



Department of
**Health, Social Services
and Public Safety**

An Roinn
**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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**REVIEW OF THE NURSING, MIDWIFERY AND
HEALTH VISITING WORKFORCE**

FINAL REPORT

SEPTEMBER 2005

CONTENTS	Page
1. EXECUTIVE SUMMARY	1
2. INTRODUCTION.....	4
3. POLICY CONTEXT.....	8
4. ANALYSIS OF CURRENT POSITION	32
5. FEEDBACK FROM CONSULTATIONS	39
6. PREDICTED SUPPLY & DEMAND ISSUES.....	47
7. CONCLUSIONS AND RECOMMENDATIONS.....	56

1. EXECUTIVE SUMMARY

The purpose of this Review of Nursing, Midwifery and Health Visiting Workforce Planning is to provide the DHSSPS with comprehensive current information on the nursing, midwifery and health visiting workforce across Northern Ireland. This will inform the Department's planning for these professions to facilitate service provision over the next 5-10 years.

The review investigates current and future supply and demand factors that will impact on the delivery and development of nursing, midwifery and health visiting services.

The Review combined several approaches:

- review of policy and contextual documents;
- wide consultation with stakeholder, and stakeholder groups;
- review of the current supply and demand picture;
- projection of the future supply and demand picture; and
- conclusions and recommendations.

Policy and Context

There is a great deal of change taking place in the Health and Personal Social Services, which has a major impact on the nursing, midwifery and health visiting workforce.

- the pressure on the health service is increasing, through efforts to reduce waiting lists, changes to service provision and ageing populations. Difficulties in recruiting and retaining staff compound the pressure. This increases the importance of a robust approach to workforce planning;
- the impact that improving service provision will have on workforce planning is complex. The balance in achieving a correct skills mix between professions, understanding future requirements, more advanced care delivery and linkages between acute, primary and community care sectors all add complexity to workforce planning;
- the continued implementation of Agenda for Change is a major issue for the HPSS. The expectation is that although staff will have better terms and conditions and greater access to career development opportunities, this will also be accompanied by associated improvements in productivity;
- the increasing age profile of the workforce will accelerate the rate of retirements over the forthcoming years, and an ageing population will also increase the demands on the healthcare system;
- community nursing continues to develop. Moving care into the community is a key strategy in delivering future healthcare. However, the full impact of this strategy on workforce planning is not yet understood.

Current Workforce

There are currently 21,705 staff within Northern Ireland on the NMC register. The corresponding level in 1999/00 was 19,036 some 14 per cent lower than the current register. Of the total current staff, 15,330 (70.6 per cent) work within the HPSS.

Stakeholder Consultation

Extensive consultation took place in this review with some 30 interviews and 10 focus groups carried out. The key findings from this are:

- a more developed approach to workforce planning involving improvements in data collection and analysis is desired by all stakeholders;
- the current service delivery in the independent sector is seen as a risk. It provides 15,000 beds for some of the most vulnerable patients. Both public and independent sectors believe the latter is under funded. This is likely to be further compounded when Agenda for Change is fully rolled out;
- there is wide support for multiple entry paths to nursing and midwifery. Concern was expressed that pre-registration training is too academic, both from a selection and a delivery point of view. There has also been a positive experience of the Open University entry route for Health Care Assistants;
- the age profile of the workforce is increasing. This will have a significant impact in the next decade. Midwifery and Mental Health are seen as particular risks;
- concern was raised around the roll out of Agenda for Change. This will have initial cost implications, but more importantly will increase demand headcount through the introduction of additional leave entitlement. However, achieving a balance by increasing productivity through the associated performance management framework will not be straightforward; and
- changes to service delivery will continue to cause supply issues – for example, junior doctor hours, consultant contracts, new ways of working, technology, and demographics. The boundaries are continually being stretched. However, the full impact of these changes needs to be considered by all relevant stakeholders.

Conclusions and Key Recommendations

When contrasted with the previous workforce planning review, the supply situation has clearly improved. Progress has and continues to be made on the balancing of numbers and this should be recognised.

There is also broad agreement that work still needs to be done to cascade the improvements that have been made at the strategic level. Attention now needs to be given to workforce planning at the operational or trust level.

Graduate attrition is particularly high, and more focus is required to understand why, especially the fallout between graduation and entering the workforce. Reducing attrition in this area will, in effect, increase the supply of staff into the workforce.

More work needs to be done to fully understand the full impact of the changing demands on the workforce. This includes, for example, the further roll out of Agenda for Change, community care strategy, junior doctor hours, advanced nursing, and GMS contracts.

Workforce planning should also be broken down into distinct strategies for workforce plan modelling, recruitment and retention, deployment and performance, and utilisation and skill mix. This approach should be deployed at a trust level, co-ordinated to support Department level planning, and be integrated with the Knowledge and Skills Framework.

2. INTRODUCTION

2.1 Introduction

Health and Personal Social Services (HPSS) are delivered in a constantly changing environment and policy makers and delivery bodies face ongoing challenges to develop services that keep pace with public expectations, increased demand and technological change.

In recent years, major reviews have been initiated in almost every area of HPSS and work is underway to implement change in:

- Primary Care - *Building the Way Forward in Primary Care* - reviewing primary care and developing the Local Health and Social Care Groups;
- Community Care – the *Community Care Review* - reviewing the health and social services provision available in the community;
- Public Health - *Investing for Health* - reducing inequalities and improving public health;
- Acute Care - *Developing Better Services* - following the review of acute hospital services a strategy for modernising hospital services is under development; and
- Quality Standards - *Best Practice Best Care* – an initiative focusing on ensuring quality standards across the HPSS.

Successful implementation of these changes and the provision of appropriate support and care to all those using HPSS services depends on HPSS staff. It needs a workforce that has the skills and flexibility to deliver the right care at the right time to those who need it – a workforce which has the right number of staff deployed in the right places and working to the maximum of their ability.

In May 2002, the Department launched a new human resources strategy – *The Employer of Choice*. The strategy aims to ensure that the people who work in the HPSS can make the best possible contribution to promoting health and social care, and that the HPSS is recognised as employer that cares for both its staff and its service users. The strategy has six strategic areas under which objectives have been set:

1. **Workforce Planning** – to implement effective, sustainable workforce planning arrangements for all staff groups and ensure that workforce issues are an integral part of service development;
2. **Retention, Recruitment, Reward and Return** – to reduce turnover, facilitate returners, attract the right people into HPSS and implement a modern pay system;
3. **Improving Working Lives** – to make the HPSS an employee friendly, healthy, safe workplace;

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4. **Equality and Fairness** – to ensure equality, New TSN and Human Rights policies and practices are appropriate;
 5. **Education and Training** – to promote lifelong learning for all staff (professional & non-professional) commensurate with business requirements and strengthen the capacity to manage change; and
 6. **Employee Relations** – to develop effective partnership working, improve negotiation, manage change, improve staff management skills, introduce employment security policies and support improvements in the HR function.

Consistent with the strategic approach to workforce planning adopted by the Department, it commissioned its first review of workforce planning for the Nursing Midwifery and Health Visiting workforce in 2002. This subsequent review is important to ensure that the data in relation to the workforce is up-to-date and accurate.

2.2 Terms of Reference

2.2.1 Purpose of Review

The purpose of this review is to provide the DHSSPS with comprehensive current information on the nursing, midwifery and health visiting workforce across Northern Ireland. This will inform the Department's planning in the provision of training for these professions to facilitate service provision over the next 5-10 years.

The review investigates, within the context of workforce planning and deployment, current and future supply and demand factors that will impact on the delivery and development of nursing, midwifery and health visiting services.

A key aim of this work is to enable the development of strategies that can assure the correct numbers of these professionals are in place and working in the most effective way to offer maximum benefit to the overall healthcare team and optimal patient outcomes.

The review takes into account professional issues including developments in service design and provision along with the needs of society in relation to provision of service.

While the focus of this review is upon the statutory sector, it is necessary to provide information on the distribution of these professionals across the voluntary, private and independent sectors, identifying numbers and specialism, and the impact this has upon overall nursing, midwifery and health visiting service.

2.2.2 Requirements

The specific terms of reference for the review were to:

- provide an analysis of the current nursing, midwifery and health visiting workforce in Northern Ireland, including:
 - size, composition, sectoral distribution, age and gender;
 - full-time / part-time working patterns and conditions;
 - internationally-recruited nurses – number and distribution geographically, sectorally and by nursing branch;
 - continuing professional development commitments;
 - specialist service commitments;
 - pressure points for supply and demand and distribution;
- provide an analysis of current and future recruitment and retention issues, including:
 - career development and specialisation;
 - impact of career breaks/individuals leaving the profession;
 - returnees;
 - working arrangements;
 - retirement trends;
 - perceived possible impact of Agenda for Change;
- provide a prediction of future supply of and demand for nurses, midwives and health visitors over the next five years including:
 - number of nurses, midwives and health visitors required to meet service demands;
 - assessment as to whether the current numbers of commissioned student places are appropriate to meet demand;
 - services demanding the skills of these professionals and the context within which these services will be delivered;
 - skill-mix options and multi-disciplinary working;
- review the impact of the supply and demand position within the workforce on the delivery of health and personal social services and make recommendations to address issues arising from the above including:
 - service development - assess the impact on nursing, numbers and training requirements;

-
- skill-mix - track the trends in skill mix for nursing including where nursing is taking on roles previously covered by medicine;
 - role extension – examine the core tasks and roles covered by nursing and identify any changes since the initial workforce planning review;
 - identification of key specialist skill demand areas;
 - use of Agency and Bank nurse hours;
 - Career Development - Examine the scope for career path development including:
 - flexibilities – examine arrangements to enable trained staff to move into another specialism;
 - identify availability of accelerated training pathways; and
 - identify any tangible impacts of nurse leadership development.

2.3 Outcome of Review

The main outcome of the review was to report on the following key elements:

- a prediction of the number of nursing, midwifery and health visiting staff that will be required over the next 5-10 year period;
- a model that can be applied to project trends in the supply and demand of nursing, midwifery and health visiting staff. The model should identify the parameters that will impact on the supply and demand of these professionals within the context of developments both within the professions and in the wider operating environment including economic context and society's requirements; and
- identify current and indicative future trends in the development of these services.

2.4 Report Structure

The remainder of the report is structured as follows:

- Section 3 – a review of the policy context;
- Section 4 – review of the current provision of nurses, midwives and health visitors;
- Section 5 - the key themes that arose from the consultation exercise, including staff views on workforce issues;
- Section 6 - predictions of supply and demand for the next 5-10 years across the three staff categories; and
- Section 7 - conclusions and recommendations for addressing the issues raised in this review.

3. POLICY CONTEXT

An important element of this workforce planning review was to understand the context and environment in which the DHSSPS has to plan its nursing, midwifery and health visiting workforce. To do this, we assessed the impact of key policies being implemented, those planned for roll out, and other relevant assessments carried out in the last few years.

The identification of these policies and strategic documents was through a number of methods:

- those identified by the project Steering Group;
- our own understanding of the drivers in workforce planning; and
- other strategy and policy documents that were highlighted by consultees and by the research carried out during the assignment.

The policies and strategies identified during the initial stages of the project were used to inform and direct the consultation and data gathering. Subsequent literature review provided additional understanding to the work.

It is important to note, that this section reflects the views of the individual authors of each document, and does not attempt to draw or infer any particular conclusions.

3.1 Developing a Regional Strategy for the Health and Personal Social Services 2002-2022¹

This document sets out the need for a 20-year strategy for Health and Social Services.

The strategy document was written in 2002 and went for public consultation, the results of which were subsequently published in July 2003. The strategy sets out to provide an overall context and direction for decision-making, set out a vision of the type of health and social services the public wants, and provide a “route map” as to how to get there.

In doing this, the document proposes that the strategy ought to:

- base itself firmly on the values of the public;
- be informed by the most up to date advice from experts and professionals;
- recognise the many achievements of health and social services; and
- take into account the many problems and growing number of challenges facing health and social services.

¹ Developing a Regional Strategy for the Health and Personal Social Services 2002 – 2022. Regional Strategy Team DHSSPS.

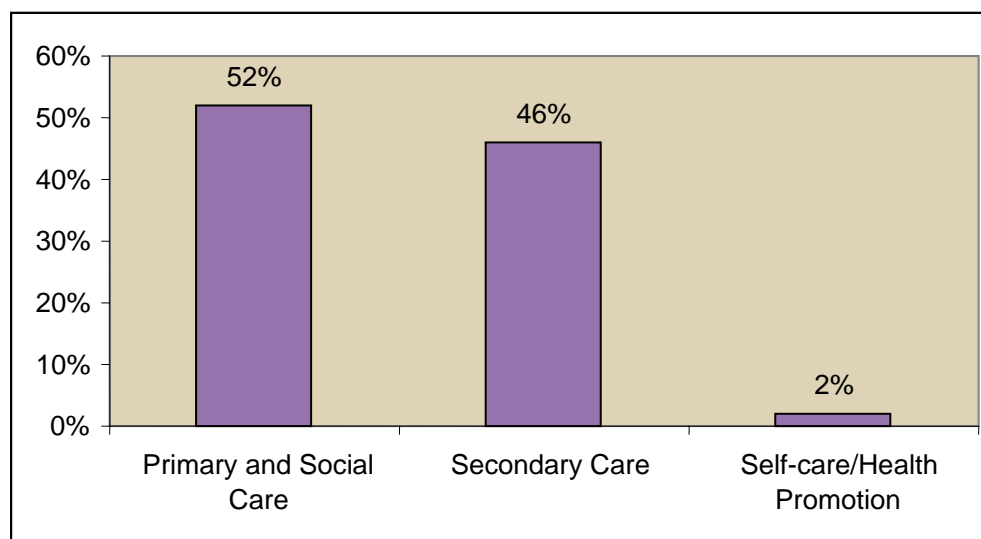
The key challenges identified by the strategy included:

- *“there are a higher number of people waiting for admission to hospital per capita in Northern Ireland than the rest of the UK;*
- *some people are waiting for more than a year for cardiac surgery. For these patients the consequences of delayed treatment can be very serious (authors’ words);*
- *General Practitioners are reporting severe pressure due to the length of their patient lists;*
- *it is difficult to ensure that people in rural areas have easy access to comprehensive and effective health and social services at a time when increased medical specialisation is resulting in smaller rural hospitals having difficulty in maintaining adequate levels of medical cover;*
- *large numbers of people are having their discharge from hospital delayed due to a lack of support available in the community;*
- *there are difficulties in recruiting and retaining staff across health and social services. There are also morale problems arising from staff having to cope with increasing pressures on health and social services; and*
- *services are having difficulty coping with winter crises or with other temporary system pressures due to lack of capacity and balance between different parts of the system of health and social services.”*

Clearly, all of the above factors will have a direct impact on the nursing, midwifery and health visiting service, and indeed the wider workforce.

The strategy document also recognised the importance of spending resources wisely. For example, it reports that the current typical distribution of health and social care resources are as shown in Figure 3.1.

Figure 3.1
Current Distribution of Health and Social Care Resources in the UK



Addressing the balance between the three areas is noted to be important, and this clearly will directly impact on the supply and demand for nurses, midwives and health visiting including the skills mix they have.

The strategy considers that important issues to be considered should include:

- “hospital services are under extreme pressure as demonstrated by waiting list figures. Although more services are being delivered in a primary care setting, there will always be a need for acute care* in hospitals, especially with the pressure of an ageing population. Additionally, developments in technology and treatment mean that hospitals will be treating diseases currently incurable; and
- there is a clear link between primary care and acute care. Without adequate provision of primary care services, the pressures on secondary care will continue to build. More resource is required to treat people earlier before they need more extensive and costly treatment.”

* (Primary care is defined by the Medical Research Council as “first contact, continuous, comprehensive and coordinated care provided to individuals and population undifferentiated by age, gender, disease or organ system.”

Acute care is defined by the Department of Health as “intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment; and does not include any of the following:

- i) care relating to conditions to do with mental health or learning disabilities;
- ii) rehabilitation;
- iii) maternity care; and
- iv) intermediate care.”

3.2 Priorities for Action 2004/2005²

Priorities for Action takes the outcomes and targets from the Government's Priorities and Budget 2004/06³ and translates them into the agenda for the HPSS.

Areas for improvement were identified in the report as:

- improved access to services. Includes addressing waiting lists, trolley waits, and delayed discharges;
- reform, modernisation and service improvement. Includes *Developing Better Services, Community Care Review, Best Practice – Best Care, and Investing for Health*;
- promoting effective integrated working across the primary, secondary and community care sectors. Recognises the interaction between sectors, organisations, professions and individuals;
- getting the balance right. Balancing investment in the different care sectors; and
- improving efficiency and performance. Using resources to full effect, whilst maximising quality of care. Boards and trusts will be expected to meet a service improvement target of 2% of budget by March 2006.

Workforce

The HPSS see a skilled, trained, motivated and caring workforce as the key to delivering the objectives contained in this Plan. According to the document, the qualified nursing workforce (headcount) has increased by 13 per cent since 1999 and there have been similar increases in medical staffing over that period. They do also recognise that that despite the rise in numbers there is still significant pressure on the workforce.

The Department increased the annual intake number of commissioned pre-registration nursing places on a 3-year programme (at Queen's University and University of Ulster) from 680 to 750 with effect from the 2002 Academic Year. In addition 15 Direct Entry midwifery student places were commissioned with effect from the 2003 Academic Year (The RCM would point out these additional direct entry places were accompanied by an associated reduction of post registration training places from 40 to 24). According to the Plan, these increased intake levels will need to be maintained as a minimum requirement in the years ahead.

However, DHPSS has stated that investment must be accompanied by reform. New ways of working that break down boundaries between professionals need to be found. This will allow staff to reach their full potential, increase job satisfaction and improve services. The extra staff will bring benefits but expanding the workforce will not be sufficient on its own to deliver the major improvements to service users that are required. DHPSS predicts radical changes are needed in the way staff work to reduce waiting times and deliver modern patient and client centred services. This

² Priorities for Action 2004/2005. Planning Priorities and Actions for the health and Personal Social Services. DHSSPS March 2004

³ Priorities and Budget 2004/06.. Government spending plans for NI for 2004/05 to 2005/06

modernisation of the workforce can be facilitated by the implementation of Agenda for Change, as detailed below.

The Department continues with its programme of workforce planning, to try and ensure there is an appropriate balance between supply and demand of qualified staff. Priorities for Action states that workforce planning is most effective if it is carried out in partnership with stakeholders. The Department will continue to involve the Service in this activity and Boards and Trusts are asked to collaborate with the Department in its ongoing programme of workforce reviews. The Department plans to carry out annual updates, with full workforce reviews every 3/4 years. Priorities for Action states that employers should ensure that they have their own local workforce plans that address recruitment and retention of their workforce.

According to the document, the Key Actions that the nursing, midwifery and health visiting workforce should take forward include:

- *“HPSS employers should, in light of Departmental workforce reviews, produce plans, approved by their boards, by 31 December 2004 to address retention issues in areas of workforce shortages;*
- *all HPSS employers should work to achieve the individual targets for the reduction of sickness related absenteeism set by the Department; and*
- *all HPSS employers must work towards 100 per cent compliance with European Working Time Directive as it applies to doctors in training from August 2004.”*

3.3 Agenda for Change

“Agenda for Change, the proposed new pay and grading system for the NHS, represents the biggest change to NHS pay since the formation of the health service in 1948. If implemented, the proposals will change the whole system of pay, annual leave, overtime and working hours for the vast majority of NHS staff.”⁴

The Agenda for Change (AfC) policy document was jointly published by the four health departments in England, Northern Ireland, Scotland and Wales in February 1999. It highlighted the need for changes to pay and career structures, and conditions of employment within the NHS. It also highlighted the need for effective career planning and performance management.

Much consultation has been carried out in the intervening period between the departments, the NHS confederation and 20 trades unions and representative bodies. For example, 88.42 per cent of the RCN voted to accept AfC – therefore, expectations are high on both the employer and employee sides. Indeed, a review of early implementers in the autumn of 2004, found responses to be largely favourable.⁵

⁴ Agenda for Change – A summary of the Proposals. Unison July 2004

⁵ Agenda for Change – A guide to the new pay, terms and conditions in the NHS. Royal College of Nursing 2004.

From a workforce planning point of view, implementation of AfC will mean significant change:

- a new grading/banding scheme, based on job evaluation will be introduced;
- harmonisation of terms and conditions across nursing, midwifery and health visiting workforce;
- increasing annual leave entitlements based on length of service;
- implementation of a Knowledge and Skills Framework (KSF); and
- implementation of a new performance management system.

AfC is also being promoted for nurses, midwives and health visiting working outside the NHS. However, nurses employed in the independent sector, other government departments, GP practices and nurse lecturers are not covered by AfC. Nevertheless, its adoption is being promoted and will also be influenced by employment market forces.

In practical terms, the main impact for workforce planning will be an overall increase in holiday leave entitlement, which will effectively reduce resource availability⁶. Projected changes are highlighted below:

Length of Service	AfC Annual leave & Public Holidays	Approximate Existing Provision ⁷
On appointment	27 days & 10 days	Approx 25 days & public holidays
After 5 yrs	29 days & 10 days	Approx 27 days & public holidays
After 10 yrs	33 days & 10 days	Approx 30 days & public holidays

However, there is an expectation that this effective resource reduction will be balanced through increases in performance/productivity. Thus, AfC is not projected to directly lead to headcount increases.

An additional point to note is that Northern Ireland Practice and Education Council (NIPEC) have just gone out to consultation on the Development Framework for Nursing and Midwifery which will ultimately support the implementation of AfC for Change.⁸

⁶ Agenda for Change – Final Agreement Dept of Health. December 2004

⁷ Current Nurses and Midwives Handbook.

⁸ Development framework for Nursing and Midwifery. Consultation Document. NIPEC. November 2004

3.4 The Employer of Choice⁹

In The Employer of Choice, the DHSSPS recognises the need to have an effective Human Resources Strategy to enable the delivery of a modern HPSS. The strategy aims to present the HPSS as an Employer of Choice – through being recognised as caring for both its staff and its service users.

The Strategy recognises the Programme for Government for 2002/2005, and sets out the priorities for addressing issues and improving public health. In order to meet these challenges, the Strategy recognises the importance of inter-relationships between areas and issues. It also sets out six strategic areas:

- *workforce planning;*
- *retention, return, recruitment and reward;*
- *improving working lives;*
- *equality and fairness;*
- *education and training; and*
- *employee relations.*

By identifying these six strategic areas, the DHSSPS has recognised the need to focus specifically on these areas.

Specifically on workforce planning, the Strategy states:

“there are widespread shortages of skilled staff in key areas, across both health and social care occupations. The HPSS is finding it increasingly difficult to recruit staff with the right skills, knowledge and experience.

Effective workforce planning aims to provide a surplus of supply, sufficient to absorb changing workforce patterns, roles and developments. It balances the training needs of staff with the demands of the service they work in. It is an exceptionally complex task, yet one that the HPSS must embrace within an integrated framework. The Strategy aims to:

- *implement effective workforce planning arrangements for all groups within the HPSS;*
- *ensure workforce planning is an integral aspect of planning for service delivery, service developments and strategic decision making;*
- *strengthen capacity and capability within the HPSS to sustain effective workforce planning arrangements;*
- *enhance team working across professional and organisational boundaries through greater integration of pre and post-registration training.”*

⁹ The Employer of Choice. A strategy for managing and developing people in the Health and Personal Social Services. DHSSPS May 2002

This recognises the need for the whole HPSS to continue to develop its capability in workforce planning and team working across different stakeholders.

On retention, return, recruitment and reward, the Strategy states:

“the HPSS depends upon the skills and knowledge of existing staff, and the availability of suitably qualified people to match the increasing demands placed on it.

As the HPSS reshapes itself to meet the needs of its service users it will require the best, appropriately skilled staff in practice at all levels. The Service needs individuals who are looking for new positions to choose the HPSS. As services develop, the demand for skilled staff rises and there is an ever-increasing need for the HPSS to:

- *reduce the turnover of scarce staff;*
- *make it easier and more attractive for staff to return to practice;*
- *attract the right people into the HPSS; and*
- *implement a modernised pay system.”*

The element of the Strategy thus recognises the need to focus effort on retention and the working environment staff experience.

The third element particularly relevant to this review is that of education and training. The key elements of this recognised by the Strategy, include:

“we want to consolidate a culture where managers recognise the benefits of education and training and where investment in staff development is seen as an investment in an improved service. The Strategy aims to:

- *promote learning for all staff, with an equal emphasis on groups who do not hold professional qualifications;*
- *develop, maintain and support a culture of lifelong learning throughout the HPSS;*
- *ensure that there is a business focus to all training and development programmes; and*
- *strengthen capacity within the HPSS to manage change effectively.”*

3.5 Ward Staffing - A Review of National Findings¹⁰

This review focuses on ward staffing, and highlights areas for improvement when planning the workforce.

The Audit Commission state that staffing the wards is by far the largest single budget item for an acute trust and the quality of care that is delivered has a major impact on health outcomes. In the course of their reviews, they have also identified that there is much room for improvement in the way staffing is planned, although they do

¹⁰ Ward Staffing – A Review of National Findings. Audit Commission November 2001

recognise that things have improved in the last decade. It is interesting to note, that they do not see “staffing” on wards as being focused on nurses only, but should be planned holistically around the needs of the patient. This would include for example, healthcare assistants and clinical support workers.

Other factors, such as the reduction in junior doctors’ hours and changes in patterns of healthcare delivery, including shortened lengths of stay for patients in hospital and the increasing use of nurses in providing specialist care, have also had an impact on the way that wards are staffed.

Another factor affecting both the costs and the quality of care delivered by staff on the wards is the use of bank and agency staff. The Audit Commission also recently published a national report examining their use. This is reviewed below.

The Commission report comments that demonstrating value for money in ward staffing involves assessing the resources and staffing levels against the amount of patient care delivered and the outcomes – the effectiveness or quality of the work that is done.

The report also states that measuring the inputs for ward staffing, that is, the number and cost of staff on each ward, is relatively straightforward. The outputs, in terms of the volume of patient care, are much more complex. This is due to differences in responsibilities across different trusts. These differences are likely to become more pronounced as the role boundaries between different types of staff continue to be challenged. Measuring the outcomes of care, in terms of clinical risk or quality, remains the most problematic task, despite advances made since 1991.

In order to understand staffing and local differences further, the Audit Commission surveyed over 3,600 wards. After eliminating known variances where possible, such as ward size, London weighting, or outpatient delivery, they found that there were significant differences in the amount that individual trusts spent on ward staffing. Those who spent more on staffing tended to employ more staff per bed rather than fewer, more expensive staff. This would all indicate that the planning of staff is inconsistent when it comes to numbers against grade mix.

The review also provided a view on the effective use of staff, including indicating allowance entitlements to be used for planning purposes. Deploying ward staff to maximise hours at the patient’s bedside requires good management. Rosters and shifts must be well planned, sickness absence minimised and study-leave used appropriately.

To measure how well trusts are achieving these aims requires an understanding of the proportion of contract hours that should be available to patients. The review detailed the following figures as typical of the trusts surveyed:

Percentage contract hours lost due to:	Percentage
Annual leave	12.5 – 13.5
Sickness absence	5.5
Maternity leave	1
Study leave	2
Total hours lost	21-22

Naturally, these figures do not include time allowances for other factors such as mentoring, management time, or mandatory training.

However, the review also highlighted that there is room for improvement in the efficiency with which some trusts deploy their staff in order to increase the actual utilisation of the staff they have in post when at work.

It also stated that clearly-defined outcome measures are required so that ward staff can demonstrate the value of the care that they deliver. These should also be defined nationally so that trusts can compare their performance. (This is probably more relevant now with the introduction of Agenda for Change).

3.6 Brief Encounters – Getting the Best from Temporary Nursing Staff¹¹

This review by the Audit Commission studied the use of agency and bank staff in the NHS.

They found that:

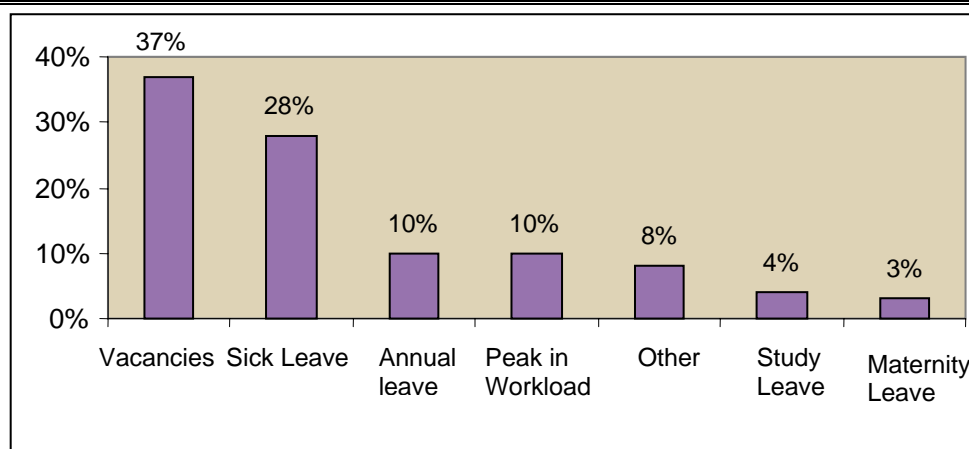
- on a typical day in the NHS, agency and bank staff covered 10 per cent of shifts;
- the use of bank and agency staff continues to grow, and costs are escalating rapidly;
- the use of temporary staff can carry risk in the delivery of patient care;
- unnecessary costs are being incurred through higher rates of pay, lack of long term agreements with agencies, and failure to check timesheets and payments;
- there was a lack of central co-ordination of staff cover; and
- unnecessary bookings could be eliminated.

¹¹ Brief Encounters – Getting the Best from Temporary Nursing Staff. Audit Commission, September 2001

The reasons for using agency and bank staff were described thus:

Figure 3.2

Reasons for Using Agency and Bank Staff in UK



The main recommendations from the review were:

- “operate the same stringent pre-employment checks for bank staff as they apply in recruitment to substantive posts and only use agencies that have equally robust practices;
- ensure that all temporary staff have an effective local induction before starting work and introduce positive identity checks as a standard procedure;
- guarantee that temporary nursing staff attend annual update training in basic life support, moving and handling, fire safety and other health and safety skills; and
- ensure bank staff are not discriminated against in accessing funding for continuing development and are paid for their time attending mandatory training.

To reduce the costs of temporary cover, trusts need to:

- establish proper contractual arrangements with a limited number of suppliers to secure lower commission charges and promote quality improvements; and
- put in place adequate controls for the authorisation of timesheets and payment of creditors.

To manage demand and improve efficiency, trusts need to:

- use cross-cover support, staff pool arrangements and additional hours when these are more cost-effective and promote good patient care;
- improve efficiency by centrally co-ordinating cover arrangements and matching better the number and mix of bank staff to demand for cover;

-
- minimise the amount of time spent by clinical staff arranging cover by standardising booking processes and promoting good communications between clinical areas and bank services; and
 - invest in information technology to modernise bank administration and speed up shift bookings.”

As a final note on the use of agency and bank staff, it can be seen from the chart above that covering vacancies (37 per cent) and sick leave (28 per cent) accounts for some 65 per cent of agency and bank staff use. It could be argued that as well as addressing the recommendations above, more effective use could be made of existing staff and resources if these two issues were more actively managed.

3.7 How Many Nurses? Nurse Workforce Planning Policy in the UK¹²

This report for the RCN reviewed recent developments in nurse workforce planning in all four countries in the UK. Key findings were:

Nursing Workforce Issues

- the age profile of the workforce is increasing. The report predicts that this is projected to create challenges in the years ahead to replace retiring nurses;
- whilst there is no commonly agreed measure of nursing shortages, most stakeholders who took part in the review acknowledge that certain specialities, for example, intensive care, theatre nursing and psychiatric nursing have higher levels of vacancies. Therefore, certain specialisms need focused attention;
- Northern Ireland was found to have a much higher proportion of grade D nurses than in other parts of the UK;
- the outflow of international nurses needs to be monitored given the high dependency on overseas nurses in certain areas; and
- reviewers found that there is a high expectation that the “character” of the workforce will continue to evolve given the development of skill mix changes and new roles. Two factors are particularly emphasised – an increase in the number of nurses in advanced roles, and the growth in the number of health care assistants. The Wanless report¹³ made some attempt to quantify this but there is little information available on which to base future projections.

¹² How Many Nurses? Nurse Workforce Planning Policy in the UK. James Buchan January 2004

¹³ Securing our Future Health : Taking a Long-Term View. D Wanless 2002. HM Treasury.

Workforce Planning Issues

The review also considered workforce planning issues. Key findings were:

- “national staffing targets have been the focus in recent years. However, whilst these targets have tended to be political commitments rather than through the analysis of need, they do show a commitment to increase numbers”;
- “there is a clear emphasis on the need for better integration of workforce planning with service planning. It is recognised that this approach is likely to work better for different occupations”;
- “there is a need to develop greater technical expertise and capacity in workforce planning”;
- “workforce planning is an inexact science, and is heavily dependent on the availability of workforce data. Difficulties with data include:
 - inconsistent trend data on attrition rates during pre-registration and midwifery education;
 - incomplete data on how many newly qualified nurses and midwives take up employment in the NHS and elsewhere;
 - little published evidence of the actual retirement behaviours of nurses – an important issue given the ageing profile of the workforce;
 - no detailed understanding of the deployment of international nurses exists;
 - incomplete data on the levels of retention of nursing staff;
 - incomplete data on other joiners and leavers; and
 - limited data available about the profile of the non-NHS nursing labour market.”

3.8 Fragile Future? A Review of the UK Nursing Market in 2003¹⁴

This review studied the key trends and dynamics in the NHS nursing workforce. It found that the driver for staffing growth has been government policy to expand and improve NHS services, based on significant year-on-year funding. It also stated that associated factors have included the impact of the European Working Time Directive, which has reduced junior doctor hours and thus increased the demand for advanced nurses. Also, there have been broader, policy led attempts to support “working differently” in the health service that develop new roles and working patterns.

¹⁴ Fragile Future? A Review of the UK Nursing Labour market in 2003. James Buchan & Ian Seccombe. RCN

The review also refers to the implementation of Agenda for Change. Interestingly, it reports that the Department of Health in England predicts that its implementation will free up around four per cent of qualified nurses' time to devote to direct patient care. (It should be noted however, there is an expectation that increases in productivity will be in part balanced against an overall increase many staff will see in their leave entitlement).

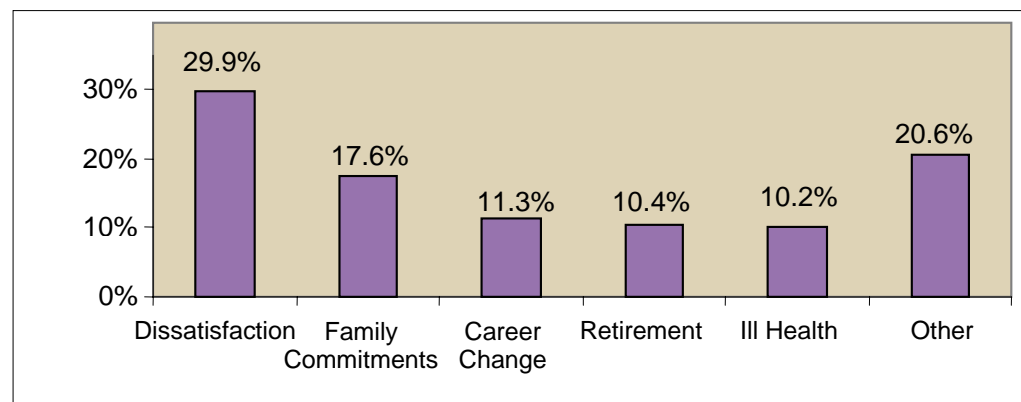
3.9 Why do Midwives Leave?¹⁵

As with any workforce experiencing challenges with shortages, recruitment of additional staff is not necessarily the answer to these shortages. The Royal College of Midwives recognised this and commissioned this work in order to identify reasons for retention difficulties and hence take action to improve retention.

Over 2300 midwives across the UK who chose not to practice post-2000 were surveyed for their views as to why they left the workforce.

The reasons for choosing to leave were as indicated below:

Figure 3.3
Reasons for Midwives Choosing to Leave the Profession



It can be seen that dissatisfaction with the job is the major reason for midwives choosing to leave. However, regardless of the reason given for leaving, high levels of dissatisfaction were reported in all groups.

Reasons for dissatisfaction were given as:

- unhappy with the practices being used to deliver midwifery services;
- the requirement to rotate through shifts and different areas of clinical practice;

¹⁵ Why do Midwives Leave? Linda Ball *et al.* Women's Informed Childbearing and Health Research Group, University of Sheffield & RCN 2002.

-
- lack of support from midwifery managers, extending to a prevalence of intimidation and “horizontal violence” (horizontal violence has been defined as “hostile and aggressive behaviour by individual or group members towards another member or groups of members of the larger group. This has been described as inter-group conflict” (Duffy 1995¹⁶). Indeed, this issue led to the commissioning of a supplementary study investigating the specific views of midwifery managers;¹⁷
 - Subsequent recommendations from the study were:
 - proper consideration of patterns of working;
 - provision of proper support;
 - assessment of the culture and organisation of midwifery, specifically around management and leadership;
 - appropriateness of pay and promotion;
 - improving recruitment through the widening of access routes; and
 - more focus on retention.

3.10 The Global Shortage of Registered Nurses¹⁸

This report examined the issue of nursing shortages globally, and considered a framework of policy interventions to address these.

The study found that a shortage of nurses is a global issue. However, it also recognised that workforce shortages are not just a nursing problem. They directly impact on the whole health system, particularly given the current developments in community and social care.

Links have been established between adequate staffing levels and positive care outcomes. The lesson here is that failure to effectively plan the nursing and midwifery workforce is likely to directly impact on the delivery of effective health care.

The report found that globally, the shortage of nurses is more pronounced in rural areas. Urban areas can offer more opportunities for promotion and progression. However, nurses already working in rural areas tended to be more settled in their posts.

Demand for health care was found to be increasing due to ageing populations, more successful interventions, and the desire for more care in the community. Indeed, nursing shortages are predicted to increase globally due to ageing populations.

¹⁶ <http://www.acegraphics.com.au/articles/hastie02.html>

¹⁷ Why do Midwives Leave. Talking to Managers. Linda Ball *et al.* Women’s Informed Childbearing and Health Research Group, University of Sheffield & RCN 2003.

¹⁸ The Global Shortage of Registered Nurses: An Overview of Issues and Actions. James Buchan and Lynn Calman. International Council of Nurses. 2004

The report summarised the critical challenges globally as being:

- whilst there is no universal definition of a nursing shortage, there is increasing evidence of nurse supply/demand imbalances in many countries;
- supply of nurses in many low-income and high-income countries is failing to keep pace with increasing demand;
- one recent estimate is that sub-Saharan African countries have a shortfall of more than 600,000 nurses needed to meet the Millennium Development Goals;
- the Organisation for Economic Co-operation and Development (OECD) reports that many of its (high-income) member countries have increasing problems of nursing shortages;
- there is a link between adequate nurse staffing levels and positive care outcomes;
- gender-based discrimination continues in many countries and cultures, with nursing being undervalued and downgraded and pigeon-holed as “women’s work”;
- violence against health workers persists in many countries, with nurses often taking the brunt because they are in the forefront of the direct delivery of care;
- three critical challenges related to nursing shortages are:
 - the impact of HIV-AIDS;
 - the internal and international migration of nurses; and
 - achieving effective health sector reform and reorganisation.

Regional Imbalances

The authors of the report found that many countries report difficulties in recruiting and retaining nurses and other health care professionals in rural areas. This is a feature of both developed and developing countries. This problem is often exacerbated by the tendency of health professionals to prefer to work in a large urban area, where job prospects and career opportunities are greater.

Defining Shortages

The report debates the actual definition of what a shortage is. For example, it cites the USA, with a nurse/population ratio of 773 nurses to 100,000 of population as having shortages. This is contrasted with Uganda who are reporting shortages with a nurse to population ratio of 6 nurses per 100,000. Therefore, the definition of shortages is relative to the level of care delivered.

Buchan also states:

“a ‘shortage’ is therefore not merely about a numbers game or an economic model, it is about individual and collective decision-making and choice. In this case the shortage is not necessarily a shortage of individuals with nursing qualifications it is a shortage of nurses willing to work as nurses in the present conditions. As such, the search for solutions to shortages has to focus on the motivation of nurses, and incentives to recruit and retain them, and encourage them back into nursing, as well as on the planning framework.”

In previous decades, nursing shortages in many countries have been a cyclical phenomenon, usually as a result of increasing demand outstripping static or more slowly growing supply of nurses. At the beginning of this new millennium, the situation is more serious. Driven by growing and ageing populations, demand for health care and for nurses continues to grow, whilst the supply of available nurses has actually fallen in some developed and developing countries. Shortages may not relate only to clinical nurses; in some countries there is a critical shortage of nurse tutors and educators, which will constrain any attempts to increase the numbers of nurses being educated.”

He also makes the point that many high-income countries, Europe included, are facing a demographic “double whammy” – they have an ageing nursing workforce caring for an ageing population. Some countries are facing this problem because of the reductions in numbers of nurses they recruited in the 1990s, as well as reduced numbers entering the workforce today.

Migration

The study found that the migration and international recruitment of nurses have become more prominent features in the last few years. The practice of “active” recruitment has generated controversy because of the potential to cause nursing “brain drain” in some developing countries. Additionally, according to the report, an equally important issue which has been less prominent in policy arenas is internal migration – from rural to urban areas, from public sector employment to private sector employment, and from nursing employment to non-nursing employment (or no employment).

International nurse migration has been a high profile issue in recent years, but it is important to view it in the broader context of all “flows” of nurses into and out of nursing employment in a country. It is also important to be clear that such migration may be temporary or permanent; in the former, there may be scope for the source country to attract back the nurse.

Interestingly, Buchan also states that some countries, for example the Philippines, are actually training nurses specifically for export. This is based on the premise that they will return cash earnings back into the local economy.

Buchan states that whilst there is nothing new in nurses moving across borders, what has changed in recent years is the increase in active (some would argue aggressive) recruitment from developed countries facing nursing shortages. Often, recruitment agencies are used as intermediaries in this process. Increased reliance on international recruitment is a key dynamic in some developed countries. For

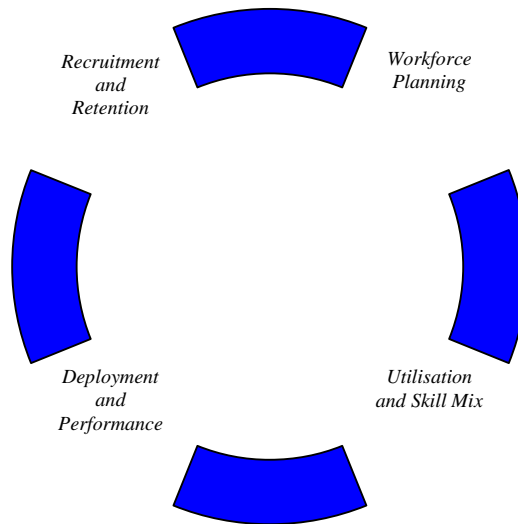
example, in the space of a few years, Ireland has moved from being a traditional exporter of nurses, to being an importer. In 1990, three-quarters of new nurses entering the Irish nursing register were “home grown”. One decade later, Ireland is reliant on recruiting from other countries for more than two-thirds of its “new” nurses. Many of these nurses come from the UK, a reverse migration.

Recommended Policy Interventions

Buchan, in his report, is very clear in what and how policies and interventions should be developed. He proposes that a policy intervention framework with four components as shown in Figure 3.4.

Figure 3.4

A Policy Intervention Framework for Workforce Planning (Buchan)



The table below details his proposals further:

Table 3.1
Details of Policy Intervention Framework for Workforce Planning (Buchan)

Component	Interventions	Requirements
Workforce Planning	<ul style="list-style-type: none"> ■ Needs assessment ■ Integrated (or aligned) planning ■ Linkage with education sector ■ Scenario modelling ■ Geographical distribution 	<ul style="list-style-type: none"> ■ Planning capacity ■ Workforce data/information ■ Stakeholder involvement
Recruitment and Retention	<ul style="list-style-type: none"> ■ Recruitment from traditional sources ■ Recruitment from “new” sources ■ Retention of current staff ■ Attract returners 	<ul style="list-style-type: none"> ■ Financial and non-financial incentives ■ Career structure and opportunities ■ Flexible working models ■ Safe working conditions ■ Nurse involvement in decision making
Deployment and Performance	<ul style="list-style-type: none"> ■ Day-to-day matching of staff with workload ■ Flexible working models ■ Shift patterns for 24 hour care ■ Full-time/part-time/temporary staff ■ In-service training/ “lifelong learning” 	<ul style="list-style-type: none"> ■ Effective local management ■ Data on activity and workforce ■ Financial and non-financial incentives ■ Allocation of necessary equipment, material, drugs etc ■ Nurse involvement in decision making
Utilisation and Skill Mix	<ul style="list-style-type: none"> ■ Strategic/policy decisions on effective skill mix of staff ■ Regulatory infrastructure ■ Legislative infrastructure ■ In-service training/ “lifelong learning” 	<ul style="list-style-type: none"> ■ Effective strategic management ■ Data on activity/output/outcome ■ Job descriptions/role definitions ■ Financial and non-financial incentives ■ Nurse involvement in decision making

To support the workforce planning framework, he also includes the following conditions:

- the framework components are interdependent;
- policy intervention must be appropriate to country context and objectives; and
- change requires leadership and, in many health systems, it also requires improved opportunities for stakeholder involvement. “Top down” change is often unsustainable: the support of nurses and other workers is required, as is the active participation of other stakeholders (the education sector, regulators, nurses’ associations, and representatives of broader civil society).

Magnet Institutions

As part of his study of success, Buchan, in his global study, discusses what constitutes a “good employer”. He reports the concept of the “magnet” hospital, developed initially in the 1980s in the United States. At a time of staffing shortages, policy attention turned to identifying the characteristics of “successful” health care employers in challenging labour markets. The initial focus of that research was to identify the human resource practices and associated organisational characteristics that enabled these hospitals to attract and retain staff, even in difficult labour market conditions.

Some of the key characteristics of successful hospitals were:

- participatory and supportive management style;
- well prepared and qualified nurse executives;
- flexible working schedules;
- clinical career opportunities; and
- emphasis on in-service/continuing education.

The report also states that the idea of the magnet institution has been sustained and developed over the successive decades through a series of research studies, and by the development of a magnet nursing services accreditation programme. This and similar approaches are now being investigated in several countries.

The main message from the various research studies is that “magnetism” does appear to be related to “better” staffing indicators, such as reduced turnover and absenteeism, and to improved quality of care. This has been attributed to the sustained implementation of a “bundle” of human resource management (HRM) interventions which fit with organisational priorities, and which support autonomous working by nurses, enable participation in decision making, facilitate career development and enable high level skills to be deployed effectively.

3.11 International Staff Review

A number of documents were reviewed in order to ascertain the issues around the recruitment and employment of overseas staff.^{19 20}

The “Here to Stay” report was commissioned by the RCN to study the employment policy and practice implications of the rapid growth in the number of internationally recruited nurses (IRNs) working in the UK.

It found that in the early to mid-1990s about one in 10 of the annual new entrants to the UK nursing register was from non-UK sources. By 2000/2001 this had risen to almost four in ten of total initial registrations, and then in 2001/2002 for the first time ever there were more overseas additions to the register than there were UK registrants. The Philippines, Australia and South Africa are the three main source countries.

According to the report, there are now at least 42,000 international nurses in the UK. This is more than double the number of IRNs working in the UK three years ago.

The study also found that there has been a shift from regarding international recruitment as a reactive, one-off last resort. It is now being planned and linked more directly to other aspects of recruitment and retention.

The main challenges reported when employing IRNs were found to be language, differences in clinical and technical skills, racism in the workplace, and the reaction of patients.

The managers consulted, rated international recruitment as a relatively “easy” method of meeting current nurse staffing requirements, compared to home-based initiatives. They reported that it is regarded as no less cost effective than other recruitment and retention policies.

“Migrant Workers in Northern Ireland” found that staff that were recruited by agencies had very mixed experiences – ranging from very poor to very supportive. This would also be backed up by the experiences of employers who have found the service delivered by recruitment agencies to be variable, and on occasion, aggressive selling techniques have been used to sell staff into trusts. Additionally, some overseas nurses were asked to pay a fee of up to £2000 to their handling agency.

When in the workplace, a number of nurses had concerns that their salary did not reflect their professional experience. Many nurses are placed on Grade D. Some felt this was unfair as it did not recognise the nursing experience they had had outside Northern Ireland.

One nurse who was consulted also complained that she had been waiting over two years to achieve NMC registration.

¹⁹ Here to Stay? International Nurses in the UK. James Buchan. RCN

²⁰ Migrant Workers in Northern Ireland. Institute for Conflict Research. June 2004

3.12 Community Nursing^{21 22}

Community nursing strategies continue to be developed. Moving more care into the community is now one of the key strategies in delivering future healthcare. In the DHSSPS Strategic Direction position paper, the stated aspiration is as follows:

“we wish to develop a workforce that is equipped to respond to the increasing demands of first contact care, ongoing care and chronic disease management, while always underpinning this with a public health approach. Nurses will be working in new settings such as intermediate care centres, drop-in clinics, treatment and diagnostic centres, and out-of-hours centres. We envisage a workforce that will be able to provide advanced generalist services, in teams with a range of skills. At the same time, there will be specialist support in clinical areas such as diabetes, epilepsy and for identified groups such as the homeless. Extended and supplementary prescribing by nurses will be an important element in the range of skills needed for nurses to complete episodes of patient care.”

They also recognise that there will be particular challenges for workforce planning across primary care, and stated that the new GMS contract will give unprecedented flexibility to practices in deciding what services they wish to offer, or not. For example, if large numbers of GPs decide not to offer out-of-hours provision, Boards may contract nurses or private companies (that employ nurses) to provide out-of-hours services. This has the potential to destabilise the workforce if community nurses – a scarce resource – are drawn away from Trusts.

As nurses increasingly undertake tasks that were previously carried out by doctors, risk management and clinical governance become ever more important. It will be important that expanded roles are developed to meet the needs of patients more smoothly, and not driven by a desire for role substitution. The Contract clearly states that practices will be rewarded under the organisational quality standards for working to Agenda for Change.

The study also stated that workforce planning would need to be very sensitive to changing local need. This will require improved professional and clinical support for nurses and robust clinical governance frameworks, especially for nurses taking on new roles. However, whilst the document recognises that an approach to workforce planning needs careful consideration, it makes no recommendations as to the approach required.

The Community Health Nursing document goes on to say that future community workforce planning should be carried out in the light of a needs analysis within the context of public health. This is required to “address holistic community health needs including the promotion of a well population”. One of the key features of locality needs investigations is that they provide the structure to develop an in-depth profile of the designated area.

²¹ Strategic Direction in Community Nursing in Northern Ireland. Position Paper November 2003. DHSSPS

²² Community Health Nursing. Current Practice and Possible Futures. Turner *et al.* NMC & DHSSPS

It suggests that community needs assessment activities could be carried out by health professionals or voluntary or community groups all working together as a means of investigating the unmet need of that community. However, this needs analysis has not yet been done, thus work is still required to fully understand community healthcare needs and ultimately plan for it.

3.13 Summary of Key Points

The key points from the review of policy and strategy documents are outlined below:

- the regional strategy that has been developed for Northern Ireland recognises that the delivery, and hence the planning of staff, needs to be driven by public need, be inclusive of all stakeholders, value the health service, and consider the increasing challenges the Service faces. The key challenges are recognised as increasing pressure on the health service (for example, waiting lists, changes to service provision and ageing population), difficulties in recruiting and retaining staff, and low staff morale. Additionally, it also recognises the importance of a robust approach to workforce planning in order to use valuable resources wisely;
- the need to improve service provision has been clearly identified. However, the impact this will have on workforce planning is complex. Consideration has to be given to getting the correct skills mix between professions, and to better understanding the future requirements on the nursing, midwifery and health visiting workforce relating to role extension, more advanced care delivery and linkages between acute, primary and community care sectors;
- the nursing workforce in Northern Ireland has grown by 13 per cent since 1999. However, it is recognised that the increased intake levels will have to be maintained in the years ahead;
- the implementation of Agenda for Change is widely anticipated across the UK. The expectation is that staff will have better terms and conditions and greater access to career development opportunities. However, an associated improvement in performance is expected from the implementation of these improvements in order to mitigate such as increases in leave entitlement;
- there is broad agreement that the way workforce planning is carried out needs to be improved through better co-ordination between stakeholder groups and professions, improving the linkages to service development, linking performance to care outcomes and more effective deployment of staff. Planning the workforce should consider the elements of workforce planning (as an activity), recruitment and retention, deployment and performance, and utilisation and skill mix;
- the cost and usage of agency and bank staff needs to be reviewed. The use of agency and bank staff continues to grow and costs are increasing. Agenda for Change may increase costs further, and the reasons for the use of agency and bank staff need to be considered;
- the increasing age profile of the workforce will accelerate the rate of retirements over the forthcoming years, and an ageing population will also increase the demands on the healthcare system;

-
- low morale among nursing, midwifery and health visiting staff is seen to be an issue. There seems to be wide dissatisfaction across the workforce, however, there is an expectation that AfC will help alleviate some of the problems;
 - nursing, midwifery and health visiting staff shortages, and indeed the definition of shortage, is not fully understood. “A shortage is therefore not merely about a numbers game or an economic model” (Buchan). There is a link between adequate staffing levels and positive care outcomes. Failure to effectively plan the workforce is likely to have an adverse effect on the delivery of effective healthcare; and
 - community nursing continues to develop. Moving care into the community is a key strategy in delivering future healthcare. However, the full impact of this strategy on workforce planning is not yet understood.

4. ANALYSIS OF CURRENT POSITION

4.1 Introduction

This section details the current level of provision of nurses, midwifery and health visitors. The following characteristics of the current workforce are detailed in this section:

- area or discipline;
- age;
- gender;
- working patterns;
- vacancy levels;
- recruitment;
- overseas nurses;
- joiners; and
- leavers.

This analysis is based on information from a range of sources, chiefly the DHSSPS payroll system (HRMS), the Nursing and Midwifery Council registration database (NMC) and the DHSSPS Survey of Vacancies. Information was not available on staff working outside of the HPSS and it was not possible to fully disaggregate the nursing, midwifery and health visiting workforce across disciplines.

The number of nurses working in mental health, learning disability and the number of midwives could be extracted based on recent internal workforce planning studies, but it was not possible to disaggregate children's and adult nurses due to HRMS not capturing this detail.

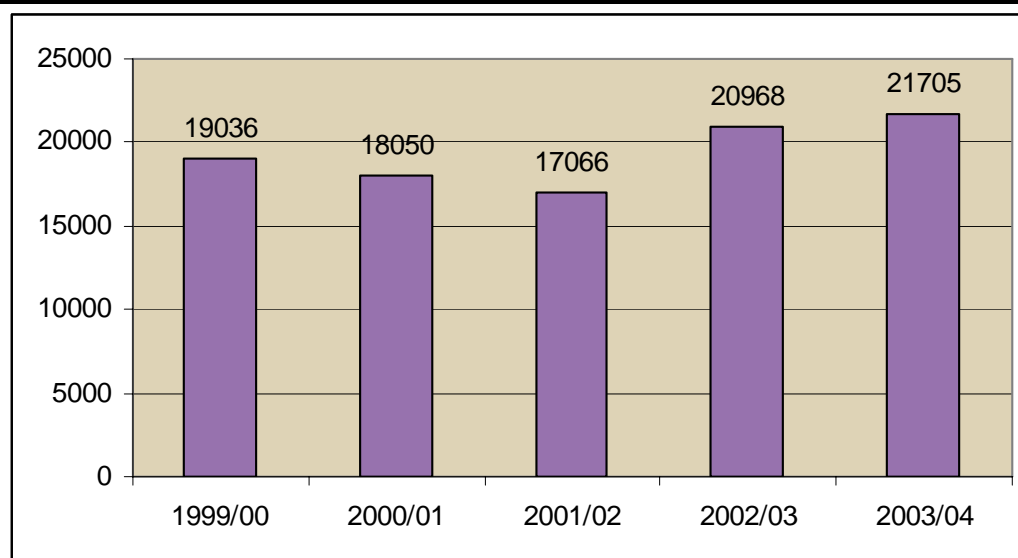
4.2 Workforce Composition

Currently there are 21,705 nurses, midwives and health visitors registered in Northern Ireland²³. Of these, 15,330 are HPSS employees with an additional 2,897 working bank only. The remaining 3,478 are assumed to work outside HPSS for example, voluntary organisations and the independent sector or have recently moved into other employment or unemployment.

Figure 4.1 overleaf details the number of nurses registered on the NMC register between 1999/00 to 2003/04.

²³ The Nursing and Midwifery Council – Statistical Analysis of the Register 1 April 2003 to 31 March 2004

Figure 4.1
Nurses, Midwives and Health Visitors Registered with NMC



Source: NMC – Statistical Registers 1999/00 to 2003/04

Figure 4.1 above shows that currently there is 21,705 staff within Northern Ireland on the NMC register. The corresponding level in 1999/00 was 19,036 some 14 per cent lower than the current register. The number of nurses and midwives decreased to 17,066 in 2001/02. Since then the number of nurses and midwives registered has increased to 20,968 in 2002/03 and 21,705 in 2003/04.

4.3 Area or Discipline

Table 4.1 below shows the number of staff per area together with the whole time equivalents (WTE) breakdown. Not all staff work full time and the WTE figures show the number of full time staff accounted for by each nurse or midwife in the headcount.

Table 4.1
Staff per Discipline as at March 2004

Discipline	Headcount	%	WTE	%	Ratio of Headcount to WTE
Adult & Children	10,949	71%	9,112	70%	1:1.20
Mental Health	2,233	15%	2,140	16%	1: 1.04
Midwifery	1,265	8%	995	8%	1: 1.27
Learning Disability	883	6%	809	6%	1: 1.09
Total	15,330	100%	13,056	100%	1: 1.17

Note: WTE – Whole Time Equivalent

Data was not available from HRMS to allow disaggregation of children's and adult nurses, whilst the Mental Health and Learning Disability data was supplied by Trusts as part of the Mental Health and Learning Disability Workforce Planning exercise.

Source: DHSSPS – HRMS and HSS Trusts

Table 4.1 above shows that almost three-quarters of qualified staff work in the adult and children sector with the remaining one-quarter working in mental health, midwifery and learning disability. Mental health nurses account for 15 per cent of total nursing and midwifery staff in Northern Ireland with midwives accounting for eight per cent and those working in learning disability accounting for six per cent.

In relation to WTE ratios, Table 4.1 above shows that mental health nurses have the lowest ratio of headcount to WTE of 1:1.04. This implies that a higher proportion of nurses in mental health are working full-time or more hours than staff in other disciplines. Midwifery is the discipline with the highest ratio of headcount to WTE of 1:1.27. This implies that a greater number of midwives are working part-time or less hours than nurses in other disciplines.

Table 4.2 below shows a historical comparison of headcount and WTE between 2001 and 2004.

Table 4.2
Comparison on Disciplines between September 2001 and March 2004

Discipline	Headcount			WTE			Ratio of Headcount to WTE	
	2001	2004	Growth	2001	2004	Growth	2001	2004
Adult & Children	10,064	10,949	9%	8,394	9,112	9%	1: 1.20	1:1.20
Mental Health	1,763	2,233	27%	1,678	2,140	28%	1: 1.05	1: 1.04
Midwifery	1,235*	1,265	2%	975	995	2%	1: 1.27	1: 1.27
Learning Disability	Not Available	883	Not Available	Not Available	809	Not Available	Not Available	1: 1.09
Total	13,428	15,330	14%	11,378	13,056	15%	1: 1.18	1: 1.17

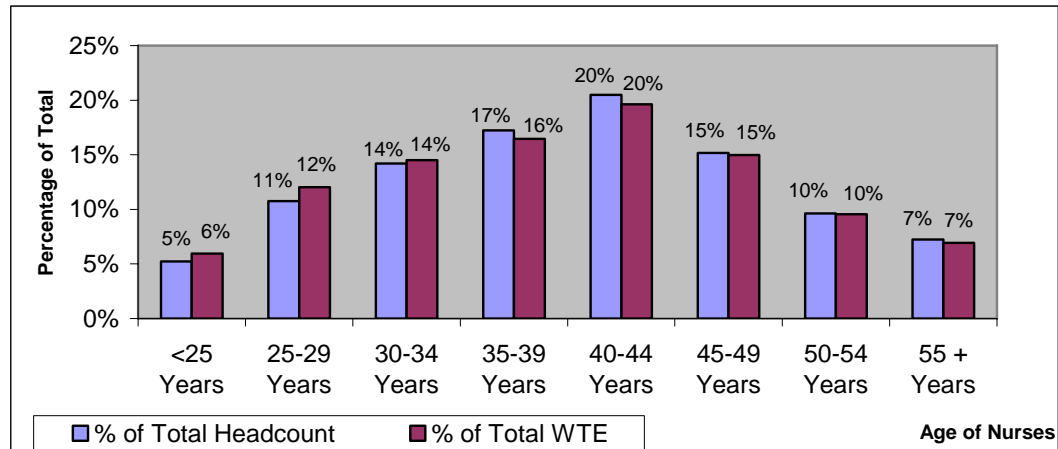
* Figure provided by DHSSPS and has been revised from figure included in 'Review of the Nursing, Midwifery and Health Visiting Workforce Final Report march 2002'
Source: DHSSPS - HRMS

Headcount has increased in all of the disciplines since 2001. The Mental Health Nursing headcount increased by more than one quarter (27 per cent). The headcount in adult and children disciplines also increased by 885 nurses or nine per cent. There is little change in headcount figures for midwifery with a growth rate of two per cent. There is also little change in headcount versus WTE ratios, indicating that part-time working has not increased in the period 2001-2004.

4.4 Age

Figure 4.2 below shows the age profile of nurses and midwives working within HPSS.

Figure 4.2
Age Profile as at March 2004



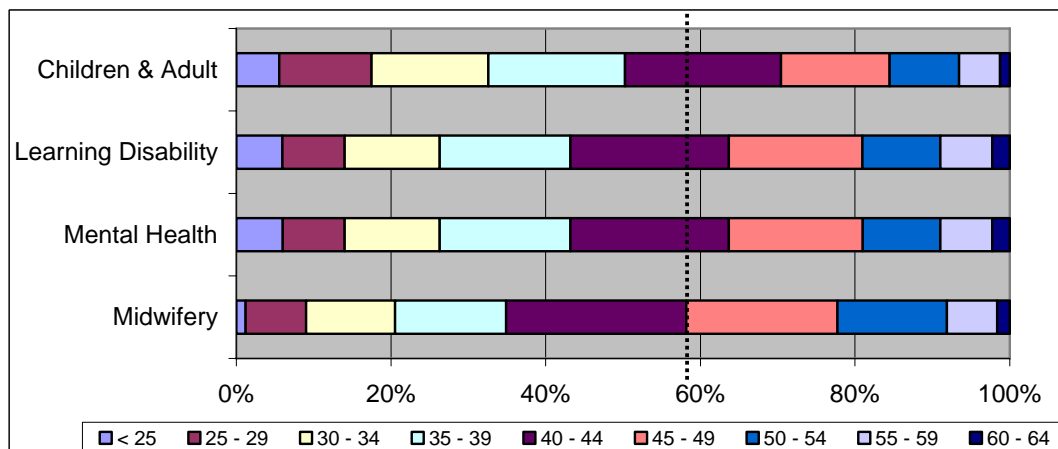
Source: DHSSPS – HRMS

Figure 4.2 indicates that two-thirds of staff are aged between 30 and 49 years old. Only 16 per cent of the workforce are under the age of 30 with 17 per cent of the workforce aged 50 or over.

Figure 4.2 above also shows that staff under the age of 30 account for a greater percentage of WTEs (18 per cent) than for headcount (16 per cent) indicating that staff within this age category work longer hours than their counterparts in other age categories.

Figure 4.3 below shows the age profile within different disciplines.

Figure 4.3
Age Profile within Disciplines



(..... Number of midwives aged 45 and over)

Source: DHSSPS - HRMS

Figure 4.3 shows that midwifery has the oldest workforce out of the four disciplines with over 40 per cent of the workforce being aged 45 or over. Only one per cent of midwives are under the age of 25 compared to six per cent of each of the other three categories.

Mental health and learning disability each have 36 per cent of their workforce aged 45 or over. Children and adult have the youngest of the four workforces with 30 per cent of its workforce aged 45 or over.

4.5 Gender

Nursing is a female dominated workforce with 93 per cent being female and 7 per cent male. Table 4.3 below shows that there has been an increase in the number of males in the nursing workforce of 220 since 2001 which is equivalent to a 26 per cent increase in the number of males. This is compared to a 13 per cent rise in the number of females.

Table 4.3
Gender Breakdown between September 2001 and March 2004

Gender	2001		2004		% Increase
	Headcount	% of Total	Headcount	% of Total	
Female	12,589	94%	14,271	93%	13%
Male	839	6%	1,059	7%	26%
Total	13,428	100%	15,330	100%	14%

Source: DHSSPS - HRMS

4.6 Working Patterns

Table 4.4
Working Patterns between September 2001 and March 2004

	2001		2004		% Increase
	Headcount	% of Total	Headcount	% of Total	
Full-Time	7,380	55%	8,573	56%	16%
Part-Time	6,048	45%	6,757	44%	12%
Total	13,428	100%	15,330	100%	14%

Source: DHSSPS - HRMS

Table 4.4 shows that there has been a small increase in the proportion of staff who work full-time when compared to 2001. In 2001 full-time staff accounted for 55 per cent of the total workforce compared to 56 per cent in 2004.

4.7 Vacancy Levels

Table 4.5 below details the number of vacancies as at June 2004. It shows that there were 746 vacancies and that this was equivalent to 678.4 whole time staff, which gives a ratio of 1:1.10.

Table 4.5
Vacancies as at June 2004

	Headcount	%	WTE	%
Qualified Nurses	723	97%	663.9	98%
Midwives	13	2%	9.7	1%
Others	10	1%	4.8	1%
TOTAL	746	100%	678.4	100%

Source: DHSSPS – Summary Bulletin on HPSS Workforce Vacancies as at 30th June 2004

A significant number of vacancies (248 vacancies) are considered to be long-term vacancies i.e. an unoccupied post as at 30th June 2004 which had been vacant for three months or more and which the organisation was actively trying to fill on the survey date.

4.8 Recruitment

In September 2001, there were a total of 690 student places available in Northern Ireland. This number has increased to 828 by September 2004. Table 4.6 below details the disciplines in which student places are available.

Table 4.6
Student Places

	2001	2004	Increase	% Increase
Adult & Children	560	660	100	18%
Mental Health	60	90	30	50%
Learning Disability	30	30	0	0%
Midwifery*	40	48	8	20%
TOTAL	690	828	138	20%

* 2001 Figures based on 2002/03 and 2003/04 figures

Source: Queen's University, Belfast, University of Ulster and DHSSPS

Table 4.6 above shows that there has been an increase of 20 per cent in the number of student places available between 2001 and 2004. There have been increases in all disciplines excluding learning disability.

Mental Health has proportionately received the greatest increase in the number of places available of 50 per cent. This is due mainly to the University of Ulster, which offered places in mental health to students for the first time in 2001/02. There are now also 30 places available for HCAs to complete a Diploma in Nursing at the Open University, 15 mental health places and 15 places for adult.

Midwifery has had an increase of 20 per cent in the number of places available to students with a new direct entry programme, coming into operation in 2003/04 as well as the existing 18 month post registration course.

4.9 Overseas Nurses

The number of overseas nurses working within HPSS has increased substantially since 2002. In 2002, there were a total of 172 permits issued for overseas nurses working within the HPSS sector. As at the 31st August 2004, a total of 815 overseas nurses were reported by trusts. (Source: DHSSPS)

4.10 Joiners

In the year ending 31st March 2004, there were 1,483²⁴ qualified nursing and midwifery staff who joined the HPSS sector. This figure includes newly registered nurses and overseas nurses. According to the Nursing and Midwifery Council register, there were 457²⁵ new admissions to the register between April 2003 and March 2004 the vast majority of which would be students recently graduating and overseas workers who have joined HPSS²⁶. The balancing figure of 1,026 (1,483 less 457) could be accounted for by nurses and midwives moving from other sectors into HPSS i.e. agency, independent sector, voluntary sector, career breaks, educators and return to practice. DHSSPS have commented that movement between the UK and Republic of Ireland is a possible route that joiners and leavers may also take.

4.11 Leavers

There was a total of 913 leavers in the year ending 31st March 2004²⁷. Of these 913 leavers, 285 were classified as retirees²⁸, meaning that 628 nurses and midwives left HPSS in 2003/04 for other reasons. The reasons for leaving were not available to this review.

4.12 Summary

Overall there has been an increase in the number of nurses and midwives between 2001 and 2004 of 1,902 staff. This is due the number of joiners into HPSS currently exceeding the number of those exiting HPSS employment. A significant number of this increase can be accounted for by the increase in the number of student places available of 138 places per year and the inflow of internationally recruited nurses.

However, in relation to age, it was noted than midwifery in particular has an ageing workforce, with over 40 per cent of its staff aged 45 years or over. Mental health and learning disability also have an ageing staff with 38 per cent of these groups being aged 45 years or over.

²⁴ DHSSPS - HRMS

²⁵ The Nursing and Midwifery Council – Statistical Analysis of the Register 1 April 2003 to 31 March 2004

²⁶ It is assumed that all 457 new admissions have joined the HPSS

²⁷ DHSSPS - HRMS

²⁸ DHSSPS – Superannuation Branch

5. FEEDBACK FROM CONSULTATIONS

5.1 Introduction

This section details the main themes as expressed through the key stakeholder interviews and focus groups. Most key stakeholders and focus groups were nominated by the project steering committee to give a broad representation of the key themes that impact workforce planning in the nursing and midwifery workforce. Additionally, some individuals and groups were identified to represent a specific area or topic.

The common themes that have emerged from the analysis of the interviews and focus groups are detailed below.

Key stakeholders and focus group composition is detailed in Appendix I.

5.2 Planning the Workforce

Improving the methodology used to plan the nursing and midwifery workforce was identified by a number of key stakeholders as a requirement. There is very broad agreement that the drivers of demand are not fully understood or adequately planned for.

Workforce planning should include:

- a co-ordinated and fully inclusive approach between the Department, Trusts, academia, trade union/service partnership, and the independent sector;
- a fully inclusive planning approach that takes an holistic approach to patient care – including medics, PAMs (Professions Allied to Medicine) and HCAs (Health Care Assistants);
- a more scientific and holistic approach that considers the stretch of boundaries much better. This would include the following:
 - development of nursing and midwifery roles;
 - development of new services;
 - changes to community, primary and acute care relationships;
 - changes to junior doctor hours;
 - changes to consultants contracts;
 - GP services;
 - demographics and succession planning;
 - better understanding of the workforce planning data and the flow of numbers required, not just those going into education, but returnees and transfers. Workforce planning data does not exist at Board level, and is

up to three months out of date at Department level. Data is not recorded and reported consistently; and

- adequate allowances for leave, sickness, secondments, study, role development, and mentorship.

Additionally, wide comment was made that more attention needs to be given to planning the workforce at a detailed level. For example, difficulties are being encountered in the retention of mental health nurses and midwives – suggestions were made that recruitment should be skewed to address particular shortfalls. Attention also needs to be given to managing for specialisms such as stoma or palliative care, and to recruiting nurse consultants.

5.3 Agenda for Change

There is much anticipation around Agenda for Change (AfC). From a management point of view, there is considerable concern about the impact it will have on headcount available given the likely increase in the level of leave most people will have, as well as the cost to implement given the expectation of higher salaries.

From a staff point of view, they would welcome the additional financial benefits many staff members are likely to receive. They would also welcome the additional transparency that a single pay scheme will give across different trusts and professions. There is also an expectation that it could potentially resolve the criticism of recent years that staff are held on Grade D too long. However, there is a lack of confidence that this grade inequality will be resolved.

In the independent sector, there is deep concern around the impact AfC will have on their ability to compete for staff, given the level of funding they currently receive to deliver care. Since they provide a capacity of some 15,000 beds for the most vulnerable of patients, and the move to provide more care in the community, it could be argued that their concerns are valid. However, there is an expectation that the yet to be published report on funding for the independent sector will recommend an uplift in the level of funding they receive, although this is tempered with some doubt around the sufficiency of this uplift.

Agencies also have an expectation that they will have to increase rates paid to their staff if they are to continue providing a service. Particularly, they argue, they will have to pay staff who currently work in the public sector extra given that they can do additional work for their trusts as paid overtime and benefit from additional pension benefits. Any increase in their rates is likely to be passed on to trusts purchasing their services.

As part of the implementation of AfC, a new performance management/career development framework will be rolled out. However, wide concern exists in the ability of the service to implement this framework effectively and make it work, both from an organisational point of view through increases in performance and productivity, and from the individual's point of view through meeting career expectations and opportunities.

5.4 Overseas Staff

Consultees have found that staff recruited from overseas are tending to stay much longer than initially anticipated. What started out as a temporary measure has now become an important element of the workforce. Many internationally recruited staff are now settling down in Northern Ireland and applying for residence.

The experience of employing overseas nurses has, in the main, been positive. They were seen as being “more caring” than many of their local contemporaries who were described as being more focused on the academic and technology approach to care. They have also brought different approaches to the delivery of nursing services, and have tried to integrate well into the local workforce.

Some respondents commented that they have had to spend longer on delivering assimilation training than they would have liked. Comment was made on the challenges in aligning some of the methods overseas staff would have used to local methods. Additionally, some concern was raised around the difficulties some staff had due to language differences. This potentially added risk to patient care. Patients also seemed to respond well to overseas nurses, although some trusts experienced a certain level of negativity from patients to be cared for by their overseas staff.

The nurses themselves have had a generally positive experience too. The majority plan to stay longer than their initial 2 year contract, although they expressed a certain level of frustration in not being able to bring their families to the UK, and the financial difficulties they face such as acquiring mortgages. The experience that overseas nurses have had in the HPSS was seen as more positive than that of the independent sector.

5.5 Recruitment

There is a view that more entry routes into nursing and midwifery are required. Training of HCA’s through the NVQ route would be welcomed. Indeed, HCA’s are seen as being a much more stable workforce – they tend to stay in their trusts as they are settled in their workplace. Return-to-practice training was also seen to be a route worth promoting by most consultees.

There was some criticism levelled at the current route into nursing and midwifery as being too academic and theoretical. Many students were described as coming out of training and lacking in practical and “caring” skills.

Trusts are now taking a much more proactive approach to recruitment. Some are now running properly structured induction programmes where nurses are rotated round different clinical areas on a regular basis. However, on the academic side, they believe that nursing and midwifery is not being promoted adequately as a career. This view is also supported by student groups who do not believe that trusts are generally active in recruiting into and promoting nursing, midwifery and health visiting.

Interest in recruiting directly into a trust was also articulated by a number of consultees. The student would be initially recruited by a trust that would then employ the nurse or midwife after registration. Universities would still deliver training, but the uncertainty of who “owns” the student would be clarified. They

would also take a more active role in the student's welfare during training, although they recognise that they still need to have broad community and acute placements. Adopting this approach would also build additional stability into long term workforce planning and give advance notice of future shortages. This approach has had some success in a number of trusts in England, for example in Manchester. Other benefits consultees would envisage include:

- more ownership of responsibility throughout the training programmes;
- better identification with the trust by the trainee; enhanced local workforce planning; and
- less wastage.

Recruitment into temporary posts was described as 'almost impossible' with most nurses choosing permanent jobs over temporary ones. This has led to these temporary positions being filled by agency and bank staff which has resulted in a greater use of agency and bank staff.

On a specific point, the Royal College of Midwives would have a concern that if the current level of student midwife places are not increased, there will be insufficient newly qualified midwives to replace those that are due to retire in the next ten years.

5.6 The Community Sector

Consultation revealed some level of frustration with the lack of clarity around the development of the sector.

All agreed that a community based approach to care was what patients prefer, and recognised that the community care strategy being developed and implemented was the right approach. However, where consultees expressed frustration was around the uncertainty of the current situation.

The sector is currently facing a number of challenges that contribute to this frustration:

- the community care strategy is not fully developed. This has an impact on the ability to plan for services. There is a clear need to understand the demand for future services much better;
- the linkages with, for example, acute trusts and GP practices need to be improved. This is required to better develop a fully integrated approach to care delivery;
- they are experiencing difficulties in recruiting nursing staff, particularly for temporary or part-time posts. This challenge is heightened when they are competing for staff with acute trusts, and also leads to extensive use of agency and bank staff;
- difficulties are also being experienced in recruiting staff in rural community care facilities. Nurses are tending to prefer to work in larger/urban trusts where career opportunities are likely to be greater;

-
- some difficulties are being experienced in recruiting staff for specific areas, for example learning difficulty and mental health. The point above also has an impact on this, given that learning difficulty training is delivered in Belfast;
 - mentoring and student nurse placements are more difficult to manage in a community care setting; and
 - they tend not to recruit overseas staff due to community perceptions.

5.7 Supply

Pre-registration supply was not seen as a particular problem. Both Universities report being significantly oversubscribed by suitable qualified applicants for each pre-registration intake. However, initial intake numbers are seen to be a particular issue in certain areas such as children's or mental health nursing. These courses are seen by students as being career limiting in the long term. Many prefer to qualify as an adult nurse first and perhaps specialise/convert later in their career to keep their options open. The perceived reluctance of the Department to allow students to switch specialities after qualifying was cited as an additional contributory factor.

A small number of consultees expressed a concern that there may be nursing redundancies in a number of years if the supply and demand were not balanced properly, for example in specialist areas. This was primarily due to uncertainty around the changing nature of service provision.

Demographics in the form of an ageing workforce were seen as being a significant issue particularly in mental health and midwifery. As well as the age profile of the workforces being towards the upper end, there was also wide concern given that staff can retire relatively early, depending on their accumulation of length of service points.

5.8 Training

The approach to training received some criticism both from academic and "user" consultees.

There was broad agreement that the way courses, both pre-registration and post registration, are designed and commissioned could be improved. There was a view that students are not coming into trusts with enough practical experience. Newly qualified staff are certainly seen as very knowledgeable and well versed in theory, but lacking in some practical skills. Universities also recognise this criticism, but would counter this with students not receiving enough or adequate mentoring and support when on placement.

Delivering practical training in the laboratory using modern techniques and equipment is also something the universities can offer, but policy currently precludes this in the delivery of hands on clinical training. Indeed, difficulties with mentorship were seen as a definite issue by both the academic and delivery sides – it could be argued that the issue would be more on the service side given that QUB have trained over 10,000 mentors.

Comment was also made on the way courses are commissioned. Academics felt that not enough lead time was given to prepare adequate course programmes and recruit staff. Indeed some examples were given that courses were commissioned in the same month they were expected to be delivered. They also felt that they were kept outside the planning and commissioning process, with the relationship between the Department being described as purchaser versus provider, and not a partnership.

Although this does not directly affect the intake of pre-registration students, it does have a knock-on effect within faculties. However, it also impacts on the development of the longer term composition and skills of the wider workforce around specialisms and specialist courses.

Uncertainty can also exist around current courses, where the long-term viability cannot be guaranteed by the Department. Whilst this is accepted, course cancellation at short notice does impact on academic staff, who are still part of the nursing, midwifery and health visiting workforce.

With regards to Continuing Professional Development (CPD), there was broad agreement that this is not being given adequate time at the workforce planning stage. Nurses and midwives are seen to be too busy to afford time to develop their skills and competencies, but are still mandated to train to maintain skills levels and meet regulatory requirements, before they begin to look to at career development training.

Lack of adequate time to spend on CPD is something that respondents seen as directly impacting on the ability of staff to develop their careers and move into other areas, specialisms or leadership positions.

As an attributable comment, NIPEC are currently promoting the use of their Development Framework as a resource to support the professional development of nurses and midwives in Northern Ireland. They believe this can aid CPD through the “creative use of time and resources.” The final version of their Development Framework is due out for consultation in late 2005.

Interestingly, consultees also stated that many staff considered capable of working in leadership positions often choose not to accept such a role. This was due to the additional workload for what was perceived as little return financially and in the time to available to carry out management or leadership activities.

5.9 Work-Life Balance

Work-life balance did not appear as a particular issue. Most consultees commented that staff can generally work the shift patterns or weekly hours they ask for, subject to working time directive and mandatory regulations. Indeed, management would admit that they have to accede to all requests for reduced hours in order to retain staff.

This would also apply to allowing career breaks in order to avoid staff leaving the workforce completely. However, there were limited concerns around the impact of career breaks given the general availability of reduced hours when requested.

Some consultees did comment that there is a certain disparity between staff in Northern Ireland and the rest of the UK, for example in the provision of child care

and financial support for students. Student bursaries were reported as six per cent lower in Northern Ireland than the rest of the UK.

5.10 Human Resources

The management of sickness absence was seen by many as being an issue. There is a broad view that sickness absence policies need more rigorous enforcement, particularly after maternity leave.

Several consultees also commented that they felt GPs were giving sick lines to staff too readily.

Maternity leave itself was seen by several consultees as a major drain on workforce headcount. However, although this is seen as a consequence of having a predominantly female workforce, stakeholders felt it should be planned for through allowance factors.

5.11 Geography

Geographical factors were raised by a number of respondents as being an issue.

For example:

- affordability and grading can be more of a problem in rural areas;
- there is a disproportionate representation in the workforce from urban areas. This can leave rural trusts difficulties in recruiting. However, many people “do time” in urban trusts and then return “home” to a rural trust;
- rural areas cannot offer the same career opportunities as urban trusts. Combined with the point above, this can result in a stagnant and ageing workforce in rural trusts; and
- some stakeholders suggested that universities should consider more satellite campuses. This may help recruit more people in rural areas and attract from wider areas.

5.12 Summary

Key summary points are detailed below:

- a more coordinated approach to workforce planning is required between stakeholders, for example the Department, HPSS, independent sector, educators, nursing organisations and patients. It is not currently seen as a partnership relationship;
- the mentorship process needs to become more robust. Nurses have difficulty around allocating time to mentor, and students cannot necessarily put what they have been taught into practice;
- the current service delivery in the independent sector is seen as a risk. It provides 15,000 beds for some of the most vulnerable patients. Both public and independent sectors believe the latter is under funded. This is likely to be further compounded when Agenda for Change is fully introduced. However,

it is anticipated that the current value for money study into the independent sector may help alleviate funding issues;

- there is wide support for multiple entry paths to nursing and midwifery. Concern was expressed that pre-registration training is too academic, both from a selection and a delivery point of view;
- the age profile of the workforce is increasing. This will have a significant impact in the next decade. Midwifery and Mental Health are seen as particular risks;
- significant concern was raised around the introduction of Agenda for Change. This will have cost implications, but more importantly will increase demand headcount through the introduction of additional leave entitlement. However, this needs to be balanced by increases in productivity through the associated performance management framework; and
- changes to service delivery will continue to cause supply issues – for example, junior doctor hours, consultant contracts, new ways of working, technology, and demographics. The boundaries are continually being stretched. However, the full impact of these changes is not fully understood.

6. PREDICTED SUPPLY & DEMAND ISSUES

6.1 Introduction

This section provides an estimate of the demand and supply for the workforce over a five-year period from 2005 to 2009. This section considers the following categories:

- supply;
- leavers;
- additional demand; and
- changes to working practices.

This section also includes a sensitivity analysis where possible changes to expected outcomes are taken into account.

Table 6.1 overleaf shows the estimated overall demand and supply of nurses, midwives and health visitors for a five year period from 2005 to 2009 prepared from stakeholder input, guidance from the project Steering Group, and our analysis. Each category is discussed in greater detail through this section.

Table 6.1

Estimated Demand and Supply (2005 to 2009)

	2005	2006	2007	2008	2009
Supply:					
Newly Qualified Nurses and Midwives entering the HPSS	651	651	651	651	651
Overseas nurses	86	86	86	86	86
Other joiners	746	746	746	746	746
Total new entrants	1,483	1,483	1,483	1,483	1,483
Leavers:					
Retirements	469	362	389	389	389
Other leavers	628	628	628	628	628
Total number of leavers	1,097	990	1,017	1,017	1,017
Excess / Shortfall (-ve)	387	493	466	466	466
Cumulative Excess/Cumulative Shortfall (-ve)	387	879	1,345	1,812	2,278
Additional Demand:					
HPSS Vacancies	149	149	149	149	149
Independent and Private Vacancies	100	100	100	100	100
Service and Capital Developments	250	250	250	250	250
Agenda for Change - Holidays	177	0	0	0	0
Agenda for Change - CPD, mentoring & performance measurement	59	59	59	59	59
Total Additional Demand	735	558	558	558	558
Supply Side Benefits					
Productivity Improvement	41	42	43	44	45
Skills Mix Benefit	30	30	30	30	30
Total Supply Side Benefits	71	72	73	74	75
Net Provision / Under Provision (-ve)	-277	6	-19	-18	-16
Cumulative Net Provision / Under Provision (-ve)	-277	-271	-290	-307	-324
Annual WTE (based on current ration of 1:1.17 headcount to WTE)	-237	5	-16	-15	-14
Cum WTE (based on current ration of 1:1.17 headcount to WTE)	-237	-232	-248	-263	-277

Note - full details on the development of this table can be seen on the following pages

Source: Deloitte MCS Limited

6.2 Supply

In total it is assumed that there will 1,483 new entrants into HPSS per annum for the next five years. New entrants have been classified into HPSS student intake, overseas nurses and other joiners and are discussed in detail below.

6.2.1 HPSS Student Intake

Table 6.2 shows student intake in each University per discipline.

Table 6.2

Student Intake

Current Student Intake (September 2004)	QUB/UU	Open University	Total
Adult	605	15	620
Mental Health	75	15	90
Learning Disability	30		30
Children	40		40
Midwifery	48		48
Sub Total	798	30	828
Attrition Rate	8%	0%	
Number Graduating	734	30	765
Registration (4%) & Non-HPSS Attrition Rate (11%)			15%
Number joining HPSS			651

Source: Queen's University, Belfast, University of Ulster and DHSSPS

In total there are 828 student places available across Queen's University, Belfast, University of Ulster and Open University. Using the previous attrition rates as supplied by the Universities, it is assumed that Queen's and the University of Ulster will experience an eight per cent attrition rate. These attrition rates will result in 765 students graduating from University per annum.

However, not all of these graduates will register as nurses and midwives. In addition, not all graduates who do register will be employed by HPSS, some will be employed by the independent and private sectors. Based on guidance from the project Steering Group, it is assumed that the total attrition rate between graduating students and students being employed by HPSS will be 15 per cent (four per cent attrition rate at registration and 11 per cent attrition rate to Non-HPSS employers). This will result in approximately 651 graduate entrants in HPSS each year (765 graduates x 85 per cent). This is a significant level of attrition. Indeed, there are perceptions that bursary provision is attracting students who do not intend to practice in nursing. This is addressed further in Section 7.

6.2.2 Overseas Nurses

Based on information provided by Trusts, the number of overseas nurses increased from 560 as at March 2003 to 779 as at March 2004, an increase of 219 overseas nurses in one year. Between March and August 2004, the number of overseas nurses has increased to 815, an increase of 36 nurses (within five months).

Straight line extrapolation would project that the number of overseas nurses will increase by approximately 86 nurses per year for the next five years (see table 6.3). The rate of International Recruitment has however been slowing down over the past few years and if this continues, intake may well stabilise at the current level. This should be kept under review by the Department.

6.2.3 Other Joiners

Table 6.3 below shows an analysis of the number of qualified nursing, midwifery and health visiting staff joiners between 1st April 2003 and 31st March 2004.

Table 6.3

Other Joiners

Joiners (1/4/03 to 31/3/04)	1483
Less newly qualified joining HPSS (Table 6.2)	651
Less annual average overseas recruits (Section 6.3.2)	<u>86</u>
Other Joiners (balancing figure)	<u>746</u>

Source: DHSSPS

Information obtained from the Department shows that the number of qualified nursing, midwifery and health visiting staff 'joiners' between 1st April 2003 and 31st March 2004 was 1,483. If the number of graduates and overseas nurses joining are excluded from this figure, it can be seen that the number of 'other joiners' has been approximately 746 nurses, midwives and health visitors per annum for the next five years, this figure is therefore used for the projected other joiners. Sources of other joiners include return to practice, recruitment from independent and private sector, and transfers from other parts of the UK and Republic of Ireland.

6.3 Leavers

Leavers have been disaggregated into retirees and other leavers and are discussed in detail below.

6.3.1 Retirees

Information on the age profile of staff was provided by DHSSPS using five year age bands i.e. 55 to 59, 60 to 64. It is assumed that staff numbers are distributed evenly within each age band.

The average age of retirement for nursing staff, as provided by DHSSPS, is 57 years old. As at March 2005 there will be 937 staff over the age of 57. It has been projected that 50 per cent of these staff will retire in 2005 (469 staff), 20 per cent in 2006 (187 staff) and 10 per cent in 2007 to 2009 (94 staff per annum). It is also assumed that staff who reach the age of 57 from 2006 onwards will retire immediately. The effect this has on headcount leaving the HPSS can be seen in Table 6.4 overleaf.

Table 6.4
Retirement

Age	Number of Staff	Retire 2005	Retire 2006	Retire 2007	Retire 2008	Retire 2009
65+	9	5	2	1	1	1
60 to 64	228	114	46	23	23	23
59	175	88	35	18	18	18
58	175	88	35	18	18	18
57	175	88	35	18	18	18
56	175	88	35	18	18	18
55	175		175			
54	295			295		
53	295				295	
52	295					295
	Total*	469	362	389	389	389

* Totals different due to rounding

Source: DHSSPS

6.3.2 Other Leavers

Information provided by DHSSPS shows that there were 913 leavers for the year ended 31st March 2004. When excluding the number of staff who retired during the year (285 staff) the number of other leavers totals 628. For planning purposes, it is assumed that the number of leavers will remain constant at 628 staff per annum over the next five years.

Retirement data was supplied by Superannuation Branch, as HRMS does not categorise reasons for leaving.

6.4 Additional Demand

There are other factors affecting the demands placed on the current nursing, midwifery and health visiting workforce. These factors are as follows:

- HPSS vacancies;
- independent and private vacancies;
- service and capital developments; and
- Agenda for Change.

6.4.1 Vacancies

As per the HPSS Vacancy Survey Report for June 2004 the number of nursing, midwifery and health visiting vacancies within HPSS totalled 746 staff. It has been assumed that these vacancies will be filled over the next five years (149 vacancies per year).

Based on the experience of members of the project Steering Group, it has also been assumed that the number of independent and private sector vacancies that are filled by HPSS staff will equal that of HPSS vacancies at 149 vacancies per year. Due to the lack of information available on independent

and private sector vacancies, a sensitivity analysis has been included in Section 6.8.

6.4.2 Service and Capital Developments

Information provided by the Steering Group indicates that the number of additional staff required for new service and capital developments may range from 150 to 350 staff. The average number of 250 has been used in Table 6.1 above. As was the case with independent and private sector vacancies, a sensitivity analysis has been completed taking into account the maximum and minimum levels of service and capital developments. See Section 6.8.

6.4.3 Agenda for Change

Agenda for Change will impact on staff with regards to annual leave. On average, staff will be entitled to an additional 3 days annual leave. Assuming that each staff member ($n = 15,330$) works 260 working days this is equivalent to 177 additional nurses being needed to cover the additional annual leave without productivity improvements factored in. Given the planned nature of AfC implementation, it is assumed that this demand is incurred as a one off demand increase in Year 1.

Agenda for change will impact nurses in other areas i.e. CPD, mentoring and performance measurement. It is assumed that nurses will need to spend an additional 5 days over 5 years (1 day per annum) in order to complete the above tasks. This is equivalent to 59 additional staff to cover these days.

6.5 Other Factors

There are expected to be changes in business processes that should lead to efficiency savings. The two main areas included are productivity improvements and skill mix benefit.

6.5.1 Productivity Improvement

In relation to productivity improvements, it is projected that there will be a productivity improvement of 1.25 per cent over five years. This is equal to an annual improvement of 0.25 per cent or 41 staff (total number of staff x 0.25 per cent).

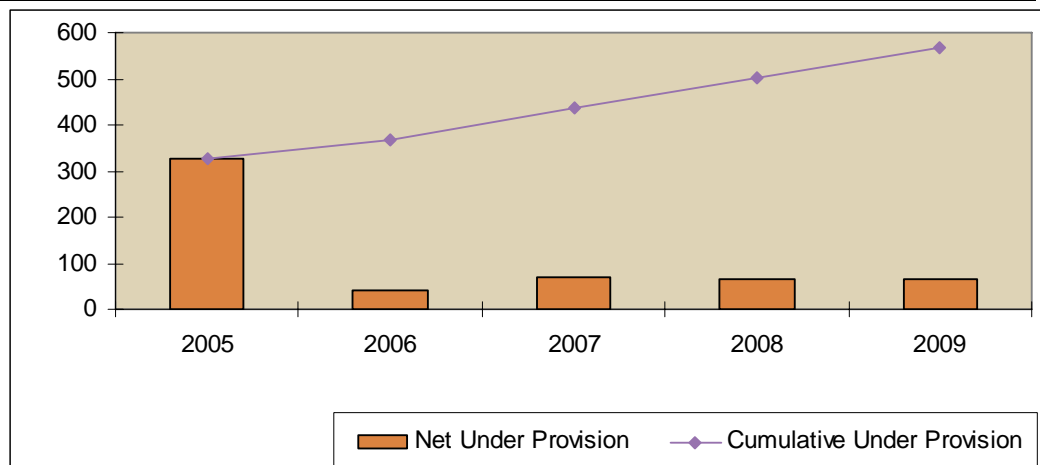
6.5.2 Skills Mix Benefit

Over the next few years, a number of Health Care Assistants (HCA's) will receive higher level training that will help to alleviate a proportion of nursing and midwifery staff workload. It has been assumed that the number of HCA's receiving this training will equate to 200 per annum and that the percentage of workload that it will help to alleviate will be 15 per cent. This will result in a skills mix benefit of 30 additional staff (200 x 15 per cent).

6.6 Provision

Figure 6.1 below shows the level of staff shortages expected between 2005 and 2009.

Figure 6.1
Net Under Provision of Staff



Source: Deloitte MCS Limited

As indicated in Figure 6.1 above, there will be a net under provision of staff for each of the next five years (i.e. demand and outflow will be greater than supply and inflow). By 2009 it is estimated that (if current conditions prevail) the cumulative net under provision will total 569 staff.

Although Table 6.1 above indicates that the number of joiners will be greater than the number of leavers this excess is insufficient to cover the extra demand being placed on the workforce.

6.7 Sensitivity Analysis

Joiners and Leavers.

Table 6.1 uses specific assumptions around the joiners and leavers numbers. The figures used are based on the data extracted from HRMS and Superannuation Branch for the previous twelve months. It was felt that this data was more accurate than taking an aggregate from the last three or five years, as these figures would not include the increase in graduates from the universities. (As recommended in the previous workforce planning report).

It should be noted therefore, that this sample forms the basis of the future supply and demand modelling for the next five years. The key assumption when using this data is that it will not vary substantially in the next five years. However, any variation in the data, either up or down, is expected to balance in the five year term of the projections.

Service Developments

Due to uncertainties surrounding some other assumptions, additional sensitivity analysis has been carried out. The scenarios used are:

- a 50 per cent increase in the number of independent and private sector vacancies;
- a decrease in the service and capital development commitments by 100 staff to 150 staff; and
- an increase in the service and capital development commitments by 100 staff to 350 staff.

Figure 6.2 below illustrates the overall effect of each of the scenarios identified above.

Figure 6.2
Sensitivity Analysis



Source: Deloitte MCS Limited

Figure 6.2 above shows the impact that each of the scenarios have on the estimated provision.

Increasing the number of vacancies in the independent or private sector filled by HPSS staff by 50 per cent, will have the effect of increasing the level of cumulative under provision over five years from 324 staff to 573 staff.

Decreasing the level of service provision and capital developments by 100 staff, will lead to a net over provision of staff in 2006 through to 2009. The cumulative total over the five year period will be 175.

Increasing the level of service provision or capital developments from 250 staff to 350 staff will increase the cumulative level of under provision from 324 to 823, an increase of 154 per cent.

6.8 Conclusion

It is estimated that from 2005 to 2009 there will be a net inflow of nurses and midwives into HPSS. However, due to additional demands being placed on the workforce, there will be an under provision of staff each year that will lead to a cumulative under provision of 324 staff for the five year period.

The sensitivity analysis conducted also shows that this issue will be compounded if independent and private sector vacancies or the level of service provision and capital development levels are revised upwards from the baseline projections.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

When contrasted with the previous workforce planning review in 2001/2002, the supply situation has clearly improved. The Department has implemented the supply recommendations from the previous review, particularly the increase in undergraduate commissioning, and the positive benefits from this are now starting to be seen on the supply side. Therefore, progress has and continues to be made on the balancing of numbers and the DHSSPS and wider HPSS should be recognised for this improvement.

This progress is seen at the strategic level in terms of an improvement in the overall supply position. As the analysis of the headline numbers in Table 6.1 above, a balance between supply and demand figures has been broadly achieved (within the constraints of the data available). This is to be commended, but must be closely monitored and managed.

Notwithstanding this, there is broad agreement by stakeholders that work still needs to be done at the operational level to cascade the improvements that have been made. There are a number of challenges ahead that need to be addressed, and these are set-out in the recommendations below.

The review has shown that for a qualitative improvement in workforce planning the focus needs to move to the level where better data can be collected, analysed, and used in relation to such as:

- operational workforce planning;
- nursing categorisation;
- absence management;
- effective staff deployment;
- skills complexity and mix; and
- localised retention policies.

The recommendations around this are articulated below. Please note, that whilst the recommendations are broken down into Department and Operational levels, they are not necessarily exclusive to each area. Co-ordination and co-operation at all levels is still required.

7.2 Department and Strategic Level Recommendations

1. **Pre Registration Places.** It is recommended that the current numbers of pre-registration places are kept at existing levels. However, this should be closely monitored and kept under review by the Central Workforce Planning Group.
2. **Open University Programme.** The Open University diploma programme for HCA's should continue to be offered as a route into nursing. However, this should be closely monitored and kept under review by the Central Workforce Planning Group.
3. **Attrition.** A greater understanding of graduate attrition should be developed, particularly concerning the period between graduation, registration and entering the workforce. Lack of certainty around this leads to additional challenges when planning the workforce. On a related point, consideration should be given to addressing the perception that increasing numbers of students are enrolling for nursing and midwifery courses as they receive a bursary, but the purpose is to attain a degree without the intention of actually practicing. Receiving a bursary negates the need to repay a student loan. The HR Directorate will work with both universities to improve attrition levels. A cumulative figure of 15 per cent has been set as an objective. (Down from 23 per cent).
4. **Co-Ordination.** Whilst the co-ordination of workforce planning has improved from the previous review, most stakeholders would agree that further improvements in the integrated approach to workforce planning should be considered. The approach to workforce planning should continue to include the Department, demand side stakeholders (trusts/boards), and the supply side (pre-registration providers, post-registration and professional development providers and NIPEC for support on competencies).

Greater co-ordination could be achieved for example by developing clearer links between workforce planning, service development and training.

5. **Workforce Planning Data.** Although improvements have been made to HRMS since the previous workforce planning review, further work should be carried out to improve the currency and relevance of HRMS data. Data currently held on the system is up to three months old and there are difficulties in extracting information relating to current workforce planning categorisations, for example nursing in adult, children's, mental health, learning disability and midwifery sectors, and such as retirements.

Consequently, it was not possible to split children's and adult nursing headcounts for this review. Mental health and learning disability headcounts were derived from recent internal HPSS workforce planning reviews. Additionally, whilst HRMS can provide data on movers, joiners, and leavers, it cannot differentiate further within these categories. Therefore, retirement data had to be extracted from Superannuation branch databases.

Current categorisation on HRMS aggregates at too high a level and with increased specialisation in nursing, disaggregation and data on staff flows are important for effective workforce planning.

The Project Board are currently developing a business case to replace HRMS. They should ensure that the statement of requirement for the replacement system meets the needs of workforce planning.

6. **Independent and Private Sectors.** The staffing levels and requirements in the independent and private sectors are not well understood, and further work should be undertaken to gain a better picture of demand and flows. Central Workforce Planning Group will take this forward.

7.3 Operational Level Recommendations

The focus of these recommendations moves from the Department to Boards and Trusts.

1. **Operational Planning.** The operational approach to workforce planning should involve developing distinct strategies for workforce plan modelling, recruitment and retention, deployment and performance, and utilisation and skill mix, i.e. “skills for health”. For example, employers will need to focus on how workforce planning can be developed to take on new or enhanced roles. It is essential that the modernisation agenda is supported through effective operational workforce planning. This approach should be deployed at a trust level and co-ordinated to support Department level planning.

Best practices, for example the “magnet institution” concept, should be incorporated into the development of these strategies. The Department could assist Boards and Trusts by issuing guidance to help with standardisation of the approach and measurement, with the Boards and Trusts responsible for detailed level planning and implementation. Local plans are therefore necessary to complement regional planning. This local planning should be supported by developing professional workforce planning capability in relevant organisations.

The Nursing Department in the DHSSPS should take this forward.

2. **Supply and Demand Drivers.** More work should be carried out to increase the understanding of workforce supply and demand drivers. It is not clear that there is full understanding of the impact on workforce requirements at local levels of such as Agenda for Change, role extension, advanced nursing, junior doctor hours, and service developments. The Central Workforce Planning Group should take this forward.
3. **Knowledge and Skills.** The continued implementation of Agenda for Change needs to be planned and executed robustly at operational level. With particular care being given to the implementation of the Knowledge and Skills Framework, in order that it is effective for the individual’s career planning and the performance of the organisation.
4. **Community Strategy.** The impact of the care in the community strategy on local workforce planning and WTE requirements should be developed as soon as possible, in order to allow future demand and deployment to be better understood.

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5. **Operational Allowances.** The operational factors impacting on workforce planning (for example, allowances for sickness, leave, maternity cover, mentoring and CPD) should be factored into operational planning in a standardised way. Particular focus should be given to mentoring and CPD, as this was highlighted as a key concern by a significant number of stakeholders. CPD is also a key element of the roll out of Agenda for Change. Effective planning for mentoring and CPD will give benefits to students and practicing staff through improving retention and the relationship with trusts.
 6. **The Student Experience.** Trusts should continue to develop personal links with students during periods of placement. Students need to be given a better experience during placement to ensure their practical skills and knowledge are being developed, and that they form an accurate view of the trust they are working in. This particularly applies to the level of mentoring support students are receiving. The continuing development of induction and rotation programmes should be encouraged.

With these further developments, the progress already achieved can be built on and the quality and effectiveness of workforce planning can continue to be improved at both strategic and operational levels.

APPENDIX I
INTERVIEWS AND FOCUS GROUPS

INTERVIEWS

SURNAME	FORENAME	ORGANISATION	CONSULTATION TOPIC
Bingham	David	DHSSPS	Policy
Blaney	Paddie	NIPEC	Education
Bradley	Martin	RCN	Staff side
Brownley	Roberta	Previously Tamara Healthcare and Sanddown group	Private sector
Caddell	Mary	RCM	Staff side
Connolly	Brenda	N&W Belfast Trust	Community
Coyle	Briega	AMICUS	Staff side
Evans	Norma	Homefirst	Private sector
Fee	Eugene	Sperrin Lakeland Trust	Acute services
Hanratty	Mary	Beeches Management Centre	Education
Hayes	Eleanor	Belfast City Hospital Trust (BCH)	International
Hill	Judith	DHSSPS	Policy
Hinds	Mary	Mater Hospital	Mixed
Mason	Carolyn	DHSSPS	Service Developments
McCann	Roisin	Rutledge Recruitment	Recruitment Agency
McCully	Amanda	Balmoral Healthcare Agency	Recruitment Agency
McKenna	Hugh	UU	Education
Mone	John	Craigavon Hospital	Acute services
Murray	Tracy	Student Rep RCN	Students
O'Brien	Diedre	RGHT	Acute services
O'Hagan	Joan	Newry & Mourne Trust	Mixed
Orr	Jean	QUB	Education
Patterson	Nicki	DHSSPS	Service Developments
Rice	Francis	DHSSPS	Service Developments
Smyth	Janice	DHSSPS	Policy
Steele	Elish	Muckamore	Learning Disability
Toal	Kevin	Armagh & Dungannon Trust	Mixed
Waddell	Mary	EHSSB	General
Way	Elaine	Foyle Trust	Nurses and health visitors
Wilson	Helen	Four Seasons Healthcare	Independent Sector

FOCUS GROUPS

FOCUS GROUP	Location
Acute/Specialists/Student mix	Belfast
Community	Londonderry
Community	Belfast
International NHS	Craigavon
International Private Sector	Belfast
Learning Disability	Belfast
Mental Health	Omagh
Midwife Manager Advisory Group	Belfast
Nursing Council	Belfast
Students	Belfast