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Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care — Review of Workforce Planning: Royal College of Nursing and the Royal College of Midwives

22 April 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mrs Pam Cameron
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Ms Breedagh Hughes	Royal College of Midwives
Ms Rita Devlin	Royal College of Nursing
Ms Maureen Dolan	Royal College of Nursing
Mr Garrett Martin	Royal College of Nursing

The Chairperson (Ms Maeve McLaughlin): Representatives from the Royal College of Nursing (RCN) and the Royal College of Midwives are here to brief members on workforce planning in the context of Transforming Your Care. Folks, you are very welcome. We have present Garrett Martin, deputy director of the Royal College of Nursing; Rita Devlin, head of professional development at the Royal College of Nursing; Maureen Dolan, vice chair of the RCN board; and Breedagh Hughes, director of the Royal College of Midwives. I invite both organisations to make a presentation, and then we will open the meeting to members' questions, comments and observations.

Mr Garrett Martin (Royal College of Nursing): Thank you, Madam Chair. The RCN thanks the Committee for the invitation to submit evidence in relation to workforce planning in the context of Transforming Your Care (TYC). I hope that members of the Committee have received our briefing paper, which, I hope, should have been helpful in preparing the ground for today's session and informing the work of the Committee on this issue.

In the briefing paper, we have endeavoured to address specific issues that were raised with the RCN in the invitation to attend. It also introduces some additional themes that we feel are important for the Committee to consider. The briefing paper provides some background information in relation to the workforce planning process for nursing and midwifery in Northern Ireland. It explains how, in July 2013, the RCN presented to former Health Minister Edwin Poots a detailed analysis of the nursing workforce in Northern Ireland, highlighting the challenges that needed to be addressed in order to help

build a nursing workforce that would be fit for purpose in addressing the significant healthcare challenges confronting Northern Ireland in the years ahead.

We note, at paragraph 12 of the Committee briefing paper, our specific concerns about a recent document from the Department entitled 'A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 to 2025)'. The RCN is particularly concerned about the growing number of nurses who are leaving Northern Ireland to work elsewhere; the increasing staff-vacancy levels in nursing reported in the DHSSPS vacancy survey; the growing number of entries on Health and Social Care (HSC) trust risk registers, detailing the risks associated with nursing staff shortages; the increasing use of bank and agency staff and associated escalating agency costs; and the fact that there are insufficient financial resources to meet demand for the specialist and advanced nursing roles required to support the medical workforce, resulting in a further depletion of an already overstretched nursing workforce.

The paper highlights the impact of inadequate or non-existent workforce planning on the nursing-home sector and GP services. We live in an integrated health and social care system where the statutory sector coexists with the independent and nursing home sector, GP practices, private clinics and voluntary organisations, to provide health and social care services for the people of Northern Ireland. These areas of practice do not exist in parallel universes. They are simply part of the same system. Workforce planning for nursing must address, in particular, the needs of the nursing-home sector and GP practices, as well as those of our hospitals, health centres and community services.

We note that the Committee recently received oral evidence from the regional workforce planning group (RWPG) in relation to Transforming Your Care. The Committee specifically asked the RCN to confirm whether it has representation on the RWPG, and the answer to that question, as we explain in our briefing paper, is that we do not. The RCN is surprised and disappointed that a group of that nature, which specifically purports to include membership from across the wider HSC, could exclude the organisation representing the largest professional group within the HSC.

The ultimate benchmark for the success of TYC is, or should be, its impact on emergency department admissions. However, between December 2013 and December 2014, the total number of attendances at the major acute hospital emergency departments in Northern Ireland actually increased by 6%. Across all emergency departments, the increase was 3%. If TYC was designed as a means to keep people out of hospital and ensure that they are able to access health services in their own homes and communities, by that criterion it has singularly failed.

The community nursing workforce in Northern Ireland faces many significant challenges. They include: high workloads and demands on the service; an excessive burden of paperwork; poor or non-existent technology; and a fear of letting patients down, due to cuts in service and workforce. The demands on community nursing services have also affected the work/life balance of nurses, with many nurses working longer, unpaid hours because that is the only way to make sure that patients receive the care to which they are entitled.

A summary analysis of the community nursing workforce is presented in the briefing paper. It illustrates the numerical decline in the community nursing workforce over the last four years, at precisely the time when the workforce should have developed in order to deliver TYC. Secondly, the figures demonstrate the ageing demographic profile of the community-nursing workforce, particularly in relation to school nursing and treatment-room practice nursing.

There is a further point to be made with specific reference to the district-nursing workforce. As table 2 on pages 12 and 13 demonstrates, many of the nurses who are categorised as district nurses by the DHSSPS are not employed as district nurses at all but as registered nurses who are deployed to work in the community. District nurses are nurses who have undertaken a specialist programme subsequent to their initial registration to equip them with the high levels of skills and expertise that are needed to lead and deliver the provision of specialist care to people with complex conditions. In simple terms, two out of every three nurses whom the Department categorises as district nurses are actually not district nurses at all.

The paper also stresses that we need to make sure, in our integrated health and social care system, that we are not trying to deliver nursing care within a domiciliary care model. The RCN is concerned about current consultation on a proposed outline for domiciliary care services. This definition of domiciliary care services includes programmes of care for older people, physical and sensory disability, mental health and learning disability. It goes on to claim that domiciliary care includes meeting:

"a service user's health needs (eg managing medication)".

This is unacceptable and potentially dangerous in the RCN's view. Meeting the health needs of patients and clients requires skilled professional nursing care that is prescribed, directed, supervised and delivered by registered nurses who have been trained to provide that care and who are accountable for the quality of the care that is provided and the experience of the patient or client.

The Committee has sought views from the RCN on the number of registered nurses who are required to implement TYC. As the briefing paper points out, commissioning involves assessing health and social care needs and then planning and designing services to meet those needs. Workforce planning is or should be an integral part of this process. It is equally a commissioning responsibility to seek assurances about staffing in the context of patient safety, quality and experience within the services commissioned. The RCN has been involved in a regional initiative to establish a framework for safe or normative nurse staffing ranges to support person-centred care in Northern Ireland. This work is currently being undertaken in phases. Phase 1 is to find safe nurse staffing ranges for acute medical and surgical settings. The previous Minister announced the establishment of the framework for these areas of practice in 2014. Phase 2 is intended to cover emergency departments and phase 3, community settings. However, the Northern Ireland Budget 2015-16 paper states that no funding is available to support work on subsequent phases of normative staffing. The RCN believes that this is unacceptable. The development of safe nurse staffing levels across health and social care is not an optional extra to be pursued as and when resources and other priorities permit: it is a matter of fundamental public safety that must be implemented fully and as a matter of urgency.

The RCN believes therefore that the answer to the Committee's question as to how many nurses are required to implement TYC lies in developing robust commissioning and workforce planning processes that are supported and underpinned by the implementation of safe staffing levels across all healthcare settings, including community healthcare settings.

At the end of the briefing paper, we draw to the Committee's attention the statement that is made in the executive summary of the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry', with which I am sure that you are familiar. In particular it states that:

"The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing".

I will not read those out, as they are in your briefing paper.

RCN believes that these warning signs are present in Northern Ireland's health and social care service today and that they can no longer be ignored. Last year, the RCN told the Committee that TYC is "a vision without action". We now need to reassess that conclusion. The Northern Ireland Executive's Budget paper for 2015-16 states that:

"The Department's budget does not allow for the funding of new service developments in 2015-16, across a number of areas including ... Transforming your Care (TYC) transitional funding".

Knowing that alternatives to acute hospital admissions are being closed, with more and more patients being funnelled into emergency departments because they are the only viable points of access to the health system, the RCN believes that we are entitled to ask whether TYC remains, in any meaningful respect, a viable strategy.

We note that, earlier today, the permanent secretary of the Health Department was scheduled to deliver a presentation at the annual conference of the Northern Ireland Confederation for Health and Social Care (NICON). It was entitled 'Beyond Transforming Your Care'. If TYC is not now the blueprint for the modernisation of the health and social care service, we ask this question: what is? Where is the new strategic direction or vision? Are we living in a system where the only mantra is that there is no money, so we will all have to muddle through as best we can? This is not leadership: it is a dereliction of duty.

I hope that this presentation, in association with our briefing paper, has been helpful to the Committee. Thank you for inviting the RCN to your meeting today. I hope that our evidence has been helpful.

Ms Breedagh Hughes (Royal College of Midwives): Thanks very much for the invitation to come and meet the Committee. Apologies for the very late tabling of what I am about to say. We have been otherwise engaged over the last few days. Sorry.

The issues in midwifery are in many ways very different from those in nursing. For example, there is no private sector for midwifery in Northern Ireland, nor are there any agency midwives, although, across the sector, we do have quite a high reliance on the use of bank midwives.

I have looked at the terms of reference for the Committee's ongoing piece of work and, in particular, the challenges that Transforming Your Care identified for maternity services going into the future. These were about giving women a realistic choice of birth location; the need for more continuity of care throughout pregnancy; the need to reduce unnecessary interventions; dealing with public health issues that face women of childbearing age to reduce ill health and disability of both mother and child; support the expectant mother in her antenatal care and connecting that support to the early years of parenthood. Transforming Your Care went on to say that it expects change to follow the pattern that is set out in the forthcoming maternity strategy from preconception through pregnancy, birth and the postnatal period. In addition, it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

At the time that Transforming Your Care was written, the Department of Health, Social Services and Public Safety was working with the royal colleges, service providers, commissioners and indeed with women themselves to develop the strategy for maternity care. I think that Mr McGimpsey was Minister when it was published. It clearly accepted the recommendations that were outlined in Transforming Your Care and has, for midwives, clearly identified the vision and the future direction of maternity services in Northern Ireland. It addresses women's choice, accessibility of services and who is best placed to be the lead maternity professional. I think that, for us, it is a unique document in that it is a maternity services strategy. It cuts right across all of the professional groupings. It applies equally to our medical colleagues, general practitioners, midwives and nurses who work in such places as neonatal intensive care units. It is a service strategy and not a uni-professional strategy. It is supported and, in fact, driven forward by our colleagues in the Public Health Agency. There is a very robust maternity strategy implementation group, which, each year, puts in place annual targets to be met by the end of the year to move the strategy forward. It is not a strategy that sits on a shelf somewhere; it is very much a living and evolving document. It spans both the acute and primary care sectors.

The premise of maternity care is that every woman needs a midwife and some will need a doctor as well. In fact, some will need more than one doctor. They may need a very highly skilled team of doctors to provide them with that wrap-around care. In Northern Ireland, the service developments in maternity care are in line with the maternity strategy. There has been robust implementation of the strategy since 2013, with women now having a wider choice of birth location; more continuity of care throughout their pregnancy; and fewer unnecessary interventions, including non-medically indicated caesarean sections. That issue was addressed by the Northern Ireland Audit Office, probably at the request of the Committee. Those are being reduced. Midwives are at the forefront in discussing public health issues, including drug and alcohol abuse, smoking, nutrition and exercise with pregnant women, who are actually very well disposed to receiving public health messages during their pregnancies for themselves, their unborn baby and other members of their family.

The only recommendation from Transforming Your Care that is still to be implemented fully is the development of the specific regional plan to support women with serious psychiatric conditions. That work is, in fact, ongoing. There is a perinatal mental health working group in Northern Ireland which has, so far, developed very robust training to identify women at risk.It has put in place an algorithm or flow chart for midwives to follow when they identify a woman at risk of perinatal mental health problems. Our difficulty is that there is not a dedicated resource for those women once they have been identified. We still do not have a mother-and-baby bed that women who are seriously unwell can be admitted to with their baby, so any woman with a mental health problem in Northern Ireland will be separated from her baby if she requires admission to a psychiatric unit, but we are campaigning on that one. We will keep going, and I am quite sure that we will get it eventually.

There is an evolving role for midwives in decreasing social complexity and enhancing parenting skills. It is a massive transition to make, as anybody who is a parent will know, from having a bump one day to having a baby — a real, live human being — the next day. We are beginning to see midwives moving to work outside the health-care system in Sure Start schemes, the early intervention transformation programme that the Public Health Agency is about to start and the family nurse

practitioner scheme. Midwives are reaching out to those who are most vulnerable in the community and working with them to help them to make that transition from pregnancy to parenthood.

Whilst there has been an increase right across Northern Ireland in the number of women choosing to have midwifery-led care throughout their pregnancy, there has also been an increase at the other end of the spectrum in the number of women with complex needs who require to have their care provided by an extensive team of health-care professionals. That is to do with women delaying having their first baby until they are older or women presenting for pregnancy with other ongoing diseases, particularly things like diabetes, epilepsy, renal disease, cardiac disease and respiratory disease.

The midwifery workforce in Northern Ireland is predominantly female: only two of our 1,300 midwives are male. It is an ageing workforce. Almost 60% are aged over 45, and, indeed, 22% of them are aged 55 and over. It is a part-time workforce, with almost 70% of midwives working part-time. At any given time, up to 5% of the workforce may be on maternity leave, so that means that, at any given time, 65 midwives are off on maternity leave in addition to any midwives who may be off on sick leave.

Midwives work flexibly across hospital and community boundaries. That is incorporated into their pre-registration training and carries through into clinical practice. In order to keep them fit for practice at any point in their career, ongoing professional development is crucial as the service develops to meet women's needs and wishes. Ongoing professional development is provided, some of it in-house, some of it by the Clinical Education Centre and some of it by the universities, but it is all unfunded, and many midwives undertake their own continuous professional development (CPD) in their own time and at their own expense.

The midwifery workforce is reviewed annually in conjunction with the Department of Health. It is a group led by the Chief Nursing Officer. We work with service commissioners and providers, the higher educational institutes and the professional organisations, which include both the RCM and the RCN. Like Garrett, I echo our concern that there is no midwife on the regional workforce planning group. We were completely unaware, for example, of the Skills for Health workforce planning diagnostic report that was provided to the Department in November 2013, so I thank the Assistant Clerk for giving me a copy of that.

The 2013 report highlighted several workforce planning issues that it might be worth the Committee taking some cognisance of: for example, that workforce planning is seen by those who work in the service as being reactive, short-term and focused on efficiencies and savings, not on future service development. It asks how you translate a service change into a workforce change and who really owns workforce planning: is it HR, or should it be the people working in the service?

By using the maternity service strategy as our framework for the development of midwifery workforce planning, we are taking service developments and looking at the midwives we currently have in place, at how the service is evolving, at where those midwives need to be and what they need to be doing, and their skills are updated constantly and reviewed throughout their career. There are midwives in places like Lagan Valley who worked in a hospital environment for 30 years and, when it became a midwife-led unit, started working in the community as well as the hospital. They are doing home births and rotate back and forth to the Ulster Hospital to update their critical skills. They are working in many different ways — more ways than anybody ever envisaged. It is still an enormously popular career, however. There were 534 applications to Queen's University this year for the three-year midwifery course and 75 for the shortened 18-month course, which is open to those who already have a nursing qualification. So, it is still a very attractive career option.

The introduction of maternity support workers to the maternity workforce has provided support to midwives and added value to the care that women receive. We have, working with the Business Services Organisation (BSO), developed a single training scheme in Northern Ireland that is adapted by each trust to meet their service needs. In some places, maternity support workers work in theatres; in other places they work in the community; in still other places they support breastfeeding women. It is about tailoring their use to meet local service need.

The major threat to midwifery is that an ageing workforce, many of whom have the ability to retire at 55, may, in today's difficult environment, choose to exercise that right. That would leave us, if they all went in the next couple of years, with an immediate 22% depletion of the workforce. It is, therefore, in everyone's interests to keep our midwives at work, happy and motivated. We are happy to add to that by answering any questions.

The Chairperson (Ms Maeve McLaughlin): Thank you for very clear briefings from both organisations. Just by way of opening up the conversation, I want to say that the daily work of your organisations and their many staff is vital to the delivery of our health service and to our wider society. I hope that you hear that genuine message from us.

I picked up on a few points of Garrett's. The reason for our doing this piece of work is that we view workforce planning as integral. Personally speaking, to promote a strategy but not to engage in workforce planning until a number of years down the line is certainly not foolproof. The first port of call should have been looking at workforce needs and planning accordingly. That is the message from this Committee, and that is why we have undertaken this work.

We are uncovering a lot of the same patterns, suffice it to say. We are looking at in the region of 29 reviews of aspects of the workforce, with a number of reports — we heard from the GPs last week — that have not been actioned. There is a real challenge in the system, if we are serious about the shift left. That leads me on to a very direct question to both colleges. The College of Nursing, at a previous meeting, talked about TYC as a vision without action. I note that you say now that you are entitled to ask whether it remains a viable strategy. My question is this: in your view, is Transforming Your Care dead?

Mr Martin: The college's response is this: what options do we have? Very few things in health care get the consensus that TYC got three years ago. Very few people said that it was a bad thing. It absolutely is the right thing to do. The problem that we, and patients, see, day in and day out, is that it is not being delivered. Look at some of the figures that we provided, and not just for emergency department waits. Another statistic that I heard recently, which is quite damning of TYC, was the increase in delayed complex discharges. That in itself indicates something about the process for getting patients out of an acute hospital in a timely and safe fashion. The community services have to be in place to facilitate that, and there has been a 30% increase. At an unscheduled care workshop a number of weeks ago, it was presented that there has been a 30% increase in the number of delayed complex discharges, which involve patients who are older or vulnerable people who need packages of care. That is an indicator that services in the community are not there. You have the figures in front of you for district nursing. I think that most patients and members of the public understand that the district nurse is the cornerstone in coordinating patient care in the community. They are the people who liaise with the different services and make sense of services for patients in the community. That 6% reduction over the last four years, a time when the figure should have been increasing, shows that, if the figures and the workforce do not change, TYC cannot be delivered.

The Chairperson (Ms Maeve McLaughlin): Can it be fixed?

Mr Martin: I would not be as pessimistic as to say that it cannot be fixed, but we are starting way beyond when we should have. This should have started not just three years ago when TYC was published; it should have started long before that. Community care and care in the community is not a new concept. TYC was not the first strategy document to identify community care as the right way to go. It requires funding in the right place and commissioning to work better in transferring that resource from the acute sector to community. It certainly needs a major overhaul of how things are being done.

The Chairperson (Ms Maeve McLaughlin): What about from your point of view, Breedagh?

Ms Hughes: We were starting from a different place. There had already been a very strong move driven by service users — the women themselves — to de-medicalise maternity care where possible. When Transforming Your Care was being developed, the maternity strategy was being developed in tandem. It looked at how to keep care locally accessible for women. You have to make a difference between the women who are low risk, and for whom that is an option, and the women who have high-risk pregnancies and need complex teams caring for them, but you do not treat every single woman as a medical disaster waiting to happen. That groundswell was already being driven forward by women and the maternity services liaison committees attached to each of the trusts.

Maternity services started much further back. We already had that move to decentralise, to keep things locally accessible, to centralise the services that needed to be centralised and to make everything else as locally accessible as we could: for example, by the time TYC was published, plans were well under way to open a midwifery-led unit in Downpatrick. That was closely followed by one in Lagan Valley, and there is also one now in the Mater. The service has evolved and continues to do so, but that process started before TYC was issued as a strategy document. In fact, we often

wondered whether they copied our maternity strategy when they were writing TYC, because it embodies many of the same principles.

The issues were very different, and we started from a different place. It is also the case that, when looking at only one discrete service, such as maternity services, you can make those changes more easily. There are fewer groups of people involved, and, generally, you do not have very ill people. It was easier for us to accomplish. It is much more difficult, as Garrett highlighted, when there is any sort of dissonance between the acute sector and the community sector. People get stuck in the system. Women and midwives now flow in and out of maternity hospitals. If a woman is completely low-risk and delivers in a midwife-led unit, whether it is a free-standing one or an alongside one in one of the bigger units, she has her baby and goes home in six to 12 hours. There is then a seamless pickup by the community midwifery service. In fact, the midwife who delivered her might also be the midwife who sees her at home. Our issues were different, and we were in a different place at the point at which the process was starting.We share the concerns about the funding, particularly because, although the service has changed, the funding structure remains the same. It is calculated on an old formula that just takes the number of births in each trust and gives the funding according to that number. It does not look at the complexity of need of some women and their babies. Some women will have very complex needs and have a very expensive birth; others will not see a doctor at any point during their pregnancy, the birth or afterwards, so they do not have complex needs and do not cost a lot of money.

Simply looking at the total number of births and then allocating the funding is not helpful, because it means that we do not have the flexibility to redirect some of those resources into the community. Why, for example, does every woman have to queue in a hospital for two or three hours to have a scan to be told that they are definitely pregnant? We would love that to be done in the community by community midwives, but they have to buy handheld scanners, and they are expensive. It is about redirecting some of the resources currently concentrated in the acute sector to the community sector in order to allow that element of care also to be transferred out into the community and keep services locally accessible for women and their families.

Ms Rita Devlin (Royal College of Nursing): In the context of TYC, workforce planning has two strands: the numbers; and the knowledge, skills and expertise. Northern Ireland is the only one of the four countries that will not increase student nurse levels this year. The education budget for post-registration nursing education and development to help nurses to keep up their skills has also been reduced, so we have a potential reduction in the number coming in and a reduction in the budget to keep them trained and developed to bring forward new ways of working and transformation.

The Chairperson (Ms Maeve McLaughlin): Given that both colleges have outlined the pressure in the system — we have seen that reflected in the last 24 hours in your decision on industrial action — is nursing safe? Is midwifery safe?

Ms Devlin: Should we not ask whether patients are safe?

Ms Hughes: As long as organisations like ours have access to those who make decisions, I am personally confident that we can get the ear of the relevant person and raise concerns directly. I think that we are probably in a better position here in Northern Ireland than our colleagues in England in particular, because there are so many hoops to jump through over there when you wish to raise a concern. However, it depends on what action is taken as a consequence of those concerns being made known.

The Chairperson (Ms Maeve McLaughlin): What about from a nursing point of view?

Mr Martin: There is certainly evidence of real concerns that patient safety is at risk. We hear that very often. Whether it is to do with staffing levels in wards, or even in community settings, we see in reports, particularly in the community, that caseloads are increasing significantly. The acuity — the dependency and needs of the patient — has increased significantly in the community. Nurses are rushing in and out of patients' houses to make sure that they can see all of their patients. They identify that as a major risk

Also, as Rita pointed out, it is not just about numbers; it is about the skill mix of the staff who care for patients. Very experienced staff have left emergency departments because they cannot take it any more. They have had enough and are burnt out. We heard of one department recently that 12 experienced staff left within a short space of time. That is a massive chunk of experienced and skilled

staff to leave a department. You may, if you are lucky, be able to backfill with new staff, but new staff take time to orientate, induct and develop to a level at which they are competent. So, absolutely, there are real safety concerns, and nurses struggle with that daily, but they do their best. They go beyond the call of duty, as you know, to try to make sure that patients are as safe as they can possibly be.

Ms Hughes: We share the concerns about the skill mix. With 22% of midwives aged over 55 and feeling the pressure sometimes, it is like a domino effect. If one person retires from a department, he or she comes in and tells everybody how wonderful retirement is. Within the next six months, half the department has gone — they can go and they do. Our nightmare is that we would be left trying to fill that gap. Even if we managed to recruit and train midwives, they are, at the end of their three-year course, very inexperienced. It takes them a number of years to reach a high level of competency, whether in nursing or midwifery, in any particular arena. We have a huge concern about that as well.

The Chairperson (Ms Maeve McLaughlin): Obviously, it is of concern to us all that patient safety may be at risk in areas where people are delivering a life-or-death service on behalf of both organisations. What is the urgent action that is required? In the last number of weeks and months, I have listened carefully to you, Breedagh, and others talking about the hard decisions and the genuine dialogue, based not just on budgets and money in the system. If somebody asked you what needed to happen urgently — A, B and C — what would they be?

Mr Martin: It is very difficult to say what would need to happen "urgently", because it takes time to train people. One of the first things that needs to be done is that the number of pre-registration places needs to be increased. In particular, we certainly need significant investment in post-registration education support for nursing staff to undertake these programmes, whether they are in specialist practice or other advanced practice programmes, to allow for some of these changes to take place. We absolutely need normative staffing, or safe staffing, levels implemented as soon as possible. We need phases 2 and 3 of that to be carried out and supported. It must be not just a paper exercise; we need the funding to follow. The nursing profession is saying, very clearly, that a certain level of staffing is required to provide safe and effective care for patients, so there is an obligation to fund and resource that need. We appreciate that it will not happen overnight, but we want a commitment that it will happen.

Ms Maureen Dolan (Royal College of Nursing): I concur with what Garrett was saying. As a nurse working on the front line, I find it very difficult — other members would also say how difficult it is — to work with the level of staffing that we have at the moment. It is not just the level of staffing but the experience of the staff who come to help on the wards. They might be agency or bank staff who are not used to the environment. Inexperienced staff are coming into acute services, for instance, where work is done on surgical wards, and that adds to the workload rather than assisting with it. A lot of experienced and valued members of staff are leaving, as Garrett said, not just to take early retirement but to work for private agencies that pay better. There is less incentive for staff, including pre-registration staff, to stay where they are when they know that, if they go to England, America or Canada, they will have incentives to work.

The Chairperson (Ms Maeve McLaughlin): That is useful because that is one of the issues that came up when we were looking at unscheduled care. People often reflect on recruitment, but the debate is about the type of recruitment and the type of staff required.

I want to go back to your point, Garrett, about pre-registration places and programmes. Your briefing paper states:

> *"trusts are not commissioning sufficient places on ... Programmes such as district nursing and health visiting."*

Why is that happening? Why is that the case?

Mr Martin: There has been a specific issue with health visiting. There was an increase in the number of commissioned health visiting places because of the risk associated with the caseloads in that area. That is, to a certain degree, being addressed. It is to do with funding and pressure. The Department does not provide backfill for a number of these programmes, so the trusts simply say that an individual has to do it in their own time. For professionals to try to develop their career, expertise and skills while working in a very stressful clinical environment is very challenging. Quite often, and more often than not, it is absolutely to do with resources and the lack of backfill to provide cover when staff are out on these programmes.

The Chairperson (Ms Maeve McLaughlin): A number of Members want to come in on this. Your paper, Garrett, refers to staffing shortages in the independent nursing homes sector.

Mr Martin: Absolutely.

The Chairperson (Ms Maeve McLaughlin): That is a serious risk, I suggest, to the viability of those nursing homes.

Mr Martin: Almost a third of our members work in the independent sector. These are, as you all know, nursing homes, and there are 10,000 nursing home beds for our older population. We believe that the service — the Department of Health and HSC as a whole — has a responsibility to ensure that there is a nursing workforce that is able to staff those independent nursing homes, but there are significant staff vacancies. They are finding it very difficult to recruit. One large independent provider had 150 registered nurse vacancies.

They recruit from the EU. There is, as you probably know, a ban on recruitment outside the EU, which is a challenge in itself. There may be some things that could be looked at in relation to that, which may help. Nurses recruited from within the EU spend a period in the private sector — the independent nursing home sector — after which, because we are in a cycle of a lack of supply to meet the demand, trusts are able to employ nurses from other parts of Europe. The independent homes sector cannot compete with the terms and conditions and the pay. Trusts now recruit those nurses because they are reporting large numbers of vacancies in nursing. It is almost a perfect storm in the nursing workforce. We highlighted the risks a couple of years ago. We had the demographic profile of nursing, and the risk was much higher in certain areas — district nursing being one of them.

It was inevitable that the changes to pension arrangements and the reduction in pre-registration nursing programmes would leave a deficit in the supply of the nursing workforce, and that is exactly what has happened. Unfortunately, the warning signs were not listened to, and that is why we are in the situation that we are in. We are playing catch-up. If we do not start picking this up now, in two or three years' time, we will be sitting at this very table, I am sure, in a worse situation than we are at present.

Ms Hughes: Midwifery is slightly different, in that we have a very robust workforce planning tool called Birthrate Plus, which helps us to look at how a service is configured. It is a bit of a guesstimate, but it is pretty much based on a huge amount of data, and we can work out how many midwives are needed, at any particular time and in any particular place, to staff the service safely. That has been backed up more recently by guidance issued by the National Institute for Health and Care Excellence (NICE) on the safe staffing of maternity units. We are in a better position to guess how many we need. That will not help us if the 22% who are over 55 all decide to lift their pension.

From our point of view, probably the single biggest thing that would help to keep workforce planning on everybody's horizon is for both the RCM and RCN to be involved in the regional workforce planning group. I do not see how the HR directorate at the Department of Health can plan for the professional workforce across Northern Ireland without speaking to us.

The Chairperson (Ms Maeve McLaughlin): OK, that is very clear. Finally, before I move on, I noted from your paper, Garrett, that 600 nurses were employed across GP practices. You referred to concerns about terms and conditions.

Ms Devlin: We are looking at practice nurses, and there are a couple of issues. Obviously, they are seen as independent. GPs are independent employers, so there are no standardised terms and conditions for practice nurses. There are a few issues with keeping practice nurses skilled, because it depends on whether GPs are prepared to pay for their education and training. Obviously, good employers pay for that. They are an ageing workforce, too. There is no standardised preparation or acknowledgement of standards of education for a practice nurse post.Some of the issues are about keeping them skilled for the services that TYC expects to be delivered through the GP and practice nurse role and the fact that the practice nurse programme is no longer commissioned by the universities because the employers would not pay for nurses to do it. There is an onus on us to look at what skills and development the practice nurse population needs for the future. TYC and the GPs are the gatekeepers, and the practice nurses do things like health assessments and signposting and try to keep patients out of hospital. It is all nursing, but it all happens in different places and they have

different skill sets. It is about recognition that workforce planning is not just about numbers but about skill sets.

The Chairperson (Ms Maeve McLaughlin): There is an obvious issue in that it may become difficult to recruit and retrain practice nurses if those issues are not resolved.

Ms Devlin: If they do not get the same terms and conditions and supervision, yes. Professional revalidation will come in in the next three years, and they need proper clinical supervision and work to do the revalidation. That could become an issue.

Mr McKinney: Strategically, does the system understand the number of nurses and does it audit the work? Does it know what is happening on this side of the wall in terms of GPs? Does the mainstream system monitor that, assess it and know what the day-to-day work of nurses in GP practices involves?

Ms Devlin: The trusts and the independent sector seem totally different. I do not know anybody, apart from us, who has an overall view of nursing as a whole. I do not know that the Department looks at that either.

Mr McKinney: This might be a leading question: is that a flaw?

Mr Martin: It is fair to say that. Part of the overall workforce planning piece should pull all that together. In fairness, work has started on nursing and midwifery workforce planning through the Chief Nursing Officer. We still have some concerns, and our organisations are certainly involved in that from a uni-professional perspective. That needs to dovetail with the overall regional workforce plan, which is where we are saying that we are not and have not been involved at the level that we absolutely need to be, but, as the paper identifies, there are still some concerns about the work in that group.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for the presentation and for coming today. One of the terms of reference of the review is to assess progress on workforce planning in support of the implementation of TYC at trust level, and the RCN briefing paper states that you are not aware of any workforce modelling at HSC/trust level. I know that you have discussed all that, but can you elaborate on the implications of that? Do you have anything further to add that has not already been said?

Mr Martin: If the trusts were sitting here, they may argue that they are doing that. We would argue that it is generally under the realms of service reorganisation, and, quite often, that is to do with trying to save money. That might sound like a very cynical view, but we deal with it on a day-to-day basis as services are being reviewed. It is about trying to take out posts to save money and, in some circumstances, to almost re-band or downgrade as a way of trying to save money. That is sometimes put under the realms of workforce planning. That is totally wrong.

Ms McCorley: Are you aware of the trusts making any investment? It seems from what you have said that the opposite is true. Are they making any investment in the training or retraining of staff to achieve the shift left in the skills mix that is needed to implement TYC? You said that they are looking for ways to save money but are probably doing the opposite.

Mr Martin: In fairness to the trusts, they are in very difficult times, and they have to live within their budgets. In relation to that, we see examples where trusts put bids to commissioners, where there may well be good and well-evidenced service reform that is evidence-based around patient care. Sometimes, commissioners are not commissioning on that basis, and we do hear from the trusts where they feel the difficulties with commissioning. From Sir Liam Donaldson's recent report, we know the difficulties and problems that we have with commissioning, and that is certainly something that we do not want to put solely on the responsibility of the trusts. The commissioners have a big, big part to play in relation to this work.

Ms McCorley: Do you feel that the trusts are investing in leadership and capability development in the nursing course?

Ms Devlin: I do a lot of training programmes for senior nurse leadership, and, last year, from our point of view, there were, as far as I know, 120 places on the leadership programme requested and commissioned by the trust, but there was no education budget at the Department to let them carry on.

Ms McCorley: It did not happen then.

Ms Devlin: It did not happen.

Ms McCorley: So, there is no investment in leadership, in reality.

Ms Devlin: Those ones were not commissioned.

Mr Martin: I think that it is fair to say that there are some but not nearly enough to provide for what is required.

Ms Devlin: I think that one of the things that we need to remember is that we are all fishing from a very small pool. We talked about the fact that 65 health visitor places were commissioned this year to meet need, but those are not 65 extra nurses. Those are 65 nurses who have come out of trusts, so everything new that happens, including new district nurses, are coming out of a trust somewhere. It is not that we are making more of them. One of the concerns that we have is that, while we can move on and improve skills and knowledge, it is from the same pool. The independent sector and we are all fishing from the same pool, and that is causing a difficulty.

Ms Hughes: I suppose that the same is true in midwifery, where, although midwives can and do work flexibly across hospital community boundaries, if you are going to move more services into the community, you have to create midwives out there to staff those services. There comes a level beyond which you cannot pull any more out of the acute service either because it needs them. There is a piece of work that we still need to do to look at what commissioning extra midwifery places might mean to get midwives in place to follow through the complete shift into the community for women with low-risk pregnancies. We would very much like to see that.

Ms McCorley: The briefing paper expressed disappointment about you not being included on the regional workforce planning group, which you talked about, and the fact that you have not been made aware of any proposals being developed by the group. How do you assess the Department's approach to involving professional bodies like the RCN and the RCM in the workforce planning that is needed to implement TYC?

Mr Martin: We need to be there, and I think that, recently, the Department and officials at the Department have not particularly been engaging in relation to the involvement of organisations like ours and other trade unions. Recently, we have had correspondence in relation to the partnership forum, as an example. The previous Minister had given a commitment that a review, regionally, will be carried out of the partnership forum. The terms of reference for the new partnership forum were agreed by Minister Poots, and, unfortunately, the permanent secretary has recently communicated to say that he does not believe that we need a partnership forum. His view is that the joint negotiating forum is the forum to discuss these issues. We disagree; we believe that the partnership forum is much greater than a negotiating forum. It is about policy, strategic direction and key stakeholders having conversations like some of the conversations that we are having here today. We are concerned that the current administration and climate is not one where we are being engaged to the level that we should be.

We will be constructive partners in this. Our record speaks for that. We will absolutely challenge, but we will be supportive of directions that are in the interests of patients and for the public in Northern Ireland. That is why we find it staggering that we are not involved to the degree that we believe we should be.

Ms Hughes: We have a huge body of knowledge because of our direct contact with nurses and midwives at the coalface that we could bring to any arena and present those views to the highest levels. At the moment, there is no way for those voices to be heard. We are not, as the Tory Government would have us believe, all in this together. We are not, at the moment, all in this together. Quite often, we do not know what we do not know, which is very worrying. Decisions are being made in isolation and there is no discussion. We were told, however, that we would receive consultation documents in the same way as anybody else, such as members of the public, and that we could respond to consultations and that would be sufficient.

Ms McCorley: It is hard to fathom the logic behind that.

The TYC document stated that a reduction of 3% of the workforce, or 1,620 staff, will be required for implementation. However, the Committee has heard from the Department that that is no longer a target. Has the Department communicated any new target to either of your organisations?

Mr Martin: No.

Ms McCorley: It was a surprise to us that that is no longer a target. It is hard to understand that. You have no knowledge of that, either.

The Chairperson (Ms Maeve McLaughlin): In terms of the regional workforce planning group, the indication to us was almost that the uni-professional reviews would help to shape workforce planning. I assume that you are saying something very different. Are the uni-professional reviews enough?

Ms Hughes: No. A uni-professional review is very helpful. We sit down with the Chief Nursing Officer, who is our professional lead in the Health Department, and discuss what the future looks like for nursing and midwifery, what type of nurses and midwives we need and how many of them we need. However, at some point in time, all the other health service professions need to sit around a table, because I could say, "We will need midwives out in the community doing ultrasound scanning for women, but we will need sonographers to help them with that, to train them or to send the people to for a second opinion. We also need to work with community pharmacists if we're going to send women in that direction". We need to know what workforce planning looks like right across the piece. For that to be seen as purely an HR function is not good enough. The professions are doing their best in the silos that we are forced into. We really need to be round a table at some high level saying, "If you're going to do that, what will the impact be on another group of staff?". We are not having those discussions, and there is no arena for having them.

Mr Martin: We need more than a document and words on a sheet of paper.

Mr McCarthy: Thanks for your presentation. Last week, I said that the three hours that I spent in this room were the worst three hours of my time in Stormont. There were presentations from the BMA and the Royal College of GPs, and they were saying exactly the same as you. I am about to spend another two hours being further depressed by what you have said. I accept that it is the truth as you see it on the ground. I hope that the people who can do something about that are listening to this conversation today. Unless and until something drastic is done to improve the situation, we are all going to suffer the consequences. Having said that, let me put on record my total and absolute admiration for the work of the nursing profession throughout Northern Ireland. It continues to do that work despite what you said about nurses being at breaking point. We understand that.

Do you reckon that the people at the top know what they are doing? We talked about Transforming Your Care last week, and I think that I used the term "dead in the water". There term "viable strategy" has also been used. It seems to me that you people are saying that it is not a viable strategy. It is dead in the water, and where do we go from here? We supported Transforming Your Care, as you said, at the time. Unfortunately, I do not know where the main author of Transforming Your Care has gone. He has left everybody fighting to move it forward. Certainly, from what you are saying, we are not moving it forward at all.

Ms Hughes: I think that this is one for Garrett. Maternity services are very small and discrete, and, as I said, work had started on transforming the maternity service before Transforming Your Care came into being, and that work continues by way of our own mini TYC — the Northern Ireland maternity strategy — which runs until 2018. So, we actually have a pathway that we are on and are following. We are doing it at the moment, absolutely within existing resources. That is not to say that there might not be resource implications further down the line but, in terms of mainstream Transforming Your Care for ill people, that is definitely Garrett's department.

Mr Martin: I think it is fair to say, and we all know, that this is very complex. These are very challenging times financially. We all have a responsibility. Organisations such as ours have a responsibility, and we are very clear about what that is. I think that, if this was easy, it would have been sorted long ago. What we are doing is highlighting the issues and concerns, and they are very serious.

Mr McCarthy: From what you have said, there does not seem to be anybody listening who can do something about it.

Mr Martin: We would like to see more honesty in the system. We would like to see people, at whatever level they are, admit where things are not going to be able to be done. We would like them to be honest with the public and organisations like ours. Absolutely, very difficult decisions have to be made that go to the heart of politics — let us face it — as well as everything else. That is the climate we are in. We owe it to the public of Northern Ireland to show that we all have a responsibility for leadership. We are not here today to engage in scaremongering or raise concerns. We know, absolutely, that there is fantastic work going on in the HSC, day in, day out. We would not want, in any way, to come here and say that everything is doom and gloom. We know that a lot of patients get fantastic care, but the downside, and what we are highlighting here today, is that there are real risks, issues and warning signs, and, if we do not all sit up and listen to them, things are going to get an awful lot worse. We all have to show some leadership.

Mr McCarthy: You mentioned that patients could be at risk because of the situation. That is a critical statement, because nobody wants to see patients put at risk at any time.

Garrett, in your briefing paper, it states that the nursing and midwifery training budgets have been cut by the Department over recent years. Are you aware whether the Department or the regional workforce planning group has any plans to change that in the near future? It seems to be not very optimistic.

Ms Devlin: The nursing education budget, pre- and post-reg, has been eroded over the last number of years. Last year, the education budget was not set.

The Chairperson (Ms Maeve McLaughlin): Apologies for the background noise. I think that somebody's phone is causing it. Can people check their phones? Sorry, Rita, go ahead.

Ms Devlin: The RCN is also a provider of nurse education, and we provide quite a bit of post-registration nurse education. Usually, it is commissioned by the Health Department, and, last year, none of our programmes were commissioned due to the fact that no nurse education budget had been set for pre-reg education. We do not know what the pre-reg nursing education budget is going to be this year yet, and we are in April.

Mr Martin: We are aware that between 20% and 30% of student nurses who qualify in Northern Ireland do not end up working in Northern Ireland. There is a school of thought that that needs to be addressed before we should increase the numbers. We do not believe that is so. We believe that the numbers need to be increased. We need to understand why such high rates of people qualify as nurses and then leave Northern Ireland. We have to absolutely understand the reason for that.

Ms Devlin: I would like to add to that. If you look at young people socially, in all walks of life, it seems to be the recognised norm that they go away for one, two or three years and then come back. That is particularly so among our young doctors and nurses. That might be something that, when we are doing workforce planning, we have to factor in. We may lose them for a couple of years, but we have to make it attractive for them to come back, with the added knowledge and skills that they have gained elsewhere. It is a fact of life that that is what our young people are doing now because the world is so small. Our nurses are very employable. Nurses from Northern Ireland are sought all over the world because of their training. They can get jobs anywhere. They are actively recruited in recruitment fairs in America, Australia and England, in particular, which would take every single nurse we trained, if it could.

Ms Dolan: Again, it is about incentives. Young nurses are leaving for incentives to set up somewhere else. They gain knowledge and experience and then come back again, certainly. However, for the like of me who never left, it can be very difficult when you are working on the ground, on the front line, and you are left with very inexperienced staff.

Mr McCarthy: Thanks very much for that. That was my next question. Is there anything that can be done to retain those highly qualified nurses?

Mr Martin: We certainly have to look at some of the recruitment processes within the trusts and how nurses are being recruited. In terms of the choice of clinical area, the career has been eroded. Ward

sisters used to be able to recruit staff to their own wards, but that too has been eroded. All those processes have been eroded. We also have to look at career pathways and the career options that nurses have when they are qualified and enter their career. So, there are a number of things that need to be done in relation to that, absolutely.

Ms Devlin: One of them is to ensure that, where you work, you have safe numbers of staff. In talking about their concerns, a lot of our nurses mention the risk that there is to their registration.

Mr McCarthy: We heard very recently of situations where nurses cannot leave their work. They stay on for an hour, or an extra hour and half, without pay, to show their dedication to the patient. That is absolutely fantastic, but it is unfair to the nurses who have to do it.

I have a couple of quick questions. Do the regional workforce planning group and the trust have any strategic plans to reduce the use of bank nurses and create more permanent posts?

Mr Martin: That would be part of the normative staffing arrangements, and that work is really just beginning. We have been given some assurance or have an expectation that the first phase of that would be complete or implemented by the end of the first quarter. We think that is optimistic, considering some of the recent communications and things that we are hearing from employers. Certainly, that would be part of it.

Ms Hughes: There is no any agency midwifery in Northern Ireland at all, but there is a heavy reliance on bank midwives. Generally, those midwives already work part-time for a trust and, if a colleague goes off sick, the trust asks all its part-timers to work additional hours to cover those missing shifts, or it asks its full-timers to work overtime. However, they are highly reliant upon the goodwill of their staff to cover any sort of absence, whether it is a planned absence, such as a maternity leave or a long-term sick leave, or an unplanned absence, such as when someone goes off sick, on bereavement leave or something like that. The trusts are highly reliant on the goodwill of their staff to cover.

Mr McCarthy: Finally, you all mentioned rural nursing and the difficulties involved. I think that you use the term "district nursing"; they are the same thing anyway. Is there anything that can be done to provide more of those? What about the use of incentives to recruit district nurses, that is, the nurses who go round the country and the rural areas?

Mr Martin: I think it is back to the point of acceptable levels of staffing, training, having enough places commissioned and supporting people to be released to do that training. Training is the key to that because, as you can see, there has been a reduction in that. Sometimes, the appropriate level of "banding", as we call it, is not given for the skills and qualifications that these nurses have.

Mr McCarthy: Thank you very much. Keep your head up. Do not let them get you down. We are all behind you; you know your job.

Mrs Cameron: Thank you for the presentation. One of the terms of reference for the review is to examine the extent to which workforce planning takes account of recruitment issues for particular geographical areas. Is that an issue for nursing or midwifery? If so, how do you think it can be addressed?

Mr Martin: I will use an example around children's or paediatric nursing, where you find that there are obviously a limited number of places on an annual basis. Because of regional recruitment, you find that Belfast tends to recruit most of those nurses who come out with their paediatric qualification. That can certainly leave some of the hospitals further out of Belfast, particularly in the west, with great difficulty in recruiting. I think the profession needs to be in charge — I think that is the right word to use — of recruitment processes within and for the profession. It should not be based solely on HR processes. We need to have solutions to those situations where we have difficulties recruiting, whether that is in rural areas or in specific specialities. We absolutely need that within any proper workforce planning, and the recruitment process needs to be tightened up to allow that to happen.

Ms Hughes: Midwifery is a popular career option. We do not have the same issues with newly qualified midwives going away. They might go away if there is not a job for them immediately available here in Northern Ireland, but, anecdotally, we know that, within a year, most of them are back in Northern Ireland and stay here. They stay in midwifery until the end of their career. So, we do not have quite the same problems as nursing. Neither do we have a problem recruiting midwives to

work in any particular geographical location. However, we do have a problem when very senior midwives retire. It can be very difficult to get people with enough skills, experience, training and leadership development, as Rita has pointed out, who are willing to step up and take that post. We have one very senior midwifery post in the South West Acute Hospital that has been vacant for two years. It has been advertised nationally three times. So, it is those posts. That post is absolutely needed to provide leadership and strategic direction to the midwives and the maternity service in that hospital. We cannot fill that post. We do not think it is the geographical location, per se; we think it is the fact that it is a post at that very senior level. So, every time I hear that a senior midwife somewhere is going to retire, I feel a bit sick. I think, "Oh Lord, I have to find another one now". That is the bigger challenge for us.

Mr Martin: On that point, we have had the gender statistics for the profession of midwifery, but, in nursing, it is 92% female. Primarily, you have a young, female workforce as well. So, issues relating to the mobility of staff are greatly reduced as well and need to be taken into account when recruiting staff.

Mrs Cameron: I have similar question. Another of the terms of reference is to examine the extent to which the workforce planning takes into account the viability of seven-day working. We know you do seven-day working, but is that an issue for either of you? If so, have you any suggestions as to how it could be addressed?

Ms Hughes: At the minute, it is a 365-days-a year, 24-hours-a-day service, so there certainly is seven-day working. It is incentivised, to some extent. If you work between 8.00 pm and 8.00 am, you will be paid an additional rate for working those unsocial hours, as you will for working on a Saturday or Sunday. I might be wrong on this, but if you are on call, you get about £12 a night. You go on call from 5.00 pm to 9.00 am. You cannot go out, have a drink or let anybody else have your car in case you are called. You get £12 for that.There is, at the moment, some incentive for people to work outwith normal working hours. There are some discussions across the water about doing away with that incentive. If that happened we would not have a health service. No nurse or midwife will provide a seven-day-a-week, 24-hour-a-day service if they are being paid the same rate for working during the day as they are paid for working at nights and weekends.

Mr Martin: From our point of view, it is exactly the same. Obviously there is a lot of empirical evidence around patient safety, and nobody would disagree that if you are admitted to hospital on a Saturday your level of care should be the same as if you are admitted on another day during the week. Nobody disagrees with the concept of having seven-day services. Nurses are used to that. We provide that, and have done so over the years. With any increase, there needs to be a commensurate increase in the workforce required to do that. That should be the same for nursing as it would be for any discipline.

Also, on the point about seniority, sometimes we hear that it is about putting senior doctors on at weekends. We also have an issue about senior nurses at weekends because of the banding issue with nurses. You find that trusts put on band 5s, the most junior nurses in our wards, to staff wards because it is cheaper. We need senior staff, properly remunerated, seven days a week. We also agree with it being rolled out for other professions, but not at the expense of nurses through trying to take away unsocial hours payments from nursing to pay for others to do it. We would find that totally and utterly unacceptable. However, as a principle we are absolutely signed up to it.

Mrs Cameron: Are the incentives for unsociable hours an additional payment, or is that built into the working —

Mr Martin: There is an additional rate for Saturday, Sunday, bank holidays and night work, but that is part of the Agenda for Change contractual terms and conditions.

Mrs Cameron: You are saying that there is an issue with the bands of the nurses that are there at the weekends, when there are also fewer doctors?

Mr Martin: Yes. Most of our wards and departments are staffed with band 5s. They are the most senior people on at weekends in most of our hospitals. We may have one or two band 7s covering a whole hospital.

Ms Hughes: Midwifery is slightly different. Most midwifes are on a band 6, which is a slightly higher band, and it reflects the fact that they are required to work anywhere and everywhere. If you are working in a maternity hospital in a ward with women who have already had their babies, and the labour ward gets busy, they just lift the phone and say "We need you in the labour ward." If you are working in the labour ward and the admissions unit gets busy, they will ring you and say "You need to come down here." They work very flexibly. In fact, if you are working in the community and the labour ward gets busy, you could get a call to come in from the community and work in the labour ward. There is, as I say, a cost to that level of flexibility, and it is about maintaining the goodwill of the staff and recognising the hours and the effort that they put in, especially out of hours, between eight at night and eight in the morning and Saturdays and Sundays.

Mrs Cameron: I suppose that is of vital importance with midwifery because no amount of planning will decide when the baby is going to arrive.

Ms Hughes: No; no amount at all. They come when they are ready, and that is it.

The Chairperson (Ms Maeve McLaughlin): On the point about banding, I note from your paper that the highest percentage of headcount is band 5 across all of the trusts. In the Western Trust, there are no band 6 nurses at all.

Mr Martin: Although there is a higher percentage of band 7s, which we welcome. Some of the trusts have banded district nurses as band 6 who effectively should be band 7s, in our view. There is a discrepancy or an inconsistency around that in the different organisations.

The Chairperson (Ms Maeve McLaughlin): I just picked up on that and wanted to raise it with you.

Mr McGimpsey: Thank you for the presentations. As Kieran has said, we had a couple of presentations last week that were fairly sobering and I have to say, as we look to the future, that your presentations have been equally sobering. Can I begin with the midwives? I know you will correct me if I am wrong, but my memory tells me that your standard used to be 26 babies per midwife. Is that right?

Ms Hughes: It is about 28; one midwife to every 28 babies.

Mr McGimpsey: And that allows you one-to-one in the labour ward.

Ms Hughes: It does.

Mr McGimpsey: Has that standard been maintained?

Ms Hughes: Yes, but it has been maintained at a cost. In order to ensure that every single woman in labour has a midwife with her, the women who have newly delivered are basically seen as the Cinderella service. If you have 20 women and 22 or 23 babies on a postnatal ward — bearing in mind that there are quite often twins in hospital — and you start the day with three midwives and a maternity support worker, you could end the day with one midwife and a maternity support worker, because your other two midwives have been called away to the labour ward to meet that standard of one-to-one care for every woman in labour. That is absolutely crucial, and that is the critical point where that care is needed, but that means that you have 22 mothers and their babies who are being cared for by one midwife and a maternity support worker, and that is not good. For example, we are trying to increase our breastfeeding rates, and women need support. Also, a lot of those women will have been delivered by a caesarean section, and they need the normal post-operative care that anybody needs. The pressure is just shifted somewhere else. Yes, we do still have one-to-one care for women in labour, and we are very proud of that here in Northern Ireland, but the pressure is just being shifted elsewhere.

Mr McGimpsey: You mentioned Downpatrick and Lagan Valley, and there was a concern that a stand-alone outside an obstetrician-led would not be as popular. Has the demand that we anticipated for Lagan Valley and Downpatrick been there, as opposed to Craigavon where you have the obstetrician-led on site?

Ms Hughes: The demand has plateaued in both Downpatrick and Lagan Valley. About 200 to 300 women a year go to Lagan Valley who otherwise would be forced to travel to Belfast. There are only 80 or 100 women a year who go to Downpatrick but, again, that is 80 or 100 women who then do not have to travel to Belfast. They are staffed in different ways. Lagan Valley has a midwife on site 24 hours a day, and during the night there is a midwife and one maternity support worker; that is it. Downpatrick does not have anybody on site at night. It has a midwife there until 8.00 pm and, if a woman rings to say that she is in labour, the midwife who is sitting at home on her £12-a-night rate will come in and meet the woman and deliver her in the unit. The costs of maintaining the service are minimal, because those midwives would be there anyway to provide the antenatal care during pregnancy and postnatal care to women who have already had their babies. If I said to you that 17 whole-time equivalents cover an area that goes from Kilkeel to Carryduff and from Ardglass to Castlewellan, and the 17 whole-time equivalent midwives provide antenatal care to every woman in that area — even if she is not going to deliver in that area, they see her during her pregnancy and when she comes home with her baby — and they deliver the women in both Downpatrick and Lagan Valley as well, you can see the extent of the flexibility of the service that they provide there.

Mr McGimpsey: OK. Thank you for that.

So the workforce is around 1,300. Is there a sense that that is roughly adequate, or do you need more? Also, how do you maintain that workforce when about 25% are liable to retire within the next five years and it takes three years to train through a dedicated degree course, or 18 months with RCN registration, to train? You also have to bear in mind that, when you take that course, you are depleting the nursing workforce. Clearly, you need to be in the planning; that is a given, both for RCN and for midwives. Do you have a sense of what your recruitment needs to be as opposed to where it is now? You work out what the problem is, and after that you work out how you address the problem.

Ms Hughes: At the moment, we think that, by and large, midwives are in the right place doing the right things, because that is important too. They should not be doing clerical jobs; they should not be portering; they should not be stocking up supplies. There are other people who are employed to do that, or should be employed to do that, to free up the midwife to do midwifery. We think that we have just about the right numbers at the minute, and we think that they are mostly doing the right things in the right places. The worry is about the future, and we watch it like a hawk. We meet the Chief Nursing Officer once a year as a nursing and midwifery group to look at education commissioning for the next year. In between times, we also meet the midwifery adviser at the Department of Health and we try to work with the heads of service out there. Every so often we ask them how many of their staff are planning to retire in the next year, so we try to keep ourselves a year ahead, but your point about the length of time that it takes to fill gaps is well made.

We had a situation some years ago in Craigavon where there was not a single unemployed midwife in all of Northern Ireland. They had a domino effect and lots of people retired, and they were left with a huge gap. They had to recruit midwives through an agency from Glasgow for a week at a time, fly them over, give them accommodation and a week's work at agency rates and then fly them back to Glasgow. At that time — I think perhaps you were the Minister at that time — extra money was given to Craigavon and we pushed 12 nurses — sorry, Garrett; we stole them from nursing — through the 18-month education programme to get them trained as quickly as we could, because, although Northern Ireland is an attractive place for people to come and do agency work, it is not all that attractive to people from elsewhere in the UK to come and settle permanently, certainly for midwifery. I am not too sure about nursing. The traffic all seems to be one way the other way.

We have developed the three-year midwifery training programme, which is the route into midwifery for most midwives because it is shorter than doing three years of nursing and then 18 months on top of it, but we also have the 18-month programme so that, if push comes to shove and we need midwives in a hurry, we can rob our nursing colleagues and get them through Queen's that bit quicker.

Mr McGimpsey: OK; thanks for that. As far as nursing is concerned, last week we heard GPs saying that the practice nurse workforce was severely stretched. As they keep getting more and more things to do they need more and more practice nurses, and they are not available. We got that message. We are also getting the message here about TYC and community nursing, and how difficult that is. In fact, TYC has basically stopped, not least because of that difficulty. The nursing workforce is, what, 16,000?

Mr Martin: Roughly, yes.

Mr McGimpsey: In the system. We have heard about nursing staffing levels in wards being at unsafe levels, and that is the main bulk of the workforce. So, effectively we are looking at unsafe levels in places. We cannot ignore that or put our heads in the sand about that, because patients will come to harm. We also have the problems with practice nurses and a problem in community nursing. You say that you are not in the workforce planning group, and it is a given that you should be in there. Do you have a sense of how many nurses we need to recruit, bearing in mind that we offer brilliant degrees for our nurses? I am aware of how attractive they are for the big hospitals in the south-east and other places overseas, and just how keen they are to recruit our nurses because they are so good.

Where do we need to be? If you work out how many nurses you need to recruit each year then it is a simple sum to work out where the money needs to be. My view is that we are in an emergency situation and we need an emergency plan with an emergency fund. It is trying to put all of that together. Where do you think we are? We have roughly 16,000 at the minute, but you have told us here about community, and we know about practice. Putting all of that in the mix, I know that you will have a rough idea.

Mr Martin: I honestly cannot put a figure on it. I am not sure if you can, Rita. I think it would be unfair to even take a guess, to be honest. It is about rolling out the programme for normative staffing and seeing where the deficits and gaps are, but it is also about the future planning. As we have pointed out and indicated in our paper, one of the areas that is neglected here is in the independent and care home sector, where older people are —

Mr McGimpsey: I was setting that to one side, because that is not directly —

Mr Martin: I do not think we can ignore that.

Mr McGimpsey: No, I understand that, but —

Mr Martin: If we do, then we are draining that sector. It is certainly something that needs to be done sooner rather than later. In relation to the community, and also mental health and learning disabilities — sometimes they are areas that are forgotten about — they are areas that require careful plans.

Mr McGimpsey: You say you need more students, and I agree with you, but roughly how many more? Do we have the capacity within the universities to train them? Where are those numbers? Where have they been over the last few years? Are they going down or up?

Mr Martin: They are going down; as we said, the number has been reduced by 9%. The issue of university capacity could be addressed if they were commissioned to take, for example, another 10%. I am sure that they could deal with that but, once again, that is a funding issue and a decision needs to be made by the commissioners and by the Department, which commissions this, to puts the funds to it.

Mr McGimpsey: Absolutely. The 10,000 beds in the independent sector is a stand-alone, but they are heavily dependent on income from the Department, is that right?

Mr Martin: Absolutely.

Mr McGimpsey: A tariff per patient.

Mr Martin: Yes.

Mr McGimpsey: They would say that that tariff per patient has hardly moved in a number of years, so they are finding it very difficult to pay the rates for nurses.

Ms Devlin: Also, patients in the independent sector are much more complex than they were when the tariff was set. A lot of those patients who are being nursed in the independent sector would previously have been nursed in acute medical wards. We did a lot of work with the independent sector home managers, who would say now that it is extremely difficult to give those patients the care that they require, with the complexities that they have and their complex nursing needs. They are not personal care needs; they are nursing needs. They are struggling, with the numbers of nurses that they have,

to give the quality of care that we would expect for older, vulnerable people and also the quality of care that RQIA is inspecting them against.

There are huge issues in that sector around being able to recruit and retain good, high-quality nurses. I spoke to an independent nursing home manager who told me that all seven of her registered nurses were from different countries; they had seven different first languages. You can imagine what that means for older people's cultural needs being met. That is a huge issue. You can imagine trying to develop a team and a vision for your service with seven people for whom English is not their first language and who are trained in totally different ways. That sector has become so reliant particularly on nurses from Europe, because they have the ability to walk in and out of jobs. That brings up huge issues for our older, more vulnerable people. If we do not look at workforce planning for nursing as a whole, our older people will be left to be looked after by people who do not understand their cultural needs.

Mr McGimpsey: Ten thousand beds is a huge population of frail elderly people with, as you say, complex needs. One of the things that community nurses are supposed to deliver is nutrition, and there was a nutrition policy. Where are we with that around ensuring that care in the community through our community nurses?

Ms Devlin: The nutrition strategy is actually a regional strategy across all the professions. It said that all patients, if they are connected in any way with the health service, should have a nutritional assessment. That includes older people who are attending GPs. It uses the malnutrition universal screening tool (MUST). That is not specifically the role of the district nurse; it applies to whatever profession the key worker for that person is.

Mr McGimpsey: Where is that policy?

Ms Devlin: It has been accepted and it is being rolled out. However, again, it is down to whether the resources are available to implement it if a patient is being looked after in their own home and they see a district nurse. In that case, they should do the MUST, but if they are being looked after, for example, by a domiciliary care worker, I cannot guarantee that it is done. The same applies if they are seeing their GP; I do not know whether the GPs have taken it on.

Mr McCarthy: The meals on wheels service has been greatly reduced over a number of years because of different things, which should not be the case.

Ms Devlin: We know that 42% of people who come into hospital come in malnourished, and we know that that has a huge impact on our older people. The nutrition policy was to prevent —

Mr McGimpsey: It is not just meals on wheels; it is diet supplements and so on —

Ms Devlin: It is an acknowledgement of the importance of nutrition for older people.The plan of that policy was to prevent malnutrition, because malnutrition leads people into hospital. I am not 100% sure where we are with the implementation of it, but I know it is across the piece regionally, and it is across all professions.

Mr McGimpsey: Thanks for that, and the best of luck. We will take very much on board what you have told us.

Mr G Robinson: I thank the team for the presentation. I have a question for Breedagh. One of the terms of reference for the review is to examine the extent to which workforce planning takes account of gender mix and the associated work patterns. The majority of the nursing and midwifery workforce is female. Are current approaches taking that into account in respect of part-time contracts or planning for maternity leaves?

Ms Hughes: This is a huge issue for us. There are about 1,300 midwives in Northern Ireland, only two of whom are men. In the region of 70% work part-time. From a trade union point of view, I can say that it is great. We have flexible working across the system, and women are able to achieve some sort of a work/life balance. However, having a service that is 70% part-time brings challenges for somebody who is trying to manage it. If you take the 65 midwives who are pregnant at any given time out of that 1,300 and add sickness absence rates, which vary across trusts from 4% to 8%, you will see that making the number of staff go round is a bit of a stretch.

As I said earlier, we are highly reliant on bank staff to fill the gaps. You will find that a lot of the midwives who work very part-time, less than half the week, will also be on the bank. That means that although they have chosen to work 18 and three quarter hours, for instance, to get a work/life balance, they could be working 35 hours, 36 hours or 37 hours in any given week. This causes stresses on women who have made a conscious decision to try to balance their work life and home life, bearing in mind that at one end of the spectrum they are having babies and at the other end, the over-55s are likely to have caring responsibilities. Making a conscious decision to reduce your working hours, which then gets negated by the need to be at work to cover for somebody else who is off sick, on maternity leave or has been bereaved or whatever or even to cope with an unexpected surge in demand, brings its challenges in managing a service.

I will give credit where credit is due: the HSC is one of those services in which it is possible to work quite flexibly. I am not sure about nursing, but, certainly, in midwifery, there is a high degree of ability to say, "I've been left widowed, or separated. It suits me to work night duty. Can you put me on night duty for six months?" By and large, the service will accommodate that. Or, people will say, "Can you put me on to work all weekends? Then my husband can take care of the children". We can do that as well. So, it makes it a very attractive employer from that point of view.

By and large, over the years, with a lot of cooperation from the trade unions, the health service has moved to this point where it is a very attractive employer for a woman who is trying to balance her work and life. It is also a way of recognising all the investment. We have just heard chat about how long it takes to train as a nurse or a midwife, how much money is invested in that and then developing those skills and experience. It would be a very stupid policy if you were to lose all of that just because you cannot be flexible and accommodate somebody's request to work specific hours.

Mr G Robinson: I have a small supplementary question to one of you in relation to the nurse subscribing situation. Do you think there is enough flexibility for —

Mr Martin: Do you mean nurse prescribing, which is nurses as prescribers? By flexibility do you mean —

Mr G Robinson: When they are training or at university, and so forth, they are maybe being asked to carry on their ordinary job as well.

Mr Martin: Yes, I was an independent nurse prescriber in my clinical practice. It is a recordable qualification within the NMC. It is a one-year part-time programme. It is probably the most demanding academic programme that I ever undertook, and the reward from it is that it allows practitioners to take on roles in relation to prescribing medication that previously would have been carried out by medical staff.

The more support that can be given to individuals undertaking that programme the better. I think that, sometimes, there is an issue about how those individuals are then allowed to practice when they go back into their workplace in that some employers may not have roles for them or may not remunerate them to the level that they should be remunerated to for having undergone such a difficult programme and been successful in getting the qualification. Sometimes, we believe that they are underused in the clinical area, but they must be properly remunerated and facilitated whilst doing the programme and when they have the qualification to be able to practice at that level. It benefits patients. It allows the service to be able to be developed in a way that can free up medical staff to do other things and to provide more timely access for patients to certain services.

Mr G Robinson: When they are doing it, do you think that there is enough flexibility from their bosses?

Mr Martin: I am not sure what you mean by flexibility. Nurse prescribers can come from lots of different areas. It could be somebody who works in an emergency department, or it could be a nurse specialist who works with patients with diabetes. There is a whole gamut of areas where nurses who are independent prescribers work. In terms of flexibility, I am honestly not sure —

Mr G Robinson: They are doing that training and trying to do their own work as well. Are the trusts allowing them enough flexibility?

Mr Martin: I have not heard of anybody coming to us to say that they are not being supported by the employer. I think that the difficulty is that, academically, it is a very difficult programme to do. The more support that can be given the better.

Mr McKinney: I have just one point. A lot of issues have been covered very comprehensively, and thank you very much for your contribution this afternoon. A buzz term in the health service is around the need for innovation. What do you understand innovation to be in that context? Are there other innovations, either through workforce practices or technology, that you would like to see that would assist in your work?

Ms Hughes: I suppose that from the midwifery perspective we can say that innovations are largely led by women, because women will come along and say what it is that they want. The challenge is thrown up to us to develop a service that meets those needs. This has certainly been our biggest driver over the last number of years.

From a trade union perspective, I suppose that innovations are about learning from good practice in other places. If you have a recruitment or retention problem, somebody else will surely have had the same problem. What did they do to tackle it, and can we replicate good practices from anywhere else? I think that this is where we miss the partnership forum so much. Previously, we could have sat down with a group of employers, departmental officials and the trade unions and bounced ideas off one another if we had a particular issue. We did one about tackling violence in the workplace, which was very successful, and we did it in partnership, learned from others and then put that into practice. That was definitely a brilliant innovation.

Ms Devlin: As nurses, we are always innovators because you learn to be a problem solver from the very beginning of your career. Where you see a problem, you identify a solution and you fix it. By their nature, nurses and midwives are innovators. It is very difficult to innovate if you do not teach people the skills of how to get the idea into a change-management programme and into practice. There are skills that can help you to do that. We are back to the whole idea that there are programmes that would help nurses, midwives, doctors or whoever to take a creative solution and bring it forward into practice. However, that again requires skill, education and somebody to get the time out to go and learn how to do it. Those are the bits that are missing.

There are lots of really good ideas out there, but nurses will say, "I do not know how to get my idea into practice". First, nobody asks them. What we would say is that, if you want to know what will work, you should ask the people who work on the front line because they can tell you. They have lots of ideas, but nobody ever asks them. What happens is that somebody else who does not know or understand the service implements a solution that does not work. Nurses and midwives will say, "I do not know why they did that because it is not going to work, and we could have told them that from the beginning".

One the one hand, we are asked to innovate, but nobody asks the questions. We could tell them very clearly. There are also skills that you require to be able to get your idea into practice. We are back to the idea of post-registration education not being commissioned to bring the innovations into practice. I would say that innovations are done to us and not with us. They are done to us, and they do not work.

Mr Martin: We tend to see the culture that we are working in as being very risk averse, and rightly so. Health care is never going to be risk free. There is always going to be an element of risk with it. Sometimes true innovation requires an element of risk-taking, albeit managed. It is all about a culture of leadership in which those innovators can flourish. The Royal College of Nursing is not found wanting in identifying those. Through our Nurse of the Year programme every year, we identify numerous nurses who are working way above the call of duty with innovative solutions.

The frustrating thing we find is that the pieces of work that innovators do are not replicated. Commissioners, or even employers, do not take them forward and roll them out further. We have numerous examples of where there is fantastic work being done in a particular area, but it does not seem to be replicated, for whatever reason. We are asking commissioners and employers to really take on board some of these innovations and start rolling them out as core business and not just being a case of "This is something innovative". A lot of them show real benefits in not just patient outcomes, which of course is what is ultimately important, but cost-effectiveness. They have real efficiencies associated with them and are the things that innovation is all about.

The Chairperson (Ms Maeve McLaughlin): I want clarity on two points before we conclude. One of the terms of reference for our piece of work is the proposed shift left of the £83 million from hospital services to community services and whether that had been modelled and planned for. In the College of Nursing briefing paper, you indicate that progress is very slow. You point out that numbers in community nursing had declined over the last number of years. You may have answered this question but I want to ask it directly: are you aware whether the regional planning working group is even looking at that as an issue?

Mr Martin: I believe that it is looking at that, but I am not aware of the detail.

The Chairperson (Ms Maeve McLaughlin): You referenced the normative staffing work and indicated that that needs to be an action going forward in the next phases. Nursing in community settings is phase 3, behind nursing in acute medical settings and nursing in emergency departments. Put bluntly, is that an example of the Department failing to prioritise community nursing?

Ms Devlin: I sit on the steering group and, to be fair to everybody, the reason it is in phase 3 is because we struggle to know how to do it. We struggle to know how to identify the numbers of district nurses that are needed. Every trust has a different model. Some are called community nurses, others are called acute hospital at home or complex needs case management. There is a different model in every trust, and it was very difficult for us. There is no model that we can look at either in England, Scotland or Wales and say that it is one that we could take forward. Within that work group we have had to almost try to design our own tools to find out how many we need. It is not that the will is not there. It is a difficult service to model against. It used to be a case of one district nurse per numbers of population, but that does not work.

Mr Martin: I will make one additional point. A lot of the information that medical and surgical staffing levels are based on is based on empirical research. There is a much bigger and wider empirical evidence base — publications in 'The Lancet', RN4CAST and European and worldwide research — that links the number of nurses and staffing to patient mortality and morbidity. That is what it is based on; it is empirical research. Unfortunately, there is a deficit in research in terms of community and district nursing services, so it is more difficult to have a framework that can do that. That is why it is probably a little bit down the line.

Mr McKinney: Does that not get right to the heart of this? It links back to Michael's question: if we do not know, how do we provide? If we do not know and do not provide then people are not going through the front door of primary care; they are going straight from home into A&E, malnourished or whatever. For me, this work has to be at the core of it. I am frustrated that, three and a half years after TYC, they are only thinking about maybe doing something about it now

Ms Devlin: To be fair, they have been looking at it. A lot of work is being done by the PHA and the chief nurse in the Department to gather up the information we need. I think that we are nearly there with a model to look at staffing levels in district nursing services, but, again, we have to think about the other models that hang on district nursing and what they look like as well.

Mr McKinney: Yes, and some of that work is only starting to be scoped out.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you all for your attendance, detail and honesty. Obviously, collectively as members, we share the urgency of addressing workforce planning adequately in relation to the delivery of the policy shift and have individually reflected concerns around the delay in processes to do that. We will certainly take on board the recommendations you have made around the normative staffing processes, the pre-registration issues and, indeed, participation in the regional workforce planning group and will reflect on all of that. We will make our own recommendations to the Department. Thank you for your attendance.