From the Deputy Chief Medical Officer
Dr Paddy Woods

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

Circular HSC (SQSD) (NICE NG11) 26/15

Subject: NICE (Clinical) Guideline NG11 – Challenging Behaviour and Learning Disabilities

Circular Reference: HSC (SQSD) (NICE NG11) 26/15

Date of Issue: 20 July 2015

Related documents:
HSC (SQSD) 3/13

For action by:
Chief Executive of HSC Board – **for distribution to:**
All HSC Board Directors – for cascade to relevant staff

Director of Integrated Care, HSC Board – **for cascade to**:
Head of Pharmacy and Medicines Management
Family Practitioner Services Leads – for cascade to relevant Family Practitioner groups

Chief Executive of Public Health Agency – **for distribution to:**
Director of Public Health and Medical Director – for cascade to relevant staff
Director of Nursing and AHPs – for cascade to relevant staff

Chief Executives of HSC Trusts – **for distribution to:**
Medical Directors – for cascade to relevant staff
Directors of Nursing – for cascade to relevant staff
Heads of Pharmaceutical Services – for cascade to relevant staff
Directors of Acute Services – for cascade to relevant staff
HSC Clinical and Social Governance Leads
Directors of Social Services – for cascade to relevant staff
Directors of Finance – for cascade to relevant staff
AHP Leads – for cascade to relevant staff

Chief Executive, Regulation & Quality Improvement Authority – **for cascade to:** relevant independent healthcare establishments

Chief Executives of HSC Special Agencies and NDPBs

For Information to:
Chair of HSC Board
Chair of Public Health Agency
Chairs of HSC Trusts
Chair of RQIA
NICE Implementation Facilitator NI
Members of NI NICE Managers' Forum

Superseded documents
None

Summary of Contents: This guideline offers evidence-based advice on prevention and interventions for children, young people and adults with a learning disability and behaviour that challenges

Status of Contents:
Action

Implementation:
As per circular. Generally, Clinical Guidelines should be implemented within 12 months of endorsement.

Enquiries:
Any enquiries about the content of this Circular should be addressed to:
Standards & Guidelines Quality Unit
DHSSPS
Room D1.4
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

SGU-NICEGuidance@dhsspsni.gov.uk

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

MAHI - STM - 089 - 2526

Dear Colleagues

NICE Guideline NG11 - Challenging Behaviour and Learning Disabilities

(http://www.nice.org.uk/guidance/ng11)

The Department has recently reviewed the above NICE guidance and has formally endorsed it as applicable in Northern Ireland.

In accordance with the process outlined in circular HSC (SQSD) 3/13 (http://www.dhsspsni.gov.uk/hsc_sqsd__3_13.pdf), the following actions should be taken

1. HSC Board / PHA
    a. Identify a Professional Lead who will consider the commissioning implications of the Clinical Guideline and co-ordinate with any other relevant commissioning teams. This Lead will identify any areas where regional planning / investment / commissioning are required, or where there is material risk to safety or quality. These will then be actioned immediately through normal commissioning arrangements or through bespoke arrangements reflecting the nature of the issue / risk.
    b. Ensure that relevant guidance is sent to the appropriate Family Practitioners.
    c. Seek positive assurance from the HSC Trusts that the required initial actions have been undertaken within a 3 month period, and that the Guideline has been implemented within a further 9 months (unless otherwise notified by the HSC Trusts).
    d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, agree appropriate arrangements with HSC Trusts. Report to DHSSPS as required at 6 monthly accountability meetings.

2. HSC Trusts
    a. Proceed with targeted dissemination, agree a clinical/management lead to coordinate implementation and consider what has to be done to achieve implementation using a risk based assessment and baseline review as appropriate to support planning. These initial actions should be undertaken within a three month period.
    b. Implement the Guideline within a further 9 months (apart from any elements where significant issues have been raised with the HSC Board/PHA).
    c. Provide positive assurances to the HSC Board that required initial actions have been taken within the 3 month planning period and that the Guideline has been implemented within a further 9 months, where appropriate.
    d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, notify the HSC Board/PHA at the earliest opportunity through the bi-monthly director level meetings and agree appropriate arrangements with them to achieve implementation.

3. RQIA
    a. Disseminate the Guideline to the independent sector as appropriate.

4. HSC Special Agencies and NDPBs
    a. Take account of this Guideline in training and other developments as appropriate.

To inform the planning process, please find attached details from the Departmental review. You should consider and take account of other relevant Departmental policies and strategies in your planning, as well as any legislative / policy caveats identified in the course of the Departmental review.

A full current list of NICE guidance endorsed for application in Northern Ireland can be found on the Department's website (http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance/sqsd-guidance-nice-guidance.htm).

Dr Paddy Woods
Deputy Chief Medical Officer

Appendix 1

Endorsed NICE guidance - Details from Departmental review

Reference Number	NICE Guideline - NG11
Title	Challenging Behaviour and Learning Disabilities
Summary of guidance	This guideline offers evidence-based advice on prevention and interventions for children, young people and adults with a learning disability and behaviour that challenges.
Related strategically relevant DHSSPS / HSC policies	None
Inter-Departmental interest	None
Legislative / policy caveats	This advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of their individual patients, in consultation with the patient and/or guardian or carer. This would, for example, include situations where individual patients have other conditions or complications that need to be taken into account in determining whether the NICE guidance is fully appropriate in their case. Where the guidance refers to the Mental Health Act, this should be interpreted within the Northern Ireland legal framework of the Mental Health (Northern Ireland) Order 1986. Available from: http://www.opsi.gov.uk/RevisedStatutes/Acts/nisi/1986/cnisi_19860595_en_1 Where the guidance indicates that informed consent should be obtained and documented, the DHSSPS guidance 'Reference Guide to Consent for Examination, Treatment or Care (2003)', which is available on the DHSSPS website, gives advice on the law concerning consent to intervention. Available from: http://www.dhsspsni.gov.uk/consent-referenceguide.pdf It should be noted that this guidance contains some recommendations for off-label use of medicines. Trusts and practitioners must be aware of their responsibilities and ensure that appropriate policies are in place when medicines are used off-label.

	Where the guidance refers to the Mental Capacity Act 2005 supplementary code of practice on deprivation of liberty safeguards, Northern Ireland health professionals should refer to interim guidance on deprivation of liberty safeguards (2010). Available from: http://www.dhsspsni.gov.uk/revised-circular-deprivation-of-liberty-safeguards-october-2010.pdf The Department of Health guidance 'Transition: getting it right for young people' does not apply in Northern Ireland. Provision of appropriate transition care for young people as they move from paediatric to adolescent and adult care will be taken forward in the Department's imminent review of paediatric services.

From the Deputy Chief Medical Officer
Dr Paddy Woods

Circular HSC (SQSD) (NICE NG54) 60/16

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

Subject: NICE Clinical Guideline NG54 - Mental health problems in people with learning disabilities: prevention, assessment and management

Circular Reference: HSC (SQSD) (NICE NG54) 60/16

Date of Issue: 08 November 2016

Related documents:
HSC (SQSD) 3/13

For action by:
Chief Executive of HSC Board – **for distribution to:**
All HSC Board Directors – for cascade to relevant staff

Director of Integrated Care, HSC Board – **for cascade to**:
Head of Pharmacy and Medicines Management
Family Practitioner Services Leads – for cascade to relevant Family Practitioner groups

Chief Executive of Public Health Agency – **for distribution to:**
Director of Public Health and Medical Director – for cascade to relevant staff
Director of Nursing and AHPs – for cascade to relevant staff

Chief Executives of HSC Trusts – **for distribution to:**
Medical Directors – for cascade to relevant staff
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HSC Clinical and Social Governance Leads
Directors of Social Services – for cascade to relevant staff
Directors of Finance – for cascade to relevant staff
AHP Leads – for cascade to relevant staff

Chief Executive, Regulation & Quality Improvement Authority – **for cascade to:** relevant independent healthcare establishments

Chief Executives of HSC Special Agencies and NDPBs

For Information to:
Chair of HSC Board
Chair of Public Health Agency
Chairs of HSC Trusts
Chair of RQIA
NICE Implementation Facilitator NI
Members of NI NICE Managers' Forum

Superseded documents
None

Summary of Contents: This guideline partially updates NICE Clinical Guideline CG42. It covers preventing, assessing and managing mental health problems in people with learning disabilities in all settings (including health, social care, education, and forensic and criminal justice). It aims to improve assessment and support for mental health conditions, and help people with learning disabilities and their families and carers to be involved in their care.

Status of Contents:
Action

Enquiries:
Any enquiries about the content of this Circular should be addressed to:
Quality Regulation and Improvement Unit
Department of Health
Room D1.4
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

SGU-NICEGuidance@health-ni.gov.uk

Implementation:
As per circular. Generally, Clinical Guidelines should be implemented within 12 months of endorsement.

Additional copies:
Available to download from
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/national-institute-health-and-care-excellence-nice

Dear Colleagues

NICE Clinical Guideline NG54 - Mental health problems in people with learning disabilities: prevention, assessment and management
https://www.nice.org.uk/guidance/ng54

The Department has recently reviewed the above NICE guidance and has formally endorsed it as applicable in Northern Ireland. This guideline updates and replaces recommendations in CG42 - Dementia: supporting people with dementia and their carers in health and social care (endorsed by DoH in September 2011). Details of the updated recommendations are detailed in Appendix 2 below.

In accordance with the process outlined in circular HSC (SQSD) 3/13, the following actions should be taken (https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-sqsd-3-13.pdf)

1. HSC Board / PHA
    a. Identify a Professional Lead who will consider the commissioning implications of the Clinical Guideline and co-ordinate with any other relevant commissioning teams. This Lead will identify any areas where regional planning / investment / commissioning are required, or where there is material risk to safety or quality. These will then be actioned immediately through normal commissioning arrangements or through bespoke arrangements reflecting the nature of the issue / risk.
    b. Ensure that relevant guidance is sent to the appropriate Family Practitioners.
    c. Seek positive assurance from the HSC Trusts that the required initial actions have been undertaken within a 3 month period, and that the Guideline has been implemented within a further 9 months (unless otherwise notified by the HSC Trusts).
    d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, agree appropriate arrangements with HSC Trusts. Report to DoH as required at 6 monthly accountability meetings.

2. HSC Trusts
    a. Proceed with targeted dissemination, agree a clinical/management lead to coordinate implementation and consider what has to be done to achieve implementation using a risk based assessment and baseline review as appropriate to support planning. These initial actions should be undertaken within a three month period.
    b. Implement the Guideline within a further 9 months (apart from any elements where significant issues have been raised with the HSC Board/PHA).
    c. Provide positive assurances to the HSC Board that required initial actions have been taken within the 3 month planning period and that the Guideline has been implemented within a further 9 months, where appropriate.
    d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, notify the HSC Board/PHA at the earliest opportunity through the bi-monthly director level meetings and agree appropriate arrangements with them to achieve implementation.

3. RQIA
    a. Disseminate the Guideline to the independent sector as appropriate.

4. HSC Special Agencies and NDPBs
    a. Take account of this Guideline in training and other developments as appropriate.

To inform the planning process, please find attached details from the Departmental review. You should consider and take account of other relevant Departmental policies and strategies in your planning, as well as any legislative / policy caveats identified in the course of the Departmental review.

A full current list of NICE guidance endorsed for application in Northern Ireland can be found on the Department's website at https://www.health-ni.gov.uk/topics/safety-and-quality-standards/national-institute-health-and-care-excellence-nice

Dr Paddy Woods
Deputy Chief Medical Officer

Appendix 1

Endorsed NICE guidance - Details from Departmental review

Reference Number	NICE Clinical Guideline NG54 https://www.nice.org.uk/guidance/ng54
Title	Mental health problems in people with learning disabilities: prevention, assessment and management
Summary of guidance	This guideline partially updates NICE Clinical Guideline CG42 - Dementia: supporting people with dementia and their carers in health and social care (endorsed by DoH in September 2011). It covers preventing, assessing and managing mental health problems in people with learning disabilities in all settings (including health, social care, education, and forensic and criminal justice). It aims to improve assessment and support for mental health conditions, and help people with learning disabilities and their families and carers to be involved in their care. The guideline includes recommendations on: • organising and delivering care • involving people in their care • prevention, including social, physical environment and occupational interventions • annual GP health checks • assessment • psychological interventions, and how to adapt these for people with learning disabilities • prescribing, monitoring and reviewing pharmacological interventions
Related strategically relevant DoH/ HSC policies	None
Inter-Departmental interest	None
Legislative / policy caveats	This advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of their individual patients, in consultation with the patient and/or guardian or carer. This would, for example, include situations where individual patients have other conditions or complications that need to be taken into account in determining whether the NICE guidance is fully appropriate in their case.

	The *Mental Capacity Act 2005* does not apply in Northern Ireland, but work is under way to implement the *Mental Capacity Act (Northern Ireland) 2016*, which incorporates mental capacity and mental health provisions. The DoH guidance *Reference Guide to Consent for Examination, Treatment or Care (2003)*, which is available on the DoH website, gives advice on determining whether a person has capacity and on what action may be taken where the person lacks capacity. Available at: https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care This guidance refers to Risk Assessment. This should be considered in the context of *Promoting Quality Care*, good practice guidance on the *Assessment and Management of Risk in Mental Health and Learning Disability Services* (DoH, revised 2010). Available at: https://www.health-ni.gov.uk/topics/mental-health-and-learning-disabilities/mental-health-and-learning-disabilities-useful This guidance refers to the *Equality Act 2010*. Northern Ireland healthcare professionals should refer to *Section 75* of the *Northern Ireland Act 1998*. Available at: http://www.legislation.gov.uk/ukpga/1998/47/section/75 This guidance refers to the *Accessible Information Standard*. Northern Ireland healthcare professionals should refer to *Making Communication Accessible for All - A Guide for Health & Social Care (HSC) Staff*. Available at: http://www.belfasttrust.hscni.net/MakingCommunicationAccessible This guidance refers to some NICE Public Health Guidance which pre-dates the introduction of the DoH process for endorsing Public Health guidelines. All Public Health Guidance endorsed by DoH can be found at: https://www.health-ni.gov.uk/articles/nice-public-health-guidance This guidance makes reference to NICE Social Care guidance which has not been endorsed by the Department.

Appendix 2

Recommendations in CG42 - *Dementia: supporting people with dementia and their carers in health and social care* that are updated by recommendations in this guidance.

Original recommend-ation(s) in CG42	Replacement recommendation(s) from NG54
Recommendation 1.3.3.2	Recommendations 1.2.9, 1.6.3, 1.6.4, 1.7.5, 1.8.17 *Recommendation 1.2.9* Health, social care and education services should train all staff who may come into contact with people with learning disabilities to be aware: • that people with learning disabilities are at increased risk of mental health problems • that mental health problems may develop and present in different ways from people without learning disabilities, and the usual signs or symptoms may not be observable or reported • that people with learning disabilities can develop mental health problems for the same reasons as people without learning disabilities (for example, because of financial worries, bereavement or relationship difficulties) • that mental health problems are commonly overlooked in people with learning disabilities • where to refer people with learning disabilities and suspected mental health problems.
	Recommendation 1.6.3 Include the following in annual health checks: • a mental health review, including any known or suspected mental health problems and how they may be linked to any physical health problems • a physical health review, including assessment for the conditions and impairments which are common in people with learning disabilities • a review of all current interventions, including medication and related side effects, adverse events, interactions and adherence • an agreed and shared care plan for managing any physical health problems (including pain).

Original recommend-ation(s) in CG42	Replacement recommendation(s) from NG54
	Recommendation 1.6.4 During annual health checks with adults with Down's syndrome, ask them and their family members, carers or care workers (as appropriate) about any changes that might suggest the need for an assessment of dementia, such as: • any change in the person's behaviour • any loss of skills (including self-care) • a need for more prompting in the past few months.
	Recommendation 1.7.5 Refer people with learning disabilities who have a suspected serious mental illness or suspected dementia to a psychiatrist with expertise in assessing and treating mental health problems in people with learning disabilities.
	Recommendation 1.8.17 Complete a baseline assessment of adaptive behaviour with all adults with Down's syndrome.
Recommendations 1.5.1.2, 1.6.2.7	*Recommendation 1.8.16* Consider supplementing an assessment of dementia with an adult with learning disabilities with: • measures of symptoms, such as the Dementia Questionnaire for People with Learning Disabilities (DLD), the Down Syndrome Dementia Scale (DSDS) or the Dementia Screening Questionnaire for Individuals with Intellectual Disabilities (DSQIID) • measures of cognitive function to monitor changes over time, such as the Test for Severe Impairment (TSI) • measures of adaptive function to monitor changes over time.

Chief Medical Officer
Professor Sir Michael McBride

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

Circular HSC (SQSD) 13/22

Subject: NICE Clinical Guidelines – Process for Endorsement, Implementation, Monitoring and Assurance in Northern Ireland

Circular Reference: HSC (SQSD) 13/22

Date of Issue: 1st April 2022

For action by:
Chief Executive of Public Health Agency – **for distribution to:**
- Director of Public Health and Medical Director – for cascade to relevant staff
- Director of Nursing and AHPs – for cascade to relevant staff

Chief Executives of HSC Trusts – **for distribution to:**
- Medical Directors – for cascade to relevant staff
- Directors of Nursing – for cascade to relevant staff
- Heads of Pharmaceutical Services – for cascade to relevant staff
- Directors of Acute Services – for cascade to relevant staff
- HSC Clinical and Social Governance Leads
- Directors of Social Services – for cascade to relevant staff
- Directors of Finance – for cascade to relevant staff

Chief Executive, Regulation & Quality Improvement Authority – **for cascade to:** relevant independent healthcare establishments

Chief Executives of HSC Special Agencies and NDPBs

For Information to:
Chair of Public Health Agency
Chairs of HSC Trusts
Chair of RQIA
Chief Executive Patient and Client Council
Chief Executive/Postgraduate Dean, NIMDTA
Chief Executive, NICPLD
Chief Executive, NIPEC
Chief Executive, NISCC
NICE Implementation Facilitator NI
Members of NI NICE Managers' Forum

Related documents:
HSC (SQSD) 12/22

Superseded documents
Circular HSC (SQSD) 3/13

Summary of Contents:
The purpose of this circular is to explain the revised arrangements for the endorsement, implementation, monitoring and assurance of NICE Clinical Guidelines in NI.

Status of Contents:
Action

Enquiries:
Any enquiries about the content of this Circular should be addressed to:
Quality, Regulation and Improvement Branch
Department of Health
Room D1.4
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

SGU-NICEGuidance@health-ni..gov.uk

Implementation:
Effective from 1st April 2022

Additional copies:
Available to download from
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/national-institute-health-and-care-excellence-nice

Dear Colleagues

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) CLINICAL GUIDELINES – PROCESS FOR ENDORSEMENT, IMPLEMENTATION, MONITORING AND ASSURANCE IN NORTHERN IRELAND

Introduction

1. This circular updates and replaces Circular HSC (SQSD) 3/13 which set out the process for the endorsement, implementation, monitoring and assurance of NICE Clinical Guidelines in Northern Ireland (NI). The circular has been updated in order to reflect the migration of the Strategic Planning and Performance Group (SPPG), formerly the Health and Social Care Board (HSCB), into the Department of Health. This circular sets out the NI process for NICE Clinical Guidelines, which relate to specific diseases and/or groups of patients/clients.

2. The new arrangements will be effective from **1st April 2022** and will apply to all HSC organisations, including Family Practitioners. It should also be noted by independent health and social care providers.

3. It will be the responsibility of HSC organisations, under the statutory duty of quality as specified in Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, to put in place the necessary systems, which should include adequate and comprehensive dissemination, as part of their clinical and social care governance arrangements, for implementing NICE guidance.

Background

4. NICE is a Non Departmental Public Body tasked with producing national guidance on the promotion of good health and the prevention and treatment of ill health, as well as having recently taken on

responsibility for developing guidance and quality standards in social care.

5. NICE guidance to promote clinical excellence and the effective use of resources for people using the NHS is designed for use in England and, as such, does not automatically apply in NI.

6. The Department established formal links with NICE on 1 July 2006 whereby guidance published by the Institute from that date would be locally reviewed for applicability to Northern Ireland and, where appropriate, endorsed for implementation in Health and Social Care (HSC). This link has ensured that Northern Ireland has access to up-to-date, independent, professional, evidence-based guidance on the value of health care interventions.

NICE Process

Departmental review of NICE Clinical Guidelines for applicability to Northern Ireland

7. The Departmental review process is initiated when NICE publishes its Clinical Guidelines.

8. The Departmental review is not a reassessment of the clinical and cost evidence used by NICE in forming its advice. NICE guidance will be proofed by the Department only to check for legal, policy and financial consequences related to its implementation in NI. As a result, the guidance may be endorsed with caveats to advise local HSC organisations of any equivalent legislation/policy or any specific instructions/requirements.

9. As part of the equality screening process, the Department will continue to issue all Clinical Guidelines to all organisations who agree to participate in the consultations on equality and human rights. All consultations will also be made available on the Department's website.

10. The local Departmental review of the majority of Clinical Guidelines is expected to be complete within 8 weeks of publication by NICE. As soon as the local review is complete, endorsement decisions will be published on the Department's website. Guidance will have links to appropriate caveats where these apply. If a piece of NICE guidance is not applicable to NI, then this will be highlighted and an explanation provided.

11. Following endorsement, Quality Regulation and Improvement Branch (QRIB) in the Department's Chief Medical Officer's Group will issue guidance directly to SPPG, the HSC Trusts, Public Health Agency (PHA) and other relevant providers and stakeholders. The SPPG (specifically Integrated Care within the SPPG) will ensure that relevant guidance is sent to the appropriate Family Practitioners. The Regulation and Quality Improvement Authority (RQIA) will disseminate guidance to the independent sector as appropriate.

Commissioning and implementing NICE Clinical Guidelines

12. The SPPG, in conjunction with the PHA, will identify commissioning and Professional leads who will consider the commissioning implications of the Clinical Guideline and co-ordinate with any other relevant commissioning teams.

13. The Commissioning and Professional Leads will identify any areas where regional planning / investment / commissioning are required, or where there is material risk to safety or quality. These will then be actioned immediately through normal commissioning arrangements or through bespoke arrangements reflecting the nature of the issue / risk.

14. On receipt of the Departmental circular, HSC Trusts will proceed with targeted dissemination, agree a clinical/management lead to coordinate implementation and consider what has to be done to achieve

implementation. Parts of the guidance may already be established practice and so a baseline review is recommended. Baseline reviews will only be used to assist HSC Trusts with implementation; they will not be required to be shared with the Department. These initial actions should be undertaken within a 3 month period and the SPPG will seek positive assurance on targeted dissemination, agreement of a clinical/management lead and implementation planning via routine director level Service Issues and Performance meetings with the HSC Trusts. If planning identifies any longer term complex issues then they should be raised at this point.

15. It is also recognised that it may not be appropriate for a HSC Trust to implement every single recommendation. A risk based assessment can be used to ensure that all significant safety and quality improvements are achieved. Where NICE indicate that a recommendation is critical, in terms of service users' safety and/or outcomes, the Department expects Trusts to implement the guidance. However, this does not override the responsibility of clinicians to make decisions appropriate to the circumstances of an individual service user. These decisions should be taken in consultation with the individual (or their family/ carer/ guardian.

16. Clinical Guidelines can cover broad aspects of clinical practice and service delivery and, as such, can often be complex and have financial and, sometimes, wider strategic implications. The working assumption is that HSC Trusts will implement Clinical Guidelines within a further 9 months following the initial 3 month planning period after the QRIB issues the guideline. The SPPG will seek positive assurance that implementation has been achieved via routine director level Service Issues and Performance meetings with the HSC Trusts. .

17. It is recognised that the implementation of aspects of a Clinical Guideline may be beyond an individual HSC Trust. This might arise through cost or wider strategic implications. In such cases, HSC Trusts

will raise these with the SPPG at routine director level Service Issues and Performance meetings. This provides a further opportunity during the 9 month implementation stage to highlight any complex issues that had not been foreseen during the 3 month planning period.

18. Where regional commissioning / investment is required, there will be occasions where the timescale for implementation will take longer than 9 months dependent on the complexity and scale of the issue, available resource and other existing commissioning priorities. The SPPG in conjunction with the PHA will agree commissioning arrangements for these through negotiations with HSC Trusts and/or other relevant providers such as the voluntary/community sector. Depending on the nature of the issues identified, there may be benefit in the establishment of a regional group, The SPPG and PHA will agree the best mechanism by which to resolve certain issues.

NICE Implementation Facilitator for Northern Ireland

18. The NICE Implementation Facilitator for Northern Ireland will support the local implementation of NICE guidance. They will work with all HSC organisations to raise awareness of NICE guidance, of NICE implementation support tools and how HSC organisations could utilise them to support quality improvement.

19. In line with the recommendation from the RQIA baseline review of the implementation process in HSC organisations that a network should be established which would include NICE implementation leads from both commissioning and providing organisations, to discuss common issues and share good practice in the implementation of NICE guidance, the NICE Implementation Facilitator for Northern Ireland has established the NI NICE Managers' Forum.

Monitoring and Assurance

20. The SPPG will be responsible for monitoring implementation of NICE guidance within the HSC.

21. The SPPG will hold routine director level Service Issues and Performance meetings with the HSC Trusts where the implementation of NICE guidelines is a standing item on the agenda. All HSC Trusts are required to provide positive assurance that the initial required actions of targeted dissemination, identification of a clinical/management lead and implementation planning have taken place. This is in addition to the positive assurance that will be sought on implementation.

22. Prior to each director level Service Issues and Performance meeting, the SPPG will provide HSC Trusts with lists of the Clinical Guidelines on which positive assurance will be sought on the initial required actions and separately on implementation. Minutes of these meetings will record Trust assurances.

23. The HSC Trusts will provide assurances at 6 monthly accountability meetings with the Department on an exceptional basis where issues have been identified.

24. The RQIA inspections against the 'Quality Standards for Health and Social Care' will include, at a high level, the implementation process for NICE guidance by both commissioners and HSC Trusts. In addition, RQIA will lead on assessing the implementation of Clinical Guidelines. After an appropriate period for older guidance or when monitoring has confirmed implementation, the Department, in consultation with RQIA, will select clinical guidelines on which RQIA will carry out and report on a detailed review.

25. The SPPG will produce an annual report on the progress made generally in commissioning services in accordance with Departmental endorsed NICE guidance.

26. Should the Department, the Public Health Agency or RQIA identify any concerns about the implementation of NICE guidance, then the issue will be added to the agenda of the next 6-monthly Accountability meeting with the appropriate organisation.

NICE Consultations and Stakeholder Registration

27. NICE undertakes extensive literature reviews to ensure the robustness of its guidance. In areas where Northern Ireland is at the cutting edge and particularly where services cross health and social care, it is important that we contribute to NICE research at the scoping stage. It is also crucial to comment at the consultation stage as there is no opportunity to influence the guidance once it is published. All HSC Trusts are strongly encouraged to register as stakeholders with NICE so that they can submit any expert comments they may have. The Trusts and healthcare professionals should register to receive the Institute's e-newsletter to be kept informed of all NICE activities and guidance in development.

28. The success of the new process depends on everyone playing their part and in particular on good communication and effective clinical leadership. Through working together co-operatively and making the most of evidence based best practice, we can achieve the best outcomes for the people of Northern Ireland.

Enquiries

29. Any queries relating to this circular should be directed to Quality, Regulation and Improvement Branch (QRIB), D1, Castle Buildings, Stormont, Belfast, BT4 3SQ, or e-mail: SGU-NICEGuidance@health-ni.gov.uk

Professor Sir Michael McBride
Chief Medical Officer

MUCKAMORE ABBEY HOSPITAL DRAFT HSC ACTION PLAN

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the

community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the Health and Social Care Board.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice across the full spectrum of learning disability services in Northern Ireland.

In this context this plan should be considered a live document which will be subject to ongoing review and development to drive further and emerging improvements to current practice.

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect the best changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
Permanent Secretary commitments				
	Completion of resettlement process commenced in 2011by the end of 2019, and the issue of delayed discharges addressed.	**HSC Trusts**	By **30 November 2019** carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to discharge.	
		HSCB/HSC Trusts	By **30 November 2019** develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge.	
		HSCB/PHA	By **31 October 2019**, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.	

		DoH	By 31 **August 2019**, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming Minister) that the resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at **Annex A**). Completed	
		DoH/HSCB/HSC Trusts	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care eg Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff.	
		HSCB/PHA	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent review of acute inpatient care. **Incremental investment plan to be developed by 31 January 2020.**	

		DoH/HSCB/HSC Trusts	By **30 September 2020,** in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability.	
		HSCB/HSC Trusts	By **30 September 2020,** in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff.	
		DoH/DoJ	By **31 December 2019,** provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	
		HSCB/HSC Trusts	By **30 September 2020**, review current forensic LD services, identify and address service development needs to support people in community settings.	
Independent Review panel recommendations				

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
1.	Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.	**HSCB/PHA**	By **31 March 2020,** deliver a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation.	
2.	An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully	**HSCB/PHA/ HSC Trusts**	By **31 March 2020** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours.	
			By **31 December 2020** finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood.	

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
	addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.			
			By **31 December 2020** review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of children's residential services.	
	Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse	**HSCB/HSC Trusts**	By **30 June 2020** review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.	
		HSCTs	By **31 December 2019** address security of tenure of people with a learning disability living in supported housing.	

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
	continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.		By **31 March 2020** complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD..	

3.	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	**Belfast Trust**	Appoint a carers consultant and co-produce a communications strategy with parents and carers. Completed	
4.	Families and advocates should be allowed open access to wards and living areas.	**Belfast Trust, & Southern and Western Trusts.**	Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey). Completed	
5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	**Belfast Trust, & Southern and Western Trusts.**	By **30 June 2020,** carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	
6.	The use of seclusion ceases.	**Belfast Trust, & Southern and Western Trusts.**	By **31 January 2020,** complete an urgent review of seclusion policy and practice in MAH (and Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families.	
		DoH	By **30 June 2020,** develop a co-produced and publish regional seclusion and restraint policy/guidance**.**	
7.	The perception that people with learning disabilities are unreliable witnesses has to change.	**Belfast Trust**	By **30 June 2020,** complete a review of Adult Safeguarding culture and practices at MAH, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent	

			Review into Dunmurry Manor.	
8.	People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	**Belfast Trust**	By **31 December 2019,** review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.	
9.	The Hospital's CCTV recordings are retained for at least 12 months.	**Belfast Trust**	By **31 October 2019,** liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.	
10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	**Belfast Trust**	By **30 November 2019,** develop an information paper and share with families and staff.	
11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	**Belfast Trust**	By **31 October 2019,** provide an information booklet to families on the complaints process.	
12.	Families receive regular progress updates about what is happening as a result of the review.	**Belfast Trust**	By 31 **October 2019,** a schedule of Trust meetings with families will be produced and circulated to families.	

Hospital staff recommendations				
13.	An enhanced role for specialist nursing staff is set out.	**Belfast Trust**	By **30 June 2020,** develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work.	
		DoH	By **31 May 2020,** complete a review of Learning Disability Nursing.	
14.	Responses to safeguarding incidents and allegations are proportionate and timely.	**Belfast Trust**	By **30 June 2020,** complete a review of Adult Safeguarding culture and practices at Muckamore Abbey Hospital, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor.	
15.	Safeguarding documentation is substantially revised.	**HSCB**	By **31 December 2020,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor.	
Senior Trust staff recommendations				
16.	A shared narrative is set out.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.	

17.	Commissioners specify what "collective commissioning" means.	**HSCB**	By **16 October 2019,** HSCB to write to BHSCT outlining the current position and status of commissioning for HSC Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor.	
18.	The transformation required in learning disability services must be values driven and well led.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.	
19.	The purpose of all our services is clear.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020,** the LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	
20.	All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.	**DoH** **HSCB/ PHA/HSC Trusts**	By **31 December 2020,** develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services. By **30 September 2020**, deliver community and home treatment services support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary.	

21.	The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop.	**HSCB/PHA/ HSC Trusts**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services	
		HSCB/HSC Trusts	By **30 November 2019**, appoint a regional bed manager for all 3 current in-patient units.	
22.	Time limited and timely Assessment and Treatment become the norm.	**HSCB/PHA/ HSC Trusts**	By **30 September 2020,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge from hospital. (See Permanent Secretary commitments).	
23.	Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020** the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.	
24.	Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in	**DoH/HSCB/ PHA/HSC Trusts**	By **31 March 2020,** all parts of the HSC will have been involved in the development of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent,	

	the short and medium term.		whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.	

RAG Rating	
Completed	
Work in progress	
Progress required/Risk of not meeting target	

GLOSSARY OF TERMS

HSC – Health and Social Care

DoH – Department of Health

DfC – Department for Communities

DoF - Department of Finance

HSCB – Health and Social Care Board

PHA – Public Health Agency

RQIA – Regulation and Quality Improvement Authority

BHSCT – Belfast Health and Social care Trust

NHSCT – Northern Health and Social Care Trust

SEHSCT – South-Eastern Health and Social Care Trust

SHSCT – Southern Health and Social Care Trust

WHSCT – Western Health and Social Care Trust

MAH – Muckamore Abbey Hospital

SAI – Serious Adverse Incident

Bamford – the Bamford Review of Mental Health and Learning Disability in Northern Ireland

LD – Learning Disability

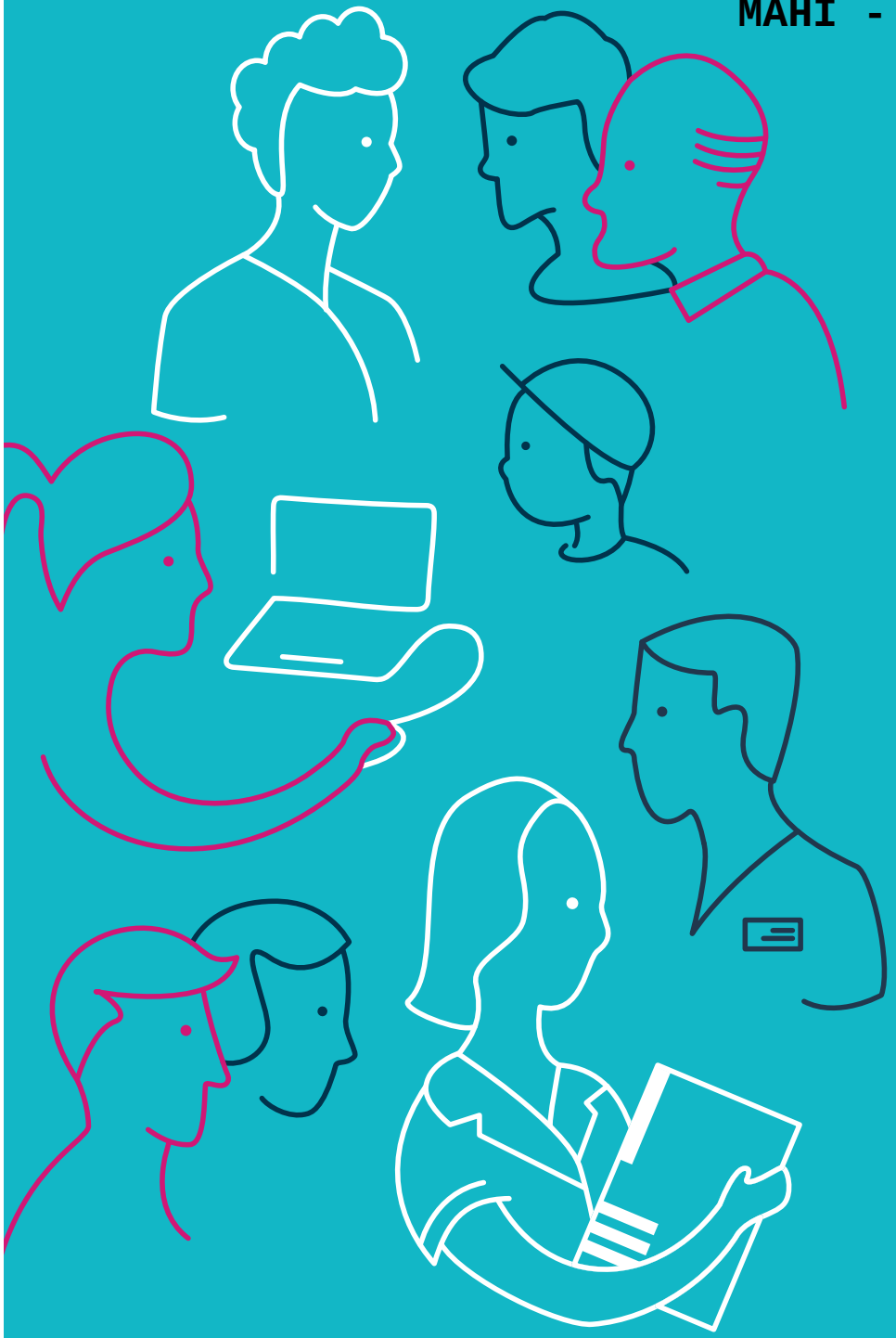
NIHE – Northern Ireland Housing Executive

ANNEX A

GOVERNANCE STRUCTURES

MAH - HSC
response governanc

Nursing & Midwifery Council



Future nurse: Standards of proficiency for registered nurses

Published 17 May 2018

Contents

Future nurse: Standards of proficiency for registered nurses

Introduction

The Nursing and Midwifery Council has a duty to review the standards of proficiency it sets for the professions it registers on a regular basis to ensure that standards remain contemporary and fit for purpose in order to protect the public. In reviewing the standards, we have taken into account the changes that are taking place in society and health care, and the implications these have for registered nurses of the future in terms of their role, knowledge and skill requirements.

The proficiencies in this document therefore specify the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings. They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. They also provide a benchmark for nurses from the European Economic Area (EEA), European Union (EU) and overseas wishing to join the UK register, as well as for those who plan to return to practice after a period of absence.

The role of the nurse in the 21st century

Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and person-centred. They are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In order to respond to the impact and demands of professional nursing practice, they must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support.

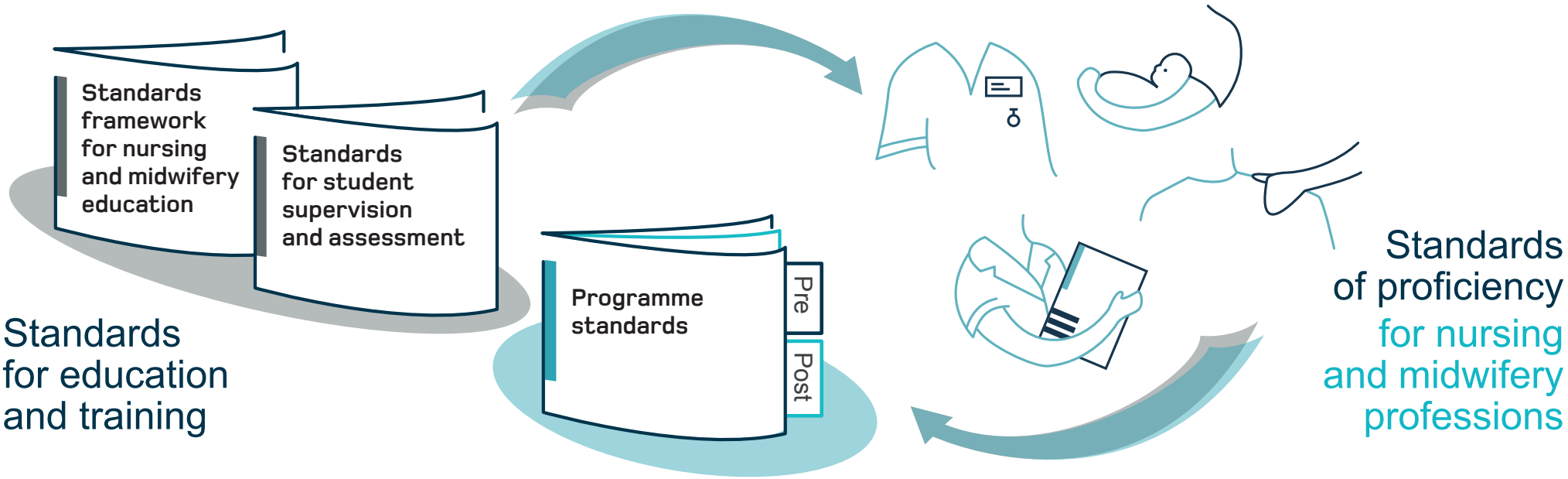
Registered nurses make an important contribution to the promotion of health, health protection and the prevention of ill health. They do this by empowering people, communities and populations to exercise choice, take control of their own health decisions and behaviours, and by supporting people to manage their own care where possible.

Registered nurses provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and beliefs. They provide nursing care for people who have complex mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly, and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation, and rapidly evolving technologies. Increasing integration of health and social care services will require registered nurses to negotiate boundaries and play a proactive role in interdisciplinary teams. The confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care therefore lies at the centre of all registered nursing practice.

About these standards

These standards of proficiency apply to all NMC registered nurses. They should be read with *Realising professionalism: Standards for education and training* which set out our expectations regarding delivery of all pre-registration and post-registration NMC approved nursing and midwifery education programmes. These standards apply to all approved education providers and are set out in three parts: Part 1: *Standards framework for nursing and midwifery education*; Part 2: *Standards for student supervision and assessment*; and Part 3: *Programme standards*, which are the standards specific for each pre-registration or post-registration programme. Education institutions must comply with our standards to be approved to run any NMC approved programmes.

Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with the flexibility to develop innovative approaches to education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards.



Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for nursing and midwifery education providers are established under the provision of Article 15(1) of the Order.

Article 5(2) of the Nursing and Midwifery Order 2001 requires the NMC to establish standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. The standards of proficiency have been established under this provision.

Future nurse: Standards of proficiency for registered nurses

How the proficiencies have been structured

The proficiencies are grouped under seven platforms, followed by two annexes. Together, these reflect what we expect a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career.

Key components of the roles, responsibilities and accountabilities of registered nurses are described under each of the seven platforms. We believe that this approach provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate.

These proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills. For example, after they register with us registered nurses will already be equipped to progress to the completion of a prescribing qualification.

The platforms are:

1. Being an accountable professional
2. Promoting health and preventing ill health
3. Assessing needs and planning care
4. Providing and evaluating care
5. Leading and managing nursing care and working in teams
6. Improving safety and quality of care
7. Coordinating care

The outcome statements for each platform have been designed to apply across all four fields of nursing practice (adult, children, learning disabilities, mental health) and all care settings. This is because registered nurses must be able to meet the person-centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges. They must also be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen fields of nursing practice.

The annexes to these standards of proficiency are presented in two sections. The annexes provide a description of what registered nurses should be able to demonstrate they can do at the point of registration in order to provide safe nursing care. Annexe A specifies the communication and relationship management skills required, and Annexe B specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely. As with the knowledge proficiencies, the annexes also identify where more advanced skills are required by registered nurses, working in a particular field of nursing practice.

Platform 1
Being an accountable professional

Registered nurses act in the best interests of people, putting them first and providing nursing care that is person-centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence-based decisions about care. They communicate effectively, are role models for others, and are accountable for their actions. Registered nurses continually reflect on their practice and keep abreast of new and emerging developments in nursing, health and care.

1. Outcomes:

The outcomes set out below reflect the proficiencies for accountable professional practice that must be applied across the standards of proficiency for registered nurses, as described in platforms 2-7, in all care settings and areas of practice.

At the point of registration, the registered nurse will be able to:

1.1 understand and act in accordance with the Code: *Professional standards of practice and behaviour for nurses, midwives and nursing associates*, and fulfil all registration requirements

1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom

1.3 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes

1.4 demonstrate an understanding of, and the ability to challenge, discriminatory behaviour

1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health

1.6 understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care

1.7 demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice

1.8 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations

1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions

1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations

1.11 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges

1.12 demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable

1.13 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues

1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments

1.15 demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice

1.16 demonstrate the ability to keep complete, clear, accurate and timely records

1.17 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills

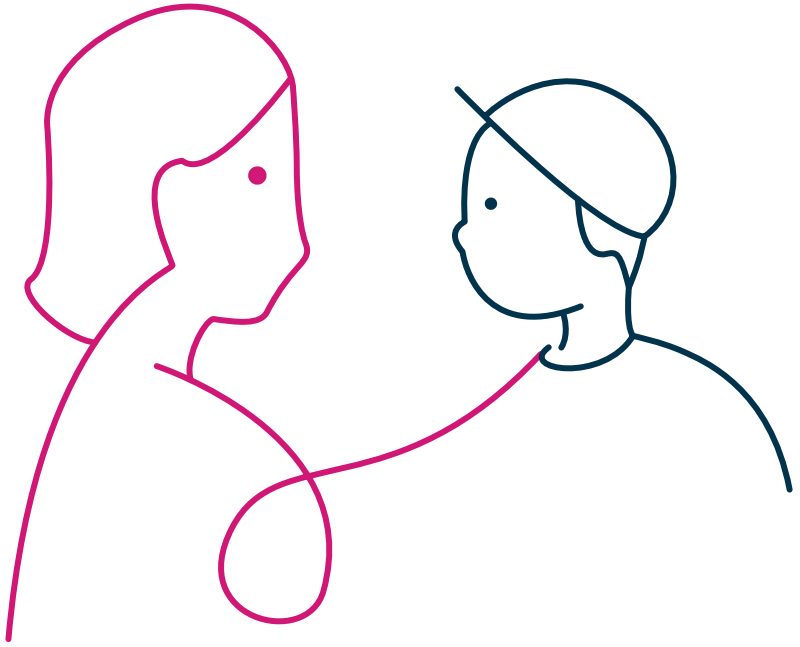
1.18 demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team

1.19 act as an ambassador, upholding the reputation of their profession and promoting public confidence in nursing, health and care services, and

1.20 safely demonstrate evidence-based practice in all skills and procedures stated in Annexes A and B.

Platform 2 Promoting health and preventing ill health

Registered nurses play a key role in improving and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to maximise their quality of life and improve health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas, and in the reduction of health inequalities.



2. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

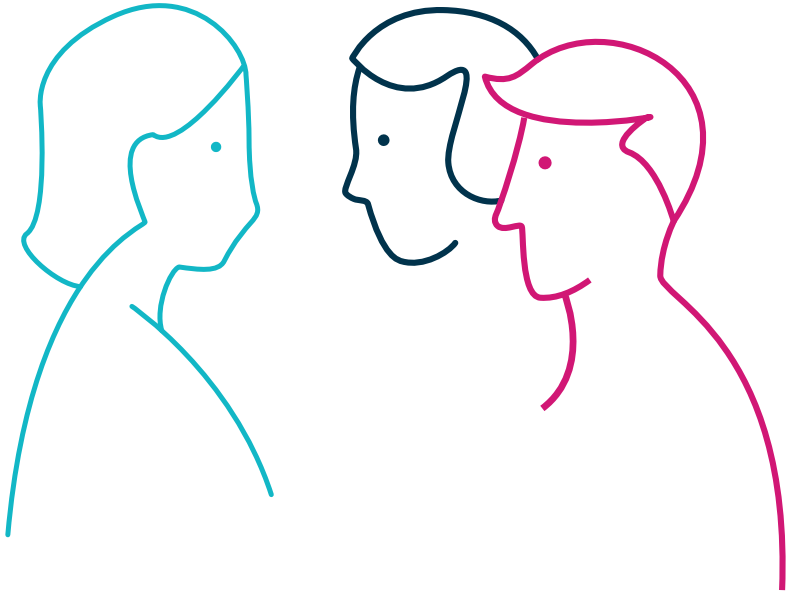
At the point of registration, the registered nurse will be able to:

2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people

2.2 demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes

2.3 understand the factors that may lead to inequalities in health outcomes

2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances



2.5 promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes

2.6 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing

2.7 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes

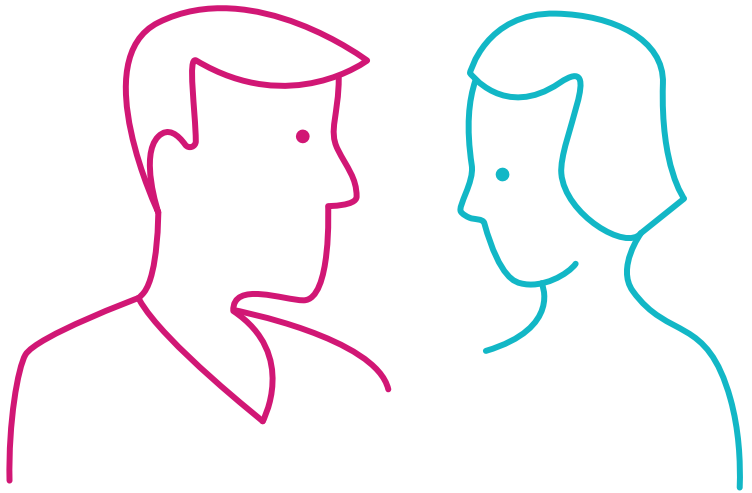
2.8 explain and demonstrate the use of up to date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments

2.9 use appropriate communication skills and strength based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability

2.10 provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care

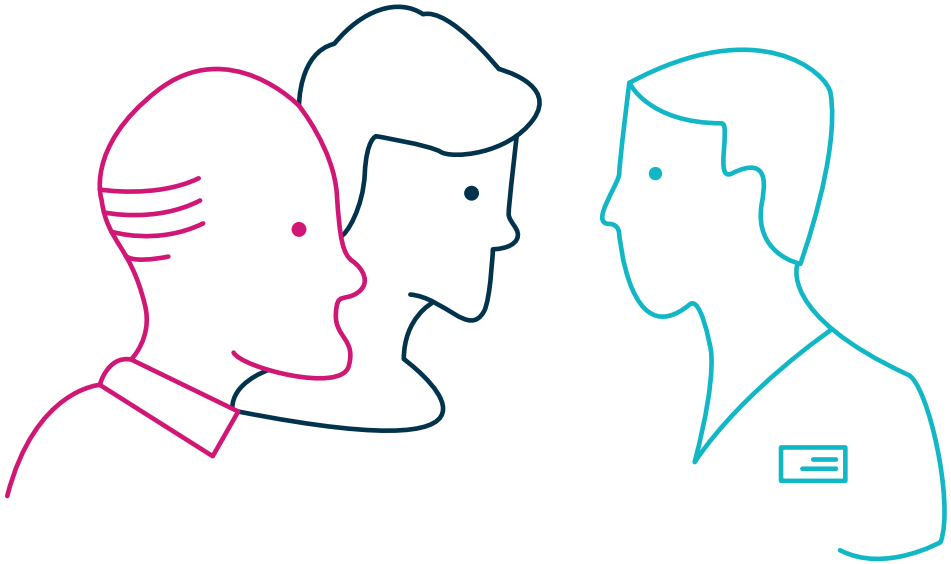
2.11 promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity, and

2.12 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.



Platform 3 Assessing needs and planning care

Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences.



3. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in assessing and initiating person-centred plans of care.

At the point of registration, the registered nurse will be able to:

3.1 demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.2 demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology and social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.3 demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person-centred care plans

3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages

3.5 demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals

3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent

3.7 understand and apply the principles and processes for making reasonable adjustments

3.8 understand and apply the relevant laws about mental capacity for the country in which you are practising when making decisions in relation to people who do not have capacity

3.9 recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable

3.10 demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation

3.11 undertake routine investigations, interpreting and sharing findings as appropriate

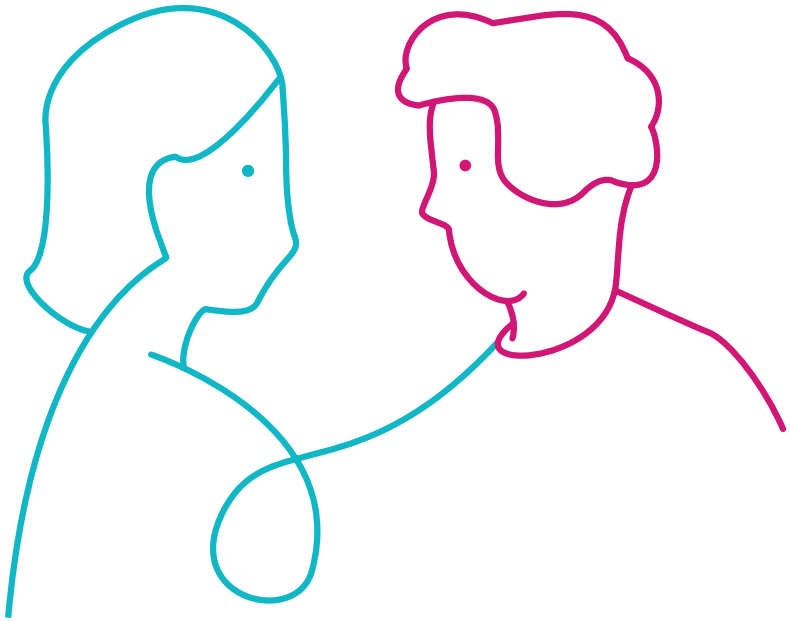
3.12 interpret results from routine investigations, taking prompt action when required by implementing appropriate interventions, requesting additional investigations or escalating to others

3.13 demonstrate an understanding of co-morbidities and the demands of meeting people's complex nursing and social care needs when prioritising care plans

3.14 identify and assess the needs of people and families for care at the end of life, including requirements for palliative care and decision making related to their treatment and care preferences

3.15 demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made, and

3.16 demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.



Platform 4 Providing and evaluating care

Registered nurses take the lead in providing evidence-based, compassionate and safe nursing interventions. They ensure that care they provide and delegate is person-centred and of a consistently high standard. They support people of all ages in a range of care settings. They work in partnership with people, families and carers to evaluate whether care is effective and the goals of care have been met in line with their wishes, preferences and desired outcomes.

4. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in providing and evaluating person-centred care.

At the point of registration, the registered nurse will be able to:

4.1 demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care

4.2 work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate

4.3 demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions

4.4 demonstrate the knowledge and skills required to support people with commonly encountered mental health, behavioural, cognitive and learning challenges, and act as a role model for others in providing high quality nursing interventions to meet people's needs

4.5 demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs

4.6 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based nursing care to meet people's needs related to nutrition, hydration and bladder and bowel health

4.7 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based, person-centred nursing care to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity

4.8 demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain

4.9 demonstrate the knowledge and skills required to prioritise what is important to people and their families when providing evidence-based person-centred nursing care at end of life including the care of people who are dying, families, the deceased and the bereaved

4.10 demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions

4.11 demonstrate the knowledge and skills required to initiate and evaluate appropriate interventions to support people who show signs of self-harm and/or suicidal ideation

4.12 demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence-based, person-centred care

4.13 demonstrate the knowledge, skills and confidence to provide first aid procedures and basic life support

4.14 understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines

4.15 demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage

4.16 demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing

4.17 apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration, and

4.18 demonstrate the ability to co-ordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings.

Platform 5
Leading and managing nursing care and working in teams

Registered nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. They are responsible for managing nursing care and are accountable for the appropriate delegation and supervision of care provided by others in the team including lay carers. They play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues.

5. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in leading and managing nursing care and working effectively as part of an interdisciplinary team.

At the point of registration, the registered nurse will be able to:

5.1 understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making

5.2 understand and apply the principles of human factors, environmental factors and strength-based approaches when working in teams

5.3 understand the principles and application of processes for performance management and how these apply to the nursing team

5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care

5.5 safely and effectively lead and manage the nursing care of a group of people, demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care

5.6 exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team

5.7 demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers

5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance

5.9 demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs

5.10 contribute to supervision and team reflection activities to promote improvements in practice and services

5.11 effectively and responsibly use a range of digital technologies to access, input, share and apply information and data within teams and between agencies, and

5.12 understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills.

Platform 6 Improving safety and quality of care

Registered nurses make a key contribution to the continuous monitoring and quality improvement of care and treatment in order to enhance health outcomes and people's experience of nursing and related care. They assess risks to safety or experience and take appropriate action to manage those, putting the best interests, needs and preferences of people first.

6. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care improvement agendas.

At the point of registration the registered nurse will be able to:

6.1 understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments

6.2 understand the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately

6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken

6.4 demonstrate an understanding of the principles of improvement methodologies, participate in all stages of audit activity and identify appropriate quality improvement strategies

6.5 demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools

6.6 identify the need to make improvements and proactively respond to potential hazards that may affect the safety of people

6.7 understand how the quality and effectiveness of nursing care can be evaluated in practice, and demonstrate how to use service delivery evaluation and audit findings to bring about continuous improvement

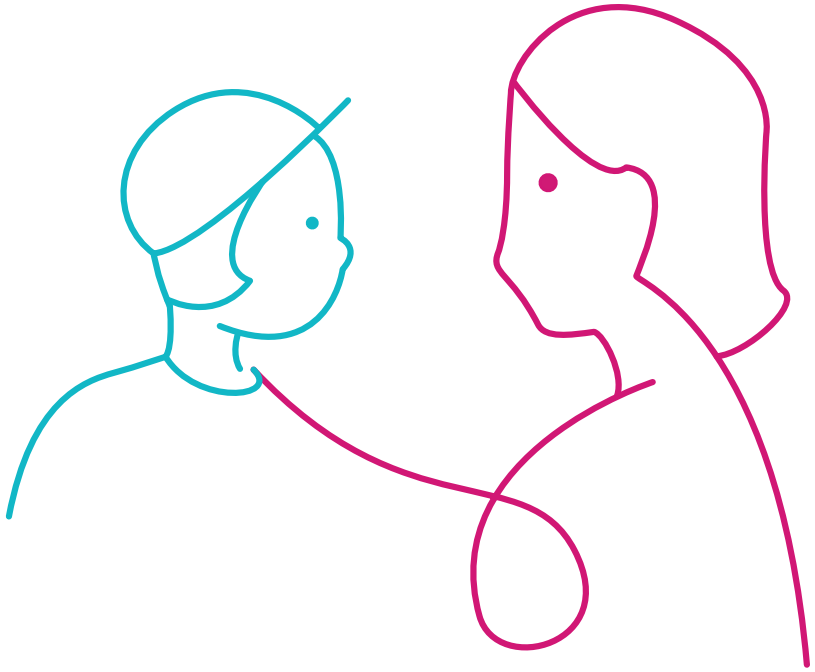
6.8 demonstrate an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice

6.9 work with people, their families, carers and colleagues to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences

6.10 apply an understanding of the differences between risk aversion and risk management and how to avoid compromising quality of care and health outcomes

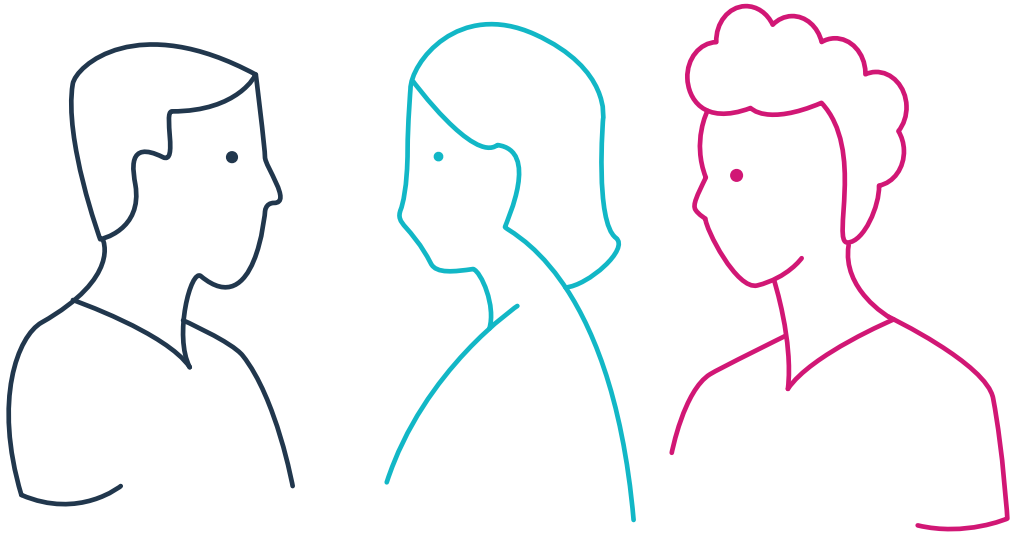
6.11 acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others, and

6.12 understand the role of registered nurses and other health and care professionals at different levels of experience and seniority when managing and prioritising actions and care in the event of a major incident.



Platform 7
Coordinating care

Registered nurses play a leadership role in coordinating and managing the complex nursing and integrated care needs of people at any stage of their lives, across a range of organisations and settings. They contribute to processes of organisational change through an awareness of local and national policies.



7. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in coordinating and leading and managing the complex needs of people across organisations and settings.

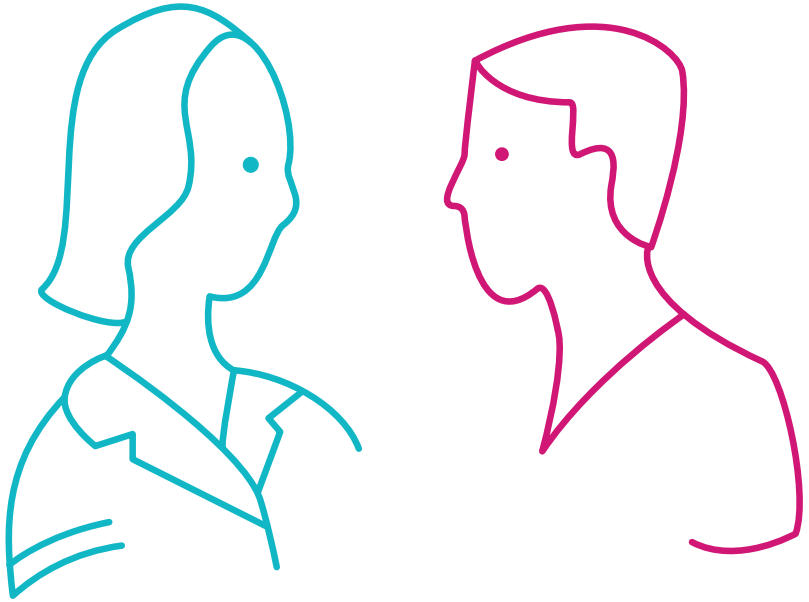
At the point of registration, the registered nurse will be able to:

7.1 understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors

7.2 understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom

7.3 understand the principles of health economics and their relevance to resource allocation in health and social care organisations and other agencies

7.4 identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care



7.5 understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs

7.6 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings

7.7 understand how to monitor and evaluate the quality of people's experience of complex care

7.8 understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives

7.9 facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care

7.10 understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services

7.11 demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed

7.12 demonstrate an understanding of the processes involved in developing a basic business case for additional care funding by applying knowledge of finance, resources and safe staffing levels, and

7.13 demonstrate an understanding of the importance of exercising political awareness throughout their career, to maximise the influence and effect of registered nursing on quality of care, patient safety and cost effectiveness.

Annexe A: Communication and relationship management skills

Introduction

The communication and relationship management skills that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes outlined in the main body of this document are set out in this annexe.

Effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive and behavioural health challenges.

This is because a diverse range of communication and relationship management skills is required to ensure that individuals, their families and carers are actively involved in and understand care decisions. These skills are vital when making accurate, culturally aware assessments of care needs and ensuring that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Where people have special communication needs or a disability, it is essential that reasonable adjustments are made in order to communicate, provide and share information in a manner that promotes optimum understanding and engagement and facilitates equal access to high quality care.

The communication and relationship management skills within this annexe are set out in four sections. For the reasons above, these requirements are relevant to all fields of nursing practice and apply to all care settings. It is expected that these skills would be assessed in a student's chosen field of practice.

Those skills outlined in **Annexe A, Section 3: Evidence-based, best practice communication skills and approaches for providing therapeutic interventions** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field of practice. Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following skills:

1. Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care

1.1 actively listen, recognise and respond to verbal and non-verbal cues

1.2 use prompts and positive verbal and non-verbal reinforcement

1.3 use appropriate non-verbal communication including touch, eye contact and personal space

1.4 make appropriate use of open and closed questioning

1.5 use caring conversation techniques

1.6 check understanding and use clarification techniques

1.7 be aware of own unconscious bias in communication encounters

1.8 write accurate, clear, legible records and documentation

1.9 confidently and clearly present and share verbal and written reports with individuals and groups

1.10 analyse and clearly record and share digital information and data

1.11 provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care

1.12 recognise the need for, and facilitate access to, translator services and material.

2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care

2.1 share information and check understanding about the causes, implications and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis

2.2 use clear language and appropriate, written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment

2.3 recognise and accommodate sensory impairments during all communications

2.4 support and manage the use of personal communication aids

2.5 identify the need for and manage a range of alternative communication techniques

2.6 use repetition and positive reinforcement strategies

2.7 assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use

2.8 provide information and explanation to people, families and carers and respond to questions about their treatment and care and possible ways of preventing ill health to enhance understanding

2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.

3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions

3.1 motivational interview techniques

3.2 solution focused therapies

3.3 reminiscence therapies

3.4 talking therapies

3.5 de-escalation strategies and techniques

3.6 cognitive behavioural therapy techniques

3.7 play therapy

3.8 distraction and diversion strategies

3.9 positive behaviour support approaches

4. Evidence-based, best practice communication skills and approaches for working with people in professional teams

4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of:

4.1.1 clear instructions and explanations when supervising, teaching or appraising others

4.1.2 clear instructions and check understanding when delegating care responsibilities to others

4.1.3 unambiguous, constructive feedback about strengths and weaknesses and potential for improvement

4.1.4 encouragement to colleagues that helps them to reflect on their practice

4.1.5 unambiguous records of performance

4.2 Demonstrate effective person and team management through the use of:

4.2.1 strengths based approaches to developing teams and managing change

4.2.2 active listening when dealing with team members' concerns and anxieties

4.2.3 a calm presence when dealing with conflict

4.2.4 appropriate and effective confrontation strategies

4.2.5 de-escalation strategies and techniques when dealing with conflict

4.2.6 effective co-ordination and navigation skills through:

4.2.6.1 appropriate negotiation strategies

4.2.6.2 appropriate escalation procedures

4.2.6.3 appropriate approaches to advocacy.

Annexe B: Nursing procedures

Introduction

The nursing procedures that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes, outlined in the main body of this document, are set out in this annexe.

The registered nurse must be able to undertake these procedures effectively in order to provide compassionate, evidence-based person-centred nursing care. A holistic approach to the care of people is essential and all nursing procedures should be carried out in a way which reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Registered nurses in all fields of practice must demonstrate the ability to provide nursing intervention and support for people of all ages who require nursing procedures during the processes of assessment, diagnosis, care and treatment for mental, physical, cognitive and behavioural health challenges. Where people are disabled or have specific cognitive needs it is essential that reasonable adjustments are made to ensure that all procedures are undertaken safely.

The nursing procedures within this annexe are set out in two sections. These requirements are relevant to all fields of nursing practice although it is recognised that different care settings may require different approaches to the provision of care. It is expected that these procedures would be assessed in a student's chosen field of practice where practicable.

Those procedures outlined in **Annexe B, Part I: Procedures for assessing needs for person-centred care, sections 1 and 2** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following procedures:

Part 1: Procedures for assessing people's needs for person-centred care

1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages:

1.1 mental health and wellbeing status

1.1.1 signs of mental and emotional distress or vulnerability

1.1.2 cognitive health status and wellbeing

1.1.3 signs of cognitive distress and impairment

1.1.4 behavioural distress based needs

1.1.5 signs of mental and emotional distress including agitation, aggression and challenging behaviour

1.1.6 signs of self-harm and/or suicidal ideation

1.2 physical health and wellbeing

1.2.1 symptoms and signs of physical ill health

1.2.2 symptoms and signs of physical distress

1.2.3 symptoms and signs of deterioration and sepsis.

2. Use evidence-based, best practice approaches to undertake the following procedures:

2.1 take, record and interpret vital signs manually and via technological devices

2.2 undertake venepuncture and cannulation and blood sampling, interpreting normal and common abnormal blood profiles and venous blood gases

2.3 set up and manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces

2.4 manage and monitor blood component transfusions

2.5 manage and interpret cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices

2.6 accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings

2.7 undertake a whole body systems assessment including respiratory, circulatory, neurological, musculoskeletal, cardiovascular and skin status

2.8 undertake chest auscultation and interpret findings

2.9 collect and observe sputum, urine, stool and vomit specimens, undertaking routine analysis and interpreting findings

2.10 measure and interpret blood glucose levels

2.11 recognise and respond to signs of all forms of abuse

2.12 undertake, respond to and interpret neurological observations and assessments

2.13 identify and respond to signs of deterioration and sepsis

2.14 administer basic mental health first aid

2.15 administer basic physical first aid

2.16 recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support

2.17 recognise and respond to challenging behaviour, providing appropriate safe holding and restraint.

Part 2: Procedures for the planning, provision and management of person-centred nursing care

3. Use evidence-based, best practice approaches for meeting needs for care and support with rest, sleep, comfort and the maintenance of dignity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

3.1 observe and assess comfort and pain levels and rest and sleep patterns

3.2 use appropriate bed-making techniques including those required for people who are unconscious or who have limited mobility

3.3 use appropriate positioning and pressure-relieving techniques

3.4 take appropriate action to ensure privacy and dignity at all times

3.5 take appropriate action to reduce or minimise pain or discomfort

3.6 take appropriate action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene.

4. **Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

   4.1 observe, assess and optimise skin and hygiene status and determine the need for support and intervention

   4.2 use contemporary approaches to the assessment of skin integrity and use appropriate products to prevent or manage skin breakdown

   4.3 assess needs for and provide appropriate assistance with washing, bathing, shaving and dressing

   4.4 identify and manage skin irritations and rashes

   4.5 assess needs for and provide appropriate oral, dental, eye and nail care and decide when an onward referral is needed

   4.6 use aseptic techniques when undertaking wound care including dressings, pressure bandaging, suture removal, and vacuum closures

   4.7 use aseptic techniques when managing wound and drainage processes

   4.8 assess, respond and effectively manage pyrexia and hypothermia.

5. **Use evidence-based, best practice approaches for meeting needs for care and support with nutrition and hydration, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

   5.1 observe, assess and optimise nutrition and hydration status and determine the need for intervention and support

   5.2 use contemporary nutritional assessment tools

   5.3 assist with feeding and drinking and use appropriate feeding and drinking aids

   5.4 record fluid intake and output and identify, respond to and manage dehydration or fluid retention

   5.5 identify, respond to and manage nausea and vomiting

   5.6 insert, manage and remove oral/nasal/gastric tubes

   5.7 manage artificial nutrition and hydration using oral, enteral and parenteral routes

   5.8 manage the administration of IV fluids

   5.9 manage fluid and nutritional infusion pumps and devices.

6. Use evidence-based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

6.1 observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy and managing the use of appropriate aids

6.2 select and use appropriate continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required

6.3 manage bladder drainage

6.4 assess bladder and bowel patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention

6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate

6.6 undertake stoma care identifying and using appropriate products and approaches.

7. Use evidence-based, best practice approaches for meeting needs for care and support with mobility and safety, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

7.1 observe and use evidence-based risk assessment tools to determine need for support and intervention to optimise mobility and safety, and to identify and manage risk of falls using best practice risk assessment approaches

7.2 use a range of contemporary moving and handling techniques and mobility aids

7.3 use appropriate moving and handling equipment to support people with impaired mobility

7.4 use appropriate safety techniques and devices.

8. Use evidence-based, best practice approaches for meeting needs for respiratory care and support, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions

8.2 manage the administration of oxygen using a range of routes and best practice approaches

8.3 take and interpret peak flow and oximetry measurements

8.4 use appropriate nasal and oral suctioning techniques

8.5 manage inhalation, humidifier and nebuliser devices

8.6 manage airway and respiratory processes and equipment.

9. Use evidence-based, best practice approaches for meeting needs for care and support with the prevention and management of infection, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

9.1 observe, assess and respond rapidly to potential infection risks using best practice guidelines

9.2 use standard precautions protocols

9.3 use effective aseptic, non-touch techniques

9.4 use appropriate personal protection equipment

9.5 implement isolation procedures

9.6 use evidence-based hand hygiene techniques

9.7 safely decontaminate equipment and environment

9.8 safely use and dispose of waste, laundry and sharps

9.9 safely assess and manage invasive medical devices and lines.

10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression

10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps and other devices

10.3 assess and review preferences and care priorities of the dying person and their family and carers

10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health

10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death

10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols.

11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation

11.1 carry out initial and continued assessments of people receiving care and their ability to self-administer their own medications

11.2 recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them

11.3 use the principles of safe remote prescribing and directions to administer medicines

11.4 undertake accurate drug calculations for a range of medications

11.5 undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product

11.6 exercise professional accountability in ensuring the safe administration of medicines to those receiving care

11.7 administer injections using intramuscular, subcutaneous, intradermal and intravenous routes and manage injection equipment

11.8 administer medications using a range of routes

11.9 administer and monitor medications using vascular access devices and enteral equipment

11.10 recognise and respond to adverse or abnormal reactions to medications

11.11 undertake safe storage, transportation and disposal of medicinal products.

Glossary

Abuse: is something that may harm another person, or endanger their life, or violate their rights. The person responsible for the abuse may be doing this on purpose or may not realise the harm that they are doing. The type of abuse may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

Cognitive: The mental processes of perception, memory, judgment, and reasoning.

Co-morbidities: the presence of one or more additional diseases or disorders that occur with a primary disease or disorder.

Demography: the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Evidence-based person-centred care/nursing care: making sure that any care and treatment is given to people, by looking at what research has shown to be most effective. The judgment and experience of the nurse and the views of the person should also be taken into account when choosing which treatment is most likely to be successful for an individual.

Genomics: branch of molecular biology concerned with the structure, function, evolution, and mapping of genomes.

Health economics: a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and healthcare.

Health literacy: the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Human factors: environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

Interventions: any investigations, procedures, or treatments given to a person.

People: individuals or groups who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and other within and outside the learning environment.

Person-centred: an approach where the person is at the centre of the decision making processes and the design of their care needs, their nursing care and treatment plan.

Self-Reflection/Reflection: to carefully consider actions or decisions and learn from them.

Strength-based approaches: strength-based practice is a collaborative process between the person supported by services and those supporting them, working together to reach an outcome that draws on the person's strengths and assets.

Vulnerable people: those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

The role of the Nursing and Midwifery Council

What we do

We regulate nurses and midwives in the UK, and nursing associates in England. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate professionals who fall short of our standards.

We maintain a register of nurses and midwives allowed to practise in the UK, and nursing associates allowed to practise in England.

These standards were approved by Council at their meeting on 28 March 2018.

Nursing & Midwifery Council

The Code

Professional standards of practice and behaviour for nurses, midwives and nursing associates

prioritise people

practise effectively

preserve safety

promote professionalism and trust

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015 **Effective from:** 31 March 2015
Updated to reflect the regulation of nursing associates: 10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:
www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates[1] must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing[2] and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

1 Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.

2 We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

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You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at **www.nmc.org.uk/standards**

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5 take all steps to make sure that records are kept securely

10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at **www.nmc.org.uk/indemnity**

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care

13.5 complete the necessary training before carrying out a new role

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The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at **www.nmc.org.uk/raisingconcerns.**

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at **www.nmc.org.uk/standards.**

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

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Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at **www.hse.gov.uk**

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 maintain the level of health you need to carry out your professional role

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at **www.nmc.org.uk/standards**

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment

21.2 never ask for or accept loans from anyone in your care or anyone close to them

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

21.5 never use your status as a registered professional to promote causes that are not related to health

21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

22.1 keep to any reasonable requests so we can oversee the registration process

22.2 keep to our prescribed hours of practice and carry out continuing professional development activities

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at **www.nmc.org.uk/standards.**

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment

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When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at **www.nmc.org.uk.**

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.1 never allow someone's complaint to affect the care that is provided to them

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

nmc
Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews
@nmcuk

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Registered charity in England and Wales (1091434) and in Scotland (SC038362)

Department of Health, Social Services and Public Safety

An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Review of the Nursing, Midwifery and Health Visiting Workforce

Final Report

March 2002

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CONTENTS

PREAMBLE

The HPSS employs over 41000 staff and is currently funded in the region of £1.9 billion per annum[1]. Two thirds of spending on the HPSS is on pay. The number of health and social care professionals in the HPSS is important for the capacity of the system however the way in which the workforce is used is even more important. The registered or enrolled nursing and midwifery workforce[2] make up approximately 26% of the total HPSS workforce and represents some 50% of the direct care workforce that is the hospital and community health care professional workforce[3].

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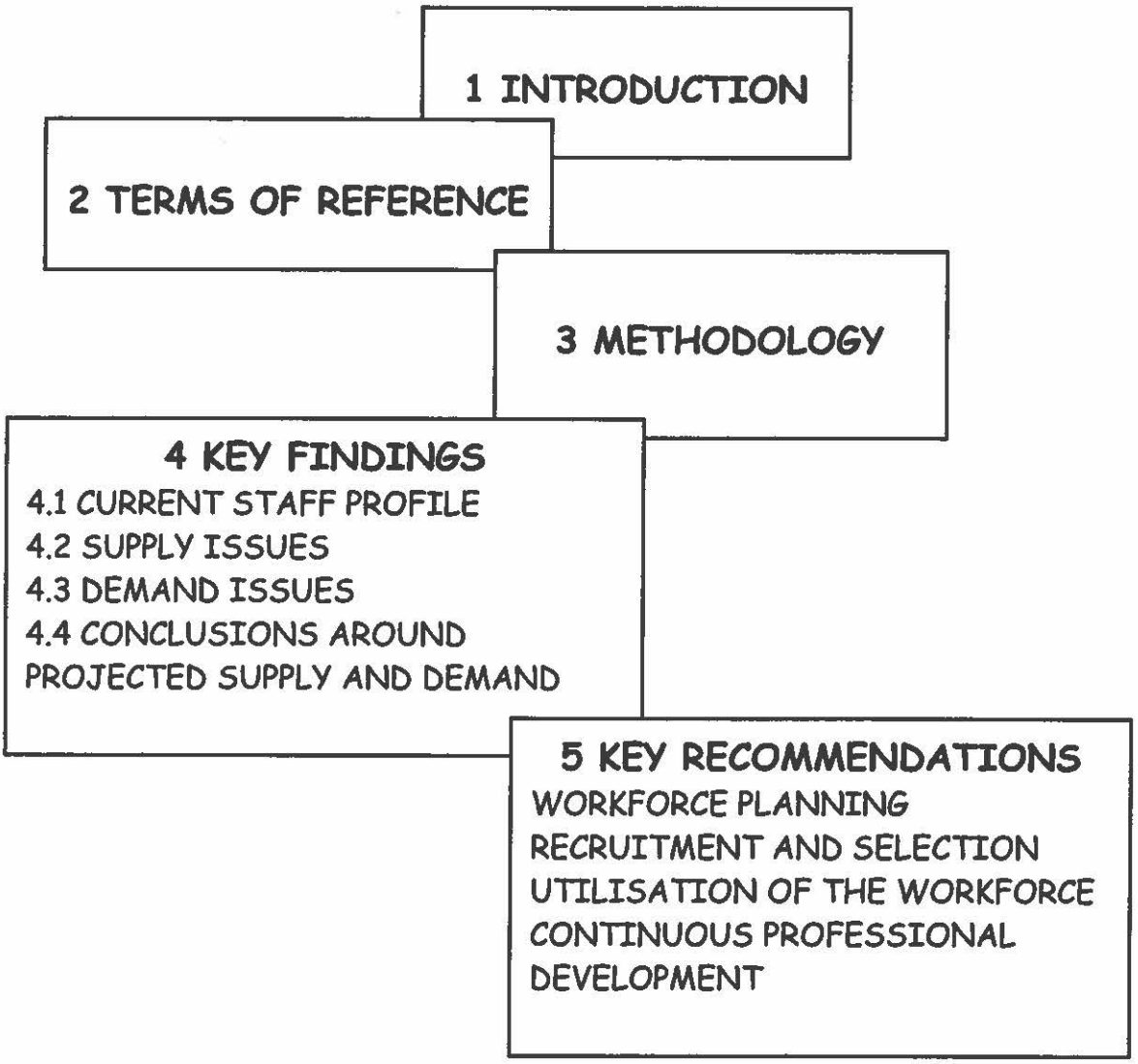
[1] www.dhsspsni.gov.uk/text2/about/about.html Funding Section
[2] Hereafter referred to as "the workforce" unless otherwise stated
[3] Source HRMS – DHSSPS Project Support Analysis Branch. Direct workforce includes nurses and midwives, unqualified care support staff, medical and dental, PAM's, and technical grades.

EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

1. INTRODUCTION

In September 2001, the DHSSPS commenced a series of uni-professional workforce reviews, which, over the period of one year, would cover the 15 main clinical professions within the HPSS. There were a number of drivers behind the initiative and these included, the publication of the Hayes Report on the future of Acute Hospital Services and the DHSSPS Consultation document 'The Employer of Choice'. Both documents highlighted the urgent need to put in place structures that will support workforce planning within and across all of the HPSS Professions. While it was determined that the initiatives, at this stage, would be taken forward on a uni -professional basis, the information and recommendations from this work would provide an important baseline in terms of developing workforce planning within HPSS across service sectors and professions.

Nursing and midwifery was the first clinical profession to be included in the workforce review initiative.

1.1. This review of the nursing, midwifery and health visiting workforce[4] in Northern Ireland provides valuable analysis of the current workforce and the future recruitment and retention issues for this workforce. It provides a prediction of future supply and demand for these professions and reviews the impact of the supply and demand position within the workforce on the delivery of health and personal social services and making recommendations to address relevant issues.

1.2. This review report has been produced under the guidance of a project group, which comprised of representatives of DHSSPS, HPSS commissioners and providers, education and staff side. KPMG Management Consultants were also appointed to support the project group in information gathering, data analysis and in the presentation of the final report.

[4] Hereafter referred to as "the workforce" unless otherwise stated.

2. TERMS OF REFERENCE

2.1. KPMG Consulting was commissioned by the Department of Health, Social Services and Public Safety between August and December 2001 to undertake a review of the workforce in Northern Ireland. The terms of reference for the review are outlined in Box 1A below.

2.2. This review was to focus on providing a qualitative report and was not required to examine economic issues or carry out detailed feasibility studies. The scope of the review was to focus on the statutory nursing sector within Northern Ireland.

BOX 1A TERMS OF REFERENCE

A. **Provide an analysis of the current nursing, midwifery and health visiting workforce in Northern Ireland, including:**
- size, composition, sectoral distribution, age and gender
- working conditions and patterns
- continuing professional development commitments
- specialist service commitments

B. **Provide an analysis of current and future recruitment and retention issues, including:**
- pay
- career development and specialisation
- impact of career breaks/ individuals leaving the profession
- returnees
- working arrangements

C. **Provide a prediction of future supply of nurses and midwives over the next five years and demand, for staff including :**
- number of nurses, midwives and health visitors required to meet service demands
- services demanding the skills of these professionals and the context within which these services are delivered
- skill-mix options

D. **Review the impact of the supply and demand position within the workforce on the delivery of health and personal social services and make recommendations to address issues that arise from the above.**

3. METHODOLOGY

3.1. A variety of methods were utilised to undertake this review. Box B below illustrates the methodology adopted in the review.

BOX B METHODOLOGY

Data Audit
An audit of the current workforce situation was carried out, identifying the current staffing profile and characteristics. This baseline information was primarily gathered from existing information held within the Department and, at Trust level on the Human Resource Management Information Systems. This information was supplemented as possible by the data from respective professional bodies.

Background Research
This was conducted to identify future and current trends impacting upon the staff and involved a keyword and heading search of relevant professional databases; a policy document review; a review of Trust and commissioner strategies to identify proposed service developments or changes and a review of benchmark data sources.

Consultation with stakeholders
This involved extensive consultation with stakeholders across all relevant disciplines and areas of the workforce as identified by the Project Group, involving the use of 48 key informant interviews and 15 focus groups. See appendix 2&3.

Analysis of data
This involved the analysis of data gathered to develop a workforce model to aid the prediction of future workforce needs by the identification of key supply and demand indicators over the period of 2002 - 2006.

4. KEY FINDINGS

The following key findings cover the current staff profile, supply and demand issues. These findings are drawn from desk research and the findings from the key informants and focus groups referred to as "respondents". Where specific sources are used these are referred to in the footnotes.

4.1. Current Staff Profile

4.1.1. There are 14947 nurses and midwives recorded DHSSPS Human Resources Management System (this includes 1529 bank staff). Registered and enrolled nurses, midwives and health visitors represent 26% of the total HPSS workforce[5] in Northern Ireland. This workforce makes up approximately 50% of the total direct care workforce in hospitals and communities.

4.1.2. The workforce can be classified into the key discipline areas of adult, mental health, learning disability and children's. These classifications include nurses working as district nurses, community learning disability nurses, community psychiatry nurses, health visitors, school nurses, occupational health nurses, treatment room nurses and so on.

4.1.3. The ratio of headcount to whole time equivalent for this workforce is 1.18:1. This is higher within specific areas of the workforce, such as midwifery and childrens where the ratio currently stands at 1.26:1.

4.1.4. A significantly higher percentage of females to males were identified as working in a part-time capacity. 42% of the female workforce as opposed to 7% of the male workforce. It was identified that part-time contracts were highly utilised in the 31 to 40 age category (54%); 41 to 50 category (55%) and the 51 to 60 category (58%).

4.1.5. The workforce is predominantly made up of the female gender with only 6% of the male gender being represented. Within midwifery the percentage of females to males is even higher with 99.9% being of the female gender.

4.1.6. The age profile of the nursing workforce shows that approximately 15% fall within the 50 + category. 55 years is the " eligible" age for retirement within the general nursing profession with some categories of staff are entitled to enhanced pension rights on reaching 55.

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[5] Source HRMS – DHSSPS Project Support Analysis Branch. Direct workforce includes nurses and midwives, unqualified care support staff, medical and dental, PAM's, and technical grades

4.1.7. The grade breakdown of nurses within Northern Ireland identifies 32% of qualified nurses currently employed at a Grade D. This is set against a background of 24.2% of qualified nurses within England being employed at this grade.

4.1.8. The total number of current vacancies within HPSS was identified as 508 WTE, representing 3.8% of the total headcount population. The total number of vacancies within the independent sector was established to be circa 400 WTE.

4.1.9. It was estimated that there are currently the equivalent of 109 WTE agency nurses regularly utilised across the province and the equivalent of 139 WTE Bank Staff.

4.2. SUPPLY ISSUES

Recruitment and retention

4.2.1. The review established that within Northern Ireland there is currently no shortage with regard to recruiting to training places for the nursing workforce. Queen's University has stated that the present ratio of applications to every place available ratio is 2.9:1.

4.2.2. An estimated 269 individuals have completed nursing Return to Practice courses within Northern Ireland since the commencement of the initiative in 1998. An additional 81 are currently in training and plans are in place to continue to offer such courses throughout NI. Survey results indicate that an estimated 80% of those who complete the course take up employment within the workforce. However, the demand for the course is anticipated to decline over the next five years.

4.2.3. At 1st April 2001, there have been 214 work permits issued for overseas nurses within HPSS. Some Trusts (notably the Royal and Ulster Hospitals) are continuing to attempt to recruit additional overseas nurses. The number of new overseas nurses joining the workforce must however be set against the fact that a number are likely to return to their home country after their work permit expires..

4.2.4. There is an average attrition rate of 8.8% for nursing students per intake. Of those graduating, evidence from first destination survey[6] results indicates that approximately 10% do not enter the HPSS sector in Northern Ireland upon graduating.

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[6] Carried out by QUB of newly registered nurses.

4.2.5. It is evident that there are increasing problems with regard to recruitment and retention for the workforce across the province with particular difficulty in recruitment to general adult and surgical wards, mental health, learning disability and the independent sector. These difficulties are mainly at grade D level but are increasingly at higher grade posts.

4.2.6. Figures provided by the DHSSPS (Leavers 2000-2001) indicate nurses and midwives who have left the service (including career breaks) over the period 2000-2001 for reasons other than retirement. In this year an estimated 259 nurses and midwives left the service, equating to 1.9% of the workforce.

4.2.7. Retention is being further affected by the reported increase in nurses moving into other related fields such as drug companies or into the private sector.

4.2.8. All respondents stressed that the above recruitment and retention issues are being exaggerated by a currently under staffed establishment. It was reported that increasingly this factor effects the quality of patient care delivered and the effective implementation of new initiatives.

Additional issues relating to recruitment and retention and thus supply of the workforce were identified.

4.2.9. **Career Progression**
Respondents highlighted lack of career progression as a major de-motivating factor. Many felt that a job evaluation initiative was required to ensure the continued development of the workforce and the profession

4.2.10. **Job Satisfaction**
Key aspects noted as having a detrimental effect on job satisfaction were increasing workload, poor infrastructure, lack of funding to support the increased provision of care in the community, limited amount of time with the patient, lack of Continuing Professional Development and a lack of leadership.

4.2.11. **Remuneration**
Continued poor remuneration was also highlighted and many stated that their concern with respect to pay was linked to a general lack of progression. Respondents indicated that they would encourage the provision of other incentives as part of the total remuneration package. For example crèches,

childcare vouchers, sponsored training and improved working environment/ facilities.

4.2.12. Life Long Learning and CPD

The majority of respondents felt that a greater focus should be placed on opportunities for life long learning in terms of resource and commitment. This was especially in light of CPD requirements of continued role extension and development of specialisms.

4.2.13. Leadership

It was highlighted that Leadership within the profession was required in order to proactively lead the workforce. It was therefore important to identify and develop future leaders at all levels throughout the professions. This was deemed to be particularly important, given the rapid rate of change occurring.

4.3. DEMAND ISSUES

A number of factors that specifically result in greater demand on the workforce were identified.

Specialisation and role extension

4.3.1. It was acknowledged that increased demand for specialist nurses within the profession would continue in the future. A number of respondents felt that this trend necessitated a re-evaluation of the core tasks and roles that nurses now undertook.

4.3.2. Key areas where it was felt specialist skills would be in demand in the acute sector were: A&E; surgery; orthopaedics; respiratory; cancer; diabetes; palliative care; drugs and alcohol care management; wound management; renal and neo-natal.

4.3.3. Key areas where it was felt specialist skills would be in demand in the community sector were: Rapid Response Units; community care; learning disability; mental health; community children's nursing; school nursing; GP teams and units; wound management; tissue viability; management of terminal illness and palliative care.

4.3.4. Key areas where it was felt specialist skills would be in demand within the midwifery profession were neo-natal; health education/counselling and midwifery led care.

4.3.5. Alongside the above increase in specialisms respondents reported an increase in role extension, which they felt, should be managed more pro-actively and with greater focus on adequate workforce planning. The majority of respondents felt that there was going to be a continued requirement to extend hours of service coverage and this would bring about an increase in workload and subsequent need for additional resource

4.3.6. The main areas identified as bringing about an increased workload within the acute sector were as follows: reduction in Junior Doctor Hours; central lines; increased interventional treatment; bloods; nurse prescribing and diagnosis/triage.

4.3.7. The main areas identified as bringing about an increased workload within the community sector were care manager role, nurse prescribing and diagnosis/ triage.

4.3.8. The main areas identified as bringing about an increased workload within the midwifery profession were suturing; increased interventional assistance; central lines and bloods.

4.3.9. In general all respondents reported an increase of between 10-30% of their time being spent on administrative tasks some of which they felt could be re-allocated to other more clerical based roles.

4.3.10. **Skill mix**

The majority of respondents were positive about extending the role of the nurse auxiliaries and assistants but stressed it would require a well-planned extension and re-structuring exercise with the appropriate training and regulations in place.

4.3.11. **Life Long Learning and CPD**

It was felt that a greater focus on Life Long Learning would increase the demand on the available workforce and therefore an increased resource requirement with regard to CPD and staff training.

4.3.12. **Clinical Training / mentorship**

All respondents agreed that increased resources were requirement to accommodate this role effectively. As a minimum, 1 hour per student per

week was considered by the respondents to be required. The favoured approach was to set the required time aside in each mentors weekly rostered hours.

4.3.13. **Increased patient expectations and societal factors**

All felt that recent and continued increase in patient expectations had meant an increase in workload, which had not been accounted for.

Key societal factors highlighted as bringing about an increase in workload were an ageing population; increased dependency of patients; increased throughput and the sophistication of treatments now available.

4.3.14. **Capital development and increased focus on treatment in primary care settings**

The key areas of planned capital development identified as bringing about an increased resource requirement were ICU/HDU bed increase (additional 116 WTE required; Development of the Cancer Centre and 4 Regional Cancer Units (additional 40 WTE); Ulster Hospital (additional 127 WTE); Craigavon Hospital (additional 11 WTE); Knockbracken Regional Secure Unit (additional 75 WTE nurses) Child and Adolescence Psychiatry Unit (additional 25 WTE); Regional Brain Injury Unit (27 WTE) and Renal Services (21 WTE); RVH Phase 2 (52 WTE); Altnagelvin (75WTE).

It was felt that the move to treatment in the primary care setting would require an approximate 10% increase in the current nursing resource employed within the GP setting.

4.4. Conclusions around Projected Supply and Demand

4.4.1. Based on the above consultations and subsequent analysis of data and assumptions, conclusions were drawn which formed the basis of a workforce model to predict anticipated supply and demand of this workforce over the years 2002-2006.

4.4.2. It was estimated that supply would decrease year on year over the period of 2002-2006 by approximately 1% - 2% each year. This figure is based only on the current situation and does not take account of factors such as Euro/Punt/Pound equilibrium, a more effective utilisation of the current workforce, development of current care

pathways, consolidation of the current service provision or an increase in the current student intake.

4.4.3. It was estimated that projected demand is set to increase and that, at a minimum, an additional 955 WTE nurses would be required over the period 2002-2006. This figure is based only on anticipated demand in the HPSS (excluding the independent sector) and includes capital developments approved / likely to be approved and the likely areas of service developments that will have an impact on the nursing workforce, as identified by the project group.

4.4.4. Based on the initial work carried out in this review, when anticipated supply is projected against anticipated demand over the 2002-2006 periods, an estimated shortfall of 2799 in the workforce is projected. This is based on an assumption that all current HPSS vacancies would be filled and agency nurse hours would be reduced dramatically over the 5-year period. This assumes no change in the assumptions presented in the review. It is clear however that more work is required to test the validity of both the supply and demand assumptions in more detail.

5. KEY RECOMMENDATIONS

Based on the conclusions of this report we have outlined a series of recommendations to be considered.

WORKFORCE PLANNING

5.1. The Department should put in place arrangements to review supply and demand on a regular basis. The profiles of supply and demand that have been built up in this report should be reviewed on at least an annual basis. The assumptions presented in the report should also be subjected to more detailed analysis.

5.2. The annual intake of pre-registration students should be increased from 680 to 750 in 2002/03 subject to funds being made available and the two Universities being able to facilitate this increase in numbers.

5.3. Both Universities should be commissioned to provide two intakes of pre-registration students per year to facilitate recruitment and employment after training.

5.4. The intake to the pre-registration midwifery programme should be increased to 40 per annum and discussions commence with QUB about the adoption of a direct entry midwifery programme.

5.5. Further work should be carried out to improve the quality of data held on the HRMS workforce information system. More research is required

into the trends and impact of 'family friendly' working hours policies to make our supply side assumptions more robust.

5.6. HPSS Employers, particularly Trusts should be required to produce their own workforce supply and demand projections.

RECRUITMENT AND SELECTION

5.7. Employers in the HPSS need to review their current Recruitment and Retention practices to ensure that they reflect best practice. It is particularly important that the recruitment process is timely and responsive to trends in the labour market.

5.8. The Department should work closely with University Pre-registration providers to ensure as best as possible that those recruited as student nurses have a long-term interest in pursuing nursing as a career in Northern Ireland.

5.9. There should be more targeted campaigns for pre-registration training to attract individuals into specific areas of shortage such as Mental Health and Learning Disability.

5.10. Trusts should seek to build relationships with pre-registration students during placements to encourage them to apply for jobs, once they have qualified.

5.11. Trusts should ensure that there are planned induction, consolidation and mentorship programmes for all new students.

5.12. The skills mix between D and E grades should be reviewed across the HPSS, as this is perceived as a significant retention factor for some Trusts.

5.13. There should be a consistent approach to the implementation of work-life balances. Other measures such as self-systems should be considered to increase flexibility, ownership and empowerment of staff.

UTILISATION OF THE WORKFORCE

5.14. There should be a significant investment to increase the number of Health Care Support Workers who are trained to NVQ level 3. A fast track training process that will facilitate 200 staff is required.

5.15. Further research needs to be carried out to ascertain the impact of the Junior Doctors Working Hours on the nursing workforce.

5.16. Work should be undertaken to examine the feasibility of new roles in health care provision to ascertain their potential impact on the nursing workforce. The 'physicians assistant' or 'health care practitioner' roles are examples. The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) will have a role in the development of this work.

CONTINUOUS PROFESSIONAL DEVELOPMENT

5.17. There needs to be a fresh emphasise on Continuing Professional Development as a means of developing and empowering the nursing workforce. NIPEC will support this development.

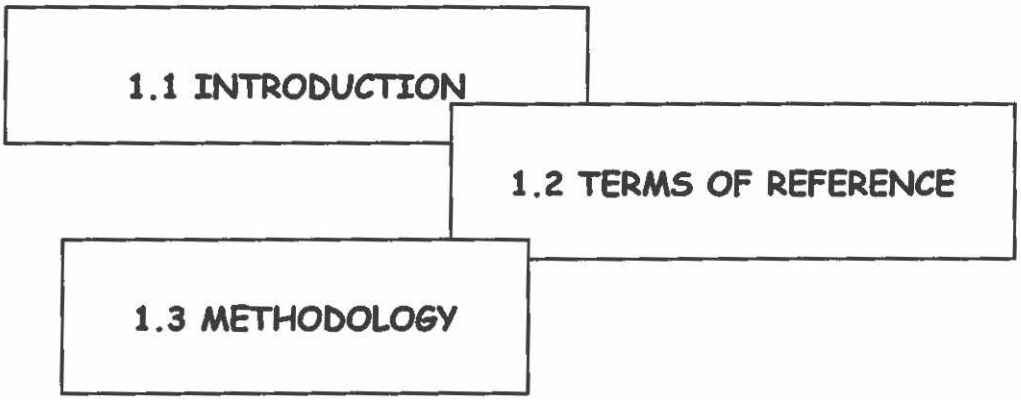
5.18. The role of the new Education Commissioning groups (ECG's) should be evaluated to review how education and training opportunities could be maximised.

5.19. Training should be offered to all staff who will be required to provide mentorship or coaching support as part of their role with adequate "protected" time set aside to ensure that this happens as part of the weekly duties. These responsibilities should be considered as a key competence when addressing aspects of re-grading issues. NIPEC will be able to support this educational development of the nursing and midwifery role.

5.20. A Training Needs Analysis should be carried out to establish the key development areas of nurse Leaders for the future. This initially should incorporate an identification process of what these leaders should "look like" in the future, the identification of who they may be an then an analysis of the development required. Management training providers should be involved in this analysis.

5.21. A more pro-active approach should be adopted with regard to career progression and the formulation of career paths that are reflective of service needs in all areas. NIPEC should lead this development.

1 INTRODUCTION TO MAIN REPORT



1. INTRODUCTION TO MAIN REPORT

1.1. INTRODUCTION

In August 2001 KPMG were commissioned by the DHSSPS to carry out an in-depth review of the HPSS nursing, midwifery and health visiting workforce in Northern Ireland. The review took place between August and December 2001 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, HPSS commissioners and providers, education and staff side (See Appendix 1 for the membership of the Project Group).

The report is presented by the Project Group and outlines:

*The background to the project
*The project methodology
*A summary of the recruitment and retention issues arising from the review and a projection of the supply and demand within the nursing and midwifery workforce over the next five years.
*The report concludes with a list of recommendations, which seek to contribute to addressing current and future workforce issues within the N.I. HPSS nursing and midwifery workforce.

The ultimate aim of the review is to assist the Department of Health, Social Services and Public Safety Northern Ireland in the development of strategies that can assure the correct numbers of nurses and midwives are in place and working in the most effective way to offer optimal benefit to the overall healthcare team and the patient.

1.2. TERMS OF REFERENCE

The terms of reference for the review were:

a) **Provide an analysis of the current nursing, midwifery and health visiting workforce in Northern Ireland, including:**
*size, composition, sectoral distribution, age and gender
*working conditions and patterns
*continuing professional development commitments
*specialist service commitments

b) **Provide an analysis of current and future recruitment and retention issues, including:**
*pay
*career development and specialisation
*impact of career breaks/ individuals leaving the profession
*returners (i.e. returning to nursing or midwifery profession)
*working arrangements

c) **Provide a prediction of future supply of nurses and midwives over the next five years and demand, for staff including :**
*number of nurses, midwives and health visitors required to meet service demands
*sectoral distribution including specialisation
*services demanding the skills of these professionals and the context within which these services are delivered
*skill-mix options

d) **Review the impact of the supply and demand position within the workforce on the delivery of health and personal social services and make recommendations to address issues that arise from the above.**

The requirement for this piece of work was to review issues at a strategic level and provide sound conclusions and recommendations relevant to the workforce as a whole. This review was not required to examine economic issues or carry out detailed feasibility studies. It's focus was to provide a starting point and baseline for workforce planning which could then be built on and expanded through future analysis.

1.3. METHODOLOGY

The methodology for the review focused on consulting with those in the current workforce, incorporating the four key disciplines of Adult, Children's, Learning Disability and Mental Health at all levels across the geographical regions of Northern Ireland. The views of under graduate students were also sought as they represent a substantial part of the future supply of the workforce.

The methodology adopted for the review included the following:

LITERATURE REVIEW AND DESK RESEARCH

This was conducted to identify future and current trends impacting upon the staff and involved a keyword and heading search of relevant professional databases; a policy document review; a review of Trust and commissioner strategies to identify proposed service developments or changes and a review of benchmark data sources.

DATA AUDIT

An audit of the current workforce situation was carried out, identifying the current staffing profile and characteristics. This baseline information was primarily gathered from existing information held within the Department and, at Trust level on the Human Resource Management Information Systems. This information was supplemented as possible by the data from respective professional bodies.

CONSULTATION WITH STAKEHOLDERS

This involved extensive consultation with stakeholders across all relevant disciplines and areas of the workforce as identified by the Project Group, involving the use of 48 key informant interviews and 15 focus groups.

KEY INFORMANT INTERVIEWS

Semi-structured in-depth interviews were carried out with 48 key representatives. (Appendix 2)

FOCUS GROUPS.

A total of 15 focus groups made up of a representative mix of disciplines, grades and primary and secondary care employees. (Appendix 3

ANALYSIS OF DATA

This involved the analysis of data gathered to develop a workforce model to aid the prediction of future workforce needs by the identification of key supply and demand indicators over the period of 2002 - 2006.

2 CONTEXT

2.1 INTRODUCTION

2.2 NORTHERN IRELAND POLICY CONTEXT

2.3 ORGANISATIONAL STRUCTURE AND INFRASTRUCTURE

2.4 OTHER WORKFORCE ISSUES AND DEMOGRAPHICS

2.5 SUPPLY ISSUES

Vacancy Levels
Pre and Post Registration Education
Job Satisfaction
Career Progression
Work-life Balance

2.6 DEMAND ISSUES

Shifting balance of Care- Primary Care
Specific Demand Areas in the Community
Junior Doctor Hours and Increasing Specialism
Nursing Careers
Increasing Demand
Increased throughput and dependency

2. CONTEXT

2.1. INTRODUCTION

It was important to set the review within an appropriate policy context before carrying out any data gathering. This informed the design of survey tools and ensures relevancy of conclusions and recommendations.

It necessitated looking at the current situation with regard to the wider Health and Social Care Policy context and the roles nurses; midwives and health visitors could play.

2.2. NORTHERN IRELAND HEALTH POLICY CONTEXT

A number of policy documents, provide the context against which we consider the workforce.

2.2.1. PROGRAMME FOR GOVERNMENT

The Northern Ireland Executive, in its second Programme for Government 2001-2004[7] identified "Working for a Healthier People" as one of its priorities.

Within this priority they stated that they would focus on:

- improving the health of all our people and reducing health inequalities;
- ensuring an environment that supports healthy living and the safe production of food;
- promoting public safety by reducing the numbers of injuries and deaths caused by accidents at home, at work and on the roads;
- modernising and improving hospital and primary care services to ensure more timely and effective care and treatment for patients; and
- enabling those with disability, mental health difficulties, chronic illness or terminal illness to achieve the highest possible standard of living and to be fully integrated within our society.

Under sub-priority 4 the Executive identifies that they continue to address workforce shortages and in particular increase the intake of student nurses to provide an output of 650 trained nurses per annum by 2004.

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[7] Northern Ireland Executive, Programme for Government, "Working for a Healthier People" 2001-2004 www.pfgni.gov.uk

In addition the Programme for Government identifies a number of key themes that should be incorporated at all stages in the development, improvement and evaluation of policies and procedures for the provision of services:

- Equality
- Human Rights
- New Targeting Social Need

2.2.2. PRIORITIES FOR ACTION

The document "Priorities for Action"[8] sets out in detail how the DHSSPS is to deliver the above priorities. The Minister for the Department of Health and Social Services and Public Safety identified that she wished to take forward the Programme for Government by focusing on certain planning priorities for the HPSS in the 2001/2002 financial year. Among these planning priorities is:

> "Tackling shortages of skilled staff, particularly in hard pressed specialised areas. This includes not only increases in the supply of qualified staff but also measures to improve recruitment and retention of staff within the HPSS."

2.2.3. BEST PRACTICE –BEST CARE

"Best Practice- Best Care", was published in April 2001[9]. Its aim was to consult on the establishment of a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS. It stated that the starting point for improving services and practices:

> "must be the development of staff who provide the services."

The document also brings into focus the plans to introduce a system of clinical and social care governance, backed by a statutory duty of quality and supported by continuous professional development.

2.2.4. INVESTING FOR HEALTH

The DHSSPS "Investing for Health" published in November 2000[10] focused on the promotion of health and well -being rather than the treatment of ill health. It encouraged professions to work with the public and communities specifically focusing on three priority groups; the very young, children and young people and older people.

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[8] DHSSPS, Priorities for Action, 2001/2002, March 2001-12-12

[9] DHSSPS Best Practice Best Care: A Framework for Setting Standards, Delivering Services and Improving Monitoring and Regulation in the HPSS, A Consultation Paper, April 2001

[10] DHSSPS "Investing for Health" November 2000

2.2.5. VALUING DIVERSITY – STRATEGY FOR NURSES, MIDWIVES AND HEALTH VISITORS

The nursing, midwifery and health visiting workforce in Northern Ireland, as outlined in the Nursing, Midwifery and Health Visiting strategy "Valuing Diversity" 1998[11] are well placed to take a lead role in addressing public health and promoting health and social well-being.

Valuing Diversity identifies activities for the workforce in Commissioning, practice, education, research and development, and leadership and management

2.3. ORGANISATIONAL STRUCTURE AND INFRASTRUCTURE

2.3.1. ACUTE SERVICES REVIEW GROUP REPORT (HAYES REPORT)

One of the most recent reviews addressing the structure of the HPSS as a whole in Northern Ireland is the comprehensive Acute Services Review undertaken by a Project Steering Group chaired by Dr Maurice Hayes[12].

The report envisages a radical change in the way hospital services are provided and managed. To whatever extent the reports recommendations are subsequently taken forward, they will have far reaching implications for the workforce in terms of numbers required, skill sets, role boundaries and organisational structures. The key recommendations set out in Hayes and relevant to this review, are highlighted in Box 2A below.

Chapter 10 of the Report refers specifically to workforce issues. It states that:

> " it would be impossible to begin to implement the changes and developments we have recommended without considering the impact on the existing workforce, the need to engage them fully in the process, their need for training and support, and the development of new skills and work practices to meet the needs of a challenging and changing future." (Page 89)

The Report also makes a number of recommendations that will directly impact on both the number of nurses, midwives and health visitors required and the

[11] DHSS "Valuing Diversity-a way forward A strategy for nursing, midwifery and health visiting " 1998
[12] Acute Hospitals Review Group Report June 2001

type of work that they will be performing. For instance, the allocation of emergency care and inpatient maternity services; the expansion of services at some sites and the reduction of services at others and the implementation of local nurse-led emergency units providing a comprehensive minor injury and illness service.

BOX 2A KEY RECOMENDATIONS OF HAYES REPORT

1 Shift significantly the balance of care from secondary care to primary care. This will mean that more nurse practitioners, advanced nurse practitioners and practice nurses will be required and there will be a need to increase the local availability of training.

2 Primary care organisations should be given the responsibility for the commissioning of community services and non-regional hospital services, in the context of a strategic plan.

3 Conduct a workforce planning exercise to cover the whole of the health and social services workforce, looking across sectors, employers and staff groups. The plan should consider the need to increase the current number of training places for doctors, nurses and other staff groups.

4 Provide acute hospital services that are consultant delivered rather than consultant led.

5 Form a new organisational structure comprising a Strategic Health and Social Services Authority (replacing the current four Health and Social Services Boards) and three Health and Social Care Systems being; the Northern, Southern and Greater Belfast.

2.4. OTHER WORKFORCE ISSUES AND DEMOGRAPHICS UK AND NORTHERN IRELAND

A number of other workforce related initiatives and reports were considered in reviewing the context within which this review takes place.

2.4.1. ENGLAND

The English NHS document "A Consultative Document on the Review of Workforce Planning for the NHS[13] ", broke these issues down further and highlighted a need to focus the areas highlighted in Box 2B.

BOX 2B
REVIEW OF WORKFORCE PLANNING - NHS
Team working
Flexible working
Patient focused workforce planning and development
Maximising the contribution of all staff to patient care
Modernising education and training
Developing new, more flexible careers
Expanding the workforce

Health care systems and the roles of nurses and midwives – the largest group of health care personnel – are changing, with more focus on healthy lifestyles and self-care, and the spread of sophisticated medical technology (requiring more specialisation by nurses)[14]. This implies an increase in the number of nurses required in the health system, working in a different way and that they will need different skills than in the past.

[13] NHS, A Consultant Document on the Review of Workforce Planning for the NHS, 2000
[14] World Health Organisation "Nursing beyond the year 2000. World Health Organisation Technical Report Series" Issue 842, 1994

2.4.2. RCN UK PUBLICATION

A recent review commissioned by the Royal College of Nursing[15] (United Kingdom statistics) noted that – See Box 2C:

BOX 2C RCN PUBLICATION UK STATISTICS

*Only one in eight of those on the UKCC register are aged under 30 compared with one in four less than 10 years ago and more than 70,000 are aged between 50 and 55 many of whom are likely to withdraw from the nursing workforce in the next few years

*More students need to be attracted if the targets for workforce growth are to be met and significant constraints on the system - such as the availability of good quality clinical placements - need to be overcome

*Most of the growth in nursing employment in the last 10 years has been in GP practice nurses (reaching more than 12,000 at the end of 1999) and in other non health HPSS sectors, where it is estimated that up to 100,000 nurses work; and

*Participation in the nursing workforce is high - it is estimated that 83% of registered nurses are in employment - and there may be no more than 73,000 non-working nurses for employers to recruit from, and at least one in five of these are thought not to intend to return to the NHS.

[15] Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine, Seventeenth report on Nursing Staff, Midwives and Health Visitors, 2000

2.4.3. WORKFORCE POSITION PAPER NORTHERN IRELAND

With respect to Northern Ireland there had since the 1990's and until recently been a reduction of the numbers of pre-registration students recruited to enter the professions. This related to up to 50% for midwifery and 20% for nursing between 1988-1998. A major constraint on expansion in student nurse numbers is the availability of sufficient good quality clinical placements in appropriate settings.

2.4.4. FLEXIBLE WORKING PATTERNS

Box 2D illustrates results from a recent survey completed by the Royal College of Nursing and Queen's University, Belfast[16]:

BOX 2D RCN & QUB SURVEY

*Those working in acute hospitals tended to by younger with 69% being aged 40 or less; in community 53% were aged 40 or under; 50 % in nursing homes and hospices and residential homes and just 45% of those working in GP surgery were aged 40 or less

*Women in the sample were more likely than men to be working in acute, community and GP surgery; males were more likely to be working in non-acute hospitals, nursing homes, hospices or residential home

*Full time contracts were most common amongst younger respondents (82% of 21 to 30 year old and 80% of 18 to 20 year olds), whilst part time contracts were most common in those aged 51 to 60 (58%), 41 to 50 (55%) and 31 to 40 (54%).

*Temporary contracts were most common amongst the 61 to 65 age group, 21% of whom were on such contracts

*42% of females worked part time compared with 7% of males

*Of those not currently working in nursing, most (78%), had left since 1996 and most commonly they had left in 1999(20%). In 2000, 17% left the profession

[16] Royal College of Nursing and Queen's University of Belfast "Research and Evaluation Services Survey" 2001 DN What is this?

2.4.5. AGE DEMOGRAPHICS

In terms of age demographics, 15% of nurses employed within the HPSS in Northern Ireland are aged over 50. Under the HPSS Superannuation Scheme nurses are permitted to retire at 55 years and it has been estimated that there is a high percentage that now take up this option due to the enhanced pension rights after 50.

2.4.6. WORKFORCE GRADING POSITION

Within Northern Ireland, 32% of nurses are employed in D grade posts which is a much higher percentage than that in England where it is 24.2% and in Scotland, 28.4%.

2.5. SUPPLY ISSUES

Across the UK, and indeed globally, the nursing workforce is experiencing substantial recruitment and retention problems. The roots of the recent nursing shortages are widely acknowledged to lie in the early 1990's due to the move to an employer led system, enlargement of the nursing home sector, the impact of junior doctors' hours initiatives, increasing technology and other scientific advances. These resulted in an underestimate of staffing numbers along with an underestimated non-NHS demand for nurses, particularly in the expanding nursing home sector.

2.5.1. VACANCY LEVELS

Evidence suggests that as of July 2001 there were approximately 477 whole time equivalent (WTE) qualified nurses and 40 WTE qualified midwifes vacancies within the HPSS nursing workforce in Northern Ireland and around 400 WTE qualified nurses vacancies in the Independent Sector.

The shortfall in Northern Ireland is highlighted by;

- reported shortage of nurses and midwives to fill existing roles,
- major difficulties in recruitment and retention within the hospital sector and independent care (care of the elderly in homes),
- increased stress levels and sickness records,
- the need to bring over nurses from other parts of the world and
- the increased use of agency/banks to cover vacant positions and holidays.

In addition, a projection based upon figures received from the Eastern Board, estimates that the total number of hours used in the Province for agency nurses equals at least 109 whole time equivalent nurses[17]

[17] EHSSB Projection Paper

With respect to bank nurses, during the period January - March 2001, Trusts reported that there were 2075 registered nurses registered with banks who provided 67,867 hours. This is equivalent to approximately 139 whole time equivalent staff.

2.5.2. PRE AND POST REGISTRATION TRAINING

PRE-REGISTRATION

When considering supply issues from a workforce perspective, the number of nurses being educated at student level is of key importance.

Commencing in September 2000, the DHSSPS commissioned 540 Diploma student places from Queen's University Belfast for 3 academic years. This was an increase of 100 places per annum on the original contract level and included 15 places on the shortened Children's Programme.

Queens University, Belfast also split their cohort between September and March of each year.

In addition, to the pre-registration at Queen's University approximately 40 students per annum pursued a 4-year degree course at University of Ulster.

Commencing in September 2001, the DHSSPS commissioned a further 100 per-registration student places from the University of Ulster – all pre-registration students at UU now undertake a three year programme leading to registration.

There is currently not a problem in recruiting students into nursing in Northern Ireland. For the September 2001 intake, Queen's University received 2.9 applications per place, which indicates that the level of desire to enter this profession is still high.

There are however reported difficulties recruiting to the mental health and learning disability branches of nursing programmes.

ENTERING HPSS WORKFORCE

The Queen's University Career Service First Destination Survey results have indicated an increasing trend for students to remain in Northern Ireland upon graduation. In 1998, out of 103 responses (low response rate), 33 % left Northern Ireland upon graduation to go to the UK or overseas. In 1999, out of 213 responses, 12% left Northern Ireland to go to the UK or overseas. Finally, in 2000, out of 280 responses, only 4 % left Northern Ireland to go to the UK or overseas.

COMMUNITY NURSING PROGRAMMES

With respect to post-registration courses in community nursing, the DHSSPS' Commissioning Plan for 2001-2002 indicated that approximately 90 places were commissioned on the Community Nursing Programmes which include health visitors, district nurses, community mental health nurses, school nurses and so on.

MIDWIFERY

Unlike Scotland, England and Wales there is currently no provision for direct entry midwifery programmes in Northern Ireland[18]. The DHSSPS has commissioned 30 diploma/degree student places from Queen's for the past three academic years commencing in 1997. Queen's received 2.5 applications per place for the September 2001 intake.

The DHSSPS are currently considering a recommendation from the Nurse and Midwife Education Strategy Group to commission direct entry midwifery programmes. If approved it is anticipated that Direct Entry Midwifery programmes will be developed in 2002/03 and commissioned from September 2003.

Of those joining the overall nursing, midwifery and health visiting profession there is a noted increase in the number of either "returnees" or "mature" first time students. Whilst on the whole this is positive it is important to bear in mind that there is a reported ageing profile amongst the nursing, midwifery and health visiting workforce and that in this decade compared with the last, proportionately more nurses will be in their 50's and beginning to consider retirement.

2.5.3. **JOB SATISFACTION**

The commonest reasons for nurses leaving their jobs have been reported as being excessive workload and inflexible roistering practices. But it is noteworthy that, in one study, 88% of nurses who left a health care organisation were reported as saying that an appropriate managerial intervention early in their leave-taking decision process would have halted their decision to leave..

It is also important to note that job satisfaction amongst nurses is not necessarily the same amongst them all. For example, there is evidence of differences between nurses working on different types of hospital wards.

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[18] Direct entry midwifery programmes commenced in England in 1990, in Wales in 1991 and in Scotland in 1992 and these courses have been running alongside the shortened 18 month courses for registered nurses. In order to qualify as a Midwife in Northern Ireland, students must first complete a pre-registration qualification and then complete an 18-month dual pathway diploma/degree exit course

In one study of nurses' job satisfaction and feelings of stress found that those in the cardiac care unit had the most positive satisfaction scores. Nurses in general surgical wards had the least positive scores on the health and stress variables and that feelings of dissatisfaction and stress were prominent in the short-stay department[19].

In addition, amongst psychiatric nurses, a perceived risk of assault (patient aggression towards nursing staff has been found to be common has been associated with both increased levels of somatic complaints amongst staff and a desire to leave that employment.

A consistent relationship has been shown for ward-based nurses between work stress, burnout intention to leave work and lack of management support, "job over spill", having to make decisions under time pressure and lack of recognition by the organisation.

The opportunity for professional development has also been identified as a key variable consistently identifying those who are more satisfied with their jobs.

In one study, opportunity for improved training was the need most frequently nominated by nurses. 63% of nurses in this study indicated that a lack of opportunity for formal study was a problem for them.

In the recent RCN Survey out of 3137 respondents, 96% said that more financial support for learning is required. Learning was seen as helping personal development, with 55% agreeing with the statement that they have a working environment that provides career progression and personal fulfilment and 69% agreeing with the statement that their employer supports their education. Conversely 90% said that heavy workloads prevent release for courses, 86% said that funding was a barrier to education and 84% said that time and resources are not available for study.

Job satisfaction has been found by some to be the most significant factor associated with nurse retention[20], and utilising people's abilities, enabling achievement, enabling autonomy, providing security, and pay levels and personal development also promote job satisfaction and enhance job retention.[21]

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[19] Landerweed J A. Boumans NPG "Work satisfaction, Health and Stress: A study of Dutch Nurses" Work and Stress 1988;2:17-26

[20] Coward RT. Horne C. Duncan RP. Dwyer JW., Job Satisfaction Among Hospital Nurses: Facility Size and Location Comparisons, J Rural Health. 1992; 8: 255-67) and Dembicki R. Varas R. Hammond J. Burn, Nurse Retention. Elements of Success, J Burn Care & Rehabilitation. 1989; 10: 177-80).

[21] Hutchinson BG. All AC. Loving GL. Nishikawa HA., Values Identified in Different Groups of Air Force Nurses. Military Medicine. 2001; 2: 139-45 and

Other significant factors in enabling greater nurse retention include work schedule flexibility, nurse/patient ratios, the organisations reputation and the perception that it cares about its staff and empowers them, and there being opportunities for achievement, responsibility, personal advancement and personal growth.

2.5.4. CAREER PROGRESSION

There is also a general perception of inadequate remuneration linked to poor career progression that needs to be considered.

The widely publicised Agenda for Change strategy promises to provide fairer and more responsive pay and career structures for NHS staff.

It was found in a recent study in Northern Ireland that 34% of respondents were employed at less than a G grade and 58% had been employed in their present grade from between 6 to 23 years. Other recent research regarding the community nursing, midwifery and health visiting workforce found that of the sample group 72% had remained at their present nursing grade for up to 11 years and 7% had served at their grade for 18-23 years or more. Offering employment structures other than traditional full-time positions can increase morale, job satisfaction and productivity[22].

2.5.5. WORK-LIFE BALANCE

Performance pressure and work-family conflicts have been reported as being particularly stressful aspects of nursing and " job strain" has been associated with higher levels of sick leave amongst nurses. A recent survey involving 276 nurses in a large Northern Ireland hospital showed that nurses in general displayed high scores on stress in relation to confidence and competency in role, home-work conflict and organisational involvement.

It is also important to note that there are examples of good practice in recruitment and retention for this workforce. With the implementation of NHS Direct services in England, this has offered nurses the opportunity to stay within the health service and improve the health of the nation but also offer a different type of role and facilitate flexible working hours. Research undertaken by KPMG in England when undertaking a review of NHS Direct for the Department of Health found that there was great enthusiasm amongst

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Allgood C. O'Rourke K. VanDerslice J. Hardy MA., Job Satisfaction Among Nursing Staff in a Military Health Care Facility, Military Medicine. Vol 165(10) (pp 757-761), 2000

[22] Source of report?

nurses to work in this new organisation, and that sites reported no difficulty in staffing to the levels required[23].

The past decade has seen a major expansion in the private nursing home sector across NI, particularly so in the last 5 years when there was a reduction of almost 700 care of the elderly beds in the public sector. The vast majority of patients accommodated in nursing homes are over 75 years of ages and as in the public sector the increasing age and dependency of patients has led to increased care needs.

[23] KPMG "Evaluating and Developing NHS Direct" Report London 1999

2.6. DEMAND ISSUES

A number of demand issues that impact on the workforce are considered.

2.6.1. SHIFTING BALANCE OF CARE – PRIMARY CARE

Many of the policy documents outlined earlier place a greater importance within the healthcare system of shifting the focus for the balance of care from secondary care to primary care.

This is further supported by new arrangements to be put in place with regard to commissioning where it is proposed that primary care organisations be given the responsibility for the commissioning of community services and non-regional hospital services.

All of this will impact directly on both the number of nurses, midwives and health visitors required and the type of work that they will be performing and also opportunities for employment.

Increasingly medical practitioners are using nurses to provide a range of health care services, both face to face and over the phone. There are several positive models of nurses and GP's working together, with, for example, asthma, diabetes, hypertension and minor illness clinics being run by nurses alone working to protocols devised and agreed jointly with GP's. In A&E settings nurse triage has been shown to be accurate and to reduce waiting times.

As highlighted earlier, there are a number of changes in the acute sector which have resulted in a shift of work to primary and community care e.g. increase in patients requiring suture removal, dressing of wounds, phlebotomy, prevention and screening work.

Box 2E identifies particular factors as having a major impact.

Box 2 E

*Shorter length of patient stay
*Increased throughput
*Increased day surgery
*Developments in technology and treatments
*Increasing sub-specialisation
*Specialised services provide on fewer sites
*More local provision of non-specialised services
*Waiting list initiatives

The Community Care Review considered the relationship between care in the community and hospital admissions and discharges. The Review found that increasing numbers of people were having their discharge form hospital delayed pending the provision of a care package and that waiting lists for day care, respite care and occupational therapy assessments were all increasing.

2.6.2. SPECIFIC DEMAND AREAS IN THE COMMUNITY

The following are some of the specific demand areas that have been noted in the community:

DISTRICT NURSES

In England and Wales around 85% of patients on caseloads reviewed were low dependency whereas in Northern Ireland the average was 66%, with correspondingly many more patients falling into the medium and high dependency classification. There was also a greater proportion of patients on the Northern Ireland caseloads receiving several packages of care.

District Nurses have also expanded their skills to support earlier discharge and to prevent admission and re-admission and the complexity and intensity of nursing care in the home has increased significantly. In some areas "Hospital at Home" and "rapid response" teams have been established. All of this places a greater burden on existing teams.

SCHOOL NURSES

The school nurse role has been changing and expanding to include the delivery of child health screening and immunisation programmes and a much more active health promotion role working closer with teachers and young people in tackling key areas for Northern Ireland, such issues as teenage pregnancy

MENTAL HEALTH NURSES

Mental Health problems are one of the most common forms of ill health in Northern Ireland. Approximately 1 in 6 adults will at any one point in time, suffer from a diagnosed condition such as depression or anxiety. The move is to a comprehensive range of locally based services away from traditional psychiatric hospitals.

Development in mental health care includes a focus on areas such as cognitive behavioural therapeutic approaches, crisis intervention programmes and assertive outreach programmes.

LEARNING DISABILITY NURSES

The demand issues identified as facing learning disability nurses are a more disperse service, higher complex needs in hospital and community, evolving specialisms e.g. behaviour nurse, increased input into special schools and the fact that in-patient hospital beds have reduced by 137 over the past five years.

TREATMENT ROOM NURSES

Treatment room nurses are picking up increased referrals in respect of A&E, earlier discharge and ambulatory care post surgery. They have also expanded their role in minor surgery, and, in some areas, nurse led minor injury units have developed.

COMMUNITY CHILDREN'S NURSES

The care of children with complex needs is increasingly taking place in the community with the community children's nurse as the key professional.

HEALTH VISITORS

The area of public health is the biggest potential growth area for health visitors. Health Visitors are leading programmes to develop parenting skills and are also involved in the areas of domestic violence, children at risk and children with special needs.

In addition, the care management process and other changes emanating from the Children's Order have produced increased administrative workloads for all community nurses, midwives and health visitors with no corresponding increase in clerical support.

MIDWIVES AND HEALTH VISITORS

Important determinants of quality and women's satisfaction with pregnancy and childbirth are the ethos of care emphasising friendliness and support, the consistency of care, good communication, and participation in decisions[24]. The midwife is ideally placed to deliver this care.

Health visitors are in a strategic position to help women with postnatal depression, and it is important that they are able to identify its presence. For example, counselling by health visitors has been shown to be valuable in managing non-psychotic postnatal depression[25].

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[24] Morgan M. Fenwick N. McKenzie C. Wolfe CDA., Quality of Midwifery Led Care: Assessing the Effects of Different Models of Continuity for Women's Satisfaction, Quality in Health Care. 1998; 7: 7-82).

[25] Sheppard M., Depression in the Work of British Health Visitors: Clinical facet, Social Science & Medicine. 1996; 43: 1637-48 and Holden JM. Sagovsky R. Cox JL., Counselling in a General Practice Setting: Controlled Study of Health Visitor Intervention in Treatment of Postnatal Depression, Br Med J. 1989; 298: 223-6.

2.6.3. JUNIOR DOCTORS HOURS AND INCREASING SPECIALISM

Other areas that have been identified as having an impact on the nursing workforce include the focus on reviewing the working hours and practices of junior doctor.

As well as impacting on the workload of the workforce this will also mean an increased focus on identifying opportunities to broaden the role of nurses along with a shift to focus on clinical specialism.

There is also evidence that the workforce is pursuing more specialist route in its own right in areas such as tissue viability, pain management, infection control and so on. There has been an increase in the development of new nursing roles in the last few years[26].

This increased specialisation and the introduction of new procedures and techniques are frequently associated with the requirement for additional qualified and more highly skilled nurses.

All of this puts a focus on nurses re-adjusting their skill set, expanding competencies in certain areas and moving around the HPSS more freely.

Recently the UK Health Secretary identified 10 things that some nurses were already doing and which all those with the appropriate skills should be able to do. They are listed in Box 2F.

BOX 2F

1. Order diagnostic investigations
2. Make and receive referrals
3. Admit and discharge patients within agreed protocols
4. Manage their own caseloads
5. Run their own clinics
6. Prescribe agreed medicines and treatments
7. Carry out a wide range of resuscitation procedures
8. Perform minor surgery and outpatient procedures
9. Use computerised decision support to triage patients to the most appropriate health professional
10. Take a lead in the way that local health services are organised and run.

[26] Evidence from Valuing Diversity Questionnaire - DHSSPS

2.6.4. NURSING CAREERS

Nursing careers and career structures have been, and are continuing to change.

The Department of Health in England has launched a strategy for nursing, "Making a Difference"[27], which proposes a four level career structure: healthcare assistant, registered practitioner, senior registered practitioner and consultant practitioner.

It proposes that progression would be determined by an assessment of responsibilities and competencies. Many nurses may have to seek further training if they are to maintain competency in this changing environment. Increased specialisation, the introduction of new procedures and techniques are frequently associated with the requirement for additional qualified and more highly skilled nurses.

2.6.5. INCREASING DEMAND

Further compounding the above demand scenario is that fact that it is generally accepted that the workload is increasing year on year.

In Northern Ireland the number of older people is increasing. A&E Departments are now treating 100,000 more patients in a year and the number of inpatients treated has increased by 40,000 between 1990- 2000 and the number of day cases has almost trebled.

Northern Ireland has the longest hospital waiting lists in the UK and also continues to rank amongst the worst in Europe in terms of life expectancy, with many of these deaths considered premature (under age 65) and potentially preventable.

It is becoming more and more accepted that if the targets outlined by the Programme for Government are to be met that the current status cannot be maintained.

2.6.6. INCREASED THROUGHPUT AND PATIENT DEPENDENCY

Also with regard to demand there is also the need to look to consolidation programmes and development of services. Across the province the pattern of provision of hospital care has and continues to change.

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[27] UK Health Secretary
Department of Health, England, Making a Difference, 2000

The net effect so far has been a reduction of over 500 acute beds in the past five years and this has increased pressure on bed availability. Higher throughputs and bed occupancy has resulted in greater in-patient dependency and more time spent on admissions and discharge and it is often the nursing staff who are at the forefront of dealing with these changes.

This high turnover of patients requires organised and co-ordinated arrangements of the discharge and transfer of patients. The amount of time spent by qualified nurses in these activities has reduced the time available for direct patient care.

In addition, reviews such as the Intensive Care Review, conducted in February 2000, resulted in a greater pressure on the services and needs to be resourced. This found that the current provision of intensive care (ICU) and high dependency (HDU) beds was below the recommended minimum.

3 FINDINGS

3.1 INTRODUCTION

3.2 WORKFORCE DEMOGRAPHIC PROFILE

Total workforce and Headcount to Whole Time Equivalent Ratio
Gender Balance
Age Profile
Grade Breakdown
Working Practices
Current Vacancy Levels
Current Recruitment Pool to Student Places
Non HPSS Nursing Staff and Overseas Nurses
Pre-registration training places available
Number of returnees

3. FINDINGS

3.1. INTRODUCTION

This section reports the findings from the desk research and data analysis. These have feed into the subsequent conclusions and recommendations, which can be found in section 7.

3.2. WORKFORCE DEMOGRAPHIC PROFILE

Available information was gathered to provide the current demographic profile of the nursing, midwifery and health visiting workforce of Northern Ireland.

Some key sources utilised at this stage are highlighted in Box 3A below:

BOX 3A KEY INFORMATION SOURCES

HRMS - current HR system in use by the Trusts across Northern Ireland
DHSSPS Vacancies Questionnaire, March 2001
DHSSPS Position Paper, 2001 NMAG & HRD
RCN Membership Survey 2001 "Time to Deliver "
DHSSPS Review of Community Health - Strategic Paper
UKCC Register statistical Information
RCM Register and associated statistics
DHSSPS Report of the Chief Medical Officer, 2000 "The Health of the Public in Northern Ireland"
In addition:
Several Workforce Reviews carried out at a Trust and Board Level identifying initiatives that are currently underway

Due to the complexity and size of the workforce we were unable to categorise the workforce into specific discipline areas but wherever possible information relevant to one particular group has been highlighted.

3.2.1. TOTAL WORKFORCE AND HEADCOUNT TO WHOLE TIME EQUIVALENT RATIO

The importance of utilising the nursing, midwifery and health visiting workforce efficiently and effectively is clearly paramount. As, of December 2001, it represented 26% of the total staff employed in the HPSS in Northern Ireland and some 50% of the total direct care workforce in the hospital and community sector..

Figures provided by the DHSSPS Project Support Analysis Branch (September 2001) indicate a total Headcount figure of **14947** qualified nurses, midwives and health visitors. Of these, **1519** (10%) are identified as being employed on bank contracts (ie staff recorded as wte of 0.03 or less by Trusts.

The UKCC Register of Nurses, Midwives and Health Visitors records **18 050** registrants with a NI address at March 2001. This suggests that there are just over **3000** nurses, midwives and health visitors working outside of the HPSS, for example in the independent and voluntary sectors within NI.

A detailed analysis of the input of bank staff has not been possible within the context of this review. They have therefore been excluded from some of the workforce data presented below.

Table 3A shows the numbers and % breakdown by the four established disciplines at pre-registration training level within nursing and midwifery. It is considered appropriate to look at the analysis by discipline from Trust information (which includes bank staff), as the centrally recorded data does not have as detailed a discipline breakdown available. It is noted that the overall total (at March 2001) is higher than that recorded by the DHSSPS systems (September 2001)

Table 3A: Total Headcount by Pre – Registration Discipline and midwifery (includes bank)

Discipline	Number	% of workforce
Adult	11047	71%
Mental Health	1892	12 %
Learning Disability	614	4 %
Children	727	5 %
Midwifery	1284	8 %

Source: DHSSPS Trust Questionnaire – March 2001

The ratio of headcount to wte staffing numbers ratio is presented in Table 3B below. For the purposes of the ratios, DHSSPS figures have been utilised which are exclusive of bank staff.

Table 3B : Headcount / WTE Ratios (Excluding bank)

Discipline	Headcount	WTE	Ratio
Adult	9515	7963	1 : 1.19
Mental Health	1763	1678	1 : 1.05
Learning Disability	240	224	1 : 1.07
Children	549	431	1 : 1.26
Midwifery	1361	1082	1 : 1.26
Total	13428	11378	1 : 1.18

(Source DHSSPS, September 2001)

The figures show a higher ratio of headcount to wte particularly within midwifery and children nursing, indicating a higher impact of part-time working. This issue must be taken into account when projecting future workforce requirements.

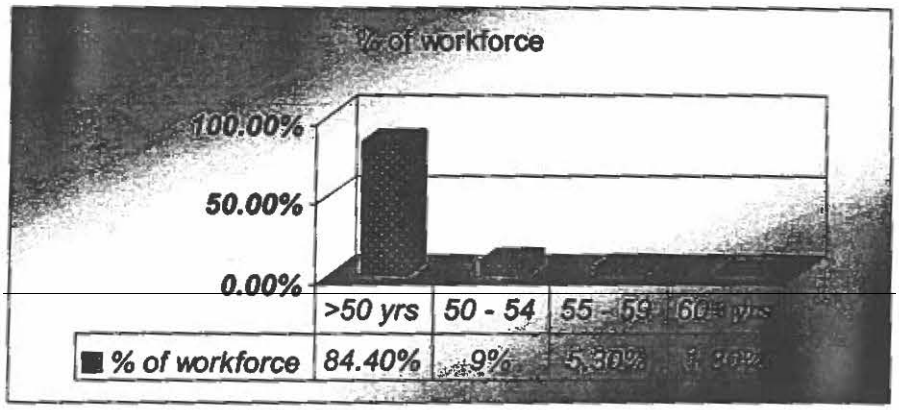
3.2.2. GENDER BALANCE

The data indicated that the workforce is largely female dominated with only 6% being of the male gender. Within midwifery the percentage of females to males is even higher with less than 1% being of the male gender.

3.2.3. AGE PROFILE

The age profile of the overall nursing workforce is shown in Table 3C and demonstrates that 15% of the workforce will be at the eligible retirement (55 years) within the next five years. At present, nurses who are employed prior to 1995 can retire at 55 years, although a recent rule change allows staff now to work beyond 65 years. A further age profile analysis by discipline is shown in Table 3D below.

TABLE 3C: Age Profile of Overall Nursing Workforce



Source: DHSSPS, September 2001

Table 3D: Age Profile By Discipline

Category	<50 years	50 - 55 years	55 - 60 years	60 + years	Total
Adult	8015 (84%)	837 (9%)	532 (6%)	131 (1%)	9515
Mental Health	1466 (83%)	183 (10%)	90 (5%)	24 (2%)	1763
Children	497 (90%)	32 (6%)	17 (3%)	3 (1%)	549
Learning Disability	191 (79%)	29 (12%)	14 (6%)	6 (3%)	240
Midwifery	1136 (83%)	135 (10%)	78 (6%)	12 (1%)	1361
TOTAL	11305	1216	731	176	13428

3.2.4. GRADE BREAKDOWN

In Northern Ireland, 32% of nurses are employed at a D grade compared to 24.2% of the workforce in England. This represents a significant difference in terms of career progression opportunities for NI nurses.

3.2.5. WORKING PRACTICES

A recent survey by the Royal College of Nursing reviewed the use of part-time and full-time contacts by female and male nursing staff. As expected the results indicated a much higher use of part-time contacts amongst female staff (42%), compared to male staff (7%).

In addition the survey showed that part-time contracts were highly utilised in the 31 to 40 age group category (54%); 41 to 50 age group category (55%) and the 51 to 60 age group category (58%). The results indicated that overall, up to 59% of nurses are working less than 35 hours per week.

3.2.6. CURRENT VACANCY LEVELS

A spot survey carried out by the DHSSPS in March 2001, indicated the following level of vacancies within the HPSS nursing workforce – see Table 3E below. The number of vacancies across the four pre-registration disciplines within nursing is also represented as a percentage of the total workforce (using the Trust workforce numbers). The information indicates that Mental Health is a particular area for concern, recording the highest % of vacancies.

The vacancy level recorded in March 2001 represents 4% of the total workforce.

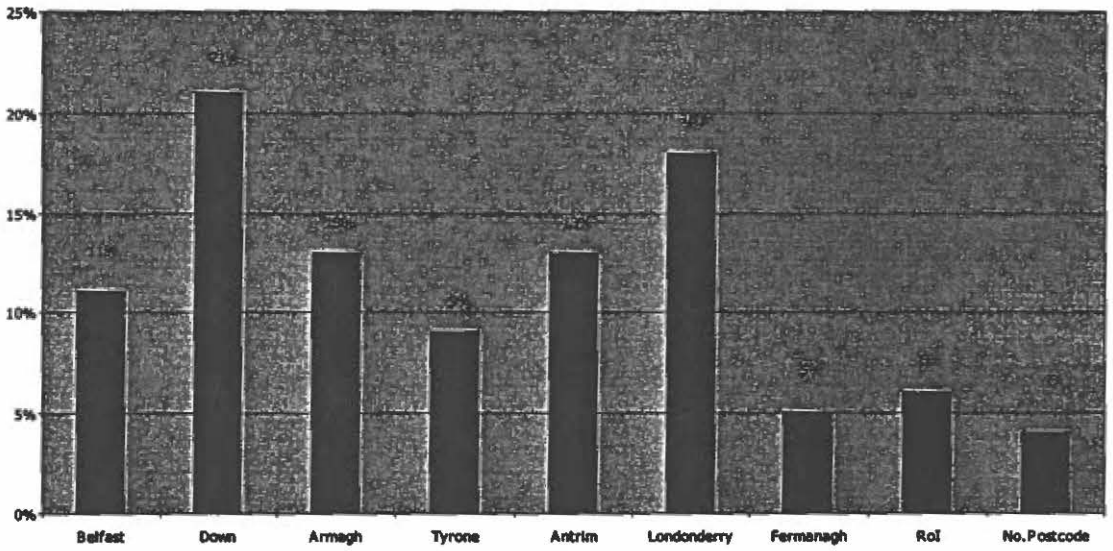
TABLE 3E March 2001 Source DHSSPS Trust Survey March 2001

CATEGORY	NUMBER	% OF WORKFORCE
ADULT	380	4%
MENTAL HEALTH	63	3.6%
LEARNING DISABILITY	16	6.7%
CHILDREN	15	2.7%
MIDWIFERY	34	2.5%
TOTAL	508	3.8%

3.2.7. CURRENT RECRUITMENT POOL TO STUDENT PLACES

Figures provided by the Universities indicate the area of residence of students entering pre-registration courses. Table 3F illustrates that a significant number of those recruited to nursing student places are from outside of the Greater Belfast Area. The implication from this is that it could possibly lead to increased retention problems at City Centre hospital locations further down the line.

Table 3F: Current Recruitment Activity with Northern Ireland by geographical region (Source: QUB recruitment statistics for September cohorts 2000 and 2001)



There are currently no problems recruiting to the student places available with an application ration of 2.9 applications to every place available in the Queens for the September 2001 intake. With respect to midwifery Queens receive 2.5 applications for every place.

This has led to applicants requiring a much higher academic standard to meet the entry criteria set by the Universities, i.e. 3 A Levels passes, as opposed to the minimum entry requirement set down by the UKCC of 5 GCSE passes.

3.2.8. NON HPSS NURSING STAFF AND OVERSEAS NURSES

As we can see from the terms of reference outlined earlier in this report, the review was to focus predominantly on the HPSS sector in terms of establishing current and anticipated future workforce numbers and skill mix.

Therefore we have not gone into detail with regards to demands in the independent and voluntary sectors. Nevertheless it is important to recognise the importance of these sectors in the provision of health and social care services. Particular issues to note are as follows:

1 Anecdotal evidence gathered through the review indicates that there are currently approximately 400 Whole Time Equivalent vacancies within the voluntary and independent sector.
2 It has been estimated that there are currently at least the equivalent of 109 Whole Time Equivalents agency nurses used regularly across the province.
3 In addition, there are approximately 400 nurses currently employed directly within GP practices across the province in roles such as practice nurses etc.
4 Since 1st April 2000 there has also been 172 permits issued for overseas nurses working with the statutory HPSS sector and 393 permits for overseas nurses working within the private nursing home sector. (this includes approximately 50 changes of employment or extensions to existing permits).

3.2.9. PRE-REGISTRATION TRAINING PLACES AVAILABLE

When considering supply issues from a workforce perspective the number of nurses being educated at student level is of obvious key importance. Table 3G provides details of the number of places within each of the 4 nursing disciplines of adult, mental health, learning disability and children. There is currently no provision for direct entry midwifery programmes in Northern Ireland unlike Scotland, England and Wales. There has however been a recent welcomed increase in the number of student places commissioned by the DHSSPS of 100. In addition to the above places at Queens University, 40 students per annum pursue a 4-year degree course at the University of Ulster.

Table 3G Number of student places within each discipline – September 2001

Discipline	Number of student places
Adult	520
Mental Health	60
Children	40
Learning Disability	30
TOTAL	650

Table 3H also shows the destination survey information received from Queens University, Belfast over the course of the last two years. These destination figures and student attrition rates (also made available from the University) have been used to calculate the anticipated supply of graduates into the nursing workforce over the next 5 years.

Table 3H Destination Survey Results (Source: QUB)

Student First Employment Destination	June 2000 Graduates	June 2001 Graduates
HPSS employment	94%	88%
Other	6%	12%

The information provided above can be used a guide, however it must be noted that the return rate of the first destination survey results is relatively low. Queens are planning to improve their methodology for collecting this data in the next year.

3.2.10. Numbers of Returnees

There has been some success over the past two to three years with regard to numbers of people returning to the nursing, midwifery and health visiting workforce. Recent data supplied by the DHSSPS outlines that 269 individual have completed return to practice courses since 1998. A further 81 people are currently in training and it is known there are 54 on waiting lists. Employment destination survey results indicate that around 80% of participants on the return to practice courses take up nursing posts.

4 KEY FINDINGS IN INTERVIEWS AND FOCUS GROUPS

4.1INTRODUCTION TO SECTION 4

4.2 SUPPLY ISSUES
Recruitment and Retention
Career Progression
Job Satisfaction
Current Remuneration
Working Terms and Conditions
Provision of Extended Services
Maternity Leave and Sick Leave
Continuing professional Development
Leadership

4.3 DEMAND ISSUES
Increased Sub-specialisation
Role Extension
Skill Mix
Continuous Professional Development
Clinical Training /Mentorship
Responsibilities
Increasing Patient Expectations
Increased Focus on Primary Care/Health Promotion
Societal Factors
Capital Development
Increased Duty Cover

4. KEY FINDINGS IN INTERVIEWS AND FOCUS GROUPS

4.1. INTRODUCTION TO SECTION 4

This section collates the various views expressed to us throughout the 48 key informant interviews and 15 focus groups (see Appendix 2&3). Different people raised many of the same issues and several issues overlapped in their origin and/or in their implications[28].

Due to the complexity and scale of the nursing and midwifery workforce we have summarised all groups in general under key generic headings that can be seen to be affecting the supply of this workforce in Northern Ireland and then, where appropriate, drawn out particular factors relevant to the identified disciplines in Box 4A.

BOX 4A Disciplines
- Adult
- Children
- Mental Health
- Learning Disability
- Midwifery
- Community
- Independent Sector

We discuss the implications and conclusions of these various issues and draw out possible recommendations in sections 6 and 7.

4.2. SUPPLY ISSUES

Respondents in relation to supply issues raised a number of issues. We have grouped these under relevant headings below.

4.2.1. RECRUITMENT AND RETENTION

All respondents in the focus groups and key informant interviews stated that they had been experiencing increasing difficulties with regard to the recruitment of staff. This was reported as having been particularly noticeable over the past two years, with some Trusts reporting **"having to advertise up to three times to fill a post".**

Particular areas of concern were stated to be in general medical, surgical and adult wards, mental health, learning disability and the independent sector. Community roles were reported as not having such extreme problems to date, but that the situation was worsening.

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[28] Everyone we spoke to put considerable time aside to talk with us and many subsequently provided us with more information which had been completed at an individual Board, Trust or project level. We are grateful for the willingness of people to participate in this review and the openness that they all showed.

A number of interviewees and focus group attendees stated that they had a number of unfilled vacancies at present and that the majority of these were at Grade D level, although there was evidence that this factor was starting to increase at higher grades also.

They felt that this was largely attributable to the fact that it is an extremely tight market; the establishments are severely under-funded at present across Northern Ireland, leading to an unacceptable workload and an inability to fill temporary vacancies.

A number of acute sector focus group attendees stated that **"management now tolerate vacancies.... we have a policy of now no longer attempting to fill temporary vacancies".**

All felt that this problem was exacerbated by the fact that they had a predominantly female workforce with a high percentage taking ordinary and additional maternity leave and requesting to return to work on a part-time basis, thereby reducing workforce capacity. Many interviewees attributed the current situation to a shortage of pre-registration students entering the system throughout the 90's.

A number of respondents noted that for some Trusts recruitment difficulties could be attributed to geographical location and the age of the workforce. It was stated that it is harder to recruit for vacancies to certain rural Trusts as they are reliant on students/nurses wanting to move back close to home but on the other hand the larger city centre Trusts have a higher level of turnover due to the same reason and a younger workforce.

Almost all respondents stated that they have tried to attract returnees over the course of the past two years, and whilst there have been some successes reported at a province wide level, the general feeling was that any future initiatives **would have limited impact.**

Only a small number of respondents have attempted to recruit internationally and they tended to be the larger acute sector establishments. Mixed views and feelings were reported with regard to this practice. Some felt it was an option that needed to be considered given the current workforce situation whilst others stated it was a **short-term fix** with **high expense attached.** Most respondents' felt that these nurses needed at least six months to get up to the same level as a student nurses graduating in Northern Ireland.

The majority of respondents stated that in Northern Ireland they did not have any huge traditional retention problems but that they were starting to notice an increase in movement between Trusts and also into the private sector, especially in the areas of mental health and children's. A number stated that this movement was being exaggerated by some Trusts increasing the salaries attached to posts/ or recruiting at a higher grade in order to attract individuals,

creating a competitive environment. It was felt by some interviewees and strongly by focus group participants that the Trusts should be working together and not in a divisive way. As one respondent stated **"we are robbing Peter to pay Paul".**

There was some concern that whilst the workforce could still be seen as relatively stable there was a growing tendency for employees to consider nursing in the UK or further afield, or to move into other related fields (drug companies, consultancy) and unrelated industries (due to the perceived value of their transferable competencies).

Another key area of concern with regard to recruitment and retention, identified by a large number of respondents, was the **move to a more and more specialised workforce**. Whilst the majority felt that this was positive in the sense of development of skills and quality of patient care, they did not feel it was effectively structured or resourced and was drawing away from the core nursing workforce which was not being developed or funded to the same extent.

Respondents in the adult sector felt it was important to stress the **problems of recruiting to general medical and surgical wards** and **in particular working with older patients.** They felt it needed urgent attention if the service provision in these areas was to be maintained and improved in line with targets and standards.

They also reported the resultant poor morale and increasing expectations placed on each employee was beginning to increase turnover at ward sister level. A number of respondents were able to identify recent situations were highly experienced, leaders on the general wards had decided to move to community or specialist roles citing **"stress"** and **"lack of management support...not worth the hassle anymore"** as major reasons.

Respondents in the children' sector noted that there was an increased draw from the independent sector with what was perceived to be better working terms and conditions and working environments e.g. Hospice. They also stated that another problem with recruitment was the funding for projects which is often based on grant aid and therefore not guaranteed on a long term basis for example posts funded from Lotteries Aid.

Respondents in the learning disability sector felt that their ability to recruit was severely hampered by uncertainty over the future strategic direction of this area of nursing and the lack of funding and support being provided. This is compounded by the closure of establishments and the focus on treatment in the community without the adequate infrastructure. They also felt strongly that the number of student places allocated by the Department was too small.

Respondents in the Mental Health sector felt that **"they were reaching crisis point in terms of unfilled vacancies".** As with learning disability the lack of

strategic direction, lack of funding, closure of establishments, focus on care in the community and a lack of attractiveness to new students were all felt to be largely responsible for the current situation.

The main reasons cited as contributing to the current recruitment and retention issues within the midwifery profession in Northern Ireland were the extremely high percentage of part-time workers, the drop in student numbers over the past 5 years and the absence of a direct entry course bringing about a graduation age range that often resulted in employees requesting flexible hours.

It was felt by the independent sector that they had been experiencing recruitment difficulties for a longer period of time (3-5 years) and that it was **"coming to a crisis point"** with interviewees providing examples of the closure of establishments due to an inability to recruit due to a lack of funding. This has led to them recruiting overseas nurses (up to 150 now working within the independent sector in Northern Ireland, mainly from the Philippines) for the past two years on fixed term contracts of two years. They felt they could not compete for staff anymore and had noticed an increasing tendency for employees to move back into the HPSS sector due to **the availability of more specialist posts, an increase in permanent contracts and the increasing workload in their own establishments.**

All respondents felt that the currently under staffed establishment was **severely affecting the quality of patient care delivered and the effective implementation of development initiatives.** A key area of concern highlighted by both focus group attendees and key informant interviewees was that there was now no longer any time to spend with patients carrying out what some called the "caring" role. This was seen to be extremely de-motivating to the workforce with the majority of focus groups stating **"this is key reason for being in the profession"** and **"I get a lot of job satisfaction from helping others and making a difference to a patients quality of life".**

4.2.2. LACK OF CAREER PROGRESSION

All respondents stressed that the lack of career progression they experienced in their roles was a major de-motivating factor as it created a stagnant workforce. A large number of interviewees felt this was a major inhibiting factor in the development of individuals and the profession and that it needed to be addressed for the workforce as a whole.

Interviewees unanimously stressed the point that Northern Ireland has the highest percentage of grade D's in the United Kingdom and a number of focus group attendees stated that they had been at grade D for **"between 10-15 years".** This issue was compounded by the fact that these individuals were being asked to perform tasks associated with an E grade and to cover for E grades as necessary and yet were not paid accordingly. The majority of focus

group attendees listed this as one of their top five de-motivators and stated that **"it's not just about money... it's the lack of clear progression, appreciation and recognition that goes hand in hand."**

This lack of progression appeared to be particularly evident in the acute sector on the general wards due to a perceived higher grading in the community sector and an increase in specialist posts.

A large number of respondents also expressed increasing frustration at the fact that the grading structure in place did not allow/encourage progression past a certain grade unless you went into management. They also found it extremely demoralising that career progression was allocated it was not funded; **"eight consultant nurse posts had been made available two years ago and funding only allocated to appoint two".**

4.2.3. JOB SATISFACTION

All sectors noted a low level of job satisfaction with aspects of their current role, although there were pockets of groups who had positive examples of high levels of satisfaction. The majority of respondents felt that a lot of the issues with regard to poor job satisfaction (See Box 4B) could be alleviated if they were adequately funded and developed.

Box 4B Key aspects noted as having a detrimental effect on job satisfaction were:

- "increasing workload,
- poor infrastructure and funding to support the increased provision of care in the community,
- limited amount of time to spend with the patient
- too much administration/risk management
- lack of Continuing Professional Development
- poor utilisation and acknowledgement of skills by other professionals
- "dumping" ground for tasks that other professions don't want to do anymore."

Some examples where individuals had noted improved job satisfaction were down to initiatives such as:

*computerised self-roistering
*improved management style and communication
*a feeling of appreciation and recognition
*higher levels of empowerment and
*flexibility of management"

In the acute adult sector there was particular concern over the amount of agency staff used and the money they were paid, with a number of focus groups stating **"it's false economy".** In some cases this appears to have resulted in HPSS staff only consenting to work extra shifts if they are organised by and paid for at agency rates.

Midwives were finding the 12-hour shift expectations with no reward especially demoralising accompanied by the **"unrealistic remuneration"** for on call duties (£5.70 per shift). They felt that there was inadequate workforce planning and this was exacerbating an already difficult situation.

Those working within the areas of Learning Disability and Mental Health felt that the uncertain future of their area of work and the increasing responsibility and associated risk associated with their roles were extremely de-motivating. They felt that the role they played in managing the **"care of the family"** and the increase in legislation accompanying this was not recognised.

It is interesting to note that the group of students, who participated in the focus groups, identified **"poor staff morale... less time allowed with the patient with the idea that talking to patients is not working"** and **"authoritarian management style"** as three key de-motivators. It must be noted though that they identified Trusts where they did feel they received a positive training experience through **"effective mentoring... forum for sharing ideas and real development".**

4.2.4. CURRENT REMUNERATION

All participants mentioned this, as something they felt needed to be improved upon. Although a number recognised that there had been advancements over recent years, they still felt that they were too far behind the rest of the United Kingdom and ROI and that this could encourage a leakage of nurses and midwives at border areas and to England or further afield.

Their main concern with respect to pay was that they saw no progression and that the financial incentive to move up a grade or take on a management role was not worth the extra responsibility. They also felt that the fact that they have been taking on additional responsibilities from other professions was **"not recognised in any tangible way".**

Some respondents felt that other incentives could be offered as part of the total remuneration package, which could be as motivating. Examples provided **were "crèches and childcare vouchers... sponsored training"** and **"improved working environment that is proper changing facilities, rest rooms and so on."**

4.2.5. WORKING TERMS AND CONDITIONS

A large number of focus group respondents expressed frustration at the fact that the degree to which flexible working and family friendly policies were made available, and therefore utilised between Trusts was **"very inconsistent".** It was seen to be at the discretion of the line manager in charge. They felt that the flexibility offered regarding hours and the ability to balance home and work life were key factors in how they viewed their role. A large number of key informants expressed growing concern at the increasing numbers requesting or utilising flexible hours or term -time working etc. Whilst they felt it was an extremely positive factor that employees' expectations were high **"it was making it increasingly difficult to form a core of workers to provide continuity of care".** They were very concerned that with the current funded establishment quota and low numbers of nurses available in the marketplace, they would not be able to keep facilitating requests and could **" loose nurses because of this".**

4.2.6. PROVISION OF EXTENDED SERVICES

The majority of respondents, both focus group and interviewees, expressed concern about the growing expectations to deliver more without the proper remuneration or increase in resources. The general feeling was that whilst efficiencies could be found to a degree, and the improved use of skill mix could alleviate some of the pressures, it was **"only putting of the inevitable".** Whilst they felt that the increase in nurse student places was a positive factor they were concerned that the **"money would not be made available to employ extra students"** and that the problem would compound itself over the coming years.

4.2.7. MATERNITY LEAVE AND SICK LEAVE

With a predominantly female workforce time off to have children is common. It was clearly evident that it was almost standard practice in all areas for individuals to take longer than the standard period of paid maternity leave and also to sometimes supplement this with 4-8 weeks sick leave at the end. It was stated that this is not accounted for when planning for workforce requirements. Some midwifery focus group participants provided examples where **"up to 30% of the funded establishment"** was off on maternity leave at the same time and they could not fill these vacancies due to their temporary nature and the shortage of numbers within the general workforce pool.

4.2.8. CONTINUING PROFESSIONAL DEVELOPMENT

The majority of respondents indicated that they felt that there was not enough time or priority allocated to this area, in particular in comparison to other professions within the healthcare setting. They used the example of the PAMS group and junior doctors to illustrate this point. They felt that the

recommendation by the profession of five days every three years was outdated.

They felt that with the general extension of their roles and the increasing amounts of responsibility, CPD should be seen as even more of a priority. A number stated that whilst they felt the role extensions were a positive thing they did not **"feel confident about carrying out some of the tasks"** due to **"a lack of time spent on training"**

A large number stated that this lack of focus was not because of a lack of desire on their or their managers' part, but an extension of the problems associated with an **"under-funded establishment and a shortage of resource to facilitate it".** A number provided examples where nurses relied on donations from external organisations or internal fund raising events to be able to source and fund attendance at training events.

A number of respondents indicated their concern that over the years it has become more and more commonplace for the training budget within Trusts to be used to fund a more academic style of training and that this inevitably meant **"less and less getting access".** Whilst they recognise the value of this on occasion they felt that there needed to be a greater amount of the money spent educating a larger proportion of the workforce rather than "niche" areas. A number of focus group attendees and students reinforced this view when they stated they felt the profession was becoming much more academically focused and that if you wanted to progress you had to **"gather up qualifications and specialise"** as **"there was no money or opportunity in mainstream nursing anymore".**

4.2.9. LEADERSHIP

The majority of focus group respondents indicated that they felt that there was **"a lack of leadership throughout the profession".** When asked to specify exactly how this manifested itself they mentioned **"a lack of communication and empowerment."**

They felt that the managers within the profession let things **"happen"** to nursing **"rather than proactively managing the situation".** Students within the focus groups who felt that this was a common area of concern throughout their clinical placements reinforced this.

An example of how much impact this can provide was indicated in a positive way when some of the community groups discussed how new management had brought about new techniques and styles to their area over the course of the past year and had **"transformed their working lives for the better".**

A number of key informant interviewees reinforced this view by indicating that they felt it was not easy to identify "managers" within the new roles of nursing and that there was a need to support managers at all levels to ensure that resources are being used effectively and efficiently.

4.3. FUTURE DEMAND

The majority of respondents expressed general concern about meeting the expanded service requirements of the role with little increase, or even a possible decrease, in resources.

The key factors affecting demand in the near future and beyond were identified as falling into the key areas outlined below. Again we have discussed the situation at a general level and drawn out any additional areas relevant to the specific sectors of the overall nursing, midwifery and health visiting workforce.

4.3.1. INCREASED SUB SPECIALISATION

It was generally felt that there would be an increased demand for specialist nurses within the health sector and that these would continue to expand in line with the medical profession.

It is important to note though that there were some respondents who felt that this move towards specialisms must be improved with a greater clarity around **"what constitutes a speciality"** and **"what is mainstream"** and a better integration and dissemination within staff teams. They felt this area could be more effectively and efficiently managed within both the acute and primary care sector **"with an appropriate focus on the dissemination of specialist skills in team environments"** and the more effective matching of resources at a strategic level to the population being served.

An example provided within the community of the above was the 24 hour rapid response units which are proving effective in meeting a gap in service needs between 5pm and 9am and enabling patients to be treated in the community.

This discussion around the specialism of the profession also brought out the concern of many about where the profession was going in the future. They felt that there needed to be **"a re-evaluation of the core tasks and roles that different areas now undertook with appropriate person job descriptions and person specifications drawn up".**

They also emphasised that **"all roles should reward key competencies that were considered an integral aspect of the roles of the profession across the range of services provided".**

Box 4C illustrates the main examples provided of the key areas where specialist skills would be in demand over the course of the next five years, in both the acute and community sectors for nursing and midwifery.
As indicated earlier a number of these initiatives are underway already. Further detailed evaluations would need to be carried out in each respective area before any real estimation of actual demand at a province wide level could be calculated.

BOX 4C
EXAMPLE SPECIALIST SKILLS AREAS
A&E
Surgery
Orthopaedics
Respiratory
Cancer
Diabetes
Palliative Care
Drugs and Alcohol
Tissue Viability Management
Renal
Intensive Care/High Dependency
Neuro-surgery
Neonatal
Rapid response teams - 24hour coverage
Mental Health - child and adolescent
Teenage pregnancy and sexual health
Management of Terminal Illness
Home ventilation - adults and children
Midwifery - health education and counselling

4.3.2. ROLE EXTENSION

Alongside the above increase in specialisms respondents reported a dual increase in role extension, some of which they agreed could be put down to natural role evolution but other key areas, which they felt, were taken on board on top of normal day to day duties.

The majority of individuals indicated that they felt this role extension was a positive move for the profession but that it needed to be more effectively managed and that the acid test of whom a task should be carried out by needs to be considered from **"the viewpoint of what is best for the patient"**.

The feeling at the moment seemed to be that this process did not happen consistently and the reduction in junior doctors' hours was highlighted consistently as an area that has had a great impact on all nurses.

There was also a degree of concern from interviewees that some of the role extensions had not been properly thought through in terms of the time taken up in obtaining the required level of skill to carry out the task effectively. The most frequent example of this was nurse prescribing where the proposed "academic" training element is to be a three-month university based course. Box 4D illustrates the main areas that were identified as having an impact and subsequent increased workload in this area.

BOX 4D INCREASED WORKLOAD

Acute
Advanced skills - central lines
Increased interventional treatment - Bloods
Nurse Prescribing
Diagnosis/Triage

Community
Care manager role
Nurse Prescribing
Diagnosis/Triage

Midwifery
Suturing
Increased interventional assistance - epidural management / C-section assistance
Central Lines
Bloods

In general all respondents reported an increase of between **"10-30%"** of their time spent on administrative/bureaucratic tasks and that this was going up all the time, especially in the community setting.

They felt that whilst they could see the necessity of some of this, a lot of it **"could be re-allocated to other clerical roles"** and their time freed up to **"spend more time with the patient which was why they had come into nursing in the first place"**.

They also indicated that **"advancements in the area of technology"** could help alleviate some of this and improve the overall service provision. Again this was highlighted strongly in the community with a greater focus on care management roles and the need to operate within a multi-disciplinary setting bringing about extra administrative work.

4.3.3. SKILL MIX

There were many opinions with regard to what constituted an appropriate skill mix and what benefits/ issues this could bring. It was felt by many that the ability to plan effectively for the workforce requirements in terms of numbers in the future would centre around clarity of the role of a " nurse".

The majority of respondents were positive about the extended role for nurse auxiliaries/assistants within the acute and community sectors but agreed that this would necessitate **"a planned extension and structuring of the role with the appropriate training and resource provided".**

It was felt by many that with a more structured career path, appropriate remuneration, training and regulation there was scope to extend this role to more effectively and efficiently utilise the skills of nurses.

It was indicated that there could be greater usage of these roles in the community sector. An example provided which is already underway was the use of nursing auxiliaries in community trusts to carry out nursing tasks where appropriate, that is taking blood pressures and blood samples. Whilst they operate under close supervision they are considered to have become highly competent in their allotted tasks, therefore freeing up nursing time and enabling **"a more efficient use of [workforce] resources".**

Other respondents also highlighted the fact that this in itself would create a greater amount of time spent supervising, which the system was not resourced for. Some suggested that " Best Practice" guidelines be set up for the different areas of the profession with regard to what the percentage skill mix should be and the practices involved.

4.3.4. CONTINUING PROFESSIONAL DEVELOPMENT

As highlighted earlier in this report, CPD and a commitment to facilitating staff training was viewed as a key factor in recruiting and retaining staff. This is set against a background of increased demand for nursing and midwifery skills and role extension/development.

The majority of respondents felt that the current requirement of 5 days every 3 years for nurses was clearly inadequate. It was felt that the provision of an adequate amount of CPD to every employee was a pivotal factor in the development of the service.

The groups provided examples of other healthcare professionals who have protected time to carry out CPD and that perhaps this should be input to the current workforce modelling tools. Current Midwifery CPD requirements were met.

In addition to the minimum time indicated above the respondents also highlighted the importance of acknowledging the increased time required for training and development (both from an academic sense and on the job training) for some specialist areas. An example used frequently was that of nurse prescribing where it was indicated that a minimum of a three month university based course (undertaken on a full-time basis) would be undertaken

and it is the intention that circa 500 nurses would be "qualified" in this area by mid 2002.

4.3.5. CLINICAL TRAINING/ MENTORSHIP RESPONSIBILITIES

This was a huge area of concern for all respondents within the interviews and focus groups.

They felt that no time or reward was allocated to facilitate carrying out these duties and that it was just expected to happen as part of their role. Again they were able to quote others, for example within the PAMS profession, where financial reward and time was set aside to effectively carry out these duties.

They felt that **"an allocated amount of time should be set aside in each mentors roistered hours every week so that they are not expected to carry out normal duties during this time".**

Some suggested that per week a student would need a minimum of 1 hour. This was reinforced by students involved in the focus groups who stated that it was obvious that **"mentors did not know what they were doing"** and that they did not feel they were learning effectively or to their expectations.

Another facet of this discussion was the concern over the increased numbers of students going through the system over the next 5 years. Whilst they supported wholeheartedly the decision of an increase in student numbers, they were concerned about **"the strain the clinical placement responsibilities would place on the currently overburdened establishment".**

4.3.6. INCREASING PATIENT EXPECTATIONS

It was clear that patients' expectations have undoubtedly increased through the Patients Charter and the increased availability and access to information. It was felt by respondents that this was a positive thing but that it had created an increased demand for nurses time in dealing with these expectations which is not accounted for when planning the workforce needs.

Another factor highlighted within this area was the change in legislation that has an effect on the extent of roles undertaken and the responsibility/ risk associated with these roles. The main examples specified are identified in Box 4E.

BOX 4E LEGAL FACTORS

Human Rights-
This focus was felt to have had an impact on the community sector and A& E staff in particular

Children's Order
This has created a large increase in the workload of health visitors and children's community nurses

Litigation
In midwifery some of the extended role opportunities involve a great deal more responsibility and therefore associated risk and this has meant an increase in litigation risk for midwives.

4.3.7. INCREASED FOCUS ON PRIMARY CARE/ HEALTH PROMOTION

There was undoubtedly an acknowledgement of a focus on the **"treatment of patients in the primary care setting"** and **"the importance of health promotion going forward".**

The majority of respondents felt that this would not mean a decrease in the demand for services in the acute sector as the current establishment was not meeting the current demand expectations.

The respondents were also concerned that despite this movement there had been limited growth in community monies and that the public health agenda was **"slow to gain momentum due to sporadic funding and the necessity to offer temporary contracts".** They identified that there will also be a need to provide higher-level acute skills in the community setting (e.g. children on ventilators, intravenous drugs, dialysis) and increasing support from non-qualified employees.

Some interviewees indicated the possibility of having what they classified as "hybrid" workers who **"worked across the acute and primary care and developed care pathways to manage this interface"** as it was indicated that more work on this area could help achieve **"a more focused and less expensive service".**

4.3.8. SOCIETAL FACTORS

The majority of respondents highlighted a number of societal factors as resulting in an increase in demand; these are identified in Box 4F.

BOX 4F SOCIETAL FACTORS IDENTIFIED

AGEING POPULATION

Advances in medicine and technology have resulted in people living longer lives and this has resulted in an increase in demand for both the acute and community settings

INCREASED DEPENDANCY

Again in relation to the above, it is now recognised the elderly who require care are generally more dependant than before and that this brings about a more resource intensive service

INCREASED THROUHPUT

The current situation within the healthcare setting has meant that patients are staying in hospital for a shorter length of time and this has meant more time being focused on admissions and discharge

TECHNOLOGY ADVANCES

The advances in medicine and associated technology have resulted in more treatments being offered and also more intervention and complex monitoring of patients.

4.3.9. CAPITAL DEVELOPMENT

Set against the background of the above there is also a capital development plan, which brings about an increase in demand for the services of nursing and midwifery.

The key areas identified by respondents were:

- *ICU/HDU bed increase
- *Cancer Centre and extended services throughout other major acute sites.
- *Ulster Hospital - development programme
- *Craigavon Hospital - development programme
- *Knockbracken Regional Secure Unit
- *Child and Adolescence Psychiatry Unit

*Regional Brain Injury Unit
* Development in renal services

4.3.10. INCREASED DUTY COVER

The general feeling was that the community sector would initially go to a 12 hour service provision coverage and that the rest would be covered on an on-call basis. This could have a huge impact on the numbers of WTE's required to provide the basic level of service.

Respondents felt that if they were going to have greater responsibility across a longer time span that they would need to be remunerated and resourced appropriately.

The majority of respondents felt that an increase in the coverage of services was going to become the norm with the advent of more acute services being provided in the community. This would also affect midwifery due to the focus on midwifery led care necessitating a 24-hour coverage system 7 days a week.

5 ASSUMPTIONS UTILISED

5.1 INTRODUCTION

5.2 SUPPLY ASSUMPTIONS
Entering the Workforce
Leaving the Workforce

5.3 DEMAND ASSUMPTIONS

5. ASSUMPTIONS UTILISED

5.1. INTRODUCTION

Using all the information gathered as outlined above, we devised and agreed with the Project Group a set of realistic assumptions around key supply and demand factors that are and will affect the nursing, midwifery and health visiting workforce in the next 5-year time span.

Box 5A lists the evidence utilised or informing these assumptions.

The strength of the evidence ranges from objective data sources across expert professional opinion and best projections available in current planned service development plans.

It should be noted that the absence of clear robust information sources result in assumptions being made with minimal hard evidence and thus utilising best judgement and advice. However it is emphasised that there is not any clear evidence base upon which to otherwise plan for the future workforce requirements.

BOX 5A EVIDENCE FOR ASSUMPTIONS

- *Workforce data from HRMS – (system completed by Trusts from PIMS and NIMS.)
- *HR Information from Boards and Trusts
- *The informed judgement of Nurse Executives, Human Resources Directors, Commissioning Nurses and other members of the Project Group
- *UK Projections in pertinent workforce documents
- *DHSSPS Identified priorities and approved Development Plans
- *UKCC Statistical Returns
- *Focus Group feedback
- *Key Informant Feedback
- *HEI's information returns
- *Other information sources including:
  - Employment Statistics
  - Superannuation Branch

Human Resource Directors on the Project Group emphasised that this was all that was available to them in their workforce strategy evaluations, indeed they identified that this review was beneficial in that it brought together the various factors which should be considered when undertaking workforce planning and development.

The model projected here should be evaluated annually, measured against actual requirements and amended accordingly. In this way a more robust model may be developed.

The assumptions made were used to formulate a "model" from which certain predictions around projected supply and projected demands have been calculated and are outlined below.

5.2. SUPPLY ASSUMPTIONS UTILISED

The supply of the nursing and midwifery workforce is affected by a number of factors which are detailed below.

5.2.1. ENTERING THE WORKFORCE

STUDENT NURSE ATTRITION RATES

Of the total entering pre-registration programmes we can assume an attrition rate of 8.8% per year for overall student numbers (pre-registration normally requires a three year programme). This figure has been identified by Queens as the average attrition rate per student intake.

STUDENT NURSES GRADUATING BUT NOT ENTERING HPSS

Assumed that 10% of students graduating in 2002 do not enter Northern Ireland HPSS. Again this figure has been confirmed from first destination survey results from QUB. It has been assumed that there will be a subsequent reduction in this figure of 2% per annum, remaining static at 4% in the last 2 years.

OVERSEAS NURSES ENTERING

Figures from the Work Permit Branch in Department of Employment identified that there are currently approximately 214 other overseas nurses employed within the HPSS. It has been projected (from interview feedback) that that there will be an additional 40 overseas nurses entering the Northern Ireland HPSS sector in 2002 and we have assumed a 2% cumulative increase on the baseline figure (254 in 2002) year on year. (Acute providers are currently exploring recruitment opportunities in Spain, India as well as further recruitment from the Phillippines.)

RETURNING TO WORKFORCE

It is anticipated that 142 individuals will participate in the return to practice courses during 2002. It is assumed that 108 (80%) of the qualified nurses will re-enter the HPSS sector in Northern Ireland in 2002 and that there will be a decrease on this figure over the next two years of a total of 40 headcount and then it will remain static.

ENTERING WORKFORCE FROM UK
Assumed that the numbers of qualified nurses entering the Northern Ireland HPSS sector is negligible when calculated as a percentage of the overall workforce population.

5.2.2. LEAVING THE WORKFORCE

OVERSEAS NURSES LEAVING
Assumed that there are 214 overseas nurses within the HPSS sector currently in Northern Ireland and that they are on a 4 year contract after which time 40% of this total capacity will be lost to the Northern Ireland HPSS sector

RETIRING FROM WORKFORCE
Assumed a "worst case scenario" with regard to retirees by calculating numbers retiring based on earliest eligible retirement age.

Therefore as nurses are "eligible" for retirement at 55(and indeed a number of specialist categories are eligible for enhanced pension contributions at 55), we have calculated the total headcount that will be eligible over the next 5 years and assumed a 70% uptake rate based on an even percentage year on year. Retirement figures from the DHSSPS indicate an average retirement age of between 54 and 58 for nurses and midwives over the four year period 1999-2002.

Also we are aware that there will be retirements due to incapacity, premature, injury and voluntary circumstances. Data over the last four years indicates the average retirement age on the grounds of incapacity to be between 49 and 55 years. These are included in the % figures presented above.

WORK-LIFE BALANCE – FLEXIBLE WORKING
Assumed that at the moment 1.25% of the total workforce capacity is lost due to an increase in the uptake of part-time working and work-life balance policies. We have assumed also that this figure is on the increase and will increase on a cumulative basis of 0.2% year on year. These figures will need to be traced perhaps twice annually.

TURNOVER LEAVING HPSS SECTOR
Figures provided by the DHSSPS (Leavers 2000-2001) indicate nurses and midwives who have left the service (including career breaks) over the period 2000-2001 for reasons other than retirement. In this year an estimated 259 nurses and midwives left the service , equating to 1.9% of the workforce. It

has been assumed that the figure of 259 will increase slightly year on year by 1% annually.

Totals have been based on a standard working week of 37.5 hours per WTE and on a total HPSS headcount basis. They do not include unqualified, Bank or Independent Sector staff.

It must be emphasised that further analysis is required to further validate the assumptions outlined above.

5.3. DEMAND ASSUMPTIONS UTILISED

These assumptions have been made against a variety of information sources and evidence. It is important to consider that the majority of the Assumptions are Policy driven and therefore inescapable.

Some assumptions are those, which we predict, are most likely – for example in relation to Junior Doctor Hour changes.

Further assumptions are highly desirable in order to allow for the development and support of the professions, for example mentoring and continuing professional development. We have not included all assumptions suggested to us but only those there is either evidence or sound and supported professional judgement for.

The key assumptions utilised have been outlined below:

DELIVERY EXPECTATIONS: ACUTE SECTOR
Assumption that to meet the delivery expectations identified at present within the acute sector associated with role extension; increased demand in general (especially in A&E and admissions and discharge); development of the interface; continued focus on the development of specialisms and the reduction of junior doctor hours will need at a minimum across the province an additional 173 WTE phased in over a 5 year period

DELIVERY EXPECTATIONS: COMMUNITY SECTOR
Assumption that to meet the delivery expectations identified at present within the community sector associated with role extension; shift of balance of care from acute to the community focusing on targets such as additional 35,000 consultations and the provision of 230 additional community care packages; development of Rapid Response Units across the province; development of paediatric nursing services and midwifery led care and development of nurse prescribing will need at a minimum across the province an additional 116 WTE phased in over a 5 year period.

DELIVERY EXPECTATIONS: CANCER SERVICES
Assumption that to meet the delivery expectations identified at present with regard to the development of cancer services across the province will need at minimum an additional 40 WTE phased in over a 4-year period

DELIVERY EXPECTATIONS: CAPITAL DEVELOPMENTS
Assumption that to meet the delivery expectations identified at present with regard to planned capital development of buildings in line with service delivery will need at minimum an additional 529 WTE across the province phased in over a 5-year period. **This is based only on those plans that have both been agreed and funded or are very likely to be agreed over the period of the workforce plan.** It includes the following;

- Knockbracken Regional Secure Unit; 75 wte
- Ulster Hospital ; 127 wte
- Craigavon Hospitals; 11 wte
- Child and Adolescence Psychiatry Unit; 25 wte
- Intensive Care Review (10 ICU beds & 16 HDU additional beds in place in March 2002. Additional 34 HDU beds planned x 3.5wte); 116 wte
- Brain Injury Unit; 27 wte
- Renal Unit (17 stations); 21 wte
- RVH Phase II; 52 wte
- Altnagelvin ; 75 wte

DELIVERY EXPECTATION: PRIMARY CARE SECTOR
Assumption that to meet the delivery expectations identified at present within the primary care sector will need at minimum an additional 40 WTE phased over a 5-year period. This reflects a percentage increase of approximately 10%.

CONTINUING PROFESSIONAL DEVELOPMENT
Assumption that at minimum across the overall workforce population there should be a 10% increase on the current number of hours it is recommended that nurses, midwives and health visitors spend on Continuing Professional Development, phased over a 3 year time span

CLINICAL MENTORING
Assumption that there should be protected time allocated to spend time with students during their clinical training and beyond in respect of adequate mentoring and support. Assumed that at a minimum this will be on the basis of 1 hour per week per student over the course of a year to be effective in year 1

CONCLUSIONS

PROJECTED SUPPLY

PROJECTED DEMAND

6. CONCLUSIONS

6.1. PROJECTED SUPPLY

Using the supply assumptions the projected supply of nurses between the years of 2002 – 2006 has been calculated.

Table 6A: Projected Supply of Nurses in NI (2001 - 2006)

Supply	2002	2003	2004	2005	2006
University Graduate Figures	394	444	557	569	569
Those entering the workforce - Overseas nurses	40	45	50	55	61
Return to practice	108	60	40	40	40
Entering N.I. from elsewhere	Negligible	"	"	"	"
Entering Total	**542**	**549**	**647**	**664**	**670**
Those leaving the Workforce – Retirees	297	297	297	297	298
Leaving HPSS nursing	259	262	264	267	269
Work life balance capacity	168	195	222	235	262
Overseas nurses leaving	-	-	-	86	-
Leaving Total	**724**	**754**	**783**	**885**	**769**
Those currently in the workforce	13428	13246	13041	12905	12684
Projected number in the workforce	13246	13041	12905	12684	12585

The issues below have been highlighted as potentially having an effect on the supply equation but which cannot be planned for at present:

A consolidation of the service provision, which frees up resources from current posts

Euro/Pound Equilibrium - If achieved this could have the effect of decreasing the supply of the nursing, midwifery and health visiting workforce in the Northern Ireland marketplace.

More effective utilisation of the available workforce. As the evidence in this report and historical data shows there is some potential for a more effective utilisation of the available workforce either by a re-allocation of certain duties to non-qualified staff, an increase in the WTE equivalent ratio, an increase in the amount of qualified nurses returning to the workforce or a more effective and efficient way of setting up care pathways and the delivery of services that is not as labour intensive.

The University of Ulster and Queens University increase their intake and subsequent output of graduates. At the moment all information suggests that the recently increased intake of 680 will remain static for the foreseeable future.

In conclusion, based on the above analysis and assumptions we are predicting that the supply of nurses over the course of the next 5 years will decrease year on year by 1 – 2 %.

6.2. PROJECTED DEMAND

The demand for this group of professionals can be seen to be a factor of:

type/range of services that are offered to/ required by patients/society

how these services are delivered, including a focus on care pathways, organisational form and allocation of roles and responsibilities within the healthcare settings and teams.

As with the above supply data it was also very difficult to obtain accurate data around future demand in terms of quantifiable figures and associated headcount requirements.

This is in the main due to the fact that there are so many variances between Trusts with regard to service provision and the method of delivery and also a lack of available published robust data as to the time and subsequent resource involved in delivering current and future services on a Northern Ireland wide level.

Therefore for the purposes of predicting demand numbers over the course of the next 5 years we have chosen to look at the examples based on the most likely assumptions highlighted earlier in this report.

Table 6B Projected Demand Figures

Demand	Year 1	Year 2	Year 3	Year 4	Year 5
Acute Sector	35	35	35	34	34
Community Sector	24	24	24	23	23
Cancer Services	10	10	10	10	
Capital Development	106	106	106	106	106
Development of Primary Care	8	8	8	8	8
CPD	9	9	9		
Student mentorship	27				
Total	**219**	**192**	**192**	**181**	**171**

In total this means that, based on the above assumptions and calculations, there is a need to make available the minimum of:

> 955 WTE across the nursing, midwifery and health visiting workforce of Northern Ireland

This table above does not take into account demand in the independent sector, as it was not within the scope of this review.

These demand figures are based on identified additional demand as provided by the consultation group and Project Group and makes the assumption that the current funded establishment figures are adequate to meet present required service expectations.

Based on the above, in order to offer an initial estimate of the numbers of additional professionals required in the system over the course of the next 5 years we have profiled the above summary figures for supply and demand, as outlined in table 6.3 below.

Table 6C Profile of projected supply against projected demand over a 5-year period.

Key Factors	2002	2003	2004	2005	2006
Supply :					
- Entering	542	549	647	664	670
- Leaving	742	754	783	885	769
- Shortfall **(A)**	(200)	(205)	(136)	(221)	(99)
Additional Demand :					
- HPSS Vacancies	170	170	170	0	0
- Independent Vacancies	134	133	133	0	0
- Agency	37	37	37	0	0
- Acute Sector	35	35	35	35	35
- Community Sector	24	24	24	23	23
- Capital Developments	106	106	106	106	106
- Primary Care	8	8	8	8	8
- CPD	9	9	9	0	0
- Mentorship	27	0	0	0	0
- TOTAL **(B)**	550	522	522	172	172
Net under provision in the workforce (A + B)	**(750)**	**(727)**	**(658)**	**(393)**	**(271)**

It is important to note that based on the current identified headcount: WTE ratio the net deficits outlined above would need to be increased to provide a realistic figure of the actual numbers of new nurses required to meet the service demands.

From the above and based on assumptions used within the report, it can be concluded that with respect to the nursing, midwifery and health visiting workforce demand outweighs projected supply. If the assumptions remain unchanged and the demand areas are confirmed, the net shortfall over the 5 year period is projected as 2799.

SENSITIVITY SCENARIOS

A number of sensitively scenarios can be presented below to review their impact on the projected shortfall figures above:

- *Decrease number of projected leavers: If the number of leavers (excluding retirees) was reduced by 20%, an additional 264 nurses would be available in the workforce*
- *Decrease number of nurses retiring at 55: If the number of nurses projected to retire at 55 years was projected as 50% of those eligible (rather than 70%) an additional 424 staff would be retained within the workforce.*
- *Lower impact of worklife balance: If the impact of worklife balance is reduced by 20% of that projected, an additional 216 nurses would be available in the workforce.*

The impact of all of the above would be an additional 904 nurses in the workforce over the 5 year period, reducing the projected shortfall above.

RECOMMENDATIONS

7. RECOMMENDATIONS

KEY RECOMMENDATIONS

Based on the conclusions of this report we have outlined a series of recommendations to be considered.

WORKFORCE PLANNING

7.1 The Department should put in place arrangements to review supply and demand on a regular basis. The profiles of supply and demand that have been built up in this report should be reviewed on an annual basis. The assumptions outlined in the reports should also be subjected to more detailed analysis.

7.2 The annual intake of pre-registration students should be increased from 680 to 750 in 2002/03 subject to funds being made available and the two Universities being able to facilitate this increase in numbers.

7.3 Both Universities should be commissioned to provide two intakes of pre-registration students per year to facilitate recruitment and employment after training.

7.4 The intake to the pre-registration midwifery programme should be increased to 40 per annum and discussions commence with QUB about the adoption of a direct entry midwifery programme.

7.5 Further work should be carried out to improve the quality of data held on the HRMS workforce information system. More research is required into the trends and impact of 'family friendly' working hours policies to make our supply side assumptions more robust.

7.6 HPSS Employers, particularly Trusts should be required to produce their own workforce supply and demand projections.

RECRUITMENT AND SELECTION

7.7 Employers in the HPSS need to review their current Recruitment and Retention practices to ensure that they reflect best practice. It is particularly important that the recruitment process is timely and responsive to trends in the labour market.

7.8 The Department should work closely with University Pre-registration providers to ensure as best as possible that those recruited as student nurses have a long-term interest in pursuing nursing as a career in Northern Ireland.

7.9 There should be more targeted campaigns for pre-registration training to attract individuals into specific areas of shortage such as Mental Health and Learning Disability.

7.10 Trusts should seek to build relationships with pre-registration students during placements to encourage them to apply for jobs, once they have qualified.

7.11 Trusts should ensure that there are planned induction, consolidation and mentorship programmes for all new students.

7.12 The skills mix between D and E grades should be reviewed across the HPSS, as this is perceived as a significant retention factor for some Trusts.

7.13 There should be a consistent approach to the implementation of work-life balances. Other measures such as self-systems should be considered to increase flexibility, ownership and empowerment of staff.

UTILISATION OF THE WORKFORCE

7.14 There should be a significant investment to increase the number of Health Care Support Workers who are trained to NVQ level 3. A fast track training process that will facilitate 200 staff is required.

7.15 Further research needs to be carried out to ascertain the impact of the Junior Doctors Working Hours on the nursing workforce.

7.16 Work should be undertaken to examine the feasibility of new roles in health care provision to ascertain their potential impact on the nursing workforce. The 'physicians assistant' or 'health care practitioner' roles are examples. The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) will have a role in the development of this work.

CONTINUOUS PROFESSIONAL DEVELOPMENT

7.17 There needs to be a fresh emphasise on Continuing Professional Development as a means of developing and empowering the nursing workforce. NIPEC will support this development.

7.18 The role of the new Education Commissioning groups (ECG's) should be evaluated to review how education and training opportunities could be maximised.

7.19 Training should be offered to all staff who will be required to provide mentorship or coaching support as part of their role with adequate

"protected" time set aside to ensure that this happens as part of the weekly duties. These responsibilities should be considered as a key competence when addressing aspects of re-grading issues. NIPEC will be able to support this educational development of the nursing and midwifery role.

7.20 A Training Needs Analysis should be carried out to establish the key development areas of nurse Leaders for the future. This initially should incorporate an identification process of what these leaders should "look like" in the future, the identification of who they may be an then an analysis of the development required. Management training providers should be involved in this analysis.

7.21 A more pro-active approach should be adopted with regard to career progression and the formulation of career paths that are reflective of service needs in all areas. NIPEC should lead this development.

OTHER REFERENCE MATERIALS INFORMING THIS REVIEW

Delivering Services and Improving Monitoring and Regulation in the HPSS, A Consultation Paper, April 2000.

DHSSPS, Investing for Health, November 2000.

NHS, A Consultant Document on the Review of Workforce Planning for the NHS, 2000.

World Health Organisation. Nursing beyond the year 2000. World Health Organisation Technical Report Series. Issue 842, 1994.

Dixon, J. Dewar, S. The NHS Plan: As Good As It Gets – Make the Most of It, Br Med J 2000; 321-315-6.

http://www.hospitalmanagement.net/informer/breakthrough/break46/ (accessed 16 September 2001).

Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine, Seventeenth report on Nursing Staff, Midwives and Health Visitors, 2000

Queen Margaret University College, Making up the Difference: A Review of the UK Nursing Labour Market in 2000, Queen Margaret University College. Edinburgh, 2000

DHSSPS, Director of Nursing, Overview of Nursing Within Northern Ireland, February 2000.

DHSSPS, Well into 2000: A Positive Agenda for Health and Social Being, 1997.

DHSSPS, Queens University of Belfast and University of Ulster, Contribution of Nurses, Midwives, and Health Visitors to the Public Health Agenda, October 2000.

DHSSPS, Position Paper: Recruitment and Retention of Nurses and Midwives and The Commissioning of Nursing and Midwifery Pre-registration Education and Training to Provide an Adequate Supply of Qualified Skilled Nursing Staff in Northern Ireland, July 2001.

Royal College of Nursing and Queen's University of Belfast, Research and Evaluation Services Survey, 2001.

Controller and Auditor General, Education and Training the Future Health Profession Workforce for England, Report by the Controller and Auditor General, February 2001.

DHSSPS, Commissioning Plan, 2001-2002

Landerweed JA. Boumans NPG, Work Satisfaction, Health, and Stress: A Study of Dutch Nurses, Work & Stress 1988; 2: 17-26.

Reading R. Allen C., The Impact of Social Inequalities in Child Health on Health Visitors' Work., J Pub Hlth Med. 1997; 19: 424-30).

Bourbonnais R. Mondor M., Job Strain and Sickness Absence Among Nurses in the Province of Quebec, American Journal of Industrial Medicine. 2001; 39: 194-202.

Shader K. Broome ME. Broome CD. West ME. Nash M., Factors Influencing Satisfaction and Anticipated Turnover for Nurses in an Academic Medical Cente,. J Nursing Administration. 2001; 31: 210-16.

Redman S. White K. Ryan E. Hennrikus D., Professional Needs of Palliative Care Nurses in New South Wales, Palliative Medicine 1995; 9: 36-44.

Pan S. Dunkin J. Muus KJ. Harris TR. Geller JM., A Logit Analysis of the Likelihood of Leaving Rural Settings for Registered Nurses, J Rural Health. 1995; 11: 106-13).

Report of the Medical Officer, The Health of the Public in Northern Ireland, 2000.

DHSSPS, Nurse on Call: District Nursing Services in Northern Ireland, Audit, 2000.

DHSSPS, Intensive Care Review, February 2000

Appendix 1 – PROJECT GROUP

Representative	Role/Organisation
David Bingham	Director of Human Resources DHSSPS
Bridie Foy	Acting Nurse Executive Craigavon HSS Trust
Deirdre O'Brien	Nurse Executive RGH HSS Trust
Brenda Connolly	Nurse Executive N&W Belfast HSS Trust
Hazel Baird	Nurse Executive Homefirst HSS Trust
Mary Waddell	EHSSB
Elaine Way	Chief Executive Foyle HSS Trust
Gerry McLaughlin	Human Resources Director HSS Trust
Terese McKernan	Human Resources Director HSS Trust
Maureen Scott	Royal College of Nursing
	Royal College Midwives
M Hanratty	Beeches
N Sheerin	HR Director - Foyle
B Flood	HRD DHSSPS
J Thompson	HRD DHSSPS
J Cairns	HRD DHSSPS
P Blaney	NMAG DHSSPS

APPENDIX 2 – KEY INFORMANTS

Representative	Role/Organisation
R McGee	S&E Belfast
M O'Hagan	City Hospital
B Connolly	N&W Belfast
M Waddell	EHSSB
M E Bradley	WHSSB
A Hughes	Integrated Care Team
J Hill	Chief Nursing Officer
N Hughes	Independent Sector
J Montgomery	Registered Homes Confederation
F Rice	DHSSPS
B Hughes	Royal College Midwives
N Morrow	Chief Pharmaceutical Officer
R Clarke	DHSSPS
E Logue	EHSSPS
A Finn	Down Lisburn Trust
P Blaney	DHSSPS
S McCloskey	Children's Community Nurse
R Sowney	Nurse Consultant
F McMurray	Queens University
H Herron	Royal College of Nursing
E Hayes	Greenpark Trust
B Foy	Craigavon
M Gordon	Causeway
E McNair	NHSSB
H Baird	Homefirst
J Orr	Queen's University
D O'Brien	Royal
C Mason	DHSSPS
J Graham	EHSSB
B Poulton	UUJ
A McVeigh	SHSSB
M Hanratty	Beeches
S Livingstone	Derry
P Mahon	Foyle
B Coyle	MSF/CPHVA
A Colgan	Altnagelvin
R Bowman	United Hospitals
M Briscoe	DHSSPS
N Sheerin	HR Director - Foyle
M Hutton	Derry
M Nesbitt	School of Nursing & Midwifery
M McMahon	Social Services Inspectorate

A Glen	N&M Group
J Irvine	Arc Project Manager
A McVey	DHSSPS
G Henry	WHSSB
G Riddle	DHSSPS

Our analysis will draw on specific qualitative patterns which emerged from this exercise throughout the body of this report.

APPENDIX 3 – FOCUS GROUPS

We held 15 focus groups, in the following locations, with a representative mix of specialisms, grades and hospital and community focus, across Northern Ireland.

Group	Location	Relevant Specialism
1	Craigavon Hospital	Adult Acute
2	Ulster Hospital	Midwifery
3	RBHSC	Children's
4	Lagan Valley Hospital	Community
5	Daisy Hill Hospital	Community
6	Causeway	Mental Health
7	Causeway	Community
8	Altnagelvin	Adult Acute
9	Altnagelvin	Midwifery
10	Musgrave Pk	Adult Acute
11	Knockbracken	Mental Health
12	Craigavon	Education
13	Homefirst	Disability
14	Queen's University	Students
15	UU Coleraine	Students

This was in order to gain mainly qualitative information on the key current and future recruitment, retention and demand indicators and the key factors that needed to be taken into account when planning workforce and service delivery needs in the future, given the current manpower situation. In all one hundred and twenty-five nurses were canvassed through the focus groups.

We feel that a great deal of valuable, relevant information was able to be gathered from these individuals, across a wide range of issues and specialisms, which were key in providing the basis of our recommendations made later in this report.

Nursing and Midwifery Review Summary 2009

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Poustie, Resydènter Heisin an Fowk Siccar

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Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) commissioned a comprehensive review of the nursing, midwifery and health visiting workforce in 2008, following on from the previous review in 2005 and update review in 2007.

As with previous reviews, this report provided a detailed profile of the workforce, identified current issues impacting on the profession and made projections of the supply and demand up to 2013. It also identified changes in the nursing and midwifery workforce since the last full review in 2005.

The report highlighted a number of action points to improve baseline data in the future and made recommendations for further work to be undertaken. The recommendations are presented with an indicative timeframe and responsible owner.

A Nursing and Midwifery workforce advisory group, comprising of members of the professions, Trust Human Resources and staff-side were convened to assist in the review.

This document gives an overview of the various branches of nursing and provides a summary of the main sections of the report.

The following sections are included;

- Introduction and description of nursing and midwifery roles
- Key issues
- Summary of Action Points
- Recommendations and Next Steps

Introduction

Nursing

To work in the Health and Social Care sector, nurses must be registered with the Nursing and Midwifery Council (NMC). It is possible to undertake either a diploma or degree course to qualify as a nurse.

Education is provided by universities, with placements in local hospitals, private sector and community settings. The first year is a Common Foundation Programme (CFP), and students then specialise in either adult, children's, mental health or learning disability nursing. Full time diploma courses run for three years. Degree courses run for three or four years.

Branches of Nursing

Adult nursing

Adult nurses are trained to care for old and young adults with diverse health conditions, both chronic and acute. They juggle numerous priorities and use caring, counselling, managing, teaching and all aspects of interpersonal skills to improve the quality of patients' lives, sometimes in difficult situations. They provide physical, psychological and emotional support. Work may be based in hospital wards, clinics or, increasingly, community settings.

Children's nursing

Children's nurses care for children and young people to age 18. They also work closely and in partnership with parents and families. They deal with a range of situations, including planned routine interventions, emergency care and complex care. Children's nursing takes place in hospitals, clinics and in the child's home. Once qualified, it is possible to specialise in hospital and community settings in areas such as burns and plastics, intensive care, community children's nursing, (which deals with children with complex physical healthcare and acute needs to facilitate early discharge), child protection and cancer care.

Introduction

Learning disability nursing

Learning disability nurses work as part of a team alongside GPs, psychologists, therapists, teachers and social workers. Nurses who qualify in this branch of nursing help those with learning disabilities to live independent and fulfilling lives. This may involve working with people in supported accommodation - typically three to four people with learning disabilities live together in flats or houses, with 24 hour support. Some nurses work with individuals who require more intensive support - for instance, in hospitals or in specialist secure units for offenders with learning disabilities. Others specialise in areas such as epilepsy management or working with people with sensory impairment.

Nursing is carried out in settings such as adult education, residential and community centres, as well as in patients' homes, workplaces and schools. Some nurses choose to specialise in education, sensory disability or the management of services.

Mental health nursing

Mental health nurses work with GPs, psychiatrists, social workers and others to co-ordinate the care of people suffering from mental illness. The vast majority of people with mental health problems live in the community. Nurses plan and deliver care for people living in their own home, in small residential units or specialist hospital services. Some are based in health centres. It is possible to develop expertise in areas such as rehabilitation, child and adolescent mental health, substance misuse and working with offenders.

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Introduction

Midwives are often the key health professional supporting, guiding and caring for the mother, baby and family through the months of pregnancy, during the birth itself and afterwards in the postnatal period.

Midwifery

Midwifery education is at degree level.

Midwives practise in a variety of settings such as hospitals, neonatal units and with GPs in community settings. There are opportunities to specialise in public health, women's health and to run specialist services, such as teenage pregnancy clinics.

Specialist Community Public Health Nurses

This group includes health visitors, school nurses and occupational health nurses. Health visitors are registered nurses or midwives who have undertaken additional training regarding the promotion of good health. They are members of the primary healthcare team, covering a specific geographical or GP practice area. They work in partnership with a network of organisations concerned with health promotion. Their work can be delivered in people's homes, schools, and health centres. Much of their work can involve targeting vulnerable groups and individuals, such as ethnic minorities and travellers.

The Advisory Group reported that it can be difficult to attract individuals into Health visiting, and that attrition rates are not easy to define.

Healthcare Assistants

Healthcare Assistants (sometimes known as nursing auxiliaries or support workers) may hold an NVQ qualification but are not qualified nurses. They work with nurses, midwives and other healthcare professionals under the delegated authority of the registered nurse or midwife, to deliver specific aspects of care.

Key Issues Explored

Headcount

The nursing and midwifery workforce has increased overall since the 2005 review. The September 2008 total headcount of qualified nursing and midwifery staff working in the HSC is 16,140 showing an increase of 5.3% on the March 2004 figures. The ratio of headcount to WTE as at March 2004 was 1.17:1 and this remains unchanged at September 2008.

The HSC nursing workforce, including nurse support staff, represents a total headcount of 20,860 in Northern Ireland (30th September 2008).

Trust / Service Area	Belfast	Northern	South Eastern	Southern	Western	Board HQ / Regional Services	Total
Acute Nurses	3,721	1,392	1,118	1,262	1,392	18	8,903
Mental Health Nurses	421	341	213	292	429	0	1,696
Learning Disability Nurses	207	22	55	130	65	0	479
Midwives	321	225	227	273	232	0	1,278
District Nurses	224	254	265	231	229	0	1,203
Health Visitors	97	140	95	122	103	0	557
Paediatric Nurses	314	105	83	89	110	0	701
School Nurses	32	26	19	23	20	0	120
Treatment Room / Practice Nurses	35	112	23	33	40	0	243
Specialist Nurses	73	169	42	90	49	5	428
Nurse Managers	141	46	156	51	13	11	418
Teacher / Trainer	7	31	4	20	1	30	93
Other Qualified Nurses	5	0	10	4	0	2	21
Nurse Support Staff	1,726	774	608	787	779	46	4,720
Total	**7,324**	**3,637**	**2,918**	**3,407**	**3,462**	**112**	**20,860**

Table 2.2.1a: Nursing, Midwifery & Health Visiting Staff (**Headcount**) by Trust and Service Area, as at 30 September 2008 (source: HRMS). It should be noted that for data protection, all figures of 5 staff or fewer within this report have been suppressed and these cells appear blank. Totals may therefore not tally.

Although workforce numbers have shown an overall increase the review noted that pressure points still exist in certain areas e.g. midwifery, mental health and neonatal nursing.

Key Issues Explored

Vacancy Rates

The level of vacancy has remained relatively stable over the past number of years. At 30th September 2008, there were 397 vacancies in Nursing and Midwifery in NI HSC, of which 126 were long-term (i.e. longer than 3 months).

A comparison of the WTE vacancies at Sept 08 by Trust for Nursing and Midwifery staff compared to medical/dental and admin and clerical workforces shows that nursing and midwifery vacancies tend to be lower than the other groups.

Overall the total vacancy rate is 1.9% and long-term 0.6% and the trend from March 2006 shows vacancy rates decreasing.

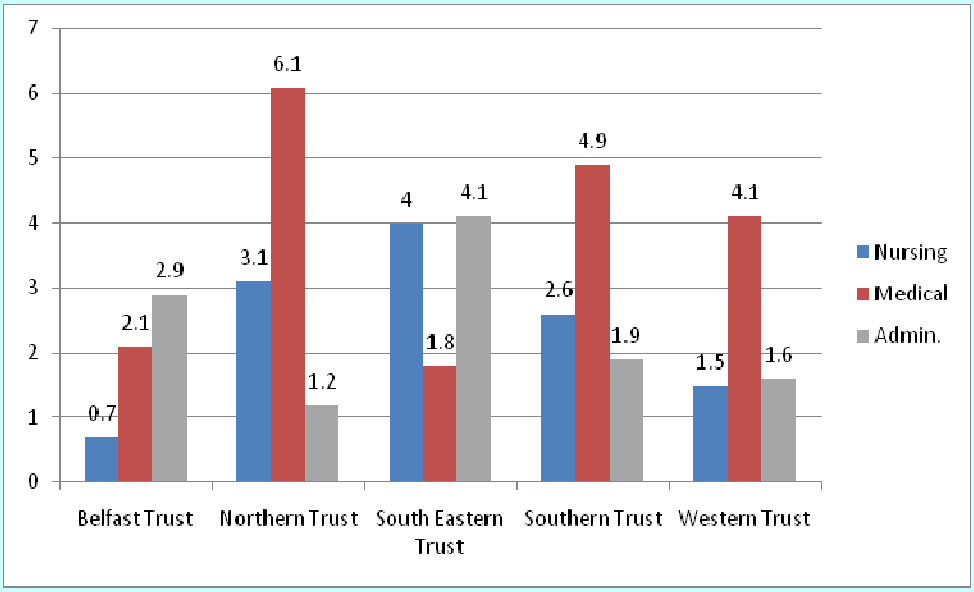

Figure 4.2.1e: Nursing, Midwifery & Health Visiting Staff – Percentage Vacancy Rates by Trust, compared against Percentage Vacancy Rates for Medical / Dental and Clerical / Administrative staff, as at 30 September 2008 (source: DHSSPS)

Full and part-time working

The percentages remained unchanged since the previous review and have remained relatively stable since 2003 with 56% of the workforce working full-time and 44% working part-time.

Agency and Bank Staff

The report noted that agency and bank staff are typically brought in to cover temporary shortfalls and fluctuating workloads. It noted that HRMS does not record the use or deployment of agency/bank staff, making it difficult to track the impact of their use. More detailed research is recommended on this. A detailed examination of control systems relating to the use of agency and bank nursing and midwifery staff within Trusts is also recommended.

Gender Profile

The workforce is currently 92% female and 8% male. This shows little change since the 2005 review.

Age Profile

The 2005 full review noted that the age profile of the nursing and midwifery workforce was increasing with 67% aged between 30-49.

The 2008 review reports an average of 40.7% of staff are aged 45 years and older.

Service areas of particular note are as follows:

Service area	% of staff aged 45 or older
Midwives	54.1%
Health Visitors	48.7%
School Nurses	57.5%
Treatment Room / Practice Nurses	52.7%
Nurse Managers	57.9%
Teacher / Trainer	75.3%

Although some of these service areas would be expected to show a higher age profile e.g. teacher/trainers, and nurse managers the above figures show that areas of concern do exist in respect of age profile and these must be closely monitored.

Internationally Recruited Nurses

Data on internationally recruited nurses is not routinely available and is not recorded on HRMS. A significant manual clerical exercise would be required at Trust-level in order to determine an estimate of the number of international nurses working in the Health sector. Stakeholder consultation did provide some useful qualitative information;

- In recent years significant numbers of nursing staff migrated to NI to work, including staff from non-EU countries.
- Worldwide shortages of qualified and experienced nursing and midwifery staff have generated a lot of workforce mobility. Certain countries e.g. the US and Australia have offered generous relocation and salary packages and the transferability of the UK professional registration facilitates free movement of the workforce
- Anecdotal evidence indicates that many of the nursing and midwifery staff who migrated into NI in the last decade have now left or are considering moving to another country. Current workforce information indicates that increases in local supply have significantly reduced the need for international recruitment.

Continuing Professional Development

A number of issues were identified through discussions with stakeholders;

- There is a requirement to develop more modular courses that will allow staff to attend training in specific modules that they perceive to be of relevance, rather than being required to attend longer programmes
- CPD represents a significant resource commitment at service level, both in time required and also in provision of staff to 'back-fill'
- Supervision of staff/mentoring roles places a high degree of demand at service level. A consensus view is that the development of practice facilitators would make an important contribution to improving support.

Although the issues below were not raised as part of the current review, as they have been the subject of much recent interest

Neonatal Nursing

Neonatal services across the UK are under increasing pressure to meet British Association of Perinatal Medicine recommended staffing levels. These state that Intensive Care cots should have at least 1: 1 nursing; High Dependency cots should have 1 nurse : 2 cots and Special Care cots 1 nurse : 4 cots. BAPM also recommend that neonatal cots should not operate at average occupancy of more than 70%.

The Department has written to the Health and Social Care Board, as regional commissioner of services to request that a review be taken forward to evaluate the neonatal cot capacity across neonatal services. This evaluation will include staffing levels, including medical and nursing staffing specifically in relation to recommendations of the BAPM.

Infection Control Nursing

As part of the Regulation and Quality Improvement Authority report –' Clostridium Difficile – RQIA Independent Review, a review of the outbreak of Clostridium difficile in the Northern Health and Social Care Trust 2008', a recommendation was made that a regional workforce plan and career structure should be developed for infection control nursing and that the development of nurse consultant posts in infection control should be considered across the region.

This work is being taken forward within the Department with an expected completion date of early Spring.

Midwifery

The HRMS data shows the number of midwives has decreased by approximately 2% since September 2003 and currently stands at 1,278 headcount.

This is against an increasing birthrate in the same period. Figures provided from the Northern Ireland Statistics and Research Agency show that births in NI were 24,451 in 2007/08, an increase of 14.5% on 2003/04 figures.

The age profile of midwives has also increased, as predicted in the previous review with the average age of a midwife being 44.3 compared to 40.8 for nursing.

In response to service needs, the Department has taken a number of steps to strengthen maternity services,

- Increase of midwifery training places over the last 3 years by over 40%. Training places were increased from 50 to 65 in 2008/09 and have been maintained at this level for 2009/10
- Investment of £3.5million to help expand maternity services at Craigavon, including recruitment of additional 12 midwives
- Secured investment to commission an additional cohort of 12 midwifery places in 07/08 specifically for the Southern Trust to rectify projected shortfall
- Funded Southern Trust to run pilot project in 2007 for 10 healthcare assistants to carry out NVQ Level 3 in maternity care to support midwives and free them up from theatre duties.
- Establishment of Midwifery-led units.

The review recommends a further increase in midwifery training places to 70 places.

Progress on actions since 2007 update review

- ***Training Commissions***

  DHSSPS reviews commission levels every year has re-configured the commission for academic year 2009-10 in response to work-force demand – reduced Adult places, increased Childrens' (by 5 places) and increased Direct Entry Midwifery (by 6 places)

- ***Improvements to HRMS***

  Although substantial work has taken place to improve the quality of HRMS data, the report indicates that further refinement is essential to ensure projections are made using robust baseline data.

- ***Attrition***

  An attrition data set to monitor attrition rate for nursing students has been agreed between the Universities and the Department; starting September 2007.
  The Department has calculated attrition rate as, on average 16%, averaged over the preceding 5 academic years

- ***Integrated workforce planning***

  The Department and Trusts must continue to work together to develop workforce plans which integrate finance, service delivery and workforce information. Professional workforce planning skills have been significantly increased and the Department should support Trusts to build further capacity for workforce planning. Trusts should develop organisational-level workforce plans. Some Trust-level workforce planning exercises have taken place however a common methodology should be developed for use by all Trusts.

- ***Supply/Demand issues in the independent sector***

  The report estimates that between 2000-3000 nurses are currently working in the independent sector however it acknowledges that difficulties remain in collecting reliable data from the private and independent sectors. The Department must continue to forge links with this sector to help inform regional workforce planning.

Summary of Action Points

Throughout the course of the review a number of action points were identified for Trusts and DHSSPS. These action points centred around taking steps to improve the quality of the baseline data for future reviews in order to improve accuracy of workforce projections.

A summary of the action points is given below;

- The inconsistencies in recording of workforce staff numbers and categorisation needs to be addressed by Trusts.
- A comprehensive baseline study of the nursing workforce in the independent sector should be carried out to assist with future workforce planning and determination of training commissions.
- Accurate recording of international workforce supply into Northern Ireland should be initiated and maintained by employers.
- The Department should maintain contact with workforce planning counterpart in the other UK countries including the Workforce Review Team in GB. This will help ensure that appropriate actions can be identified and implemented to keep NI in step with other parts of the UK.
- The Department should consider conducting a benchmarking analysis of nursing and midwifery resources in NI, in terms of standard metrics such as nurse-to-bed ratios and percentage of qualified staff in each clinical area.
- HSC Trusts should seek to provide evidence-based estimates of future workforce requirements based on their quantified assessment of need. A common methodology should be adopted to ensure consistency of approach.

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Summary of Action Points

- HSC Trusts should ensure that population health needs are assessed in detail when planning future service delivery models and the related workforce requirements.
- The Department and Trusts should consider how the impacts of the Comprehensive Spending Review and changing patterns of care provision, i.e. focus being placed on primary and community care, could be quantified in future workforce planning exercises.
- The impact of changes within Children's services such as development of the new Childrens Hospital, will require close attention, and will need to be quantified for inclusion within future workforce planning exercises at HSC Trusts level.
- The number of consultant-level nursing posts should be investigated and analysed. Related initiatives, including nurse leadership, might also be examined.
- The Royal Colleges, NMC and the Department should examine whether nurses are specialising too early in their careers and whether this is restricting their flexibility.
- Trusts should continue to monitor closely their sickness absence levels within the nursing and midwifery profession and should ensure that the benefit of reductions in absence levels are factored into workforce plans on an annual basis.
- HSC Trusts, in liaison with the Department, should take steps to ensure that no double counting appears in the staffing data sets, and that staff moving between jobs or employers can be tracked and recorded correctly on HRMS. Careful attention should also be paid to staff being re-coded, to ensure the data on HRMS is correct and consistent.
- The recommendations from Review of Health Visiting and School Nursing and Mental Health and Learning Disability workforce should be considered by DHSSPS

Recommendations

The review recommends ***NO CHANGE*** to the number of commissioned training places which are currently approved as the projections indicate relative balance in supply and demand with a potential minor over-supply over the next 5 years.

An increase to **70 places** in midwifery is recommended to address service changes planned by Trusts, including the development of midwifery-led units, developments in professional practice/skill-mix, flexible working arrangements and family-related career breaks.

Further work is recommended in respect of workforce turnover for all of the service areas examined

It is recommended that DHSSPS should apply a model for prediction of supply and demand including the following characteristics;

- Establishment of the baseline
- Workforce turnover
- Impact assessment of future workforce supply
- Impact assessment of future demand
- Benchmarking
- Skill-mix/new roles

Greater engagement between DHSSPS and the representative body 'Independent Health Care Providers' to ensure data from the independent sector is factored into regional planning as far as is practicable.

The review recommends continued liaison with RQIA, the Regulation and Quality Improvement Authority to examine any workforce data they have collected which might be helpful.

The report recommends a shift in responsibility for workforce planning – primary responsibility for organisational-level workforce planning should be held by HSC trusts with the Department leading at regional level. The Regional Board must recognise the key role it must play in workforce planning to support the HSC Trusts and the DHSSPS.

The Way Forward

The Department will now share the recommendations with Trusts, and the Regional Board with a view to progressing actions.

Actions – Department

- Carry out a comprehensive baseline study of the nursing workforce in the independent sector
- Continue liaison with workforce planning counterparts in other UK countries
- Consider conducting a benchmarking analysis of nursing and midwifery resources in NI, in terms of standard metrics such as nurse-to-bed rations and percentage of qualified staff in each clinical area
- The number of consultant-level nursing posts should be investigated and analysed. Related initiatives, including nurse leadership, should also be examined
- Examine, in conjunction with Royal Colleges and the NMC, whether nurses are specialising too early in their careers and whether this is restricting their flexibility
- Recommendations of the reviews of health visiting and school nursing and mental health and learning disability workforce, should be considered by DHSSPS

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The Way Forward

Actions – HSC Trusts

- Address inconsistencies in recording workforce staff numbers and categorisation
- Maintain an accurate record of international workers
- Adopt a common methodology to provide evidence-based estimates of future workforce requirements
- Population health needs should be assessed in detail when planning future service delivery models and the related workforce requirements
- Continue to place focus on monitoring and reducing sickness absence levels and ensure reductions are factored into workforce plans on an annual basis
- Maintain close attention to changes within children's services such as development of the new children's hospital with a view to factoring in within future workforce planning exercises

Actions – Joint

- Consider how the impacts of the Comprehensive Spending Review and changing patterns of care provision, i.e. focus being placed on primary and community care could be quantified in future workforce planning exercises
- HSC Trusts, in liaison with the Department should take steps to ensure that no double counting appears in the staffing data sets, and that staff are re-coded correctly to ensure HRMS data is correct and consistent.

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The Way Forward

The next comprehensive review of the nursing and midwifery workforce will take place in 2011 however there will be update reviews in advance of this date. The update reviews will monitor progress on the actions and identify new and emerging issues for the workforce. Additionally, the Department will liaise with the HSC Nursing workforce leads as necessary regarding nursing workforce issues.

Any queries regarding the content of this review should be emailed to wpu@dhsspsni.gov.uk