The Nursing and Midwifery Resource: Final Report of the Steering Group

Towards Workforce Planning

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Minister's Foreword

It gives me great pleasure to publish *Towards Workforce Planning* — the final report of the steering group examining the nursing and midwifery resource. The significance of this study should not be underestimated as it presents the first large-scale work on the subject in Ireland. For the first time a comprehensive approach to workforce planning for nursing and midwifery is identified. A set of recommendations with 118 attributable actions provides a framework not only for future planning but also for the continued supply of the nursing and midwifery resource. One of the pillars in ensuring the continued supply of registered nurses in the future is the introduction, this year, of the four-year undergraduate pre-registration nursing degree programme. The Government has made a significant investment in the development of the programme, infrastructure and increase in student places. I note that many of the recommendations for planning are made on an interim basis pending the establishment of systems for integrated planning set out in the Health Strategy. I would like to compliment the steering group for the initiative taken in generating debate on the best approach to integrated workforce planning.

The broad focus of the study is most impressive — the approach is not merely confined to the calculation of workforce numbers. I am particularly pleased to see the emphasis placed on retaining the very valuable experienced staff currently employed in the health system and to understanding the reasons why staff leave any particular organisation. The *National Study of Turnover in Nursing and Midwifery* undertaken by UCC as part of this study, documents for the first time the turnover rate in nursing and midwifery and provides the framework for continuing to monitor this important indicator.

Estimating future requirements, particularly for the nursing and midwifery resource, is not an exact science. There is an urgent need to develop a profile of the current labour force, to better understand its dynamics and behaviour, and to highlight those variables or indicators that will provide information for monitoring and policy decision making. A major achievement of the study was the establishment of the *National Nursing and Midwifery Human Resource Minimum Dataset*. This is a critical instrument to the successful implementation of workforce planning and should now be adopted and used by all organisations employing nurses and midwives. It is vitally important that the momentum established during this study in obtaining baseline data is built on year by year.

A top-down and bottom-up approach is proposed by the steering group with workforce planning for nursing and midwifery taking place at local, regional and national level on an ongoing basis. I am very pleased to accept the proposal of the steering group that the entire process be lead at national level by a Workforce Planning Function for Nursing and Midwifery within the Nursing Policy Division, pending the development of integrated workforce planning systems within the Department. I am also very conscious of the major contribution to be played by personnel from An Bord Altranais, the National Council for the Professional Development of Nursing and Midwifery, the Health Service Employers Agency, the Office for Health Management, the Higher Education Institutions, the eight regional Nursing and Midwifery Planning and Development Units, Human Resource Departments and nurse and midwife managers throughout the system.

In every aspect of the health system the contribution of nurses and midwives is fundamental. Action on this report will form a vital part in planning for the future of Ireland's nursing and midwifery workforce. I look forward to hearing about the progress of the Steering Group being established to guide the implementation of the recommendations contained in this report.

Finally, I wish to thank all who have contributed to the preparation of this report and to acknowledge the pivotal role played by the steering group and the nurse researchers.

Micheál Martin

Micheál Martin, T.D.
Minister for Health and Children

Acknowledgements

This report is the result of three-and-a-half years intensive study, the first of its kind in Ireland. I greatly appreciate the role played by my predecessor Ms Peta Taaffe in initiating the study. It was a pleasure to take over the chair of such a committed group.

As the title, *Towards Workforce Planning* indicates, this is just the beginning of an ongoing process. The focus is on setting up structures and processes to plan for future nursing and midwifery resource requirements.

In presenting this final report on *The Nursing and Midwifery Resource,* I must firstly pay tribute to the members of the steering group for their enthusiasm and personal contributions to the study, each of whom gave willingly of their time and expertise. I must also thank the nurse research officers Maureen Flynn and Elizabeth Farrell; they not only produced this comprehensive report but also played a major role in the Nursing Policy Division.

It would not have been possible to bring the study to completion without the excellent assistance of a very wide range of individuals and organisations. The success of the study was especially reliant on the members of the minimum dataset project teams at St. James's Hospital and the North Western Health Board. A substantial contribution was also made by: Pat Foley and David Yeo of the PPARS National Project team; along with Hugh Magee and Pat Lynch (Information Management Unit); and Killian McGrane and Des Williams (External Personnel) based in the Department of Health and Children. The expertise and guidance of Professor Jim Buchan, Queen Margaret College, Edinburgh was also very much appreciated.

Another central component of the study was the completion of the first *National Study of Turnover in Nursing and Midwifery* in Ireland, which is published as a separate accompanying document to this report. This significant study was led by Professor Geraldine McCarthy with a committed research team based at University College Cork. Most importantly, I wish to thank all the registered nurses, midwives and managers who participated in the turnover study.

Invaluable assistance was generously provided from a number of organisations and groups: An Bord Altranais, the Nursing and Midwifery Planning and Development Units, the Health Service Employers Agency, the National Implementation Committee for the Pre-Registration Nursing Degree Programme, the Dublin Academic Teaching Hospitals, the Office for Health Management and the National Council for the Professional Development of Nursing and Midwifery.

Finally a sincere thanks is offered to all the members of the Nursing Policy Division, who consistently provided support throughout the study.

Mary McCarthy

Ms. Mary McCarthy
Chief Nursing Officer
Chair of the Steering Group

Members of the Steering Group

Ms Peta Taaffe* *Chair*	Chief Nursing Officer, Nursing Policy Division, Department of Health and Children (retired October 2001)
Ms Mary McCarthy *Chair*	Chief Nursing Officer, Nursing Policy Division, Department of Health and Children (commenced October 2001)
Mr Bernard Carey*	Principal Officer, Nursing Policy Division, Department of Health and Children
Ms Marie Kennedy	Principal Officer, Nursing Policy Division, Department of Health and Children (from April 2002)
Ms Yvonne O'Shea*	Chief Education Officer, An Bord Altranais. Currently Chief Executive Officer, National Council for Professional Development of Nursing and Midwifery
Ms Kay O'Sullivan*	Director of Nursing, Cork University Hospital, Wilton, Cork
Ms Jacqui Crinion*	Development Specialist, Office for Health Management (nominee of Health Board CEOs)
Dr Ruth Barrington*	Chief Executive, Health Research Board (resigned December 2000)
Dr Cecily Begley*	Head of School of Nursing and Midwifery, Trinity College Dublin (resigned October 2000)
Mr Michael Shannon	Nurse Adviser (General Nursing), Department of Health and Children (joined April 1999). Currently Director of Nursing, Letterkenny General Hospital, Co. Donegal
Ms Siobhán O'Halloran	Nurse Adviser (Mental Handicap Nursing and Education), Department of Health and Children (joined April 1999). Currently Executive Director National Implementation Committee for Pre-registration Degree in Nursing
Ms Anna Lloyd	Nurse Adviser (Paediatric Nursing), Department of Health and Children (joined April 1999)
Mr Martin McDonald	Project Manager, Health Service Employers Agency (joined September 1999)
Ms Mary Brosnan	Midwifery Adviser, Department of Health and Children (joined February 2000). Currently Assistant Director of Midwifery, National Maternity Hospital, Holles Street
Ms Eilish Hardiman	Director of Nursing, St. James's Hospital, Dublin (nominee Dublin Academic Teaching Hospital's Group, joined January 2001)
Ms Mary Courtney	Director of Nursing and Midwifery Planning and Development Unit, Western Health Board (nominee of Health Board CEOs, joined January 2001)
Mr Jim Brown	Director of the Nursing and Midwifery Planning and Development Unit, North-Western Health Board (alternative representing Directors of Nursing and Midwifery Planning and Development Units)
Ms Mary Kelly	Director of Human Resource, Northern Area Health Board (nominee of Health Board CEOs, nominee of Health Board CEOs, joined January 2001)
Ms Anne-Marie Ryan	Chief Education Officer, An Bord Altranais (joined April 2001)

Researchers

Ms Maureen Flynn*	Nurse Research Officer, Nursing Policy Division
Ms Elizabeth Farrell	Nurse Research Officer, Nursing Policy Division (from March 2001).

* = The initial steering group, of eight members

An initial steering group, of eight members, chaired by the Chief Nursing Officer, was convened to oversee the project. Mr Michael Shannon, Ms Siobhán O'Halloran and Ms Anna Lloyd joined the steering group on 26 April 1999. Mr Martin McDonald, Health Service Employers Agency, was invited to join the steering group on 13 September 1999. Ms Mary Brosnan, Midwifery Advisor, joined the group on 7 February 2000. Dr Ruth Barrington and Dr Cecily Begley resigned from the steering group following publication of the interim report. In January 2001, Ms Eilish Hardiman was nominated by the Dublin Academic Teaching Hospitals Group. The Health Board CEOs group nominated Ms Mary Courtney and Ms Mary Kelly. Ms Anne-Marie Ryan joined the group in her role as Chief Education Officer with An Board Altranais in April 2001.

The Department appointed Ms Maureen Flynn, on contract, on secondment from St. Vincent's University Hospital, Elm Park as a Nurse Researcher for the *Study of the Nursing and Midwifery*. For approximately one year (January to the end of November 2001), she also worked part-time as a member of the Project Team preparing the Health Strategy *Quality and Fairness: A Health System for You*. Because of this an additional nurse researcher was recruited to ensure continuity of the *Study of the Nursing and Midwifery Resource*. Ms Elizabeth Farrell was appointed, in March 2001, on contract, on secondment from the Mater Misericordiae Hospital, Dublin.

Ms Peta Taaffe (Chief Nursing Officer 1998-2001) chair of the steering group retired in October 2001. Ms Mary McCarthy chaired the group following the retirement of Ms Taaffe. During the course of the study many of the members were appointed to new positions, but continued their membership of the steering group: Mr Michael Shannon now Director of Nursing, at Letterkenny General Hospital; Ms Siobhán O'Halloran now Executive Director of the National Implementation Committee; Ms Mary Brosnan now Assistant Director of Midwifery at the National Maternity Hospital, Holles Street; and Ms Yvonne O'Shea now the Chief Executive Officer of the National Council for the Professional Development of Nursing and Midwifery. Ms Marie Kennedy, Principal Officer, Nursing Policy Division, Department of Health and Children, joined the steering group in April 2002 replacing Mr Bernard Carey.

The steering group recognised that the nurse researchers were not in a position to provide expertise on all areas required for workforce planning. For this reason a resource group was established, in September 1999, to provide advice and support at various stages of the project.

Members of Resource Group

Professor Jim Buchan	Queen Margaret University College, Edinburgh, Scotland
Mr Pat Foley	Personnel, Payroll, Attendance and Related Systems (PPARS), National Project Office
Ms Elva Gannon	Head of Employer Advisory Service, Health Service Employers Agency
Mr Kilian McGrane	Personnel Management and Development, Department of Health and Children
Ms Deirdre Hogan	Deputy Chief Executive Officer, An Bord Altranais
Mr Patrick Lynch	Information Management Unit, Department of Health and Children
Mr Hugh Magee	Information Management Unit, Department of Health and Children
Mr William Murphy	Director of Human Resources, North-Western Health Board
Mr David Yeo	Personnel, Payroll, Attendance and Related Systems (PPARS), National Project Office.

In particular advice was sought on the Department of Health and Children's health services personnel census and the work of the Personnel, Payroll, Attendance and Related Systems (PPARS) National Project Team in implementing the SAP/HR system for the public health services. The staff of An Bord Altranais provided significant support in obtaining and updating statistical information from the Register of Nurses maintained by the Board. Advice was also sought on the minimum data required for forecasting, sources of information and legal issues related to employment and data transfer. Assistance was obtained in evaluating and designing in-house systems for information retrieval and reporting. The Personnel Officers and Directors of Human Resource provided guidance on human resource issues when required. An awareness of the approach adopted by other countries to forecasting health human resource requirements was obtained through linkages with Professor Jim Buchan, in addition to the Advisory Board Company, the International Council of Nurses, the Permanent Commission on Nursing (PCN) and the World Health Organisation.

Members of Minimum Dataset Pilot Projects

Members of St. James's Hospital Project Team

Ms Eilish Hardiman	Director of Nursing
Ms Dolores Browne	Project Leader
Ms Paula Phillips	Assistant Director of Nursing, Nursing Administration
Ms Annmarie Dooley	PPARS Project Implementation Manager

Members of St. James's Hospital Resource Group

Ms Ann McNeely	Personnel Officer (Acting)
Ms Fiona O'Grady	Clerical Officer
Ms Catherine Shanley	Personnel Department
Mr Gareth Long	Personnel Department
Ms Maeve Phelan	Recruitment, Nursing Administration
Ms Eileen Wilde	Recruitment, Nursing Administration
Mr Mark Towey	Recruitment
Ms Michelle Guerin	Personnel Department
Ms Kate Murphy	Database Administrator
Ms Susan Bradley	SAP Application Support Administrator
Ms Pamela Brennan	Training Officer
Ms Deirdre O'Reilly	Training Officer
Mr Pat Foley	Personnel, Payroll, Attendance and Related Systems, National Project Office
Mr David Yeo	Personnel, Payroll, Attendance and Related Systems, National Project Office

Members of North-Western Health Board Team

Mr Jim Brown	Director of the Nursing and Midwifery Planning and Development Unit
Ms Paula Kavanagh	Project Leader, Nursing and Midwifery Planning and Development Unit
Ms Mary Kilgannon	Staff Nurse, Nursing and Midwifery Planning and Development Unit
Ms Mary McGovern	Clerical Officer, Nursing and Midwifery Planning and Development Unit
Ms Pauline McGovern	Clerical Officer, Nursing and Midwifery Planning and Development Unit
Ms Bernie Cosgrove	Clerical Officer, Nursing and Midwifery Planning and Development Unit
Ms Anita Gallagher	Assistant Staff Officer, Nursing and Midwifery Planning and Development Unit

Members of the North-Western Health Board Resource Group

Ms Ann Glancy	PPARS Implementation Officer, Ballybofey, Co. Donegal
Ms Maria Chrystal	Personnel Administration Manager, Manorhamilton
Mr Martin McMenamin	PPARS Training Officer, Letterkenny General Hospital
Mr Emyard Burns	Personnel, Sligo/Leitrim Mental Health Services
Ms Emma Casserly	Personnel, Sligo/Leitrim Community Services
Ms Angela Maguire	PPARS, Letterkenny General Hospital
Ms Dorothy Robinson	PPARS, Letterkenny General Hospital
Ms Clodagh McGee	Personnel, Donegal Community Services
Ms Ramona Coen	Personnel, Sligo General Hospital
Ms Eithne Fox	Corporate Recruitment Manager, Manorhamilton
Ms Mary O'Doherty	Personnel, Manorhamilton
Ms Bea O'Friel	Personnel, Letterkenny General Hospital
Ms Geraldine McIntyre	Personnel Administrator, Letterkenny General Hospital
Ms Mary Tighe	Assistant Director of Mental Health Services, Markievitz House, Sligo
Ms Cathy Quinn	PPARS Administration, Manorhamilton
Ms Honor Stewart	Assistant Director of Nursing, Sligo General Hospital
Ms Maureen McGinley	Nursing Office, Letterkenny General Hospital
Ms Caroline McGuinness	Nursing Office, Sligo General Hospital
Mr Tony Liston	Corporate Learning and Development Manager, Ballyshannon
Ms Karen Crawford	Training Officer, Learning and Development Unit, Ballyshannon
Mr Pat Foley	Personnel, Payroll, Attendance and Related Systems, National Project Office
Mr David Yeo	Personnel, Payroll, Attendance and Related Systems, National Project Office.

Executive Summary

The past five years have seen a dramatic change in the composition and organisation of the nursing and midwifery workforce in Ireland. For many years we had a constant supply of newly qualified nurses and midwives, with strong competition for every available post. This situation has now changed. We have moved from a position in the mid-1990s where there was generally a surplus of available nurses and midwives to one where many employers are required to introduce targeted measures, including actively recruiting from abroad, to meet the staffing requirements of the service. In the past pre-registration nursing students formed an integral part of the workforce whereas now they are full-time third level students. A new undergraduate four year honours degree programme has been introduced as the pathway for entry to nursing in Ireland. A rigid approach to work organisation has given way to greater flexibility in employment patterns, availability of alternative employment choices and a recognition of increasing cultural diversity associated with global mobility.

Perhaps the biggest single impact on nursing and midwifery has been the implementation of the recommendations of the *Report of the Commission on Nursing* published in 1998. This report sets out some 200 recommendations relating to the development of nursing and midwifery, embracing regulation, practice, education, management, professional development and research; the goal being greater professionalisation of nursing and midwifery, expanded scope of the nursing role and enhanced service delivery. The *Commission on Nursing* also identified the need to strengthen the workforce planning function in the Department of Health and Children (Para 7.16). It is envisaged that these developments will underpin the continued attractiveness of nursing as a career choice in a tightening labour market where the number of school leavers is predicted to fall considerably.

In light of this changing environment it was recongised that there was a need to develop a more systematic approach to workforce planning for the future nursing and midwifery resource. The Department of Health and Children established a steering group to study the nursing and midwifery resource in Ireland in December 1998. The principal aims of the study were to analyse the current position with regard to the workforce, to advise on methodologies for the projection of future needs and to recommend how these needs may be met through future planning. An interim report was published in September 2000 which contained an overview of relevant literature, profiled the nursing and midwifery workforce and recommended actions on a number of pressing issues.

The final report *The Nursing and Midwifery Resource: Final Report of the Steering Group — Towards Workforce Planning* builds on the work of the interim report, concludes the research and presents the analysis undertaken during the study. Its significance stems from the fact that it represents the first large-scale piece of work on this subject in Ireland. For the first time a comprehensive approach to workforce planning for nursing and midwifery is identified. A set of recommendations with 118 attributable actions provides a framework for the future planning and supply of the nursing and midwifery resource.

Chapter 1 details the overall purpose and context of the project. It outlines the seven objectives agreed for the study. Progress on each of the objectives is presented in subsequent chapters. This major study spanned three and a half years, necessitating a project management approach in three phases:

- Phase 1: exploring the scope of the task, searching the literature and reviewing statistical information.
- Phase 2: creating a baseline of statistical information and profiling the nursing and midwifery population in Ireland.
- Phase 3: identifying the structures and processes required for forecasting.

Chapter 1 also outlines progress achieved in implementing the initial recommendations of the interim report. A number of issues influenced progress. These lay in three significant areas: deficits in essential information required for forecasting; absence of national policies on the appropriate number and ratio of nursing and midwifery staff required for service provision; and lack of mechanisms for estimating workload.

Chapter 2 provides an estimate of the number of nurses and midwives currently employed in the public and private health services and identifies the major trends affecting the employment of nurses and midwives since 1990. Detailed information was provided by An Bord Altranais with current and trend information from the Register of Nurses. Information was collected from a variety of sources and for the first time presents the most comprehensive picture available of the composition of the nursing and midwifery workforce in Ireland. Information was also collected on mobility of staff, trends in registration, numbers commencing pre- and post-registration education programmes and attrition from pre-registration nursing education. It also tracks recruitment from abroad. The detailed statistical data indicate that applications for nursing education have been maintained at a high level in recent years and, in particular, the most welcome attainment of an increase of 34 per cent in applicants for nursing to the Central Applications Office (CAO) in 2002. A process for monitoring attrition rates from training in the future is also presented.

The analysis undertaken for Chapter 2 demonstrates that while all available sources of information have been investigated, data have not been collected or collated for workforce planning purposes. The conclusion is that there is an urgent need for a reliable standard mechanism for collection and collation of information by employers and policy-makers at local, regional and national level in order to support effective workforce planning.

Chapter 3 describes the development of a national minimum dataset consisting of information relating to nursing and midwifery employment. The purpose of developing this dataset was to create a national standard to ensure the availability of the necessary data to support forecasting. Two pilot projects were undertaken between May and November 2001, at St. James's Hospital and the North-Western Health Board, to establish protocols and guidelines for the process of obtaining demographic, employment and qualification details for nurses and midwives. For the first time a definitive agreement on the composition of a minimum dataset on employment of nurses and midwives was reached. The Personnel, Payroll, Attendance and Related Systems (PPARS) provided the architecture for the projects. The national PPARS SAP HR system was set up during 1999 as a joint initiative of the Department of Health and Children and the Health Board CEOs. This system is a computer-based tool designed to facilitate delivery of a fully integrated human resource management function.

The two pilot projects demonstrated that it is possible to collect information necessary for the *National Nursing and Midwifery Human Resource Minimum Dataset*. They highlighted the vital importance of

standardisation in terminology. The significance of the pilot projects is the identification of requisite data items and the development of systems for the collection of standardised information for each nurse and midwife that can be aggregated for reporting purposes. This provides a powerful tool that can be used not only at central but also at local, organisational and regional level for workforce planning purposes. The possibility for enhancing information through an electronic exchange between employment databases and the Register of Nurses was highlighted in the pilot studies. It emerged that the potential for the use of the information is greatest at local level where nurse managers have immediate access to information to underpin local workforce requirements and professional development plans. An employment database alone cannot provide all the data necessary for comprehensive workforce planning. The importance of establishing supplementary mechanisms for collecting information on numbers of leavers and vacant posts was highlighted. The combined learning during the pilot projects is described in detail together with proposals for the future. This will provide a very valuable resource to others approaching similar developments for the first time.

Chapter 4 provides an estimate of the turnover rate among registered nurses and midwives employed in the health services for 1999, 2000 and 2001. A *National Study of Turnover in Nursing and Midwifery* was commissioned to inform the deliberations of the steering group. The study was undertaken by a research team led by Professor Geraldine McCarthy, Department of Nursing Studies, University College Cork. The complete report of the research study is published separately as an accompanying document to this report. The findings indicate that turnover in nursing and midwifery varies enormously throughout the health system. Across hospital bands and services the overall turnover rate has decreased from 17 per cent in 1999, to 15 per cent in 2000 and 14 per cent in 2001. While turnover rates have not generally reached levels experienced in other countries, it is a real issue requiring focused attention.

International experience indicates that clinical nurse managers have a vital role to play in creating the local conditions conducive to staff retention. The importance of individual nurses and midwives taking ownership and responsibility for their role in retaining colleagues in practice is paramount to the success of any retention strategy. This study clearly indicates the imperative for each organisation to develop a specific retention strategy for nurses and midwives.

Chapter 5 examines methods to foresee the likely changes in the health system that will influence the demand for nurses and midwives. Four broad areas are addressed: futures thinking, the use of scenario planning, the drivers for service demand, and recent developments which will affect the supply of nurses and midwives in the near and longer term. The Health Strategy *Quality and Fairness: A Health System for You* (2001), presents the blueprint for the development of the health and personal social services over the next 10 years. The strategy describes the composition and quantum of services that will be developed over the next decade. The action plan of the strategy gives a clear indication of the additional nursing and midwifery services required to give effect to the goals and objectives of the strategy. Anticipated changes in the environment of health care, demands for a workforce that can support the needs of a diverse population, and the impact of information technologies on clinical work create unprecedented challenges for nursing practice, management and education. This analysis highlights the importance of incorporating futures thinking in workforce planning methodologies.

Chapter 6 provides an overview of the literature pertinent to workforce planning methods as an introductory resource for nurse and midwife planners approaching the task for the first time. Much of the international literature advocates the creation of integrated workforce plans for the entire health service, rather than separate plans for each discipline. The importance of integrating the process of workforce planning with service planning is also emphasised. The Health Strategy (2001) clearly indicates that integrated workforce planning is the approach to be adopted for the Irish health services. It commits

the Department of Health and Children to leading the development of such a system aimed at anticipating the number and type of staff required to provide a quality health service. There is a strong recognition in the strategy that strategic, long-term integrated workforce planning must become a core activity of the human resource function of the health services. In this report consideration is given to the main assumptions on which future projections for the requirements of nurses and midwives should be based. It is recognised however that there are deficiencies in the following: information sources; workload assessment tools; staffing systems; workforce planning techniques; and expertise to currently engage in assessments of the numbers of nurses and midwives required in the future.

In Chapter 7 recommendations are presented to address the findings in relation to each of the seven objectives of the study. Actions designed to ensure an adequate supply of nurses and midwives to meet future workforce requirements are also presented. Responsibilities are specified for advancing the recommendations under the following broad headings: supply of nurses and midwives; retention; marketing and promoting nursing and midwifery; interim framework for preparing workforce plans; profiling the workforce; methodologies for workforce planning; information sharing; and implementation of the recommendations of the report. It also recommends the best possible approach, at this point in time, to workforce planning for nursing and midwifery and how this may be kept under review. Many of the recommendations are made on an interim basis pending the establishment of systems for integrated planning set out in the Health Strategy. A top-down and bottom-up approach is envisaged with workforce planning taking place at local, regional and national level.

Overall what emerged from the extensive analysis was the absolutely vital need for a formal and comprehensive approach to workforce planning at national, regional and local level. This must be supported by accessible dynamic information systems providing timely and accurate data. A systematic standardised approach is required. This will be facilitated by the use of templates to be developed by commissioning a workforce planning tool specific to the Irish health care environment. The amount of knowledge and expertise required for workforce planning should not be underestimated. Nursing and Midwifery Planning and Development Units working in collaboration with Human Resource Departments have a central role to play in achieving a successful approach to workforce planning.

A major achievement of the study was the establishment of the *National Nursing and Midwifery Human Resource Minimum Dataset*. This is a critical instrument for the successful implementation of workforce planning and should now be adopted and used by all organisations employing nurses and midwives. The minimum dataset alone will not provide the information requirements for forecasting. It is also essential to continue to collect information on turnover rates and vacant posts and to analyse underlying reasons for leaving employment. The key message is the necessity to actively engage in activities that will retain valuable nursing and midwifery staff.

The report identifies how we must harness the technology now available in tandem with implementing systems and processes to enable the workforce planning function to develop to its full potential. Workforce planning must be aligned with both strategic objectives at national level and the service planning process within organisations. It sets out a process for implementation, monitoring and evaluation. The proposals outlined in this study are only the beginning of an ongoing process which seeks to bring workforce planning centre stage. Integrated workforce planning is clearly the way forward. The enthusiastic response of employers is fundamental to success. The objectives set out will only be achieved with the commitment of the necessary resources and the wholehearted support of nurses and midwives throughout the service.

Glossary and Abbreviations

A&E	Accident and Emergency
A/DON	Assistant Director of Nursing
AAN	American Academy of Nursing
ABA	An Bord Altranais
ASCII	American Standard Code for Information Interchange
AMNCH	Adelaide and Meath Hospital Dublin incorporating the National Children's Hospital
AMP	Advanced Midwife Practitioner
ANCC	American Nurses Credentialing Center
ANP	Advanced Nurse Practitioner
ANS	Army Nursing Service
Ass. Dir	Assistant Director
BSc	Bachelor of Science
CAO	Central Applications Office
CCN	Critical Care Nursing
CDEC	Child Development Education Centres
CEO	Chief Executive Officer
Cert.	Certificate
CHAIR	Coronary Health Attack Ireland Register
CHSE	Clinical Health Sciences Education
CMS	Clinical Midwife Specialist
CNM 1	Clinical Nurse Manager 1
CNM 2	Clinical Nurse Manager 2
CNM 3	Clinical Nurse Manager 3
CNS	Clinical Nurse Specialist
CPN	Community Psychiatric Nurse
CPR	Cardiopulmonary Resuscitation
CSO	Central Statistics Office
CUH	Cork University Hospital
DATHs	Dublin Academic Teaching Hospitals The group includes The Adelaide and Meath Hospital Dublin incorporating the National Children's Hospital, Beaumont Hospital, James Connolly Memorial Hospital, Mater Misericordiae Hospital, St. James's Hospital, and St. Vincent's University Hospital, incorporating St. Michael's Hospital
DCU	Dublin City University
DFR	Defence Force Regulation
DHS	Department of Health Services (California)
DHSSPSNI	Department of Health, Social Services and Public Safety — Northern Ireland
DOHC	Department of Health and Children
DOMINO	**Dom**iciliary Care **In** and **O**ut of Hospital
DON	Director of Nursing
ENB	English National Board
ENT	Ear Nose and Throat
ERHA	Eastern Regional Health Authority
ESRI	Economic and Social Research Institute
EU	European Union
F/T	Full-time
FÁS	The Training and Employment Authority
FETAC	Further Education and Training Awards Council
Float	Where staff are diverted to from one area to another to meet service need
GMS	General Medical Services
GPs	General Practitioners
H.Ed.Dip	Higher Education Diploma
H.Dip	Higher Diploma

HB	Health Board
HCA	Health Care Assistant
HDNS	Higher Diploma in Nursing Studies
HEA	Higher Education Authority
HEIs	Higher Education Institutions
HHR	Health Human Resource
HHRM	Health Human Resource Management
HHRP	Health Human Resource Planning
HIPE	Hospital In-patient Enquiry System
HIV/AIDs	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPSS	Health Personal and Social Services
HR	Human Resource
HRB	Health Research Board
HRH	Human Resources for Health
HRHC	Human Resource Health Care
HSEA	Health Service Employers Agency
HWAC	Health Workforce Advisory Committee (UK)
I/V	Intravenous
IBEC	Irish Business and Employer Confederation
ICN	International Council of Nurses
ICT	Information Communication Technology
ICU	Intensive Care Unit
IDS	Intellectual Disability Services
IHHRP	Integrated Health Human Resource Planning
IMU	Information Management Unit — Department of Health and Children
INO	Irish Nurses Organisation
ISD	Information and Statistics Division (Scottish Health Department)
IT	Information Technology
KILM	Key Indicators of the Labour Market
LCR	Labour Court Recommendation
MBA	Masters in Business Administration
MHB	Midland Health Board
MMH	Mater Misericordiae Hospital
MS	Microsoft
MSc	Master of Science Degree
MSC	Ministerial Standing Committee (Australia)
MWHB	Mid-Western Health Board
N	Total sample
NAC	Nursing Applications Centre
NAMIC	National Strategy for Nursing and Midwifery in the Community
NAPS	National Anti-Poverty Strategy
NCC	Nursing Careers Centre
NCCRI	National Consultative Committee on Racism and Interculturalism
NCEA	National Council for Education Awards. The legal successor to this body is the Higher Education and Training Awards Council (HETAC) established on the 11 June 2001
NCHD	Non-Consultant Hospital Doctor
NDP	National Development Plan
NEHB	North-Eastern Health Board
NHS	National Health Service (UK)
NIC	National Implementation Committee for Pre-registration Nursing Education Degree Progamme
NIDD	National Intellectual Disability Database
NIHS	National Health Information Strategy
NMDSN	Nursing Minimum Dataset developed for the Netherlands
NMH	National Maternity Hospital
NMPDU	Nursing and Midwifery Planning and Development Unit
NMS	Nursing Management System
No.	Number
NPIRS	National Psychiatric In-patient Reporting System
NQNs	Newly qualified nurses
NSTNAM	National Study of Turnover in Nursing and Midwifery
NSW	New South Wales (Australia)
NUI	National University of Ireland

NWHB	North-Western Health Board
OECD	Organisation for Economic Cooperation and Development
OHM	Office for Health Management
Para	Paragraph
P/T	Part-time
PCN	Permanent Commission for Nursing
PD	Personnel Development
PDP	Personal Development Plan
PEG	Percutaneous Endoscopic Gastrostomy
Ph.D	Doctor of Philosophy
PHIS	Public Health Information System
PIN	Personal Identification Number
PPARS	Personnel, Payroll, Attendance, and Related System
PPF	Programme for Prosperity and Fairness
Profession	The Nursing and Midwifery Profession as defined by the Nurses Act, 1985
PRSI	Pay Related Social Insurance
QNHS	Quarterly National Household Survey
RCN	Royal College of Nurses
RCSI	Royal College of Surgeons in Ireland
Rec	Recommendation
Resource	Human resources, money, materials, skills, knowledge, techniques and time needed or available for the performance or support of action directed towards specified objectives
RGN	Registered General Nurse
RM	Registered Midwife
RMHN	Registered Mental Handicap Nurse
RN	Registered Nurse (USA)
RNT	Registered Nurse Tutor
RPHN	Registered Public Health Nurse
RPN	Registered Psychiatric Nurse
RSCN	Registered Sick Children's Nurse
SAP	Systems, Applications and Products for Data Processing
SEHB	South-Eastern Health Board
SEN	State Enrolled Nurses
SHA	Strategic Health Authorities
SHB	Southern Health Board
SI	Statutory Instrument
SIWPG	Scottish Integrated Workforce Planning Group
SNIP	Student Nurse Intake Assessment Project (Scotland)
SVUH	St. Vincent's University Hospital
TCD	Trinity College Dublin
TD	Teachta Dála
The National Council	National Council for the Professional Development of Nursing and Midwifery
UCC	University College Cork
UCD	University College Dublin
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
UKSO90	United Kingdom Standard Occupational Classification 1990
USA	United States of America
VFM	Value for Money
VH	Voluntary Hospitals
VHI	Voluntary Health Insurance
WHB	Western Health Board
WHO	World Health Organisation
WIT	Waterford Institute of Technology
WTE	Whole-Time Equivalent
'n'	Number in sample
£	Irish Pounds
€	Euro

CHAPTER 1

Context and Development

1.1 Introduction

The *Commission on Nursing* in its final report — *A Blue Print for the Future* (1998) — identified a need to strengthen the workforce planning functions in the Department of Health and Children (Para 7.16). The Nursing Policy Division of the Department acted on the recommendation by setting up a *Study of the Nursing and Midwifery Resource* in December 1998.

An initial steering group, of eight members, chaired by the Department's Chief Nursing Officer, was convened to oversee the project. The group first met on 15 December 1998. The membership was expanded in January 2001 and brings together expertise in policy, research, nursing education, nursing management, human resource management, nursing employment and regulation. Over the three and a half years of the study the steering group met on twenty-seven occasions.

A number of factors in the national environment influenced the approach to the study: the growth in the Irish economy and the health services; globalisation; nursing shortages; and, more particularly, developments in nursing practice and education. An interim report of the study was published in September 2000, entitled *The Nursing and Midwifery Resource, Interim Report of the Steering Group*, and it was circulated widely throughout the health system. A copy of the interim report and final report can be located on the Department of Health and Children's website (http://www.doh.ie/pdfdocs/nurmidre.pdf; http://www.doh.ie/publications/nmrfr.html). A Gantt chart setting out the detailed plan for the study following publication of the interim report is contained in Appendix 1.

1.2 Terms of reference

Detailed terms of reference were agreed for the study, on 2 July 1999. The original terms were set out in the interim report of the study. The primary objective was to forecast, as far as possible, future nursing and midwifery workforce needs. A number of obstacles prevented the original project objectives being realised. These lay in three significant areas: deficits in essential information required for forecasting; absence of national policies on the appropriate number and ratio of nursing and midwifery staff required for service provision; and lack of mechanisms for estimating workload. Within six months it became clear that the lack of a national employment database for nursing and midwifery or a regional structure for leading and co-ordinating forecasts was a major impediment to the study. The interim report of the study indicated that it would not be immediately possible to undertake reliable numeric forecasts. At the time there was no central information held on: age of nurses in employment; their employment type; vacancy; turnover; or early retirement rates.

The *Report of the Commission on Nursing* (1998) provided the impetus for unprecedented change in nursing and midwifery in Ireland. This study took place during a time of rapid transition when significant changes were introduced that considerably altered the context in which nurses and midwives practise. Each of the following has an impact on the approach that might be taken to forecasting: implementation of the recommendations of the *Commission on Nursing*; plans for the introduction of degree entry to

nursing; introduction of a clinical career pathway; substantial changes and development in management roles; changes to skill mix; greater professionalisation of nursing and midwifery; and the development of the new national health strategy. Following publication of the interim report the project focused on ensuring the availability of some of the requisite information for predicting future requirements and sourcing information on workforce planning methods.

To reflect the change in focus for the study, substantial amendments were made to the terms of reference on 25 April 2001. The steering group decided, on the basis of detailed analysis, that it would not be feasible at that time to devise a sufficiently accurate system for the projection of future needs. It was agreed that the focus should be on providing advice on methodologies that might be used including recommendations on how these needs may be met through future planning. In the absence of essential information required to undertake numeric forecasts, it was not considered wise to attempt to identify the workforce requirements for nursing and midwifery in the immediate future or over a ten-year period. Therefore, action on this objective was deferred. The final aim and objectives for the study are set out in Table 1.2-1.

Table 1.2-1 – Terms of reference for the study of the nursing and midwifery resource

Aim of the Project

- To analyse the current position with regard to the nursing and midwifery workforce
- To advise on methodologies for the projection of future needs
- To recommend how these needs may be met through future planning

Objectives

- To estimate the number of nurses and midwives currently employed in the public and private health services
- To identify the major trends affecting the employment of nurses and midwives since 1990
- To ensure the availability of the requisite information for forecasting, including any other demographic details, data on leavers and vacant posts and post-registration education opportunities available nationally
- To estimate the turnover rate among registered nurses and midwives employed in the health services and the underlying reasons
- To identify and recommend the best possible approach to human resource planning for nursing and midwifery
- To identify the main assumptions on which future projections for the requirements of nurses and midwives should be based
- To recommend the measures necessary to meet the workforce requirements in nursing and midwifery and how they may be kept under review

The steering group agreed that a detailed analysis of skill-mix issues or workload dependency assessment was beyond the scope of the current project. However, it is anticipated that these matters will receive in-depth consideration within each health board region when projections are being made for future requirements in the longer term.

1.3 Interim report

The main conclusion of the interim report was that there is insufficient information on the composition and geographic spread of the current nursing and midwifery workforce in order to prepare numeric forecasts of future nursing and midwifery needs. However, in the absence of numeric forecasts there are many pragmatic actions that can be taken to assist in ensuring that there are adequate numbers of nurses and midwives with the appropriate qualifications available in the future. The focus has been on bridging the information gaps identified in the earlier part of the study, in addition to implementing the recommendations made in the interim report. A series of presentations at conferences and meetings with key stakeholders were held to disseminate the findings of the interim report.

1.3.1 Progress on the recommendations of the interim report

The steering group took the unusual step of including recommendations in an interim report. This approach was adopted, as many of the issues identified were considered too important to delay until the publication of a final report. This section gives a progress report on the recommendations set out in the interim report.

Nursing and Midwifery Planning and Development Units

Health boards have prioritised the establishment of the Nursing and Midwifery Planning and Development Units (NMPDUs), all of which were in place by March 2002 (Rec 4.1.1). This is an immensely important development which addresses a key obstacle to progress in the preparation of nursing and midwifery human resource plans, i.e. the lack of a regional structure for leading and co-ordinating forecasts. The Nursing and Midwifery Planning and Development Units will have an essential role in driving the assessment and preparation of human resource plans within each organisation and co-ordinating plans for their entire region.

Close liaison has been maintained between this study and the Directors of the new units. Progress is being made on the appointment of nurse managers to take lead responsibility for this role, within each unit. The Directors have signalled that preparation of regional forecasts in respect of each division of the register, within each health board region, will require input of data managers. Particular attention has focused on the resources each will require for setting up systems for forecasting. Establishing systems for forecasting will involve staffing, training, access to information, software systems, reporting tools and expertise on analysis. The Directors of the Nursing and Midwifery Planning and Development Units advised that it will not be possible to prepare reliable forecasts until there is a national framework for assessing nurse/midwife staffing and skill mix.

It was recommended that each Nursing and Midwifery Planning and Development Unit should develop a systematic mechanism for establishing the numbers (persons) and whole-time equivalent (WTE) of nurses/midwives employed in the independent sector for their region. Work on this issue is in its infancy in all boards. The issue was considered by the NWHB as part of the nursing and midwifery minimum dataset pilot project (see Chapter 3) and also by each unit during the continued data collection on turnover in a sample of organisations for their region (see Chapter 4). Challenges and issues for consideration were identified. Not all organisations are in a position to, or sometimes willing to, return data. The grade titles/codes and contract types used for the public health service do not always apply. Not all organisations in the independent sector are familiar with the concept and calculation of a WTE number.

Personnel, Payroll, Attendance and Related System (PPARS)

The interim report recommended that the PPARS system should be exploited to obtain ongoing, detailed, accurate information on employment of nurses and midwives in the public health service (Rec 4.1.2). The roll-out of PPARS is at various stages of development in the MHB, MWHB, NEHB, NWHB, WHB, SHB, Area Health Boards within the Eastern Region Health Authority and St. James's Hospital, Dublin. The SEHB and the large teaching hospitals in the ERHA area are not currently participating in the project. The interim report also indicated that appropriate supports in the form of personnel, expertise, infrastructure and finances should be provided to ensure the expansion of the system throughout the public health system. Two pilot projects were established at St. James's Hospital and the Nursing and Midwifery Planning and Development Unit, NWHB (see Chapter 3 for a detailed description of the projects). The Department of Health and Children provided dedicated funding to fast-track the collation of demographic, employment and qualifications data for all nurses and midwives employed in the pilot sites.

The interim report indicated that the role and relationship (in relation to workforce planning) between the PPARS employment database and the professional Register of Nurses maintained by An Bord Altranais, be considered and clarified. The importance of an interchange between the two systems was identified in the minimum dataset pilot projects undertaken by St. James's Hospital and the NWHB. A significant number of respondents (62 per cent St. James's Hospital and 63 per cent NWHB) failed to provide complete information on their An Bord Altranais registration details, e.g. their registration number (Personal Identification Number (PIN); division/s of the Register of Nurses; or copy of certificate to verify registration). Issues identified were brought to the attention of the executive of An Bord Altranais. An Bord proposes that from 2003, the registration notice issued yearly will include information on the relevant division of the Register of Nurses (RGN, RMHN, RM, RNT, RPHN, RPN, RSCN) as well as name, PIN number, and date of issue. Text is to be included in a prominent place on the registration notice to indicate that it should not be discarded as it contains valuable information. In the future the Board will investigate the feasibility of including such information on the registration card. This would make it easier to confirm details of registration, as the card is portable.

Employers are responsible for ensuring that staff employed as registered nurses and midwives are entitled to practise as such by confirming on an annual basis that they are actively registered with An Bord Altranais. The function is normally executed through the Director of Nursing or Midwifery who ensures that systems are in place for verifying registration. The current systems are manual and involve the nurse presenting a paper copy of her/his certificate of registration and confirmation of same being noted in personnel files by nurse managers or personnel staff. The process can take considerable time to complete. A series of meetings between technical staff of An Bord Altranais and the PPARS project team have taken place to explore the feasibility of electronic transfer of information between the two organisations. Options for data matching, exchange components and file formats have been prepared. The importance of including the exact name registered with An Bord Altranais on the employment database was identified during the investigation. An Bord Altranais clearly stipulates that nurses/midwives may only practise under the name in which they are registered; for this reason the exact name should be on the employment database.

To fulfil the requirements of the Data Protection Act, 1988, consent is required from each individual nurse, or a person acting on his or her behalf, to the electronic transfer of information between the employer and An Bord Altranais. For new employees it could be possible to obtain consent when the contract of employment is being agreed. An alternative process would need to be arranged for existing staff.

Approach to forecasting

The interim report recommended that a regional approach to forecasting within a national framework be adopted (Rec 4.1.3). It suggested that this should be undertaken on an ongoing basis, using templates that can be tailored to reflect the local context and environment. The focus should be on the need for health care services. The interim report also indicated that technical support and statistical expertise at local and national level would be required to design models for forecasting. For the reasons outlined earlier in this Chapter it was not possible to make progress on this recommendation.

The proposals for strengthening human resources set out in the Health Strategy *Quality and Fairness: A Health System for You* (2001) clearly indicate the approach to be adopted to forecasting workforce requirements. The strategy states that 'the Department will lead the development of an integrated system of workforce planning aimed at anticipating the number and type of staff required to provide a quality health service' (p 116). The intention is to align workforce planning with strategic objectives and the service planning process and by so doing, to promote the use of skill mix and involve integration with

education, training and professional bodies. The strategy also indicates that in adopting an integrated approach to workforce planning the Department will build on existing initiatives and available data regarding workforce needs. This current study indicates that there are significant deficits in the available data on nursing and midwifery.

The Health Strategy also places emphasis on a Health Services Skills Group, which has been set up under the Programme for Prosperity and Fairness (PPF). Framework I and II of PPF have relevance for workforce planning. The group involves the social partners, relevant Government Departments, agencies and third level institutions, with a representative steering group. One of the roles of the group will be to develop estimating techniques that will assist in anticipating future skills needs of the health service and their associated resource requirements.

This report, the Health Strategy and the work of the Health Services Skills Group will determine progress on predicting the future requirements for nurses and midwives. Assessments of the requirements for one discipline should not be made in isolation from all others providing care and services to users of the health system. A summary of the methodologies and principles used internationally for workforce planning is set out in Chapter 6 of this report.

Nurse education and training

During negotiations between the Department of Health and Children and nursing unions in October 1999, an agreement was reached on an increase in the number of pre-registration training places to 1,500 for the following three years. The decision to increase the number of pre-registration training places over the three years was welcomed by the steering group. The interim report recommended that the annual intake of nursing students should continue at the 2000 level (1,500 places) until at least 2003 (Rec 4.1.4). This figure was exceeded in 2001 when the intake for nursing students to the three-year pre-registration diploma-nursing programme was 1,648. This increase is a key strategy in addressing the nursing shortage and concerns that surround the availability of newly qualified nurses in 2005 following the introduction of the four-year degree programme for nurses in 2002.

A four-year undergraduate pre-registration nursing degree programme will be implemented on a national basis at the start of the academic year 2002/3. The nursing degree programme is to commence in September 2002 with dedicated funding for 1,640 places annually (1,057 general nursing, 343 psychiatric nursing and 240 mental handicap nursing). If all available places are filled and there is no attrition from programmes the number of newly qualified nurses available to join the workforce over the next 10 years (2001-2011) will be 15,171.

As recommended by the *Commission on Nursing*, applications for pre-registration nursing education programmes are now made through the Central Applications Office (CAO). The move to the CAO in 2001 has put nursing on an equivalent level with other third level career options available to school leavers. In keeping with the recommendation in the interim report, the Nursing Careers Centre, in consultation with the Department of Health and Children, closely monitored the effect of transferring the application system for nursing students to the CAO in 2001. Initial indications are that as of 1 February 2002, 8,822 applications for the direct entry degree programmes were received by the CAO (an increase of 34 per cent) of which 1,846 (21 per cent) were mature applicants. The high level of applications reflects the popularity of nursing as a career and the success of marketing campaigns.

As recommended by the interim report between 2000 and 2001 funds in excess of €1.27m (£1m) were made available to the Nursing Careers Centre and schools of nursing to fund local and national campaigns

to promote nursing as a career. It was also recommended that the Nursing Careers Centre should take steps to improve the profile of nursing as a career amongst males. Statistics in Chapter 2 of this report indicate that there was a small increase in the number of males commencing nurse education between 1999 and 2000. The number of male students increased as follows: general nursing increased from 45 males in 1999 to 55 in 2000; psychiatric nursing increased from 66 males in 1999 to 74 in 2000; and mental handicap increased from 12 males in 1999 to 19 in 2000. In 2000 psychiatric nursing attracted the highest number of male students (24 per cent), general nursing (10 per cent) and mental handicap nursing (5 per cent). These statistics illustrate the scope for attracting males to the profession.

Such promotional campaigns will need to be continued and developed in order to attract sufficient numbers of school leavers into nurse training/education. This is particularly important in an environment where a declining school-leaving population has greater access to an increased range of higher education programmes and better employment opportunities than any previous generation.

With support from the Department of Health and Children, the Federation for Voluntary Bodies providing services to persons with an intellectual disability has prepared a video to promote mental handicap nursing as a career. This year (2002) two videos have been commissioned by the Nursing and Midwifery Planning and Development Unit of the Eastern Regional Health Authority to promote midwifery and paediatrics as career options.

Professional development

The recommended expansion of higher/postgraduate diploma programmes in specialised areas of clinical practice, particularly outside Dublin, has continued (Rec. 4.1.5). Funding has been provided to support the development of higher/postgraduate diploma courses, in partnership between health service providers and third level institutions. Courses include: intensive care unit, coronary care unit, accident and emergency nursing, and theatre nursing in the SEHB; peri-operative nursing in the MWHB; critical care, theatre and gerontology nursing in the SHB; gerontology and oncology nursing in the WHB; cognitive behaviour psychotherapy in the NWHB and intensive care and paediatric accident and emergency nursing in the ERHA. A total listing of programmes and places available is located at Appendix 2.

The Department of Health and Children has provided significant financial support for nurses/midwives undertaking specialist programmes. The Specialist Nursing Courses Circular (150/2000) issued on 9 December 2000 outlined the initiative. Nurses or midwives undertaking certain post-registration programmes in specialised areas of clinical practice[1] receive full pay while doing so, and are entitled to have fees paid in full, in return for a commitment to continue to work within the public health service in the specialist area for one year following completion of the programme. In May 2001 this initiative was extended to include all higher/postgraduate diploma and certificate programmes in specialised areas of clinical practice (Circular 47/2001).

The recommended increase in the number of places on the higher/postgraduate diploma in public health nursing programmes has been achieved. In 2001 there were 95 places available. This represents an increase of 30 places (32 per cent) above the number available in 2000 (65 places). As recommended the revised sponsorship arrangements (to encourage uptake of places) for student public health nurses announced in July 2000 has continued (Circular 84/2000). Under this initiative all student public health

[1]accident and emergency; critical care including intensive care, coronary care, cardiac and burns; and peri-operative including peri-anaesthesia, operating theatre and operating department courses.

nurses are sponsored by a health board, have their fees paid, and are paid a salary at the minimum of the staff nurse scale while studying and 80 per cent of the minimum point of public health nurse scale for the duration of the clinical placement period. In return student public health nurses (PHNs) must undertake to remain in employment as public health nurses with the sponsoring health board for a minimum period of two years.

The interim report also recommended the continuation of the student midwives and student paediatric nurses initiative launched in August 2000 (Circular 95/2000) and December 2000 (Circular 149/2000) respectively. The initiative was aimed at addressing the shortage of midwives and paediatric nurses and the fall in applications for midwifery and sick children's education. Academic fees are paid for all students studying for the post-registration higher/postgraduate diploma in midwifery and sick children's nursing. These students are paid on the minimum point of the staff nurse scale while training. This is in return for a commitment on the part of the students to work for at least two years following qualification as midwives or sick children's nurses within the public health service.

An important initiative was launched in August 2000 to retain experienced staff and ensure that equal opportunity is afforded to practising nurses and midwives in obtaining additional academic qualifications. At the launch of the pre-registration nursing degree programme, in November 2001, a commitment was given to continue the free fees initiative to support registered nurses and midwives in undertaking certain undergraduate part-time degree programmes until 2005, at a total cost of at least €19 million (£15 million). Under this initiative a nurse or midwife undertaking such a programme is entitled to have his or her fees paid in full by the employing agency. This is subject to the nurse/midwife giving a written undertaking that he or she will continue working in the public health service for a period of up to two years following completion of the degree programme (Circular 98/2000).

In additional to the specific initiatives outlined above, significant earmarked funding has been provided to health service providers for continuing nurse/midwife education. This is to support the provision of local accessible continuing nurse education and the establishment of programmes in response to service needs.

Return-to-practice courses

As recommended in the interim report a support package was put in place by the Department of Health and Children so that nurses and midwives undertaking return-to-practice courses are no longer required to pay fees and receive a salary while undertaking such courses (Rec. 4.1.6). This is in return for a commitment to practise in the public health services following completion of the programme (Circular 151/2000). Concern has been expressed at the variation in interpretation of the circular across organisations. Some agencies have invested considerable time in verifying previous experience so that the nurses can be placed on the appropriate point on the scale during the return-to-practice course. Other organisations wait and make that payment when the nurse has signed a contract of employment following successful completion of the course. The Nursing Policy Division is considering this issue. The interim report also recommended that the Nursing and Midwifery Planning and Development Units develop local systems for monitoring the uptake of places and subsequent career path of participants on return-to-practice courses. The Directors have acknowledged that this role is crucial and reported that the units are progressing in their work on the issue.

The report recommended that the return-to-practice courses in general, psychiatric and sick children's nursing be expanded and flexible models of delivery be introduced. The interim report also recommended that a specific return-to-mental-handicap-nursing programme for the Intellectual Disabilities services should be developed. In June 2001 €64,000 (£50,000) was provided in respect of a

'back to work' scheme for registered mental handicap nurses to be developed by the National Federation of Voluntary Bodies providing services to people with mental handicap. The Federation advertised the new 'refresher' course in the national newspapers on 3 and 10 February 2002. The return-to-mental-handicap-nursing course is of five weeks duration and is run by the Sisters of Charity, Jesus and Mary, Moore Abbey, Monasterevin, Co. Kildare and the Cope Foundation, Cork. Candidates may attend the course at the location of their choice.

Recruitment of nurses and midwives from abroad

The Nursing and Midwifery Planning and Development Units, in consultation with human resource departments and local directors of nursing, have a role to play in accessing the requirements for the recruitment of nurses and midwives from abroad for a particular region. They also have a role to play in monitoring effectiveness, following best practice guidelines.

Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives

The steering group for this study recognised the need for guidance on best practice with regard to the recruitment of nurses and midwives from abroad (including EU and non-EU countries). A small working group, chaired by the Chief Nursing Officer, the Department of Health and Children, was established to develop a guidance document specifically as a resource for employers. The document *Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives* was published in December 2001 and is available on the Department's website http://www.doh.ie/publications/bpronm.html. The guidelines are intended to assist health service employers in ensuring that best human resource practice is followed at all stages in the recruitment process. Particular emphasis is placed on the need for appropriate induction, orientation and adaptation programmes for nurses and midwives coming to Ireland from abroad. The guidelines set out five principles: quality, ethical recruitment, equity, inclusiveness and the promotion of nursing and midwifery. The document indicates that the preparation and support of nurses and midwives in adapting to working as members of a culturally diverse team is crucial to the success of international recruitment.

Co-ordinated approach to the recruitment of nurses from aboard

The interim report recommended that the ERHA take steps to ensure a more co-ordinated approach to the recruitment of nurses from abroad, including participation at recruitment fairs (Rec 4.1.7). The Nursing and Midwifery Planning and Development Unit in the ERHA is currently exploring a Government-to-Government recruitment initiative to recruit foreign nurses under a fixed-term contract. A pilot project is being established, a project manager has been appointed, a pilot site identified and a projected time frame of one year agreed.

The Dublin Academic Teaching Hospitals (DATHs) group has established a co-ordinated approach and pooling of resources for recruitment of nurses nationally and internationally within the member hospitals. The group decided that international recruitment is necessary to meet the needs of the service. One recruitment company was awarded the contract, effective from 1 November 2001. An operational policy has been agreed between the DATHs for the day-to-day management of the contract, for example accommodation, airfares etc. A review is to be carried out at the end of six months. A joint approach has been adopted by the DATHs in relation to employment advertisements and the attendance of representatives at job-fairs.

In mid-2001 the Spanish Ambassador to Ireland contacted the Minister for Health and Children *vis-à-vis* the possible establishment of a Government-to-Government initiative on the recruitment of Spanish nurses to work in the Irish health services. Subsequent to this contact two representatives of the Nursing Policy Division of the Department, along with representatives of FÁS, met with the Chief Nursing

Officer of Spain and officials of the Ministry for Employment in Madrid in February, 2002. The meeting was very successful and moves to establish the initiative are ongoing.

Application for registration of foreign nursing qualifications

An Bord Altranais has acted on the recommendation to further streamline the process of application for registration of foreign nursing qualifications (Rec. 4.1.7). An indication of the interest in working as a nurse or midwife in Ireland is evident from the large numbers of nurses (4,519) from overseas who applied for professional registration in 2001 (An Bord Altranais, provisional figures at end November 2001). The number of applications each year has increased dramatically over recent years (see Chapter 2 for further details). The Board has committed supplementary resources and personnel to assessing applications for registration.

The National Co-ordinator for Clinical Placements

The recommended funding was allocated for the appointment of a nurse manager to co-ordinate the provision of supervised clinical placements for nurses and midwives from abroad who are required to undertake such placements prior to registration (Rec. 4.1.7). The National Co-ordinator for Clinical Placements commenced employment at the HSEA in March 2001. The role involves co-ordinating the provision of clinical placements in hospitals approved for this purpose by An Bord Altranais. The remit is nationwide in relation to ensuring availability of sufficient placements. The Co-ordinator works in partnership with Nursing and Midwifery Planning and Development Units, Directors of Nursing, representatives from Schools of Nursing and Clinical Placement Co-ordinators in the achievement of their objectives and those of the role.

In 2001 a considerable expansion was achieved in the number of approved locations within which clinical placements could take place and an increase in the number of placements provided in some existing locations was also achieved. The Co-ordinator is responsible for ensuring that appropriate and acceptable clinical supervision is provided in new locations. The total number of clinical placements provided in hospitals throughout Ireland in 2001 was 2,047. Over 1,000 placements were provided for nurses recruited by employers outside of approved training hospitals. Over 500 such placements were co-ordinated through the HSEA from mid-2001 following the introduction of the position. It is anticipated that in respect of 2002 a very significant proportion of all placements will be co-ordinated centrally as the various employing organisations recruiting from abroad will have become more familiar with the process. To assist in this matter the Department of Health and Children provided dedicated funding for Clinical Placement Co-ordinators (11 WTE) with accompanying clerical back-up to support supervised clinical placements for non-EU nurses in 2001. This initiative has been continued for 2002. An information leaflet *Thinking about Nursing in Ireland* was developed in 2001 as a source of information for non-EU nurses considering employment in Ireland.

Appropriate procedural arrangements have been agreed with a majority of the Private Nursing Home sector and, in particular, an agreement has been reached between the Dublin Academic Teaching Hospitals and the organisations representing Nursing Homes for facilitating, through the National Co-ordinator, the placement of nurses being recruited by the Nursing Home sector. It has also been possible to facilitate more formally the provision of placements by hospitals outside of the greater Dublin area for the Private Nursing Home sector.

Effective utilisation of the professional skills of nurses and midwives

The interim report noted the establishment of a joint working group representative of nursing unions and health service employers (Para 7.63) and a separate working party (the Review Group on Health Service Care Staff, Para 4.55) to establish standard criteria in relation to the education and training of care assistants. Skill-mix is an important issue that will inform future forecasting systems. The report of

the working group (Para 7.63) entitled *Effective Utilisation of Professional Skills of Nurses and Midwives* was published in May 2001 (available at http://www.doh.ie/publications/eupsnm.html). The report sets out fifteen specific recommendations to support the introduction on a national basis of the grade of Health Care Assistant/Maternity Health Care Assistant as a member of the health care team to assistant and support the nursing and midwifery function.

A national six-month training course for health care assistants commenced in November 2001. Seventeen pilot programmes are being delivered by health services in conjunction with The Further Education and Training Awards Council (FETAC). The pilot sites were selected in consultation with the Directors of the Nursing and Midwifery Planning and Development Units and represent all spectrums of health care and cross all the health board regions. An external evaluation will be prepared by September 2002. Following this the programme will be available nationally.

A second aspect of the effective utilisation of the professional skill of nurses and midwives relates to nurse staffing. The *Commission on Nursing* (1998) recommended that the 'Department of Health and Children, health service providers and nursing organisations examine the development of appropriate systems to determine nursing staffing levels' (Para 7.63). The Commission also placed particular emphasis on staffing in care of the elderly when they recommended that 'the Department of Health and Children examine, as a matter of urgency, conditions and staffing level in care of the elderly' (Para 9.4). Both of these recommendations are included in the priority action plan agreed by the monitoring committee, for the implementation of the recommendations of the *Commission on Nursing*, for the years 2002 and 2003. The monitoring committee (5 April 2002) agreed that a reconstructed group on the *Effective Uilisation of the Professional Skills of Nurses and Midwives* chaired by the Chief Nursing Officer be established in 2002 to address the second recommendation in Para 7.63 (the development of appropriate systems to determine nursing staffing levels).

As part of a recruitment and retention project the Dublin Academic Teaching Hospitals convened a sub-group to consider skill mix issues. Limited published material was found that focused on the utilisation of nurse demand methods in Ireland. A taxonomy of nurse demand methods was identified by the group (Arthur and James, 1994). This places the methods into three broad approaches: consensus approach (intuitive method, consultative method); top-down approach (staffing norms, staffing formula); and bottom-up management approach (nursing interventions, patient dependency). The group found that while individual hospitals had employed outside consultants to determine work processes and skill mix of theatre, outpatients, medical and surgical department, there is no standardised method. The findings of the project indicate a lack of consistency and guidance in determining the nursing staff complement across the group of DATHs. The findings also indicate a lack of clarity regarding responsibility and authority and a somewhat centralised approach to determining nursing numbers and nursing quality in relation to competence (Dublin Academic Teaching Hospitals, 2001). The extent of the issues identified by the DATHs skill-mix group highlights the urgent need for a national approach to the matter of nurse staffing and skill mix.

To ensure consistency in approach and reliability of human resource plans for nursing and midwifery it is necessary to have a framework from which to work. There is a requirement for agreement and a common understanding of national norms for staffing, nurse-patient ratios, dependency assessment and skill mix to underpin the planning process. The steering group identified such agreement and understanding as central to progress in the development of workforce plans for nursing and midwifery.

In the eighteen months since the publication of the interim report considerable progress has been made on each of its main recommendations.

1.4 Project Plan

An original project plan was devised for this study which approached the task in three distinct phases:

- Phase 1 Explorative phase
- Phase 2 Creating the baseline
- Phase 3 Forecasting future requirements

The Gantt chart setting out the initial plan for the study was presented in the interim report. Following publication of the interim report the plan was revised, focusing on ensuring the availability of a nursing and midwifery human resource minimum dataset. Project management principles were used to continue work on Phase 2 (creating the baseline) and to develop structures and processes allowing for work on Phase 3 (forecasting future requirements) at a future date.

Progress on each phase of the study is set out in the following sections.

1.4.1 Phase 1 — Explorative phase

The project initially focused on establishing the scope of the task, searching the literature and compiling statistical information. During this stage the nurse researchers consulted widely with members at all levels within the health services. The purpose was to assess the availability of information and to learn of issues specific to each division of the register and the various categories of organisations employing nurses and midwives. A detailed account of the explorative phase of the study was published in the interim report in September 2000.

1.4.2 Phase 2 — Creating the baseline

The second phase of the study focused on bridging some of the information gaps that currently make it impossible to formulate reliable predictions of future nursing and midwifery requirements.

Progress on issues identified for action in the interim report

The interim report set out actions required to ensure that a minimum dataset is available for human resource planning for nursing and midwifery. This section gives a brief update on each of the issues.

Health services personnel census

Information in respect of the health service personnel census at 31 December 2000 can be accessed on http://www.doh.ie/statistics/hses.html. It is expected that up-to-date data relating to employment levels at end 2001 will be available autumn 2002. This is a welcome development as nurse managers within the service can now view the staffing numbers across regions and benchmark their own service against other services.

A working group has been established by the Department of Health and Children to examine key issues around the timely, accurate and verifiable collection of employment-related information together with issues around grade category classification and grade codes. There is to be a phased introduction of a 'Direct Patient and Client Care' grade category[2]. This will involve the transfer of specific grades to the new grade category so that an accurate representation of the employment structure of today's health service will be available.

[2]The 'Direct Patient and Client Care' grade category has been provisionally defined as 'personnel who provide direct client care and assist or free medical, nursing and health care professionals to perform their clinical duties, as well as staff who provide a management or supervisory role for such personnel. A qualification may or may not be a requirement depending on the grade'.

The implementation of time management and payroll modules by the PPARS agencies will, in the future, facilitate timely collection of census data by easing difficulties in calculating whole-time equivalents. In the interim period an improvement in the quality and accessibility of census information is taking place together with a refinement of collection procedures.

As recommended the grade codes for nursing and midwifery used in the health services personnel census were further expanded and rationalised to reflect changing role titles (Rec. 4.2.1). Grade codes were reviewed for the 2000 and 2001 census, which is taken at 31 December annually. Obsolete codes were removed; codes inappropriately allocated to the nursing category were reallocated; title changes were made; codes added for new grades; and guidelines were issued for completion. To further facilitate accurate completion, instructions were given that personnel completing the returns for the census should seek advice and assistance from nursing administration on nursing and midwifery staffing. The Directors of the Nursing and Midwifery Planning and Development Units were asked to bring the importance of accuracy of census returns to the attention of directors of nursing throughout the various health board regions. Copies of the grade codes/titles and guidelines for the 2001 census can be located in Appendix 3.

The interim report also recommended that a separate annual census of nursing employment in grant-aided bodies and services funded through Section 65 arrangements be undertaken in co-operation with relevant agencies. From 31 December 2001 health boards are being asked to provide data on grant-funded agencies together with returns for the health services personnel census. This information will mean that a more complete picture of public health service employment is available.

The Register of Nurses

The Register of Nurses maintained by An Bord Altranais underpins the regulation and control of the nursing and midwifery profession. The register can be a powerful tool in supporting workforce-planning assessments. However, professional registration takes primacy over all other possible uses of information from the register. The interim report of this study indicated that An Bord Altranais should move to require nurses and midwives to update personal data held on the register when paying the annual retention fee (Para 4.2.2). This recommendation is partly reliant on revisions to the Nurses Act, 1985 which will take account of the recommendations of the *Commission on Nursing* (Para 4.46, 4.49 and 4.53). The steering group supports the changes to the registration procedure, recommended by the *Commission on Nursing*, which will have the effect of keeping the register up to date and relevant in terms of human resource planning.

The need for systems for recording qualifications in specialised areas of clinical practice and subsequent career paths of successful graduates was addressed in the minimum data pilot projects undertaken by St. James's Hospital and the NWHB (see Chapter 3 for detailed description of the pilot studies). The projects focused on developing an employment database using the PPARS SAP HR system that had a facility to make a record of all registrable and academic qualifications held by nurses and midwives employed in any given area. To facilitate this a detailed catalogue listing all qualifications held by staff in the pilot study sites (1,689 nurses and midwives) was developed. The catalogue currently lists over 320 qualifications (see Appendix 4). A process was identified whereby the Nursing and Midwifery Planning and Development Units will co-ordinate additions to the catalogue. An Bord Altranais and the National Council were involved in developing the process and are available for advice when required.

Vacant nursing and midwifery positions

As recommended the Health Service Employers Agency (HSEA) arranged for health service employers on a quarterly basis to provide information on nursing and midwifery vacancies, in standard format (Rec.

4.2.4). A National Survey on Nursing Resources was undertaken by the HSEA for the last day of September 2000, January 2001, April 2001, July 2001, October 2001, January 2002 and April 2002. To ensure that information is readily available for a calendar year the steering group recommend that data be collected for the last day of March, June, September and December rather than the time intervals currently used. Details of the methodology for the survey are given in Chapter 2 of this report.

The interim report indicated that the information on vacant posts should be sufficiently detailed to allow for the reporting and analysis of trends between divisions of the register and geographic locations of the health service. The survey has been expanded to include data in relation to recruitment and retention, employment of agency nurses, use of overtime and recruitment from abroad. It is now possible to identify a trend over the last six surveys. The number of reported vacant posts appears to be relatively constant and relates mainly to the eastern region. While all sectors reported that recruitment was well ahead of resignations/retirements, vacancies still exist. These circumstances arise where the volume of additional nursing posts being created outstrips capacity to recruit. A combination of using agency nurses and overtime working enables the service to cope with gaps arising as a result of vacant posts, while employers continue the recruitment process.

While providing valuable information this survey only relates to members of the HSEA and does not cover organisations in the private sector. Nor is it detailed enough to give information on the number of vacancies by division of the Register of Nurses. An assumption can be made that vacancies identified in maternity hospitals, intellectual disability and mental health services require nurses/midwives who are registered in the relevant division of the Register of Nurses. This is not as easy for large general hospitals that may require registered general, sick children's, psychiatric nurses or midwives. Greater diversification of information on vacancies would be required to determine exactly how many nurses from each division are required. As the health boards provide information in aggregate form it is not possible to establish the number of vacancies that pertain to public health nurses.

Age profile of nurses and midwives

The interim report indicated that health agencies should compile information in standard format (centrally monitored) on the age of nurses and midwives in employment in both the public and private health services (Rec. 4.2.5). Without such information it will not be possible to undertake reliable predictions of the future workforce requirements. The collation of information on age is a very significant challenge for organisations that do not have an electronic up-to-date personnel system for nurses and midwives. This will be possible for some organisations and health boards through PPARS.

Information requirements to underpin workforce planning

In order to undertake projections it is essential to have information on (among others) the following issues:

- number of nurses and midwives employed in the public health services and the independent sector
- age of nurses and midwives employed
- turnover rate of nurses and midwives
- number of nurses and midwives leaving to work abroad
- retirement rate of nurses and midwives
- number of vacant nursing and midwifery posts
- number of pre-registration education places provided and uptake of places

- attrition rate from pre-registration nursing education programmes
- number of nurses and midwives returning to practice
- number of nurses and midwives recruited from abroad
- availability of specialist education
- desired number, ratio and skill mix of nurse/midwife necessary to provide effective quality service to patients in the different sectors of the health system (acute hospitals, long-stay, rehabilitation, mental health, intellectual disability services, maternity, children's, community and general practice)
- a reliable mechanism for assessing and determining patient/client dependency
- staffing requirements necessary to support proposed developments in the health system.

This section gives a brief overview of some of the initiatives undertaken to secure the required information. Details of the statistics collected are presented in Chapter 2 of the report.

Nursing and Midwifery Minimum Dataset pilot projects

Information on the numbers of nurses and midwives employed in the health system is key to creating the baseline. A proposal for the data fields required to form an employment minimum dataset was compiled with advice from the Information Management Unit of the Department of Health and Children and the international literature. The purpose was to provide accurate and standardised information on nursing and midwifery employment in Ireland so as to inform assessment of what the future demand is likely to be. To test the minimum dataset and a methodology for collecting requisite information, two pilot projects were commissioned by the steering group. The PPARS Project Team and members of the Information Management Unit were asked to assist in the matter. The Nursing and Midwifery Planning and Development Unit of the NWHB and St. James's Hospital were selected to undertake the pilot projects. Two uniquely different projects were selected so as to:

- challenge and test what became know as the *National Nursing and Midwifery Human Resource Minimum Data Set* in diverse and different nursing and midwifery populations
- develop a process that could be adapted to a wider nursing and midwifery population without changing core principles and definitions
- ensure that all employers can provide reliable data, in a standardised format, that can be used at local level and can provide comparable information that can be collated nationally.

The pilot projects commenced in June 2001 and were completed in November 2001 (see Chapter 3 for further details). They demonstrated the high level of capability of the PPARS SAP HR system in responding to the requirements of the minimum data set. The experience of the minimum dataset pilot projects is that it is possible to collect and report information using the PPARS SAP HR system. However, the fact that the system is maintained centrally in the Human Resource Departments and Nursing and Midwifery Planning and Development Units militates against the information being kept up to date. The pilot studies highlighted a significant difference in the age profile of nurses employed in both sites. In St. James's Hospital the age grouping with the greatest number of nurses was 25-29 years (21 per cent) whereas in the NWHB the age grouping with the greatest number of nurses and midwives was 45-49 years (18 per cent). This fact alone highlights the implications for planning. The outcome of both pilot projects was used to inform the deliberations of the steering group.

Survey of nursing employment in the independent sector

To date the numbers and profile of nurses working in the independent sector (private hospitals and clinics, private and voluntary nursing homes, grant-aided bodies, GP practices, hospices, and nursing agencies) has not been collated centrally. To achieve a realistic understanding of the future demand for registered nurses and midwives it is necessary to establish a baseline for nursing employment in this sector. For this reason a survey of nursing employment in the independent sector was undertaken in May/June 2000. The findings of the survey were used to estimate total employment in the independent sector at approximately 10,000 persons. An overview of the survey is set out in Chapter 2 and Appendix 5 of this report.

National Study of Turnover in Nursing and Midwifery

A significant obstacle in predicting future requirements for replacement of nurses and midwives in service is the deficit of an index of turnover specific to the Irish health care environment. In January 2000, the Health Research Board commissioned a *National Study of Turnover in Nursing and Midwifery* on behalf of the steering group. The study was funded for 15 months and undertaken by a research team at the Department of Nursing Studies, University College Cork. The purpose of the research was twofold: to estimate turnover rate amongst registered nurses from employment in the Republic of Ireland and to identify the underlying reasons for this loss to the health service.

The interim report encouraged all of the sample sites in the *National Study of Turnover in Nursing and Midwifery* to participate fully in the research project, in order to ensure that realistic information is available on turnover for nursing and midwifery employment (Rec. 4.2.7). Data collection finished in March 2001 with 100 per cent response rate for 1999 and 87 per cent for 2000. The turnover rate across all 128 participating organisations in 1999 was 17 per cent and 15 per cent in the organisations that responded in 2000. This study provides, for the first time, an index of turnover in nursing and midwifery by division of the register and geographic region of the country. A complete report of the research study entitled the *National Study of Turnover in Nursing and Midwifery* (2002) is published separately as an accompanying document. A summary of the main aspects of the study is given in Chapter 4 of this report.

Regional feedback meetings

A draft report of the *National Study of Turnover in Nursing and Midwifery* was presented to the steering group in June 2001. To ensure dissemination and to elicit recommendations with actions on the study findings three regional feedback meetings were arranged in September and October 2001. The programme was planned in collaboration with the UCC research team and the directors of the Nursing and Midwifery Planning and Development Units. In total 164 actions were proposed during the three meetings, details of which can be located in Chapter 4 of this report.

Trend analysis of turnover in nursing and midwifery

To ensure continued availability of information on turnover in nursing and midwifery the Directors of the Nursing and Midwifery Planning and Development Units agreed to co-ordinate the collection of turnover data from the organisations within their region that originally participated in the University College Cork (UCC) study. Details on turnover for 2001 can be located in Chapter 4 of this report. In 2002 the Directors intend to expand the survey and collect turnover data from all organisations within their regions.

Survey of return-to-nursing and midwifery programmes

In February 2000 and again in March 2001 a survey was undertaken to gain an insight into the provision of return-to-nursing and midwifery programmes. Details of the findings are found in Appendix 6. In 2001, twenty-five courses were identified of which 15 were for general nursing, 4 for midwifery, 4 for

psychiatry, and 1 for sick children's nursing. This is an increase of nine additional courses since the survey in 2000. There is a steady increase in the total number of places available: 241 in 1998; 314 in 1999; 393 in 2000. The number of places for 2001 was not finally confirmed at the time of the survey. All organisations providing courses in 2001 indicated that they would be continuing to do so in 2002. While there is a constant increase in the number of places, there appears to be a decline in uptake. The length of courses, identified in the survey, ranged from 4 to 9 weeks duration. The responses to the survey indicated that An Bord Altranais had approved each course. The organisations provided certificates of attendance to participants. There was no academic association or recognition for the programmes.

It was not possible to determine how many nurses/midwives subsequently secured employment, as most organisations do not conduct follow-up evaluations. There is a real deficit of information in tracking the subsequent employment of nurses and midwives who completed programmes. This issue is being addressed by the Nursing and Midwifery Planning and Development Units.

Survey of post-registration courses in specialised areas of clinical practice

Part of creating the baseline involved conducting a survey in June 1999, repeated in March 2000 and in March 2001. This was to obtain a national overview of the provision of post-registration courses in specialised areas of clinical practice, and the number of places available. Summary results for the most recent survey can be located in Appendix 2.

During 2000/2001, thirty new post-registration programmes were developed. Of these, eighteen were based outside Dublin. The total number of programmes has risen from 43 in 1999 to 59 in 2000 and 80 in 2001. The majority of new courses commenced in the academic year 2001/2. The survey indicated that from January 2002 there would be 331 additional places. During 2001 there were a total of some 882 places on post-registration courses in specialised areas of clinical practice. There has been a substantial increase in the number of programmes and places for accident and emergency nursing, gerontological nursing, critical care nursing and peri-operative nursing. A variation exists in the length of the higher/postgraduate diploma programmes, some of which are based on an academic year (10 months) and others on a full calendar year. A small number are offered over two years. A small number of hospitals continue to offer a hospital certificate course while also providing places for higher/postgraduate diploma programmes. This is part of the transitionary arrangements. In some situations staffing for specialist units has influenced this decision.

Survey of continuing education opportunities

In October 2001 a survey was conducted across the 14 Higher Education Institutions (HEI) providing nurse education programmes. A 93 per cent response rate was achieved. The aim was to establish the extent of continuing education opportunities for nursing and midwifery and also to invite comment on the qualifications catalogue listing held on the PPARS SAP HR system. Each HEI was asked to review the qualifications listing and indicate if any amendment to titles were required and also if there were any omissions. On the basis of the responses the listing was amended and restructured.

Monitoring attrition from pre-registration nursing degree programmes

An Bord Altranais can currently provide information on attrition from diploma nurse education programmes (see Appendix 7). A small number of students successfully pass the registration examinations but do not in fact register and therefore do not practise in the particular area of nursing and midwifery in which they were studying. Although the numbers are small they have been increasing over recent years. Indications from higher education sources in Ireland suggest that at present the drop-out rate for pre-registration diploma nurse education is lower then for other third level courses. This may change in the future. The largest single change in the history of nursing education in Ireland is about to take place

this year. This involves the full integration of nurse education to the third level sector and the introduction of an undergraduate degree as the single pathway to entry to nursing in Ireland. It is vitally important that attrition from courses is closely monitored throughout this epic change.

During this study the steering group initiated discussion with the executive of An Bord Altranais and the National Implementation Committee for pre-registration nursing education degree programme (NIC) to identify structures and processes for the continued monitoring of attrition from nursing education programmes. The advice of the NIC was obtained in categorising indices of attrition and identifying options for data collection (see details in Chapter 2). An Bord Altranais approved the proposed process at the meeting held on 6 February 2002.

This section of the report chronicles the actions that have been taken in relation to the use of information from: the health services personnel census; the Register of Nurses; the quarterly survey on the nursing resource (HSEA); together with challenges in establishing the age profile of nurses and midwives and an index for turnover. This concentrated activity is focused on ensuring that better quality information is more readily available on the nursing and midwifery workforce within the Irish health system. Despite intensive activity we still do not have a comprehensive employment database for nursing and midwifery either in the public health services or the independent sector. The actions described here are the first steps in creating such a system. Concerted and continued efforts will be required by the Department of Health and Children, the health boards, human resource departments, regional nursing and midwifery planning and development units and individual organisations to ensure that the momentum created by this study is continued.

Phase 2 — Creating the baseline: outcome

The need to streamline requests for information from agencies was highlighted during this phase of the study. Directors of Nursing and Human Resource Managers are receiving multiple requests for information on nursing and midwifery employment. Each agency requires information in different formats for different time periods. There is a real sense of frustration and information request fatigue. Currently the HSEA collect information quarterly (for the previous 12 months) on numbers leaving, recruited, vacant posts, overtime and agency. The Nursing and Midwifery Planning and Development Units collect information on turnover (6 monthly for 2001) comprising total WTE employed on a given date and the number of WTE leavers in a given time period. This information is then submitted to the Nursing Policy Division for collation nationally. Human resource departments in health boards and other agencies request information (January/February each year) for the health services personnel census and at other specified time periods to fulfil specific requests. The need for one agency to request and collate information centrally was highlighted by this study.

Part of this phase of the study involved collating together in one place the information that is available on the nursing and midwifery resource in Ireland between 1990-2001 (see Chapter 2). The baseline is just that — a base from which to build. It is vitally important that this information is published and disseminated on a yearly basis so that the trend, and analysis thereof, can be used to inform policy and decision-making in relation to nurse and midwife staffing on an annual basis. It is not enough to just calculate a baseline at one particular point in time or for a specific study; this work must be ongoing.

1.4.3 Phase 3 — Forecasting future requirements

The approach to Phase 3 has changed substantially during the course of the study. Circumstances determined that it would not be immediately possible to prepare numeric forecasts as originally planned. This particularly related to the feasibility of co-ordinating input of senior nurse managers in forecasting assessments, in the absence of the regional Nursing and Midwifery Planning and Development Units,

which were not fully established. Serious questions arose in relation to the availability and comprehensiveness of information sources. The steering group were also reluctant to commit to a forecasting exercise without specific modelling tools and expertise tailored to an Irish health care environment. In addition it was considered inappropriate to attempt to anticipate future service requirements in advance of the publication of the Health Strategy. The Health Strategy (2001) provides a detailed plan for the entire health system and determines the shape and quantum of services to be provided and developed over the next 10 years.

Approach to forecasting

At the World Health Organisation (WHO) Ministerial Conference on Nursing and Midwifery in Europe held in Munich on 17 June 2000, Ministers accepted that commitment and serious efforts towards strengthening nursing and midwifery should be supported by developing 'comprehensive workforce planning strategies to ensure adequate numbers of well educated nurses and midwives'. The Munich Declaration — *Nurses and Midwives: a Force for Health* — was signed in the presence of Mary Hanafin, Minister of State at the Department of Health and Children. The WHO (1985) advises that there are no established international standards for workforce provision. Each country (and each locality within the country) must select approaches to human resource planning suitable to its own needs and conditions.

During this phase of the study the focus has been on identifying and recommending the best possible approach to workforce planning for nursing and midwifery. Another important aspect of this phase of the study was to identify the main assumptions on which future projections for the requirements of nurses and midwives should be based. A search for available literature on forecasting methodologies was undertaken. An overview of the main approaches adopted internationally is set out in Chapter 6 of this report. Key sources of information were also located through attendance at conferences and meetings with other researchers. An overview of each of the meetings and conferences is set in Table 1.6-1. The collective learning from the various meetings and conferences is summarised in the sections below.

Table 1.6-1 – Meetings and conferences attended during Phase 3 of the study

Meeting/Conference	Purpose	Date
PCN Standing Committee of the Nurses of the EU	Attendance and presentation at Workforce Seminar on Nursing Shortages and Recruitment held in Dublin	20 November 2000
Professor Jim Buchan	Advice on next steps for *Study of the Nursing and Midwifery Resource*	20 November 2000
Professor Miriam Wiley	Advice on approach to forecasting	16 January 2001
"Mr David Amos and Professor Anna Maslin	Exchange of experiences between the NHS Executive/Department of Health UK and the Irish Department of Health and Children	23 February 2001
Health Board Directors of Human Resources	Feedback on the interim report and suggestions and advice on phase 3 of the study	1 March 2001
Mr Peter Bacon and Associates	Review of methodology used for the report *Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists*	22 March 2001
Professor Jim Buchan	Participation in WHO study exploring the policy implications of the international migration and mobility of nurses	9 May 2001

Meeting/Conference	Purpose	Date
Alliance of Nursing Unions	Update on *Study of the Nursing and Midwifery Resource* and data collection for the minimum dataset pilot projects	30 May 2001
European Health Management Association Conference	Presentation of paper and meetings with international researchers	27-30 June 2001
Dublin Academic Teaching Hospitals — Dataset subgroup	Ensuring synchronisation and standardisation of definitions underpinning the *Nursing and Midwifery Human Resource Minimum Dataset*	22 June 2001
International Council of Nurses Conference	International Council of Nurses 22nd Quadrennial Congress	10-15 June 2001
Fifth Annual National Magnet Nursing Conference	Attendance at conference and site visits to North Carolina Baptist Hospital of Wake Forest University Baptist Medical Centre, North Carolina	26 October 2001
Council of International Hospitals Membership Meeting	Attendance at meeting — *A Delicate Balance Managing the Staff, Maximising Capacity in an Era of Shortage*	8 November 2001

The Student Nurse Intake Planning (SNIP) assessment exercise undertaken in Scotland remains the example of best practice for determining the number of pre-registration places provided for each branch of nursing. The principles of the system rather than the detail could possibly apply to Ireland. In relation to models for forecasting it is best to start with a simple system that can be refined over time, instead of locking into detail very early. Professor Buchan highlighted the need to ensure that flexibility is built into the process. He raised several issues that should be considered in the development of any system.

- Identifying persons with the competency and understanding to develop the system. Managing the process of induction and hand-over
- The need for a strong technical group for system design. Personnel should be involved from the start to ensure that there is full comprehension of the role and function of the system
- The danger of resting all one's hopes in an individual. There needs to be a capacity to develop and sustain the system in the long term. One approach is for a system to be designed in-house with the possibility of buying-in expertise and assistance rather than outsourcing the project
- A period of intensive work upfront
- Review of the annual cycle. All the required data should be collected by January to allow time for verification prior to using information for forecasting. Data-gathering should take place in the Summer/Autumn for the following year
- Projections based on the next five years' requirements. Three years out is likely to be the most accurate
- Continuous information collection
- Need to acquire skills regionally in order to undertake the forecasts.

Professor Buchan advised that by any measure it would be impossible to have detailed comprehensive forecasts prepared for Ireland by the end of 2001. It was indicated that there should be a clear explicit objective before engaging in any forecasting exercise. The imperative of having personnel with expertise in forecasting directly involved was emphasised. It was highlighted that at a minimum a system for data capture and then a methodology to apply forecasting techniques using the information available would be required. Time constraints, availability of data, scale of the project (given that nursing and midwifery

comprises over 36 per cent of the workforce in the public health system) and finance will determine the approach that should be adopted to the project.

Mr Peter Bacon gave an overview of the methodologies employed by the Economic Consultants for the study they undertook to forecast the *Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists* (2001). He also indicated the minimum dataset used. The workforce situation in the therapy professions was analysed in terms of four gaps that exist in the number of personnel that are employed. These are: the number of unfilled vacancies at present; the number of posts that would be created if services in Ireland reached objectively set targets; the number of additional places that will arise due to demographic and survival trends; and the number of new posts that will arise due to demands for an enhanced quality of health care services. It was highlighted that the objective of the report was not to estimate total employment levels, but to assess existing deficits and future requirements above existing levels.

The Advisory Board Company hosted a conference in London (November 2001) which provided an opportunity to meet personally with staff of the company who gave advice on the minimum dataset required for forecasting. The focus of the meeting was on managing staff and maximising capacity in an era of shortage. Papers were presented on best practice for dramatic improvement in hospital staff recruitment and best practice for improving nursing manager performance. A teleconference was held (December 2001) with the key researchers who prepared the projections for nursing requirements in the USA (see Chapter 6).

During Phase 3 the researchers met with representatives of the four nursing unions within the Nursing Alliance to provide an update on the progress and approach to the study and particularly to obtain their support for data collection during the minimum dataset pilot projects. The representatives appreciated the need for accurate information on nursing employment and were pleased to give support. A formal letter was requested and issued which was used to cascade down to local union representatives in each of the pilot sites.

The focus of discussion with the DATHs recruitment and retention project dataset group was to ensure synchronisation and standardisation of the definitions underpinning the *Nursing and Midwifery Human Resource Minimum Dataset* being developed by the steering group. A number of important issues was highlighted. Information collected on nursing employment in the DATHs group is mainly reliant on paper systems and different systems are used in the hospitals within the group. The process was reported to be very time-consuming. The subgroup indicated the need to identify clear role responsibilities for ongoing data collection on nursing employment in each organisation.

A meeting with members of the National Health Service (NHS) Executive and the UK Department of Health revealed that a major media campaign (TV radio and poster) was successfully launched by the NHS executive to *Recruit Back a Friend to the Health Service*. Copies of the promotional material was shared with the group. A director to head up and co-ordinate international recruitment was appointed to the UK Department of Health. National and local teams have been appointed to work with the director. The UK Department is making Government-to-Government agreements on recruitment, particularly within the EU. Guidance on International Nursing Recruitment was issued in November 1999. This sets out the national standards in relation to recruitment.

Attendance at a number of international meetings allowed the steering group to keep abreast of workforce developments for nursing and midwifery. The International Council for Nurses (ICN) conference in Copenhagen (June 2001) provided an opportunity to meet with researchers involved in

human resource planning for nursing and midwifery in USA, Scotland, Australia and England. At this meeting attention was brought to an international study on mobility of nurses. The steering group agreed to assist in a research study being undertaken on behalf of the World Health Organisation. This involves case studies to examine trends and policy implications relating to the international migration and mobility of nurses. Seven countries were included in the study: Ireland, UK, Australia, USA, Ghana, Jamaica and Norway. The report of the study is due to be presented later this year. Presentations at the *European Health Management Association* conference confirmed the extent of the global nursing shortage. Estimates presented indicate that the UK will need 57,000 nurses by 2004 (West, 2001) and the Netherlands will require 73,247 by 2008 (van Dijk, 2001). The fifth Annual National Magnet Nursing Conference, *Creating Our Future Today: New Challenges, New Directions* (October 2001), gave an opportunity to visit the North Carolina Baptist Hospital of Wake Forest University Baptist Medical Centre, an 880-bedded tertiary care facility in Winston-Samlem, North Carolina. Senior nurse managers facilitated tours of the emergency department, surgical floors, day care, operating department and oncology units. Meeting with nurses in their own clinical environment provided a greater appreciation of the systems for nursing governance, staffing levels, roles and skill mix and also the levers used to retain staff. Of particular interest was the operation of the nursing council within each section of the hospital.

Phase 3 — Forecasting: outcome

During this phase of the study detailed consideration was given to the structures and process necessary to support workforce planning for nursing and midwifery. The emphasis is on ensuring that an appropriate framework is developed to support workforce planning at three levels in the system — local, regional and national. A search was undertaken for examples of international models of best practice (see Chapter 6). Integrated workforce planning is clearly identified as the recommended approach to workforce planning. This is endorsed in the proposals of the Health Strategy (2001). With integrated planning in mind the steering group are recommending an interim framework for workforce planning for nursing and midwifery. The recommendations and detailed actions are set out in Chapter 7 of the report. This is a transitory arrangement pending the development of systems for integrated workforce planning. The intention is to ensure that the momentum established during this study is sustained in order that the information base is maintained and used. This is only the first sep in the development of a new intensified approach to workforce planning that will require serious commitment on an ongoing basis.

1.5 Other developments

The steering group are also aware of many other developments in nursing and midwifery that will influence the future supply of nurses and midwives. This particularly relates to pre and post-registration nursing education. An overview of the main advancements is set out in the sections below.

1.5.1 Pre-registration nursing education

Pre-registration nursing education has undergone radical change over recent years, during which time it has moved from an apprenticeship model of education and training to a diploma based programme firmly rooted in higher education and this year to a degree programme fully integrated in higher education institutions.

Nursing Education Forum

A Nursing Education Forum was established in early 1999 to prepare a strategic framework for the implementation of a nursing degree programme. The Minister for Health and Children Mr Micheál Martin TD launched the Report of the Nursing Education Forum on 24 January 2001. At this point the Government agreed in principle to the introduction of the proposed degree programme in Autumn 2002. The common thread throughout the implementation strategy developed by the Nursing Education

Forum was 'partnership'. This involves all stakeholders from the health sector and the higher education sector working together in a spirit of close co-operation to ensure the successful implementation of the degree programme.

Inter-Departmental Steering Committee

In response to a recommendation of the Nursing Education Forum, an Inter-Departmental Steering Committee was established to consider funding and policy issues. The steering committee includes representatives of the Departments of Health and Children, Finance, and Education and Science as well as the Higher Education Authority.

The steering committee has been engaged in intensive negotiations with representatives of the Conference of Heads of Irish Universities and the Institutes of Technology in relation to their capital and revenue funding requirements. These negotiations were successfully concluded in October 2001.

National Implementation Committee for Pre-registration Nursing Degree Programme

The Report of the Nursing Education Forum also recommended the formulation of a National Implementation Committee (NIC) to oversee the implementation of the pre-registration nursing degree programme. The membership of the Committee is representative of key stakeholders in nursing education in Ireland, namely, the Department of Health and Children, the Department of Education and Science, health service providers, statutory and voluntary bodies, higher education institutions and An Bord Altranais.

Its initial task was to prepare a plan of the processes and actions necessary to ensure the implementation of the Forum's recommendations in a structured, co-ordinated and coherent manner, in compliance with the timescale set out in the report. An updated project plan is available on the NIC website launched in September 2001 www.nursing-nic.ie.

The Report of the Nursing Education Forum contains forty-five recommendations. To date sixteen recommendations have been completed, twenty-two are in progress and a further seven require implementation.

Government approval for degree programme

On 1 November 2001 the Minister for Health and Children announced that the Government had agreed a four-year undergraduate pre-registration nursing degree programme to be implemented at thirteen higher education sites throughout the country at the start of the academic year (2002/2003). This historic decision will finally put the education of nurses on a par with the education of other health care professionals.

Extra training places

The Government also approved plans for increasing the number of nursing training places to coincide with the implementation of the degree programme in 2002. Funding for ninety-three additional places in mental handicap and psychiatric nursing at Athlone, Letterkenny, Tralee and Waterford Institutes of Technology has been provided. This will yield 392 extra places over the four years of the degree programme. A total of 1,640 places (1,057 general nursing, 343 psychiatric nursing and 240 mental handicap nursing) annually on the new degree programme will thus be available. Maintaining the annual student intake at this level for the foreseeable future is a key element of the overall strategy for ensuring the development of sufficient nurses for the health services.

Sponsorship scheme for public health service employees

To coincide with the implementation of the four-year nursing degree programme the Minister approved the introduction of a new sponsorship scheme for eligible, suitable and experienced public health service employees wishing to train as nurses. Successful applicants will be allowed to retain their existing salaries throughout the four years of the degree programme in return for a commitment to work as nurses for their health service employer for a period of five years following registration as a nurse. Up to forty sponsorships nationally will be available each year.

State enrolled nurse initiative

On 14 February 2001, the Minister for Health and Children announced a special initiative to assist state enrolled nurses (SENs) to become registered nurses. Under this initiative, any SEN working in the Irish health service can apply for a non-means-tested grant of €7,618 (£6,000) to undertake a nursing conversion programme in the United Kingdom. The grant will be paid in return for a commitment on the part of the SEN concerned to work as a nurse in the Irish health service following completion of the programme and registration with An Bord Altranais. Detailed arrangements for the operation of this particular initiative are set out in the Department of Health and Children's Circular No. 9/2001.

Pre-registration midwifery education — pilot direct entry programme

Since the 1970s post-registration as a general nurse was the education pathway into a career in midwifery. The *Commission on Nursing* identified the need to generate an alternative Direct Entry Midwifery programme to facilitate individuals who wish to pursue midwifery as a career, without a nursing background. The first pilot programme offering the opportunity to achieve a Diploma in Midwifery by Direct Entry was established in June 2000.

This initiative is a tri-partite arrangement between Trinity College Dublin, The Rotunda Hospital, Dublin and Our Lady of Lourdes Hospital, Drogheda. The student midwives, twenty in number, are undergoing a three-year diploma programme, which is due to be completed in June 2003. On completion of the three-year programme, a full evaluation will be undertaken to assess the feasibility of this model of education as a viable option for the education of midwives in the future.

1.5.2 Post-registration nursing education

Post-registration nursing education has also undergone fundamental change over recent years. During this time it has moved from a certificate model of education and training to a higher/postgraduate diploma-based programme firmly rooted in higher education.

Post-registration paediatric nursing education

The Report of the *Commission on Nursing* recommended that the content, duration and academic award of the Sick Children's Nursing course be reviewed. A review group was formulated for this purpose. The *Report of the Paediatric Nurse Education Review Group* was published in December 2000 and its recommendations have been accepted by the Department of Health and Children. An implementation plan was developed and the outstanding recommendations have been included in the action plan for the implementation of the *Report of the Commission on Nursing* 2002-2003.

Recommendations implemented to date relate to a fees and salary initiative for sick children's nursing students, the establishment of clinical specialist post-registration courses at higher/postgraduate diploma level within paediatric nursing (intensive care and accident and emergency), the funding of collaborative student RSCN recruitment initiatives and the funding of a feasibility study to explore the provision of paediatric nurse education in Cork.

Working group on paediatric nursing education

A Paediatric Nurse Teachers Working Group representative of key stakeholders was convened on 24 October 2001. The group prepared a strategy for the further integration of paediatric nurse education into the third level sector. It has been agreed that priority be given to the development of an integrated general/paediatric programme at pre-registration level.

Post-registration mental handicap nursing education

The *Report of the Commission on Nursing* (1998) recognised the need to develop educational programmes to underpin the role of clinical nurse specialists and advanced nurse practitioners in mental handicap services. In addition the Commission commented that services for people with an intellectual disability in Ireland have undergone a period of rapid change and development, providing a greater focus and emphasis on integration in school, work and in the community. Furthermore the Commission noted that the role of the mental handicap nurse needed to be increasingly defined and specialised in order to respond to the changes taking place within the services and the client population.

To date there has been very little development in post-registration education in mental handicap nursing. Mental handicap nursing exists as one division of the overall discipline of nursing in Ireland. As such it requires a unique but small body of knowledge and skill to support its practice within the overall context of nursing. From this perspective there is a need to guard against micro specialisation as the clinical nurse specialist and the advanced nurse practitioner emerge. Micro specialisation can lead to career 'cul de sacing', creating inflexibility within the workforce, which in turn stifles responsive service provision.

Prior to the establishment of the National Council for the Professional Development of Nursing and Midwifery the Nursing Policy Division of the Department of Health and Children initiated a consultative process with mental handicap nurses to determine both the specialist and advanced nursing roles undertaken by mental handicap nurses and the educational framework required to support these advanced and specialist roles. A report detailing the findings of this project entitled *A Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* is due for publication. The report sets out ten recommendations in relation to the development of specialist and advanced practice together with the educational framework needed to support these developments. Plans are being developed for the introduction of a higher diploma in community mental handicap nursing in the NWHB.

Post-registration midwifery education

Nurses who wish to pursue midwifery as a career in Ireland currently undertake a further two years of study in a school of midwifery, in partnership with third level institutions. On successful completion of the programme, the graduates obtain an academic qualification and entry to the midwifery division of the Register of Nurses, maintained by An Bord Altranais. The increase in the theoretical component of the post-registration programme for student midwives, from thirteen to twenty-six weeks per year, has been an extremely positive development for the profession. The increased theory time facilitates the development and expansion of the curriculum to allow student midwives to gain additional skills in research and to cover aspects of the midwifery programme in significant detail. The Irish midwifery programme is now similar in theoretical content to those in other European states. This initiative was supported by the Department of Health and Children, in response to recommendation 10.12 of the *Commission on Nursing*.

Working group on midwifery education

The first meeting of this working group took place on 3 December 2001. The group members represent the various stakeholders involved in midwifery education and service. The remit of the group included

consideration of alternative models for midwifery education, in the context of changes in provision of maternity services and changes in nursing education.

Public health nursing education

Public health nurses (PHNs) are registered general nurses and registered midwives who have completed the higher/postgraduate diploma in Public Health Nursing from either University College Dublin (1987) or University College Cork (1994). Admission to the programme requires a general nursing and midwifery qualification and two years post-registration experience. In addition registered health visitors who are registered midwives with one year's post-registration experience in midwifery are also entitled to register as PHNs on completion of a three-week orientation under the supervision of a director of public health nursing.

In October 2002 the Western and North-Western Health Boards in partnership with the National University of Ireland, Galway and St. Angela's College, Sligo will be facilitating a higher/postgraduate diploma in nursing studies (public health nursing) for approximately 30 students. The programme will be modular and comprise six modules, three of which will be core and three specialist. It will be run full-time over one calendar year, or part-time over a two-year period. Plans are being developed for the introduction of a higher/postgraduate diploma in community mental health nursing in 2003.

In 1994 An Bord Altranias recommended that midwifery should no longer be a prerequisite for PHN education. In 1997 a review of public health nursing carried out on behalf of the Department of Health and Children questioned the need for PHNs to be qualified midwives. More recently the report of the *Commission on Nursing* supported these views (Para 8.30). It is argued by some PHNs that midwifery is an important preparation for public health nursing because of the focus on health and independent decision-making and because a large part of the role of the PHN focuses on maternal and infant health. Others argue that the capacity of the PHN service to meet the health and social care needs of modern Ireland will be enhanced by opening the entry to public health nursing to a wider group of nursing competencies. An Bord Altranais established a working party in March 2002, to determine the content and duration of a programme in maternal and child health as an alternative to the mandatory midwifery qualification for public health nursing. This is an area that will also be addressed in the development of the *National Strategy for Nursing and Midwifery in the Community,* currently being prepared by the Nursing Policy Division of the Department of Health and Children.

Community registered general nurses

Registered general nurses play an important role within the public health nursing team. The *Commission on Nursing* recommended that prior to commencing work in the community registered general nurses be provided with in-service education and orientation/training in community nursing (Para 8.38). This recommendation is being considered in the development of the *Strategy for Nursing and Midwifery in the Community*.

Practice nursing

An introductory course for practice nurses was commenced by the Department of General Practice, Royal College of Surgeons in Ireland in the early 1990s. This continued until 2000 when the programme was expanded and developed into a higher/postgraduate diploma in practice nursing facilitated by the Faculty of Nursing and Midwifery at the Royal College of Surgeons in Ireland. Since 1996 the education committee of the Irish Practice Nurses Association has provided a course entitled Introduction to Practice Nursing once every year in Cork. The course consists of a series of lectures, run over 12 days. A certificate of attendance is awarded to the participants on successful completion of a course project. The course is approved by An Bord Altranais and the Irish College of General Practitioners.

National Council for the Professional Development of Nursing and Midwifery

The National Council for the Professional Development of Nursing and Midwifery (The National Council) was created on foot of a Statutory Instrument from the Minister for Health and Children (SI No 376 of 1999). In recognition of the importance of continuing education programmes for nurses and midwives in the provision of quality care, the National Council has funding to support additional developments in continuing education by health boards and voluntary organisations. While the prime responsibility for the provision and funding of continuing education lies with health boards and the Nursing and Midwifery Planning and Development Units the National Council does provide additional funding in accordance with agreed criteria (National Council, February 2001). Programmes are funded in response to submissions received through the Nursing and Midwifery Planning and Development Units.

The National Council will be taking responsibility for determining the appropriate level of qualification and experience for entry into specialist nursing and midwifery practice, the accreditation of specialist nursing and midwifery courses for the purpose of clinical nurse/midwife specialist (CNS/CMS) and advanced nurse/midwife practitioner (ANP/AMP) appointments and the accreditation of post-registration courses as identified by the *Commission on Nursing* (6.14). Currently these functions remain vested in An Bord Altranais under the Nurses Act, 1985 and will transfer to the National Council following the amendment of the Act. The National Council published guidelines on the development of courses preparing nurses and midwives as Clinical Nurse/Midwife Specialists and Advanced Nurses/Midwife Practitioners (May, 2002).

Centres for Nurse Education

The *Commission on Nursing* identified the need for a comprehensive and coherent system of continuing nurse education, providing equity in access, availability of programmes and funding. The Commission recommended that Schools of Nursing become Centres of Nursing Education, providing a range of educational and training services to nurses in the health services. The Centres will be involved in the provision of in-service training and professional development for nurses and midwives within a health service (5.61).

In particular the Centres will have a role in:

- providing education and programmes of professional development across all divisions of nursing
- identifying in partnership with the Directors of Nursing and Midwifery Planning and Development Units the education, training and development needs to support the delivery of nursing care
- providing a comprehensive training and development programme in accordance with annually agreed objectives
- ensuring that training and development is aligned to national initiatives and to organisational objectives. While the Centres are responsible for delivery of education to all nurses within a catchment area, the education and development programmes delivered by the centre need to meet the needs of the region as a whole and also meet national needs
- ensuring very close working relationships and liaison between higher education institutions and all health service agencies
- promoting cross-divisional and interagency educational practices
- promoting the professional development of staff as integral to the management of the nursing and midwifery resource

- sourcing and evaluating internal and external education and training providers
- establishing and/or maintaining systems to record education, training and development activities in accordance with agreed procedures
- evaluating education, training and development activities
- encouraging and supporting the research agenda at local and national level
- ensuring that education, training and development activities are grounded in sound evidence.

Following extensive consultation throughout the country it has been decided that there will be eighteen Centres of Nurse Education. A Board of Management, representative of all stakeholders within a given catchment area, will oversee the centres. Centres of Nurse Education will operate under the overall direction of a director. The role of the Director will be to develop and manage a centre, providing accessible, high-quality training, education and development to nurses across all divisions and specialisms within the centre's geographical remit.

1.6 Summary

This Chapter of the report presented the context and details on the development of the *Study of the Nursing and Midwifery Resource* and the systems put in place to support the study. Some of the difficulties encountered in the initial phases and the process put in place to address these were highlighted. An overview of the management of the project and some of the decisions made were given. The next Chapter of the report profiles the nursing and midwifery population registered and employed in Ireland. Detailed statistics pertinent to workforce planning are presented.

CHAPTER 2

Statistical Data

2.1 Introduction

Workforce planning in the health services is based upon the availability of reliable information. The ability to ensure the right number of suitably qualified people, available in the right place and at the right time, is vital to meet service needs. The accuracy of the planned outcome will be dictated by the quality of the information on which it is based. The key information sources providing statistics of varying levels on nursing and midwifery workforce are: the Department of Health and Children's health services personnel census, the Central Statistics Office (CSO) population census, and An Bord Altranais registration statistics. Following the identification of the three key sources of information the steering group recommended in the interim report of this study that the Health Service Employers Agency conduct a quarterly survey on vacancies and monitor recruitment from abroad (see section 2.2.4). The key sources provide information in a non-standard format at different time intervals. Collating and combining this information to any degree of accuracy shows anomalies and discrepancies. These data require interpretation and comparison if possible and in turn comparison brings issues of reliability and validity into question.

This chapter relates to objective one and two of the study:

- to estimate the number of nurses and midwives currently employed in the public and private health service
- to identify the major trends affecting the employment of nurses and midwives since 1990.

It presents an overview of demographic information on public and independent sector health service employment along with the key sources of information on nursing and midwifery updated since the interim report of this study. Descriptive statistics and trend analysis in the supply and demand for nurses and midwives in Ireland during 1990-2001 are presented.

2.2 Sources of information on supply and demand of nurses and midwives

Nurses and midwives are employed in a wide range of services. Information on the employment of nurses and midwives in the public health service is primarily collected and collated by the Department of Health and Children in the health services personnel census. The independent sector, private services and other services do not have information centrally available. A listing of the main employers requiring nursing and midwifery services is set out in Table 2.2-1.

Table 2.2-1 – Employers of nurses and midwives

Public Health Services	Source of Information
Health Boards	
• Acute Hospitals	DOHC Health Services Personnel Census
• Long-Term Care	DOHC Health Services Personnel Census
• Mental Health Services	DOHC Health Services Personnel Census
• Intellectual Disability Services	DOHC Health Services Personnel Census
• Community Services	DOHC Health Services Personnel Census
Voluntary Organisations (Public Funding)	
• Voluntary/Joint Board Hospitals	DOHC Health Services Personnel Census
• Specialist Hospitals	DOHC Health Services Personnel Census
• Intellectual Disability Services	Partly through DOHC Health Services Personnel Census
• Physical Disability Services	Directly from organisations
• Specialist Agencies	DOHC Health Services Personnel Census
Independent/Private Services	
Private Hospitals/Clinics	Not centrally available
Private/Voluntary Nursing Homes	Not centrally available
Voluntary Intellectual Disability Services	Not centrally available
Voluntary Hospices	Not centrally available
Nursing Agencies	Not centrally available
Industry/Occupational Health	Not centrally available
Other Services	
General Practice — Practice Nurses	General Medical Services (GMS) Payments Board
Prison Nursing Services	Department of Justice, Equality and Law Reform
Army Nursing Services	Department of Defence

2.2.1 An Bord Altranais — Register of Nurses

An Bord Altranais provides a wealth of information on the registration of nurses and midwives. The Registration Department supplied data on the active Register of Nurses, inactive file, new qualifications registered each year, verification for work abroad, age profile for each division of the register and nurses and midwives in training. The information available provides data on the likely supply of nurses and midwives in the future. The Register of Nurses is not a workforce-planning tool and fulfils the purpose for which it was designed. The Nurses Act, 1985 provides for the Register of Nurses. Section 27.1 states that:

> The Board shall, in accordance with rules made by the Board, maintain a register of nurses which shall be divided into the divisions specified in such rules and such divisions shall include a division applicable to midwives (Part III, 27.1).

Section 25(b) of the Nurses Act, 1985 provides that the Board may, with the consent of the Minister for Health and Children, charge a fee for the retention of the name of a person in the register.

Rule 1.8 of the Nurses (Registration) Rules, 1988 provides the basis for the charging of an annual retention fee as follows:

(a) continued registration of each person admitted to the register shall be subject to the payment of the appropriate retention fee

(b) the retention fee shall be payable in respect of each calendar year following the year in which the initial registration takes place except that in cases where initial registrations take place between 1 September and 31 December the retention fee shall not be payable in respect of that calendar year immediately following such registrations

(c) the Board at its absolute discretion may on request from any registered nurse decide on hardship grounds to reduce the amount of the annual retention fee payable by such nurse and the Board may require such evidence of hardship as it considers necessary to enable it to make such decision.

A nurse who fails to pay the annual retention fee is liable to have his or her name erased from the register. The procedure for such erasure is set out in Section 39 of the Nurses Act, 1985:

'39—(1) Where a nurse—

(b) has failed to pay a retention fee charged by the Board after the Board had, not less than two months previously by notice in writing sent by pre-paid post to the person, at his address as stated in the register, requested payment of the fee on more than one occasion, the Board may decide that the name of such person should be erased from the register or that, during a period of specified duration, registration of the person's name in the register should not have effect.'

The retention year commences on 1 January. A demand notice for payment of the retention fee is sent to each named nurse on the register, on or before the start of each retention year. The process for erasure from the register for non-payment of the annual retention fee generally commences in the first quarter of the year, when a reminder notice is sent to each nurse who has not paid all retention fees due to date.

The list of names for erasure is generally prepared for the Board's consideration in the second quarter of the year. The list contains the names of nurses who are in arrears normally for two or more years. The Board then makes the decision to erase the listed names from the register. Each nurse is advised of this decision, is given details of arrears, and advised of the right to appeal to the High Court under Section 39 (3) of the Nurses Act, 1985. In addition the nurse is advised that the Board will consider rescinding its decision if the outstanding fees are paid within twenty-one days, or if the nurse, being entitled to do so, applies for inclusion on the Inactive File.

After twenty-one days have elapsed from the date of the decision of the Board, application is made *ex parte* to the High Court for confirmation of the decision. On receipt of the Court Order the Board writes to each nurse whose name has been erased, to confirm the decision, together with an application for restoration to the register.

In addition the Board advises the Minister for Health and Children and the employer, where known, of the decision to erase the name from the register. This is carried out in accordance with Section 46 of the Nurses Act, 1985.

The name of any person which has been erased from the register for non-payment of the retention fee may at any time be restored to the register by direction of the Board. The restoration fee of €95.00 is payable together with the retention fee arrears (applicable as of April 2002).

The Register of Nurses is divided into seven main divisions. The numbers of qualifications per division are presented on Table 2.2-2. As a nurse or midwife can hold more than one qualification, the total figure (94,223) does not represent the total number of individuals (68,663) on the active and inactive file of the register in 2001.

Table 2.2-2 – Division of the Register of Nurses

	Number of Qualification under each division
Registered General Nurse (RGN)	55,634
Registered Psychiatric Nurse (RPN)	10,890
Registered Mental Handicap Nurse (RMHN)	3,955
Registered Sick Children's Nurse (RSCN)	4,299
Registered Midwife (RM)	16,158
Registered Public Health Nurse (RPHN)	2,150
Registered Nurse Tutor (RNT)	532
Other	605
Total number of qualifications recorded on the register	**94,223**
Note: 2001 provisional figures as of 27 November 2001	

Source: An Bord Altranais, Registration Department 2001

As the Register of Nurses is 'live', entries are constantly being made and therefore the total figures for the various categories will vary on a daily basis. The register records qualifications, not employment details. There is a facility for recording employment details, but in practice the section is not consistently completed by nurses and midwives, as updating of employment details is voluntary, not mandatory. Because the primary function of the register is to record qualifications it cannot be relied on as the sole information base for forecasting. The Register of Nurses provides information on the number of qualified nurses and midwives who keep their registration 'live'. The fact that someone is registered with An Bord Altranais indicates that the person is qualified to practise as a registered nurse or midwife, but does not necessarily mean that the person is actually working as a nurse or midwife. It is also worth noting that registration with An Bord Altranais within a given division of the Register of Nurses may not necessarily correlate with the area in which the nurse is actually practising. Increasingly nurses are working across the span of the health services and not confined to employment derived from the traditional divisions of nursing. However, the register facilitates the provision of valuable information to support nursing and midwifery human resource assessments.

2.2.2 Department of Health and Children — health services personnel census

The health services personnel census system currently details directly funded posts in health boards, voluntary and joint board hospitals, intellectual disability services and specialist health agencies. The census is taken on 31 December each year and reflects a 'snapshot' of employment levels at that date. The functions of the census include:

- monitoring employment levels in the health service
- providing detailed information for workforce planning purposes
- monitoring service developments
- costing of pay awards.

Health boards directly fund some of the voluntary intellectual disability services; others are principally funded under Section 65 of the Health Act, 1953. This section enables health boards to assist, financially or otherwise, organisations providing services which are similar or ancillary to those provided by the boards. In the past the census results did not represent total nursing and midwifery employment in the public health services since these personnel are not direct employees. While staff employed in twenty-two directly funded intellectual disability services are included in the health services personnel census,

those employed in Section 65-funded services are not. From 31 December 2001 health boards are being asked to provide data on grant-funded agencies together with returns for the health services personnel census. This information will mean that a more complete picture of public health service employment is available.

The primary purpose of the health services personnel census is to monitor employment levels and provide information that can be used for workforce planning. However, because of the manner in which the census is currently constructed it has significant limitations in relation to workforce planning. Although described as a census, individuals are not identified and there are no central data on the age of nurses and midwives employed. Despite its limitations, some valuable trend information is available from the census. At present the census is the only source of centralised information on the employment of nurses and midwives in the public health services.

The census of employment in the public health services each year has information on nursing by gender, grade and organisation available since 1990. Agencies are required to return only those employees in employment on the census date — 31 December of the year in question. A standardised data collection format is used. Responses can now be made electronically. The previous year's returns are sent to the agencies as a template for amendment and, in order to assist in compiling responses, guidelines and a grade code booklet are supplied. All health boards and voluntary organisations are asked to nominate a liaison person to link with the Information Management Unit and the External Personnel Departments for the census.

The preliminary whole-time equivalent (WTE) figure for murses and midwives for the health services personnel census on 31 December 2001 is 31,428.1 (36,089 individuals). This is an increase of 2,250.7 (8 per cent) in one year. This figure is provisional, based on initial returns from agencies, and is currently being audited by the Department of Health and Children. On 31 December 2000, 29,177.3 whole-time equivalents (33,474 persons) nurses and midwives were employed in the public health service. The WTE is calculated on the basis of the number of hours worked in the two-week period prior to 31 December of the year in question divided by the standard number of hours worked in a normal two-week period and expressed to two decimal places. The formula to calculate a whole-time equivalent is set out in Table 2.2-3.

Table 2.2-3 – Whole-time equivalent

Formula

$$\text{WTE} = \frac{\text{number of hours worked over two weeks (excluding overtime)}}{\text{standard number of hours worked over two weeks}}$$

Source: Department of Health and Children, guidelines for the completion of the health services personnel census at 31 December 2001

The purpose of the WTE figure is to gain a realistic understanding of the number of hours used in the delivery of the service. The number of persons employed does not take into account the fact that an increasing number of staff work reduced hours, either job-sharing or part-time. Therefore it is necessary to have both a WTE (29,177.3) and a persons number (33,474) to plan for service provision. The difference between the WTE and persons figure is due to the numbers opting for job-sharing (3,069.6 WTE, 6,102 persons) and part-time work (1,216 WTE, 2,025 persons). Table 2.2-4 shows the WTE and number of persons by nursing employment status for 31 December 2000.

Table 2.2-4 – Nursing employment status 2000

Job-sharing		Locum		Part-time		Full-time		Sessional		Temporary		Training	
No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE
6,102	3,069.63	1,329	967.53	2,025	1,215.96	19,180	19,180	128	49.19	3,756	3,756	954	938.97

Source: Department of Health and Children, Health Services Personnel Census, 31 December 2000

It is essential that the census is correctly completed in order to facilitate accurate assessment of staffing levels in the health service. In the interim report for this study the steering group recommended further expansion and rationalisation of the grade codes for nurses and midwives. On the advice of the Nursing Policy Division, grade codes have been rationalised and the guidelines booklet updated annually (see Appendix 3). To ensure that each employer completes the census in a standardised format, employment status definitions are included with the guidelines. The following are the employment status definitions for the health services personnel census, as described in the guidelines for 2001 (see Table 2.2-5).

Table 2.2-5 – Employment status definitions for the health services personnel census

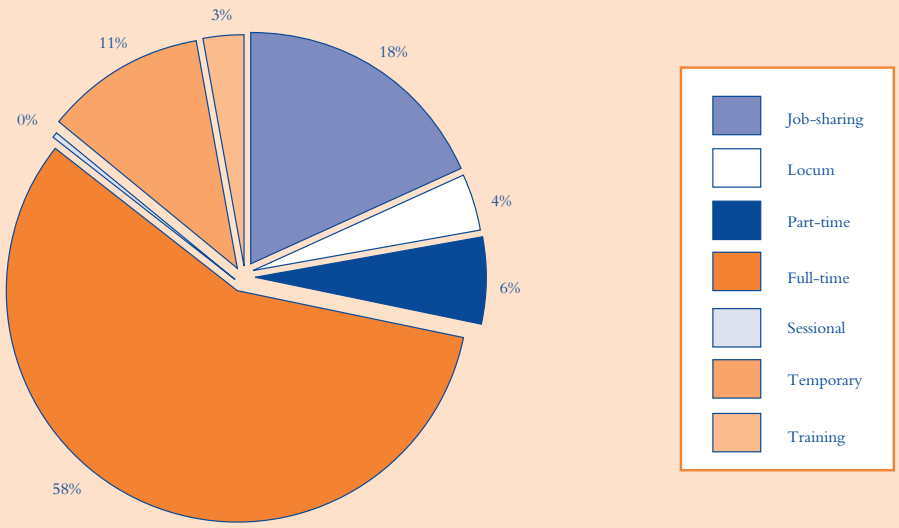
Employment Status	Description
Full-time	Filling a full-time post on a whole-time permanent basis
Job-share	Filling a permanent post on a job-sharing basis
Temporary	Filling a permanent post on a whole-time basis with a temporary contract/status
Locum	Filling a post already occupied on which you are paying a second salary. Staff employed in a locum capacity. A locum is employed to provide cover for a member of staff who is on annual leave, maternity leave etc. i.e. where two people receive salary in respect of the same post. It does not include a person employed to provide cover for a staff member who is on career break. Members of staff, for whom locums are employed as cover, should also be included in their respective columns
Part-time	Staff working less than the number of hours specified for the equivalent full-time post
Sessional	Staff paid in notional three-hourly sessions
Training	Non consultant hospital doctors, non-diploma student nurses and other trainee staff

Source: Department of Health and Children, guidelines for the completion of the health services personnel census, at 31 December 2001

There were 33,474 nursing and midwifery persons reported in the health services personnel census on 31 December 2000: 58 per cent (19,180) were permanent; 11 per cent (3,756) were temporary; 18 per cent (6,102) were job-sharing; 6 per cent (2,050) were part-time; 3 per cent (1,329) were locum; 3 per cent (954) were training; and less than 1 per cent (128) were sessional (see Figure 2.2-1).

FIGURE 2.2-1

Proportions for each nursing and midwifery employment type 2000



Source: Department of Health and Children, health services personnel census, 31 December 2000

2.2.3 Central Statistics Office — population census

A population census for the Republic of Ireland is undertaken every five years, in the month of April. The last census was conducted in 1996 and was due in 2001. The Government postponed the census scheduled for 29 April 2001 in order to minimise the risk of spreading foot and mouth disease. The Government took this decision following detailed discussions between the Central Statistics Office, the Expert Group on Foot and Mouth Disease and Government Departments. The census took place on 28 April 2002. The preliminary findings indicate that the population now stands at 3,917,336 people.

The Central Statistics Office (CSO) provided specific information from the 1996 census on the occupational grouping for nurses and midwives. At that time 38,838 nurses and midwives were identified of which 37,838 were reported to be employed (1,000 unemployed). Of the total employed 9,805 (25.9 per cent) indicated that they were employed part-time. It is unclear if all former nurses who may now be working in the home or unemployed reported the principal occupation they previously held.

The coding frame used by the CSO is the United Kingdom Standard Occupational Classification 1990 (UKSOC90) modified slightly for the Irish Census. The descriptors for the occupational grouping 'nurses and midwives' (code 340) provided by the CSO indicate that the terms 'nurse' and 'midwife' are widely interpreted. The list of descriptors (354 in total) for the group suggests that there may have been some overlap in the occupational codes for nurses and midwives (340) with other related groupings.

Contact was made with the CSO to offer advice in relation to nursing and midwifery for the population census 2002. Copies of the grade titles/codes and guidelines used by the Department of Health and Children were sent to the CSO. A matching exercise has taken place so that the titles commonly used can be equated with the codes used by the CSO. A number of new questions have been included. Some of these relate to nationality, place of birth and area of current residence, time of departure to work, and personal care for relatives. The newly structured questionnaire contains a filter question which asks the current principal employment status for the previous two years. This will eliminate nurses and midwives who have not worked in the profession over the past two years.

2.2.4 Health Service Employers Agency — nursing resource survey

Prior to the publication of the interim report the Health Service Employers Agency (HSEA) had been collecting data from time to time in relation to nursing vacancies. This process was largely related to its representational role on behalf of employers in assessing the implications of increasing difficulties in the recruitment of nurses. The agency was involved in, for example, the collection and collation of information in respect of appearances before the Joint Oireachtas Committee on Health and Children or in presentations to third parties in relation to claims for adjustment in pay and/or conditions of employment.

The interim report for this study recommended the following in relation to vacant nursing and midwifery positions and the recruitment of nurses and midwives from abroad:

> Health service employers should develop appropriate mechanisms for monitoring the recruitment of nurses from abroad (Para. 4.1.7).
>
> The Health Service Employers Agency should arrange for information on nursing and midwifery vacancies, in standard format, to be provided by health service employers on a quarterly basis. This information should be sufficiently detailed to allow for reporting and analysis of trends between divisions of the register and geographic locations of the health service (Para 4.2.4).

Following publication of the interim report the HSEA commenced the collection of data in relation to vacancies on a quarterly basis. While the recommendations of the interim report related only to information on vacancies, it was quickly established that a more detailed approach to the collection of data would allow for more rigorous analysis of the trends and changes in the recruitment and retention of nurses. In particular, it was recognised that detailed information was required in relation to the recruitment of nurses from abroad, nurses leaving employment and the actual overall levels of recruitment within the system. In addition, it was considered prudent to track the utilisation of Agency nurses within the system and, also, the increasing utilisation of overtime working to cover vacant positions. Details of the quarterly trends in the HSEA *National Survey on Nursing Resource* are set out in section 2.3.3.

2.2.5 Sources of information — summary

Section 2.2 identifies the main centralised sources of information on nursing and midwifery in Ireland. Table 2.2-6 shows the trend in information available from the key sources which indicate that registrations and numbers employed have continued to increase over time. The difference between the numbers employed in the public health service and those on the active register in 2001 is 20,522 individuals.

Table 2.2-6 – Source of information on nursing and midwifery

	1996	1997	1998	1999	2000	2001
Personnel Census DOHC (individuals)	30,303	30,736	30,301	30,875	33,474	36,089*
Population Census CSO (next census April 2002)	37,838	—	—	—	—	—
Register of Nurses (active) ABA (names)	44,822	47,157	49,041	50,221	53,072	56,611**

Notes:
*Figure for 2001 health services personnel census is provisional (14 May 2002)
**An Bord Altranais figure as of 27 November 2001
CSO Population Census due April 2001 was deferred until 28 April 2002 due to foot and mouth restrictions

Source: Department of Health and Children health services personnel census, CSO Population Census 1996 and An Bord Altranais, Registration Department

The next section of the Chapter relates to how information on the likely demand for nurses and midwives is collated and reported.

2.3 Demand for nursing and midwifery services

The interim report for this study identified four main categories that classify demand, arising from: the provision of the current services; unmet need due to vacant positions; expansion of existing services; and replacement requirements resulting from nurses and midwives leaving the health service.

2.3.1 Demographic information — public health service

Population distribution

The Central Statistics Office estimated Ireland's population at 3,838,900 in April 2001 (3,917,336 provisional figure for 2002). This estimate is based on the census carried out on 31 April 1996. Table 2.3-1 shows the population distribution across health board areas in 1996.

Table 2.3-1 – Distribution of the population between health boards

Health Boards	Numbers	%
Eastern Regional Health Authority and Area Health Boards	1,295,939	35.7
Midland Health Board	205,542	5.7
Mid-Western Health Board	317,069	8.7
North-Eastern Health Board	306,155	8.4
North-Western Health Board	210,872	5.8
South-Eastern Health Board	391,517	10.8
Southern Health Board	546,640	15.1
Western Health Board	352,353	9.7
Total Health Boards	**3,626,087**	**100**

Source: Central Statistics Office, 31 April 1996

Health human resources

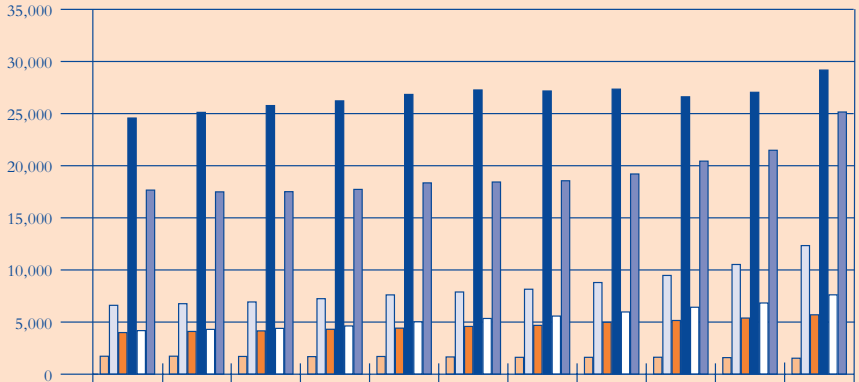
The numbers employed and type of employment in the public health service are published by the Department of Health and Children. The health service personnel census conducted by the Department is the only centrally available information on employment in the public health service. On 31 December 2000 the number of all grades employed totalled 81,513 whole-time equivalent (WTE). The number of people who work in the public health services makes health one of the largest public service employers.

The demand for nursing and midwifery services can be appreciated by the fact that the nursing profession is the largest single category of staff employed in the public health service. In 2000 over one third (36 per cent) of all staff employed in the public health service were nurses and midwives. An insight to the integral role of nurses and midwives in the provision of health care can be gained from the figures presented in this section.

The health services personnel census is divided into six main categories Maintenance/Technical, Management/Administration, Medical/Dental, Nursing, Paramedical and Support Services. Significant growth in employment in the public health sector has occurred. The proportion of staff employed in the public health service by category for 2000 is shown in Figure 2.3-1.

FIGURE 2.3-1

Total employment per category in the Public Health Service 1990-2000



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Maintenance/Technical	1,722	1,726	1,701	1,686	1,698	1,655	1,618	1,618	1,626	1,591	1,533
Management/Administration	6,607	6,763	6,930	7,243	7,607	7,885	8,151	8,794	9,474	10,525	12,338
Medical/Dental	3,994	4,100	4,155	4,310	4,417	4,581	4,684	4,976	5,153	5,385	5,698
Nursing	24,574	25,118	25,771	26,220	26,839	27,267	27,170	27,346	26,611	27,044	29,177
Paramedical	4,180	4,299	4,395	4,628	5,024	5,345	5,576	5,969	6,422	6,831	7,613
Support Services	17,661	17,491	17,510	17,728	18,353	18,437	18,556	19,207	20,440	21,482	25,154

Source: Department of Health and Children, health services personnel census, 31 December 2000

Figure 2.3-1 summarises the numbers of WTE working within the public health system over the period 1990-2000. It is evident that the overall number of WTE employed in the public health system has increased by some 22,776, or 39 per cent over the ten-year period. This illustrates the significant commitment of additional resources to the public health system during the decade. Across the categories of personnel the following increase in staffing is presented on Table 2.3-2.

Table 2.3-2 – Growth in number employed by the public health service over ten years

	1990	1990 %	2000	2000 %	1990-2000 % Increase
Maintenance/Technical	1,721.89	2.93	1,533.14	1.88	–10.96
Management/Administration	6,649.25	11.32	12,366.44	15.17	85.98
Medical/Dental	3,993.58	6.80	5,697.77	6.99	42.67
Nursing	24,573.53	41.84	29,177.28	35.79	18.73
Paramedical	4,179.76	7.12	7,612.81	9.34	82.14
Support Services	17,618.70	30.00	25,125.34	30.82	42.61
Total	**58,736.71**	**100.00**	**81,512.78**	**100.00**	**38.78**

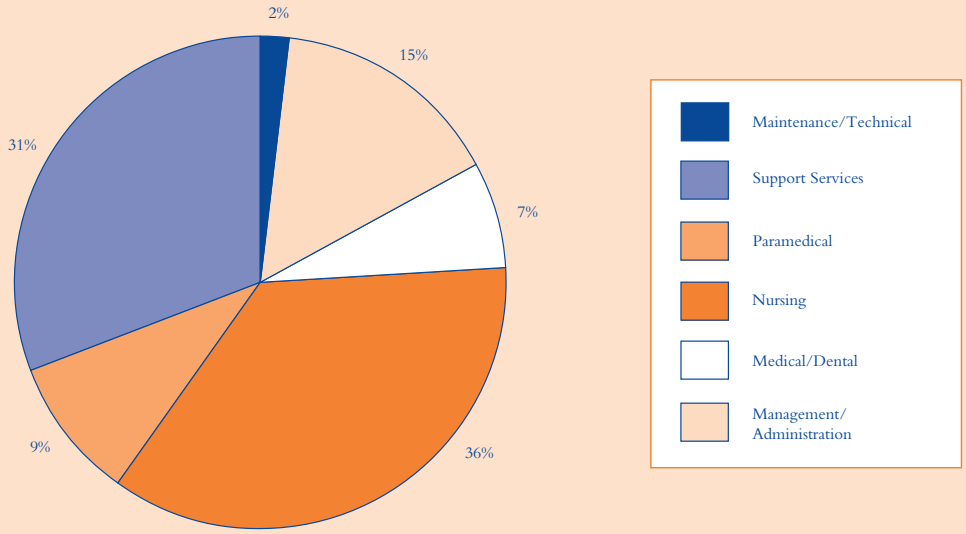
Source: Department of Health and Children, health services personnel census, 31 December 1990-2000

While nursing and midwifery accounts for the highest proportion of staff per category — 42 per cent in 1990 and 36 per cent in 2000 — there seems to be a disproportional increase over the 10 years. The nursing category has increased by 19 per cent (4,604) while support services, which account for 31 per cent of the total number employed in 2000, have increased by 43 per cent (7,507) between 1990 and 2000. However, this increase reflects substantial investment in a range of services such as childcare and disability services. It is important to note that of all staff classified as management/administration, nearly two-thirds are involved in front-line services for patients, and that a further 5 per cent deal with legislative

and information requirements. The growth in clerical and administrative staff can be attributed to the large numbers of support staff employed to assist doctors, nurses and health professionals and relieve them from excessive clerical duties. Figure 2.3-2 shows the proportion of staff employed in each category in the public health service for 2000.

FIGURE 2.3-2

Proportion of staff employed in the public health service 2000



Note: the category of Management/ Administration also includes grades that are of direct service to the public, such staff as Consultant's Secretaries, Community Welfare Officers, Outpatient Department Personnel, Ward Clerks, Medical Records Personnel, Telephonists and Computer Personnel who are engaged in front line duties.

Source: Department of Health and Children, health services personnel census, 31 December 2000

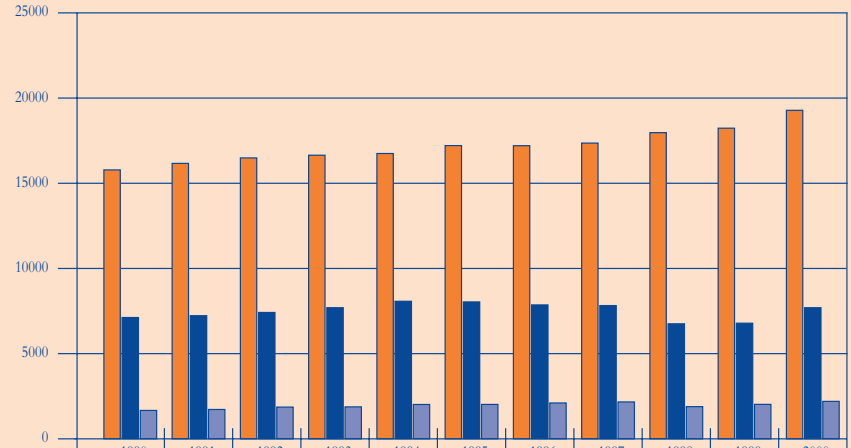
2.3.2 Nursing and midwifery employment — public health service

The 2000 health services personnel census indicates that the total number of nurses and midwives working with health boards was 19,282 WTE (66 per cent of the public health service employment); while the voluntary/joint board hospitals was 7,696 WTE (26 per cent of the public health service employment); and intellectual disability services was 2,199 (8 per cent of the public health service employment). These statistics are illustrated in Figure 2.3-3. Table 2.3-3 shows the trend in employment of nurses and midwives across the public health service from 1990 to 2000.

The numbers of nurses and midwives employed by the public health services continues to rise. Over the ten-year period, the numbers of individual nurses and midwives employed has increased by 6,754 (WTE 4,603.75). Nursing and midwifery staff numbers increased from 24,573.53 to 29,177.28, a rise of 19 per cent over the ten-year period (see Figure 2.3-4).

FIGURE 2.3-3

Number of WTE nurses and midwives employed in each service



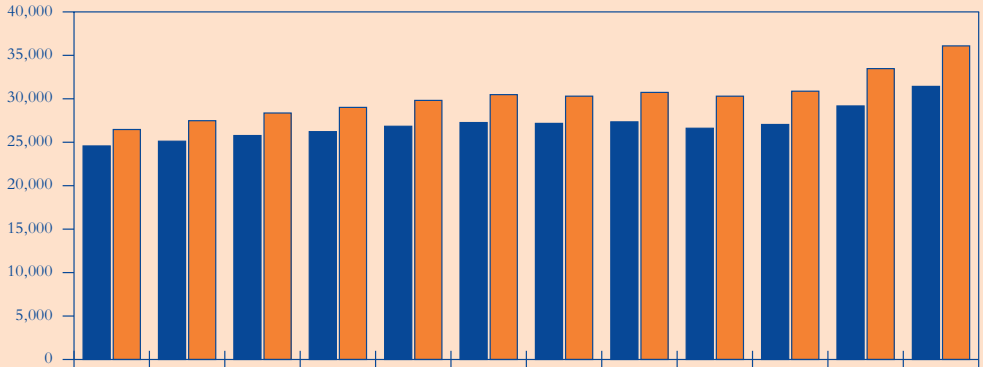
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Health Boards	15,784	16,167	16,488	16,647	16,747	17,211	17,204	17,358	17,970	18,233	19,282
Voluntary Hospitals	7,121	7,227	7,418	7,696	8,074	8,036	7,860	7,822	6,751	6,787	7,696
Intellectual Disability Services	1,668	1,724	1,864	1,877	2,018	2,020	2,106	2,166	1,890	2,024	2,199

Note: all figures expressed as WTE - excludes those on career break

Source: Department of Health and Children, health services personnel census, 31 December each year

FIGURE 2.3-4

Trend in employment of nurses and midwives



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*
WTE	24,574	25,118	25,771	26,220	26,839	27,267	27,170	27,346	26,611	27,044	29,177	31,428
Persons	26,466	27,480	28,365	29,011	29,816	30,480	30,303	30,736	30,301	30,875	33,474	36,089

Note: *figure for 2001 health services personnel census is provisional (14 May 2002)

Source: Department of Health and Children, health services personnel census, 31 December each year

It should be noted that nursing students participating in the registration/diploma programmes were excluded from the 1998 census onwards as they are now supernumerary to the workforce. However, some students were inadvertently included in the published figures of the census for 2000 (598.8 WTE or 611 persons). Therefore the amended data for 2000 would read 28,578.5 WTE and 32,863 persons.

A breakdown of the number of individual nurses and midwives employed in each health board region over the ten-year period is given in Table 2.3-3. It must be emphasised that a large number of nurses employed in voluntary organisations in the eastern region are not included in the figures given for the three area health boards within the ERHA.

Table 2.3-3 – Numbers of nurses and midwives employed in the public health service 1990-2000

Health Sector Employer	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
ERHA and Area Health Boards	2,817	3,014	3,039	3,129	3,123	3,157	3,313	3,325	3,367	3,203	3,212
Midland Health Board	1,133	1,157	1,187	1,227	1,244	1,267	1,302	1,333	1,419	1,398	1,452
Mid-Western Health Board	1,670	1,735	1,780	1,729	1,763	1,748	1,660	1,689	1,769	1,748	1,970
North-Eastern Health Board	1,203	1,243	1,256	1,271	1,257	1,380	1,373	1,415	1,809	1,907	1,897
North-Western Health Board	1,489	1,533	1,554	1,567	1,552	1,580	1,542	1,540	1,539	1,667	1,762
South-Eastern Health Board	2,142	2,179	2,233	2,275	2,390	2,507	2,460	2,457	2,477	2,556	2,771
Southern Health Board	2,818	2,807	2,882	2,905	2,866	3,091	3,096	3,106	3,010	3,181	3,427
Western Health Board	2,513	2,498	2,556	2,544	2,552	2,481	2,458	2,493	2,580	2,572	2,790
Total Health Boards	15,784	16,167	16,488	16,647	16,747	17,211	17,204	17,358	17,970	18,233	19,282
Total Voluntary Hospitals	7,121	7,227	7,418	7,696	8,074	8,036	7,860	7,822	6,751	6,787	7,696
Total Intellectual Disability Services	1,668	1,724	1,864	1,877	2,018	2,020	2,106	2,166	1,890	2,024	2,199
Grand Total	**24,574**	**25,118**	**25,771**	**26,220**	**26,839**	**27,267**	**27,170**	**27,346**	**26,611**	**27,044**	**29,177**

Notes:
All figures expressed as WTE — excludes those on career break
Student nurses were included in the figures up to 1998. Then this grade code was removed, as diploma-nursing students are supernumerary

Source: Department of Health and Children, health services personnel census, 31 December each year

Patient care support

The effective delivery of services is based on a team approach with other grades employed to support and assist in the delivery of nursing and midwifery care. A review of the total returns of the health services personnel census highlighted the difficulties in defining the grades and numbers of staff specifically employed to support patient care. There is considerable overlap in roles particularly between domestic, porter and auxiliary staff. For illustrative purposes returns for the grades specifically employed to support nurses and midwives are set out in Table 2.3-4. The figure for ward clerk under-represents the numbers, as many are reported in the general category 'grade 3 clerical officer'. The number of support staff has increased. However, the total figure of 6,801 for 2000 does not provide a complete picture of the WTE staff supporting nursing and midwifery, because of the difficulty in disaggregating the various support roles.

For the census 2002 the grade Health Care Assistant (HCA) will be included. The grade codes and titles for support staff providing direct patient care (nursing and midwifery support) will be reviewed and rationalised.

Table 2.3-4 – Patient care support

Category	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Attendant/Aide									1,397	1,552	1,951
Care Assistant		6	163	256	290	327	444	491	560	802	1,388
Nurses Aides										83	143
Nursing Auxiliary/Orderly	4,151	3,990	3,895	3,962	4,076	4,263	4,355	4,656	3,597	3,501	3,193
Ward Clerk	12	21	24	44	48	54	61	72	81	112	126
Total	**4,163**	**4,018**	**4,082**	**4,261**	**4,414**	**4,644**	**4,859**	**5,219**	**5,635**	**6,050**	**6,801**

Notes:
All figures expressed as WTE
Due to interpretation of grades and role titles staff are reported differently across some agencies. For this reason other grades who may perform nursing support duties are excluded from the figures given

Source: Department of Health and Children, health services personnel census, 31 December each year

Ratio of nurse to population

The difference in the numbers of nurses and midwives employed in each health board is reflective of the population distribution. The statistics in previous censuses reflect the dominant position of the Eastern Regional Health Authority and Area Health Boards (Table 2.3-3). An examination of the distribution shows that the Eastern Regional Health Authority and Area Health Boards have a substantially larger proportion of the population, at 35.5 per cent, followed by the Southern Health Board, 10.8 per cent. In Table 2.3-4 an estimated number of nurses and midwives per 1,000 is given. Caution is advised when interpreting these figures as the estimated number of nurses and midwives per 1,000 population is approximated using the 1996 population census (3,626,087) and the health services personnel census for 2000. The estimated number of nurses and midwives per 1,000 population would be less if using a current population figure (2001 estimated 3,838,900) as the population was estimated, by the CSO, to have increased by 5.8 per cent since 1996.

Table 2.3-5 – Proportion of nurses and midwives per 1,000 population

Health Sector	Population CSO Census 1996	Number WTE 2000	Estimated number of Nurses/Midwives per 1,000 population
Eastern Regional Health Authority (HB = 3,212, IDS = 1,247, VH = 6,879)	1,295,939	11,338	8.74
Midland Health Board (HB = 1,452, IDS = 28, VH = 0)	205,542	1,480	7.20
Mid-Western Health Board (HB = 1,970, IDS = 301, VH = 120)	317,069	2,391	7.54
North-Eastern Health Board (HB = 1,897, IDS = 0, VH = 0)	306,155	1,897	6.19
North-Western Health Board (HB = 1,762, IDS = 29, VH = 0)	210,872	1,791	8.49
South-Eastern Health Board (HB = 2,771, IDS = 143, VH = 0)	391,517	2,914	7.44
Southern Health Board (HB = 3,427, IDS = 250, VH = 483)	546,640	4,160	7.61
Western Health Board (HB = 2,790, IDS = 202, VH = 214)	352,353	3,206	9.09
Total Public Health Services	**3,626,087**	**29,177**	**8.04**

Notes:
Nurses and Midwives per 1,000 population is estimated using the population as reported by the CSO on 31 April 1996
HB = Health Board, IDS = Intellectual Disability Services, VH = Voluntary Hospitals

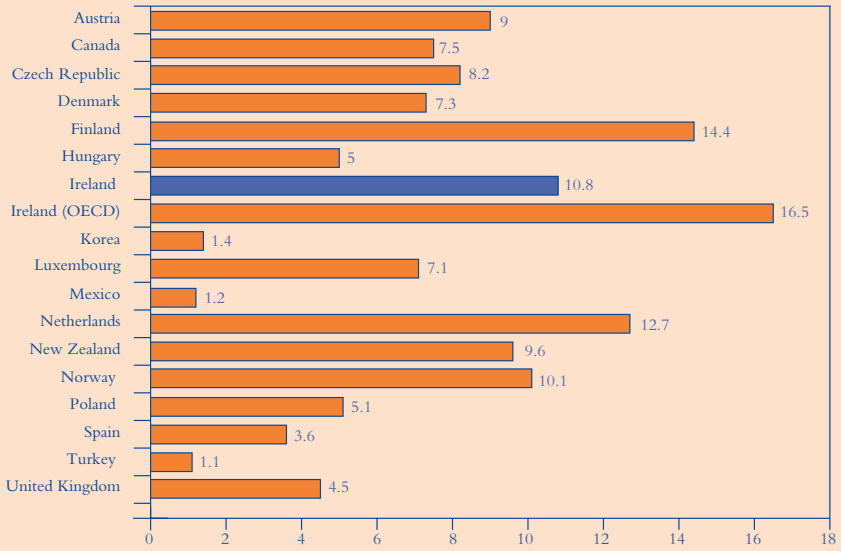
Source: Central Statistics Office, 31 April 1996. Department of Health and Children health services personnel census, 31 December 2000

The proportion of nursing and midwifery staff per 1,000 population is highest in the Western Health Board at 9.09. The North-Eastern Health Board has the lowest across the boards at 6.19. Across the public health service there are 8.04 nurses and midwives per 1,000 population.

Caution is advised in cross-country comparisons of nurse-population ratios. The Organisation for Economic Co-operation and Development (OECD, 2001) has reported ratios for selected countries using full-time equivalent of 'practising nurse' per 1,000 population for 1999 (see Figure 2.3-5). Full-time equivalent differs in various countries; for example in the NHS (UK) it is 37.5 hours, while in Ireland it is 39 hours (Buchan, 2002). The OECD reports that Ireland has the highest ratio of nurses per 1,000 population at 16.5. However, the OECD have included 10,389 nurses on the inactive Register of Nurses in this calculation. Although the OECD rely on the accuracy of the data from the various countries and warn there may be differences in definitions and the point in time in which data are collected, the ratio reported for Ireland appears significantly inflated. This study identified a very different ratio. Table 2.3-5 shows the ratio of nurses and midwives per 1,000 population for the Irish public health service in 2000 as 8.04. If the estimated number of 10,000 nurses and midwives in the independent sector are included, the ratio of nurses and midwives per 1,000 population would be approximately 10.8. Another reason for this inflated ratio is that the calculation is based on head count, not WTE, and does not take account of flexible working such as part-time hours and therefore does not reflect a full-time equivalent figure.

FIGURE 2.3-5

Number of practising nurses per 1,000 population by country



Note: two figures are given for the ratio of nurses and midwives per 1,000 population for Ireland - that calculated by the OECD (16.5) and that calculated during this study (10.8)

Source: Organisation for Economic Co-operation and Development — Health Data 2001

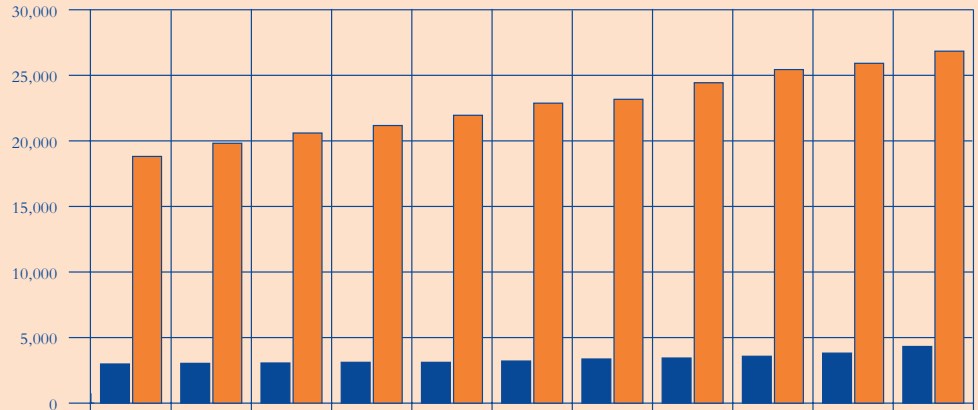
Grade of nurses and midwifes employed in the public health service

The health services personnel census gives a breakdown of the numbers (WTE) employed for each of the grades recognised for nursing and midwifery (see Appendix 9). A trend in the numbers (individuals) employed in each grade for the ten years 1990-2000 can be seen in the table presented in Appendix 10.

Role titles have changed over the period, resulting particularly from recommendations of the *Commission on Nursing*; these are reflected in the tables. The grades have been regrouped to give an impression of the numbers employed in clinical and management roles. Over the ten-year period the numbers employed in both the management and clinical grouping have increased considerably. In the management grouping there has been an increase of 45 per cent (1,336) from 1990 to 2000. Figure 2.3-6 shows that the increase in the numbers of nursing and midwifery management grades was relatively stable until 1997 with the greatest number of new positions created in the latter part of the decade. Since 1997 the number of individual nurses and midwives in management posts has increased by 26 per cent (881).

FIGURE 2.3-6

Nursing and Midwifery - Management and Clinical Grades 1990-2000



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Management	2,986	3,035	3,062	3,114	3,113	3,211	3,367	3,441	3,575	3,814	4,322
Clinical	18,815	19,820	20,601	21,172	21,953	22,878	23,172	24,433	25,439	25,917	26,842

Source: Department of Health and Children, health services personnel census 1990-2000

The number of nurses and midwives employed in the clinical grouping has also increased significantly over the decade. Between 1990 and 2000 this category has increased steadily year by year and represents and overall increase of 43 per cent (8,027).

2.3.3 Nursing and midwifery vacancies in the public health services

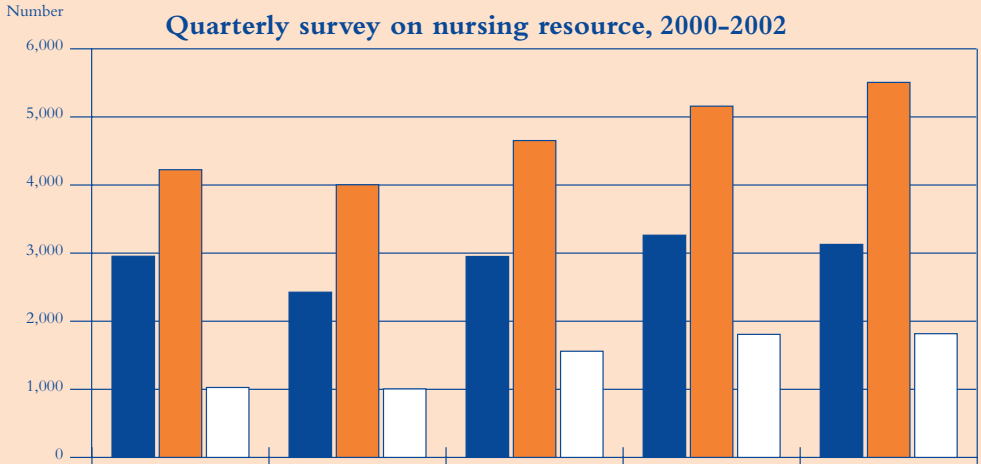
The Health Service Employers Agency published the first quarterly report on the *National Survey on Nursing Resources* as at 30 September 2000. Each quarterly survey of employers provides national data and analysis in relation to the nursing and midwifery workforce. The participating organisations are made up of employers who are members of the HSEA. The member organisations which are surveyed comprise the ten health boards, twenty-eight voluntary hospitals, and voluntary organisations within the intellectual disability sector (twenty-one services). The survey reports on total recruitment, recruitment from abroad, vacancies, employment of agency nurses and overtime. Since commencement, six surveys have been conducted and are based on the position as existed on 30 September 2000, 31 January 2001, 30 April 2001, 31 July 2001, 31 October 2001, 31 January 2002 and 30 April 2002 for the previous 12-month period. Findings for the most recent survey are currently being collated by the HSEA. If data were collected for the end of March, June, September and December it would ensure that information would be available for a full calendar year without the necessity for additional data collection.

Resignation and recruitment

The first survey reporting the position on 30 September 2000 collected data on the number of nurses recruited and the number who resigned from voluntary hospitals, and did not report on recruitment from abroad. For this reason the data for resignations, recruitment and recruitment from abroad are presented on the five following surveys. Figure 2.3-7 shows the numbers resigned and recruited for 31 January 2001 to 31 January 2002 for the previous twelve months.

FIGURE 2.3-7

Quarterly survey on nursing resource, 2000-2002



	Jan-01	Apr-01	Jul-01	Oct-01	Jan-02
Total resigned	2,954	2,426	2,951	3,263	3,128
Total recruited	4,225	4,004	4,653	5,158	5,507
Recruited abroad	1,027	1,006	1,559	1,807	1,817

For 12 months ending 30/31

Note: the total recruited is the number recruited over the previous 12 months and includes the number recruited from abroad

Source: Health Service Employers Agency, *National Survey on Nursing Resources* 2000-2001

Across the five surveys the numbers recruited exceed the numbers who resigned for the previous 12-month period. For the period reporting the position on 31 January 2001, 1,271 more were recruited than resigned (1,316 vacancies reported). On 30 April 2001, 1,578 more were recruited than resigned (1,316 vacancies reported); on 31 July 2001, 1,702 more were recruited than resigned (1,252 vacancies reported); on 31 October 2001, 1,895 more were recruited than resigned (1,322 vacancies reported); and on 31 January 2002, 2,380 more were recruited than resigned (1,089 vacancies reported). The findings for the most recent survey (30th April 2002) are currently being collated by the HSEA.

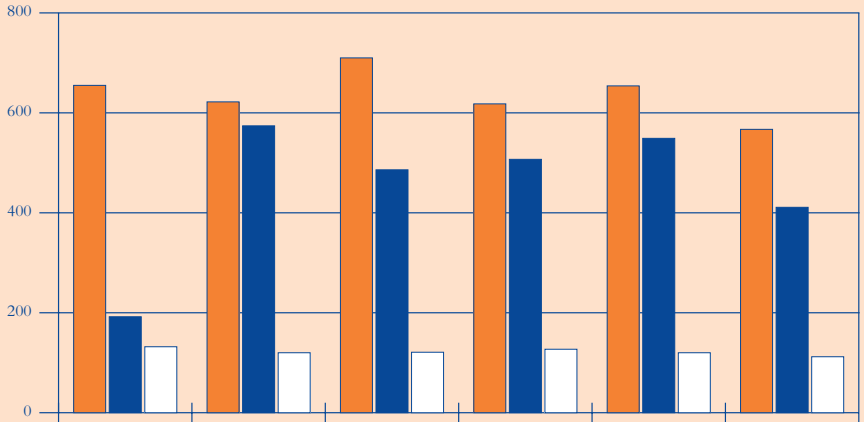
Vacancies, agency and overtime hours

The quarterly survey also reports on the number of vacancies, the employment of agency nurses and the amount of overtime. It is important to note that on occasions some agencies did not report on the volume of overtime hours. Therefore caution is urged in comparing responses. Figure 2.3-8 illustrates the trend in nursing vacancies for the six surveys conducted in 2000, 2001 and 2002. The total number of vacancies was 979 for the year ending 30 September 2000; 1,316 for the year ending 31 January 2001; 1,316 for the year ending 30 April 2001; 1,252 for the year ending 31 July 2001; 1,322 for the year ending 31 October 2001; 1,089 for the year ending 31 January 2002. Across the six surveys the highest number of vacancies for the previous 12-month period was reported on 31 October 2001. In the most

recent survey in January 2002 this figure had dropped significantly. The difference between October 2001 and January 2002 was 233 vacancies, a decrease of 17 per cent.

FIGURE 2.3-8

Quarterly survey on nursing resource - vacancies, 2000-2002



	End Sept-00	End Jan-01	End April-01	End July-01	End Oct-01	End Jan-02
Health Boards	655	622	710	618	654	567
Voluntary Hospitals	192	574	486	507	549	411
Intellectual Disability Sector	132	120	121	127	120	112

Note: for 12 months ending 30/31 of each month

Source: Health Service Employers Agency, *National Survey on Nursing Resources* 2000-2001

The service gaps resulting from nursing vacancies are made up through the employment of agency nurses and overtime hours worked by those already employed in the public health service. A comparison of the figures reported on 31 January 2001 and 31 January 2002 shows the following:

- vacancies have decreased by 226 (17 per cent)
- average number of agency nurses has increased by 35 (8 per cent)
- average number of overtime hours has increased by 1,223 (37 per cent)

The figures for agency and overtime working are set out in table 2.3.6.

Table 2.3-6 – Vacancies, employment of agency nurses and overtime

	End Sept. 2000	End Jan. 2001	End April 2001	End July 2001	End Oct. 2001	End Jan. 2002
Number of Vacancies	978.86	1,315.52	1,316.35	1,251.94	1,322.31	1,089.10
Average Number of Agency Nurses	278.15	423.28	498.65	416.75	396.16	458.21
Average Number of Overtime Hours*	2,122.66	3,298.83	4,448.70	2,895.05	4,157.98	4,521.44

Note: *Overtime hours — figures were not consistently supplied by some health agencies

Source: Health Service Employers Agency, *National Survey on Nursing Resources* 2000-2001

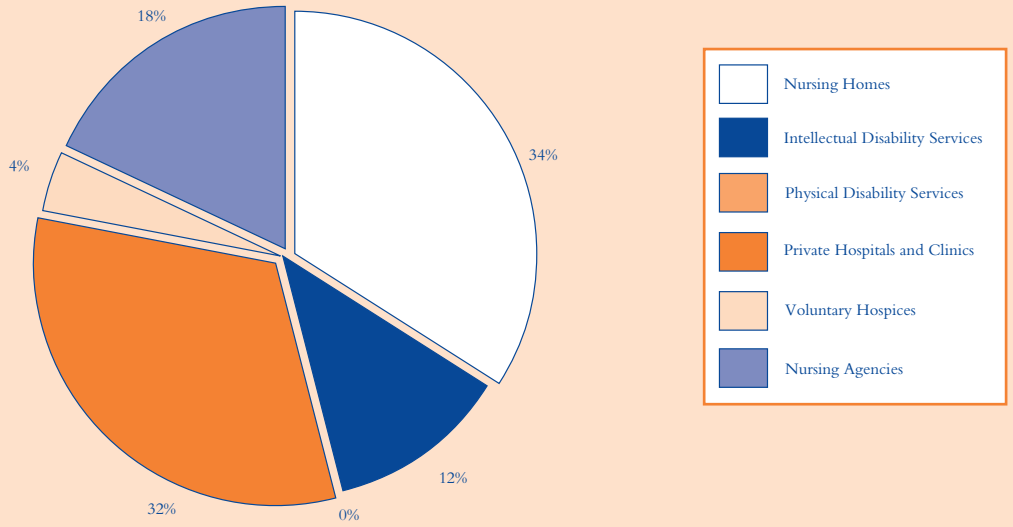
2.3.4 Nursing and midwifery employment — independent sector

To date the numbers and profile of nurses working in the independent sector (private hospitals and clinics; private and voluntary nursing homes; grant-aided bodies, GP practices, hospices, and nursing agencies) have not been collated centrally. To achieve a realistic understanding of the future demand for registered nurses and midwives it is necessary to establish a baseline for nursing employment in this sector. For this reason a survey of nursing employment in the independent sector was undertaken in May/June 2000. Details of the survey can be located in Appendix 5.

The survey indicated that in total 5,361 (3,564 WTE) nurses or midwives were employed in the participating organisations. Of this: 34 per cent (1,940) in nursing homes; 32 per cent (1,790) in private hospitals and clinics; 18 per cent (991) in nursing agencies; 12 per cent (695) in intellectual disability services; 4 per cent (201) in voluntary hospices; and less than 1 per cent (14) in physical disability services. The percentage employed in each grouping of the independent sector in the survey is presented at Figure 2.3-9.

FIGURE 2.3-9

Percentage employed in each grouping of the independent sector



Source: *Survey of Nursing Employment in the Independent sector* (April 2000) Nursing Policy Division, Department of Health and Children

The variation between the persons and WTE figure is due to the numbers working on a part-time or job-sharing basis. A very different pattern of work than that in the public health services is evident from the results of the survey. This particularly applies to private and voluntary nursing homes where substantial numbers (1,273 — 66 per cent) of nurses were reported to be employed on a part-time basis. Job-sharing was identified by private hospitals and clinics (22 per cent), voluntary hospices (17 per cent), and intellectual disability services (9.6 per cent). Job-sharing was not reported as a contract type by any private or voluntary nursing home. Because of the nature of the employment relationship, full-time, part-time or job-sharing, as defined for the survey, does not apply to nursing agencies. The breakdown of the responses for contract type can be located at Table 2.3-7 and Figure 2.3-10.

Table 2.3-7 – Numbers in the independent sector holding various contract types

Sector	Persons full-time	Persons part-time	Persons job-sharing	Total persons employed	Total WTE employed
Private and Voluntary Nursing Homes	667	1,273	—	1,940	1,322
Intellectual Disability Services	536	92	67	695	622
Physical Disability Services	4	9	1	14	10
Private Hospitals and Clinics	1,077	327	386	1,790	1,443
Voluntary Hospices	129	38	34	201	167
Nursing Agencies*	N/A	N/A	N/A	991	N/A
Totals	**2,413**	**1,739**	**488**	**5,631**	**3,564**

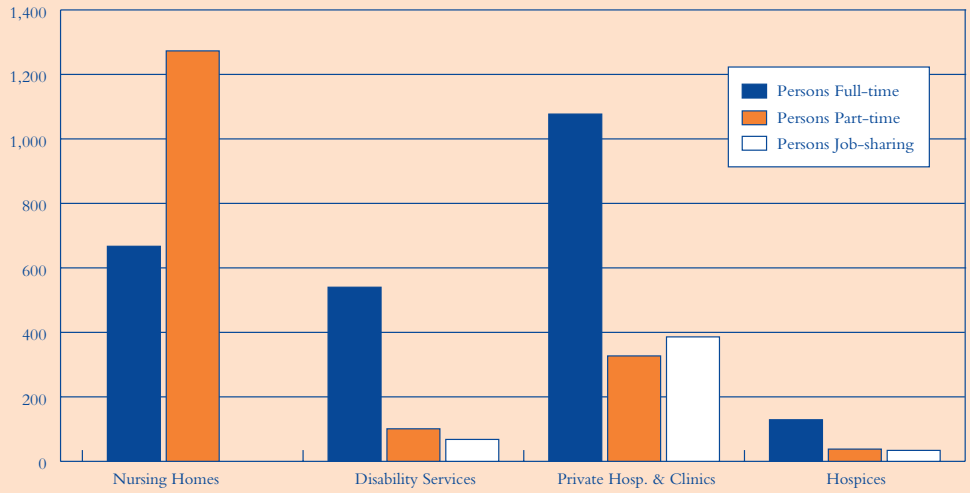
Note: *This figure was reported as the total number of nurses employed by 11 agencies either on a full-time for part-time basis; it was not possible to calculate a WTE figure from the responses given

Source: *Survey of Nursing Employment in the Independent sector* (April 2000) Nursing Policy Division, Department of Health and Children

It was not possible to report on the breakdown for age because not all respondents completed this question and discrepancies were found in many of the responses.

FIGURE 2.3-10

Contract type for the main groupings in the independent sector



Source: Survey of Nursing Employment in the independent sector (April 2000) Nursing Policy Division, Department of Health and Children

Respondents were also asked to indicate the number of vacant nursing or midwifery posts at the end of April 2000. Nursing agencies were not asked about vacancies. Four hundred and two vacancies were identified, with the highest number in the intellectual disability services (see Table 2.3-8). This would

suggest that at the time the vacancy rate across the 313 organisations participating in the survey (4,640 persons employed) was approximately 8.6 per cent.

Total employment in the independent sector

Based on the findings of the survey it was estimated that approximately 10,000 nurses were employed in the independent sector in April 2000. This figure is calculated on the assumption that there is a similar spread of service size, employment numbers and vacancies in the organisations that did not respond to the survey. The figure was calculated separately and based on the percentage response rate for each sector. The accuracy of the estimation is highest in sectors with higher response rates. The number of practice nurses identified by the GMS was added to the calculations as they also form part of the independent sector. A recent survey undertaken by the Irish Nurses Organisation (INO Practice Nurses Section and Irish Practice Nurse Association, 2002) indicates that 98 per cent of practice nurses see a mixture of both GMS and private patients. From this it can be estimated that 2 per cent of practice nurses are employed solely on a private basis by GPs and are not reflected in the figure supplied by the GMS payments board. Details of the calculations are set out on Table 2.3.8.

Table 2.3-8 – Estimated persons employed in each grouping within the independent sector

Sector	Percent response	Number persons	Vacant posts	Estimated total persons
Private and Voluntary Nursing Homes	58	1,940	119	3,567
Intellectual Disability Services	66	695	150	1,282
Physical Disability Services	56	14	—	25
Private Hospitals and Clinics	89	1,790	130	2,159
Voluntary Hospices	75	201	3	272
Nursing Agencies	48	991	N/A	2,072
General Practice*	N/A	*621	N/A	633
Totals		**6,254**	**402**	**10,010**

Note: *Figure obtained from the GMS payments Board for 2000

Source: *Survey of Nursing Employment in the independent sector* (April 2000) Nursing Policy Division, Department of Health and Children

It must be emphasised that the final figure (10,000) for employment in the independent sector is an estimate based on very large assumptions and relates only to one particular point in time. If we are to gauge the number of nurses and midwives required for this sector in the future it is absolutely imperative that a baseline for numbers employed and age profile is calculated on an annual basis and that the trend is monitored over time. There is a pressing need for formal ongoing processes for determining the numbers of nurses and midwives employed in the independent sector. It is important that incentives are built into any data-gathering processes to ensure higher participation rates. It will also be necessary for the information collection to be collated at a local and regional level. The proposals in the Health Strategy (2001) for additional acute hospital and long-stay beds, service developments, capacity expansion and the focus on public/private partnerships all indicate that the numbers of nurses and midwives required for this sector will increase substantially in the next 7 to 10 years.

2.3.5 Nursing employment — General Practice

Over recent years there has been a growing demand for nurses to work with general practitioners (GPs). Practice nurses are employed by general practitioners to deliver a broad range of services, such as immunisation, women's health services, ante natal care, wound care, counselling and asthma care. In 1989 the Department of Health established a system of supports for GPs. A subsidy is available for GPs

participating in the General Medical Service (GMS) with a patient panel size of at least 100 towards the cost of employing a practice nurse. The amount of the subsidy increases in bands of 100 with the maximum subsidy applicable to a GMS patient panel size of 1,200 and a full-time nurse. A pro rata subsidy applies to practice nurses employed on a part-time basis. Private GP practices are also employers of practice nurses.

Information on the employment of practice nurses in the GMS is available from the General Medical Services Payments Board. In 1999, 501 GPs (373 practices) received subsidies to employ 466 practice nurses. The number of practice nurse employed has increased each year, 2000 (621), 2001 (636). The number of hours worked by each practice nurse are individually negotiated between the GP and the nurse. These range from less than 10 hours to 40 hours per week. The numbers employed in each health board area are set out in Table 2.3-9. With the emphasis on primary care and the expansion of services provided by general practitioners, it is likely that this group will expand in the future.

There is currently no information on the number of practice nurses employed privately (outside the GMS Scheme) by GPs or the age profile of practice nurses employed through the GMS scheme.

Table 2.3-9 – Employment of practice nurses

Health Board	No. of Nurses 1999	No. of Nurses 2000	No. of Nurses 2001
Eastern/ERHA	88	111	131
Midland	38	47	45
Mid-Western	47	67	69
North-Eastern	53	74	81
North-Western	42	52	48
South-Eastern	63	90	87
Southern	87	116	117
Western	48	64	58
National	**466**	**621**	**636**

Source: General Medical Services Payment Board, 2002

2.3.6 Nursing employment — Army Nursing Service

The Irish Defence Forces also require nursing services, which are provided by the army nursing service (ANS), a constituent part of the Defence Forces. The ANS was established to provide nursing and other professional paramedical services to the military hospitals. The ANS is governed by specific provisions of the Defence Act and regulated by a single Defence Force Regulation (DFR A14), but members of the ANS are not subject to military law. The Director of the Medical Corps provided information (April 2001) on the ANS for this study. At present there are thirty-eight nurses employed in the services. The retirement age for members of the ANS is sixty-five years. The average predicted retirements on age grounds for the next ten years is one per year.

2.3.7 Nursing employment — Prison Nursing Service

The Director of Nursing in the Irish Prison Services provided information for this study. In 1999 a new twenty-four-hour nursing service was established for prisons with the recruitment of an initial cohort of prison nurse officers. Additional recruitment drives are planned for the coming years, so that there will be a comprehensive nursing service for all prisons in the country staffed by approximately 150 nurses.

A group to review the structure and organisation of prison health care service was set up by the Minister for Justice, Equity and Law Reform in late 1999 and published its findings in September 2001. The

report provides a blueprint for restructuring a range of prison health services, including nursing. One of the recommendations from the review group is the establishment of a line management structure for nurses working within the prison system. At the end of 2000, fifty-nine nurses were employed in the Irish prison service and on 4 January 2002, sixty-three nurses were employed (see Table 2.3-10). The attrition rate is low at 3 per cent with only two nurses leaving the service since its inception in 1999. The projected need for nurses remains at 150 and may change if planned expansion programmes take place. The current cohort of nurses employed is reported as mature with a wealth and variety of experience, which benefits the current service. However, nurses in the prison service can opt to retire after thirty years service and this may be problematic in the future as the current cohort reaches retirement age.

Table 2.3-10 – Number of nurses working in the prison service

	2000*	2001**
Number of Nurses Employed	59	63

Notes:
*2000 as of 31 December 2000
**2001 figures as of 31 December 2001

Source: Director of Nursing, Irish Prison Service, 2001

2.3.8 Nurses and midwives seeking to work abroad

A demand for nurses and midwives is created when Irish nurses and midwives opt to travel and work abroad. This has been a long tradition in Ireland initially created by the lack of available positions in Ireland in a time of over-supply during the 1980s. It is very difficult to track the numbers who leave to work abroad on an annual basis. An indication of the likely numbers can be gained from the statistics maintained by An Bord Altranais on the number of verifications of qualifications issued.

The number of requests from nurses and midwives for verification of qualifications can give an indication of the demand created for replacement. Table 2.3-11 presents the trend in requests for verifications and destinations with 2,604 requested in 1989 and 1,229 in 2001. The UK was the most requested verification destination in 1989 at 71 per cent (1,848) followed by Australia 20 per cent (525) and the USA 6 per cent (167). The verification requests for the UK have continued to decrease over this twelve-year period. In 2001 Australia was the most requested destination for verifications at 53 per cent (650) followed by the UK at 40 per cent (497) and USA at 4 per cent (45). It is likely that the statistics for 2001 will change by the end of the year as the provisional figures were reported by An Bord Altranais on 27 November 2001.

Table 2.3.11 – Verification of Irish qualifications 1989-2001: destinations

Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*
UK	1,848	905	584	617	440	649	799	573	440	285	262	462	497
Other EU	10	3	10	16	11	10	21	11	11	9	12	15	16
Australia	525	260	137	69	173	262	380	448	462	460	503	535	650
USA	167	78	71	19	23	30	19	23	20	18	40	20	45
Canada	42	76	27	16	6	2	7	4	6	7	12	14	7
Other	12	16	16	17	31	47	46	20	44	30	31	12	14
Total	**2,604**	**1,338**	**845**	**754**	**684**	**1,000**	**1,272**	**1,079**	**983**	**809**	**860**	**1,058**	**1,229**

Notes:
*2001 figure is preliminary
The above table is the total number of requests for verification
A nurse or registration body may request a verification more than once and for more than one qualification
The number of nurses requesting is the distinct number of nurses, some of whom made more than one request

Source: An Bord Altranais, Registration Department, 2001

It is important to note that although a nurse or midwife requests verification of a qualification this does not necessarily mean that he or she will go abroad. The record of verifications only applies to those countries that require verification and therefore it cannot be assumed that this is the total number who leave on an annual basis. Some countries such as Australia and the USA require verification for each state, which may lead to a small amount of double counting in the figures. An Bord Altranais has approximated the number of nurses requesting verification — taking into account that a nurse or registration body may request more than once, and for more than one qualification (see Table 2.3-12).

Table 2.3-12 – Number of nurses requesting verifications

	2000	2001
Total requests for verification	1,058	1,294
Number of nurses requesting*	764	747

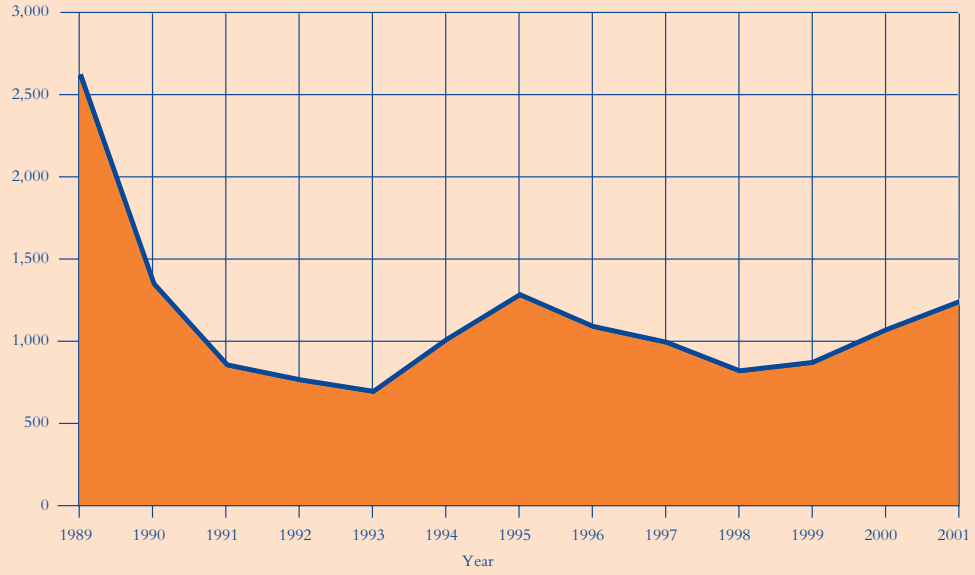
Notes:
The number of nurses requesting is the distinct number of nurses, some of whom made more than one request
*Approximation due to unavailability of distinct figures from the US and UK
2001 figure provisional as of 27 November

Source: An Bord Atlranais, Registration Department, 2001

The number of Irish nurses and midwives intending to work abroad has continued to decrease substantially since 1989, possibly due to availability of employment in Ireland. Although there is still a considerable shortage of nurses and midwives, the number of verifications requested started to rise again in 2000 and 2001. Figure 2.3-11 illustrates the decrease over time since 1989 and a rise again in recent years.

FIGURE 2.3-11

Trend in verification of Irish qualifications 1989-2001



Notes:
2001 figure is preliminary
The above figure presents the total number of requests for verification. A nurse or registration body may request more than once and for more than one qualification

Source: An Bord Altranais, Registration Department, 2001

2.3.9 Turnover rate in nursing and midwifery

In order to anticipate the future demand for nursing and midwifery services it is essential to understand the trend in choices taken by nurses to move, change employer or leave the workforce. One accepted technique for assessing this trend is to use a turnover index to represent the rate in percentage terms. For planning purposes it is necessary to present the statistics by division of the Register of Nurses and geographic region of the country. During this study a structure and process for calculating a turnover rate for each area on an ongoing basis was identified. A detailed description of the process is set out in Chapter 4.

2.3.10 Retirement rate in nursing and midwifery

Another important information source required to anticipate the future demand for nurses and midwives is the rate of retirement (early and on statutory age grounds). This information is held locally within each individual organisation. Some information might be obtained from the health services superannuation schemes. However, there are several discrete systems in operation, some of which are paper based with information contained within the files of individual nurses/midwives. Health boards, St. James's Hospital and Beaumont Hospital participate in the Local Government Pension Scheme operated by the Department of the Environment and Local Government. The Department of Health and Children administers the scheme for the voluntary hospital sector and intellectual disability services. In the longer term it will be possible to gather this information from organisations using the PPARS SAP HR system or other personnel systems that are universally used for a particular region.

2.4 Supply of nurses and midwives

The interim report for this study identified four principal sources for the supply of nurses and midwives: nurses in practice, newly qualified nurses, re-joiners and the inflow of registered nurses from abroad. The Register of Nurses maintained by An Bord Altranais is an essential source of information, as a nurse or midwife must be registered in order to practise. Other sources of information that will play a vital role in the supply of nurses in the future include the Higher Education Institutions which will monitor attrition from pre-registration nursing degree programmes (see section 2.4.7).

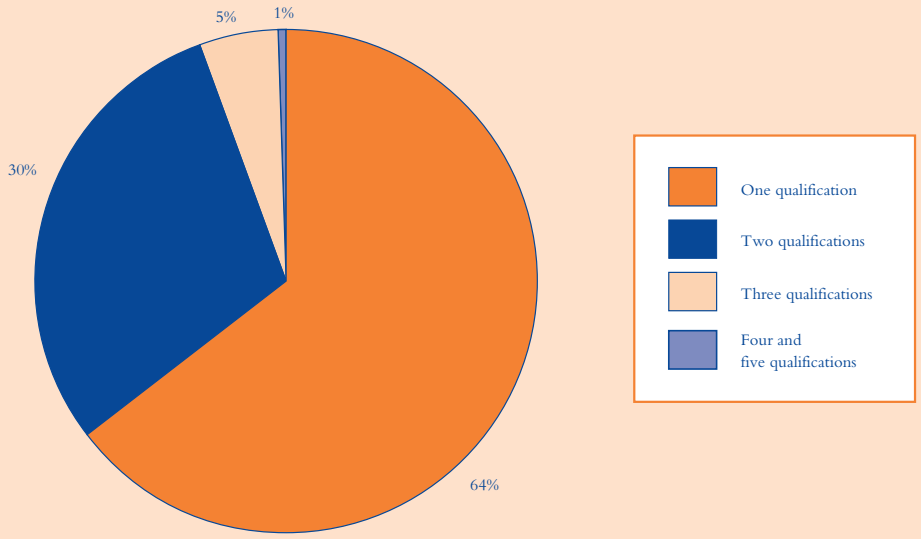
2.4.1 An Bord Altranais — Register of Nurses

The trend in the number of nurses and midwives registered between 1991 and 2001 is set out in Appendix 11. Over the 10-year period the 'active' register has increased by 19,326 and the 'inactive' register by 6,632 (total increase 25,958).

Section 28.2 of the Nurses Act, 1985 provides for the registration of a person in more than one division of the Register of Nurses. Many nurses and midwives hold more than one registrable qualification. For this reason the total on the register (68,663 individuals) does not correlate with the numbers of qualifications registered (94,223) in 2001. Figure 2.4-1 shows the breakdown of registered qualifications per nurse for 2001. Of the 68,663 nurses on the 'active' and 'inactive' file in 2001, 44,024 (64 per cent) hold one qualification, 20,369 (30 per cent) hold two qualifications, 3,462 (5 per cent) hold three qualifications and 350 (1 per cent) hold four and five qualifications.

FIGURE 2.4-1

Number of Registered Qualifications per Nurse 2001*



Note: *2001 figure is provisional as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

Some nurses not in employment opted to pay the annual retention fee and thereby maintain their name on the active file of the Register of Nurses. For this reason the number on the active register does not reflect the number of nurses and midwives in the workforce. A formal process is in place for removing the names of nurses and midwives who do not pay the annual retention fee (described earlier in section 2.2.1).

Inactive file

The Board provides a facility for registered nurses and midwives who are not working to identify themselves as 'inactive' and therefore relieving them of the requirement to pay the annual retention fee. From 1997 to 2001 there has been an increase in the numbers (3,010) requesting their names to be placed on the 'inactive' file. Table 2.4.1 shows the trend on the inactive file, and gives an indication of nurses who need to be replaced in the service.

Table 2.4-1 – Register of Nurses — Inactive File

Year	1997	1998	1999	2000	2001
Retired	1,955	2,659	2,705	2,902	3,944
Unemployed	763	767	730	678	684
Career break/Leave of Absence	983	1,109	1,099	1,132	1,271
Working abroad	3,756	3,974	3,792	3,731	3,916
Other	1,586	1,922	1,901	1,959	2,238
Total	**9,043**	**10,431**	**10,227**	**10,402**	**12,053**

Note: 2001 figure as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

Table 2.4.1 shows that the working abroad category accounted for 32 per cent (3,916) of the 'inactive file' in 2001. This figure has changed little between 1997 and 2001, increasing by 160 over the time period. It is important to note that individuals voluntarily register on the 'inactive' file. Some nurses and midwives choose to remain on the 'active' file by paying their annual retention fee even though they may not be working or in the country. Others who are well established in careers outside nursing and midwifery may request to have their name included on the 'inactive' file. These are likely to be included in the 'other' category.

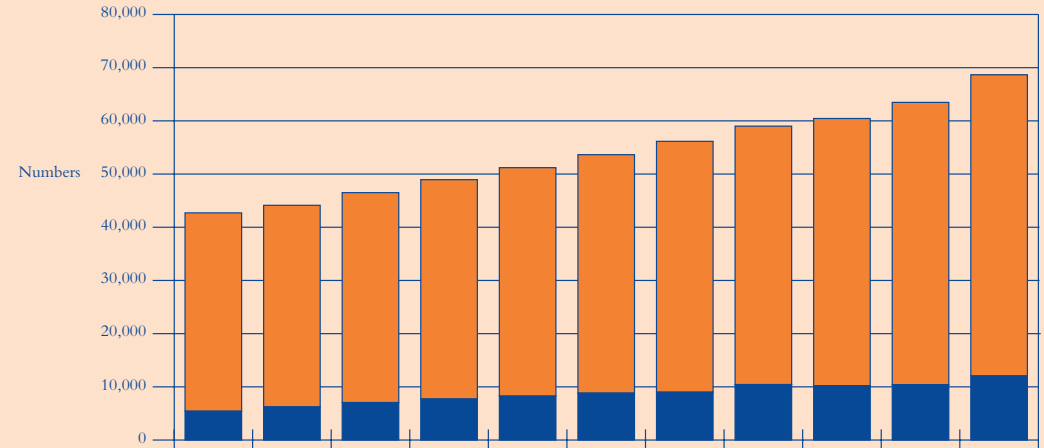
Of the inactive file the numbers retired have doubled over the five-year period by 1,968 (increase of 100 per cent). The unemployed number has decreased by 79 over the five-year period (10 per cent decrease). The career break/leave of absence category has increased by 288 (29 per cent increase). Working abroad has increased by 160 (4.2 per cent increase) over five years. The miscellaneous category 'other' has increased by 653 (41 per cent increase).

2.4.2 Registered nurses and midwives in practice

It is difficult to know exactly how many nurses and midwives registered with An Bord Altranais are actually employed and practising as nurses or midwives. The figures from An Bord Altranais Registration Department show that there were 68,663 nurses and midwives on the register in 2001; of these 56,611 were on the 'active' and 12,052 on the 'inactive' file. Figure 2.4-2 presents the ten-year trend for the 'active' and 'inactive' files maintained by An Bord Altranais. During this period the total number on the active register increased by 19,326 (52 per cent).

FIGURE 2.4-2

Register of Nurses - active and inactive



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Active file	37,285	37,902	39,460	41,233	42,937	44,822	47,157	48,579	50,221	53,072	56,611
Inactive file	5,420	6,228	7,049	7,712	8,263	8,819	8,998	10,431	10,227	10,402	12,052

Notes:
2001 figure is provisonal as of 27 November 2001
All other years based on those 'active' and 'inactive', as of 31 December of that year.

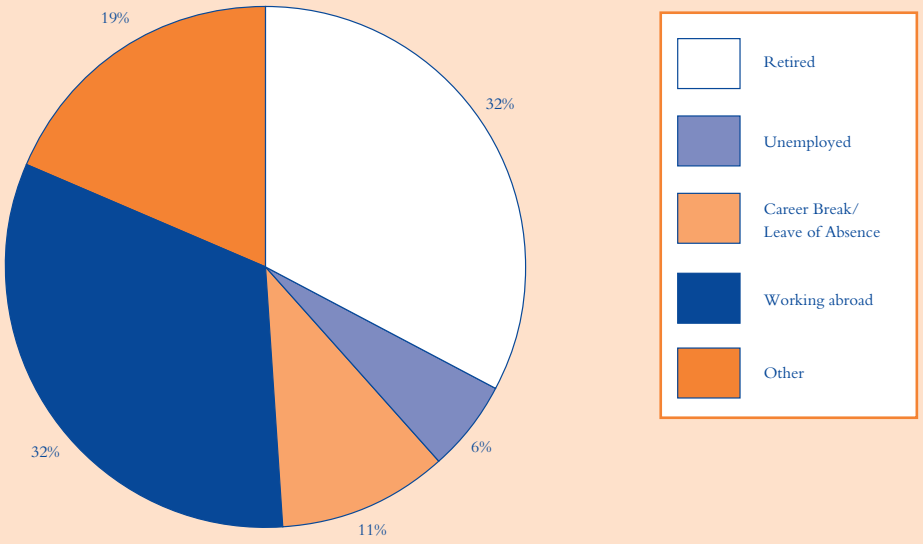
Source: An Bord Altranais, Registration Department, 2001

2.4.3 Potential re-joiners

An indication of the potential supply of experienced nurses and midwives can be gained from examining the 'inactive' register (see Figure 2.4-3). This category of the register holds the names of nurses and midwives who could possibly be attracted back into the service. In 2001, 32 per cent (3,944) of the 'inactive' file members were reported as retired. If this is subtracted from the total on the 'inactive' file (12,053) a possible pool of 8,109 (68 per cent) remains. The breakdown of the remaining group on the inactive file is categorised as follows: 32 per cent (3,916) working abroad; 11 per cent (1,271) career break/leave of absence; 6 per cent (684) unemployed; and unspecified other 19 per cent (2,238). It is unlikely that the group working abroad would be immediately available for work in Ireland. Therefore the potential pool is reduced to 4,193. Caution is urged in interpreting these figures as the 'other' group is likely to contain many former nurses and midwives who are now working in alternative or allied careers. Chapter 1 describes the support package for nurses and midwives who undertake the return-to-practice courses and Appendix 6 reports the survey of return-to-nursing and midwifery courses 2001. The survey highlights the deficit of information in the subsequent tracking of employment following the courses.

FIGURE 2.4-3

Register of Nurses - inactive file 2001



Note: 2001 figure is provisional as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

There is a general perception that there is a surplus of nurses and midwives registered with An Bord Altranais, but not recorded on employment records, who could be attracted to work. As the various sources of information are collected for differing purposes it is understandable that difficulties arise when comparing the information. If the figures are considered very broadly, the majority of nurses and midwives on the register can be accounted for. When reviewing data for the year 2000, the Register of Nurses reported a total of 53,072 nurses while the Department of Health and Children health services personnel census indicated that there were 33,474 individual nurses and midwives employed in the public health service in 2000. The *survey of nursing employment in the independent sector* 2000 estimated a figure of 10,000 nurses employed. Taking into consideration the numbers employed by the prison and army nursing services, the number unaccounted for by employment records is estimated at approximately 9,000. The calculations are set out in Table 2.4-2.

Table 2.4-2 – Estimated numbers of nurses and midwives — 2001

Professional Register		
Register of Nurses (Active) 2000	53,072	
Employment Records		
DOHC Health Services Personnel Census 2000	33,474	
Employment in the Independent Sector (estimate)	10,000	
		Sum = 43,774
Other employers		
Army, prison and others (approximately)	300	
Estimated total number of nurses on the register not captured on available employment records = 9,298		

Source: An Bord Altranais, Registration Department 2000. Department of Health and Children health services personnel census 2000, *survey of employment in the independent sector,* 2000

The data presented on Table 2.4-2 suggest that 63 per cent of nurses and midwives on the Register of Nurses are working in the public health services and that in total about 82 per cent of all registered nurses and midwives are working in paid employment in the profession. A similar situation is reflected in Scotland where 65 per cent of those on the Register are working in the NHS and 81 per cent of all registered nurses and midwives are employed (Buchan, 2001).

2.4.4 Gender of nurses and midwives

Gender is an important issue when considering the likely supply of personnel for the workforce. Some staff including nurses and midwives are likely to seek to reduce their working hours at certain times during their career to allow greater time for family responsibilities. There is a growing trend for a number of men to seek time for family responsibilities. It is important to have knowledge of the gender and age profile of nurses and midwives employed in any particular area so that plans can be made for likely replacement/substitute requirements in the future.

The gender of all staff employed in the public health service is predominantly female at 80 per cent (76,854 persons) and male 20 per cent (19,000) as reported by the health services personnel census on 31 December 2000. It is often correctly highlighted that the nursing profession is predominantly female. Of the total nursing and midwifery staff, 92 per cent (30,651) employed in the health service were female and 8 per cent (2,823) were male (see Appendix 8). Analysing the data across the groupings reported for the health services personnel census in 2000, four of the grades report the percentage of females above 78 per cent. In the past the medical/dental category was predominantly male. However, this trend is changing — 36 per cent of the group were female in 2000. The category with the highest percentage males is the maintenance and technical group at 91 per cent. Table 2.4-3 shows the gender for the main grade categories reported in the health services personnel census for the year 2000.

Table 2.4-3 – Gender of staff employed in the public health service

	Female	Male	Total Female and Male	Female as percentage of total
Maintenance/Technical	146	1,415	1,561	9.35
Management/Administration	11,292	2,210	13,502	83.63
Medical/Dental	2,344	4,130	6,474	36.21
Nursing	30,651	2,823	33,474	91.57
Paramedical	6,962	1,499	8,461	82.28
Support Services	25,459	6,923	32,382	78.62
Total	**76,854**	**19,000**	**95,854**	**80.18**

Source: Department of Health and Children, health services personnel census as of 31 December 2000

A similar picture emerges when analysing the gender of nurses and midwives registered with An Bord Altranais. Over the past six years the ratio of females to males has remained relatively constant. The number of males has increased between 1996 and 2001 by 1,518 (41 per cent). The largest increase in males in any of the six years occurred between 2000 and 2001. The number of male nurses registering from aboard, in 2001, may have influenced the increase. The number of males from 31 December 2000 to 27 November 2001 rose by 709. Over the six years 1996 to 2001 the number of males has increased by 40.64 per cent. Table 2.4-4 shows the gender of nurses and midwives registered with An Bord Altranais from 1996-2001 and the percentage of males and females for each year.

Table 2.4-4 – Gender for nurses and midwives registered

Year	1996	1997	1998	1999	2000	2001*
Male	3,686 7%	3,871 7%	4,101 7%	4,245 7%	4,495 7%	5,204 8%
Female	49,955 93%	52,284 93%	54,909 93%	56,203 93%	58,979 93%	63,459 92%
Total	**53,641**	**56,155**	**59,010**	**60,448**	**63,474**	**68,663**

Notes:
*2001 figure is provisional, based on the 'active' and 'inactive' file as of 27 November 2001
Figures for 1996-2000 are based on those 'active' and 'inactive', as of 31 December of that year

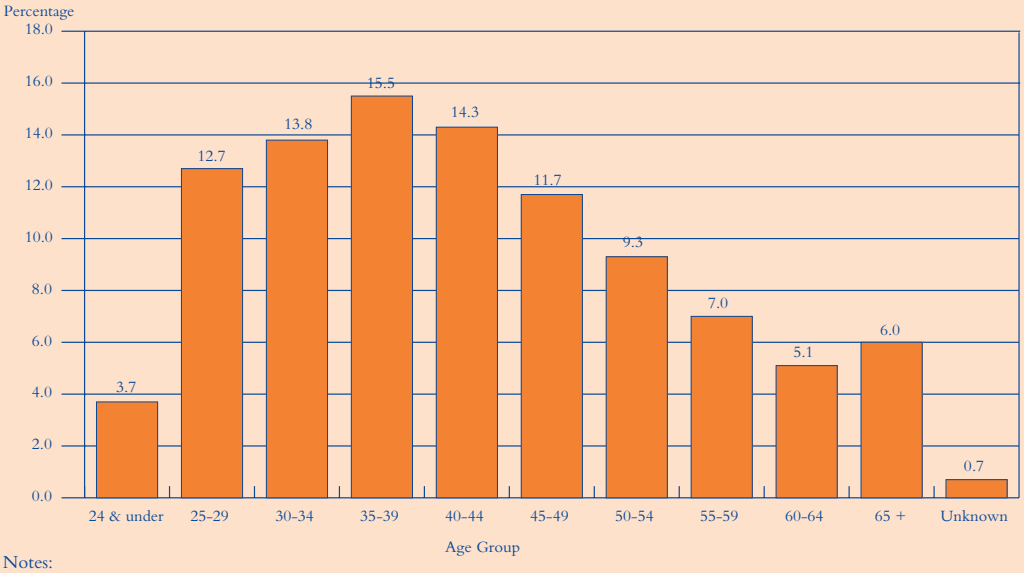
Source: An Bord Altranais, Registration Department, 2001

2.4.5 Age profile for each division of the Register of Nurses

One of the key elements required for workforce projections is an age profile of the current staff employed. According to Buerhaus *et al* (2000) the size of the nursing and midwifery workforce in the next twenty years will be largely determined by the number and age of those already in employment, while changes resulting from the numbers entering the student population will only be felt gradually. Age is essential to predicting retirements, recruitment and career breaks. The Register of Nurses is the only current source of information on the age of nurses in the country. It gives an indication of the age of nurses and midwives registered; however, this does not necessarily reflect the actual age of nurses and midwives employed. The age distribution of all nurses and midwives on the 'active' and 'inactive' files are presented in Figure 2.4-4. It is apparent from the information that there is a reasonably even distribution across the five-year age groupings, with higher numbers in their thirties and early forties. This would suggest that there should be sufficient numbers to replace nurses retiring over the next ten years, if supplies of newly qualified nurses, re-joiners, and nurses from abroad continue to grow, and nurses in the middle age bracket continue in practice.

The implications of an ageing registered nurse workforce are of concern in the USA. Within the next ten years, the average age of RNs is forecast to be 45.4 years, an increase of 3.5 years over the current age, with more then 40 per cent of the RN workforce expected to be older then 50 years (Buerhaus *et al*, 2000). In the UK one key characteristic of the nursing and midwifery profession is that there is an ageing cohort. In 2000 it was reported that 13 per cent are less than 30 years and a reason given was the comparatively smaller intakes of new (and younger) practitioners from pre-registration education. This may be compounded by the attempt to encourage mature 'returners' to NHS employment (Buchan 2001). The age profile in Ireland is somewhat different, with 16 per cent of nurses and midwives under 30 years of age in 2000. However, the age profile presented is for qualifications registered and not for nurses and midwives in employment.

FIGURE 2.4-4
Age Profile of all nurses and midwives registered with An Bord Altranais for 2000



Notes:
Figures based on those 'active' and 'inactive', for those who were registered on or before 31 December 2000
Age is taken as 2000 minus year of birth
Example, age group 30-34, date of birth = born between 1 January 1966 and 31 December 1970

Source: An Bord Altranais, Registration Department, 2001

Table 2.4-5 shows the trend in the age profile of nurses and midwives on the 'active' and 'inactive' file of the Register of Nurses from 31 December 1999 to 28 November 2001.

Table 2.4-5 – Age profile of all nurses and midwives registered with An Bord Altranais

Age group	24 and under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 +	Unknown	Total
Year 1999	2,354	7,573	8,720	9,619	8,721	6,870	5,675	4,094	3,045	3,315	462	60,448
Year 2000	2,367	8,090	8,781	9,846	9,069	7,442	5,904	4,468	3,252	3,804	451	63,474
Year 2001*	2,682	8,858	9,654	10,292	9,453	8,207	6,310	4,876	3,466	4,336	421	68,663

Notes:
*2001 figures provisional, as of 27 November 2001
1999 and 2000 figures based on those 'active' or 'inactive' who were registered on or before 31 December of that year

Source: An Bord Altranais, Registration Department, 2001

The age profile in table 2.4-5 represents the entire group of nurses and midwives on the register. A critical part of analysing the future requirements for the supply of nurses and midwives is to examine the age distribution of nurses on each division of the Register of Nurses. Table 2.4-6 presents the numbers for each division of the register under the ten age groups. The total number of entries across all divisions of the register in 2000 was 89,932. This represents 63,474 individuals, as a nurse or midwife may have multiple entries on the register. Of the 63,474 'active' and 'inactive' names on the register in 2000, 63 per cent hold one qualification, 31 per cent hold two qualifications, 5 per cent hold three qualifications and 1 per cent hold four and five qualifications.

Table 2.4-6 – Age distribution by division of the Register of Nurses — 2000

Age group	24 and under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 + and unknown	Total each Division	Estimated per 1,000 population
RGN	2,068	7,325	7,799	8,158	7,215	5,971	4,701	3,719	2,803	3,216	52,975	13.79
RPN	176	489	757	1,707	2,166	1,737	1,474	952	590	682	10,730	2.79
RMHN	197	609	728	929	776	367	136	77	27	32	3,878	1.01
RSCN	83	694	714	886	673	514	334	134	77	59	4,168	1.08
RM	14	619	1,444	2,077	3,138	3,006	2,038	1,493	1,045	1,180	16,054	4.18
PHN	0	22	162	195	229	409	353	305	219	233	2,127	0.55
Total	**2,538**	**9,758**	**11,604**	**13,952**	**14,197**	**12,004**	**9,036**	**6,680**	**4,761**	**5,402**	**89,932**	

Notes:
Figures are for the number of entries on the register across divisions; therefore the cumulative is greater than the number of individuals
Figures based on those 'active' or 'inactive', on or before 31 December 2000
Age is taken as 2000 minus year of birth. Example, for age group 30-34, date of birth = born between 1 January 1966 and 31 December 1970
Estimated qualifications per 1,000 population is calculated using the population as reported by the Central Statistics Office, Census 30 April 1996

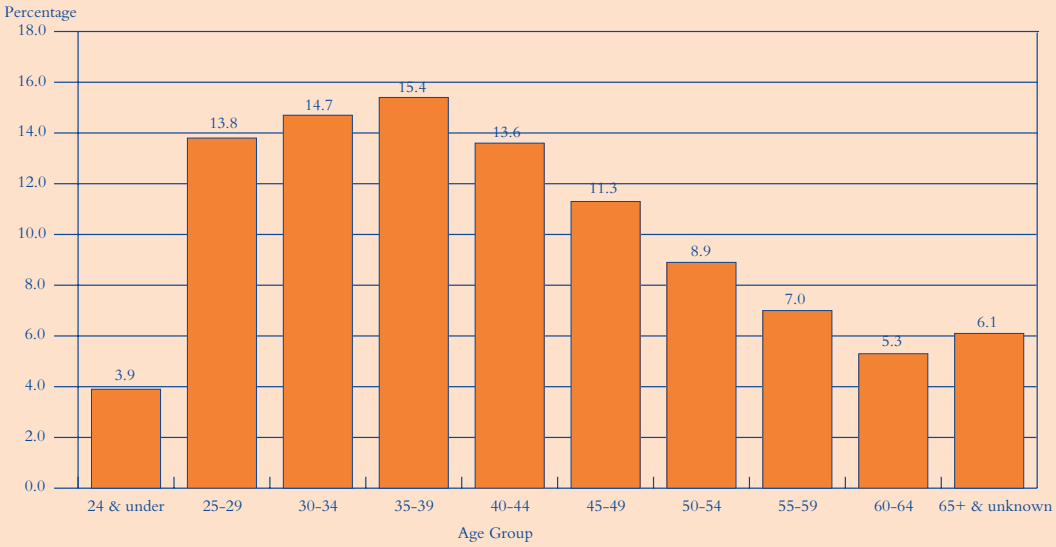
Source: An Bord Altranais, Registration Department, 2001

Registered General Nurse (RGN)

Figure 2.4-5 illustrates the percentage of the numbers qualified as a general nurse in each age group. The bar chart clearly shows that 62 per cent (32,565) of general qualifications recorded are of individuals 44 years of age and under. The other 38 per cent (20,410) are 45 years and over. It is encouraging for the future supply that the largest number of qualifications are in the 30 to 34 age group (7,799) and 35 to 39 age group (8,158) — with an overall 15 per cent in each age group.

FIGURE 2.4-5

Percentage of nurses by age on the RGN division of the Register 2000



Note: age is taken to be 2000 minus year of birth

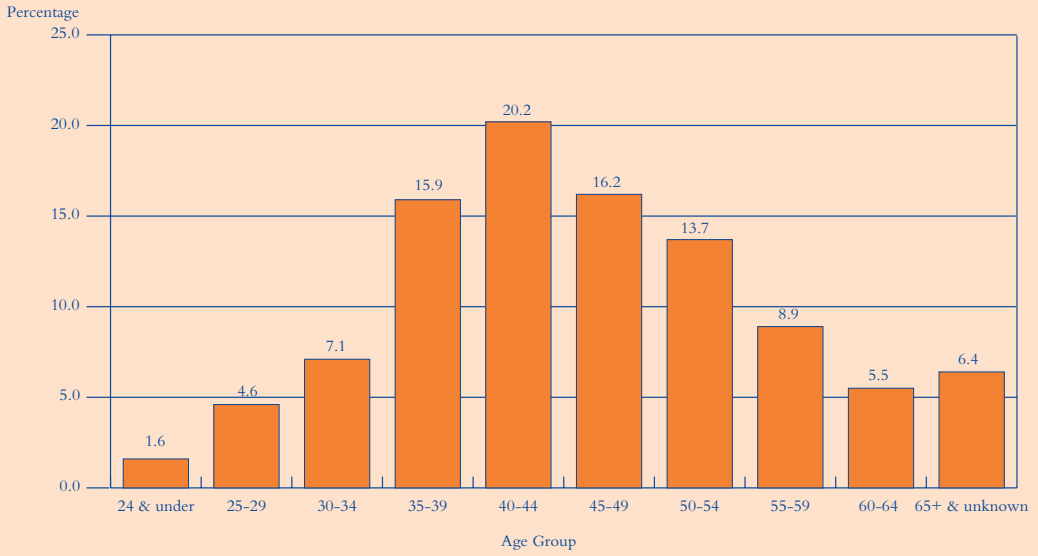
Source: An Bord Altranais, Registration Department, 31 December 2000

Registered Psychiatric Nurse (RPN)

The percentage of psychiatric qualifications recorded in the age group less than 44 years is 50 per cent (5,295) and over 45 years is 50 per cent (5,435). Looking at both groups above and below 45 years, the data appear to be balanced, but when it is noted that 20 per cent (2,166) are in the 40 to 44 age group the figures become a matter for concern. Projecting into the future, within five years the 40 to 44 age group will all have moved into the 45 to 49 year age group. Projecting forward by the year 2007, over 65 per cent of psychiatric nurses will be over 45 years, unless there is a large number recruited into the profession. This is of concern when the retirement age of 55 years for the majority of psychiatric nurses is taken into account and only 14 per cent (1,422) in 2000 were under the age of 34 years (see Figure 2.4-6).

FIGURE 2.4-6

Percentage of nurses by age on the RPN division of the Register 2000

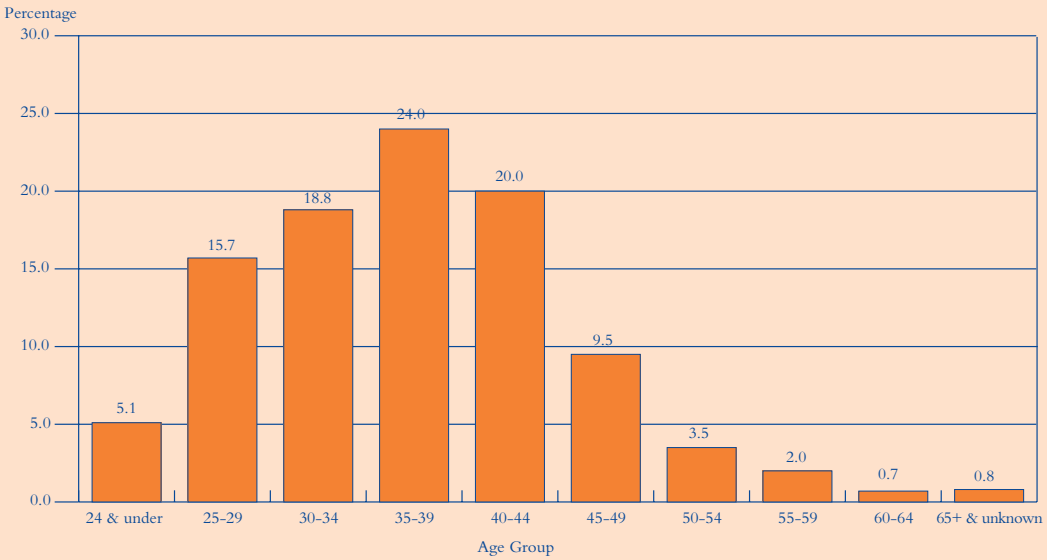


Notes:
Figures based on those 'active' or 'inactive' on or before 31 December 2000
(Age is taken to be 2000 minus year of birth)

Source: An Bord Altranais, Registration Department, 2001

FIGURE 2.4-7

Percentage of nurses by age on the RMHN division of the Register 2000



Notes:
Figures based on those 'active' or 'inactive' on or before 31 December 2000
(Age is taken to be 2000 minus year of birth)

Source: An Bord Altranais, Registration Department, 2001

Registered Mental Handicap Nurse (RMHN)

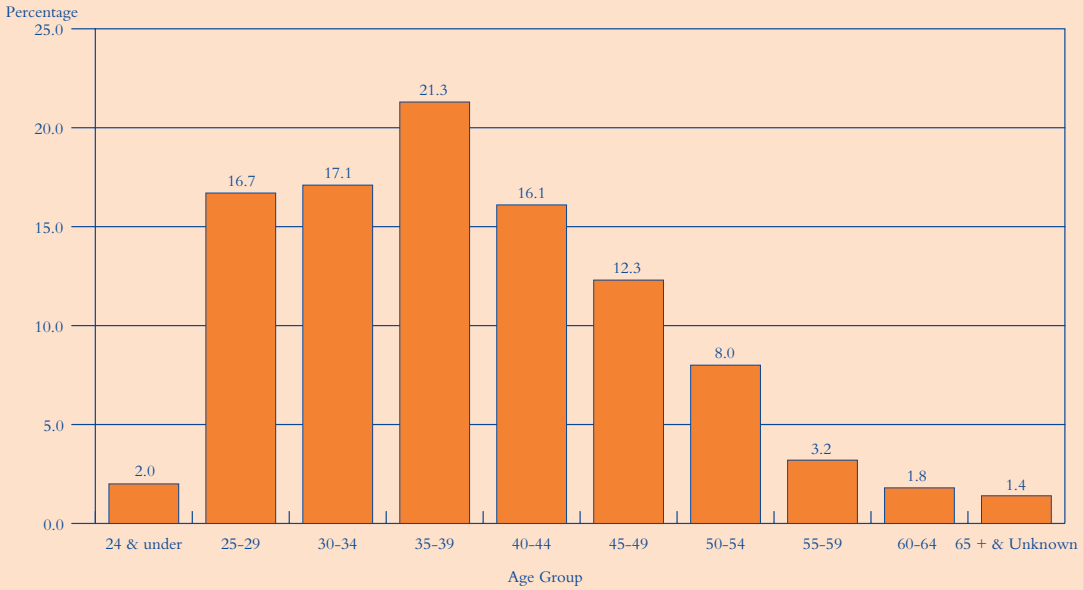
The proportion of qualifications registered to RMHN less than 44 years of age is 84 per cent (3,239) and above 45 years is 17 per cent (639). The peak age group in 2000 is 35 to 39 years of age with 20 per cent (929) qualifications recorded in this group (see Figure 2.4-7).

Registered Sick Children's Nurse (RSCN)

The profile for RSCN shows 73 per cent (3,050) less than 44 years and 26 per cent (1,118) over 45 years. The largest age group is the 35 to 39 years with 21 per cent (886) of the qualifications recorded (see Figure 2.4-8).

FIGURE 2.4-8

Percentage of nurses by age on the RSCN division of the Register 2000



Notes:
Figures based on those 'active' or 'inactive' on or before 31 December 2000
(Age is taken to be 2000 minus year of birth)

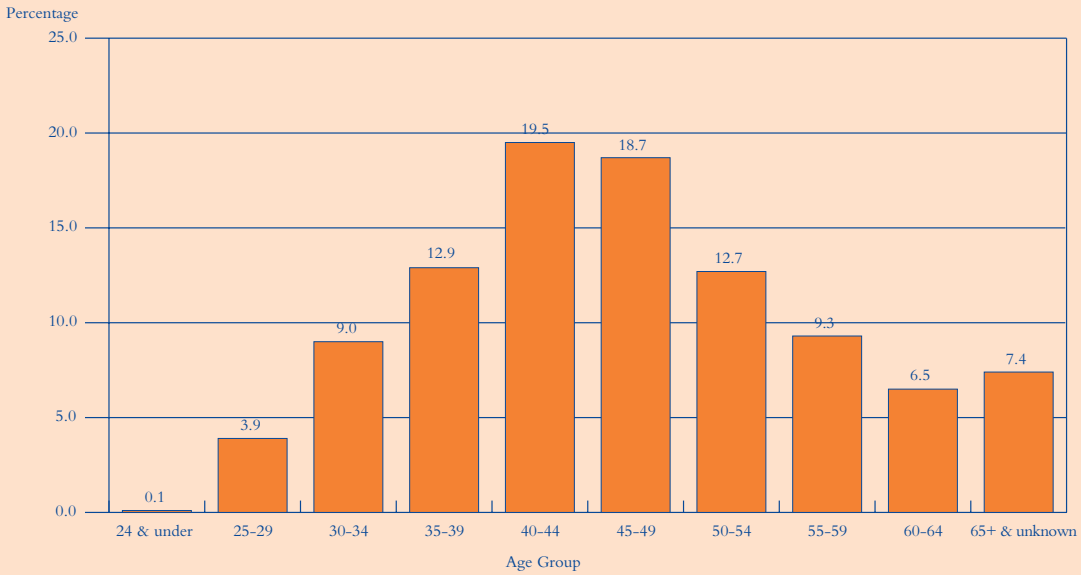
Source: An Bord Altranais, Registration Department, 2001

Registered Midwife (RM)

The profile of registered midwives shows that 46 per cent (7,292) are less than 44 years of age with 55 per cent (8,762) over 45 years. When projecting into the future, the peak age shown on the bar chart is 40 to 44 years at 20 per cent. This will mean that in five years this group of 3,138 will be above 45 years of age. The supply of registered midwives is further compounded by the fact that historically nurses tended to train as midwives following RGN qualification and did not necessarily stay practising midwifery. The numbers practising do not reflect the numbers that are qualified. In recent times, the perception of a requirement to have a midwifery qualification for promotion in areas outside the maternity services has declined. This may account for the low numbers less than 29 years of age, with only 4 per cent (22) having an RM qualification in this age grouping (see Figure 2.4.9).

FIGURE 2.4-9

Percentage of nurses by age on the RM division of the Register 2000



Notes:
Figures based on those 'active' or 'inactive' on or before 31 December 2000
(Age is taken to be 2000 minus year of birth)

Source: An Bord Altranais, Registration Department, 2001

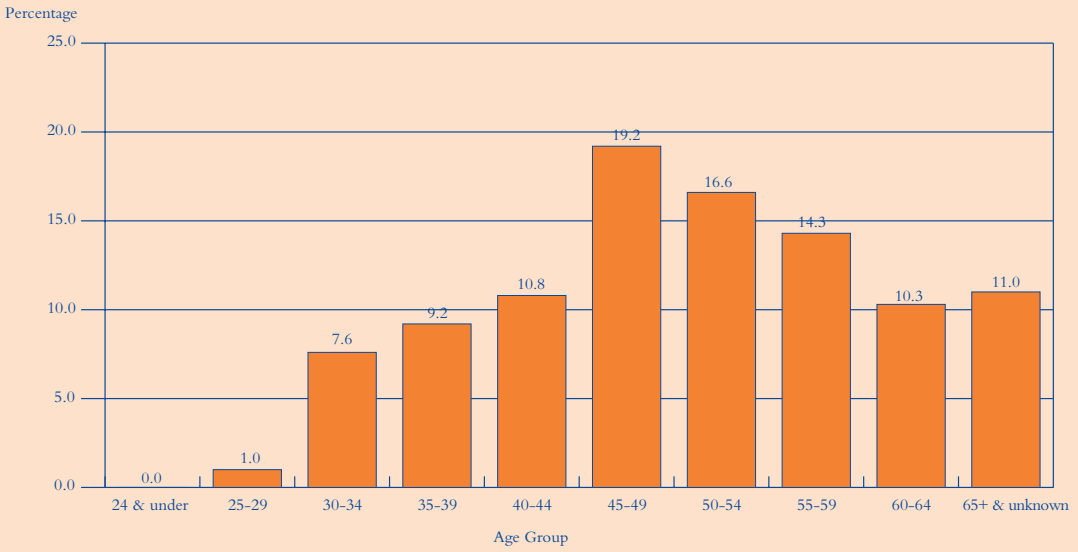
Registered Public Health Nurse (PHN)

Reviewing age profiles of nurses within all divisions, the PHN data for 2000 are of most concern. Only 29 per cent (608) are under the age of 44 years and 71 per cent (1,519) over 45 years. Only 1 per cent (22) with a PHN qualification are under the age of 29 years (see Figure 2.4-10). This may be related to the fact that in order to access the higher/postgraduate diploma in Public Health Nursing the individual must be an RGN and an RM and have post-registration clinical experience. The age group with the highest peak is the 45 to 49 with 19 per cent (409) in this group. In five years another 11 per cent will move into the 45 to 49 age group. The percentage over 45 years by the year 2007 may rise above 80 per cent for all PHNs, unless numbers recruited and retained in the profession increase.

Serious questions must be asked about the future supply of public health nurses, particularly as the demand for services is likely to increase dramatically. The Health Strategy (2001) clearly signposts a reorientation of the services to focus on primary care with significant expansion of local inter-disciplinary team-based services available on a twenty-four-hour basis. *Primary Care: A New Direction* (2001) indicates that there is likely to be a requirement for an additional 2,000 nurses and midwives to practise in inter-disciplinary teams over the next ten years.

FIGURE 2.4-10

Percentage of nurses by age on the division of the PHN Register 2000



Notes:
Figures based on those 'active' or 'inactive' on or before 31 December 2000
(Age is taken to be 2000 minus year of birth)

Source: An Bord Altranais, Registration Department, 2001

2.4.6 Pre-registration nurse education/training places 1997-2001

The successful recruitment and selection of nursing students is vital to the continued supply of newly qualified nurses each year. The number of applicants for education/training places each year gives an indication of the interest in nursing as a career.

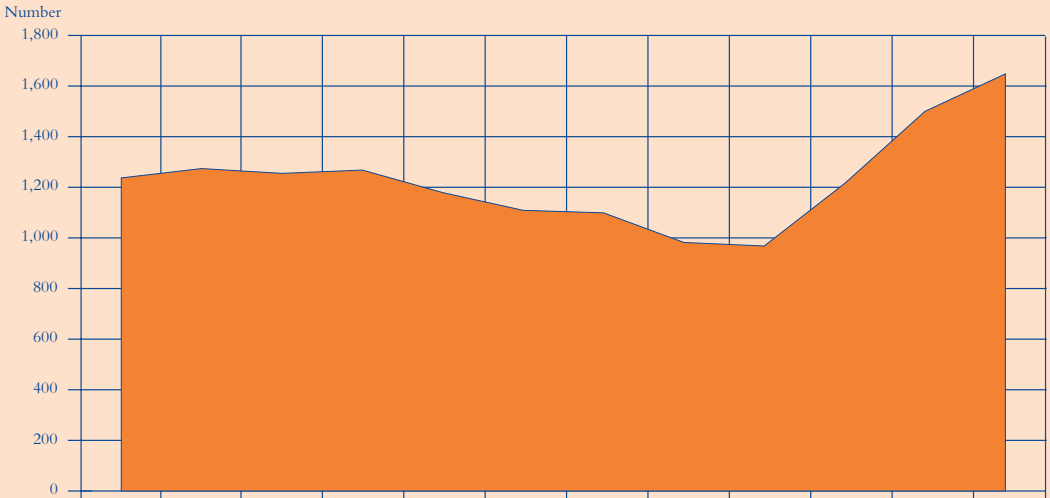
Provision of pre-registration nurse education places

Since 1998 the Department of Health and Children has funded a substantial increase in the number of pre-registration nurse training/education places. During negotiations between the Department and nursing unions (October 1999) an agreement was reached on an increase in the number of pre-registration training places to 1,500 for the following three years. The Labour Court endorsed the agreement (LCR 16330). This meant an increase of approximately 300 places above the number available in 1999 (1,215). Such an increase should significantly impact on the numbers of newly qualified nurses coming to the workforce from 2003 onwards.

An upward trend in the provision of pre-registration places can be seen from 1998 where there were 968 places funded across the three divisions: 1999 — 1,215 places; 2000 — 1,500 places; and 2001 — 1,648 places. The provision for 2001 represents the highest number over an eleven-year period (see Figure 2.4-11). The nursing degree programme will commence in September 2002 with dedicated funding for 1,640 places annually. This includes 93 additional training places in mental handicap and psychiatry yielding 392 extra places over the four years of the degree programme.

FIGURE 2.4-11

Total number of pre-registration training places funded 1990-2001



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Total	1,237	1,274	1,255	1,268	1,179	1,109	1,099	982	968	1,215	1,500	1,648

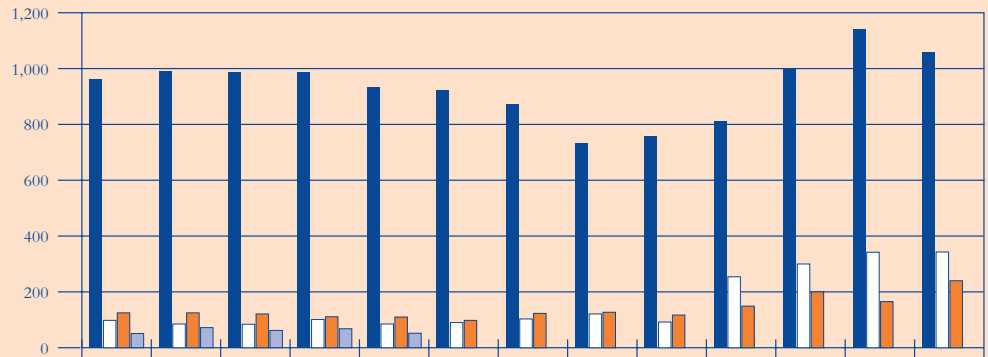
Notes:
Total figures include General, Psychiatric, Mental Handicap Nursing
In 1996, the pathway for registration as a Sick Children's Nurse changed from pre-registration to a post-registration higher/postgraduate diploma education programme. Therefore figures are not included from 1995 onwards for Sick Children's Nursing.

Source: Nursing Policy Division, Department of Health and Children, 1990-2001

Between 1990 and 2001 the Department of Health and Children has funded a total of 14,734 nurse training/education places for general, psychiatric, mental handicap and sick children's nursing. The lowest numbers of students were taken into training in 1997 and 1998. Given that the duration of the current diploma programme is three years, the smallest numbers of newly qualified nurses were available to join the workforce in 2000 and 2001. This can in some way explain the high number of vacancies over the last two years. From 2002 onwards the numbers of newly qualified nurses eligible to join the Irish workforce will be increasing steadily. The nursing degree programme will commence in September 2002 with dedicated funding for 1,640 places annually. If all available places were filled and there was no attrition from programmes the number of newly qualified nurses available to join the workforce over the next ten years (2001-2011) would be 15,171.

FIGURE 2.4-12

Number of pre-registration training places funded 1990-2002



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
General	963	992	988	988	932	921	873	734	759	812	1,000	1,141	1,057
Psychiatric	98	85	84	101	85	90	103	121	92	254	300	342	343
Mental Handicap	125	125	121	111	110	98	123	127	117	149	200	165	240
Sick Children's	51	72	62	68	52								

Notes:
In 1996, the pathway for registration as a sick children's nurse changed from pre-registration to a post-registration higher/postgraduate diploma education programme. Therefore figures are not included from 1995 onwards for sick children's nursing

Source: Nursing Policy Division, Department of Health and Children 1990-2002

Applications for pre-registration nurse education

Since 1996 a number of different agencies have been responsible for the application and selection system for nursing students, which was described in the interim report and summarised on Table 2.4-7. As recommended in the *Report of the Commission on Nursing*, the administration of the selection process for the diploma programme was transferred to the Central Applications Office (CAO) in 2001, in advance of the move to the degree programme in 2002, with two application routes: standard code applicants and mature code applicants.

School leavers (standard applicants) applying for pre-registration nursing education programmes compete on the basis of leaving certificate points only. The standard system operated by the CAO gives applicants two sets of choices, one for degree courses and another for diploma/certificate courses. Up to ten courses may be chosen in each set. In 2001 the addition of the 'Nursing Applicants System' gave applicants a third set of choices for nursing courses. A separate application form and a nursing application handbook have been devised and are available from the CAO. The form contains three nursing lists and applicants can select from up to ten general, ten psychiatric and eight mental handicap nursing education programmes.

Mature applicants applying for pre-registration nursing education programmes must be 23 years of age or over in January of the year in question. The application process for mature students includes a written assessment and those who achieve a specific standard are invited for interview. Those who pass the interview are then placed on a list for each course for which they have applied. The applicant's score on the written assessment is compared to others on the same course list. Not all applicants who are successful at the written assessment and interview may receive the offer of a place.

The total number of applicants for pre-registration nurse education in 2002 was 8,822. Of this number 1,846 (21 per cent) were mature applicants. The number of places available in 2001 was 1,547 and has risen to 1,640 in 2002, a 6 per cent increase. Initial indications are that between 2001 and 2002 there was a substantial increase (34 per cent) in the number of applicants (information supplied by CAO, 1 February 2002). Table 2.4-7 shows the increase in places available and applicants over seven years.

Table 2.4-7 – Number of places and applicants for pre-resignation/nurse training/education programmes

	1996	1997*	1998*	1999*	2000*	2001	2002
Number of places available	1,099	982	967	1,215	1,500	1,547	1,640
Number of applications	N/A	4,011	4,034	5,570	5,030	6,578	8,822
Number of applications per place	—	4.1	4.2	4.6	3.3	4.2	5.4

Notes:
1996 applications for general nurse training managed by Nursing Applications Centre (NAC) Galway
1997 applications for general, psychiatric and mental handicap (diploma 40 places) nurse training managed by Price Waterhouse
1998 applications for general and psychiatric nurse training managed by Civil Service Commission/Local Appointments Commission
1999 applications for general and psychiatric nurse training managed by An Bord Altranais, Nursing Careers Centre
2000 applications for general, psychiatric and mental handicap nurse training managed by An Bord Altranais, Nursing Careers Centre
2001 applications for general, psychiatric and mental handicap nurse training managed by the Central Applications Office (CAO)
2002 applications for general, psychiatric and mental handicap nurse training, managed by the Central Applications Office (CAO)

*1997, 1998 and 1999 applications made separately to National Application Centre (NAC) for Mental Handicap Nurse training. There was considerable overlap between the applicants to the NAC and An Bord Altranais Nursing Careers Centre

Source: Nursing Policy Division, Department of Health and Children (1999 and 2000), An Bord Altranais Nursing Careers Centre (2000) and Central Applications Office (2001, 2002)

There is considerable mobility of the nursing workforce between Ireland and the UK. For this reason it is important to consider the numbers commencing nurse education programmes in the UK. In 2000/2001 entries to pre-registration nursing programmes in England were 19,604 and Scotland 3,036; both figures were the highest for the previous decade. The number in Wales for 2000/2001 was 1,122. In Northern Ireland 1999/2000, there were 502 entries to pre-registration nursing programmes; the highest number reported in the previous ten years was 815 in 1989/1990. In March 2001 the estimated in-training population of students in the UK was 62,000 (Buchan, 2001).

Nursing student intake 2001

The application process for 2001 resulted in a total of 7,383 offers to 3,290 offerees, with an acceptance of 1,747 (including 22 deferrals) and a total registration in the Higher Education Institutions (HEI) of 1,648 nursing students. Table 2.4-8 gives the breakdown across the pre-registration programmes for 2001.

Table 2.4-8 – Nursing student intake 2001

	Total Offers	Offerees	Acceptance	Deferral	Total Registered with HEI	
General Nursing	3,115	2,502	1,199	16	1,141	99 extra students
Psychiatric Nursing	2,345	1,745	364	3	342	37 extra students
Mental Handicap Nursing	1,923	1,435	184	3	165	35 places not filled

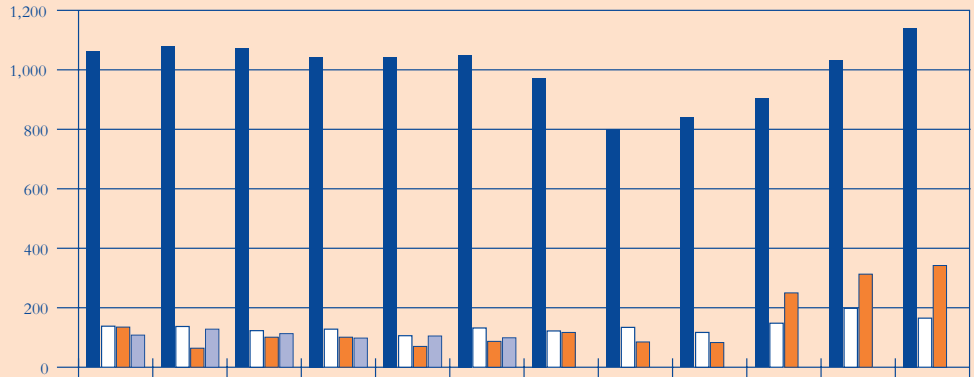
Source: Nursing Policy Division, Department of Health and Children and the Central Applications Office, 2001

Pre-registration nursing students commencing training each year

An indication of the future supply of nurses and midwives can be obtained from the An Bord Altranais candidate register, as all students are required to be entered as candidates. The numbers entering the candidate register for each division of nursing for the years 1990-2000 are set out in Figure 2.4-13. Unlike the information from the Department of Health and Children on the number of places funded, the candidate register includes post-registration students in general nursing and in earlier years in psychiatric, mental handicap nursing and sick children's nursing.

FIGURE 2.4-13

Number commencing nurse education/training 1990-2001



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
General	1,062	1,078	1,071	1,043	1,043	1,050	972	800	839	904	1,032	1,141
Mental Handicap	138	137	123	128	106	132	122	134	117	148	198	165
Psychiatric	135	64	101	101	70	87	117	85	83	250	313	342
Sick Children's	108	128	113	98	105	99						

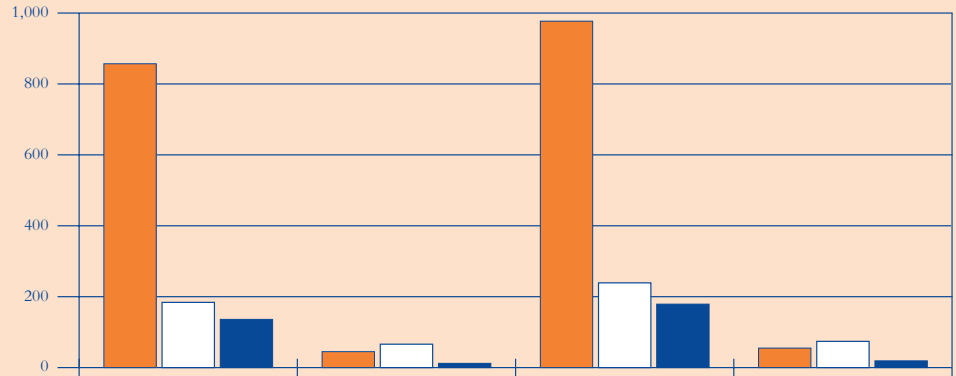
Note: numbers include post-registration students in general, psychiatric, mental handicap and sick children's nursing in earlier years

Source: An Bord Altranais, Registration Department, 1990-2001

Figure 2.4-14 shows the number commencing training by gender. Psychiatric nursing attracted the highest number of male students with 26 per cent (66) in 1999 and 24 per cent (75) in 2000. General nursing attracted 8 per cent (45) male students in 1999 and 10 per cent (55) in 2000. Mental handicap nursing attracted the least number of male students with 5 per cent (12) in 1999 and 5 per cent (19) in 2000. These statistics illustrate the scope for attracting males to the profession. This will be particularly important as the school-leaving population decreases over the coming years.

FIGURE 2.4-14

Numbers commencing nurse education/training by division and gender



	1999 Female	1999 Male	2000 Female	2000 Male
General	857	45	977	55
Psychiatric	184	66	239	74
Mental Handicap	136	12	179	19

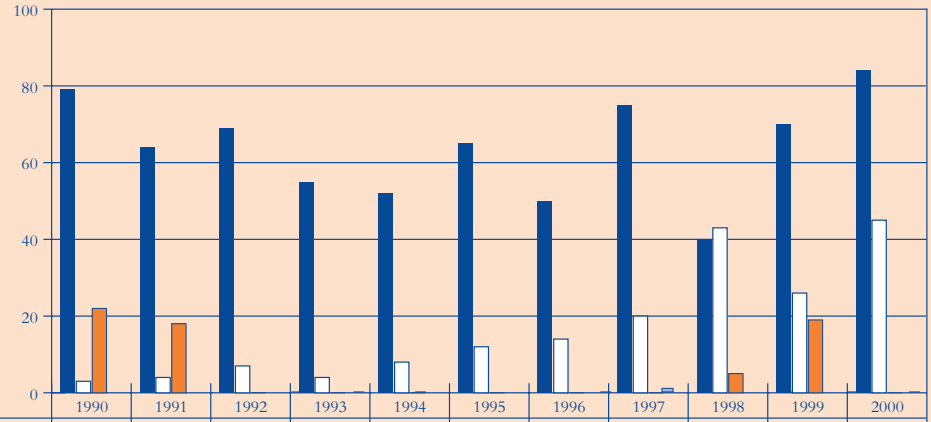
Source: An Bord Altranais, Registration Department, 31 December 1999 and 2000

2.4.7 Number of student nurses/midwives discontinuing training

The potential supply of nurses and midwives is reduced by nursing students who discontinue training, transfer to alternative programmes, are unsuccessful in exams or do not register on successful completion of their education programme. An Bord Altranais supply statistics based on a comparison of the numbers on the Candidate Register and those subsequently registering qualifications. Figure 2.4-15 shows the total loss each year for general, midwifery, psychiatric, sick children's and mental handicap nursing. The four categories under which the loss is reported are: 'discontinued', 'passed not registered', 'quit', and 'transferred'. Over the decade the total loss across general, midwifery, psychiatric, sick children's and mental handicap nursing students is difficult to estimate exactly. For example in 1999 26 students were reported in the category 'passed not registered', but all 26 registered in 2001. The total numbers lost in the other three categories ('discontinued', 'quit' and 'transferred') over the decade is 768. Details for each division can be found in Appendix 7.

FIGURE 2.4-15

Number of students discontinuing or not registering 1990-2000



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Discontinued	79	64	69	55	52	65	50	75	40	70	84
Passed not Registered	3	4	7	4	8	12	14	20	43	26	45
Quit	22	18	0	0	0	0	0	0	5	19	0
Transferred	0	0	0	0	0	0	1	0	0	0	0

Notes:
Registered = qualification registered with An Bord Altranais
Discontinued = the Board were officially informed that the student had discontinued training
Passed not registered is taken as those who finished their training but did not register
Quit = there is no subsequent record of the student completing training
Quit is an approximation of those expected to finish in a given year but of whom there is no record of registration/discontinuation before the next year end
Figures for the numbers Discontinued and Passed but not registered are continuously changing

Source: An Bord Altranais, Registration Department

Monitoring attrition from pre-registration programmes

The interim report of this study highlighted the need for continued monitoring of the annual fallout rate of nursing students from pre-registration education programmes. In the UK a controversy is ongoing in relation to attrition rates from pre-registration nursing education. With no standard measure or consensus on dropout rate, attrition is difficult to assess. The report of the National Audit Office (UK) commented that data collection on attrition from pre-registration education in England and Wales needs improvement and indicates an overall attrition rate of about one student in six (16 per cent) (Buchan, 2001). To date, in Ireland, information on the number of students discontinuing training or failing to register following successful completion of examinations has been made possible through the use of the Candidate Register and prompt reports from Principal Tutors to An Bord Altranais. The role of An Bord Altranais in relation to statistics was set out in the Nurses Act, 1985 which states: 'The Board may maintain statistical records and make such records available for research and planning, including manpower planning purposes' Section 36 (3). The specifics for the operation of the Candidate Register are set out in the Nurses Rules (1988) 'the Board shall establish and maintain a register of candidates admitted for training on which the name of every such candidate shall be entered' (Part IV section 10.1). The Nurses Rules also indicate that the 'Matron or Director of Nursing or Chief Nursing Officer or Principal Tutor or Tutor or other appropriate person shall inform the board when a student nurse ceases training before completion of the course and the reason therefor' (Part IV 10.7). A revised process identifying roles and responsibilities has been agreed for the pre-registration nursing degree programme.

From a workforce planning perspective, it is essential to monitor the trend in attrition from pre-registration education programmes by division. The four-year undergraduate pre-registration nursing degree programme is planned on a national basis to commence in the academic year 2002/3, with 1,640 places annually. If all available places were filled and there was no attrition from programmes the number of newly qualified nurses available to join the workforce over the next 10 years (2001-2011) would be 15,171. For illustrative purposes, factoring in a figure of 10 per cent attrition would reduce the numbers to 13,500. However, we currently have no basis on which to establish the likely rate of attrition from nursing degree programmes.

A schedule of meetings between the Nursing Policy Division of the Department of Health and Children, An Bord Altranais, and the National Implementation Committee (NIC) was set up to ensure a process was identified, for continued monitoring of attrition, during the transfer of nursing education to the Higher Education Institutions (HEI). During the discussions a process for collection of requisite information, was identified, involving four specific steps which are detailed in the following sections. It was agreed that the purpose is to collect key indicators of attrition on an annual basis to provide data to assist with forecasting the potential number of newly qualified entrants to the workforce by:

- division of the nurses register
- category of entry to the education programme (school leaver/mature student)

The group considered the need for a clear definition of attrition. However, having consulted the literature it was established that there was an absence of consistency in definitions that specifically apply to loss from an educational programme. It was agreed that it would be necessary to define the data field that could be used as indicators of attrition. The data fields necessary to monitor attrition were identified as: (i) total leavers, which comprises discontinuation, deferrals, transfers within nursing programmes, transfers across programmes; (ii) finishers; numbers registering as a nurse; and (iii) information on total finishers not registered within one year of course completion (see Table 2.4-9 for an outline description of each data field and source of information). This approach was adopted to avoid differences in interpretation on which information should be supplied. The steering group suggested that a useful outcome of this process would be the development of a definition of attrition from pre-registration nursing degree education for an Irish context.

Step One — Entry to the Candidate Register

- Following registration for the first time with a HEI the nursing student submits an application for entry to the Candidate Register to An Bord Altranais. The HEI student number is supplied on the application form.
- An Bord Altranais supply each nursing student with an individual Candidate Register number confirming the pre-registration division of nursing being studied.
- At a fixed date An Bord Altranais informs the allocations function through the head of department/school the number of students, by year, on the Candidate Register for their particular HEI, requesting confirmation that the students listed are still registered for the course (see Table 2.4-9).
- The allocations function identifies students who have not applied for entry to the Candidate Register.

- The HEI amends the list for a specified date and returns the file to An Bord Altranais indicating the numbers who have been lost from the programme each year using indicators of attrition (see Table 2.4-9).

Step Two — Data collection within each HEI

- The head of the department/school through the allocations function appointed in each of the HEIs is responsible for ensuring the collection and collation of the data on attrition for his or her organisation (this issue was agreed by the NIC on 12 September 2001).
- Information is collected on an on-going basis and annual reports prepared in each of the HEIs offering pre-registration nursing education programmes.
- A specified date is to be set, collaboratively, between An Bord Altranais and the HEIs for collation and reporting each year.
- Each HEI is to supply An Bord Altranais with information on nursing students who have successfully completed the four-year programme each year (following exam board meetings).

Step Three — data collection nationally

- Information on attrition is forwarded by An Bord Altranais (annually) to the Nursing Policy Division, Department of Health and Children to inform national forecasts for future requirements for nurses and midwives and decision-making on the number of pre-registration places.

Step Four — dissemination of information on attrition

- Information is disseminated to the Nursing and Midwifery Planning and Development Units, by the Nursing Policy Division in the Department of Health and Children, for use in regional strategic plans.

The Allocations Function referred to in step one was a recommendation of the Nursing Education Forum (2000). The Forum recommended that the role be established in each third level institution and be centred around organising and supporting clinical placements. The report stated that an allocations function be put in place to co-ordinate the placement of students for clinical learning (p 67). Part of the remit of the allocations function specifically refers to maintaining records of placements and student allocations.

The process for nationally collating the information gathered in each HEI was agreed at the board meeting of An Bord Altranais on 6 February 2002. It is anticipated that data collection necessary for monitoring attrition from pre-registration nursing degree programmes will commence at the start of the academic year 2002/3 and that the rate of attrition will be published on an annual basis.

Evaluation is an important aspect of any new process. During discussions with An Bord Altranais it was agreed that the Board would evaluate the operational aspect of collecting information for monitoring attrition from pre-registration programmes, and that the Nursing Policy Division would evaluate the effectiveness of the information from a planning perspective.

Table 2.4-9 – Process for monitoring attrition from pre-registrations nursing degree programmes

No.			
1	**An Bord Altranais** Provide a listing to each HEI of all pre-registration nursing degree students by year on the Candidate Register (on specified date)		
2	**Higher Education Institution** Amend the list for a specified date under the various headings below and returns file to An Bord Altranais		
	Category of Leavers	**Numbers by each division of the Register of Nurses** • General Nursing • Psychiatric Nursing • Mental Handicap Nursing	**Numbers per category of entry to the programme** • School Leaver • Mature Student*
3	Leavers Sutudent Nurses who have officially discontinued the programme (Head of Department signs a discontinuation form)		
4	Deferrals • Prior to start of programme • During the programme		
5	Transfers within nursing programmes Number of nursing students who transfer from one pre-registration nursing degree to another nursing programme [data source -official records for approval of transfer]		
6	Transfers across programmes Number of nursing students who transfer out of a nursing pre-registration degree programme to another programme in the HEI [data source — official records for approval of transfer]		
	Total leavers (sum of 3+4+5+6)		
7	Finishers Numbers finishing the four-year nursing degree programme each year [data source — exams register]		
Item 1: To be provided to each HEI by An Bord Altranais Item 2: Each HEI to cross-reference the listing from An Bord Altranais Items 3-7: To be collected by each HEI and forwarded at an agreed point in time on an annual basis to An Bord Altranais			
8	Total lost nationally Information to be collated by An Bord Altranais on the basis of information supplied by each HEI for the year in question		
9	Numbers registering as a nurse Numbers finished academic programme who register with An Bord Altranais up to one year after completion of programme [data source — An Bord Altranais Candidate Register and Register of Nurses]		
10	Total finishers not registered		
Item 8: to be collected at an agreed point in time with An Bord Altranais Item 9/10 to be collated by An Bord Altranais one year following completion of each four-year degree programme Note: *A mature student is one who is over 23 years in January prior to the year of entry			

Source: Proposed by National Implementation Committee and agreed by An Bord Altranais 6 February 2002

2.4.8 Places on post-registration courses

Applicants post-registration sick children's course

In 1996, the pathway for registration as a sick children's nurse changed from pre-registration to a post-registration higher/postgraduate diploma education programme. For entry to the programme it is necessary to be a registered general, psychiatric or mental handicap nurse. Table 2.4-10 details the trend in applications per place for the RSCN programme across the three schools of nursing. There was a substantial decline in the number applying between 1996 and 1997; this decline has continued.

Table 2.4-10 – Applications for places on post-registration sick children's programme

	1996	1997	1998	1999	2000	2001
Number of applications per place	12	5.1	3.7	2.6	1.8	1.8

Note: Average given is across the three schools. Some applicants apply to two or three schools.

Source: School of Nursing, Our Lady's Hospital for Sick Children, The Children's Hospital, Temple Street, The National Children's Hospital, January 2002

Current developments in relation to paediatric nurse education are outlined in Chapter 1. The paediatric hospitals continue to face significant difficulties in recruiting students into existing educational programmes leading to registration as an RSCN. Table 2.4-11 details the trend in places available, uptake of places and attrition from programmes over recent years.

Table 2.4-11 – Trend in places available, uptake and attrition 2000-2002

Date	Places available	Places filled	Number leaving before completion of programme
October 2000	71	70	5
April 2001	66	52	6
October 2001	67	57	4
April 2002**	66	59	*

Notes:
Figures are given for the three schools combined
*Information pending
**Information provisional for 2002

Applicants post-registration midwifery courses

Post-registration general nurses who wish to pursue midwifery as a career in Ireland currently undertake a further two years' study in a school of midwifery in partnership with a third level institution. On successful completion of the programme the graduates obtain an academic qualification and entry to the midwifery division of the Register of Nurses as maintained by An Bord Altranais. Table 2.4-12 shows a modest increase in applications for 2001. The total number of applicants across the seven schools of midwifery is as follows: 1999 total applications 542; 2000 total applications 308; 2001 total applications 350. The difference between the number of applications in 2000 and 2001 was 42. Two of the seven schools of midwifery reported an decrease in the number of applicants in 2001.

Table 2.4-12 – Applications for places on post-registration midwifery courses

	No of intakes	Places each year	1999		2000		2001	
			Applicants	Ratio	Applicants	Ratio	Applicants	Ratio
Coombe Women's Hospital	2	36	145	4.02	83	2.30	63	1.75
National Maternity Hospital	2	36	106	2.90	46	1.27	75	2.08
Rotunda Hospital	2	36	91	2.53	43	2.17	63	1.75
Our Lady of Lourdes Hospital Drogheda*	1	20 18	50	2.50	32	1.60	24	1.33
St. Munchin's Hospital Limerick**	2	20 23	47	2.35	32	1.60	32	1.39
University College Hospital Galway***	1	15 17	56	3.73	30	1.76	40	2.35
St.Finbarr's and Erinville Hospitals Cork****	2	32	47	1.47	42	1.31	53	1.65

Some applicants apply for two or more schools

Notes:
*Our Lady of Lourdes Hospital Drogheda had 20 places in 1999 and 2000 and 18 in 2001
**St. Munchin's Hospital Limerick had two intakes in 1999/2000 and one in 2001 with 20 places in 1999/2000 and 23 in 2001
***University College Hospital Galway had different starting numbers — 1999 (15 places); 2000 and 2001 (17 places)
****St. Finbarr's and Erinville Hospitals only had one intake in 2000

Source: Schools of Midwifery — Human Resource Departments

Direct entry diploma in midwifery

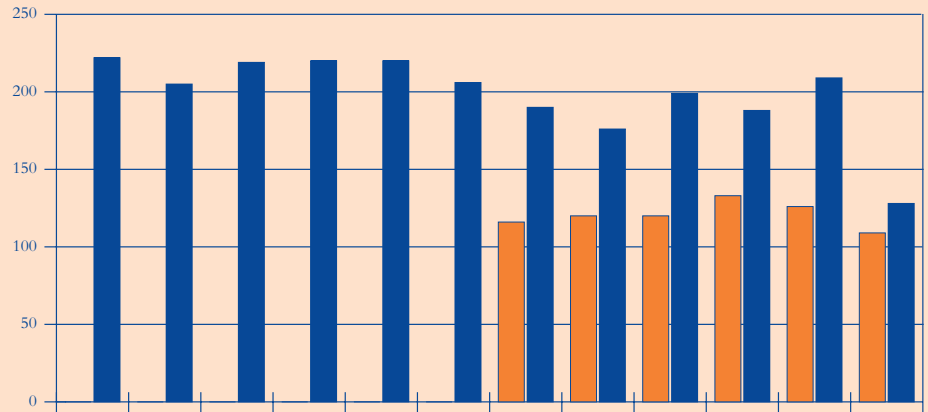
For the past thirty years access to midwifery education was dependent on the applicant being a registered general nurse. The *Commission on Nursing* identified a need to generate an alternative programme to facilitate individuals without a nursing background. The direct entry diploma in midwifery pilot programme commenced in June 2000. The initiative is a tri-partite arrangement between the Rotunda Hospital, Dublin, Our Lady of Lourdes Hospital, Drogheda, University of Dublin, Trinity College Dublin. The pilot diploma is a three-year programme (June 2000 to June 2003). Twenty students commenced the diploma in June 2000. By the end of the first year, four students had discontinued and one did not pass year one assessments. The numbers of students that commenced year two of the pilot was 15, an attrition rate of 25 per cent.

Numbers commencing post-registration midwifery and sick children's courses

The 2001 figures for numbers commencing both post-registration midwifery and sick children's courses have dropped dramatically. This is despite the fact that applicants to post-registration sick children's courses have maintained the ratio of 1.8 applicants per place in 2000 and 2001. The figures for post-registration midwifery courses are more surprising, with an overall ratio across the seven schools delivering the course, of 1.76 applicants per place. The trend over the previous ten years shows that the numbers commencing midwifery education in 2001 was the lowest recorded figure at 128 students (Figure 2.4-16), despite the apparent high level of interest generated by applications. Some applicants may apply for two or more schools, which may inflate the figures of applicants per

place. The data for the post-registration sick children's programmes from 1996 is shown on Figure 2.4-16. The 109 students commencing the sick children's programme in 2001 is the lowest figure reported over the six years.

FIGURE 2.4-16
Number of students commencing post-registration midwifery and sick children's courses 1990-2001



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*
Sick Children's	0	0	0	0	0	0	116	120	120	133	126	109
Midwifery	222	205	219	220	220	206	190	176	199	188	209	128

Notes:
2000 figures are inclusive of the pilot direct entry midwifery course
*2001 figure provisional as of 27 November 2001

Source: An Bord Altranais, Registration Department

Numbers commencing post-registration public health nursing

Table 2.4-13 shows the trend in the number of applicants for places on the higher diploma in public health nursing. The number of applicants for places on the University College Dublin and University College Cork higher diploma in public health nursing in 2001 is the highest number recorded over the past four years (applicants must be both a registered general nurse and a registered midwife). Over four years the number of applicants and places has increased across the two Universities: in 1998, 147 applicants for 58 places; in 1999, 127 applicants for 63 places; in 2000, 158 applicants for 65 places; and in 2001, 284 applicants for 95 places. Although University College Dublin increased the intake of students from 38 in 2000 to 61 places in 2001 there still seems to be scope to extend the number of places, particularly in light of the age profile of PHNs described in section 2.4.5.

Table 2.4-13 – Applications for places on higher diploma in public health nursing

	1998			1999			2000			2001		
	Places	Applicant Numbers	Ratio	Places	Applicant Numbers	Ratio	Places	Applicant Numbers	Ratio	Places	Applicant Numbers	Ratio
University College Dublin (UCD)	35	85	2.43	37	70	1.89	38	100	2.63	61	130	2.13
University College Cork (UCC)	23	62	2.69	26	57	2.19	27	58	2.14	34	154	4.53

Some applicants apply for both

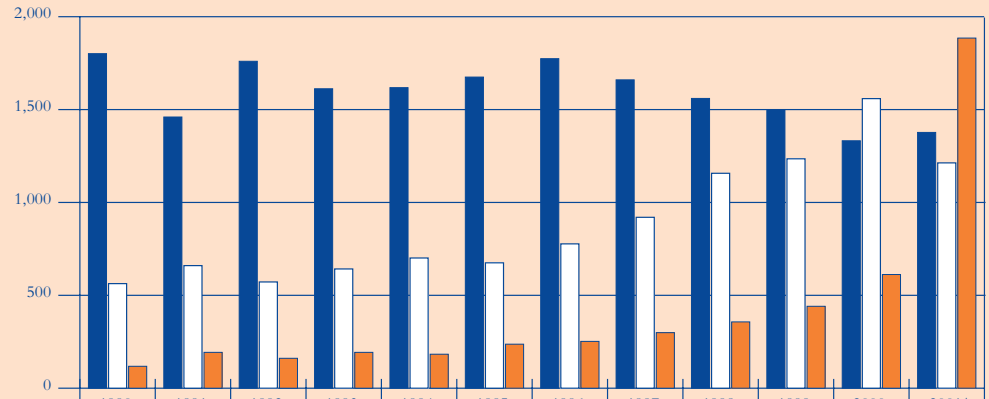
Source: School of Nursing and Midwifery UCD, Department of Nursing Studies, UCC

2.4.9 Nurses registering new qualifications 1990-2001

The origin of the supply of nurses and midwives registering new qualifications with An Bord Altranais is presented in Figure 2.4-17. The trend over the eleven years since 1990 shows a dramatic increase in the numbers of non-EU qualifications being registered with An Bord Altranais.

FIGURE 2.4-17

Origin of new qualifications registered with An Bord Altranais



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*
Ireland	1,801	1,460	1,760	1,612	1,618	1,675	1,774	1,660	1,560	1,495	1,332	1,377
EU	563	660	572	642	701	675	777	920	1,157	1,235	1,559	1,213
Non-EU	118	193	161	193	183	237	252	299	357	441	612	1,885

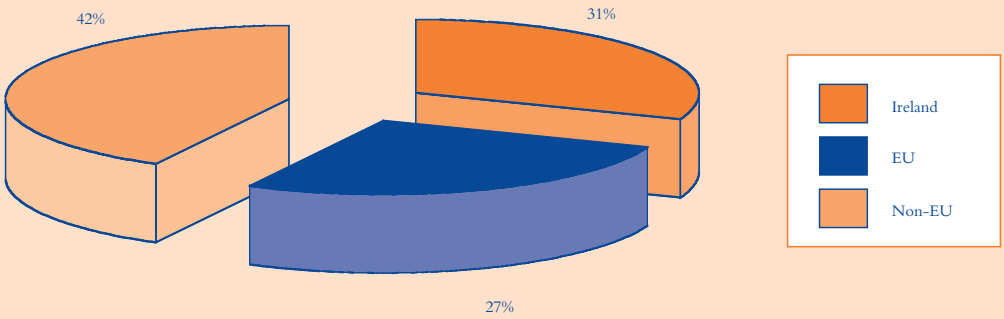
Note: *2001 figures are provisional as of 27 November 2001

Source: An Bord Altranais Registration Department, 2001

The Registration Department of An Bord Altranais categorises qualifications obtained as either in Ireland, under a EU Directive or in a non-EU country. As of the 27 November 2001 the Board had registered nurses and midwives from the following: Ireland 1,377 (31 per cent), European Union 1,213 (27 per cent) and non-European Union 1,885 (42 per cent).

FIGURE 2.4-18

Origin of new qualifications registered with An Bord Altranais 2001*



Note: *2001 figures are provisional as of 27 November 2001

Source: An Bord Altranais Registration Department

In recent years the recruitment campaigns for overseas nurses and midwives in EU countries other than Ireland and non-EU countries have resulted in a large number of registrations. The number of new registrations by country for 2000 and 2001 clearly indicate the reliance of the Irish health system on nurses trained outside the country (see Table 2.4.14).

Table 2.4-14 — Total number of new registrations by country across the seven divisions of the Register of Nurses

	Ireland		EU		Non-EU	
	2000	2001	2000	2001	2000	2001
Total	1,332	1,377	1,559	1,213	612	1,885

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

The general division of the Register of Nurses (2000, 2001) shows that the most dramatic increase is in the non-EU group (see Table 2.4-15). In 2000, 592 individuals registered qualifications obtained as general nurses in non-EU countries. In 2001 the figure increased to 1,844 (an increase of 1,252 non-EU RGNs). The largest proportion of qualifications registered in 2001 were obtained outside the EU. These were comprised predominantly of nurses from the Philippines (1,433); Australia (141); India (60); South Africa (60); and Nigeria (46). The figures are provisional (as of 27 November 2001) and will increase when the full year figures are available.

Table 2.4-15 — Origin of new qualifications on the General Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
General	Australia					154	141
	Austria			3	3		
	Bahrain					1	
	Belgium			2	1		
	Brazil						1
	Bulgaria						1
	Cameroon						1
	Canada					8	6
	Czech Republic						1
	Denmark				5		
	Finland			28	9		
	France			8	1		
	Germany			20	15		
	India					3	60
	Ireland	667	912				
	Italy			1			
	Jordan					16	7
	Kenya						1
	Korea, Republic of					3	2
	Netherlands			6	2		
	New Zealand					48	46
	Nigeria					6	26
	Norway					5	
	Peru						1
	Philippines					262	1,433
	Romania						2
	South Africa					45	60
	Spain			36	19		
	Sweden			10	2		
	Switzerland					2	1
	Trinidad and Tobago					2	1
	Ukraine						1
	United Republic of Tanzania						2
	United Kingdom			1,068	851		
	United States of America					35	43
	Zambia					1	2
	Zimbabwe					1	5
	Total	**667**	**912**	**1,182**	**908**	**592**	**1,844**

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

The Psychiatric division of the Register of Nurses shows that in 2001 the largest source of nurses was from EU countries other than Ireland. 135 psychiatric nurses registered qualifications obtained in the United Kingdom compared with 49 from Ireland (see Table 2.4-16).

Table 2.4-16 — Origin of new qualifications on the Psychiatric Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
Psychaitric	Australia					8	9
	Canada					1	
	India						1
	Ireland	98	49				
	New Zealand					3	5
	Nigeria					1	1
	South Africa						2
	Switzerland						1
	United Kingdom			135	133		
	Total	**98**	**49**	**135**	**133**	**13**	**19**

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

The Mental Handicap division of the Register of Nurses shows that the majority of new qualifications registered in 2001 were obtained in Ireland at 80 followed, by the United Kingdom at 34 and New Zealand at 3 (see Table 2.4-17).

Table 2.4-17 — Origin of new qualifications on the Mental Handicap Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
Mental Handicap	Ireland	127	80				
	Netherlands			1			
	New Zealand						3
	United Kingdom			47	34		
	Total	**127**	**80**	**48**	**34**		**3**

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

The Sick Children's division of the Register of Nurses in 2001 shows that 99 of the new qualifications registered are from Ireland followed, by 45 from other EU countries and 2 from non-EU (see Table 2.4-18).

Table 2.4-18 — Origin of new qualifications on the Sick Children's Nurses Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
Sick Children's	Australia						2
	Belgium				1		
	Germany				2		
	Ireland	111	99				
	United Kingdom			62	42		
	Total	**111**	**99**	**62**	**45**		**2**

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

The Midwifery division of the Register of Nurses shows that in 2001, 158 qualifications were obtained in Ireland, 83 from other EU countries and 14 from non-EU countries (see Table 2.4.19).

Table 2.4-19 — Origin of new qualifications on the Midwifery Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
Midwifery	Australia					6	9
	Finland				5		
	Germany			1	1		
	Ireland	254	158				
	New Zealand						2
	Nigeria						1
	Philippines						1
	South Africa						1
	United Kingdom			113	77		
	Total	**254**	**158**	**114**	**83**	**6**	**14**

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department

The Public Health division of the Register of Nurses shows that the majority of new qualifications registered in 2001 were obtained in Ireland at 41, followed by the United Kingdom at 11 (see Table 2.4-20).

Table 2.4-20 — Origin of new qualifications on the Public Health Nurses Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
Public Health	Ireland	67	41				
	United Kingdom			11	9		
	Total	**67**	**41**	**11**	**9**		

Note:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department

The majority of new qualifications registered in the Tutors division in 2001 were obtained in Ireland at 38 followed by 1 from the United Kingdom and 1 from Australia (see Table 2.4-21).

Table 2.4-21 — Origin of new qualifications on the Tutor's Division of the Register of Nurses, 2000-2001

Division	Country	Classification by Country					
		Ireland		EU		Non-EU	
		2000	2001	2000	2001	2000	2001
Tutor	Australia					1	1
	Ireland	8	38				
	United Kingdom			7	1		
	Total	**8**	**38**	**7**	**1**	**1**	**1**

Notes:
Figures are taken as registered qualifications only, excluding applicants and those in training
2000 figures as of 31 December 2000
2001 figures as of 27 November 2001

Source: An Bord Altranais, Registration Department, 2001

The data presenting new registrations by country across the seven divisions clearly indicate a change in international recruitment, with significant growth in overseas nurses registering with An Bord Altranais. In 1999, of the 3,181 newly registered qualifications: 1,504 were obtained in Ireland; 1,211 were obtained in the EU; and 466 were obtained in non-EU countries (15 per cent of all new qualifications). This situation changed in 2000 — of the 3,503 new qualifications registered 612 (17 per cent of all new qualifications) were obtained in non-EU countries. The provisional figures for 2001 shows a dramatic change — of the 4,475 new qualifications registered 1,885 (42 per cent of all new qualifications) were obtained in non-EU countries. This is not only an Irish phenomenon; admissions from overseas applicants to the UKCC Register has also grown rapidly in recent years. In 2000/2001 a total of 7,705 internationally recruited nurses were added to the UKCC Register representing 33 per cent of all new

admissions. In 1999/2000 there were 7,404 new international registrants, and the main source countries were South Africa, Australia and the Philippines (Buchan, 2001).

2.5 Summary

This Chapter set out to illustrate demographic and employment profiles of nurses and midwives. The proposal was, within the constraints of the available sources of information, to identify the trends over ten years. A summary of the main messages from the statistics is set out in Table 2.5-1. Currently there is no method for systematic collection of nursing and midwifery employment data in Ireland. This has been one of the major barriers to estimating numerically the future requirements for nursing and midwifery.

The approaches to data collection and interpretation identified in this study show variance at regional and local level, and these pose a significant challenge to generating comparable information across the sector. Obtaining detailed information on a particular specialty is extremely difficult and time-consuming and the quality of the data can be uncertain.

Table 2.5-1 – Summary of statistics

The main messages from the chapter indicate that the demand for nurses and midwives has increased over time.

Employment of nurses and midwives in Ireland

In 2000, nursing and midwifery accounted for 36 per cent of public health service employment and has increased by 19 per cent over the ten years 1990-2000 (see section 2.3.1). During the same ten-year period the number of nurses and midwives on the Register of Nurses (active) maintained by An Bord Altranais increased by 52 per cent. It is estimated that 82 per cent of nurses and midwives registered are in paid employment and of this 63 per cent are employed in the public health services (see section 2.4.2).

Of the nurses and midwives employed in the public health service in 2000, 66 per cent were in health boards, 26 per cent were in the voluntary/joint board hospitals and 8 per cent in intellectual disability services (see section 2.3.2).

It is estimated that approximately 10,000 nurses and midwives are employed in the independent sector. Across the services surveyed in 2000, 43 per cent reported that nurses and midwives are employed full-time with the other 57 per cent employed part-time or job-sharing. This is significantly different from the public health services where the majority of nursing and midwifery staff were employed full-time (see section 2.3.4).

Nurses and midwives per population

Across all the public health service the estimated number of nurses and midwives per 1,000 population is 8.04. The highest proportion is calculated for the Western Health Board at 9.09 (see Table 2.3-5).

Verification of Irish qualifications

The verification of Irish qualifications gives an indication of intent of a nurse or midwife to travel. The number of verifications was at its peak in 1989 at 2,604. Over a decade later the numbers have continued to decrease to 860 in 1999. However, in 2000 and 2001 the numbers of verifications requested have increased to 1,017 and 1,294 respectively (see section 2.3.8).

Inactive file

Excluding the 'retired' category on the 'inactive file' of the Register of Nurses, the names of 8,109 nurses and midwives are included. Of this number the 'working abroad' category is the largest and accounts for 3,916 nurses and midwives. Therefore there are 4,193 nurses and midwives who might potentially be attracted back into the workforce. However, 2,238 did not give the reason for requesting that their name be placed on the inactive file. Many of these may now be well-established in careers outside nursing (see section 2.4.1).

Active file

Of the 53,072 nurses and midwives reported on the 'active file' of the Register of Nurses in 2000, approximately 9,000 nurses and midwives are not captured on available employment records (see Table 2.4.2).

Gender

The gender of staff employed in the health service is predominantly female at 80 per cent. For nursing and midwifery 92 per cent employed in the public health service are female. Similarly An Bord Altranais has reported a figure of 92 per cent to 93 per cent females on the 'active' and 'inactive' files of the Register of Nurses consistently over a six-year period. This demonstrates that there is scope to attract more males into the profession (see section 2.4.4).

Age profile

The age distribution of the 62,987 nurses and midwives on the Register of Nurses (active and inactive) in 2000 is reasonably balanced. The highest number of nurses and midwives are in the thirty-five to thirty-nine age group at 16 per cent (9,846). Overall 61 per cent of nurses and midwives on the Register of Nurses are under 44 years of age (see section 2.4.5).

When the numbers of nurses and midwives who register qualifications under each division of the register are examined, some divisions show an ageing cohort. The two divisions that are most affected are registered psychiatric nurses and registered public health nurses.

The availability of psychiatric nurses in ten years time is an issue for consideration with 50 per cent of registered psychiatric nurses over 45 years of age and a potential retirement age of 55 years for the public health service. To address this issue the number of pre-registration training places for psychiatric nurses has increased over the years (see Figure 2.4-6).

The availability of public health nurses will be influenced by the fact that over 71 per cent of those registered are over 45 years. Over the past four years the number of applicants for places on the higher diploma in public health nursing has nearly doubled. The number of places over the past four years has increased, with 58 places (147 applicants) in 1998 and 95 places (284 applicants) in 2001 (see Figure 2.4-10).

Post-registration courses

For the past two years there has been a ratio of 1.8 applicants per place for post-registration sick children's nursing courses. The actual number of places filled is less than the number of places available over the same time period. Over the past three years there has been a significant attrition rate from the programme (see Table 2.4-10).

The overall numbers applying for post-registration midwifery education programmes was 1.76 applicants per place in 2001. However, the numbers commencing training in 2001 (128 students) is the lowest figure recorded over the decade (see Table 2.4.12).

Recruitment from abroad

Recruitment from abroad in recent years has been extremely high, with 1,213 nurses registered with An Bord Altranais from EU states outside Ireland and 1,885 from non-EU countries in 2001. The total registering non-EU and EU qualifications outside Ireland was 3,098. This is over double the number who registered qualifications obtained in Ireland (1,377 qualifications) (see section 2.4.9).

The amount of time and effort necessary to collect, collate and trend data over time must not be underestimated. This study has established valuable links with relevant stakeholders who are significant providers of information. The study has also identified structures such as the regional Nursing and Midwifery Planning and Development Units and established relationships with potential providers of data for the future.

An important achievement of the study is the development of awareness among employers and nurses and midwives of the importance of sound reliable data on which to plan for the future. Throughout the study this awareness strategy was actively pursued and achieved through the publication and dissemination of the interim report on the *Nursing and Midwifery Resource*. Opportunities were also taken, whenever possible, to profile the study and emphasise the importance of reliable data through meetings and presentations.

Since the interim report, information has been continually collected, collated and trends identified. Progress has been made on new sources of information on employment. For the first time an estimate of the numbers employed in the independent sector has been established. Another example of progress in monitoring the situation is the *National Study on Nursing Resources*, undertaken by the HSEA, which reports information on vacancies, resignation, recruitment, agency and overtime hours.

One of the keys to ensuring adequate future supply of nurses is through the addition of newly qualified nurses to the workforce. The steering group for this study identified the potential of increased attrition from pre-registration nursing degree education with the full integration of education within Higher Education Institutions in 2002. A structure and process to monitor attrition from pre-registration programmes was developed and agreed during the study. Monitoring attrition will ensure that any significant loss in pre-registration students can be identified year by year. The numbers of pre-registration nursing education places has increased each year; the number of student places in 2002 will be 1,640 — the highest over the past eleven years.

2.6 Conclusion

The objective of the study relating to this Chapter was to estimate the number of nurses and midwives employed and identify the major trends affecting employment in the profession. Far from creating a sound baseline this Chapter demonstrates, that while all available sources of information have been investigated, data is not collected or collated for workforce planning purposes. The information provided established the best possible baseline, estimated numbers and trends in employment. The conclusion is that there is an urgent need for a reliable standard mechanism for collection and collation of information at local, regional and national level from a human resource perspective. The next Chapter describes pilot projects which were established to test the feasibility of such a process.

CHAPTER 3

Minimum Dataset Pilot Projects

3.1 Introduction

To achieve effective workforce planning and forecasting, it is essential to have a reliable and accurate database for all nurses and midwives employed in the health services. There is currently no readily available, complete standardised source of information on the nursing and midwifery workforce in Ireland. The steering group considered the best possible approach to address the gaps in information. In 1994, the International Council for Nurses (ICN) published a reference document on planning human resources for nursing which the steering group took into consideration. The ICN and international literature indicates that datasets (supply and demand) should be established before forecasting can be conducted. The report of the reference group on the *Student Nurse Intake Planning* assessment, commissioned by the Scottish Executive Health Department (2001), states that establishing a baseline from which the forecast can be developed is crucial. The interim report (2000) of this study compared Irish information sources with those recommended as a minimum requirement for forecasting. The report stated:

> It is evident that there are major weaknesses in the current information base. Concerns about the adequacy, accuracy and timeliness of the data sources held on nursing and midwifery employment have been identified. A significant gap is the paucity of information on nurses and midwives employed in the independent sector (p 24).

The steering group identified the need for a nationally agreed minimum dataset to provide readily available, accurate and standardised information on nursing and midwifery in Ireland. To test the minimum dataset and a methodology for collecting requisite information, a pilot project was commissioned by the steering group.

This Chapter describes the development of a national minimum dataset for nursing and midwifery employment undertaken to address objective three of the study:

- to ensure the availability of the requisite information for forecasting, including any other demographic details, data on leavers and vacant posts and post-registration education opportunities available nationally.

The standard definitions and items that constitute the minimum dataset are also presented. The minimum dataset pilot projects are outlined and the reporting possibilities from the data to aid future workforce planning are presented.

3.2 National Nursing and Midwifery Human Resource Minimum Dataset

The main objective in developing the dataset was to identify categories and items for inclusion. Based on international literature, and following advice from the Information Management Unit at the Department of Health and Children, the steering group developed a national minimum dataset for

nursing and midwifery employment. The dataset developed was based on the concept of collecting information at the lowest level possible, on each nurse and midwife employed within the eight health board/authority regions, using nationally agreed standardised definitions. Factors considered in developing the *National Nursing and Midwifery Human Resource Minimum Dataset* are outlined in Table 3.2-1.

Table 3.2-1 – Factors considered in developing the minimum dataset

The content of the *National Nursing and Midwifery Human Resource Minimum Dataset* should:

- be appropriate for forecasting
- facilitate strategic planning at a number of levels: national, regional, organisational and local
- fulfil regional and local management requirements
- be specific and complete
- contain unambiguous and clear terms
- be understandable and objective with clear and concise standard definitions
- be realistic and feasible
- follow a logical sequence/presentation
- ensure data quality and comparability
- be structured and formatted to interface with the Personnel, Payroll, Attendance and Related System (PPARS) Systems Applications and Products for Data Processing (SAP) Human Resource (HR) system

Following eight drafts the steering group, with the input of the Information Management Unit, agreed the minimum dataset. This consists of thirteen items of information to be gathered for each individual nurse and midwife (presented in Table 3.2-2).

Table 3.2-2 – National Nursing and Midwifery Human Resource Minimum Dataset

Data for each individual nurse and midwife under the following thirteen headings:

- Health Board/Authority Region
- Place of Employment
- Work Address/Assignment
- Sex
- Date of Birth
- Nationality
- An Bord Altranais (Irish Nursing Board) Personal Identification Number
- Grade/Job Title
- Position Title (local title)
- Commitment
- Contract
- Registrable Qualifications
- Academic Qualifications

3.2.1 *National Nursing and Midwifery Human Resource Minimum Dataset* standard definitions

The steering group developed a definition for each of the thirteen items in the minimum dataset to ensure clarity and consistency so that each user would interpret the terms in a similar manner. The minimum dataset definitions are shown in Table 3.2-3. As the pilot project progressed, the definitions were tested and adapted to achieve a clear standard interpretation. Eleven drafts of the definition were produced. The steering group approved the final standard definitions on 6 November 2001.

Table 3.2-3 – Minimum dataset standard definitions

Health Board/Authority Region
Title of health board area: North-Western Health Board, Western Health Board, Southern Health Board, South-Eastern Health Board, Midland Health Board, Mid-Western Health Board, North-Eastern Health Board, Eastern Region Health Authority (Northern Area Health Board, East Coast Area Health Board, South-Western Area Health Board and 36 voluntary organisations).

Place of Employment
Name of individual organisation where the nurse/midwife is employed.

Work Address/Assignment
Area of assignment within the place of employment (e.g. name of ward/unit/community care area). Primary work base or sub cost centre.

Sex
Male/Female

Nationality
The PPARS SAP HR system provides a textual listing of nationalities and country of origin under the heading.

An Bord Altranais Personal Identification Number
Personal Identification Number (PIN) issued by An Bord Altranais for each individual nurse/midwife on the Register of Nurses maintained by the board.

Grade/Job Title
The title used within the organisation, e.g. Staff Nurse, Clinical Nurse Specialist, Clinical Midwife Manager (CMM2), accompanied by the grade code issued by the Personnel Division, Department of Health and Children for each grade in the public health service. There are currently 67 grade codes for nursing and midwifery. Each individual nurse/midwife must be assigned one of the listed codes.

Position Title
The local title used to describe the role, e.g. CNM2 (Delivery Unit), Clinical Nurse Specialist (Diabetes) etc.

Commitment

Full-time/Whole-time
Filling a full-time post on a whole-time basis, for a specified period (usually thirty-nine hours per week). The agreement on flexible working in the health service will mean that nurses who were previously classified as job-sharers and change their hours of commitment to anything other than 19.5 will be referred to as part-time.

Part-time
Nurses and midwives working less than the number of hours specified for the equivalent full-time post on an on-going basis. Recorded as hours worked in a two-week period.

Job-share
Filling a permanent post on a job-sharing basis. One full-time position filled by two nurses or midwives (who each work half time). The agreement on flexible working in the health service will impact on this in the longer term. Technically job-sharing may be subsumed within the flexible working arrangement insofar as a nurse could request to work 19, 20, 21 hours per week as opposed to 19.5.

Locum
Filling the position, on a short-term basis, of a nurse or midwife temporarily absent due to annual leave, maternity leave, courses or other reasons.

Contract
Permanent: filling a permanent position on a whole-time/part-time/job-sharing basis with a permanent contract.
Temporary: filling a permanent position on a whole-time or part-time basis with temporary contract status.

Registrable Qualifications
A nurse or midwife whose name is entered on the Register of Nurses maintained by An Bord Altranais. Evidence of this is established by viewing the registration notice issued by An Bord Altranais following payment of the annual retention fee. The register is divided into seven divisions: Registered General Nurse (RGN); Registered Psychiatric Nurse (RPN); Registered Mental Handicap Nurse (RMHN); Registered Sick Children's Nurse (RSCN); Registered Midwife (RM); Registered Public Health Nurse (RPHN); and Registered Nurse Tutor (RNT). To be entered on the SAP/HR system the qualification must be registered with An Bord Altranais.

Academic Qualifications
An academic nursing qualification is one that is derived from the following:

- A nursing/midwifery programme of studies
- Not less than six months duration or its equivalent in contact time
- Provided by a third level institution, or an institution approved by An Bord Altranais (Category II)/or the National Council for Professional Development of Nursing and Midwifery for the provision of post-registration certificate courses
- Involves an assessment process which results in the award of a hospital/community certificate which is approved by An Bord Altranais (Category II)/the National Council, or certificate, diploma, undergraduate degree, higher/postgraduate diploma, masters degree or PhD (awarded by the third level institution) arising from a nursing/midwifery programme of studies.
- General academic programmes with no nursing/midwifery content are listed in a general section of a qualifications catalogue and should be entered as such, e.g. Master of Business Administration (MBA) or Diploma in Social Studies.

An additional definition for nursing skills and training was developed for use at organisational level.

Nursing Skills and Training
Record of particular skills held by nurses (relevant to service provision) which were obtained though continuous professional development or short courses (less than 6 months duration).

3.2.2 Leaver and vacancy

In addition to testing the standard definitions for the minimum dataset, the steering group requested that a process for collection of information on leavers and vacancies be investigated. The standard definitions for leaver and vacancy tested by the pilot sites are shown in Table 3.2-4.

Table 3.2-4 – Standard definitions for leaver and vacancy

Leaver
An individual registered nurse/midwife who is exiting (i.e. leaving the payroll) from a permanent or temporary (full-time, part-time or job-sharing) position. A nurse/midwife changing commitment should not be regarded as a leaver, e.g. changing from full-time to part-time hours.

Reasons for leaving
If possible, information on reasons for leaving should be collected. The nurse or midwife may be leaving because of any of the following reasons:

- Taking up employment in another health organisation
- Leaving the profession
- Retirement
- For disciplinary reasons — dismissal
- Death

Vacancy

- A vacancy is a permanent or temporary nurse/midwife post for which the employer has financial resources, has advertised, but cannot fill, at present.
- A vacancy is a post that cannot be filled because no nurse/midwife is available, except on a day-to-day basis through an agency.
- The post holder does not have to be permanent for the post to be deemed 'filled'.
- Promotional posts where staff nurses or higher grades are acting-up should not be classified as vacant posts.
- Posts where nurses are on career breaks should be filled permanently and therefore should not be classified as vacant posts unless there are difficulties filling the position.
- Positions filled by agency nurses on an ad-hoc basis should be classified as vacant (agency nurses who are consistently filling a duty line on the roster should be noted).
- A post that is filled by a registered nurse/midwife who does not hold the preferred qualification should not be classified as vacant.
- The information collected should relate to the last day of the month in question.

3.3 *National Nursing and Midwifery Human Resource Minimum Dataset* pilot projects

The steering group for the project agreed that a pilot project would provide the best means of developing and testing methodologies to secure the requisite information on the minimum dataset. The Personnel, Payroll, Attendance, and Related System (PPARS) project team and members of the Information Management Unit (IMU) of the Department of Health and Children were asked to assist in this matter. A Nursing Data Quality (NDQ) project proposed by PPARS in November 2000 formed the basis for developing the pilot project.

3.3.1 Title of minimum dataset

When commissioning the pilot projects the title *Nursing and Midwifery Minimum Dataset* was used. During the process, it became apparent that this title was unspecific and could be confused with other datasets related to clinical nursing outcomes or research. For this reason a new title was adopted for the dataset, *National Nursing and Midwifery Human Resource Minimum Dataset*. The steering group recommended that this title be used in the future.

3.4 Criteria for selecting pilot sites

The steering group agreed the criteria for selecting pilot sites with advice from the PPARS national team. The criteria were as follows:

- SAP HR Phase I had been implemented for the Health Board/Authority Region.
- The Director of the Nursing and Midwifery Planning and Development Unit had taken up the post.
- A wide range of nursing roles, grades, and locations was covered by the PPARS for the area.
- There was a readiness on the part of nurse or midwife managers to participate in the pilot project.

On the basis of the above criteria the North-Western Health Board (NWHB) and St. James's Hospital, Dublin were invited to participate in the pilot projects. The steering group chose the different pilot sites to:

- challenge and test the *National Nursing and Midwifery Human Resource Minimum Dataset* in diverse and different nursing and midwifery populations
- develop a process that could be applied to a wider nursing and midwifery population without changing the core principles and definitions. The concept is to ensure that every site can provide reliable data, in a standardised format, that can be used at local level and provide comparable information that can be collated nationally.

Additional funding was offered to fast-track the compilation of comprehensive information on nursing and midwifery employment in the pilot sites. A meeting on 30 May 2001 was held with the Alliance of Nursing Unions. The purpose of the meeting was to seek support for *the National Nursing and Midwifery Minimum Dataset Human Resource* pilot projects. The nursing unions unanimously gave their support to the pilot projects.

3.5 Terms of Reference

Specific detailed terms of reference were agreed for the *National Nursing and Midwifery Human Resource Minimum Dataset* pilot projects on 18 May 2001. These are set out in Table 3.5-1.

Table 3.5-1 – General Terms of Reference — National Nursing and Midwifery Human Resource Minimum Dataset pilot projects

Aim of the project

- To focus on ensuring that a comprehensive dataset is collected for all nursing and midwifery staff working in the defined area (including public and private organisations).

Objectives

- To establish protocols and guidelines for the process of obtaining demographic, qualification and employment details for nurses and midwives
- To enter, verify, update and maintain full demographic information on the SAP HR system for nurses and midwives employed in the area
- In consultation with stakeholders to devise and agree standard definitions for all items included in the dataset
- To compile and test a qualifications catalogue for nurses and midwives for the PPARS SAP HR system. The minimum data to be recorded against each qualification to be tested and agreed during the pilot projects. A process for verification of individual qualifications to be identified. The catalogue to comprise three distinct sub-sections (registered qualifications, academic qualifications, skills/training)
- To establish procedures for the addition of qualifications to the catalogues
- To test the interaction between the Register of Nurses maintained by An Board Altranais and the PPARS SAP HR system
- To develop a methodology to generate summary reports for nursing and midwifery
- To recommend a nursing data maintenance strategy to ensure continued updating of nursing data following completion of the pilot projects.

Time frame

A minimum of three months and a maximum of four months was proposed and agreed by the two pilot sites for completion of the projects. Both pilot projects were given an agreed extension to address the various complexities of the projects. The pilot projects commenced in both sites on 1 June 2001 and the final report from both pilot sites and the PPARS project team was submitted in November 2001.

Meetings

Members of the Nursing Policy Division of the Department of Health and Children, along with representatives of the PPARS project team, advised and supported the two pilot projects. The facilitative meetings became known as the working group. Seven meetings were held, the first on 18 May 2001 and the final meeting on 20 November 2001. The meetings ensured the synchronisation of the pilot sites, and focused on having data consistency, addressing commonalities, sharing ideas, and solving problems as they arose. The meetings channelled efforts toward achieving the objectives while providing a framework for processing issues in a standardised format.

Reporting

It was agreed that a final report would be submitted including details of protocols, guidelines, standard definitions, and samples of summary reports. The pilot sites also agreed to propose the main assumptions on which future projections for the requirements of nurses and midwives for the region should be based. A brief progress report was forwarded to the Chair of the steering group on a monthly basis. A final report was presented to the steering group on 29 November 2001.

3.6 The national PPARS Project Office

The national Personnel, Payroll, Attendance and Related System (PPARS) Project Office at Sligo is tasked with facilitating the introduction of the Systems Applications and Products for Data Processing, Human Resource (SAP HR) software system into a number of the Irish health agencies. One of the first tasks has been the transfer of employees' personnel records on to computer and then the use of SAP HR for day-to-day personnel administration tasks. This will be followed in later phases of the project with the recording of attendance and absence, planning, budgeting, and payment of salaries. Further details about PPARS can be accessed on the website www.ppars.ie.

The current implementation of the SAP HR system allows the academic and professional qualifications of nurses and midwives to be recorded. This, for example, will allow the age profile of targeted nursing and midwifery groups to be ascertained, as well as their qualifications and skills, their employment type and turnover rate. In time the data collected will allow for career and succession planning, job profiling, skills matching, and identification of skills shortfall to allow for the planning of training/education. The PPARS national project team embraced the opportunity to participate in the pilot project with defined objectives shown in Table 3.6-1.

Table 3.6-1 – Objectives for PPARS involvement in pilot project

- To promote and demonstrate to Irish health agencies and the Department of Health and Children the utility of the SAP HR system as a data recording and reporting tool
- To assist the steering group for the *Study of Nursing and Midwifery Resource* in their search for a suitable minimum dataset for use as a planning tool for the present and into the future, for workforce planning for the nursing and midwifery profession
- To provide an important contribution in building an information base which will continue to assist health agencies concerned, their Directors of Nursing and in particular the recently appointed Directors of Nursing and Midwifery Planning and Development Units
- To initiate the process of building a comprehensive centrally managed qualifications catalogue for future use in all health agencies
- To advance wider user access and acceptability of the SAP HR system, i.e. to increase the level of organisational penetration, in terms of both the number of sites and the number and range of staff involved
- To develop, in a consultative manner with other parties involved, all the attendant design principles, clarification of best business processes and procedures, and the necessary definitions associated with managing this process
- To learn about the potential capabilities of the Personnel Development (PD) module of the SAP HR system, for planning future applications and implementations in the Irish health agency context
- To create a willingness amongst the agencies to develop the PD module and understand the potential benefits they would derive from using SAP HR for this purpose
- To develop expertise within the PPARS project team that would be applicable in future implementations of this kind and in other SAP modules
- To reinforce implementation efforts in related areas of the SAP HR system.

The support activities provided by the PPARS national project team was divided into a number of areas: qualifications catalogue, data migration, security access role, data merge process, data extraction report, specific data output reports, and production of an electronic minimum dataset file.

3.6.1 Qualifications catalogue

The major part of the work undertaken by the PPARS national project team was in the production and update of the Qualifications Catalogue (see paragraph 3.8).

3.6.2 Data migration

Before the start of the pilot project data about the qualifications, skills and training of the nursing and midwifery staff were not gathered through the SAP HR system. St. James's Hospital did not record information in any other system, while some agencies in the NWHB used a Nursing Management System (NMS) for this purpose.

About 10 years ago, the NWHB collected data on the qualifications of nursing staff. This was entered on to the Nursing Management System, but was not updated regularly. More recently, a Microsoft Access database was set up for one of the acute hospitals, which recorded data on the nursing staff's qualifications and skills, periods of academic study and attendance at training courses. This database was kept up-to-date.

As part of the preliminary work for this project, an extract of the qualifications information from the Nursing Management System and data from the Microsoft Access database were combined to create one large Microsoft Excel spreadsheet. However, the data proved to be incomplete and inexact:

- Prior to migration, an attempt was made to match the qualifications in the spreadsheet with an equivalent course in the qualification catalogue, each of which carries a unique identity number. There were 126 different qualifications in the spreadsheet but only 73 of them could be matched to equivalent, or nearly equivalent, names in the catalogue.
- Once the identity number of the qualification in the catalogue had been added to the qualification in the Microsoft Excel spreadsheet, the data were migrated into the NWHB's SAP HR system. In the process 465 records were rejected by SAP HR. The reasons for this were that the employees' personnel numbers were either inactive, that is, the employee had either left the NWHB's employment or retired, or the numbers were test items.

The following conclusions about the contents of any source data file can be drawn from this: the title of any qualification must be recorded correctly to avoid confusion; an attempt should be made to keep the data up-to-date; and prior to migration, the data in the file should be edited with all historic out-of-date data deleted.

3.6.3 Creation of new security access role

For the purposes of the pilot project, a special user role was created. This role, named ZQUALIFICATIONS, was assigned to certain users and allowed them to have access only to a restricted area of the SAP HR system. In those areas only, the user could input, modify or delete data. The rationale for this restriction was that the work being performed during the pilot project was limited to very specific areas of the system. It also meant that access to areas where more sensitive data (such as salary details) were recorded was not possible.

3.6.4 Data merge process

For the purposes of the pilot project, it was decided to send pre-populated questionnaires to all nurses and midwives employed in the pilot sites in the public health services and blank questionnaires for the independent sector. Pre-population of individual information already transferred to the SAP HR system on to the questionnaire required a data merge process. The information on each individual nurse and midwife on the SAP HR system was merged on to the questionnaire. This data merge process is described under data collection, paragraph 3.7.2.

3.6.5 Production of specific data output reports

The SAP HR system contains a large amount of data on the staff employed by the health agencies. One of the strengths of SAP HR is its reporting function, which allows the data to be analysed and output via a number of mechanisms (see paragraph 3.12.1).

3.6.6 Production of electronic minimum dataset file

It was a requirement of the pilot projects that an electronic file of the data collected during the project for the minimum dataset be submitted to the Information Management Unit, Department of Health and Children (see paragraph 3.12.2).

3.7 Data collection

One core objective of the pilot projects was to establish protocols and guidelines for collecting demographic, qualifications and employment details for nurses and midwives. One aspect of this was to test the feasibility of collecting and collating each item on the *National Nursing and Midwifery Human Resource Minimum Dataset*. Each pilot site had to give considerable time to the planning process for collecting requisite information. Issues considered are set out in Table 3.7-1.

Table 3.7-1 – Data collection considerations

- Resources to capture data
- Evidenced-based sound methodology
- Technical abilities of the SAP HR system
- Skills and abilities of project team
- Identification of the target population
- Effective and efficient mechanism for collection of information from disparate areas
- Ensuring reliability of information returned
- Feasibility of accessing data with current recording systems
- Collation of information to meet local and national reporting requirements.

3.7.1 Inclusion/exclusion criteria

Identification of inclusion/exclusion criteria was necessary to define the target population in both pilot sites. This was to ensure a standardised approach and comparability of the cohorts. Information on all individuals occupying nursing and midwifery posts was included. The pilot sites identified a number of nurses and midwives employed in areas outside of nursing within the sites. To assure clarity on the issue a definition for a nursing or midwifery post was developed for the purposes of defining the target population. Excluded from the target were nurses or midwives working through an agency. For the pilot project in the NWHB it was necessary to define the independent sector. This assisted in the decision-making process to include or exclude an organisation in the grouping for the independent sector.

Table 3.7-2 – Supporting inclusion/exclusion definitions

The following criteria must be fulfilled for a post to be considered a nursing or midwifery post:

- The post is classified/approved by the Human Resource Department as a nursing or midwifery post.
- Registration with An Board Altranais is an essential requirement for the post.
- The post is listed on the Department of Health and Children grade code listing for nurses and midwives.

Agency nurse
A registered nurse/midwife who holds active registration with An Bord Altranais and is providing nursing services on a casual basis arranged thorough a nursing agency. Nurses/midwives working through a nursing agency are not direct employees of the organisation and do not have a formal contract of employment. Nurses working through an agency may be working full-time or part-time hours. As agency nurses are not employees of the organisation (on the payroll) they should not be included in the *National Nursing and Midwifery Human Resource Minimum Dataset*.

Independent sector (health services)
Organisations providing health care services (private and voluntary) outside the direct health board structure, some of whom may provide services on behalf of a particular health board.

3.7.2 Data collection instrument

One fundamental step in the process of human resource planning is the collection of accurate, reliable and valid data. Survey design was the method of choice, with a questionnaire as the data collection instrument. Each question evolved from the *National Nursing and Midwifery Human Resource Minimum Dataset* (see paragraph 3.2). The template for the questionnaire was developed by the steering group in consultation with the working group for the pilot projects.

The intention was to pre-populate the questionnaire, which was a Microsoft Word document, with information held on SAP HR, e.g. the person's name and address, work location, contract type, hours worked, and the academic and professional qualifications held. The employee was asked to confirm that the information was correct, or update it with the proper information.

To achieve this merge function, the PPARS national team developed a report that produces a file containing the required data on all nurses and midwives in the SAP HR database. This report is named ZREP53. The Microsoft Word questionnaire template was amended to include the field names corresponding to the data output from ZREP53. When the Microsoft Word merge process was run, it populated the fields in the questionnaire template with the data from the output file.

One problem was found with this process at St. James's Hospital. When the ZREP53 report was run and the merge process completed, questionnaires were sent to some nurses at an old work address. Investigation showed that their SAP HR records had their correct work address on record. However, due to a problem in delimiting those records with the proper date, the previous (and now incorrect) work address was being selected. The ZREP53 report was modified, and checked, showing that the problem had been rectified. When St. James's Hospital re-ran the ZREP53 report, in order to send out reminder letters to their staff, the correct work address was pickedup in every case.

In the North-Western Health Board two questionnaires were used. The pre-populated format was used for the public sector and a blank questionnaire with exactly the same questions used for the independent sector. The North-Western Health Board compared the use of each type of questionnaires and their conclusions are shown in Table 3.7-3.

Table 3.7-3 – Questionnaire comparison

Pre-populated Questionnaire
- Confidentiality issues arose regarding sending a questionnaire with sensitive data to individuals. Certain nurses and midwives would have clerical staff opening mail on their behalf and in some cases the mailbox is in a public area with a risk of it being opened by other personnel.
- Difficulties were experienced in that respondents did not always complete the correct section and incorrect information was not always amended.

- Having the questionnaire pre-populated on the left and blank columns on the right for correction caused confusion and was not adhered to by the nurses on many occasions.
- Country of origin appeared to give rise to difficulty in that only 10 per cent completed this field, compared with an 82 per cent completion when using the blank questionnaire.
- Forms could not be photocopied or replaced easily. External printing methods (professional printer) could not be used.
- Printing of 2,600 merged questionnaires was a lengthy and difficult process.

Blank Questionnaire

- Blank questionnaires had a better completion rate.
- Printing was easy and photocopying was possible. The services of professional printers could be availed of.
- Distribution was easier.
- Confidentiality issues did not arise, as the form did not divulge information.
- There was a greater reliance on the legibility of the respondent's handwriting.
- Blank questionnaires issued to Directors for distribution meant greater ownership and involvement from senior personnel, giving more credence to the project and possibly leading to better return.

Processing the data proved to be considerably time-consuming, due to the fact that some questionnaires were not filled in completely. To demonstrate this, the St. James's Hospital project team reported the following:

- An Bord Altranais registration notice: 18 per cent (N = 115) of respondents did not include their An Bord Altranais registration notice or PIN card. A phone call was made to individuals requesting them to send in the copy registration notice by post or by hand.
- Confirm country of birth: 34 per cent (N = 240) of respondents did not include their country of birth. As it was part of the decision rules and guidelines, a follow-up phone call was made to individuals to ask their country of birth.
- RGN/RM details: 39 per cent (N = 213) of respondents did not include their RGN/RM details in the professional section of the qualifications catalogue. A follow-up phone call was made to gather this information.
- Qualifications that attract an allowance validated by Clinical Nurse Manager: 4 per cent (N = 26) of respondents did not have their qualifications validated by their line manager. These qualifications were entered as 'not validated' and returned to individuals for verification by their line manager.
- Staff members' signature on 'Declaration': 5 per cent (N = 29) of respondents did not sign the declaration. A phone call was made to the individuals in question requesting them to call to Nursing Administration to sign the Declaration. In some cases Nursing Administration returned them via internal post for signature.

3.8 Nursing and midwifery qualifications catalogue

The PPARS national project team, with advice from the steering group, had developed a nursing and midwifery qualification catalogue on the SAP HR system, prior to the commencement of the pilot projects. The nursing and midwifery qualifications catalogue is a simple listing of qualifications and in no way validates any particular qualification. A record of a qualification on the catalogue against an individual nurse or midwife does not relate to competency. The nursing and midwifery qualification catalogue lists all nursing and midwifery related courses by title and allocates a code number. The pilot sites were asked to compile and test a qualification catalogue for nurses and midwives for the PPARS SAP HR system. The pilot sites collected information on the title of the qualification, start date, finish

date and awarding body. At the commencement of the pilot project, the catalogue contained about 150 entries, in the following areas:

- professional qualifications (such as registered general nurse, registered sick children's nurse, etc)
- academic qualifications particular to nurses and midwives (such as certificates, degrees, diplomas etc)
- academic qualifications for healthcare and public administration staff (such as certificates, degrees, diplomas etc)
- skills and training (such as resuscitation techniques, life support training).

Over the course of the project the qualifications catalogue for nurses and midwives was developed further and tested by the PPARS team, on the SAP HR system. A matching exercise took place between course titles supplied on returned questionnaires, with the appropriate course and catalogue number in the qualifications catalogue. A 'holding bay' was established on a spreadsheet for courses that did not have a catalogue number allocated or were awaiting a decision on addition to the catalogue (nursing or general). A procedure for the addition of qualifications to the catalogue was agreed (see section 3.8.2).

The schools/departments of nursing of the universities and institutes of technology were invited on 15 October 2001 to comment on the Qualification Catalogue listing held on the PPARS SAP HR system. One of the objectives for the pilot studies specifically related to the academic nursing qualifications: *To compile and test a qualifications catalogue for Nurses and Midwives for the PPARS SAP/HR system*. The fourteen universities and institutes of technology were asked to validate the content and advise on additions. Each Higher Education Institution (HEI) was asked to:

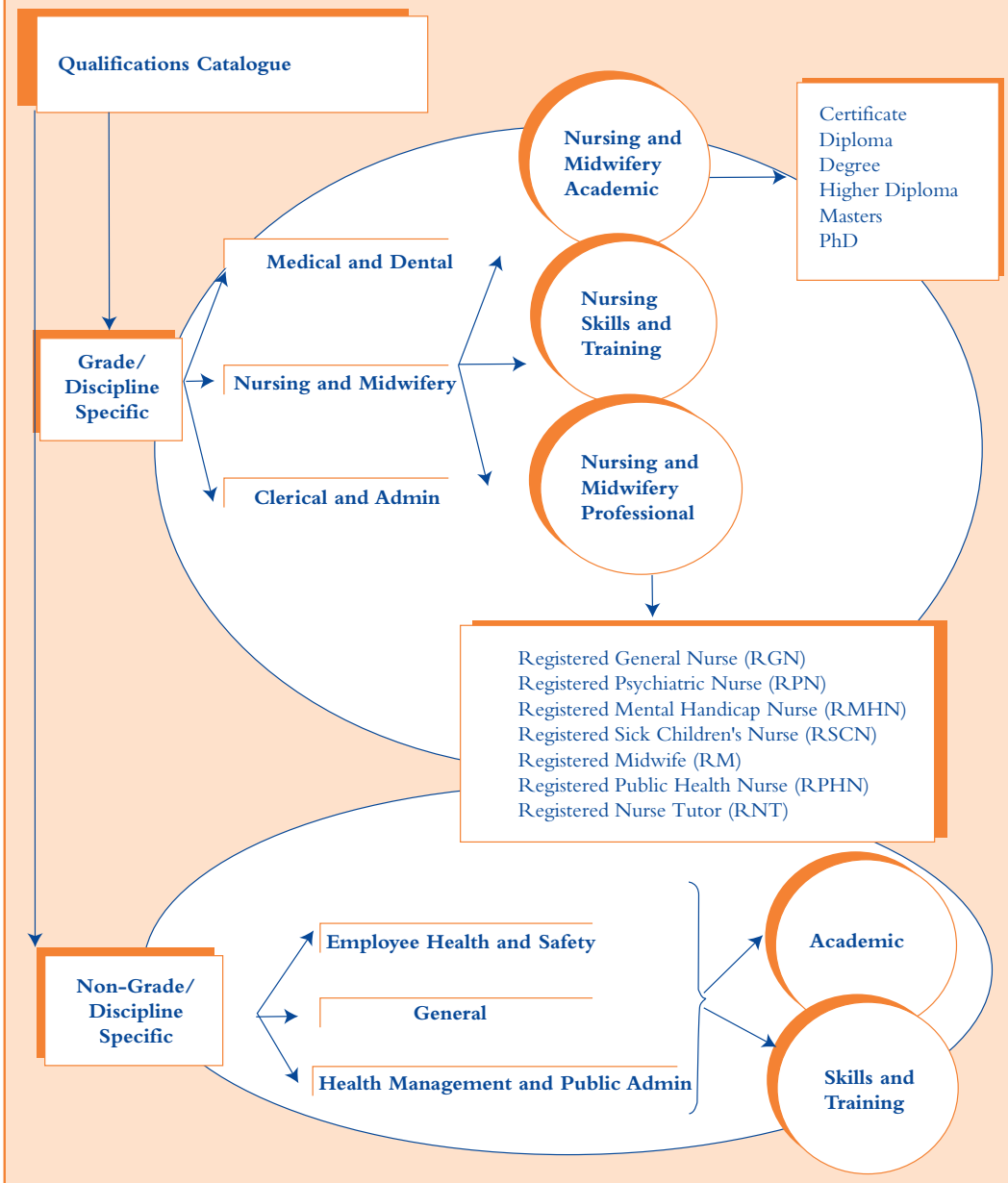
- review the PPARS SAP qualifications listing and indicate if any amendments to titles were required, and
- review PPARS SAP qualifications listing and indicate if there were any omissions.

On the basis of information received from the HEIs the catalogue was amended.

During the course of the pilot project the catalogue was modified in a number of ways. It more than doubled in size to over 320 entries, to include many more academic courses that the pilot projects were revealing were held by staff. Many of these courses and qualifications had not existed when the catalogue was first compiled, such as the bachelor of science in specialist nursing practice and the advanced diploma in specialist practice in nursing (with all their variants). Many of these additional qualifications had been awarded by institutions outside the state, such as in Northern Ireland and in the rest of the United Kingdom. At the same time, the opportunity was taken to restructure the catalogue to make it easier to search for the required entry. A general category was included where academic qualifications and skills, which were not particular to nursing or midwifery alone, could be placed. Items in this category include reflexology and aromatherapy.

The structure of the nursing and midwifery qualification catalogue comprises three distinct sub-sections: registered qualifications, academic qualifications, and nursing and midwifery skills and training as represented diagrammatically in Figure 3.8-1.

FIGURE 3.8-1
Illustration of the Qualifications Catalogue on PPARS SAP HR system



For the purposes of the pilot project the following two sub-sections of the nursing and midwifery qualifications catalogue were rigorously tested.

- Registered qualifications, divided into seven divisions: Registered General Nurse (RGN); Registered Psychiatric Nurse (RPN); Registered Mental Handicap Nurse (RMHN); Registered Sick Children's Nurse (RSCN); Registered Midwife (RM); Registered Public Health Nurse (RPHN); and Registered Nurse Tutor (RNT). Registration with the UKCC or other Nursing Boards, such as those in USA or Australia, were not included. Only the above seven qualifications held on the Register of Nurses maintained by An Bord Altranais were included. The rationale for this decision is that a nurse or midwife must be registered with An Bord Altranais to practise as a nurse or midwife in Ireland. Nurses or midwives with qualifications obtained abroad have to apply for assessment of their qualification prior to being entered under one of the divisions of the Irish Register of Nurses.
- Academic qualifications: the listing is subdivided by award level — certificate, diploma, degree, higher/postgraduate diploma, masters, PhD. The standard definitions to inform decisions on whether an academic qualification is to be entered into the nursing and midwifery qualifications catalogue held on the PPARS SAP HR system are set out on Table 3.2-3.

The nursing and midwifery qualifications catalogue is specifically designed for recording nursing and midwifery qualifications. General academic programmes with no nursing or midwifery content are listed in the general section of the catalogue and should be entered as such, e.g. master of business administration (MBA) or diploma in legal studies.

3.8.1 Special data extraction report for notes qualification infotype

During the NWHB survey, information was gathered on the date that a qualification was acquired, and the awarding educational establishment. SAP HR does not have a specific database item (or infotype) to record this information. However, in the qualifications infotype (0024) there is a 'Note' section. The decision was made to include the information in this note.

The downside of this decision was that the normal database reporting features in SAP HR did not give access to this Note field. To allow a report to be produced from the information in this Note field a special SAP report was written by PPARS. This SAP report is named ZREP55.

The ZREP55 report can be used to search the SAP HR database using criteria such as personnel number, details of employment type and contract type, as well as organisational area of work. For each person who fulfils the criteria, his or her qualification details and any associated Note field entry are output to a data-file.

3.8.2 Additions to the nursing and midwifery qualifications catalogue

On return of the questionnaires each pilot site undertook a matching exercise between course titles supplied by the respondent and the appropriate course and catalogue number supplied by the qualifications catalogue on the SAP HR system. Unmatched qualifications or any that were difficult to make a decision on or interpret were held on a spreadsheet known as a 'holding bay' until the qualification was added to the catalogue or the issue was clarified.

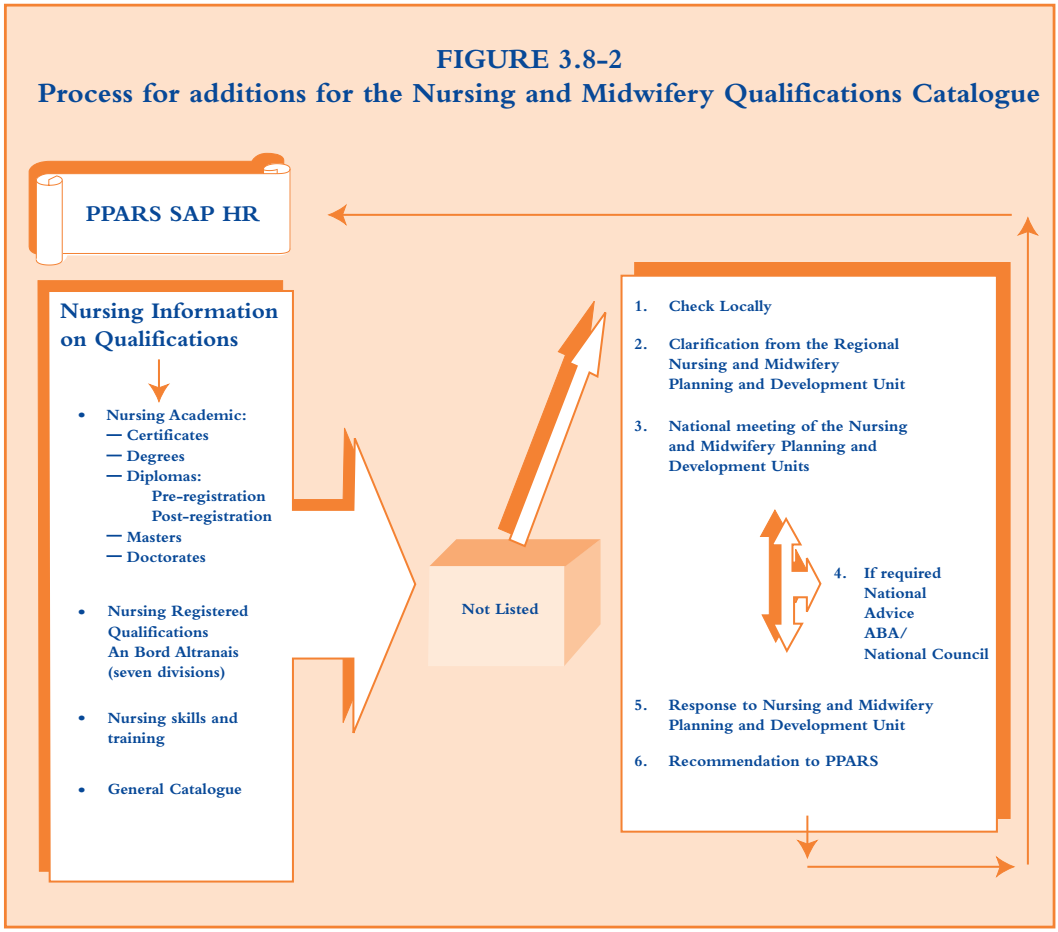
During the pilots the steering group sought advice on the catalogue from An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery. Following a number of meetings further changes were highlighted that required additions, deletions and restructuring. This process will continue into the future as new academic courses are designed, as nurses and midwives go abroad for training, and as nurses and midwives are recruited from overseas. However, it is expected

that the amount and frequency of changes to the catalogue will reduce. A listing of the grade discipline specific qualifications under nursing and midwifery held on the SAP HR system, as at June 2002, is outlined in Appendix 4.

The PPARS National Project Office has designed a form, to be used when a qualification is to be added to the catalogue or an existing one is to be modified. Details of the required change should be approved before being submitted to the PPARS National Project Office, so that only officially sanctioned changes are included.

A process for approval of additions to the nursing and midwifery qualifications catalogue was agreed between An Bord Altranais, the National Council for the Professional Development of Nursing and Midwifery, Directors of the Nursing and Midwifery Planning and Development Units, the national PPARS project team, the Nursing Policy Division in the Department of Health and Children and the steering group for the study. This process is designed to ensure the ongoing development of a comprehensive centrally managed qualifications catalogue which is standardised. A principal function of the Nursing and Midwifery Planning and Development Units is that of monitoring and forecasting the workforce requirements for nursing and midwifery in their region. It is for this reason that the responsibility for managing and sanctioning additions to the qualifications catalogue in a collective and consistent format predominantly lies with the Nursing and Midwifery Planning and Development Units. The flow chart in Figure 3.8-2 demonstrates the agreed process.

FIGURE 3.8-2
Process for additions for the Nursing and Midwifery Qualifications Catalogue



3.9 Data entry

Valid and reliable information entered on the SAP HR system is an essential prerequisite to future forecasting. In order to achieve an optimal standard and reduce data entry error and bias and minimise subjective decision- making, rules and guidelines were developed for verification of information on the questionnaire (both pre-populated and blank questionnaires) and subsequent data entry on to the SAP HR system. Synchronisation and standardisation of the guidelines and decision rules were agreed between the two pilot sites and with advice from the PPARS project team on 16 July 2001. The guidelines for verification of information returned on the questionnaire prior to data entry are outlined in Table 3.9-1.

Table 3.9-1 – Guidelines for verification of information on the questionnaire

Prior to inputting any information on the SAP HR system each returned questionnaire must be reviewed by the designated person who is responsible for checking that all information is complete.

Step 1
Confirm that all questions on the questionnaire have been completed and are legible. Contact individuals for clarification as necessary.

Step 2
Check that the individual nurse has signed the declaration on the questionnaire to verify that all information is correct. If the declaration is not signed by the nurse or midwife the questionnaire is returned to the individual for verification of information.

Step 3
Confirmation that copies of all necessary documents are attached to the questionnaire.

- An Bord Altranais registration notice
- Confirmation of ABA PIN number entered on the questionnaire
- Confirmation of date issued (proof of payment of retention fee). Therefore the expiry date will be 31 December of the year in question — entered in the system as 30 April of the following year to allow time for payment
- Confirmation of qualifications registered with An Bord Altranais (showing division of the Register of Nurses)
- Copy of certificates, diplomas etc to verify the qualifications that attract additional payment or qualifications that are essential to employment in the post
- As necessary, contact individuals for missing documentation.

Step 4
Check each questionnaire against the decision rules.
Follow up on all ambiguous or unclear information.

Step 5
A record of individual vetting on each questionnaire should be noted on the questionnaire sheet.

Step 6
When the designated person is satisfied that all the information required is complete, each individual questionnaire is then signed off by the designated person before the data are entered on the SAP HR system.

Step 7
Enter data on the SAP HR database following PPARS guidelines for accessing and navigating the system.

3.9.1 Purpose of the decision rules

The aim of the decision rules is to ensure the data entry process is as objective as possible, thereby ensuring that the information on the SAP HR system is reliable (Table 3.9-2).

Table 3.9-2 – Questionnaire decision rules

Name
Decision rule: St. James's Hospital and the NWHB devised local protocols on which name is to be entered (An Bord Altranais, known as, maiden name, married name etc).

Personnel Identification Number
Decision rule: The individual identifier (Personnel Number) was pre-printed on the questionnaire. If the personnel number is not filled in it must be checked against employment records/listings.

Sex
Decision rule: The sex of the individual must be indicated on the questionnaire. If sex is not indicated it must be verified with the relevant nurse manager (CNM 1, 2 or 3).

Date of Birth
Decision rule: As each individual nurse signs a declaration to verify that all information is correct, the date of birth given by the individual on the questionnaire is accepted. If the date of birth is absent, contact should be made with the individual through his or her work address for missing information. If this is unsuccessful contact should be made with the relevant nurse manager (CNM 1, 2 or 3) for assistance.

Nationality
Decision rule: If information is missing the individual must be contacted for details.

Country of Birth
Decision rule: If information is missing for both nationality and country of birth the individual must be contacted for relevant details. If information is complete for nationality but missing for country of birth the individual should be contacted for details (if other queries are being followed up).

An Bord Altranais Number
Decision rule: An Bord Altranais PIN to be verified against the copy of the current registration notice. In the SAP HR system, under '**Start'** — date of first registration (regardless of division) with An Bord Altarnais should be entered. The '**To'** option on this screen is not used. The '**Next'** renewal date should be entered as 30 April of the following year.

If the ABA registration notice is not appended to the questionnaire, follow the alternative checking procedure systematically until the record can be verified as follows:

- If the individual's registration notice is not attached and only the card is available then 01/01/01 is to be entered.
- Check the organisational An Bord Altranais listing to verify information.
- Make direct contact with the individual for a copy of the ABA registration notice.
- If unsuccessful, contact the relevant nurse manager (CMN 1, 2 or 3) for assistance.
- A list of all outstanding registration details is to be maintained.

Health Board Region
Decision rule: The individual must be inputted in the Health Board Region currently being addressed.

Work Location (only applies to NWHB)
Decision rule: The official name of the organisation where the nurse is employed should be entered.

Work Address/Area of Assignment (applies to both St. James's Hospital and NWHB)
Decision rule: If the individual identifies two areas of assignment, the area of the greatest commitment is to be entered. Local protocols were devised for dealing with floating/rotating staff.

Job Title/Grade Code
Decision rule: The job title must correspond with the Department of Health and Children grade code titles for Nursing and Midwifery (regardless of the name used locally). If the job title is not on the Department of Health and Children grade code list, the equivalent code should be identified and entered.

A record of job titles not found on the Department of Health and Children grade code listing was made during the pilot project, including how they were subsequently entered.

If job title and grade code are inconsistent, contact was made with Personnel, Payroll, Nursing Administration or Management for advice.

Position Title
Decision rule: Position title can be entered as stated by the individuals and used by organisations.

Contract Type
Decision rule: There are only two options (Temporary or Permanent). If not completed contract type should be verified with the individual or Nursing Administration/Personnel.

Commitment (Full-time, Job-sharing/Part-time)
Decision rule: If there is any doubt about the accuracy of the contract indicated or if this section is not completed contact should be made with the relevant Nurse Manager (CNM 1, 2 or 3) or Nursing Administration/Management.
If part-time indicated, hours for a two-week period must be recorded. If missing, contact should be made with the relevant nurse manager (CNM 1, 2 or 3).

Registered Qualification
Decision rule: Registered qualifications (Division of Register of Nurses maintained by An Bord Altranais) should not be entered until confirmed by a copy of An Bord Altranais registration notice appended to the questionnaire. If An Bord Altranais registration notice is not appended to the questionnaire check An Bord Altranais listing, obtained by the organisation to verify information. Direct contact is made with individuals if they are not on the listing and if this is unsuccessful the nurse manager was contacted.

Academic Nursing Qualifications
Decision rule: Academic qualifications are entered against a nurse's or midwife's name in the following instances:

- When evidence of successful completion of the course is seen by the relevant nurse manager (copy of certificate/diploma/degree etc). In this case, the qualification is noted as VALIDATED. This is essential for qualifications attracting a qualification allowance or those essential for the post.
- When the nurse reports successful completion of the course but evidence has not been viewed by the nurse manager. In this case the details are entered but noted as NOT VALIDATED.

The following details should be given for each academic qualification

- Title of course and level of award, e.g. certificate, diploma etc. (should be already listed on the catalogue)
- Awarding body
- Date qualification was obtained/ finish date.
- A module within a programme, which is used to build up credits towards an academic qualification, should not be recorded. For example, access to degree programme should not be recorded, where it forms part of the undergraduate award, until the full qualification is obtained (BSc or BNS). The final qualification obtained at the completion of the programme should be the one recorded.
- Stand-alone access modules, which enable entry to the undergraduate programme but do not form part of the undergraduate award, should be entered on the catalogue. There is no specific academic level attached to this form of an access programme (use category for miscellaneous).
- Courses in progress should not be recorded until the qualification has been formally awarded and the relevant certificate of completion is provided as evidence of successful completion.
- Where a qualification is not listed on the catalogue, this should be placed in the 'holding area' and a note placed on the individual nurse's entry on the SAP HR system.
- If the qualification is not specifically a nursing or midwifery qualification it should be entered under the general catalogue.

The next section provides a brief overview of the different processes and experiences during each of the pilot projects.

3.10 North-Western Health Board pilot project

The NWHB was established under the 1970 Health Act and has responsibility for the administration and provision of health and personal social services in the counties of Donegal, Sligo, Leitrim and a section of Cavan. The area is substantially rural covering 2,600 sq. miles and has a total population of approximately 213,000 people (NWHB, 2001). The population of Donegal North is 121,000, while that of Sligo, Leitrim, South Donegal and West Cavan is 92, 000. In total 2,710 nurses were identified as working in the health service in the North-Western Health Board. The geographical spread of services for this population poses a major challenge for the North West in its delivery of services.

3.10.1 North-Western Health Board pilot project — terms of reference

Aim of the project

The aim of the project was to collect a comprehensive dataset for all nursing staff working in the North West, in both the public and independent sectors of the health services.

Objectives of the study

- To establish protocols and guidelines for the purpose of obtaining demographic, employment and qualification details for nurses and midwifes in the NWHB
- To enter, verify, update and maintain full demographic information on the SAP HR system for nurses and midwives employed in the area
- In consultation with stakeholders to devise and agree standard definitions for all items included in the dataset
- To compile and test a qualifications catalogue for nurses and midwives for the SAP HR system
- To establish procedures for the addition of qualifications to the catalogue
- To test the interaction between the Register of Nurses maintained by An Bord Altranais and the SAP HR system
- To develop a methodology to generate summary reports for nursing and midwifery. Investigate methodology for reporting on leavers/vacancies
- To recommend a nursing data maintenance strategy to ensure continued updating of nursing data following completion of the pilot project.

3.10.2 Outline of the pilot process in the North-Western Health Board

Project team

A project team was set up in the Nursing and Midwifery Planning and Development Unit (NMPDU) North-Western Health Board, comprising a project leader, nursing and clerical staff. A resource group was established to give advice and provide expertise on wider issues (membership of the NWHB project and recourse team is listed at the start of the document).

Time frame

At national level, a time frame of four months was agreed with an extension of one month given to conclude the project.

Time schedule

At local level, a time schedule was drawn up with priorities and deadlines reflected in the timetable, which mapped out questionnaire design, pre-population of the questionnaire, printing and delivery schedules. It also proposed a closing date for return of the questionnaire, and involved data validation, data entry requirements and report planning time frames.

Training programme

A training programme was undertaken by the project team to familiarise personnel with aspects of the PPARS SAP HR system that would be required to carry out the project. Navigational skills, enquiry and update skills were essential to form a basis on which to build. The project itself formed part of the training process, with learning needs changing as the work progressed.

Communication process

A communication process was drawn up with a view to informing nurses and midwives of the nature of the project and eliciting their support. This involved meetings with key stakeholders, directors and service heads. The opportunity was taken to attend nursing and midwifery staff meetings at hospitals.

Geographical location search

A geographical location search was undertaken, which identified a considerable spread in the 73 sites employing nurses and midwives in the North-West region. Routes and travel plans were drawn from this. An exercise was undertaken to match physical locations with the organisational structure of the SAP HR system. This involved learning the terminology and naming conventions.

Target population

The target population of 2,710 nurses and midwives in the NWHB region was viewed on the SAP HR system. A listing of nurses in all sites on the organisational structure was produced by the national PPARS project team (by using SAP report called ZREP53). Inclusion/exclusion criteria were drawn up and selection criteria to isolate the number of nurses in the NWHB was finalised.

Questionnaire

A questionnaire was designed, pre-populated with existing information from the SAP HR system and delivered to the work location of nurses employed by the North-Western Health Board.

A second blank questionnaire was designed and delivered to 350 nurses in the independent sector in the region as no previous information was held for them. As this information could not be held on the SAP HR system, a separate database was established by the Unit, to enter the returned information. Personal data, employment details and qualifications were recorded on this Microsoft Access database, mirroring the structure of the minimum dataset for the public sector.

Data entry for the public sector

Data entry for the public sector to the SAP HR system was undertaken with two approaches to comply with security requirements for access to information. Nursing and Midwifery Planning and Development Unit staff entered personal details and qualifications while designated PPARS key users entered or modified employment details.

An Bord Altranais PIN number

A manual process to verify An Bord Altranais PIN numbers was established. An interaction between the Register of Nurses maintained by An Bord Altranais and the SAP HR system was explored: work is still in progress on this issue.

Summary reports

A methodology to generate summary reports from the SAP HR system for nursing and midwifery was investigated. A team was established to draw up the necessary specifications that would be required to carry out analysis of data. An electronic file was produced by the national PPARS project team (using a SAP report named ZREP57), was supplied to the Department of Health and Children at the end of the project, containing the data for the minimum dataset, obtained from returned questionnaires from the public sector.

An electronic file pertaining to the minimum dataset compiled from returned questionnaires from the independent sector was produced by the project team in the Nursing and Midwifery Planning and Development Unit. Summary reports for the independent sector were produced using Microsoft Excel.

Response rate

The response rate for return of questionnaires was 35 per cent by September 2001, increasing to 37 per cent in October with a final return of 42 per cent. In total 2,710 questionnaires were issued, with 1,148 returned as shown in Table 3.10-1.

Table 3.10-1 – North-Western Health Board response rate

Sector	No. Issued	October Returns	October Returns %	November Returns	November Returns %
Public	2,360	889	37.6	999	42.3
Independent	350	126	36	149	42.5
Total	**2,710**	**1,015**	**37.4**	**1,148**	**42.3**

The response rate was lower than expected. Factors that may have contributed were:

- the timing of the event — peak summer period with leave and ward closures
- geographical spread of the area
- delay in delivery of questionnaires
- information sessions held prior to receipt of questionnaire — may have had an impact on returns
- the high number of internal transfers and secondments, which made locating nurses difficult at times.

A proposed nursing data maintenance strategy was drawn up to ensure continued updating of the minimum dataset following completion of the pilot project.

3.11 St. James's Hospital pilot project

St. James's Hospital is the largest acute general hospital in the Republic of Ireland and is the major teaching hospital for Trinity College, Dublin. The hospital provides a comprehensive range of diagnostic and treatment services, many with national or regional status, and is at the leading edge of clinical practice and research. It employs over 2,800 staff and houses 760 beds.

St. James's Hospital has piloted the internationally well established clinical directorate model of management in Ireland since 1996. Each clinical directorate groups specialties, both medical and surgical, that complement each other in the multi-specialty treatment of illness categories. St. James's Hospital has almost completed a phased re-organisation of its management structure into a system of directorates, each headed by a clinical director.

3.11.1 St. James's Hospital pilot project — terms of reference

Aim of the project

The aim of the project was to collect a comprehensive dataset for all nursing staff working in St. James's Hospital.

Objectives of the study

To set up protocols and guidelines for the purpose of obtaining a minimum dataset, including qualifications of nurses employed at St. James's Hospital

- To verify, enter, update and maintain full personal and professional details on the SAP HR system
- In consultation with stakeholders, to devise and agree standard definitions for all items included in the minimum dataset
- To test current qualifications catalogue on the SAP HR system
- To establish procedures to add qualifications to the catalogue
- To explore the possibility of interaction between the IT system for the Register of Nurses maintained by An Bord Altranais and the SAP HR system and make recommendations
- To develop a methodology to generate summary reports of nursing and midwifery data
- To recommend a data maintenance strategy to ensure continued updating of nursing data following completion of the pilot project
- To collect 'Training and Development' data of nurses during this process
- To develop a methodology to calculate leavers
- To develop a methodology to calculate nursing vacancies at St. James's Hospital.

3.11.2 Outline of pilot process in St. James's Hospital

The *National Nursing and Midwifery Human Resource Minimum Dataset* at St. James's Hospital did not include midwives as midwifery services are not provided at the hospital. All existing nurses and nurses newly recruited during the pilot were included in the project. Newly recruited nurses are processed through the Personnel Department or Nursing Administration, depending on their employment status.

For the pilot the nursing workforce of the hospital was categorised into three groups and each group accessed as follows:

- Existing nursing staff — details collected using a questionnaire
- New permanent nurses — details collected during the recruitment process by the Personnel Department
- New temporary nurses — details collected during the recruitment process by Nursing Administration.

Project team

A project team was set up in St. James's Hospital comprising a project leader and nursing and clerical staff. A resource group was established to give advice and provide expertise on wider issues (membership of the St. James's Hospital project and resource team is listed at the start of the document).

Time frame

At national level, a time frame of three months was agreed with an extension of two months given to conclude the project.

Time schedule

At local level, project preparation and planning were considered and a time schedule with priorities and deadlines was established to collect the minimum dataset. This schedule included questionnaire design, pre-population, printing, distribution and the collating of returns.

Training programme

Three components were considered under training: IT training; SAP HR training; standard definitions, guidelines and rules.

IT training

IT training was required for the project team members and individuals carrying out hiring and maintenance function in the Recruitment and Selection, Personnel Department, and Nursing Administration. In the future directorate nurse managers and line managers will require training.

SAP HR system training

An IT training programme was essential before entering, verifying, updating and maintaining data on the SAP HR system. A two-hour training session per person was facilitated in the Training and Development Department, covering 'display' and 'maintenance'. The project team members were computer literate which was an advantage in facilitating the smooth running of the project. The overall training requirement for the project team is proficiency in Microsoft Word and Excel, with a member of the team experienced in the use of the following SAP HR system components:

- SAP HR — personnel administration
- SAP HR — organisational management
- SAP HR — qualification entry
- SAP HR — standard and ad hoc reporting.

Standardised definition, guidelines and rules

There was limited time to create awareness for nurse managers and recruitment staff on decision rules and guidelines, standard definitions, qualifications catalogue and correct completion of the questionnaire.

Communication process

A communication process was drawn up with a view to informing nurses of the nature of the project and eliciting their support. An awareness campaign took place prior to the commencement of the pilot. Posters were displayed in all clinical areas and each nurse was sent a letter outlining the aims of the project and requesting participation. Meetings with key stakeholders, directorate nurse managers and service heads were also arranged.

Target population

The target population was identified on the SAP HR system consisting of 1,151 nurses in total. A listing of nurses in all sites of the organisational structure was produced in electronic form by the St. James's Hospital PPARS project team.

Questionnaire

A questionnaire was designed, pre-populated with existing information from the SAP HR system. It was delivered to the work location of the 1,151 nurses employed at St. James's Hospital by the directorate nurse managers.

Data collection

Existing nursing staff — details collected using a questionnaire.

A mail shot questionnaire addressed to each nurse was given to the directorate nurse managers for distribution to nursing staff. The nurse's personal and employment details already recorded in SAP HR system populated the questionnaire. The individual nurse was asked to check if the existing details were correct and amend if incorrect. The questionnaire also included a copy of the qualifications catalogue. Each nurse recorded his or her qualification against the catalogue. Qualifications that attracted an allowance, or those essential for a post, as well as the nurse's current An Bord Altranais PIN, were validated by the nurse's line manager. Each individual nurse returned the completed questionnaire to the project officer in Nursing Administration. Personal details were amended as required and qualifications recorded.

New permanent nurses — details collected during the recruitment process by the Personnel Department.

The recruitment and selection function of the Personnel Department requests that each candidate bring all relevant documents to the interview. This includes certificates of qualifications and current An Bord Altranais registration PIN. The nurse manager must verify the following during the interview:

- current An Bord Altranais registration and PIN
- qualifications that attract an allowance
- qualifications essential for the post.

The nursing qualifications record form is attached to the candidate's file. When a nurse is appointed to a permanent position, Recruitment and Selection function in the Personnel Department record the nurse's qualification on the SAP HR system. Un-verified qualifications are recorded as 'not validated' on the SAP HR system. Any queries on nursing qualifications are discussed with the Human Resource Manager (Nursing) in Nursing Administration.

New temporary nurses — details collected during the recruitment process by Nursing Administration.

The directorate nurse manager in Nursing Administration requests that each candidate bring to the interview all documents relating to qualifications, including current An Bord Altranais registration and PIN. At the interview the directorate nurse manager verifies the following:

- current An Bord Altranais registration and PIN
- qualifications that attract an allowance
- qualifications essential for the post.

The clerical support function in Nursing Administration records personal details, qualifications and An Bord Altranais PIN on the SAP HR system.

An Bord Altranais PIN number

A manual process for verifying An Bord Altranais PIN number for nurses on the SAP HR system is undertaken by each directorate nurse manager on an annual basis. An interface between the Register of Nurses maintained by An Bord Altranais and the SAP HR system which would avoid duplication and reduce a time-consuming process continues to be investigated by the parties concerned.

Summary reports

A methodology to generate summary reports from the SAP HR system, for nursing and midwifery, was investigated. A team was established by the national PPARS project team to draw up the necessary specifications that would be required to carry out analysis of data. An electronic file (ZREP 57) was produced supplying data for the minimum dataset, obtained from returned questionnaires.

Response rate

The total number of questionnaires distributed in St. James's Hospital was 1,151. Fifty-eight of these were casual employees and did not form part of the cohort. The remaining 1,093 nurses were then considered to be the total target population. Two months on from the date of distribution, response rate was 39 per cent. A report was drawn up using the SAP HR system, which listed nurses who had failed to return the questionnaire, grouping them by clinical directorate. The list was distributed to directorate nurse managers who were asked to contact each nurse and remind him or her once more to complete the questionnaire. This approach yielded another 10 per cent. The overall response rate was 49 per cent, 541 questionnaires returned from a total of 1,093, by the cut-off date of 19 October 2001.

A proposed nursing data maintenance strategy was drawn up to ensure continued updating of the minimum dataset following completion of the pilot project.

3.12 Reporting

3.12.1 Production of specific data output reports from the SAP HR system

The SAP HR system contains a large amount of data on the staff employed by the health agencies. One of the strengths of SAP HR is its reporting function, which allows the data to be analysed and output via a number of mechanisms:

- The use of SAP standard reports
- The use of reporting tools, called SAP Query and Ad Hoc Query, which allows the user to specify the data to be analysed, and the presentation method. These two reporting tools are very powerful. However, training is required before one becomes adept at their use
- The use of specific reports, produced centrally by PPARS, which can be run by a user, to reports of a consistent nature, using the same data fields, in a certain format.

Before any of the reporting tools can be used successfully, the records to be included in the report need to be identified. The two sites participating in the pilot project each maintained a spreadsheet of the personnel numbers of staff whose records were reviewed (It should be borne in mind that a person's record may not need to be modified with data from the returned questionnaire, as the data already on SAP HR may have been totally correct. However, the fact that the questionnaire has been returned and the record reviewed did need to be stored, by including the person's personnel number in the spreadsheet). At the end of the project, those particular staff records were modified by including a new entry into infotype 19 (Monitoring of Dates) in SAP HR. This new entry was sub-type 36, Nursing Survey Date. This process was achieved by PPARS by running an SAP report, called ZREP58.

If similar surveys are carried out in other health agency areas in the future, it is recommended that infotype 19, sub-type 36 should be updated by the user at the time of review of the staff record. This would avoid the need to keep a separate spreadsheet of personnel numbers, and the necessity of having to run ZREP58 after the end of the survey period. At the end of this process, those nurses who had returned a questionnaire, and whose records had been reviewed, were specifically identified (by having

an infotype 19, sub-type 36 entry in their record). This meant that any reports would be limited to those particular nurses and midwives.

In addition the steering group had specified a number of reports that should be included in the final reports on the pilot project (see Table 3.12-1).

Table 3.12-1 – Requested reports and PPARS coding

PPARS Reporting Code	**Aggregate form:**
A1	Numbers returning An Bord Altranais PIN Number
A2	Gender
PPARS Reporting Code	**Summary statistics for a specified date:**
B1	Nationality × Health Board Area × Organisation × Grade
B2	Grade × Age Band × Organisation
B3	Registration × Age Band × Organisation × Grade
B4	Grade x Commitment × Organisation
B5	Grade × Contract Type × Organisation
B6	Commitment × Contract Type
B7	Organisation × Academic Qualification
B8	Number of vacant posts
B9	Numbers of leavers in the previous year

A review of these requirements showed that a number of these reports could be combined together to form three single reports. To that end, PPARS produced three reports that the user could run from the initial SAP HR screen, by entering the appropriate transaction code as shown in Table 3.12-2.

Table 3.12-2 – Report combinations

Report Number	Report Name/Transaction Code	Report Code Combination
1	Transaction code: z__nurse__aba__pin	Report combines requirements A1 and B3
2	Transaction code: z__nurse__national	Report combines requirements A2 and B1
3	Transaction code: z__nurse__contract	Report combines requirements B2, B4, B5 and B6

Details of the group reports are as follows:

- Report B7 can be produced by using the SAP standard report 'Qualifications Overview'
- The final two reports, B8 and B9, must be produced manually — the SAP HR system does not hold the necessary data and therefore cannot produce the reports at present
- Once the three reports have been run, the dataset produced can be exported in spreadsheet format to Microsoft Excel for analysis, to produce the required graphs and tables.

3.12.2 Production of electronic minimum dataset file

A requirement of the pilot project was that an electronic file of the data collected during the project should be submitted at its conclusion to the Information Management Unit, Department of Health and Children. The detailed content, structure and format of this dataset was agreed with the Information Management Unit. PPARS wrote a programme, called ZREP57, which can be run by a user to produce the required data-file.

The ZREP57 report produces the dataset in a comma-delimited text file format, suitable for import to software programmes used by the Department of Health and Children. The dataset is actually split into five separate files, the first containing the demographic data for each respondent to the questionnaire with a unique sequential reference number, while the four other files contain details of the qualifications for those same people, from the four major qualification groups.

3.12.3 Data submitted to the Information Management Unit

It was decided that the simplest method of accepting data was in ASCII delimited files. This was examined and cleared with the PPARS team and the Information Management Unit (IMU) in the Department of Health and Children. File definitions and formats were agreed and submitted to the IMU. These files were then transposed into indexed paradox datasets. A relational database was created from the datasets and a reporting system was built around this relational model. Initial reports were generated showing information related to demography, academic qualifications, registered qualifications and general qualifications. Because of the nature of the datasets cross-reporting is also available to the system.

3.13 Proposals of pilot project teams

A set of proposals was developed based on the experience of the pilot projects. The proposals are a combination of those arising from each of the individual reports from St. James's Hospital, the North-Western Health Board, and the national PPARS project team.

Table 3.13-1 – Combined proposals of the pilot project teams

Administrative issues

- The Nursing and Midwifery Planning and Development Unit should play a key role in the preparation of regional nursing and midwifery human resource forecasting and strategic planning.
- An individual within the Nursing and Midwifery Planning and Development Unit should be assigned lead responsibility for this function.
- The project leader or a key member of the project team should be an experienced user of the SAP HR system.
- Project team members should be proficient in the use of Microsoft Word and Excel (for functions such as mail merge, printing procedure, saving as variant, saving to local file).
- Clarity of roles and responsibilities between the Organisation and the Nursing and Midwifery Planning and Development Unit and other key personnel contributing to the human resource planning process should be examined and agreed.
- Synchronisation between the Nursing and Midwifery Planning and Development Unit and training units is required to ensure consistency of data capture across a broad range of courses which will include up-skilling courses and the addition of courses to the general catalogue.
- A full and comprehensive analysis of the time scale should be undertaken prior to the commencement of future projects, taking into consideration the workload and the scope of the project.
- Analysis of equipment and office needs are important, with provisions made for good printing and photocopying facilities.

Training

Training project team

- Detailed training is required on aspects of the SAP HR system, personnel administration, organisational management, qualification entry and standard/adhoc reporting.
- Training should take place simultaneously during the planning and setting-up of the project and as necessary on an on-going basis.

Training for nurse and midwife managers

- The Nursing and Midwifery Planning and Development Unit should arrange training for nurse and midwife managers who will be involved in data collection for the *National Nursing and Midwifery Human Resource Minimum Dataset*. Expert input may be required from other sources (PPARS trainers, human resource departments etc).
- Workshops, arranged by the Nursing and Midwifery Planning and Development Units, for nurse managers and key members of staff, should be held for each organisation collecting data on nursing and midwifery employment.
- Needs assessment should be undertaken locally to determine the duration of the training programme.

Data collection

- Significant time and effort should be allocated to an awareness programme to educate nurses and midwifes, within each organisation. Awareness of the importance of individual contributions to future workforce planning of the profession may assist in increasing the return rate of questionnaires.
- Data collection for future projects should not take place during the peak holiday period.
- Explicit inclusion and exclusion criteria should be used in future projects. In order to ensure clarity the criteria for inclusion should stipulate the grade codes, job and position titles when extracting the population from existing SAP HR files.
- A process should be developed by Nursing and Midwifery Planning and Development Units to continue to forge links and collect information from the independent sector.
- In the longer term information should be collected in the work setting with laptops to facilitate direct entry of data on the SAP HR system. A mechanism for verifying information would need to be identified for this process.

Nursing and Midwifery Human Resource Minimum Dataset

- The items on the minimum dataset should continue to be collected for all nurses and midwives in the pilot site areas (response 49 per cent at St. James's Hospital and 42 per cent for NWHB by the end of the project period) and also nationally.
- Decision rules for data entry, developed for the pilot projects, should be used for all future developments to ensure consistency of data held on the system. The rules may need to be tailored to specific contexts and environments.
- Alternative interim measures for collecting information on WTE are required, as this information cannot be obtained from the PPARS system until phase II of its implementation. The proposal for deriving a WTE from data collected by questionnaire was not effective, as there was a very poor response to the request for average part-time hours in a two-week period.
- Collecting information on nationality and country of origin was not effective because of differing interpretations in the responses.
- An alternative mechanism will need to be devised for collecting information from the independent sector. The pilot identified significant obstacles in collecting comprehensive information on the independent sector, as grade codes and contract type are not consistent with those collected for the public health system. Issues around ownership of the information need to be considered.

SAP HR system

- A development request should be forwarded, by the PPARS national team to SAP designers, to configure nationality as 'Filipino' not 'Philippines'.
- Key PPARS users should be identified in each human resource (organisation) area to advise and optimise on information-gathering.

The questionnaire

- Blank questionnaires should be used for future developments with a personalised covering letter to each nurse.

Text and design of questionnaire

- The format layout and structure of the questionnaire should be reviewed to address areas where there was a deficient response in the pilot projects.
- A standardised questionnaire should be developed based on the experiences of both pilot projects. The questionnaire and SAP HR system headings should be synchronised — particularly for field names such as contract type and commitment.
- The name requested on the questionnaire must be that entered on An Bord Altranais Register of Nurses. This exact name must subsequently be that entered on the SAP HR database (to facilitate an electronic exchange of information between the employment database and the Register of Nurses).
- Future developments should consider collecting information on 'nationality' only, to avoid confusion between 'nationality' and 'country of origin'.

Definitions and guidelines

- Standard definitions were devised for each item on the minimum dataset and should be used for all data collected in the future.
- The standard definitions should be used and refined further as necessary.
- A national strategy should be put in place to agree changes or additions to the definitions already agreed.
- The national standard definition of a 'vacant post' should be used for all grades and future developments.
- A procedure for internal transfers of staff to include nurses on rotation programmes should be established by each health agency with input from the local SAP project team, Finance Department, Personnel/ Human Resource Department and service managers.

Qualifications catalogue

- The regional Nursing and Midwifery Planning and Development Units should provide the lead on approving the addition of new courses to the qualifications catalogue for nursing and midwifery, with advice from An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery where necessary.
- The standard procedure for submission of courses to the PPARS national team for inclusion in the qualifications catalogue should be followed.
- Each agency should document a process which will trigger the submission of a request for an addition to the qualifications catalogue.
- An educational resource person should be identified to assist new project teams in understanding qualification titles and matching these with the qualification catalogue.
- A link between the training and events module (Learning and Development Unit) and the qualification catalogue should be forged in order to ensure consistency.
- As a minimum, the date on which a qualification was obtained and the name of the awarding body should be recorded with each qualification entered.

The Register of Nurses

- The registration card issued by An Bord Altranais should include the division(s) of the register as well as the PIN number, against which the nurse or midwife's name is recorded.
- Future projects should adopt 30 April of the following year as the renewal date at which the annual retention fee for An Bord Altranais registration must be paid. This is in accordance with the Report of the Commission on Nursing (1998 Para 4.49).
- The national PPARS team should send current information held on the SAP HR system (electronically) to An Bord Altranais, including: date of birth, Registered PIN, divisions of the Register of Nurses, start date of registration. Such a file to be updated by An Bord Altranais and returned to the national PPARS team for uploading to the SAP HR system. This would remove the need for individual input to each nurse's record annually.

Reporting

- The SAP HR system can report on the minimum dataset.
- An alternative mechanism for reporting on employment in the independent sector will be required.
- The SAP HR system usage has developed to ensure that information on leavers can be collected from the system. This will allow the calculation of turnover and vacancy rates.
- Standard reports should be capable of meeting the needs of various service heads at local, regional and national level.

Ongoing maintenance

- Resources will be required to maintain and enhance the human resource database.
- A senior nurse, in each organisation, should be assigned responsibility to manage and co-ordinate the collection of information for the *National Nursing and Midwifery Human Resource Minimum Dataset*.
- A dedicated staff member should be identified for maintenance and co-ordination of the database.
- The director of nursing and nominated members of the nurse management team should have access to the information on nursing and midwifery held on the SAP HR system for their organisation.
- Information pertaining to the Register of Nurses (Nursing Professional Registered) on the SAP HR system should be updated annually.
- An academic qualifications data maintenance strategy should be drawn up by each organisation.
- Funding of courses for nurses should be conditional on receipt of course completion data.
- The recruitment process should include verification of qualifications identified as essential for the position.

3.14 Conclusion

An exploratory approach was used to develop and test the *National Nursing and Midwifery Human Resource Minimum Dataset* and mechanisms to collect data on leavers and vacant nursing and midwifery posts. In the first instance consensus was used to determine the items for inclusion in the minimum dataset. This methodology was further supported by the international literature, advice from the Information Management Unit at the Department of Health and Children, the steering group and the resource group for the study. The *National Nursing and Midwifery Human Resource Minimum Dataset* emerged from this

process. The second step was to test the methodologies for collecting information for the minimum dataset through the commissioning of the pilot projects, thus ensuring content validity of the dataset. The third approach was the analysis of the collected data and the usefulness of the dataset for human resource planning in Ireland.

The pilot projects demonstrated that it is possible to collect the information necessary for all items on the *National Nursing and Midwifery Human Resource Minimum Dataset*. However, this does not provide information on leaver and vacant posts which would have to be collated through alternative mechanisms. The resources and skills required for planning and developing such systems cannot be underestimated. The *National Nursing and Midwifery Human Resource Minimum Dataset* has been rigorously tested in a variety of nursing and midwifery employing organisations and populations. The pilot projects have established a template for obtaining demographic, employment and qualifications data in a standard format along with information that can equally be used at local, organisational, regional and national level for workforce planning. This standard template when used by all the health board/authority regions will be an effective and powerful tool to underpin forecasts of nursing and midwifery resource requirements in the future.

CHAPTER 4

Turnover and Retention

4.1 Introduction

The interim report identified a number of gaps in the information required to conduct reliable forecasts of future workforce requirements, in particular, lack of information on turnover of nurses/midwives across the health system. Buchan (2001a) indicates that an analysis of the dynamics of the nursing labour market has to give consideration to turnover and wastage and to defining what each term means. The Health Research Board (HRB) was asked by the Department of Health and Children to commission research to estimate the rate of attrition among registered nurses from employment in the Republic of Ireland and to identify the underlying reasons for this loss to the health services.

This Chapter addresses objective four of the study:

- to estimate the turnover rate among registered nurses and midwives employed in the health services and the underling reasons.

It outlines the *National Study of Turnover in Nursing and Midwifery* — the research design, methodology, study sample, findings and conclusions. It also provides a synopsis of the output of the regional meetings hosted to disseminate findings of the study and considers the implications and actions necessary to address the issues highlighted in the research. The latter part of the Chapter presents practical approaches to the development of retention strategies based on the international literature and experiences of Irish retention projects.

4.2 *National Study of Turnover in Nursing and Midwifery*

In January 2000, the *National Study of Turnover in Nursing and Midwifery* was commissioned by the HRB. The study was funded for fifteen months. Professor Geraldine McCarthy from the Department of Nursing Studies, University College Cork, National University of Ireland, led the research team.

The complete report of the research study entitled the *National Study of Turnover in Nursing and Midwifery* (McCarthy, Tyrrell, and Cronin, 2002) is published separately as an accompanying document to this report. A summary of the main aspects of the study is given in the sections below. The purpose of the research was two-fold: to estimate turnover rate amongst registered nurses from employment in the Republic of Ireland and to identify the underlying reasons for this loss to the health service.

Turnover represents a major problem for the nursing profession internationally. It is apparent from the literature that a multitude of personal and organisational factors may influence turnover. Based on the literature, the researchers identified that turnover behaviour was reported as a culmination of attitudinal, decisional and behavioural components.

4.2.1 Research design — *National Study of Turnover in Nursing and Midwifery*

The study was designed in three major phases spanning fifteen months. An overview of the study is given in Table 4.2-1.

Table 4.2-1 – Phases of *National Study of Turnover in Nursing and Midwifery*

Phase	Description
PHASE 1	• Immediate identification of turnover rate for 1999 (January — December) from 128 sites (response rate 100 per cent, n=134 sites). A questionnaire was distributed to nurse managers/ personnel managers to collect data on all nurses who left the service in 1999. This was repeated in 2000 (January — December), for comparative purposes (response rate 87 per cent, n=120 sites). • Identification of turnover rate (1999 and 2000) of registered nurses working in Nursing Homes in Ireland (response rate 55 per cent, n=126 sites).
PHASE 2	• Distribution of questionnaires to collect data on turnover rate and reasons for leaving from nurse 'leavers' in the 128 health care organisations. Similar data were collected from both nurse managers and 'leavers' from March 2000 to February 2001. Where both responded just one set of data ('leaver') was used. Data analysis was based on 1,921 individual responses. Telephone interviews were also conducted with 140 nurse 'leavers'.
PHASE 3	• Distribution of questions to registered nurses (n=352) working in Band 1 hospitals to elicit information on 'intent to stay' and 'intent to leave', and underlying reasons.

Source: McCarthy *et al* (2002) *National Study of Turnover in Nursing and Midwifery*

4.2.2 Study sample — *National Study of Turnover in Nursing and Midwifery*

The terms of reference for the study required a national sample covering all divisions of nursing but did not particularly focus on any one division. A national sample covering six divisions of nursing (general, mental handicap, psychiatric, maternity, sick children's and public health) and all health care facilities (public, voluntary and private) were selected in partnership with the steering group for the *Study of the Nursing and Midwifery Resource*. One hundred and sixty-eight organisations were initially identified for the sampling frame of which 128 (a total of 134 individual sites) agreed to participate in the study.[3] The terms of reference guided the approach used to identify and contact the national sample for each of the three phases of the study.

For Phase 1 a sample based on national nursing statistics was selected in partnership with the steering group (n=168). It was used to obtain a representative sample of 128 health care sites in the Republic of Ireland. This covered public, private and voluntary organisations within the seven health board geographic regions and the voluntary hospitals/ the three area health boards within the ERHA. In collaboration with the Department of Health and Children, 230 nursing homes were asked to also participate in Phase 1 of the study. A 55 per cent response rate was achieved (n=126).[4]

The same health care organisations identified in Phase 1 participated in Phase 2 of the study. The purpose of this approach was to continue to track turnover rates and to identify reasons for turnover. A total of 1,921 registered nurses and registered midwives, including staff nurses/midwives, managers and educators employed by diverse health services completed and returned questionnaires over a twelve- month period (March 2000-February 2001). As turnover for 1999 proved greatest in band one hospitals, it was decided in collaboration with the steering group to sample nurses in these hospitals in Phase 3. Thirty-five

[3]128 health care organisations participated. Limerick Regional Hospital returned data for 3 sites (Limerick Regional Hospital, St. Munchin's Maternity Hospital and Croom Orthopaedic Hospital); Monaghan General Hospital returned for Monaghan and Cavan General Hospitals; and the Daughters of Charity Services returned for Dublin and Limerick.

[4]Nursing homes participated in Phase 1 of the study only.

registered nurses were targeted and completed questionnaires in ten of the band one hospitals. A total sample of 352 was achieved.

Significant difficulties were encountered in collecting and ensuring consistency of data returned during the research. These related to data availability, reliability, and information systems, in addition to structures for data collection. An independent process for validating information was not available to the research team. It took varying lengths of time to establish and confirm channels of communication with each of the participating organisations. Some nurse managers had not collected this type of data before, resulting in delays in data collection necessitating multiple follow-up contacts. In some services monthly turnover was too high and the contact person did not reach all nurse 'leavers'. There was a heavy reliance on the contact person to ensure questionnaire completion. Some of the nominated personnel had existing heavy workloads and lacked secretarial support. However, as can be seen in the following, significant data were collected arising from the sustained commitment from all concerned.

4.2.3 Summary of findings — *National Study of Turnover in Nursing and Midwifery*

A summary of the main findings is given in the sections below. The figures presented are those from the original report and are based on the information supplied by participating organisations.

Turnover rates

Overall, 6,209 nurses left employment during the course of the study. Of these, 3,363 left their positions in 1999, the remaining 2,846 left in 2000. Numbers of leavers from individual services and hospital bands are outlined in Table 4.2-2.

Turnover rates were highest in band one hospitals, band two hospitals, private hospitals, band three hospitals, and intellectual disability services. These varied in rate from 12 per cent to 29 per cent in 1999 and 14 per cent to 20 per cent in 2000. When comparisons were made across services and years, band one hospitals appeared to have a decrease in overall mean turnover rate, from 29 per cent (in 1999) to 20 per cent (in 2000). However, in five of the services (band three, four, and five hospitals, psychiatric and intellectual disability services) a mean increase of between 2 per cent and 3 per cent was seen in turnover rates.

Reasons for leaving

Results of the turnover study show that the two major reasons for leaving a current position were reported to be to pursue other employment in nursing (35%), and to travel abroad (21%). A further 12 per cent left to pursue studies in nursing. A variety of other reasons were reported including, to study outside nursing (14%), to pursue employment outside of nursing (4%), and unhappy/discontented (5%).

To further explore reasons for leaving, respondents in Phase 2 were asked to indicate if they wished to participate in a telephone interview. Two hundred and twenty-four nurses/midwives volunteered to be interviewed and 140 were available when a member of the research team phoned them. While this is a large sample for a qualitative study, the findings cannot be generalised to the population at large. However, some of this information does corroborate the quantitative data. Data were thematically analysed and the main themes identified. Among the themes that emerged were the pressures of work (in particular the stress experienced by nurses as a result of increased demands placed upon them) and the increased workload and high cost of living especially in Dublin. Nurse leavers identified a number of negative work issues including perceived deteriorating standards of care, bullying, lack of managerial support and lack of autonomy. All of the above influenced their decision to leave. Other issues which arose pertained to work contracts. These included the temporary nature of employment and lack of access

to job-sharing. Some nurse leavers identified lack of promotion opportunity and poor job satisfaction as influencing factors. This information represents the views of the 140 nurses who were interviewed and not necessarily those of the entire Phase 2 sample.

Table 4.2-2 – Turnover rate 1999 and 2000 across bands/services

Hospital Band/ Service	Total number WTE nurses employed 1999	Nurses who left employment 1999	Turnover rate 1999 %	Total number WTE nurses employed 2000	Nurses who left employment 2000	Turnover rate 2000 %
Band 1 hospital	6,539	1,873	29	7,395	1,464	20
Band 2 hospital	3,997	669	17	3,520	562	16
Band 3 hospital	1,296	151	12	1,144	174	15
Band 4 hospital	565	34	6	421	32	8
Band 5 hospital	126	8	6	125	11	9
Community Care	1,232	109	9	1,158	85	7
Psychiatric Services	3,194	200	6	2,972	224	8
Intellectual Disability	1,450	173	12	1,250	173	14
Private Hospitals	921	146	16	752	121	16
Grand Total	**19,320**	**3,363**	**17 (12*)**	**18,737**	**2,846****	**15 (12*)**

Notes:
Data shown are based on figures supplied by each participating site

Data from sick children's nursing are not presented separately; it was not possible to disaggregate these data from the relevant acute hospital band grouping

Organisations may have used different interpretations when answering the question 'total whole-time equivalent nurses employed.' This may account for apparent anomalies in the WTE reported for one year to another and across hospitals of similar size

* Mean of the nine services
**Based on 87 per cent return rate in 2000 of all the sites that returned data in 1999

Source: McCarthy *et al* (2002) *National Study of Turnover in Nursing and Midwifery*

Factors which could have promoted retention or prevented turnover

In questionnaire results nurses reported the factors which would have encouraged them to stay. These included, among others: better pay (22%), more opportunities to develop skills (18%), better resources (16%), more autonomy and control over care delivery (15%), access to professional development (14%), better quality of management (13%), better managerial attitude (13%) and improved promotion prospects (13%).

Results indicate that for approximately 44 per cent (850 nurse leavers, in Phase 2), work provided a moderate degree of satisfaction with regard to:

- opportunities to use skills, work with preferred patients and experience a sense of self-worth
- respect, co-operation and teamwork
- job security and working on preferred rota/shift
- familiarity with routine, equipment and personnel.

Results also indicated that dissatisfaction was felt with:

- pay and fringe benefits
- amount of work to be done (a perception of overwork was expressed)

- nurse management (which was perceived as not being supportive of the goals and concerns of staff)
- levels of authority and autonomy.

Perceived benefits from resigning related to 'time for myself' and 'time for my family'. Nurses considered that there was a moderate amount of access to professional development. A majority (54%) reported some form of continuing professional development, typically in the form of 'in-service education'(25%) and 'study days/seminars' (29%), with fewer respondents identifying 'study leave' (12%) and 'financial support' (10%). Promotional opportunities were perceived as being 'poor', 'infrequent' or 'very rare'.

Intent to 'Leave' or 'Stay'

The literature suggested that intent to leave is the best predictor of actual turnover behaviour. In Phase 3 of the study, the researchers surveyed registered nurses (n=352) working in band 1 hospitals to elicit information on the following five areas: 'intent to stay', 'intent to leave', current employment (within next 6-12 months), underlying reasons, and factors encouraging retention. Of the sample, 84 nurses (24 per cent) indicated they were actively seeking work or a change of employment.

The findings indicate that there was a general perception of mobility amongst nurses who completed the questionnaire, where:

- eighty-three per cent indicated that it would be 'quite easy' or 'very easy' to find a job with another employer
- sixty-one per cent indicated that it would be 'quite easy' or 'very easy' to find another nursing job
- seventy-eight per cent indicated that there were 'quite a few' or 'a great many' nursing jobs available.

With regard to academic qualifications, data suggest that a high percentage of those who intend to leave hold a bachelor's degree. Of interest is that when data pertaining to 'academic qualifications held' were cross-tabulated with 'intent to stay' and 'intent to leave', it emerged that 22 per cent of those who expressed an intent to leave held a bachelor's degree as compared to only 8 per cent of those who intended to stay. Participants with a high level of job satisfaction were more likely to show an intention to stay in current employment. Those with no kinship responsibilities were more likely to show an intention to leave positions.

4.2.4 Conclusions — *National Study of Turnover in Nursing and Midwifery*

The research indicates that the rate of turnover in nursing and midwifery is a significant issue across services in the Irish health care system. While some decreases were identified in band one hospitals, these are counterbalanced by increases in many other services. When turnover rates for all services studied were examined, a rate of 17 per cent was seen for 1999 and 15 per cent in 2000, while there was much variation in rate between the services studied, with band four and band five hospitals and the psychiatric services having the lowest rates in both years, and bands one, two and three hospitals having the highest rates. Overall, turnover rates compare well with those reported by other researchers, principally those in the United Kingdom: 14 per cent (Gray and Phillips, 1994) and in the United States: 27 per cent (Lum et al, 1998) and 14 per cent to 21 per cent (Health Care Advisory Board, 2001). However, statistics show a notably lower rate for Scotland at 8 per cent (Buchan, 2001a). It appears, therefore, that while the turnover rates in the present study may be causing concern for some services, especially for those with the highest rates, figures are still quite a distance from the 50 per cent level reported by Price and

Mueller in 1981. In this context, it is important to acknowledge that rates may not yet have reached those of other countries.

Data collection for two years (1999 and 2000) cannot show trends or flows over time. Particular issues for individual years need to be noted. For example the nurses' strike in 1999 may have influenced nurses' decision to change employers. In smaller hospitals (band four and five hospitals) in the year 2000 a substantial number of new CNM2 posts were introduced which will have impacted on the movement of nurses and midwives. The importance and value of continuing data collection and analysis is highlighted by this study. A serious commitment to ongoing collection and analysis is paramount.

The findings of the study indicate that the majority of leavers left medical and surgical positions. When asked why they were leaving 35 per cent indicated that the main reason was to pursue other employment in nursing. It appears therefore that while nurses were leaving the organisation, they were not leaving the profession and hence their skills may be re-deployed in another part of the health service. Other prominent reasons for leaving were to travel abroad (21 per cent) and to pursue further studies in nursing (12 per cent).

Interestingly, nurse leavers in the study reported high levels of job satisfaction. Yet despite this, they left their jobs. The researchers indicated that this finding appears to be at variance with the literature. It appears that the sample of nurse leavers, while not particularly dissatisfied with their work, left for other reasons. It was demonstrated that nurses with high levels of job satisfaction were more likely to show an intention to stay in their current employment than were nurses who had lower levels of job satisfaction. The research demonstrates that both kinship responsibilities and job satisfaction could together be used as predictors of nurses' 'intent to stay' or 'intent to leave'.

A number of common characteristics emerged when data from the 'leavers' in Phase 2 of the study were compared with those who expressed intent to leave in Phase 3. These include: aged between 21 and 35 years; female and single; no childcare responsibilities; holding a single registration (RGN) and Bachelor's degree; permanent post and registered for five years or less. It also emerged that nurse 'leavers' have varied levels of clinical experience; were employed as staff nurse/ staff midwife; work in medical surgical nursing, critical care, midwifery or elderly care.

It appears from both qualitative and quantitative data relating to reasons for leaving that significant numbers might have been retained if retention strategies promoting greater autonomy, professional development, managerial support, or an improved professional practice environment had been introduced.

Based on the findings of the study the UCC research team made recommendations for mechanisms for continued trend analysis of turnover, retention strategies and further research, as set out below.

- Turnover data should be continually collected and comparisons made across sites. To be undertaken in each health board or area health authority and collated nationally.
- The responsibility for recording and monitoring turnover and for returning data to the Department of Health and Children should rest with each health board or area health authority and this responsibility should be discharged through personnel in the Nursing and Midwifery Planning and Development Unit.
- A standard method for data collection should be devised, agreed and used so that information returned on a regular basis to the Department of Health and Children could be used for national comparative purposes and for workforce planning.

- Systems and structures for collection of data should be established in individual health services.
- Research on the career intentions of nurses at the point of registration should be considered.
- Consideration should be given to devising and introducing specific retention strategies and monitoring their effects in reducing overall turnover rates.
- Further research based on intent to leave should be conducted.

The first *National Study of Turnover in Nursing and Midwifery* established a mechanism for monitoring turnover across services and divisions of the Register of Nurses. The data collected for 1999 and 2000 and the changes in turnover rates clearly identified the importance of monitoring the situation on an on-going basis. The next section of this chapter describes the processes put in place for the continued monitoring of turnover rates.

4.3 Continued data collection on turnover in nursing and midwifery

Immediate action was taken on several of the recommendations made by the UCC research team. The directors of the Nursing and Midwifery Planning and Development Units, appointed in 2001, agreed to co-ordinate the collection of turnover data from the organisations within their region that originally participated in the UCC study (128 sites). In an early stage of development the directors committed the units to this role in order to ensure that there was no gap in the trend analysis of turnover in nursing and midwifery in Ireland. In 2002 the directors intend to expand the survey and collect turnover data from all organisations within their regions.

In consultation with the UCC research team, the nurse researchers for the *Study of the Nursing and Midwifery Resource* revised the data collection instrument. A standardised format for data collection, a sample cover letter and a mailing list (public health service and nursing homes) was supplied to each director. Summary information was collected (WTE employed, WTE 'leavers' and contract type), in standard format by two separate surveys. For the first six months (1 January 2001 to 30 June 2001) and then for the second six months (1 July 2001 to 31 December 2001).

Table 4.3-1 – Turnover rate for nurses and midwives 2001 across health board regions

Area	WTE 1999	WTE Leavers 1999	Turnover Rate 1999 %	WTE 2000	WTE Leavers 2000	Turnover Rate 2000 %	WTE 2001	WTE Leavers 2001	Turnover Rate 2001 %
ERHA	8,399	2,125	25	7,781	1,734	22	8,289	1,713	21
MWHB	1,489	216	15	1,505	181	12	1,330	107	8
MHB	726	59	8	469	56	12	869	56	6
NEHB	1,052	88	8	1,027	78	8	1,054	83	8
NWHB	1,158	107	9	1,069	115	11	1,401	96	7
SEHB	1,511	113	7	1,529	118	8	1,729	172	10
SHB	3,122	406	13	3,295	451	14	3,650	500	14
WHB	1,863	249	13	2,062	113	5	2,108	145	7

Notes:
2001 figures (91 per cent response) are based on an invitation by the director of the Nursing and Midwifery Planning and Development Unit to the UCC Research sample organisations (128) to supply data

Figures do not include turnover in nursing homes

Sources: McCarthy *et al* (2002) *National Study of Turnover in Nursing and Midwifery* and Nursing Policy Division, Department of Health and Children

A very high response rate was achieved (see Table 4.3-2). This can be attributed to: the local knowledge of staff in the Nursing and Midwifery Planning and Development Units; work which had been undertaken by the research team at UCC to encourage the establishment of data collection procedures within each site; and the investment made in forging linkages. The experience again reiterates the requirement to identify responsibility for provision of information, support and train local staff (particularly on the format for calculating WTE), and ensure access to electronic personnel systems. The information was collated and analysed centrally in the Nursing Policy Division and returned to the directors for clarifications.

The information collected indicates that the highest turnover rates were found in the ERHA (21%); SHB (14%); and SEHB (10%). Turnover rates increased in the SEHB (8% in 2000 to 10% in 2001) and in the WHB (5% in 2000 to 7% in 2001). In all other health boards/authority areas the rate decreased for 2001 (see Table 4.3-1). In 2001, turnover rates were highest in band one hospitals (20%), band two hospitals (15%), private hospitals (14%), band three hospitals (10%) and intellectual disability services (10%). Turnover rates decreased in all services and band hospitals except for community care services where the rate increased from 7% (2000) to 8% (2001) and band one hospitals were the rate remained stable (20%).

An initial comparison of the turnover rate across the three years 1999, 2000 and 2001 shows a substantial change (see Table 4.3-2). However, it is important to note that the data presented are based on a response rate that varied from year to year — 1999 (100%), 2000 (87%), and 2001(91%). Therefore this information should be treated with caution because reliable comparison cannot be made over the three years.

Table 4.3-2 – Comparison of turnover rates 1999, 2000, and 2001 across bands and service

Band/ Services	No of Sites 1999	WTE 1999	Number Leavers 1999	Turnover Rate 1999 %	No of Sites 2000	WTE employed 2000	Number Leavers 2000	Turnover Rate 2000 %	No of Sites 2001	WTE employed 2001	Number Leavers 2001	Turnover Rate 2001 %
Band 1	11	6,539	1,873	29	11	7,395	1,464	20	12	8,428	1,642	20
Band 2	15	3,997	669	17	14	3,520	562	16	12	3,575	523	15
Band 3	12	1,296	151	12	11	1,144	174	15	11	1,338	129	10
Band 4	11	565	34	6	8	421	32	8	11	713	56	8
Band 5	9	126	8	6	8	125	11	9	9	158	6	4
Community care	27	1,232	109	9	25	1,158	85	7	26	1,376	104	8
Psychiatric services	20	3,194	200	6	18	2,972	224	8	17	2,725	148	5
Intellectual Disability	18	1,450	173	12	16	1,250	173	14	18	1,470	143	10
Private Hospitals	9	921	146	16	8	752	121	16	6	776	111	14
Grand Total	**134**	**19,320**	**3,363**	**17 (12*)**	**120**	**18,737**	**2,846**	**15 (12*)**	**122**	**20,559**	**2,862**	**14 (10*)**

Notes:
*Mean turnover of the 9 services

1999 figures are based on the sample of organisations that agreed to participate in the UCC *National Study on Turnover in Nursing and Midwifery*

2000 figures are based on the sample of organisations (87 per cent response) that continued to supply data for the UCC *National Study*

2001 figures (91 per cent response) are based on an invitation by the director of the Nursing and Midwifery Planning and Development Unit to the UCC Research sample organisations to supply data

Since the 2000 survey Our Lady of Lourdes hospital was reclassified as a band one hospital (there are now 12 band one hospitals)

Data from sick children's nursing are not presented separately as it was not possible to disaggregate the data from the relevant acute hospital band grouping

Sources: McCarthy *et al* (2002) *National Study of Turnover in Nursing and Midwifery* and Nursing Policy Division, Department of Health and Children

Overall turnover in nursing and midwifery across bands and services has decreased in the last three years: 1999 (17%), 2000 (15%) and 2001 (14%). Mean turnover has consistently decreased in: band two hospitals — 1999 (17%), 2000 (16%), 2001 (15%); and private hospitals — 1999 (16%), 2000 (16%), 2001 (14%). Over the three years mean turnover gradually increased in band four hospitals — 1999 (6%), 2000 (8%) and 2001 (8%). Mean turnover has fluctuated across the three years in: band three hospitals (12%, 15% and 10%); intellectual disability services (12%, 14% and 10%); community care services (9%, 7% and 8%); band five hospitals (6%, 9% and 4%); and psychiatric services (6%, 8% and 5%).

For 2000 and 2001 data were collected for half-year intervals (January-June and July-December). This study and the UCC research team identified a similar trend, suggesting that the largest amount of turnover takes place in the second six months of any given year. This can be explained in some way by the fact that new nurses, emerging from the pre-registration diploma programme, qualify and register in late autumn and often take up a short-term position (6-9 months) to gain experience before making longer career plans. This would account for a higher movement of staff in late summer and early autumn as these nurses move on and others commence post-registration education programmes.

Definition of turnover

The need for a standardised definition of turnover was highlighted during the data collection. Organisations may have used different interpretations when answering the question 'total whole-time equivalent nurses employed' (i.e. employment ceiling *versus* actual number in employment). This may account for apparent anomalies in the WTE reported for one year to another and across hospitals of similar size. To address this issue guidance notes were prepared for the full year survey of turnover in 2001.

> Turnover is used to refer to the totality of nurse 'leavers' from an organisation. This includes those moving within a sector (e.g. from one acute hospital to another), those moving between sectors (e.g. from a public health service employer to private healthcare), and those leaving paid employment altogether (e.g. through ill health or to retirement).

4.3.1 Implications of high staff turnover

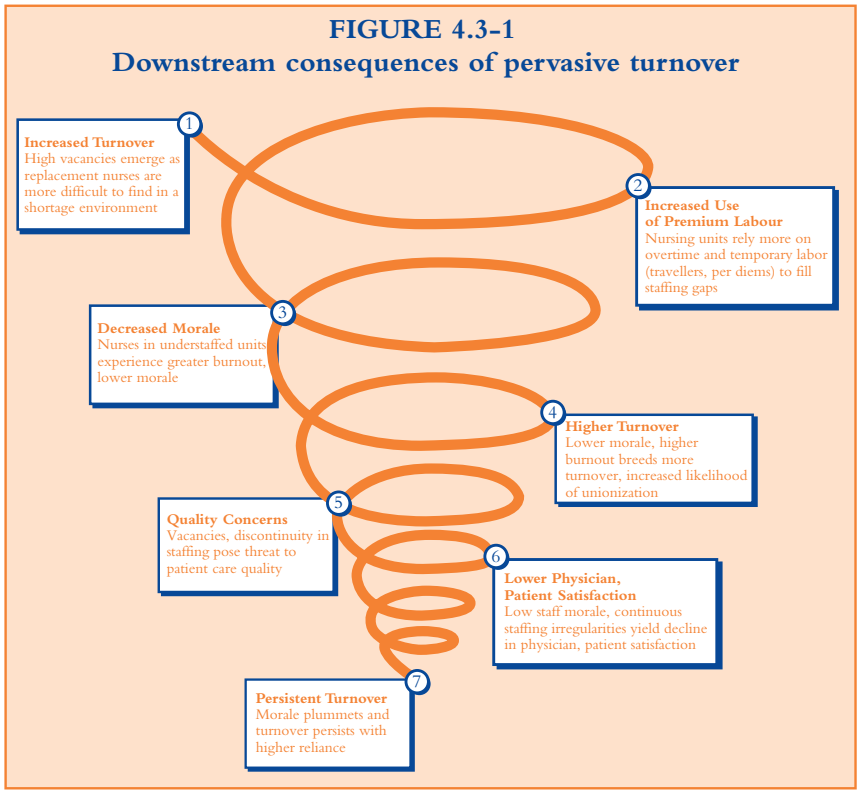
Internationally the turnover rate in nursing has been historically high. This has not always been the case in Ireland. Until recent times (late 1990s) Ireland had an abundance of recruits to the nursing profession with stiff competition for posts and a perception of low levels of turnover. However, this was not numerically quantified. A detailed review of the literature pertinent to turnover can be located in Chapter One of the *National Study of Turnover in Nursing and Midwifery* (McCarthy *et al.*, 2002). The main factors associated with turnover are age, work experience, tenure, kinship responsibilities, education, promotional opportunity, pay, distributive justice, work environment, alternative employment opportunity/ job market, job commitment, job satisfaction and behavioural intention.

The consequences of turnover are often considerable — turnover 'feeds on itself' as fewer and fewer experienced staff struggle to do more with less. The intensity of workload created as a result of high turnover can lead to decreased satisfaction among nurses, other members of the care team and among patients. This phenomenon has been described in terms of a staffing spiral, which is illustrated in Figure 4.3-1.

A high level of turnover has been demonstrated to have a destabilising effect on the working environment, in terms of the ability to care for patients, the quality of care provided, loss of continuity of care, loss of skills and local knowledge, increased workload, and the pattern of communication. In addition to threatening the quality and continuity of patient care and contributing to lower morale, the

cost of nurse turnover is estimated by the Advisory Board Company (2000) in the USA to be four to five times higher than typically accounted for by employers. This is primarily due to lost productivity, preceding the resignation of staff and in the process of inducting the newly hired nurse or midwife.

FIGURE 4.3-1
Downstream consequences of pervasive turnover



Source: Nursing Executive Center (2001) *Becoming a Chief Retention Officer,* p11

4.4 Dissemination of the findings of the *National Study of Turnover in Nursing and Midwifery*

A draft report of the *National Study of Turnover in Nursing and Midwifery* was presented to the steering group in June 2001. To ensure dissemination and to elicit recommendations with actions on the study findings, it was agreed to host regional feedback meetings. The programme was planned in collaboration with the UCC research team and the directors of the Nursing and Midwifery Planning and Development Units. The purpose of the meetings were two-fold:

- to give participating organisations an opportunity to hear the detailed findings of the study prior to publication
- to obtain opinions and advice in the development of a national action plan for retention of nurses and midwives.

Directors of nursing from the 128 sites and 126 nursing homes participating in the *National Study of Turnover* were invited along with the link person responsible for the provision of data in each of the

organisations. An experienced group of senior nurse managers, recruitment specialists, personnel officers, human resource personnel and members of the steering group for this study attended the three meetings. The venues and numbers attending from each health board area are set out in Table 4.4-1 below. Almost all of the 128 organisations arranged for representatives to attend one of the regional meetings. Nearly all those attending were from the public health system. A very small number of representatives from private nursing homes attended each of the three meetings.

Table 4.4-1 – Regional meetings — venues and numbers attending

Date 2001	Venue	Health board regions including voluntary organisations, private hospitals and nursing homes	Number attending	Number of workgroups	Number of proposed actions
17 September	Tullamore Court Hotel, Tullamore	NWHB, WHB, MHB, SEHB and NEHB	44	7	69
19 September	Burlington Hotel, Dublin	HB, NAHB, SWAHB, ECAHB and voluntary organisations within ERHA	58	5	50
9 October	Rochestown Park Hotel, Cork	SHB, SEHB and MWHB	38	4	45
		Total	**130**	**16**	**163**

The programme was divided into two sections — presentation of the research findings and workshop activity. During the morning session a short overview of the context for the turnover research and the progress of the *Study of the Nursing and Midwifery Resource* were given. Members of the research team from UCC presented the main findings from each of the three phases of the research study and facilitated a discussion on the implications of the findings.

4.4.1 Proposals for retention

During the afternoon the participants were grouped into workgroups and asked to identify actions (in light of the research findings) which they considered could assist in retaining nurses and midwives in practice within their organisations. Each group was asked to:

- identify ten actions which would impact on the retention of nurses and midwives
- state who the action should be taken by and at what level (individual nurses, nurse managers, organisation, health board, national)
- state the time scales within which the action is to be achieved
- rank each of the ten actions in order of priority.

In total 164 actions were proposed during the three meetings. Many of the actions were broad in nature and contained several sub-actions. In general the proposals were wide ranging, detailed and often quite specific. The actions identified could be initiated at many levels. The following were all identified as having a role to play: individual nurses and midwives; nurse mangers; health board personnel including staff of the Nursing and Midwifery Planning and Development Units; personnel within the Health Service Employers Agency (HSEA); advisers at the Nursing Policy Division and policy makers within the Department of Health and Children. The time scales given for the actions were for the most part unquantifiable (e.g. ongoing, as soon as possible, immediate, yesterday) and absent in some cases.

Each of the proposed actions was recorded, collated and indexed and a coding scheme was devised. Content analysis, as described by Burns and Grove (1997), was used as a systematic means of measuring the frequency, order and intensity of occurrences of the proposed actions. The 164 actions were reviewed for recurring themes/patterns and regrouped. A decision trail was maintained. Twenty main themes were identified and the numbers of actions related to each theme was quantified. The actions were then collapsed to give summary descriptions for each theme. The main themes and descriptors are set out in Table 4.4-2 and the following text.

The themes were grouped into five main categories and rank-ordered based on the intensity of the proposals (see Table 4.4-2). The categories were derived on the basis of connectiveness across the themes and to facilitate a logical review of the information. Professor McCarthy and members of the steering group, who attended the regional meetings, validated the outcome of the analysis.

Table 4.4-2 – Suggested actions for retention grouped by main categories and themes

Main categories and themes	No of workgroups proposing actions related to each theme	Percent of workgroups proposing actions related to each theme
National, regional and local policy		
• Strategy for recruitment and retention	10	62.5
• Nurse education	9	56.2
• Pay	8	50.0
• Marketing nursing and midwifery	5	31.2
• Workforce planning	4	25.0
• Incentives for medical surgical practice	4	25.0
Management		
• Management role, style and development	9	56.2
• Team building	8	50.0
• Communication	7	43.7
• Value, respect and acknowledgement of staff	7	43.7
• Information data systems	3	18.7
Professional nursing practice		
• Support for quality professional nursing practice	13	81.2
• Involvement in decision-making — autonomy and empowerment	12	75.0
• Induction and orientationu	7	43.7
Organisational support		
• Career pathways and support for professional development	15	93.7
• Quality of working life and environment	10	62.5
• Fringe benefits	6	37.5
Staffing		
• Staffing ratios, skill mix and workload measurement	15	68.7
• Flexibility in rostering	10	62.5
• Health care assistants (HCA) and other support staff	6	37.5
Total Categories = 5; Themes = 20; Main Action = 164; Workgroups = 16	**164**	**100**

Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

The five main categories relate to: policy development at three levels within the system (national, regional and local); management functions; professional nursing practice; level of organisational support; and staffing issues. An appreciation of the emphasis placed on the various themes can be obtained by examining the frequency with which the theme is identified across all the workgroups. The fact that over 50 per cent (10) of the actions were identified by more than half of the work groups indicates a general consensus in the required direction. When Table 4.4-2 is examined in detail it can be seen that career pathways and support for professional development were highlighted as the key retention action by 10 of the 16 workgroups (93.7%). Other issues that rated highly were: support for quality professional nursing practice (81.2%); involvement in decision-making — autonomy and empowerment (75%); staffing, skill mix and workload measurement (68.7%); strategy for recruitment and retention (62.5%); flexibility in rostering (62.5%); quality of working life and environment (62.5%); nurse education (56.2%); and management, role style and development (56.2%).

A greater appreciation of the approach proposed for each of the themes can be gained from the descriptors of the actions. An element of overlap can be seen in the descriptions for each theme. For example workforce planning and staffing is included in both the 'national, regional and local policy' category and also the 'staffing' category. However, a different context and focus is intended in each category.

Suggested actions for retention — national, regional and local policy category

Six main themes were allocated to the policy category, which pertains to policy at all levels within the system. The themes were: strategy for recruitment and retention; nurse education; pay; marketing nursing and midwifery; workforce planning; and incentives for medical and surgical practice. The actions suggested by the workgroups for this category centre on ensuring that a multifaceted policy approach is put in place to ensure an adequate supply of nurses and midwives in the near and longer-term. Descriptors of the actions proposed by participants in the workgroups are set out, in note form, under each of the six themes in Table 4.4-3 below.

Table 4.4-3 – Suggested actions for retention — national, regional and local policy category

Strategy for recruitment and retention

- Decentralise recruitment processes from central health board level — involve CNM2s in recruiting and selecting staff for their area of practice — speed up the recruitment process
- Devise a co-ordinated approach to recruiting nurses from abroad
- Discontinue the use of staff nurses/ permanent panels
- Make all nurses and midwives permanent following probation of six months regardless of hours worked during the six months
- Devise a national recruitment-specific transfer policy for nurses and midwives transferring from one hospital or agency to another
- Introduce a travelling nurses programme with twinning between UK/Australia and Ireland
- Standardise a national retention policy across public and private sectors to include: exit interviews at local level, on-going audit of turnover (local level), meaningful work for all staff, autonomy/devolved responsibility, staff development programme, staff induction programme/mentorship/coaching, and evaluation/review of staff satisfaction and complaints.

Nurse education

- Increase number of pre-registration nurse training places
- Provide preceptors for all nursing students
- Provide national standards for entitlements to study leave
- Provide cover for release for study leave
- Increase availability of specialist courses outside Dublin
- Introduce a system of accreditation for attendance at study days/conferences
- Provide in-service education, access to diploma and higher degrees, relevance to service needs/developments.

Table 4.4-3 – Suggested actions for retention — national, regional and local policy category — *contd.*

Pay
- Have higher entry level salaries
- Improve pay differentials for promotional posts
- Offer an alternative from early retirement to hold experienced nurses in the service for longer
- Devise long-service rewards
- Extend qualification allowance to ensure equity for 'generalist nurses'
- Give financial recognition for high pressure areas.

Marketing nursing and midwifery
- Talk up the profession — particularly among nursing students and the public
- Sell the positive aspects — link to professional development opportunities; stop moaning/whining
- Use web sites to attract new recruits and nurses to return to practice.

Workforce planning
- Have a strategic group at health board level for workforce planning (public, voluntary and private sector)
- Develop guidelines for patient/staff ratios nationally
- Base all planning on the proposals in the Health Strategy (2001)
- Engage in active planning for new recruits to the workforce in 2005 (year where there will be reduced numbers resulting from the introduction of a four-year undergraduate nursing degree programme).

Incentives for general medical surgical practice
- Enhance value of acute medicine/surgery (non-specialist areas) through development and availability of post-registration postgraduate diploma courses
- Introduce national programme (update/refresher) for medical/surgical nurses
- Ensure recognition for working in medical/surgical area.

Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

Suggested actions for retention — management category

Actions pertaining to management formed the second largest category. The five main themes identified were: management role, style and development; team building; communication; value, respect, and acknowledgement of staff; and information data systems. Each of the actions suggested by the workgroups related to core management functions which could be used to retain nurses and midwives in employment in a particular organisation. An enabling approach to people management pervades the management theme. The importance of specific preparation for management roles and continuing management development is emphasised.

Table 4.4-4 – Suggested actions for retention — management category

Management role, style and development
- Develop the role of clinical manager to lead and develop staff; nurture staff — feeling valued, induction/orientation, support professional development, flexibility, supported by senior management, increased autonomy, local decision making and trust
- Ensure clarity in relation to management roles (Office for Health Management competency report)
- Develop a shared nursing governance programme
- Ensure management of bullying culture — hard management can be perceived as bullying; respect colleagues
- Research what is happening to middle nurse managers
- Provide management development courses which include content on service planning, project management, information technology, human resource management and financial management.

Team building
- Provide good team structures to facilitate multi-disciplinary team working
- Flatten hierarchical structures
- Invest in team building — develop competencies
- Consider self-managed teams through the use of integrated care pathways.

Communication
- Develop an explicit strategy for communication to ensure a sense of ownership, motivation and enjoyment
- Ensure two-way communication through all layers of the organisation
- Provide feedback for everyone.

Table 4.4-4 – Suggested actions for retention — management category — *contd.*

Value, respect, acknowledge staff
- Recognise and acknowledge work well done
- Value/respect the worth, autonomy and experience of staff.

Information data systems
- Introduce standardised systems and databases to continuously monitor nursing and midwifery employment — particularly turnover in all organisations; to be co-ordinated by directors of the Nursing and Midwifery Planning and Development Units in each health board/ area health authority
- Provide access to the PPARS Human Resource Module in each organisation.

Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

Suggested actions for retention — professional nursing practice category

Three main themes were included in the professional nursing practice category. These were: support for quality professional nursing practice; involvement in decision-making, autonomy and empowerment; and induction and orientation. The emphasis was on empowering actions that would create environments, and systems for nursing practice that could deliver quality care. The aims are to ensure that nurses and midwives obtain optimum job satisfaction and so opt to remain in practice.

Table 4.4-5 – Suggested actions for retention — professional nursing practice category

Support for quality professional nursing practice
- Develop and expand the role of the nurse
- Provide clinical supervision with resources and support for staff
- Help all nurses/midwives to recognise scope of practice
- Provide evidence-based standards for patient care with focus on clinical developments
- Ensure quality of care audit and risk containment.

Involvement in decision-making, autonomy and empowerment
- Provide clinical autonomy — individualising nursing and midwifery care for each patient, e.g. use of primary nursing
- Encourage the empowerment of staff, by increased involvement in decision-making and increased autonomy
- Devolve decision-making authority to bedside level
- Allow for nurses and midwives to have input to service planning
- Devolve budget control to unit level, with education and support for same
- Provide for staff-nurse membership of project teams and task forces.

Induction and orientation
- Provide a structured induction and orientation programme for all new staff
- Identify preceptor 'buddies' for all new staff.

Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

Suggested actions for retention — organisational support category

The organisational support category contains three main themes: career pathways and support for professional development; quality of working life; and environment/fringe benefits. The actions proposed by the participants in the workgroups for this category were focused on the provision of career support, a healthy working environment and the maximising of fringe benefits. A brief description of the actions associated with each of the three themes is set out in Table 4.4-6.

Table 4.4-6 – Suggested actions for retention — organisational support category

Career pathways and support for professional development
- Ensure a personal and professional development plan for all staff including a learning contract
- Make systems available for career guidance, personal development, self appraisal, and staff counselling
- Provide access/policy for continuing professional development.

Table 4.4-6 – Suggested actions for retention — organisational support category — *contd.*

Quality of working life/environment and fringe benefits
- Arrange social events within the organisation
- Provide modern environment and staff facilities — parking, crèche, changing, dining, office space and rest rooms
- Ensure access to occupational health services
- Provide safe environment and equipment to assist in lifting and handling
- Develop a family friendly work ethos.

Fringe benefits
- Provide fringe benefits: low cost pharmacy, health club, accident and emergency treatment, group schemes, crèche facilities, health insurance, car parking, subsidised meals, uniform allowance etc.

Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

Suggested actions for retention — staffing category

Participants in the workgroups placed issues relating to staffing high on the agenda. Three main themes were identified in this category: staffing ratios, skill-mix and workload measurement; flexibility in rostering; and health care assistants and other support staff. The focus was on the availability of adequate numbers and ratio of staff and also systems to assist in determining what this number should be. Importance was placed on flexibility in rostering and acknowledging the need for staff to have a balance between work and personal life. The main actions proposed by the participants in the workgroups, for this category, were clustered under the thematic headings in Table 4.4-7.

Table 4.4-7 – Suggested actions for retention — staffing category

Staffing, skill-mix and workload measurement
- Develop systems for workload analysis — ensuring adequate staff for the workload
- Ensure that staffing arrangements in each area include annual leave, maternity and sick leave relief
- Ensure that skill mix assessment includes work load measurement, balance of nationals and overseas nurses, skills of staff, supernumerary role of CNM2; involve staff in decision making on the appropriate mix
- Use support structures to devolve non-nursing duties.

Flexibility in rostering
- Acknowledge qualifications and allow movement
- Enable work allocation to area/specialty of preference
- Demonstrate openness, fairness and transparency in preparing duty rosters
- Encourage the collaborative development of rosters by staff
- Devolve self-rostering to unit level; enables ownership
- Provide for flexible working hours with a well structured weekend rota to allow a balance between working and time off.

Health care assistants and other support staff
- Introduce additional health care assistants (HCAs) with appropriate training
- Employ sufficient support staff, health care assistants, porters, clerical and maintenance personnel.

Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

The breath of the actions proposed by the workgroups across the three meetings demonstrated a high level of creative thinking. A wide variety of actions, which could be used to minimise triggers for leaving, were collected. Many of the actions are budget neutral, centre on people management and could be immediately implemented. The output from the regional meetings is being published in this report so that nurse and midwife managers throughout the system can use it as a basis for discussion when considering retention strategies for their own particular service.

The importance placed on the requirement to positively invest energies on retaining staff can be appreciated in the level of interest and involvement in the regional feedback meetings. Together with the findings of the *National Study of Turnover in Nursing and Midwifery* the output of the regional feedback meetings forms a good basis for developing an action plan for minimising triggers for leaving, specific to an Irish health care environment.

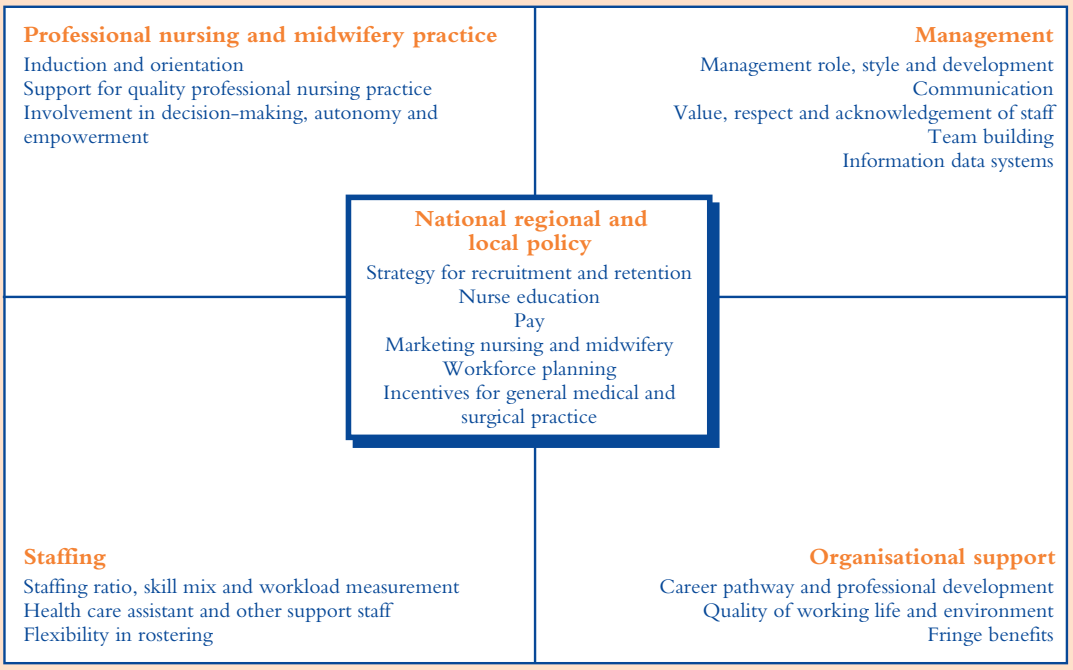
4.5 Suggested action plan for retention

A top-down and bottom-up approach was used in finalising an action plan for retention of nurses and midwives. The 164 actions proposed at the regional feedback meetings were formulated by a broad group of senior managers working throughout the health system. The themes and descriptors were reviewed to ensure that they contained actions that would address factors, identified by staff nurses in the *National Study of Turnover in Nursing and Midwifery* (Phase 2 and 3) as those which could have promoted retention or prevented turnover.

A final five-point action plan was identified on the basis of the research findings which provides a generic template for considering issues affecting retention of nursing and midwifery staff. The plan, illustrated in Figure 4.5-1, is based on the output from the regional feedback meetings and the *National Study of Turnover in Nursing and Midwifery*. The plan is broad and should be tailored to the specific context and environment in which nurses and midwives practise. Policy to underpin the proposed actions is central to the plan and is therefore placed at the centre of the illustration. The diagram is intended as a simple prompt to be used to generate ideas for developing local action plans focused at lessening the numbers choosing to leave employment with a particular unit or organisation.

It must be emphasised that the actions proposed need to be undertaken by many people at all levels throughout the health system. There is a role for, among many others, policy makers, directors of human resources, directors of nursing, clinical nurse managers and individual practitioners. Clinical nurse managers have a very powerful role to play, as front-line managers, in creating the local conditions conducive to staff retention. The importance of individual nurses and midwives taking ownership and responsibility for their role in retaining colleagues in practice is paramount to the success of any action plan for minimising triggers for leaving.

FIGURE 4.5-1
Suggested action plan for retention developed at regional meetings



Source: Regional feedback meeting for the *National Study of Turnover in Nursing and Midwifery* (September and October 2001)

The next section gives an overview of some of the initiatives, introduced over recent times, which are aimed at reducing turnover in nursing and midwifery.

4.6 Initiatives for retention of nurses and midwives

For the purposes of discussion, issues which impact on the retention of nurses and midwives can be divided into two general areas: policy developments and specific retention initiatives. A synopsis of each is set out in the following sections.

4.6.1 Policy developments

In recent times policies have been prepared and action has taken place addressing issues that will assist in retaining nurses and midwives in practice. Key among these are the proposals contained in the new health strategy. An overview of some of the policy developments is given below.

Health Strategy — developing human resources

One of the six key frameworks for change set out in the Health Strategy (2001) is 'Developing Human Resources' so that the vital contribution made by all staff working in the health system can be harnessed fully and further developed. A key objective of the human resource framework is to develop and explicitly value staff at all levels of the health system.

The focus is on making the health service an employer of choice by developing the human resource function, investing in education and training and implementing best practice employment policies. The strategy highlights that many factors, other than additional financial rewards, draw staff to join and remain with a particular employer. These include:

- best practice employment policies and procedures
- positive strategies for improving the work environment and the quality of working life
- a positive and participative style of management which makes for a stimulating work environment
- a culture that emphasises the value of continuous learning and improvement in the skills and experience of everyone working in the system (p 116).

Two of the 121 actions set out in the Health Strategy Action Plan specifically pertain to retention of staff. The Office for Health Management and the Health Services Employers Agency are to produce guidelines on best practice in recruiting and retaining staff by September 2002 (Department of Health and Children, 2001). Retention rates for the system and individual employers are to be measured in order to benchmark minimum standards and set targets for reducing turnover rates. Health service employers are to be encouraged to adopt innovative approaches to job design. The Strategy suggests that initiatives such as flexible working and training, arrangements of atypical working hours and specific family-friendly approaches are to be aimed at meeting the needs of health service workers and their families as well as the efficiency of the service.

A detailed action plan for people management is to be developed by the Department of Health and Children and the Health Services Employers Agency by October 2002. The plan is to be developed in consultation with the Health Services National Partnership Forum and implemented jointly through management, unions and partnership structures. The action plan for people management will seek to ensure that the health service has the right people, with the right competencies, in the right numbers,

organised and managed in the right way, to deliver the goals and objectives of the Health Strategy. The plan is to elaborate on the following points:

- Invest in training and education
- Devise and implement best practice employment policies and procedures
- Manage people effectively
- Improve the quality of working life
- Develop performance management
- Promote improved industrial relations in the health sector
- Develop the partnership approach further (p 122-124).

Report on Nursing Management Competencies

The factors that underlie performance effectiveness in nursing management were objectively researched and defined in behavioural terms in a study commissioned by the Office for Health Management. The *Report on Nursing Management Competencies* (Rush, McCarthy, and Cronin, 2000) identified competencies required of top, middle and front-line nurse managers in the future. There is a common framework running through the model at all levels of nursing management. This can be described as making a positive leadership impact by: interpersonal facilitation and influence; organising, integrating and evaluation skills; performance-honed resilience and resourcefulness; all underpinned by a solid foundation of technical and operational capacity. The specific competencies for front-line managers have particular relevance for staff retention. When describing the competency of 'building and leading a team' the researchers focused on leading a team confidently, motivating, empowering and communicating with staff and blending diverse styles into a cohesive unit, coaching and encouraging improved performance. This report provides a framework as a basis for competency-based development for nurse managers.

Empowerment of Nurses and Midwives Steering Group — an agenda for change

The Minister for Health and Children established a high-level steering group on the empowerment of nurses and midwives in February 2000. The purpose was to devise an agenda for the meaningful involvement of nurses and midwives in the management of services. The steering group has identified four central themes to drive its agenda forward: management development, service planning, communication and the meaning of empowerment. Sub-groups have been established to advance work on each of the themes and develop action plans. In particular the work of the management development sub-group impacts on the preparedness of nurse managers for their key role as human resource managers. Pilot management development programmes catering for CNM2, CNM3 and middle-level nurse managers were commissioned in 2000 and 2001. Over 250 nurses and midwives have completed or are in the process of completing programmes, which are being externally evaluated. The intention is to roll out the management development programmes by preparing detailed guidelines (content and provider assessment) so that health service employers can commission similar programmes throughout the health system. A pilot programme for CNM1s in a health board area is currently taking place.

The sub-group on empowerment commissioned a national study to explore nurses' and midwives' understanding of empowerment within the context of the public health services. This large-scale study is being undertaken by a team headed by Professor P.A. Scott, head of nursing at Dublin City University. It is anticipated that the final report of the study will be published later this year. The findings of the study will provide very useful insights for developing strategies that will empower and retain nurses and midwives in practice.

Anti-bullying policy

Bullying is one of the issues which leads to disharmony in the workplace and may lead to the decision of some staff to leave employment. Bullying, at whatever rank, or whatever level, is always regarded as a form of harassment. Workplace bullying undermines organisational performance by causing poor morale, higher absenteeism, stress-related illness, reduced productivity and higher turnover of staff. A comprehensive policy for dealing with allegations of workplace bullying was prepared by representatives of all the major health service unions, a cross-section of employing authorities, the Irish Business and Employers Confederation (IBEC) and the Health Service Employers Agency and published specifically for the health service. The document defines bulling as follows:

> Persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which make the recipients feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress (2000 p 3).

The existence of an anti-bullying policy in itself is not sufficient to eradicate unacceptable forms of behaviour amongst staff. Clinical and midwife managers have a particular responsibility to prevent bullying by treating all staff with dignity and respect at all times. One of the key objectives of the policy document is to enable line managers to identify bullying behaviours and take appropriate action and provide effective procedures for dealing with allegations. All nurses and midwives have an obligation to discourage unacceptable forms of behaviour in the workplace through their own conduct and by being supportive of colleagues who are experiencing bullying.

Cultural diversity in the workplace

In Ireland we are currently experiencing an increasingly competitive labour market with unemployment at a low level and substantial numbers of job vacancies to be filled in the health service (see Chapter 2 section 2.3.3). A large number of nurses and midwives have been recruited from abroad to fill vacant posts. Government figures estimate that significant numbers of immigrants are expected to choose to live in Ireland over the coming years. A key element in retaining staff is the recognition of the diversity of those working in the health system and also the users of the service. Attitudes and prejudices may exist towards using limited resources to treat a person from another country, or towards working alongside an individual whose first language is not English. The health service cannot offer a quality nursing or midwifery service to a user if there is no one to communicate directly with that person, or if it does not value its entire staff equally.

The Office for Health Management (OHM) has published a discussion paper, *Managing Talent and Difference in the Health Services: The Case for Diversity* (2001), which is a key resource and identifies best practice in this area. More recently the Department of Justice, Equality and Law Reform has published a discussion document to inform the consultative process *Towards a National Action Plan Against Racism in Ireland* (2002). Creating an environment where all people, no matter what their level, role, background or discipline, feel included and have their contribution valued and their achievements recognised is the ideal to be aimed for. A work environment which is sensitive to cultural diversity can contribute to reducing turnover and absenteeism. Another useful document was published by the National Consultative Committee on Racism and Interculturalism (NCCRI) and the Irish Health Services Management Institute, in March 2002 entitled *Cultural Diversity in the Irish Health Care Sector: towards the development of policy and practice guidelines for organisations in the health sector.* The focus of the document is on meeting the need for the development of conceptual and practical guidance for the health care sectors in responding to cultural diversity.

The Employment Equality Act, 1998 and the Equal Status Act, 2000 are important examples of anti-discrimination legislation, with wide-ranging scope. In Ireland discrimination is outlawed on nine distinct

grounds: gender, marital status, family status, sexual orientation, religious belief, age, disability, race and membership of the Traveller community. The legislation is one of the drivers towards a multifaceted diversity approach.

The HSEA is undertaking a project dealing with the issues of equal opportunities and accommodating diversity in the workplace. This exercise is an initiative under the National Framework Committee for the Development of Equal Opportunities at the level of enterprise, established under the Programme for Prosperity and Fairness. The committee is committed to ensuring that equal opportunities policies and practices are developed and implemented, on a voluntary basis, at enterprise level by agreement between employers and unions. The project comprises the following distinct elements:

- guidelines for developing an equal opportunity/diversity strategy and action plan for health service employers
- a guide to equality legislation which is practical and illustrative of how best to accommodate diversity in the workplace.

The HSEA is developing tools, including guideline document and training materials, to assist line managers to meet their obligations under the equality legislation and to guide them in relation to equality/diversity aspects of the people management role.

Another aspect of diversity, important to nursing and midwifery in the future, is the focus on team working. The health service depends on the professionalism and values of each professional group but this in some cases has a downside. The Irish health service has often been described as a system comprised of different, separate professional groups (clinicians, administrators and managers) working in 'silos' with different loyalties and agendas. Such approaches often hinder inter-disciplinary team working. The Commission on Nursing (1998) indicated that movement between professional groups or levels has traditionally been discouraged, resulting in barriers which restricted the opportunity for people to realise their full potential for the benefit of patient care and treatment. Traditionally nurses and midwives have been at the forefront of team working within nursing and midwifery. Now there is a need to continue to be open and adapt to becoming members of networked, inter-disciplinary team-based organisations that respect the diversity of different professional groups.

4.6.2 Retention initiatives

Considerable time and effort has being invested in a wide range of initiatives aimed at retaining and recruiting nurses and midwives, some of which are publicised and formally reported. Many other worthwhile strategies are planned at local level and are often not widely publicised. An overview of some of the initiatives instigated over recent years is presented in the following sections.

Department of Health and Children/ HSEA initiatives

The Minister for Health and Children launched a nursing and midwifery recruitment and retention initiative on 29 November 2000. The initiative was designed to attract qualified nurses and midwives who were not working, back into the public health service, retain nurses and midwives in the public health service and address the need for more trained nurses in specialist areas. Key features of the initiative were: a new scheme of flexible working time under which nurses may apply to work between 8 and 39 hours per week; the abolition of fees for back-to-nursing courses; fee support and full salary for nurses while undertaking certain specialist training; and the introduction, for the first time, of retaining pay, up to €1,905 (£1,500) for nurses returning to the workforce. The initiative introduced permanent part-time work for the first time. With the new flexibility nurses were enabled to work as few as 8 hours a week and have superannuation entitlements. Prior to this nurses and midwives in the public service

could only be made permanent if they worked 19.5 hours (job-sharing) or 39 hours per week (full-time). The initiative was supported by a specially developed advertising campaign using radio and print media to market nursing as a career with the specific objective of encouraging nurses back into the system.

One of the suggestions at the regional feedback meeting held to identify an action plan for retaining nurses in practice (see Section 4.4.1) was the possibility of establishing international exchange programmes. The HSEA facilitated a visit from Central Sydney Area Health Service, Sydney, Australia to learn about the establishment of an International Nursing Exchange Consortium (January 2002). The consortium is being established with the following overall aims:

- Enhance the development of nurses through a formalised nurse exchange programme
- Maximise opportunities to retain nurses through increased job satisfaction
- Create an association for the purposes of conducting joint initiatives relating to clinical practice and research
- Provide direct employment opportunities for nurses who intend to travel without the need to utilise nursing recruitment agencies
- Provide a mechanism to supplement staffing levels during peak seasonal periods
- Establish a network to share nursing quality initiatives.

It is planned that the consortium will function on a cost neutral basis and subject to agreement between the partners; there would be a reciprocal employment arrangement within the consortium group of hospitals. Nurses interested in participating in an exchange would be assisted in selecting the appropriate area in which to work or seek further experience. Those pursuing research interests would be linked to the relevant clinicians or managers. Directors of nursing and human resource managers in Irish hospitals were invited to consider joining the consortium.

Dublin Academic Teaching Hospitals — nurse recruitment and retention project

The chief executive officers and the directors of nursing of the Dublin Academic Teaching Hospital (DATHs)[5] and St. Luke's Hospital commissioned research on the recruitment and retention of nurses in Dublin. The research was conducted by the nursing practice development co-ordinators in each of the six hospitals between November 1999 and January 2000. The study systematically reviewed nursing vacancy rates and associated factors as a direct result of the acute shortage of nurses experienced by the group of hospitals. The study investigated: WTE number of vacancies for clinically based nurses and bed closures in the group of hospitals; job satisfaction rates and factors influencing retention of nurses; factors influencing nurses' decisions to terminate employment; factors influencing nurses to reduce working hours, and specific initiatives in place in each hospital that promote recruitment and retention of nurses. An action plan was devised as follow-up to the *DATHs Nursing Recruitment and Retention Group Report* (2001). A project management approach was adopted and five sub-groups were established, each chaired by one of the directors of nursing from the group. The sub-groups were as follows: recruitment, governance, database, career pathways and skill mix. Priorities were identified for each of the sub-groups; the necessary actions and responsibility were clearly identified. A director of nursing chaired each of the sub-groups. A project manager was appointed to co-ordinate and manage the project in December 2000.

[5]Dublin Academic Teaching Hospitals group includes The Adelaide and Meath Hospital Dublin incorporating the National Children's Hospital, Beaumont Hospital, James Connolly Memorial Hospital, Mater Misericordiae Hospital, St. James's Hospital, and St. Vincent's University Hospital, incorporating St. Michael's Hospital.

Recruitment sub-group

The objective of the group was to recommend a co-ordinated approach and pooling of resources for recruitment nationally and internationally within the DATHs group.

It was agreed that international recruitment was necessary to meet the needs of the DATHs group. The group tendered jointly to select suitable supplier/s. One recruitment company was awarded the contract, effective from 1 November 2001. Certain performance criteria have been written into the contract including the following:

- Quality is not negotiable
- Eighty per cent of the nurses across the specialties must be available and suitable for employment
- Twenty per cent of the supply must come from countries that do not require supervised placements
- The supply of nurses must be delivered within the timeframes agreed and specified in the contract.

An operational policy has also been agreed between the DATHs for the day-to-day management of the contract, for example accommodation, airfares etc. A review will be carried out at the end of six months. A joint DATHs hospital focus was agreed for advertisements, including bi-annual advertising for registered nurses in the national newspapers and relevant professional journals outlining the benefits each hospital has to offer. A schedule of job fairs to be attended by the DATHs is approved on an annual basis.

The nursing agencies that currently supply the DATHs group were invited to meet the steering group and financial controllers on 7 June 2001. It was agreed that this was a first step in preparing to go to the market with a EU tender. Each agency gave a presentation on how it proposed to meet the needs of the DATHs. Various issues came to light as a result of this, including discrepancies in rates charged to the hospitals, administration fees, specialist fees and holiday pay. The meetings also highlighted quality issues, for example verification of Cardiopulmonary Resuscitation (CPR), manual handling, intravenous policies and Garda clearance. It was agreed that each hospital would retain its own agency and agree a standard, as no one agency could supply all needs. A specification has been drawn up for agreement by the DATHs, focusing on:

- a standard of service delivery within the agreement period
- the exact quantity to be provided over the period
- when and where the service is to be provided
- the cost of the service and payment terms
- remedies if any of the above are not delivered on.

It is proposed to go to tender with the nursing agencies as soon as possible. The ERHA have been invited to be part of this initiative.

A job description and salary scale has been prepared and agreed between the steering group for a human resource manager for nursing and midwifery. It has been agreed that a staff member (Grade V clerical) should support the human resource manager and that this post should be filled simultaneously. Funding is currently being sought for the posts.

The directors of nursing reviewed the study leave policies across the five hospitals and a common DATHs study leave policy and learning contract has been agreed.

Nursing governance sub-group

The nursing governance sub-group was established in October 2000. The sub-group reviewed the DATHs recruitment and retention action plan specifically relating to nursing governance and staff participation. The following outcomes for the sub-group were agreed.

- Identify shared nursing governance programmes.
- Review structures and systems of governance within the DATHs.
- Identify relevant committees in the DATHs group, outline terms of reference, membership, effectiveness and lifespan.
- Outline organisation structure of each hospital within the DATHs group.
- Outline communication policy and systems within each of the DATHs.
- Repeat staff satisfaction audit in 2002.

In May 2001, Ms Jacqueline Geoghegan addressed both the steering group and the sub-group. Ms Geoghegan developed and implemented the first UK model of governance in 1995 and has since helped others to develop similar models. The sub-group drew up a proposal to implement a pilot on governance in each of the DATHs over a six-month period.

In order to implement the pilot, a 0.5 WTE clinical facilitator at CNM 2 level was appointed by each of the DATHs. A pre-pilot education package was put together, led by the director of nursing and nurse practice development co-ordinators and a number of education sessions were held for the facilitators. It was agreed that for the pilot, it was necessary to select wards with a nursing vacancy not greater than 13 per cent. As nursing governance directly impacts on retention issues, the pilot sought participation from general medical and surgical wards, as these clinical areas demonstrated a high vacancy level across the DATHs. The pilot frame is six months and two wards were chosen within each hospital: each ward identified a staff nurse as a team leader for the pilot. Each team chose a particular aspect of the nursing service for change. Topics included: ordering microbiology tests on computer for patients by nurses, follow-up care of patients on nebulizers, improved nursing reports and in-service education. The pilot will be evaluated with a pre- and post-pilot survey to assess staff nurses' satisfaction with their working environment and level of involvement in decision-making.

Database sub-group

The sub-group focused on producing a minimum dataset for all registered nurses that could be used as a standard within the DATHs. This consisted of five key components:

- General (demographic details)
- Professional registerable qualifications
- Employment (history)
- Education
- Leavers.

The professional qualifications catalogue was drawn up in association with the PPARS team and the Department of Health and Children had already undertaken work in this area (see Chapter 3). An

overview of resource scheduling/monitoring was carried out but it was agreed that further work would have to be done to investigate scheduling in more detail. A template was agreed for the capture of statistical information from all the DATHs and this is submitted to the project co-ordinator's office on a monthly basis.

The information captured includes the staff complement for each hospital, the number employed, the number of whole-time equivalents employed, the number of vacancies, the number of agency and overtime hours monthly. Information on starters and leavers on all clinically based nurses is also collected including a breakdown of those newly qualified, Irish starters and those from both European and non-European countries. A record is also kept of nurses who are currently obtaining supervised clinical experience as part of the process for registration with An Board Altranais, including those being facilitated for subsequent employment in nursing homes. The feasibility of capturing up-to-date information on leavers is currently being examined. Ongoing liaison has taken place between the sub-group and this study through meetings with the project manager.

Career pathways sub-group

The career pathways subgroup has explored a wide range of issues to address the agreed terms of reference. The main areas considered were the following:

- In-service education
- Rotation of new staff
- Preceptorship courses
- Return to practice
- Personal portfolios
- DATHs acuity allowance.

A common preceptorship programme has been developed. This has been reviewed by the steering group and An Bord Altranais has granted category 1 approval for the course. The operational aspects of running this course have yet to be finalised. A draft job description for clinical facilitator medical/surgical has been drawn up. It was agreed by the group that this job description should be used universally throughout the DATHs group. Slight changes can be made to adapt for individual hospitals.

The sub-group reviewed the content of the return-to-practice course held by the various hospitals. A document has been circulated to the steering group. The group has also undertaken telephone surveys to determine the uptake of work following completion of the return-to-practice course within the DATHs. The co-ordination of the course within the DATHs and operational aspects of providing the programme have still to be finalised.

In relation to succession planning a draft document has been presented to the DATHs steering group which includes: career pathways in nursing and preparing for management roles. Specific competencies have been defined, relevant to CNM1, CNM2 and CNM3. The work of the National Council and Office for Health Management has been taken into consideration in preparing this document. The final report of the sub-group was submitted in April 2002. A meeting with the Director of the Nursing and Midwifery Planning and Development Unit for the ERHA has taken place to discuss the report.

Skill mix sub-group

The skill mix sub-group circulated two questionnaires to establish the present situation within the DATHs with regard to:

- Skill mix
- Staff complement
- Grade mix within nursing and multi-disciplinary teams.

In order to define opportunities for skill mix, permission was granted to use a questionnaire developed in St. James's Hospital. The questionnaire, *Utilisation of Nursing Activity Analysis* (the role and work of clinically based staff), was distributed to 66 nurses to establish the roles and work of clinically based staff (response rate 45 per cent). A survey of 58 nurse managers was also undertaken. Results were analysed and the report entitled *Skill Mix Group Report,* with recommendations, was completed in December 2001. The final recommendations include the following: that a project person be appointed at CNM2 level with a designated practice development focus within a very specific remit; that a standardised nurse demand method be selected to facilitate rather than dictate decisions on nurse staffing requirements; that a systematic skill-mix process operate across the DATHs group. Human and financial resources need to be in place. It is intended that activity be monitored both before and after the introduction of skill-mix assessment and that changes to examine patient outcomes and education of nursing personnel in relation to the method be used.

The report of the recruitment and retention committee — St. Patrick's Hospital

The issue of high nursing turnover and concerns over recruitment is not confined to general nursing and midwifery. St. Patrick's Hospital is a 285-bedded private psychiatric teaching hospital located in central Dublin. In addition, in collaboration with St. James's Hospital and the SWAHB, it provides a number of continuing care beds and a community mental health service for a catchment area of 90,000 people, covering an area of the south inner city and the suburbs. St. Patrick's Hospital provides mental health services in the inner city of Dublin. A Recruitment and Retention Committee was established at the hospital in November 2000. The role of the committee was:

- to identify staff recruitment and resignation patterns at the hospital in as much detail as is practicable
- to conduct an analysis to identify any patterns or trends in staff resignations
- to identify issues in recruitment and retention that are within the control of the hospital
- to examine conditions and opportunities for nurses which might impact positively on staff recruitment and retention.

A review of literature, a collection of statistical data and focus group interviews among staff were undertaken. A final report was presented in June 2001. The report sets out twenty-two recommendations with practical actions aimed at retaining the current staff in practice. A list of the broad areas covered by the recommendations is given below:

- Collection of nursing staff turnover statistics
- Intensified psychiatric nursing practice development
- Focus on team work and multi-disciplinary care patterns
- Enhanced communications
- Formal staff orientation

- Support for nursing education and research
- Staff recruitment, employment patterns, opportunities and incentives.

This project demonstrates a proactive approach to an identified problem.

ERHA — group examining retention strategies

In October 2001 a group of senior nurses from the ERHA attended the Fifth Annual National Magnet Hospital Conference, *Creating Our Future Today: New Challenges, New Direction,* in North Carolina. The purpose of attending this conference was to identify key issues within organisational structures that supported retention and could be modified and implemented in an Irish context. The group attending the conference also undertook a number of site visits to explore issues relating to the role of advanced nurse practitioners. Since returning a number of follow-up meetings have taken place to plan how best to disseminate the learning points and information gathered during the conference. A conference relating to retention of nurses was held during May 2002, *Health Care: Influencing the System and Retaining Staff.* The conference targeted key individuals who have an impact on nursing retention, including nurse managers (CNMs and DONs) human resource managers and other interested stakeholders. A number of master classes were also arranged for directors of nursing.

ERHA — research on midwifery issues

In particular the Dublin maternity hospitals are experiencing significant difficulties with regard to staff turnover. Issues identified by Henrichsen (2001) as contributing to this are increased workload and stress levels, an obstetric-led service, reduced autonomy, litigation, increased birth rates, shorter hospital stay and deficiencies in national planning. In view of the particular difficulties the Nursing and Midwifery Planning and Development Unit in the ERHA, in conjunction with the three maternity Dublin maternity hospitals, has commissioned an in-depth study of the issue. A researcher was recruited and the study commenced in February 2002. The terms of reference for the study are as follows:

- Establish the current number of midwifery vacancies at all staff grades within the three hospitals
- Examine exit interview information and survey a representative sample of leavers to determine factors influencing their decision to leave employment
- Identify factors that may have influenced midwives leaving employment
- Examine the current employment patterns of leavers
- Identify the number and grade of midwives who have reduced their monthly hours within the past three years and establish factors influencing their decision
- Identify midwives who have remained in current employment for a minimum of two years and establish the factors influencing their decision to remain
- Examine current initiatives being undertaken to improve recruitment and promote retention of midwives within the Dublin maternity hospitals.

A report is to be produced by July 2002, including an action and implementation plan to be agreed by all parties.

Having established the numeric rate of turnover in nursing and midwifery in Ireland and some of the initiatives aimed at addressing the issue, the next section of the chapter presents some of the lessons to be learned from other countries.

4.7 Lessons from other countries

It appears from the international literature that Ireland is not alone in its experience of increasing rates of nursing and midwifery turnover and difficulties in filling vacancies. Although a cyclical trend, there is growing evidence that nurse retention has become an endemic problem throughout the world (The Advisory Board Company, 2000). An acute nursing shortage, high hospital nurse job dissatisfaction and reports of uneven quality of hospital care have been highlighted in an international study undertaken by Aiken *et al* (2001). The research involved 43,000 nurses from more than 700 hospitals in the United States, Canada, England, Scotland and Germany. Nurses in distinctly different health care systems reported similar shortcomings in their work environments and in the quality of hospital care. While the competence of and relation between nurse and doctor appeared satisfactory, the study identified core problems in work design and workforce management which were reported to threaten the provision of care. The researchers indicated that resolving these issues, which they suggested are amenable to managerial intervention, was essential in preserving patient safety and care of consistently high quality. An approach developed in the mid 1980s in the USA and gaining increasing attention today is that of the *Magnet* Hospitals.

4.7.1 *Magnet* hospital strategies

Magnet hospitals are defined as organisations able to attract and retain a staff of well-qualified nurses and therefore consistently able to provide quality care. Hospital nursing, in these institutions, has proven to be an excellent career choice for professional nurses. The term *Magnet* was used to highlight the staff attraction/retention characteristics of these institutions. The source of the definition was a policy study commissioned by the American Academy of Nursing (AAN) in 1981 and published in 1983 (McClure, Poulin, Sovie, and Wandelt).

Most published studies on nursing turnover focus on the reasons why nurses leave jobs or on their dissatisfactions in their present settings. The original *Magnet* study looked at the problem from a different perspective, focusing on the reasons why nurses stay in their jobs and on reasons for job satisfaction (McClure et al, 1983). Furthermore, the study concentrated on the specific organisational factors contributing to the retention of registered nurses in hospital settings. The elements of identified *Magnet* hospitals were presented within three major categories: (i) the leadership attributes of the nursing administrations; (ii) the professional attributes of the staff nurses; (iii) the environment that supports professional practice.

This study is important as it initiated a series of studies over a twenty-one-year period on the characteristics of professional nursing practice environments which make organisations attractive to nurses. This has brought to prominence the internal organisational characteristics that can be used to attract nurses to employment.

The applicability of the *Magnet* Hospital model outside American hospitals has been examined in the UK. However, there are fundamental differences between the general taxation-funded, universal coverage public system in the UK and the insurance-based, mainly private sector system in the US, which makes comparison difficult. Buchan first studied the implications of the *Magnet* Hospital concept for the UK nursing labour market in 1992 (Buchan, 1994). He undertook detailed case studies of employment practices in ten USA hospitals and ten Scottish hospitals with specific attention to remuneration practice, methods of organising nursing care, establishment-setting and flexible hours. The investigation was conducted during a time of economic recession in both the UK and the USA. Fewer problems recruiting and retaining staff were reported. In both countries the impact of the general economic downturn was cited as a factor in reducing job mobility, keeping nurses in jobs, working

longer hours and postponing career breaks. American respondents rated flexible hours provision as the most effective single strategy, with planned orientation, peer-review-based merit pay, clinical ladders, continuing education and hospital nursing committees amongst the factors rated as effective for nurse recruitment and retention. Scottish respondents rated continuing education provision as the single most effective intervention, and generally reported reliance on a narrower range of strategies to recruit, retain and motivate nursing staff. Hospitals in the US were found to make better systematic use of employment indicators such as absenteeism and turnover rates in evaluating the effectiveness of their recruitment and retention strategies, and in monitoring problems.

When publishing the results of the investigation Buchan (1994) advised that Scottish hospitals could gain new insights into effective employment and deployment of nurses, but elements of the *Magnet* hospital concept could not be successfully 'imported' to the National Health Service (NHS) in a piecemeal manner. He cautioned that the introduction of flexible hours of work and encouraging professional autonomy were not enough. Significant structural changes were also required which involved the commitment of management at all levels and the availability of appropriate resources and expertise.

Five years later Buchan (1997) examined whether the concept of *Magnet* hospitals was still valid, in the climate of US hospital mergers, alliances and acquisitions by private firms. He concluded that *Magnet* hospitals had generally retained excellent standards of efficiency and quality improvement, under cost-containment pressures. Despite the differences in health systems, he suggested, the core characteristics of the *Magnet* hospital concept were relevant to the UK. He commented that it is not the *Magnet* hospital label itself which is important, but the emphasis on the concept of quality care, effective staff deployment and high levels of job satisfaction which signify the attainment of the label. This is likely to be correct. However, with the aggressive marketing of the *Magnet* title in the USA, nurses have come to expect a certain type of work environment in these organisations.

Since the publication of the original study the focus on *Magnet* hospitals has increased with the establishment of a *Magnet*-orientated credentialling system established by the American Nurses Credentialling Centre (ANCC). This credentialling mechanism enables hospitals to apply for *Magnet* status. The title of the programme is the *Magnet Nursing Services Recognition Programme for Excellence in Nursing Services*. Those that apply pay an application fee, prepare supporting documentary evidence, and host a site visit by ANCC consultants. The accreditation is awarded for a four-year period (ANCC, 1998,1999). Currently 50+ health care organisations across the USA hold accreditation. The average length of employment among registered nurses on staff in *Magnet*-accredited hospitals is 8.85 years, illustrating success in retention.

The programme provides a framework to recognise excellence in:

- the management philosophy and practices of nursing services
- adherence to standards for improving the quality of patient care
- leadership of the chief nurse executive in supporting professional practice and continued competence of nursing personnel
- attention to the cultural and ethnic diversity of patients and their significant others, as well as the care providers in the system (ANCC, 1998).

The characteristics of the nursing professional practice environment identified during the *Magnet* studies are now used as part of the recruitment and retention strategies of American hospitals. The forces identified as vital for *Magnet* hospitals have been researched and expanded over a period of twenty-two years and are summarised in Table 4.7-1.

Table 4.7-1 – Forces of magnetism

Force and descriptor
1. Quality of nursing leadership — strong visible, accessible nurse leaders
2. Organisational structure — decentralised flattened structure; no turf wars
3. Management style — chief nurse executive, associate directors and unit managers; using a collaborative participative approach
4. Personnel policies and programmes — supportive, employee-friendly and flexible
5. Professional models of care — generally based on primary nursing or a hybrid thereof
6. Quality of care — monitored
7. Quality assurance — constructive and patient-focused
8. Consultation and resources — available to RNs
9. Level of autonomy — given to individual RNs for their clinical practice. RNs expected to be autonomous and to use the full scope of practice set down by the Nurse Practice Act for the relevant State
10. Community and the hospital — profile and participation of the hospital staff in the development of the community
11. Nurses as teachers — of patients and colleagues; the item that is reported to give most satisfaction
12. Image of nursing — seen as a vital and professional element of the service delivery
13. Nurse-physician relationships — collaborative and mutually respectful
14. Professional development — orientation; in-service; continuing education; formal education; and career development supported

Source: Jones-Schenk, J. (2001); Fifth Annual National *Magnet* Hospital Conference (2001)

The *Magnet* title is used by institutions in the USA both as a symbol of success in recruitment and a method of attempting to attract future nursing recruits. In the current competitive health care environment earning *Magnet* hospital status is perceived as a prime marketing advantage, attesting to quality patient care and a professional working environment.

4.7.2 Retention responsibilities of line managers

The impact line managers can have in retaining staff is highlighted throughout the international literature. Of particular note is the work of the Nurse Executive Center of the Advisory Board Company in the USA. Best practices for nursing retention suggest that the most successful long-term retention efforts centre on charging front-line managers with primary responsibility for retention (Advisory Board Company, 2000). It is the clinical nurse or midwife managers at ward/unit or community care area who are best positioned to effectively diagnose and act on the myriad of specific retention issues and opportunities within an area. The Nursing Executive Center has published an implementation handbook for nurse managers on *Becoming a Chief Retention Officer* (2001). Eight practices are identified as the key nurse manager activities in retaining staff. These are set out on Table 4.7-2.

Table 4.7-2 – Clinical nurse/midwife manager's role and responsibilities in retaining staff

Focus	Key nurse manager retention roles	Sample activities
Recruitment and orientation	CNM/CMM and staff involvement in interviews	• Nurse manager collaborates with staff to interview, assess, and recruit new employees; avoids potential mismatches and promotes new staff assimilation
	Precepetorship for new nurses and midwives	• Nurse manager improves preceptorship, delegates new staff support, and encourages peer interactions, easing new employee's transition into the unit

Table 4.7-2 – Clinical nurse/midwife manager's role and responsibilities in retaining staff — *contd.*

Focus	Key nurse manager retention roles	Sample activities
Diagnosing turnover risk	Constant monitoring and addressing reasons for staff leaving	• Nurse manager monitors and logs retention risks, developing specific plans for action to retain high-risk individual and addressing unit-wide dissatisfactions
	Audit of what would make job easier	• Nurse manager meets monthly with staff regarding rosters, availability of supplies, and other details; takes subsequent steps to 'clear the hassle factors'
Coaching and development	Individual personal and professional development plans	• Nurse manager works with nurse or midwife to create and implement individual career 'development plan'; delegates operational and clinical responsibilities
	Regular formal feedback to staff nurses and midwives	• Nurse manager offers regular feedback for staff nurses, midwives and patient care teams; improves staff motivation
Building the team	Each ward develops a communication system and evaluates effectiveness	• Open communication — staff-to-staff, staff-to-manager, and manager-to-staff improves staff understanding, connection and affinity to hospital/organisation
	Social events to enhance team spirit	• Unit events, both social and work-related, foster loyalty; working relationships encourage staff motivation and attainment of shared unit goals.

Source: Adopted from Nursing Executive Center (2001) *Becoming a Chief Retention Officer*

A recent USA study (Health Care Advisory Board, 2001) highlights the relative importance of key hospital nursing attributes in decreasing nursing turnover. In order of importance these were identified as: compensation, scheduling options, intensity of work, growth opportunities, competence of clinical staff, support services, effectiveness of direct manager, participation in decision making and recognition. A review of the activities suggested by the Nursing Executive Center (2001) for maximising impact on retention indicates that nurse managers should be carrying out a number of key activities (see Table 4.7-3). Some of the functions may be new and others an enhancement of existing activities that can address the root causes of turnover from the moment staff-nurses or midwives are employed to their on-going training and development.

The approach adopted in the USA is echoed in a recent article on the volatile Irish employment market. McCann (2001) proposes six essential steps for becoming an *Employer of Choice*: (i) look at your managers, (ii) create a recognition culture, (iii) create a healthy working environment, (iv) create an atmosphere of continual self-improvement, (v) put your best foot forward (pay as much salary, and give an many benefits as you can afford) and (vi) match people with jobs. The article highlights the impact of poor managers who can completely cancel out the positive effects of heavy investment in recruitment advertising and attractive remunerations packages. He advises measuring staff turnover by unit/manager so that the real problems can be identified, the rationale being that 'unless you know which managers are hemorrhaging people you can't do anything about it.' Good management is identified as the key to good retention, providing training, coaching and support to manage people in a way that encourages productivity and retention.

Table 4.7-3 – Actions for retention

Focus	Key nurse manager retention roles	Sample activities
Managing the Unit	Retention diagnosis	• Weekly staff brainstorming • Daily unstructured unit time • Nurse manager open-door policy • Unit staff retention records • Suggestion box • Anonymous exit interviews
	Unit operations	• Comprehensive unit admission guidelines • Unit equipment audit • Just-in-time supply management • Unit rostering guidelines • Communication protocols
	Unit leadership	• Off-site unit events • Organisation-wide clinical nurse/midwife manager collaboration • Personal skills improvement plan
Managing the Individual	Customising education	• On-unit education • Scheduled education time • Flexibility of study leave • Staff nurse educational development plan
	Customising staff jobs	• Individual personal and professional development plans • Unit-specific management positions • Senior nurse mentoring
	Enhancing communication	• Patient/family rounds • Two-way hospital/unit communication • Senior executive communication with staff
	Enhancing feedback	• On-time performance review • Informal nurse feedback • Staff performance evaluation training • Nurse manager upward feedback

Source: Adapted from Nursing Executive Center (2001) *Becoming a Chief Retention Officer*

4.8 Conclusion

There are three main strands in this Chapter: the Irish experience of turnover, recent developments initiated to address some of the issues, and lessons from other countries. The *National Study of Turnover in Nursing and Midwifery* and the subsequent collection of data by the Nursing and Midwifery Planning and Development Units indicate that turnover in nursing and midwifery is a very real issue requiring focused attention. It is apparent from the research that the turnover rate may escalate to that experienced in the international nursing workforce, particularly as almost a quarter of the group sampled in the research indicated that they were seeking to change employer. The main message is the prerequisite for:

- personal development planning for all staff
- communication channels with good-quality feedback loops
- profiling and developing managerial roles
- proactively planning to minimise the risk of losing staff
- monitoring the trend over time.

The international literature and the outcome of the regional meetings held to feed back the findings of the turnover study all provide practical approaches that can be used as a means to minimise the trigger for leaving a particular organisation. It is therefore recommended that:

- turnover rate in nursing and midwifery across the divisions and geographical regions in the country be monitored and published on an annual basis
- directors of the Nursing and Midwifery Planning and Development Units have responsibility for collecting, co-ordinating and analysing information on turnover in nursing and midwifery for their region on an annual basis
- each organisation employing nurses and midwives develops a retention strategy specifically for its service
- the effectiveness of the strategy be monitored and revised in the light of turnover rates
- clinical nurse/midwife managers be directly involved in the selection of nurses or midwives to work in their particular ward unit or service
- nurse managers be specifically equipped for their role in people management and prepared for the central role they have in creating the practice environment to retain staff in employment in their particular area.

The material presented in this Chapter can be used as a basis for the development of such a strategy. The importance of individual nurses and midwives taking ownership and responsibility for their role in retaining colleagues in practice is paramount in any strategy for minimising the risk of losing staff.

CHAPTER 5

The Future

5.1 Introduction

An integral part of forecasting is the ability to anticipate the major influences on the future environment, sometimes referred to as horizon-scanning or 'futures thinking'. In addressing the question of 'futures' in health care, the WHO (1994) use the following definition:

> 'futures' thinking provides a set of tools that can help explore probable, plausible, possible and preferable futures to help guide present and future actions. Health futures studies, the application of futures methods to the field of health and health services, can help us anticipate potential health threats and health development opportunities.

'Futures' involves the identification, description and assessment of scenarios that reflect possible developments in trends and seeks to anticipate the outcome of these developments. It involves preparing for the unexpected. Nursing's future is inextricably bound to society's future and the future of health care.

Previous Chapters identified retrospective trends and this Chapter examines methods to foresee the likely changes in the health system that will influence the demand for nurses and midwives. It deals in part with objective five of the study:

- to identify and recommend the best possible approach to human resource planning for nursing and midwifery.

Four broad areas are addressed: futures thinking; the use of scenario planning; the drivers for service demand; and recent developments that will affect the supply of nurses and midwives in the near and longer term.

5.2 Futures thinking

Futures thinking is described as a tool for wiser action that stimulates the imagination, encourages creativity, identifies threats and opportunities, and allows us relate possible future choices and consequences to our values. An interesting text specifically written for nursing is *Creating Nursing's Future: Issues, Opportunities, and Challenges* (Sullivan, 1999) and is based on a conceptual framework founded on the work of futurists Hancock and Bezold (1994). The framework proposes comparing the probable future (if current trends continue) with a preferred future (the one we'd like to see happen), which enables us to design strategies to achieve the future desired. Trends, scenarios, visions, and strategies are four components of health futures work. Trends and scenarios explore what might happen, while visions clarify what we want to create. Strategies link plausible and preferred futures to action. Sullivan (1999) describes the three main challenges for nursing leaders seeking to use health futures in the following terms:

- integration of more visionary and scenario-based futures methods with the more standard, near-term planning approaches
- consideration of the roles of health care providers within the wider role of the determinants of health

- involvement of the whole range of customers and the entire community in designing the health and health care system that the community wants (p12).

One thing that is clear from the futures literature is that tomorrow's nurses and midwives must be well-educated and well-prepared if they are to exert leadership to positively influence the new health care systems as they emerge. The future world will be more, rather then less, diverse than today's and nursing must be proactive in preparing for this diversity. Diversity in nursing and among the patients who depend on nursing for their care must be recognised and appreciated. In the future nursing will need to be committed to improving health worldwide by removing barriers to good care both in Ireland and beyond. When the rate of change is rapid, incessant, and even traumatic, people with the capacity to plan for, manage and adapt to the change effectively will be successful.

5.3 Scenario planning

Scenario planning is a way of attempting to describe how the future might look and feel under certain assumptions. Royal Dutch/Shell developed scenario planning during the oil crises of the early 1970s (Hibberd, 2001). The purpose of scenarios is not to pinpoint future events but to highlight large-scale forces that might push the future health system. Given the impossibility of knowing precisely how the future will play out, Wilkinson (1995) advises that scenarios be created in plural so that each diverges markedly from the others and points to several possible futures. This kind of scenario planning should be an integral part of planning and policy making for health care. One of the important aspects of scenario building is preparing alternative strategies to address scenarios, thus insulating against shocks and facilitating planned responses.

A report commissioned by the UKCC Education Commission was published on *Healthcare Futures 2010* in the UK (Warner et al., 1998). This report was used to inform the Commission and provide an evidence base which includes contemporary views on the future of health care in the UK. The document provides useful content that could be used to inform discussions on the likely futures for nursing and midwifery in Ireland. The report suggests that the greatest challenge when contemplating the future is to be able to cope with the inescapable uncertainty of any projections. Three disparate scenarios were identified, as follows:

- muddling through — a world of constraints on health care expenditure and implacable pressure for even greater efficiency and effectiveness, within a broadly collectivist ethos
- economic strength and consumer choice — high level of health care expenditure combining with a culture of consumer assertiveness and devolved decision making
- individual choice and free market — a hard-pressed NHS increasingly reduced to a 'safety net' service, with active encouragement of private and other provision (p 39-49).

The conclusion is that the future will not be straightforward or simple. The report summarises this in terms of a series of paradoxes, i.e. a number of apparent contradictions which will co-exist and which nurses and midwives will have to manage. These are summarised in Table 5.3-1.

In 1999 the International Council of Nurses (ICN) published a *Guidebook for Nurse Futurists*. The text contains ICN's vision for the future of nursing and contains a wealth of information on trends affecting nursing and midwifery. The major trends affecting nursing were identified as: nursing education changes, advances in nursing, turmoil in the profession, working environment of nurses, regulation, governance of nursing and relationships with other health professions. Four very different scenarios of how nursing and society might evolve up to 2020 were presented. These are: business as usual, gloom and doom,

visionary leadership and technology transformation. The document also contains instructions for undertaking participatory strategic thinking exercises within organisations. Two methodologies are described for exploring the uncertain future. The first explores the preferred future. The second examines likely and potential futures by scanning emerging developments, identifying trends and building and using scenarios.

Table 5.3-1 – The complex future of health care — the paradoxes

Health care in the future will be characterised by:		
More money	...AND...	Continuing relative shortage of resources
Central/regional strategy	...AND...	Growing local diversity of provision and roles
Emphasis on prevention	...AND...	Great demand for cure and palliation
Continued dominance of the hospital	...AND...	Considerable emphasis on care closer to home
Public reliance on professionalism	...AND...	Greater lay assertiveness
More, well-educated and assertive patients	...AND...	Continuing need to serve those with little personal access to information
Greater demand for high-tech medicine	...AND...	Growing demand for complementary approaches
Demand for high technical competence and 'scientific rationality' amongst nurses and midwives	...AND...	Continuing need for 'human' qualities and the time to express them
Blurring of professional boundaries	...AND...	Separate professional traditions and organisations and public expectations
Greater incidence of the diseases of old age	...AND...	Continuing demands for younger people
Continuation of old moral certainties	...AND...	Moral uncertainty in new and challenging environments
The public's core expectations of nurses and midwives will be little altered	...AND...	Nurses and midwives will demand new roles in order to fulfil their own expectations

Source: Healthcare Futures 2010 (1998)

The document indicates that in an earlier, slower-moving time, past experience was a fairly reliable guide to the future. Leaders in nursing could reasonably assume that the future would simply be a bigger and better version of the world with which they were familiar. This kind of continuity cannot now be taken for granted.

Scenarios can also be used in mathematical models for forecasting. A planning exercise undertaken in Scotland uses this methodology. A workforce planning survey and modelling exercise ascertains the overall supply and demand for nurses, midwives and health visitors in Scotland. This is conducted annually and is commonly known as the Student Nurse Intake Planning (SNIP) assessment. In the SNIP national modelling for the year 2001 three separate scenario assessments were undertaken (baseline, pessimistic and optimistic) to inform the decision on the intake to adult general, paediatric, mental health, learning disabilities, and midwifery programmes. The assumptions built into the modelling exercise are changed by a specific percentage rate for each scenario. The model takes account of demographic trends, including the age profiles of nurses currently employed, and the number of students required to be trained (estimated over a five-year cycle). As mentioned earlier in scenario planning there is no right answer and professional judgment plays as important a role as the process of analysis itself. On the basis of the evidence produced by each of the scenario assessments the steering group for the SNIP plans made the final decision on the number of intakes to each programme.

At the *Call to the Nursing Profession Summit* held in the USA in September 2001 the overarching desired future for nursing, was defined after substantial brainstorming and refinement, as follows:

> nursing is the pivotal health care profession, highly valued for its specialized knowledge, skill and caring in improving the health status of the public and ensuring safe, effective, quality care. The profession mirrors the diverse population it services and provides leadership to create positive changes in health policy and delivery systems. Individuals choose nursing as a career, and remain in

the profession, because of the opportunities for personal and professional growth, supportive work environments and compensation commensurate with roles and responsibilities (p 7).

'Futures thinking' was also addressed as an important issue in the development of the Irish Health Strategy (2001). A Consultative Forum was established to provide widespread input to the development of the new Health Strategy. The Forum was divided into eight sub-groups to prepare proposals on particular topics. One of the groups specifically addressed the issue of futures. The group's report is available on the Department of Health and Children website http://www.doh.ie/hstrat/repfut.pdf. The work of the group focused on the development of a range of reflections on a number of themes that are of central importance to futures' thinking, relevant to the Irish health system. The themes were: demography/disease patterns; the physical environment; science and technology; social trends; organisation and management; public expectations; and health care ethics. During their deliberations the group also developed a number of scenarios covering a range of situations/issues in the health sector. One of these specifically relates to the future of nursing in the Irish health services. An outline of the scenario is presented on Table 5.3-2.

Table 5.3-2 – Scenario for the future of nursing in the health services

What is the future for the role of nursing in the health services?

- We are likely to have fewer nurses — recruitment and retention of nurses will be a challenge and will require a more flexible approach.
- Some of the care currently provided by nurses will be provided by trained health-care assistants.
- Nurses will be trained to degree status and many will possess postgraduate degree qualifications.
- There will be more generic elements in the education and training of health-care professionals, including nurses.
- There will be more clinical nurse specialists and advanced nurse practitioners.
- There will be more nurse-led services both within institutions and in the community, e.g. nurse-led services in A&E, nurse-led services in remote geographic locations, nurse-led services for care of the elderly.
- Nurses will be involved in prescribing medications.
- Nurses will span the boundaries of their profession; for example, some of the functions currently carried out by doctors will be fulfilled by nurses.
- Nurses, therefore, will have to expand the scope of their own practice.
- Nurses will occupy a higher profile in the community.
- Nurses in the community will work more closely with other professionals and voluntary organisations in promoting health and well-being rather than treating illness. This will be particularly true of care of the elderly.
- Nurses will play a more prominent role in the promotion of mental health and well-being in community-based psychiatric services.
- Services for people with learning disabilities will be based on close co-operation between multi-disciplinary community-based teams.
- Midwifery services will be more community based and midwife-led.
- Hospital settings will be more high-tech, acute-care in focus and the role of nurses will develop with this.
- Nurses will be required to become more facilitative in assisting individuals to achieve a higher level of health rather than prescriptive. This will require that nurses receive more education and training in communication and management skills.
- The organisation of health care provisions will be based on systems of multi-disciplinary teams.
- Nurses will be required to be more involved in research in order to provide a broader Irish base for evidence-based care and link care to best practice.
- Nurses will be more involved in the planning of health care.
- Nurses will be called upon to exercise more authoritative clinical judgement and this will in turn require of them to articulate more clearly for other health care professionals and health care administrators the content of the clinical wisdom contained within their profession, i.e. what it means to be an expert nurse.

Source: Report of the Health Strategy Consultative Forum Sub-Group on Futures (June 2001)

The above examples of scenario planning give an insight into the use and value of the technique. They provide descriptions of plausible futures which bring together the drivers and how they may interrelate. Scenarios are not intended to be predictions, as many of the elements may not come about in the way described. Neither are they intended to be mutually exclusive. Different elements of each may well co-exist in the future. The examples given can be used to inform discussion and development of likely

scenarios for future nursing and midwifery practice in Ireland. The next section highlights the major influences that will drive the demand for nursing and midwifery services in the future.

5.4 Major influences on the future demand for nursing and midwifery resources

Rising prosperity, as the Health Strategy (2001) highlights, has led to expectations of a high quality of life. At the same time, the pressures of modern life have increased the numbers experiencing stress in their daily lives. Changes in family structures and community life may mean that supports are less available than in the past. Changes in Irish society mean that groups such as older people, people with disabilities, people with mental illness, and those with chronic illnesses will require additional nursing services. This section of the report highlights some of the areas that should be considered by planners when considering the likely demand for nursing and midwifery services in the future. The developments can be broadly grouped into areas relating to the following: demographic changes; health system developments; national developments; science and technology; and developments in nursing and midwifery.

5.4.1 Demographic changes

Population distribution

Preliminary finding of the Central Statistics Office Census 2002 indicate that there are 3,917,336 people in the State. The diversity in the numbers of nurses and midwives required can be appreciated by the fact that well over one third (35.7 per cent) of the population are located in the Eastern Regional Health Authority (ERHA) area. The ERHA estimates that by 2011, the population of the region is likely to be around 1.6 million. This will mean that the population of the region will have grown by 33 per cent since 1981. Such a profile poses challenges for those charged with ensuring that the demand for nursing and midwifery services is adequately catered for. This equally applies in densely populated urban areas and sparsely populated or inaccessible rural areas where there may be long distances between professionals and those receiving care.

Emigration and migration

In 1990 there was a net outflow of about 25,000 people per year from Ireland. That figure is now reversed. On the basis of trends in recent years, it is estimated that approximately 10,000-11,000 people will seek asylum in Ireland on an annual basis. Growth in the Irish economy has also attracted large numbers of economic migrants to the country. This is a relatively new phenomenon. The health system, including the nursing and midwifery resource, needs to respond to the increasing diversity in Irish society in a way that ensures full access to quality health care that is culturally and linguistically appropriate. Coupled with this influx is a continuation of the trend towards urbanisation, particularly to the greater Dublin region. The National Spatial Strategy is being developed to provide a framework for a more even national expansion and growth. The trend towards urbanisation however is likely to continue.

Globalisation

Globalisation means that borders between individuals, organisations, societies and cultures are diminishing. Globalisation is driven by many factors including: advances in information technology and communications; international travel and commerce; as well as the growth of multinational business. These innovations have accelerated the development of globalised systems of health care and a globalised workforce. This is evidenced by the fact that patients now select, and in some cases are given the option to travel in order to obtain the necessary treatment. In addition, Ireland is now moving towards a more multi-ethnic/multi-cultural society. In health, this presents a need to plan for diversity, with a wider range of needs to be addressed affecting both the nursing and midwifery workforce and user groups.

Ageing population

Population trends will have an important impact on the demands and pressures in the health system in the future. Population projections for the next 20 years show that not only will the population increase but also the number of older people will form a larger portion of the population (Figures 5.4-1). Use of health and personal social services increases with age — not just services specifically for older people, but all personal and social services.

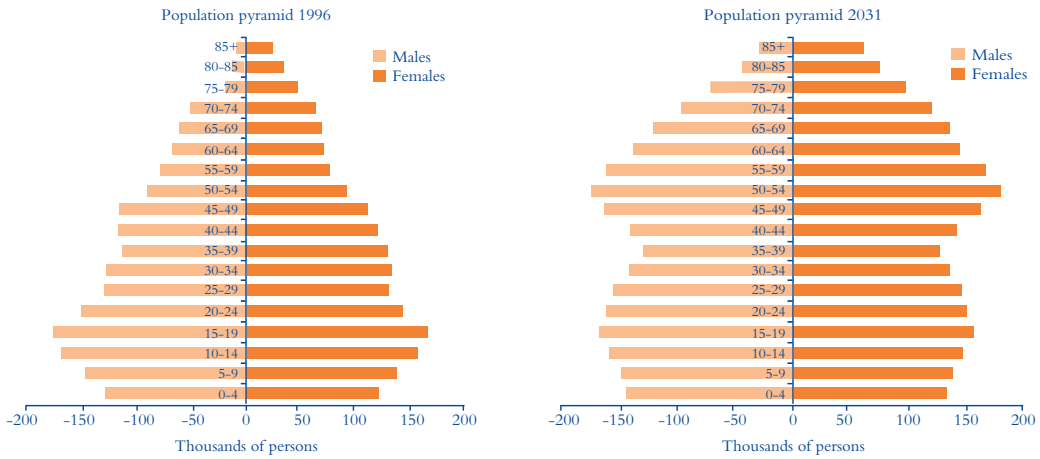
FIGURE 5.4-1

Irish population projections

Source: Central Statistics Office

FIGURE 5.4-1

Irish population projections



Source: Central Statistics Office

Life expectancy

The Health Strategy (2001) highlights the fact that life expectancy at birth has substantially increased for Irish women and men over the past four decades, although life expectancy is still poorer for men (73.4 years in 1997) than for women (78.6 years in 1997). Life expectancy has also increased in older age groups. However, this increase is relatively small. For example, the increase between 1970 and 1997 was only 1.7 years for males and 2.5 years for females. Despite improvements, Irish life expectancy at age 65 years was still the lowest of all 15 EU countries in 1997.

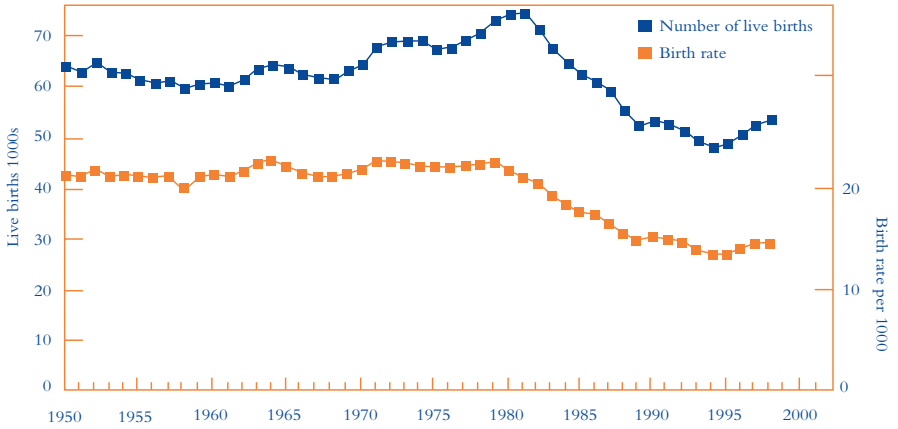
Improvements in life expectancy in Ireland reflect the lower mortality rates seen in infants and young children over recent years. The increases in life expectancy at birth contrast with the relatively small increases for older people, for whom the prevention and management of chronic conditions continue to represent a major challenge. An additional demographic feature is the progressive ageing of the older population itself, where the fastest growing age segments are in those in the 70s and 80s groupings. Figure 5.4-1 presents the population pyramid estimated for 2031. It is evident that the requirement for nursing care for older people will intensify over the coming decades.

Birth rate

While the increasing older population is perhaps the most distinctive feature of the changing population pattern there are other important demographic trends. Birth rates in Ireland peaked in the 1970s. In the 1980s through to the mid 1990s there was a marked decline in birth rates. Since 1996 there has been a reversal in this trend (see Figure 5.4-2). These changes have been attributed to changes in the migratory trends. Migration in Ireland has traditionally focused on emigration. In recent years however this has changed significantly, with fewer people choosing to leave the country and increasing numbers of emigrants returning home. Ireland has also become a popular destination for people from other countries. The migrants currently coming to Ireland are primarily in the 25-40 age-group and will therefore be accessing maternity and paediatric services. To meet the needs of all ethnic groups within Irish society nurses and midwives need to develop new knowledge and skills in communication and cultural awareness. The continued increasing birth rate is a very important feature which must be considered when planning human resource requirements for future maternity and paediatric nursing services.

FIGURE 5.4-2

Births, numbers and rates 1950-1998



Source: Central Statistics Office

The young population

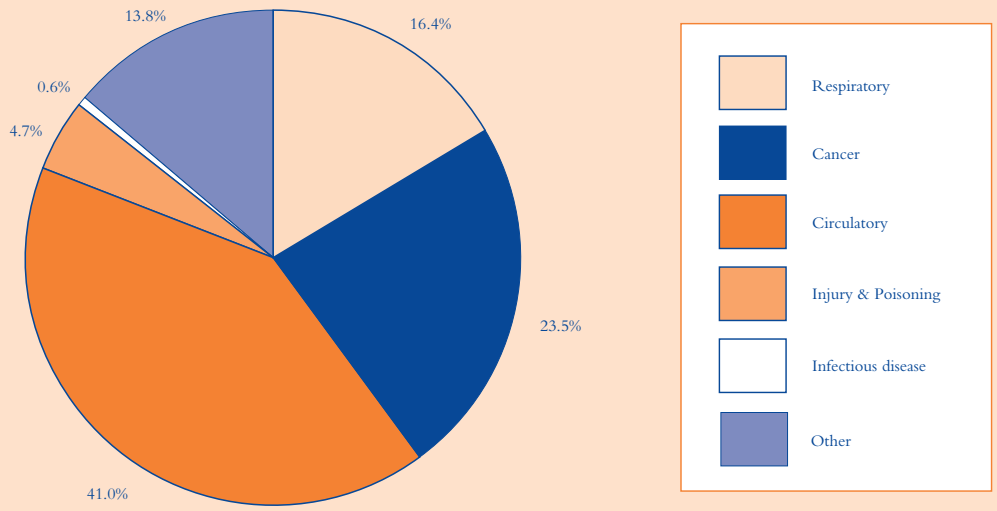
The 1996 census showed that there were 1,137,057 children, 18 years of age or younger, living in Ireland (details for the 2002 Census will be available mid-2003). This number represents 32 per cent of the total population and is higher than the European average (Department of Health and Children, 1999). These numbers may drop slightly over the next two to three decades, according to the CSO population projections, but the young will continue to constitute a very significant and increasingly diverse proportion of our population. Healthy children are more likely to grow to become healthy adults and events in childhood determine well-being in adulthood. Societal changes have significant impact on family structures. Fewer families reflect the traditional model. The increasing number of lone parents, the growing number of men involved in child care and extended family arrangements means that, for many people, caring is becoming increasingly complex. The health and nursing care needs of children are diverse and require specific consideration in the workforce-planning context.

Major causes of mortality

Circulatory disease and cancer account for nearly 65 per cent of deaths every year in Ireland (Figure 5.4-3). The relative contribution of cancer to overall mortality has been increasing in recent decades. For example, cancer accounted for only 11 per cent of overall mortality in 1950 compared with 25 per cent in 1999. This pattern is likely to continue in future years due to current population trends and it highlights the need for nurses with specialist knowledge and skills in the care of patients with cancer.

FIGURE 5.4-3

Mortality by cause, all ages, Ireland 1999



Source: Central Statistics Office

Public Health Information System

The Public Health Information System (PHIS) is a database and software application developed by the Information Management Unit of the Department of Health and Children which allows health indicator data to be mapped, graphed and analysed by county, health board and over time. The system is distributed on CD ROM and is supported in particular by the public health departments within the health boards where it is used extensively. The system includes detailed vital statistics data on fertility and mortality, and also provides baseline population data as well as projected populations. It incorporates hospital

inpatient information derived from the Hospital Inpatient Enquiry (HIPE) and summary cancer incidence figures supplied by the National Cancer Registry. The latest version (version 6) has a number of improved software enhancements and will be released by end 2002.

Mental health

The National Psychiatric In-Patient Reporting System (NPIRS) provides a vital source of information for planning mental health services. Data on in-patient psychiatric facilities are obtained from the computerised database set up in 1963 and maintained by the Health Research Board. The *Report of the Activities of the Irish Psychiatric Services* (Daly and Walsh, 2001) is another important resource for planning. It presents data on: admissions to and discharges from psychiatric in-patient facilities; a census of the in-patient population at the end of the year; and the activities of community psychiatric services.

The Health Strategy (2001) indicates that mental health is recognised increasingly as a major challenge facing health services in the twenty-first century. In 2000, there were 24,282 admissions to Irish psychiatric hospitals, a rate of 901 per 100,000 population aged 16 years and over (National Psychiatric In-Patient Reporting System). Of these, 7,290 (30 per cent) were first admissions. First admission rates have shown little change over the past 35 years, whereas all admission rates have increased by almost 50 per cent. At the end of 2000 there were slightly more than 4,000 patients in Irish psychiatric hospitals, compared with over 20,000 forty years earlier in 1960. In 2000, 79 per cent of in-patients were resident in health board hospitals, 12 per cent in general hospital psychiatric units and 9 per cent in private hospitals. This is a remarkable change in the provision of mental health care services. Lengths of stay in hospital have decreased, illustrating a move towards more frequent crisis intervention use or short in-patient treatment combined with more extensive community-based care.

In Ireland, it has been estimated that 10 per cent of the general population suffers from depression and 1 per cent from schizophrenia (Health Strategy, 2001). It is likely that the numbers of people presenting to the mental health services for treatment will increase in the coming years, due in part to the modernisation of the services and the reduction in the stigma associated with their use. The ageing population and the increasing incidence of social phenomena such as drug abuse and family breakdown is also likely to contribute to increasing demands for mental health nursing services in the future.

Intellectual disability

The annual report of the National Intellectual Disability Database Committee (NIDD) (Mulvany, 2001) indicates that in April 2000 there were 26,760 people registered with the database, with a prevalence rate of 7.38 / 1,000 total population. Of this population 55 per cent were assessed as having moderate, severe or profound intellectual disability. This represents a figure of 14,741 persons and it is widely acknowledged that it is these groups of people who, in the main, will require services that are delivered by nursing staff.

The NIDD provides needs assessments of people with intellectual disability for the years 2001-2005. Three distinct categories of need were identified as follows:

- Unmet need: people who have no service whatever
- Service change: those people who already have an intellectual disability service but will require that service to be changed or upgraded
- Persons accommodated in psychiatric hospitals: those who need to transfer out of the psychiatric services for both residential and day services.

The key features outlined in the *Assessment of Need 2001-2005* (Department of Health and Children, 1997) are set out below.

- There is decrease in the numbers of children in the more severe categories of intellectual disability, reflecting the decline in the birth rate during the 1980s and early 1990s and improved

obstetric care. However, it should be noted that a number of children born in the late 1990s are presenting with more severe management difficulties and associated medical fragility including pervasive developmental disorders.

- There is an increase in the size of the ageing population in the more severe range of intellectual disability. A cohort effect, whereby a high incidence rate of intellectual disability in the 1960s is now reflected in the relatively large numbers of adults who have survived. This suggests that the increase in numbers has resulted in the following:
    - an increased demand for residential placements
    - fewer places becoming free because of increased life-expectancy; hence the role of the mental handicap nurse in the community needs to develop and expand to meet the needs of individuals and their family in their own home
    - an increased need for therapeutic support services for people who continue to live with their families in order to enable this caring arrangement to continue, e.g. facility-independent community mental handicap nursing teams
    - an increased demand for more intensive services such as assessment and respite, developmental education centres, behavioural support, mental health services etc
    - an increased demand for services designed specifically to meet the needs of the older person with an intellectual disability.

Since 1999, the numbers in receipt of full-time residential services has increased in the moderate, severe and profound categories. There is a clear relationship between level of disability, age and use of services. Day services tend to be accessed by younger individuals of higher ability, whilst primarily older people with moderate, severe and profound levels of intellectual disability use residential services. These patterns can inform future service developments. The patterns are also crucial in informing workforce needs, with particular reference to nursing requirements for intellectual disability services in the future.

Demography summary

Based on past trends and current patterns, the Health Strategy Consultative Forum (Futures sub-group) identified the demographic trends for Ireland over the next 10 years. The broadly representative group set aside time to consider the issue in some detail. Their conclusions form a sound base that can be used by other planners. These are set out below:

- The population of the Republic of Ireland is likely to be in the region of 4.5 million by 2010.
- There is already a disproportionate concentration of the country's population in the greater Dublin area, and this trend is set to increase over the next 10 years, if unchecked.
- Infant mortality rates in Ireland will continue to decline in line with the EU average.
- Trends in perinatal mortality rates will continue to decline, but will remain above EU average.
- Male and female life expectancy at birth will continue to increase, although a gap is identified relative to the EU average.
- Female life expectancy is likely to continue to be higher than male life expectancy.
- The principal causes of morbidity in Ireland will continue to be circulatory diseases, respiratory diseases, cancer, mental health problems and accidents.

- There is a significant increase in mental health problems nationwide, with a high suicide rate, especially among young males.
- The mortality rate in Ireland will continue to be higher than the EU average, due largely to the much higher levels of cancer (in particular lung cancer and breast cancer) and ischaemic heart disease.
- Lifestyle issues have a major bearing on mortality and morbidly rates (Consultative Forum, Futures Sub-Group, 2001).

Against this demographic background, more subtle and changing social influences further affect health. In Ireland, the following social patterns are becoming important:

- Demographic changes are resulting in an older population.
- Migration within the state is leading to greater urbanisation, particularly in the east.
- Family structures are changing with more households requiring a dual income.
- Housing costs are outstripping the ability of many families to service a mortgage.
- Increased marginalisation is leading to increased criminality.
- Greater social inequalities are leading to deep concentrations of poverty in Irish society.
- Educational opportunities are not equally spread across all sectors of society (Consultative Forum, Futures Sub-group, 2001).

This section of the report visibly points to the impact that demography will have on the requirement for nursing and midwifery services in the future.

5.4.2 Health system developments

Developments in the health system have a direct and major influence on the environment in which nurses and midwives practise. This section highlights the principal developments that will impact in the future. These are: the Health Strategy (2001); the proposals for primary care; the review of the acute hospital bed capacity; the Report of the Committee on Accident and Emergency Services; the cardiovascular and palliative care strategy; the audit of value for money in the health system; the publication of the national health information strategy; the Heath Services National Partnership Forum; service planning; and an increase in entitlements for medical cards.

National Health Strategy

The Health Strategy, published in November 2001, sets out the blueprint for the development of the health and personal social services over the next 10 years. The strategy describes the composition and quantum of services that will be developed over the next decade. In this regard the inclusion of an action plan which specifies the deliverables, timescale and responsibility for each of the 121 actions, is very helpful. The action plan gives a clear indication of the nursing and midwifery resource required to give effect to the goals and objectives of the strategy. Almost all the actions have relevance for nursing and midwifery services. A selection of the actions that will have a particular impact on the number of nurses and midwives required for the workforce are set out in Table 5.4-1.

Table 5.4-1 – Health Strategy actions influencing nursing and midwifery

- Extension of the breast and cervical cancer screening programmes (Action 11)
- A revised implementation plan for the National Cancer Strategy (Action 12)
- The Heart Health Task Force to monitor and evaluate the implementation of the prioritised cardiovascular health action plan (Action 13)
- A policy for men's health and health promotion to be developed (Action 15)
- Measures to promote sexual health and safer sexual practices (Action 16)
- Implementation of Travellers Health Strategy (Action 20)
- Implementation of 'homelessness — an integrated strategy' and Youth Homelessness Strategy (Action 21)
- Implementation of the National Drugs Strategy (Action 22)
- The health needs of asylum seekers to be addressed (Action 23)
- A new action programme for mental health to be developed (Action 25)
- An integrated approach to meeting the needs of ageing and older people to be taken (Action 26)
- A comprehensive strategy to address crisis pregnancy to be prepared (Action 28)
- An action plan for rehabilitation services to be prepared (Action 30)
- A national palliative care service to be developed (Action 31)
- Full implementation of the AIDS Strategy (Action 33)
- A plan for responsive, high quality maternity care to be drawn up (Action 58)
- A review of paediatric services to be undertaken (Action 59)
- A national review of renal services to be undertaken (Action 60)
- Organ transplantation services to be further developed (Action 61)
- A new model of primary care to be developed (Action 74)
- Additional acute hospital beds (3,000) to be provided for public patients (Action 78)
- Management and organisation of waiting lists to be reformed (Action 82)
- A substantial programme of improvements in accident and emergency departments to be introduced (Action 86)

Source: Health Strategy *Quality and Fairness: A Health System for You* (2001)

The extent of the capacity-development required can be appreciated by the detailed list of developments outlined above. The programme of investment envisaged to provide the necessary capacity in primary care, acute hospitals and long-stay units will require significant numbers of additional nursing staff. Of particular relevance is: the increase in acute hospital beds by 3,000; the introduction of 1,370 additional assessment and rehabilitation beds in hospitals and 600 additional day places for specialist areas; and the opening of 7,000 additional day centre places in the community for older people. The investment will be incremental and the new developments will be introduced over the next 10 years. The exact number of nurses and midwives required for the expansion in services will need to be carefully planned.

Proposals for primary care

Strengthening primary care is one of the six frameworks for change set out in the Health Strategy. The detailed proposals described in the accompanying document *Primary Care: A New Direction* are designed to reorient the health services towards primary care — as the first and ongoing point of contact with the health system. The proposal is for the introduction of inter-disciplinary team-based services, locally available twenty-four hours a day seven days a week. Central to the proposal is the establishment of primary care teams and associated primary care networks. In the long term approximately 600-1,000 primary care teams will be required nationally (based on a population of 3.8 million). Nurses and midwives will be key members of the inter-disciplinary primary care team. The number and ratio of team members will depend on needs assessment, location and population size served by the team. The nurse /midwife function may include advanced nurse practitioners, clinical nurse specialists, public health nursing, midwifery, mental health, practice nursing and general nursing competencies. For illustrative purposes the document estimates that approximately an additional 500 GPs and 2,000 nurses/midwives will be required assuming two-third implementation (400-600 teams) over the next ten years. The changes are focused on improving health by access for all to primary care services, especially out of hours, and improving links between primary and secondary care. The scale of the developments will result in an increase in the demand for nursing and midwifery services.

Review of acute hospital bed capacity

A report of the national review of acute hospital bed capacity was published in January 2002. The review was carried out by the Department of Health and Children in conjunction with the Department of Finance and in consultation with the social partners. Changes in bed capacity over the period 1980-2000 were examined. The focus of the report is on bed capacity in publicly funded acute hospitals. In 1980, approximately 8,000 day case treatments were recorded, constituting 2 per cent of all non-outpatient care. In 2000, there were approximately 320,000 day-cases, representing 38 per cent of all hospital activity and 68 per cent of elective hospital activity. The average length of stay is now 6.6 days, reduced from 9.7 days in 1980. Estimating future demands, particularly demand for hospital services, is not an exact science and the review outlines a range of variables which affect the determination of acute hospitals' bed requirements. These are: acute bed occupancy levels, waiting lists, advances in medical technology, increasing expectations/demand, projected demographic changes, reforms to outpatient departments and accident and emergency services, reformed primary care, substitution of inpatient with day procedures, measures to reduce delayed discharge, adherence to public-private mix ratio, improved efficiency in hospital, recent population changes and current acute hospital activity.

The Government has announced that it will provide for an additional 3,000 acute hospitals beds by 2011. This was informed by the detailed analysis and having particular regard to the developments in relation to primary care and services for older people envisaged in the Health Strategy. There will need to be a substantial increase in the number of nursing staff with the relevant competencies to equip them to care for patients who will be treated in the additional beds. The National Hospitals Agency, recommended for establishment by the Health Strategy, will determine the most appropriate distribution of the additional capacity by specialty and region in consultation with health boards, the Eastern Regional Health Authority, professional bodies and other relevant interests. It is vitally important that workforce planning for nursing is built into this process.

Report of the Committee on Accident and Emergency Services

A report on Accident and Emergency Services was published by Comhairle na nOspidéal in February 2002. The report is based on the outcome of an extensive consultative process (written submissions and meetings with key stakeholders); analysis of statistics on attendances at emergency departments; and a review of pertinent literature. The report examines and makes recommendations on the provision of emergency services in public hospitals in the Republic of Ireland. It explores factors that affect the efficiency and effectiveness of services and deals with emergency trauma policy and staffing. The central role of nursing staff in the delivery of emergency care is acknowledged in the report. The Committee endorced the direction of the National Council in developing the framework for the position of Advanced Nurse/Midwifery Practitioners and welcomed the policies and developments taking place in relation to extending the role of nurses in emergency departments in the future.

Cardiovascular and Palliative Care Strategy

Policy documents in relation to cardiovascular health and palliative care services contain some recommendations that should be taken into consideration when considering ratios for nurse staffing. The Advisory Forum on the cardiovascular health strategy identified a programme of work for 2001-2004 which sets out the priorities in implementing the 211 recommendations in the report *Building Healthier Hearts* (Department of Health and Children, 1999a). Priorities are set for each year. The issue of nurse staffing levels is identified as a key issue. The document states: 'in relation to hospital services — nursing staffing levels should be examined as a matter of urgency' (p 14).

The Minister launched the report of the National Advisory Committee on Palliative Care on 4 October 2001. The report sets out a series of recommendations on how palliative services should be provided.

Of particular interest are the recommendations made for minimum staffing levels of specialist palliative care nurses required in different care settings. This is one of the first policy documents to set out in numeric terms the minimum ratio of nurses required for a specialist area. The recommendations for staffing in the report were determined by the consensus of the committee, having regard to its expertise in the area and having consulted available literature.

Audit of value for money in the Irish health system

A value for money audit of the Irish health system was commissioned by the Department of Health and Children and undertaken by Deloitte and Touche and York Health Economics Consortium. The full report was published in November 2001. The main conclusion was that significantly increased and sustained investment in both human resources and the health information infrastructure are required in order to meet the complex information requirements for delivering and managing a high quality health service. The report indicates that, other than anecdotally, the health sector is unable to demonstrate definitely that value for money (VFM) is being achieved, although there are pointers to suggest good VFM in some areas (p 289).

In relation to health human resources the audit stated that the level of staff shortages in the health system is of particular concern and indicated that formal structures and processes need to be in place to support detailed human resource planning. The authors recommended a fundamental assessment of particular skills requirement in the system (p187). It was advised that the assessment should stem from needs assessment being carried out as part of service planning and resource allocation. The ongoing requirement for all clinical roles should then be determined and assessed against what the education system is geared to deliver. The conclusion is that co-ordinated workforce planning is urgently needed across the entire health sector.

National Health Information Strategy

In April 2000 the Minister for Health and Children established a steering group to prepare a National Health Information Strategy (NIHS). Many common themes emerged during the consultation process undertaken to inform the development of the strategy which are also identified in this report. The NIHS strategy is being primarily developed in order to support the achievement of the vision, goals, and objectives set out in the Health Strategy. The NIHS will provide the framework for ensuring that all the dimensions of the health sector are fully supported by top quality health information. Of particular importance is the information required for health human resource planning. Workforce planning is based upon information and the accuracy of the outcome is dictated by the quality of information. The establishment of the Health Information and Quality Authority set out in the Health Strategy (2001) will pay a pivotal role in the process. The independent statutory authority is to be responsible for:

- developing health information systems
- promoting and implementing a structured programme of quality assurance
- reviewing and reporting on a selected set of services each year
- overseeing accreditation and developing health technology assessment.

The NIHS strategy is to be published later this year. It will set out a framework which will allow for technical standards for information, the use of minimum datasets, data definitions, coding standards and the use of unique identifiers. This strategy will have an important function in ensuring the availability of requisite information for health human resource planning.

Health Services National Partnership Forum

The Health Services National Partnership Forum was set up in 1999. The forum underlines the role of staff at all levels beyond the basis of service delivery in finding solutions to shared concerns in the workplace. A Health Services National Partnership Office was established as a central facility to promote and facilitate the implementation of partnership within the health service. Eighteen facilitators have been employed by the Office to assist parties, through a process of consensus building, problem-solving and project delivery to achieve the goals and objectives of the health services partnership agreement. Partnership committees have been established in health boards and other organisations. The committees are developing jointly agreed agendas for actions. Local partnership working groups are taking on the agenda and developing and implementing changes and improvement for patients, clients and staff. The partnership structures provide an important vehicle to engender a culture of involvement and participation by managers, staff and trade unions with the ultimate aim of improving and providing the highest quality service to patients and clients.

Service planning

Under the provisions of Section 6 of the Health Amendment Act, 1996 health boards are required within 42 days of the receipt of their (financial) determination, to adopt and submit a service plan to the Minister. The service plan must contain a programme/care-group-based presentation of the board's services for the year in question. Part of the process also involves the preparation of a more detailed operational plan. All service expansions and new developments are highlighted in the service plan together with the strategy for the human resources necessary to deliver on the key priorities. It is immensely important that nurses and midwives are consulted during the preparation of service plans within each organisation. The *Empowerment of Nurses and Midwives Steering Group* (see Section 4.6.1) established a sub-group to examine ways in which nurses and midwives would become more fully involved in the service planning process. The outcome sought is that the process would give nurses and midwives an opportunity to:

- access the service plan documentation
- be part of the review of the service plan for the current year
- shape and influence decision-making on what is proposed for the next year's service plan in relation to their area of practice
- receive feedback on progress in relation to implementation of the service plan as it relates to their areas.

The chair of the empowerment steering group issued guidelines to the CEOs of health care agencies in 2001 regarding preferred practice for involvement of nurses and midwives in service planning. A training video was prepared to illustrate best practice in service planning across all divisions of nursing and midwifery and widely distributed thoughout the health system in 2001. A guidance book is currently being prepared to assist nurses and midwives in participating in the service planning process.

Increase in entitlements for medical cards

The system of eligibility for services greatly influences the patterns of demand for nursing and midwifery care. The Health Act, 1970 provides the foundation for the assessment of eligibility for health services in Ireland. The Health Strategy (2001) described this in the following terms:

> any person, regardless of nationality, who is accepted by the health boards as being ordinarily resident in Ireland, is eligible for health and personal social services. About one-third of the population holds medical cards, which entitle them to receive services free of charge. Non-medical

cardholders are entitled to some services free of charge. Effectively, everyone has coverage for public hospital services with some modest charges, and some personal and social services, but only medical cardholders have free access to most other services (including general practitioner services) (p 43).

Eligibility for medical cards is based on a notion of 'hardship'. This is defined by income guidelines drawn up by the health board CEOs, which are used as a means test to determine eligibility. An example of the threshold guidelines are as follows: for a single person living alone (under 66) it is currently €132 per week and for a married couple (under 66 years) it is €190.50 per week with additional allowances for children under 16 and dependent others. The Health Strategy (2001) commits to increasing the income guidelines for the medical card, thereby increasing the percentage of the population entitled to free medical services. It also proposes four extra GP visits under the Maternity and Infant Care Scheme to cover general childhood illness and the introduction of a pilot home subvention scheme. The likely impact on the workload of practice nurses, public health nurses and general nurses working in the community can be appreciated. It is essential that plans are made for the expansion of human resources necessary for the expansion in access to services. The experience of the recent expansion of the medical card scheme to the entire population over 70 years of age provides a real example of the planning required when making significant changes to the system of eligibility.

5.4.3 National developments

National developments influence the environment within which nurses and midwives practise and are therefore important considerations when examining future requirements. The main influences identified during this study were: participation and buoyancy of the Irish labour market; the National Anti-Poverty Strategy health targets; outcome of the benchmarking studies; the progress of the national development plan; the publication of the spatial strategy; and developments in other services with a large requirement for health care such as the prisons.

Participation in the Irish labour force

The significant growth in the Irish economy in recent years has allowed for substantial additional investment in the health services, including the introduction of additional nursing and midwifery positions. Sustained investment is dependent on a buoyant economy. There has been a significant change in the general employment market during the three-and-a-half years of this study. In December 1998 the seasonally adjusted unemployment rate was 6.4 per cent. This decreased steadily each month (4.7 per cent by December 1999 and 3.6 per cent by December 2000) until the end of 2001 when the number unemployed started to rise again (4.0 per cent December 2001). The interim report of this study highlighted a cycle of inflows and outflows from the Irish labour market, which are directly related to the economic circumstances prevailing at the time. The change over the life of this study gives an indication of the volatility of the labour market and the speed with which the environment can change. The general unemployment rate is currently at 4.3 per cent (June 2002). The buoyancy of the general labour market has an impact on the nursing and midwifery workforce. The extent to which nurses and midwives are likely to remain in employment in the health service, seek jobs outside the health service, or leave employment altogether is influenced by the perceived availability of alternative positions.

National Anti-Poverty Strategy targets for health

At the United Nations world summit for social development held in Copenhagen in March 1995, the Irish Government, together with other governments, endorsed a programme of action aimed at reducing overall poverty and inequality throughout the world. Arising from this commitment, an inter-departmental policy committee prepared the *National Anti-Poverty Strategy* (NAPS) for Ireland, which

was launched in 1997. The Government gave a commitment in the Programme for Prosperity and Fairness to review the *National Anti-Poverty Strategy* across all relevant Government departments and to develop NAPS targets in the health area with an associated monitoring and implementation framework. The aim of the NAPS health targets, prepared in 2001, is to reduce health inequalities and associated poverty. Future practice should include input for nurses and midwives in poverty proofing significant health policy developments and the delivery of services in a manner which takes account of the varying needs of marginalised and excluded groups. The potential to lead on and support advocacy programmes on behalf of client groups and communities is significant for nurses and midwives.

Benchmarking

A public sector benchmarking body was established by the Government and reported on the 30 June 2002. Grades examined by the body were agreed between the public sector employers and the Public Services Committee of the Irish Congress of Trade Unions. These grades comprise what is known as 'List A'. All other relevant grades are listed as 'List B' grades, with defined relationships with a specified 'List A' grade. The 'List A' grades selected for nursing are as follows: staff nurse, clinical nurse manager 1, 2 and 3, assistant director of nursing, director of nursing, principal nurse tutor, public health nurse and nurse tutor. This is the first ever job-evaluation exercise of such a widespread nature within nursing in Ireland. The work of the benchmarking body took place in several stages: collection of factual information; written statements by employers and trade unions; observation/comments on submissions; research conducted by consultants on behalf of the benchmarking body; further written statements and oral presentations; and finally conclusions and recommendations. The recommendations are grounded in a coherent and broadly based comparison with jobs and pay rates across the economy. The report, published in June 2002, should have an impact on the ability of the health service to attract nurses and midwives to seek promotion in the future.

National Development Plan

The National Development Plan (NDP) involves an investment of over €52 (£40) billion of public, private and EU funds over the period 2000-2006. The plan provides for significant investment in the health service. The NDP will involve a total capital investment of €2.5 (£2) billion in the health sector. The priorities for the investment are to: provide facilities for persons with an intellectual disability; develop a range of facilities for older people; address major needs in the provision of modern accommodation for people with a mental illness and people with a physical disability; provide a comprehensive, quality and accessible acute hospital infrastructure; address child care needs; and maximise the potential of information and communication technology (ICT) in the health care sector. An update on the implementation of the plan can be located on the NDP website http://www.ndp.ie/newndp/. The capacity expansion to be achieved through the NDP will require matched planning for health human resources, particularly for the nursing and midwifery resource.

National Spatial Strategy

The National Spatial Strategy is currently being prepared by the Department of the Environment and Local Government and is due for publication in 2002. The strategy will provide a broad planning framework for the location of development in Ireland over the next 20 years. It will identify potential development patterns for different areas and set out overall policies for creating the conditions necessary to influence the location of different types of development in the future. In-depth research has now been completed on a range of issues such as location of enterprise, quality of life issues, infrastructure and population and labour force trends. Summaries of these findings can be located on the National Spatial Strategy website www.irishspatialstrategy.ie. A consultation paper *Indications for the Way Ahead* was published in September 2001. The work has concluded that the approach to achieving balanced regional development that shows most promise is one based on the following:

- Strengthening the number and distribution of strong players — urban centres — possessing the right characteristics of size, population, infrastructure and competitiveness and with the ability to energise the potential of surrounding urban and rural areas
- Building upon the different characteristics and capabilities of various areas through matching policies and local circumstances. In considering cities, towns, rural areas and the economic and social links between them, Ireland can be viewed in terms of a number of functional areas
- Developing these functional areas by energising them through focusing in each on the strengths of a limited number of places in a way which allows all parts of these areas to realise their potential for economic and social development (Department of Environment and Local Government, 2001).

The strategy will determine the locations of population development and the necessary services in the future. The outcome of the discussions and the Spatial Strategy when published should be considered when planning health human resources.

Prison services

The report of the *Group to Review the Structure and Organisation of Prison Health Care Services* was published in May 2001. The report set out 43 separate recommendations for the development of: primary medical and nursing services; psychiatric, dental, pharmacy and drug treatment services within the prison environment; and secondary medical care. The first nurse officers were introduced into the prison system in March 1999. Existing prison staff may, if suitable, be seconded to train as nurses. By May 2001 there were 53 nurse officers providing nursing services in the prison system. At the time 12 of the 17 prisons in the country did not have a nursing service. This gives an indication of the demand for development in the future. The report recommends a promotional structure for nursing with the introduction of a new nurse manager role.

5.4.4 Science and technology

Among the principal drivers for demand for service is the rising importance of the internet and the greater expectation from the public of health providers. Technology has democratised information and in the process shifted the points of access and control from the professional to the educated public. The development of software that makes it easy to browse, search and download information has led to this change.

In the future there will be an increasingly better-educated public with growing expectations in relation to the quality and choice of services they receive. Through the use of information technology those attending clinics or being admitted for care have often accessed information regarding their condition and treatment options on the internet. The relationship between the client and professionals, particularly health care professionals, is changing. This has been characterised as follows:

> the previous model of paternalism, with decisions on a person's health care being dispensed by a doctor or nurse, is now being replaced by a co-operative partnership, with patients taking responsibility for their own health, and being aided to reach decisions on treatment in co-operation with a doctor, nurse or other health care professional (Consultative Forum, 2001).

Cures for potentially fatal disease, other more advanced diagnostics, biotechnology applications, tissue engineering, imaging capacity, progress in laser technology, minimalist and robotic surgery, and advances in drug development, all hold the possibility of lengthening life and improving its quality. Such advances will impact greatly on the environment in which nurses and midwives practise and also on the knowledge

base and skills required to provide care in new ways. Information technology (IT) advances are also likely to revolutionise nursing and midwifery care. Massive growth in individual IT access and the greater integration of health care IT systems will provide many more options for care delivery modes. The concept of health telematics has given rise to tele-medicine, tele-education and tele-nursing. Tele-nursing is the practice of nursing over distances using telecommunications technology (The National Council of State Boards of Nursing, 1997). These advances include access to a variety of patient care databases; opportunities to share and work to standardised evidence-based protocols and decision-support systems; and the possibility of remote consultations/care through telematics. The advent of the 'virtual' nurse will impact on the demand for nursing and midwifery services.

The Health Strategy (2001) highlights the fact that the availability of new treatments and technologies will bring greater demands for new services, some with major ethical implications that will impact on the practice of nurses and midwives. The application of technology in the prevention and management of disease has given rise to mapping of the human genome, developments in organ transplantation, the advent of function-enhancing bionics, together with high-cost diagnostic devices. Increased access to information will continue to create a heightened demand for high-tech interventions and therefore greater levels of participation in clinical decision-making. In the future sophisticated robots, capable of monitoring vital signs and blood electrolyte and oxygen levels, will be available. More professional nurses will find themselves in the role of clinical evaluator using expert assessment skills to help families and care givers make decisions about types of treatment or referrals to other levels of care. Hence technological sophistication is creating unparalleled ethical questions and conflicts while bringing about critical diagnostic and therapeutic development. The preparation of nurses to understand this relationship and be skilled in enabling individuals maximise health opportunities will present a serious challenge.

Technological advances are set to revolutionise the world in which health care operates. Consideration of such developments must be built into any system devised for the projection of future nursing and midwifery requirements.

5.4.5 Developments in nursing and midwifery

The single biggest influence on contemporary nursing and midwifery practice in Ireland is *The report of the Commission on Nursing* published in 1998. The report and its 200 recommendations set out the framework for the development of nursing and midwifery, regulation, practice, education, management, professional development and research. Substantial progress has been achieved on the implementation of the recommendations. The progress is chronicled in the annual reports published in 2001d and 2002a by the Monitoring Committee established to oversee the implementation of the recommendations (available on the Department of Health and Children Website http://www.doh.ie/publications/imprec.html, and http://www.doh.ie/publications/conpr2.html). The recommendations of the Commission will continue to be the driving force and influence on nursing and midwifery in Ireland. An overview of some of the major developments arising from the *Report of the Commission on Nursing* are set out in the sections below.

Nursing and midwifery leadership

Leadership is a vital ingredient in the development of any profession. Leaders create visions, climates, conflict, change, and new leaders (Manfredi, 1995). Leaders are charged with the responsibility of creating a vision and providing direction. Charisma, consideration of individuals and intellectual stimulation are considered essential components of leadership (Bass, 1990). Charismatic leaders have been found to provide followers with a vision and a sense of mission that instils pride and trust and gains respect. They also foster inspiration, raise confidence, and communicate high expectations. Followers emulate leaders by trusting and accepting the visions and values that are presented (Bass, 1987). Effective leadership is

based on the full involvement of followers and on seeking opportunities to energise and empower through individual attention, personal advisement, and mentoring (Dunham-Taylor *et al*, 1993). The essential role of leaders was clearly acknowledged by the Commission on Nursing (1998) who highlighted the ongoing need for support and leadership development of nurses and midwives. The report of the *Nursing Management Competencies* (Rush, McCarthy and Cronin, 2000) emphasised the central role of leadership competencies of front-line, mid- and top-level managers. The Office for Health Management has responded by establishing a series of programmes specifically targeted at harnessing the leadership potential of nurses and midwives. Johnson and Johnson in conjunction with the Kings Fund offers a leadership programme which provides a major opportunity for nurses to achieve a strategic-level position. It is unique in its focus on the profile of the nurse leader of the future and was developed with the support and advice of over 100 people in the NHS. Its emphasis is on personal impact and learning through experience. Since 2001 this programme has been made available to three candidates from the Republic of Ireland.

The drive of leaders will be critical to the future development of the nursing and midwifery profession and service delivery.

Establishment of the regional Nursing and Midwifery Planning and Development Units

The Commission on Nursing (1998) highlighted the need for planning to take place at a regional level. The report stated that:

> the rapid development of nursing and midwifery, the increasing opportunities for nurses and midwives to focus and specialise in their practice, raises concerns in relation to the potential for increased fragmentation of the nursing and midwifery service. These developments will require the effective planning of the nursing and midwifery resource, particularly in identifying the educational and skills requirement of nursing and midwifery within a health board area (Para 7.15).

One of the principal functions of the units is to plan strategically and assure the quality of the nursing and midwifery services for the health board region. It is envisaged that these units will play a lead role in monitoring and forecasting the workforce requirements for nursing and midwifery in their region. Each of the forecasts will then be brought together in the development of national forecasts for future nursing and midwifery resources. The positions of directors of the Nursing and Midwifery Planning and Development Units were filled over the last two years. The role description for the directors places a large emphasis on their part in planning the future workforce requirements for the region.

Enhanced promotional opportunities

The recommendations of the Commission on Nursing gave rise to substantially increased promotional opportunities for nurses and midwives not only in management but also through the establishment of a new clinical career pathway. An outline of the enhanced opportunities available in recent years is set out in the following sections.

First line nursing and midwifery management

The Commission on Nursing recommended (Para 7.45) a new first line management structure comprising three grades:

- clinical nurse or midwife manager 1 (reporting to a clinical nurse or midwife manager 2)
- clinical nurse or midwife manager 2 (in charge of a ward or unit of care)
- clinical nurse or midwife manager 3 (in charge of a department).

The Commission noted that it would be extremely rare for all three levels of nursing and midwifery management to be operating in the same unit. However, it recognised that in certain areas the complexity and level of activity could justify the establishment of a level of first line nursing and midwifery management above that of CNM 2.

Sixty-nine new clinical nurse or midwife manager 3 posts were subsequently established in band one and certain band two hospitals as part of the 1999 nurses' pay settlement. In addition, the Labour Court recommended the creation of at least 25 CNM3 posts in psychiatry over a two-year period (LCR 16261, August 1999). Arising from this, 33 posts were sanctioned in 2000 (1 for each mental health area). While no specific recommendation was made in relation to the intellectual disability sector, the Department of Health and Children considered that there is a positive role for such posts within the larger services which provide specialist and high support nursing services. Proposals for the establishment of CNM 3 posts for this sector are being examined at present.

An additional 1,100 CNM 1 posts have also been approved in line with the criteria in paragraph 7.43 of the Report of the Commission on Nursing. In this context, where the circumstances warranted a CNM 2 post, this was established instead.

Additional promotional posts have since been established in a wide range of band three to five hospitals following agreement reached in 2000 on nurse management structures for these hospitals. Further promotional posts have resulted from agreements reached on the grading of certain positions in the mental health services.

Senior staff nurse posts

A procedure to fill 2,500 posts at senior staff nurse/midwife level was agreed with the Alliance of Nursing Unions as part of the 1999 nurses' pay settlement. The Labour Court recommended the creation of these posts to be paid at a rate of 5 per cent above the staff nurse/midwife rate. This development takes account of the Commission on Nursing (Benner model of skill progression referred to in Chapter 3 and in Para 6.64) and the reality of existing practice within nursing. In practice, in excess of 3,300 nurses have accessed senior staff nurse or midwife positions under this system.

Following the filling of the first quota of posts and the subsequent comprehensive review, the eligibility criteria for the future filling of senior staff nurse or midwife positions was revised. Under the new procedure to be eligible for a senior staff nurses post, a staff nurse must have:

- twenty years post-qualification service (excluding training) on 5 November each year; six of the twenty years must have been in the Irish public health service
- at least three of the last six years served in the Irish public health service
- one year's continuous service with his or her current employer at the date of application.

Clinical career pathway for nurses and midwives

The National Council for the Professional Development of Nursing and Midwifery (National Council) recommended by the Commission on Nursing was created on foot of a Statutory Instrument from the Minister for Health and Children (SI Number 376 of 1999). The mission of the National Council is to promote and develop the professional role of nurses and midwives in order to ensure the delivery of quality nursing and midwifery care to patients/clients in a changing health care environment. To this end the establishment of the clinical career pathway is a function vested in the National Council. This includes the monitoring of developments in relation to specialist and advanced practice. The National Council liaises and works in partnership with directors of nursing or midwifery and the directors of the

Nursing and Midwifery Planning and Development Units. This includes a review of geographic spread, national and local developments and the appropriateness of the clinical nurse/midwife specialist (CNS/CMS) and the advanced nurse/midwife practitioner (ANP/AMP) role development.

There has been a growth in specialisation in nursing and midwifery worldwide. In recognition of nurses and midwives already functioning as clinical nurse/midwife specialists, an Immediate Career Pathway for confirming such nurses and midwives into CNS/CMS posts was developed by the National Council. The closing date for applications under this pathway was 30 April 2001. In future all CNSs/CMSs will be required to have a minimum of five years post-registration experience, two years experience in the specialist area of clinical practice, basic competence level and a higher/postgraduate diploma in clinical practice Future Career Pathway). This will require further development of educational programmes to meet developing health service needs.

In the interim an Intermediate Career Pathway has been developed (National Council, April 2001). The Intermediate Career Pathway came into effect on 1 May 2001 and is the process through which CNS/CMS posts are developed and approved, and suitably qualified nurses and midwives appointed into these posts. This process involves partnership between service providers, the Nursing and Midwifery Planning and Development Units, the Department of Health and Children, the health boards and the National Council. To date 1,364 CNS/CMS posts have been approved (see Table 5.4-2).

Table 5.4-2 – Clinical nurse/midwife specialist posts approved by the National Council

Division of the Register of Nurses	Immediate	Intermediate	Number approved
General	775	30	805
Psychiatry	375	6	381
Midwifery	27	—	27
Sick Children	53	2	55
Mental Handicap	96	—	96
Total	**1,326**	**38**	**1,364**

Note:
Statistics are presented according to division of the Register of Nurses, therefore *psychiatry* includes community mental health nurses and *general* includes practice nurses and registered general nurses working in the community

Source: The National Council for the Professional Development of Nursing and Midwifery, 3 July 2002

The National Council has developed a definition and core concepts of the role of the advanced nurse/midwife practitioner (ANP/AMP) (National Council, May 2001). The establishment of ANP/AMP posts is a process comprising two parts, firstly approval of site preparation and job description and secondly accreditation of the individual nurse/midwife. The first site preparation and job description for advanced practice status was approved, December 2001, in emergency nursing. It is anticipated that the role of the ANP/AMP will be developed across all divisions of nursing and midwifery in the future. It is anticipated that these developments will be vital to the process of capacity building within the health system and also alter the dynamics of inter-disciplinary team working.

Flexible working

Employment practices must enable organisations to secure the workforce they need and allow people with increasingly complex lives to participate in paid work. A major recruitment and retention initiative, costing in excess of £5 million (€6.35 million) was announced by the Minister for Health and Children on 29 November 2000. This initiative included the introduction of flexible working arrangements in the health service with a view to enhancing the recruitment and retention initiatives that have been put

in place. Under this arrangement staff may work on a permanent and pensionable basis for hours other than standard weekly working hours. This arrangement was effective from 1 February 2001.

Staff may now be recruited to permanent and pensionable part-time positions. Staff recruited to temporary part-time positions are now facilitated in joining their pension schemes from date of appointment.

Scope of practice

The *Scope of Nursing and Midwifery Framework* published by An Bord Altranais on 8 June 2000 has far-reaching and important implications for nursing and midwifery. The scope of nursing/midwifery practice is defined as the range of roles, functions, responsibilities and activities which a registered nurse/midwife is educated, competent and has the authority to perform.

The framework provides a context within which nursing and midwifery roles can be expanded. It is anticipated that nurses and midwives, in the future, will respond to new health-care demands by expanding current practices and developing new roles. Consideration should be given to the development of expanded roles when the methodologies for forecasting nursing and midwifery human resource requirements are being prepared.

Nurse prescribing

In many countries nurses and midwives now prescribe pharmaceutical preparations as part of the holistic delivery of care. In Ireland The Commission on Nursing (1998) indicated that there is a need to allow greater flexibility to nurses and midwives in the administration of non-prescribed drugs according to agreed protocols with medical practitioners. The Commission recommended that An Board Altranais, as a matter or urgency, review the guidelines relevant to the area (Para 4.16). This issue was again raised in the *Review of the Scope of Practice for Nursing and Midwifery* (2000). The review recommended that a project be initiated to evaluate nurse and midwife prescribing in relation to both non-prescription and prescription-only medications, including a review of the legislation. In September 2001 *The Review of Nurse and Midwives in the Prescribing and Administration of Medicinal Products* commenced. The National Council and An Bord Altranais are jointly undertaking and funding the three-year project. A steering committee and project team has been established and detailed terms of reference have been agreed (www.ncnm.ie and www.nursingboard.ie).

Nursing and midwifery research

The fundamental aim of nursing and midwifery practice is to promote people's health and provide excellent and sensitive care to individuals and families. As science technology and the demands of the public for sophisticated health care become increasingly complex it is essential that the empirical underpinnings of nursing practice be continuously built and strengthened.

The report of the Commission on Nursing (1998) recommended that the Nursing Policy Division in the Department of Health and Children, in consultation with appropriate bodies, draw up a national strategy for nursing and midwifery research (Para 6.77). In response the Chief Nursing Officer convened a consultative committee, representative of those with a core interest in research to draft a research strategy for nursing and midwifery in Ireland. The final report is due to be published in 2002. The strategy will have a key role in establishing processes to ensure the development of a research-based culture with continuous improvement in quality of nursing/midwifery care delivered. The Health Research Board and the National Council have established a joint appointment between the two organisations to take responsibility for leading the development of nursing and midwifery research. The Chief Nursing Officer at the Department of Health and Children is establishing a nursing and midwifery

research committee to progress, monitor and evaluate the implementation of the *Research Strategy for Nursing and Midwifery*.

Research in nursing and midwifery strives to strengthen the knowledge base used in the practice, education and management of the professions in a manner capable of effecting positive outcomes for the recipients of health care. In 1990 the Fourth Conference of European Health Ministers endorsed this view by recognising that research-based practice can improve the quality of nursing and midwifery care and also improve the status of the professions (Council of Europe Publishing, 1996). This endorsement illustrates the need to recognise the centrality of research to future workforce planning.

Care of the older person

The Commission on Nursing (1998) recognised the pivotal role nurses have in the care of the older person. The Commission, in a chapter devoted to this area, suggested that 'care of the elderly offers substantial opportunities for nurse led services' both in hospital and community settings and spanning several divisions of nursing (RGN, RPN, RMHN, and RPHN) (Para 9.2). Demographics presented earlier in this chapter (Section 5.4.1) indicate the increasing demand there will be for nursing services as the number of older people as a percentage of the overall population continues to increase. This theme was continued in the Health Strategy (2001). The Ombudsman's Report on the Nursing Home Subvention Scheme (2001) raised issues regarding service eligibility and charges for long-stay care. The strategy indicates a commitment to clarification and simplification of eligibility arrangements, the introduction of cover for two weeks' respite care per annum for dependent older persons and increased capacity in day- and long-stay places. All these developments will have a significant impact on the requirement for nursing services in the future. Another source of information on the likely need for services for older people is the survey of long-stay units undertaken by the Department of Health and Children. The report *Long-Stay Activity Statistics 2000* provides information on bed occupancy, sex, age, level of dependency, medico/social status, admissions and discharges and length of stay. A recent UK report *The Future Healthcare Workforce* (2002) examines the potential for new roles in services for older people and explores workforce planning issues and the impact on education and training for the proposed new roles.

The Commission on Nursing recognised the need to promote 'care of the elderly as a career in nursing in order to continue to attract high calibre nurses into the service' and for a concerted effort to integrate and co-ordinate a comprehensive service for older people. The Nursing and Midwifery Planning and Development Units have an important role to play in co-ordinating and planning for a diverse range of services for older people. The Department of Health and Children is currently in the process of appointing a nurse adviser with responsibility for care of older people/ palliative care. This is a particularly important development as nursing has an significant contribution to make in framing policy for services for older people.

Mental health nursing practice

Mental health nursing practice has been greatly influenced by the publication and implementation of the report *Planning for the Future* (1984). The document set out a strategy and template for the development of a community based mental health service in Ireland. Mental health nursing practices have been developed and modified over recent years. Specialist teams such as homecare teams, dedicated rehabilitation teams and assertive outreach teams are new concepts in contemporary mental health service delivery which are replacing existing generic mental health sector teams. The implications for human resource planning in relation to mental health nursing go beyond the redeployment of nurses from existing hospital-based services to community setting. The emphasis in the future will be on recruiting,

retaining, developing and educating nurses capable of delivering mental health services that are people-centred, equitable, accountable and quality driven. The Health Strategy (2001) proposes a review of *Planning for the Future* and the development of a new strategy for mental health taking account of developments in practice, changing demographics and population needs and demands.

National Mental Health Nursing Advisory Forum

It is proposed to establish a National Mental Health Nursing Advisory Forum during 2002. The purpose is to: facilitate consultation and communication between the Department of Health and Children and the mental health nursing profession on issues related to nursing policy and practice; provide advice to the Department on issues relevant to mental health nursing; provide an opportunity for practising mental health nurses to act as a resource to the Department in policy and strategy development, highlight and promote areas of best practice and promote research and evidence-based practice. The forum will not act as a vehicle for industrial relations issues. It is intended that an annual report of the forum's activities will be presented to the Chief Nursing Officer. The forum will act as a valuable mechanism for considering issues related to human resource requirements for mental health services of the future.

Mental handicap nursing practice

The Report of the Commission on Nursing (1998) commented that services for people with an intellectual disability in Ireland have undergone a period of rapid change and development providing a greater focus and emphasis on integration in school, work and community. Furthermore, the Commission noted that the role of the mental handicap nurse needed to be increasingly defined and specialised to respond to the changes taking place within the services and the client population.

The National Intellectual Disability Database (NIDD) indicates that there is significant demand for community-based placements both from people requiring residential services for the first time and from people in existing residential placements for whom community living is now the preferred option. Additionally, it has been noted by the NIDD that there is an increase in the demand for intensive specialist therapeutic placements in both residential and community settings. There is also a significant demand for high-support intensive day placements. These demands have implications for the development of specialist nursing services within the intellectual disability services. Discussion on the development of specialist and advanced nursing practice has been initiated through a project which prepared a *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing*.

The urgency of demand for specialist posts and services requires that a cohort of appropriately placed and qualified specialist nurses are introduced to the system. This is necessary to attract and retain a sufficient supply of competent practitioners both now and into the future.

Child Development Education Centres

Child Development Education Centres (CDECs) were established in 1983, following the publication of *Education and Training of Severely and Profoundly Mentally Handicapped Children in Ireland — Report of the Working Party to the Minister for Education, Minister for Health and Minister for Social Welfare*. The purpose of these centres is to provide education for school-going children with severe and profound intellectual disability, between the ages of five and eighteen years. The primary focus of the learning activities in the CDECs is awareness of self and the environment and the development of independence in life skills. The matter of appropriate staff, skill mix and reporting relationships for nurses within CDECs should be considered in workforce plans for the intellectual disability services.

Paediatric nursing practice

Underlying all paediatric nursing practice is the basic tenet that the needs of children differ fundamentally from those of adults. This necessitates that specific and particular consideration be given to the clinical, developmental and environmental needs of children when services are planned. The *Report of the Paediatric Nurse Education Review Group* (2000) notes that ever-increasing numbers of acutely and chronically ill children with complex needs require appropriately skilled nursing care in community and hospital settings. Parents expect that nurses caring for children are specifically competent to do so, yet this report highlights that there is an absence of national guidance related to the employment of specifically qualified nurses to care for children. A 1999 unpublished survey, undertaken by the three Dublin paediatric hospitals and surveying 20 paediatric units around Ireland, showed that 65 per cent of nurses working in these units were RSCNs. Concerns exist around attempting to maintain this situation in a context where fewer nurses are applying for and undertaking existing RSCN education programmes. Anecdotal evidence illustrates that nursing care for children is provided in adult settings — accident and emergency departments, operating theatres, intensive care units, outpatient departments, adult orthopaedic, surgical and Ear Nose and Throat (ENT) units. It however remains unclear how institutions delivering this care provide for the unique nursing needs of children. This situation highlights the need for focused planning in relation to nursing resource requirements necessary to meet the needs of children across all care settings and levels of nursing practice.

Community paediatric nursing

Children require health care throughout childhood ranging from post natal care and support through health surveillance and immunisation to secondary and tertiary level care and intervention. It is increasingly the case that children with acute, chronic or complex conditions, requiring specifically skilled nursing care, are being cared for at home rather than in hospital (Report of the Paediatric Nurse Education Review Group, 2000). It is vital that appropriate nursing expertise is available as care for acutely ill children moves to the primary care setting. It is the experience of hospital-based paediatric nurses that parents are leading and indeed demanding a shift in care from hospital to home.

Support is not always available in the community for children with acute nursing care needs. There is anecdotal evidence that public health nurses, in some areas, meet these needs but there is considerable pressure between this and the need to maintain and develop the public health role. There is also evidence that paediatric clinical nurse specialists and others are outreaching into people's homes in order to provide specifically skilled paediatric nursing care to children with specialist nursing needs. An unpublished study found that 78 per cent of paediatric clinical nurse specialists, employed in the three Dublin paediatric hospitals, undertake home visits to children and families (Lloyd, 2000). A pilot paediatric community link nurse post was developed at Letterkenny General Hospital in 2001. Following the positive evaluation (early 2002) this service is being established as a permanent nursing service. In Sligo General Hospital a clinical nurse specialist (paediatric community liaison) has been appointed and the role is planned for evaluation in 2003.

These contextual data make it clear that Ireland is facing a similar situation to that described by the British Paediatric Association in 1996 who comment as follows: 'secondary care of children outside the comprehensive hospital children's department is the area of child health which will see most growth, development and innovation in the next decade.'

National Paediatric Nursing Advisory Forum

The National Paediatric Nursing Advisory Forum was established in 2001. It provides a mechanism through which the Department of Health and Children can access additional expert advice from

paediatric nurses and aims to give paediatric nurses an opportunity to contribute meaningfully to the policy-making process. It comprises paediatric nurses from a variety of grades who work across a range of practice settings. The forum has the potential to provide an arena for discussion particularly relevant to workforce planning.

Midwifery practice

The Midwifery Sub-Committee of An Bord Altranais produced the third edition of the *Guidelines for Midwives* in September 2001. These comprehensive guidelines were revised for the first time since 1994 and provide an excellent resource for the midwifery profession. The guidelines have two main aims: to provide registered midwives with information pertaining to legislation governing or affecting their practice and to make midwives aware of the responsibilities and accountabilities that accrue to them as a result of such legislation. The guidelines also assist midwives in decision making and enhance their ability to provide excellent care based on the best available evidence. Every midwife who is registered with An Bord Altranais received a copy of this document.

Midwifery led units

In recent years there has been a growing demand from women for greater choice in the provision of maternity services. The report of the *Maternity Services Review Group to the North-Eastern Health Board* (2001) recommended the establishment of midwifery led units across the region, in Cavan and Drogheda with the phased opening of units at Dundalk and Monaghan as soon as possible. The NEHB responded by setting up a working party to examine the feasibility of establishing midwifery led units. A pilot programme will commence in the near future.

Domiciliary midwifery

During the past thirty years in Ireland, child birth for the vast majority of women, midwives and obstetricians have provided services in hospital settings. With national birth rates of more than 50,000 annually, less than 1 per cent of births occur in the home with the care of domiciliary midwives. Trends in birthing practices have been influenced by broader social and demographic changes in Ireland. Consumers now request more choice in the model of maternity care chosen and the location of birth. Many women now opt for the choice of home birth and require the services of community midwives. Prior to 1998, there were no established community midwifery programmes affiliated to maternity hospitals, although hospitals facilitated individual requests by women to have home births. In most cases, the only opportunity in the past for women to choose a home birth, attended by a midwife, was to engage the services of an independently employed domiciliary midwife.

At the present time there are many examples of excellent community midwifery practice in Ireland, providing much optimism for future development. Several pilot programmes are in progress throughout the country, exploring various models of organising domiciliary midwifery services.

- Community midwives in University College Hospital, Galway provide a hospital outreach community midwifery service for women in the Galway region, with options including home birth, DOMINO (domiciliary in and out) birth in hospital and post-natal follow-up at home. The scheme has been in progress since November 1999 and is currently in the process of a final evaluation of the model of care.
- In the National Maternity Hospital, Dublin, the DOMINO community midwifery service has been successfully piloted and very positively evaluated on completion of a two-year programme

in the summer of 2001. Following successful evaluation of the programme funding has been provided to continue this model of care in the National Maternity Hospital.

- The community midwifery service in the Southern Health Board is an excellent example of co-operation between independent midwives and service providers. This pilot programme is evaluating the services offered by independent midwives who are sub-contracted to provide domiciliary services. This has been in progress since June 2001 and has been extremely well received.

Many other health boards throughout the country provide community midwifery services to facilitate home births, ante-natal care or post-natal care in the community to mothers and babies. Currently, there are approximately twenty independent midwives in Ireland providing care to women who wish to engage the direct services of domiciliary midwives.

National Midwifery Advisory Forum

This group was established in November 2000 as a mechanism to enhance communication between the Midwifery Advisor in the Department of Health and Children and the midwifery profession. It was recognised that there are many issues arising within a policy context which have implications for the profession and that it is important to access the experience and knowledge of midwives in practice around the country. The National Midwifery Advisory Forum membership is comprised of midwife representatives from clinical practice, management, midwifery tutors providing hospital-based education programmes and university-based midwifery lecturers, An Bord Altranais and the National Council.

The development of this forum has presented an important opportunity to consult regularly with midwives involved in all aspects of the profession including delivery of midwifery care, management of maternity services and education of the profession. Membership from a cross-section of maternity units around the country ensures that there is geographical representation, in addition to the inclusion of midwives who are based in regional and tertiary hospital-based services, community and independent midwifery services.

Meetings rotate at venues throughout the country on a two-monthly timeframe and are chaired by the midwifery advisor. The Forum has facilitated the production of discussion documents pertaining to many policy areas including the Health Strategy and the National Nursing and Midwifery Research Strategy. It is a vehicle for discussion of the extension of areas of midwifery practice such as community midwifery services and midwifery led services in the future.

Public health nursing practice

The role of the PHN was outlined in circular 27/66 (Department of Health, 1966). It encompasses health promotion and disease prevention, screening/ early detection and nursing care. New job descriptions for the various nursing grades working in the community were developed in 2000 (Circular 41/ 2000). These reflect the recommendations of the Commission on Nursing (1998). PHNs are based in community health centres and are attached to defined geographical areas. There are variations in the population size served by PHNs ranging from 1:2,500 to 1:5,099 depending on density of population and levels of vulnerability. PHNs work with individuals, families and communities. The current service is offered five days per week, 09.00-17.00 hours, with planned essential service at weekends. The geographic focus of the role provides unique opportunities for a population, public health approach to health and social needs assessment and for community development approaches to health promotion.

Reflecting the holistic approach to health which the role encompasses in addition to providing nursing care, PHNs provide information, guidance and support in relation to a wide range of issues including ante-natal and parenting classes, breast-feeding support, family planning, post-natal depression, substance abuse, bereavement, continence, behaviour change and many other areas, according to the needs of the individual, family or community.

The holistic approach to health which is integral to the role of the PHN has many strengths. However, some PHNs have expressed frustration and concern at the daily conflict which they experience in prioritising curative work over prevention. Societal changes have also resulted in an increase in the number of vulnerable families and the incidence of child protection issues. Mobilisation of services and resources to meet the needs of clients requires close collaboration with other disciplines and agencies. Liaison and collaboration with general practitioners and practice nurses varies, with some PHNs having close working relationships and others with minimum.

In recent years some PHNs have taken up posts in the pre-school service, immunisation programmes and family development programmes. Others have moved into posts which focus on particular groups including Travellers and asylum seekers or into areas such as continence promotion.

The acute shortages of public health nurses is a recent phenomenon particularly in the Eastern Regional Health Authority. The plan in the Health Strategy (2001) to add a total of 3,000 acute beds to the system will have a direct impact on the number of patients being discharged into the community. The allocation, in 2001, of medical cards to all persons over the age of seventy years nationwide has a major impact on the workload for the community nursing service. The availability of a primary nursing care out of hours beyond the present limit of 09.00-17.00 hours will be a challenge to a service that is already working to full capacity.

Community registered general nurses

Registered general nurses (RGNs) play an important role within the public health nursing team. However, until the report of the Commission on Nursing (1998) their employment was in a temporary capacity. The Commission recommended that where registered general nurses are employed in the community it should be in a permanent capacity in line with service need. They also indicated that flexible permanent part-time employment opportunities be provided to registered general nurses working in the community. This provides the opportunity to align service needs with the personal circumstances of such nurses.

The focus of the registered general nurse is on home nursing services provided in accordance with a care plan developed in collaboration with PHNs. The Commission recommended that prior to commencing work in the community, registered general nurses should be provided with in-service orientation and training in community nursing (Para 8.38, Commission on Nursing, 1998).

Practice nursing

Few nurses were employed by general practitioners until the introduction of the general medical services (GMS) subsidy in 1989 (Department of Health, circular 5/89). At that time the proposed role of the general practice nurse was expressed vaguely in terms of providing 'active nursing to patients of the practice' (Department of Health, 1989). To date, a dearth of research on practice nursing poses some difficulties in defining the characteristics of practice nurses and their role. Anecdotal evidence suggests that many nurses have developed practice nursing in response to patients' needs and have extended the

range of services available to patients locally, in general practices. Recently the National Council has recognised the expanded practice nursing role and many practice nurses have been granted CNS status. Patients are referred to the practice nurse by self-referral, GPs, public health nurses, community general nurses, medical secretaries, patient's family or neighbours, hospital nursing and medical staff, clinical nurse specialists and pharmacists. Depending on the patient/clients' needs the practice nurse may teach, advise and support; assess, monitor and evaluate; administer therapeutic interventions; triage; and provide ante- and post-natal care. The practice nurse is frequently the first point of contact for walk-in emergencies. The practice nurse administers prescribed treatments and when indicated may teach individuals/carers how to administer medications. Effective teamwork is essential to ensure a high standard of patient care and patient-focused nursing and medical services. Practice nurses collaborate with medical colleagues to achieve this aim.

It has been suggested that practice nursing developed in an ad hoc fashion, outside existing nursing structures. To address this issue the Commission on Nursing (1998) made two specific recommendations:

- that all nurses working in the community would undertake a common core community nursing education with specialist streams in, for example, general practice nursing (Para 8.57, p 160)
- that practice nurse facilitators would be appointed within each health board to advance the development of practice nursing within the context of community nursing (Para 8.53, p 159).

Professional development co-ordinators for practice nurses

The appointment of professional development co-ordinators for practice nurses will support the development of practice nursing within the context of community nursing and primary care. The proposed introduction of a common core community nursing education programme with a specialist stream in general practice nursing is a welcome development.

Public Health and Nursing

In January 1999 the chief nursing officers of the Department of Health and Children and the Department of Health Social Services and Public Safety in Northern Ireland initiated the first of a series of cross-boarder meetings focusing on nursing and public health. The aim of the meetings was to find ways to maximise the potential for all nurses and midwives to contribute to the health of the public. In February 2001 (Mason and Clarke) the two government departments jointly published an all-Ireland statement on public health and nursing. The *Nursing Vision of Public Health* is that public health is wider then community nursing and that all nurses and midwives have a valuable contribution to make to the public health agenda. Perhaps more then any other social, health or medical workers, nurses cross the boundaries between public, voluntary and private health and social care sectors. It is intended that the vision document be used as a starting point of action rather than as final guidance. The vision is dynamic in the sense that it will evolve over time as the understanding of the enormous contribution that nurses make to the public health agenda moves forward.

National Strategy for Nursing and Midwifery in the Community

The Nursing Policy Division of the Department of Health and Children is currently leading on the development of a National Strategy for Nursing and Midwifery in the Community (NAMIC). In 1966 the Department of Health issued a circular (circular 27/66) outlining the objectives of a community-based nursing service. Thirty-six years later, there is an increase in the number and diversity of nursing and midwifery personnel working in the community and an increase in the complexity of health and social care needs. These changes are recognised to some extent in circular 41/2000, through the provision

of revised job descriptions for a range of nursing personnel including those based in the community. The Commission on Nursing (1998) recommended that the Department of Health and Children issue a revised strategy statement on the role of public health nursing. The Commission identified a number of issues to be addressed in developing the future direction of nursing in the community:

- the need for community nursing to respond to the wide societal and health care changes of the last thirty years; 'there is a need for a fundamental reappraisal of nursing services in the community' (Para 8.54)
- the need for advanced skills among community nurses in needs assessment, to ensure responsive health care provision (Para 8.55)
- the need for 'the development of a more coherent and integrated structure for the delivery of nursing services in the community' (Para 8.56)
- the need to develop the capacity of each community nurse to work effectively in a community setting; 'a community nursing education programme could develop the community nursing skills of each discipline' (Para 8.57)
- the need for a clear vision. The Commission identified that: 'There is a need for the profession to develop a coherent vision for the future direction of nursing in the community which reflects the needs of the community rather than the status of individual groups within the profession' (Para 8.58).

The Department of Health and Children (2001a) proposes the introduction of an inter-disciplinary team-based approach to primary care provision. *Primary Care: A New Direction* contains a detailed action plan which sets out twenty actions. Action 20 relates to the preparation of the Strategy for Nursing and Midwifery in the Community. The recommendations made in the Health Strategy will play a key role in directing the Strategy for Nursing and Midwifery in the Community. It will also be guided by the principles underpinning the Health Strategy (2001): equity, people-centredness, quality and accountability, and those specifically selected for primary care: continuity of care, a holistic approach and improved population health.

Another influence in the development of the strategy is the Munich Declaration. In June 2000, WHO (Europe) hosted a Ministerial Conference on Nursing and Midwifery in Munich, Germany. The aim of the conference was: 'to bring about a consensus on how nurses and midwives together with other health care and related professionals, and in partnership with patients and service users, could best address health care priorities in the different member states and provide evidence-based care and/or health promotion' (WHO, 2000). The conference concluded with each of the member states (including Ireland) reaching a consensus in the signing of the Munich Declaration. The Munich declaration is particularly focused on strengthening the roles of nurses and midwives in the area of public health. Of particular relevance to the Strategy for Nursing and Midwifery in the Community are the recommendations for Governments to:

- establish and support family-focused community nursing and midwifery programmes and services
- enhance the roles of nurses and midwives in public health, health promotion and community development.

Structures and progress in preparing the Strategy for Nursing and Midwifery in the Community

The Strategy for Nursing and Midwifery in the Community seeks to provide a sustainable community nursing and midwifery service that will effectively meet the health needs of the population of Ireland within primary care. The aim of the strategy is to address the deficits in the current system by providing a strategic template for the integration of nursing and midwifery services within a primary care setting. The strategy will identify and build on the existing diversity of nursing and midwifery competencies and will seek to maximise the use of these in the provision of a needs-led, high-quality and sustainable primary care service.

On 1 October 2001 a lecturer was seconded from the School of Nursing and Midwifery Queen's University Belfast to work as project officer for the strategy. The Chief Nursing Officer, Department of Health and Children convened the first meeting of the Steering Group on 28 November 2001 at which time terms of reference for the strategy were agreed.

The first stage in the consultative process commenced on 4 and 5 December 2001 when a consultative meeting was convened. Over 90 representatives from a wide range of interested groups, including nursing, midwifery, medicine, voluntary sector, health and social care professionals, education, statutory bodies and policy makers attended the meeting to provide a focus and direction in the development of the strategy. Day one included formal presentations on community practice in Finland, the Netherlands, Northern Ireland, England and across Ireland and a video link up was made with Scotland to learn of the pilot of the WHO family health nurse. Day two focused on the development of a shared vision for nursing and midwifery in the community and the identification of priorities for action.

Analysis of the data generated during the consultative meeting grouped the priorities for action into three areas: practice, policy/structural issues and education. The steering group agreed to build on the outcomes of the consultation meeting and to:

- seek further consultation with members of the public, GPs and other relevant groups
- establish a website for the strategy (www.namic.ie)
- establish three small working groups focusing on the priorities for action.

It is planned that a draft strategy document will be presented at a consensus conference and that the final document will be ready by the end of the year. The preparation of the strategy is a vital step required in advance of the preparation of workforce plans for community nursing. The framework proposed in the strategy will assist in determining the demand for nursing and midwifery services in the community. In the absence of such a framework it would not be appropriate to consider preparing such plans.

Future professional development

Cognisant of the fact that the development of practice involves the development of generalist, specialist and advanced practice roles, the National Council is undertaking the preparation of discussion papers on the future professional development of all nurses and midwives in Ireland. This review will involve broad consultation with the profession and a review of international experiences. A call for submissions has been circulated widely. The process also involves consultation meetings with groups of nurses and midwives.

This consultation will inform the discussion papers which will review what new roles need to develop and what developments need to occur in existing roles in order to support contemporary health policy and patient need. Consideration will also be given to structures and supports needed for the development of roles.

5.4.6 Sources of information on demand for the nursing and midwifery resource

The matters discussed in previous sections draw on many of the sources of information that can be used as a resource when anticipating the likely demand for nursing and midwifery services. It is suggested that the main sources (relevant to the service) be made available to nurses and midwives to use when considering the future requirements for their particular area of practice. Some of this might be drawn from the list set out below.

- Acute Hospital Bed Capacity: a national review
- Coronary Heart Attack Ireland Register (CHAIR)
- CSO Population Census
- Department of Health and Children Long-Stay Activity Statistics (2002b)
- Hospital Inpatient Enquiry (HIPE) data and Casemix Programme
- Infectious disease database
- National Cancer Registry
- National Intellectual Disability Database
- National Psychiatric In-Patient Reporting System (NPIRS)
- National Roads Authority Accident database
- *Primary Care: A New Direction*
- Public Health Information System (PHIS)
- *Quality and Fairness: A Health System for You*
- Report of the Activities of the Irish Psychiatric Services
- Service Plan for the health board in question
- Sudden Infant Death Register
- Suicide/Para-Suicide database

5.4.7 Summary of major influences on the future demand for nursing and midwifery resources

This section demonstrated that the demand for nursing and midwifery resources is subject to a myriad of complex influences. Any attempt at workforce planning must recognise that nursing and midwifery does not exist in a vacuum but is affected by broad societal trends which include social, political, cultural, technological and economic factors. The next section considers how these current patterns of change can inform future thinking in relation to the supply of nurses and midwives in the coming decades.

5.5 Major influences on the future supply of nursing and midwifery resources

Historically the supply of nurses and midwives has been derived predominantly from the output of pre-registration nursing education programmes delivered in Ireland. In recent years, however, there has been a need to augment traditional patterns of recruitment from alternative sources. Additional numbers of registered nurses are now recruited into the system, some from abroad and others through agencies, return-to-practice courses and conversion courses for state-enrolled nurses.

This section examines specific areas that require consideration in addressing the future supply of nurses and midwives. These are: recruitment into pre-registration education and recruitment of registered nurses and midwives. The section concludes by raising broad issues on the future of nurse education which will need careful consideration in order to ensure a vibrant and stable nursing and midwifery resource in the future.

5.5.1 Recruitment to pre-registration education

While nursing has long been an occupational group subject to swings in supply and demand, the current gap between the need for nurses and the ability of the nursing education system to produce them is widening at a rapid pace.

Changing student demographics are reflected in an increasing diversity within current student intakes. The number of mature students entering nursing is now exceeding allocated quotas. As the age of pre-registration nursing students rises (see Chapter 2) the number of years of practice decreases, also effecting changes in supply. While the number of male nursing students has risen significant progress is required to achieve an equitable gender balance within the student population.

A significant increase in the diversity of the population is affecting the nature and prevalence of illness and disease. Subsequent changes in nursing practice are required in an effort to respect diverse values and beliefs. Responding to the health care needs of a diverse population, however, also requires that the workforce in nursing be representative of that diversity and points to the recruitment of minority groups. By embracing racial and ethnic diversity in the system of nurse education a rich cultural environment for learning can be created. The nursing profession and schools/departments of nursing studies have an important role to play in promoting, recruiting and retaining students who reflect the diversity of the client population in Ireland. To deliver effective health care the nursing population should be representative of the ethnic groups within the population, show sensitivity to cultural differences, communicate in the same language, and understand the different value systems related to health status and health care.

The *Population and Labour Force Projections 2001-2031* published by the CSO (1999) suggests that the number of secondary students will decline by over 20 per cent in the period up to 2011. Proactive student recruitment and the maintenance of an intensive media/marketing campaign will be required for nursing to compete in an increasingly competitive labour market. In tandem with this the public image of nursing needs revitalisation to recalibrate outdated perceptions and attract the diversity of nursing students needed to meet the needs of a rapidly growing multi-racial multi-ethnic society in Ireland.

Models of pre-registration nursing and midwifery education will always need development and redesign so as to ensure a resource capable of meeting the health-care demands of modern society. This has been

the subject of recent detailed debate in the United Kingdom. The Report of the UKCC's Post Commission Development Group (2001) identified six models for the future shape of pre-registration nursing education. The models are as follows:

- the existing four branches of nursing enhanced (mental health, child, adult and learning disabilities) with practice divided equally between hospital and community
- the existing four branches of nursing integrated with social care
- six branches of nursing including new separate branches for the care of older people and community nursing
- two branches of nursing child and adult
- two branches of nursing hospital and community
- the generalist nurse with specialisation following registration (p 47-57).

Each model was discussed in relation to responsiveness to patient need, inter-professional opportunities, feasibility, regulatory and resource implications. In Ireland the points of entry to pre-registration nurse education have been the subject of debate for a considerable time. Following the recommendation of the Nursing Education Forum, a review of the literature and a discussion paper is being prepared by An Bord Altranais to examine the rationale for, and impact of, maintaining three points of access to pre-registration nursing. The initial phase will also embrace a review of literature in respect of sick children's nursing and midwifery. International experience indicates that there is no one best model of pre-registration nursing education. For the future it is paramount that whichever model is adopted or developed, it is cognisant of the intrinsic relationship between preparatory education and workforce needs.

5.5.2 Recruitment of registered nurses and midwives

There are particular issues in relation to optimising the future supply of registered nurses and midwives as one means of ensuring the sustainability of this essential source for meeting workforce requirements. Of particular interest at this point is the development of return-to-practice courses, agency nursing, recruitment of nurses and midwives from abroad and state enrolled nurse (SEN) conversion courses.

Return-to-nursing and midwifery courses

Under the initiative announced by the Minister for Health and Children in November 2000, fees for back-to-practice courses have been abolished, and nurses and midwives undertaking such courses now receive a salary in return for a commitment to rejoin the public health service following completion of the course. Many of the courses are being delivered on a flexible part-time basis. This initiative is designed to ensure that there are no barriers preventing nurses who may wish to return to work from doing so. The result of recent campaigns indicates that there are small numbers of nurses and midwives interested in returning to work. It must therefore be recognised that this represents an invaluable but small pool for future supply.

Agency nursing

While supply is important the attractiveness of a career in nursing and midwifery in the public health services may well be related to the availability of work and related conditions. The perception of multiple career options and the desire for flexibility in working patterns appears to have promoted the growth of

nursing agencies. Health service employers, particularly in urban areas, have become increasingly reliant on agency nurses due to the current shortage of nursing staff (see Chapter 2, Section 2.3.3). The shortage and ease of finding work though agencies has driven up the cost of supply and at the same time has somewhat masked the shortages. The implications of reliance on agency nursing for service delivery and quality must be seriously considered in future plans for supply of the nursing and midwifery resource. It is probably timely to suggest that alternative mechanisms for meeting gaps in supplying service warrant serious consideration. For example it may be possible to establish in-house banks to address in part the gaps currently being filled by staff supplied through nursing agencies. Any initiative undertaken must take account of the provisions made in the Organisation of Working Time Act, 1997.

State enrolled nurses

The state enrolled nurse (SEN) (second level nurse) was a nursing grade established in the UK health system that is not recognised in Ireland. Duties focused on assisting the registered nurse in practical nursing care. The qualification was introduced in the UK under the 1943 Nurses Act; it comprised a two-year training programme and requires lower entry qualifications than those for pre-registration nursing education programmes. The implementation of a revised nurse education structure in the UK (Project 2000) resulted in the abolition of training courses for SENs and the provision of conversion courses to registered nurse status.

There are a number of personnel employed in various capacities in the Irish health system who have a state enrolled qualification obtained in the UK. There is no tradition in Ireland of a registerable nursing qualification other then registered nurse. Similarly, there is no precedent for the provision of conversion courses of the type provided for SENs in the UK. The Commission on Nursing, having considered the matter, did not recommend any change in the Rules of An Bord Altranais in relation to the recognition of the SEN qualification or the provision of conversion courses in Ireland. In 2001, the Minister for Health and Children announced a special initiative (non-means tested grant) to assist personnel with a state-enrolled nursing qualification, working in the Irish health services, to undertake a nursing conversion programme in the UK. While this may be a short-term source from which to draw a supply of registered nurses it is acknowledged that it is a small but critical mass which should not go untapped.

Recruitment from abroad

The nursing and midwifery shortage now being experienced by health service employers has been addressed in some part through the recruitment of significant numbers of nurses from abroad. In the short term this has been an effective strategy to meet the service needs. However, a cautionary note needs to be sounded in relation to the continued availability of foreign nurses. While some counties, such as the Philippines, have an over-supply of nurses at present, there is a global shortage of nurses and midwives. Countries experiencing shortages are competing with one another to attract nurses/midwives and it is likely that this competition will intensify in future years. *Guidance for Best Practice on the Recruitment of Oversees Nurses and Midwives* (2001), published by the Department of Health and Children, is an essential resource designed to underpin practices when recruiting from abroad. It is envisaged that recruitment patterns of this nature will need to continue in the immediate future. In the longer term, the solution for Ireland lies in ensuring adequate annual intakes of nursing and midwifery students and in retaining registered nurses and midwives in the workforce.

5.5.3 Future of nurse education

At the outset it must be recognised that, in terms of contemporary health care, nursing and midwifery are no longer just a reciprocal kindness but have become a highly complex set of professional behaviours,

which require serious educational investment. Hence this section deals with the broad educational matters related to the future supply of a responsive workforce.

Trends in nurse education

The National League for Nursing identified ten trends to watch in relation to the future of nursing education in the United States (Heller, Oros, and Durney-Crowley, 1999):

- changing demographics and increasing diversity
- the technological explosion
- globalisation of the world's economy and society
- the era of the educated consumer, alternative therapies, genomics, and palliative care
- shift to population-based care and the increasing complexity of patient care
- the cost of healthcare and the challenge of managed care
- impact of health policy and regulation
- the growing need for inter-disciplinary education for collaborative practice
- the growing nursing shortage/opportunities for lifelong learning and workforce development
- significant advances in nursing science and research.

The Minister for Health and Children, launching the arrangements for the introduction of the pre-registration nursing degree commencing in the academic year 2002/2003, commented that education and health are now the two pillars upon which the profession of nursing rests. It is therefore recognised that the supply of nurses and midwives for the future is dependent on continued collaboration between service providers and the educational system.

Competency-based education

No one doubts that in general the better educated the professional the more likely he or she is to perform well and to contribute to the health gain of the nation. Education therefore will continue to play an essential role in ensuring that nurses and midwives have appropriate knowledge and competence. New expectations of contemporary practice competencies are emerging due to broad societal changes. The World Health Organisation (2001a) claims that the identification of nursing and midwifery competencies has the following benefits:

- sets the framework for educational preparation and assessment
- makes clear to the public what can be expected from the profession
- clarifies respective roles
- provides the basis for standard setting
- assists the profession in monitoring standards of performance.

It is now appropriate that the traditional knowledge, skills and attitudes expected of practising nurses and midwives be translated into competencies. Today the consequences of incompetence can be far-reaching and expensive. Contemporary expectations present quite a different set of competencies and consequences from those of the past, for both academic and service sectors. Such competencies will need to be responsive to patient/client needs and the needs of population groups. These changes are giving rise to debate about the competencies required for practice, how they should be learned, and how individuals should be held accountable for competent performance.

The challenge now relates to thinking differently and creatively about nursing roles and positions within a changing health care system. It will no longer be sufficient to use simple functional titles across the continuum of care. Part of this debate centres on the need to explore competency-based approaches to education which in turn are capable of supporting a competency-based approach to employment. Models of this nature have the potential to contribute to the generation of an increasingly flexible workforce.

Clinical learning settings for the future

Nursing and nursing education continue to be faced with numerous changes. The challenge is to ensure that the education systems of the future keep pace with the changes arising from health care reform and developments. Creativity and innovation will be required to achieve the desired learning competencies of future nursing students. Distance education, experiential learning, patient simulations, diversity of educational practice placements, new clinical learning settings, tele-education among others are all issues for consideration. The Health Strategy (2001) places great emphasis on primary care and moving the focus of care to the home/community setting. The shift should be reflected in the development of additional and new community clinical learning settings for nursing and midwifery students.

A debate surrounds the question of whether service providers should be paid for providing pre-registration clinical placements. A recent review article published in the *Journal of Advanced Nursing* found no case for paying for clinical placements. Lloyd, Jones and Akehurst (2000) concluded, 'because the presence of students on clinical placement is associated with both costs and benefits, efforts should be made to ensure that both ward-based and community-based placements are distributed as fairly as possible between locations so that no one location is unduly advantaged or disadvantaged by the number of students which it receives' (p 432).

Education levels

The minimum data set pilot projects undertaken as part of this study illustrated the variety and range of education qualifications held by nurses and midwives. The qualifications were obtained at different times, following programmes of different length and content, during the development of nursing education in Ireland and are at various educational levels. There is a plethora of different titles specific to the awarding body. These range from certificates, diplomas (pre- and post-registration), undergraduate degrees (BSc, BSc Nursing Science, BSc Nursing Studies, Bachelor of Nursing Studies etc), higher diplomas (higher diploma in nursing studies, postgraduate diploma, graduate diploma, advanced diploma, advanced diploma in specialist practice in nursing), and masters degrees (see listing in Appendix 4). There is an obvious need for rationalisation of titles and education pathways particularly as entry to nursing education will be at degree level from the academic year 2002/2003. Levels of awards need to be defined in terms of the knowledge, skill and competence to be acquired by learners.

The work of the National Qualifications Authority of Ireland, established in February 2001, will have relevance for nursing education pathways. The Authority has three principal objects, which are set out in the Qualifications (Education and Training) Act, 1999:

- the establishment and maintenance of a framework of qualifications for the development, recognition and award of qualifications based on standards of knowledge, skill or competence to be acquired by learners
- the establishment and promotion of the maintenance and improvement of the standards of awards of the further and higher education and training sector, other than in the existing universities
- the promotion and facilitation of access, transfer and progression throughout the span of education and training provision.

The levels in the framework will need to be linked to international developments and descriptors, particularly in Europe where much work has been undertaken by the European Centre for the Development of Vocational Training in respect of vocational awards. This is also being undertaken in relation to higher education and training on foot of the Bologna Declaration of June 1999 and the creation of a European higher education area. The Authority has proposed a set of seven broad principles that could underpin the establishment of the national framework of qualifications. These are: transparency, simplicity, quality, equality, relevance, comprehensiveness and flexibility.

Access transfer and progression

The Qualifications Act, 1999 defines access, transfer and progression as follows:

- Access — the process by which learners may commence a programme of education and training having received recognition for knowledge, skill or competence required
- Transfer — the process by which learners may transfer from one programme of education and training to another programme having received recognition for knowledge, skill or competence acquired
- Progression — the process by which learners may transfer from one programme of education and training to another programme, where each programme is of a higher level than the preceding programmes.

The promotion and facilitation of access, transfer and progression raises many important issues for nursing. Among these are: accreditation of prior and experiential learning; systems of credit accumulation; recognition of learning units (undertaken at various rates of progress and perhaps not all in a continuous process); the need to build on a learner's most recent award; the accommodation of variety in outcome descriptions; the involvement of under-represented groups of learners; the desirability of multiple access points and modularity; the need for progress both within and between nursing/midwifery education providers and awarding bodies; and the need for updating learning.

In relation to nursing and midwifery, progression refers to transfer along pathways within the pre-registration programme itself and progression following completion of the pre-registration degree programme. The concept of progression is of great importance for career pathways in nursing, particularly post-registration education programmes. It would be somewhat short-sighted at this point to consider changes in pre-registration education in isolation from post-registration programmes. The Qualifications

Act, 1999 and the World Health Organisation (2001) suggest that programmes developed for adult learners should be part of an overall framework. Access, transfer and progression are greatly simplified in the context of modular approaches to programme design and delivery. This approach is being adopted in the development of new curriculums for nursing education.

Inter-disciplinary education

For the future, nursing roles and responsibilities will be linked to organisational and health care outcomes. Emerging inter-disciplinary models tend to be population-focused and have fluid professional leadership, open membership and an emphasis on outcomes. This points to a significant revision of business practices and clinical discretion. The ongoing challenge will be to maintain the unique contribution of nursing and midwifery as organisations shift from a reliance on discrete professions to a competency- and team-based approach to employment.

There is a growing need for inter-disciplinary education to foster collaborative practice in the future. A wide range of knowledge and skills is required to effectively and efficiently manage the comprehensive needs of patients and populations. The Health Strategy (2001) indicates that the health care delivery system will rely on teams of nurses, doctors, physiotherapists, social workers, counsellors, pharmacists and others working together in inter-disciplinary teams. Nurses and midwives must demonstrate leadership and competence in inter-disciplinary and collaborative practice. The education system has a significant part to play in preparing nurses for this role. The way forward is the utilisation of teaching methods that incorporate opportunities for inter-disciplinary education and collaborative practice to prepare nurses for their unique professional role and to understand the role of other disciplines in the care of patients.

Educational preparation for advancing practice

The escalating shortfall in nurses available to fill vacant positions is a reflection of a different dynamic than merely a shortage. That dynamic is predicated on extraordinary advances in all of the health sciences, exploding developments in technology and unprecedented changes in the health care environment. These factors have led to radical changes in the responsibilities of all nurses, thereby creating a need for reform in relation to the competency profile of the nursing workforce. As post-registration education frameworks for advancing practice are considered there is a need to ensure broad entry to programmes, equitable access and a practical geographic spread of courses across the country. Programmes comprising core and specialist elective modules designed to match health service needs will have to be considered.

Health care provision is complex and multi-faceted and the response of advanced practice is at an early stage in Ireland. The National Council recognises that the educational preparation for advanced nursing and midwifery practice is a process that involves a partnership between all stakeholders. As such, there is great scope for innovation in both the development of roles in line with service need and of education courses to prepare practitioners to meet those needs. Collaboration and partnership between service providers and educational institutions will enhance the relevancy of educational programmes and take cognisance of emerging trends in health care needs and provision. In the future all clinical nurse/midwife specialists will be required to have a higher/postgraduate diploma in clinical practice (future career pathway). This will require the development of educational programmes to meet developing health service needs.

The National Council has also developed a definition and core concepts of the role of the advanced nurse practitioner/ advanced midwife practitioner. Advanced practitioners are highly experienced in

clinical practice and will be required to be educated to masters degree level (or higher). Educational preparation must include substantial clinical modular components pertaining to the relevant area of advanced practice.

The National Council will be taking responsibility for the determination of the appropriate level of qualification and experience for entry into specialist nursing and midwifery practice, the accreditation of specialist nursing and midwifery courses for the purpose of CNS/CMS and ANP/AMP appointments and the accreditation of post-registration courses. The Nurses Act, 1985 invested these functions in An Bord Altranais. However, the report of the Commission on Nursing recommended that they be transferred to the National Council through the enactment of new legislation (6.14). Key considerations include accessibility, geographic spread and maximising the use of education resources. The National Council is currently developing a database in relation to the provision of post-registration education, which will be a web-based resource.

5.6 Summary of major influences on the future supply of nursing and midwifery resources

The mission of nursing and midwifery education is about the preparation and maintenance of a workforce to meet the needs of an increasingly diverse population in an ever-changing health care environment. This section of the report highlighted some contemporary educational developments across the spectrum of nursing and midwifery designed to prepare, enhance and retain a vibrant and responsive nursing and midwifery resource. To ensure a sufficient supply of nurses and midwives to meet society's needs for high quality care, the alignment of educational preparation, regulation, scope of practice and practice roles in all settings is required. The key factor in sustainable workforce planning is that of retention. With a system already in shortage, the numbers of newly qualified nurses will not address the shortage in the near term. Retention of the highly skilled nurses and midwives who are currently employed in the public health workforce is essential.

5.7 Conclusion

The chapter indicates that anticipated changes in the environment of health care, demands for a workforce that can support the needs of a diverse population, and the impact of information technologies on clinical work create unprecedented challenges for nursing and midwifery practice and education in Ireland. The absolute need for futures thinking in workforce planning methodologies is highlighted. Given the fundamentally caring tradition of nursing and midwifery, both the probable and the preferred visions for the future direction of nursing practice and education must be considered during workforce panning. Patient advocacy and caring for patients at the bedside are activities often hidden in the cost of health care. Therefore the most challenging question now being asked is: how can the caring capacity of nurses and midwives survive into the future?

CHAPTER 6

Overview of Workforce Planning Methods

6.1 Introduction

For many years there has been a constant supply of newly qualified and experienced nurses and midwives in Ireland with strong competition for every available post. In this secure environment no imperative existed for employers to engage in workforce planning assessments or to develop expertise in forecasting techniques. This situation has been radically reversed in the last few years. Like many other countries Ireland is now focusing on the best way to plan for the future nursing and midwifery resource requirements. This Chapter presents an overview of the literature pertinent to workforce planning methods as an introductory resource for nurse and midwife planners approaching the task for the first time. Together with Chapter 5 the focus is on addressing objective five and six of the study:

- to identify and recommend the best possible approach to human resource planning for nursing and midwifery
- to identify the main assumptions on which future projections for the requirement of nurses and midwives should be based.

This Chapter provides an overview of workforce planning methods and is divided into four main sections. The first section concentrates on providing an understanding of the definitions, rationale, obstacles, prerequisites and educational preparation required for workforce planning. The second section describes some of the technical aspects of the approaches that can be adapted to workforce planning, for example: the aim and principles underpinning the process; the concept of demand/supply modelling and simulations; assumptions, timeframes and planning parameters. The third section focuses on the importance of integrated workforce planning, exploring what this means in an Irish context. The last section of the Chapter summarises some of the international approaches adapted to workforce planning.

6.2 Workforce planning

One key element of effective staffing is the development of appropriate workforce planning mechanisms. Planning processes need to be able to monitor indicators of supply and demand for nursing and midwifery staff, while taking into account the demographics of the client population, and the strength of the workforce, and assess the extent to which a balance of demand and supply can be achieved. Workforce planning mechanisms must be underpinned by a clear understanding of the definition of the term, including the rationale for planning, potential obstacles, prerequisites and the preparation and expertise necessary to prepare meaningful plans.

6.2.1 Definitions

Workforce planning is the contemporary term which has generally replaced the phrase of 'manpower' planning. There are a variety of definitions for workforce planning in the literature, each of which differs

slightly in emphasis. The steering group has adopted the following composite definition for the purpose of this study:

> A planning process undertaken to ensure there are sufficient staff available at the right time, with the right skills, diversity and flexibility, in the right place, to deliver high quality care to meet the needs of individuals and communities (Department of Health UK 2000; International Council of Nurses 1999; Richter, 1984; WHO, 1980).

In some situations human resource planning is the preferred title (International Council of Nurses, 1994). Human resource planning involves forecasting an organisation's human resource needs, creating charts that show planned succession, and producing a record of the skills and abilities needed by individuals in order to progress within the organisation (McKenna, 1998). This is sometimes referred to as Health Human Resource (HHR) planning. The steering group for this study elected to continue to use the term workforce planning as it is more widely in use. Definitions for the terms regularly used in the process of workforce planning are set out in Table 6.2-1.

Table 6.2-1 – Terminology commonly used in workforce planning

Demand	Sum of the amounts of the various types of health services that the population of a given area will seek and has the means to purchase at the prevailing prices within a given time period
Demand forecasting	Estimating future needs for people and competencies by reference to corporate and functional plans and forecasts of future activity levels
Forecast	A conjecture or scenario of what may happen in the future
Forecasting requirements	Analysing the demand and supply forecasts to identify future deficits or surpluses with help of models, where appropriate
Gap	The difference between projected positions and human resources supply. It can be a positive number indicating surplus workforce or a negative number indicating unmet projected position
Human resource planning	A strategy for the acquisition, utilisation, improvement and retention of an enterprise's human resources. Previously known as manpower planning. The systematic and continuing process of analysing an organisation's human resource needs under changing conditions and developing personnel policies appropriate to the longer-term effectiveness of the organisation. It is an integral part of corporate planning and budgeting procedures since human resource costs and forecasts both affect and are affected by longer-term corporate plans
Human resource need	An organisation's forecast of needed staff size and skill mix for the designated planning period
Labour supply	The size of the workforce, along with its skills and geographic location and its willingness and ability to be productive
Requirements	Amount of services, personnel, etc. required to satisfy a given set of assumptions about how the (health) sector does, could or should function
Resources	Human resources, money, materials, skills, knowledge, techniques and time needed or available for the performance or support of action directed towards specified objectives
Skill mix	The inter-personnel ratios of different categories of (health) workers
Supply	Availability and characteristics of resources and services at a given time or at a future time according to specified assumptions about production, losses and use
Supply forecasts	Estimating the supply of personnel by reference to analyses of current resources and future availability, after allowing for wastage.

Sources: World Health Organisation (2001); National Institutes of Health (2000); Armstrong (1998); Mullins (1996); and International Council of Nurses (1994)

The definitions emphasise the systematic nature and continuing process required in workforce planning. In general there appears to be consensus in the understanding of 'supply' and how future supply is anticipated. A variety of approaches and terms are used in relation to predicting demand. Some studies refer to 'requirements', others to 'demand', and others to 'needs'.

At a recent meeting in the UK, Armour (2002) drew attention to misconceptions about workforce planning. She indicated that it is not: finger in the air number crunching; setting numbers for education commissioning; isolated to training levies; centred around occupation codes; a demand for numbers for certain professions; or an isolated procedure. Whatever terminology is used workforce planning is a fundamental planning tool, critical to quality performance; it contributes to achievement of health system goals by providing a basis for justifying budget allocation and workload staffing levels.

6.2.2 Rationale for workforce planning

Health care is particularly labour intensive. In any organisation, staffing requirements are a complex resource to manage and plan for. This is especially the case for the health service, for the following reasons:

- variations in levels of skill, attitudes toward work, in addition to motivation and behaviour
- the difficulty of producing health professionals at short notice
- the challenge of changing work patterns, once established, even though circumstances change
- uncertainty in the prediction of the patterns of employee behaviour, particularly in terms of their propensity to leave
- limitations of substituting persons of differing skills and work experience for each other (Hornby, Ray, Shipp and Hall, 1980).

Past experiences indicate that, while complex, it is vitally important that workforce planning assessments are undertaken and co-ordinated at national level. With the changes in nursing education the necessary lead-in time has extended to at least five years. Therefore a decision to increase or decrease the number of education places takes longer to have an impact. Information on the projected workforce needs is an important ingredient to ensure optimum efficiency and availability of necessary staff.

Major capacity expansion in the health services over the next ten years is proposed in the Health Strategy (2001). Statistics presented in Chapter 2 of this report highlight the challenge currently being encountered in meeting the workforce requirements for the present system. Past experiences show that failure to aggressively plan for the future workforce needs results in nursing and midwifery shortages and a decreased ability to meet service requirements. International experience indicates that this particularly relates to: reduced beds; cancelled surgeries; and decreased capacity in accident and emergency and outpatient departments (Health Care Advisory Board, 2001). Persistent vacant posts wear down the morale of valuable staff and often result in an increased patient load, in addition to more paper work, the necessity to 'float' nurse and midwives between wards and services, and an increased pressure for staff to undertake overtime. It is evident that the delivery on the proposed Health Strategy developments will be contingent on the capability of the system to proactively plan for and provide additional numbers of nurses and midwives. This reinforces the urgency of engaging in workforce planning assessments for future nursing and midwifery resource requirements.

6.2.3 Obstacles to effective workforce planning

The major impediments to initiating workforce planning for nursing and midwifery are identified in the literature. They include the following:

- absence of an integrated comprehensive approach within organisations
- scarcity of information and consequent lack of problem awareness
- ineffective utilisation and communication of available data
- lack of readily available, accurate, current and complete sources of information on nursing/midwifery supply
- collection of data only occasionally or for other purposes
- problems associated with differences in reporting periods
- changes in definitions and approaches to calculation
- survey intervals and other factors influencing data quality and comparability
- difficulty in data collection because of migration between regions and to and from other countries (ICN, 1993/1994; Prescott, 1991; Richter, 1984; Hornby et al; 1980; WHO, 1980).

Problems with workforce planning in the past in the UK have been identified in the following key areas: (i) data not owned by service providers; (ii) planning seen almost as a 'luxury' or 'specialist' role, not linked to generalist human resource functions; (iii) difficulties with information systems and data input, and (iv) planning not always linked with strategic direction. Many workforce development constraints have influenced the ability to plan effectively. Some of these relate to: money; time; labour market; organisational instability; inflexibility to change; parochialism; short-termism; lack of imagination; tribalism; fear; shortage of skills in workforce planning; and organisational development (Axelby, 2002).

Many of these issues are evidenced in Ireland and were identified as constraints on the current project. The recommendations made in Chapter 7 concentrate on enhancing both information sources and quality as a base for forecasting. The framework proposed focuses on the introduction of formal structures and processes that will address some of the impediments to workforce planning identified by other countries.

6.2.4 Prerequisite for workforce planning

The literature indicates that there are certain prerequisites to be considered and addressed before workforce planning exercises can be undertaken. This particularly pertains to information, expertise and commitment to the process at all levels in the system. The Advisory Board Company, USA (2001) suggested that, when making registered nurse (RN) projections, the following trended information is critical:

- enrolment and graduate data from nursing schools; age at graduation; work setting of new graduates
- workforce data, including age distribution, work status (nursing or non-nursing) and work setting
- total population data.

The following have been identified as being essential organisational elements providing a framework for effective workforce planning activities:

- top management support
- accountability at all levels
- integration of other planning processes with workforce planning
- a simple, systematic and well-documented process (National Institutes of Health, 2000).

One of the key process elements essential for effective workforce planning is agreement on the methods for determining the appropriate staffing levels, tailored for the complexities of the various care settings and specialties. For example, what is the optimum number of nurses necessary to provide care for patients in a 20-bed surgical ward that will ensure a quality service and value for money? In order to determine this and other issues in relation to staffing, every effort is required to expedite the examination of (i) the development of appropriate systems to determine nursing staffing levels, and (ii) the conditions and staffing levels in particular areas such as services for care of the older person as recommended by the Commission on Nursing (1998). The outcome will inform vital elements of the framework for workforce planning.

With the above in mind, the steering group is proposing a series of recommendations to ensure that the prerequisites for effective workforce planning are put in place (see Chapter 7).

6.2.5 Preparation for workforce planning

Workforce planning is a key role of managers in the health system. The current focus on the process is new to nurse and midwifery managers and therefore requires careful preparation. As the relevance of the results of workforce planning depends on the capacity of planners, at local, regional and national level and the quality of the data, it is essential that all participants are knowledgeable on the techniques used and have a clear understanding of the desired outcome. Hall (1993) indicates that participants and advisers in the planning exercise should together have a sound knowledge base in the following areas:

- health and human resource planning
- health and human resource economics
- health and human resource policy
- health and human resource statistics
- health legislation
- public health administration
- social sciences related to health
- hospital and facility planning
- education in the health professions
- educational planning
- nursing and midwifery sciences
- other health disciplines (e.g. medicine, epidemiology, administration, personnel management, nutrition, demography)
- community mobilisation.

The workforce planning process is too complex to be the sole responsibility of one person, one unit or even one organisation. All those involved in the process should be prepared for the role. A great deal of

co-operation and co-ordination is required among those involved. As a new function it is acknowledged that those participating in the workforce planning process should be appropriately prepared for the task. For this reason the steering group is making specific recommendations for the preparation of an education programme specifically designed to meet the needs of nurse and midwifery managers. It is envisaged that a standard education package would be developed that could be cascaded though a 'train the trainers' approach or other appropriate methods.

The above examines the understanding and rationale for workforce planning. The following section explores workforce planning methodologies.

6.3 Workforce planning methodologies

The literature accessed during this study indicates that flexibility, relevance and validity in planning require both ready access to timely and accurate information and the use of appropriate conceptual and analytic techniques for planning in a rapidly changing health system. Computer-based modelling eases the computational difficulties and burdens experienced in previous years. Strong linkages and open exchanges among key stakeholders, multi-disciplinary expertise (nursing, economics, computer science, epidemiology, medicine, sociology, etc.) and working in collaboration with policy and administrative decision-makers and planners are essential for an effective outcome.

This section of the report deals with some of the issues pertinent to workforce planning methodologies — aim of workforce planning, principles underpinning planning, models for forecasting supply and demand, the use of simulation, assumptions and planning time frames and levels.

6.3.1 The aims of workforce planning

Prior to engaging in a complex planning exercise it is essential to have a clear understanding of the purpose and desired outcome. The aim of workforce planning is described by Armstrong (1998) and is synopsised on Table 6.3-1.

Table 6.3-1 – Aims of workforce planning

To ensure that organisations:

- obtain and retain the number of people needed with the skills, expertise and competencies required
- make the best use of human resources
- are able to anticipate the problems of potential surpluses or deficits of staff
- develop a well-trained and flexible workforce, thus contributing to the organisation's ability to adapt to an uncertain and changing environment
- reduce dependence on external recruitment when key skills are in short supply by formulating retention, as well as employee development, strategies.

Source: Armstrong (1998)

Although not specifically prepared as the aim of workforce planning for nursing and midwifery, the above have direct relevance to this area.

6.3.2 Workforce planning principles

It is important that the principles underpinning each workforce planning study are identified at the start of the process and used as the test against which plans are measured. An example of the principles proposed by the Scottish Integrated Workforce Planning Group (SIWPG) are set out in Table 6.3-2.

Table 6.3-2 – Principles of workforce planning

- Integrate with planning for services — and planning for learning, finance and organisational development.
- Improve the balance of demand and supply — by understanding and managing workforce demand as well as supply.
- Do this across multiple dimensions — of time, organisation, geography and staff group.
- Use a workforce planning approach appropriate to the issue — without over-sophistication.
- Use a continuous, iterative process — which includes monitoring and evaluation.
- Maximise flexibility.
- Plan for service delivery teams — with the best mix of skills.

Source: *Planning Together — Final Report of Scottish Integrated Workforce Planning Group* (2002)

The approach taken by the new United Kingdom (UK) Workforce Development Confederations in the UK is also based on an approach underpinned by principles:

- starts from service need
- skills and competences first: then numbers and types of staff
- multi-disciplinary: services not professions
- requires responsive education and training
- looks to future requirements
- mainstream — workforce planning (Sands, 2002).

Another example of the use of principles in the workforce planning process is that of the Workforce Confederation for Northern England. The Confederation have adopted the following underlying principles: partnership, flexibility, innovation, excellence and facilitation (Axelby, 2002).

The International Council of Nurses (1994) identified 'Ten Commandments' of human resource planning (see Table 6.3-3). The advice is given on the basis of reviewing systems for planning used internationally.

Table 6.3-3 – Ten Commandments of human resource planning

1. Use a workforce projection model that is applicable to your country or regional realities, i.e. use realistic methods.
2. Do not isolate the planning of some health workforce categories from that done for relevant other categories. In other words, the supply and productivity of, and requirement for, many different categories are strongly interrelated.
3. Link health workforce planning to health service planning, but not too closely. The two types of planning involve different time periods and levels of detail.
4. Give as much or more attention to requirements as to supply.
5. Give adequate attention to policies designed to decrease losses as a way to bring supply and requirement into balance, i.e. don't just think of training more health workers but also of reducing losses, increasing productivity, or reducing demand.
6. Remember that the number of health workers is only part of the question; their quality, motivation, utilisation and other considerations are also very important.
7. Test the reasonableness of your projections of supply and requirements, i.e. use common sense and check (and re-check) for errors!
8. Project for a long period of time (10-25 years), use the projections for a short period of time (3-5 years), and update your projections often.
9. Provide for both planning 'process' and planning 'products', i.e. the way the study is done and who is involved are as important as the results.
10. Accept that time shall prove your projections wrong; accordingly, be humble and remember that the final test is not whether the 'plan' made accurate predictions, but that it helped move policy and actions in the 'right' direction.

Source: Adapted from International Council of Nurses (1994)

The main message from the 'Commandments' is not to over-emphasise supply planning to the exclusion of predicting future demand requirements. The importance of an integrated approach to workforce planning and the need for synchronisation with other planning processes is also evident. Workforce planning can be seen as an art form and a balancing act. It is bigger than just the public health service and is constantly changing.

The approaches to workforce planning described in the literature are all clearly based on identifying core principles.

6.3.3 Workforce planning steps

A review of several models for workforce planning undertaken by the National Institutes of Health (2000) has shown that the components vary depending upon the needs of organisations. However, the general processes all rely on:

- integration — with other planning processes, in particular strategic planning, organisational objectives and the budget process
- analysis — of projected workforce supply based on projected retirements and attrition data on current workforce
- forecast — of workforce needs including identification of skills needed in the future
- strategies — with action items to address needed or surplus skills
- evaluation — dynamic process that ensures the workforce model remains valid and that objectives are being met in support of the organisation's performance goals.

This is reinforced in the general management and health care literature. Mullins (1996) indicates that whatever the scope and nature of the workforce plan at least four main stages can be identified: (i) analysis of existing resources; (ii) supply forecast (estimation of likely changes in resources by a target date); (iii) demand forecast (forecast of staffing requirements necessary to achieve corporate objectives by target date); (iv) personnel management action programme (measures to ensure the required staffing resources are available when required).

6.3.4 Demand and supply indicators

A wide range of different models for forecasting human resource requirements has been used in workforce planning studies. At it simplest this centres on identifying sources of supply, anticipating future demand, analysing the gap between supply and demand and introducing plans to address the deficit. Some of the key elements to be taken into account when considering demand and supply indicators are described by Buchan (2001). The main items are set out on Table 6.3-4. The list is not intended to be exhaustive, but to highlight the complexities of a process aiming at matching supply and demand with uncertain uptake of available positions in the workforce.

Table 6.3-4 – Demand and supply indicators

Demand (for health care)
- Size and demographic profile of 'client' population
- Government policies (level/allocation of resources and funding between different areas)

Demand (institutional decisions on meeting demand)
- Organisational policies/practice (case mix; patient length of stay; staff mix; medical priorities and interventions and resources)

Demand (for nurses and midwives)

- Derived from aggregate effect of above factors/decisions, particularly level/allocation of resources and staffing mix, e.g. willingness of employers to employ (linked to perceived scope for substitution between different staff group, e.g. nurses and health care assistants)

Supply (of nurses and midwives)

- Size of 'pool' of qualified nurses available for labour market
- Age profile and labour market behaviour (e.g. turnover rates; career breaks; retirement patterns; part-time work, etc.)
- Employment options and alternatives (e.g. to nurse or not to nurse; to nurse in the public or private sectors; to nurse in particular geographical region, hospital or specialty).

Source: Buchan (2001a) *Scotland's Nurses at Work: A Review for the Health Department, Scottish Executive*

In 1994, the International Council for Nurses (ICN) published a reference document on planning human resources for nursing. In the text the information sources (data sets) required before forecasting can be conducted were identified. The data sets are classified in two major groups: supply data sets and requirements (demand) data sets. The minimum data sets needed are summarised on Table 6.3-5. This listing was used to assist the steering group in identifying information gaps in the current systems.

The literature indicates that forecasting should be a dynamic process that facilitates planning for different scenarios (National Institutes of Health, 2000; Hart, 1997). Most models operate by undertaking analysis of historic trends and then projecting these forward under a number of assumptions. Each approach, although different, fails to consider all the factors involved. This is why in many countries calculations to arrive at the final estimate of requirements have used a combination of methods. Each model presents certain advantages as well as disadvantages. The selection of the most appropriate method, according to the International Council of Nurses (1994), will depend on:

- the degree of Government involvement in planning and health care delivery
- the quality of the available database and planning expertise
- the degree to which the forecasts will be acceptable within the present context of a country
- the extent to which the forecasts take into account past experiences in the production and utilisation of health personnel (p 24).

In general several levels of forecasting appear to be undertaken to arrive at a final estimate of the requirements. These can be broadly divided into models for predicting demand requirements and those focused on anticipating supply.

Table 6.3-5 – Minimum supply and requirements data sets needed for forecasting

Supply data set — availability and characteristics of resources and services at a given time, or at a future time according to specified assumptions about production, losses and use

Personnel characteristics of nursing/midwifery personnel
- Age
- Sex
- Place of birth
- Employment status (full/part-time, retired)

Education/Training
- Type of nursing education
- Year of graduation
- Licensure status (if applicable)
- Post-basic education/certification

Specific characteristics of the job to be performed
- Institutional or health facility setting
- Geographic location
- Type of work (task analysis)
- Job title and classification

Requirements data set — amount of services, personnel, etc. required to satisfy a given set of assumptions about how the (health) sector does, could or should function.

Staffing issues
- Vacancy rates and turnover rates in the various occupational categories

Population in relation to nursing services
- Size of population by age group
- Size of the urban population (by city)
- Size of the rural population
- Birth rate
- Infant mortality rate by geographical area
- Life expectancy by geographical area
- Population covered by the various types of health facilities

Nature of the health system
- Number of health facilities (by category)
- Distribution of health facilities (by category)
- Utilisation data of the health facilities (by category)
- Work hours of health personnel by category (full-time equivalents)
- Vacancy and turnover rates of the health facility (by category)

Health economics
- Costs of employed human resources
- Costs of basic training
- Number of training institutions and programmes
- Student intake/graduate output

Source: International Council of Nurses (1994) *Planning Human Resources for Nursing*

Predicting demand

Any assessment of the future staffing requirement for the health services must begin with a consideration of the likely pattern of future demand for health care. The International Council of Nurses (1994) describes four main models to estimate workforce requirements. These are: health needs, service targets, health demands and workforce/population ratios. A brief synopsis of each approach is given on Table 6.3-6.

Table 6.3-6 – Methods used to estimate workforce requirements

Health needs
The health needs model bases its calculations on a given population's health needs as estimated by health professionals. In most cases optimum health is sought, but when resources are scarce the goal may be to provide a minimum level of health/nursing care. The result formally recognises the health system's goal and implies that quality assurance has been considered. However, the forecast is often unrealistic as there are no financial limitations in this exercise and research has not yet been able to provide quantifiable indicators linking processes of care and outcomes.

Service targets
The service targets model sets certain goals that are intended to produce personnel in numbers (or ratios), changing the current supply by a certain percentage e.g. 5 per cent, 10 per cent within a certain period of time. Health authorities generally set targets and the use of this approach presupposes a highly centralised health system. This method seeks a good balance between what the population needs, what it wants, what medical technology can offer and what society can actually deliver at a given time.

Health demands
Estimates of health demands may be determined by identifying (i) the numbers and kinds of health services a given population will actually use at a given time and at a given cost or (ii) the quantity and type of services employers are willing and able to purchase at a given time and at a given cost. Current health service utilisation rates are a good measure of the met demand. The unmet demand must still be forecasted if this is to be taken into consideration by planners.

Workforce/population ratios
Workforce/population forecasts may be based on observed or historically proven manpower/population ratios when the existing numbers are considered adequate. Where the current status is found to be unsatisfactory, manpower/population ratios must be newly estimated by planners according to given assumptions relating to objectives and trends.

Source: International Council of Nurses (1994)

Accurate demand forecasting is crucial to planning and budgeting activities. According to a *Healthcare Financial Management* article, any quantitative forecasting method should be 'easily calculated' by in-house staff members using readily available information and existing tools. It should also yield results that are 'understandable' by both the financial management staff and those who use the results for decision-making. A group of alternative approaches to predicting demand is set out in Table 6.3-7.

Some demand models use the rate of growth in qualified nurses as a proxy for the demand. This approach assumes that the health system has established the correct number of nurses and midwives required to provide optimum service. Information sources are not sophisticated enough to make such an assumption for the Irish health care environment.

Table 6.3-7 – Forecasting methods to predict demand

Per cent adjustment
This calculates the per cent difference in demand between two consecutive years, Year 1 and Year 2, then projects Year 3 demand by assuming the same per cent change will apply from Year 2 to Year 3. While this method is highly trackable, it fails to consider any seasonal effects.

Twelve-month moving average
This involves projecting any specific month's demand by averaging the total demand of the immediately preceding 12 months; this method works well for short-term forecasting, but yields results that tend to lag behind recent trends and seasonal effects.

Trendline
This method plots historical utilisation by month (i.e. utilisation on the y-axis, and corresponding numbered months on the x-axis) then calculates the best-fitting straight line between the points. Projections are based on a linear extension of the best-fit line. This method takes into consideration recent trends and is more accurate than the previous two methods.

Seasonalised forecast
This requires the most computation. The method first determines the effects of seasonal variation by calculating seasonal indices (the monthly average divided by the yearly average). A trendline is then calculated based on the 'deseasonalised' data. This method recognises the overall trend in demand for services and the cyclic nature of health services demand. While significantly more complex to construct, these models offer a more nuanced perspective on future demand. Demand modelling, then, is more important than ever as hospitals anticipate greater volume growth.

Source: Healthcare Financial Management quoted by Nursing Executive Center (2001)

Having considered the international literature, this review focused on identifying issues specific to an Irish health care environment. The directors of the Nursing and Midwifery Planning and Development Units were asked to consider the factors likely to affect demand for the nursing and midwifery resource in Ireland. A focus group discussion was used to debate the issues. The factors were divided into four broad areas: health need, health demand, service need, and employment practices. The listing presented on Table 6.3-8 is illustrative and intended to stimulate debate when methodologies for predicting future demand are being developed.

Table 6.3-8 – Factors affecting demand for the nursing and midwifery resource

Macro	Micro (factors affecting)
Health need	• Demographic trends • Ageing population • Size of population • Death rates and birth rates • Life expectancy • Health status
Health demand	• Health facilities — distribution of facilities, utilisation of facilities • Technology • Increase in service — day care • Increase in acuity of inpatients • Reduced length of stay for inpatients
Service need	• Service provisions and plans • Financial costing/ health budget • Health Strategy — *Quality and Fairness: A Health System for You* • *Primary Care: A New Direction* • Policy changes • Expanding role/scope of practice of nursing and midwifery • Strategy for Nursing and Midwifery in the Community (NAMIC) • Cancer initiatives • Cardiovascular strategy • Disability services • Health promotion • Child care • Developmental posts
Employment practices	• Workplace flexibility • Flexitime, family policy • Rosters • Annualised hours • Workload analysis • Skill-mix

Source: Directors of the Nursing and Midwifery Planning and Development Units (January, 2002)

Predicting supply

In general supply models predict the overall number of nurses and midwives working with the public and private health system. The necessary data fields required are: the number of qualified workforce by age profile; effective pool by age profile; participation rates by age profile; projected entrants to the register (training output and overseas entrants) and death rates for the age profiles (Hart, 1997). From this it can be appreciated that availability of information on age is central to supply models.

The directors of the Nursing and Midwifery Planning and Development Units were again asked for assistance in identifying issues affecting supply. They outlined a series of factors (macro and micro) that currently affect the supply of nurses and midwives in Ireland and which could be considered in future planning assessments. These were grouped into two broad areas: the workforce population and personal characteristics of nurses and midwives (see Table 6.3-9).

Table 6.3-9 – Factors affecting supply of nurses and midwives

Macro	Micro (factors affecting)
Workforce Population	
Nursing student group (intake in each division)	• Number in each year's intake • Attrition during programme • Attrition post-graduation • Age profile of student (less service years)
Current nurses/midwives in employment	• Service need per specialty • Retirement • Leave for personal development • Leaver, transfer, location change • Roster/shift developments • Career break/ parental leave • Flexi-time
Promotional posts	• Development of clinical career pathways • New developmental posts • Management posts • Promotion to non-nursing health related posts, education posts, new specialties • Secondments to project work/research • Scope of practice — new areas of practice
Post-registration secondments	• Secondments to post-basic specialist courses
Areas of recruitment	• Recruitment of new nurses/midwives • Return-to-practice courses • Overseas recruitment • Health professional sponsorship initiative • State enrolled nurse (SEN) conversion • Re-assignment, following long-term sick leave
Bank/agency/overtime nurses	• Use of overtime • Flexi-hours introduction (reduction in available hours from permanent staff)
Personal characteristics	
Age	• Less service contribution due to early retirement
Location	• Transfers to birth location
Employment status	• Flexible hours, job-share, parental leave
Specialty of work	• High mobility rate in specialties
Work setting	• Suitability to person
Job title and position	• Matching suitability with each nurse
Contentment	• If leaving, rate related to specific issues may be addressed

Source: Directors of the Nursing and Midwifery Planning and Development Units (January, 2002)

Overview of forecasting approaches

A review article *Forecasting models for human resource in health care* (O'Brien-Pallas *et. al*, 2001) was considered by the steering group. The article provides a valuable resource as it reviews the approaches published between 1996 and 1999 that have been used to forecast human resource requirements for nursing. The systematic search initially yielded 1,768 publications. Following appraisal and validity assessment 308 were selected for inclusion in the review. Of these, 199 were available. The review highlights the three commonly used approaches to forecasting: supply/utilisation-based, demand-based and econometric. An overview of the various approaches used in each category and a description of the methods are given in Table 6.3-10. Although these approaches are grouped into three broad categories, researchers commonly combine several forecasting designs in a single study.

Table 6.3-10 – Forecasting approaches

Approach	Description of methods
Supply/utilisation-based	
• Manpower personnel to population ratios • Utilisation-based	• Determination of need is based on calculation of the number of personnel required to serve future populations in the same way that the current population is being served. • It is based on adjusting and projecting current levels of service provision with expected demographic changes in the population being served. • The current stock, entries, attrition, demographics, training, and workforce participation patterns of each profession have been the primary information used in this process. • Estimates reflect neither need nor demand for health human resource, but merely project the status quo.
Demand-based	
• Normative or empirical • Health needs • Professional needs • Needs-based • Biological • Service targets	• Determination of need is based on calculation of requirements on meeting service needs of the estimated future population in cost-effective ways. • It is based on quantity and types of services that health professionals feel people need. • Resource requirements are quantified based on determining the burden of illness in the population. This method has proven effective for many public health measures, but otherwise tends to produce estimates of health human resource demand that exceeds practical limits. • Determination of demand is based on what the consuming public actually wants. • It involves setting targets for the delivery of health services. • Health human resource requirements are linked to consequent increases and decreases in service volume and complexity.
Econometric	
• Economic or effective • Health demand • Econometric • Functional or rationalised • Effective demand • Bureau of labour statistics	• It estimates the number of personnel required by the health system within the context of current and future resource constraints. • It is based on determining what price (through taxes, direct pay, or varying arrangements of insurance) people are willing to pay for services. • Both met and unmet needs are included in this framework. • It attempts to answer the question of which services are technically feasible. • It is a macro economic model. • Health system components, including health human resource, are evaluated in the context of the economic system and labour market as a whole.

Source: Adapted from O'Brien-Pallas *et. al*, (2001)

The authors commented that each method provides substantially different estimates of future health human resource requirements. One of the main issues highlighted in the review is that 'health human resource planning in most countries is intermittent, varying in quality, and often carried out without adequate data' (p 121). Some important points, relevant to this study, were highlighted in the review.

- Much of the workforce planning undertaken to date does not consider the complex factors that influence health human resource.
- Supply and demand approaches have dominated.
- Simulation models offer the most promise for the future.
- Sufficient attention must be directed to determining client, nurse, and system benchmarks for quality in modelling health human resource requirements.
- The forecasting methods described have demonstrated their accuracy and usefulness for specific situations but none has proven accurate for long-term forecasting or for estimating needs for large geographical areas or populations.
- Lack of comprehensive databases, use of manpower-to-population ratios, and inaccurate projections of population growth have contributed to the current health workforce situation.

- The wide choice of methodologies has not clearly improved the accuracy of forecasting.
- Forecasting is not restricted to single method approaches.
- Each of the many potential approaches for forecasting health human resource requirement reflects limitations.
- Estimates become increasingly unstable the further one projects into the future.
- The potential for overestimating 'true need' exists with projections based on supply.
- Labour force participation patterns tend to be less predictable.
- Failure to recognise the considerable substitution potential across allied health professions can further reduce the accuracy of supply side forecasting.
- The need for testing economic, social, and cultural 'shocks' to the system and alternative views of how nursing care may be delivered in the future is required.
- Planners and researchers must realise that there is no right number of nurses (O'Brien-Pallas *et. al,* 2001).

The most informative finding of the review is that single discipline occupation studies are common and fail to consider such important issues as inadequate service levels or the effects of shared competencies and substitution between health occupations. Health human resource planning should be an iterative process and cannot be viewed as a permanent forecast or estimation.

6.3.5 Simulation models

Simulation is a technique used (supported by computer programmes) to determine the likely match or gap between predicted supply and staff demand for a given workforce. The WHO (1998) draws the distinction between planning and projection.

> . . . planning models result in a plan, while projection and simulation models refer to models used for developing alternative projection scenarios for the purposes of analysing their relative benefits and costs.

Simulation is a powerful technique. Hall (2000) suggests that it allows planners to explore consequences of alternative policies, facilitates input and output sensitivity analysis, and makes it easier to involve stakeholders throughout the process. The extent to which simulation provides useful scenarios for consideration depends on the quality of the data used in the model and on the extent to which the variables modelled reflect the system as a whole. Mullins (1996) cautions against the use of very complex computer programmes for workforce planning assessments. The advice given is that multifaceted computer techniques can be helpful but should be applied only as appropriate to the amount of detail and accuracy required. What is most important is the recognition of the need for effective planning to suit the requirements of the particular organisation.

A micro-computer-based integrated model to project supply requirements for health human resources was commissioned by the WHO in 1992. The *ToolKit for Planning, Training and Management* was designed for the World Health Organisation. The purpose of the *ToolKit* was to assist countries with the development of long-range (20-30 years) strategic human resource development plans. Detailed information is required for the two main data entry areas of the system — supply model and requirements model. These are then combined to give detailed projections and reports. A comprehensive help system accompanies the model. A major feature of the system is that it allows for integrated workforce planning for at least five health disciplines. The Human Resource for Health (HRH) model makes it possible to test the likely effects of alternative scenario assumptions on HRH supply. The extent of the information required for the system would not be readily accessible for Ireland.

In 1998 a new simpler model (HRH Short) was designed to help planners with intermediate-range (5-15 years) projections and policies. It was advised that the HRH models are best if applied for a variety of health occupations, not a single one, since the 'mix' is as important as the absolute numbers. It was indicated that the models might not be entirely suited to Ireland as they were originally designed for developing countries.

6.3.6 Assumptions

The importance of identifying the assumptions being made when preparing workforce plans is identified in the literature. During this study the directors of the Nursing and Midwifery Planning and Development Units identified some of the possible assumptions that might be considered in future planning assessments (see Table 6.3.11).

Table 6.3-11 – Suggested assumptions for consideration in workforce planning for nursing and midwifery

- The number of student nurses entering the education system on an annual basis will continue at the level of 2002 for the foreseeable future.
- The average turnover rate will remain at that identified in the *National Study of Turnover in Nursing and Midwifery* and decrease in some circumstances.
- The reduction in junior hospital doctor's hours will have an impact on nursing and midwifery.
- Implementation of the proposals in the Health Strategy (2001) will require significant capacity expansion of nursing and midwifery services.
- Recruitment from abroad is likely to stabilise over the coming years.
- Employment of agency staff will continue.
- Implications of national strategies, i.e. Cancer Strategy, Cardio-vascular Strategy, Palliative Care Strategy, and Traveller Health Strategy leading to considerable numbers of development/project posts, will ultimately impact on the supply and availability of nursing and midwifery personnel for existing health services.
- Migration from employment in the ERHA to other health board regions will continue.
- Increased participation in specialist graduate and degree programmes will take staff from the workplace and increase the requirement for replacements.
- Increased specialisation and advance practice posts will create a demand for replacement staff.
- Flexible working hours will result in reduced hours of service provision which will have an impact on demand for staff.
- New developments in consultant-led services and childcare services will impact on demand for personnel.
- The demand for midwifery-led care will increase.
- Return-to-practice programmes will supply a small number of staff on an annual basis.
- Increased technology and shorter hospital stay will increase the workload for nurses and midwives.
- Extension of Health Care Assistant Training Programmes in coming years should have an impact on the supply of nurses.
- In the coming years the predicted reduction in school leavers will have an impact on the numbers of school leavers applying for nursing.

Source: Directors of the Nursing and Midwifery Planning and Development Units (January, 2002)

Best practice indicates that the main assumptions on which forecasts for the requirement of nurses and midwives are based should be identified, agreed nationally and made explicit in all workforce plans. The list given on Table 6.3-11 could be used to stimulate discussion on the assumptions that might be built into data used in any Irish system for modelling supply and demand.

6.3.7 Information on international flows

The literature indicates that international labour market analysis is an important component of workforce planning. Continuous cycles of over- and under-supply of health human resources worldwide, particularly for nursing, reflect the inadequate projection methods used to estimate future requirements and the failure to consider the evidence supplied by ongoing labour market trends (Buchan, Edwards

2000; O'Brien-Pallas *et. al,* 1998; Pong, 1997; Aiken and Salmon, 1994; Schroeder, 1994). Figures released by the International Council for Nurses in April 2001 describe an emerging global crisis and a worldwide shortage of nurses. The international mobility of nurses has become a contentious issue in the context of a growing and critical global shortage of nurses. Very severe nursing shortages have been identified in the UK, Netherlands, Poland, Switzerland, Canada and the USA (ICN, 2001; Irwin, 2001; Butler, 2000; Buchan, 2000). Most countries are recruiting heavily from Australia, South Africa, Spain, Germany, the Philippines, India and Nigeria to meet service requirements. Irwin (2001) suggests that recruiting from abroad can be a very expensive short-term fix.

It is now acknowledged that migration of health professionals in and out of countries must be part of health human resource planning. Globalisation and the migration of workforces have increased the need to make use of labour market indicators in planning. The ability to model international nurse flows is limited by the lack of mobility data in comparable form. The International Labour Office has identified eighteen indicators, which are intended to monitor trends and provide for compatibility across regions (see Table 6.3-12). It is intended that the Key Indicators of the Labour Market (KILM) will assist countries in examining the overall status of the health workforce in the broader labour market of their country, by comparison with countries at similar levels of development. The capacity of countries to participate varies widely around the world. For this reason the proposal is to focus on five indicators (labour force participation rates; employment to population ratio; employment by sector; unemployment, under-employment and inactivity; and youth employment) for world comparison. It is important that systems for workforce planning in Ireland provide information on these key indicators.

Table 6.3-12 – International Labour Organisation's key indicators of the labour market (KILM)

Participation in the world of work	
1	Labour force participation*
2	Employment-to-population ratio*
3	Status in employment
4	Employment by sector*
5	Part-time workers
6	Hours of work
7	Urban informal sector employment
8	Unemployment, underemployment and inactivity*
9	Youth employment*
10	Long-term employment
11	Under-employment by education attainment
12	Time-related under-employment
13	Inactivity rate
14	Educational attainment and illiteracy
15	Real manufacturing wage
16	Hourly compensation costs
17	Labour productivity and unit labour costs
18	Poverty and income distribution

Note: * priority key indicators

Source: International Labour Office available at: http://www.ilo.org/public/english/employment/strat/polemp/dilm/toc—f.htm

Currently there is no one model capable of interpreting the complex flows of nurses' movements to produce accurate assessments of future changes. However, an exchange of information at least would help prevent ill-informed recruitment in countries where there are shortages and allow for collaboration

on the ethical dimensions to international recruitment. This issue is of critical importance to EU policy makers. A session at the European Health Forum in September 2001 considered whether health care human resource planning at European level was a useful or feasible tool to predict and plan movements of health care personnel including nurses.

6.3.8 Time frame

In preparing workforce plans there is one functional consideration that must be decided — the planning time frame. Managers need to balance the certainty of short-term planning against the need to plan for longer-range objectives. The literature assessed as part of this study indicates that a three- to five-year time frame for workforce planning will generally provide a reasonable balance between the extremes of short and long-term planning (Scottish Executive, 2001; National Institutes of Health, 2000; International Council of Nurses, 1994; O'Brien-Pallas, 1993). The main message is the need to engage in both short-term and long-term planning on an ongoing basis with frequent review and re-planning built into the process.

6.3.9 Planning levels

Many planners ask: What is the appropriate level for developing workforce plans? A review of the literature suggests that there is no single answer to the issue of appropriate planning levels. The most useful guide is to make sure the output of planning levels relates to the organisation programme or to departmental strategic objectives and has relevance to budget-holding areas. There should be flexibility to determine planning levels that make managerial sense and that support strategic plans. A bottom-up and top-down approach is advocated. In this situation plans should at least be prepared at three levels: national, regional and local. The size of the organisation will determine whether a single plan is prepared or whether the local plan will reflect a constellation of plans for the range of services provided by the organisation.

6.3.10 Planning parameters

The supply of nurses is determined centrally though Government funding that supports and determines the number of pre-registration, post-registration and return-to-practice places. Statistics presented in Chapter 2 of this report clearly indicate that the public health service is not the sole employer of nurses and midwives in Ireland. It is estimated that approximately 63 per cent of nurses and midwives are employed in the public health service. This figure suggests that the independent sector (37 per cent) will also have considerable supply requirements. There is significant movement between the public and independent sectors. Employees have a wide choice of employment opportunities. It is therefore prudent that an inclusive approach be adapted to workforce planning assessments. This should include employers in the public and independent sectors (private and voluntary organisations). Such an approach requires openness and partnership where employers in all sectors work together and share information on employment of nurses and midwives for the purpose of workforce planning.

This section of the report identifies a multitude of approaches which vary in levels of detail and theoretical approach. Careful examination is required to select the most appropriate approach and model sensitive to an Irish context and environment. Despite extensive searches this study did not identify 'off the shelf' models that could be adapted for use in workforce planning assessments for the nursing and midwifery resource in Ireland. The most important feature of all plans is the comparability of plans prepared at different levels across sectors and time intervals. This enforces the need for a standardised tool that can be used at all levels in the system. Such a tool does not currently exist. The steering group concluded that the best way forward is to commission a national tool for integrated workforce planning which can be used on an on-going basis and tailored to reflect the local context and environment. It is

possible that this tool could be piloted and evaluated in the development of forecasts for nursing and midwifery services. It would be important that the new Health Information and Quality Authority being established in 2002 would be involved in the commissioning process (see Chapter 5 for an outline of the role of the authority).

6.4 Integrated workforce planning

Much of the international literature advocates the creation of a human resource plan for the entire health service, rather than separate plans for each discipline. This is commonly referred to as integrated health human resource planning (IHHRP) or integrated workforce planning. It involves determining the numbers, mix and distribution of health providers that will be required to meet population health needs at some identified future point in time.

Some people consider that integrated workforce planning simply applies to planning across staff groups (inter-disciplinary team working) and across organisational levels. The literature suggests that the most fundamental issue is to integrate the planning of service delivery and planning of the workforce. A recent paper commissioned by the World Health Organisation describes integration in terms of how health human resource planning is linked with service planning and the need for labour market indicators to be incorporated into service planning (O'Brien-Pallas, 2001a). The advice given is that health human resource planning should be broad in nature, incorporating the entire health workforce. The paper concludes that while strides have been made in the practice of resource planning worldwide, health human resource planning in most countries has been poorly conceptualised, intermittent, varying in quality, profession-specific in nature, and without adequate vision or data upon which to base sound decisions.

The report of the Scottish Integrated Workforce Planning Group (SIWPG) *Planning Together* was published in January 2002. The short-term expert group was charged with proposing improvements for workforce planning for the National Health Service in Scotland. The report concluded that workforce planning is highly complex and should operate across a number of dimensions. A series of recommendations are made for: structures and mechanisms (local, regional and national); policies; and resources to plan the workforce requirements. The key benefits of integrated workforce planning were described in the document. These are clearly set out in the report:

- better match of teams to service delivery
- more effective use of existing and potential skills
- minimised chance of service failure from workforce difficulties
- greater flexibility to handle demand peaks
- rationale to inform choice between service options
- realistic basis for the timing of developments (p 11).

The most important message from the SIWPG group is that services should always be planned with implications for the workforce in mind; service planning and workforce planning should be integrated. The key step for sustainable improvement was considered to be fostering a change in management culture so that those who develop and manage services always look for the workforce implications and those who manage workforce supply always do so to support services. A web-based toolkit is currently being developed as an interactive resource of information, ideas and good practice in relation to integrated workforce planning for Scotland.

The indication in the final report of SIWPG is that the configuration of services may radically change over the next few years to meet the needs of the modernisation agenda in Scotland. The suggestion is that traditional professional boundaries will require to be realigned if workforce planning is to be successful.

The Scottish Executive, Health Department endorsed the report *Planning Together* and have responded by making a series of recommendations to create a dynamic and effective integrated workforce planning function at national, regional and NHS board level. A national workforce development unit sitting within the Human Resource Directorate of the Health Department is to be established. The approach being adopted is integrated planning for particular aspects of service requirements, for example integrated breast services, traumatic brain injury and primary care. The Scottish Executive recently published *Working for Health* which sets out the new infrastructure for workforce development which is to be put in place by end September 2002.

Having established the international trend to adopt an integrated approach to workforce planning, the next section examines the proposals for integrated workforce planning in Ireland.

6.4.1 Integrated workforce planning in Ireland

The adoption of an integrated approach to workforce planning has emerged as a key concept in the context of the modernisation and future development of a quality health service in Ireland. The establishment of an effective system of integrated workforce planning for the entire health sector is clearly central to creating the skilled, competent and qualified workforce that meets the changing demands of the health system. It is also essential to the delivery of the goals and objectives set out in the Health Strategy (2001).

The requirement for the development of national workforce planning systems in the health service is underpinned by the gradual onset of Ireland's demographic transformation projected over the coming decade which will be manifested in particular by such trends as population growth/ageing and a moderation in labour force growth overall. These factors will have important implications for the health service in the context of ensuring an appropriate balance between the demand for and the supply of skilled and trained health and social care personnel in an environment of continued labour market shortages. They also point to the imperative of ensuring the availability of comprehensive high quality (timely, accurate and verifiable) information on the human resource profile of the current health service personnel through such measures as sustained investment in the implementation of the PPARS information technology system in order to support the upgrading of the health service personnel census and other critical employment-related information.

Health Strategy — proposals for workforce planning

The Health Strategy explicitly identifies the requirement for the adoption of an integrated approach to workforce planning. It commits the Department of Health and Children to leading the development of such a system aimed at anticipating the number and type of staff required to provide a quality health service. There is a strong recognition in the strategy that strategic, long-term workforce planning must become a core activity of the human resource function of the health services. It emphasises that this will necessitate a further strengthening and deepening of relationships with educational providers in order to match the number of training places with the demand for skilled personnel across a broad range of health and social care disciplines. Moreover, in such an environment human resource policies within the health service must be firmly orientated to ensuring that the training and continuing professional development needs of health and social care professionals are properly supported. The strategy also emphasises the need to align workforce planning with the strategic objectives and the service planning process undertaken in

the health boards. This will help ensure that human resource requirements are fully encompassed in service development initiatives.

The international experience supports the creation of a human resource plan for the entire health service (i.e. integrated workforce planning) rather than the adoption of separate plans for individual professions as has been the case in Ireland over recent years. However, approaches and methodologies designed by such organisations as the World Health Organisation (WHO) to assist in the development of long-range strategic human resource development plans require detailed information that is as yet unavailable in Ireland. Other simpler models are available for medium-term projection purposes which have been primarily designed for developing countries. These models highlight the benefits of adopting an integrated approach to workforce planning since the mix between professions is as important as absolute numbers of personnel.

In order to minimise, at the outset, the information requirements and complexity of models required to implement integrated workforce planning in the Irish health service, an initial approach is strongly indicated where the assessment of the workforce requirements of any particular health and social care profession/group takes appropriate account of the complementary demand for other health and social care personnel simply by ensuring that the projections contained in the study are based on a proper analysis of the multi-disciplinary environment in which the particular profession/group operates.

The Health Strategy envisages that workforce planning led by the Department of Health and Children will build on existing initiatives and available data regarding workforce needs. The measures required to strengthen the capacity for integrated workforce planning in the Irish health service will therefore be built on some important milestones in the area of human resource planning in the health service as set out below.

Programme for Prosperity and Fairness (PPF) — Health Services Skills Group

The Programme for Prosperity and Fairness (Section 3.10.22) called for the establishment of a Health Services Skills Group composed of representatives of the social partners, relevant Government Department/agencies and third level institutions. The Health Strategy (Chapter 5 — Framework for Human Resources) highlights the role of the Health Services Skills Group in working closely with the Department of Health and Children to help identify ways of meeting workforce requirements of the health system.

The Health Services Skills Group, as an expert group representing key stakeholders concerned with education, training, skills development and human resource planning in the health sector, provides advice and guidance in relation to the range of issues highlighted in the PPF including:

- identify in a systematic way the skills needs of the different sectors of the health service and advise on the actions needed to address them
- develop estimating techniques that will assist in anticipating future skills needs of the health service and their associated resources requirements
- advise on the promotion of the education and continuous training needed to meet the skills needs of the sectors.

The Health Service Skills Group therefore has an important role to play in monitoring and overseeing workforce planning studies for the health service and in advising on education and training initiatives to address the skills needs of the health sector overall. The inaugural meeting of the Health Services Skills Group was held on the 30th May 2002.

Medical Staffing

In April 2001, the Government approved the publication of the *Report of the Forum on Medical Manpower* (Forum Report) and the *Report of the National Joint Steering Group on the Working Hours of Non-Consultant Hospital Doctors* (Hanly Report) and the establishment of a National Task Force to progress both reports.

The National Task Force on Medical Staffing was formally launched on 21 February 2002. The Task Force is preparing and costing an implementation plan for a new approach to hospital services, based on appropriately trained doctors providing patients with the highest quality service. The recommendations contained in the two reports map out major changes in the way acute health services will be delivered, detail proposals for the reduction of the hours of non-consultant hospital doctors (NCHD) to the level required by the EU Working Time Directive and address a wide range of issues — including more flexible work practices, medical education, training and more family-friendly policies.

The National Task Force on Medical Staffing has a remit to prepare a detailed programme to implement the EU Working Time Directive (Council Directive 93/104/EC and 2000/34/EC) and to progress both the Hanly Report and the Forum Report. This process is designed to oversee the introduction of safe, equitable and patient-focused services. It will be necessary to revise existing service provision, working arrangements, medical education and training in order to develop and improve effective hospital services.

The key work of the Task Force in the area of medical workforce planning will be to:

- oversee the implementation of detailed strategies for reducing the working hours of NCHDs, so that a 48-hour working is achieved by 2009
- address the associated medical staffing needs of the Irish hospital system
- consider the medical education and training requirements arising from any changes to the current model of delivering services.

The National Task Force will also prepare national guidelines for health agencies to ensure national conformity and continuity on key areas of workforce planning.

As stated in the Health Strategy, a key issue for the Task Force will be to quantify the resource requirements and costs that would arise if a consultant-delivered hospital service were developed in place of the existing consultant-led system, with a reduction in the number of NCHDs. The Forum Report and the Hanly Report saw considerable advantages in such a move.

The Health Strategy includes a number of relevant commitments, including the following:

- substantial increases in the number of consultants, with the number and location to be determined taking account of the advice of the Task Force
- significant increases in the number of places for postgraduates (and, if required, undergraduates) in medical colleges and on training schemes for specialist registrars 'to the level required to ensure that a fully trained doctor is available to all hospital patients when necessary'
- closer links with FÁS and equivalent agencies in the EU and with medical and training colleges so as 'to increase the level of senior clinical decision-makers and, where appropriate, to attract more doctors to the Irish health services'; and to review requirements for permanent registration.

The nursing profession is represented on the Task Force. A key issue for the Task Force will be the contribution of skill mix in the context of reducing NCHD working hours. The Hanly Report has established that, at present, 17 per cent of the hours worked by NCHDs are spent on 'inappropriate' duties. The reassignment of such duties to where they should most appropriately be carried out may have implications for other health service personnel.

Health and social care professionals

Health and social care professionals include, among others, the following: clinical biochemists, environmental health officers, psychologists, chiropodists/podiatrists, dieticians, orthoptists, physiotherapists, radiographers, speech and language therapists, occupational therapists, social workers, medical scientists, care workers and resident managers. The reports of the *Expert Group on Various Health Professionals* (April 2000) recommended the development of a strategy for workforce planning for health and social care professional groups. The report drew attention in particular to the need to boost the output of the training and education system to keep pace with the demand for skilled staff.

The creation of a Policy Unit for therapists within the Department of Health and Children as recommended by the Expert Group Report is expected to act as an important impetus to achieving progress in relation to the development of workforce planning initiatives.

The document *Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists* (study undertaken by Peter Bacon and Associates) provides a comprehensive assessment of workforce needs for qualified personnel in the therapy health care sector to 2015. The study was commissioned in response to severe labour shortages affecting the therapy professions at the present time.

The methodology adopted in the report identified a number of significant gaps or deficits in the number of trained therapy personnel:

- the divergence of current employment levels from the number of approved and funded posts, reflecting high vacancy levels
- the shortfall of approved employment levels from good practice international benchmarks
- additional posts required over the next 15 years to meet *quantitative* (i.e. increased population of patients reflecting demographic trends/ rising life expectancy) and *qualitative* (i.e. higher quality of health care demand) requirements.

Based on this analysis, the report concluded that a major expansion is essential in the numbers of therapy professionals over the next fifteen years comprising:

- a doubling in the number of physiotherapists
- an increase of over 150 per cent in occupational therapists
- a fourfold increase in speech and language therapists.

This requires a significant increase in training places with a recommended annual increase of 75 course places for both speech and language therapy and occupational therapy and 25 course places for physiotherapy.

Other key recommendations of the report relevant to the workforce planning agenda relate to:

- the development of methodologies for the estimation and projection of health care demand as a basis for human resource planning in the health service

- the provision of sufficient clinical placements within the health service through the establishment of a national network of clinical placement co-ordinators
- the need for fast-track qualification and a review of the existing training system
- progress in the implementation of career structure, workload, working practices and skills-mix issues encompassed in the context of the *Report of the Expert Group on Various Health Professions* (April, 2000).

6.5 International practice

In October 2001 government chief nurses and other delegates from 66 countries meet to discuss how best to deal with — the global growth of nursing shortages (*Global Nursing Partnership: strategies for a sustainable nursing workforce*, 2001). At the meeting it was acknowledged that many countries need to enhance, reorientate, and integrate their workforce planning capacity across occupations and disciplines to identify the skills and roles needed to meet identified service needs (Buchan, 2002a). Nursing shortages are not just a problem for nursing they are a health system dilemma that undermines effectiveness and requires health system solutions which focuses on prospective planning. This section gives an overview of some of the approaches adapted to workforce planning for nursing and midwifery in other countries. Many more examples may exist which were not identified during this study.

6.5.1 USA

The size of the registered nurse (RN) workforce in the USA is forecast to be nearly 20 per cent below projected requirements by 2020 (Buerhaus *et al*, 2000). The Bureau of Labour Statistics, employment projections to 2010 indicate that all levels of nursing are expected to grow quickly and substantially. Job growth for RNs, LPNs and Nurses aides/orderlies and attendants is projected to be more than 1 million jobs (The Centre for Health Workforce Studies, 2002). In addition to a decline in overall labour supply, the projections indicate a continued ageing of the RN workforce in the USA. With concerns about the shortage of nurses, legislation has been introduced and passed during 2001 in thirteen States calling for the formation of commissions, task forces or councils to study the nursing shortage and make recommendations to state officials with resolutions for issues pertaining to nurse education, recruitment and retention. In order to implement planning for the nursing workforce nine States have introduced legislation in 2001 that will require the collection of data on nursing supply and demand.

In mid 2001, the American Nurses Association (ANA) convened a steering committee of national nursing organisation representatives to work swiftly to develop a comprehensive strategic and tactical plan to address the growing disparity between the supply and demand of nurses, through a nursing summit. The *Call to the Nursing Profession Summit* held in September 2001 was attended by over sixty national nursing organisations. Ten domains became the focal point for discussion were domain-specific outcomes were determined. The domains were: leadership and planning; economic value; delivery systems; work environment; legislation/regulation/policy; public relations/communication; professional/nursing culture; education; recruitment/retention and diversity. The report *Nursing's Agenda for the Future* (2002) is intended to serve as a compass, and as a means to achieve nursings desired future through a synergy of effort that minimises duplication, maximises resources and amplifies results. Each domain's work is guided by co-champions, organisations that will monitor the implementation and results of the identified work plans.

Nursing organisations across the USA are working collaboratively to avoid a major crisis in nurse staffing levels some examples are set out below.

New York

In April 2001, the New York State Board of Regents set up a Blue Ribbon Task Force on the Future of Nursing. The role of the task force was to address the nursing shortage in New York State, find

solutions and consider the long-term future of nursing. Members of the task force included leaders from education, health care and government. In the report *Protecting the Public* (2001) the task force recommended solutions to the nursing shortage under the following broad headings: recruitment, education, technology, data collection, and clarity regarding existing laws and legislation (see Table 6.5-1). The report indicates that the shortage of nurses in New York State is different from that in the past, defined by several new variables, including an ageing workforce, increased career opportunities for women, the image of the profession, managed care and other cost containment measures, low unemployment, a shortage of nursing educators, and a decreasing population of nurses overall.

Table 6.5-1 – Regents Blue Ribbon Task Force on the Future of Nursing

Recruitment
Expand the nursing workforce by recruiting additional numbers of men, minorities, non-practising nurses, and recent high school graduates.

Education
Provide additional academic and financial support systems to increase the pool of nursing school graduates and create career ladders.

Technology
Increase the application of labour-saving technology to eliminate unnecessary, duplicative paper work and improve access to and communication of patient information, thereby improving workplace conditions.

Data collection
Develop a reliable central source of data on the future need for nurses in the workforce upon which employers, policy makers, futurists, researchers and legislators may base public policy and resource allocations.

Clarify existing laws and regulations
Scope of practice for nurses — issue practice guidelines to clarify the legal scope of practice of nursing, including those tasks which do not require licensure. These guidelines will reaffirm the individual practitioner's responsibility for patient care, even within demanding workplace settings.

Patient abandonment — familiarise field with existing regulations which describe patient abandonment, clarifying that refusal to work a double shift or other mandatory overtime in ordinary circumstances does not necessarily constitute professional misconduct. This information to be provided to nurses, hospitals, nursing homes and home care agency administrators.

Source: *Protecting the Public* (September, 2001)

California

A large increase in the RN workforce is needed to keep pace with the rapid growth of California's population. For California to maintain a stable ratio of RNs to population, it has been estimated that an additional 43,000 RNs will be needed by 2010, and an additional 74,000 will be needed by 2020 (Coffman, Spetz, 1999). Recommendations for educators, employers, and state policy-makers were made for a concerted and co-ordinated approach to avert shortages. It was suggested that the magnitude of the impending shortage was too large for the RN labour market to resolve and legislation was introduced which set out mandated staffing levels.

In 1999, the California legislature passed mandated nurse-staffing laws aimed at improving patient care outcomes by directing the Department of Health Services (DHS) to create fixed staffing ratios. As required California DHS has moved forward

> to adopt regulations specifying nurse-to-patient ratios for general acute care hospitals, acute psychiatric hospitals, and special hospitals, and prohibits hospitals from assigning unlicensed personnel to perform nursing functions in lieu of a registered nurse, and unlicensed personnel from performing certain functions (State of California, Chapter 945/Statutes, 1999).

Recent research in California indicates the need for additional research before determining minimal RN staffing requirements (Bolton *et. al*, 2001). Data showed wide variation in structure and outcomes among 38 hospitals and among 257 nursing units. For medical-surgical units, pressure ulcer and falls analyses indicated that hospital and units where patients received more than 70 per cent of their care from RNs had similar rates as hospitals where less than 50 per cent of care was provided by RNs. The researchers suggested that an understanding of the association between use of resources for patient care, their characteristics and processes (direct nursing interventions), and the effect on patients (nurse-sensitive patient care outcomes) must be a prerequisite to determining the appropriate number and skill level of nurses and other direct patient care staff to provide safe, high-quality patient care. The advice given is that other state or agency representatives considering ratio legislation or other major shifts in policy on nurse staffing first consider whether they have the analytical capacity to assess nurse-sensitive patient care outcomes before and after implementations of major policy changes in order to evaluate whether legislative remedies had the intended effect.

6.5.2 Canada

Health care reforms in the 1990s in Canada caused some dramatic changes that affected the nursing profession (Advisory Committee on Health Human Resources, 2000). In Ontario a *Nursing Taskforce* was appointed by the Ministry of Health in 1998. The purpose was to identify how changes in the nursing profession have affected the delivery of health care services, and to recommend how the province's health system could be improved through nursing service. The taskforce found that nurses were the group most affected by casulisation of the workforce, system restructuring, and downsizing. Their conclusion was that there were not enough young, graduate nurses in full-time positions to ensure there will be an experienced workforce to care for patients, as the population grows older. The lack of comprehensive data on human resource management trends and impacts (particularly turnover and redeployment) was found to hinder human resource planning. The taskforces report *Good Nursing, Good Health An Investment for the 21st Century* was published in January 1999 (Joint Provincial Nursing Committee). A series of eight short, medium and long-term recommendations were made for an immediate investment, on a permanent basis, in the nursing service for Ontario. The main goal of Ontario's nursing strategy is to stabilise nursing human resources thought effective recruitment and retention strategies. A progress report on the *Nursing Taskforce Strategy* was published on behalf of the implementation monitoring subcommittee in Summer 2001. Funding of one million dollars annually for five years is being provided to the *Nursing Effectiveness, Utilisation and Outcomes Research Unit* for nursing human resources research and the development of nursing databases.

In September 1999, the federal/provincial/territorial Ministers of Health directed the Advisory Committee on Health Human Resources (ACHHR) to prepare options for consideration to strengthen health human resources development. As part of this work, the ACHHR Working Group on Nursing Resources, in consultation with nursing stakeholders, developed *The Nursing Strategy for Canada* (2000). The goal of the strategy is to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed and deployed to meet the health needs of Canadian residents. Eleven strategies for change were proposed in the strategy and are organised around key themes which are: unified action; improved data, research and human resource planning; appropriate education; and improved deployment and retention strategies. The strategy acknowledges that forecasting workforce supply and demand is a complicated exercise. The conclusion is that human resource planning must be done with the full integration of all information, in a transparent fashion, and focus on developing a number of different but plausible scenarios based on good data and sound policy. Quality of work life is identified as one of the most important factors in recruitment and retention, thus having an impact on the current and the future supply of nurses in Canada. The range of issues identified included appropriate workload, professional leadership and clinical support, adequate continuing education, career mobility

and career ladders, flexible scheduling and deployment, professional respect protection against injuries and diseases related to the work place, and good wages.

In June 2002 the Canadian Minister of Health, announced that Health Canada is to provide $250,000 for the development of *Healthy Workplace Guidelines* for Canadian nurses. Under the leadership of Health Canada's Office of Nursing Policy and in partnership with leading nursing and health care organisations. The initiative is to translate existing research and experience into guidelines that can be used by nurses employers, unions, government and others to improve the working conditions of Canadian nurses.

6.5.3 Australia

Over the last 5 years significant attention has been given to workforce planning by the health departments in each of the Australian States. An example of the activities of some of the States are given in the following sections. In New South Wales (NSW) a Ministerial Standing Committee (MSC) on the Nursing Workforce was established in early 2000 in response to ongoing concerns regarding issues affecting the nursing workforce and to provide advice to the Minister for Health and the Director-General of Health. The group published *NSW Nursing Workforce Action Plan* in September 2001. The report concludes that there is no quick and easy solution to recruiting and retaining nurses. The plan indicates that comprehensive research on workload, case-mix, skill mix and patient outcomes is necessary. The action plan presents twenty-two objectives designed to create an environment that is supportive, adaptable, and sustainable and one that achieves positive outcomes for nurses and consumers in NSW.

The state of Victoria in Australia has also opted to mandate nurse-staffing ratios. Agreement was reached between the Australian Nursing Federation, the Department of Human Services and the Victorian Hospitals Industrial Association on 23 August 2001. The parties agreed to implement new patient-nurse ratios. Ratios are applied to patients (occupied beds), not beds. The ratios were arrived at after consulting widely amongst the parties and identifying current best practice. During the life of the agreement, patient dependency systems are being piloted in the public sector to provide a greater evidence base on which to determine the ratios.

The health workforce section within the Department of Human Services has the responsibilities for ensuring that there is an adequately prepared health workforce in sufficient numbers to provide health service for the Victorian population. This is generally achieved by conducting periodic studies relating to the nurse labour force planning. The most recent studies were undertaken in 1991 and 1993. The model used since this time has been updated reflecting changes in information technology and processing capacity. Overall the model simulates demand and supply patterns and identifies the effects of changes to different variables in order to bring the two into line. An evaluation of previous studies was undertaken in 1998. The overall objective of the evaluation was to determine whether the predictions were accurate and whether underlying assumption were valid and are still applicable in the health industry today. One of the finding of the evaluation was that labour force projections and studies should be undertaken on a three to five year basis and should not attempt to predict needs and supply beyond such a timeframe. The full report *Evaluation of the Nursing Labourforce Planning* (1998) can be located at http://www.dhs.vic.gov.au/phd/9903083/9903083.pdf.

The Health Workforce Planning and Analysis Unit and the Health Advisory Unit of Queensland Health published the outcome of a major study of the Midwifery Workforce in 1998. The report *Midwifery /Workforce Planning for Queensland* provides advice on the future annual training requirements for new entrants to Queensland's midwifery workforce for five years and at a broader level to the year 2011. A research project was undertaken to obtain the information required to facilitate the estimation of the training requirements.

6.5.4 New Zealand

A Health Workforce Advisory Committee (HWAC) was established in April 2001 under section 12 of the New Zealand Public Health and Disability Act, 2000. The role of the committee is to advise the Minister of Health on health workforce issues that the Minister specifies by notice to the committee. The key tasks are:

- to provide an independent assessment for the Minister of Health of current workforce capacity and foreseeable workforce needs to meet the objectives of the New Zealand health strategy and the New Zealand disability strategy
- to advise the Minister on national goals for the health workforce and recommend strategies to develop an appropriate workforce capacity
- to facilitate co-operation between organisations involved in health workforce education and training in order to ensure a strategic approach to health workforce supply, demand and development
- to report progress on the effectiveness of recommended strategies and identify required changes.

The committee has just completed an initial stocktake of workforce, data, data sources, health workforce issues, and a preliminary analysis of future direction for health workforce development.

6.5.5 United Kingdom

Workforce planning assessments for future nursing and midwifery requirements are undertaken by each of the four countries in the UK. An overview of the approach adopted in each country is given in the following sections.

England

In England *The NHS Plan* 2000 set out ambitious proposals for more, better-paid staff working together in new ways for the benefit of patients, sweeping away outdated demarcations that have blocked improvements in care. Numerical targets were set for additional consultants, GPs, nurses and allied health professionals. It is widely acknowledged that workforce is the key constraining factor in delivering *The NHS Plan* (Axelby, 2002 and Sands, 2002). The plan set out to maximise staff growth and indicated that 20,000 additional nurses and midwives will be required for the services by 2004. Delivering *The NHS Plan* (2002) set further expectation saying that by 2008 there will be 35,000 more nurses, midwives and health visitors than in 2001.

The Department of Health is developing a five-year human resource strategy and delivery plan. In April 2002, a consultation document was published by the National Workforce Taskforce and the HR Directorate, Department of Health the final document was published in July 2002, *HR in the NHS Plan More Staff Working Differently* (available at www.doh.gov.uk/hrinthenhsplan). The plan is built on four pillars; making the NHS a model employer; ensuring the NHS provides a model career through the concept of the skills escalator; improving staff morale and building people management skills. The mechanisms are set out on Table 6.5-2.

New workforce planning arrangements have been put in place as part of the implementation of *The NHS Plan*. National structures include top-down planning from the establishment of a National Workforce Development Board, and Workforce Numbers Advisory Board; bottom-up planning from stakeholders represented in multiple Workforce Development Confederations; and planning across the whole service by Care Group Workforce Teams. An outline of the key function of each of the groups is set out in Table 6.5-3. The Workforce Development Confederations are the key local components of workforce planning. They are membership organisations that bring together local NHS and non-NHS employers to plan and develop the whole healthcare workforce, driving forward work to increase staff numbers and change the

way in which staff are trained and educated, through developing and spreading improved ways of working, tackling problems of recruitment and retention, and enhancing the working lives of staff.

Table 6.5-2 – *The NHS Plan* — human resource strategy

Pillar One *Making the NHS a Model Employer*	• Improving working lives standard • Organise build and manage a diverse workforce • Child care strategy • Flexible careers scheme • Staff involvement and partnership
Pillar Two *Ensuring the NHS Provides a Model Career*	• The *Skills Escalator* — range of options for developing and extending careers, supported by high quality learning and development opportunities. Encouragement to renew and extend skills and knowledge to move up the escalator, at the same time, roles and workload can be passed down the escalator where appropriate. • Four modernisations — workforce planning; pay; regulation; and learning and personal development
Pillar Three *Improving Staff Morale*	• Improving the image of the NHS as an employer • Improving working lives
Pillar Four *Building People Management Skills*	• Building capacity, quality and 'attitude' • Strengthened HR management.

Source: *HR in the NHS Plan* (2002); Sands (2002) The New Workforce Development Confederations: *A National Perspective*

A key role of the Workforce Development Confederations is to develop, commission and manage training programmes for all staff including postgraduate medical and dental education, based on integrated planning across medical and non-medical staff groups. The challenge for the new Confederations is to move towards planning for skills/competencies rather than professions and balance the NHS plan targets against new role development — a rich relationship that will: respect the contributions people make and the baggage all bring; facilitate involvement in each other's worlds; challenge the stereotypes people use; and hold on to what is creative and energising about difference (Teape, 2002).

The HR consultation document reports that an overarching scenario-planning project is being undertaken as part of the work to look at the range of factors that will drive change, and the possible models in terms of service configuration and skill mix. To help quantify the impact of these scenarios, three quantitative models are being developed: a whole-systems model of patient flows, a model which maps projected activity on to workforce demand, and supply modelling to show the available workforce under a number of options. When complete this work will be of particular interest to those developing workforce planning techniques for Ireland.

Table 6.5-3 – UK structures for workforce planning for the national health service

National Workforce Development Board	• Stakeholder group • Advise ministers on strategic directions for workforce development • Translate strategic aims into an agenda for action • Monitor progress against agreed programmes
Workforce Numbers Advisory Board	• Advise National Workforce Development Board on the number of undergraduate and postgraduate training commissions needed each year and in what areas • Reconcile identified needs of Care Group Workforce Teams with available resources • Small expert group

Care Group Workforce Teams	• Carry forward workforce development implications of Government policy in their area • Take a national view of the skills and workforce required to deliver the NHS Plan and National Service Frameworks • Develop a strategy to deliver this workforce through increased numbers and training and development • Small and expert but engaging stakeholders
Workforce Development Confederations	• Will be 27 coterminous with Strategic Health Authorities • Not just the employed staff • Membership organisations: bring together NHS and non-NHS, higher education institutions and postgraduate institutes and others to plan the whole healthcare workforce • Strategic: vision for workforce, future training needs • Operational: securing delivery • Supporting service delivery • National and local role • Upwardly accountable to the Department of Health for use of resources • Outwardly accountable to members

Source: Sands (2002) The New Workforce Development Confederations: *A National Perspective*

Northern Ireland

In Northern Ireland the registered or enrolled nursing and midwifery workforce make up approximately 26 per cent of the total health and personal social services (HPSS) workforce and represents some 50 per cent of the direct care workforce[6] that is the hospital and community health care professional workforce. In September 2001, the Department of Health, Social Services and Public Safety (DHSSPS) commenced a series of uni-professional workforce reviews, which, are to cover the fifteen main clinical professions within the HPSS. While it was determined that the initiatives, at this stage would be taken forward on a uni-professional basis, the information and recommendations from this work are to provide an important baseline in terms of developing workforce planning within HPSS across services sectors and professions.

Nursing and midwifery was the first clinical profession to be included in the workforce review initiative. KPMG Management Consultants were commissioned by the DHSSPS in 2001 to undertake a review of the nursing and midwifery workforce in Northern Ireland. A project group was formed to guide the review. The group comprised of representatives of the DHSSPS, HPSS commissioners and providers, education and staff side. The review (due to be published this year) will provide valuable analysis of the current workforce and the future requirement and retention issues. It will also present prediction of future supply and demand and review the impact of the supply and demand position within the workforce on the delivery of services. The report will make recommendations to address relevant issues.

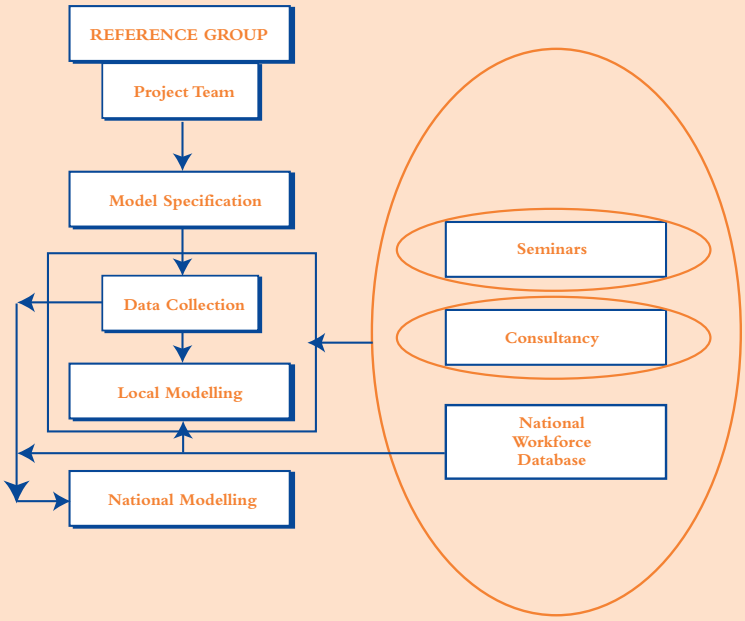
Scotland

As mentioned elsewhere in this report the Scottish approach to workforce planning for nursing and midwifery is widely regarded as an example of best practice. The Scottish Executive has been centrally collecting workforce data for nursing and midwifery since 1979. In 1996, the Chief Nursing Officer commissioned the Directorate of Human Resource for the NHS in Scotland and the Information and Statistics Division (ISD) to determine the need for newly qualified nurses and midwives. This was required to inform the planning of student intakes to pre-registration diploma courses, which are funded by the Scottish Executive, Health Department. The exercise is now conducted annually through systematic project management and a partnership approach with the key stakeholders, thus ensuring a

[6]Direct workforce includes nurses and midwives, unqualified care support staff, medical and dental, professions allied to medicine and technical grades.

top-down and bottom-up arrangement (see Figure 6.5-1). This approach is an example of involving employers in national level nurse workforce planning. It attempts a whole-system perspective, by factoring in estimates of future demand for nurses in the private sector.

FIGURE 6.5-1
Model for Student Nurse Intake Planning (SNIP) assessment Scotland



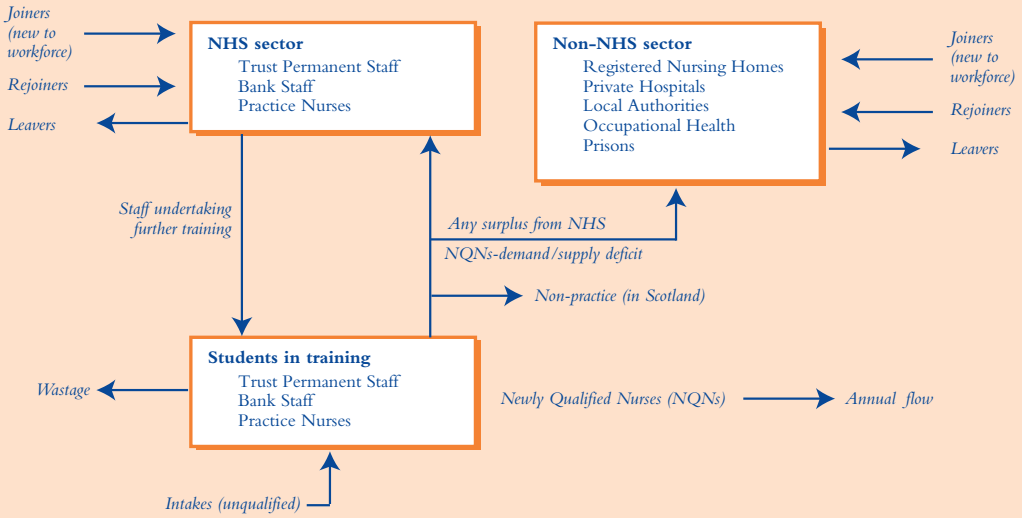
Source: Scottish Executive (2001) *Student Nurse and Midwife Numbers*

Once all the data have been quality assured, collated and analysed, scenario planning is used as a base for the decision on the number of places to contract for each branch programme (adult, learning disabilities, mental health, paediatrics, and midwifery). National and local modelling systems have been designed to assist in the assessment. Two separate computerised systems have been developed for use in the annual SNIP exercise:

- the local computerised model, designed to assist Trusts when preparing local forecasts, and
- the national computerised model, designed to produce national forecasts based on the input of extensive supply and demand information from trusts, health boards, private hospitals and universities.

Figure 6.5-2 illustrates the various components of modelling used in the SNIP assessment.

FIGURE 6.5-2
Student Nurse Intake Planning
Modelling Supply



Source: Scottish Executive (2001) *Student Nurse and Midwife Numbers*

There is much to learn from the principles involved in the design of the Scottish system. However, because of information deficits in Ireland it would probably be necessary to build a system specifically designed to reflect the Irish context.

Wales

In Wales an annual workforce planning exercise is undertaken.[7] A bottom-up approach to planning is adopted in which directorates send their workforce plans to a central point within each Trust. The information is collated annually and a Trusts plan is subsequently sent to the head of Workforce Planning in the Human Resources Division of the National Assembly for Wales. Workforce planning guidance notes are circulated and assistance and support are provided. Data requirements include details for all NHS staff groups (medical and dental staff, nurses and professional and technical staff, support staff, managers, clerical staff and ancillary staff) both in primary and secondary care. The workforce planning process for 2002 requires data centrally for a five-year period. It is advised that all plans include a 20 per cent enhancement for annual leave, sick leave and study leave (13 per cent annual leave, 5 per cent sickness and 2 per cent study leave). The emphasis is on a patient centred approach to the whole planning process based on need and not vacancies. The data from each Trust is collated centrally to form an all Wales picture. The information is then used to inform the commissioning of education and training places on an All Wales basis, also in developing staffing targets and informs longer term recruitment and retention initiatives. To increase the pool of qualified staff available to work in the NHS Wales nurse student places have increased by 27 per cent.

[7]Correspondence with Chief Nursing Officer Wales and senior Workforce Planning Manager, NHS Directorate Wales, 18 June 2002.

Following a review in 2001 workforce planning is to be supported by a new decision making structure at an All Wales level, led by a steering group chaired by the Director of the NHS in Wales. The group will be responsible for planning the future workforce in terms of numbers, skill mix and job design, and ensuring the workforce is available through education and training commissioning. Based on staffing needs identified in the 2001 workforce planning process a target has been set with plans for 6,000 more nurses by 2010.

6.5.6 Netherlands

A nursing minimum dataset has been developed for the Netherlands (NMDSN). The purpose is to provide a method and define data necessary to describe the diversity and complexity of different patient populations, and the variability of patient-related nursing care activities (Goosen *et. al*, 2000). Based on this information it is possible to determine the complexity of care and nursing workforce and establish general indicators for the quality of nursing care from benchmark information across the Netherlands. The NMDSN is also used for trend analysis, budget negotiation and policy making.

6.5.7 Organisation for Economic Co-operation and Development (OECD)

The OECD is undertaking a 'Human Resources for Health Care' (HRHC) project. This was conceived, in late 2001, as a component of the *OECD Health Project*. The study is focusing on two skilled categories: physicians and nurses. The project is intended to provide decision-makers with evidence-based policies in this field, through a detailed empirical and policy analysis of best practices in OECD countries. It is hoped that this effort will contribute to the improvement of the efficient delivery of health services. The study is to address the following broad policy issues:

- what are the human resource — physicians and nurses — requirements of health care systems that are socially sustainable and able to meet the expectations of OECD citizens and patients?
- what are the policy and planning tools available to policy-makers to influence the size, distribution and composition of the health workforce in order to improve access for all citizens while preserving the affordability of health systems?
- what are the policy tools, financial incentives and organisational arrangements available to improve health care system performance through a more efficient use of human resources?
- what are the implications of health care system reforms for their human resources? How can they cope with dynamic changes?

The study when complete (planned for late 2003) will provide valuable information to inform workforce planning in Ireland.

The high priority being attached to the ongoing availability of the nursing and midwifery resource is evidenced by the examples given here of initiatives used by other countries to address the issue. A variety of approaches are adopted. Most countries appear to have established high-level Ministerial committees or taskforces to prepare proposals, to address nursing and midwifery shortages and to plan for the future. Many have developed action plans. Some countries have opted to set mandated nurse-patient ratios. It seems that these ratios were based on professional judgement and consultation with stakeholders. There appears to be a deficient evidence base to underpin the decisions. In general this approach was adopted because of the absence of requisite information and systems for determining the number of nurses and midwives required for each type of service. Several international projects are in progress that are considering the issue of workload assessment, skill mix and safe staffing. The findings of these studies when available will be of assistance in informing the approach adopted in Ireland.

6.6 Conclusion

The literature accessed during this study suggests that workforce planning involves considerable uncertainties. It is not an exact science. However, workforce planning can assist in foreseeing changes and identifying trends in staff resources so that the necessary human resource policies can be adopted to avert major problems. It must be remembered that workforce planning will not necessarily prevent shortages occurring, but effective planning systems will give early warning of where shortages may occur, and provide a mechanism for early and effective intervention while there is still a choice of action. The literature accessed indicates growing recognition that, even when adequate data are available, workforce planning can focus too narrowly on headcounts rather than taking into account what skills and competencies are required to meet projected demand. Statistics presented in Chapter 2 indicate that vacancy levels may be decreasing. However, in the future the focus will need to be on ensuring that the skills and competencies of the nursing and midwifery workforce match service needs. International experience intimates that workforce planning should not be conducted in isolation, but should be integrated for all disciplines within the overall approach to service planning. Employers and higher education institutions should be directly involved in the process. The challenge is meeting both individual and organisational needs in implementing workforce plans.

What emerged from the overview of the literature is the absolute need for a formal planned and comprehensive approach to workforce planning at national, regional and local level. In the next Chapter a series of recommendations and actions are presented, designed to establish a formal approach to workforce planning for the nursing and midwifery resource requirements of Ireland.

CHAPTER 7

Recommendations

7.1 Introduction

The ongoing availability of nursing and midwifery resources to meet service requirements in the future was the main concern of the steering group leading this study. During the three and a half years of the study considerable time was devoted to the investigation and identification of the most appropriate way forward through comprehensive workforce planning. The workforce planning process should not be viewed simply as a matter of quantitative calculation. It involves complex issues, policies and the diverse interests of groups at all levels within the health system. Best international practice would suggest that integrated workforce planning is the mechanism for the future. This is endorsed in the Irish Health Strategy, which clearly commits the Department of Health and Children to integrated planning for health human resources. This report makes a series of recommendations for the development of systems and processes for workforce planning for nursing and midwifery aimed at integrated planning in the future. Many of the recommendations are made on an interim basis pending the establishment of systems for integrated planning set out in the Health Strategy. Workforce planning cannot end with the production of a once-off plan. Those involved in planning, implementation and evaluation need to maintain a continuous dialogue and have mechanisms for ongoing review and adaptation of plans in light of changing circumstances.

The recommendations presented in this chapter address the findings related to each of the seven objectives of the study and most particularly, recommend the measures necessary to meet the workforce requirements in nursing and midwifery and how they may be kept under review.

7.2 Recommendations

Recommendations with specific actions are made for the following eight broad areas: supply of nurses and midwives; retention of nurses and midwives; marketing and promoting nursing and midwifery; interim framework for nursing and midwifery workforce planning; profiling the nursing and midwifery workforce; methodologies for workforce planning; availability of information; and implementation of the recommendations of this report. To assist the reader each of the 118 actions are numbered. An overview of the agency with responsibility for the implementation of each action is set out at the end of the chapter.

7.3 Supply of nurses and midwives

It is recommended that the following actions be taken to ensure a continued supply of staff for the delivery of nursing and midwifery services.

7.3.1 Pre-registration

1 The number of pre-registration nursing education places (1,640) agreed for the commencement of the four-year undergraduate degree programme for general, psychiatric and mental handicap nursing (2002/3) should continue and be reviewed in the light of workforce plans.

2 Applications for pre-registration nursing degree education and the numbers commencing programmes should continue to be monitored by An Bord Altranais through the operation of the Candidate Register, and through liaison with the Central Applications Office (CAO) and Admissions Officers of the Higher Education Institutions (HEIs). This should be done in close collaboration with the Department of Health and Children.

3 Attrition from pre-registration programmes should be monitored by the head of department/school through the nursing allocations function in each of the Higher Education Institutions (HEIs) and reported to An Bord Altranais at an agreed time on an annual basis.

4 An Bord Altranais should monitor and evaluate the operational aspects of collating information on national attrition from pre-registration nursing degree programmes and supply such information to the Nursing Policy Division of the Department of Health and Children on an annual basis.

5 The Nursing Policy Division of the Department of Health and Children should evaluate the effectiveness of the information on attrition for human resource planning and publish the rate on an annual basis.

6 Higher Education Institutions should continue to explore all opportunities for shared learning between health care professionals at undergraduate levels in order to foster inter-disciplinary team working in future developments.

7 Health service employers should seek to build relationships with pre-registration nursing students during placements to encourage then to apply for jobs in their organisation when they have qualified.

7.3.2 Post-registration

8 The National Council for the Professional Development of Nursing and Midwifery should undertake an annual survey of programmes and places on post-registration programmes in specialised areas of clinical practice in consultation with the directors of the Nursing and Midwifery Planning and Development Units and the Higher Education Institutions.

9 The Nursing Policy Division of the Department of Health and Children through the National Council for the Professional Development of Nursing and Midwifery and the Nursing and Midwifery Planning and Development Units should support the expansion of current programmes and the development of new programmes, across the divisions of nursing and midwifery, on the basis of service requirements.

10 Post-registration courses in specialised areas of clinical practice should be developed for the mental health and intellectual disability sector to meet service needs.

11 Recent initiatives to support nurses and midwives undertaking higher and postgraduate diplomas and certificate courses in specialised areas of clinical practice should be continued in order to meet service needs.

12 Recent measures to encourage the uptake of public health nursing, midwifery and sick children's nursing education places should be continued in order to meet service needs in those particular divisions.

13 The steering group supports the recommendation of the Commission on Nursing (1998) that registration as a midwife should no longer be a mandatory requirement for entry to the higher diploma in public health nursing or for registration as a public health nurse. The steering group note that An Bord Altranais has established a working group to determine the content and duration of a course in maternal and child health.

14 Integrated programmes at pre-registration level should be developed as recommended in the report of the Paediatric Nurse Education Review Group.

15 Cognisance should be taken of the deliberations of the Midwifery Education Advisory Forum examining the future pathway for midwifery education.

16 Nursing and Midwifery Planning and Development Units should conjointly review and expand (six-monthly) the qualifications catalogue developed during the minimum dataset pilot projects.

7.3.3 Patient care support staff

17 As recommended in the *Report of the Working Group on the Effective Utilisation of the Professional Skill of Nurses and Midwives*, health care assistants (HCAs) should be introduced where appropriate throughout the health system, as members of health care teams, to assist and support nurses and midwives. This should be informed by the evaluation of the national 6-month pilot training programme for HCAs, which is being delivered by the health services in conjunction with the Further Education and Training Awards Council (FETAC).

18 Regard should be given to the skill mix required in relation to the increased use of health care assistants.

19 Cognisance should be taken of the outcome of the deliberations of the working group that is developing appropriate systems to determine nursing staffing levels as recommended by the Commission on Nursing (Para 7.63).

7.3.4 Return to nursing and midwifery

20 The Nursing and Midwifery Planning and Development Units and individual health service providers should continue to promote and facilitate programmes in returning to nursing or midwifery practice.

21 The Nursing and Midwifery Planning and Development Units should track the uptake and immediate career path of participants on return-to-practice courses.

22 Recent initiatives to support nurses and midwives undertaking return-to-practice courses (payment of fees and salary) should be continued, to meet service need.

7.3.5 Recruitment of nurses and midwives from abroad

23 Health service employers should have a co-ordinated approach to overseas recruitment of nurses and midwives where the need exists.

24 Health service employers should use mechanisms to directly recruit nurses and midwives from abroad, for example through Government-to-Government initiatives.

25 Employers should use the *Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives* published in December 2001 when recruiting from abroad.

26 The National Co-ordinator for Clinical Placements post, attached to the Health Service Employers Agency, should continue in existence for as long as there is a need to access clinical placements for nurses and midwives being recruited from aboard.

7.3.6 Agency and bank nursing and midwifery

27 Health service employers should adopt a co-ordinated approach in relation to the engagement of agency nurses and midwives.

28 Where possible, and without prejudice to the provisions of the Organisation of Working Time Act, 1997, an in-house nursing bank should be established in preference to the engagement of agency nurses and midwives.

7.3.7 Developments in service delivery

29 Workforce plans for the supply of the nursing and midwifery resource should take account of the development and restructuring of roles across the health system in light of changing health care needs and workforce plans.

30 Nursing and midwifery competencies should continue to be developed, within the scope of the nursing and midwifery practice framework, to meet changing health care needs.

31 The introduction of clinical nurse/midwife specialists and advanced nurse/midwife practitioners throughout the health system should be monitored and evaluated by the National Council for the Professional Development of Nursing and Midwifery in collaboration with Nursing and Midwifery Planning and Development Units, Directors of Nursing and service providers.

32 Evaluation of the effectiveness for service delivery of clinical nurse/midwife specialists and advanced nurse/midwife practitioners roles should be initiated by the National Council for the Professional Development of Nursing and Midwifery.

7.4 Retention of Nurses and Midwives

It is recommended that the following strategies are pursued in relation to retaining nursing and midwifery staff in practice.

33 All employers of nurses and midwives should be able to demonstrate that they have prioritised staff retention as part of the overall organisational human resource plan.

34 Each organisation employing nurses and midwives should develop a retention strategy for their service, reflecting the proposals for developing human resources set out in the Health Strategy (2001). This is as important for organisations in the independent sector as it is for employers in the public health service.

35 Retention strategies should include provision for programmes to address cultural diversity awareness in both the workforce and workplace.

36 The effectiveness of the retention strategies should be monitored and revised in light of turnover rates and feedback from leavers.

37 Information on reasons for leaving should be collected from nurses and midwives leaving employment.

38 Clinical nurse/midwife managers should be involved in recruitment and selection of staff for their particular area where possible.

39 Clinical nurse/midwife managers and middle nurse managers should be given explicit responsibility for retention of staff in their service area.

40 Every nurse and midwife should be facilitated and supported to develop a personal development plan (PDP) in the context of service needs and development.

41 A record (electronic) of each individual nurse/midwife's qualifications (registerable, academic and skills/training) should be held on an employment database to facilitate and plan for the professional development needs of staff within each organisation.

7.5 Marketing and promoting nursing and midwifery

It is recommended that further strategies should be developed for the promotion of nursing and midwifery as a career.

42 Funding should continue to be provided by the Department of Health and Children to support national and local campaigns aimed at promoting nursing and midwifery as a career.

43 The Nursing Careers Centre and relevant health service providers should continue to undertake promotional campaigns in order to maintain the attractiveness of nursing amongst school leavers and mature students.

44 The Nursing Career Centre and individual health service providers should continue to develop linkages with career guidance teachers. The promotion of nursing and midwifery as a career option among second- level students should be combined with the heightening of awareness amongst junior certificate students.

45 The Nursing Career Centre and individual health service providers should actively promote, among health care assistants, the *Sponsorship Scheme for Health Service Workers* who wish to peruse nursing education.

46 The Nursing Careers Centre should undertake a promotional campaign targeted to achieve a greater gender balance within the profession.

47 The Nursing Careers Centre should develop additional national initiatives to promote mental handicap and psychiatric nursing as a career option among school leavers and mature applicants.

48 The Nursing Careers Centre, in collaboration with relevant health service providers, should undertake a promotional campaign to attract applicants to sick children's nursing, public health nursing and midwifery education/training programmes.

49 Promotional material should acknowledge the cultural diversity reflected in contemporary Irish society.

50 Collaboration should continue between health service providers and the higher education institutions in relation to promoting nursing and midwifery as a career to ensure maximum uptake of places.

7.6 Interim framework for nursing and midwifery workforce planning

It is recommended that the following actions be taken at central, regional and local level in relation to workforce planning for nursing and midwifery on an interim basis, pending the establishment of the integrated workforce planning system provided for in the Health Strategy.

7.6.1 Central level

51 The Nursing Policy Division of the Department of Health and Children should lead the development of national workforce plans for nursing and midwifery until such time as the integrated workforce planning system provided for in the new Health Strategy (Action 100) is established.

52 The Nursing Policy Division of the Department of Health and Children should set up a Workforce Planning Function for Nursing and Midwifery during this interim period. Appropriate staffing including nurse or midwife researcher(s), supports and structures should be put in place to facilitate this work. The Workforce Planning Function should be resourced and assigned by Autumn 2002.

53 An appropriately qualified and experienced person should be appointed to the Nursing Policy Division of the Department of Health and Children to lead this work on an ongoing basis. The appointee should have access to personnel with expertise in workforce planning and systems analysis.

54 A Steering Group for Workforce Planning for Nursing and Midwifery should be set up by the Nursing Policy Division of the Department of Health and Children, by end 2002, to guide and advise on the development of workforce plans. The Chief Nursing Officer should determine the composition and chair the group in an ex-officio capacity.

55 The Workforce Planning Function for Nursing and Midwifery within the Nursing Policy Division of the Department of Health and Children should initiate on the development of a programme to educate nurse and midwife managers in the preparation of workforce plans for the profession.

56 The Workforce Planning Function for Nursing and Midwifery within the nursing policy division of the Department of Health and Children should receive and analyse the information from the *National Nursing and Midwifery Human Resource Minimum Dataset* submitted by the eight regional Nursing and Midwifery Planning and Development Units.

57 The Nursing Policy Division of the Department of Health and Children should liaise closely with other divisions within the Department considering workforce issues for health care professionals, particularly medical and health and social care staff.

58 There should be close collaborative working between the Steering Group for Workforce Planning for Nursing and Midwifery with the Health Services Skills Group established in 2002.

59 Appropriate linkages should be developed with the proposed new Health Information and Quality Authority due to be established this year.

60 The Nursing Policy Division should continue to collaborate with the Nursing and Midwifery Advisory Group, Department of Health, Social Security and Public Safety, Northern Ireland in planning and addressing workforce issues to include mobility and registration across jurisdictions.

7.6.2 Regional level

61 The Nursing and Midwifery Planning and Development Units in association with Human Resource Departments should play a lead role in the preparation of regional strategic plans for the nursing and midwifery resource.

62 An experienced individual within the Nursing and Midwifery Planning and Development Unit should take lead responsibility for the preparation of regional nursing and midwifery workforce plans. Appropriate staffing, supports and structures should be put in place to facilitate this work.

63 Each of the eight Nursing and Midwifery Planning and Development Units should adopt the process identified during the *National Nursing and Midwifery Human Resource Minimum Dataset* pilot projects. Due regard should also be given to the joint proposals made; based on the findings of the pilot project in the North Western Health Board and St. James's Hospital (as set out in Chapter 3).

64 The Nursing and Midwifery Planning and Development Units in collaboration with Human Resource Departments should lead on the development of data maintenance strategies to ensure that timely and relevant information is available on employment of nurses and midwives for the organisations within their functional area.

65 The Nursing and Midwifery Planning and Development Units should facilitate and co-ordinate delivery of the education programme to prepare nurse and midwife managers for workforce planning for the profession.

66 Linkages between the Nursing and Midwifery Planning and Development Units and other relevant departments within the health boards should continue in relation to workforce planning.

67 Linkages between the Nursing and Midwifery Planning and Development Units and service providers in the independent and voluntary sectors should continue to be developed for the purposes of gathering information on human resource planning for nursing and midwifery.

68 Nursing and Midwifery Planning and Development Units in border areas should continue to collaborate with their counterparts in Northern Boards in planning and addressing issues in relation to mobility across the jurisdictions.

7.6.3 Local level

69 The director of nursing or midwifery within each organisation should take responsibility for the preparation of local nursing and midwifery workforce plans.

70 Responsibility for collecting and collating information on nursing and midwifery employment should be specifically assigned to a named person in every individual organisation/institution employing nurses and midwives.

71 Organisations should ensure the availability of appropriate personnel, information technology and systems to collect information, on an ongoing basis, for the *National Nursing and Midwifery Human Resource Minimum Dataset*, as well as on leavers and vacant posts.

72 Standardised information should be held in electronic format (on a database) and updated on an on-going basis so that accurate information can be reported from the system at any given point in time. This information should be held on the Personnel, Payroll, Attendance and Related System (PPARS) SAP Human Resource Module or other comparable system that can interface with the PPARS system.

73 The exact name entered on the Register of Nurses maintained by An Bord Altranais should be included on the employment database.

74 The director of nursing or midwifery and nominated members of the nurse management team should have on-site access to the information held on the SAP HR or other personnel system for their organisation.

75 A data maintenance process should be put in place in every individual organisation/institution employing nurses and midwives to ensure that information is accurate and updated on an on-going basis.

76 Electronic personnel systems should be capable of producing reports to meet the needs of the various service heads at local, regional and national level.

77 Nurse and midwife managers should be prepared for their participation in the preparation of workforce plans for nursing and midwifery for their organisation.

7.7 Profiling the nursing and midwifery workforce

It is recommended that the following measures should be taken in relation to profiling the nursing and midwifery workforce.

7.7.1 The Register of Nurses

78 Consideration should be given to making the Register of Nurses available on An Board Altranais's web site (name, PIN number, and divisions of the register) in the amendments to the Nurses Act, 1985.

79 As recommended by the Commission on Nursing (4.53) the requirement for very nurse and midwife to give particulars of their employer and position held on payment of the annual retention fee should be considered in the amendments to the Nurses Act, 1985.

80 The registration notice issued by An Bord Altranais on an annual basis should include the division(s) of the Register of Nurses (RGN, RPN, RMHN, RM, RSCN, RPHN, RNT) as well as the PIN number against which the nurse or midwife's name is recorded.

81 The inactive file of the Register of Nurses should be refined to provide more comprehensive information on the reasons for selecting to move to the inactive file.

82 An electronic process for enabling employers to obtain confirmation that nursing and midwifery staff are registered with An Bord Altranais, on an annual basis, should be put in place.

83 Detailed statistics from the Register of Nurses will be published by An Bord Altranais on an annual basis and circulated widely throughout the health system.

7.7.2 National Nursing and Midwifery Human Resource Minimum Dataset

84 The *National Nursing and Midwifery Human Resource Minimum Dataset* should contain the following information for each individual nurse/midwife:

- health board region
- place of employment (name of organisation)
- area of assignment (ward/unit/community care area)
- sex
- date of birth
- nationality
- An Bord Altranais PIN number
- job title/grade
- commitment (full-time, part-time etc)
- contract type
- registrable qualifications
- academic qualifications.

85 The *National Nursing and Midwifery Human Resource Minimum Dataset* should be able to provide information in aggregate form on the number of persons (headcount) and whole-time equivalent (WTE) employed in each health board region.

86 Standardised definitions for each item on the *National Nursing and Midwifery Human Resource Minimum Dataset* should be used (set out in Chapter 3).

87 In association with the minimum dataset, information on numbers of leavers and vacant nursing and midwifery posts in the public health services should be collected on an on-going basis.

88 The Nursing and Midwifery Planning and Development Units should collect information based on the *National Nursing and Midwifery Human Resource Minimum Dataset* to estimate employment and vacancies in the independent sector.

89 The collection of information on employment in the independent sector should include identification of the employment of practice nurses, school nurses and occupational health nurses employed in higher education and private industry within the region.

90 The Nursing and Midwifery Planning and Development Units should:

- monitor the age profile of nurses and midwives employed in each region, by division of the register, in order to determine the implications for staff replacement
- monitor retirement rates for nurses and midwives employed in the region by division of the register in collaboration with Human Resource Departments
- develop data maintenance strategies, in association with individual health service organisations, to ensure that information on the *National Nursing and Midwifery Human Resource Minimum Dataset* is updated on an ongoing basis
- provide standardised data on the *National Nursing and Midwifery Human Resource Minimum Dataset* for the public health service and independent sector to the Department of Health and Children on an annual basis and when otherwise requested
- initiate in consultation with Human Resource Departments and the National PPARS Project Office an electronic process for enabling employers to obtain confirmation that nursing and midwifery staff are registered with An Bord Altranais, on an annual basis.

7.7.3 Health Services Personnel Census

91 The Workforce Planning Function for Nursing and Midwifery within the Nursing Policy Division of the Department of Health and Children should continue to assist and co-operate in reviewing returns for each census.

92 The use of the category 'nursing unclassified' for the health services personnel census should be phased out where possible.

93 Health boards should involve the Nursing and Midwifery Planning and Development Unit in the process of completing returns for the health services personnel census for nursing and midwifery, and in any regional estimates of baseline employment.

94 The grade codes for support staff involved in direct patient care (nursing and midwifery support) should be identified, reviewed and rationalised. Guidelines for the returns for these grades should be prepared.

95 A new grade code for Health Care Assistant should be introduced for the 2002 census.

96 In association with the annual health services personnel census the Workforce Planning Function should ensure that information on nurses and midwives employed outside the health services (army and prison services) are sourced from the relevant Departments.

97 The Workforce Planning Function should liaise with the Central Statistics Office (CSO) on matters relating to nursing and midwifery returns in the population census.

7.7.4 Survey of nursing resource

98 The numbers of nurses and midwives recruited to the service (from Ireland and abroad), leaving (including retiring) and vacant posts should be monitored by the Health Service Employers Agency on a quarterly basis (end March, June, September and December).

99 Health boards should involve the Nursing and Midwifery Planning and Development Units in the process of completing returns for the Health Service Employers Agency surveys on the nursing and midwifery resource.

100 The completed survey should be widely available to all interested parties.

7.7.5 Monitoring turnover

101 Data collection on turnover should be extended to cover (beyond the sample sites included in the *National Study of Turnover in Nursing and Midwifery*) all organisations within the public and independent sector in each health board/authority region.

102 Turnover for nursing and midwifery, across divisions of the register, should be calculated annually, and monitored on an on-going basis by the Nursing and Midwifery Planning and Development Units.

103 The Workforce Planning Function should receive and analyse the information on turnover at central level.

7.8 Methodologies for workforce planning

It is recommended that the following approaches be adopted on an interim basis with a view to the establishment of the integrated workforce planning system provided for in the Health Strategy. Methodologies for workforce planning should be developed in tandem with Human Resource Departments.

104 Close collaboration should take place between nursing management, the Nursing and Midwifery Planning and Development Units and Human Resource Departments in the preparation of workforce plans for nursing and midwifery.

105 Workforce plans for nursing and midwifery should be prepared at local level by directors of nursing; at regional level by the Nursing and Midwifery Planning and Development Unit; and at national level by the Workforce Planning Function for Nursing and Midwifery within the Nursing Policy Division of the Department of Health and Children with input from the Nursing and Midwifery Planning and Development Units.

106 At regional and national level projections for nursing and midwifery human resource requirements should be undertaken for the short, medium and longer term.

107 Directors of Nursing/Human Resource Departments should prepare local projections for nursing and midwifery human resource requirements on an annual basis.

108 The workforce planning process should take cognisance of developments arising from the Health Strategy (2001), Service Plans, new initiatives and the implications of the National Development Plan.

109 The Department of Health and Children should commission, in consultation with the Health Information and Quality Authority, the development of a national tool for integrated workforce planning which can be used on an on-going basis and tailored to reflect the local context and environment. This tool could be piloted and evaluated in the development of forecasts for nursing and midwifery services.

110 A mechanism for future trend analysis and agreeing parameters used in modelling workforce requirements should be built into the process.

111 The main assumptions on which forecasts for the requirement of nurses and midwives are based should be identified, agreed nationally and made explicit in all workforce plans.

112 Every effort should be made to expedite the examination of (i) the development of appropriate systems to determine nursing staffing levels and (ii) conditions and staffing levels in care of the elderly services in accordance with the views of the Commission on Nursing. The outcome of both will inform vital elements of the framework for workforce planning. The nurse adviser being appointed with responsibility for care of the older person/ palliative care should be involved in this process.

7.9 Availability of information

It is recommended that information pertaining to workforce planning for nursing and midwifery is widely circulated throughout the health system.

113 The Nursing Policy Division of the Department of Health and Children should publish an annual report with statistics profiling and reviewing supply and demand of the nursing and midwifery resource.

114 Two-way communication between each individual organisation, the regional Nursing and Midwifery Planning and Development Unit and the Nursing Policy Division of the Department of Health and Children should be established so that all staff participating in the process of data collection and preparation of projections for workforce requirements receive feedback on the processes.

7.10 Implementation of recommendations

It is recommended that the following action be taken for implementation, monitoring, and evaluation of the recommendations.

115 The Steering Group for Workforce Planning for Nursing and Midwifery should monitor and evaluate the implementation of the recommendations in this report.

116 The personnel responsible for the workforce planning function within the Nursing Policy Division of the Department of Health and Children should prepare, as the first priority, a plan and proposed timeframe for the implementation of the recommendations in this report.

117 The Steering Group for Workforce Planning for Nursing and Midwifery should continue to function until the structures and processes for integrated workforce planning are established within the Department of Health and Children.

118 The Nursing and Midwifery Planning and Development Units should advise the Chief Nursing Officer of the Department of Health and Children on the structures and processes in place to support the collection of information for the *National Nursing and Midwifery Human Resource Minimum Dataset*.

7.11 Summary of accountabilities for implementation of recommendations

This section of the report regroups the main actions and identifies the organisation with lead responsibility for ensuring delivery on the activities necessary for implementation of the recommendations in the report. The text in this section provides a synopsis of the actions. The reader is advised to refer to the earlier text where the full recommendations and actions are set out. For ease of reference the specific action number is included at the end of each bullet point. As the workforce planning function within the Nursing Policy Division will have a central role in implementing the recommendations contained in this report the function should be assigned by Autumn 2002 at the latest. The proposed steering group should also be established by end 2002.

7.11.1 Nursing Policy Division of the Department of Health and Children

- Continue to provide for 1,640 undergraduate degree places for nursing annually (action 1)
- Continue to provide funding for national and local promotional campaigns to promote nursing and midwifery as a career choice (action 42)
- Establish a Workforce Planning Function for Nursing and Midwifery within the Nursing Policy Division of the Department of Health and Children by autumn 2002 (action 52)
- Appoint an appropriately qualified and experienced person to lead this work on an ongoing basis (action 53)
- Identify and secure appropriate staffing, supports and structures to facilitate workforce planning (action 52)
- Arrange for access to personnel with expertise in workforce planning and systems analysis (action 53)
- Establish a Steering Group for Workforce Planning for Nursing and Midwifery chaired by the Chief Nursing Officer by end 2002 (action 54)
- Expedite the development of appropriate systems to determine nurse staffing levels (action 112)
- Continue recent initiatives to support continuing nurse education, return-to-practice and uptake of places on post-registration courses (action 11, 12, and 22)
- Support the expansion of current programmes and the development of new programmes on the basis of service requirements (action 9)
- Consider the recommendation of the Commission on Nursing in relation to registration in the amendments to the Nurses Act, 1985 (action 79)
- Further develop linkages and collaborate with the Nursing and Midwifery Advisory Group, Northern Ireland in relation to workforce planning for nursing and midwifery including mobility and registration across jurisdictions (action 60).

7.11.2 Workforce Planning Function for Nursing and Midwifery within the Nursing Policy Division of the Department of Health and Children

- Prepare a plan and proposed timeframe for the implementation of the recommendations in this report (action 116)
- Lead the development of national workforce plans for nursing and midwifery (action 51 and 105)
- Advise the Department when commissioning a national tool for forecasting integrated workforce requirements, in consultation with other divisions within the Department and the Health Information and Quality Authority when established (action 57, 59,108 and 109)
- Identify the main assumptions on which forecasts for the requirement of Nursing and Midwifery are to be based (111)
- Initiate the development of education programmes to prepare nurse and midwife managers for their participation in the preparation of workforce plans (action 55)
- Receive reports on the *National Nursing and Midwifery Human Resource Minimum Dataset* from each Nursing and Midwifery Planning and Development Unit (action 90)
- Receive, co-ordinate and analyse information on turnover in nursing and midwifery on a national basis (action 103)
- Disseminate information on the annual attrition rates from pre-registration nursing education programmes (action 6)
- Provide advice on the health services personnel census returns for nursing and midwifery (action 91, 92, 93 and 94)
- Request information on numbers employed in the army and prison services on an annual basis (action 96)
- Liaise with the Central Statistics Office on nursing returns for the population census (action 97)
- Publish an annual report with statistics profiling and reviewing the supply and demand for the nursing and midwifery resource (action 113 and 114)
- Broaden links and enhance communication and involvement between groups examining workforce planning for other disciplines (action 57, 58, 59 and 60).

7.11.3 Steering Group for Workforce Planning for Nursing and Midwifery

- Monitor and evaluate the implementation of the recommendations in this report (action 115)
- Continue to function until the structures and processes for integrated workforce planning are established within the Department of Health and Children (action 117)
- Liaise with the Health Services Skills Group established in 2002 (action 58).

7.11.4 Health Service Employers Agency

- Monitor recruitment of nurses and midwives (from Ireland and abroad) (action 98)
- Monitor the number of vacant posts for nursing and midwifery (action 98)
- Make the findings for the quarterly *Nursing Resource Survey* available to all interested parties (action 100)
- Continue to facilitate the national provision of supervised clinical placements for nurses and midwives from aboard (action 26).

7.11.5 An Bord Altranais

- Include relevant division(s) of the Register of Nurses on the registration notice issued yearly (action 80)
- Receive and respond on electronic queries from employers for confirmation that nursing and midwifery staff are registered (action 82)
- Review the categories used for the inactive file of the Register of Nurses (action 81)
- Investigate the feasibility of making details from the Register of Nurses available on the Board's website (action 78)
- Monitor attrition rates from pre-registration nursing education programmes (action 4)
- Publish detailed statistics from the Register of Nurses on an annual basis (action 83).

7.11.6 Nursing Careers Centre

- Undertake national promotional campaigns to attract sufficient numbers of school leavers and mature students to nursing programmes (action 43, 44 and 49)
- Undertake initiatives targeted to achieve a greater gender balance among applicants to nursing education programmes (action 46)
- Promote the Sponsorship Scheme for Health Care Workers (action 45)
- Monitor applications for undergraduate nursing education and the numbers commencing programmes (action 2)
- Develop national initiatives to promote mental handicap and psychiatric nursing (action 47)
- Develop national initiatives to promote sick children's nursing, public health nursing and midwifery as career options (action 48).

7.11.7 The National Council for the Professional Development of Nursing and Midwifery

- Undertake an annual survey of programmes and places on post-registration courses in specialised areas of clinical practice (action 8)
- Support the expansion of current programmes and the development of new programmes on the basis of service requirements (action 9)
- Monitor and evaluate the introduction of clinical nurse/midwife specialists and advanced nurse/midwife practitioners throughout the health system in collaboration with Nursing and Midwifery Planning and Development Units, Directors of Nursing and service providers (action 31)
- Initiate research on the effectiveness for service delivery of clinical nurse/midwife specialists and advanced nurse/midwife practitioners roles (action 32).

7.11.8 Higher Education Institutions

- Collaborate with health service providers to ensure maximum uptake of places on nursing and midwifery education programmes (action 2 and 50)
- Monitor uptake of places and attrition rates from undergraduate nursing degree programmes and supply information to An Bord Altranais (action 3)
- Explore all opportunities for shared learning between health care professionals at undergraduate and postgraduate level (action 6)
- Develop integrated programmes at pre-registration level for sick children's nursing (action 14)
- Provide programmes for continuing professional development for nurses and midwives (action 9, 10 and 40)
- Develop new post-registration education programmes to meet the needs of the health system (action 9, 10 and 15)
- Liaise with An Bord Altranais, the National Council for the Professional Development of Nursing and Midwifery, the Department of Health and Children, health service providers and other relevant bodies on issues related to the supply of newly qualified nurses and midwives (action 2 and 8).

7.11.9 Nursing and Midwifery Planning and Development Units

- Identify an experienced individual within the Nursing and Midwifery Planning and Development Unit with lead responsibility for preparation of regional workforce plans for nursing and midwifery (action 62)
- Lead in the preparation of regional strategic plans for the nursing and midwifery resource in consultation with the Human Resource Departments (action 61, 105, 106 and 107)
- Prepare proposals for the expansion of current post-registration courses in specialised areas of clinical practice and the development of new courses on the basis of service needs within the region (action 9 and 15)
- Continue to prepare (in collaboration with Directors of Nursing and service providers) for the expansion of clinical nurse/midwife specialists and advanced nurse/midwife practitioners for the region (action 29 and 31)
- Co-ordinate and facilitate the delivery of education programmes to prepare nurse and midwife managers for their participation in the preparation of workforce plans (action 65)
- Introduce and expand the processes identified during the *National Nursing and Midwifery Human Resource Minimum Dataset* pilot projects (action 63 and 84)
- Collect and collate information on the *National Nursing and Midwifery Human Resource Minimum Dataset*, in addition to information on leavers and vacant posts, to estimate employment in the public health services and the independent sector for the region (action 84, 85, 86, 87, 88 and 89)
- Ensure data maintenance strategies are put in place for updating information on nursing and midwifery employment within the region (action 64 and 90)
- Initiate in consultation with Human Resource Departments and the National PPARS Project Office electronic processes for enabling employers to obtain confirmation that nursing and midwifery staff are registered with An Bord Altranais, on an annual basis (action 90)
- Provide standardised data on the *National Nursing and Midwifery Human Resource Minimum Dataset* to the Department of Health and Children on an annual basis and when otherwise required (action 90)
- Calculate turnover in nursing and midwifery for the region on an annual basis (action 101 and102)
- Monitor the age profile of nurses and midwives employed across the region (action 90)
- Calculate retirement rates for nurses and midwives in collaboration with the Human Resource Department (action 90)
- Review and recommend appropriate additions to the qualification catalogue developed for the PPARS SAP HR system (action 16)
- Work with Human Resource Departments in completing returns for the quarterly nursing resource survey conducted by the Health Service Employers Agency (action 99)
- Monitor uptake and subsequent career paths of nurses and midwives undertaking return-to-practice courses within the region (action 21)
- Advise on the annual returns for the health services personnel census for nursing and midwifery (action 93)
- Continue to develop linkages with other relevant departments within the health boards and service providers in the independent and voluntary sectors in relation to workforce planning (action 66, 67 and 68)
- Advise on the introduction of health care assistants (HCAs) to assist and support nurses and midwives throughout the region (action 17, 18 and 19)
- Prepare an annual review for the Chief Nursing Officer of the Department of Health and Children on the collection of information for the *National Nursing and Midwifery Human Resource Minimum Dataset* (action 118).

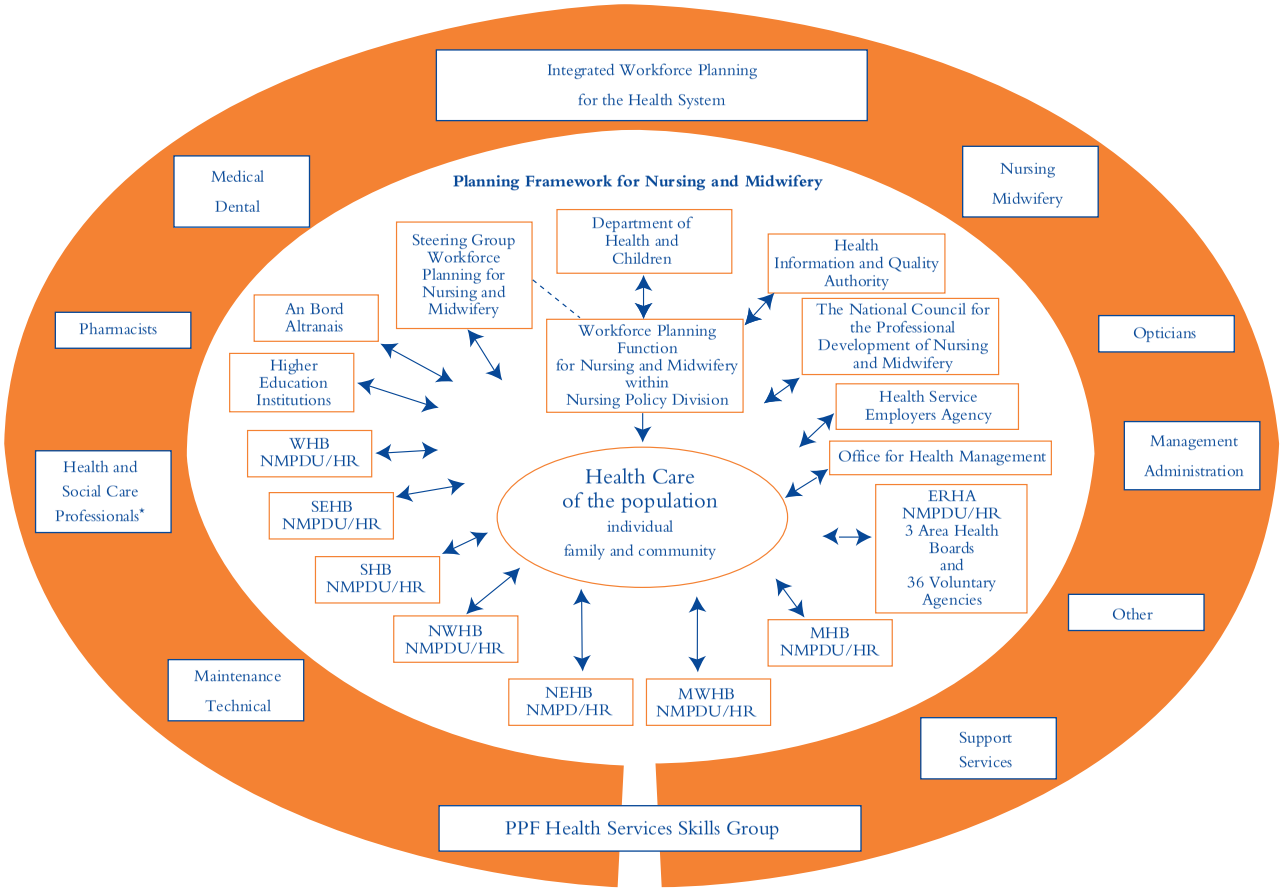
7.11.10 Individual organisations/institutions

- Lead on the development of nursing and midwifery workforce plans for the organisation (action 69, 106,107 and 108)
- Identify a named person with responsibility for collecting and collating information on nursing and midwifery employment (action 70)
- Provide appropriate personnel, information technology and systems to collect information (action 71)
- Provide the director of nursing or midwifery and their nominees on-site access to nursing and midwifery employment data held on personnel systems (action 74)
- Prepare nurse and midwife managers for their participation in the preparation of workforce plans for the organisation (action 77)
- Hold standardised information on the *National Nursing and Midwifery Human Resource Minimum Dataset* in addition to information on leavers and vacant posts in electronic format (on a database) and update this on an on-going basis (action 71, 72, 73 and 85)
- Put in place a data maintenance strategy for ongoing update of the *National Nursing and Midwifery Human Resource Minimum Dataset* (action 75)
- Prepare local projections for nursing and midwifery human resource requirements on an annual basis (action 69 and 105)
- Facilitate all potential candidates in returning to nursing and midwifery practice (action 20)
- Use the *Guidance for Best Practice on the Recruitment of Overseas Nurses Midwives* when employing nurses from aboard (action 23, 24 and 25)
- Adopt a co-ordinated approach to the recruitment of overseas nurses and midwives (action 23 and 24)
- Adopt a co-ordinated approach to the engagement of agency nurses and midwives (action 27)
- Where possible establish an in-house nursing/midwifery bank (action 28)
- Prepare a retention strategy for nursing and midwifery for the organisation (action 33, 34 and 35)
- Review and revise the effectiveness of the retention strategy in light of attrition rates, on an annual basis (action 36 and 37)
- Encourage clinical nurse/midwife managers and middle nurse/midwife managers to take responsibility for retention of staff (action 39)
- Involve clinical nurse/midwife managers in selecting staff for their particular area of responsibility (action 38)
- Provide systems for a record (electronic) of each individual nurse/midwife's qualifications (registerable, academic and skills/training) (action 41)
- Facilitate and support the development of a personal development plan for all nurses and midwives in employment in the context of service needs and development (action 40)
- Prepare plans for the expansion of clinical nurse/midwife specialist and advanced nurse/midwife practitioner posts for the organisation (action 31)
- Where appropriate introduce health care assistants (HCAs) to assist and support nurses and midwives (action 17, 18 and 19).

7.11.11 Summary of Structures for Workforce Planning

The recommendations and actions set out in this chapter describe the proposed structures and processes to be put in place to support workforce planning for nursing and midwifery. The main bodies/agencies involved are set out in Figure 7.11-1. The outer ring is used to illustrate the emphasis and importance of integrated workforce planning and close collaboration between all the interested parties. The framework with the specific structures for workforce planning for nursing and midwifery is set out in the midsection of the diagram. This will change when integrated workforce planning is put in place. The individual, families and communities are placed at the centre of the diagram. This is to emphasise the fact that the main focus of workforce planning is on the provision of health care for the population, in particular that delivered by nurses and midwives. In the longer term it is envisaged that integrated planning will be undertaken for the health system encompassing medical, dental, health and social care professionals, administration, management, technical, maintenance, support staff and others. The Health Services Skills Group established under the Programme for Prosperity and Fairness (PPF) will have an important role to play in integrated planning and thus is illustrated as the link for the outer circumference of the diagram.

FIGURE 7.11-1
Interim arrangements for workforce planning for nursing and midwifery



*includes among others: Clinical Biochemists, Environmental Health Officers, Psychologists, Chiropodists/Podiatrists, Dieticians, Orthoptists, Physiotherapists, Radiographers, Speech and Language Therapists, Occupational Therapists, Social Workers, Medical Scientists, Care Workers and Resident Managers.

A top-down and bottom-up approach is envisaged with workforce planning for nursing and midwifery taking place at local, regional and national level. At national level the entire process is to be led by a workforce planning function for nursing and midwifery to be established within the Nursing Policy Division in the Department of Health and Children, by autumn 2002. The interim framework emphasises the contribution of Human Resource Departments and Nursing and Midwifery Planning and Development Units in leading and co-ordinating plans for each region. The involvement of statutory bodies and the higher education institutions are an essential component and thus are incorporated in the diagram. A steering group for workforce planning for nursing and midwifery is to be established to monitor the implementation of the recommendations in this report. All of the structures are transitional pending the establishment of the systems for integrated workforce planning set out in the Health Strategy (2001).

7.12 Conclusion

Because nurses and midwives are vital in ensuring access to and quality of health care, it is critical that policy makers at all levels within the health system understand and develop appropriate responses to the issues identified in this study that will impact on the demand and supply of the nursing and midwifery resource.

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APPENDICES

APPENDICES

APPENDIX 1

Plan of Work
Study of the Nursing and Midwifery Resource
October 2000 – April 2002

Plan of Work (Phase 2/3)

Study of the Nursing and Midwifery Resource

Major Issue	2000-2002	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April
Project Management	Steering Group/Resource Group Meetings			*		*	*		**	*			*	*	**	**	*	*	*	*
	Review/revise Project Plan																			
	Correspondence/minutes/liasion/updates for stakeholders																			
Census of Independent Sector	Finalise report/ prepare text (appendix)																			
National Study of Turnover	Link/meet with UCC research team								*	*	*		*	*	*					
	Assist in editing report/ liaise with Publisher/UCC team													*	*				*	*
	Regional feedback meetings — plan/host/review										*		**	*						
	Develop National Action Plan on Retention													*						
	Prepare materials/ Co-ordinate/ advise on data collection 2001																			
Survey of Return-to-Practice Programmes	Plan survey, disseminate questionnaires																			
	Monitor returns/ follow up/ validate responses																			
	Collate responses — prepare report																			
Survey of Specialist Courses	Plan survey, disseminate questionnaires																			
	Monitor returns/ follow up/ validate responses																			
	Collate responses — prepare report																			
Survey of Post-Registration Opportunities	Plan survey, disseminate questionnaires, analyse, prepare report																			
Minimum Dataset Pilot Projects	Select pilot sites/ agree work processses/meetings						*		**		*	*	*	*						
	Prepare/agree National Minimum Dataset																			
	Prepare/agree/test — standard definitions																			
	Prepare/agree/test — qualifications catalogue — Q definitions														*			*		
	Liaise/meet with and support pilot sites								*	*	*	*	*	*	*					
	Agree final reports																			
Best Practice on Recruitment from Abroad	Convene Group/ agree work processes										*	*	*	*						
	Draft text/section for Final Report																			
Update Statistics in Interim report	Persons/WTE — DOHC Census																*		*	
	ABA Registration Statistics/Age/Pre-registration places																			
	GMS — Practice Nurses																			
	Justice — Prison Nursing Service																			
	Defence — Army Nursing Services																			
	Collate and Draft Report of Statistics																			
Approach to HR Projections	Review literature on forecasting methodologies																			
	Investigate assumptions for forecasting																			
	Agree and recommend approach to ongoing projections																			
Linkages	Directors Nursing and Midwifery Planning/ Development Units				*			*		*	*	*		*	*	*		*	*	*
	DATHs Recruitment and Retention Project			*			*		*		*									*
	DOHC/HSEA/National Council																			
	Medical Manpower Forum																			
	Effective Utilisation of Professional Skills of Nurses/Midwives		*	*		**		*												
	An Bord Altranais/National Implementation Committee												*	*	*	*	*	*	*	*
Final report	Draft sections/ formulate recommendations																	*		
	Liaise with publisher/ editing/ design/plan launch																*			*

* = *Meetings*

APPENDIX 2

Survey of availability of Post-Registration Courses in Specialised Areas of Clinical Practice

Nursing Policy Division
Department of Health and Children

March 2001

Introduction

The Nursing Policy Division of the Department of Health and Children conducted a survey (March 2000) to obtain a national overview of the provision of post-registration courses in specialised areas of clinical practice and the number of places available. This survey was repeated in March 2001.

Methodology

In March 2001 the Principal Nurse Tutor in each of the Schools of Nursing and the Director of the Department of Nursing Studies at 14 Universities/Institutes of Technology were contacted to obtain the required information. A full response was received. The data collection tool that was designed and tested in the previous survey (2000) was used. The data collection instrument sought information on: the number of places; duration of the course; number of intakes per year; level of award; and academic association. The Directors of the Nursing and Midwifery Planning and Development Units were asked to review the survey findings. The results are summarised on the tables attached.

Summary of Findings

- During 2000/2001 thirty new post-registration programmes were developed. Of the thirty new courses, eighteen were based outside Dublin (see Table 1).
- At the time of the survey (March 2001) the majority of new programmes were due to start in September/October 2001.
- During 2001 there were a total of 882 plus places on post-registration courses in specialised areas of clinical practice (see Table 4 for details of the programmes and places available). Some programmes have unlimited places; therefore this is an estimated figure.
- In 2000/2001, 337 plus additional places were estimated to be available (see Table 1). All but three of the third level institutions were involved in the provision of specialist education for nurse/midwives (see Table 2).
- Thirty of the fifty-one sites/schools surveyed provide specialist education programmes (see Table 2).
- Total number of programmes: in 1999 — 43, in 2000 — 59, and in 2001 — 80. A comparison of the programmes and places can be found on Table 3.
- A variation exists in the length of the Higher Diploma programmes, some of which are based on an academic year (10 months) and others on a full calendar year. A small number are offered part-time over two years.
- There has been a substantial increase in the number of programmes and places for accident and emergency nursing (4 new courses), gerontological nursing (4 new courses), and peri-operative nursing (5 new courses) (see Table 4).
- The Challenging Behaviour course (Cregg House, Sligo) and the Rehabilitation course (National Rehabilitation Centre) were new in 2001.
- A small number of hospitals continue to offer a hospital certificate course while also providing places for Higher Diploma programmes. This is part of the transitionary arrangements. In some situations staffing for specialist units has influenced this decision. It is anticipated that the majority of certificate courses will be phased out over the next few years.

Table 1 – New Courses in 2001

Course	Hospital	3rd Level	No. Places
Accident and Emergency	Letterkenny General	NUI RCSI	6
Accident and Emergency	UCHG	NUI Galway	6
Accident and Emergency	Sligo General	St. Angela's via NUI Galway	4
Accident and Emergency	Waterford Regional	NCEA/WIT	4
Behaviours that Challenge	Cregg House	St. Angela's via NUI Galway	6
Cognitive Behavioural Psychotherapy	Cregg House	St. Angela's via NUI Galway	6
Clinical Health Sciences	Places available nationally	TCD	40
Clinical Practice	Places available nationally	TCD	40
Critical Care Nursing	Waterford Regional	NCEA/WIT	6
Critical Care Nursing	Sligo General	St. Angela's via NUI Galway	4
Gastroenterology Nursing	Planned for 2001	UCD	6
Gerontological Nursing	St. James's Hospital	TCD	No limit
Gerontological Nursing	University College Hosp. Galway	WHB, NUI Galway	30
Gerontological Nursing	St. Finbarr's & CUH	NUI Cork	25
Infection Control Nursing	Letterkenny General	RCSI/NUI	10
Intensive Therapy/Care Nursing	Waterford Regional Hospital	WIT	4
Intensive Therapy/Care Nursing	University College Galway	WHB, NUI Galway	17
Oncology Nursing	University College Galway	NUI Galway	6
Orthopaedic Nursing	AMNCH College of Nursing	TCD	5
Paediatric Accident & Emergency	AMNCH & Temple Street Hosp.	TCD	Not available
Paediatric Accident & Emergency	Temple Street Hospital	UCD	5
Paediatric Critical Care	Our Ladys Hosp. & Temple St.	UCD	7
Paediatric Intensive Care	Temple Street Hospital	UCD	Awaiting validation
Peri-operative Nursing	CUH, Bon Secours, Sth. Infirmary/ Victoria, Mercy & Tralee	NUI Cork	20
Peri-operative Nursing	Limerick Regional Hospital	University of Limerick	20
Peri-operative Nursing	University College Hosp. Galway	NUI Galway	6
Peri-operative Nursing	Sligo General	St. Angela's via NUI Galway	4
Peri-operative Nursing	Waterford Regional Hospital	WIT	4
Renal/Nephrology Nursing	Mater Misericordiae Hosp.	UCD & places nationally	6
Rehabilitation Nursing	National Rehab, Beaumont, Mater Misericordiae Hosp.	UCD & places nationally	15
Respiratory Care Nursing	Beaumont Hospital	RCSI/NUI	25
Total increase in places			**337+**

Note: Pertains to information available in April 2001

Table 2 – Response to Survey of Courses in Specialised Areas of Clinical Practice

Hospital/School of Nursing	Specialist Courses	University/Institute of Technology	Specialist Courses
ANMCH, College of Nursing Tallaght	Yes	Center for Nursing Studies, NUI Galway	Yes
Beaumont Hospital, Dublin	Yes	Department of Nursing Studies, NUI Cork	Yes
Central Mental Hospital, Dublin/St. Brendan's Hospital	Yes	Dublin City University	Yes
Centre for Mental Health Nursing, Waterford	No	Dundalk Institute of Technology	No
Coombe Women's Hospital, Dublin	No	Faculty of Nursing Royal College of Surgeons	Yes
COPE Foundation	No	Letterkenny Institute of Technology	Yes
Cork University Hospital	Yes	School of Nursing and Midwifery Studies, Trinity College	Yes
Cregg House, Sligo	Yes	School of Nursing and Midwifery, NUI Dublin	Yes
James Connolly Memorial Hospital	Yes	Science Department, Athlone Institute of Technology	Yes
Letterkenny General Hospital (St. Conal's)	Yes	University of Limerick	Yes
Marymount Hospice, Cork	Yes	Waterford Institute of Technology	Yes
Mater Misericordiae Hospital	Yes	St. Angela's College of Education, Sligo	Yes
National Maternity Hospital, Dublin	Yes	Institute of Technology, Tralee	No
National Rehabilitation Hospital, Dun Laoghaire	Yes	Galway-Mayo Institute of Technology, Castlebar	No
Our Lady of Lourdes Hospital, Drogheda	No		
Our Lady's Hospital for Sick Children	Yes		
Portiuncula Hospital	No		
Regional Hospital Limerick	Yes		
Rotunda Hospital	Yes		
Royal Victoria Eye and Ear Hospital, Dublin	Yes		
Sligo General Hospital	Yes		
St. James's Hospital, Dublin	Yes		
St. Luke's Hospital, Dublin	Yes		
St. Marys Orthopaedic Hospital, Cappagh	Yes		
St. Patrick's Hospital, Dublin	No		
St. Vincent's Hospital, Fairview, Dublin	Yes		
St. Vincent's University Hospital, Dublin	Yes		
St. Finbarr's Hospital, Cork (Care of the Elderly Services)	Yes		
St. Finbarr's and the Erinville, Cork (Maternity Services)	No		
University College Hospital Galway	Yes		
Waterford Regional Hospital	Yes		
Tralee General Hospital	No		
The Children's Hospital, Temple Street, Dublin	Yes		
Stewart's Hospital, Palmerstown, Dublin	No		
Daughters of Charity, Clonsilla, Dublin	No		
St. Vincent de Paul, Lisnagry, Co. Limerick	No		
St. Anne's Moore Abbey, Monasterevin, Co. Kildare	No		
St. Mary's, Drumcar, Co. Louth	No		
School of Psychiatric Nursing, University, Galway	No		
SHB Regional School of Psychiatry, University College Cork	Yes		
St. Davnet's Hospital, Monaghan	No		
St. Joseph's Hospital, Limerick	No		
St. Ita's, Portrane, Dublin	No		
Mayo General Hospital, Castlebar, Co. Mayo	No		
Tullamore General Hospital, Co. Offaly	No		
St. Michael's Hospital, Dun Laoghaire, Co. Dublin	No		
Bon Secours Hospital, Cork	Yes		
Mercy Hospital, Cork	Yes		
Regional Maternity Hospital, Limerick	Yes		
St. Francis Hospice, Raheny, Dublin	No		
St. John of Gods, Stillorgan	Yes		

Note: Pertains to information available in April 2001

Table 3 – Review of Availability of Post-registration Courses in Specialist Areas of Clinical Practice 1999-2001

Year Post-Registration Courses in Specialist Areas	1999 Courses	Locations	2000 Courses	Locations	2001 Courses	Locations
Accident and Emergency Nursing*	3	Dublin	7	Dublin, SHB, SEHB	9	Dublin, SHB, SEHB, NWHB
Behaviours that Challenge	1	NWHB	—	—	1	NWHB
Breast Care Course	—	—	1	Dublin	1	Dublin
Burns Nursing	—	—	1	Dublin	1	Dublin
Cardiovascular Nursing	1	Dublin	1	Dublin	—	—
Cognitive Behavioural Psychotherapy*	—	—	—	—	1	NWHB
Child and Adolescent Psychiatry	1	Dublin	1	Dublin	1	Dublin
Clinical Health Sciences Education*	—	—	—	—	1	Dublin
Clinical Practice*	—	—	—	—	1	Dublin
Coronary Care Nursing	2	Dublin	3	Dublin, NWHB	3	Dublin, NWHB
Critical Care Nursing*	2	Dublin	6	Dublin, SEHB, SHB, WHB	7	Dublin, NWHB, SEHB, SHB, WHB
Diabetic Nursing	2	Dublin	2	Dublin	1	Dublin
Ear, Nose and Throat Nursing	1	Dublin	1	Dublin	1	Dublin
Forensic Psychiatric Nursing	1	Dublin	1	Dublin	1	Dublin
Gastroenterology Nursing*	—	—	—	—	1	Dublin
Gerontological Nursing*	3	Dublin, MHB	4	Dublin, MHB	8	Dublin, MHB, NWHB, SHB, WHB
HIV/AIDs Nursing	1	Dublin	—	—	—	—
Infection Control Nursing*	1	Dublin	—	—	1	Dublin
Intensive Therapy/Care Nursing*	5	Dublin, WHB	4	Dublin, NWHB	4	Dublin, NWHB, SEHB, WHB
Mental Health Nursing	—	—	1	Dublin	—	—
Neonatal Intensive Care*	—	—	—	—	1	Dublin
Neurological/Neurosurgical Nursing	1	Dublin	1	Dublin	1	Dublin
Nursing Informatics	—	—	1	Dublin	1	Dublin
Oncology Nursing*	1	Dublin	1	Dublin	4	Dublin, WHB
Ophthalmic Nursing	1	Dublin	1	Dublin	—	—
Orthopaedic Nursing*	2	Dublin, NWHB	2	Dublin, NWHB	3	Dublin, NWHB
Paediatric Accident and Emergency Nursing*	—	—	—	—	2	Dublin
Paediatric Critical Care Nursing	—	—	—	—	2	Dublin
Paediatric Intensive Care Nursing Course	1	Dublin	1	Dublin	—	—
Palliative Care Nursing	1	Dublin	2	Dublin, SHB	1	Dublin
Peri-Anaesthesia Nursing (Anaesthetic Nursing)	2	Dublin	2	Dublin	1	Dublin
Peri-Operative (Operating Dept/Theatre Nursing)*	5	Dublin	8	Dublin, NWHB, SEHB	11	Dublin, NWHB, SEHB, SHB, WHB
Practice Nursing	1	Dublin (short course)	2	Dublin, SHB	1	Dublin
Rehabilitation Nursing*	—	—	—	—	1	Dublin
Renal/Nephrology Nursing*	1	Dublin	2	Dublin	3	Dublin
Respiratory Care Nursing*	—	—	—	—	1	Dublin
Special/Intensive Nursing Care Newborn	3	Dublin	3	Dublin	3	Dublin
Wound Management and Tissue Viability*	—	—	—	—	1	Dublin
Total	**43**		**59**		**80**	

Notes:

Pertains to information available in April 2001

*Denotes new course commenced since survey in 2000

Source 2000: Principal Nurse Tutors (30) and Heads of Nursing — Third Level Education (11)
Source 2001: Principal Nurse Tutors (51) and Heads of Nursing — Third Level Education (14)

Table 4 — Detail of Post-registration Courses in Specialised Areas of Clinical Practice 2001-2002

	Places 00	Places 01	Duration 2001	Level of Award 2001	Academic Association 2001
Accident and Emergency Nursing					
St. Vincent's University Hospital (Discontinued)	6	—	—	Hospital Certificate/ABA Category II (2000)	—
Beaumont Hosptial	6	6	12 months	HDNS (Accident and Emergency Nursing)	Faculty of Nursing RCSI/NUI
AMNCH College of Nursing*	8	5	12 months	Postgraduate Diploma	Conjoint with TCD
University College Hospital Galway **	—	6	12 months	HDNS (Accident and Emergency Nursing)	NUI Galway
Sligo General Hospital**	—	4	12 months	HDNS (Accident and Emergency Nursing)	St. Angela's & NUI Galway
Letterkenny General Hospital**	—	6	12 months	HDNS (Accident and Emergency Nursing)	St. Angela's & NUI Galway
St. James's Hospital	9	10	10 months (39 weeks)	Postgraduate Diploma	Conjoint with TCD
School of Nursing and Midwifery UCD	26	20	24 P/T 12 accelerated	HDNS (Accident and Emergecny)	NUI Dublin, places available nationally (MMH & SVUH)
CUH/SHB, Cork Voluntaries and Bons Secours*	10	10	12 months	HDNS (Accident and Emergency)	NUI Cork
Waterford Regional Hospital/SEHB ** (2001)	—	4	12 months	Post-Graduate Diploma	NCEA / Waterford Institute of Technology
Sub-total	***65***	***71***			
Behaviours that Challenge					
Cregg House (NWHB)	—	6	12 months	HDNS Behaviours that Challenge	St. Angela's College & NUI Galway
Breast Care Course					
St. Luke's and St. Annes, Rathgar	8	10	5 months	Hospital Certificate of Completion	None
Burns Nursing					
St. James's Hospital	4	4	6 months (26 weeks)	Hospital Certificate/ ABA Category II	None
Cognitive Behavioural Psychotherapy**					
Mental Health Services (NWHB)	—	6	12 months	HDNS Cognitive Behavioural Psychotherapy	St. Angela's College & NUI Galway
Child and Adolescent Psychiatry					
Eastern Health Board	12	12	12 months	Diploma	Dublin City University
Clinical Health Sciences Education					
University of Dublin, Trinity College**	—	Min 20/ Max 40	12 months	Postgraduate Diploma in CHSE	University of Dublin, Trinity College
Clinical Practice					
University of Dublin, Trinity College**	—	Min 20/ Max 50	12 months	Postgraduate Diploma in Clinical Practice	University of Dublin, Trinity College

Table 4 — Detail of Post-registration Courses in Specialised Areas of Clinical Practice 2001-2002 — *contd.*

	Places 00	Places 01	Duration 2001	Level of Award 2001	Academic Association 2001
Coronary Care Nursing					
St. Vincent's Hospital (Discontinued)	5	—	6 months	Hospital Certificate/ABA Category II	None — in discussion with NUI Dublin
Beaumont Hospital	6	6	12-15 months	HDNS (Coronary Care Nursing)	Faculty of Nursing RCSI/NUI
Letterkenny General Hospital*	3	10	16 months	HDNS (Coronary Care Nursing)	Facutly of Nursing RCSI/NUI
Mater Misericordiae Hospital*** (1999) cert	—	20	24 P/T 12 accelerated	HDNS (Coronary Care Nursing)	NUI Dublin
Sub-total	***9***	***36***			
Critical Care Nursing					
AMNCH College of Nursing*	8	5	12 months	Postgraduate Diploma (ICU/CCU)	Conjoint with TCD
St. James's Hospital	8	8	12 months	Postgraduate Diploma (ICU/CCU)	Conjoint with TCD
School of Nursing and Midwifery UCD	44	50	24 P/T 12 accelerated	HDNS (Critical Care Nursing)	NUI places available nationally (MMH & SVH)
University College Hospital Galway*	6	6	12 months	Higher Diploma	NUI Galway
CUH/SHB, Cork Voluntaries and Bons Secours*	18	15	12 months	Higher Diploma (ICU/CCU)	NUI Cork
Waterford Regional Hosptial/SEHB ** ('01)	—	6	12 months	Higher Diploma	NCEA/Waterford Institute of Technology
Sligo General** (Commence 09/01)		4	12 months	HDNS (Critical Care Nursing)	St. Angela's & NUI Galway
Sub-total	***84***	***94***			
Diabetic Nursing					
Beaumont Hospital	not this year	not this year	—	HDNS (Diabetic Nursing)	Faculty of Nursing RCSI/NUI
School of Nursing and Midwifery UCD	20	10	24 P/T 12 accelerated	HDNS (Diabetes Nursing)	NUI places available nationally (MMH)
Sub-total	***20***	***10***			
Ear, Nose and Throat Nursing					
Royal Victoria Hospital	7	6	12 months	HDNS (Ear, Nose and Throat Nursing)	Faculty of Nursing RCSI
Forensic Psychiatric Nursing					
Central Mental Hospital, Dundrum & St. Brendan's	12	25	6 months	EHB Certificate (2000)	Faculty of Nursing RCSI (2001)
Gastroenterology Nursing					
School of Nursing and Midwifery UCD** (Planned 2001)	—	6	24 P/T 12 accelerated	HDNS (Gastroenterology Nursing)	UCD places available Nationally (MMH)
Gerontological Nursing					
James Connolly Memorial Hospital	12	10	24 months (part-time)	HDNS (Gerontological Nursing)	Faculty of Nursing RCSI/NUI
St. James's Hospital**	No limit	No limit	24 months (part-time)	MSc (Gerontological Nursing)	TCD places available nationally (max 40, min 20)
St. James's Hospital**	—	No limit	12 months (full-time)	MSc (Gerontological Nursing)	TCD places available nationally (max 40, min 20)
St. James's Hospital	8+	8+	12 months (full-time)	Postgraduate Diploma	TCD places available nationally (max 50, min 20)
St. Marys, Mullingar/St. Vincent's, Mountmellick	30	30	12 months (part-time)	National Diploma (NCEA Level 3)	NCEA/Athlone Institute of Technology
Letterkenny School of Nursing*	10	10	12 months (full-time)	Postgraduate Diploma	Trinity College, Dublin
University College Hospital Galway **	—	30	12 months (full-time)	HDNS (Gerontological Nursing)	WHB, NUI Galway
St. Finbarrs and Cork University Hospital**	—	25	12 months (full-time)	HDNS (Gerontological Nursing)	NUI Cork
Sub-total	***50***	***105+***			

Table 4 — Detail of Post-registration Courses in Specialised Areas of Clinical Practice 2001-2002 — *contd.*

	Places 00	Places 01	Duration 2001	Level of Award 2001	Academic Association 2001
Infection Control Nursing					
Beaumont Hospital	not this year	not this year	24 months	Hospital Certificate	Faculty of Nursing RCSI
RCSI (multiple clinical sites)**	—	20	24 months	Higher Diploma	Faculty of Nursing RCSI/NUI
Sub-total		***20***			
Intensive Therapy/Care Nursing					
Mater Misericordiae Hospital (Discontinued)	12	—	6 months	Hosptial Certificate / ABA Category II	None — final certificate course
St. Vincent's University Hosptial (Discontinued)	5	—	6 months	Hospital Certificate / ABA Category II	None — both HDNS and certificate course offered
Beaumont Hosptial	6	6	12 months	HDNS (Intensive Therapy Nursing)	Faculty of Nursing RCSI/NUI
Letterkenny General Hospital*	3	10	16 months	HDNS (Intensive Therapy Nursing)	Faculty of Nursing RCSI
Waterford School of Nursing**	—	4	12 months	HDNS (Intensive Therapy Nursing)	Waterford Institute of Technology
University College Hospital Galway**	—	17	12 months	HDNS (Intensive Therapy Nursing)	WHB, NUI Galway
Sub-total	***26***	***37***			
Neonatal Intensive Care					
Coombe, National Maternity & Rotunda Hospital**	—	15	16 months	HDNS (Neonatal Intensive Care)	Faculty of Nursing RCSI/NUI
Neurological/Neurosurgical Nursing					
Beaumont Hospital	6	6	12-15 months	HDNS (Neurological Nursing)	Faculty of Nursing RCSI/NUI
Nursing Informatics					
School of Nursing and Midwifery UCD	20	20	12 months	Diploma in Nursing Studies	UCD, places available nationally
Oncology Nursing					
St. Luke's/St. Anne's Hospital Rathgar/St. James's	10	12	12 months	Postgraduate Diploma (F/T)	Trinity College
St. Luke's/St. Anne's Hospital Rathgar/St. James's	10	10	24 months	Postgraduate Diploma (P/T)	Trintiy College
School of Nursing and Midwifery UCD	49	60	24 P/T 12 accelerated	HDNS (Oncology Nursing)	NUI places available nationally (includes paediatric stream)
University College Hospital Galway**	—	6	12 months	HDNS (Oncology Nursing)	NUI Galway
Sub-total	***69***	***88***			
Operating Dept/Theatre Nursing					
St. Vincent's University Hospital (two intakes)	12	6	12 months	Hospital Certificate / ABA Category II	In dicussion with UCD
Mater Misericordiae Hospital***Discontinued	8	—	12 months	Hospital Certificate / ABA Category II	Final cert course
Beaumont Hospital	6	6	12 months	HDNS (Theatre Nursing) or (Anaes./Recovery Room Nursing)	Faculty of Nursing RCSI/NUI
AMNCH College of Nursing Tallaght	8	5	12 months	Postgraduate Diploma	Conjoint with TCD
Sub-total	***34***	***17***			
Ophthalmic Nursing					
Royal Victoria Hospital	7	—	12 months	HDNS (Opthalmic Nursing)	Faculty of Nursing RCSI

Table 4 — Detail of Post-registration Courses in Specialised Areas of Clinical Practice 2001-2002 — *contd.*

	Places 00	Places 01	Duration 2001	Level of Award 2001	Academic Association 2001
Orthopaedic Nursing					
Sligo General Hospital &					
Our Lady's Manorhamiliton	15	12	12 months	Higher Diploma in Orthopaedic Nursing	St. Angela's & NUI Galway
St. Mary's Hospital Cappagh	10	12	12 months	HDNS (Orthopaedic Nursing)	Faculty of Nursing RCSI/NUI
AMNCH College of Nursing**	—	5	12 months	Postgraduate Diploma	Awaiting Validation by TCD
Sub-total	***25***	***29***			
Paediatric Accident & Emergency					
Our Lady's Hospital for Sick Children &					
The Children's Hospital Temple Street	—	N/A	24 P/T 12 accelerated	HDNS (Paediatric A&E)	Awaiting Validation by UCD
AMNCH College of Nursing**	—	5	12 months	Postgraduate Diploma	Awaiting Validation by TCD
Sub-total	***0***	***5***			
Paediatric Intensive Care Nursing					
Our Lady's Hospital for Sick Children	12	6 (only 4 filled)	6 months	Hospital Certificate/ ABA Category II	Our Lady's Hospital for Sick Children
Our Lady's Hospital for Sick Children &					
The Children's Hospital Temple Street**	—	7	24 months P/T	HDNS (Paediatric Critical Care Nursing)	UCD
Sub-total	***12***	***13***			
Palliative Care Nursing					
School of Nursing and Midwifery UCD	40	50	24 P/T 12 accelerated	HDNS (Palliative Care Nursing)	NUI Dublin, places available nationally
Department of Nursing Studies NUI Cork*	15	—	2 academic years	BSc with specialist track in Palliative Care	NUI Cork, SHB/Marymount Hospice
Sub-total	***55***	***50***			
Peri-Anaesthesia Nursing					
School of Nursing and Midwifery UCD	15	15	24 P/T 12 accelerated	HDNS (Peri-Anaesthesia Nursing)	NUI Dublin, places available nationally
Peri-Operative Nursing					
St. James's Hospital	10	10	12 months	Postgraduate Diploma	Conjoint with TCD
Letterkenny General Hospital*	4	10	16 months	HDNS (Peri-Operative Nursing)	Faculty of Nursing RCSI/NUI
School of Nursing and Midwifery UCD*	16	16	24 P/T 12 accelerated	HDNS (Peri-Operative Nursing)	NUI Dublin, places available nationally
Limerick Regional Hospital**	—	20	12 months	HDNS (Peri-Operative Nursing)	University of Limerick
University College Hospital Galway**	—	6	12 months	HDNS (Peri-Operative Nursing)	NUI Galway
CUH, Mercy, Tralee & Bons Secours**	—	20	12 months FT	HDNS (Peri-Operative Nursing)	NUI Cork
Waterford Regional Hospital/SEHB**	—	4	12 months	HDNS (Theatre Nursing)	Waterford Institute of Technology
Sligo General Hospital**	—	4	12 months	HDNS (Peri-Operative Nursing)	St. Angela's & NUI Galway
Sub-total	***30***	***90***			

Table 4 — Detail of Post-registration Courses in Specialised Areas of Clinical Practice 2001-2002 — *contd.*

	Places 00	Places 01	Duration 2001	Level of Award 2001	Academic Association 2001
Practice Nursing					
Faculty of Nursing RCSI	30	30	24 months (part-time)	Higher Diploma in Practice Nursing	Faculty of Nursing RCSI/NUI, GP, Surgeries
Department of Nursing Studies NUI Cork*	15	—	2 academic years	BSc with specialist track Practice Nursing	NUI Cork, all Health Boards and GPs
Sub-total	***45***	***30***			
Rehabilitation Nursing					
School of Nursing and Midwifery UCD**	—	15	24 P/T 12 accelerated	HDNS (Acquired Brain/Spinal Cord Injuries)	National availability (Beaumont, MMH, National Rehabilitation)
Renal/Nephrology Nursing					
AMNCH College of Nursing*	8	5	12 months	Postgraduate Diploma	Validated by TCD
Beaumont Hospital*	9	8	24 months	BNS Nephrology Nursing	Dublin City University
School of Nursing and Midwifery UCD**	—	6	24 P/T 12 accelerated	HDNS (Renal Nursing)	UCD, places available nationally
Sub-total	***17***	***19***			
Respiratory Care in Nursing					
Faculty of Nursing RCSI (part-time)	—	25	12-24 months	HDNS (Respiratory Care in Nursing)	Places available nationally (Beaumont Hospital)
Special /Intensive Nursing Care Newborn					
National Maternity Hospital, Holles Street (two intakes)	16	8	6 months	Hospital Certificate / ABA Category II	None at present
Coombe Women's Hospital	6	6	6 months (26 weeks)	Hospital Certificate / ABA Category II	None at present
Rotunda Hospital	6	8	6 months	Hospital Certificate / ABA Category II	None at present
Sub-total	***28***	***22***			
Wound Management and tissue Viability					
Faculty of Nursing RCSI (part-time)	—	25	12-24 months	HDNS (Wound Management & Tissue Viability)	Places available nationally (Letterkenny General Hospital)

Notes:

Pertains to information availiable in April 2001

* Denotes new course commenced since survey in June 1999

** Denotes new course commenced since last survey in March 2000

*** Denotes changed from Certificate course to HDNS since last survey in March 2000

HDNS = Higher Diploma in Nursing Studies

Cardiovascular Nursing now offered as an option in the HDNS (Critical Care Nursing) UCD

Source 2000: Principal Nurse Tutors (30) and Heads of Nursing — Third Level Education (11)

Source 2001: Principal Nurse Tutors (51) and Heads of Nursing — Third Level Education (14)

Table 5 — Course Developments Being Considered for 2002/2003

	Places	Duration	Level of Award	Academic Association
Beaumont Hospital				
Operating Department Nursing	6	12-15 months	Higher Diploma	DCU
Limerick Regional Hospital				
Coronary Care Nursing	8	12 months	Higher Diploma	University of Limerick
Intensive Care Nursing	8	12 months	Higher Diploma	University of Limerick
Orthopaedic Nursing	8	12 months	Higher Diploma	University of Limerick
National Maternity Hospital				
Neonatal Nursing	8	12 months	Higher Diploma	Under discussions
Our Lady's Hosp. for Sick Children				
Critical Care Nursing (part-time)	6 to 8	24 months	Higher Diploma	UCD
Critical Care Nursing (full-time)	6 to 8	12 months	Higher Diploma	UCD
HD Nursing Studies (part-time)	6 to 8	24 months	Higher Diploma	UCD
HD Nursing Studies (full-time)	6 to 8	12 months	Higher Diploma	UCD
Royal Victoria Eye & Ear Hospital				
HD ENT Nursing	6	15 months	Higher Diploma	RCSI/NUI
HD Opthalmic Nursing	6	15 months	Higher Diploma	RCSI/NUI
Sligo General Hospital				
Accident & Emergency Nursing	6	12 months	Higher Diploma	St. Angela's via NUI Galway
Critical Care Nursing	6	12 months	Higher Diploma	St. Angela's via NUI Galway
Peri-Operative Nursing	6	12 months	Higher Diploma	St. Angela's via NUI Galway
SHB Regional School Psychiatric				
Psychiatric Nursing	20 to 25	12 months	Higher Diploma	UCC
St. Angela's College				
Public Health Nursing	12	12 months	Higher Diploma	St. Angela's via NUI Galway
Community (Mental Handicap Nursing)	6	12 months	Higher Diploma	St. Angela's via NUI Galway
University College Cork				
Paediatric Nursing	25	18 months	Higher Diploma	UCC
Psychiatric Nursing	25	12 months	Higher Diploma	UCC
University College Dublin				
Genontological Nursing	N/A	12 months	Higher Diploma	UCD
Rheumatology Nursing	N/A	12 months	Higher Diploma	UCD
Pain Management	N/A	12 months	Higher Diploma	UCD
Urology Nursing	N/A	12 months	Higher Diploma	UCD
University College Galway				
Palliative Care Nursing	N/A	12 months	Higher Diploma	NUI Galway

Notes:
Pertains to information available in April 2001
N/A = not available

Source 2000: Principal Nurse Tutors (30) and Heads of Nursing — Third Level Education (11)

Source 2001: Principal Nurse Tutors (51) and Heads of Nursing — Third Level Education (14)

Table 6 — Post-registration courses leading to registration with An Bord Altranais

	Places	Duration	Award	Academic Association
Midwifery 2001				
National Maternity Hospital (2 intakes per year)	36	24 months	Higher Diploma in Midwifery	NUI Dublin, linked to employment in designated Maternity Hospitals
Coombe Women's Hospital (2 intakes per year)	36	24 months	Higher Diploma in Midwifery	NUI Dublin, linked to employment in designated Maternity Hospitals
Rotunda Hospital (2 intakes per year)	36	24 months	Postgraduate Diploma in Midwifery	Trinity College Dublin, linked to employment in designated Maternity Hospital
Our Lady of Lourdes Hospital, Drogheda	17	24 months	Postgraduate Diploma in Midwifery	Trinity College Dublin, linked to employment in designated Maternity Hospital
Erinville/St. Finbarr's Hospitals, Cork (2 intakes per year)	32	24 months	Higher Diploma in Midwifery	NUI Cork, linked to employment in designated Maternity Hospitals
St. Munchin's Hospital, Limerick (2 intakes per year)	20	24 months	Higher Diploma (Midwifery)	University of Limerick, linked to employment in Maternity Hospitals
University College Regional Maternity Hospital, Galway	17	24 months	Higher Diploma in Midwifery	NUI Galway
Sub-total	***194***			
Sick Children's Nursing 2001				
Our Lady's Hosp. for Sick Children (2 intakes per year)	60	18 months	HDNS (Sick Children's Nursing)	NUI — Dublin, linked to employment in designated Children's Hospitals
The Children's Hospital Temple St. (2 intakes per year)	52	18 months	HDNS (Sick Children's Nursing)	NUI — Dublin, linked to employment in designated Children's Hospitals
AMNCH College of Nursing, Tallaght (2 intakes per year)	21	18 months	HDNS (Sick Children's Nursing)	Trinity College Dublin, linked to employment in designated Children's Hospital
Sub-total	***133***			
Public Health Nursing 2001				
School of Nursing and Midwifery NUI — Dublin	35	12 months	HDNS (Public Health Nursing)	UCD places available nationally
Department of Nursing Studies NUI — Cork	25	12 months	Higher Diploma in Public Health Nursing	UCC places available nationally (175 applicants this year)
Sub-total	***60***			

Note: HDNS = Higher Diploma in Nursing Studies

Source: Principal Nurse/Midwifery Tutors, pertains to information available in April 2001

APPENDIX 3

Guidelines and Grade Codes for Nursing and Midwifery

Department of Health and Children, Health Services Personnel Census 2001

1. Introduction

The report of the Commission on Nursing (1998) *A Blue Print for the Future* made 200 recommendations for the future development of nursing and midwifery. Many of the recommendations affect the role, function and title of nursing positions. Some changes have been made during 1999 and others were implemented in 2000. The grade codes for the Department's personnel censuses have been changed to reflect the recommendations implemented during 2001. The following detailed guidelines are provided to assist in compiling the returns for the 2001 census.

The Department's personnel census is a crucial source of information on employment of nurses and midwives in the public health services. For this reason particular care is required in selecting the correct grade code for the returns.

It is advisable to consult with nursing administration for advice on the changes prior to completing the census returns.

Following consultation with the Health Services Employment Agency (HSEA) the following principles were agreed.

2. Nursing Students

Due to the changes in nursing education you should no longer have traditional apprentice student nurses on your pay roll. For this reason you should NOT use the following codes:

Name	Code
Student Nurse I	2224
Student Nurse II	2232
Student Nurse III	224Y

A new code was introduced in 1999 for Diploma Nursing Students (2216). As nursing students are not employees and not on the payroll they should no longer be identified in the annual personnel census. Nursing Students should not be included in the census.

3. Post-Registration Student Nurses

Due to changes in nurse education you should no longer have traditional post-registration (general) student nurses on your pay roll. The following codes should No Longer be used:

Name	Code
Post-Registration Student Nurse, Year 1	2901
Post-Registration Student Nurse, Year 2	2902
Student Midwife	4297

Post-registration students who are undertaking the Higher Diploma in Sick Children's Nursing, or Midwifery and are on the payroll of the organisation should be reported using the following codes:

Name	Code
Post-Registration Student Nurse — Sick Children's	2062
Diploma Student Midwife	2208

4. Staff Nurse

To allow for more focused planning for nursing it is necessary to differentiate between General, Psychiatric, Sick Children's, Mental Handicap and Midwifery Staff Nurses. For this reason you are asked to take particular care to ensure the Department has the fullest information on the staff nurses employed by your organisation.

Please grade code individuals on the basis of the position they were recruited to fill:

Division of Register of Nurses	Position	Code
Registered General Nurse (RGN)	Staff Nurse — General	2135
Registered Sick Children's Nurse (RSCN)	Staff Nurse — Sick Children's	2136
Registered Mental Handicap Nurse (RMHN)	Staff Nurse — Mental Handicap	213T
Registered Psychiatric Nurse (RPN)	Staff Nurse — Psychiatric	2674
Registered Midwife (RM)	Staff Midwife	2143
Dual Qualified Nurse	Dual Qualified	2437

As the census is not designed to record qualifications, please code each individual staff nurse/midwife on the basis of the position he or she was recruited to fill.

Staff Nurse — Sick Children's (2136)

This code was introduced for the first time in 1999. For planning purposes it is important that staff nurses who are employed as Sick Children's Nurses are returned as such. It is not sufficient to return Sick Children's nurses as 'Staff Nurse — General'. The returns for the 2000 census suggest that there are only 92.5WTE Sick Children's nurses employed in the public health service — this could not be accurate.

Staff Midwives (2143)

It is particularly important that Staff Midwives are identified by every organisation employing midwives. In the past it appears that many agencies have returned midwives as 'Staff Nurse — General'. It is not sufficient to return Staff Midwives nurses as 'Staff Nurse — General'. The returns for the 2000 census suggest that there are only 667.5 WTE midwives employed in the public health service — this could not be accurate.

5. Dual Qualified (2437)

The Labour Court award relating to allowances and dual qualifications (LCR 16083) recommended that only those who held dual qualifications in October 1996 should access the dual qualified scale. The introduction of a new regime of location and qualification allowances superseded the dual qualified scale for those working in recognised locations or in recognised locations with specific post-registration qualifications appropriate to their work.

The 2000 census identified 1,435.57 WTE dual qualified nurses employed in the public health service. Please limit the use of the dual qualified code as it is not possible to differentiate between Staff Nurse (General); Staff Nurse (Psychiatry); Staff Nurse (Sick Children's); Staff Nurse (Mental Handicap); and Staff Midwife.

The classification Dual Qualified Nurse should now be confined to the cadre of dual qualified nurses identified in October 1996 and those recruited specifically as Dual Qualified Nurses (which will not be the norm).

6. Senior Staff Nurse

The Labour Court (LCR 16330) recommended the introduction of new senior staff nurse posts. The following grade codes were included in the census for 2000. However, the returns indicate that not all organisations were using the codes appropriately:

Name	Code
Senior Staff Nurse — General	2173
Senior Staff Nurse — Mental Handicap	2105
Senior Staff Nurse — Sick Children's	219X
Senior Staff Nurse — Psychiatric	2157

For clarity it is proposed to combine the two Senior Staff Nurse Dual Qualified Groups and use a single code as set out below:

Name	Code
Senior Staff Nurse — Dual Qualified	2181
Senior Staff Nurse — Dual Qualified Psychiatric	2165 (obsolete)

7. Public Health Nursing

The Commission on Nursing recommended a change in title for promotional grades in public health nursing. The title Superintendent Public Health Nurse (SPHN) has changed to Director of Public Health Nursing (2801).

There should NOT be two separate returns for Assistant SPHN and PHN Senior. Please note that both should be returned using a single code Assistant Director of Public Health Nursing (281X).

Registered General Nurses employed in the community should be returned using the code Staff Nurse — General Community (202X). The returns for the 2000 census suggest that there are only 6.44 WTE Staff Nurse — General Community employed in the public health service — this could not be accurate.

Registered General Nurses employed in the community should NOT be returned as Public Health Nurses even if they are acting in a locum capacity.

In summary the following grade codes should be used for community nursing:

Name	Code
Staff Nurse — General (Community)	202X
Public Health Nurse	2828
Assistant Director of Public Health Nursing	281X
Director of Public Health Nursing	2801

8. Nursing Management

The Commission on Nursing made several recommendations in relation to title changes for nurse managers, many of which were introduced in 1999 and 2000.

The grade code Home Superintendent (2045) should no longer be used. If you have such a position (unlikely) please return as CNM3 (207Y).

Director of Nursing

The title Matron should no longer be used. The preferred title is Director of Nursing (Commission on Nursing, Recommendation). The following codes should be used:

Name	Code
Director of Nursing 1	2903
Director of Nursing 2	2904
Director of Nursing 2a	2905
Director of Nursing 3	2906
Director of Nursing 4	2907
Director of Nursing 5	2908

When reporting the Director of Nursing it is very important that the correct code is selected. In 1997 a five-point classification system was developed to form a banding structure for Director of Nursing/ Matron grades. The bands range from the Director of Nursing of a small community hospital (band five) to the director of nursing (band one) of a large acute hospital.[8] The banding is based on type of hospital, the number of nursing staff and the presence of an accident and emergency department. A summary of the criteria for each band is given below.

Band 1
Must satisfy all of the following criteria:
- activity levels at 20,000 patients per annum (through combination of in-patient admission and day cases)
- full recognition for pre-registration nurse training
- responsibility for 200 nursing staff or over, and
- Accident and Emergency department with over 15,000 attendances per annum.

Band 2
Must satisfy the following criteria:
- activity levels above 10,000 patients per annum (through combination of in-patient admissions and day cases), and
- responsibility for 100 nursing staff or more.
- Directors of Nursing employed in Intellectual Disability services should NOT be included in this group.

Band 2a
This grouping refers to Directors of Nursing employed in Intellectual Disability Services only.

Band 3
Must satisfy the following criteria:
- activity levels above 1,000 in-patient admission per annum.

Band 4
Must satisfy the following criteria:
- hospital budget in 1996 in excess of £1 million, or
- additional responsibilities attached to the Matrons post which involve responsibility for services provided at other geographical locations.

Band 5
- remaining District Hospitals.

Deputy Director of Nursing

A small number of organisations may still have a Deputy Director of Nursing position. The code is Director of Nursing, Deputy 2011.

[8]Details of the banding structure were circulated following the industrial relations negotiations in 1997 in what is commonly called the 'Blue Book'.

Assistant Director of Nursing

The original code for Assistant Director of Nursing (2038) is now obsolete. Assistant Directors of Nursing should be returned using the code relevant to the band classification of the organisation where they are employed.

Name	Code
Assistant Director of Nursing 1	2910
Assistant Director of Nursing 2	2911
Assistant Director of Nursing 3	2912
Assistant Director of Nursing 4	2913

Clinical Nurse Managers

The Commission on Nursing recommended the introduction of new titles and grades for front line nurse/midwife managers. Clinical Nurse Manager 3 posts have been introduced during 2001 some in place of Unit Nursing Officer posts. In order to rationalise the codes Clinical Nurse Manager 2 — Cancer Nurse Co-ordinator (2054) is being removed from the listing and in the future should be returned as Clinical Nurse Manager 2 (2119). The following grade codes should be used:

Name	Code
Clinical Nurse Manager 3	233X
Clinical Nurse Manager 3 — Night	2046
Clinical Nurse Manager 3 — Theatre	2356
Clinical Nurse Manager 3 — Mental Health	238Y (new code)
Clinical Nurse Manager 2	2119
Clinical Nurse Manager 2 — Night	2372
Clinical Nurse Manager 2 — Theatre	2429
Clinical Nurse Manager 2 — Mental Health	2658
Clinical Nurse Manager 2 — Cancer Nurse Co-ordinator	2054 (obsolete)
Clinical Nurse Manager 1	2127
Clinical Nurse Manager 1 — Theatre	2259
Clinical Nurse Manager 1 — Mental Health	2527

9. Nursing Management — Mental Health Nursing

The Commission on Nursing recommended changes in the titles for Nurse Managers in the mental health services:

Old Title	New Title	Code
Nursing Officer (Psychiatric) Chief	Director of Nursing — Mental Health	2526
Nursing Officer (Psychiatric) Assistant Chief	Assistant Director of Nursing — Mental Health	2542
New Grade Code	Clinical Nurse Manager 3 — Mental Health	238Y
Nursing Officer 1	Clinical Nurse Manager 2 — Mental Health	2658
Nursing Officer 2	Clinical Nurse Manager 1 — Mental Health	2527

10. Clinical Nurse/Midwife Specialist

The Commission on Nursing and the Labour Court (LCR 16330) recommended the introduction of new posts. Posts should not be returned as Clinical Nurse/Midwife Specialist (CNS/CMS) unless they have been approved as such by the National Council for the Professional Development of Nursing and Midwifery. The following grade codes should be used:

Name	Code
Clinical Nurse Specialist	2325
Clinical Midwife Specialist	2313

Infection Control Sisters

The code for Infection Control Sister (2402) is now obsolete and from now on should be reported with the Clinical Nurse Specialist group.

Community Mental Health Nurse

The Commission on Nursing recommended that a specific grade for community psychiatric clinical nurse specialists be developed and that they should be designated 'community mental health nurses'. Community Psychiatric Nurses (CPN) have been given the opportunity to convert to Community Mental Health Nurses. The codes are as follows:

Name	Code
Nurses (Psychiatric), Community	2704 (old grade)
Community Mental Health Nurse	2301

11. Advanced Nurse/Midwife Practitioners

The Commission on Nursing recommended the introduction of new Advanced Nurse/Midwife Practitioner posts (ANP/AMP). Posts should not be returned as ANP/AMP unless they have been approved as such by the National Council for the Professional Development of Nursing and Midwifery. The following grade codes should be used:

Name	Code
Advanced Nurse Practitioner	2267
Advanced Midwife Practitioner	2283

12. Nursing and Midwifery Planning and Development Units

The Commission on Nursing recommended the establishment of a Nursing and Midwifery Planning and Development Unit for each health board area (eight for the country). Each health board should now have a director for their Nursing and Midwifery Planning and Development Unit (except for the MWHB where the Director will take up appointment early in 2002). The following grade codes have been added to the grade code listing:

Name	Code
Director of the Nursing and Midwifery Planning and Development Unit	2291
Assistant Director of the Nursing and Midwifery Planning and Development Unit	2453 (new code)

13. Nursing Unclassified

Please limit the use of this code to situations where there is absolutely no appropriate grade code available. Returns made using this code are particularly unhelpful when planning future nursing and midwifery requirements.

14. Summary of changes to grade codes

The following is a list of changes to grade codes for Nursing (additions or renamed codes) since the 2000 census.

Renamed Codes

Existing Name	New Name	Code
Nurse Psychiatric	Staff Nurse — Psychiatric	2674

Obsolete Codes

Name	Comment	Code
Assistant Director of Nursing	Use the code relevant to the band of hospital	2038
Clinical Nurse Manager — Home	Report as CNM2 or CNM3 as appropriate	207Y
CNM2 — Cancer Nurse Co-ordinator	No longer applicable (code as CNM2)	2054
Diploma Student Nurse	Pre-registration Nursing Students are not employees and should not be included	2216
Home Superintendent	No longer applicable (code as CNM3)	2045
Matron Welfare Home	Should be coded as DON Band 5 (2908)	2909
Post-registration Student Nurse Y 1	Programme no longer available	2901
Post-registration Student Nurse Y 2	Programme no longer available	2902
Public Health Nurse (Senior)	Should be coded as Assistant Director PHN	2798
Sister, Infection Control	Report as Clinical Nurse Specialist	2402
Trainee Psychiatric Nurse	No longer applicable	2694
Staff Nurse Senior (Dual-Qualified Psychiatric)	Code as Senior S/N (Dual Qualified) 2181	2165
Student Midwife	Code as Diploma Student Midwife 2208	4297
Student Nurse I	No longer applicable	2224
Student Nurse II	No longer applicable	2232
Student Nurse III	No longer applicable	224Y

New Grade Code

Grade	Code
Advanced Nurse Practitioner	2267
Advanced Midwife Practitioner	2283
Assistant Director of the Nursing and Midwifery Planning and Development Unit	2453
Clinical Nurse Manager 3 — Mental Health	238Y

It is recommended that agencies consult with Nursing Administration for advice on the changes prior to completing the census returns.

Grade Code Listing for Nursing and Midwifery for the Annual Health Services Personnel Census 2001

Grade	Code	Obsolete	Comment
Advanced Nurse Practitioner	2267	N	New Grade
Advanced Midwife Practitioner	2283	N	New Grade
Assistant Director of Nursing (Mental Health)	2542	N	
Assistant Director of Nursing (obsolete)	2038	Y	Use code relevant to band of hospital
Assistant Director of the Nursing & Midwifery P&D Unit	2453	N	New
Assistant Director of Nursing 1	2910	N	
Assistant Director of Nursing 2	2911	N	
Assistant Director of Nursing 3	2912	N	
Assistant Director of Nursing 4	2913	N	
Assistant Director of Public Health Nursing	281X	N	
Clinical Midwife Specialist	2313	N	
Clinical Nurse Instructor/Teacher	2712	N	
Clinical Nurse Manager 1	2127	N	
Clinical Nurse Manager 1 — Theatre	2259	N	
Clinical Nurse Manager 1 (Mental Health)	2527	N	
Clinical Nurse Manager 2	2119	N	
Clinical Nurse Manager 2 — Cancer Nurse Co-ordinator	2054	Y	Report as CNM2
Clinical Nurse Manager 2 — Home (obsolete)	207Y	Y	Report as CNM2 or CNM 3 as appropriate
Clinical Nurse Manager 2 — Night	2372	N	
Clinical Nurse Manager 2 — Theatre	2429	N	
Clinical Nurse Manager 2 (Mental Health)	2658	N	
Clinical Nurse Manager 3	233X	N	
Clinical Nurse Manager 3 (Mental Health)	238Y	N	New Grade
Clinical Nurse Manager 3 — Night	2046	N	
Clinical Nurse Manager 3 — Theatre	2356	N	
Clinical Nurse Specialist	2325	N	
Clinical Nurse Specialist, Infection Control	2402	Y	Report as CNS
Clinical Placement Co-ordinator	241Y	N	
Community Mental Health Nurse	2301	N	
Diploma Student Midwife	2208	N	
Diploma Student Nurse	2216	Y	Pre-registration student nurses are NOT employees and should NOT be included
Director of Nursing (Mental Health)	2526	N	
Director of Nursing (obsolete)	2003	Y	Use appropriate hospital band
Director of Nursing 1	2903	N	
Director of Nursing 2	2904	N	
Director of Nursing 2A	2905	N	
Director of Nursing 3	2906	N	
Director of Nursing 4	2907	N	
Director of Nursing 5	2908	N	
Director of Nursing, Deputy	2011	N	
Director of Public Health Nursing	2801	N	
Director of the Nursing & Midwifery P&D Unit	2291	N	
Dual Qualified Nurse	2437	N	
Nurse (Psych), Community	2704	N	
Nurse Planner	200X	N	
Nurse Tutor	2501	N	
Nurse Tutor (Psych)	2586	N	
Nursing Practice Development Co-ordinator	2445	N	
Nursing Unclassified	2992	N	Please eliminate where possible
Post Registration Student Nurse — Sick Children's	2062	N	
Post Registration Student Nurse, Year 1	2901	Y	Not to be used
Post Registration Student Nurse, Year 2	2902	Y	Not to be used
Principal Nurse Tutor	247X	N	
Principal Nurse Tutor (Psych)	2585	N	
Public Health Nurse	2828	N	
Public Health Nurse, Senior (Obsolete)	2798	Y	Code as Assistant Director of PHN (281X)
Public Health Nurse, Student	2836	N	

Grade	Code	Obsolete	Comment
Senior Staff Midwife	2089	N	
Senior Staff Nurse (Dual-Qualified)	2181	N	
Senior Staff Nurse (Dual-Qualified Psychiatric)	2165	Y	Code as Senior Staff Nurse (Dual Qualified) 2181
Senior Staff Nurse (General)	2173	N	
Senior Staff Nurse (Mental Handicap)	2105	N	
Senior Staff Nurse (Psychiatric)	2157	N	
Senior Staff Nurse (Sick Children's)	219X	N	
Staff Midwife	2143	N	
Staff Nurse — General	2135	N	Ensure that these personnel are correctly graded
Staff Nurse — Mental Handicap	213T	N	Ensure that these personnel are correctly graded
Staff Nurse — Sick Children's	2136	N	Ensure that these personnel are correctly graded
Staff Nurse General (Community)	202X	N	Ensure that these personnel are correctly graded
Staff Nurse, Psychiatric	2674	N	Renamed (formerly Nurse, Psychiatric)
Student Midwife (obsolete)	2275	Y	Code as Diploma Student Midwife (2208)
Student Nurse I (obsolete)	2224	Y	No longer applcable
Student Nurse II (obsolete)	2232	Y	No longer applcable
Student Nurse III (obsolete)	224Y	Y	No longer applcable
Student Nurse Unclassified (obsolete 93)	222T	Y	No longer applcable
Trainee Psychiatric Nurse (obsolete)	2694	Y	No longer applcable
Tutor Principal II (obsolete)	2488	Y	Use appropriate grade
Tutor Principal III (obsolete)	2496	Y	Use appropriate grade
Tutor, Midwifery	2097	N	

Notes:
For details of Census 2000 go to www.doh.ie/statistics

N = No obsolete
Y = Yes obsolete

Source: Department of Health and Children, *Health Services Personnel Census, Nursing and Midwifery Grade Code Guidelines,* 2001

APPENDIX 4

Nursing and Midwifery (Grade Discipline Specific) Qualification Catalogue Listing

PPARS SAP HR System

QK 85000001 Nursing & Midwifery (divided into 3 main sections)

Section 1: Registerable Qualifications Listing

QK 85000003 Nursing & Midwifery Professional, Registered Qualifications with An Bord Altranais

Q 80000756 Registered General Nurse (RGN)
Q 80000757 Registered Mental Handicap Nurse (RMHN)
Q 80000761 Registered Midwife (RM)
Q 80000765 Registered Nurse Tutor (RNT)
Q 80000759 Registered Psychiatric Nurse (RPN)
Q 80000758 Registered Public Health Nurse (PHN)
Q 80000762 Registered Sick Children's Nurse (RSCN)

Nursing & Midwifery Professional, Closed Register (An Bord Altranais)

Q 80000001 Advanced Psychiatric Nurse
Q 80000002 Fever Nurse
Q 80000003 Infectious Diseases Nurse
Q 80000004 Orthopaedic Nurse
Q 80000764 Registered Clinical Nurse Teacher (RCNT)
Q 80000798 Sanatorium Nurse
Q 80000760 Tuberculosis Nurse

QK 85000352 Return to Nursing & Midwifery Practice

Q 80002082 Return to General Nursing
Q 80002083 Return to Mental Handicap Nursing
Q 80002081 Return to Midwifery
Q 80002084 Return to Psychiatric Nursing
Q 80002085 Return to Sick Children's Nursing

Section 2: Academic Qualifications Listing

QK 85000004 Nursing & Midwifery Academic

QK 85000089 Nursing & Midwifery Certificates

Q 80000829 Cert. in Accident & Emergency Nursing
Q 80000803 Cert. in Anaes./Recovery Room Nursing
Q 80001784 Cert. in Behaviour Modification Nursing
Q 80002060 Cert. in Behaviour Psychotherapy Nursing
Q 80001785 Cert. in Behaviour Therapy
Q 80001961 Cert. in Bone Marrow Transplant
Q 80001962 Cert. in Breast Cancer Nursing
Q 80000745 Cert. in Burns Nursing
Q 80000827 Cert. in Cardio/Thoracic Nursing
Q 80001786 Cert. in Care of the Dying Patient
Q 80002051 Cert. in Clinical Teaching
Q 80002061 Cert. in Cognitive Therapy
Q 80000801 Cert. in Coronary Care Nursing
Q 80000806 Cert. in Counselling for Nurses
Q 80000824 Cert. in Critical Care Nursing
Q 80000808 Cert. in Diabetic Nursing
Q 80001928 Cert. in District Nursing
Q 80000834 Cert. in ENT Nursing
Q 80002046 Cert. in General Nursing
Q 80002057 Cert. in Genito-Urinary Infections
Q 80000810 Cert. in Gerontology Nursing
Q 80002050 Cert. in Health Visiting
Q 80001967 Cert. in High Dependency Nursing

Q 80001788 Cert. in Infection Control Nursing
Q 80000811 Cert. in Infectious Disease Nursing
Q 80000818 Cert. in Intensive Care Nursing
Q 80001789 Cert. in Intensive Care Nursing (Paediatric)
Q 80002052 Cert. in Intensive/Coronary Care Nursing
Q 80000799 Cert. in Management (Nursing)
Q 80002058 Cert. in MaxilloFacial Nursing
Q 80002053 Cert. in Medical Nursing
Q 80002048 Cert. in Mental Handicap Nursing
Q 80002047 Cert. in Midwifery
Q 80000813 Cert. in Neonatal/Intensive Care Newborn
Q 80001774 Cert. in Neurological/Neurosurgical Nursing
Q 80001823 Cert. in Nursing Elderly People
Q 80000814 Cert. in Obstetrics
Q 80000828 Cert. in Oncology Nursing
Q 80000815 Cert. in Ophthalmic Nursing
Q 80000831 Cert. in Orthopaedic Nursing
Q 80002071 Cert. in PaediatricCardiothoracic Nursing
Q 80001746 Cert. in Palliative Care Nursing
Q 80001773 Cert. in Psychiatric Nursing in Forensic
Q 80000817 Cert. in Psychiatric Nursing
Q 80000819 Cert. in Rehabilitation Nursing
Q 80000830 Cert. in Renal Care Nursing
Q 80001969 Cert. in Respiratory Disorders Nursing
Q 80001927 Cert. in Sciences for Nurses
Q 80001791 Cert. in Sexually Transmitted Disease Nursing
Q 80002049 Cert. in Sick Children's Nursing
Q 80000821 Cert. in Spinal Injuries (Nursing)
Q 80000826 Cert. in Stoma Care (Nursing)
Q 80002054 Cert. in Surgical Nursing
Q 80000832 Cert. in Theatre Nursing
Q 80001792 Cert. in Theatre Nursing (Paediatrics)
Q 80001974 Cert. in Theory/Therapy Eating Disorders
Q 80000822 Cert. in Tropical Diseases Nursing
Q 80000833 Cert. in Urology Nursing

QK 85000118 Nursing & Midwifery Diplomas

QK 85000188 Nursing Diplomas (pre-registration)

Q 80001733 Diploma in Nursing
Q 80000774 Diploma in Nursing (General)
Q 80000763 Diploma in Nursing (Mental Handicap)
Q 80000025 Diploma in Nursing (Psychiatry)
Q 80000980 National Diploma in Nursing in General Nursing
Q 80000981 National Diploma in Nursing in Mental Health
Q 80000982 National Diploma in Nursing in Psychistric Nursing

QK 85000226 Higher Educ. Diploma in Nursing [project 2000]

Q 80001845 H Ed Dip in Nursing — Adult
Q 80001847 H Ed Dip in Nursing — Children's
Q 80001846 H Ed Dip in Nursing — Mental Health
Q 80001848 H Ed Dip in Nursing — Learning Disability

QK 85000006 Nursing & Midwifery Diplomas (post-registration)

QK 85000229 Nursing & Midwifery Diplomas

Q 80001794 Diploma in Anatomy & Physiology
Q 80000777 Diploma in Asthma Care
Q 80001938 Diploma in Breast Care Nursing
Q 80000787 Diploma in Burns & Plastics Nursing
Q 80000772 Diploma in Business Studies Nursing Management

Q 80000783 Diploma in Cardiovascular Nursing
Q 80000026 Diploma in Challenging Behaviour
Q 80000027 Diploma in Child & Adolescent Psychiatry
Q 80001084 Diploma in Counselling for Nurses
Q 80002063 Diploma in Diabetic Nursing
Q 80000770 Diploma in Gerontological Nursing
Q 80001817 Diploma in H. Educ — Prof Dev in Nursing
Q 80002062 Diploma in H. Educ — Training & Learning
Q 80001933 Diploma in HIV & GU Nursing
Q 80000791 Diploma in Human Anatomy
Q 80000781 Diploma in Infection Control
Q 80001934 Diploma in Intensive Nursing Science
Q 80000775 Diploma in Learning Disabilities
Q 80001796 Diploma in Legal/Ethical Aspects Nursing
Q 80001849 Diploma in Medical Ethics
Q 80000782 Diploma in Microbiology
Q 80001797 Diploma in Midwifery
Q 80000784 Diploma in Neonatal Intensive Care
Q 80000773 Diploma in Nurse Management
Q 80001747 Diploma in Nursing Informatics
Q 80000769 Diploma in Nursing Studies
Q 80000771 Diploma in Occupational Health Nursing
Q 80001087 Diploma in Oncology
Q 80000785 Diploma in Ophthalmic Nursing
Q 80000797 Diploma in Orthopaedics
Q 80002064 Diploma in Palliative Care
Q 80001799 Diploma in Pathology
Q 80001801 Diploma in Pharmacology
Q 80001937 Diploma in Physics & Chemistry
Q 80001800 Diploma in Physiology
Q 80001936 Diploma in Practice Nursing
Q 80001798 Diploma in Prof. Development in Nursing
Q 80001802 Diploma in Psychology
Q 80001085 Diploma in Public Health Nursing
Q 80001803 Diploma in Research Methods
Q 80000796 Diploma in Social Care in Mental Health
Q 80002065 Diploma in Sociology for Nurses
Q 80000793 Diploma in Spinal Injuries
Q 80000794 Diploma in Teaching & Assessing
Q 80001804 Diploma in Teaching Methods
Q 80001850 Diploma in Teaching Natural Family Planning
Q 80000795 Diploma in Tropical Nursing
Q 80001908 National Diploma in Nursing

QK 85000007 Nursing & Midwifery Degrees

QK 85000279 Nursing & Midwifery Degrees (pre-registration)

Q 80001981 BSc Midwifery
Q 80001978 BSc Nursing (General)
Q 80001980 BSc Nursing (Mental Handicap)
Q 80001979 BSc Nursing (Psychiatry)

QK 85000280 Nursing & Midwifery (post-registration)

Q 80001824 Bachelor in Community Nursing Studies
Q 80001700 Bachelor of NS — Practice Development
Q 80001699 Bachelor of NS — Renal
Q 80000753 Bachelor of Nursing Management
Q 80000751 Bachelor of Nursing Studies (BNS)
Q 80001825 BSc Community Nursing

Q 80000754 BSc Midwifery
Q 80001896 BSc Midwifery Science
Q 80001086 BSc Nephrology
Q 80000755 BSc Nurse Education
Q 80000749 BSc Nursing
Q 80001826 BSc Nursing Management
Q 80001898 BSc Nursing Science
Q 80001897 BSc Nursing Studies
Q 80000752 BSc Practice Development
Q 80001793 BSc Professional Development in Nursing

QK 85000281 BSc Specialist Nursing Practice (SNP)
Q 80001827 BScSNP A&E Nursing for Adults
Q 80001828 BScSNP A&E Nursing for Children
Q 80001829 BScSNP Anaesthetic Nursing for Adults
Q 80001830 BScSNP Anaesthetic Nursing for Children
Q 80001831 BScSNP Cancer Care Nursing
Q 80001832 BScSNP Cardiology Nursing
Q 80001833 BScSNP Cognitive Behaviour
Q 80001834 BScSNP Intensive Care Nursing for Adults
Q 80001835 BScSNP Intensive Care Nursing for Children
Q 80001836 BScSNP Mental Health Care
Q 80001837 BScSNP Neonatal Intensive Care
Q 80001838 BScSNP Nursing Care of Older People
Q 80001839 BScSNP Nursing Care of Patients with Stroke
Q 80001840 BScSNP Orthopaedic Nursing for Adults
Q 80001841 BScSNP Orthopaedic Nursing for Children
Q 80001842 BScSNP Psychosocial Interventions
Q 80001843 BScSNP Renal Nursing
Q 80001844 BScSNP Stoma Care Nursing

QK 85000006 Nursing & Midwifery Diplomas (post-registration)
QK 85000090 Nursing & Midwifery Higher Diplomas
Q 80001712 H.Dip in Intensive & Coronary Nursing
Q 80001775 H.Dip in Midwifery
Q 80001776 H.Dip in Paediatric Nursing
Q 80002086 H.Dip in Peri-operative Nursing
Q 80000750 H.Dip in Public Health Nursing
Q 80000032 H.Dip in Renal Nursing
Q 80001724 H.Dip in Respiratory Care in Nursing Practice
Q 80001816 H.Dip in Sick Children's Nursing
Q 80000557 H.Dip in Social & Vocational Rehab Stud.
Q 80000030 H.Dip in the Management of Behaviour

QK 85000251 Higher Diploma in Nursing Studies HDipNS
Q 80001715 HDipNS Clinical Practice (CP)
Q 80001717 HDipNS (CP) Gastroenterology
Q 80001812 HDipNS (CP) Gerontological Nursing
Q 80001814 HDipNS (CP) Paediatric CCN
Q 80001815 HDipNS (CP) Pain Management
Q 80001718 HDipNS (CP) Rehab Spinal Injuries
Q 80001716 HDipNS (CP) Renal
Q 80001813 HDipNS (CP) Rheumatology Nursing
Q 80001707 HDipNS Critical Care Nursing (CCN)
Q 80001709 HDipNS in CCN (Cardiovasular)
Q 80001708 HDipNS in CCN (Intensive Care)
Q 80001703 HDipNS Accident & Emergency Nursing
Q 80001704 HDipNS Anaesthetics & Recovery Room Nursing

Q 80000766 HDipNS Cardiovascular Nursing
Q 80001899 HDipNS Cognitive Behaviour Psychotherapy
Q 80001705 HDipNS Coronary Care Nursing
Q 80000767 HDipNS Diabetes Nursing
Q 80001706 HDipNS E.N.T. Nursing
Q 80001710 HDipNS Gerontological Nursing
Q 80002087 HDipNS in Behaviours that Challenge
Q 80001711 HDipNS Infection Control Nursing
Q 80001713 HDipNS Intensive Care Nursing
Q 80001975 HDipNS Neonatal Intensive Care
Q 80001714 HDipNS Neuroscience Nursing
Q 80001810 HDipNS Nurse/Midwifery Education
Q 80000768 HDipNS Oncology Nursing
Q 80001719 HDipNS Operating Department Nursing
Q 80001720 HDipNS Ophthalmological Nursing
Q 80000031 HDipNS Orthopaedic Nursing
Q 80001721 HDipNS Pain Management
Q 80001777 HDipNS Palliative Care Nursing
Q 80001722 HDipNS Peri-Anaesthesia Nursing
Q 80001723 HDipNS Peri-Operative Nursing
Q 80000033 HDipNS Practice Nursing
Q 80002088 HDipNS Public Health Nursing
Q 80002089 HDipNS Sick Children's Nursing
Q 80001725 HDipNS Theatre Nursing
Q 80000034 HDipNS Wound Management & Tissue Viability

QK 85000375 Graduate Diploma in Specialist Nursing
Q 80000987 Graduate Diploma in Specialist Nursing (Critical Care)
Q 80000977 Graduate Diploma in Specialist Nursing (Accident and Emergency)
Q 80000979 Graduate Diploma in Specialist Nursing (Perioperative)

QK 85000125 Nursing & Midwifery Post Grad Diplomas
Q 80001726 Post Grad Dip Accident & Emerg. Nursing
Q 80001971 Post Grad Dip Child & Adolescence Mental Health
Q 80001728 Post Grad Dip Clinical Practice Nursing
Q 80001805 Post Grad Dip Education for Nurses & Midwives
Q 80001806 Post Grad Dip Gerontological Nursing
Q 80001727 Post Grad Dip Health Sciences Education
Q 80001729 Post Grad Dip ICU & CCU Nursing
Q 80001869 Post Grad Dip Mental Health Older People
Q 80001807 Post Grad Dip Midwifery
Q 80001778 Post Grad Dip Oncology Nursing
Q 80001983 Post Grad Dip Orthopaedic Nursing
Q 80001982 Post Grad Dip Paediatric A&E Nursing
Q 80001730 Post Grad Dip Paediatric Nursing
Q 80001808 Post Grad Dip Palliative Care Nursing
Q 80002090 Post Grad Dip Peri-operative Nursing
Q 80001731 Post Grad Dip Renal Nursing
Q 80001809 Post Grad Dip Sick Children's Nursing
Q 80001732 Post Grad Dip Theatre Nursing

QK 85000200 Nursing Advanced Diplomas
Q 80001818 Advanced Diploma in Education Studies for Nurses

QK 85000228 AdvDip in Specialist Practice in Nursing
Q 80001851 AdvD SPN A&E Nursing for Adults
Q 80001852 AdvD SPN A&E Nursing for Children
Q 80001853 AdvD SPN Anaesthetic Nursing — Adults

Q 80001854 AdvD SPN Anaesthetic Nursing — Children
Q 80001855 AdvD SPN Cancer Care Nursing
Q 80001856 AdvD SPN Cardiology Nursing
Q 80001857 AdvD SPN Cognitive Behaviour
Q 80001858 AdvD SPN Intensive Care Nursing — Adults
Q 80001859 AdvD SPN Intensive Care Nursing — Children
Q 80001860 AdvD SPN Mental Health Care
Q 80001861 AdvD SPN Neonatal Intensive Care
Q 80001862 AdvD SPN Nursing Care of Older People
Q 80001863 AdvD SPN Nursing Care Patients w Stroke
Q 80001864 AdvD SPN Orthopaedic Nursing — Adults
Q 80001865 AdvD SPN Orthopaedic Nursing — Children
Q 80001866 AdvD SPN Psychosocial Interventions
Q 80001867 AdvD SPN Renal Nursing
Q 80001868 AdvD SPN Stoma Care Nursing

QK 85000136 Nursing & Midwifery Masters

Q 80000748 MA Nursing
Q 80000744 Master of Medical Science (Nursing)
Q 80001819 MEd (Health Science)
Q 80001870 MPhil Nursing
Q 80001701 MSc Advanced Nursing/Midwifery
Q 80001973 MSc Child & Adolescent Mental Health
Q 80000746 MSc Gerontological Nursing
Q 80001702 MSc Midwifery
Q 80000747 MSc Nursing
Q 80001946 MSc Nursing (Healthcare Informatics)
Q 80001972 MSc Nursing (Research)
Q 80001900 MSc Nursing Applied Health Care Management
Q 80001903 MSc Nursing Mental Health Older People
Q 80001902 MSc Nursing Nurse Education
Q 80001904 MSc Nursing Renal
Q 80001901 MSc Nursing Studies

QK 85000005 Nursing & Midwifery Doctorates

Q 80000029 Doctorate in Nursing Science
Q 80000028 PhD Nursing

QK 85000227 Nursing Academic — Other

Q 80000812 Cert. in Nursing Theory & Development
Q 80001697 Cert. in Research Methods for Nurses
Q 80000807 Cert. in Teaching & Assessing
Q 80001970 Emergency Nurse Practitioner
Q 80001734 Nursing Access Courses

QK 85000353 Stand-alone Modules (Nursing)

Q 80002100 Biology and Nursing Issues in Resus
Q 80002093 Communication and Interpersonal Skills
Q 80002095 Counselling and Nursing
Q 80002092 Human Physiology
Q 80002101 Infection Control Nursing
Q 80002097 Management of Asthma and COPD
Q 80002091 Nursing Research Appreciation
Q 80002098 Pain Management in Nursing
Q 80002099 Pharmacology for Nurses
Q 80002094 Professional Issues in Nursing
Q 80002096 Psychology and Nursing

QK 85000127 Nursing & Midwifery Skills & Training

Q 80002068	Breast Screening
Q 80002070	Breastfeeding
Q 80001737	Cannulation for Nursing
Q 80002069	Cervical Screening
Q 80002056	Community Psychiatric Nursing
Q 80001779	Defibrillation for Nursing
Q 80002055	Diabetic Nursing
Q 80002075	Doppler Studies
Q 80000809	Endoscopy for Nursing
Q 80000823	HIV and AIDS Management for Nursing
Q 80001736	I.V. Protocol for Nursing
Q 80002076	P.E.G. Feeding
Q 80002073	Pain Management
Q 80001787	Palliative Care Nursing
Q 80001780	Phlebotomy for Nursing
Q 80001781	Plastering for Nursing
Q 80001790	Practice (G.P.) Nursing
Q 80000816	Promotion of Continence
Q 80001907	Stoma Care Nursing
Q 80001782	Suturing for Nursing
Q 80002059	Urological Nursing
Q 80002074	Wound Management

QK 85000351 Nursing & Midwifery Support

Q 80002079	Clinical Placement Coordinators Course
Q 80002078	Preceptorship
Q 80002077	Support & Assessing in Clinical Practice

Notes:
The above qualification listing is grade discipline specific to nursing and midwifery as of June 2002

Chapter 3, Table 3.8-1 illustrates two other grade discipline specific categories—

- Medical/Dental
- Clerical/Administration.

Non-grade discipline specific has three categories—

- Employee Health and Safety
- General
- Health Management and Public Administration.

If a qualification reported by a nurse or midwife is not discipline specific to nursing or midwifery, the qualification is recorded under the appropriate grade discipline or non grade discipline specific section of the catalogue.

APPENDIX 5

Survey of Nursing Employment in the Independent Sector

Nursing Policy Division
Department of Health and Children

May/June 2000

Survey of Nursing Employment in the Independent Sector

To date the numbers and profile of nurses working in the independent sector (private hospitals and clinics; private and voluntary nursing homes; grant-aided bodies, GP practices, hospices, and nursing agencies) has not been collated centrally. To achieve a realistic understanding of the future demand for registered nurses and midwives it is necessary to establish a baseline for nursing employment in this sector. For this reason a survey of nursing employment in the independent sector was undertaken in May/June 2000.

Survey Population

All organisations outside the directly funded public health service, where nurses or midwives are likely to be employed, were asked to participate. A variety of information sources was used to identify a total listing of organisations for inclusion in the survey (see Table 1). A cross-check was made to ensure that none of the organisations were already included in the Department of Health and Childrens Health Services Personnel Census for the public health service. It is recognised that nurses are employed in private industry in various roles, particularly occupational health, academia and research. A decision was taken to exclude this group from the survey, as it is outside the traditional health service, and also because of the difficulty in compiling a listing of potential organisations. Detailed information on the number and profile of practice nurses employed by GPs through the General Medical Service (GMS) scheme is available from the GMS Payments Board (see Chapter 2 section 2.3.4). For this reason it was not considered necessary to include this group in the paper survey.

Table 1 – Information Sources used to Identify Sectors for Inclusion in the Survey

Sector	Source of Information
Private and Voluntary Nursing Homes	• List of approved private nursing homes obtained from each Health Board • Organisations making returns for the annual survey of patients in long-stay units conducted by the Department of Health and Children • Membership of the Irish Nursing Homes Organisation • Membership of Federation of Catholic Voluntary Nursing Homes
Intellectual and Physical Disability	• List of Grant Aided (section 65 funded) agencies obtained from External Personnel, Department of Health and Children • Membership of the National Federation of Voluntary Bodies Providing Services to people with Mental Handicap • National Association for the Mentally Handicapped of Ireland — Directory of Services
Private Hospitals and Clinics	• Membership of Independent Hospitals Association • Voluntary Health Insurance (VHI) — Directory of Hospitals • Irish Medical Directory
Voluntary Hospices	• Hospice Directory 1999 • Irish Medical Directory
Nursing Agencies	• Health Service Employers Agency • Golden Pages • Individual Contacts
General Practice	• General Medical Services Payment Board • Practice Nurses Association

Methodology

A simple data collection form was designed. The proposal was to collect information on numbers of nurses (full-time, part-time, job-sharing) by grade and age grouping, together with the number of vacant posts on the last payday in April 2000. Detailed guidelines setting out the purpose of the survey, standard definitions for the items included, and step-by-step guidelines for completing the questionnaire were prepared. Respondents were asked to only include those directly employed as nurses/midwives. Explicit instruction was given to exclude agency nurses and staff with nursing qualifications not specifically employed as nurses. The methodology was designed with the assistance of the Information Management Unit of the Department of Health and Children. The instruments for the survey were piloted.

A different data collection form was designed for nursing agencies which asked for the number of persons working solely with the agency and the number working with the agency and another main employer either within or outside the health service. Agencies were also asked to give the total number of hours worked by nurses in each of the three groups. It was intended to use this information to calculate a WTE figure for agency nursing. However, it was not possible as the question was only partly answered or not answered at all by many of the respondents.

Data Collection

Following amendments, some 600 requests to participate in the survey were posted to the Director of Nursing/ Chief Executive Officer/ Proprietor of each organisation in early May 2000. The support and co-operation of the Irish Nursing Homes Association, the Federation of Catholic Voluntary Nursing Homes, the National Federation of Voluntary Bodies Providing Services to People with an Intellectual Disability, the Independent Hospitals Association of Ireland, and the Irish Hospice Foundation was obtained for the survey.

Prepaid return envelops where included to encourage maximum response by the closing date. Reminder letters were circulated and follow-up calls were made during July and August 2000. Some organisations were later excluded due to closure or by virtue of the fact that they did not employ nurses or midwives. An Post returned some envelopes as the address was unknown. This particularly applied to the nursing home sector. Six private nursing homes indicated that they had closed because of nursing shortages. Many of the smaller intellectual and physical disability services responded indicating that they did not employ nurses. One of the nursing agencies had closed. One employment agency indicated that they only place nurses on temporary contracts with clients for research or occupational health positions. This agency indicated that it had a large number of nurses on its database who were seeking positions out of the health services. On the basis of this information the total number of relevant organisations within each sectors was estimated as 534 (see Table 2).

Response Rate

The response rate for the various sectors was diverse, ranging from 48 per cent to 89 per cent (see Table 2). The highest response rate was obtained from private hospitals and clinics (89 per cent). Despite personal contacts and visits to nursing agencies a very low response rate was obtained. Only one of the large nursing agencies operating in the Dublin area responded. This was attributed to concerns about the sensitively of the information and market share.

Table 2 – Response to Survey of Employment in the Independent Sector

Sector	Number set out	Number Relevant	Number responding	Per cent response
Private and Voluntary Nursing Homes	433	409	236	58
Intellectual Disability Services	66	41	27	66
Physical Disability Services	11	9	5	56
Private Hospitals and Clinics	53	44	39	89
Voluntary Hospices	10	8	6	75
Nursing Agencies	25	23	11	48
Totals	**598**	**534**	**324**	**65 mean %**

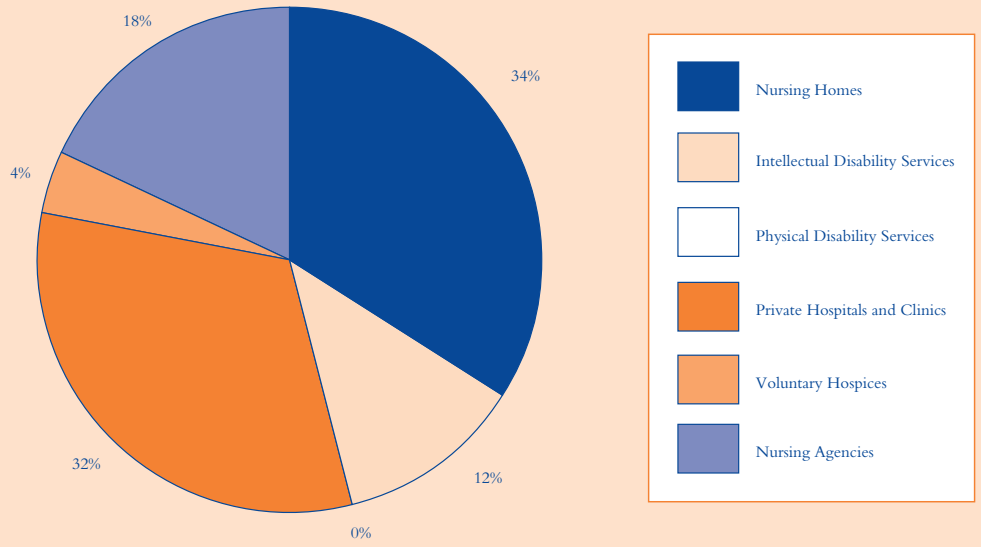
Analysis and Findings

Each individual response was indexed, reviewed and entered on a data capture and reporting system designed by the Information Management Unit of the Department of Health and Children. Each cell on the system represented a piece of data on the survey form. The system automatically calculated WTE for part-rime and job-sharing persons, based on the hours worked and standard nursing full-time working hours for the organisation. The system was programmed to give summary reports. The design architecture was modular and further reports can be incorporated.

The survey indicated that in total 5,361 (3,564 WTE) nurses or midwives were employed in the participating organisations. Of this: 34 per cent (1,940) in nursing homes; 32 per cent (1,790) in private hospitals and clinics; 18 per cent (991) in nursing agencies; 12 per cent (695) in intellectual disability services; 4 per cent (201) in voluntary hospices; and less than 1 per cent (14) in physical disability services. The percentage employed in each grouping of the independent sector in the survey is presented at Figure 1.

FIGURE 1

Percentage employed in each grouping of the independent sector



The variation between the persons and WTE figure is due to the numbers working on a part-time or job-sharing basis. A very different pattern of work than that in the public health services is evident from the results of the survey. This particularly applies to private and voluntary nursing homes where substantial numbers (1,273, 66 per cent) of nurses were reported to be employed on a part-time basis.

Job-sharing was identified by private hospitals and clinics (22 per cent), voluntary hospices (17 per cent), and intellectual disability services (9.6 per cent). Job-sharing was not reported as a contract type by any private or voluntary nursing home. Because of the nature of the employment relationship full-time, part-time or job-sharing (as defined for the survey), does not apply to nursing agencies. The break down of the responses for contract type can be located at Table 3 and Figure 2.

Table 3 – Numbers in the independent sector holding various contract types

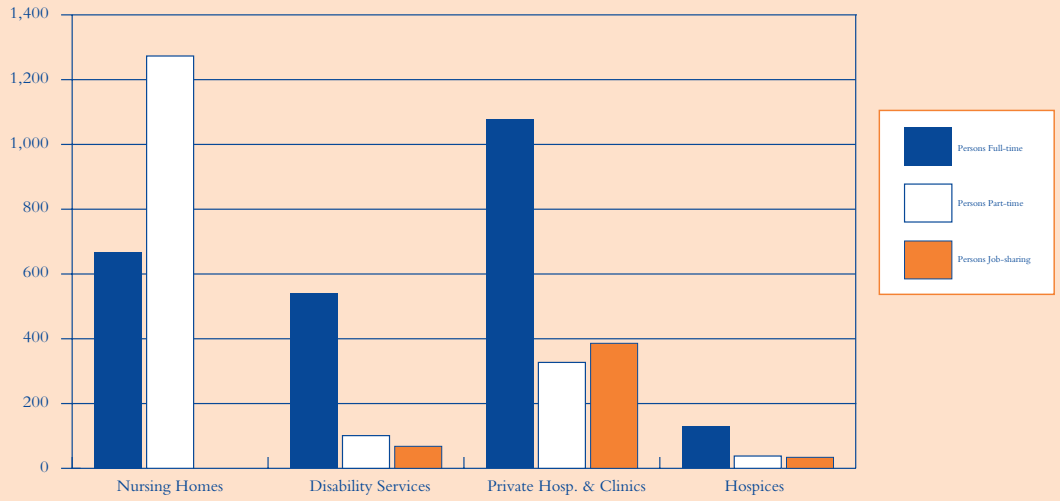
Sector	Persons Full-time	Persons Part-time	Persons Job-sharing	Total persons employed	Total WTE employed
Private and Voluntary Nursing Homes	667	1,273	—	1,940	1,322
Intellectual Disability Services	536	92	67	695	622
Physical Disability Services	4	9	1	14	10
Private Hospitals and Clinics	1,077	327	386	1,790	1,443
Voluntary Hospices	129	38	34	201	167
Nursing Agencies*	N/A	N/A	N/A	991	N/A
Totals	**2,413**	**1,739**	**488**	**5,631**	**3,564**

*This figure is the total number of nurses (head count) employed by 11 agencies either on a full-time for part-time basis. It was not possible to calculate a WTE figure from the responses given

It was not possible to report on the breakdown for age because not all respondents completed this question and discrepancies were found among many other responses.

FIGURE 2

Contract type for the main groupings in the independent sector



Respondents were also asked to indicate the number of vacant nursing or midwifery posts at the end of April 2000. Nursing agencies were not asked about vacancies. Four hundred and two vacancies were identified with the highest number in the intellectual disability services (see Table 4). This would suggest that at the time the vacancy rate across the 313 organisations participating in the survey (4,640 persons employed) was approximately 8.6 per cent.

Total employment in the independent sector

Based on the findings of the survey it was estimated that approximately 10,000 nurses were employed in the independent sector in April 2000. This figure is calculated on the assumption that there is a similar spread of service size, employment numbers and vacancies in the organisations that did not respond to the survey. This figure was calculated separately and based on the percentage response rate for each sector. The accuracy of the estimation is highest in sectors with higher response rates. The number of practice nurses identified by the GMS was added to the calculations as they also form part of the independent sector. A recent survey undertaken by the Irish Nurses Organisation indicates that 98 per cent of practice nurses see a mixture of both GMS and private patients. From this it can be estimated that 2 per cent of practice nurses are employed solely on a private basis by GPs and are not reflected in the figure supplied by the GMS payments board. Details of the calculations are set out on Table 4.

Summary of Survey

This survey gives an indication for the first time of the number of nurses and midwives employed in the independent sector and the contract types. Because of their independent status the organisation participating in the survey would not have previously supplied employment information to the Department of Health and Children. This may have attributed to the variation in the response rate across the groupings. Collection of the information at central level may have also affected the response rate as impact of local knowledge and linkages was lost. In the future the Nursing and Midwifery Planning and Development Units, established since the completion of this survey, will have a very significant role to play in the co-ordination of data collection for each region. The grade codes and titles used by the Department of Health and Children do not always apply to the independent sector. The survey highlighted differences in interpretations and understandings of grade titles and the methodology for calculating WTE. It also demonstrated that vacancies and difficulties in filling nursing and midwifery posts is not a phenomenon confined to the public health service.

Table 4 – Estimated persons employed in each grouping within the Independent sector

Sector	Per cent response	Number persons	Vacant posts	Estimated Total persons
Private and Voluntary Nursing Homes	58	1,940	119	3,567
Intellectual Disability Services	66	695	150	1,282
Physical Disability Services	56	14	—	25
Private Hospitals and Clinics	89	1,790	130	2,159
Voluntary Hospices	75	201	3	272
Nursing Agencies	48	991	N/A	2,072
General Practice	N/A	621*	N/A	533
Totals		**6,254**	**402**	**10,010**

* Figure obtained from the GMS Payments Board, 2000

Implications of the survey findings

It must be emphasised that the final figure (10,010) for employment in the independent sector is an estimate based on very large assumptions and relates only to one particular point in time. If we are to gauge the number of nurses and midwives required for this sector in the future it is absolutely imperative that a baseline for numbers employed and age profile is calculated on an annual basis and that the trend is monitored over time. There is a pressing need for formal ongoing processes for determining the numbers of nurses and midwives employed in the independent sector. It is important that incentives are built into any data-gathering processes to ensure higher participation rates. It will also be necessary for information collection to be collated at a local and regional level. The proposals in the Health Strategy (2001) for additional acute hospital and long-stay beds, service developments, capacity expansion and the focus on public/private partnerships all indicate that the numbers of nurses and midwives required for this sector will increase substantially in the next 7 to 10 years.

APPENDIX 6

Survey of Return-to-Nursing and Midwifery Courses

Nursing Policy Division
Department of Health and Children

March 2001

Introduction

In March 2001, the Nursing Policy Division of the Department of Health and Children conducted a survey to obtain information on the provision of return-to-practice (nursing/midwifery) courses. This is a yearly survey, which has been undertaken since 1998.

Methodology

The Principal Nurse Tutor in each of the Schools of Nursing and hospitals across the country (51 in total, see Table 2) were contacted to obtain the required information. A full response was received. The data collection tool, which had been designed and tested in previous surveys, was used to ensure the achievement of a reliable comparison over time. The data collection instrument sought information on the following: number of places; duration of courses; number of intakes per year; uptake of places; level of award/academic association; and numbers subsequently employed. The results are summarised on the tables attached. The directors of the Nursing and Midwifery Planning and Development Units were asked to review responses for completeness.

Summary of Findings

- Many hospitals refer to the courses as 'return to practice' rather than 'back to nursing and midwifery courses'.
- Among the sample group 25 courses were identified. Of these fifteen were for general nursing, four for midwifery, four for psychiatry and one for sick children's nursing (see Table 1).
- Formal return-to-practice courses were not identified for public health nursing. A return-to-practice course for mental handicap nursing was due to commence in Cregg House in 2001. Although not reported in this survey, the National Federation of Voluntary Bodies providing services to people with intellectual disabilities planned a return-to-mental-handicap nursing course in 2002.
- An increase in the number of courses available was reported (fifteen in 2000 and 25 in 2001; see Table 3).
- The return-to-nursing (general) courses are geographically spread across the country (7 in Dublin and 9 in the remainder of the country).
- A steady increase in the total number of places available was reported: 1998 — 241, 1999 — 314, 2000 — 393. At the time of the survey (March 2001) there were 466 places available with four new proposed courses commencing later in 2001.
- While there was an increase in the number of places a decline in up-take was reported. In 1998, 16 places were unfilled. This increased to 47 in 1999 and 103 in 2000. In March 2001 the number of places reported unfilled was 208.
- There was a variation (from four to eight weeks) in the length of return-to-practice courses reported.
- Two providers reported flexibility in delivery of the course. Beaumont Hospital delivers a part-time and full-time option. The North Eastern Health Board (Our Ladys, Navan, Louth & Meath Hospitals, Mental and General Services) delivers a part-time course for general and psychiatric nursing.
- It was not possible to determine how many nurses/midwives subsequently secured employment, as most hospitals do not conduct follow-up evaluations.

- There is a real deficit of information in tracking the subsequent employment choices of nurses and midwives who completed programmes.
- The survey indicated that very few nurses/midwives who undertook return-to-practice courses were subsequently employed by the organisations running the programme. This particularly applies to the acute hospital sector.
- All oganisations providing courses in 2001 indicated that they would be continuing to do so in 2002.
- All hospitals indicated that the courses have been approved by An Bord Altranais.
- Certificates of attendance are awarded to participants. There is no academic association or recognition for the programmes.

Table 1 – Availability of Return-to-Practice Nursing and Midwifery Courses 2001

Division of Nursing	Number of hospitals offering courses
General Nursing	15
Psychiatric Nursing	4
Mental Handicap Nursing	1 proposed to commence 2001
Sick Children's Nursing	1
Midwifery	4
Public Health Nursing	0 no formal courses
Total	**25**
Note: Pertains to information available in July 2001	

Table 2 – Responses to Survey of Return to Practice Nursing/Midwifery Courses

Hospital/School of Nursing	Return to Nursing
ANMCH, College of Nursing Tallaght	Yes
Beaumont Hospital, Dublin	Yes
Central Mental Hospital, Dublin	No
Center for Mental Health Nursing, Waterford	Yes
Coombe Women's Hospital, Dublin	No
COPE Foundation	No
Cork University Hospital	Yes
Cregg House, Sligo	No
James Connolly Memorial Hospital	Yes
Letterkenny General Hospital (St Conal's)	Yes
Mater Misericordiae Hospital	Yes
National Maternity Hospital, Dublin	Yes
National Rehabilitation Hospital, Dun Laoghaire	No
Our Lady of Lourdes Hospital, Drogheda	Yes with NEHB
Our Lady's Hospital for Sick Children	Yes
Portiuncula Hospital	No
Regional Hospital Limerick	Yes
Rotunda Hospital	Yes
Royal Victoria Eye and Ear Hospital, Dublin	No
Sligo General Hospital	Yes
St. Brendan's Hospital, Dublin	No
St. James's Hospital, Dublin	Yes
St. Luke's Hospital, Dublin	No
St. Mary's Orthopaedic Hospital, Cappagh	No
St. Patrick's Hospital, Dublin	No
St. Vincent's Hospital, Fairview, Dublin	No
St. Vincent's University Hospital, Dublin	Yes

Hospital/School of Nursing	Return to Nursing
Bon Secours Hospital, Cork	No
Cavan Monaghan Care of the Elderly Services	Yes
Daughters of Charity, Clonsilla, Dublin	No
Mayo General Hospital, Castlebar, Co. Mayo	No
Mercy Hospital, Cork	No
NEHB Regional Education Programme	Yes
Regional Maternity Hospital, Limerick	Yes
School of Psychiatric Nursing, University, Galway	No
SHB Regional School University College Cork	No
Stewart's Hospital, Palmerstown, Dublin	No
St. Anne's, Moore Abbey, Monasterevin, Co. Kildare	No
St. Davnet's Hospital Monaghan	No
St. Finbarr's and the Erinville, Cork	Yes
St. Francis Hospice, Raheny, Dublin	No
St. Ita's Portrane, Dublin	Yes
St. John of Gods, Stillorgan, Dublin	Yes
St. Joseph's Hospital Limerick	No
St. Mary's, Drumcar, Co. Louth	No
St. Michael's Hospital, Dun Laoghaire, Co Dublin	No
St. Vincent de Paul, Lisnagry, Co. Limerick	No
The Children's Hospital, Temple Street, Dublin	No
Tralee General Hospital	Yes
Tullamore General Hospital, Co. Offaly	No
University College Hospital Galway	Yes
Waterford Regional Hospital	Yes

Notes:
Pertains to information available in July 2001

Yes = Return-to-Practice Course offered
No = Return-to-Practice Course not offered

Table 3 Provision of Return-to-Practice Nursing and Midwifery Courses (1998-2001)

Hospital	Year	Length	Places	Intakes	Up-take	Employed In-house	Employed Elsewhere	Employed Total
Beaumont Hospital, Dublin *P/T 8 weeks mornings F/T 4 weeks*	1998 1999 2000 2001	4 weeks PT/FT PT/FT PT/FT	16 21 21 32	1 2 2 2	12 21 11 not yet known	1 3 4PT 1FT not yet known	10 4 3 not yet known	11 7 8 not yet known
Centre Mental Health Nursing, Waterford *Course commenced 2nd May 2000 (full-time)*	2000 2001	6 weeks 4 weeks	15 15	1 1	15 15	Not available not yet known	Not available not yet known	Not available not yet known
Cork University Hospital *(full-time)*	1998 1999 2000 2001	4 weeks 4 weeks 4 weeks 4 weeks	32 32 32 32	2 2 2 2	32 32 32 32	7 3 Not available not yet known	14 22 Not available not yet known	21 25 Not available not yet known
James Connolly Memorial Hospital *(full-time)*	1998 1999 2000 2001	6 weeks 6 weeks 6 weeks 6 weeks	12 12 12 12	1 1 1 1	12 6 not yet known	Not available Not available Not available not yet known	Not available Not available Not available not yet known	Not available Not available Not available not yet known
Letterkenny General Hospital *(full-time)*	2000 2001	8 weeks 4 weeks	24 24	1 1	24 22	Not available not yet known	Not available not yet known	Not available not yet known
Limerick Regional Hospital *(full-time)*	1998 *1999 2000 2001	4 weeks N/A 4 weeks 4 weeks	34 N/A 30 27	1 N/A 1 1	34 N/A 29 27	2 Not available Not available Not available	Not available Not available Not available Not available	2 Not available Not available Not available
Mater Misericordiae Hospital *(full-time)*	1998 1999 2000 2001	4 weeks 4 weeks 4 weeks 4 weeks	28 84 84 70	2 6 6 5	22 72 45 not yet known	Not available 1 1 not yet known	Not available not yet known	Not available 1+ not yet known not yet known
National Maternity Hospital, Holles Street *duration depends on length out of practice* *(full-time)*	1998 1999 2000 2001	4/8 weeks 4/8 weeks 4/8 weeks 4/8 weeks	12 12 12 12	1 1 1 1	12 5 8 not yet known	2 2 Not available not yet known	Not available 2 Not available not yet known	2 4 Not available not yet known
NEHB *(part-time)* *Commencing September 2001*	2000 2001	8 weeks 8 weeks	22 22	1 1	22 22	22 not yet known	 not yet known	22 not yet known
Our Lady's Hospital for Sick Children *(full-time)* *Insufficient applicants for intake 2001* *Decision to hold course every other year*	1998 1999 2000 2001	4 weeks 5 weeks 5 weeks —	12 12 12 —	1 1 1 —	12 7 5 —	5 2 1 —	3 2 4 —	8 4 5 —
Our Lady of Lourdes Hospital, Drogheda *(full-time)* *Expanded programme facilitated by NEHB training section*	1999 2000 2001	6 weeks 6 weeks 9 weeks	10 10	1 1	10 10 not yet known	Not available Not available not yet known	Not available Not available not yet known	Not available Not available not yet known
Rotunda Hospital *duration depends on length out of practice* *Course not provided* *(full-time)* *Proposed to commence in October 2001*	1998 *1999 2000 2001	6/8 weeks N/A 6/8 weeks 6/8 weeks	6 N/A 6 N/A	1 N/A 1 N/A	6 Not available Not available not yet known	1 Not available Not available not yet known	2 Not available Not available not yet known	3 Not available Not available not yet known
Sligo General Hospital *(full-time)*	1999 2000 2001	4 weeks 4 weeks 4 weeks	16 16 16	2 2 2	17 18 16	4 3 not yet known	13 5 not yet known	17 not yet known
St. Finbarr's Hospital Cork (Maternity) *duration depends on length out of practice* *(full-time)*	1998 1999 2000 2001	4/8 weeks 4/8 weeks 4/8 weeks 4/8 weeks	10 10 10 10	1 1 1 1	10 7 10 not yet known	Not available 1 Not available not yet known	Not available 4 Not available not yet known	Not available 5 Not available not yet known
St. James's Hospital, Dublin *2nd course cancelled Oct '99* *low application* *(full-time)*	1998 1999 2000 2001	5 weeks 5 weeks 5 weeks 5 weeks	22 22 22 60	2 1 2 2	22 8 10 18 to date	0 1 3 not yet known	21 approx. 10 12 not yet known	21 11 15 not yet known
St. Vincent's University Hospital *(full-time)* *Course commenced on 23 March 2001*	1998 1999 2000 2001	5 weeks 6 weeks 6 weeks 6 weeks	15 15 15 15	1 1 1 1	9 14 11 14	Not available 3 3 not yet known	Not available Not available Not available not yet known	Not availiable 3 3 not yet known
University College Hospital Galway *(full-time)*	1998 1999 2000 2001	4 weeks 4 weeks 4 weeks 4 weeks	20 40 22 22	1 2 1 1	20 40 22 22	Not available Not available Not available not yet known	Not available Not available Not available not yet known	Not available Not available Not available not yet known
Waterford Regional Hospital *(full-time)*	1998 1999 2000 2001	4 weeks 4 weeks 4 weeks 4 weeks	22 28 28 48	2 2 2 2	22 28 28 48	2 3 Not available not yet known	Not available Not available Not available not yet known	2 3 Not available not yet known

Table 3 Provision of Return-to-Practice Nursing and Midwifery Courses (1998-2001) — *contd.*

New Return-to-Practice Courses Planned — 2001

Hospital	Year	Length	Places	Intakes	Up-take	Employed In-house	Employed Elsewhere	Employed Total
AMNCH College of Nursing Tallaght	2001	12 weeks	15	1	N/A	not yet known	not yet known	not yet known
Cregg House *Proposed to commence 2001*	2001	4 weeks	—	—	—	—	—	—
NEHB (Psychistric course, part-time) *Commencing September 2001*	2001	8 weeks	10	1	N/A	not yet known	not yet known	not yet known
Regional Maternity Hospital Limerick	2001	8 weeks	12	1	12	3	4	7
St. Ita's Portrane, Dublin *Course to commence in September 2001*	2001	6 weeks	N/A	1	N/A	not yet known	not yet known	not yet known
St. John of Gods, Stillorgan	2001	4 weeks	12	2	N/A	not yet known	not yet known	not yet known
Tralee General Hospital	2001	4 weeks	N/A	1	N/A	not yet known	not yet known	not yet known

Summary

Total places available (per year)	1998	1999	2000	2001
Total places availiable	241	314	393	466 four new courses, place numbers unavailable (July 2001)
Number of places filled	225	267	290	258 places filled (July 2001)
Number of places not filled	16	47	103	208 places not filled (July 2001)
Number employed	71	80	53	7 not possible to determine due to deficiency in information

Notes:
Pertains to information available in July 2001

N/A denotes not available

*Course not provided that particular year

APPENDIX 7

Total Number Lost to Registration 1990-2000

An Bord Altranais Candidate Register

An Bord Altranais Candidate Register — Total Number Lost to Registration 1990-2000

Division	Discontinued	Quit	Transferred	Passed not Registered	Total Lost
General	43	14	0	1	57
Midwifery	7	1	0	1	8
Psychiatric	6	3	0	1	9
Sick Children's	14	0	0	0	14
Mental Handicap	9	4	0	0	13
1990 Total	**79**	**22**	**0**	**3**	**101**
General	33	8	0	0	41
Midwifery	6	0	0	2	6
Psychiatric	6	1	0	0	7
Sick Children's	16	2	0	0	18
Mental Handicap	3	7	0	2	10
1991 Total	**64**	**18**	**0**	**4**	**82**
General	27	0	0	3	27
Midwifery	7	0	0	3	7
Psychiatric	11	0	0	0	11
Sick Children's	9	0	0	1	9
Mental Handicap	15	0	0	0	15
1992 Total	**69**	**0**	**0**	**7**	**69**
General	25	0	0	2	25
Psychiatric	8	0	0	0	8
Sick Children's	11	0	0	1	11
Mental Handicap	11	0	0	1	11
1993 Total	**55**	**0**	**0**	**4**	**55**
General	30	0	0	4	30
Midwifery	3	0	0	3	3
Psychiatric	5	0	0	0	5
Sick Children's	4	0	0	1	4
Mental Handicap	10	0	0	0	10
1994 Total	**52**	**0**	**0**	**8**	**52**
General	31	0	0	2	31
Midwifery	4	0	0	3	4
Psychiatric	13	0	0	1	13
Sick Children's	6	0	0	1	6
Mental Handicap	11	0	0	5	11
1995 Total	**65**	**0**	**0**	**12**	**65**
General	30	0	1	6	31
Midwifery	3	0	0	5	3
Psychiatric	6	0	0	1	6
Sick Children's		0	0	2	0
Mental Handicap	11	0	0	0	11
1996 Total	**50**	**0**	**1**	**14**	**51**

Division	Discontinued	Quit	Transferred	Passed not Registered	Total Lost
General	42	0	0	1	42
Midwifery	12	0	0	14	12
Psychiatric	6	0	0	0	6
Sick Children's	5	0	0	5	5
Mental Handicap	10	0	0	0	10
1997 Total	**75**	**0**	**0**	**20**	**75**
General	25	5	0	22	30
Midwifery	2	0	0	12	2
Psychiatric	0	0	0	0	0
Sick Children's	9	0	0	9	9
Mental Handicap	4	0	0	0	4
1998 Total	**40**	**5**	**0**	**43**	**45**
General	37	15	0	26	78
Midwifery	13	2	0	0	15
Psychiatric	2	0	0	0	2
Sick Children's	11	2	0	0	13
Mental Handicap	7	0	0	0	7
1999 Total	**70**	**19**	**0**	**26**	**115**
General	48	0	0	30	78
Midwifery	15	0	0	6	21
Psychiatric	7	0	0	6	13
Sick Children's	10	0	0	2	12
Mental Handicap	4	0	0	1	5
2000 Total	**84**	**0**	**0**	**45**	**129**

Notes:

'Discontinued' = the Board were officially informed that the student had discontinued training

'Quit' = there is no subsequent record of the student completing training. Quit is approximation of those expected to finish in a given year but no record of registration/discontinuation before next year end

'Passed not registered' is taken as those who finished their training but did not register

Figures for the numbers 'discontinued' and 'passed but not registered' are continuously changing

It was not possible to separate 'Quit' and 'passed not registered' for 2001

'Total Lost' = sum of all potential qualifications not registered in a particular division of the Register

Source: An Bord Altranais, Registration Department

APPENDICES

APPENDIX 8

Nurses and Midwives Grade by Gender 2000

Department of Health and Children Health Services Personnel Census

Health Services Personnel Census — Nurses and Midwives Grade by Gender — 2000

Grade	Total WTE	Total Number Persons	Female Persons	Male Persons	Female per cent of total	Male per cent of total
Assistant Director of Nursing (Mental Health)	120.08	121	55	66	45	55
Assistant Director of Nursing 1	120.72	125	118	7	94	6
Assistant Director of Nursing 2	69.77	71	65	6	92	8
Assistant Director of Nursing 3	4.00	4	4	0	100	0
Assistant Director of Nursing 4	13.00	13	12	1	92	8
Assistant Director of Public Health Nursing	76.50	78	78	0	100	0
Clinical Midwife Specialist	7.00	10	10	0	100	0
Clinical Nurse Instructor/Teacher	45.50	48	44	4	92	8
Clinical Nurse Manager 1	500.73	552	540	12	98	2
Clinical Nurse Manager 1 — Theatre	12.00	12	11	1	92	8
Clinical Nurse Manager 1 (Mental Health)	355.21	361	207	154	57	43
Clinical Nurse Manager 2	1,666.09	1,751	1,710	41	98	2
Clinical Nurse Manager 2 — Cancer Nurse Co-ordinator	2.50	3	3	0	100	0
Clinical Nurse Manager 2 — Night	83.40	95	94	1	99	1
Clinical Nurse Manager 2 — Theatre	137.56	148	146	2	99	1
Clinical Nurse Manager 2 (Mental Health)	447.59	454	258	196	57	43
Clinical Nurse Manager 3	117.91	122	108	14	89	11
Clinical Nurse Manager 3 — Night	111.29	119	105	14	88	12
Clinical Nurse Manager 3 — Theatre	17.00	17	17	0	100	0
Clinical Nurse Specialist	27.50	28	27	1	96	4
Clinical Nurse Specialist, Infection Control	14.00	15	15	0	100	0
Clinical Placement Co-ordinator	47.00	49	45	4	92	8
Community Mental Health Nurse	5.50	6	6	0	100	0
Diploma Student Midwife	337.00	337	334	3	99	1
Diploma Student Nurse	598.80	611	572	39	94	6
Director of Nursing (Mental Health)	33.00	33	4	29	12	88
Director of Nursing 1	13.00	13	12	1	92	8
Director of Nursing 2	15.00	15	12	3	80	20
Director of Nursing 2A	36.00	37	34	3	92	8
Director of Nursing 3	26.00	26	24	2	92	8
Director of Nursing 4	70.00	70	63	7	90	10
Director of Nursing 5	42.00	42	41	1	98	2
Director of Nursing, Deputy	3.50	4	4	0	100	0
Director of Public Health Nursing	31.00	31	30	1	97	3
Director of the Nursing & Midwifery P&D Unit	1.00	1	1	0	100	0
Dual Qualified Nurse	1,435.57	1,755	1,547	208	88	12
Nurse (Psychiatric), Community	125.33	131	64	67	49	51
Nurse Planner	4.00	4	4	0	100	0
Nurse Tutor	129.55	142	129	13	91	9
Nurse Tutor (Psychiatric)	14.00	14	9	5	64	36
Nursing Practice Development Co-ordinator	13.50	14	12	2	86	14
Nursing Unclassified	673.34	729	543	186	74	26
Post Registration Student Nurse — Sick Children's	8.00	8	6	2	75	25
Post Registration Student Nurse, Year 1	135.93	143	141	2	99	1
Post Registration Student Nurse, Year 2	105.00	105	103	2	98	2
Principal Nurse Tutor	69.00	71	54	17	76	24
Principal Nurse Tutor (Psychiatric)	10.00	10	4	6	40	60
Public Health Nurse	1,422.14	1,686	1,685	1	100	0
Public Health Nurse, Student	19.00	19	19	0	100	0
Senior Staff Midwife	20.00	23	23	0	100	0
Senior Staff Nurse (Dual Qualified)	89.51	105	99	6	94	6
Senior Staff Nurse (Dual-Qualified Psychiatric)	4.00	4	3	1	75	25
Senior Staff Nurse (General)	464.54	540	540	0	100	0
Senior Staff Nurse (Mental Handicap)	42.04	46	43	3	93	7
Senior Staff Nurse (Psychiatric)	91.50	93	43	50	46	54
Senior Staff Nurse (Sick Children)	0.50	1	1	0	100	0
Staff Midwife	667.50	829	828	1	100	0
Staff Nurse — General	14,509.82	17,279	16,903	376	98	2
Staff Nurse — Mental Handicap	669.52	788	717	71	91	9
Staff Nurse — Psychiatric	3,137.40	3,394	2,207	1,187	65	35
Staff Nurse — Sick Children's	92.50	97	93	4	96	4
Staff Nurse General (Community)	6.44	12	12	0	100	0
Tutor, Midwifery	9.50	10	10	0	100	0
Total	**29,177.28**	**33,474**	**30,651**	**2,823**	**92%**	**8%**

Source: Department of Health and Children, *Health Services Personnel Census,* 2000

Nurses and Midwives Grade by Whole-Time Equivalent 1990-2000

Department of Health and Children Health Services Personnel Census

Health Services Personnel Census — Nurses and Midwives Grade by Whole Time Equivalent, 1990-2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Assistant Director of Nursing	151	155	160	162	159	149	153	163			
Assistant Director of Nursing 1									99	94	121
Assistant Director of Nursing 2									69	75	70
Assistant Director of Nursing 3										5	4
Assistant Director of Nursing 4										19	13
Assistant Director of Nursing — Mental Health	130	124	125	127	116	120	119	118	111	117	120
Assistant Director of Public Health Nursing	2	2	2	2	8		15	20	20	86	77
Clinical Instructor/Teacher	60	57	60	59	56	40	39	38	39	35	46
Clinical Midwife Specialist											7
Clinical Nurse Manager 1	215	194	203	199	196	228	229	223	310	254	501
Clinical Nurse Manager 1 — Mental Health		165	183	237	261	262	361	356	295	397	355
Clinical Nurse Manager 1 — Theatre											12
Clinical Nurse Manager 2	1,037	1,093	1,107	1,126	1,167	1,181	1,195	1,241	1,393	1,400	1,666
Clinical Nurse Manager 2 — Cancer Nurse Co-ordinator	3										
Clinical Nurse Manager 2 — Home	14	14	14	14	12	13	14	14	15	14	
Clinical Nurse Manager 2 — Night	82	81	82	83	89	90	91	87	94	87	83
Clinical Nurse Manager 2 — Mental Health	737	583	554	501	462	472	484	476	418	497	448
Clinical Nurse Manager 2 — Theatre	112	109	115	138	126	127	131	134	143	138	138
Clinical Nurse Manager 3	86	81	79	70	68	77	88	106	90	112	118
Clinical Nurse Manager 3 — Night	90	91	89	90	90	87	89	91	87	88	111
Clinical Nurse Manager 3 — Theatre	10	12	12	14	14	13	14	16	15	19	17
Clinical Nurse Specialist											28
Clinical Nurse Specialist — Infection Control	7	16	8	9	9	10	12	13	11	11	14
Community Mental Health Nurse											6
Clinical Placement Co-ordinator										40	47
Diploma Student Midwife											337
Diploma Student Nurse											599
Director of Nursing	188	186	183	187	177	177	174	178	N/A	2	N/A
Director of Nursing 1									21	19	13
Director of Nursing 2									10	16	15
Director of Nursing 2A									77	49	36
Director of Nursing 3									10	24	26
Director of Nursing 4									52	60	70
Director of Nursing 5									19	39	42
Director of Nursing, Deputy	8	7	8	7	8	12	12	9	8	5	4
Director of Nursing — Mental Health	36	36	37	35	33	33	33	33	33	31	33
Dir. Nursing/Midwifery/Planning/Development Unit											1
Director of Public Health Nursing	29	30	31	28	27	28	29	29	28	30	31
Dual Qualified Nurse	312	266	317	371	383	636	716	777	799	860	1,436
Home Superintendent								1	1	1	N/A
Matron Welfare Home									3	N/A	N/A

Health Services Personnel Census — Nurses and Midwives Grade by Whole Time Equivalent, 1990-2000 — *contd.*

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Nurse (Psychiatric), Community	199	194	185	177	171	152	151	150	148	149	125
Nurse (Psychiatric), Head Night (obsolete grade — 91)				2	2	2				N/A	N/A
Nurse Planner						1	1	2	1	2	4
Nurse Tutor									165	181	130
Nurse Tutor (Psychiatric)		2	2	2	3	6	6	6	18	8	14
Nursing Practice Development Co-ordinator										15	14
Nursing Unclassified	220	215	293	256	312	306	210	221	274	174	673
Post Registration Student Nurse — Sick Children's											8
Post Registration Student Nurse, Year 1				26	40	112	105	92	143	111	136
Post Registration Student Nurse, Year 2				16	19	11	157	146	101	99	105
Principal Nurse Tutor	31	39	34	36	32	32	34	31	25	38	69
Principal Nurse Tutor (Psychiatric)	21	23	22	21	21	22	17	17	8	8	10
Public Health Nurse	1,291	1,294	1,283	1,299	1,305	1,301	1,305	1,334	1,377	1,412	1,422
Public Health Nurse, Senior	38	44	48	56	56	81	67	71	64	N/A	N/A
Public Health Nurse, Student											19
Senior Staff Midwife											20
Senior Staff Nurse (Dual Qualified)											90
Senior Staff Nurse (Dual-Qualified Psychiatric)											4
Senior Staff Nurse (General)											465
Staff Nurse General (Community)											6
Senior Staff Nurse (Mental Handicap)											42
Senior Staff Nurse (Psychiatric)											92
Senior Staff Nurse (Sick Children)											1
Staff Midwife	440	440	451	440	455	415	439	391	503	703	668
Staff Nurse — General	11,089	11,575	12,010	12,423	12,897	13,777	14,053	15,036	15,602	15,116	14,510
Staff Nurse — Mental Handicap	104	116	232	208	193					591	670
Staff Nurse — Psychiatric	3,526	3,618	3,600	3,547	3,632	3,480	3,492	3,475	3,456	3,410	3,137
Staff Nurse — Sick Children's										10	93
Student Midwife	443	437	437	437	439	419	391	378	451	379	N/A
Student Nurse I	1,327	1,360	1,351	1,308	1,266	1,109	716	479			N/A
Student Nurse II	822	767	850	858	839	822	627	352			N/A
Student Nurse III	1,261	1,243	1,124	1,191	1,211	1,276	1,244	904			N/A
Student Nurse Unclassified (obsolete 93)	396	377	388	349	371	69					N/A
Trainee Psychiatric Nurse (obsolete)										6	
Tutor Principal II	13	13	15	19	16	23	75	79		N/A	N/A
Tutor Principal III	46	59	74	83	93	88	76	57		N/A	N/A
Tutor, Midwifery	4	4	6	7	7	8	7	7	10	11	10
Year Total Whole-Time Equivalent	**24,574**	**25,118**	**25,771**	**26,220**	**26,839**	**27,267**	**27,170**	**27,347**	**26,612**	**27,044**	**29,177**

Note: N/A = not applicable

Source: Department of Health and Children, *Health Services Personnel Census,* 1990-2000

APPENDICES

APPENDIX 10

Nurses and Midwives Grade by Number (individuals) 1990–2000

Department of Health and Children Health Services Personnel Census

Health Services Personnel Census — Nurses and Midwives Grade by Number (individuals) 1990-2000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Management											
Assistant Director of Nursing	152	155	161	163	159	151	154	165	N/A	N/A	N/A
Assistant Director of Nursing 1									100	98	125
Assistant Director of Nursing 2									70	77	71
Assistant Director of Nursing 3										5	4
Assistant Director of Nursing 4										19	13
Assistant Director of Public Health Nursing	2	2	2	2	8		15	20	20	86	78
Assistant Director of Nursing — Mental Health	130	125	126	128	117	121	120	119	111	117	121
Clinical Nurse Manager 1	218	197	207	203	200	234	239	233	325	277	552
Clinical Nurse Manager 1 — Mental Health		165	184	239	263	266	364	360	302	406	361
Clinical Nurse Manager 1 — Theatre											12
Clinical Nurse Manager 2	1,046	1,106	1,119	1,141	1,185	1,208	1,230	1,279	1,436	1,459	1,751
Clinical Nurse Manager 2 — Cancer Co-ordinator											3
Clinical Nurse Manager 2 — Home	15	15	15	15	13	14	15	14	15	14	N/A
Clinical Nurse Manager 2 — Mental Health	740	586	557	504	465	475	488	480	421	502	454
Clinical Nurse Manager 2 — Night	85	85	86	88	94	95	96	93	103	99	95
Clinical Nurse Manager 2 — Theatre	112	110	115	140	130	131	135	139	149	145	148
Clinical Nurse Manager 3	86	81	79	70	69	79	89	107	92	118	122
Clinical Nurse Manager 3 — Night	91	93	91	91	93	89	90	92	88	91	119
Clinical Nurse Manager 3 — Theatre	10	12	12	14	14	13	14	16	15	19	17
Director of Nursing	188	186	183	187	177	177	174	178		2	N/A
Director of Nursing 1									21	19	13
Director of Nursing 2									10	17	15
Director of Nursing 2A									77	52	37
Director of Nursing 3									10	24	26
Director of Nursing 4									52	60	70
Director of Nursing 5									19	39	42
Director of Nursing — Deputy	8	7	8	7	8	12	12	9	8	5	4
Director of Nursing — Mental Health	36	36	38	36	33	33	34	33	33	31	33
Director of Public Health Nursing	29	30	31	28	27	28	29	29	28	30	31
Dir. of Nursing/Midwifery Planning/Development Unit											1
Home Superintendent								1	1	1	N/A
Matron Welfare Home									3	N/A	N/A
Nurse Planner						1	1	2	1	2	4
Nurse (Psych), Head Night (obsolete grade — 91)				2	2	2					
Public Health Nurse -Senior	38	44	48	56	56	82	68	72	65	N/A	N/A
Sub-total Nurse/Midwife Management	*2,986*	*3,035*	*3,062*	*3,114*	*3,113*	*3,211*	*3,367*	*3,441*	*3,575*	*3,814*	*4,322*

Health Services Personnel Census — Nurses and Midwives Grade by Number (individuals) 1990-2000 — *contd.*

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Clinical Nursing and Midwifery											
Clinical Midwife Specialist											10
Clinical Nurse Specialist											28
Clinical Nurse Specialist — infection control	7	16	8	9	9	10	12	13	11	12	15
Community Mental Health Nurse											6
Dual Qualified Nurse	333	287	346	404	424	716	792	863	919	988	1,755
Nurse (Psychiatric), Community	202	197	189	182	175	157	153	154	152	155	131
Public Health Nurse	1,469	1,474	1,507	1,526	1,586	1,521	1,561	1,617	1,640	1,638	1,686
Senior Staff Midwife											23
Senior Staff Nurse — Dual Qualified											105
Senior Staff Nurse — Dual Qualified — Psychiatric											4
Senior Staff Nurse — General											540
Senior Staff Nurse — Mental Handicap											46
Senior Staff Nurse — Psychiatric											93
Senior Staff Nurse — Sick Children's											1
Staff Midwife	488	504	529	520	540	500	527	462	606	872	829
Staff Nurse — General	12,462	13,339	13,911	14,500	15,065	16,189	16,394	17,582	18,376	17,898	17,279
Staff Nurse General — Community											12
Staff Nurse — Mental Handicap	108	120	243	226	209					679	788
Staff Nurse — Psychiatric	3,746	3,883	3,868	3,805	3,935	3,785	3,733	3,742	3,735	3,665	3,394
Staff Nurse — Sick Children's										10	97
Sub-total Clinical Nursing and Midwifery	*18,815*	*19,820*	*20,601*	*21,172*	*21,943*	*22,878*	*23,172*	*24,433*	*25,439*	*25,917*	*26,842*

Health Services Personnel Census — Nurses and Midwives Grade by Number (individuals) 1990-2000 — *contd.*

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Education											
Clinical Nurse Instructor/Teacher	66	60	63	63	60	44	43	41	43	37	48
Clinical Placement Co-ordinator										40	49
Diploma Student Nurse											611
Diploma Student Midwife											337
Nurse Tutor									175	196	142
Nurse Tutor (Psychiatric)		2	2	2	3	6	6	6	18	8	14
Nursing Practice Development Co-ordinator										16	14
Post Registration Student Nurse — Sick Children's											8
Post Registration Student Nurse, Year 1				26	40	112	106	92	144	111	143
Post Registration Student Nurse, Year 2				16	19	11	157	146	101	99	105
Principal Nurse Tutor	32	40	35	36	33	34	35	32	25	38	71
Principal Nurse Tutor (Psychiatric)	21	25	24	23	23	24	19	18	8	8	10
Public Health Nurse, Student											19
Student Midwife	443	437	437	438	440	419	392	378	452	380	N/A
Student Nurse I	1,330	1,366	1,354	1,313	1,266	1,115	716	479			N/A
Student Nurse II	822	765	854	868	840	824	629	352			N/A
Student Nurse III	1,261	1,243	1,127	1,193	1,226	1,289	1,264	923			N/A
Student Nurse Unclassified (obsolete 93)	397	377	388	349	371	69				7	N/A
Tutor, Midwifery	4	4	6	7	7	8	7	7	10	11	10
Tutor Principal II	13	13	15	19	16	23	78	80			N/A
Tutor Principal III	48	62	77	87	97	94	80	62			N/A
Sub-total Nurse/Midwife Education	*4,437*	*4,394*	*4,382*	*4,440*	*4,441*	*4,072*	*3,532*	*2,616*	*976*	*951*	*1,581*
Unclassified											
Nursing Unclassified	228	231	320	285	319	319	232	246	311	193	729
Sub-total Unclassified	*228*	*231*	*320*	*285*	*319*	*319*	*232*	*246*	*311*	*193*	*729*
Year Total Persons	**26,466**	**27,480**	**28,365**	**29,011**	**29,816**	**30,480**	**30,303**	**30,736**	**30,301**	**30,875**	**33,474**

Notes:
Excludes Career Breaks

N/A = not applicable

Source: Department of Health and Children, *Health Services Personnel Census,* 1990-2000

APPENDIX 11

Trend for Qualifications Registered by Nurses and Midwives 1991-2001

An Bord Altranais — The Register of Nurses

Trend for Qualifications Held by Nurses and Midwives 1991-2001

	1991		1992		1993		1994		1995		1996		1997		1998		1999		2000		2001*	
Active Nurses	37,285		37,902		39,460		41,233		42,937		44,822		47,157		48,579		50,940		53,072		56,611	
Inactive File	5,420		6,228		7,049		7,712		8,263		8,819		8,998		10,431		10,389		10,402		12,052	
Total Nurses	**42,705**		**44,130**		**46,509**		**48,945**		**51,200**		**53,641**		**56,155**		**59,010**		**61,329**		**63,474**		**68,663**	
	(+3,110)		(+1,425)		(+2,379)		(+2,436)		(+2,255)		(+2,441)		(+2,514)		(+2,855)		(+2,319)		(+2,145)		(+5,189)	
	Total R	*New Q*	Total R	*New Q*	Total R	*New Q*	Total R	*New Q*	Total R	*New Q*	Total R	*New Q*	Total R	*New Q*	Total R	*New Q.*	Total R.	*New Q.*	Total R.	*New Q.*	Total R.	*New Q.*
General	N/A	*1,578*	36,222	*1,614*	37,966	*1,600*	39,970	*1,722*	41,734	*1,641*	43,870	*1,824*	46,075	*1,950*	48,542	*2,095*	50,661	*2,143*	52,760	*2,351*	55,634	*4,012*
Psychiatric	N/A	*128*	8,287	*186*	8,884	*170*	9,236	*162*	9,470	*208*	9,799	*225*	10,070	*186*	10,419	*238*	10,558	*235*	10,815	*177*	10,890	*211*
Mental Handicap	N/A	*109*	2,465	*175*	2,645	*170*	2,814	*150*	3,031	*206*	3,231	*178*	3,420	*161*	3,588	*140*	3,745	*164*	3,823	*106*	3,955	*133*
Sick Children's	N/A	*137*	2,851	*147*	2,962	*104*	3,091	*103*	3,242	*141*	3,407	*131*	3,595	*175*	3,818	*189*	3,993	*182*	4,179	*161*	4,299	*148*
Midwifery	N/A	*361*	12,743	*319*	13,191	*337*	13,592	*305*	13,968	*302*	14,394	*327*	14,776	*307*	15,211	*319*	15,618	*340*	16,124	*351*	16,158	*295*
Public Health	N/A	*22*	1,619	*48*	1,664	*42*	1,717	*47*	1,778	*58*	1,853	*73*	1,925	*69*	1,978	*53*	2,062	*86*	2,132	*71*	2,150	*57*
Tutor	N/A	*19*	257	*4*	283	*24*	295	*17*	328	*31*	372	*45*	404	*31*	446	*40*	476	*31*	491	*16*	532	*44*
Other	N/A	*0*	587	*0*	597	*0*	601	*0*	607	*0*	611	*0*	612	*0*	616	*0*	620	*0*	620	*0*	605	*0*
Total	**62,940**	*2,354*	**65,031**	*2,493*	**68,192**	*2,447*	**71,316**	*2,506*	**74,158**	*2,587*	**77,537**	*2,803*	**80,877**	*2,879*	**84,618**	*3,074*	**87,733**	*3,181*	**90,944**	*3,233*	**94,223**	*4,900*
Change in number	(+4,444)		(+2,091)		(+3,161)		(+3,124)		(+2,842)		(+3,379)		(+3,340)		(+3,741)		(+3,115)		(+3,211)		(+3,279)	
Average Quals per Nurse	1.47		1.47		1.47		1.46		1.45		1.44		1.44		1.43		1.43		1.43		1.37	

Notes:

N/A Not available

Many nurses have multiple qualifications. For this reason the number of new qualifications each year is greater than the increase in numbers of total registered

*The figures for 2001 are provisional, as of 27 November 2001

The new qualifications registered each year include first registrations and subsequent registrations

The increase in the number of nurses on the register between 1991-2001 was 61.78 per cent

The general population growth 1991-1996 was 2.8 per cent (CSO '96) For these years nursing numbers increased by 26 per cent

Based on those Active and Inactive, as of 31 December of each year

Source: An Bord Altranais Annual Reports — Total Registration Statistics

APPENDICES

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APPENDICES