Evolving and Transforming to Deliver Excellence in Care

A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2025)

Updated May 2016

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

NIPEC

HSC

FOREWORD BY THE DHSSPS CHIEF NURSING OFFICER

It is vital that the Nursing and Midwifery workforce in Northern Ireland offers enough flexibility and innovation for future changes in service delivery models and public need.

To this end, this Workforce Plan for Nursing and Midwifery:

- Sets out clearly the education and training commissions we intend to make between 2015 and 2025;
- Explains the context and processes on which these decisions have been made;
- Provides the aggregate number of commissions and the trend increases and decreases within and between key groups and specialties;
- Highlights key trends and emerging themes from the wider health and social care system and other workforce plans that may have implications for service delivery in future years;
- Identifies key challenges that will need to be addressed if we are to make improvements in the workforce planning processes next year and beyond so that the investments we make better reflect the future needs of patients and clients.

We appreciate that there is no exact science or agreed methodology for predicting or responding to future patient and client need. Therefore we must work closely with a wide range of stakeholders to help us make these difficult judgments, within a finite budget. This will require a culture of transparency and openness, where we can share and challenge each other's assumptions to ensure that the decisions we make result in safe, effective, person-centred and compassionate care with improved outcomes and positive patient and client experiences.

The recommendations for action contained within this Plan aim to lay the foundation for the development of a competent, confident, critical-thinking and innovative nursing and midwifery workforce in Northern Ireland for the future. To take this forward, I will ensure that the Regional Workforce Planning Group places this Plan on their agenda and work-plan to ensure robust multi-disciplinary workforce planning.

I would like to express my sincere thanks to the members of the Project Steering Committee who committed their time, energy and expertise to the development of this Workforce Plan. I would also like to thank all of the individuals across the HSC system who provided us with evidence and information and the wide range of stakeholder representatives who contributed to and participated in various meetings,

surveys, workshops, focus groups and interviews during this process. The Central Nursing Advisory Committee CNMAC have completed an indepth examination of Band 5 recruitment processes and this paper has also been drawn upon to include an updated position for 2016.

A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for project managing the development of this Plan and to Skills for Health for their permission to reproduce material from their Six Steps Methodology to Integrated Workforce Planning (2009).

Mrs Charlotte McArdle
DHSSPS Chief Nursing Officer

The starting point for any discussions on our Nursing and Midwifery workforce requirements should be patient and client needs and in particular the workforce requirements necessary to ensure the best possible outcomes.

Everything else flows from that.

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EXECUTIVE SUMMARY

Evolving and Transforming to Deliver Excellence in Care has been developed to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to meet the health and care needs of the population in Northern Ireland over the next ten years, and beyond. A range of methods were employed between January and November 2014 including reviewing the international literature, gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups, interviews and meetings with stakeholders across the Health and Social Care system, including the independent sector, and reviewing relevant policies and strategies to identify proposed service developments or changes over the next ten years.

Throughout the project, participants repeatedly highlighted the challenges facing nurses and midwives during a period of transition from predominantly hospital-based to community settings. These include a growing number of older people, children and other vulnerable groups with complex needs in the community; the rise in the number of people with long-term conditions and co-morbidities requiring complex nursing care; the associated drive to prevent hospital admissions and to ensure end of life care at home; the requirement for specialist and advanced level practice and non-medical prescribing; the increase in the delivery of nurse and midwife led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, stakeholders reported a range of recruitment processes that have led to the perception of a developing culture of "*any nurse will do*". Nonetheless, an interest and enthusiasm to drive improvements in service responses and delivery to ensure safe, effective and person-centred care were evident during stakeholder engagement. It was clear throughout the project that all employers are starting to feel the effects of the well documented global shortage of Nurses.

A series of recommendations have been developed which command a consensus among stakeholders. Chief among them are:

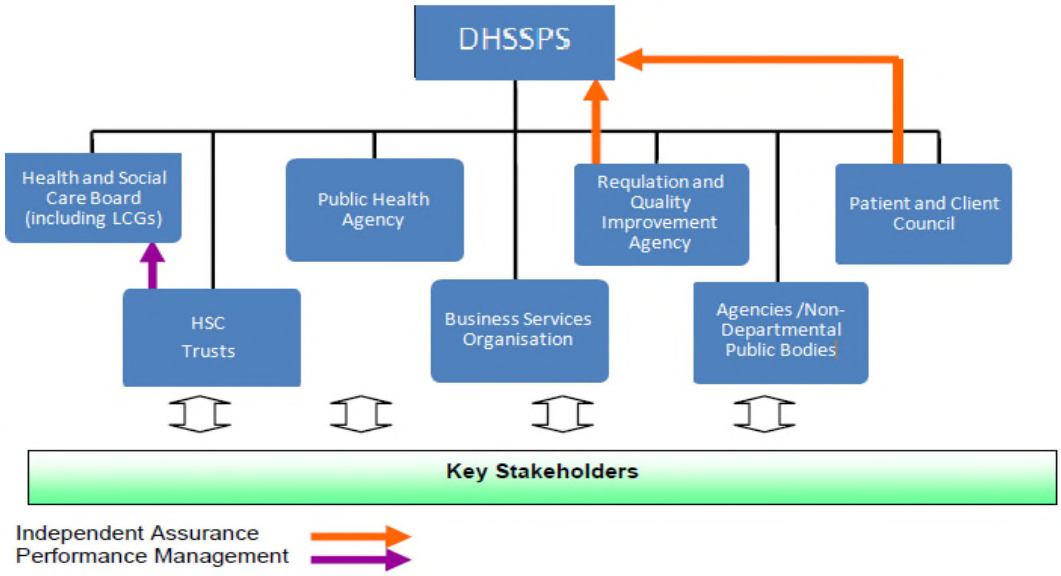
- the need for a strategic approach to the future supply and demand of Nursing and Midwifery to make Northern Ireland a destination Employer of Choice;
- a review of HSC Trusts' nursing and midwifery recruitment processes;
- a review of the nursing and midwifery workforce within the independent sector;
- implementation of pre and post registration education programme forecasts;
- the introduction of Advanced Practice Programmes across the statutory and independent sectors.

An action plan and structure for taking the work forward is proposed along with a monitoring process.

INTRODUCTION

Health and social care in Northern Ireland are provided as an integrated service with a number of organisations working together to plan, deliver and monitor health and social care (Figure 1):

Figure 1: Northern Ireland Health and Social Care Structure



Source: (DHSSPS, 2011a)

Nurses and midwives comprise the largest part of the Health and Social Care (HSC) workforce delivering services 24 hours a day, 365 days a year, designed to meet peoples' health and healthcare needs across the age spectrum and in every health sector (statutory and independent) including primary, secondary and tertiary care, and in schools, prisons and workplaces. While the role of the professions has always been highly valued, recent reports have highlighted the need to maximise and further release the potential of the nursing and midwifery workforce to provide safe, effective, person-centred and compassionate care (Francis, 2013; International Council of Nurses, 2014).

This is particularly relevant with the *Transforming Your Care* agenda (DHSSPS 2011b), driving the transition of service delivery from predominantly acute hospital based to community settings and other key policy directives (DHSSPS, 2011c; DHSSPS, 2012a; DHSSPS, 2012b; DHSSPS, 2013a; DHSSPS, 2014a). To support this, more nurses will be needed with skills in complex case management, advanced and specialist practice knowledge, and the confidence to work independently in community rather than acute hospital settings.

Workforce planning has become a key component of all health and social care planning as the impacts of demographic changes and a shrinking labour market are increasingly understood. Not only will the needs of patients and clients continue to change and demand for our services increase, but the workforce profile and characteristics of our staff will also change as our own workforce ages.

Workforce planning involves commissioning the services required to implement strategic priorities and the workforce to deliver those services. NHS England's (2014) recent publication *Five Year Forward View,* highlights that we can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.

To support this, the HSC system has a vital role to play in the commissioning of pre and post-registration nursing and midwifery education programmes. This requires partnership working between the DHSSPS, Health and Social Care Board (HSCB), HSC Trusts, Local Commissioning Groups (LCGs), Integrated Care Partnerships (ICPs) and the independent sector organisations. This is particularly pertinent to *Delivering Care* (DHSSPS, 2013b), the policy direction for agreeing nurse staffing levels in Northern Ireland. The first phase of this work is in the process of implementation and will require additional funding, during a period of significant financial constraints.

The last major *Review of the Nursing and Midwifery Workforce in Northern Ireland* was published by the DHSSPS in 2009. This included workforce projections up to and including 2013 therefore the production of this Workforce Plan is timely. During the period between 2009 and 2014, there has been a 4% (whole time equivalent) increase in the number of registered nurses and midwives, which includes student health visitors and midwives. We now have an ageing nursing and midwifery workforce with up to 46% eligible to retire over the next ten years in some practice areas, who will need to be replaced with the HSC system.

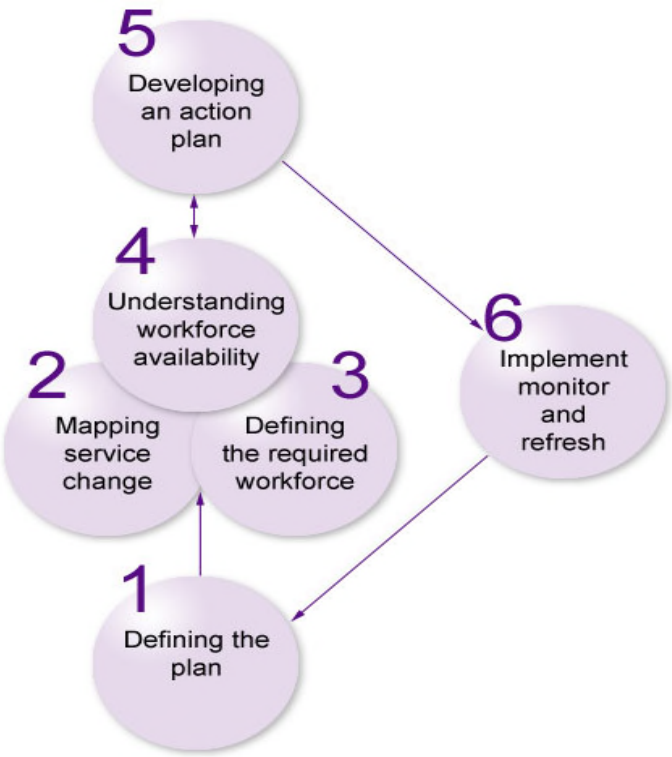
This Workforce Plan will support the needs of the nursing and midwifery workforce in an increasingly demanding working environment. It will assist the DHSSPS in the development of strategies to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to support the delivery of safe, effective and person-centred care and meet the needs of the service overall. The recommendations will also aim to lay the foundations for the development of a more systematic and standardised approach to nursing and midwifery workload and workforce planning processes to improve the current situation.

SIX STEP METHODOLOGY FOR WORKFORCE PLANNING

Effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, within the correct budget, delivering services to provide the best possible patient and client care. Workforce planning is complex and comprises of many elements.

The Skills for Health Six Steps Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this Workforce Plan (Figure 2):

Figure 2: Six Step Methodology to Integrated Workforce Planning (Skills for Health, 2009)



This high-level stepped approach has been endorsed by the health and social care workforce planning community across Northern Ireland. It has proven useful in supporting the establishment of information on the supply and demand factors relevant to the nursing and midwifery workforce.

This in turn has helped to inform decision-making on the number of nursing and midwifery education and training places to be commissioned between 2015 and 2025 and to develop an understanding of the issues impacting on recruitment, retention and career progression of those employed.

GUIDING PRINCIPLES OF THE WORKFORCE PLAN

The following principles were employed to guide the development of this *Workforce Plan for Nursing and Midwifery (2015-2025)*:

Guiding Principles

- ✓ The Nursing and Midwifery Workforce Plan is set within the wider context of the international perspective on workforce, education and training, legislative, professional and practice issues, taking into account and reflecting activity at national, regional and local levels;
- ✓ The Plan will take account of the demographics and health and care needs of the patient and client population in Northern Ireland, the services for which there is expressed demand, the profile and dynamics of workforce supply and availability, and assess the extent to which a balance of demand and supply can be achieved;
- ✓ The whole of the registered nursing and midwifery workforce is taken into account, including the numbers, skills and skill mix required;
- ✓ There is a willingness and commitment from health and social care organisations to share high level data;
- ✓ A person-centred approach is central to health and care delivery, treatment, outcomes and patient and client experience;
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required;
- ✓ Human resources and finance departments must be central to supporting the service delivery and planning agenda;
- ✓ Stakeholder engagement should be employed throughout the whole process of implementation;
- ✓ The Plan will include recommendations and actions to ensure it is integrated within the overall approach to service planning within the wider health and social care system.

ABBREVIATIONS

AfC	Agenda for Change
ANP	Advanced Nurse Practitioner
BSO	Business Services Organisation
CNMAC	Central Nursing & Midwifery Advisory Committee (DHSSPS)
DHSSPS	Department of Health, Social Services & Public Safety
ECG	Education Commissioning Group
GP	General Practitioner
HC	Headcount
HSC	Health & Social Care
HSCB	Health & Social Care Board
ICP	Integrated Care Partnership
Independent sector	Includes independent, voluntary and private sectors
ICN	International Council of Nurses
LCG	Local Commissioning Group
NMC	Nursing & Midwifery Council
NIPEC	NI Practice & Education Council for Nursing and Midwifery
NISRA	Northern Ireland Statistics and Research Agency
PHA	Public Health Agency
RCN	Royal College of Nursing
RCM	Royal College of Midwifery
RQIA	Regulation and Quality Improvement Authority
RWPG	Regional Workforce Planning Group (DHSSPS)
Staff in Post	The total number of staff employed (usually of a given group)
WTE	Whole Time Equivalent
WHO	World Health Organisation

STEP 1: DEFINING THE PLAN

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

1.1 Purpose

In December 2013, the DHSSPS Chief Nursing Officer commissioned the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) to manage a project to develop a Workforce Plan for Nursing and Midwifery.

The Project Objectives:

- Identify the profile and characteristics of the current nursing and midwifery workforce;
- Review the literature and relevant policies and strategies;
- Analyse recruitment and retention issues;
- Engage and consult with relevant stakeholders;
- Utilise a recognised workforce model to predict trends and requirements;
- Produce a final report with recommendations and an action plan to address these.

The primary purpose of this Plan is to support the forecasting of the number of Nursing and Midwifery Council (NMC) approved pre-registration nursing and midwifery and post-registration specialist nursing places to be commissioned on an annual basis over a ten year period (2015–2025).

This will enable relevant organisations to have a workforce pool to draw from in order to employ sufficient nurses and midwives who will deliver person-centred practice and, in partnership with the wider care delivery team, improve outcomes for patients, clients and their families.

The Plan will ensure:

- A clear understanding of the future direction of the nursing and midwifery workforce in Northern Ireland;
- An integration with service and financial strategies;
- A base of realistic and affordable assumptions;
- Short and medium term changes to service are taken account of;
- Engagement with clinical staff and wider stakeholders;
- A link to commissioning plans;
- The provision of an evidence base.

It will build on a range of significant work streams already commissioned, some of which have been completed.

Commissioned Work Streams:

- An overview of the Nursing and Midwifery Workforce;
- A scoping of new roles required as a consequence of *Transforming Your Care* (DHSSPS, 2011b);
- *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b);
- *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- *A Career Pathway for Nursing and Midwifery* (NIPEC, 2014).

All of the above work streams will, because of their focus on the development of the nursing and midwifery workforce, supplement the Plan which will be the umbrella document addressing the many issues currently facing the workforce.

1.2 Scope

Considering the wide range of health and healthcare services provided in Northern Ireland, this Plan is by necessity, broad in its scope, acknowledging that nurses and midwives deliver care 24 hours a day, 365 days a year, across the age spectrum. It has relevance to registered nurses and midwives employed within the statutory and independent sectors, taking account of primary, secondary and tertiary care settings and the major areas of practice to include: both the nursing and midwifery professions, the three parts of the NMC register and associated fields of practice and Agenda for Change (AfC) Bands ranging from Band 5 to Executive Nurse.

As the primary purpose of this Plan is to support the prediction of pre and post registration education places to be commissioned for nurses and midwives, health care support staff have not been included in this Plan.

Availability of nursing and midwifery workforce statistics relating for the independent sector were limited at the time of developing this Plan therefore it has proven difficult to include accurate, up-to-date figures. However, some important information obtained during stakeholder engagement has been included, particularly the need to strengthen reported recruitment issues. Nonetheless, work currently underway relating to nursing and midwifery within this sector will be taken into consideration during the implementation of the recommendations contained within this Plan.

A range of methods were employed between January and November 2014 to meet the project aim and objectives including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups and interviews with stakeholders across the HSC system and reviewing relevant policies and strategies to identify proposed capital and service developments or changes over the next ten years. The findings have been used to inform and shape the content and recommendations included within this Plan.

1.3 Ownership

The need to ensure the support and ownership of the health and social care system and the professions was considered critical in the development of this Plan. A Regional Steering Committee was therefore established to oversee the project, chaired by the Chief Nursing Officer, with representation from the DHSSPS, the five HSC Trusts, Public Health Agency, Business Services Organisation, Independent Sector and Professional and Trade Union organisations. Membership of the Project Steering Committee is listed in Annex A. Extensive stakeholder engagement and analysis of relevant statistical data was conducted and all relevant health policy documents were reviewed and a full list may be found in Annex B.

The Plan takes account of, and requires synergy with, the full range of legislative, policy and professional requirements and developments aimed at enhancing standards, care delivery and patient and client outcomes. It must also be considered in the multi-professional and inter-agency context of the settings in which nurses and midwives work. For this reason, it is important that it is linked with other relevant Workforce Reviews and Plans, in particular, the full range of Medical Workforce Reviews. The Plan will inform the education commissioning process in partnership with the Regional Workforce Planning Group (RWPG), as outlined in the monitoring process at point 6.2.

STEP 2: MAPPING SERVICE CHANGE

This is the first of three interrelated steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

2.1 Population and Health Profile

In Northern Ireland we have the fastest growing population of any country within the UK (DHSSPS, 2013a). The Northern Ireland Statistics and Research Agency (NISRA, 2014) reported that births in Northern Ireland have remained stable over the last 5 years with 25,300 live births registered during 2012. They also projected the population to rise from 1.79 million in 2010 to nearly 2 million in 2025 (an increase of almost 8 per cent).

There are 430,763 children and young people under the age of 18 in Northern Ireland (PHA, 2014). The number of people aged 65 and over is forecast to increase by 42 per cent, from 260,000 to 370,000. Significantly, though, the number of people of working age is only projected to increase by 1.4 per cent, from 1,109,000 to 1,124,000, by 2025. Over the same period, the number of people aged 85 and over will increase by 25,000 to 55,000.

In 2012, there were 14,756 deaths registered in Northern Ireland, an increase of 552 deaths (3.9%) compared to 2011. Of the 14,756 deaths registered in 2012, just under half (49%) of deaths occurred in hospital. A further 27% died in their own home, followed by 18% in a nursing home. The remaining 6% of deaths occurred elsewhere (NISRA, 2014). The average age at death has increased over the last 30 years from 70.1 years in 1982 to 76.4 years in 2012 (NISRA, 2014).

The main cause of death was cancer accounting for 28% of deaths in Northern Ireland. According to NISRA (2014), cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in Northern Ireland has increased from 18% in 1981 to 29% of all deaths in 2011. By way of contrast, deaths in 2011 due to ischemic heart disease decreased by 60% since 1981 from 4,909 to 1,966 (PHA, 2014).

Life expectancy across the region has improved by 8 years for females and 6 years for males since 1980/82. In 2008/10 males can expect to live to the age of 77.1 years and females to the age of 81.5 years. As overall life expectancy in Northern Ireland has continued to rise over the past 30 years (O'Neill et al., 2012), so has the likelihood of developing a long-term condition or experiencing co-morbidities (more than one long-term condition). A report by the Institute of Public Health in Ireland (2010) predicted that between 2007 and 2020 the prevalence of long term conditions amongst adults in Northern Ireland, namely Hypertension, Coronary Heart Disease, Stroke and Diabetes, is expected to increase by 30%.

The prevalence of long-term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2014). Across Northern Ireland the most prevalent long-term conditions are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

During 2011/12 long-term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 of the population (aged 18+).

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2014).

The number of alcohol related deaths has been increasing over the past decade. Since 2001, there has been a total of 2,785 alcohol related deaths, 68% of which have been deaths to males. Of this total, 854 or 31% were registered to Belfast Local Commissioning Group's (LCG's) area of residence (PHA, 2014).

The Health Survey Northern Ireland (DHSSPS, 2014c) indicated that three-quarters of children aged 2-10 years old (75%) were either underweight or normal weight, while a fifth (19%) were overweight and 6% were classed as obese. Overall, a quarter of adults (25%) were measured as obese with a further two-fifths (37%) classed as overweight. Males (69%) were more likely than females (57%) to be overweight or obese.

In Northern Ireland between 2001 and 2011, 37,500 people died prematurely of conditions which were potentially preventable. An additional 8,765 people died prematurely of conditions which, if diagnosed and treated early enough, might have been avoidable (PHA, 2014).

High levels of mental health problems, self-harm, suicide and alcohol and drug abuse are reported in the homeless population and an estimated 2/3 of prisoners have mental health problems (PHA, 2014). *Transforming Your Care* (DHSSPS, 2011b) highlighted that 24% of women and 17% of men in NI have a mental health problem – over 20% higher than the rates in England or Scotland. *The Service Framework for Mental Health and Wellbeing* (DHSSPS, 2011d) highlights that 10-20% of older people (aged 65 years or over) suffer from serious mental health problems. Similarly, *Healthy Child Healthy Future* (DHSSPS, 2010c) reported that the prevalence of mental health problems amongst children and adolescents is estimated at 20% and 'Looked After Children' are amongst the most socially excluded of our child population. In addition, children and young people with complex physical needs are increasingly being supported at home, including ventilated children (DHSSPS, 2011b).

The Dementia Strategy (DHSSPS, 2011e) indicates that levels of dementia are projected to increase to 60,000 by 2051 from 19,000 in 2010. Between 17-21% of the population have a physical disability, and around 37% of households include at least one person with a disability (NISRA, 2014).

2.2 Drivers for Change

The success of the *Transforming Your Care* (DHSSPS, 2011b) strategy, particularly in respect of the delivery of new service models, is significantly dependent on the development of an appropriately trained and competent nursing and midwifery workforce. The challenges facing nurses and midwives during this period of transition include a growing number of older people, children and other vulnerable groups requiring nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; high levels of mental health problems; the associated drive to prevent hospital admissions and to ensure end of life care at home; the development of eHealth technologies, including tele-monitoring; the requirement for advanced physical assessments and non-medical prescribing; the increase in the delivery of nurse led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, public expectations of health and social care are changing and patients and carers expect high-quality services to be delivered close to their homes.

To effectively meet emerging demographic, social and disease challenges and drive the transition of service delivery from predominantly acute-based to community settings, as outlined in *Transforming Your Care* (DHSSPS, 2011b), there is an increasing need for Specialist Nursing expertise particularly with skills in complex case management, advanced specialist practice knowledge, and the confidence to work autonomously in community rather than acute hospital settings.

A number of Specialist Nursing roles have already been developed in Northern Ireland, particularly in the areas of long-term conditions management, and increasingly in the management of conditions such as urology, dermatology, cancer, diabetes, Parkinson's disease, chronic heart failure and dementia. In many cases the involvement of a Specialist Nurse can prevent patients from being re-hospitalised (RCN, 2010).

The independent sector is becoming increasingly important in the delivery of care; mainly due to demographic changes and as our population continues to age. Increasingly more of the nursing workforce is employed within these sectors and it is important that the knowledge, skills and experiences attained within these settings are recognised and cultivated to ensure a highly skilled and flexible workforce for the future.

The demands for nursing and midwifery services will become greater as the health and social care landscape in Northern Ireland continues to evolve, during the shift from acute to community based services and given the recent onus on quality and patient safety highlighted in a range of recent regional and national strategies, reviews and public inquiries including:

- Quality 2020 Strategy (DHSSPS, 2011c)
- Public Inquiry into the Outbreak of Clostridium Difficile (Hine, 2011)
- Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)
- Independent Review into Healthcare Assistants and Support Workers (Cavendish, 2013)
- Winterbourne View Report (DH, 2013)
- Review into the Quality of Care (Keogh, 2013)
- Improving the Safety of Patients (Berwick, 2013)
- Management of Unscheduled Care Report (RQIA, 2014)

The need for investment in high quality, nursing and midwifery services has never been greater.

It is therefore important that consideration is given to ensuring that 'the right number with the right skills are in the right place at the right time with the right attitude, doing the right work, at the right cost, with the right work output (WHO, 2010), to achieve the quality goals set by health and social care organisations. To enable this we need to ensure that effective education and training and continuous professional development is available and ongoing to support the way forward. Ultimately, we want to assure our patients and clients that every service is safe and effective and provided by staff who are caring and compassionate.

2.3 Financial Challenges

Although the HSC continues to face significant financial challenges it must play a full and active role in delivering the efficiencies required to reduce the expenditure set by the Northern Ireland Executive. The implications of the efficiency challenges facing the HSC workforce over the next ten years will be significant, particularly in relation to meeting existing commitments; irrespective of any modernisation, reform and improvement.

A key financial objective within the *Transforming Your Care* (DHSSPS, 2011b) reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. The *Transforming Your Care* report highlights the intention to shift approximately 5% (£83 million) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme. In order to affect this shift of care and funding out of hospital services and into the primary/community setting, the HSCB will commission services to be delivered in a different way.

2.4 Service Changes

2.4.1 Strategic Direction and Transformation

Although Northern Ireland differs from much of the rest of the UK, in having an integrated health and social care system, it faces many of the same challenges (outlined in the diagram below) and must deliver similar changes if it is to be successful and sustainable in the future.

Source: Adapted from the NHS Confederation (2014)

The demographic changes described previously demonstrate the need to preserve and sustain our health and social care services in the face of increasing demands and to meet the care needs of the population within a difficult financial climate.

2.4.2 Regional Reviews and Strategies

Successful outcomes in the provision of health care are linked to the broader public health agenda and require integrated working at local and regional levels. The HSC has begun to address the challenges it expects to face, commencing work on a number of initiatives aimed at continuously improving the quality of services. A number of reviews and strategies (Annex B) are at various stages of development and implementation. Key themes arising from which will have an impact on the Nursing and Midwifery workforce are identified below:

Healthcare Policy

- Focus on measuring effectiveness, reducing variations and improving productivity
- High profile for improving quality of care and safety
- Designing effective healthcare systems and structures
- Continuing effort to improve evidence-based decisions on provision of services
- Revision of pattern of hospital services, concentration of specialisms and more care closer to home
- Personal and public involvement (PPI)

Supply of Healthcare

- Growing role for the independent sector
- Substantial investment in information technology
- Increase in the use of telecare to support people at home

Demands for Healthcare

- Changing patterns of disease, shifting dependency ratios
- Changing modes of service delivery
- Financial constraints
- Continuing emphasis on health promotion and prevention
- Persistent health inequalities
- High priority on supporting self-care in long-term conditions
- Growing demand for patient choice
- Developments in technology
- Move to 7 day working to support Integrated Care Pathways
- Outpatient Reform
    - increased use of virtual clinics
- Enhanced Care at Home Models
    - enhancement of community nursing services
    - rapid response to patients out of hours suffering an acute episode
    - single gateway multidisciplinary approach
- Stroke Care
    - increase direct entry to stroke units from 70% to 90%
    - early supported discharge
- Older persons' assessment and liaison (OPAL) Teams
    - specialist geriatric assessment outside of care of elderly wards
    - daily in-reach to ED's for screening
    - rapid access to out-patient clinics
- Alternatives to admission -
    - Shifting of resource to the community

Step 3: Defining the Required Workforce

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

3.1 Workforce Projections

Significant workforce change and development is expected to support enhanced community and primary care services associated with the implementation of *Transforming Your Care* (DHSSPS, 2011b). This will result in substantial training, re-training and re-deployment of associated nursing and midwifery staff, creating significant pressure on the Education Commissioning Budget as community based specialist practice programmes are full-time and are among the most costly elements of the Education Commissioning budget to fund. Similarly, there are a range of *Hot Spot Areas* which will have an impact on the nursing and midwifery workforce projections over the next ten years, as presented below.

Add in action point

The full time nature of Specialist Practice Programmes should be reviewed and consideration given to delivering these programmes on a part time basis

3.1.1 Hot Spot Areas

Impact of a Global Shortage of Nurses and Midwives

A range of reports and studies warn that global shortages are placing the nursing and midwifery workforce under pressure and risking the quality of patient care (Kelly et al., 2011; Van den Heede & Aiken, 2013; Imison & Bohmer, 2013; ICN, 2014). In the UK, the Centre for Workforce Intelligence (2013) forecast a likely reduction of 63,800 nurses over the period 2013 to 2016. Similarly, an NHS Employers report (2014) highlighted that 83% of NHS Trusts in England are currently experiencing qualified nursing workforce supply shortages.

In addition, there has been an outward shift of many of the internationally recruited nurses who moved to Northern Ireland during the last decade, mainly among the

Filipino and Indian nursing community. This is particularly pertinent to the independent sector who report significant difficulties in attracting and retaining nurses, even from overseas, at a time when an increasing number of patients and clients are being cared for by this sector. Northern Ireland employers from all sectors are holding major Job Fairs in an attempt to recruit, retain and attract nurses and midwives to their organisation. Similarly, employers from outside Northern Ireland are offering competitive relocation packages and choice of specialty with enhanced training to attract nurses and midwives. The evidence suggests that the international shortage of nurses will continue to be an issue of particular importance for Northern Ireland during the period of this Workforce Plan. In CNMAC's paper December 2015 (Annex C) there is a recommendation that immediate steps be taken to support a regional international recruitment process from both EC and Non EU countries

Action Point: A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice.

Impact of Recruitment Processes for Nurses and Midwives

During the development of this Plan, stakeholders identified a range of recruitment issues within HSC Trusts relevant to nursing and midwifery. The current practice of recruiting to temporary posts and/or the development of long waiting lists for posts, whereby nurses in particular are offered posts which do not take into consideration areas of preference or alignment to knowledge and skills, has led to the perception of a developing culture of "*any nurse will do*". This practice is counter-productive and is not resulting in ensuring the right nurse is deployed in the right area.

Similarly, recruitment processes and methods employed to backfill maternity leave and sickness absence were reported by stakeholders as difficult and protracted, leading to staff being under extreme pressure and experiencing heavy workloads; resulting in increased levels of workplace stress and low morale impacting on patient care. The impact of regional recruitment was reported as further concern. The CNMAC paper December 2015 gives more detail on the issues surrounding recruitment of Nursing and Midwifery staff.

Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review.

Action Point: Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review to support the implementation of this Workforce Plan.

Impact from Other Professional Groups

Workforce planning is currently underway for the medical profession to determine both the required size and distribution, by specialty, across Northern Ireland. Whilst there has been some success in recruiting to medical vacancies during 2013/14, pressures still remain in the system at both Consultant and Specialty Doctor level (Emergency Departments and Medical Specialties). Filling General Practitioner (GP) Specialist training roles is also proving difficult which will impact on future GP recruitment. With proposed reductions in the number of trainees within medical specialties and difficulty recruiting to all junior medical posts, this Plan is anticipating greater medical workforce pressures especially in some key areas where there are existing recruitment issues.

During the course of developing this Plan and further to recommendations made by the College of Emergency Medicine, work is underway to consider where Advanced Nurse Practitioners (ANPs) may offer a solution to the recruitment difficulties being experienced within the medical profession and/or where their competencies can best meet service needs. Areas to date include Primary Care, Community Care, Emergency Departments and Urology and it is expected that there will be similar recommendations from the Medical Paediatric Review. The Northern Ireland *Advanced Nursing Practice Framework* (DHSSPS, 2014b) provides a mechanism for greater understanding of the definition, role and competencies required to practice at this level. The HSC Trusts must take the opportunity to link the development of new roles explicitly to the planning process and commission future training numbers based on such plans alongside developing funding streams. This may require additional funding or a re-profiling of overall staff budgets within these areas.

Action Point: Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.

Implementation of Delivering Care

Demand for nursing and midwifery in Northern Ireland is set to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). During a scoping exercise on implementation of the first phase, it was anticipated that an additional 284 (WTE) adult nurses would be required to meet the normative nurse to bed and skill mix ratio in acute and specialist medicine and surgery. This is also a policy direction in the other UK countries;

England now requires all hospitals to publish staffing levels on a ward-by-ward basis and guidance from NICE (2014) is likely to strengthen the demand for nursing and midwifery in many areas. Scotland and Wales are moving in a similar direction. It is anticipated that any recruitment exercise required to address implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

During the development of this Plan, stakeholders from the independent sector reported that they are forced to recruit from other countries due to the significant recruitment and retention issues within this sector. Therefore, in order to address any concern regarding instability of nurse staffing within the Independent sector consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within this sector.

Action Point: An infrastructure to support learning and assessment in practice and availability of a period of preceptorship must be available within the independent sector similar to that already available within the Statutory Sector to ensure adequate supervision, support and guidance to enable consolidation of nursing and midwifery training.

The second, third and fourth phases of *Delivering Care* are running concurrently at present and intend to replicate the methodology used during phase one to produce a range for staffing levels within Emergency Departments, District Nursing and Health Visiting teams.

These phases are due to report by the end of March 2015 and may have further implications for nurse staffing in those areas. The project will subsequently look at other areas such as mental health, learning disability, children's and midwifery however an agreed timeline is yet to be established for these areas.

Action Point: Ensure that as new and emerging evidence and developments become available from *Delivering Care* (DHSSPS, 2013b), these are reflected within the implementation, monitoring and refresh stage of the Workforce Plan.

Professional Issues for Nursing and Midwifery

As previously outlined at point 2.2 above, many factors will present challenges for the nursing and midwifery professions over the next ten years and beyond. Similarly,

a range of professional issues will have a significant impact on the nursing and midwifery workforce, including the following:

- A Revised NMC Code for Nurses and Midwives;
- A new NMC Model of Revalidation;
- Implementation of *Delivering Care: Nurse Staffing Levels* (DHSSPS, 2013b);
- Development of Advanced and Specialist Practice roles and implementation of the *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- Implementation of *Job Planning Guidance for Clinical Nurse Specialists* (NIPEC, 2012);
- Implementation of the *Preceptorship Framework* (NIPEC, 2013);
- Mentorship and practice training in community settings;
- Implementation of *Standards for Supervision for Nursing* (DHSSPS, 2007) and *Midwives Rules and Standards* (NMC, 2012);
- Nursing and Midwifery accountability and delegation of care;
- Implementation of a *Career Pathway for Nursing and Midwifery* (NIPEC, 2015).

Technology and Technical Skill Demands

Changes in technology continue and we wish to embrace these changes in order to reap the benefits that they will bring in terms of more efficient and effective working. Already facilities such as video conferencing, Apps, digital dictation, e-learning, electronic prescribing, use of tablets and remote working are starting to become a reality for some nurses and midwives and support staff. However, accessibility to information and communication technology facilities require further enhancement in many areas, particularly within community nursing.

Many nursing and midwifery staff encounter telehealth and telecare applications in their daily work and an increasing number are taking a lead role in telehealth and telecare programmes. By expanding access to specialist services, providing real-time health advice, and remotely monitoring both care environments and health status, telehealth and telecare programmes have the potential to reduce visits by patients to care providers (and vice versa), facilitate more localised care, provide more timely diagnosis and intervention, and even reduce costs (RCN, 2014).

It is difficult to comprehend how much technology might have changed by the end of this workforce planning period. However, in order to gain maximum benefit from future technological change the HSC will require a workforce with increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

Action Point: Provision of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.

This is a commissioning responsibility which must be addressed if we are to offer patients and clients a better quality service, with easier access to the services required and to ensure effective and efficient utilisation of this particular workforce.

STEP 4: UNDERSTANDING WORKFORCE AVAILABILITY

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

4.1 Workforce Figures (based on HRPTS data at March 2014)

Workforce data and information in relation to the overall workforce within the HSC sector in Northern Ireland are held and maintained on a new system, Human Resources, Payroll, Travel and Subsistence (HRPTS). This system was introduced using a phased approach during 2013 and 2014 and is now in use across all of the HSC organisations. The HRPTS data is continually updated and managed locally by the employer organisations. The DHSSPS produces a quarterly statistical summary report for the whole of the HSC workforce.

The data relating to the nursing and midwifery workforce available on HRPTS provides a reasonable baseline demonstrating the numbers presently employed within the HSC workforce. It should, however, be noted that some areas have been difficult to analyse using the data, due to the categorising of some staff and some inconsistencies in the core data provided from HSC Trusts. At present, HRPTS grades all such staff as acute nurses, and although detailed interrogation of the system may permit the identification of staff statistics by sub-specialty, this is not easily done and is not part of the routine quarterly reporting.

Similarly, although the strategic direction, outlined in *Transforming Your Care* (DHSSPS, 2011b), is to drive the transition of service delivery from predominantly acute-based to community settings, the number of District Nurses, who are key professionals in supporting this agenda, has reduced by 13% since the previous Workforce Review (DHSSPS, 2009). This would suggest that some HSC Trusts are categorising these nurses on HRPTS under other grades, for example, 'Specialist Nurses' as during the same timeframe, Specialist Nurses at Bands 5 and 6 increased by 104%. In addition, the coding of some Band 5 and Band 6 nurses as 'Specialist Nurses' needs to be addressed as Band 5 nurses do not practice at a

Specialist level. HSC Trusts' workforce plans should address these categorisation and coding issues.

Action Point: The HRPTS categorisation and coding of the workforce needs to be reviewed and addressed by the HSC Trusts, particularly in respect of District Nurses and Specialist Nurses.

The figures included within this Plan are reported as they have been recorded on HRPTS. To allow meaningful analysis, bank staff and staff on career breaks have been excluded. Where staff have more than one post in the same organisation, or even within a different organisation, each post will have been counted in the 'Staff in Post' headcount, but the whole-time equivalent (WTE) will reflect the proportion of standard hours that are worked in each post. Staff who are temporarily absent from their position, for example due to maternity leave or sick leave, have been included in the analysis. In contrast to previous Nursing and Midwifery Workforce Reviews, Prison Nurses, who are now employed by the South Eastern HSC Trust, have been included in the 2014 workforce figures (n=55.2 WTE).

The data obtained for the purpose of this Workforce Plan includes a breakdown of the current workforce figures, inter alia, by:

- **Employing organisation;**
- **Service area (e.g. acute, midwifery, mental health, etc);**
- **Age;**
- **Gender;**
- **Headcount (HC) and Whole Time Equivalents (WTEs);**
- **Full-time or part-time status.**

4.2 HSC Workforce Profile

At the time of developing this Plan, the most recent statistical report was for the workforce as at 31st March 2014, therefore this point in time has been selected as the baseline for analysis.

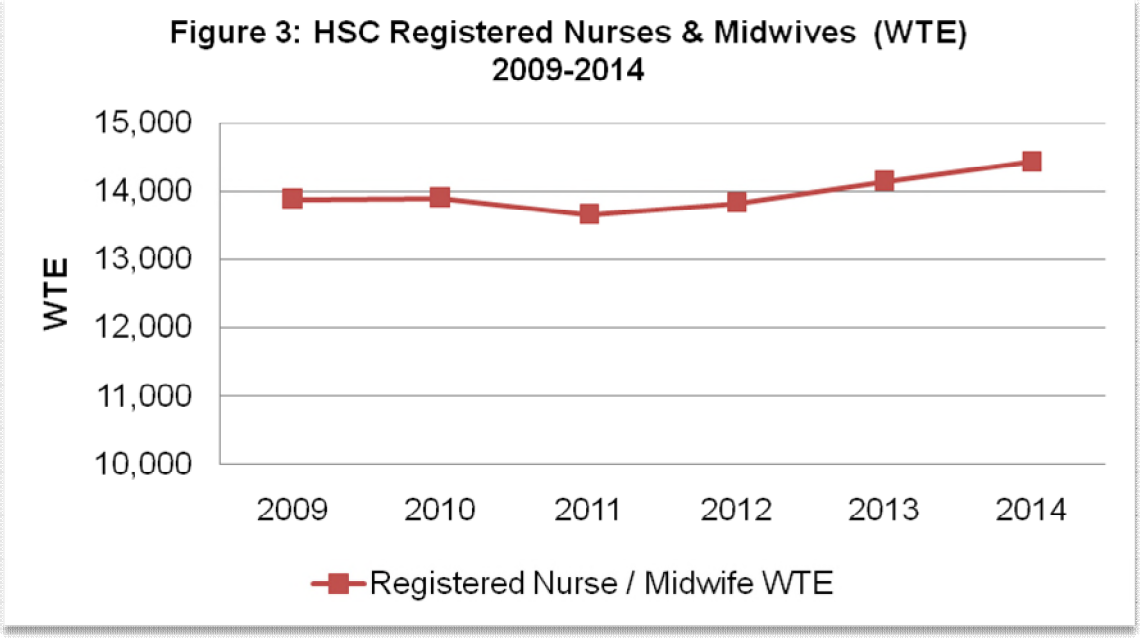
4.2.1 Composition of the Registered Nursing and Midwifery Workforce

The HSC employs 16,646 or 14,328.7 Whole Time Equivalent (WTE) registered nurses and midwives (excluding bank staff and career breaks) with a comprehensive range of skills geared towards meeting the needs of patients and clients (Table 1). It is the largest staff group within the HSC, accounting for around 27% of all staff.

Table 1: HSC Registered Nurses & Midwives as at 31st March 2014

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	**16,646**	**14,328.7**

Since the previous Nursing and Midwifery Workforce Review (DHSSPS, 2009), levels of registered nurses and midwives (including student midwives and health visitors for comparison) remained steady between 2009 and 2010, with a slight reduction in numbers during 2011 (Figure 3).



*includes student midwives and student health visitors for comparison with 2009 Review.

Table 2 demonstrates that overall, comparing 2014 with 2009, whole-time equivalent number of registered nurses and midwives have increased by 4%.

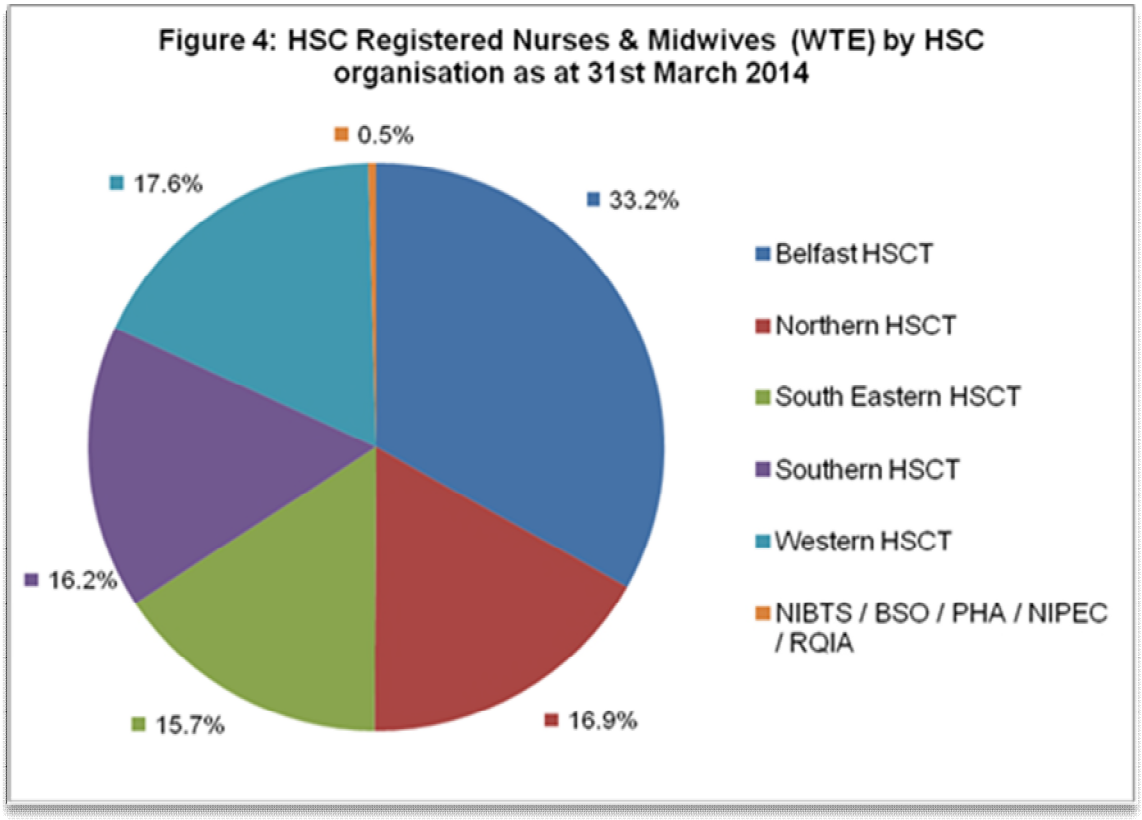
Table 2: Comparison of HSC Registered Nurses and Midwives (including post-registration students) 2009 and 2014

Combined Grades	2009		2014 *		% Change 2009-2014	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses / Midwives	16,251	13,875.9	16,646	14,328.7	3.1%	4.0%
Student Midwives / Student Health Visitors			105	99.8		
Total	16,251	13,875.9	16,751	14,428.5	3.1%	4.0%

*Figures include Student Midwives and Health Visitors for comparative purposes. The 2014 figures include Prison nursing staff (55.2 WTE).

4.2.2 Employing Organisation

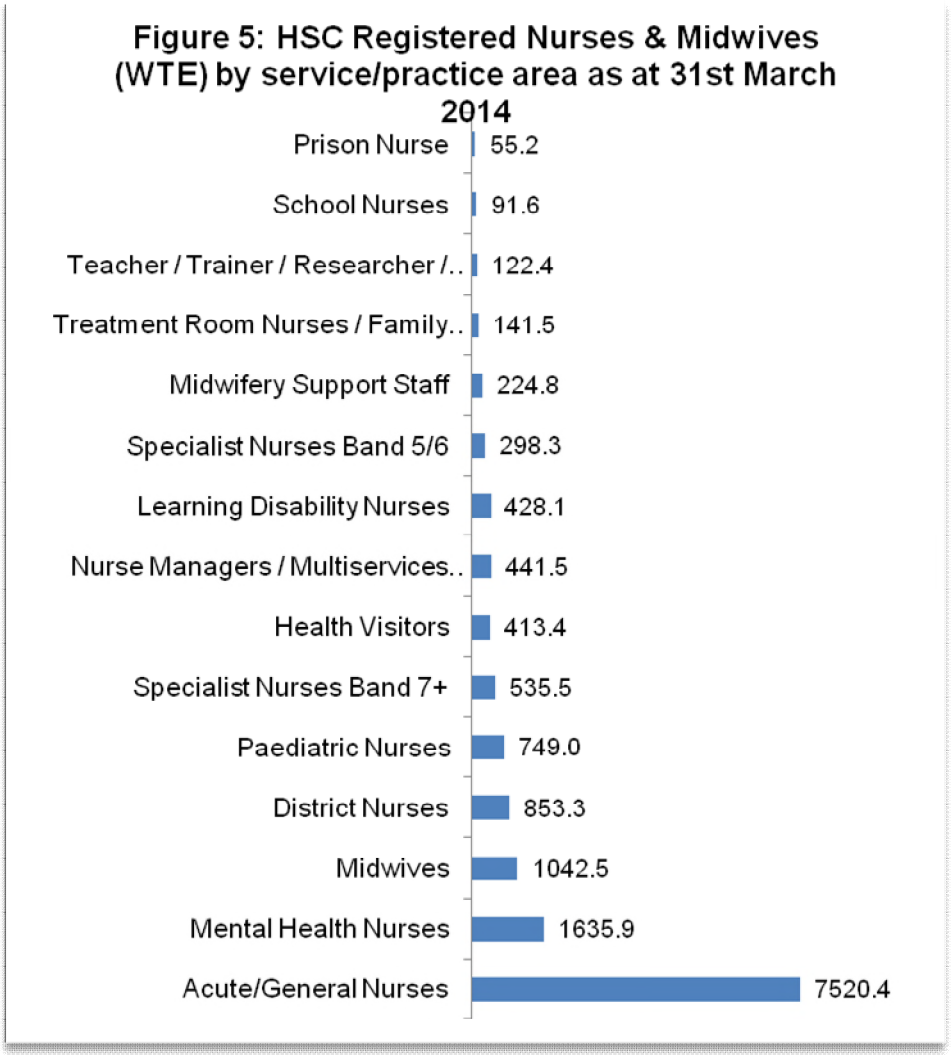
Belfast HSC Trust employs the largest percentage of the registered nursing and midwifery staff (33.2%), with the other HSC Trusts employing between 15.7% and 17.6% (Figure 4). However, it is important to note that the Belfast HSC Trust provides a range of regional services.



4.2.3 Registered Nurses and Midwives by Practice Area

Figure 5 below illustrates the number of registered nursing and midwifery staff by service/practice area. As previously highlighted, the data recorded on HRPTS by all HSC Trusts is not consistently coded to permit analysis of particular areas, such as, acute nurses working within specific wards, departments or sub-specialties.

Similarly, there appear to be some inconsistencies across all HSC Trusts in relation to how nursing staff are categorised on HRPTS, particularly District Nurses, who may, on some occasions have been categorised as other grades, for example, 'Specialist Nurses'. These issues present potential difficulties regarding the prediction of nursing and midwifery commissions within specific service/practice areas and will therefore be considered when discussing the predicted commissions over the next ten years within this Plan.

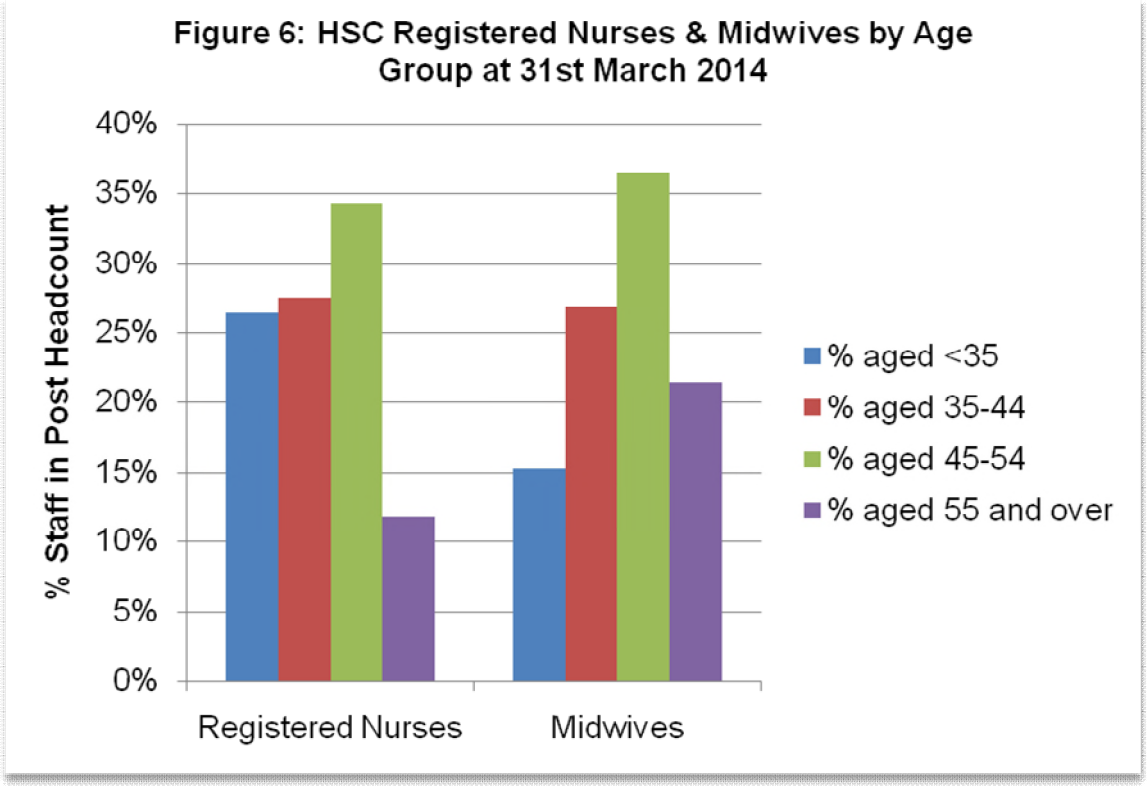


A more detailed illustration of the registered nursing and midwifery workforce by service/practice area within each HSC organisation has been included in Annex C.

4.2.4 Age of the Registered Nursing and Midwifery Workforce

Figure 6 presents (by staff category) the percentage of registered nursing and midwifery staff within each age category (using staff in post headcount). In terms of the 4 age categories presented, analysis shows that the highest proportion of staff within each category are aged 45-54. Midwives have the largest percentage of staff aged 45 and over (58%), followed by registered nurses (46%).

This compares with the 2009 Review which reported midwives had the largest percentage of staff aged 45 and over (54%), followed by registered nurses (39%).



Further analysis shows that the midwives category has the largest percentage of staff aged 55 and over (21%), compared to registered nurses (12%). This compares with the 2009 Review which reported that 13% of midwives were aged 55 and over and 8% of registered nurses were aged 55 and over. A more detailed illustration of the registered nursing and midwifery workforce by service/practice area and age has been included in Annex D.

Ensuring the health needs of our ageing workforce is essential, not least in recognising that some nursing, midwifery and support roles have a substantial physical element which may become more onerous, particularly with the transition of service delivery from predominantly acute-based to community settings (DHSSPS, 2011b), and the increase in patterns of lone working which this often entails. In

addition, the Health and Safety Executive (2013) identified differences in the sickness absence patterns between younger and older workers which need to be considered. Typically younger workers tend to be absent more often, but for shorter periods of time, whereas older workers are less likely to be absent less frequently but are more likely to have a longer period of absence.

The figures included in Annex E present the current numbers of staff aged 45 – 54 years who are likely to retire within the next five to ten years (or who may otherwise be more liable to leave the service for other reasons), particularly in the front-line service areas of mental health nursing (43%), district nursing (43%), health visitors (44%), school nursing (46%), specialist nursing (55%) and nurse managers (59%). Similarly, the numbers and the health and well-being of staff aged 55 or older, particularly in the front-line service areas of midwifery (21%), school nursing (21%), teaching and training (22%) will need to be considered. Furthermore, in other service areas, particularly acute nursing, where the age profile is generally younger and the workforce is predominantly female, the continuing incidence of part-time working and maternity leave is likely to prove challenging, particularly in respect of filling shifts which are relatively unpopular, including weekends and nights.

4.2.5 Registered Nursing and Midwifery Workforce by Gender

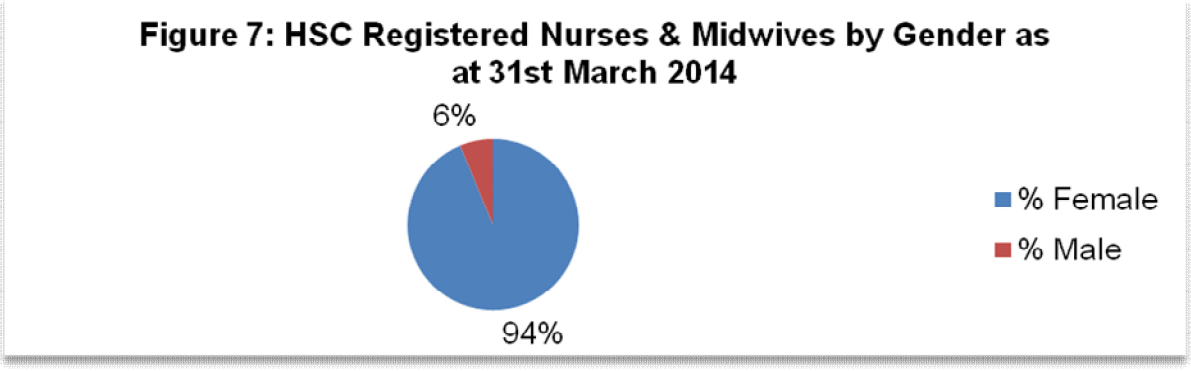
Table 3 demonstrates that 15,597 of the registered nursing and midwifery workforce are female with 1,049 being male.

Table 3: HSC Registered Nurses & Midwives by Gender (headcount)

Combined Grades	Female	Male	Total
Registered Nurses/Midwives	15,597	1,049	16,646

Figure 7 outlines that the figures are consistent with the 2009 Review which reported that 91.9% of the overall workforce was female and 8.1% male.

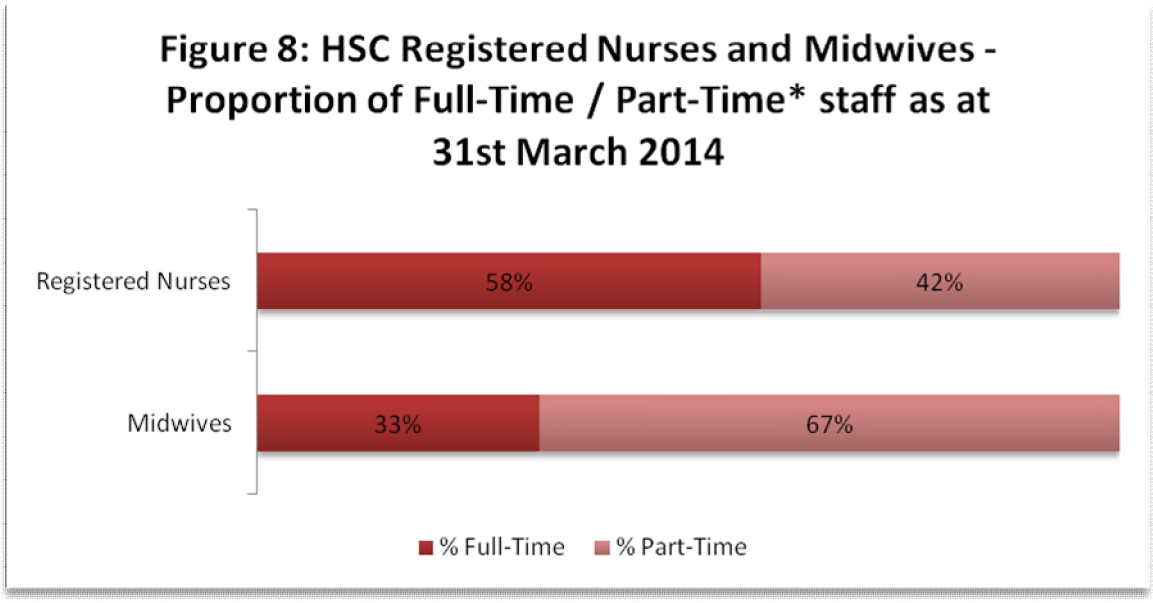
Figure 7: HSC Registered Nurses & Midwives by Gender as at 31st March 2014



A detailed illustration of the registered nursing and midwifery workforce by service/practice area and gender has been included in Annex E.

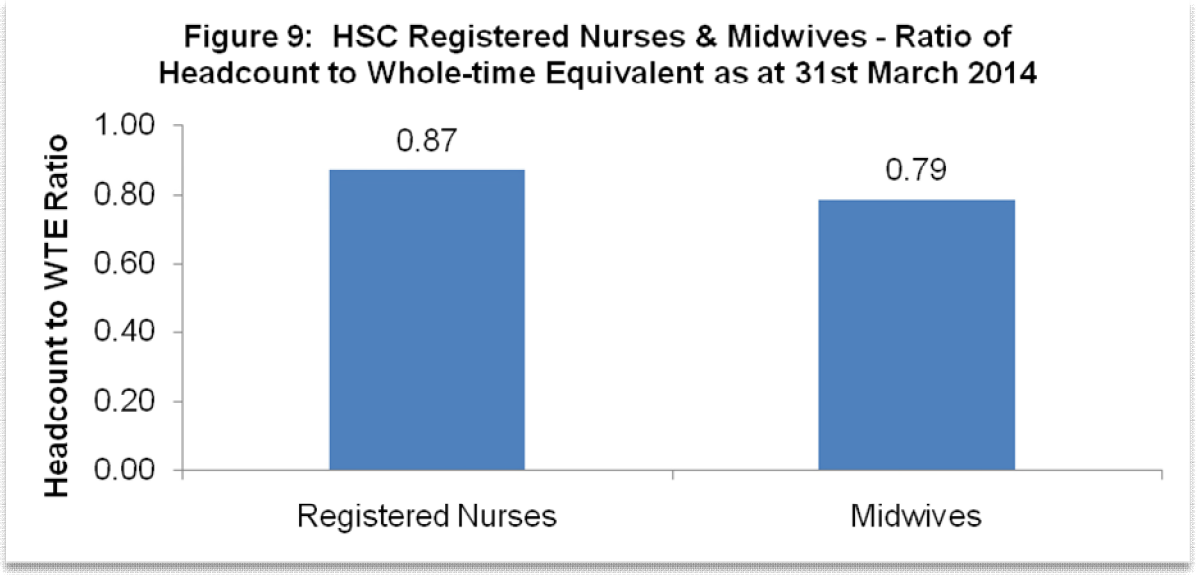
4.2.6 Registered Nursing and Midwifery Working Patterns and Conditions

In terms of contract type, analysis of registered nursing and midwifery staff whole-time equivalents (WTE) shows that the midwives category has a greater proportion of part-time staff at 67% compared to the registered nurses (42%): (Figure 8).

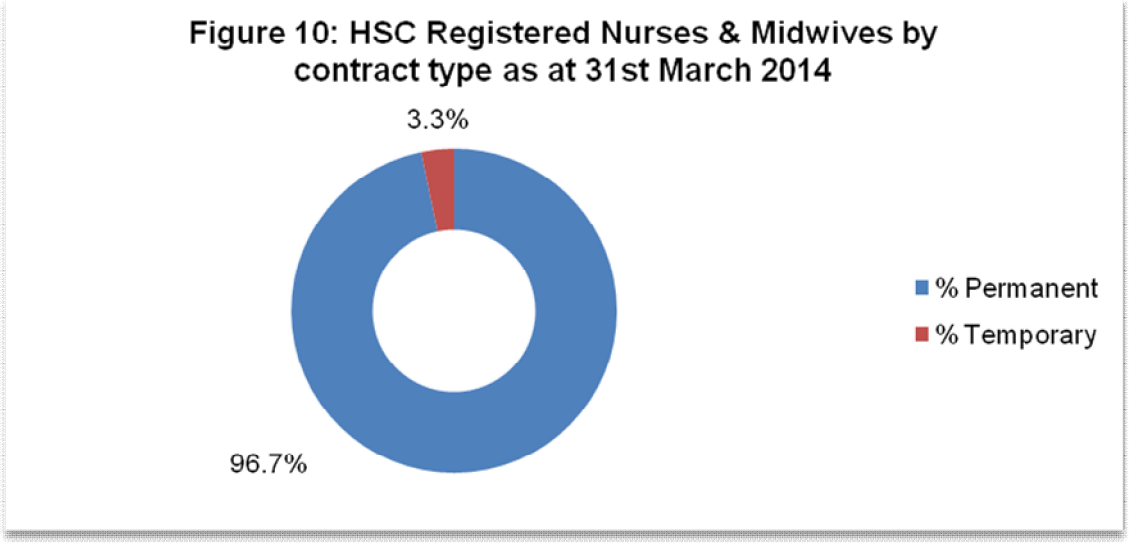


* Part-time is defined as anyone working less than full-time hours (i.e. 37.5 hours per week).

As demonstrated in Figure 9 below, although the midwives category shows a greater proportion of part-time staff, analysis of the overall headcount to whole-time equivalent ratio shows that they have a marginally lower ratio (0.79) compared to the registered nurses category (0.87).



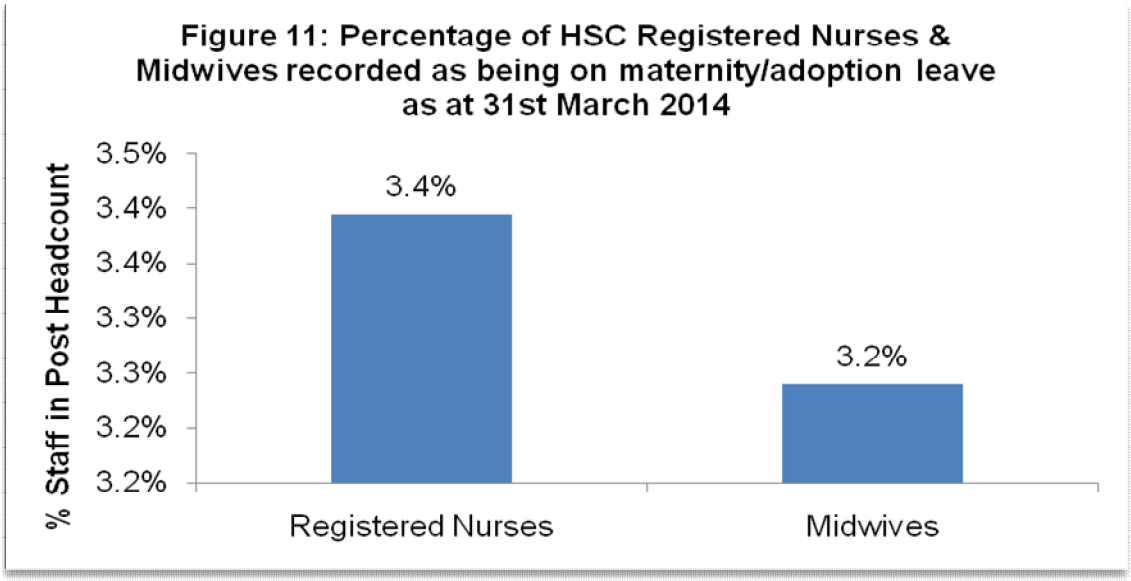
Analysis of contract type in HPRTS shows that the registered nursing and midwifery workforce consists of mostly permanent contracts (excluding bank), as presented in Figure 10.



The whole-time equivalent contribution of bank staff cannot currently be analysed, however, the majority of registered nursing and midwifery staff bank contracts held within HRPTS are for staff who also have a substantive post within HSC organisations (around 80%).

4.2.7 Registered Nursing and Midwifery Staff Maternity/Adoption Leave

Figure 11 below shows analysis of attendance/absence type in HRPTS and shows the percentage of staff recorded as being on maternity/adoption leave as at 31st March 2014.



A breakdown of registered nursing and midwifery staff recorded as being on maternity leave as at 31st March 2014 is presented in Table 4 below.

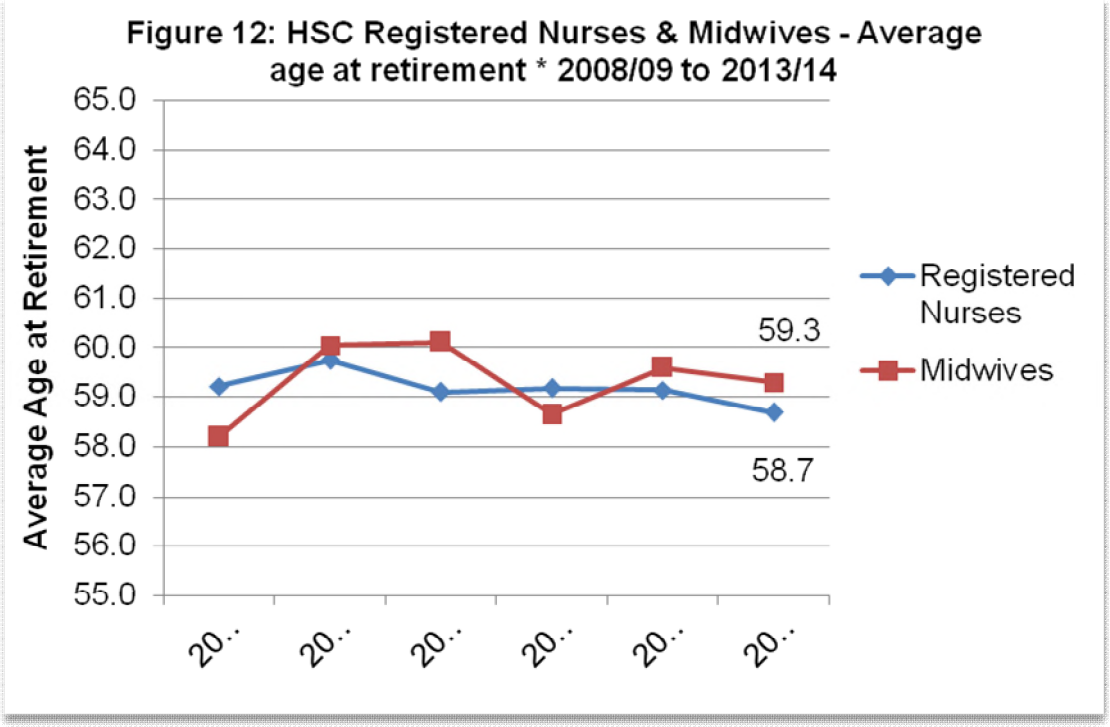
Table 4: Percentage of HSC Registered Nurses & Midwives recorded as being on maternity/adoption leave as at 31st March 2014 (Headcount and Whole-time equivalent)

Staff Category	Recorded as being on Maternity/ Adoption Leave		Total staff		% recorded as being on Maternity / Adoption leave	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses	520	464.0	15,319	13,286.2	3.4%	3.5%
Midwives	43	36.7	1,327	1,042.5	3.2%	3.5%

Although HRPTS high level statistics demonstrate that overall maternity rates are fairly low, representing 3.4% of registered nurses and 3.2% of midwives, at team level maternity absences can have a significant impact, for example, an Orthopaedic theatres team – 2 out of 10 staff on maternity leave = 20% or a Health Visiting team – 3 out of 16 staff on maternity leave = 19%.

4.2.8 Registered Nursing and Midwifery Staff Retirement Trends

Retirements present an opportunity for change and redesign of the workforce. However, it is worth noting that there is often a wealth of skills and experience embodied in these people, gained over many years of service, which will be lost to the HSC and will therefore take time to develop and re-establish. Eligibility for retirement can differ for specific grades of nurses and midwives or due to the pension scheme in question. Average age at retirement for registered nurses decreased slightly in 2013 but has ranged from 58.8 - 59.6 over the last 5 years. For midwives, average retirement age was increasing during the period 2008-2010, with a dip in 2011/12, followed by a period of increase in 2012/13 and 2013/14 (Figure 12).



*The above figures include those with 'Reason Left' recorded as Retirement, Ill Health Retirement or Voluntary Early Retirement (excluding bank staff), but only for those aged 55+.

It might be expected that retirements could be predicted with some degree of accuracy; however, this Plan is being written at a time when such predictions are more difficult due to the current economic climate and pension changes for staff. For instance, with effect from 1 April 2011 employers can no longer operate policies that include a compulsory retirement age. In addition, by 2015 the state retirement age for men and women will be 65 years. It could therefore be expected that women may reconsider the age at which they retire resulting in a gradual increase in age.

Similarly, it seems likely that public sector pension schemes will change during the period of this Plan, based on the Hutton Review of Public Sector Pensions (2011). The main changes will include linking the age at which the Occupational Pension is paid (based on a career average rather than a final salary scheme) to the age at which the State Pension is paid. The implications of these changes might be that staff will continue to work beyond the age at which they had previously planned to retire under the existing scheme, in order to match their existing pension or improve on this. Alternatively, the proposed changes may prompt staff to retire earlier than planned, prior to any definitive changes. Furthermore, *Mental Health Officer Status* is held by many staff which enables them to retire at the age of 55 years, without any reduction to their pension. This status is not available to staff who did not have it granted before 6 March 1995, so the numbers who fall into this category will be reducing during the timescale of this Plan.

The decision about when to retire will be a personal one, whether related to any or all of the above issues, the economy and how it impinges on people's lives or for other reasons. Predicting numbers that are expected to retire is not precise, but we can assume, based on historical trends, that staff will leave when they reach the current average retirement age for their group. Further work on the impact of the age profile and pension changes should be undertaken to support this Plan, particularly during annual reviews.

Action Point: The impact of the nursing and midwifery age profile and relevant pension changes should be undertaken to support the implementation of this Plan, particularly during annual reviews.

4.2.9 Registered Nursing and Midwifery Staff Health and Wellbeing

The DHSSPS collects high level sickness absence information from HSC organisations twice a year. HSC Trusts must continue to support in the best way possible, those of its staff who suffer ill health.

Figure 13 below shows the trend of sickness absence rates amongst registered nursing, midwifery and support staff, ranging between 6 and 6.6%.

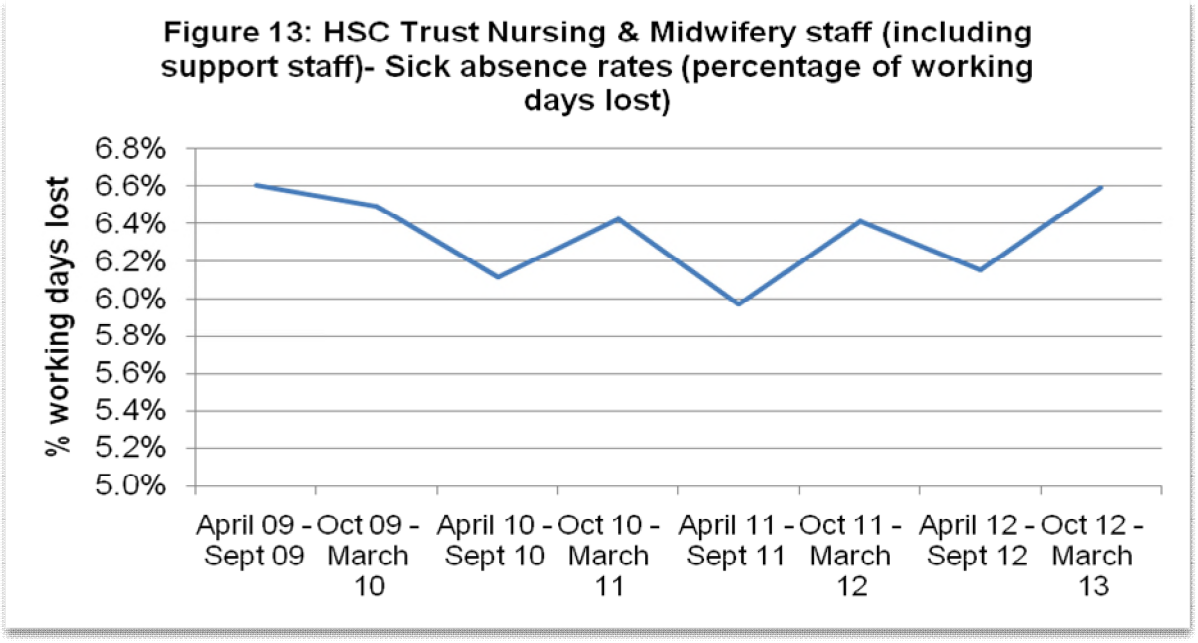
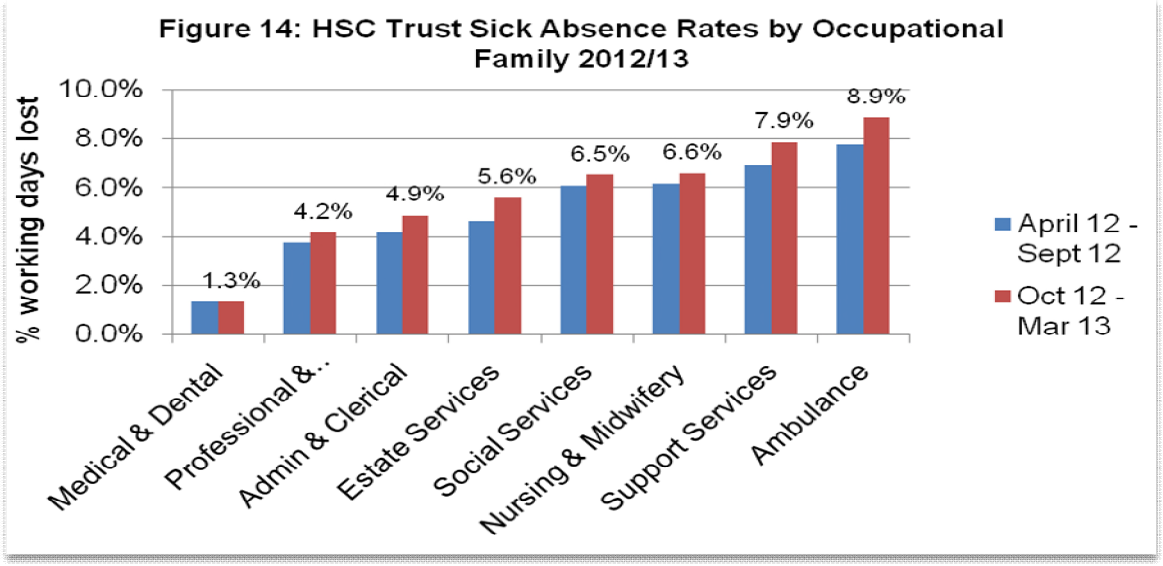


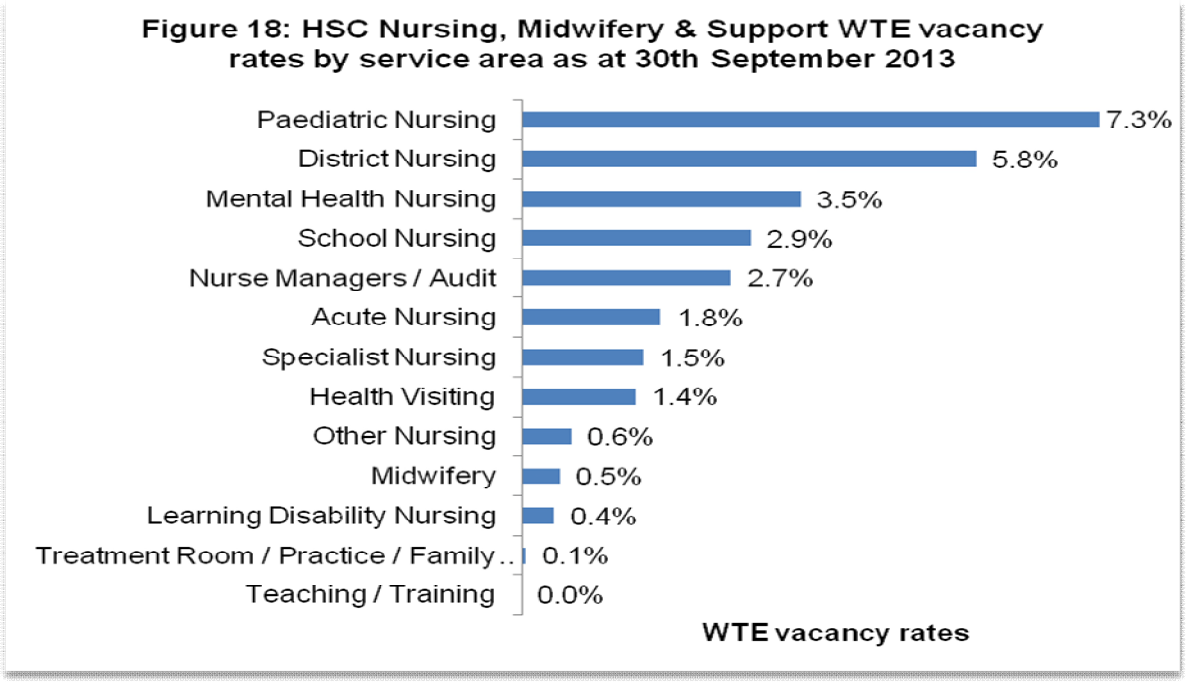
Figure 14 below shows a comparison of sickness absence rates in other occupational families for the two collection periods in 2012/13. The registered nursing, midwifery and support workforce had a similar sickness absence rate during 2012/13 to the social services workforce but not as high as support services or ambulance staff (note the percentage label in the chart relates to the period October to March).



Delivering Care (2013b) includes a 5% target for Sickness Absence. The regional average for the monitoring period October 2012 – 31 March 2013 is up from 6.41% last year to 6.6% therefore a significant reduction in sickness absence will be required to meet this target. The HSC Trusts should continue to seek to reduce sickness absence rates over the period of this Plan (2015-2025).

4.2.10 Nursing and Midwifery Vacancies and Supplemental Staffing

A vacant post is defined as a post '*actively being recruited to' (DHSSPS*). The DHSSPS collects data on vacancies via a survey twice a year. Figure 18 below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.



All HSC Trusts had varying levels of vacancies, at 30th September 2013, amounting to 470 (headcount) or 419.1 (WTE) vacant posts, representing a rate of 2.3% (based on WTE) across the HSC nursing & midwifery occupational family, with the highest vacancy rates in paediatric nursing (7.3%), district nursing (5.8%), mental health nursing (3.5%) and school nursing (2.9%) at that time. Vacancy numbers, rates, Agenda for Change bands and service areas across the HSC Trusts are presented in Annex F.

HSC Trusts operate their own staff banks or overtime system and/or utilise agency staff to supplement the nursing, midwifery and support workforce. This is normally in response to vacancies, planned and unplanned/sickness absence in order to minimise service disruption and ensure service standards are maintained. HRPTS figures demonstrate that the majority of bank contracts (around 80%) are held by registered nurses and midwives who already have a substantive post within the relevant Trust.

HSC Trusts' Financial Returns submitted to the DHSSPS (Table 5) demonstrate variations in the use of bank and agency staff.

Table 5: Bank/Agency Expenditure from DHSSPS Finance Directorate 2008-2013

Agency Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
08/09	8,829,000	622,401	2,581,926	1,289,099	846,399	14,168,825
09/10	6,066,000	481,465	3,303,414	1,185,710	1,268,818	12,305,407
10/11	2,818,000	612,964	3,398,887	452,734	1,525,742	8,808,327
11/12	3,114,000	836,225	2,031,664	263,240	2,070,303	8,315,432
12/13	3,742,000	1,078,594	2,768,074	672,111	1,591,350	9,852,129
Total	**24,569,000**	**3,631,649**	**14,083,965**	**3,862,894**	**7,302,612**	**53,450,120**

Bank Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2008/09	6,957,000	7,059,211	494,641	2,732,462	3,046,598	20,289,912
2009/10	10,861,422	4,138,646	2,511,105	3,703,771	2,971,304	24,186,248
2010/11	12,833,926	4,684,905	2,847,489	4,097,985	3,891,876	28,356,181
2011/12	15,067,266	5,612,623	5,604,662	6,327,428	3,158,444	35,770,423
2012/13	16,664,000	6,242,135	6,207,717	7,825,280	4,774,951	41,714,083
Total	**62,383,614**	**27,737,520**	**17,665,614**	**24,686,926**	**17,843,173**	**150,316,847**

Source: Trust Financial Returns (TFR E&S)

It is important to note that HSC Trust data on bank and agency staff is primarily financial, and HRPTS does not record the use or deployment within specific service

areas of agency and bank staff, making it difficult to track the impact of their use. In addition, the whole-time equivalent (WTE) contribution of bank staff cannot currently be analysed by HRPTS.

This compares with the picture across Northern Ireland at the time of the previous review (DHSSPS, 2009), with 2006/07 returns for bank and agency nursing costs (Table 6) showing the following:

Table 6: Bank/Agency Expenditure from DHSSPS Finance Directorate 2006-2007

Bank and Agency Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2006/07	10,552,000	798,000	1,758,000	464,000	982,000	**14,553,000**

Source: Trust Financial Returns (Expenditure: Salaries and Wages)

The use of bank and agency staffing has more than doubled in the intervening years since the last nursing and midwifery workforce review (DHSSPS, 2009). As demonstrated in the Report into Mid-Staffordshire NHS Trust (Francis, 2013), there appears to be a clear link between temporary staff and poorer outcomes for patients and families.

The Keogh Report (2013) also noted a positive correlation between inpatient to staff ratio and a high hospital standardised mortality ratio (HSMR) score. Another key finding was that actual nurse staffing levels in the 14 Trusts were below those that had been reported in national indicators. High use of temporary staff, higher use of health care assistants, low levels of nurse staffing at nights and weekends, and relatively high levels of nurse vacancies were among key staffing issues.

One recommendation was that '*Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience*.' The Report also noted the National Quality Board's (2013) guide to nursing, midwifery and care staff capacity and capability and further guidance has recently been published by the National Institute of Clinical Excellence (2014).

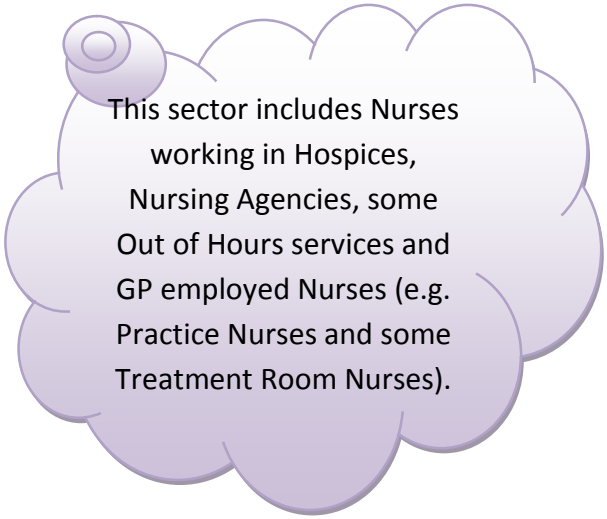
To support this, significant work is ongoing in Northern Ireland to address the use of bank and agency with mechanisms and processes in place within HSC Trusts to facilitate the use of the most cost effective supplementary staffing solution, be it bank

or overtime. In addition, the Nurse Leaders in Northern Ireland have agreed that as posts are filled via *Delivering Care*, the use of bank/agency/overtime must be reduced by 75% when the work has been completed. A Regional Initiative, led by the Chief Nursing Officer, *Evidencing Care through Key Performance Indicators for Nursing and Midwifery* will monitor compliance with the agreed 75% reduction, as a further assurance that the use of bank and agency staff will be minimised alongside a reduction in vacancies and absenteeism.

It is in the best interest of each employer, the staff and the patient to reduce to the lowest possible level the use of nursing and midwifery bank and agency staff within Northern Ireland. HSC Trusts must implement *Delivering Care: Nurse Staffing in Northern Ireland* (DHSSPS, 2013b) to reduce vacancies and the use of bank and agency staff to ensure safer patient and client care.

4.3 Workforce Figures for the Independent Sector

The independent healthcare sector refers to private, voluntary and not for profit establishments covering a wide variety of services and organisations (Skills for Health, 2011).



Historically it has proven difficult to obtain accurate, up-to-date workforce figures for nurses within the independent sector. This is mainly because no mechanism or process currently exists whereby independent sector employers are required to present their workforce data in a consistent manner and/or many employers in this sector may be concerned about commercial sensitivity and are not prepared to release workforce data.

This is consistent with attempts to gather data from this sector during the previous Workforce Review (DHSSPS, 2009) which suggested that the total number of nursing staff may be as low as 2,000 or well over 3,000. A UK wide *RCN Employment Survey* (2013a) indicated that 12.3% of Northern Ireland respondents (n=9,553) reported working within this sector. Comparing this with the NMC register at 31st March 2014, it appears that the number of nurses working within this sector ranges from 2,731 to 3,475.

Although the previous Review (DHSSPS, 2009) indicated that the Regulation and Quality Improvement Authority (RQIA), the independent HSC regulatory body for Northern Ireland, were seeking to gather workforce data from the independent sector, no data was available during our period of stakeholder engagement.

The independent sector providers are facing a growing complexity of care; some are delivering consultant lead intermediate care bed services, fracture rehabilitation services, assessment bed services, acute mental health and alcohol dependency services along with their nursing care and dementia care services. Their need for registered nurses is increasing as they respond to these demands yet they are unable to recruit sufficient numbers of nurses to meet demand and are currently recruiting extensively overseas.

This is supported by a recent report from the Care Quality Commission (CQC; 2014), the inspectorate for health and social care in England, which highlighted a severe shortage of nurses in nursing homes, made worse by the efforts of NHS hospitals to hire more staff following the Report into Mid-Staffordshire NHS Trust (Francis, 2013).

This sector has been lobbying to increase pre-registration nursing places in Northern Ireland throughout the compilation of this Nursing and Midwifery Workforce Plan. The Four Seasons Group alone recruited 209 registered nurses via European Union (EU) routes during 2014. They now have to recruit further afield and in December 2014 they undertook recruitment trips to Cochin in India and to Manila in the Philippines as they can no longer acquire the volume of nurses required through either local recruitment or the EU route.

The EU nurses recruited by the Independent Sector often move on to HSC posts within one year of coming to Northern Ireland as they will then have no work permit restrictions.

The new NMC registration process for non EU nurses is currently not clear due to the delay in UK Visas and Immigration (UKVI) making determination on the entry visa type for these NMC applicants. The NMC have been in discussion with UKVI and a decision on the change of policy is imminent. The Department of Health in England has been lobbying for a decision by UKVI due to the magnitude of the nursing shortages they are facing.

Action Point: A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.

Step 5: Developing An Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical.

5.1 Commissioned Nursing and Midwifery Student Places

Learning and development is an intrinsic element of workforce planning; necessary for the attainment and maintenance of professional registration, the further development of nursing and midwifery roles, competence and capability and, ultimately, the delivery of safe, effective and person-centred care.

5.1.1 Pre-registration Nursing and Midwifery Commissioning

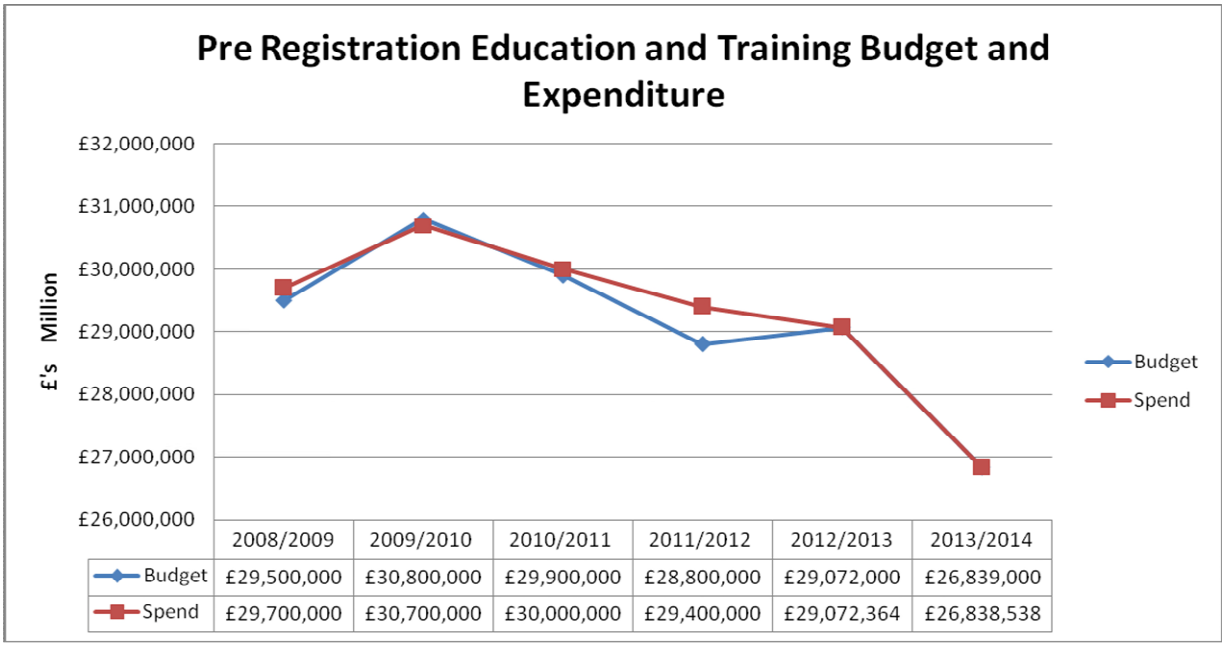
The DHSSPS commissions pre-registration nursing and midwifery education in Northern Ireland; delivered by three providers, namely Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. From 2011, Northern Ireland moved from diploma/degree to degree level only programmes, incorporating the Nursing and Midwifery Council (2010) requirements.

The commissioning profile should be continually assessed to ensure it meets the needs of service. Table 7 demonstrates that the number of pre-registration nursing and midwifery places commissioned has fallen in recent years from 792 in 2008/2009 to 685 in 2014/2015 despite reported difficulties in recruiting nurses to the Independent sector. As previously reported, this sector is continuing to recruit from overseas, however recruitment and retention difficulties exist.

Table 7: the number of pre-registration nursing and midwifery places commissioned

Branch	Pre-Registration Commissioned Places by Year						
	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Adult	525	535	471	471	444	444	444
Adult OU	0	18	0	9	9	7	9
Mental Health OU	36	18	18	9	9	18	16
Children's	55	60	60	60	55	55	55
Mental Health	99	99	99	99	96	96	96
Learning disability	15	30	30	30	30	30	30
Midwifery D/Entry	30	30	30	30	35	35	35
Midwifery, Additional Registration	32	35	35	35	25	25	0
Totals	**792**	**825**	**743**	**743**	**703**	**710**	**685**
Year of completion	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**

Figure 19 below shows that the Pre-registration Nursing and Midwifery Education Commissioning Budget has been significantly reduced from £29,500,000 in 2008/2009 to £26,839,000 in 2013/2014, representing a 9% reduction.



The RCN (2013b) in their publication '*Frontline Nurse: Nursing on Red Alert*', reported concerns about the reduction in training places as a key factor contributing

to an impending nursing shortage. As the nursing commissioning and education process takes at least three years it may be some time before we feel the full effects of this reduction in supply. It will then take several years to respond to a potential nursing shortage through the education system. England in particular is currently recruiting aggressively in Northern Ireland and offering relocation packages of up to £3,000 to new nurse graduates here. This is a trend that will continue until the education system can address the shortfall of nurses in the other three countries. England, Scotland and Wales have all increased pre-registration nurse training places in 2015/2016 due to the impact of nursing shortages. This Review recommends increasing Pre-registration numbers by at least 100 places.

5.1.2 Post-registration Nursing and Midwifery Commissioning

The DHSSPS also commissions post-registration education for nurses and midwives from a range of providers across Northern Ireland, which includes the three universities, independent providers, such as the Royal College of Nursing and the Clinical Education Centre and in some cases Universities outside Northern Ireland. Programmes are also funded for provision at local HSC Trust level.

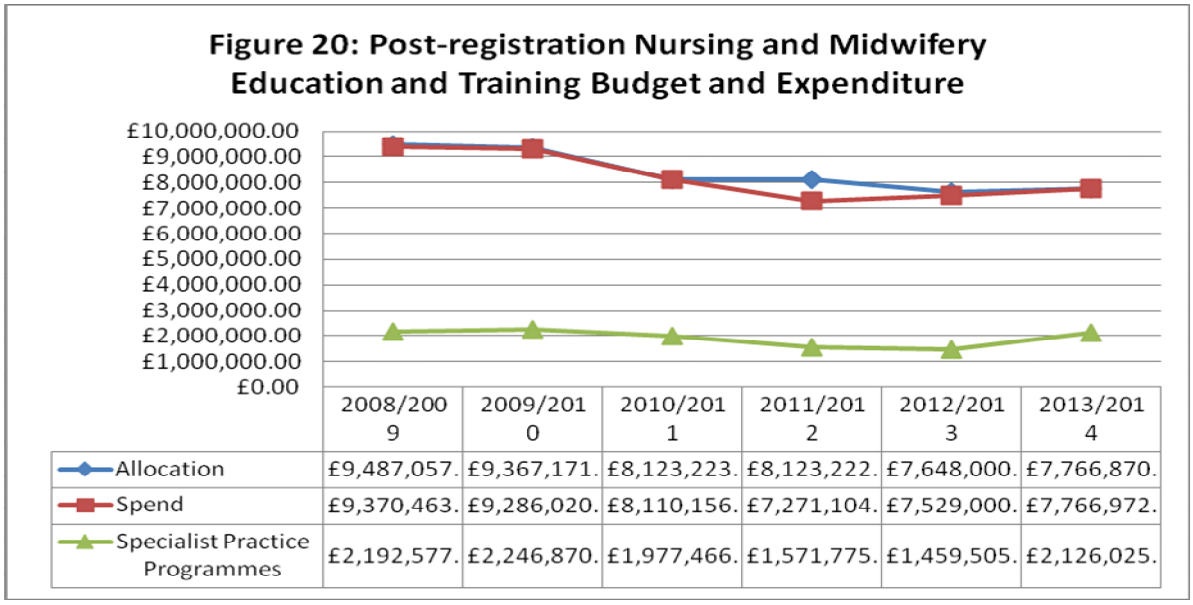
In addition, the DHSSPS commissions 32 *Return to Practice* programmes on an annual basis within the four fields of practice including Adult, Children's, Mental Health and Learning Disability Nursing. The University of Ulster reports that competition remains oversubscribed for these programmes with between 80-90 applications per year. Presently there is no pathway for NMC Part 3 registrants, including Health Visitors.

The commissioning process is currently managed through the DHSSPS Education Commissioning Group (ECG). Commissioned programmes include study days, stand alone modules and short courses leading to an NMC regulated programme such as Specialist Practice Qualifications.

Nursing and Midwifery post registration education is crucial to maintain competence and to develop new specialist skills for specialist roles, including District Nursing, Health Visiting, Infection Prevention, Neonatal Care, Respiratory Disease and Diabetes.

The nursing and midwifery post-registration education and training and expenditure budget from 2008/2009 to 2013/2014 is presented in Figure 20 below which demonstrates that the Post-registration Nursing and Midwifery Education Commissioning budget allocation has been significantly reduced since 2008/2009 by £1,720,187.00, representing a 19% reduction.

Figure 20: Nursing and Midwifery Education Commissioning Budget Allocation



	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Allocation	£9,487,057.	£9,367,171.	£8,123,223.	£8,123,222.	£7,648,000.	£7,766,870.
Spend	£9,370,463.	£9,286,020.	£8,110,156.	£7,271,104.	£7,529,000.	£7,766,972.
Specialist Practice Programmes	£2,192,577.	£2,246,870.	£1,977,466.	£1,571,775.	£1,459,505.	£2,126,025.

*Specialist Practice Programmes relate to Replacement Monies for staff back fill (based on full-time, midpoint Band 5)

5.1.3 Continuing Professional Development Commitments

NMC revalidation places a high degree of demand on nurses and midwives to demonstrate they remain fit to practice. Continuing professional development (CPD) is necessary for the maintenance of NMC registration, the delivery of high quality nursing care and the further development of nursing and midwifery roles. Lord Willis, speaking at the 2014 RCN Congress, argued that training for nursing should continue long after registration:

> *"I would like to look at continuous professional development (CPD) and preceptorship because when a nurse has finished training they are not the finished article and should continue to learn throughout their career. For that to happen we need a seismic change to CPD".*

During our discussions with stakeholders, a number of issues were identified:

- the increasing requirements for nursing and midwifery staff to undertake mandatory training restricts their ability to undertake some CPD pursuits. CPD represents a major resource commitment at service level, both in time required to be released from service delivery, and also in the provision of staff to *back fill*;

- the increasing complexity of patient and client clinical need in the independent sector requires nurses to up-skill to reduce reliance on the HSC Trusts' workforce to support the independent sector staff;

- supervision of staff/mentoring roles places a high degree of demand at service level this has been particularly emphasised by the Independent sector;

- training should be developed according to programmes of care;

- the annual appraisal system must be linked to the Education Commissioning Process to ensure that staff develop in a way that is consistent with HSC Trust Reform Plans, regional strategies and priorities;

- HSC organisations must embed succession planning and ensure strong and capable leadership at all levels within nursing and midwifery to develop practice, improve quality of care and optimise patient and client outcomes.

5.2 Risk Assessment

This Workforce Plan emphasises the importance of continuing to develop Key Performance Indicators linking workforce metrics, such as, vacancies, use of bank and agency staffing and absenteeism to quality metrics, for example, patient falls, pressure ulcers, omitted or delayed medication and patient experience data.

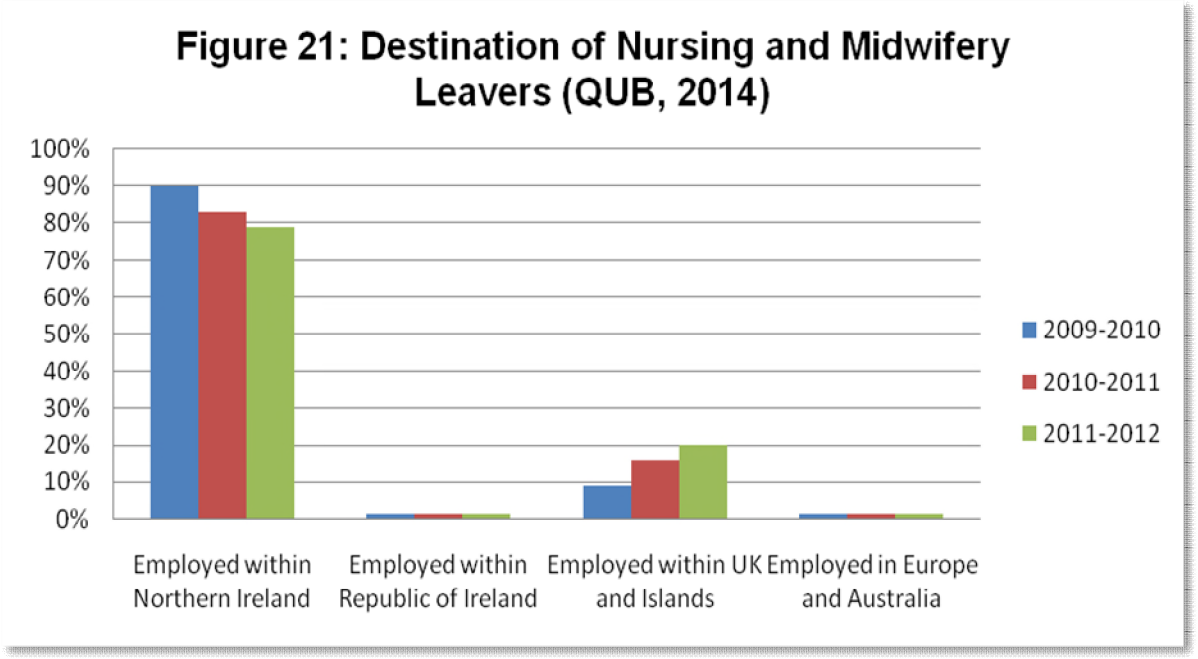
The HSC Trusts' Executive Directors of Nursing are responsible for the identification, mitigation and, where possible, avoidance of risks, including risks associated with the workforce. Risks should be recorded and managed through a robust corporate approach to Risk Management and monitored via accountability arrangements with the DHSSPS.

5.3 Student Nurses and Midwives

5.3.1 Destination of Student Nursing and Midwifery Leavers

Within recent years, countries such as the US, Canada and Australia have been offering generous salary and relocation packages, and fast-tracked residency status with the prospect of naturalisation, for example, the '*US Green Card*' system. Similarly, the transferability of the UK professional registration facilitates the free movement of both nurses and midwives currently working within the UK (including Northern Ireland).

Figure 21 below presents the findings from a survey conducted by Queen's University, Belfast. This demonstrates an increasing trend (currently 21%) for newly qualified nurses and midwives being employed outside Northern Ireland following completion of their programmes. It is important to note that those nurses and midwives *Employed within Northern Ireland* (Figure 21) include the independent sector who use the same *pool* as the HSC to recruit from.



At the time of developing this Plan, comparable destination figures were unavailable from the University of Ulster and Open University in Northern Ireland. However, the University of Ulster suggested that a lower number of student nurse graduates, representing approximately 7%, went to work elsewhere in the UK over the last four years, with no figures presented for other countries.

5.3.2 Attrition rates for Northern Ireland

The number of students leaving before completing their pre-registration training in Northern Ireland is provided below. The numbers provided are inclusive of students who have left midwifery training.

Academic Year	Total
2010/11	51
2011/12	80
2012/13	63
2013/14	46
2014/15	65

Trainee nurses and midwives are admitted to universities by academic year and therefore the information is available by academic year rather than financial year.

This loss represents almost 10% per year.

Action Point: Further work should be commissioned immediately to track destination and attrition rates for all Universities in Northern Ireland.

5.3.3 Perspective from Student Nurses and Midwives

As part of this Plan, final (3rd) year Student Nurses and Midwives (direct entry and additional registration programmes) were asked to participate in a survey to ascertain their views on taking up a post in Northern Ireland following completion of their educational programme and NMC registration.

Ninety six students commenced the survey with 87 (90.6%) completing it. The key findings are presented below.

Students were asked if they felt a sense of duty/responsibility to stay in Northern Ireland on completion of their programme. From a total of 85 respondents, 39% (n=33) reported that they did feel a sense of duty/responsibility to stay in Northern Ireland, however 61% (n=52) reported that they did not.

"Yes preferably in Trust areas where I've had placements as I've got to know patients, staff and families over the last 3 years" (Student)

"I originally would have felt so however over the course of my training I have felt disheartened with how poor the recruitment process is with waiting lists rather than specific posts" (Student)

"I would rather stay at home and be close to friends and family but with offers of much better pay and benefits I plan on moving on" (Student)

"I know the DHSSPS have paid for my training and provided a bursary but permanent jobs are scarce" (Student)

Students were asked "What would encourage you to take up a post in Northern Ireland". The main reasons reported from those who responded (n=90, 94%) include:

being close to home * good promotion opportunities * a supportive employer

good preceptorship programme * job security * choice to work in area of interest

familiar with the system * permanent post * early advertisement of posts

Students were asked "What would discourage you from taking up a post in Northern Ireland". The main reasons reported from those who responded (n=91, 95%) include:

temporary contract * lack of staff on wards * unsupportive working environment

poor preceptorship programme * waiting lists for jobs * placed in area I don't want

lack of opportunity to progress * working conditions putting registration at risk

The majority (67%, n=64) of those who responded reported that they would consider moving to another part of the UK or abroad when qualifying?

"Nurses seem to be held with a higher outlook in society in other countries and offered rotational programmes" (Student)

"Easier to obtain permanent jobs with better career opportunities and terms and conditions elsewhere" (Student)

"Higher standards of care, better staff working relationships" (Student)

"Elsewhere they give you an opportunity to work in your preferred area in nursing and opportunities for preceptorship" (Student)

Students were asked if they would consider a post in the independent sector on completion of their programme, with 58% (n=56) reporting Yes, 29% (n=28) reporting No and a further 13% (n=12) reporting they would, but only if they could not obtain a post within the HSC. From a total of 85 respondents, 60% (n=51) also agreed they would consider a rotational Graduate Scheme (across the statutory and independent sectors) at MSc level if they were unable to obtain a post following completion of their programme. The main reasons reported include:

beneficial to gain experience * great way to further education and develop skills

brilliant opportunity to transition and feel confident * gain insight into other areas

create better quality nursing care * increase suitability for different environments

5.4 Factors impacting on the Nursing and Midwifery Workforce

There are many factors impacting on the Nursing and Midwifery Workforce as discussed in the previous sections. The key factors which will have a significant impact on the demand and supply over the next ten years have been extrapolated from a variety of sources and include:
:

- impact of more nurses and midwives delivering care closer to and in the patient's/client's own home *(Transforming Your Care*; DHSSPS, 2011b);
- increasing numbers of patients being looked after in the independent sector, major recruitment issues and relying on recruiting overseas (stakeholder engagement);
- the impact of the independent sector, which include Practice Nurses and some Treatment Room Nurses, using the same *pool* as the HSC to recruit from;
- impact of rising numbers of the population over the age of 85 years and rising levels of long-term conditions (DHSSPS, 2013a);
- impact of the age profile and imminent high number of retirements, particularly in relation to the Health Visiting, District Nursing, Mental Health Nursing and School Nursing workforce (HRPTS);
- implementation of *Delivering Care* (DHSSPS, 2013b); the first phase (acute and specialist medicine and surgery) recommended an increase of 284 (WTE) registered nurses (adult) in addition to current staffing levels;
- impact of working patterns (94% female, 42% working part-time in some areas) and reported recruitment difficulties in covering maternity leave and sickness absence (HRPTS);
- impact of a global shortage of nurses with destination figures from Queen's University, Belfast demonstrating an increasing trend (21%) for employment of new nursing graduates outside Northern Ireland;
- impact of attrition rates of almost 10% in pre-registration training
- impact of regional recruitment (stakeholder engagement);
- reported recruitment issues of an attitude that *"any nurse will do*", management of long waiting lists with a lack of preference for nurses in where they choose to or are trained and experienced to work and holding of vacancies (stakeholder engagement);
- releasing staff to avail of further training and development opportunities due to difficulties in backfilling posts (stakeholder engagement);
- ensuring adequate programmes are in place to support CPD, mentorship, preceptorship and a career pathway for nurses and midwives (stakeholder engagement);
- increasing role of ICT and the impact of training and development and embedding such innovations in practice (stakeholder engagement).

5.5 Pre-registration Nursing and Midwifery Education Forecasts

5.5.1 Introduction

This section includes figures and tables relating to each of the Pre-Registration Branch programmes including Adult Nursing, Children's Nursing, Mental Health Nursing, Learning Disability Nursing and Midwifery.

Where relevant to the above Branches, Additional Registration and Community Nursing Programmes have also been included. The tables assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses and 59.5 years for midwives).

5.5.2 Pressures Points Identified for Education Commissioning

Significant pressures on the Nursing and Midwifery Education Commissioning Budget exist, particularly with regard to the community practice placements which are increasing due to policy direction of *Transforming Your Care* (DHSSPS, 2011b). HSC Trusts reported that the commissioning of Additional Registration programmes should also be considered carefully as under AfC terms and conditions, nurses with two such qualifications will attract a higher pay band; which has prevented advertisement of this type of position.

Additional Registration programmes do however have their place, particularly when shortages of nurses in specific practice areas exist, as training can be undertaken within a much shorter time frame. Similarly, some areas should support staff to undertake Additional Registration programmes, for example, Emergency Departments, Children's and Mental Health, where nurses require the knowledge and skills to treat a wider range of conditions and co-morbidities.

5.5.3 Adult Nursing

In addition to the main factors detailed previously, those impacting particularly on the Adult Nursing Workforce include:

- Impact of *Delivering Care (DHSSPS, 2013b)* on acute and specialist medical and surgical wards;
- Planned new builds (hospitals) all with single room accommodation;
- Difficulties in recruiting middle grade doctors particularly to Emergency Medicine and plans to introduce Advanced Nurse Practitioners;
- Impact of Reviews, Strategies and Service Frameworks;
- Implementation of the recommendations from the Francis Report (2013);
- Increased acuity in hospital, co-morbidities, high dependency patients within medical and surgical areas with no extra resource;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct care;
- Advances in technology and associated training and development needs;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns including high numbers of female (95.4%) and part-time staff (46%).

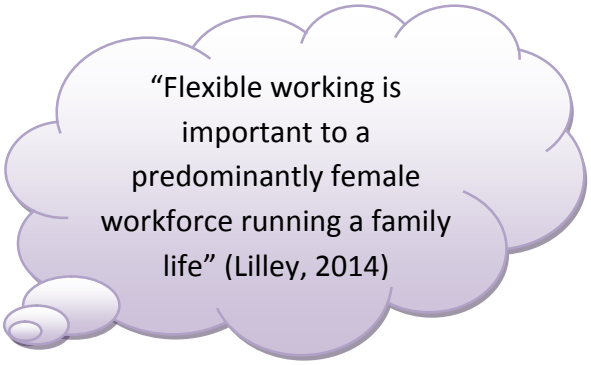


Table 8 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 – 59	60+	Total	% aged 55 and over
2015	2,933	1,214	1,375	1,358	1,441	761	337	9,419	12%
2020	***1,098***	2,933	1,214	1,375	1,358	1,441	761	9,419	23%
2025	***1,441***	***1,098***	2,933	1,214	1,375	1,358	1,441	9,419	30%
2030	***1,358***	***1,441***	***1,098***	2,933	1,214	1,375	1,358	9,419	29%

Table 9a below demonstrates the number of commissioned education places for adult nursing between 2008/09 and 2014/15.

Table 9a: Adult Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	**08 09**	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Direct Entry	559	570	489	489	462	469	469

Considering all of the above, the first reaction is to consider increasing the number of commissioned education places for adult nursing. However, we must keep in mind that Queen's University, Belfast report losing 21% of new graduates to positions outside of Northern Ireland. Focused work must take place to retain these newly qualified nurses and midwives as well as increasing Pre-registration Adult Nurse commissions by 100 places.

Taking factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%) and retirement and previous education commissions for this group into consideration, Northern Ireland must show a demonstrable improvement in employing these newly qualified nurses, however Adult Pre-registration Nurse places must be increased by at least 100 places as soon as possible. In addition, retirements over the next 10 years are expected to rise from the current 11% rate to 30%. Therefore proposed commission forecasts from 2015 - 25 are presented in Table 9b below:

Table 9b: Proposed Adult Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places *	560	560	560	560	560	560	560	560	560	560

* These figures include Return to Nursing programmes

Northern Ireland must show an immediate and demonstrable improvement in employing their new graduate nurses as due to the three year lead in period, we cannot respond quickly enough to the demand discussed at length within this Workforce Plan.

5.5.4 Children's Nursing

In addition to the main factors detailed previously, those impacting particularly on the Children's Nursing Workforce include:

- Planned new builds (hospitals) and impact of the Regional Children's Hospital on recruitment in other HSC Trust;
- Difficulties in recruiting middle grade doctors to this speciality and plans to introduce Advanced Nurse Practitioners;
- Implementation of Paediatric, Neo-natal and Medical Reviews;
- Age appropriate settings for children up to the age of 18 years - requiring a significant workforce shift;
- Increase in the number of children with complex needs in the community and transitions required to support this;
- Reduction in the trend of filling children's nursing posts with general nurses and need to consider qualified skill mix;
- Difficulties in providing mentorship and preceptorship and a limited career pathway;
- A predominantly young, female (95.4%) workforce with 50% working part-time hours.

Table 10 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	351	128	105	123	126	42	11	886	6%
2020	***53***	351	128	105	123	126	42	886	19%
2025	***126***	***53***	351	128	105	123	126	886	28%
2030	***123***	***126***	***53***	351	128	105	123	886	26%

The HSC will lose up to 53 children's nurses to retirement imminently based on current retirement trends. Table 11a below demonstrates the number of commissioned education places for children's nursing between 2008/09 and 2014/15.

Table 11a: Children's Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	55	60	60	60	55	55	55
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	4	6	6	5	2	7	7
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	4	6	6	4	5	3	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends and previous education commissions for this group, alongside new build plans and increasing numbers of children with complex needs requiring care in the community this Plan would recommend an increase in pre-registration numbers (Direct Entry and Additional Registration programmes) as presented in Table 11b below.

Table 11b: Proposed Children's Nursing Commission Forecasts 2015/16 – 2024/25

Proposed Places	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	64	70	70	70	60	55	55	55	55
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	0	10	0	10	0	10	0	10	0	10
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	10	0	10	0	10	0	10	0	10	0

5.5.5 Mental Health Nursing

In addition to the main factors detailed previously, those impacting particularly on the Mental Health Nursing Workforce include:

- Mental health nurses being recruited to learning disability posts to fill deficits;
- Reform within mental health continues with the closure of long-stay wards by 2015 – need to consider future challenges associated with this;
- Planned new builds (hospitals) all with single room accommodation;
- Development of Advanced Nurse Practitioners/Consultant Nurses in condition specific/specialist need areas, i.e. addictions, eating disorders, dementia;
- Increasing nurse prescribing role;
- Increased care of patients with co-morbidities and complex care required;
- Implementation of pending Capacity legislation, the Service Framework for Mental Health and Well-being (DHSSPS, 2011d), Dementia Strategy (DHSSPS, 2011e), Bamford Action Plan (DHSSPS, 2012b) and Recovery Orientated Practice;
- Increase in public health and mental health prevention/early intervention roles;
- Issues related to availability of male staff particularly for acute and PICU settings;
- The need to strengthen the knowledge and skills in evidence based therapeutic interventions to support the implementation of the Psychological Therapies Strategy;
- The need to strengthen senior mental health nursing leadership to ensure nursing issues and needs are identified and addressed;
- Increasing age profile of this workforce and the impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (75.8%) and part-time staff (17%).

Table 12 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	318	212	258	375	362	142	53	1,720	11%
2020	***195***	318	212	258	375	362	142	1,720	29%
2025	***362***	***195***	318	212	258	375	362	1,720	43%
2030	***375***	***362***	***195***	318	212	258	375	1,720	37%

The HSC will imminently lose up to 195 mental health nurses to retirement. Table 13a below demonstrates the number of commissioned education places for mental health nursing between 2008/09 and 2014/15.

Table 13a: Mental Health Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	99	99	99	99	96	96	96
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	16	7	1	0	0	1	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	2	4	4	0	2	0	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan would recommend an initial decrease in pre-registration numbers with a subsequent increase as presented in Table 13b below.

Table 13b: Proposed Mental Health Nursing Commission Forecasts 15/16 – 24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	90	90	95	95	100	110	120	120	120	120
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	10	0	10	0	10	0	10	0	10	0

This Plan also recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. Similarly, increasing the length of the Mental Health Programme is recommended to ensure it includes an element of evidence based psychotherapeutic intervention training to best meet the new challenges this workforce is facing regarding early interventions.

Action Point: Review and future proof the Mental Health Nursing programmes to ensure the workforce are equipped to fulfill an increasing public health role, support co-morbidities and unmet physical needs and deliver evidence based psychotherapeutic interventions.

5.5.6 Learning Disability

In addition to the main factors detailed previously, those impacting particularly on the Learning Disability Nursing Workforce include:

- Difficulties experienced in recruiting learning disability nurses;
- Planned learning disability specialist nursing home for high complex needs within the Belfast HSC Trust;
- Increasing numbers of people with a learning disability and older people;
- More complex care in the community, increasing co-morbidities, challenging behaviour and unmet physical needs;
- Need for improved therapeutic interventions, crisis response, prevention of hospital admissions and early discharge;
- Strengthening knowledge and skills to work effectively with children and developing skills in traditional nursing procedures i.e. enteral feeding, catheterisation and medicines management;
- The need to strengthen senior learning disability nursing leadership to ensure nursing issues and needs are identified and addressed;
- The need for a clear service model for learning disability nurses to determine the future roles and skills required and impact of implementation of *Strengthening the Commitment* (DHSSPS, 2012d)
- Nurses increasingly working in service areas registered as social care settings including residential, domiciliary and day care;
- Issues related to availability of male staff (14.2%);
- Impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (85.8%) and part-time staff (25%).

Table 14 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	134	69	58	65	87	32	20	465	11%
2020	***52***	134	69	58	65	87	32	465	26%
2025	***87***	***52***	134	69	58	65	87	465	33%
2030	***65***	***87***	***52***	134	69	58	65	465	26%

The HSC will lose up to 52 learning disability nurses to retirement imminently based on current retirement trends. Table 15a below demonstrates the number of commissioned education places for learning disability nursing between 2008/09 and 2014/15.

Table 15a: Learning Disability Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	15	30	30	30	30	30	30
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	0	6	1	0	1	2	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	6	7	0	0	0	10	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan recommends maintaining training numbers, as presented in Table 15b.

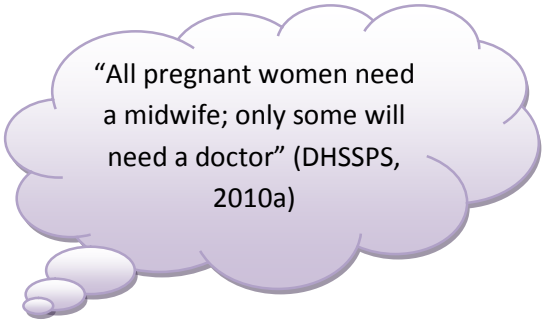
Table 15b: Proposed Learning Disability Nursing Commission Forecasts 15/16-24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	30	30	30	35	35	35	35	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	0	10	0	10	0	10	0	10	0	10

This Plan recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. A review of the Learning Disability programmes is recommended to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

Action Point: Review and future proof the Learning Disability Nursing programmes to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

5.5.7 Midwifery



In addition to the main factors detailed previously, those impacting particularly on the midwifery workforce include:

- A steadying birth rate (NISRA, 2013), with rising social and medical complexities;
- Major role in the promotion of normalising birth and as the lead professional for women with straightforward pregnancies (DHSSPS, 2012a);
- Key coordinator of care within the multidisciplinary team for complex pregnancies as highlighted in *Midwifery 20:20* (DHSSPS 2010a);
- Impact of a shift to community based care, increasing midwife led care in births and home births alongside free standing birthing centres;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns within this group including high numbers of female and part-time staff (67%);
- There are currently more midwives than there are jobs available.

Table 16 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	247	170	193	196	290	207	77	1,380	21%
2020	***284***	247	170	193	196	290	207	1,380	36%
2025	***290***	***284***	247	170	193	196	290	1,380	35%
2030	***196***	***296***	***284***	247	170	193	196	1,380	28%

The previous Review (DHSSPS, 2009) recommended that the number of commissioned places for midwifery should be increased, mainly due to the ageing profile. However, significantly lower numbers retired than expected therefore this workforce is now much older.

Furthermore, the projected retirements are expected to increase during this Review period from a current level of 21% to 35%. The HSC will lose up to 284 midwives to retirement imminently based on current retirement trends. Table 17a below demonstrates the number of commissioned education places for midwifery between 2008/09 and 2014/15.

Table 17a: Midwifery Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	30	30	30	35	35	36	35
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (18 mths)	32	35	35	30	25	25	20

Not all newly qualified midwives are being offered a post following completion of their programme. The cohorts of direct entry are obtaining posts in midwifery within a year of qualifying. There is an acknowledgment however of a loss back to nursing positions from the 18 month programme, due to a lack of available posts.

Taking this into consideration and based on the factors impacting on the workforce highlighted above, new mothers are becoming older and are increasingly presenting with co-morbidities which make the Addittional Registration Programme indispensable. Midwifery numbers commissioned should aim to meet those presented in Table 17b below.

Table 17b: Proposed Midwifery Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	35	35	35	35	30	30	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (18 mths)	20 per year up to 21/22 and then 15 from 22/23 onwards									

5.6 Post-registration Nursing Education Forecasts

5.6.1 Introduction

The areas in this section include figures and tables relating to the post-registration programmes (District Nursing, Health Visiting and School Nursing). These programmes refer to registered nurses who work in community settings. For the purpose of assessing demand and supply we have excluded some areas, for example, Mental Health, Learning Disability and Paediatric Nurses because they are predominantly supplied by pre-registration programmes, as previously highlighted.

These programmes (full-time) currently receiving Replacement Monies (based on Midpoint Band 5) include:

- District Nursing (10mths)
- Health Visiting (12mths)
- School Nursing (12mths)

The tables included in the sections below assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses).

5.6.2 District Nursing

In addition to the main factors detailed previously, those impacting particularly on the District Nursing Workforce include:

- Changing profile of district nursing including increased role in palliative care, intravenous infusions, rapid response, 24/7 working patterns;
- Implementation of Reform Plans and Integrated Care Partnerships;
- Changing demographics: increase in older people, long-term conditions, complex care in the community and acuity management;
- Implementation of various strategies and service frameworks;
- Registered nurse skill mix in district nursing teams will impact on the number required to be undertake the specialist practitioner programme which will be determined by the pending phase of *Delivering Care for District Nursing;*
- DHSSPS Guidance (2010d) on care management, assessment and care planning requirements;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct patient care;
- Impact of evolving futuristic technologies and training and development;
- Impact of the age profile and imminent high number of retirements related to the district nursing workforce;
- Impact of working patterns within this group including high numbers of female (97.5%) and part-time staff (53%);

Table 18 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	137	117	191	207	251	117	38	1,058	15%
2020	***155***	137	117	191	207	251	117	1,058	35%
2025	***251***	***155***	137	117	191	207	251	1,058	43%
2030	***207***	***251***	***155***	137	117	191	207	1,058	38%

The HSC will lose up to 155 district nurses to retirement imminently and this trend is set to more than double from 15% to 43% during the period of this Plan. Table 19a below demonstrates the number of commissioned education places for district nursing between 2008/09 and 2014/15.

Table 19a: District Nursing Education Commissions 2008/09 – 2014/15

	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Commissioned Places	18	12	9	9	17	26	23

Based on the significant factors impacting on this workforce, as highlighted previously and the Minister for Health's commitment to double the number of district nurses in training, this Plan would recommend increasing the commissioned numbers as presented in Table 19b below.

Table 19b: Proposed District Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	40	40	40	30	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for District Nursing* has been agreed.

5.6.3 Health Visiting

In addition to the main factors detailed previously, those impacting particularly on the Health Visiting Workforce include:

- Health Visiting is on the Risk Register of every HSC Trust and the Public Health Agency for risk associated with the delivery of the Universal Screening Programme and Safeguarding;
- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Increased role within Family Nurse Partnerships (Ministerial Target 2014/15);
- Increase in the black and minority ethnic population (BME) and the need for interpreters;
- Public health challenges: childhood obesity, peri-natal, infant, child and adolescent mental health, domestic abuse, child abuse, child sexual exploitation (CSE), deprivation and poverty;
- Increase in referrals from social services regarding children under 4 years old (5% between 2007 and 2012);
- *Delivering Care for Health Visiting* has not yet been published and will need to be taken account of when considering future commissioned education places;
- Impact of working patterns within this group including high numbers of female (99.7%) and part-time staff (48%);
- Impact of the age profile and imminent high number of retirements.

Table 20 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	84	62	76	117	122	62	18	541	15%
2020	***80***	84	62	76	117	122	62	541	34%
2025	***122***	***80***	84	62	76	117	122	541	44%
2030	***117***	***122***	***80***	84	62	76	117	541	36%

The HSC will lose up to 80 health visitors to retirement imminently and this trend is set to more than double during the period of this review from 15% to 44%. Table 21a below demonstrates the number of commissioned education places for health visiting between 2008/09 and 2014/15.

Table 21a: Health Visiting Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	29	26	24	18	25	37	61

Based on the factors impacting on this workforce as highlighted previously, this Plan would recommend the commissioned numbers as presented in Table 21b below.

Table 21b: Proposed Health Visiting Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	45	45	45	40	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for Health Visiting* has been agreed.

5.6.4 School Nursing

In addition to the main factors detailed previously, those impacting particularly on the School Nursing Workforce include:

- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Increase in students with chronic diseases, mental health issues and high-risk behaviours;
- Improving access to early prevention and support for children and families and help reduce the need for referral to social services;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Impact of working patterns within this group including high numbers of female (100%) and part-time staff (78%);
- Impact of the age profile and imminent high number of retirements.

Table 22 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 – 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	24	29	61	78	82	43	32	349	21%
2020	***74***	24	29	61	78	82	43	349	36%
2025	***82***	***74***	24	29	61	78	82	349	46%
2030	***78***	***82***	**74**	24	29	61	78	349	40%

The HSC will lose up to 74 school nurses to retirement imminently and this trend is set to increase incrementally throughout the period of this review from 21% to 46%. Table 23a below demonstrates the number of commissioned education places for school nurses between 2008/09 and 2014/15.

Table 23a: School Nursing Education Commissions 2008/09 – 2014/15

	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Commissioned Places	4	0	6	2	4	5	0

Based on the factors impacting on this workforce as highlighted previously, retirement trends**,** part-time working and low numbers commissioned since the previous Review (2009)**,** this Plan would recommend increasing the commissioned numbers as presented in Table 23b below.

Table 23b: Proposed School Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Proposed Places	20	20	20	15	15	15	20	20	15	15

5.6.5 Specialist Nursing

Specialist nursing has a key role to play in the delivery of *Transforming Your Care* (DHSSPS, 2011b) and education places need to be commissioned focusing particularly on Programmes of Care, for example, Frail Elderly, Respiratory, End of Life Care, Diabetes and Stroke. The current reliance on Learning Needs Analysis, as part of the Education Commissioning Process, needs to be strengthened and this Plan recommends the development of an Education Commissioning Direction Framework. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Plan well in advance of commissioning the new services.

Action Point: Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

Education Commissioning must set the direction of travel and focus both the strategic and service priorities. The current Education Commissioning Plan must be re-profiled and focus on strategic and service priorities rather than be based wholly on individual/personal development.

Specialist Nursing numbers have increased dramatically since the previous *Review of the Nursing and Midwifery Workforce* (DHSSPS, 2009) as presented in Table 24 below. It is believed that this is not an accurate picture as the numbers include AfC Band 5 nurses, however Band 5 nurses do not practice at a specialist nursing level. Conversely, the numbers of district nurses have reduced significantly. It is widely accepted by HSC Trusts that this increase is an HRPTS coding issue. The specialist nurse section of HRPTS should undergo a data cleanse exercise to better understand both specialist nursing and district nursing numbers.

Table 24: Comparison of Specialist Nurses and District Nurses (WTE) between 2009 and 2014 as recorded on HRMS and HRPTS

Categorisation/Year	2008	2009	2010	2011	2012	2013	2014
Specialist Nurses Bands 5, 6 & 7	386.4	425.8	495.7	687.7	752.7	807.6	787.6
Variance		+39.4	+69.9	+192	+65	+54.9	-20
District Nurses	972.6	932.9	902.0	823.5	833.7	860.3	850.4
Variance		-43.3	-30.9	-78.5	+10.2	+26.6	-9.9

5.7 Summary of Nursing and Midwifery Education Commissions 2015 - 2025

Table 25 below presents a summary of the proposed nursing and midwifery education commissions over the next 10 years, taking into account the factors impacting on the workforce as highlighted previously.

Table 25: Summary of Proposed Education Commissions 2015 - 2025

Programme	Commissioning Projections (all programmes must be reviewed on an annual basis to reflect changes in demand, attrition rates and destination figures)									
	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Adult Nursing	560	560	560	560	560	560	560	560	560	560
Children's Direct Entry	55	64	70	70	70	60	55	55	55	55
Children's Additional	0	10	0	10	0	10	0	10	0	10
Children's Community	10	0	10	0	10	0	10	0	10	0
Mental Health Direct Entry	90	92	95	95	100	110	120	120	120	120
Mental Health Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Mental Health Community	10	0	10	0	10	0	10	0	10	0
Learning Disability Direct Entry	30	30	30	35	35	35	35	30	30	30
Learning Disability Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Learning Disability Community	0	10	0	10	0	10	0	10	0	10
Midwifery Direct Entry	39	35	35	35	35	30	30	30	30	30
Midwifery Additional	25	20	20	20	20	20	20	15	15	15
District Nursing	40	40	40	30	30	30	30	30	30	30
Health Visiting	40	45	45	45	40	30	30	30	30	30
School Nursing	20	20	20	15	15	15	20	20	15	15

Action Point: Due to the huge reform agenda, all Nursing and Midwifery educational programmes at both pre and post registration level should have a taught element on Quality Improvement methodologies and ideally be required to identify and implement a quality improvement project.

Step 6: Implement, Monitoring and Refresh

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

6.1 Next Steps / Further Work to be Undertaken

The overall ambition of this Workforce Plan is to ensure we have a healthy, productive workforce, who are appropriately trained, and will provide the highest quality healthcare services at the right time in the right place. Change requires leadership and, in many health and care systems, it also requires improved opportunities for stakeholder involvement. "Top down" change is often unsustainable: the support of nurses and midwives is required, as is the active participation of other stakeholders (commissioners, education providers, professional and union organisations and other key professionals, particularly medical staff). The recommendations outlined in this Plan can support informed decision-making and prioritisation at a local and regional level.

To take this forward, the Regional Workforce Planning Group (RWPG) will oversee the implementation of the recommendations, underpinned by a robust implementation and monitoring strategy.

The following actions, to be undertaken include:

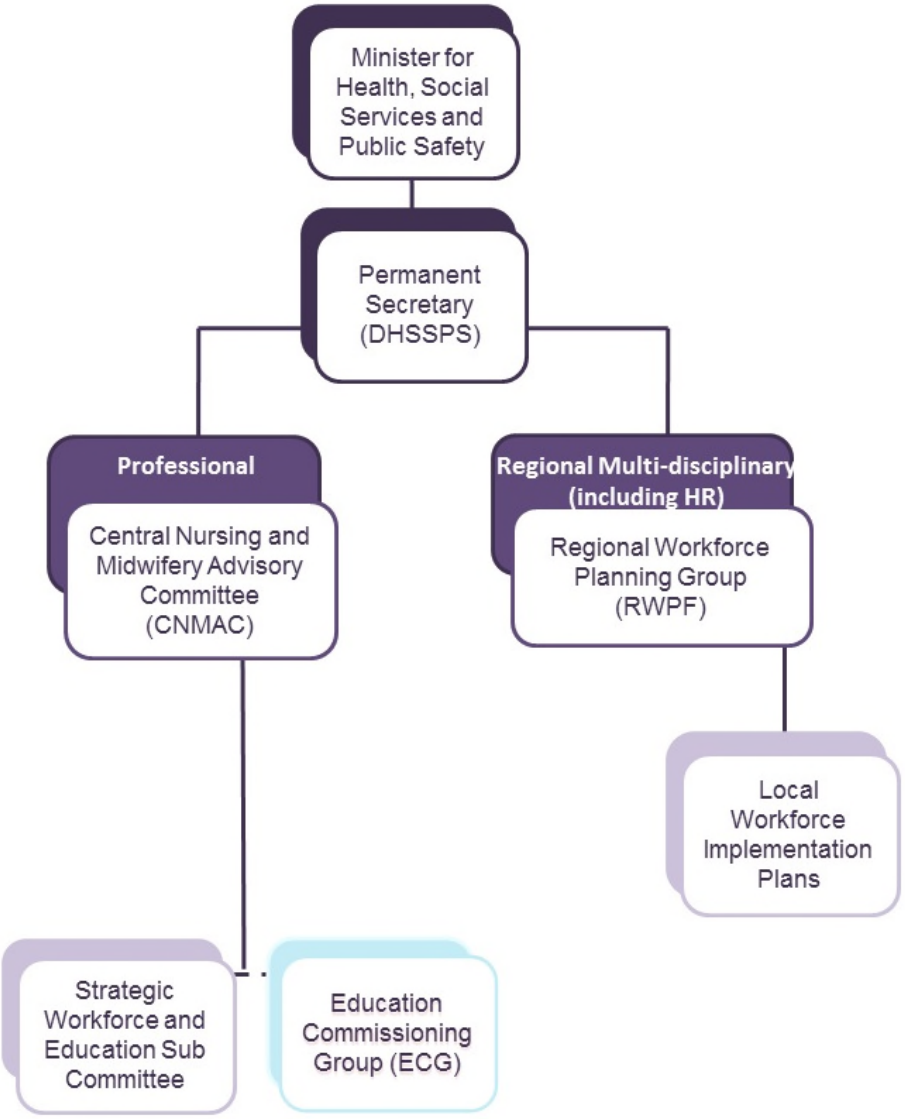
- Costing the Recommendations for consideration within this Plan
- Present the Plan and Recommendations to the DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) for professional approval
- Present the Plan and Recommendations to the Regional Workforce Planning Group for DHSSPS approval
- Once agreed, CNMAC's Workforce and Education Sub-Committee will be charged with overseeing and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews as at 5.5.6.

6.2 Monitoring Process

The monitoring of this Plan will sit in tandem with the Regional Workforce Key Performance Indicators currently being developed, particularly in relation to vacancy rates, bank and agency usage and associated improvements on recruitment processes, as presented in Figure 22.

The DHSSPS Chief Nursing Officer will include this information during mid and end of year Accountability Meetings.

Figure 22: Structure for implementation and monitoring of the Workforce Plan



CONCLUSION

Major workforce change is expected to support the many developments being undertaken in Northern Ireland over the next 5 to 10 years. There includes a shift of resource from acute hospital to community and primary care settings which will require substantial re-training and re-deployment of staff in nursing and midwifery. This will have a significant impact on the Nursing and Midwifery Education Commissioning Budget, however immediate steps should be taken to ensure this budget is delivering value for money before making projections on any additionality.

Demand for nursing and midwifery in Northern Ireland is likely to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). The second, third and fourth phases are due to report by the end of March 2015 however, no timeline has been agreed for areas such as mental health, learning disability, children's and midwifery. It is anticipated that any recruitment exercise required to address the implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

In addition, a range of reports and studies have highlighted the likelihood of a significant decline in the future supply of nurses in the UK (Centre for Workforce Intelligence, 2013; Imison & Bohmer, 2013; NHS Employers, 2014). This is already being felt in Northern Ireland and we are in the process of commencing our own international recruitment campaign during 2016 whilst we still face competition with other countries who are recruiting aggressively from within our universities. Employers in Northern Ireland must make themselves attractive to newly qualified nurses if they are to grow and maintain a steady workforce.

Whilst we have included the use of retirements to make our education commissioning forecasts, we must be aware of the needs of the independent sector as they will be using the same *pool* from which to recruit nurses in addition we are in an era of increasing demand This Plan recommends increasing training numbers at pre-registration level by at least 100 places.. The Plan also urges an immediate review of post-registration education programmes to ensure they are commissioned to meet regional strategies and priorities and to ensure best value for money.

Practitioners, managers, educationalists and commissioners will be required to interpret and apply the recommendations contained within this Plan, based on local circumstances. Similarly, organisational and corporate commitment will be required if it is to result in positive change and outcomes. The Regional Workforce Planning Group (RWPG) will oversee the implementation of this Plan to ensure a nursing and

midwifery workforce capable of meeting the health and care needs of the people of Northern Ireland over the next decade and beyond.

RECOMMENDATIONS

No	Recommendation
Theme: Future Supply and Demand of Nursing and Midwifery	
1	A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice including a radical review of the recruitment processes, methods and timescales used within HSC Trusts and categorisation and coding of nurses and midwives on HRPTS.
2	Destination and attrition rates for all Universities in Northern Ireland should be tracked on a yearly basis.
3	A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.
Theme: Supporting Nurse Training	
4	Consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within the independent sector.
Theme: Annual Review	
5	Ensure that emerging evidence from further phases of *Delivering Care* (DHSSPS, 2013b), additional registration programmes and the impact of the nursing and midwifery age profile and relevant pension changes, are reflected during annual reviews.
6	Commissioning of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.
Theme: Education Programmes and Commissioning	
7	Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.
8	Ensure that all pre and post registration Nursing and Midwifery educational programmes include a taught Quality Improvement methodologies element and ideally be required to identify and implement a quality improvement project. Review and future proof the Mental Health and Learning Disability Nursing programmes to ensure the workforce is equipped to fulfil an increasing public health role, manage and provide interventions to those with co-morbidities and/or complex physical and mental health needs.
9	Consideration needs to be given to delivering the Specilaist Practice Community Programmes on a part time basis
10	Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

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ANNEXES

Annex A

Membership of Project Steering Committee (Working Group member)

Charlotte McArdle (Chair)**,** Chief Nursing Officer**,** DHSSPS
Catherine Daly, Under Secretary, DHSSPS
Dr Paddy Woods, Deputy Chief Medical Officer, DHSSPS
Paula Smyth, HRD, DHSSPS
Caroline Lee, Nursing Officer, DHSSPS (Working Group member)
Dr Carole McKenna, Senior Officer, NIPEC (Project Lead) (Working Group member)
Alison Dunwoody, Deputy Principal Statistician, DHSSPS (Working Group member)
Angela McLernon, Chief Executive, NIPEC (from July 2014)
Dr Glynis Henry, Chief Executive, NIPEC (to June 2014)
Richard Cardwell, Assistant Statistician, DHSSPS
Damien McAllister, Director of HR, NHSCT
Joan Peden, Co-Director of HR, BHSCT
Ann McConnell, Assistant Director of HR, WHSCT
Myra Weir, Assistant Director of HR, SEHSCT
Monica Molloy, Senior HR Manager, BHSCT
Iain Gough, Senior HR Manager, SHSCT
Hugh McPoland, Director of HR, BSO
Nicki Patterson, Executive Director of Nursing, South Eastern HSC Trust
Olive Macleod, Executive Director of Nursing, Northern HSC Trust
Alan Corry-Finn, Executive Director of Nursing, Western HSC Trust
Brenda Creaney, Executive Director of Nursing, Belfast HSC Trust
Francis Rice, Executive Director of Nursing, Southern HSC Trust
Pat Cullen, Interim Director of Nursing and AHP, PHA
Janice Smyth, Director, RCN
Breedagh Hughes, Director, RCM
Kevin McAdam, HSC Representative, Unite
Anne Speed, HSC Representative, Unison
Carol Cousins, Independent and Voluntary sector representative (from August 2014)

Annex B

Northern Ireland Health Policy and Strategy Documents

Title	Published
A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland (DHSSPS, 2004)	Dec 2004
Improving the Patient and Client Experience (DHSSPS, 2008)	Nov 2008
Service Framework For Respiratory Health And Wellbeing (DHSSPS, 2009)	Jan 2009
Adult Safeguarding in Northern Ireland. Regional and Local Partnership Arrangements (DHSSPS, 2010)	Mar 2010
Living Matters Dying Matters. A Palliative and End of Life Care Strategy for Adults in Northern Ireland (DHSSPS, 2010)	Mar 2010
Improving Dementia Services in NI: A Regional Strategy, Consultation Paper (DHSSPS, 2010)	May 2010
Healthy Child, Healthy Future. A Framework for the Universal Child Health Promotion Programme in Northern Ireland (DHSSPS, 2010)	May 2010
A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery 2010-2015 (DHSSPS, 2010)	Jun 2010
A Strategy for the Development of Psychological Therapies Services (DHSSPS, 2010)	Jun 2010
Midwifery 2020, Delivering Expectations (DHSSPS, Welsh Assembly, DH, & Scottish Government, 2010)	Sep 2010
Delivering Excellence Supporting Recovery: Professional Framework for Mental Health Nursing 2011-2016 (DHSSPS, 2010)	Oct 2010
Safeguarding Children Supervision Policy for Nurses (DHSSPS, 2011)	Feb 2011
Service Framework For Cancer Prevention, Treatment And Care (DHSSPS, 2011)	Feb 2011
Service Framework For Mental Health And Wellbeing (DHSSPS, 2011)	Oct 2011
Quality 20:20, A 10 year Strategy to Protect and Improve Health and Social Care in Northern Ireland (DHSSPS, 2011)	Nov 2011
Improving Dementia Services in Northern Ireland. A Regional Strategy (DHSSPS, 2011)	Nov 2011
Transforming Your Care: A Review of Health and Social Care in NI (DHSSPS, 2011)	Dec 2011
Learning Disability Service Framework (DHSSPS, 2011)	Dec 2011
Strengthening the Commitment, the UK Modernising Learning Disability Nursing Review (DHSSPS, Welsh Assembly, DH, & Scottish Government; 2012)	Apr 2012
Promoting Good Nutrition. A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016 (DHSSPS, 2011)	Jun 2012

A Strategy for Maternity Care in Northern Ireland 2012-2018, (DHSSPS, 2012)	Jul 2012
Fit and Well – Changing Lives (DHSSPS, 2012)	Jul 2012
Service Framework For Learning Disability (DHSSPS, 2012)	Sept 2012
Delivering the Bamford Action Plan 2012-2015 (DHSSPS, 2012)	Nov 2012
Transforming Your Care: Vision to Action, A Post Consultation Report (DHSSPS, 2013)	Mar 2013
Transforming Your Care: Strategic Implementation Plan (DHSSPS, 2013)	Oct 2013
Service Framework For Older People (DHSSPS,2013)	Sept 2013
A Review of Paediatric Healthcare Services Provided in Hospitals and in the Community, Consultation Document (DHSSPS, 2013)	Nov 2013
A Review of Children's Palliative and End of Life Care in NI, Document for Public Consultation (DHSSPS, 2014)	Jan 2014
Strengthening the Commitment, One Year On, Progress Report on the UK Modernising Learning Disability Nursing Review (DHSSPS, 2014)	Apr 2014
Making Life Better. A Whole System Strategic Framework for Public Health (DHSSPS, 2014)	Jun 2014
Modernising Learning Disabilities Nursing Review Strengthening the Commitment. Northern Ireland Action Plan (DHSSPS, 2014)	Mar 2014
Service Framework for Cardiovascular Health and Wellbeing 2014 – 2017 (DHSSPS, 2014)	May 2014

Note: this is not an exhaustive list.

Annex C

HSC Registered Nurses & Midwives by HSC organisation and Service/Practice Area as at 31st March 2014 (HRPTS)

	Belfast HSCT		Northern HSCT		South Eastern HSCT		Southern HSCT		Western HSCT		NIBTS / BSO / PHA / NIPEC / RQIA		Total	
Combined Grades	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Acute/General Nurses	3,413	2,930.7	1,276	1,088.7	1,307	1,114.0	1,350	1,125.7	1,388	1,247.3			8,751	7,520.4
Mental Health Nurses	434	414.9	326	311.2	249	233.8	310	289.9	401	386.1			1,720	1,635.9
Learning Disability Nurses	212	198.2	30	27.4	35	30.3	113	100.1	75	72.2			465	428.1
District Nurses	200	170.4	226	172.4	222	172.1	187	148.2	223	190.2			1,058	853.3
Midwives	339	264.8	228	176.3	256	201.0	281	212.8	222	186.5			1,327	1,042.5
Health Visitors	77	65.1	118	98.1	84	73.6	118	98.4	92	78.3			489	413.4
Paediatric Nurses	384	320.8	139	119.0	104	79.6	124	105.3	135	124.3			886	749.0
School Nurses	31	23.5	24	16.4	20	13.9	29	19.4	21	18.5	37	34.0	125	91.6
Treatment Room Nurses / Family Planning Nurses	29	17.5	114	67.2	25	16.4	24	16.9	32	23.4			224	141.5
Specialist Nurses Band 5/6	98	81.0	120	99.8	50	42.3	30	22.8	60	52.4			358	298.3
Specialist Nurses Band 7+	157	143.4	119	113.2	91	83.6	105	96.5	94	89.7			575	535.5
Nurse Managers / Multiservices Manager / Non Acute Ward Sister /	113	103.9	109	106.1	128	121.0	67	60.3	41	40.2			468	441.5
Prison Nurse					56	55.2							56	55.2
Teacher / Trainer / Researcher / Counsellor	22	18.1	33	29.7	7	7.0	31	22.4	18	14.6	33	30.6	144	122.4
Total	5,509	4,752.3	2,862	2,425.5	2,634	2,243.8	2,769	2,318.7	2,802	2,523.8	70	64.6	16,646	14,328.7

Annex D

HSC Registered Nurses & Midwives by Service/Practice Area and Age (based on headcount) as at 31st March 2014 (HRPTS)

Combined Grades	<25	25-29	30-34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total
Acute/General Nurses or Prison Nurses	438	1,136	1,336	1,172	1,274	1,183	1,268	685	315	8,807
Mental Health Nurses	33	111	174	212	258	375	362	142	53	1,720
Learning Disability Nurses	24	55	55	69	58	65	87	32	20	465
District Nurses	7	41	89	117	191	207	251	117	38	1,058
Midwives	6	54	143	167	189	194	290	207	77	*1,327
Health Visitors		16	44	53	66	111	119	62	18	*489
Paediatric Nurses	72	145	134	128	105	123	126	42	11	886
School Nurses /Treatment Room Nurses / Family Planning Nurses	0	10	14	29	61	78	82	43	32	349
Specialist Nurses Band 5/6	13		48	49	63	92	63	23	7	358
Specialist Nurses Band 7+		29		46	112	173	144	56	15	575
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit / Researcher / Counsellor	16			37	77	140	147	55	15	487
Teacher / Trainer			7	5	24	35	26	21	7	125
Total	581	1,584	2,085	2,084	2,478	2,776	2,965	1,485	608	16,646

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex E

HSC Registered Nurses & Midwives by Service/Practice Area and Gender as at 31st March 2014 (HRPTS)

Combined Grades	Female	Male	Total	% Female	% Male
Acute/General Nurses	8,352	399	8,751	95.4%	4.6%
Mental Health Nurses	1,304	416	1,720	75.8%	24.2%
Learning Disability Nurses	399	66	465	85.8%	14.2%
District Nurses / Treatment Room Nurses / Family Planning Nurses	1,250	32	1,282	97.5%	2.5%
Midwives / Health Visitors	1,810	6	1,816	99.7%	0.3%
Paediatric Nurses	874	12	886	98.6%	1.4%
School Nurses	125	0	125	100.0%	0.0%
Specialist Nurses Band 5/6	346	12	358	96.6%	3.4%
Specialist Nurses Band 7+	540	35	575	93.9%	6.1%
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit	425	43	468	90.8%	9.2%
Prison Nurse	42	14	56	75.0%	25.0%
Teacher / Trainer / Researcher / Counsellor	130	14	144	90.3%	9.7%
Nurse / Midwifery Support	4,023	625	4,648	86.6%	13.4%
Total	19,620	1,674	21,294	92.1%	7.9%

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex F

HSC Nursing, Midwifery and Support Staff Vacancies as at 31st March 2014

	Nurse Support		Qualified Nurses						
Pay band	1 - 4		5 - 7		8 - 9		TOTAL		Overall WTE Vacancy Rate *
Staff Group	HC	WTE	HC	WTE	HC	WTE	HC	WTE	
Acute Nursing	63	54.3	132	120.0	1	1.0	196	175.3	1.8%
Mental Health Nursing	7	7.0	74	71.9	0	0.0	81	78.9	3.5%
Learning Disability Nursing	0	0.0	3	3.0	0	0.0	3	3.0	0.4%
Midwifery	2	1.1	7	4.8	0	0.0	9	5.9	0.5%
Health Visiting	0	0.0	18	15.0	0	0.0	18	15.0	1.4%
District Nursing	7	5.6	41	33.6	0	0.0	48	39.2	5.8%
Paediatric Nursing	14	10.6	66	62.3	0	0.0	80	72.9	7.3%
School Nursing	3	2.3	1	0.7	0	0.0	4	3.0	2.9%
Treatment Room / Practice / Family Planning Nursing	0	0.0	1	0.1	0	0.0	1	0.1	0.1%
Specialist Nursing	0	0.0	16	12.7	1	1.0	17	13.7	1.5%
Nurse Managers / Audit	0	0.0	7	6.7	5	5.0	12	11.7	2.7%
Teaching / Training	0	0.0	0	0.0	0	0.0	0	0.0	0.0%
Other Nursing	0	0.0	1	0.5	0	0.0	1	0.5	0.6%
Total	96	80.8	367	331.3	7	7.0	470	419.1	2.3%
WTE Vacancy Rate		2.0%		2.3%		1.9%		2.3%	2.3%

* The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).

For further Information, please contact

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This document can be downloaded from the NIPEC website
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December 2014