# Section 1: Strategic Direction and Rationale

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1. Executive Summary

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Foreword and Acknowledgements

We are pleased to introduce Delivering Care: A Framework for Nursing and Midwifery Workforce Planning to Support Person Centred Care in Northern Ireland. The Framework is being developed in a phased approach to include nursing and midwifery workforce ranges across hospital and community settings in all programmes of care.

Delivering Care sets out a guide for commissioners and providers of Health and Social Care services for planning and discussing nursing and midwifery workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge, and one that we recognise is all the more important as we move into one of the most financially challenging periods in the history of the National Health Service.

The publication of this first phase of work around normative staffing levels is intended to stimulate conversations around workforce planning. Conversations about the delivery of safe, effective, person centred care. Conversations between Chief Executives and Directors of Nursing to be assured that there are mechanisms in place to develop and build robust workforce plans. Conversations between Human Resource Managers, Finance Managers and Hospital Planners to understand the needs of patients and clients and how those needs are met in relation to workforce planning.

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

It is within this context that this framework is part of the Public Health Agency’s response to the duties detailed in the Health and Social Care framework and the Department of Health Social Services and Public Safety commissioning directions and Health and Social Care Board commissioning plan. The framework also takes account of the views of the Royal College of Nursing and strategic direction within the Department of Health Social Services and Public Safety policy context, including the Northern Ireland Strategy for Nursing and Midwifery, to support the envisaged changes for the nursing and midwifery workforce into the future.

As nurses and midwives we all have a duty to ensure staffing levels are appropriate and adequate under the stipulations of the Nursing and Midwifery Council.

We would like to express our 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.

We 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 Chief Executive of the Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC) and lead Senior
Professional Officer for the significant project management and co-ordination, facilitation, and contribution to drafting of documents provided during the development of the Framework.

Finally, we 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.

Effective workforce planning is more than getting the numbers right; it is also needed to ensure that the current members of nursing and midwifery staff have the right skills and appropriate support to meet the future demands of our services and provide the quality of care for patients, clients, women and children.

It is our hope that you will find this work useful and will draw upon it to better understand the environment of care within which we all operate, whether that be as commissioners or providers.

Signed

TBA with Chair of Steering Group
Delivering Care: A Framework for Nursing and Midwifery Workforce Planning to Support Person Centred Care in Northern Ireland.

The Framework is made up of the following constituent elements:

- Assumptions of the Framework
- Normative Staffing Range
- Planned and Unplanned Absence Allowance
- Influencing Factors that impact on Workforce Planning.

And is made up of two complimentary documents:
# GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
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<tr>
<td>Hospital Care</td>
<td>The utilisation of a hospital bed during an episode of in-patient treatment or care</td>
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<td>Normative Staffing Ranges</td>
<td>The parameters of optimum nursing to bed ratios, within which it is anticipated that the vast majority of wards/care settings in a defined specialty will conform.</td>
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<td>Regional Services</td>
<td>Specialist services which are provided from one or two hospital sites for people throughout the region</td>
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<tr>
<td>Framework</td>
<td>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.</td>
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<td>Ward</td>
<td>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.</td>
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<td>Professional Regulatory Requirements</td>
<td>Activity within nursing and midwifery roles which is a professional regulatory requirement, but not necessarily a direct element of direct care provision. This includes: compliance with standards set by the regulatory body, supervision, and compliance with governance arrangements.</td>
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## Classification of Clinical Care Settings

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<td>Medicine</td>
<td>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.</td>
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<td>Specialist Medicine</td>
<td>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.</td>
</tr>
<tr>
<td>Surgery</td>
<td>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.</td>
</tr>
<tr>
<td>Specialist Surgery</td>
<td>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.</td>
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EXECUTIVE SUMMARY

Delivering Care: A Framework for Nursing and Midwifery Workforce Planning to Support Person Centred Care 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. This Framework is also a key part of the Public Health Agency’s response to 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 for the nurse staffing levels component within investment proposals.

The Framework documents will 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 and Influencing Factors.

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

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

The first phase of publication of the Framework includes two sections:

Section 1: Strategic Direction and Rationale

This Section includes the following elements:

- Background, context and strategic drivers for developing normative staffing ranges
- Defining the ranges
- Planned and unplanned absence allowance

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2 Please see pages 3 – 5 of this document.
Section 2: Using the Framework for Medical and Surgical Care Settings

This Section includes the following elements:

- Normative staffing ranges for general and specialist adult hospital medical and surgical care 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.

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

1.2 The Independent Inquiry into the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust\(^3\) 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\(^4\) sets out the direction of travel for HSC services in Northern Ireland over the next five years. This is supported by the Commissioning Plan\(^5\), 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


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**. **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** 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** and as part of the Health and Social Care Board (HSCB)/Public Health Agency (PHA) Commissioning plan 2011/12.

**Evidence Base Related to Staffing Levels and Patient Outcomes**

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

- Fewer registered nurses, increased workload, and unstable nursing unit environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units in a mixed method study combining longitudinal data (5 years) and primary data collection.

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

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6 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.
Links have been demonstrated between lower numbers of registered nurses and increased length of stay and associated cost.\(^{13}\)

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.\(^{14}\)

**Evidence from Public Inquiries**

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

*Mid Staffordshire NHS Foundation Trust*

The recommendations of the Francis Inquiry\(^ {15}\) 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.’\(^ {16}\)

*Public Inquiry into the Outbreak of Clostridium Difficile*

The Public Inquiry into the Outbreak of Clostridium Difficile\(^ {17}\) 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.’\(^ {18}\)

*House of Commons Health Committee*

A number of recent high profile cases such as Mid Staffordshire, Maidstone, Tunbridge Wells and Stoke Mandeville provided an insight for the Health Committee in 2009, into the negative impact and subsequent lived effect to patient centred care for the public, where too few nurses are deployed to provide services.\(^ {19}\)

**3.0 DEFINING A RANGE**

3.1 It was anticipated from the outset of this work that the process of developing normative staffing ranges will be continued in order to address other areas of clinical practice such as: emergency department, community, mental health and learning disability care settings.

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Aim

3.2 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

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

Objectives

3.4 Objectives were designed to enable production of the Framework and achieve the required outcomes of Phase 1 which included: the production of a regional descriptor of a normative range of staffing levels for general and specialist adult hospital medical and surgical care 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 20 of this document.

Why Develop a Range?

3.5 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio. 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.

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

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

3.8 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.

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

3.9 It should be recognised that the Framework refers to staffing ranges expressed as nursing/bed ratios. This reflects the view that the family of nursing (or midwifery) comprises both registered and unregistered staff, included collectively within the ratios.

3.10 For the purpose of developing the Framework, a number of underpinning assumptions must be considered when understanding how a range is set and might be used, in conjunction with the factors that influence workforce planning. These assumptions are:

Planned and Unplanned Absence Allowance

i. The ranges incorporate a Planned and Unplanned Absence Allowance of 24%. This allowance refers to periods of anticipated absence from work and should, therefore, be factored into the workforce planning process. This includes annual leave, sickness, and mandatory study leave. This element is further defined at page 14 of this Framework and it should be noted that the defined percentage will be subject to review and potential amendment by the Chief Nursing Officer on the advisement of relevant professional forums, reflecting developments in training requirements and training delivery methods.

Skill Mix

ii. This term refers to the ratio of registered to unregistered nursing/midwifery 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. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity, a skill mix comprising a higher level of unregistered staff may be appropriate.

Skill mix should also take account of an allocation of a Ward Sister’s/Charge Nurse’s time for managerial and professional responsibilities ranging from 40 – 60% of total available time.

A level of skill mix will be determined regionally for a variety of care settings in Northern Ireland by the Steering Group of the Delivering Care Project, in consultation with the Department of Health, Social Services and Public Safety (DHSSPS), PHA, HSC Trusts and staff side organisations. The skill mix relevant to a particular setting will be included within the subsequent ‘Using the Framework for..’ sections.

Management of Recruitment

iii. 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.

21 ‘Sickness’ refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
22 For definitions of acuity and dependency please see Influencing Factors, Delivering Care, Section 2.
23 Royal College of Nursing. (2009). Breaking down barriers, driving up standards. London, RCN. P 18. This review recommended that Ward Sisters/Charge Nurses be supervisory to shifts in order 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’.
Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

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

**Influencing Factors**

iv. It is acknowledged that workforce planning for nursing and midwifery staff is both complex and diverse. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation 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 Normative Staffing Ranges Project has defined these factors within four domains:

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

It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a medical or surgical setting.

**Defining a range for Medicine and Surgery**

3.11 During 2009/10, a ‘task and finish’ group, supported by the DHSSPS, took forward work to define and agree a range of nursing/bed ratios for a number of general and specialist, medical and surgical areas within the acute care sector. A data refreshing exercise, carried out as part of the Delivering Care Project, provided a continuum measurement from which a range might be set, based on existing staffing complements within Northern Ireland. During the completion of this work, it became apparent that it would be helpful to agree normative 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.

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24 For information related to skill mix please see Delivering Care Section 2, point ii, page 4.
26 Ibid.
3.12 It should be noted that HSC Trust organisations had previously reviewed funded establishments based on a range of workforce planning tools including Telford and the Association of United Kingdom University Hospitals.

3.13 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).

MEDICINE

Definitions

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

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

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

3.17 **Figure 1** below, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 and similarly, a small number existing at the higher end of the range. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 14 of this document).

![Figure 1: Normative Staffing Range for Medicine and Specialist Medicine.](image)

3.18 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 supernumerary Ward Sister supervision/

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management responsibilities, this equates to 31.6 WTE on a basis of 40% for those activities, in this example. With a skill mix of 70:30 this allows for 22.12 WTE Registered staff (0.7 x 31.6) and 9.48 WTE unregistered staff (0.3 x 31.6).

3.19 Pages 10 – 12 provide an illustration of the types of activity and numbers of staff that this range will represent for a general medical ward. It is also worthy of note that in addition to illustrated 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. 4.10, page 15, of this document.

The illustration below highlights a snapshot of the activity in an actual medical ward in Northern Ireland.

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.

Patient Profile

Figure 2, page 12, graphically presents a broad overview of the profile of individuals and their personal needs identified within hospital medical wards. It should be noted that this is not exhaustive of the totality of care provided.

Environment

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

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

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

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

Diagram 1, page 11, depicts a typical ward layout.

This environment of care means nurse staffing is divided into two teams Zone A and Zone B.

Zone A = 2 x 6 bedded bays
Zone B = 8 single rooms and 1 x 4 bedded bay
Diagram 1: Ward Layout.

Staffing Profile

Table 1 below, presents the required staffing complement that cares for the people outlined in the patient profile in Figure 2, page 12.

Table 1: Staffing Complement

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<td>1</td>
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<td>1</td>
</tr>
<tr>
<td><strong>Night Duty</strong></td>
<td></td>
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<tr>
<td>Registered</td>
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<td>3</td>
<td>3</td>
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<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Band 3</td>
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<tr>
<td>Band 2</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

This equates to a nursing:bed ratio of 1.3 and a skill mix of 70:30% registered/unregistered staff. Included in calculations in this illustration is 0.5 WTE (50%) allowance for supervisory and management responsibilities of the Ward Sister/Charge Nurse and 24% Planned and Unplanned Absence Allowance.
Figure 2, above, shows the demographics of people within acute care services. 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 1.8m people and is the fastest growing population in the UK. The number of people over 85 years old is predicted to increase by 19.6% by 2014, and those over 75 years increasing by 40% by 2020. More people are living longer, with long term conditions and disabilities, which can be further complicated by more than one condition in some cases.29

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SURGERY

Definitions

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

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

3.19 Figure 3 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. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 14 of this document). For further information as to how the ranges were described and agreed, please go to page 20 of this document.

Figure 3: Normative Staffing Range for Medicine and Specialist Surgery.
4.0 **PLANNED AND UNPLANNED ABSENCE ALLOWANCE**

*Definition*

4.1 Planned and Unplanned Absence Allowance (PUAA) refers to periods of absence from work, which can be described as anticipated and, therefore, must be factored into the workforce planning process. This comprises annual leave, sickness, and mandatory study leave.

4.2 It is acknowledged that PUAA are included in current funding within HSC Trusts ranging from 18% to 23%.

*Rationale*

4.3 Telford (1979) 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’ in any method of effective workforce planning.

4.4 In 2006, the Royal College of Nursing recommended a PUAA of 25%. Similarly, the Healthcare Commission recommended a minimum of 24% in 2005, prior to the implementation of Agenda for Change.

4.5 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). Professional activities were identified as: training, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local governance activities. Leave is also directed to be built into weekly job planning for consultant teams, including an average of 10 days per year of professional activity. It should be noted that sickness absence was not accounted for within the framework.

4.6 In 2002, the Auditor General for Scotland identified a requirement for Planned and Unplanned Leave Allowance to be taken into account within nursing workforce planning processes, outlined in Table 2 below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Leave</th>
<th>Sick Leave</th>
<th>Study Leave</th>
<th>Total Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>13.5%</td>
<td>5.5%</td>
<td>3%</td>
<td>22%</td>
</tr>
</tbody>
</table>

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

**Table 2:** Planned and Unplanned Absence Allowance, Auditor General Scotland

---

30 ‘Sickness’ refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
32 Ibid, page 2 of the referenced document.
Annual Leave

4.7 The implementation of Agenda for Change\(^{39}\) 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%.

4.8 For the purposes of the Framework, annual leave is calculated at the mid point of the Agenda for Change\(^{40}\) 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

4.9 Priorities for Action\(^{41}\) 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

4.10 In response to the increased intensity and complexity of patient care and the need to support the continuing provision of safe, effective, person centred care, mandatory training needs have significantly increased for the nursing and midwifery workforce in the last 10 years from 2002. This includes regulatory requirements such as: meeting the Nursing and Midwifery Council (NMC) Standards for Learning and Assessment in Practice\(^{42}\), statutory midwifery supervision and the Chief Nursing Officer’s standards for supervision in nursing\(^{43}\), 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 3, page 17. There is a regulatory requirement for professional updating, elements of which may be undertaken in a registrant’s own time. As more robust revalidation models are progressed in light of the Francis Inquiry\(^{44}\), it is essential that PUAA can accommodate this.

4.11 The nursing and midwifery workforce has a high percentage of individuals that choose part-time working arrangements - 56% full time, 44% part time\(^{45}\). 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.

Future Allowances

4.12 It is 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.

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\(^{42}\) Nursing and Midwifery Council. (2010). *Standards for Pre-registration Nursing Education*. London, NMC.

\(^{43}\) Chief Nursing Officer for Northern Ireland. (2007). *Standards for Supervision in Nursing*. Belfast, DHSSPSNI.


\(^{45}\) Ibid.
4.13 The revised allowances, stipulated at Table 4, have been agreed through the Delivering Care Project, using those defined by the Auditor General (2002)\(^\text{46}\) as a starting point, taking into consideration the elements mentioned in paragraphs 4.7 – 4.11, page 15. 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.

Table 4: Comparative Planned and Unplanned Absence Allowances

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Leave:</th>
<th>Sick Leave:</th>
<th>Study Leave:</th>
<th>Total Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>13.5%</td>
<td>5.5%</td>
<td>3%</td>
<td>22%</td>
</tr>
<tr>
<td>2012</td>
<td>15%</td>
<td>5%</td>
<td>4%</td>
<td>24%</td>
</tr>
</tbody>
</table>

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

### TABLE 3
EXAMPLES OF STATUTORY\(^{47}\) AND MANDATORY\(^{48}\) TRAINING FOR NURSING AND MIDWIFERY STAFF\(^{49}\)

<table>
<thead>
<tr>
<th>Core skills – all staff*</th>
<th>Annual commitment (average in hours)</th>
<th>One off commitment (average in hours)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, diversity and human rights</td>
<td>-</td>
<td>7.5</td>
<td>To include complaints handling</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Health and Safety</td>
<td>2.5</td>
<td>3.75</td>
<td>To include COSHH / waste management</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>3.75</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Moving and handling</td>
<td>3.75</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>3.75</td>
<td>-</td>
<td>Increased training required as per role and responsibility</td>
</tr>
<tr>
<td>Safeguarding children</td>
<td>3.75</td>
<td>-</td>
<td>Increased training required as per role and responsibility</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>3.75</td>
<td>-</td>
<td>Basic life support to Advanced Life Support dependent on need</td>
</tr>
<tr>
<td>Information governance</td>
<td>-</td>
<td>3.75</td>
<td>To include record keeping, data protection etc.</td>
</tr>
</tbody>
</table>

**Statutory and mandatory training for nursing and midwifery**

<table>
<thead>
<tr>
<th></th>
<th>Annual commitment (average in hours)</th>
<th>One off commitment (average in hours)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical policy and guidelines updates</td>
<td>7.5</td>
<td>-</td>
<td>MUST nutrition tools / tissue viability / PEWS / haemovigilance etc.</td>
</tr>
<tr>
<td>Nursing / Midwifery specific training</td>
<td>15</td>
<td>-</td>
<td>Includes statutory supervision &amp; obstetric emergencies for midwives / mentorship etc. for nurses</td>
</tr>
<tr>
<td>Clinical skills</td>
<td>11.25</td>
<td>-</td>
<td>Includes end of life care / violence and aggression etc.</td>
</tr>
<tr>
<td>New equipment / technologies</td>
<td>7.5</td>
<td>-</td>
<td>New equipment training needs including Point of Care Testing</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64.5</strong></td>
<td><strong>15</strong></td>
<td></td>
</tr>
</tbody>
</table>

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**

\(^{47}\) **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.

\(^{48}\) **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.

\(^{49}\) It should be noted that unregistered staff do not attend training which is in place as a result of a professional or regulatory requirement.
5.0 MONITORING THE FRAMEWORK

5.1 HSC Trusts will be monitored in relation to application of Delivering Care: A Framework for Nursing and Midwifery Workforce Planning to Support Person Centred Care in Northern Ireland year-on-year through the indicators of performance measures across Health and Social Care. In addition, normative staffing will also be monitored through the Chief Nursing Officer’s Professional Assurance Framework. Nursing and Midwifery 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 and midwifery 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 nursing and midwifery 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 for 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
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 22. A Working Group was also established, Membership and Terms of Reference included at Appendix 3, page 23.

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

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

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

Process Summary

Two time-limited literature reviews were undertaken to inform the work of the project. The first was conducted by the Business Services Organisation, Clinical Education Centre, and reviewed methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally. The conclusions from this review were that existing knowledge and practice in relation to staffing ratios and workforce planning remained relevant. In addition, there has been the recent development in England of an electronic tool to assist workforce planning – the Safer Nursing Care Tool[^50]. 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

[^50]: 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](http://www.institute.nhs.uk/quality_and_value/introduction/safer_nursing_care_tool.html)
addition, work to establish agreed normative 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 normative staffing ranges for specialist medical and surgical care settings, to support the generalist ranges, given that many general clinical settings currently exist with cohorts of beds dedicated to other types of services in specialist care.

The ranges for the data refreshing exercise provided a continuum measurement from which a range might be set, based on existing staffing complements within Northern Ireland. It should be noted that HSC Trust organisations had previously reviewed funded establishments based on a range of workforce planning tools including Telford\textsuperscript{51} and the Association of United Kingdom University Hospitals\textsuperscript{52}. 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 normative 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.


\textsuperscript{52} Association of UK University Hospitals (2009) \textit{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

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHA</td>
<td>Mary Hinds, Director of Nursing and Allied Health Professions (Chair)</td>
</tr>
<tr>
<td></td>
<td>Pat Cullen, Assistant Director of Nursing and Safety, Quality and Patient/Client Experience (Interim Chair) from April 2012.</td>
</tr>
<tr>
<td>WHSCT</td>
<td>Alan Corry-Finn, Executive Director of Nursing</td>
</tr>
<tr>
<td>SEHSCT</td>
<td>Myra Weir, Assistant Director of Human Resources (from April 12)</td>
</tr>
<tr>
<td>BHSCT</td>
<td>Nicki Patterson, Co-Director of Nursing (Workforce)</td>
</tr>
<tr>
<td>PHA</td>
<td>Siobhan McIntyre, Regional Consultant Nurse, Chair of Working Group</td>
</tr>
<tr>
<td>DHSSPS</td>
<td>Kathy Fodey, Nursing Officer, Workforce</td>
</tr>
<tr>
<td>Regional Partnership Forum</td>
<td>Rita Devlin, Senior Professional Development Officer (RCN)</td>
</tr>
<tr>
<td>HSCB</td>
<td>Paul Turley, Assistant Director Commissioning, (non-registrant)</td>
</tr>
<tr>
<td>Patient Client Council</td>
<td>Maeve Hully, Chief Executive</td>
</tr>
<tr>
<td>NIPEC</td>
<td>Maura Devlin, Interim Chief Executive (to August 2011)</td>
</tr>
<tr>
<td></td>
<td>Glynis Henry, Chief Executive (from Sep 2011)</td>
</tr>
<tr>
<td>NIPEC</td>
<td>Angela Drury, Senior Professional Officer (Lead Officer)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Representative</th>
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</thead>
<tbody>
<tr>
<td>PHA</td>
<td>Chair – Siobhan McIntyre, Regional Consultant Nurse</td>
</tr>
<tr>
<td>NIPEC</td>
<td>Angela Drury, Senior Professional Officer NIPEC (Lead Officer)</td>
</tr>
<tr>
<td>DHSSPS</td>
<td>Kathy Fodey, Nursing Officer, Workforce</td>
</tr>
<tr>
<td>DHSSPS</td>
<td>Mary Maguire, Health Estates</td>
</tr>
<tr>
<td>SHSCT</td>
<td>Glynis Henry, Assistant Director of Nursing (Workforce Lead) until August 2011, replaced by Lynn Fee February 2012</td>
</tr>
<tr>
<td>NHSCT</td>
<td>Allison Hume, Assistant Director of Nursing (Workforce Lead)</td>
</tr>
<tr>
<td>SEHSCT</td>
<td>Caroline Lee, Assistant Director of Nursing (Workforce Lead)</td>
</tr>
<tr>
<td>WHSCT</td>
<td>Brendan McGrath, Assistant Director of Nursing (Workforce Lead)</td>
</tr>
<tr>
<td>BHSCT</td>
<td>Nicki Patterson, Co-Director Nursing (Workforce Lead)</td>
</tr>
</tbody>
</table>

**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

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