

Delivering Care: Nurse Staffing in Northern Ireland

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

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

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

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Preface

A message from the Minister for Health and Public Safety

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

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

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

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

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

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report¹ (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

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

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

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

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

an unassailable case for change and strategic reform. The Nursing and Midwifery workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

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

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

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

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

Chief Nursing Officer

Delivering Care: Nurse Staffing in Northern Ireland.

The framework is made up of the following constituent elements:



Assumptions of the Framework



Nurse Staffing Ranges

And is made up of two complimentary documents:



GLOSSARY OF TERMS

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

EXECUTIVE SUMMARY

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

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

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

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

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

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries³.

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

Section 1: Strategic Direction and Rationale

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

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

² Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

³ Please see pages 1 - 3 of this document.

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

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

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

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

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

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

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

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

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

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

SECTION 1: STRATEGIC DIRECTION AND RATIONALE

1.0 INTRODUCTION

- 1.1 The subject of nurse staffing in hospital wards and community settings has been a topic of debate and discussion for a number of years. Ensuring appropriate staffing has been referenced in inquiries and investigations, shown in research evidence and is viewed by patients and their carers as a key element in influencing the quality of care.
- 1.2 The Independent Inquiry into the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust⁴ highlighted the need for appropriate staffing levels to support safe, effective, person centred care.

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

“The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care.”

“The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff.”

“People must always come before numbers. Individual patients and their treatment are what really matters.....This is what must be remembered by all those who design and implement policy for the NHS.”

2.0 BACKGROUND AND CONTEXT

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

Regional Policy and Strategy

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

Transforming Your Care

The strategic review of Health and Social Care (HSC): *Transforming Your Care*⁵ sets out the direction of travel for HSC services in Northern Ireland over the next five years. This is supported by the Commissioning Plan⁶, which details year on year service provision, priorities and standards that services must meet. The implications of the changes to services in the next five years are significant, particularly in the development of new service models and the response the workforce will be required to make in support of these changes. Examples include:

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

⁴ Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, HMSO.

⁵ Department of Health Social Services and Public Safety/Health and Social Care Board. (2011). *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.

⁶ Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB.

- › Greater emphasis on the prevention of ill health.

Quality 2020

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

The People’s Priorities

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

A Partnership for Care

The need to develop a framework to support effective workforce planning was identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*⁹ and as part of the Health and Social Care Board (HSCB)/Public Health Agency (PHA) Commissioning plan 2011/12¹⁰.

Evidence Base Related to Staffing Levels and Patient Outcomes

- 2.3 Significant research has been undertaken into the issues of both nurse staffing levels and skill mix, thereby providing a wide literature base in relation to the association between lower numbers of registered nurses and significant reduction of the quality of patient outcomes¹¹. Examples include:
- › Fewer registered nurses, increased workload, and changing nursing teams in care environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units in a mixed method study combining longitudinal data (5 years) and primary data collection¹².
 - › Features of the hospital work environment, such as better staffing ratios of patients to nurses, nurse involvement in decision making, and positive doctor-nurse relations, are associated with improved patient outcomes, including mortality and patient satisfaction¹³.

⁷ Department of Health Social Services and Public Safety. (2011). *Quality 2020, A 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland*. Belfast, DHSSPS.

⁸ Patient Client Council. (2010). *The People’s Priorities. A View from Patients, Service Users, Carers, and Communities on Future Priorities for Health and Social Care in Northern Ireland*. Belfast, PCC.

⁹ Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.

¹⁰ Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB. Available for download at: <http://www.hscboard.hscni.net/publications/Commissioning%20Plans/490%20Commissioning%20Plan%202011-2012%20-%20PDF%20993KB.pdf>

¹¹ Flynn, M. and McKeown, M. (2009). ‘Nurse staffing levels revisited: a consideration of key issues in nurse staffing levels and skill mix research’. *Journal of Nursing Management*. 17, 759 – 766.

¹² Duffield, C., Diers, D., O’Brien-Pallas, L., Aisbett, C., Roche, M., King, M., Aisbett, K. (2011). Nursing staffing, Nursing workload, the work environment and patient outcomes. *Applied Nursing Research*. 24(4), pp 244 – 255.

¹³ Aiken, L.H., et al. (2011). Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal*. 344, e1717.

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

Evidence from Public Inquiries

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

Mid Staffordshire NHS Foundation Trust

The recommendations of the Francis Inquiry¹⁶¹⁷ identified the importance of including nursing staff at all levels in discussions related to standards of care and the resources required to deliver safe and effective, person centred care. Referring to the long term failures of the Trust, Robert Francis QC stated: *'The quality of nursing during that period suggested that staffing levels had been acknowledged to have been too low as long ago as 1998.'*¹⁸

Public Inquiry into the Outbreak of Clostridium Difficile

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

NHS Review

The NHS review into the quality of care and treatment provided by 14 hospital trusts in England²¹ by Professor Sir Bruce Keogh recommended that *'nurse staffing levels and skill mix'* should *'appropriately reflect the caseload and the severity of illness of the patients they are caring for.'* This recommendation was made in light of the fact that the review teams found inadequate numbers of nursing staff in a number of ward areas, which was compounded by an over-reliance on unregistered support staff and temporary staff.

¹⁴ Cho, S.H., et al (2003). The effects of Nurse Staffing on Adverse Events: Morbidity, Mortality and Medical Costs. *Nursing research*. 52, pp 71-79.

¹⁵ Health Care Commission. (2005). *Ward Staffing*. London, Health Care Commission.

¹⁶ Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.

¹⁷ Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London, TSO

¹⁸ *Op Cit*, n 16, page 396.

¹⁹ Hine, D. (2011). *Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals*. Available for download at: <http://www.cdifinquiry.org>

²⁰ *Ibid*, page 76.

²¹ Keogh, B. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Available for download at: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

Why Develop a Range?

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

Aim

- 2.6 The overarching aim of the work was:

To support the provision of high quality care, which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

Scope and Objectives

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

Range not Ratio?

- 2.9 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio²². This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.
- 2.10 It is anticipated that on occasion nurse staffing may be outside the policy range. In such cases the Executive Director of Nursing must provide assurances about the quality of nursing care to these patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.
- 2.11 It is expected that HSC Trusts will take account of the staffing ranges contained in this framework in developing proposals to meet the objectives within *Transforming Your Care*, in supporting new proposals for additional resources and when developing efficiency and productivity plans.

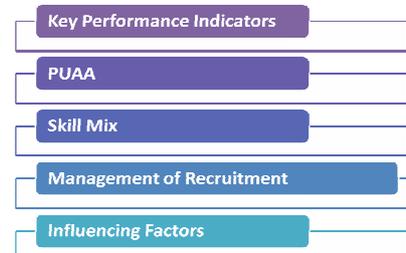
²² Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies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

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

ASSUMPTIONS OF THE FRAMEWORK

3.0 Introduction

- 3.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.
- 3.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.



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

- 3.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of this document supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.
- 3.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

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

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

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

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

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

ASSUMPTION 2: PLANNED AND UNPLANNED ABSENCE ALLOWANCE

- 3.5 Planned and Unplanned Absence Allowance (PUAA) refers to periods of absence from work, which can be described as anticipated and, therefore, must be factored into the workforce planning process. This comprises annual leave, sickness²³, and mandatory study leave. It was necessary, therefore, when describing nurse or midwifery²⁴ staffing to agree an allowance which could be factored in to any subsequently developed range.

Rationale

- 3.6 Telford (1979)²⁵ remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom. This methodology recognises the need for 'allowances and amendments for sickness, absence, holidays, in-service training and nursing education'²⁶ in any method of effective workforce planning.
- 3.7 In 2006, the Royal College of Nursing recommended a PUAA of 25%²⁷. Similarly, the Healthcare Commission recommended a minimum of 24% in 2005²⁸, prior to the implementation of Agenda for Change²⁹.
- 3.8 Other professions have reflected a requirement to build in allowances for planned and unplanned leave. For example, the medical profession referred to the necessity of 'supporting professional activities' within the Consultant Contract Framework (2003)³⁰. *Professional activities* were identified as: training, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local governance activities. Leave is also directed to be built into weekly job planning for consultant teams, including an average of 10 days per year of professional activity³¹. It should be noted that sickness absence was not accounted for within the Consultant Contract framework.
- 3.9 In 2002, the Auditor General for Scotland³² identified a requirement for Planned and Unplanned Leave Allowance to be taken into account within nursing workforce planning processes, outlined in **Table 1**, page 7.

²³ 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.

²⁴ It should be noted that this element of the assumptions of the framework is applicable to nursing and midwifery.

²⁵ Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.

²⁶ *Ibid*, page 2 of the referenced document.

²⁷ Royal College of Nursing Policy Unit. (2006). *Setting Appropriate Ward Nurse Staffing levels in NHS Acute Trusts*. London, RCN.

²⁸ Health care Commission. (2005). *Ward Staffing*. London, Health Care Commission.

²⁹ Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf

³⁰ Department of Health, Social Service and Public Safety. (2003) *Consultant Contract Framework*. Available for download at: <http://www.dhsspsni.gov.uk/scu-consultantcontract.pdf>

³¹ Department of Health, Social Service and Public Safety. (2008). *Regional Guidance on Job Planning for Medical and Dental Consultants in Northern Ireland*. Available for download at: <http://www.dhsspsni.gov.uk/regional-guidance-on-job-planning-for-medical-and-dental-consultants-in-northern-ireland.pdf> Page 15 - 16.

³² Audit Scotland. (2002). *Planning ward nursing – legacy or design?* Edinburgh, Auditor General.

Table 1:**Planned and Unplanned Absence Allowance, Auditor General Scotland³².**

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

Annual Leave

- 3.10 The implementation of Agenda for Change³³ provided an increase from 25 to 33 days' leave for staff with a service record of 10 years or over. This substantial increase would, therefore, require that the allowance for annual leave calculated within PUAA is increased from that adopted in 2002. A reduction in the number of public holidays from 12 to 10 provided an overall net increase of 16%.
- 3.11 For the purposes of the framework, annual leave is calculated at the mid point of the Agenda for Change³⁴ leave allocation, which is 29 days + 10 days public holidays = 39 days. There are 260 working days per year for a full time/37.5hr person. This equates to 39/260 = **15%**.

Sickness Absence

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

Mandatory Study Leave

- 3.13 In response to the increased intensity and complexity of patient care and the need to support the continuing provision of safe, effective, person centred care, mandatory training needs have significantly increased for the nursing and midwifery workforce in the last 10 years from 2002. This includes regulatory requirements such as: meeting the Nursing and Midwifery Council (NMC) Standards for Learning and Assessment in Practice³⁶, statutory midwifery supervision and the Chief Nursing Officer's standards for supervision in nursing³⁷, as well as a range of clinical competencies which are required to comply with national and regional policy or standards. Examples of the types of training required for all staff and professional staff and associated hours required are outlined in **Table 2**, page 9. There is a regulatory requirement for professional updating, elements of which may be undertaken in a registrant's own time. As more robust revalidation models are progressed in light of the Francis Inquiry³⁸, it is essential that PUAA can accommodate this.
- 3.14 The nursing and midwifery workforce has a high percentage of individuals that choose part-time working arrangements - 56% full time, 44% part time³⁹. Training must be provided on the basis of headcount as opposed to Whole Time Equivalents, which considerably increases the overall number of staff requiring training.

³³ Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf

³⁴ The NHS Staff Council. (2014). *NHS terms and conditions of service handbook*. Available for download at: <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

³⁵ Department of Health, Social Service and Public Safety. (2010). *Priorities for Action 2010 - 2011*. Belfast DHSSPSNI.

³⁶ Nursing and Midwifery Council. (2010). *Standards for Pre-registration Nursing Education*. London, NMC.

³⁷ Chief Nursing Officer for Northern Ireland. (2007). *Standards for Supervision in Nursing*. Belfast, DHSSPSNI.

³⁸ Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.

³⁹ *Ibid.*

Future Allowances

- 3.15 It was therefore proposed that the average level applied in 2002 of 22% should be reviewed to reflect the changes to annual leave allowances, and statutory and mandatory training requirements for professional and non-professional staff within a ward team.
- 3.16 The revised allowances, stipulated at **Table 3**, below, have been agreed by the Nursing and Midwifery Leaders in Northern Ireland, using those defined by the Auditor General (2002)⁴⁰ as a starting point, taking into consideration the elements mentioned in paragraphs 3.10 – 3.14, page 7. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods. The ranges incorporate a Planned and Unplanned Absence Allowance of 24%.

Table 3: Comparative Planned and Unplanned Absence Allowances

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

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

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

TABLE 2

EXAMPLES OF STATUTORY⁴¹ AND MANDATORY⁴² TRAINING FOR NURSING AND MIDWIFERY STAFF⁴³

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

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

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

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

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

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

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

ASSUMPTION 3: SKILL MIX

- 3.19 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity⁴⁴, a skill mix comprising a higher level of unregistered staff may be appropriate. A level of skill mix will be determined regionally for a variety of care settings by the Nursing and Midwifery Leaders in Northern Ireland, based on best available evidence such as recognised workforce planning tools, related to the care setting under consideration. The skill mix relevant to a particular setting will be included within the subsequent '*Using the Framework for..*' sections. To reference the skill mix for general and specialist medical and surgical adult hospital care settings, please see page 3 of Section 2.
- 3.20 Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to '*fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.*'⁴⁵⁴⁶
- 3.21 An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

ASSUMPTION 4: MANAGEMENT OF RECRUITMENT

- 3.22 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.
- 3.23 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:
- › Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
 - › Avoidance of overuse of temporary staff, for example, bank and agency staff
 - › Matching of staff skill and band mix to patient acuity and dependency within approved guidelines⁴⁷
 - › Timely and ongoing review of risk assessments linked to service reconfigurations.

⁴⁴ For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.

⁴⁵ Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.

⁴⁶ Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.

⁴⁷ For information related to skill mix for medicine and surgery, please see *Delivering Care* Section 2, page 3.

ASSUMPTION 5: INFLUENCING FACTORS

- 3.24 It is acknowledged that workforce planning for nursing staff is both complex and diverse⁴⁸. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation⁴⁹ is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:
- › Workforce
 - › Environment and Support
 - › Activity
 - › Professional Regulatory Requirements.
- 3.25 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a care setting. Further information on factors which influence workforce planning in medical and surgical settings can be found in Section 2, pages 7 - 13.

NURSE STAFFING RANGES

4.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery MEDICINE

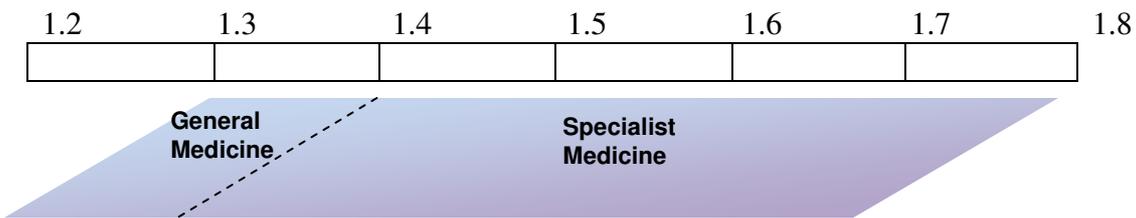
- 4.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units for example: Medical Assessment Units.
- 4.2 A **specialist medical care setting** is defined as comprising: adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, where a higher degree of acuity is anticipated, including for example: specialist respiratory medicine, neurology, coronary care, acute stroke/lysis (general stroke care may often be located within the general medical normative staffing range). This also includes short-stay units, for example: Medical Assessment Units.
- 4.3 In some general ward areas, existing ***in both medical and surgical settings***, a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24 bed general respiratory ward. As models of care for general medicine move towards specialisms, the number of specialist beds may increase. Where this occurs, a number of calculations will need to be made on two or more cohorts of patients to determine an overall appropriate nursing/bed ratio.
- 4.4 **Figure 1**, page 12, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and

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

⁴⁹ *Ibid.*

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

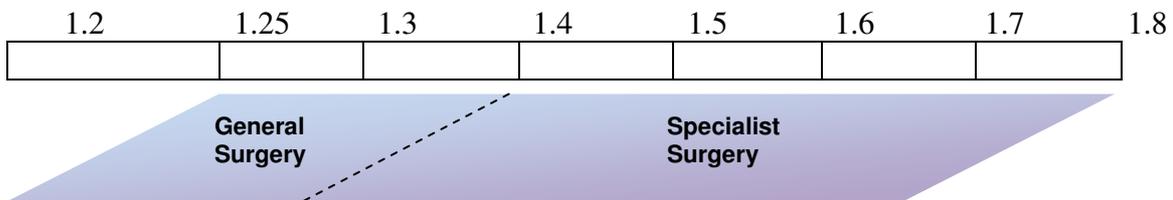
Figure 1: Nurse Staffing Range for General and Specialist Medicine.



SURGERY

- 4.5 A **general surgical care setting** is defined as comprising adult surgical patients admitted for elective or emergency surgery, including for example: urology, gynaecology, breast and endocrine surgery, orthopaedic surgery, vascular and general surgery.
- 4.6 A **specialist surgical care setting** is defined as, comprising adult surgical patients admitted for elective or emergency surgery where a higher degree of surgical acuity and/or progressive recovery is anticipated, including for example: neurosurgery, plastics, cardiac and head and neck surgery.
- 4.7 **Figure 2** below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for PUA. For further information as to how the ranges were described and agreed, please go to page 19 of this document.

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



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

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

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

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

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

ILLUSTRATIVE EXAMPLE

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

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

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

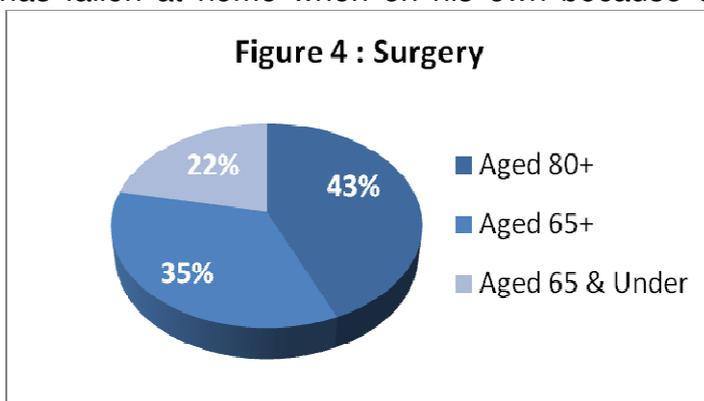
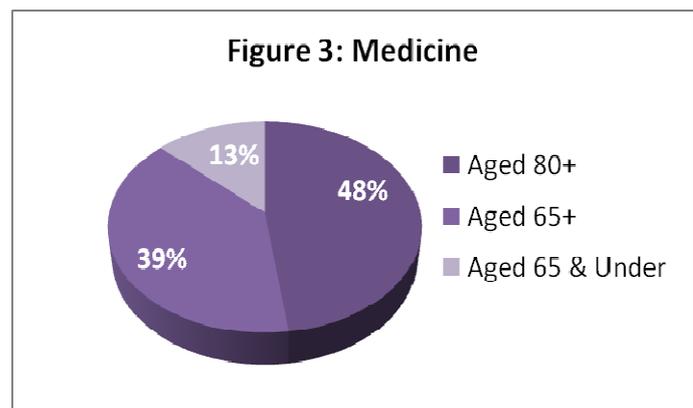
Patient Profile

John's story is typical of someone who is being cared for within adult hospital-based acute medical services in Northern Ireland. John is 81 years old. He lives on his own and has recently been experiencing difficulty breathing. 17 years ago, he suffered a number of small strokes from which he fully recovered and he now remains on medication to prevent further deterioration. Two years ago he had

his right kidney removed because a malignant tumour had been found. He is usually independent, but suffers from severe pain from osteoarthritis in both knees which means he walks with a stick. His mobility is quite limited as a result and recently he has been increasingly unsteady.

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

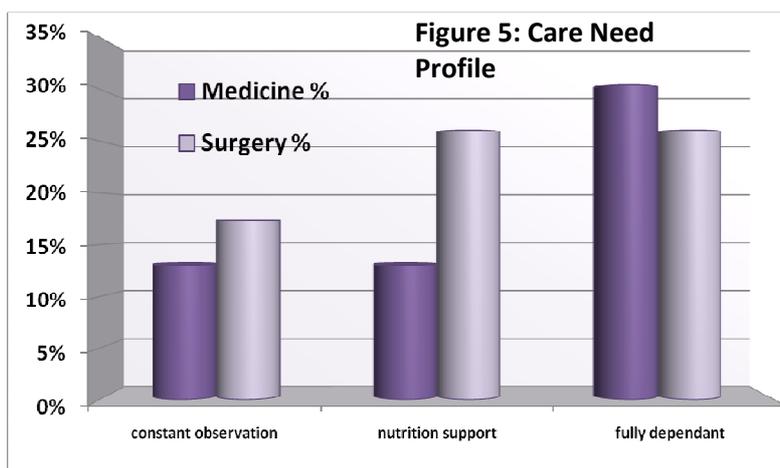
observation. His breathlessness is diagnosed as being a symptom of congestive cardiac failure, for which he receives an intravenous drug which increases his urinary



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

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

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



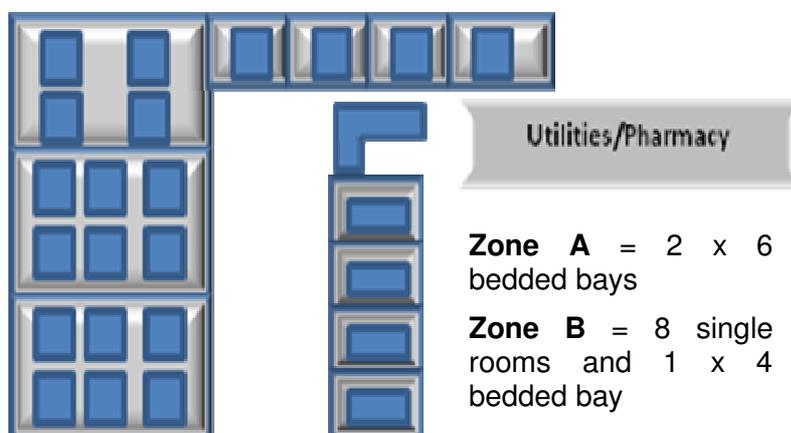
Northern Ireland has a population of approximately 1.8 million people and is the fastest growing population in the UK. The number of people over 85 years old is predicted to increase by 19.6% by 2014, and those over 75 years increasing by 40% by 2020. More people are living longer, with long term conditions and disabilities, which can be further complicated by more than one condition in some cases⁵⁰ and a requirement for complex drug regimen.

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

Environment

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

Diagram 1: Ward Layout.



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

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

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

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

This also applies to the location of departmental adjacencies such as x-ray and diagnostics particularly important when nursing staff are required to escort patients to other clinical areas/settings for diagnostics/ interventions/treatments.

Staffing Profile

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

Table 4: Staffing Complement

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

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

5.0 IMPLEMENTING AND MONITORING THE FRAMEWORK

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

6.0 CONCLUSION

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

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

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

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

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

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

Appendices

Appendix 1 - METHODOLOGY OVERVIEW AND PROCESS SUMMARY

Methodology Overview

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

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

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

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

Process Summary

Two time-limited literature reviews were undertaken to inform the work of the project. The first was conducted by the Business Services Organisation, Clinical Education Centre, and reviewed methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally. The conclusions from this review were that existing knowledge and practice in relation to staffing ratios and workforce planning remained relevant. In addition, there has been the recent development in England of an electronic tool to assist workforce planning – the Safer Nursing Care Tool⁵¹. The second literature review focused on available evidence-based staffing ranges or ratios, which have been developed for adult hospital medical and surgical specialties. This review, carried out by the PHA, confirmed that little work had been reported in relation to evidence-based staffing ranges/ratios for particular adult hospital medical and surgical specialties.

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

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

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

The ranges for the data refreshing exercise provided a continuum measurement from which a range might be set, based on existing staffing complements within Northern Ireland. It should be noted that HSC Trust organisations had previously reviewed funded establishments based on a range of workforce planning tools including Telford⁵² and the Association of United Kingdom University Hospitals⁵³. Given that Planned and Unplanned Absence Allowances (PUAA) were included in historical funding within legacy Health and Personal Social Services Boards of between 18% to 23%, ranges were set to reflect the recommended 24% PUAA (please see page 14 of this document).

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

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

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

- i. A relevant Glossary of Terms
- ii. Definition of staffing ranges in relation to general and specialist adult hospital medical and surgical care settings
- iii. Definition of a Planned and Unplanned Leave Allowance
- iv. Definition of a number of Influencing Factors, which impact upon the delivery of safe and effective care, and which determine the ratio within a staffing range at which a nursing team might be set.

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

⁵² Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.

⁵³ Association of UK University Hospitals (2009) *Patient Care Portfolio*. AUKUH acuity/dependency tool: implementation resource pack, London: AUKUH. Tool and related literature are available for download from www.aukuh.org.uk

APPENDIX 2 - MEMBERSHIP OF STEERING GROUP

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

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Steering Group are as follows:

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

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

APPENDIX 3 - MEMBERSHIP OF THE WORKING GROUP

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

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Working Group are as follows:

- TOR1 To contribute to the achievement of the project aims and objectives.
- TOR2 To participate in the agreement and testing of a tool to define staffing ranges in general and specialist adult medical and surgical hospital care settings.
- TOR3 To participate in the amendment and testing of the tool in other general and specialist hospital care settings.
- TOR4 To participate in the amendment and testing of the tool in mental health and learning disability inpatient and community care settings.
- TOR5 To contribute to reports offered to the Steering Group.
- TOR6 To contribute to the interim and final reports for submission to the PHA.
- TOR7 To adhere to principles of confidentiality in relation to communication and dissemination of information regarding the project.
- TOR8 To approve appropriate communiqués for wider dissemination.
- TOR9 To review the impact of the tool 12 months after development and implementation.

APPENDIX 4 - ABBREVIATIONS

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