence of sustained transformation funding and/or a restoration of recurrent funding commensurate with the size of nursing and midwifery workforce, this will have significant implications 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.**

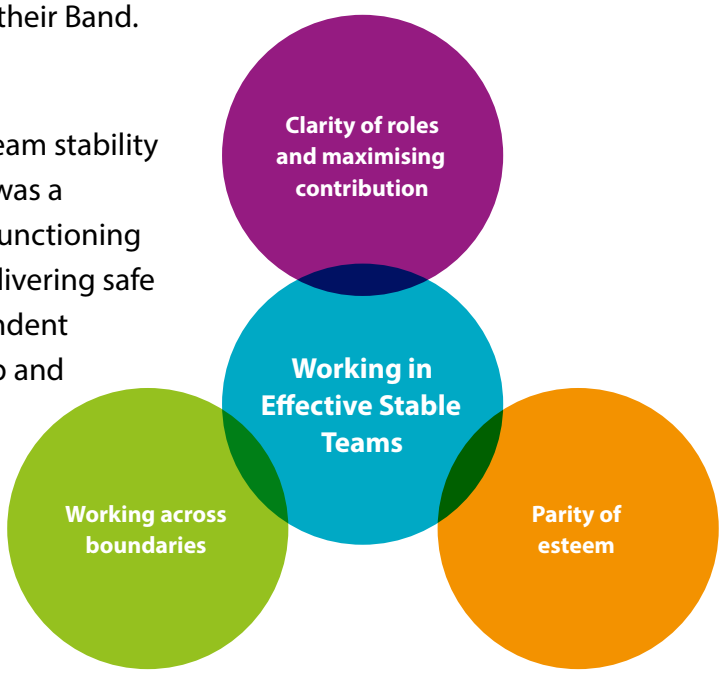
Working In Effective Stable Teams

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.

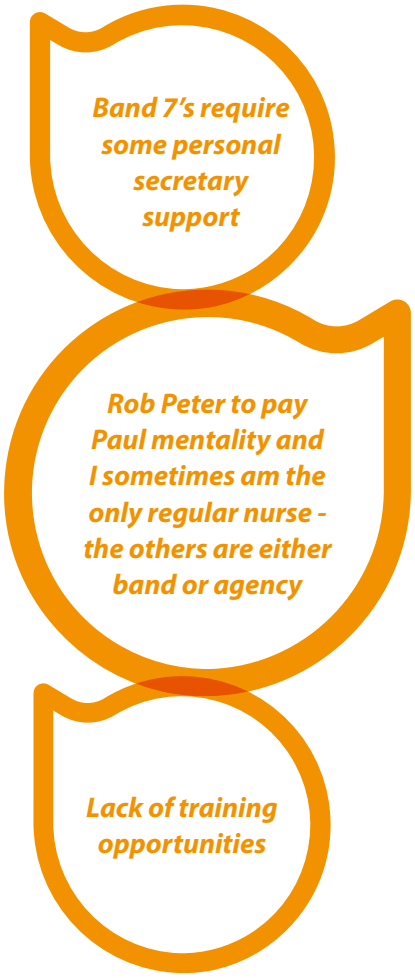
NI has much fewer opportunities for nurses and midwives above pay Band 5 than the rest of the United Kingdom. This lack of opportunity frustrates the professions in NI, as they feel there is very little opportunity for career progression, with no reward for midwives and those nurses who are working at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

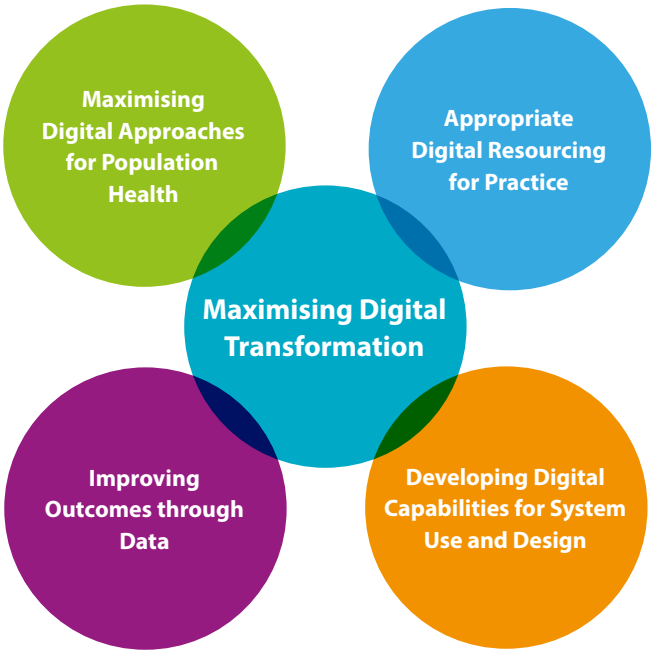
Encourage the role of technology to keep [those with mental health issues] connected with family and other members of the community e.g. WhatsApp

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.

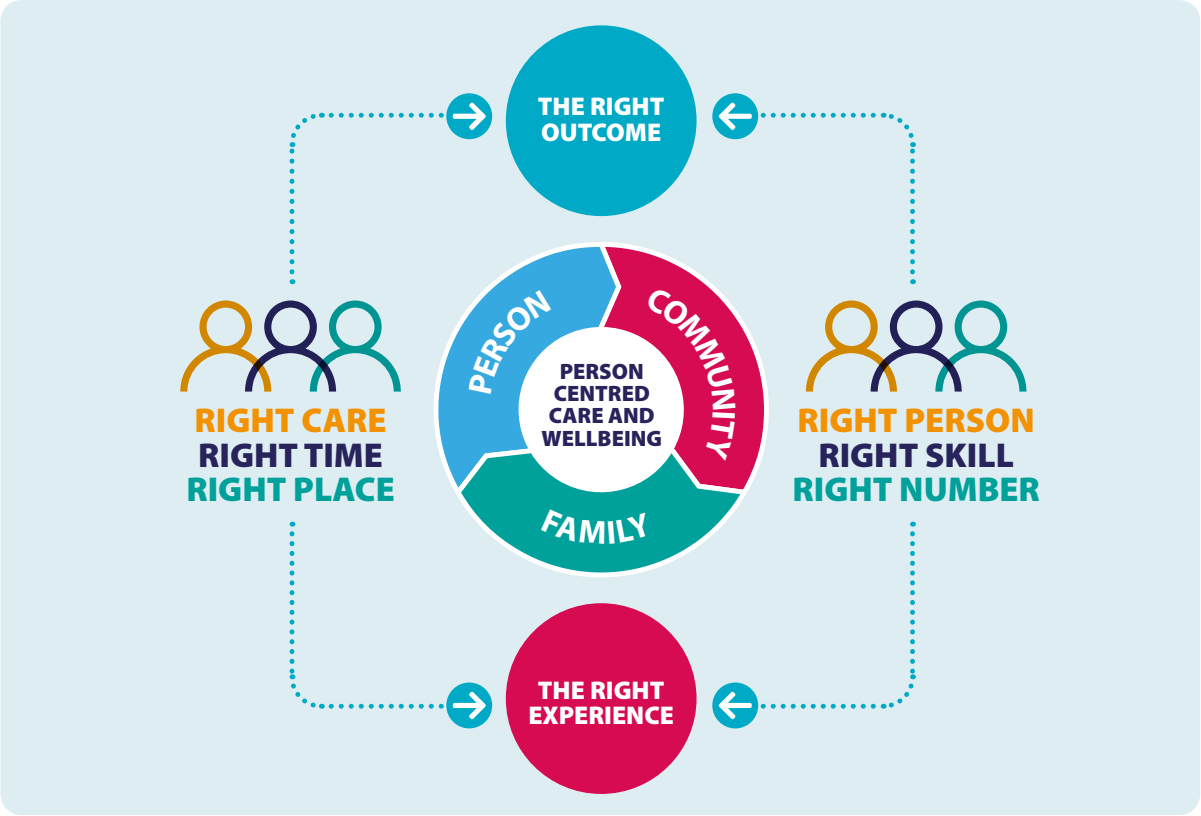
Doing the right thing in the most effective way – working in partnership

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)
- eHealth – Sean Donaghy (HSCB)
- Former Director of Nursing – Alan Corry-Finn
- Deputy Chief Nursing Officer – Rodney Morton (DoH)
- Director of Nursing – Eileen McEneaney (NHSCT)
- RCM – Breedagh Hughes / Karen Murray
- Independent Sector – Carol Cousins (Four Seasons)

Additional Support

Additional support was also provided by the following:

- Angela Reed, NIPEC
- Heather Finlay, DoH
- Mary Frances McManus, DoH
- Verena Wallace, DoH
- Dr. Dale Spence, DoH
- Alison Dawson, 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
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