SYSTEMS, NOT STRUCTURES:

CHANGING HEALTH & SOCIAL CARE

Expert Panel Report

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The Panel would also like to record their gratitude to the many organisations and individuals from across the HSC who gave of their time and expertise to informing this work. The report would not have been possible without their involvement.

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SECTION 1

THE PANEL'S REMIT AND THE POLITICAL SUMMIT

In his speech of 4 November 2015, the then Minister for Health, Simon Hamilton MLA, announced that in response to recommendation 1 of **The Right Time, The Right Place** report by Sir Liam Donaldson, he would appoint an expert, clinically led panel to consider and lead an informed debate on the best configuration of Health and Social Care services in Northern Ireland.

Sir Liam's report stated:

"A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standards of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest".

The Panel was appointed in January 2016 and comprises local and international members. The Panel was given the remit to:

- Produce a set of principles to underpin reconfiguration of health and social care services.
- Support and lead debate including at a political summit to be held in early 2016 to agree the principles.
- Use the results of the political summit to develop a clinically informed model for the future configuration of health and social care, which will ensure world class provision for everyone in Northern Ireland.
- Clearly quantify the specific benefits in health outcomes that will be derived from the new model, both for individuals and the Northern Ireland population as a whole.

Political Summit: 17th February 2016

The panel along with MLAs and advisors from the DUP, Sinn Fein, UUP, SDLP and Alliance met for a one day health summit to discuss the need for change and agree a set of principles that would guide the panel in structuring a New Model of Health and Social Care for the people of Northern Ireland. Each party provided both verbal and written comments to a 'draft set of principles'. In turn the panel considered all comments and revised the principles to take as many of these on board as possible.

The final set of principles is attached at Annex A.

Engagement

The Panel has engaged extensively with stakeholders across health and social care, and the following key messages were heard consistently:

- The unsustainable nature of the 'status quo'. Major workforce gaps in all areas of the current model of service requiring significant investment in agency staff to maintain the current distribution of acute care.

- Underinvestment in primary and social care, the very services that can prevent hospital admission, because of over-investment in the current hospital model.

- Even with the funding used to purchase independent sector and 'in-house' waiting list initiatives, there are increasing delays for elective care.

- The contribution of unpaid carers and the voluntary sector, and the desire for the voluntary sector to be a trusted partner in care.

- Independent providers are delivering significant elements of care in domiciliary and residential care home settings and are struggling to cope with current funding levels.

- The need to invest in improving the health of our population and to take a more co-ordinated approach to supporting people with complex needs.

SECTION 2

THE BURNING PLATFORM – AN UNASSAILABLE CASE FOR CHANGE

Context

In the course of its work, the Panel has heard repeated references to 'review fatigue'. In essence, there seems to be a sense that the Health and Social Care (HSC) system has repeatedly spent significant time and resources analysing the challenges it faces, identifying the weaknesses in the current model, making recommendations for change, but subsequently failing to enact the necessary transformation to make these happen. The timeline at fig. 1 gives a sense of the main reforms and reviews that the system has experienced since the 1970s.

Across the system, there has been a broad consensus among those the panel has spoken to that there is a need for transformational change in the way services are delivered and the way our system is organised. It is important to fully understand the nature of the challenges and demands that health and social care services face, and also the reasons why the model that is currently in place is outdated and is not the one that Northern Ireland needs. Many of these issues will not come as a surprise to those working across the system or those who use its services. Indeed, many of these issues were plainly articulated to us from a number of different sources, who made clear their concerns with regard to factors such as rising demand, changing demographics and patterns of illness, financial sustainability, workforce planning and vulnerable services. Although there are committed and talented people at all levels of the system, the system itself is not making the most effective use of the available public funds to meet service users' needs.

Northern Ireland is not alone in facing these challenges. Health and social care systems across the developed world are currently struggling with the question of how to adapt their services to deal with continuously rising and changing patterns of demand. Most countries also recognise that simply adding more money and resources to tackling these issues is not enough to make services higher quality and sustainable, radical transformation is required. This is not an easy thing to do; change and transformation are always difficult, they create uncertainty and they require us to give up what we have in exchange for something new. This is particularly difficult when it involves something that is very important to us, such as the health and social care services that we and our families will all need to call on at some point in our lives.

Fig. 1 – Reviews and Reforms of Health and Social Care in Northern Ireland

1973	The HPSS (NI) Order provided for the establishment of four Health and Social Services Boards, responsible for administering and arranging provision of services.
1989	A Government white paper introduced the concept of an internal market. In Northern Ireland, this led to the establishment of 19 Trusts.
1998	Fit for the Future proposed the abolition of the internal market with commissioning decisions taken as close as possible to patients and clients and centred on primary care.
2001	The Acute Hospitals Review suggests the establishment of a single Strategic Health and Social Services Authority to replace the four HSS Boards. It also recommends moving to a service with 9 acute hospitals
2002	Developing Better Services supports significantly reducing the number of HSC organisations, including the creation of a single regional authority. Also recommends the 15 Local Health and Social Care Groups (LHSCGs) should be brought together.
2002	GP fundholding abolished. Arrangements for LHSCGs, as committees of the four HSS boards are put in place to assess need and design services. 15 were in place by 2005.
2005	The Appleby Review focuses on the need for rigorous performance management and greater incentivisation of strong performance.
2007	The then Minister decides against a regional Health Authority. Instead, he confirms the creation of 5 new integrated Trusts, 5 Local Commissioning Groups, a smaller Health and Social Care Board focused on commissioning, financial and performance management, and a Public Health Agency.
2011	Transforming Your Care sets out a broad new model of care, moving away from hospitals and into primary, community and social care services. Recommends 5-7 hospital networks
2014	Sir Liam Donaldson endorses the policy behind TYC but recommends the appointment of an impartial panel of experts to deliver the right configuration of HSC services.
2015	Following the Donaldson report and an internal review of commissioning, the then Minister launches a consultation on a review of the HSC administrative structures. The review recommends abolition of the HSCB.
2016	The appointment of an international expert panel to develop a clinically informed model for the future configuration of health and social care.

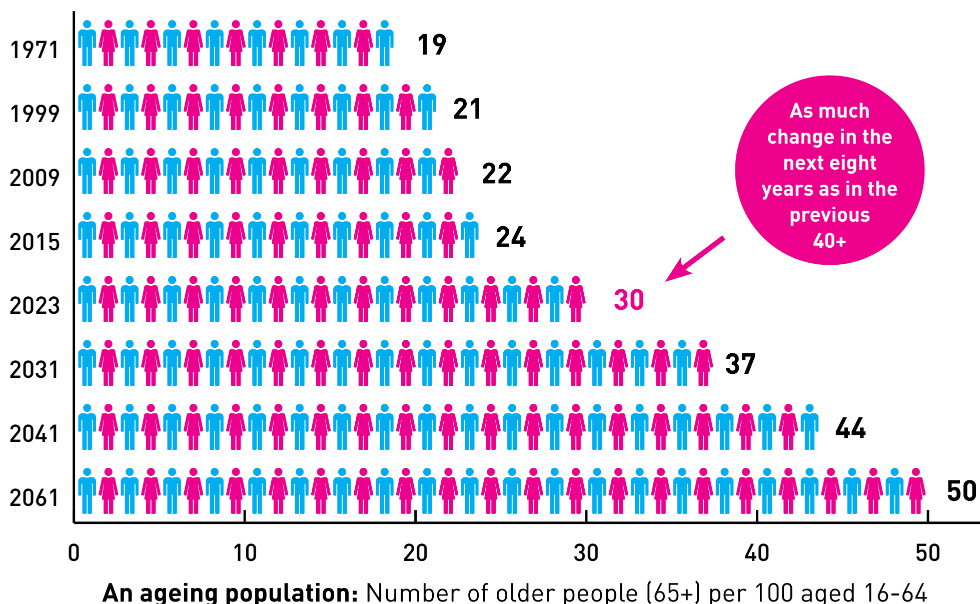
However, it is important that the case for change is clearly understood by those who use and those who deliver these services, and also the risks of not making these changes in a planned and transparent way. In this section of the report, the evidence that the existing system is already struggling to sustain services in the face of these changing circumstances is set out and the case made for new service models. Without systematic and planned change, already stretched services will undoubtedly be forced into unplanned change through fire-fighting and crisis.

The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it. This report presents an opportunity that must be seized and acted upon.

Demographic Change

As a population, we are living longer than ever before and, for most of our lives, are healthier than ever before. When the NHS was created in 1948, life expectancy was 65.8 years for men and 70.1 years for women. It is now 78.1 for men and 82.4 for women. The number of older people in our community is also increasing as a proportion of the overall population. In 2013 there were estimated to be 279,000 people aged 65 and over, with 33,000 of them over 85 years. This is projected to increase considerably in the next 20 years to 456,000 and 79,000 respectively. As the graph below demonstrates, the demographic shift for the period from 2015-2023 will be equal to the demographic shift in the preceding 40 years.

Fig. 2 – Population Projections (2015-2061)

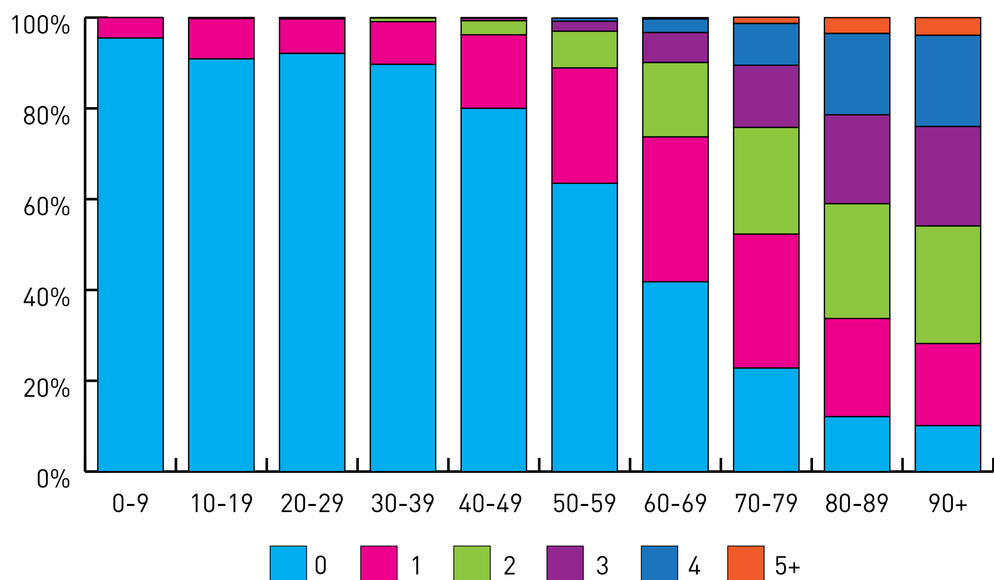


It is a similar picture across the UK and Ireland. However, out of all the UK countries, at 43.1% Northern Ireland had the largest percentage growth of people aged 85+ between mid-2004 and mid-2014. This is projected to continue over the 25 year period between mid-2014 and mid-2039.[1]

This increase in life expectancy is a great achievement, but it signals a major shift in demography and in patterns of demand for health and social care services. Ageing brings an increased likelihood of some degree of disability, dependency and illness, and older people are now the main users of Northern Ireland's health and social care services. The rate of disability among those aged over 85 is 67% compared with only 5% among young adults.[2] Dementia is also a growing issue for our older population, with 60,000 people projected to be suffering from the condition by 2051.[3] In addition, the profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses.

As well as living longer, developments in how we are able to treat and manage conditions mean that we are all much more likely to develop and live with one or more long term conditions. The table below[4] clearly demonstrates that as we get older, the likelihood of multiple morbidities increases dramatically, meaning that the care and treatment that we require becomes much more complex.

Fig. 3 – Co-morbidities by Age Band



1. NISRA Statistical Bulletin: 2014-Based Population Projections for Northern Ireland (published 29 Oct 2015)
2. Transforming Your Care, Health and Social Care Board, December 2011
3. Dementia Strategy, DHSSPS, 2010
4. Source – Health and Social Care Board, 2016

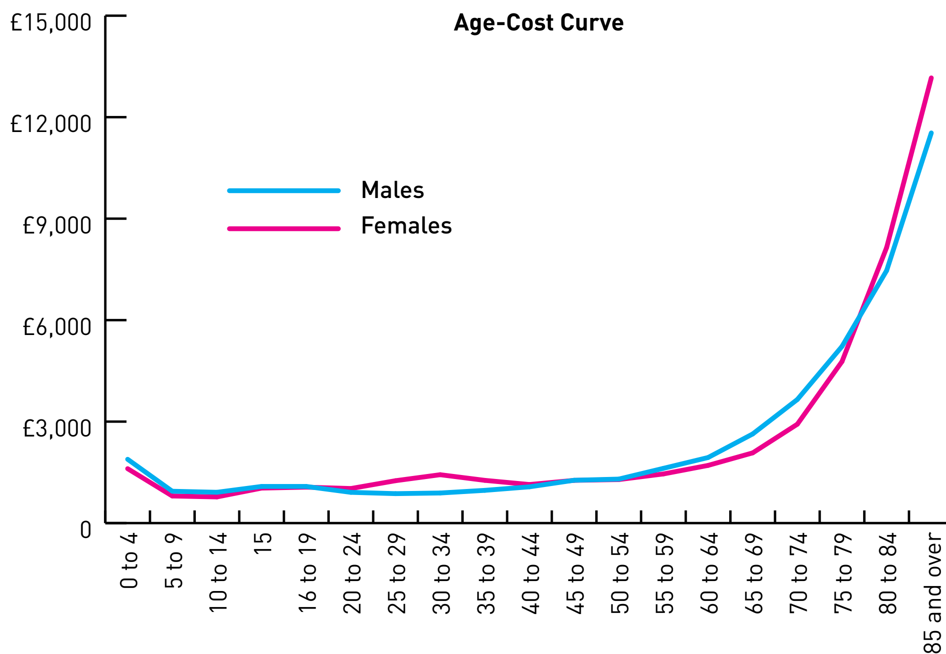
Impact on the HSC system

According to the latest figures, currently in Northern Ireland:

- Two thirds of acute hospital beds are currently occupied by people aged over 65;
- 9,670 people over 65 live in residential care or nursing homes;
- Approximately 23,400 users weekly receive domiciliary care.

In terms of costs, users aged over 65 account for more than two-fifths of HSC spending – 42%, compared to their population share of 14%. Whereas the average cost of treating a 55-59 year old stands at £1,970 per head, this rises to over £6,000 for 75-79 year olds and £14,000 for the over 85s.[5]

Fig. 4 – Age/Cost Curve



Ultimately, all of these figures and statistics illustrate a significant success story for Health and Social Care. As a population, we are seeing a marked reduction in acute life-threatening illnesses, but in their place we are now dealing much more commonly with long term conditions and disability as a result of the population's increased longevity.

16000

The pressure that this is placing on the HSC's finite resources cannot be resolved by continuing to rely on the current acute care model. The change in the nature of the demand facing the system is not reflected in the ways services are designed

12000

9000

5. Source – Department of Health

and delivered. The vast majority of care is provided in the person's home or in local communities by unpaid carers, primary and community care teams, and the voluntary and independent sector. Acute hospitals are designed to deal with acute illness, not chronic conditions, and yet the beds in acute wards are filled with those whose needs may well be met more effectively and more efficiently elsewhere. The question that needs to be posed is whether the current system, which was set up to meet the needs of the mid to late 20th century, is still the right one to meet the changing patterns of illness and demand that we face in the 21st century.

Health Inequalities

While overall people are living longer and healthier lives, health inequalities continue to be a major issue. Life expectancy for males in the most deprived areas of NI is on average 7.5 years less than their counterparts in the least deprived areas. For females, the differential is 4.3 years.[6]

Fig. 5 – Deprivation & Life Expectancy

6. Source – Department of Health

The healthy life expectancy of people in the most and least disadvantaged areas differs dramatically. On average males live 58. 7 years in good health, females 62.2 years. However, female healthy life expectancy in the most deprived areas is 14.2 years lower than in the least deprived areas; and comparable figure for male healthy life expectancy is 11.8 years.

These inequalities also have a detrimental impact on the HSC system.

- There are 9 admissions to hospital for every 20 people in the most deprived areas compared to 6 admissions for every 20 people in the least deprived areas;
- Emergency admissions to hospital are 74% higher in most deprived communities than in the least deprived;
- Elective admissions to hospital are 25% higher in most deprived communities than least deprived;
- Hospital day cases are 21% higher in most deprived communities than least deprived.

Evidence from Marmot's review of health inequalities in England indicates that addressing health inequalities requires co-ordinated action across the wider determinants of health.[7] Action is required across government, to do more to improve universal public services as well as more targeted services for those with greater need.

In fact, research shows that only about 20% of health outcomes are related to clinical care: 10% is related to physical environment (air and water quality, built environment, etc); 40% is related to socio economic factors (education, employment, social support, community safety); and 30% is related to behaviours.[8] The diagram below shows some of the key indicators highlighting the gaps between most and least deprived.[9]

Fig. 6 – Health Inequality Indicators

Indicator	Baseline Year	Unit of Difference	Simple Gap
Male Life Expectancy	2009-11	Years	7.2
Female Life Expectancy	2009-11	Years	4.4
Infant Mortality[20]	2007-11	Deaths / 1,000 live births	0.8 (16%)
Smoking during Pregnancy	2012	Percentage	22 (280%)
Breastfeeding	2012	Percentage	30 (52%)
Key Stage 2 - Communication	2011/12	Percentage	20 (24%)
Key Stage 2 - Mathematics	2011/12	Percentage	21 (24%)
GCSE	2011/12	Percentage	22 (35%)
Alcohol-related Admissions	2009/10 - 2011/12	Admissions / 100,000 population	1,246 (452%)
Teenage Births	2011	Births / 1,000 Females	3.9 (570%)
Suicide	2009-11	Deaths / 100,000 population	21 (244%)

7. Fair Society, Healthy Lives, Marmot, 2010
8. http://www.countyhealthrankings.org/our-approach, County Health rankings and roadmaps, Robert Wood Johnson Foundation
9. Source – Department of Health

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We can see that health and health inequalities are interrelated with the economy, economic inactivity, poverty, social isolation, educational underachievement, criminal justice, regeneration, and many other parts of government.[10]

Access to health and social care services is of course an essential component for the population's health outcomes, but as mentioned above, there is evidence that it is not in itself as important as lifestyle and environment – the circumstances in which people live, work and bring up their children.

While much of this is beyond this panel's terms of reference, it is clear that the Department of Health needs to continue to work in partnership with other departments and sectors to tackle the underlying social, economic and environmental determinants of health across the population. Local health and care partnerships, if properly organised, can also do much through local initiatives and shared budgets to address these fundamental determinants of health and wellbeing. As a major employer, the HSC has much to contribute to 'pathways to employment' through apprenticeships and other schemes to improve employability, and the estate owned by the HSC can provide opportunities for affordable housing. The HSC can also be a leader in the 'green economy' and improve the environment in local areas.

Rising Demand

As mentioned above, the demand for health services is growing and will continue to grow, driven by demography, an increase in chronic conditions, emergence of new technologies and changing practice in health care.

Currently in Northern Ireland:

- 1 in 5 people have a long-standing health condition;
- 60% of people are overweight (37%) or obese (23%);
- Almost one in five adults in Northern Ireland shows signs of a mental illness;
- 10.3% of the population claim Disability Living Allowance;
- The population is getting older;
- People have higher expectations.

These factors are creating pressures across the system and putting increasing demands on an already stretched system.[11]

10. Marmot, 2010

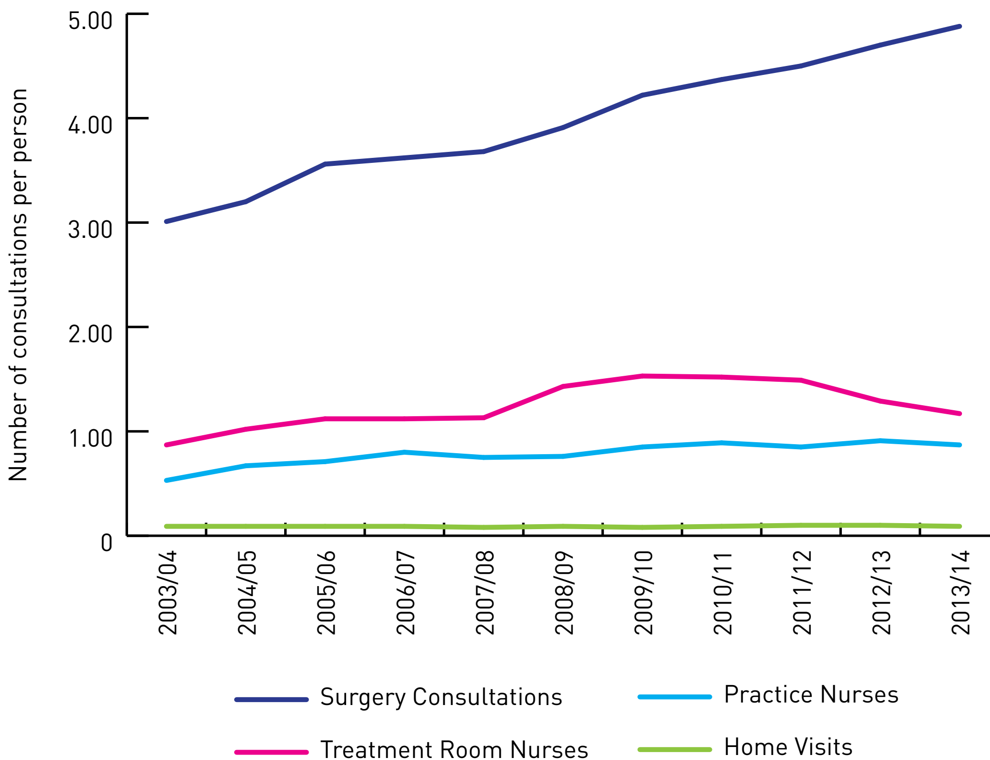
11. Source – Department of Health

Primary Care Service

Primary Care, as provided by General Practitioners (GPs), is the entry point to the Health and Social Care system for the majority of clients. Over the period 2008/9 to 2013/14, the demand for access to GP surgeries has increased on average by 21.5% whilst over the same period demand for GP Out of Hours (OOH) services has increased by 18%.

As the figure below shows[12], since 2003, there has been a steady and persistent rise in consultation rates for GPs. In 2008/9, 10.2 million consultations were undertaken by GP Practices; in 2012/13, 12.4m consultations were undertaken. This equates to an average of 6.9 consultations per patient per year in NI which is at the very high end of the spectrum compared with other OECD countries. In the south of Ireland the figure is 3 consultation per patient per year.

Fig. 7 – Consultation Rates



In conjunction with the rise in the number of consultations, there is also a growing number of complex patients who are more likely to have several co-morbidities.

12. Ibid

This rising demand cannot be resolved by the existing reactive model of care.

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Hospital Services

People who require more specialist care are referred by their GP to the acute hospital sector. In addition to this, Emergency Departments provide a 'front door' to people who either self refer or who are assessed by primary care as needing urgent care. In 2011, **Transforming Your Care** forecast that the demand for acute services could grow by around 4% per year by 2015 and suggested that without change this would require:

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 40,000 extra ambulance responses.

In fact, these estimates have proved to be a significant underestimate.
The Department of Health's figures show that:

- The number of outpatient appointments, including appointments in the independent sector, increased by almost 121,000 between 2010/11 and 2013/14.
- The number of inpatient and day case hospital admissions, including those in the independent sector, increased by almost 48,000 by 2013/14.
- The number of Category A, B and C ambulance responses increased by almost 52,000 between 2010/11 and 2014/15.
- There has been a 5.7% increase in the number of inpatient admissions to hospital over the period. However, within the overall figures, there has been a 13.3% increase in non-elective admissions.
- In 2014/15, more than three-quarters (77.9%) of inpatient admissions were non-elective compared to 72.6% in 2010/11. Such an increase in emergency and urgent admissions can impact on hospitals' capacity to meet the demand for elective care, meaning more cancelled operations and appointments, and longer waiting times as priority is given to responding to the increasing demand for urgent care. This has been a major factor in the rise in waiting lists and waiting times for elective care in Northern Ireland.

In 2014/15 the financial constraints on the public sector led to a reduction in both in-house and independent sector waiting list initiatives. As a result, the number of outpatient appointments and hospital admissions dipped slightly (although still remaining significantly higher than 2010/11) while demand continued to increase. This resulted in sharp increases in waiting times and waiting lists (see table below[13]).

13. Source - HSCB

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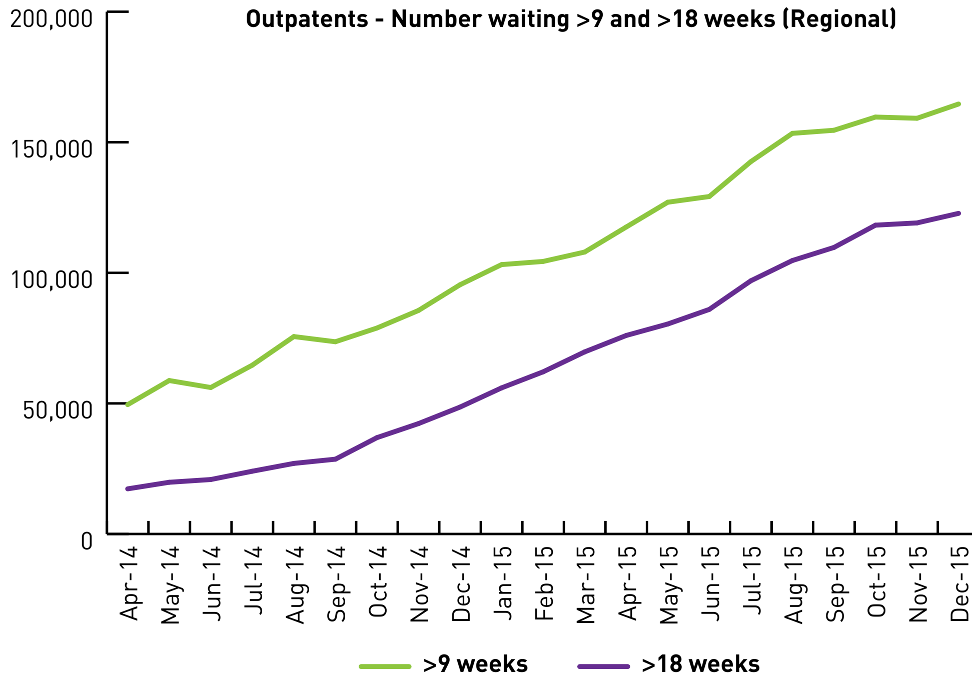
Fig. 8 – Outpatient Waiting Times



These figures more accurately reflect activity rather than demand. The increase in elective care waiting times indicates that there is further, unquantified demand for care.

As the growing waiting lists clearly show, the existing model is not addressing these challenges effectively.

Social Care Services

Although health and social care services are integrated in terms of delivery organisations in Northern Ireland there are differences between them. Provision of social care is often determined by different legislation. Unlike healthcare it is not universally free at the point of delivery with adults receiving social care being subject to means testing.

There is a far greater diversity of providers of social care than health care with very significant amounts of social care being delivered by the private and voluntary sectors. How to deliver adult social care on a sustainable basis in ways that reflect people's preferences for how they want to lead their lives is an important challenge but this has not been the focus of this report and it is understood that the Department of Health is undertaking a separate exercise to consider these issues. They are however related. The purpose of social care is to promote social wellbeing including protection from abuse, reducing social isolation and the

promotion of independence. Poor social wellbeing can have a negative impact on the quality of people's lives, including their health and in turn can have an impact on other public services, including healthcare, criminal justice and the benefits system. Social care can be particularly important in helping prevent people from being admitted to hospital and in facilitating their discharge when medically fit. Pressures on social care will inevitably have an impact on healthcare.

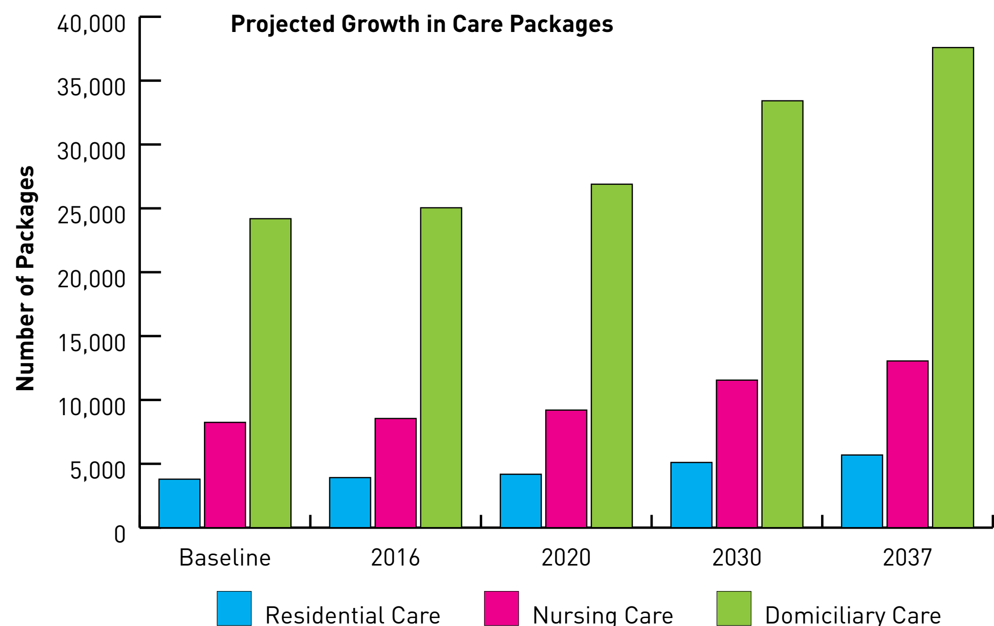
Expenditure on the Elderly Programme of Care amounts to 62% of total expenditure on adult social care services, with £543m of a total £873m being spent in this area.[14] Therefore, it is clear that an increase in the older population will require more support from the adult social care system and will require significant additional resources to adequately provide for people in need of care and support.

Using NISRA 2014 based population projections the Department of Health has carried out a crude projection of future demand for domiciliary care, residential care and nursing home care following the same growth rate as the population (18-64 and 65+).[15] The projections indicate that:

- an additional 4,050 care packages will be required in 2020 compared to current levels, an increase of 15%;
- an additional 20,101 care packages will be required in 2037 compared to 2016, an increase of 68%.

The graph below demonstrates the projected growth in the numbers of packages required:

Fig. 9 – Projected Growth in Care Packages (estimate)



14. Source – Department of Health
15. NISRA 2014-Based Population Projections, Projections by sex and single year of age (published 29 Oct 2015)

Demand and the Patient/User Experience

Of course, none of the preceding three service areas exists in isolation and any increase in demand, or lack of capacity to deal with this demand, in one part of the system has significant implications for the others.

This can be demonstrated most clearly by the impact caused by unmet demand for social care at both the front end (i.e. admission to hospital) and back end (i.e. discharge from hospital) of the system. The level of care people receive in their own community increasingly plays an important role in supporting people to live in their own homes and reducing the need for medical interventions either in a primary or secondary care setting. It also plays a fundamental role in the way the system operates by providing a way out of hospitals and a route back to the community or to an individual's home.

The sum of all this pressure is building to create a perfect storm for the entire Health and Social Care system. Patients are admitted to hospital unnecessarily because they can't access the treatment they need in their community, and, once admitted to hospital, are forced to stay longer than they need to because of the absence of domiciliary care packages to support them at their homes. This immediately causes:

- Pressures on the number of available beds;
- Unnecessarily busy Emergency Departments;
- Reduced capacity for dealing with elective/scheduled care;
- Poorer patient experience;
- Increased pressures on health and social care staff.

Ultimately, if there is insufficient capacity in social care to meet demand, this has a serious impact across the system in terms of increased GP appointments, Emergency Department attendances, higher rates of hospital admission and delayed discharges for patients who are well and ready to leave the hospital setting.

Workforce

The HSC's workforce is its biggest resource, its biggest strength and its biggest cost. Our health and social services cannot function without the commitment and skills of the people who work in them. These are also the people who have to cope at the coalface with the impact of the enormous pressures caused by rising demand.

Health and social care systems in Northern Ireland and in other jurisdictions, are reporting severe difficulties in recruiting and retaining staff. There is a growing doomsday scenario of not having enough GPs, hospital consultants and junior doctors, nurses, Allied Health Professionals, and social care staff that will inevitably lead to people not receiving the care they need.

There is also a recognised frustration among the highly educated and experienced workforce at all levels of the system with the lack of opportunities to work to the full level of competence to which they are trained.

Current health and social care models and the workforce designed to provide and implement those models are not sustainable in the long term and focus too much on a paternalistic approach based on ill health rather than working with patients towards a model of self care that is based on maintaining the health of the population. Breaking down the professional boundaries between staff and creating new generic roles is critical to providing an integrated, sustainable model of care for the population.

The transformation required in workforce will require a significant mind shift from the traditional, hierarchical and often professional silo approach to roles and responsibilities. It will require the relaxing of some of the strong and restrictive professional regulatory barriers that often delineate one professional role from another. For a workforce that maintains patient safety, professional regulation will always remain a prerequisite to protect the public from rogue professional practice.

A key message from the preparatory phase of producing this report was that without a radical review of the workforce in Northern Ireland the ambition to deliver co-ordinated care around patient need at population health level, local community level and individual level, the required transformation will not be possible.

Some of the issues and challenges facing workforce development currently in NI, as in the rest of the UK, have been highlighted in the Nuffield Trust report - Reshaping the Workforce to Deliver the Care Patients Need, 2016. They include:

- Lack of role clarity
- Lack of regulation and competency framework
- Understanding the implications of nurse staffing ratios
- Fragmentation of care
- Professional resistance[16]

Recent reviews of the service in NI (TYC, the Donaldson Review, Quality 20/20 etc.) have identified that in order to transform services fundamentally, it will require a modern health and social care workforce that can work collaboratively to meet the needs of the population.

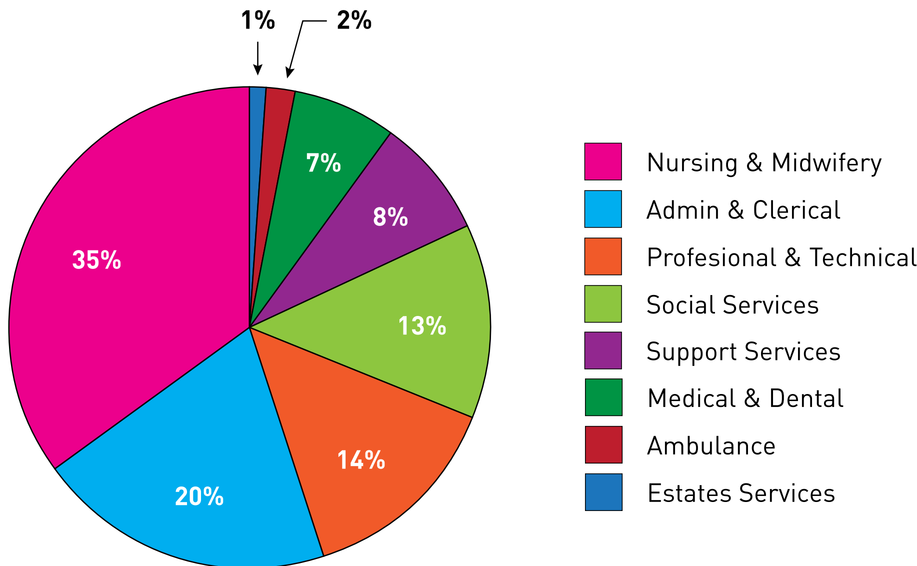
16. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

An approach to a workforce that responds to a population health model requires one of a blended nature where staff, professional and unregistered/unregulated, are recognised for the combined expertise they bring to a health and social care team that is built around the needs of patients. This will require a real shift from the current, sometimes narrow professional boundaries, to one that recognises that nurses, doctors, allied health professionals, and Health Care Assistants all have a role to play and one that focuses on having the right people in the right place at the right time to provide/contribute to the best care pathway for patients.

The success of any new service model will be absolutely dependent on staff being employed and deployed in such a way that makes the best use of their skills and which allows them to continue to develop as professionals while providing the services that users and patients need. The patient experience, and their perception of the quality of care they receive, depends in a very significant way on having well-trained, experienced and motivated frontline staff.

The HSC currently employs 54,637 whole time equivalent members of staff. The mix of staff is primarily driven by the need to support the existing care model, which is institutionally based. Comparing the most recent data with the mix of staff set out in TYC, it would appear that there has been little progress in attempting to shift resources away from this model. (See chart below)

Fig. 10 – Workforce Mix



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The Panel has found that one of the major flaws of the current medical workforce mix is that it is focused on filling rotas and maintaining existing services, even where there are clear signs that these are not sustainable, rather than on detailed forecasting of demography and need. As one professional put it, "we are currently papering over the cracks in the current system, rather than investing in long term strategic change".[17]

As a case in point, it is proving extremely difficult to recruit and retain junior medical staff to deliver services where they would be unlikely to get the experience they need in terms of volumes and case mix in order to maintain their skills and develop new skills. This is reflected in the current, highest ever level of vacancies in training posts.[17]

Locum/Agency Costs

In recent years there have also been stark increases in costs associated with locum and agency staff to provide a safe service where it is not possible to recruit to permanent positions. The Northern Ireland HSC currently spends almost £77 million on locum and agency staff across the HSC workforce and these costs have been steadily rising. This is more than it spends on the entire GP OOH service.

Fig. 11 – Locum/Agency Spend 2010/11-14/15[18]

Agency Spend (includes locums)	2010/11	2011/12	2012/13	2013/14	2014/15
Medical & Dental	23,644,956	23,093,817	32,439,996	32,558,600	38,506,733
Nursing & Midwifery	6,916,885	8,641,658	9,852,129	11,116,340	12,094,055
Prof & Tech	1,217,178	2,388,060	4,940,249	3,978,227	3,039,152
Admin & Clerical	5,002,680	6,618,493	10,915,492	10,830,821	10,561,767
Support Services	2,033,150	2,882,374	4,725,091	5,273,308	6,312,881
Estates & Maintenance	0	0	10,084	601	19,945
Social Services	4,082,394	4,620,066	5,529,989	5,819,582	5,811,160
Ambulance	140,208	89,451	140,436	101,210	135,929
Other	0	22,429	124,726	0	26,988
Total	43,037,451	48,356,348	68,678,192	69,678,689	76,508,610

17. Source - NIMDTA

18. Source – Department of Health

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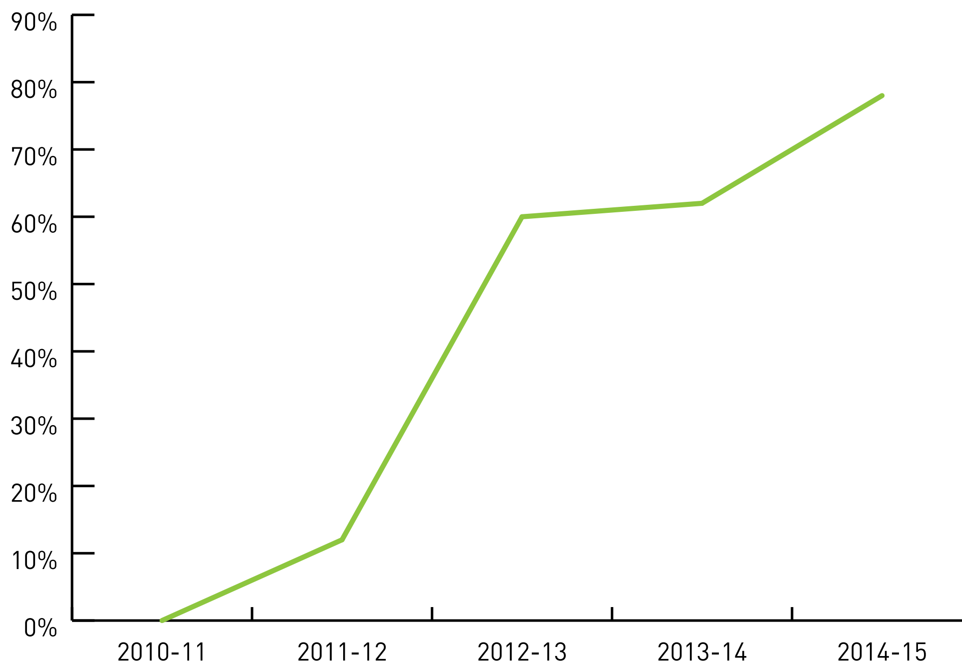
In only five years, the amount the HSC spends on agency and locum cover has increased by 78%. The panel has even been presented with anecdotal evidence that for some junior doctors, the benefits of taking on locum work have superseded the benefits of having a permanent position.

Fig. 12 – Total Annual Locum/Agency Spend Increase from 2010 Level



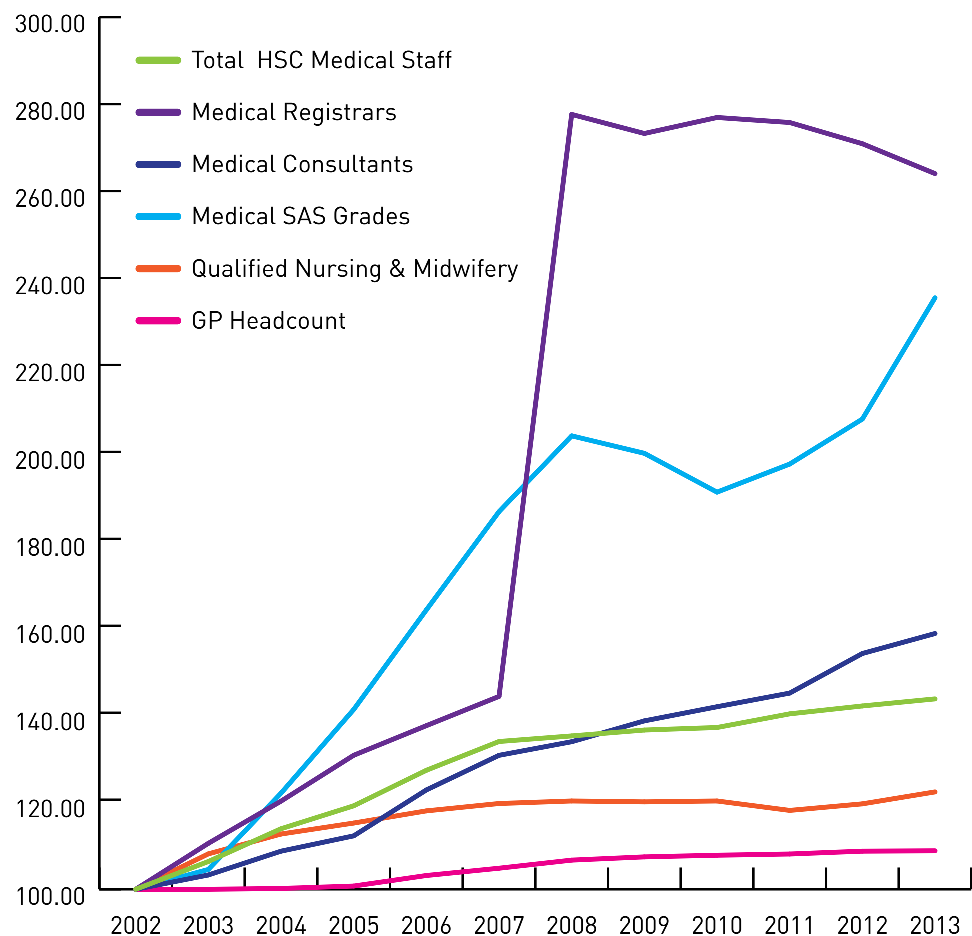
Much of the marked increase shown above is due to the high cost of filling rotas and propping up services where there is little or no chance of recruiting staff into permanent positions. It is also worth highlighting that what the system spends on locums or agency staff is money that is not available for investing in other parts of the HSC. Locums are expensive to employ and this money could be much more effectively invested in developing services that are sustainable in the long term. This would also have real benefits for staff, who would have improved professional development and job satisfaction, and for patients, in terms of the quality of care they receive and the continuity of the people delivering that care.

The locums themselves are of course not the problem, but their presence on this scale is a symptom of the structural problems facing the service. The answer is not providing more funding to try to fill these vacancies. This hasn't worked. The answer is changing the model of care to make sure that we create the right kinds of posts for all health professionals working in the system – posts that give our workforce the opportunity to use and develop their skills as part of wider teams, working together to best meet patients' needs. Many permanent staff have highlighted continuity and consistency issues in a service that relies on transitory locum and agency staff.

Primary Care Workforce

There are 347 General Practices in Northern Ireland, which are staffed by 1279 GPs. Data produced by the Department of Health suggests that the growth in the GP medical workforce has not kept pace with demand, or indeed with the growth in hospital medical staff. Furthermore, the average list size of 1641 patients per GP is the highest in the UK.

Fig. 13 - Index of Northern Ireland Medical and Nursing Workforce 2002 – 2013 (base 100)[19]



The age profile of the general practice workforce also shows that just under a quarter of GPs here are aged 55 or older, which means that many will be planning to retire in the near future.[20]

19. BMA Northern Ireland, General Practice in Northern Ireland: The case for change, February 2015

20. Ibid

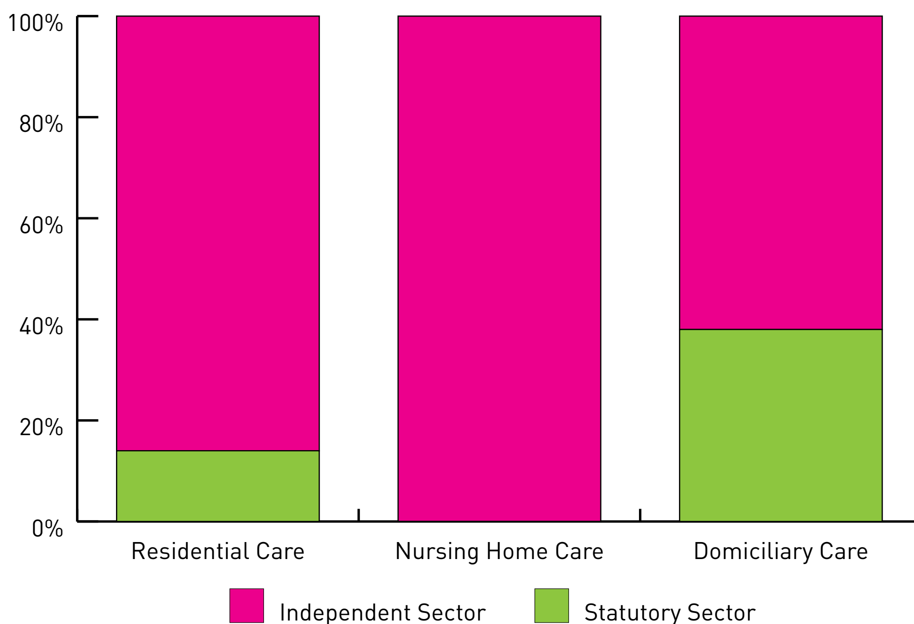
Fig.14 – GP workforce by age band

AGE BAND	% OF GPs
29-34	11
35-39	18
40-44	14
45-49	16
50-54	17
55-59	16
60-64	6
65 and over	2

Social Care Workforce

Social care is different from the other parts of the system insofar that it is largely commissioned by the HSC from for-profit and voluntary sector providers. The independent sector now provides 100% of nursing home care, 83% of residential care and 62% of domiciliary care. There is also still a significant proportion of care that is provided in-house by Health and Social Care Trusts and they and the independent sector are often put in the difficult position of competing for the same pool of staff.

Fig. 15 – Sectoral Distribution of Care Providers



Approximately 12,000 people are employed in the residential, nursing home and domiciliary care sectors.[21]

21. Can we trust the trusts? (ICHP, UKHCA) 2013

There are some significant concerns about the availability of an adequate future workforce to meet growing demographic demand. In England, for example, it is estimated that an additional one million care workers will be required by 2025.[22]

Recruitment and retention difficulties may, in part, be due to terms of employment including the use of zero hours contracts and staff being paid below the minimum wage.[23] The Commissioner for Older People has also identified the need for a well trained and registered social care workforce which is respected, valued and properly remunerated with opportunities for career progression.

In recent years, some providers have argued that the fees paid by the HSC are insufficient to attract and retain staff and that this risks creating instability, threatening the economic viability of their services. Indeed, some domiciliary care providers have already withdrawn from the market, citing affordability as the reason. Similarly, in the residential and nursing home market there have been some high profile closures, with the potential for more in the coming year.

This is a great, and growing, risk to the entire HSC. As we have stated above, if the social care sector fails to meet demand this will place enormous pressure across the rest of the system – particularly in relation to hospital admissions and discharges.

In the context of the demographic challenges outlined above, it must always be remembered that the most important, and the largest group by far, of staff delivering care services in Northern Ireland is unpaid.

Carers NI estimate that carers save the government some £2.4 billion and it is clear that the support of carers is absolutely essential in order to ensure the sustainability and viability of the system. Engaging and supporting carers is a fundamental aspect of maintaining service users within their own home and it is essential that the HSC improves its performance in this area.

22. The Future Care Workforce (ILC) 2014

23. The scale of minimum wage underpayment in social care (Resolution Foundation) 2015

Nursing and Midwifery

There are in excess of 16000 registered nurses and midwives employed by the HSC in Northern Ireland. This constitutes almost one third of the health and social care workforce in a variety of settings.

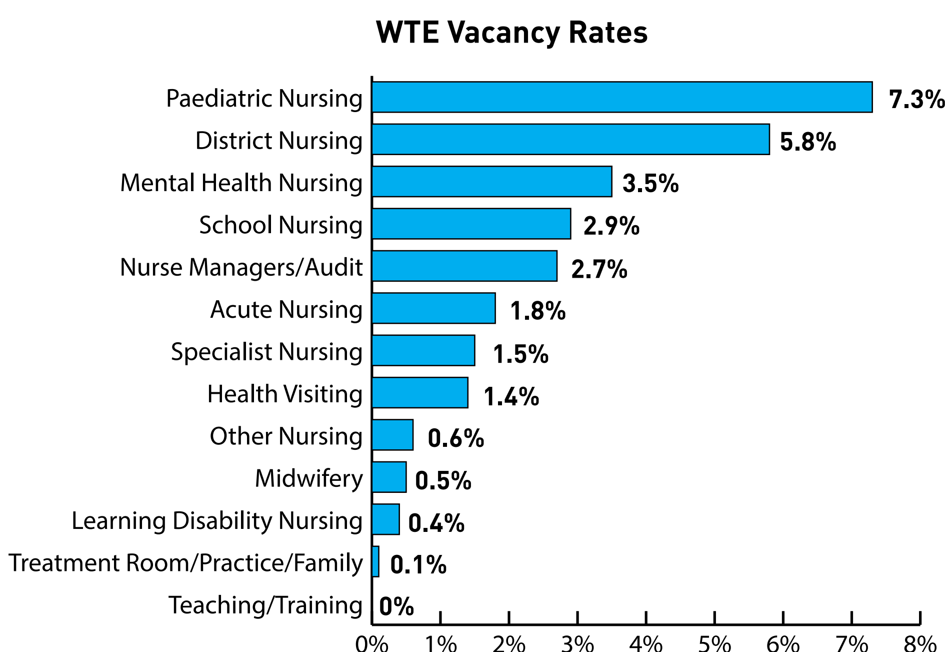
Fig. 16 – HSC Registered Nurses & Midwives as at 31st March 2014[24]

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	16,646	14,328.7

Figures from 1st October 2015 show that there were 531 (480 whole time equivalent) vacancies.

A vacant post is defined as a post '**actively being recruited to**'. The Department of Health collects data on vacancies via a survey twice a year. The figure below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.[24]

Fig. 17 – Available Vacancy Rates of Permanent Posts (based on whole-time equivalent) as at 30th September 2013



24. Source – Department of Health

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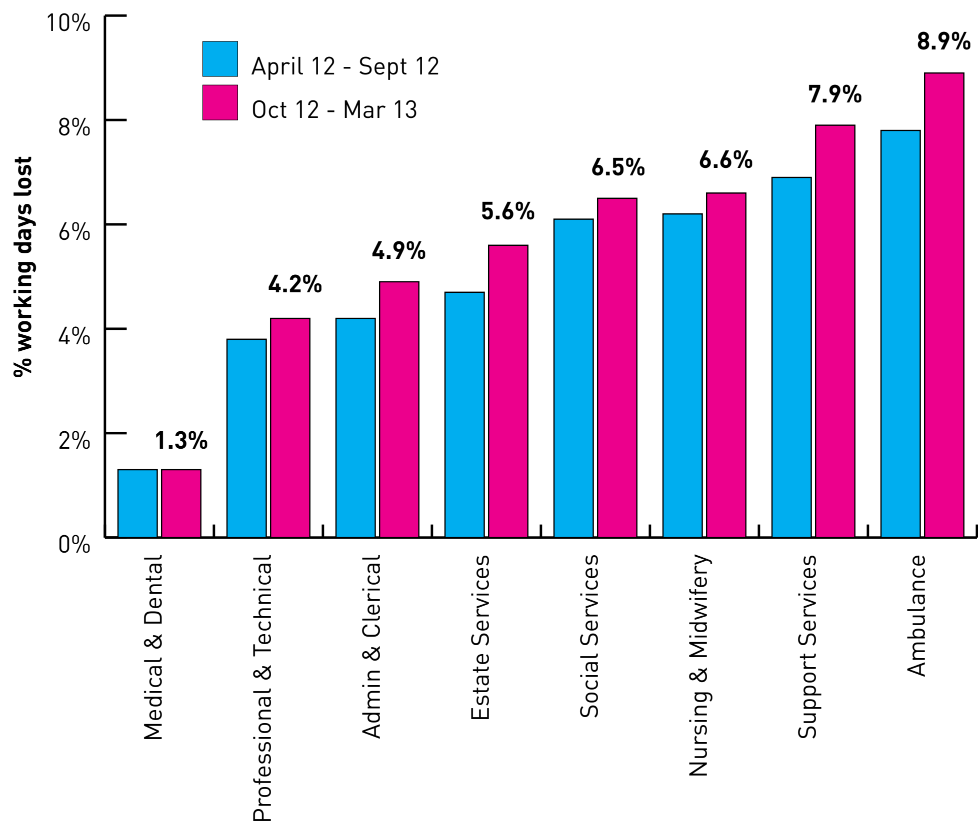
Organisations reported that they did not expect to be able fill all these vacancies. In particular, they noted difficulties at a local level in recruiting to a number of specialties, including mental health services, care of older people, non-acute hospital care, theatres, critical care, general medicine, community, learning disability and prison health. However the composition of difficult to recruit specialities varied from Trust to Trust.

In addition, the graph below shows absence rates by occupational family across the HSC. We can see that absence rates are rising across all areas.[25]

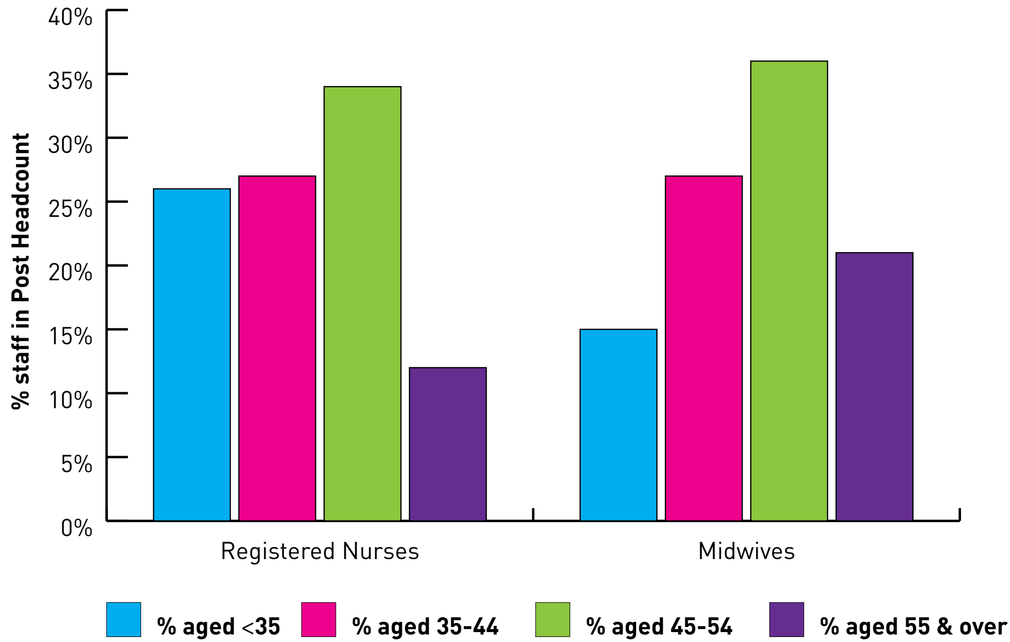
Fig. 18 – Absence Rates by Occupational Family



25. Source – Department of Health
26. Source – Department of Health

Furthermore the age profile of the nursing workforce shows the majority of the qualified staff to be above 45 years old, within a 10 -15 year period of average retirement age. The graph opposite shows the nursing and midwifery workforce broken down by age.[26]

Fig. 19 – Nursing and Midwifery Workforce by Age



Working patterns have also changed significantly. Almost half of qualified nurses are now working part time and almost two thirds of midwives.

Earlier this year, the then Minister took action to address these recruitment issues by increasing the number of commissioned student nurse places in Northern Ireland universities by 100 for the 2016/17 intake. This is very positive, but it will not impact on the service until 2019/2020. Steps are currently being taken to support a region wide recruitment process for nurses from EU and Non-EU countries.

Staff Morale

These issues are also reflected in the reported experience of staff in the HSC. In the most recent HSC staff survey, only 35% of staff felt that there were enough staff in their team to carry out the work and a significant proportion (36%) reported having experienced injury or illness as a result of work related stress. HSC Occupational Health Consultants have noted an increase in the number of staff presenting with stress related illness.

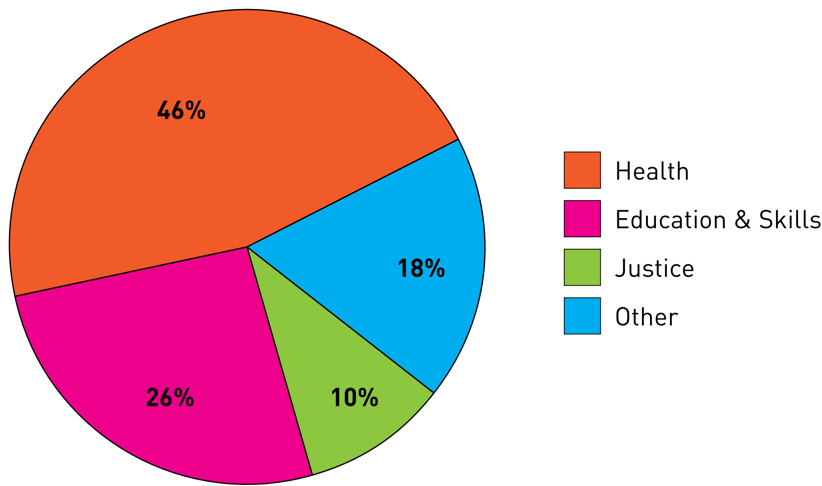
The cumulative effect of staff vacancies is ever-increasing workloads, higher risk of illness and a constant focus on the short term over the strategic. This risks creating a culture that exists by 'fire fighting' only. Innovation, learning from best practice and implementation of new systems are the unfortunate casualties of such a system. In all the encounters with stakeholders, from every part of the health and social care system, the panel have received the same message in terms of the need to invest properly in the staff that provide health and social care in voluntary, community, primary and secondary care settings.

The demands facing the current service model are putting severe pressures on the workforce. This is not fair to them or to the people who rely on them for care. Resolving this is not about money, it is about creating an environment in which staff are enabled and empowered to do the jobs they have been trained to do in a way that meets patients' needs. As the evidence above demonstrates, the current model has the patients in the wrong place and at the wrong time; this brings organisational de-motivation as staff feel unable to provide the highest quality of care to those they serve.

Financial Sustainability

As can be seen in the chart below, the Department of Health's budget is the largest among the Executive departments by some distance, with a budget of almost £4.6 billion, or 46% of the entire NI Executive spend.[27] The next largest sector in terms of budget is Education & Skills, with a little more than half of the health and social care budget.

Fig. 20 – Northern Ireland Budget by Sector



If we accept a conservative estimate of inflation at 1%, new medical developments at 1% and demand rising at 4%, then the Health and Care system as currently configured would require at least a 6% budget increase each year simply to stand still.[28]

Using this rationale, if the system continues in its current form, we can expect costs to double by 2026/27 simply to maintain current levels of performance.

Other

Justice

Education & Skills

27. OECD Reviews of Health Care Quality: United Kingdom 2016, p242

28. http://www.nuffieldtrust.org.uk/node/4190)

Fig. 21 – HSC – Projected Costs 2014/15 – 2020/21

Year	Total (£billion)	Year	Total (£billion)
2014/15	£4.6	2021/22	£6.92
2015/16	£4.87	2022/23	£7.34
2016/17	£5.17	2023/24	£7.78
2017/18	£5.48	2024/25	£8.25
2018/19	£5.81	2025/26	£8.75
2019/20	£6.16	2026/27	£9.23
2020/21	£6.53	2027/28	£9.83

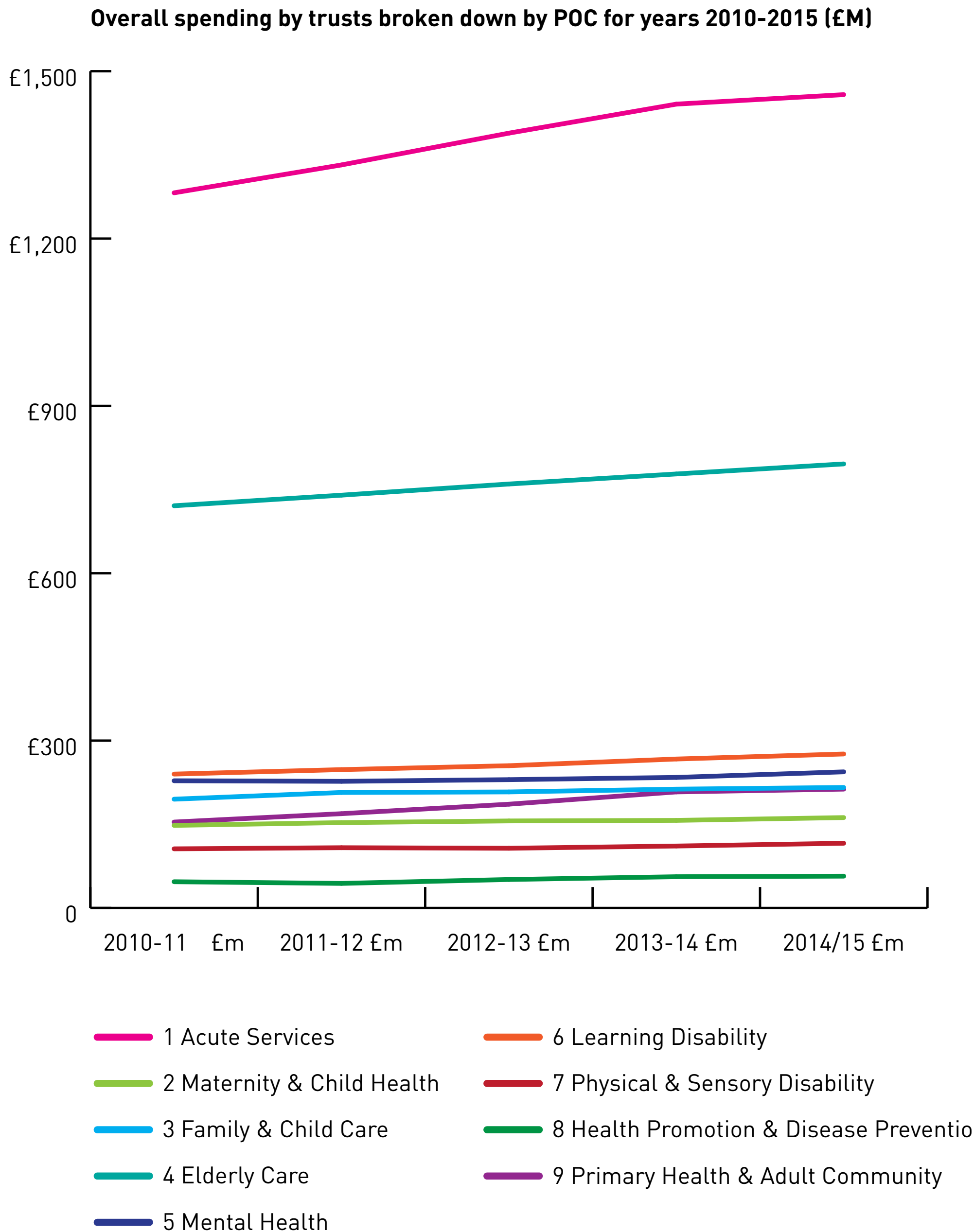
Although it is now more than ten years old, Professor John Appleby's 2005 review was an exhaustive look at how resources were being used across the system, with a particular focus on elective care and waiting times. Appleby updated his own results in 2011 and found that per capita spend in Northern Ireland was roughly 11.5% higher than in England, but that there is an 11.6% higher level of need. We can therefore draw the conclusion that the system is as well funded as other UK jurisdictions, with perhaps a very slightly lower level of funding per head once local levels of need and deprivation are taken into account.

However, Appleby's review also found significant disparities in some programmes of care. For example, according to his figures, mental health needs in Northern Ireland were estimated to be nearly 44% higher than in England, while actual per capita spending on these services was in fact 10-30% lower.[29]

These findings would support the argument that it is not the level of funding that it necessarily the problem, rather than how it is used to deliver services. If we consider the division of funding within the system by programme of care, it can quickly be seen that the majority of resources are invested in the acute hospital sector, which dwarfs all of the other programmes of care in scale.

29. Appleby, J (2011) Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12-2014/15, Department of Health

Fig. 22 – Funding by Programme of Care 2010/11-2014/15



As we can see from the graph above, spending on the acute sector continues to grow, although it is reassuring to note that the rate of increase has slowed down when compared to other programmes of care. While this may be indicative of a push by the system towards community based services, it also illustrates clearly that there is still a long way to go in making the shift from acute to community real and meaningful.

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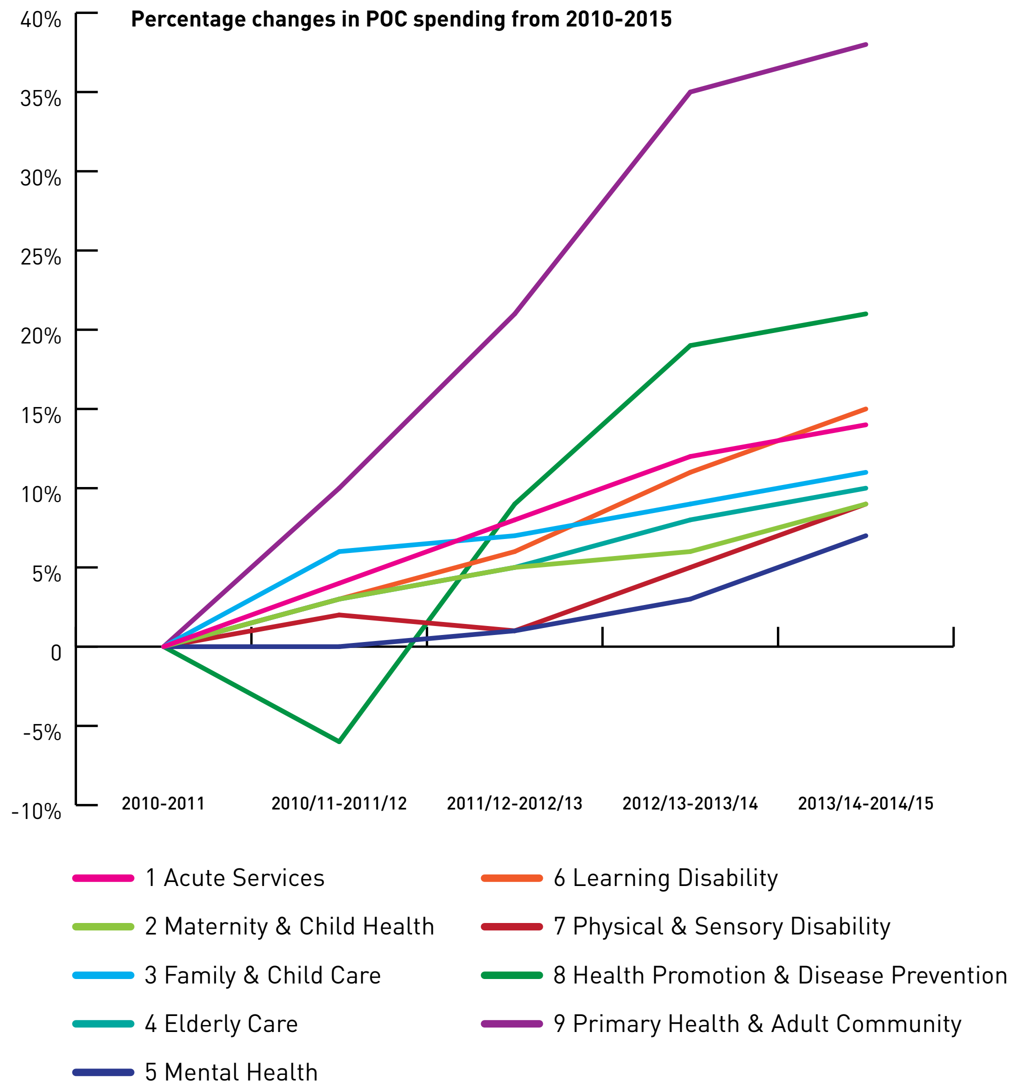
Fig 23 – Rate of Increase of Spending by Programme of Care 2010/11 – 2014/15



The OECD's report on Healthcare Quality across the United Kingdom, published in 2016, concluded that while there were examples of good practice in shifting resources from the acute sector to the community sector, there was no evidence that this was being managed systemically or strategically. Their report also concluded that funding was largely managed in silos and was often based on historical funding arrangements rather than an assessment of population need.

For a budget this size, the current one year commissioning cycle is also far too inflexible and short term to allow for any sustained investment or innovation. The Panel has heard from many sources that this prevents long term strategic planning and encourages a short term 'sticking plaster' approach to services, perpetuating the status quo rather than enabling transformation.

A real strategic approach to this will require a greater level of inter-sectoral funding, longer term commissioning cycles, and increased work across government to address the wider health determinants.

SECTION 3

VISION FOR A NEW MODEL FOR HEALTH AND SOCIAL CARE – ORGANISING FOR SUCCESS

There is an unassailable case for change. If we do not change the way we provide health and social care, the situation will only continue to get worse – the demand will continue to increase, activity will remain static and waiting times will continue to lengthen.

Following on from the evidence above, it is clear that:

- Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.
- Transformation will require key cultural and operational changes in health care systems and in the way these systems are accessed by the public.
- Something very different has to happen at the delivery of care level.
- The funding mechanisms are not currently sufficiently aligned with the need to integrate care at the provider level.
- Health and social care are not working together as effectively as they might. If they were, there would be better outcomes and reduced waste.
- Front line improvements and innovation at the provider level need to be encouraged, sustained and scaled up where they can demonstrate three outcomes of the Triple Aim.
- The workforce needs to be empowered and engaged in designing the new models of care.
- The public should be honestly informed about why change is needed. Service users should be supported and encouraged to become 'informed and expert patients' who take individual action to manage their own health and well-being.

Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.

The Panel has heard a strong sense of frustration among those working in the system, particularly from those on the front line, that the current pattern of investment which is prioritised to maintaining the current configuration of hospital

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services.

care would be better utilised in a new model of care outside hospital which better supports improved population health and well-being. The Donaldson report also identified the need to rationalise hospital infrastructure as a key part of reform.

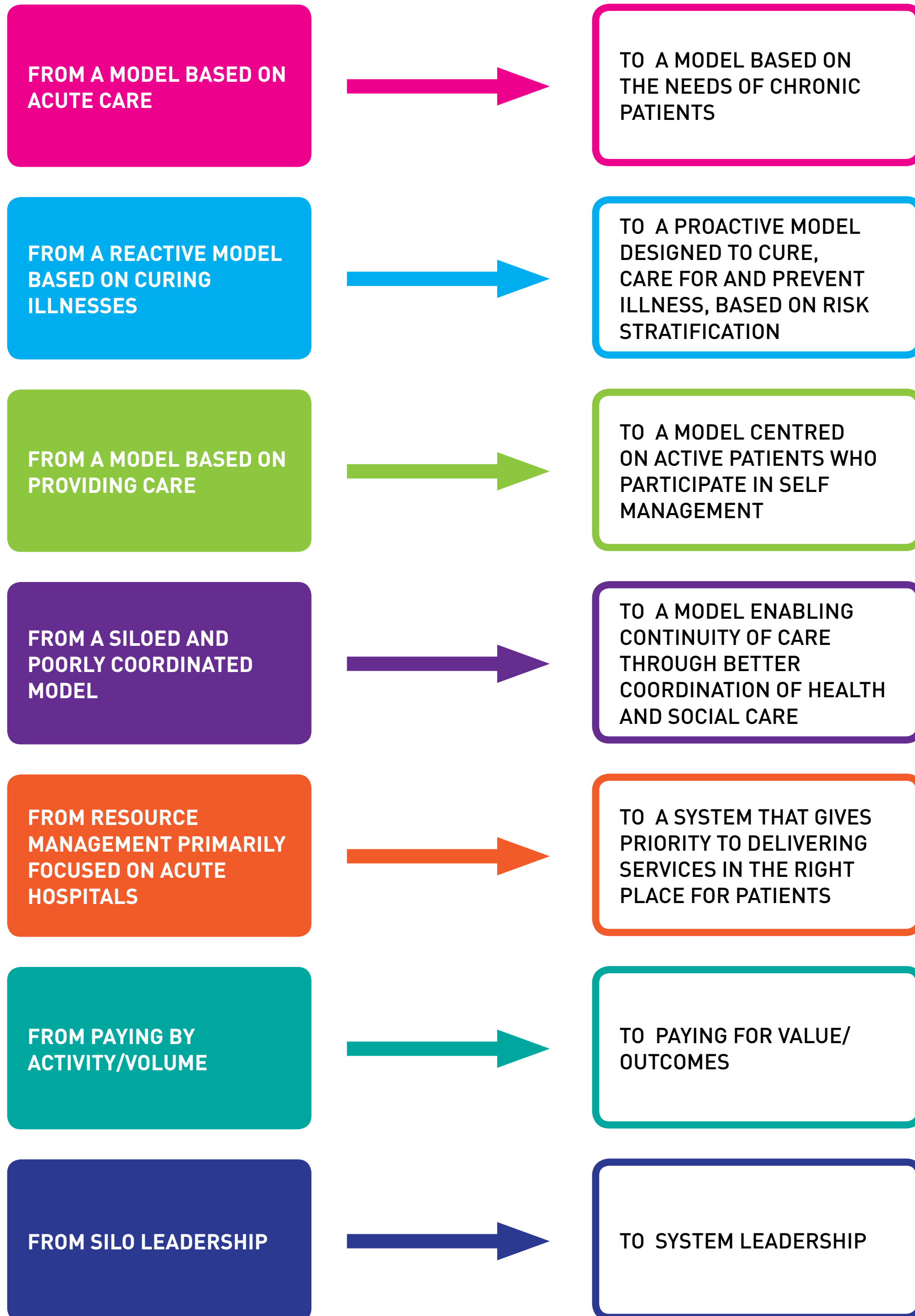
As a panel, we agree that it will absolutely be necessary to rationalise the provision of some specialist acute services as part of changing the service delivery model. As identified by Hayes, Compton and Donaldson, the current configuration of acute services is simply not sustainable in the short to medium term. As part of the transformation process, it will be necessary to reorganise services in such a way that resources are freed up from some parts of the existing model in order to allow them to be used for implementing new models that will offer higher value care. With respect to how this rationalisation is achieved, we will come back to this later in the report.

However, rationalising services is not the same as transforming the health and care system and the two should not be confused. The current overreliance on acute infrastructure is a contributory factor to the challenges facing the sector rather than their sole cause. While some rationalisation and concentration of specialist resources will be necessary to allow new delivery models to take effect, they are not ends in themselves. The meaningful transformation is in moving to a more patient centred, population health model, delivered at a sustainable cost.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services. In some cases this may mean that some buildings/hospitals will close; in others it may mean that these buildings are used in different ways to provide a more effective and responsive service to meet the local population's needs.

The table opposite shows the main ways in which the system needs to change.

Fig 24 – Transformation



The Triple Aim

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

Although health care systems internationally are different from each other in many ways, they all have the same fundamental challenges:

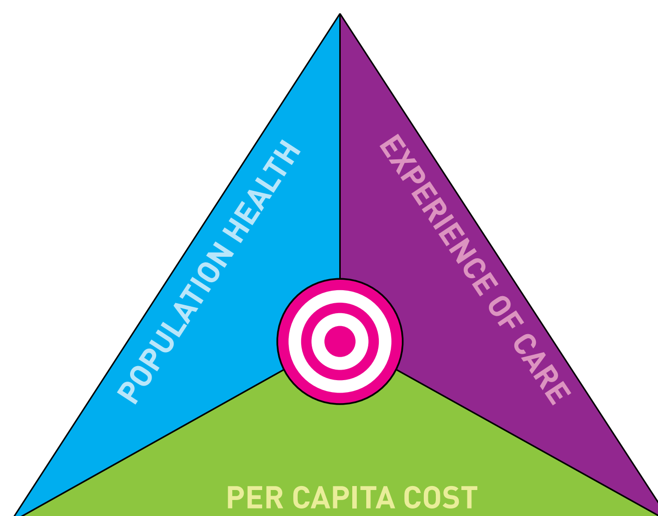
- All have sub-optimal organisation of care;
- Most are paying for volume and not for value;
- All use about 50% of expenditure on only 5% of the population;
- All have key challenges in prevention, quality and patient safety;
- Chronic patients receive fragmented and non continuous care; and,
- All could do more to reduce costly hospital admissions and readmissions.

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI). It is characterized by a simultaneous focus on three objectives:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and,
3. Achieving better value by reducing the per capita cost of health care.

Fig. 25 – The Triple Aim



The Triple Aim is perceived by many as a key framework to improve services, but it will not happen at scale unless there is a powerful policy intervention regionally as well as empowered innovation at a local level. The Panel proposes to use this framework to move forward on the broader health and social care transformation.

Of course, all of the policies and strategies in the world will not succeed if they do not pay attention to the people who deliver services on the front line. On this basis, the panel recommends including a fourth dimension (sometimes called the quadruple aim) based on improving the work life of those who deliver care.

RECOMMENDATION 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

The ongoing economic crisis in Europe has made the numerous vulnerabilities of all health care systems more visible. The immediate reaction in many countries has been cost containment. Senior leaders have reacted to this difficult immediate context by seeking efficiencies and, as a result, day to day crisis management has been centred on taking some major cost containment decisions, especially regarding human resource salaries, the pharmaceutical budget and co-payments.

However, there is a growing acknowledgement that these interventions do not correct the main problem of health care – its basic design around reactive episodic care and a weak focus on population health.

In other words, even if these crisis decisions are handled in an effective way, they do not create in themselves the capacity for health systems to cope with the future challenges of demography, chronicity, prevention, fragmentation, sustainability and patient centeredness.

Today in Europe, as well as elsewhere, most of the policy decisions in health care are not about having to decide whether to ration or to transform. Rather it is about finding the right balance of both and not letting rationalisation dominate the broader transformation. This document considers both agendas, and the Panel would recommend progressing and managing them both simultaneously.

The Triple Aim provides a new framework for a strategic response. While it may sound theoretical, it is practical in its application and has already been used to guide a number of prototypes in Northern Ireland which are already showing powerful results. We will cover some of these projects later in the document.

Advancing towards a Local Accountable Care System

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos.

The Panel has heard consistently and agrees that care should be personalised, preventative, participative and predictive. However none of those objectives can be achieved in the present reactive and fragmented system. The HSC therefore requires a new organisational form at the local delivery level, an organisational arrangement which will allow those approaches to be embedded in the culture of everyday health care.

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos. We need to move away from this hospital centred model of care to a more integrated model.

The Panel has heard of changes to the provider sector that are already being carried out to achieve the size and scale required to better manage, and indeed change, the current demand for services. General Practice is moving from the 'small business' approach to bring together Practices within larger geographies as 'Federations'. By working more collectively, it is hoped these Practices can share skills and services, manage workforce pressures, operate more efficiently and more effectively meet the rapidly increasing demand for primary care services. Services within Trusts are increasingly networking on a cross-Trust, cross-profession and indeed NI-wide basis where these services are specialised and there is a need to collaborate to meet demand. Trusts sub-contract with the community, voluntary and independent sectors for health and social care provision. There is a mix of provider models for GP OOH services.

So the provider sector – Primary Care, Trusts, 3rd sector and independent sector – is already becoming increasingly integrated and inter-dependent without structural reform. However, this is happening in the absence of strategic intent, and is operating under traditional contract models and output targets that do not support the system transformation which is required to address the challenges set out in section 2. This report proposes the development of Accountable Care Systems to integrate – by agreement, and without the need for structural reform – the provider sector to take collective responsibility for all health and social care for a given population and with a joint capitated budget linked to population based outcomes under agreement with the commissioning system to be decided by the Minister.

There are models where this collective provider model is starting to emerge. For example, the Sustainability & Transformation Plans (STPs) in England, where 44 planning and delivery systems have been set up based on geographical footprints, and charged with planning and delivering system-wide change. This will include a more integrated approach to health and well-being, self care, more proactive care for those with the most complex needs, and a smaller, more efficient hospital sector. This is all intended to both improve care outcomes and drive out collective financial deficits in their areas. Accountable Care Systems will also provide a structure for better patient engagement, empowering people to become active participants in their own care.

There are lessons learned from Accountable Care Systems elsewhere that provide evidence of the key components that can be put in place to drive more integrated working without structural reform. These are:

- Size and scale – the population footprints must be of sufficient size to manage the majority of population's care needs, to take accountability for managing variations in demand and expenditure, and to take 'internal decisions' to change the delivery of care, but also importantly to support local partnership working and risk sharing;
- A defined population where the new model of care can be delivered at pace, focusing on the stratified risk of that population – already available in General Practice if this information is collated and shared;
- New working arrangements, including shared leadership, shared accountability and devolved budgets, development of new roles to push the boundaries of the skilled but not qualified workforce and the 'generic professional case manager', and a partnership approach with the 3rd sector to deliver a more standardised service offering within local communities to reduce loneliness and isolation, improve well-being and to provide high quality care;
- New support tools, including shared information, accessible patient and client records, and a capitated funding system that incentivises an integrated provider response;
- Service user engagement, at population, service and individual level;
- Cost and quality measures which are measurable, comparable and outcome based.

Under an ACS, providers would collectively be held accountable – under a shared leadership model – for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk share arrangements and incentives. They would also need to have maximum autonomy to make rapid and sustained changes to improve care and outcomes for the population they serve.

Of course, not all services will be amenable to this model. Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level – to ensure specialised resources are concentrated on a small number of high volume sites, that they are sustainable in the long term, that inefficient duplication is avoided, and that they can be supported and incentivised to innovate and to develop world-class treatment.

Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level

Transformation to deliver the Triple Aim will also require a new approach to the commissioning and delivery of care. The Department of Health carried out a review of commissioning in 2015 and found that the current system was complex, slow to take strategic decisions, unresponsive and with too much emphasis placed on

activity/volume over value/quality. The current commissioning model has also failed to effectively shift accountability to the provider level and this has led to an overly transactional approach. It is worth highlighting that the lack of a devolved budget and insufficient autonomy have been identified in other jurisdictions as key reasons why some population based models have not achieved their potential.

RECOMMENDATION 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,
- Regionalised planning for specialist services.

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations.

Building on Existing Foundations

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations. The Panel believes that many of the key elements of a more integrated organisation, such as Integrated Care Partnerships as 'learning labs' for what will make integrated delivery systems work best and the emerging GP Federations, are already in place, but these building blocks need to be taken to the next level and be fully enabled with devolved autonomy and incentivising funding mechanisms linked to measurable population outcomes in order to truly become local Accountable Care Systems.

Furthermore, Northern Ireland has already made real progress in establishing an array of management and organisational processes, all of which help to provide the tools needed to move forward quickly. However these need to be further developed and strengthened in the following ways:

Adding Depth to Structural Integration of Health and Social Care

The formal integration of health and social care should be a key strength of the existing system and will provide a strong foundation to pursue reform. However,

in practice, the benefits of integration have not been fully exploited and it would seem that there are still significant administrative silos that prevent this happening. Integration in name only is not enough and if the Panel's proposed model is to be successful there has to be better integration between all parts of the health and social care system. This level of integration will require a great deal more work on how the system plans, funds and purchases care across acute care, general practice and community health, and social care provided by statutory, independent and community , voluntary and charitable providers.

The development of the Accountable Care Systems suggested in this report will greatly reinforce the necessary health and social integration on the ground.

The primary function of social services is to improve and protect people's social wellbeing when it is vulnerable. Social wellbeing refers to the extent that people are socially connected, engaged in purposeful activity, in control of their own lives and are protected from abuse and exploitation. The primary reasons to promote and protect people's social wellbeing are because it is essential to people's quality of life and it safeguards people's human rights. However not surprisingly there is also a strong relationship between people's social wellbeing and their health. This is one of the main reasons integration between health and social care services is seen as a desirable feature of healthcare systems.

The health impact of better integration between health and social care services is reinforced by more and more studies. The impact of social factors such as income, educational attainment, access to nutritional food, good quality housing and employment status is well documented. There is a growing evidence base and literature about the importance of social determinants of health in improving the health of populations. The relative contributions of genetics (20%), health care (20%), and social, environmental and behavioral factors (60%) are well documented.[30]

Northern Ireland is better placed than others to continue reinforcing the combined action of health and social services. The move to local integrated systems of care will provide an even better platform for this happen. However it can also present challenges.

When difficult funding decisions need to be made it can be difficult to secure investment in social services when faced with competing demands for healthcare investment. However there is a strong economic rationale for investing in social interventions.

The increasing use of new commissioning models (payment models) will be a key lever towards improved health and social integration. New payment models that hold these local integrated care organisations accountable for people's health and the cost of treatment can be used to maximise the benefits of integration. A focus on holistic outcomes that includes the promotion of social wellbeing and penalises outcomes that undermine it, such as unnecessary hospital readmissions, will make the health and social care system more sustainable and more importantly improve people's quality of life.

30. Chiu, G. et al. (2009) Relative contributions of multiple determinants to bone mineral density in men. Osteoporos Int, 20(12), 2035-2047

Payment schemes such as these would give these local organisations an economic logic to incorporate social interventions into their approach to care.

Targeted programmes can link individuals with chronic conditions to social support schemes. For example, community health workers can conduct home visits to low--income families with children with uncontrolled asthma. There are examples in which this type of intervention has reduced the use of emergency care by two thirds.[31] Managerially the children in such a scheme would be identified by a risk stratification approach in a community. This type of intervention is a practical example of targeting inequalities in a community as the targeted group are children of low income families.

Furthermore it makes economic sense as unmet social needs are associated with higher rates of emergency care, hospital admissions and readmissions. A recent study found that the 10 health conditions that accounted for the highest health care expenditure are linked to unmet social needs. These include heart disease, mental disorders, asthma, diabetes and hypertension.[32]

There are therefore numerous reasons for this integrated approach to become progressively the standard of care in Northern Ireland.

Expanding and investing in eHealth infrastructure

eHealth is a broad concept, defined as the use of electronic means to deliver information, resources and services related to health.

Data and enabling technologies are vital components of a modern healthcare system. We hold large amounts of information on behalf of our patients and we need to look after this, but we also need to use it as effectively as possible to deliver improved outcomes for individual patients, for the wider population, and for society as a whole.

The introduction of the Electronic Care Record (NIECR) has revolutionised the way health and care can be delivered by providing care staff with an up-to-date record that avoids duplication of tests and information gathering, and allows information to be used in ways that can lead to better decisions on prevention, treatment and care.

However, while a great deal of good work has already been carried out, much of the data that is held on patients is inaccessible to other systems within the HSC; it exists in data silos that do not communicate with other core datasets. More work needs to be done in terms of linking these systems and increasing interoperability. The Department of Health and the network of Chief Clinical Information Officers are in an ideal position to lead in setting the direction for eHealth, and in ensuring engagement from the wider clinical community.

31. Greineder, DK, Loane KC, Parks P (1999) A randomized controlled pediatric asthma outreach program. J Allergy Clin Immunol March 1999;103(pt 1):436-440
32. Agency for Health Care Research and Quality. DHHS . USA . 2011 - Medicla expenditure panel survey

Northern Ireland should continue to invest in this area, with the ultimate aim of providing patients with ready access to their own records. A conversation with patients and their representatives may also need to occur to discuss how the system uses HSC data and linked public sector datasets in medical research, population health planning and infrastructure development.

Patients should also have the right to see their own data and the system should move towards greater openness and access. This would allow patients to see this information and use it in managing their own health needs.

Advances in telecare, telemonitoring and electronic assistive technologies are also making a significant difference to the way services are delivered. Used effectively, they can make a valuable contribution to the quality of services by improving coordination of services, overcome geographical distances between patients and providers, enabling patients to live independent lives for longer, and engaging patients in their own health and well-being.

In a population health model such as that proposed by the panel, data, analytics and new technologies are key enablers in driving clinical innovation, and also in supporting patient self management and health ownership.

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Northern Ireland is in an ideal position to take advantage of opportunities in eHealth, and position itself as a global leader in this field. There is a single HSC system, a collaborative network of organisations, engaged patients, two high quality universities and a thriving commercial IT sector. The Health and Social Care Board's eHealth strategy, which was published earlier this year, sets out how the HSC will work with industry, academia, the community and voluntary sector, other public sector bodies and government departments, and international partners to further develop uses of e-Health as a driver to improve health, well-being, prosperity and job creation.

Developing the Workforce

In addition, the health and social care system here has a powerful and expert workforce.

Despite the challenges, Northern Ireland already performs strongly in many aspects of health and social care delivery and, building on the strong foundation of its integrated workforce, has the existing capacity and capability to continue to lead the way in developing and implementing new and modern care pathways.

However, reconfiguring health and social care services will depend on the ability to reshape the workforce to support the new models of care.

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An effective workforce where skills and competence are aligned and support new service models needs to have as its key aims:

- The improvement of quality;
- Financial efficiency;
- The long term health and wellbeing of communities.

Having the right number of appropriately skilled staff is a critical determinant of the quality and efficiency of the health and social care system, yet there is a growing and recognised gap between patient needs and the skills and knowledge of the workforce that cares for them.

While across health and social care systems here, as in other countries, organisations are reporting severe difficulties in recruiting and retaining staff, it is also recognised that there is a frustration among the highly educated and experienced workforce, of the inability to progress to the level of competence to which they are educated.

Integration of health and social care should permit easier transferability of staff and skills across the clinical and non-clinical workforce but this will require a shift in our approach to traditional workforce boundaries, restrictions and jurisdictions.

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There is also a clear need to invest not only in the immediate and short term future workforce but also on the pipeline for the longer term.

In Northern Ireland there is a real opportunity to adapt the current nonclinical workforce to meet the growing needs for patients to remain at home in local communities. There is an emerging body of evidence that shows that integrated workforce models configured around defined populations support improved population health outcomes, a better care experience, and also a reduction in the per capita cost of health care.

Immediate actions need to be taken to support the workforce to continue to deliver high-quality care to patients, clients and carers through this period of transformation. The Panel suggests that work is commenced to remove the artificial governance barriers that make role developments difficult to achieve and therefore the transferability referred to above difficult to attain.

For this to be successful, the HSC will need to:

- Put in place strong supporting systems and governance structures, including supervision of new and extended roles;
- Create a culture that supports experimentation and change; and
- Cultivate good relationships with local workforce and training bodies.[33]

33. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

Within primary care in Northern Ireland there is a need to move from the predominantly GP led model of care to a more blended approach that accommodates the rich range of professionals working in partnership to meet the needs of the practice population. This can create a robust, extended primary care team serving a local population level, including Nurses, Doctors, Allied Health Professionals, Health Care Assistants, Pharmacists, Mental Health Professionals and Social Care workers all have a role to play in improving the service offering delivered by primary care, with an increased focus on prevention and early intervention and the active management of complex patients to support them to better manage their conditions.

In order to achieve this, it will be necessary for those at the head of the HSC to create a safe environment for local innovation. This means the workforce is not only engaged for clinical purposes, but also organisational and managerial innovation.

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A recent Vanguard document **"New Care Models and Staff Engagement: All Aboard"** draws out an approach to ensure staff are at the heart of decisions about new models of care.

This approach includes:

- Enabling different groups of staff across organisations to "break down the barriers" – to allow them to break out of old working patterns and think differently.
- Recognising that those on the front line of care have the best ideas about how to improve it – but also that they need to feel empowered to do so.
- Recognising that if staff feel that their contribution is valued, they will want to do all they can to make new care models a success.

The panel strongly believes it will be essential to reinforce this work and to invest heavily in staff engagement.

Improving Quality – Frontline Innovation

Quality improvement has taken on increased importance internationally in recent years. Drawing on the successful practice of 'improvement science' which was first applied in manufacturing and industry, a number of countries have sought to adapt this and apply the principles to health and social care services. To date, there have been some impressive results with this approach in areas such as Qulturum, in Sweden, Ko Awatea, in New Zealand, and Healthcare Improvement Scotland.

In Northern Ireland, the Panel has seen impressive examples of innovation and improvement going on across the HSC. However, it is also clear is that there is a lack of capacity and capability to scale these projects up and to sustain them across the system. While the Quality 2020 strategy shows that there is a clear

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While the Quality 2020 strategy shows that there is a clear commitment to quality improvement at the top of the organisation, it is not clear that this has pervaded the HSC to the extent that it can be considered to be part of everyday business.

commitment to quality improvement at the top of the organisation, it is not clear that this has pervaded the HSC to the extent that it can be considered to be part of everyday business. The Panel was told that "quality improvement is still viewed as peripheral, an activity for a small number of HSC staff". This may be a reflection of the operational pressures in the current system, which restrict opportunities for staff to become informed and experienced in improvement methodology.

A new approach may be required to support staff across the system to adopt a 'right fit' methodology dependent on their need for improvement, whether this is to:

- Do it right – standardising/removing variation to improve efficiency;
- Do it better – improving existing systems to achieve better performance;
- Do it differently – innovate and change existing systems to improve outcomes.

The previous Minister announced that the Department of Health would develop plans for an Improvement Institute to drive forward innovative improvements in how health and social care services are delivered. The intention is that this would be able both to build on the emerging improvement and innovation hubs in each Trust and to bring them together regionally, but also to support individual professional and managerial staff to develop their skills and expertise in leading and delivering innovation and quality improvements and to share these skills and expertise with others.

The Panel would endorse this approach – any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user voice represented as part of this. The purpose of the Institute should be to create the conditions in which this improvement becomes the norm, from the bottom of the organisation up and the top of the organisation down.

Health and the Wider Economy

Health and social care is a significant part of Northern Ireland's Gross Domestic Product and it accounts for a sizeable proportion of jobs and public spending. A report by the Economy and jobs initiative task and finish group found that:

- Annual spend in the sector is £4.5 billion, with capital expenditure of £200 million.
- Staff employed within the Health and Social Care sector account for 9% of all employee jobs in Northern Ireland.
- The Health and Social Care sector creates approximately 10% of the total economic output of Northern Ireland.

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Economic discussions about the HSC most commonly focus on the cost of running it. However, we should also recognise the enormous contribution it makes to the Northern Ireland economy.

Northern Ireland has previously been described as "small enough to be agile but big enough to matter." If the health and social care sector here can lead the way in transforming how services are delivered, then it has the potential to be a world leader in developing innovative services and products. The proposed new model, based around Triple Aim, would help to support healthcare market opportunities for Northern Ireland going forward, particularly in terms of the range of enabling technologies and processes that need to be developed to meet modern patterns of demand.

Any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user voice represented as part of this.

RECOMMENDATION 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in eHealth to support improved self management, care at home and use of information to drive better population health outcomes.
- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).
- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.
- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

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Emerging Practices

In addition to these areas where work is already ongoing, there are some emerging processes which the HSC may wish to explore and adopt.

Value Based Care

This Panel considers the present resources would be better used in a value based care model. This report strongly recommends Northern Ireland should start taking this route as the short term changes will in themselves be insufficient to provide a high quality and sustainable health and social care system.

A value based model in Northern Ireland would need to reinforce an integrated primary and community health and social care delivery model so that more can be done out of hospitals, encouraging work across organisational boundaries, as well as strengthened primary care sector in order to effect a shift in the balance of care. This will involve paying for value instead of simply paying for activity, accelerating home care technological support schemes, and improving coordination with the voluntary, community and independent sector as true partners in care.

This process has the potential to harness the strengths of different parts of the system, across organisational silos, across sectors and beyond what is traditionally considered to be the health and social care sector.

Co-Production

The relationship between health and social care professionals has changed significantly in recent years. There has been an increasing acceptance that people who use services and have healthcare needs will have views on how they should be treated as individuals and as groups who have interests in services. It is now recognised that people should be treated with respect and listened to and that major changes to services should be consulted upon.

Co-production describes an approach that takes this changed relationship to a new level. Co-production involves breaking down barriers between professionals and the people they serve, recognising people who use services as assets with unique skills. It involves a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.

There is a difference between co-production and participation: participation means being consulted while co-production means being equal partners and co-creators. The benefits of adopting co-production include delivering change that is owned by service users rather than being resisted by them and designing services that reflect the knowledge and expertise that comes from using services.

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SECTION 4

ROADMAP FOR IMPLEMENTATION

Creating a Compelling Vision

Together, all of actions set out above will strengthen services in the community so that more can be done out of hospitals, encouraging work across organisational boundaries, as well as with strengthened primary care in order to effect a shift in the balance of care.

This is of course the strategic direction of travel that was outlined in Transforming Your Care – and it is still the direction that the system needs to move in. However, as the previous pages indicate, the Panel feels that we need to go much further. There is now a significant body of evidence internationally to show the elements that are necessary to achieve this kind of transformation, and also to demonstrate that this kind of strategic shift can produce better outcomes for local populations.

However, in order for this to happen, all these approaches need to be aligned around a common vision of transformation and not be a series of isolated initiatives. The Panel has concluded that at least part of the reason that TYC has not been the success many hoped, is that it became just one initiative among many and not the overriding strategy guiding the entire organisation's decision making.

However, in order for this to happen, all these approaches need to be aligned around a common vision of transformation and not be a series of isolated initiatives.

For these reforms to be successful, they have to become the strategy for health and social care. It will not be enough for senior managerial and clinical leaders to pay lip service to the concepts outlined here, they must underpin every decision that is made and every new policy that is developed. The Minister will need to take some time to consider what this vision will be and how it will be communicated to staff and to the public. The Panel hopes that this report will help to provide the foundations for this vision.

RECOMMENDATION 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

Components of Transformation

Transforming the HSC is an enormous and complex task that will need to be progressed steadily over at least the next ten years and which will require a combination of change strategies. The Panel has identified three separate components for practical implementation:

1. **Driving the system towards Accountable Care Systems**
2. **Aggressively scaling up good practice**
3. **Rationalisation and stabilisation**

The HSC operates within a parliamentary democracy and as the political context cannot be avoided, it must therefore be managed.

While each of these stages has a different lifespan, they are all urgent, they are all connected, and they should all be launched simultaneously.

The mid-term goal is to establish new accountable care systems. The second component helps to create the conditions for the new delivery model by scaling up good practice where it is consistent with the overall vision. The third component does not change the model of care, but it is necessary to free up resources to allow the system to transform.

1. Driving the system towards Accountable Care Systems

This is a mid-term agenda, but it must start now.

The political context is of critical importance in any transformation process, as is the impact of politics on shaping the environment governing large-scale change. The Panel has frequently heard that there is a need to remove health from politics but in reality the importance of politics is a feature of all health systems and can ultimately determine whether and how far large-scale change succeeds or not. To paraphrase Tip O'Neill, the former House Speaker in the USA, all politics is local and this is nowhere more apparent than in decisions about local health services. The HSC operates within a parliamentary democracy and as the political context cannot be avoided, it must therefore be managed. Those seeking to introduce change, need to provide compelling evidence for why the change is necessary and a clear sense of the benefits the new model will offer.

The longer term demands of transformation are especially acute since electoral cycles often militate against long-term change. Results are looked for in the short term and this is especially evident in the type of change favoured which tends towards short term impact rather than long term reform.

If a health system transformation is going to thrive, it will require supportive policies that incorporate longer time horizons[34] with regular milestones to build confidence in the direction of travel. The work on the Principles carried out with the local political parties in a political summit earlier in the year was intended precisely to help future implementation and help to get beyond those short timeframes that drive output targets (principles at annex 1) by demonstrating the need for long term and sustained reform that will deliver improvements in population outcomes.

The Principles helped to create the right environment but much more needs to be done to reinforce and strengthen that environment.

As stated above, one absolutely fundamental component in creating this environment is the development and communication of a clear vision for health and social care and a robust implementation plan to deliver it.

The task in the mid-term is to transform the model of care in Northern Ireland. This has been indicated in previous reviews. All stakeholders interviewed by the Panel agreed with the need to drive towards new models of care but they called for a stronger implementation agenda.

To this end this Panel offers an approach to implementation for these mid-term changes. These actions should start now. Northern Ireland is investing a considerable amount of resources into health care but the present payment and delivery system will not create the organisation of the future.

Northern Ireland has the scale and capacity to do this. However this transformation will not happen at scale unless there is a powerful policy intervention. It needs to be conceived and implemented as an integrated package.

We therefore propose a series of time bound actions linked to the three dimensions of the Triple Aim framework which will take the health and care system in Northern Ireland to a population based model of care. Following on from the work of Sikka, Morath and Leape, we also suggest adding a fourth component – that of the health and care professional's experience.[35]

Northern Ireland is investing a considerable amount of resources into health care but the present payment and delivery system will not create the organisation of the future.

RECOMMENDATION 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing each of the following actions should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

34. Halfon N & Conway P (2013) The Opportunities and Challenges of a Lifelong Health System N Engl J Med 2013; 368:1569-1571

35. Sikka, R, Morath, J, & Leape, L (2015) The Quadruple Aim: care, health, cost and meaning in work

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Population Health

- Some work on risk stratification has already been carried out at General Practice level. This should be built on to introduce a comprehensive, system wide approach to risk stratification in of the entire NI population.

- Governance arrangements to be developed for new Accountable Care Systems (ACS), including integrated capitation budgets based on the services (excluding the most specialised services) required by the population served by the ACS to be devolved to these new autonomous and accountable provider partnerships.

- Starting immediately, progressively phase in early adopter accountable care systems, bringing together the provider sectors for a defined population into a single accountable leadership. The ACS would be responsible for utilising a capitation based budget across organisational and professional boundaries including local infrastructure to achieve agreed improvements in population outcomes.

- The Programme for Government is moving towards outcome based measures to judge the impact of political decisions and the use of public funding on the population, and the success measures for the new ACS should also be outcome focused, and should be measures of population health with priorities for improvement. The Panel recommends the development of a relatively small set of outcome based metrics which set the challenge for the new Accountable Care Systems.

Patient Experience of Care

- The use of co-production as an approach should be mandated in accountable care systems and service redesign.

- Provide the population with individual access to their health and care information.

Per Capita Cost

- Introduce new cost and quality measures which are measurable, comparable and outcome based.

- Start the process of paying for value and not only paying for activity. By the year 2020, 50% of the budget should be commissioning value.

- As new value based commissioning approaches are implemented and local integrated organisations take form, ensure that the metrics being used include combined social and health indicators.

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- Move to a rolling three year budget cycle to allow for more strategic commissioning/planning of services.

Staff Experience

- The Department to lead on the development of an 8-10 year workforce strategic framework, aimed at identifying immediate workforce challenges and planning the workforce to meet the demands of the new delivery model.
- New workforce models to be designed around defined populations and associated care functions. This should include enhanced roles for the skilled but not qualified workforce.

RECOMMENDATION 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

The transformation process will take years, and must be sustained over the longer term. The political administration can expect some short term results from the process but must create a mid-term strategy which is sustainable over time.

RECOMMENDATION 7

For this purpose, the panel recommends the creation of a transformation board, supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.
- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

2. Aggressively Scaling up Good Practice

Not only does Northern Ireland have many of the elements that are necessary to allow it to move forward, it has numerous examples of good practice that are consistent with the overall vision described above. Many of these could simply be scaled up and implemented on a regional basis where they will drive the system change and improved population outcomes set out in this report.

Targeting Mental Health

Implementation of the Rapid Assessment Interface and Discharge Project

This project was developed in recognition of the fundamental role that mental health plays in promoting and sustaining positive physical health. There are strong relationships between presenting physical ill-health and underlying mental health problems and by addressing these needs we can support better health outcomes and recovery rates.

The Rapid Assessment, Interface and Discharge Team (based on the Birmingham RAID model) is a multidisciplinary mental health team based in an acute hospital setting. It brings together diagnosis, treatment, psychosocial and psychological based approaches to ensure the best outcomes for patients. The service is a specialised multidisciplinary liaison psychiatry and psychological medicine team that provides rapid, timely and high quality interventions to promote the recovery and well-being of patients who present at Emergency Departments and/or are admitted to general hospitals.

The service replaces the multifaceted approach to mental health referrals with a single point of contact for all mental health referrals. The team operates 7 days per week and over 24 hours, responding within 2 hours to all Emergency Department referrals and within 24 hours to routine ward based referrals or quicker if deemed necessary.

Whilst the Northern Trust RAID is a hospital based service, one of the key benefits of the service is its ability to outreach into the community and to act as a conduit to mental health services. Improved communication with community teams such as community mental health teams and Older Persons Teams have supported discharge planning within wards and support earlier discharge from Hospital. There is enhanced communication with Primary Care and GP's are provided with a report, in respect to RAID involvement.

This innovative model has required a new way of thinking and approach to service delivery. It has required staff who previously worked on their own to adopt a different way of working which included; working as part of a strong cohesive team, working across organisational boundaries, and working shifts for previous 9am-5pm workers.

The RAID concept has been evaluated by the London School of Economics in Birmingham. This has shown reduced length of stay and enhanced discharge processes. Early indications show similar emerging patterns in Antrim Area Hospital. RAID input has also contributed to the reduction of emergency hospital readmissions within 30 days, thus reducing the overall cost of care.

Dealing with Chronic Conditions

An Integrated Respiratory Service

Within the Western Health and Social Care Trust in 2013, deaths due to respiratory diseases accounted for 16.2% of the total number i.e. 2% higher than the NI average. In addition, the majority of deaths occur in the elderly population and this is therefore expected to rise. This has implications for service provision, including an increased need for social and emotional support, especially for those patients with chronic respiratory diseases and their families and carers.

Having mapped existing services and reviewed good practice elsewhere, it was decided to create a WHSCT Integrated Respiratory Service that would enable patients with a chronic respiratory condition to be cared for in the most appropriate setting, by the most appropriate person, with access to specialist respiratory advice to enable the patients to achieve maximum health and improved health outcomes.

Previously patients with a chronic respiratory disease may have received care from a diversity of core services and this contributed to confusion for patients, duplication of services, inconsistency of approach, and inequity of access.

A new Community Respiratory Team (CRT) ensured that the patient population and their carers would receive a high standard of co-ordinated care, be better informed and educated about self-management, have improved functional ability, and have enhanced access to other services e.g. palliative care, pulmonary rehabilitation, oxygen services, support networks and voluntary agencies.

A single point of contact was put in place at each of the three sites. Referral processes were streamlined to an electronic referral system. A new operational framework was developed and communicated to all services that refer and work with the CRT. To support the CRT, a respiratory consultant rota was established as well as a monthly multi-disciplinary team meeting for complex patients managed by the CRT in the home setting. Direct referrals from GPs to the team were introduced as well as from the Northern Ireland Ambulance Service. Databases to record data were developed for all sites.

This team provides a streamlined service for GPs, hospital staff and patients. This model ensures a more coordinated and responsive service and acts as the interface between the acute hospitals, the community service, primary care and the

community and voluntary sector. Referrals are accepted from Hospital Discharge Service, GPs, NIAS, self-referral (patients previously with the service), Out of Hours and Respiratory Outpatients Service.

The programme has delivered great benefits in terms of patient experience, reduced waiting times, improved self management, reduced admissions to hospital, and, above all, better outcomes for patients.

Providing Alternatives to Hospitalisation

Acute Care at Home

The Southern Health and Social Care Trust (SHSCT) has the fastest growing over 65 years population in Northern Ireland and is set to grow by 35% from 2012 to 2023, with the over 85 year old population set to grow by 73% in the same period.

Emerging evidence from models in Torafen and Lanarkshire indicated that a consultant led community Acute Care at Home (AC@H) service was proving to be an effective way of caring for acutely ill older patients in their home as an alternative to an admission to an Acute hospital.

Following 18 months of planning, Phase 1 of the consultant led AC@H service commenced in September 2014 aiming to assess patients within 2 hours of referral. The primary focus of the service is to maintain older people at home in the event of an acute illness or unexpected deterioration in health through the prevention of inappropriate admission or facilitation of early discharge. The service provides medical triage, assessment, diagnosis and treatment as an alternative to in-patient care specifically to those at risk of or potentially requiring admission to hospital, i.e. in the absence of such care, they would otherwise require inpatient treatment.

The patients have the same access as patients in an acute hospital ward to laboratory results and to diagnostic appointments (for CT scans, Ultrasound scans, X-ray, MRI scan).

The Team consists of Consultant Geriatricians, Speciality Doctor, Specialist Occupational Therapist, Specialist Physiotherapist, Specialist Nurses, General Nurses, Pharmacist, as well as Healthcare Rehabilitation Assistants and Clerical support. Clinical and managerial leadership provided strategic direction and inspired confidence in other stakeholders.

In the 19 months from 22/9/2014 to 30/4/2016 the service has safely cared for over 830 acutely unwell patients in the community who otherwise would have been admitted to an acute hospital. Consultants and other professionals report that older people are recovering much quicker, the risk of acquiring a hospital acquired infection is eliminated and risk of falls is greatly reduced, with little or no incidence of delirium, than if they had been in an inpatient setting.

The Trust worked in partnership from the outset with the Local Commissioning Group and the Integrated Care Partnerships throughout the development and implementation of the service. Working with the LCG enabled agreement on a service model with key performance indicators. The ICP were key to developing strong interfaces with primary care and community pharmacy.

The service could be replicated across the regions however it will be slow to develop fully at scale due to workforce issues.

Better Aftercare for Patients

Transforming Cancer Follow Up (TCFU)

TCFU is a strategic partnership between Macmillan, DoH, HSCB, PHA and NICaN which commenced in 2011. The TCFU project team and wider multidisciplinary cancer teams across all five Trusts have striven for transformational change to the follow-up and survivorship needs of patients on completion of cancer treatment. TCFU is a large scale, complex, service improvement programme testing new models of cancer follow up that has begun to transform how after care services are delivered. It was initiated through a patient workshop in 2009 where key messages were heard from people affected by cancer.

More people are now living with a cancer diagnosis which is an indication that things are improving and that the cancer landscape is changing for the better. Services need to adapt to those changes.

It's widely acknowledged that the current system of review and follow-up is not sustainable – it is not efficient and it does not fully meet the supportive care needs of patients.

TCFU allows patients to be provided with information tailored to their specific needs, provided in a format that signposts them to self-management support services and provides guidance on life style changes to maximise health and well-being and get their lives back on track; while at the same giving reassurance and a clear point of access back into the system if required.

The TCFU project team and wider multidisciplinary cancer teams across all 5 Trusts in NI have delivered transformational change to the follow-up and survivorship needs of patients on completion of cancer treatment.

TCFU has shown that by taking full account of the views of patients and by carefully adapting the services we provide it is possible to develop better more patient centred services whilst at the same time working more efficiently to meet increasing demand for scarce resources.

In the interests of space, each of these projects is only briefly summarised here, a full case study of each project is included at the end of this report.

International Good Practice

Other countries and regions are heading in the same direction using best practice examples as an approach to change the model of care. They indicate both better health outcomes and higher efficiency in the use of resources.

These are a few examples.

- Pharmacist Consultations for High-Risk Patients. Pharmacists meet with high-risk patients and their caregivers at primary care clinics or in their homes to provide medication management and education. Pharmacist consultation programmes have demonstrated a 30% reduction in 30-day readmissions.

- Nurse led models of care. In the Netherlands, ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce who were unable to properly care for patients with co-morbidities, leading to a decline in patient health. Giving district nurses far greater control over patient care broke this lose-lose approach and is demonstrating significant care improvement as well as an overall reduction in cost.

- This community nurse-led care model sees management functions shared between staff and ensures at least 60% of time spent is with patients. The Buurtzorg – or "neighbourhood care" – model uses teams of district nurses to deliver care in people's homes. These teams are self-managed and co-ordinate care with other healthcare professionals, such as GPs and Allied Health Professionals. They work within guidelines including the requirement to use 3% of their turnover for training, have a diversity of nurse specialisms, and to share eight defined management and administrative responsibilities between them. The nurses have access to coaches for wider support and a central back office that processes their billing, but are responsible for their team's own finances and use of time.

- Reinforce Tele-Primary Care Visits consultations with primary care physicians (also known as Virtual Primary Care or Tele-Outpatient Visits) decrease total cost of care and help patients avoid more complex interventions. Studies comparing e-visits with face-to-face care demonstrated net savings.

RECOMMENDATION 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

RECOMMENDATION 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes.

3. Rationalisation and Stabilisation

Rationalisation

One key aspect of this is the need to rationalise services to liberate resources that can be invested in transformation. The majority of resources in the HSC are still invested in delivering acute care, and within this some services are being delivered sub-optimally in terms of both quality and value. There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes.[36 37 38 39]

Continuing to invest large sums of money in trying to keep unsustainable services in place will only serve to delay their collapse and represents a significant opportunity cost to reforms elsewhere in the system. More importantly, it is also contributing to variation in terms of the quality of care received by those using services in different Trust areas. In a population the size of Northern Ireland, this is unacceptable. In changing the way services are provided, it will be important that decision makers clearly demonstrate the evidence for, and benefits of, change.

Given the importance of this process as an enabler for wider reform, it is dealt with separately in the following section.

Stabilisation

The significant rises in waiting lists and waiting times in the past year have received significant media coverage. While clinicians and managers have made every effort to ensure that the clinical impact on patients has been kept to a minimum, it is clear that this mismatch between demand and capacity has had a negative impact on the public's confidence in the HSC. While the longer term transformation must

36. Bilimoria, K et al (2008) Directing surgical quality improvement initiatives: comparison of perioperative mortality and long-term survival for cancer surgery, J Clin Oncol

37. Morris, S, (2014) Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

38. Crawford, R & Greenberg, D (2012) Improvements in survival of gynaecological cancer in the Anglia region of England: are these an effect of centralisation of care and use of multidisciplinary management? BJOG: An international Journal of Obstetrics and Gynaecology

39. Meyer, J et al (2014) Assessment of Cardiology and Cardiac Surgery for Congenital Heart Disease in Northern Ireland and the Republic of Ireland

be progressed, it will also be important to increase public trust in the system by reducing waiting times to an acceptable level.

The Department of Health and the Health and Social Care Board are currently developing an elective care plan which will set out proposals for dealing with this issue in the short and longer term. Although the plan is still being developed, the Panel has been briefed on the direction of travel. In the Panel's view, this is consistent with the vision articulated in this document and should be implemented as a matter of urgency. It is expected that the elective care plan will be ready by the time that this report is published.

RECOMMENDATION 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Leadership for Implementation/Organisational Culture

This report signals the need to rationalise services as well as to implement transformational change. Both of these are extraordinarily difficult and will require a planned approach to change. Furthermore, the requirement to accelerate the development of local integrated care organisations implies a new profile of leadership both locally and centrally.

It has been estimated that the success of any transformational change initiative is likely to result largely from a mix of politics and context.[40] The Panel has tried to create a positive and constructive political context for these changes by holding a political summit at the beginning of the process, providing a safe space for discussion and debate on these important and contentious issues. We have also been engaging with the political parties both before and after the elections in NI. The continued involvement of the political representatives will be an important factor in the process from now on.

Based on previous analysis (Ovreveit 2012) the Panel believes that transformational change can be successfully implemented if senior management leans on:

- the growing evidence on community based integrated networks;
- the development of the right implementation competence;
- a favorable financial and regulatory context.[41]

40. Hunter D et al (2015) Doing transformational change in the English NHS in the context of "big bang" redisorganisation : Findings from the North East transformation system, Journal of Health Organization and Management 2015 29:1 , 10-24

41. Ovretveit J &Klazinga N (2012) Learning from large-scale quality improvement through comparisons Int J Qual Health Care, 24(5):463-9

The Panel sees no reason why these conditions cannot be created in Northern Ireland. One can see from the existing building blocks explained above that Northern Ireland has an at least as good, and probably better, chance than others to move forward successfully.

The Panel believes that one key element of that implementation competence is to develop a balanced top down/bottom up approach to leadership.

That balanced approach of top down and bottom up leadership will be key to implementation. It is people, not strategies, that bring about change and it is relationships, not systems, which make it work. The model of care proposed for the future in this report will require a new form of system leadership in order to achieve integration of care and true networking among delivery organisations.

This requires an environment where staff can innovate on organisational issues that improve delivery of care

A planned approach to a transformative process needs some form of 'system leadership' at a senior level and most likely a combination of approaches such as 'push' which could imply top down policies, targets and timescales, and 'pull' which is more focused on shared values, empowerment and vision. At this level, health care transformation seems to be best achieved by a 'channeling' leadership, i.e. people who facilitate and direct the organisation's energy in a way that gets the most out of people.

This implies avoiding pushing policies onto the system. Rather, it implies developing a vision and creating the conditions for local improvement as a key mechanism to facilitate implementation.

A key component of this channeling leadership will be to develop a "high involvement culture" with health care professionals. They are the key agent of change.

That is to say that the one key predictor of positive patient outcomes and satisfaction is the level of employee engagement. Evidence indicates that staff engagement is also linked to improved financial performance in an organisation.[42]

This approach to "high involvement cultures" requires an environment where staff can innovate on organisational issues that improve delivery of care (and not only on clinical issues).

Command and control from above will not accomplish this and it will fail to exploit the energy in the organisation. The changes required by the Triple Aim approach will be more successful if they are implemented in a setting which encourages clinician and health professional engagement.

In this sense change is everybody's business.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC. Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to

42. West M & Dawson J (2012) Employee engagement and NHS performance, Kings Fund

Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. **All three groups will need to be prepared to defend the decision publicly.**

This approach will not happen spontaneously. It has to be made **actionable**.

One key approach for this will be to continue eliminating regulatory obstacles and simplifying the structures which block local innovation. The focus on health and social integration implies local networking and local leaders building partnerships. Local innovation is key to achieve integration of delivery organizations.

RECOMMENDATION 11

The Panel recommends that at the strategic leadership level, the HSC should:

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Starting the Conversation

If we are to fully support transformation, as well as reconfiguration of services, there is a potential to more fully engage the power of our staff, partners and the public. The new "social movement" approach, currently being adopted in the NHS, provides helpful context.

These new approaches, often underpinned by social media, can act as catalysts for discussion and a way of mobilising communities and individuals to become more involved in the way health and social care is delivered. They offer greater connectivity with voices that might otherwise be hard to reach, opportunities for collaboration, thought diversity, and a culture of openness.

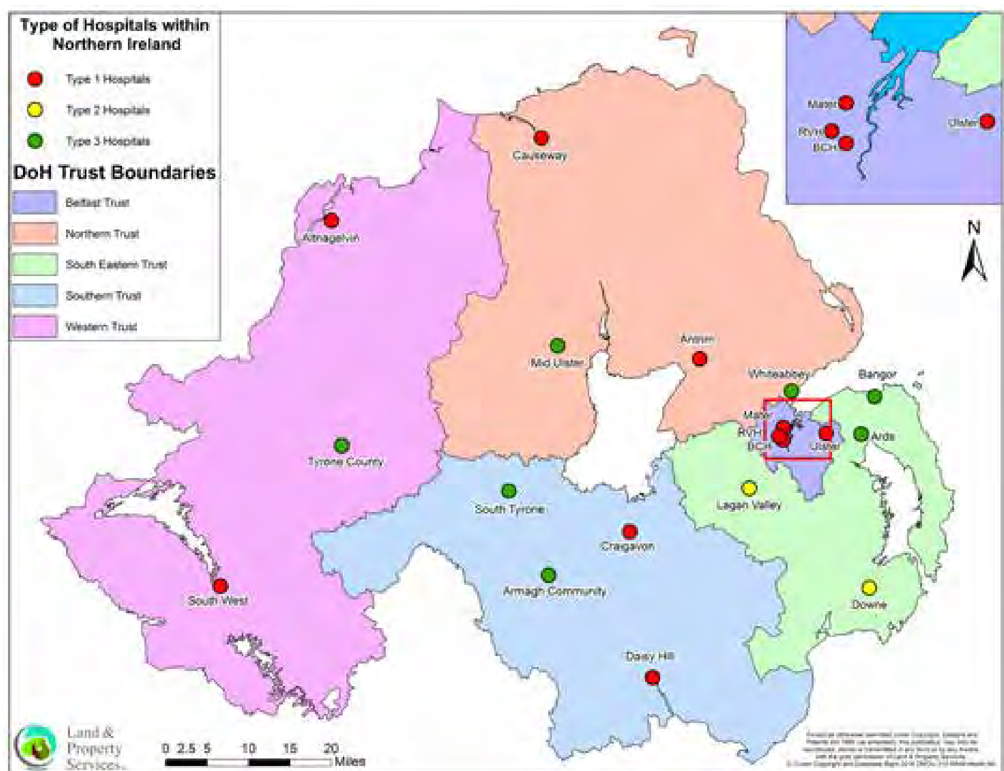
Some existing projects in the HSC are leading the way on this type of work. The Safety, Quality and Experience programme (SQE) in the South Eastern Trust, the HSC Knowledge Exchange, NICON and HSC Change Day are all good examples of initiatives that try to engage with staff or service users beyond the traditional, more formal processes.

At the 2016 NICON conference, more than 450 delegates expressed their support for the panel's final principle – that Northern Ireland could be a world leader in health care transformation – and these people were joined by over 2 Million people on social media, who were in some way able to be part of the conversation. There is significant opportunity to build on this approach and use new forms of media to communicate far more widely than has been possible in the past.

RECOMMENDATION 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Fig. 26 – HSC Hospitals by type and HSC Trust



SECTION 5

RATIONALISATION

Through the extensive engagement held by the Expert Panel, we heard many common messages. These included:

- That previous reports over many years had signalled the need to rationalise acute services in Northern Ireland, but that implementation was slow due to resistance to change and the absence of a strong strategic approach to transformation.

- That some hospital services were increasingly vulnerable because of workforce shortages and junior doctor training requirements.

- That much needed investment in community services development was hindered because of the high costs of maintaining the current configuration of hospitals, particularly for these vulnerable specialties where often expensive locum and agency staffing was the only option for safe staffing, thus preventing development of those services that would provide an effective alternative to hospital-based care – a vicious circle resulting in ever increasing pressure on all parts of our health and social care system and increasing concerns about the quality and safety of some services.

- That the system is inconsistent from site to site.

Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Earlier in this report we referred to the sense of frustration among clinicians and senior leaders at the slow pace of change up to this point. Indeed, we have heard the view expressed that unless this report contains a detailed list of hospitals and services that should close, then it will be judged to have failed.

If the model proposed in this report is to be successfully implemented, then it is inevitable that the way services are currently provided will need to change. The evidence contained in the burning platform shows the clear impact of inaction. Furthermore, changing these services is not optional; it is inevitable. The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Implementing these changes is not about making savings, it is about how we use the money we have to deliver the highest possible quality and value of care to patients and service users. The money that is currently being used to prop up

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The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

unsustainable services does not deliver good value or the best quality of care for patients and could be reinvested in other parts of the system, particularly in areas such as general practice and primary care, mental health, learning disability and community care.

Focusing resources on specialist sites means that:

- Patients are seen in the right place and by the right person as soon as possible. Evidence shows that having all the services available on the same site improves the care delivered to the patient and the clinical outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service;
- The services are more stable and there is a better environment for patients and staff;
- There are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions; and,
- This achieves the Triple Aim of better population health, better quality care and better use of resources.

However, as a panel we do not agree either that a prescriptive list should form part of this report. Changing the delivery of services is not like flicking a switch; they cannot simply be turned on and off at will. Hospital and community based services do not exist in isolation from each other and decisions in one area will inevitably have implications for the others. Decisions such as this must be taken carefully; they must be evolutionary; and, they must be carried out service by service, understanding the connectivity between clinical services that form the infrastructure of a hospital.

Furthermore, in the course of the many meetings, seminars, events and visits that the Panel has held and attended, it has become clear that clinicians and managers here already have a strong vision of what needs to be done to make services sustainable. The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

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Process

While it is not appropriate for this report to dictate to people in different parts of Northern Ireland what services they should and should not expect to be located in their area or local hospital, it can provide a basis for a process within which these difficult but necessary decisions can be made.

1. Rationale for Reviewing Services

If we are serious about improving services and instituting large scale transformation, then these kinds of decisions:

- Must only be made in order to improve services – to create a more stable, sustainable service, to reduce waste and increase value;
- Must contribute to the overall vision – they should help to achieve the Triple Aim of better population health, better quality care, and better use of resources;
- Must be evidence based and clinically led – to ensure that the service meets patient and user needs more effectively, and that it can attract and retain high quality staff;
- Must be transparent – to include open communication and discussion with affected communities; and,
- Must contribute to the overall vision – they should help to achieve the broader model of integrated, community based care networks.

2. Criteria for Assessing Sustainability

This panel has developed a set of criteria for assessing the sustainability of services. We believe that those taking the decisions on the sustainability of a service should apply the following criteria:

- There is clear evidence that the outcomes for patients using these services are below acceptable levels either in the services as a whole or in particular hospitals, or where there are safety concerns.
- There is a clear clinical pathway for the patient population. Co-produced with patient groups.
- The service cannot meet professional standards or minimum volumes of activity needed to maintain expertise.

- The permanent workforce required to safely and sustainably deliver the service is not available/cannot be recruited or retained, or can only be secured with high levels of expensive agency/locum staff.
- The training of Junior Doctors cannot be provided to acceptable levels.
- There is an effective alternative 'out of hospital' care model or an alternative 'shared care' delivery model.
- The delivery of the service is costing significantly more than that of peers or of alternative 'out of hospital' alternatives due to a combination of the above factors.

3. Centralising Services – Case Studies

The use of the above criteria implies the centralisation of certain services. This section provides some examples of its benefits when carried out by clinicians and managers working in partnership. The examples show how services can be changed in ways that benefit patients, improve quality and make more efficient use of resources whether they are at local, regional or international level.

A. London Stroke Services

The English Department of Health's National Stroke Strategy identified that care in a stroke unit was the single most important factor in improving patients' outcomes after stroke. Based on these findings, in 2010 acute stroke services were centralised across in London. Prior to this, acute stroke services were provided in 30 hospitals. After reconfiguration, specialist care was provided in eight designated hyperacute stroke units 24/7.

Following the reforms, there was a significant reduction in mortality at 3, 30 and 90 days after admission. There was also a significant reduction in length of hospital stay.[43]

43. Morris, S, (2014), Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

B. Trust Level – Stroke Services in the Southern Trust

In 2012, the RQIA carried out a review of stroke services. Overall the key findings were that stroke services in NI were too fragmented between hospital sites, many patients were not being cared for in optimal environments, community services were underdeveloped and new time-critical interventions, such as thrombectomy, were not always available on a 24/7 basis. The review also highlighted the need for progression of clinical competencies and training relating to stroke and the establishment of clearly defined stroke units and dedicated stroke wards. This has proved difficult to achieve and sustain in smaller hospitals where recruitment and retention of specialist staff is a recognised problem.

In 2014, following public consultation, a decision was taken to create a single specialist stroke inpatient unit within the Southern Health and Social Care Trust, at Craigavon Area Hospital. The Trust is proposing to provide a consistent and specialist service 24/7 in one centre rather than spreading the specialist team of staff across four sites. Daisy Hill Hospital will continue to provide ongoing rehabilitation and support through community stroke teams working to a regionally agreed care model.

The proposals are consistent with clinical evidence which shows that patients are 25% more likely to survive or recover from stroke if treated in a specialised centre. Other benefits will include:

- High quality medical care
- Improved levels of Stroke Care in line with National Audit (SSNAP) recommendations – appropriate staffing levels to allow early assessment, observation and early rehabilitation input.
- The highest quality medical care in hospital (more concentrated levels of specialist medical, nursing and AHP care).
- Patients being admitted to a Stroke Unit as a ward of first admission. Latest medical evidence demonstrates that where patients are treated in specialist stroke units they achieve best outcomes.
- Better rehabilitation outcomes - a specialised service which will bring community and hospital based staff together as an integrated team providing care to Stroke patients. This will provide more focused care and continuity of service provision throughout the patient's pathway.

Reduced length of stay in hospital - more focused community based rehabilitation to allow Stroke patients to be discharged from hospital earlier and recover at home.

C. Regional level – Primary Percutaneous Coronary Intervention

Heart attack is a leading cause of mortality and morbidity in Northern Ireland. Approximately 40% of hospitalised heart attack patients have the more serious ST Elevation Myocardial Infarction (STEMI) heart attack. Traditionally a STEMI heart attack was treated by giving patients a clot-busting drug (thrombolysis). Patients then went a few days later to a catheterisation laboratory (cath lab), while still in hospital to have a metal stent inserted.

Primary Percutaneous Coronary Intervention (pPCI) involves the patient being taken immediately to a cath lab to widen the artery, clear the blockage and have a stent inserted, instead of using clot-busting drugs. Primary PCI reduces the mortality, complication rates and length of stay in hospital. A pPCI service needs direct admission to a designated centre with dedicated cath lab facilities capable

of undertaking the procedure 24/7. Running this requires many highly skilled staff, including interventional cardiologists, clinical physiologists, nurses and radiographers. Each centre needs to do a minimum number of cases each year to maintain standards.

The best fit which gave maximum geographical coverage for the NI population within an agreed travel time, while having enough caseload to maintain team skills, was to have 2 pPCI centres, one in Belfast (RVH) and one at Altnagelvin.

Making this work required commitment, coordination and agreement from senior clinical staff and managers in all six Trusts. A regional group was set up, chaired by a Consultant in public health from PHA, supported by the regional cardiac network coordinator, senior commissioner and finance officers from HSCB.

Obtaining agreement on clinical pathways and protocols was relatively straightforward. What was more difficult was trying to recruit the right number of trained interventional cardiologists to provide a sustainable out of hours rota for the Altnagelvin service, while ensuring sufficient workload to maintain their skills.

The group explored options to provide the night-time rota cover by consultants who would have daytime commitments in other hospitals, crossing Trust boundaries. The same approach was used for the Belfast pPCI service, seeking to offer opportunities to interventionalists working in other hospitals who wished to join the pPCI rota. In tandem, where there were other known gaps in cardiology services, such as in outpatient clinics, or cardiac MRI, if options were available to sort those within the overall configuration of new consultant posts then that was considered.

New IT systems were also agreed to share important patient information, both for patients waiting a daytime cath lab procedure and those waiting for cardiac surgery.

This regionally coordinated process ignored organisational boundaries when seeking the best solution for the population. Rather than focussing solely on pPCI, it used the opportunity to improve other aspects of cardiology services, with the end result that local services were strengthened as well as providing a new regional service. Primary PCI was centralised into 2 locations, because that was the best way to achieve a sustainable high quality service for patients, but others such as cardiac MRI and non-complex pacemaker implantation were able to be decentralised. This required close cooperation between clinical and management teams in all six Trusts. All had to make compromises to deliver a better, stronger cardiology service for the people of Northern Ireland.

D. Cross-Jurisdictional Level – Children's Congenital Heart Surgery

In recent years the regional Paediatric Congenital Cardiac Surgical (PCCS) Service, provided by the Belfast Trust, developed vulnerability in its surgical service due to new international safety and quality standards which could not be met because

of our relatively small population size. As evidenced by clinical reviews neither surgical centre (Belfast or Dublin) had been delivering a service which meets current international standards of both institutional case volume and consultant staffing: the service in Belfast did not meet the surgical case volume threshold, and the Dublin service has a medical staffing level in both intensive care and cardiology that is significantly lower than in comparably sized UK and European centres.

By December 2014 Belfast could not continue to provide an emergency and elective surgical service, and by April all interventional cardiology procedures ceased in Belfast (as these require the presence of a surgeon).

An International Working Group (IWG), led by Dr John Mayer from Boston Children's Hospital recommended the establishment of an all-island congenital heart disease (CHD) service, with a single surgical centre in Dublin capable of meeting international standards for surgical practice volumes, supported by specialist cardiology hubs in Belfast and other locations. The 'hub and spoke' network would involve all stakeholder groups including patient representative organisations in its governance structure, and be supported by enhanced telemedicine links, improved transportation, and a clinical research programme.

The all-island CHD Network was established in April 2015, following a public consultation on the recommendations of the expert group. In endorsing the IWG's recommendations, commitment was also given to the development of a specialist Children's Heart Centre in Belfast, enhancing existing facilities at the Clark Clinic within the current footprint of the Royal Belfast Hospital for Sick Children and making it fit for purpose until the new Children's hospital opens in 2021/22. This will secure the role of RBHSC as an integral part of the in the all-island 'hub and spoke' network, functioning as a 'Level 2' cardiology centre, i.e. providing the full range of non-surgical care required by CHD patients until they are ready to transition into the adult service.

The all-island CHD Network involves the two Health Departments, commissioners, service providers (management and clinicians) and patient representatives in a collaborative non-statutory structure to deliver an all-island CHD Service in line with the relevant legal and accountability arrangements that apply in each jurisdiction.

4. Maintaining Momentum

While criteria were previously developed as part of TYC, there is little evidence of these being applied in a systematic way to services or conditions. The panel believes that the Department should consider formal endorsement of these criteria and that a timetable for applying these should be developed, prioritised by specialty.

Based on the evidence the panel has received, the specialties that are currently in most need of reform would seem to be:

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Priority 1

- EMERGENCY & URGENT CARE
- STROKE SERVICES
- PRIMARY CARE INCLUDING GP OUT OF HOURS
- GENERAL SURGERY
- PATHOLOGY
- VASCULAR

Priority 2

- PAEDIATRICS
- PALLIATIVE CARE
- OBSTETRICS
- RADIOLOGY
- NEONATAL SERVICES[44]
- TRAUMA
- UROLOGY
- REHABILITATION
- COMMUNITY BASED ELDERLY CARE
- BREAST SERVICES

RECOMMENDATION 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

44. Paediatrics, obstetrics and neonatal services are clinically linked and should be considered together.

5. Seeing the Big Picture

Having heard from many different leaders in different parts of the system, the Panel is in no doubt that local clinical leaders know exactly what they would like to do to optimise delivery of services for their patients and service users. However, it is also clear that in the interests of patients across the whole of Northern Ireland, decisions that will have a significant impact regionally or across Trust boundaries, must be taken in a regional context and must be consistent with the long term vision.

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We therefore recommend the establishment of an appropriately resourced transformation business unit, based in the centre of the system. This unit should be tasked with providing a strategic view on projects with a regional impact – joining local and regional considerations while firmly focused on delivering better outcomes for patients. We are not advocating an expansion of bureaucracy and the past tendency to create unwieldy process management in taking forward change must be avoided.

The projects themselves would still be clinically/locally led and the role of the unit would be to bring a regional perspective to such decisions ensuring that patients' requirements are fully met. Given the inter-connections between medical conditions, this would also ensure that all the related regional impacts arising from proposed change are not being taken in isolation of the wider vision.

RECOMMENDATION 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

6. Change is Everybody's Business

In taking these decisions, it is of course vitally important that there is clear engagement with communities both at a local level and regionally. People will need to be able to understand why a service is changing and what will take its place. The Panel considers this to be a fundamental component of any changes. Health professionals must support local representatives in explaining the rationale for change and the alternatives which will provide better care. Where the centre is leading and co-ordinating changes to hospital services, this should be led by professional leaders with support from clinical leaders in those services.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC. Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

When developing the criteria above, the Panel met with clinical leaders from across the Health and Social Care system and was struck by the support for and commitment to driving these difficult changes and wider transformation forward.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. All three groups will need to be prepared to defend the decision publicly and openly, and to honestly communicate the need for change with local politicians, the public and individual service users.

SECTION 6

LIST OF RECOMMENDATIONS

Recommendation 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

Recommendation 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Recommendation 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in e-health to support improved self management, care at home and use of information to drive better population health outcomes.

- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).

- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.

- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Recommendation 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

Recommendation 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing the actions detailed in the main body of the report should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

Recommendation 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

Recommendation 7

For this purpose, the panel recommends the creation of a transformation board supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.

- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

Recommendation 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

Recommendation 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

Recommendation 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Recommendation 11

The Panel recommends that at the strategic leadership level, the HSC should

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.

- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.

- Take the formal decision to empower leadership close to the front line.

Recommendation 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

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Recommendation 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

Recommendation 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

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APPENDIX A

THE EXPERT PANEL'S PRINCIPLES FOR HSC REMODELLING

Vision Statement

"To create a fair and sustainable, including financially sustainable, Health and Social Care system that delivers universal, high quality, safe services that meet the Northern Ireland population's needs and which deliver world class outcomes for patients and service users."

Ethos

1. **The system should be collaborative, not competitive.**
   There are several components to this principle. Firstly, even in the short term it will not be safe or effective to deliver all services locally. Organisations must work together to provide high quality care to patients. Secondly, unwarranted variance across the system should be minimised. Patients should be able to receive the same standard of care anywhere in the region. Thirdly, the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care. Finally, remodelling of the system should be a transparent and collaborative process.

2. **The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction.**
   Like many health services worldwide, HSC resources and service developments are often locked into reactive 'disease care', which focuses on increasingly expensive diagnostics and treatment. It must be acknowledged that there should be an increased emphasis on investment in prevention and health promotion, particularly for vulnerable communities who are at highest risk of experiencing inequalities. It must also be acknowledged that addressing wider health determinants requires a cross-sectoral approach, although there is much that the HSC can do in terms of designing new models of care.

3. **Patients should be active participants in their own care, not passive recipients.**
Patients should be treated with respect and empowered to stay healthy and care for themselves where possible. Patients should also be supported and encouraged to take greater ownership of their own health outcomes. The public rightly expects access to safe, sustainable and high quality health and social care services; however, as part of the relationship between the HSC and citizens, the public should also be enabled to take greater responsibility for their own health and well-being, and to use services appropriately.

Delivery Model

4. **Health and Social Care is already integrated in Northern Ireland. Remodelling must build on this strength and take a whole system perspective.**
The HSC in Northern Ireland is an integrated system, to the envy of many countries. Remodelling must ensure that different parts of the system are connected, interdependent, that they talk to each other and that they form an integrated whole. Patients should be able to transition smoothly between social care, community care and hospital care.

5. **Only people who are acutely unwell need to be in a hospital.**
Hospital is often not the right answer. There is evidence that for patients who do not need acute care, being in an acute hospital can be harmful. Research also indicates that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services. Studies have shown extremely positive feedback and satisfaction levels from patients who were treated in community settings and the HSC must continue to develop strong community care models.

6. **Very specialist services can be based anywhere in Northern Ireland.**
In the face of increased specialisation and ever rising demand, it is not practical or desirable to try to deliver specialist services everywhere. However, it is true that specialist services could be delivered anywhere. Any acute hospital in Northern Ireland has the potential to become a regional centre. Furthermore, the HSC should continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services.

7. **The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes.**
Co-ordinated workforce and service planning should be carried out on the basis of the population's need rather than with the aim of maintaining services which are not sustainable in the long term.

8. **The real value of Health and Social Care is in its people, not its buildings.**
HSC staff should be given the freedom to innovate and deliver services in a way that best meets people's needs, safely, quickly, and with respect and compassion. This implies more local autonomy and innovation within a defined policy framework. Northern Ireland has a wealth of knowledge and expertise that should be harnessed and developed to allow us to provide the highest quality services to patients. Local initiatives should be encouraged and best practice should be shared across the region.

Implementation

9. **Whole system remodelling is a medium to long term process.**
Funds will continue to flow into the health and social sector but simultaneously there must be significant gains in productivity. New care models allow for increased productivity. Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term.

10. **The system must be supported to implement change with pace and scale.**
Change is inevitable and must be embraced. There is an appetite and a will to implement planned change among staff. Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care.

11. **Technology should be developed and adopted where it can support and enable transformation.**
Northern Ireland has one of the most advanced electronic care record systems in Europe. New technologies offer enormous potential for improved self-management, telemedicine, information sharing and communication across sub-systems. Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services. This will bring benefits to patients, the HSC and the economy.

Leadership and Culture

12. **The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public.**
    Implementation will require strong political and technical leadership. Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change.

13. **Northern Ireland can be a world leader in transforming health and social care**
    Many countries are facing the same challenges and difficult choices as Northern Ireland. This process is an opportunity for Northern Ireland to be a pioneer in designing and delivering health and social care services fit for the 21st Century.

APPENDIX B

LIST OF ENGAGEMENT MEETINGS

CO3

DOH

NIASW

RCN

BMA

Patient & Client Council

PPI Seminar event

Sinn Fein

DUP

UUP

SDLP

Alliance

BHSCT

NHSCT

Meeting with representatives from all HSC Trusts

HSCB

PHA

Dr George O'Neill, GP

QUB

Clinical leaders seminar event

NIPSA

RQIA

Pathology Network NI

NICON

Royal College of Surgeons

Royal College of Paediatricians

Age NI

NHS England

Greater Manchester Health & Devolution

ICP & LCG Delegation

AHP Delegation

Senior Nurse Delegation

ABPI

Contact NI

Commissioner for Older People for NI

Chief Clinical Information Officers

Unison

BMA – NI GPC

Safety Forum

Institute for Healthcare Improvement

Community Pharmacy NI

HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

12 Month Progress Report October 2017

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

SECTION 1: CONTEXT AND AMBITION

1. On 25 October 2016, the then Minister of Health, Michelle O'Neill launched an ambitious 10 year approach to transforming health and social care ***Health and Wellbeing 2026: Delivering Together***[1]. *Delivering Together* was based on the report of the Expert Panel, led by Professor Rafael Bengoa, *Systems, not Structures: Changing Health and Social Care*[2] which was published on the same day.

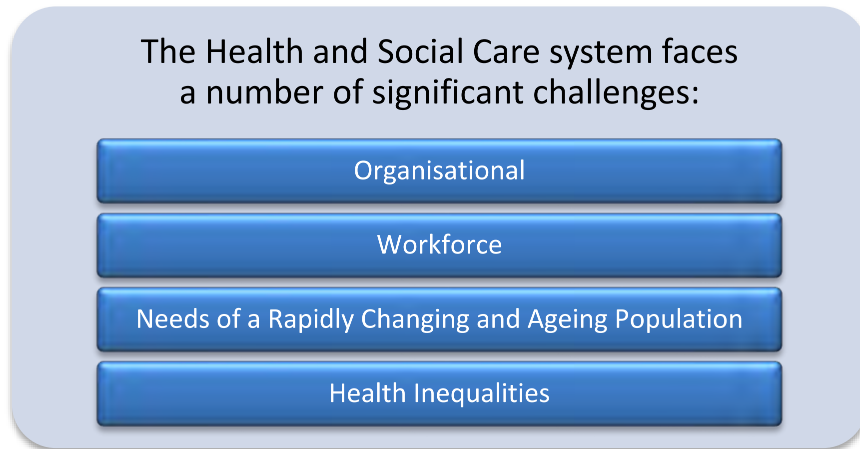
2. This vision for the future also drew on the findings of previously commissioned reports including *Transforming Your Care*[3] and Sir Liam Donaldson's report *The Right Time, The Right Place*[4]. The direction of travel in *Delivering Together* secured universal buy-in at political, system and service user level and is now the single roadmap for radical health and social care transformation.

3. It seeks to radically reform the way services are designed and delivered with a focus on person centred care rather than the current emphasis on buildings and structures. The aim of this report is to demonstrate the progress on the commitments in *Delivering Together* one year into the programme.

The Case for Change

4. *Delivering Together* set out a clear and unassailable case for change. The inability to meet the extraordinary demands and pressures created by an ageing population; the stark differential in health and social care outcomes between the most and least deprived areas; the current service delivery model being no longer fit for purpose and the challenges in attracting and retaining staff to prop up an outdated system means that transformation is not an option, it is an imperative.

[1] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[2] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report
[3] http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf
[4] https://www.health-ni.gov.uk/publications/right-time-right-place



5. It is clear that we have a 20th century model seeking to deliver services for a 21st century population and that the current delivery models continue to have an increasingly negative impact on the quality and experience of care, constraining the ability of Trusts and the wider system to transform itself.

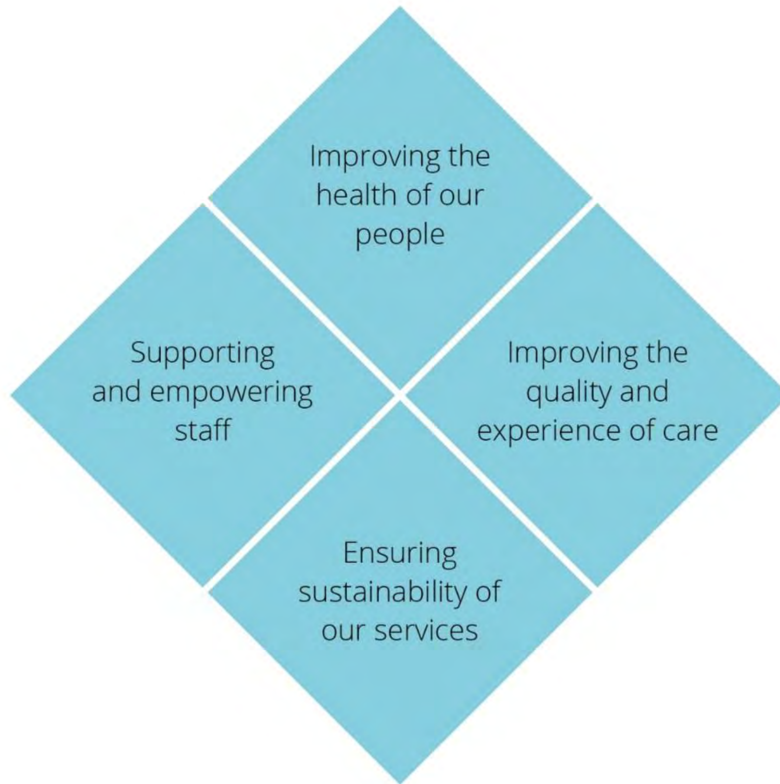
The Ambition

6. *Delivering Together* is driven by the Northern Ireland Executive's draft Programme for Government and sets out an ambition to support people to lead long, healthy and active lives.

7. The model of person-centred care in *Delivering Together* focusses on prevention, early intervention and supporting independence and wellbeing. This enables the emphasis of health and social care services to move from the treatment of periods of acute illness and reactive crisis approaches, towards a more holistic approach to health and social care where people are supported to stay healthy, well and safe in the first place.

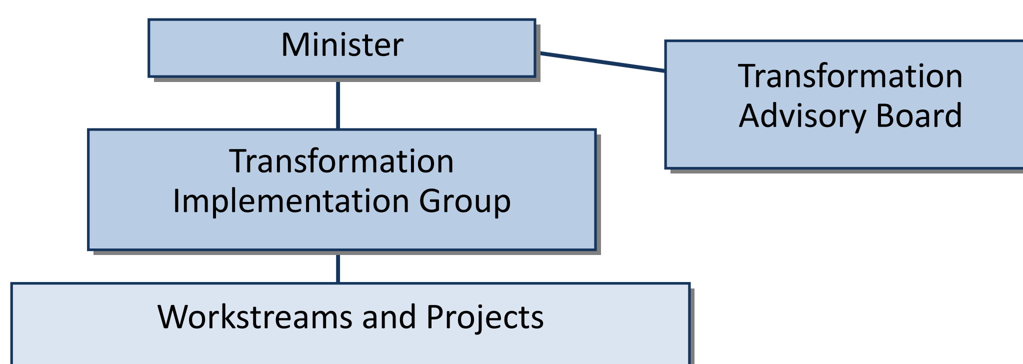
8. When care is needed, people will have access to safe, high quality care and are treated with dignity, respect and compassion. Staff will be empowered and supported to do what they do best while services will be efficient and sustainable for the future.

9. Underpinning this ambition are four key aims, namely:



SECTION 2: LEADING & GOVERNING THE CHANGE

10. The requirement for a transformation oversight structure with membership drawn from within and outwith the HSC was an explicit commitment of *Delivering Together.* In November 2016, a Transformation Implementation Group was established to provide leadership in driving forward transformation. A Transformation Advisory Board was also formed to provide strategic advice to the Minister on the direction of reform.



Transformation Advisory Board

11. The Transformation Advisory Board (TAB) is chaired by the Health Minister, and members include Professor Bengoa, Chair of the Expert Panel, along with trade union, service user and community and voluntary sector representatives, and the Permanent Secretary of the Department of Health. Full details of membership is included at Appendix 1.

12. The TAB met once in February 2017. Due to the current political position, no further meetings of the TAB have been possible, however senior Departmental Officials continue to engage with members.

Transformation Implementation Group

13. A Transformation Implementation Group (TIG) is chaired by the Permanent Secretary of the Department of Health and comprises senior leaders from the Department of Health, HSC and Trust Chief Executives, along with a consultant

surgeon and a General Practitioner. Since its establishment, this group has met fortnightly.

14. An opportunity is taken at the start of each TIG meeting to showcase a local project or innovative practice that is strategically aligned and underpins transformation across the HSC. To facilitate this, TIG meetings are held in different venues across the HSC. The notes and actions from TIG meetings are regularly published on the Department's website at: https://www.health-ni.gov.uk/publications/transformation-implementation-group-tig-meetings-notes-and-action-points

15. The TIG provides strategic leadership and oversight to the design, development and implementation of transformation, working across the traditional organisational boundaries to lead and manage the change agenda. Details of membership is included at Appendix 1.

16. TIG continues to draw on Professor Bengoa's extensive knowledge of health systems and health reform, along with his awareness of the specific challenges facing the health and social care system in Northern Ireland. Importantly, this also brings an element of continuity to the transformation process following the completion of the Expert Panel report.

Workstreams

17. In taking forward the changes, a number of priority actions have been initiated under the leadership of TIG. In some instances, workstreams were established and in others, work was already ongoing. Taking this work forward at an operational level draws largely on colleagues across the HSC, and indeed beyond, who bring skills, knowledge and experience from a wide range of backgrounds.

18. Partnership working and co-production remain key tenets of the way change is developed and implemented moving forward. The people who use services and those that deliver them need to be involved in the decisions that are made about the design of services.

19. The work undertaken so far has sought to adopt a more inclusive and transparent approach, as illustrated, for example, by the work to reshape stroke services and the design of a Community Development Framework.

20. Important activities which will enable and support transformation continue to happen outside of the formal programme arrangements, with staff in many different disciplines working together to come up with innovative practices and models of care that make a real difference to patients.

SECTION 3: PROGRESS AGAINST OUR AMBITIONS

21. To support people to lead long, healthy and active lives, the focus of health and social care services, and how and where those services are delivered, needs to change. This will be challenging, and will take sustained and incremental effort over the next ten years. This section sets out the progress made towards our stated aims.

22. *Delivering Together* also set out a range of priority actions for the initial 12 month period to make a positive and ambitious start towards the stabilisation, reconfiguration and transformation of the health and social care system. Appendix 2 provides an update on these actions.

23. Reforming a complex health and social care system does not happen overnight. Much of the work that has been undertaken so far is the kind of necessary preparatory and enabling work that is not immediately visible. It has been critically important to build these foundations and engage with the people who use services, and those who provide them, to ensure that the changes improve outcomes for the population, and are sustainable in the long term.

Changing our models of care

Building capacity in communities and in prevention

To reduce inequalities and ensure the next generation is healthy and well. This includes a focus on working with communities to support them to develop their strengths and use their assets to tackle the determinant of health and social wellbeing. Alongside this, link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities.

24. A workstream has been established to design and implement a **Community Development Framework,** to provide the community and voluntary sector with the tools, training, and standards it needs to help grow the sector to meet the future demands associated with transformed HSC services. In partnership with HSC staff, the voluntary and community sector, and service users, the workstream will finalise the framework early in 2018.

25. Through the implementation of the **Healthy Child, Healthy Future programme** parents are being supported to make healthy choices, which promotes the health and wellbeing of their children and families. Whilst progress has been made, due to workforce capacity issues the programme remains to be fully delivered.

26. The **Making Life Better programme** continues to set the strategic direction for improving population health and addressing inequalities in health. The emphasis has been on working collaboratively to address the factors that impact on health and wellbeing and health inequalities to create the conditions for individuals, families and communities to take greater control over their lives, and be enabled and supported to lead healthy lives. There is already a great deal of work underway, including the **Healthier Lives Programme** led by the Public Health Agency (PHA).

27. In relation to **Family Support Hubs,** progress has been made with building further connections to other Hub arrangements, and those involved believe there is increased likelihood of better outcomes for children and families. Subject to funding, the Hubs will be further enhanced and expanded.

28. A number of projects have been concluded within the **Early Intervention Transformation Programme,** and four new projects have been agreed. Work includes equipping parents with the skills to ensure children have the best start in life, supporting families earlier, and a focus on the development of the children's workforce, including teachers, social workers, doctors, nurses and police officers. A Gateway Review has commenced.

29. Considerable work continues on the development of the **Looked After Children Strategy**, and an implementation plan has been developed. A series of workshops are ongoing looking at issues relevant to looked after children, and a range of innovative proposals are being developed to meet the aims of the strategy. It is hoped the Looked After Children Strategy will go out to public consultation in the autumn of 2017. Alongside this, consultation on the **Adoption and Children Bill** has concluded and analysis is ongoing.

30. The implementation of the **Improving and Safeguarding Social Wellbeing Strategy** continues to make progress, with all five HSC Trusts having established a Local Engagement Partnership. A framework for social work/care and social wellbeing, co-produced with people who use services and social workers, has been developed and was launched at the Moving Forward Together Leadership Event in June 2017. A draft Evaluation Framework has been developed to measure the impact of strategy. In addition, an Innovation Overview Report highlighting the innovations funded between 2012 and 2016 has recently been published.

Enhancing support in primary care

Providing more support in primary care to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems. The future model of primary care will be based on multi-disciplinary teams embedded around general practice.

31. A workstream has been established to take forward the development and implementation of **multi-disciplinary teams in primary care**. Alongside the core membership of the workstream group – which includes a service user, a GP, Trust staff and professionals from the Health and Social Care Board (HSCB) and PHA – members of the group have been meeting with a wide range of partners. A service user reference group has also been established.

32. In its first phase of work, the group has been reviewing existing models of primary care multi-disciplinary working, from a range of countries and reviewing existing best practice here in Northern Ireland, including a workshop with a wide range of stakeholders. The group has also undertaken research to understand demand and pressures in GP and nursing services.

33. There has been close working with a number of other workstreams, for instance, to consider how primary care multi-disciplinary teams can link better with the community sector. Drawing on all this work, the group expect to have a draft set of principles to underpin a primary care multi-disciplinary model by the New Year, alongside a plan setting out the immediate next steps to start developing the model on the ground.

34. Alongside this work, by March 2017, named **District Nurses and Health Visitors for each GP practice** were in place, and there was an increase in the number of **GP training places** from 85 to 97, in August 2017.

35. Having a pharmacist as part of the primary care team improves the quality and safety of prescribing and supports value for money in medicines prescribing. It relieves work pressure on GPs, freeing up their time for patients with more complex medical needs. **Practice Based Pharmacists** (PBPs) started to take up post in September 2016, it was further expanded in January 2017, and

continues to grow. By August 2017, 296 (88%) of the GP practices in a GP Federation had access to a PBP, and it is expected this will increase to 100% by March 2018. By April 2021, nearly 300 PBPs are expected to be in place.

36. In line with the increasing focus on multi-disciplinary and inter-professional working set out in the draft HSC Workforce Strategy, two key programmes have commenced. In January 2017, the first cohort of **Physician Associate** students started a post-graduate programme with Ulster University, which will include placements in primary care.

37. The new **Advanced Nurse Practitioner** (ANP) programme (also with Ulster University) began in September 2017, and this includes a cohort for primary care who will be supported and facilitated in their clinical practice by the Down GP Federation. The development of the ANP role in primary care is being piloted as a potential nursing workforce solution to increase capacity in primary care services and support the GP workforce in delivering effective primary care services.

38. The development of a new framework for **Community Pharmacy** has begun, with a Memorandum of Understanding signed in January 2017, and the design of services and cost investigation completed by June 2017. Concluding this work is dependent on budget and consideration by an incoming Minister.

Reforming our community and hospital services

Reforming community and hospital services so that they are organised to provide care where and when it is needed. Within this, it is inevitable that the role of our hospitals will fundamentally change as they focus on delivering the highest quality of specialist and acute care.

39. A public consultation on the **Criteria for Reconfiguring Health and Social Care Services** was concluded in February 2017, and the report is awaiting consideration by an incoming Minister.

40. A workstream has been established to undertake **Service Reconfiguration Reviews**, and under this umbrella, significant progress has been made:

    - **Elective Care Centres** – A clinically led group was established in March 2017 and has been working to collect and analyse evidence that will inform the development of elective care surgery centres. This group is due to deliver its report in autumn 2017.

    - **Stroke** – The pre-consultation on the reshaping of stroke services concluded in September 2017. Working closely with *Chest, Heart & Stroke* and the *Stroke Association*, widespread engagement took place with stroke survivors, their families, carers, charities and other key stakeholders to listen to views, concerns and ideas on how to reshape stroke services. The findings will inform the design of a new model, and it is hoped this will be published for formal public consultation early in 2018.

    - **Diabetes** – Progress has been made with the implementation of the Diabetes Strategic Framework, which was published in November 2016. NI Diabetes Network has since been established, and a number key workstreams are underway (including footcare pathway and structured diabetes education). Workplans for 2017/18 for these areas have been agreed and are currently being progressed.

- **Imaging** – Public consultation on a future model for Imaging commenced in October 2017. Preliminary work continues on the review's recommendations.

- **Paediatrics** – The paediatric strategies were published in November 2016, and a paediatric network has been initiated and is being led by the PHA. Planned completion for network design is January 2018.

- **Pathology** – Consultation on the proposals for the modernisation of pathology services was completed earlier in February 2017 and the HSCB is working with the Pathology Network to finalise the proposals.

- **Breast Assessment Services** – A review of Breast Assessment services is underway. Criteria for assessing service options for future service models of care have been proposed. A range of engagement activities have taken place including meetings with major cancer charities, surveys with 500 patients, public meetings and patient focus groups. The HSCB is currently working on final proposals for a new model of care.

- **Ambulance Services** – The report of the Demand and Capacity Review on Field Operations and Control Room Operations has been approved, and the NI Ambulance Services (NIAS) is currently developing an action plan for implementing the findings of the review.

41. The **Elective Care Plan**, to address the issue of long waiting lists, was published in February 2017. Work is ongoing to monitor progress. However, investment is required to take forward the commitments in the Plan.

42. Progress has been made across the region on the development of the **Acute Care at Home service** with patients receiving treatment at their own home as an alternative to an admission to hospital. These services are providing complex integrated care in peoples own homes, and depends on strong local joined up working across providers. As well as an expansion in geographical coverage, Acute or Enhanced care at home services have seen an increase in the number of referrals over the last year. This service will continue to be expanded over coming years.

43. In relation to the **Reform of Adult Social Care and Support**, an Expert Advisory Panel established to identify reform proposals has completed its work, which is to be considered by an incoming Minister, prior to publication and public consultation. As part of this work, the Panel engaged with carers and their representative organisations, and support for carers will continue to be a key focus of this reform agenda as this work moves forward. Work is underway to identify opportunities to continue engagement and to plan for the forthcoming consultation.

44. Achieving parity of esteem for mental health continues to be a priority, while investment is dependent on funding. In particular, work has progressed on establishing a **Regional Mental Trauma Service** to address the unmet mental health need of trauma associated with the legacy of the conflict in Northern Ireland. A Partnership Board and Implementation Group have been put in place to take forward this service, and recruitment of staff to manage trauma caseload across the Trusts is underway. A paper setting out the options for the future **development of perinatal services**, including proposals for a specialised Mother and Baby Unit, is ready for consideration by an incoming Minister.

Organising ourselves to deliver

Organising ourselves to ensure that the administrative and management structures make it easier for staff to look after the public, patients and clients. Embracing new models of care has the potential for harnessing the strengths of different parts of our systems, working and delivering together across traditional boundaries.

45. Within the broad framework defined by previous Ministers, including confirmation that the Health and Social Care Board will close, progress has been made in terms of developing future models for performance and financial management.

46. Proposals for the future role and function of the PHA have been developed and these are currently being considered. Work is now underway to identify the future operating model post closure of the HSCB, for consideration by an incoming Minister. It is critical that any changes permanent or transitional are made in the context of supporting new models of service delivery and the broader transformation agenda.

Enabling Sustainable Transformation

Partnership Working

The health and social care system belongs to all of us and everyone must be treated with respect, listened to and supported to work as real partners within the health and social care system, including the adoption of creative and innovative ways to **maximise partnership working and involvement**.

47. Partnership working is a key tenet of the way change is developed and implemented moving forward. A **Co-production Working Group,** led by the Chief Nursing Officer and involving people with a vast range of relevant experience, are developing a co-production guide to support partnership working across health and social care. This will be published in the coming months.

48. Work continues on the development and procurement of a **Real Time User Feedback System** which would be of benefit to all those who both use and deliver services, and training to support the continued rollout of the Q2020 Attributes Framework is ongoing.

Improving Quality and Safety

We need to establish **an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart.** There needs to be greater alignment between quality improvement, partnership with those who use our services and how we regulate those services.

49. The initial design work for a **Regional Improvement System,** which will enable the health and social care system to take a strong position on quality improvement, was completed by February 2017. A regional workshop to further develop the model was held in June 2017 and a small number of significant areas of practice have been identified which would enable a test of scale and spread. These will be taken forward in Phase 1 (July 2017-March 2018).

Investing in our workforce

To ensure we have **the people and the skills needed** to support sustainable models of care, taking account of increasing demand, informed by robust information and analysis, and mapped to configuration of services and increased focus on primary care.

50. Work is well advanced on the development of a **Health and Social Care workforce strategy.** This will include areas such as retention and recruitment, opportunities for introducing new job roles and upskilling initiatives. It will also focus on ensuring that health and social care is a rewarding and fulfilling place to work and train.

51. Membership of the Workforce Strategy Steering Group, which is leading the development of the strategy, is wide ranging and includes Trusts, primary care, professionals and trade union side. This collaborative approach will be continued into the implementation of the strategy.

52. In line with the commitment to develop proposals through co-production, three initial 'engage' events were held in January 2017, with over 200 attending. This was followed by a programme of focus groups, open to all HSC workers. The draft Strategy is currently under consideration by the Transformation Implementation Group, in readiness for an incoming Minister.

53. In addition, **the Nursing and Midwifery Task Group,** was established in December 2016. It is chaired by Sir Richard Barnett, and as well as HSC representation, its membership includes the Royal College of Nursing, the Royal College of Midwifery and Ulster University. It aims to maximise the contributions of nursing and midwifery to improving outcomes for the population, and is conducting a series of workshops across NI to co-produce potential actions. It is due to report in March 2018.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, it must be underpinned by a **new approach to collective and system leadership.** All those working in health and social care will feel able to effect change and improvement in care.

54. The HSC-wide Collective Leadership Strategy was launched in October 2017 setting out an approach for the creation of a culture of high quality, continually improving, compassionate care and support.

55. The development of the strategy embodied a partnership approach. The work was led by a core group with a wide membership, including HSC, DoH, Trade Union Side, a GP, a service user, and a representative from the voluntary and community sector, and there was engagement events with over 400 people from across different levels, professions and experiences.

56. The implementation and embedding of the strategy across the HSC system is now being mobilised.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and getting beyond organisational and professional silos.

57. Work continues towards a **new patient portal,** which will allow people living with dementia and their carers to have secure on-line access to their own health and care information, with a delivery date now set for the summer of 2018.

58. There has been an increase in the number of community pharmacies with access to **Northern Ireland Electronic Care Record** (NIECR), with the rollout of this continuing to take place during 2017. A proposal for rollout of access to NIECR for all pharmacies is expected to be agreed by March 2018. Work is

ongoing to develop an optometry specific view within NIECR, and a pilot is expected to commence early in 2018.

59. The development of a more consolidated and common patient and user record remains a priority. The **Electronic Health Care Record (EHCR)** programme has been rebranded as the **Encompass Programme**. Evidence indicates that investment in a digital record-in-common will dramatically contribute to improving the health and wellbeing of the community including user experience, quality, safety and ultimately, health outcomes. An initial review of the Outline Business Case has been completed by both Department of Health and Department of Finance, and there continues to be significant engagement with HSC professionals on early design.

SECTION 4: LOOKING AHEAD

60. The new models of care will see citizens interact with the HSC system in a different way. This can only happen with the understanding, commitment and involvement of the population, which will require an ongoing and open public debate, and strong political leadership.

61. Whilst progress can continue to be made in bringing forward proposals for change, difficult decisions will be required, as set out by the Executive and the then Minister upon the launch of *Delivering Together*. The nature of these decisions and their impact on the population warrants Ministerial consideration.

62. The financial position remains challenging and this is not anticipated to change. The Executive agreed that transformation cannot happen without investment. It is inevitable that the pace of transformation will be impacted by the level of funding available.

63. Under the funding arrangement provided for by the confidence and supply agreement, £200m will be made available for transformation. A further £50m will be invested in mental health services over 5 years. It is important that this funding is invested in initiatives which will enable and deliver transformation, ensuring our models and systems are fit for the future, rather than addressing current pressures.

64. The pace and scale of change is dependent on a range of internal and external factors. The Transformation Implementation Group continues to plan, prioritise and sequence actions to ensure that momentum is maintained and impact is maximised.

APPENDIX 1

MEMBERS OF THE TRANSFORMATION ADVISORY BOARD:

- Minister of Health (Chair)
- Richard Pengelly (DoH Permanent Secretary and Chair of the Transformation Implementation Group)
- Rafael Bengoa (Chair of Expert Panel)
- Mairead McAlinden (Expert Panel member)
- Seamus McAleavey (Voluntary and Community sector representative)
- Brian O'Hagan (Co-chair of the regional PPI forum)
- Maria Somerville (Person with caring experience)
- John Patrick Clayton (Trade Union representative)

MEMBERS OF THE TRANSFORMATION IMPLEMENTATION GROUP:

- Richard Pengelly (Permanent Secretary, DoH; Chair)
- Deborah McNeilly (Deputy Secretary, DoH)
- Jackie Johnston (Acting Deputy Secretary, DoH)
- Michael McBride (Chief Medical Officer)
- Sean Holland (Chief Social Services Officer, DoH)
- Charlotte McArdle (Chief Nursing Officer, DoH)
- David Gordon (Director of Communications, DoH)
- Valerie Watts (Chief Executive, HSCB and Interim Chief Executive, PHA)
- Martin Dillon (Chief Executive, BHSCT)
- Tony Stevens (Chief Executive, NHSCT)
- Anne Kilgallen (Chief Executive, WHSCT)
- Francis Rice (Interim Chief Executive, SHSCT)
- Hugh McCaughey (Chief Executive, SEHSCT)
- Shane Devlin (Chief Executive, NIAS)
- Liam McIvor (Chief Executive, BSO)
- Alan Stout (General Practitioner)
- Mark Taylor (Consultant in General and Hepatobiliary Surgery, BHSCT)

APPENDIX 2

PERFORMANCE AGAINST DELIVERING TOGETHER ACTIONS

Key Deliverable		Target	Position
1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work the Health and Social Care Board, as well as the recommendations from the Expert Panel	January 2017	Elective Care Plan published February 2017
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by • increased GP training places; • continued investment in Practice Based Pharmacists; • ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; • supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and • Further rollout of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies	March 2017	Research continues into potential models of multi-disciplinary teams in primary care with ongoing engagement with stakeholders. GP Training Places increased August 2017. 88% GP practices in a Federation had access to a Practice Based Pharmacist by August 2017, and investment and expansion continues. Named District Nurses and Health Visitors for each GP practice were in place March 2017. Work ongoing with regard to Social Workers. Physician Associates programme commenced January 2017; Advanced Nurse Practitioner programme commenced September 2017. The online triage system, AskMyGP, continued to be rolled out and piloted by 20 practices. Consultation proposals on GP Federations under development.
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	October 2017	A series of alternative placement options for looked after children have been developed through co-production discussions, led by the

Key Deliverable		Target	Position
			HSCB and South Eastern HSC Trust. These are undergoing further testing with wide range of stakeholders and will thereafter be finalised for Ministerial consideration.
4	Following the completion and evaluation of a pilot project, roll out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists**.	October 2017	There has been an increase in the number of community pharmacies with access to Northern Ireland Electronic Care Record (NIECR) and rollout continues. Work is ongoing to develop an optometry specific view within NIECR and pilot is expected to commence in first quarter of 2018.
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	November 2016	The development of a new framework has commenced. A Memorandum of Understanding was signed January 2017.
6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	November 2016	Consultation on criteria for service reconfiguration completed February 2017, and report drafted for consideration by incoming Minister. Programme of service reconfiguration reviews underway.
7	Following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future.	November 2016	Consultation on the proposals was completed in February 2017 and the Health and Social Care Board (HSCB) is working with the Pathology Network to finalise the proposals.
	Move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups.	November 2016	Diabetes Strategic Framework published November 2016. NI Diabetes Network has since been established, and a number key workstreams are underway (including footcare pathway and structured diabetes education). Workplans for 2017/18 for these areas have been agreed and are currently being progressed.
	Launch and commence implementation of the **Paediatric**	November	The paediatric strategies were published in November 2016, and a

Key Deliverable		Target	Position
	Strategies (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families.	2016	paediatric network has been initiated and is being led by the PHA.
	Launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients.	February 2017	The pre consultation on the reshaping of stroke services concluded in September 2017, working closely with clinicians, stroke survivors and voluntary groups. Formal public consultation on more detailed proposals for change expected in early 2018.
	Following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice.	February 2017	Public consultation launched October 2017.
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres**.	October 2017	A clinically led group has been established to collect and analyse the data and evidence for future models, and use this to bring forward proposals. The group is due to report in autumn 2017.
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	March 2017	A broad structural framework was set out in January 2017, work on detailed operating model design is ongoing.
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	April 2017	Programme of innovative projects agreed in August 2017. Implementation plans to be developed.
11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	November 2016	A series of engagements with staff and service users took place November 2016 to January 2017.
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	November 2016	Oversight structures (Transformation Advisory Board and Transformation Implementation Group) in place November 2016.

Key Deliverable		Target	Position
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the longer term sustainability of the adult social care system.	April 2017	The work of the Expert Advisory Panel Report on the Reform of Adult Care and Support is complete and its report will be considered by incoming Minister prior to public consultation.
14	Consult on proposals for, and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	October 2017	A specification and business case is under development for the procurement of a Real Time User Feedback System.
15	Complete the initial design work for the **Improvement Institute**.	February 2017	Initial design work completed by February 2017. Small number of significant areas of practice identified to test scale and spread model during Phase 1 (July 2017-March 2018).
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	May 2017	Work is ongoing with a wide range of stakeholders. A draft strategy nearing completion for consideration by TIG and incoming Minister.
17	Develop an **HSC-wide Leadership Strategy**, to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	May 2017	HSC Collective Leadership Strategy launched October 2017.
18	Expand the range of information and interaction available to citizens on-line and development of a **patient portal** for dementia patients.	October 2017	Work continues on identification of a preferred supplier with a delivery date now set for the summer of 2018.

Department of Health
An Roinn Sláinte
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HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

Progress Report - May 2019

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SECTION 1: INTRODUCTION

1. *Health and Wellbeing 2026: Delivering Together*[1] provides a ten-year road map for the transformation of Health and Social Care (HSC) services in Northern Ireland. The first progress report, published in October 2017[2], outlined actions taken since its launch in October 2016.

2. This update builds on that position, and outlines the extensive, transformative work which has been undertaken to date.

3. Transformation of HSC services is a complex long-term ambition dependent on a wide range of enablers, many of which will be covered later in this report. The two most critical factors influencing the scale and pace of change remain to be political leadership and additional investment. It is a matter of record that some three months after the launch of *Delivering Together* the local Assembly and Executive was dissolved. Whilst this is regrettable *Delivering Together* set out a clear direction of travel and an initial action plan which has allowed significant progress across a broad range of critical areas.

4. At the launch of *Delivering Together*, the Northern Ireland Executive agreed that transformation could only be realised if additional money was made available, over and above the amount required to deliver existing HSC services.

5. The budget for 2019/20 does not provide sufficient funding to meet current demand. In short, the budget as it currently stands is insufficient to meet rising pressures across hospital, general practitioner (GP) practices, social care and mental health services, or to systematically tackle the growing waiting list backlog.

6. This is far from ideal in terms of the planning and management of services. Financial difficulties will also continue to intensify in coming years as demand increases. This is due to an ageing population with greater and more complex needs, increasing costs for goods and services, and growing expertise and innovation which means an increased range of services.

7. That said, as result of the Confidence and Supply agreement announced in June 2017, additional non–recurrent funding of £200m was made available to kick start transformation over the two year period beginning 2018/19.

8. In 2018/19, £100m was allocated to the following priority areas, with up to:
   - £30m to help tackle elective care waiting lists;
   - £15m to support services in primary care;
   - £15m to support development of our workforce;
   - £30m to help reform hospital and community services;
   - £5m to help build capacity in communities and prevention;
   - £5m to enable the transformation process.

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1. https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
2. https://www.health-ni.gov.uk/publications/delivering-together-progress-report-october-2017

9. Whilst it is recognised that this short-term, non-recurrent investment limits HSC's ability to make the long-term changes needed to sustain services for future generations, it has provided much needed seed-funding and has helped make a real difference to those who work for, and those who use, HSC services.

10. The investment profile for 2019/20 funding is currently under development and will build on the positive start made in 2018/19.

SECTION 2: AMBITION

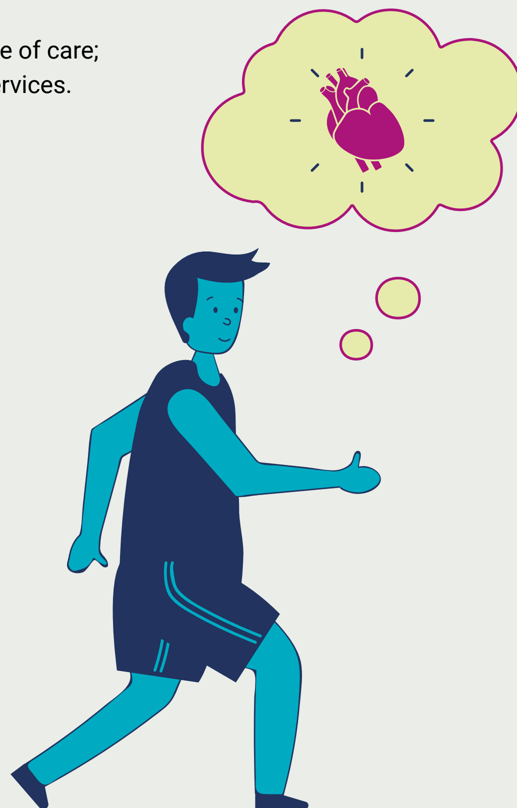
11. The vision for HSC transformation, *Health and Wellbeing 2026: Delivering Together*, was based upon the report of an expert panel, led by professor Rafael Bengoa, entitled, *Systems, not Structures: Changing Health and Social Care*[3], and was published on the same day.

12. *Delivering Together* seeks to radically reform the way HSC care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than on buildings and structures.

13. It also sets out a clear and unassailable case for change which includes; the current system's inability to meet the extraordinary demands and pressures created by an ageing population, the stark differential in health and social care outcomes between the most and least deprived areas, the current service delivery model being no longer fit for purpose, and the challenges in attracting and retaining staff to prop up an outdated system.

14. *Delivering Together* is aligned with the aspirations set out within the Northern Ireland Executive's draft Programme for Government, with the ambition to support people to lead long, healthy and active lives.

15. Four key aims underpin this ambition:
    - Improving the health of our people;
    - Supporting and empowering staff;
    - Improving the quality and experience of care;
    - Ensuring the sustainability of our services.



3. https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

SECTION 3: LEADING & SUPPORTING CHANGE

16. Established in November 2016, the Transformation Implementation Group (TIG) continues to provide strategic leadership in driving forward the transformation agenda. It is chaired by the permanent secretary of the Department of Health and comprises senior leaders from across HSC.

17. In addition to this, a Transformation Advisory Board (TAB), whose purpose is to advise a minister, continues to liaise with Departmental officials to support the delivery of transformation. Full details of current membership of both groups is included at Appendix 1.

18. A Transformation Programme has been established to support delivery of the commitments made in *Delivering Together*. This programme is managed by the Department of Health, with extensive engagement and partnership across HSC. It is also working to understand the approaches to, and share learning from HSC developments across the rest of the UK and beyond.

SECTION 4: PROGRESS AGAINST OUR AMBITIONS

19. *Delivering Together* committed to transforming the whole HSC, as one system, by:

- **Building capacity in communities and in prevention;**
- **Providing more support in primary care;**
- **Reforming our community and hospital services;**
- **Organising ourselves to deliver.**

20. The remainder of this report outlines progress to date.

BUILDING CAPACITY IN COMMUNITIES AND IN PREVENTION:

Significant work is underway with communities to create the environment that helps support them to develop their strengths, and to use their assets to tackle the underlying social determinants of health and wellbeing.

SUPPORTING FAMILIES

21. A programme of work is currently underway to reform the services which support some of the most vulnerable families and children here. This work includes a regional roll-out of a new social work model, *Signs of Safety*, which saw 1,727 social workers trained in 2018/19.

22. This new way of working aims to empower families to build on their own strengths, and to put arrangements in place to support the wellbeing of the family, and to safeguard children.

23. A trial project aimed at preventing children from being taken into care on a repeated basis is well advanced. Additionally intensive support and diversionary activities are being provided to children and young people to help prevent the breakdown of foster care placements. A new approach to foster care recruitment has also been introduced.

24. A joint care and justice campus is also planned between the Departments of Health and Justice aimed at providing young people in secure accommodation with a more consistent model of care, focused on meeting their needs and diverting them from the justice system. For those 16 and 17-year-olds who present as homeless a pilot project is underway to test a new housing solution.

25. Support is also being provided for families with troubled adolescents, young fathers in prison and those with drug and alcohol problems.

26. Looked after Children are also being supported with their educational needs through the promotion of the Looked after Children Champion role which aims to raise educational outcomes at Key Stage 2 in conjunction with the Department of Education.

27. The *Getting Ready for Baby* initiative has also proved successful, increasing the numbers of mothers initiating breast feeding within the programme by 75%, as well as increasing the numbers of children accessing a three-year-old plus review.

28. Work continues to build upon the success of the *Early Intervention Transformation Programme (EITP)*, including *Family Support Hubs* working to better understand the needs of families, particularly those who are hard-to-reach, with the aim of offering early support before the need for statutory service involvement.

29. Another key initiative in the work to reduce inequalities, and to ensure that the next generation is healthy and well, is the *Family Nurse Partnership*, which is currently working to improve outcomes for first-time teenage mothers and their children.

30. On top of intensive and structured home visiting, this initiative teams specially-trained family nurses with teenage mothers, from early pregnancy until their child is two-years-old. To date 10 new family nurses have been recruited, which has provided 230 additional places on the programme for teenage mums. Evaluation of the programme to date has shown that this model plays a significant role in breaking the cycle of intergenerational disadvantage, deprivation and exposure to multiple other adverse childhood experiences.

31. *The Infant Mental Health Framework* aims to support those working with children up to three-years-old, and in critical need of support, to increase their mental health knowledge and skills. New teams to support this work have been established in both the Belfast and South Eastern Health and Social Care Trusts, to increase the capacity of parents to address the needs of their children in their first 1,000 days.

32. This extensive programme of work will be supported by the development and introduction of new strategies, including a new, *Looked after Children Strategy,* and a new, *Family and Parenting Support Strategy*.

33. A comprehensive review of the assessment framework used in connection with children and families by Social Services and their partner agencies has also begun, as well as work on delivery of the *Improving and Safeguarding Social Wellbeing Strategy*, which is supporting greater involvement through local engagement partnerships, and putting improvement at the heart of social work.

PREVENTION

34. *Delivering Together* outlines the need to move beyond simply managing illness, ensuring that our HSC services supports people to stay well; physically, mentally and emotionally. The introduction of an *HIV Prevention Clinic* is just one initiative which aims to do just that.

35. Opened in July 2018 at the Belfast Health and Social Care Trust, the pilot clinic has already seen 375 patients across 128 clinics, including a number of high risk individuals, who were not previously regularly engaging with services. The clinic aims to prevent new cases of HIV in high risk populations, with these services in high demand at present.

36. A new health outreach for people experiencing homelessness, the Inclusion Health Hub, began taking clients in February 2019, with the aim of improving access to healthcare for a population who experience severe health inequalities and barriers to accessing healthcare. The Homeless Nursing Team offers GP, dental, nursing and podiatry support, with three GP outreach sessions held each week. Patients can drop-in to be seen, or can be referred. To date, the service has successfully registered 60 new patients with a further 19 patients having been seen as temporary residents.

37. *Healthy Places* is a new cross-cutting programme which aims to improve health, reduce inequalities, and improve wellbeing and wider social outcomes. The programme is initially being taken forward in three pilot sites of Ballycastle, Lisnaskea, and in Belfast, the Ardoyne and Greater Ballysillan area, with a focus on testing new ways of working in a more co-ordinated way across statutory and non-statutory bodies for the benefit of the community.

38. A programme of community engagement is well underway in each area, and assets and resources are being fully mapped. The next stage will be aligning delivery and resources to address the identified needs. The idea is to take the learning from these three places and, if the approach is successful, scale and spread the programme to other areas in due course.

39. Integral to the *Healthy Places* initiative, is the work that is also underway to look at the establishment of a regional networking forum to explore and promote best practice with a strong focus on interface with local government.

SUPPORTING COMMUNITIES

40. As part of ongoing work to build capacity in our communities, a programme of initiatives has been established to support and improve the quality and safety of people living in nursing and residential care homes in Northern Ireland.

41. A peer support system has been established in an effort to enhance understanding of working with older people and to make care homes an attractive and rewarding place to work. 12 peer workers have already been recruited to deliver a training programme to care home staff.

42. A Nursing Home Workforce Seminar was held in March 2019, with representatives from health departments across the UK and Ireland, together with local expertise, to share their knowledge of issues relating to the care home workforce. Work is also underway to enhance engagement with service providers.

43. *Intermediate care at home* is another way in which work is ongoing to build capacity in communities. As a result of Transformation Funding, *intermediate care at home* has been enhanced to provide patients, usually older people, with the care they need after leaving hospital, or when they are at risk of being sent to hospital.

44. This service is provided to people in different places, for example, in a community hospital, residential home, or in their own home with the aim of helping people avoid going into hospital unnecessarily, to be as independent as possible after a stay in hospital, and to prevent people from having to move into a residential home until they really need to. A variety of professionals offer this type of specialised care - from nurses and allied health professionals (AHP), to social workers - with capacity for this service increased in 2019.

45. *Delivering Together* outlined the requirement to bring forward a Community Development Framework which would provide the voluntary and community sector with the tools, training, and standards it needs to help grow the sector to meet the future demands associated with transformed HSC services. This work is progressing well in partnership with staff, the voluntary and community sector, and service users.

46. The Community Development and Health Network (CDHN) was recently appointed to build the capacity of the voluntary and community sector by, amongst other things, establishing and hosting a community development online portal, developing and delivering a community development curriculum informed by National Occupational Standards, and by building sustainable, resilient, collaborative communities through delivery of a community mentorship programme.

47. A mapping exercise of existing community development and health inequalities training is now also underway.

48. Also supporting local people is the *Community Resuscitation Programme* - supported by the Northern Ireland Ambulance Service - which aims to increase survival of cardiac arrest outside of hospital. In the last year work has been undertaken in schools and across councils to establish lifesaver groups, and to provide best practice for those who own an Automated External Defibrillator (AED). Members of the public have also been trained to perform CPR.

PROVIDING MORE SUPPORT IN PRIMARY CARE:

Significant work has been brought forward to allow more access to services within primary care.

PRIMARY CARE MULTI-DISCIPLINARY TEAMS

49. A new model for primary care multi-disciplinary teams has been developed which is seeing local GP practices focus not just on managing ill-health, but also on the physical, mental and social wellbeing of communities.

50. Practice-based physiotherapists, social workers and mental health practitioners, are now based in a number of GP practices. These new teams are being supported by increased investment in district nursing, health visiting, training, and access to appropriate specialist advice.

51. Enhanced teams are now been rolled out across Down, Derry/Londonderry and West Belfast GP Federation areas. These areas account for approximately 365,000 people who will potentially benefit from this new model of care.

52. Problems with muscles and joints are a significant part of a GPs workload with unacceptably long waiting lists for referral to more specialist services. To tackle this significant issue, practice-based physiotherapists are now working in GP practices across all three roll-out areas. This new approach aims to relieve GP workloads, reduce waiting times, and reduce the need for referrals by making these expert practitioners the first point of contact.

53. Research suggests that up to a fifth of GP time is spent on social issues that are not principally about health[4], with GPs not always best placed to address these issues which may be underlying ill health. Practice-based social workers have therefore been recruited and have started in practices in the Down area, with further roll-out planned. Assistant social workers have also been recruited and will take up posts shortly.

54. The third of the new practice-based roles is that of mental health practitioners. This new role will address another area of high demand, ensuring expert assessment, treatment and referral of those with mental health issues. Recruitment to these posts has recently started.

55. Data analysts have also been recruited to work across practices to help in the use of data to understand and identify opportunities for early intervention which may be social rather than medical, such as helping people to exercise more, or addressing loneliness. To support this approach, investment is being focussed to create capacity in local social prescribing initiatives.

4. A Very General Practice: How Much Time Do GPs Spend On Issues Other Than Health?; Citizens Advice; 2015.

56. To accommodate new teams an investment of over £2m has been made in practice premises.

57. An independent evaluation of the new multi-disciplinary team approach will be carried out to assess impact and inform further roll-out.

FURTHER EXPANDING THE MULTI-DISCIPLINARY TEAM

58. In addition to the model of primary care multi-disciplinary working outlined above, there are a number of other initiatives designed to improve patient care and support new ways of working. For instance, administrative staff in some GP practices are being training to expand their skills, and reduce the administrative burden on GPs, freeing their time to see patients and deal with other clinical tasks.

59. Two paramedics have been trained as community paramedics and are embedded within rural GP practices in border areas. Their enhanced training and skills has allowed them to undertake assessments of patients with chronic long-term conditions, as well as minor illnesses and injuries, including undertaking home visits.

60. A further significant development has been the introduction of the first locally trained, advanced nurse practitioners (ANPs) in primary care. ANPs are highly skilled, with the ability to diagnose a very wide range of patients and to offer significant support to GPs and wider multi-disciplinary team members.

61. Currently, five ANPs are completing their training working within multi-disciplinary teams across the Down area. This has allowed them to see and support over 15,000 patients. Training is now underway for a further 15 ANPs to support local people across Derry/Londonderry, Armagh, Dungannon, and East Belfast.

62. The District Nursing Framework, *24 Hour District Nursing Care No Matter Where You Live*, was launched in February 2018 with a focus on preventative and proactive care. Implementation is now underway, with a group established to oversee delivery.

63. Central to this framework is the development of a Neighbourhood District Nursing prototype model, which sees self-managing teams of district nurses working with a high degree of autonomy, and working closely with multi-disciplinary teams. Neighbourhood district nursing coaches and support staff have been recruited, with a new transformational district nursing model being tested in a number of areas including, Newcastle, Limavady, Moy, West Belfast and Ballycastle.

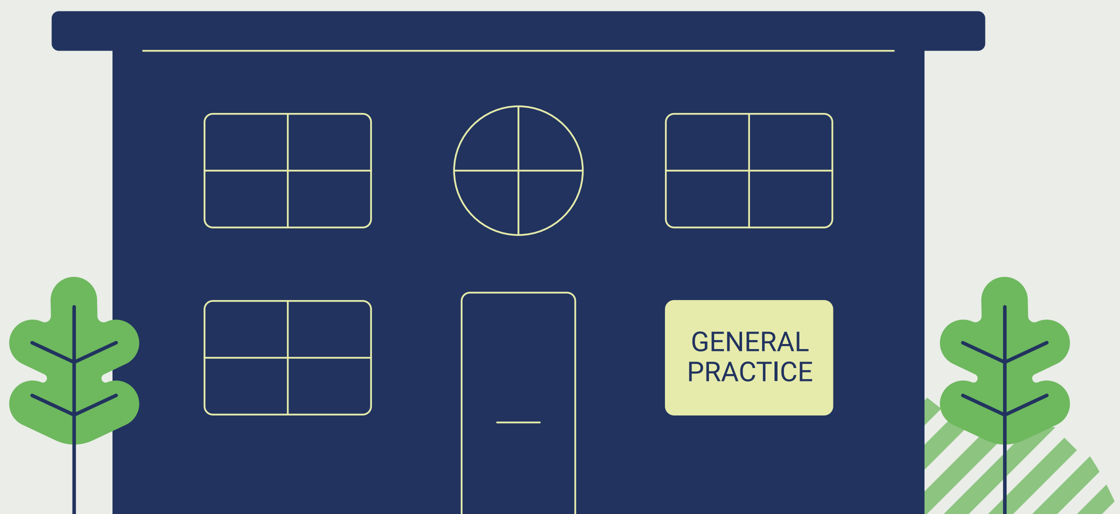
64. Practice-based pharmacists are also working as part of the teams in GP practices, with the aim of ensuring quality and safety of prescribing, whilst also supporting value for money, offering support to other members of the primary care team, and freeing up GP time to dedicate to patients with more complex needs. Every GP practice in Northern Ireland now has access to a practice-based pharmacist with, approximately 274 pharmacists to be based within local GP practices by the end of the summer.

65. Community pharmacy also plays a significant role in preventative and proactive care within communities, stemming the flow of patients to other parts of the health and social care system. Support has been provided to enable community pharmacies to enhance their clinical capability and capacity and support their transformation into health and well-being hubs.

66. *The Pharmacy First service for sore throats, colds and flu-like illness* was launched on 1st December 2018 and ran until 31st March 2019. The service aimed to displace activity, including consultations, advice and generating prescriptions for common winter conditions, from GPs to a community pharmacy based service. 21,715 consultations took place at 432 community pharmacies during the winter months.

67. The service was co-designed by the Health and Social Care Board and Community Pharmacy Northern Ireland, following a review of the current evidence base for the management of common winter conditions.

68. The Department of Health, along with the Health and Social Care Board is also committed to ensuring that the network of community pharmacies can continue to support the needs of local populations. Work is ongoing on a needs assessment for community pharmacy services in Northern Ireland.



WORKING AT SCALE

69. To support the reform in primary care, the 17 GP Federations in Northern Ireland have taken on a coordination role allowing initiatives like practice-based pharmacists and primary care multi-disciplinary teams to be rolled-out at scale.

70. GP Federations are also currently developing and rolling out new ways of working, including the development of crisis response teams to support practices facing particular challenges, and a *GP Hub Model*, to address pressures facing early evening, and GP out-of-hours, services.

REFORMING OUR COMMUNITY AND HOSPITAL SERVICES:

The role of our hospitals will fundamentally change as we focus on delivering the highest quality of specialist and acute care, outside of structural boundaries.

ELECTIVE CARE

71. An investment of £30m from the £100m Transformation Fund available in 2018/19 was allocated to the reduction of elective care waiting lists. Whilst not transformational in itself, this significant investment was made in the full understanding that immediate action was needed to reduce excessive waiting times – an issue that continues to attract significant criticism and remains a huge frustration for those accessing services.

72. As a result of this investment, by the end of February 2019, approximately 100,000 more patients had been diagnosed, assessed or treated. Whilst a positive outcome the funding has served only to slow the growth in elective care waiting times. Long-term investment over and above what is required to deliver existing services, is required to make sustainable change.

73. New ways of working are under development to meet patients' needs within GP practices rather than waiting to be seen in a hospital setting. As a result, eight nurse endoscopists are currently being trained to carry out endoscopy procedures.

74. A GP led vasectomy service has been established using non-scapel procedures for the first time locally. Since October 2018, over 642 procedures – which would otherwise have required a hospital referral – have now been carried out in GP practices in Belfast. The service will be further rolled out in 2019/20.

75. GPs are also delivering services for photo dermatology triage, gyneacology, muscular skeletal (pain), and enhanced minor surgery, with over 3,256 patients treated since December 2018.

76. Primary care optometrists are engaged in new initiatives to stem the flow of referrals into hospitals, managing non-sight threatening acute eye problems in the community and carrying out non-complex post-operative cataract reviews, in addition to offering community-based ocular hypertension reviews.

77. A priority in the transformation agenda is to enable improved access to elective care services by establishing regional centres, known as *Day Case Surgery Hubs*, to provide a dedicated resource for less complex planned surgery. This new approach will help ensure that patients do not go beyond clinically-indicated review dates, reducing the risk of harm, whilst simultaneously freeing capacity in secondary care. Whilst additional travel times to these centres may be inevitable waiting times will be greatly reduced.

78. The Department of Health/NISRA 2017 Health Survey indicated that 78% of those surveyed would be prepared to travel beyond the nearest acute hospital if treatment was available in a more timely manner. 82% of people surveyed thought that a journey time of up to one hour would be reasonable.

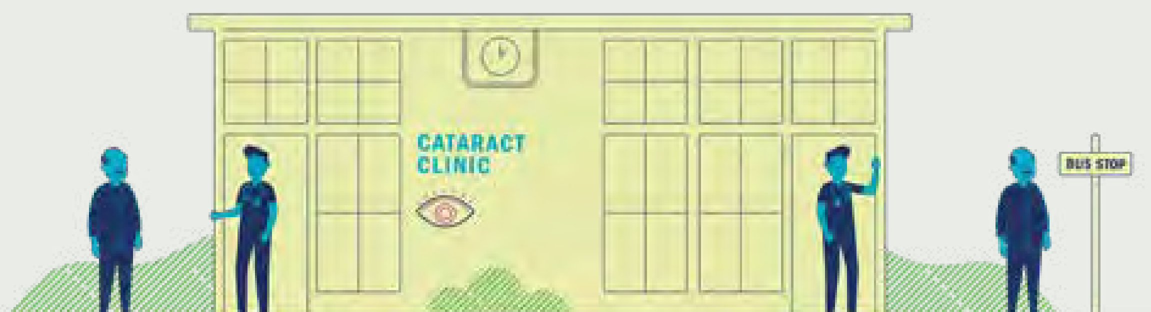
79. In December 2018 a significant step forward was made through the introduction of new prototype day case surgery hubs. Centres for the treatment of varicose veins are now up and running at Lagan Valley Hospital, and Omagh Hospital and Primary Care Complex. In the Mid-Ulster Hospital, Downe Hospital, and the South Tyrone Hospital, similar prototypes have been introduced for the treatment of cataracts.

80. This work will ultimately help to inform a regional model for Northern Ireland, which will be subject to public consultation.

81. The Department has announced plans of future additional hubs for a wide range of specialties including general surgery and endoscopy, urology, gynaecology, orthopaedics, ENT, paediatrics and neurology.

82. By December 2020, the Department of Health aims to transfer more than 100,000 day cases, 25,000 endoscopies and 8,000 paediatric procedures to this new model.

83. Whilst the work underway to address the waiting list crisis is positive, the Department of Health's Elective Care Plan[5] published in February 2017, was clear that transformation was required to sustainably improve elective care services and will require significant funding over a number of years, as part of broader investment in reform.



5. https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

REFORM OF ADULT SOCIAL CARE AND SUPPORT

84. The Expert Advisory Panel's report, *Power to People*, was published in December 2017. Whilst awaiting ministerial approval, work has been advanced to consider options and develop an action plan with input from a wide range of stakeholders, Citizens' Forum and Independent Expert Carers panel.

85. This work will ensure that the voice of carers is heard at all levels of the decision making process. Work is also underway with the voluntary and community sector to understand how this approach could be replicated to form a service user panel.

MENTAL HEALTH SERVICES

86. Supporting our mental health is a key priority in *Delivering Together*. As well as being a key focus in the work to develop primary care multi-disciplinary teams, there are a number of additional initiatives being taken forward through the introduction of mental health practitioners.

87. A *Multi-Agency Triage Team* (MATT) prototype has been operational from July 2018 and is due to run until March 2020. Supported by the Transformation Fund, this project involves two police officers, a mental health nurse and a paramedic working together to respond to people with mental health problems, aged 18 and over, who have accessed the 999 system.

88. The service currently operates on Friday and Saturday nights, between 7pm-7am, covering areas within the South Eastern Health and Social Care Trust. To date there have been over 150 referrals to this service.

89. A new pilot *Derry Community Crisis Intervention Service*, launched at the start of 2019, to support local people who are in crisis, reducing unnecessary transfers to emergency departments or to police custody. Similarly, a crisis de-escalation pilot commenced in Belfast in March 2019, to support local people and their families with weekend, out of hours support to those aged 18 and over, presenting in social and emotional crisis.

90. In addition to this, a Towards Zero Suicide Collaborative Board has been established in Northern Ireland as part of the *UK Zero Suicide Alliance*, and will be supported by the Institute of Healthcare Improvement, placing Northern Ireland in a strong position to benefit from learning and innovation from across the UK and Europe on this important issue.

91. Work has progressed on establishing a *Regional Trauma Network* to address the unmet mental health need of mental trauma. A partnership board and implementation group have been put in place to take forward this service, and recruitment of staff to manage trauma caseload across Trusts is underway.

92. Work has begun on developing a five year plan for mental health. A project board has been set up, with a stakeholder event held in November 2018 to initiate work. Further development of Children and Adolescent Mental Health Services (CAMHS) is included in this work, with the continued roll out of, *Working Together: A pathway for children and young people through CAMHS*, and training targeted to further support implementation, including GP training.

93. Work is also ongoing on future development of perinatal services, including specialist community perinatal teams.

ACUTE CARE AT HOME

94. Progress has also been made regionally on the development of the Acute Care at Home service, with more than 3,500 patients receiving treatment in their own home this year, as an alternative to hospital admission. This is an increase of approximately 10% on the previous year. Further roll-out is planned for 2019/20.

RECONFIGURING HEALTH AND SOCIAL CARE SERVICES

95. The consultation report on the criteria for reconfiguring health and social care services has been published. This is the outworking of the commitment within *Delivering Together* to consult on the seven reconfiguration criteria proposed in the Expert Panel Report.

96. The post consultation criteria will be adopted as policy within the Department of Health, in conducting upcoming service reviews as part of the Transformation Programme.

97. The criteria can be viewed at: www.health-ni.gov.uk/consultations/health-and-social-care-transformation-consultation-criteria-reconfiguring-health-and-social-care.

DAISY HILL PATHFINDER PROJECT

98. The *Daisy Hill Hospital Pathfinder Project* was established in response to increasing concerns about the future sustainability of Daisy Hill Hospital Emergency Department due to ongoing difficulties in securing senior medical cover, particularly in the out of hours period. This was against a backdrop of significant public concerns about the future of Daisy Hill Hospital.

99. The aim of the pathfinder was to develop a new model, through a co-production approach, to ensure safe and sustainable unscheduled care services to meet the needs of the Newry and Mourne population.

100. Implementation of this work is underway, with significant progress made in providing a stable Emergency Department workforce, stronger links with local GPs, enhanced services for the sickest patients, and improved patient flow.

101. A new Direct Assessment Unit opened in February 2019 and is taking referrals from GPs, the Northern Ireland Ambulance Service, and specialist services. The unit will allow quicker access to senior doctors, direct telephone discussion between clinicians and GPs, an increase in clinical assessments for adults with medical needs. Frail older people will also benefit from diagnosis, observation, treatment and rehabilitation in an appropriate area outside of the Emergency Department.

FERMANAGH AND WEST TYRONE PATHFINDER

102. In response to service pressures, a pathfinder has been established to undertake a review of the current service provision in the area.

103. An intensive period of community engagement has commenced which will be followed by a recalibration of the population health data, to inform the development of transformative service models designed to meet the specific needs of this population. The work will have both a hospital and community focus, with the ambition of establishing early pilots in spring 2019.

104. Professor Rafael Bengoa who led the expert panel and the development of *Systems not Structures* endorsed the direction of travel at a recent health summit.

RECONFIGURATION OF STROKE SERVICES

105. A public consultation on reshaping stroke services was launched on 26th March 2019, with plans to enhance existing provision to create specialised hyperacute stroke units offering 24/7 access to faster diagnosis and cutting edge treatments.

106. Currently, eight hospitals routinely provide thrombolysis to stroke patients, but despite the dedication of staff, most are struggling to consistently meet national best practice standards of care for stroke patients.

107. The central aim of the reconfiguration of stroke services is to significantly reduce disability and save more lives. The proposed new network of hyperacute stroke units will ensure that patients have access to the best possible care in regional centres of excellence no matter where they live, or what time they are admitted.

108. The reforms will address variance in the use of the clot busting, thrombolysis, and support greater access to thrombectomy, the groundbreaking procedure that removes a clot from the brain.

109. The consultation on Reshaping Stroke Care will run until 19th July 2019 and follows a pre-consultation in 2017. The consultation paper also outlines planned improvements in the treatment of transient ischemic attack (TIA), also known as mini-stroke, as well as improvements to community-based stroke care.

110. The consultation proposes extending the HEMS air ambulance service to coordinate with emergency road transport for patients with strokes and other conditions in remote rural areas to ensure they arrive at hospital for treatment as quickly as possible. The public consultation report is available at: www.health-ni.gov.uk/reshaping-stroke-care.

RECONFIGURATION OF DIABETES SERVICES

111. Significant progress has been made with the implementation of the Diabetes Strategic Framework and action plan, which was published in November 2016.

112. Particular progress has been made in improving access to technology, with over 33,000 prescriptions written for flash glucose monitors this year.

113. Progress has also been made in establishing a prevention programme for those at high risk of developing the condition. The new *Diabetes Prevention Programme* is aimed at people who have been identified as pre-diabetic. The programme is facilitated by health coaches who help participants change their lifestyle, diet and physical activity.

114. In addition, an education programme has now been established for each type of diabetes, as well as agreement and implementation of standardised protocols for the management of diabetes in all inpatient settings. Progress has also been made in the development of a comprehensive foot care pathway, focussed on preventing foot complications caused by diabetes and reducing the number of amputations.

PROVISION OF IMAGING SERVICES

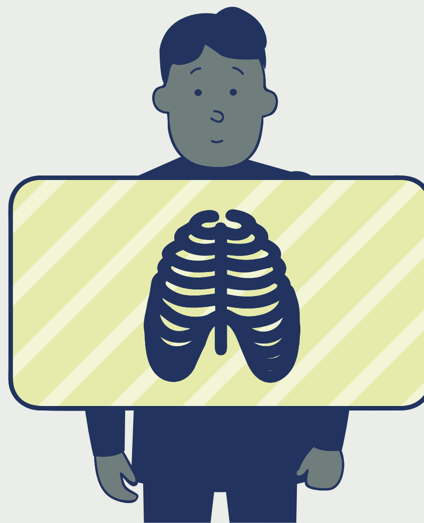
115. Imaging services are a critical component of the health service in terms of diagnosis, monitoring and treatment of diseases and conditions. In June 2018 the Strategic Framework for Imaging Services in Health and Social Care was published, with the aim of enhancing and modernising services over the next 10 years.[6]

116. As part of the framework a training scheme has been expanded to increase the number of radiology trainees, with the first cohort of these due to enter the workforce this summer. There has also been an expansion in the number of places on the undergraduate course for diagnostic radiographers.

6. www.health-ni.gov.uk/publications/strategic-framework-imaging-services-health-and-social-care

117. HSC Trusts are participating in a regional programme to achieve accreditation against the imaging quality and safety standards set by the Royal Colleges.

118. Work is ongoing to consider the future of picture archive and imaging systems. This will replace the three current imaging systems in use in Northern Ireland with a single regional service. It aims to improve patient safety through an improvement in patient diagnostic services and improved ability to share imaging information regionally.



IMPLEMENTATION OF PAEDIATRIC SERVICES

119. *Delivering Together* committed to launching and commencing work on the implementation of paediatric strategies. The two 10 year children's strategies, 'Strategy for Children's Palliative and End-of-Life Care', and the 'Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community', were published in November 2016.

120. To date, work to implement these strategies has focused on delivering age-appropriate care, reducing Emergency Department attendance and hospital admissions, chronic disease management, establishment of a Child Health Partnership Network, and improving palliative and end-of-life care for children and young people.

121. To deliver age-appropriate care, the initial focus has been on implementing the regional minimum upper age limit for paediatric services to the 16th birthday. Southern, Northern, Western and South Eastern Trusts have now implemented this across their paediatric services.

122. The Belfast Trust is working towards full implementation of the upper age limit at the Royal Belfast Hospital for Sick Children, subject to resources continuing to be made available. The next phase will be to develop improved transition arrangements and to secure wider adolescent health service improvements.

123. Transformation Funding has also allowed Trusts to introduce a range of initiatives, including strengthening community services to reduce the need for unscheduled hospital attendances, and expanding short-stay assessment services. These short-stay assessment units provide ambulatory care as well as assessment and treatment of acutely unwell children, avoiding the need for hospital admission where possible. Other new models of care are also being developed, including the development of primary care paediatric hubs where specialist paediatrians work alongside general practitioners and other members of the primary care team.

124. In the management of chronic disease, all HSC Trusts have identified psychology support as a priority development area. Investments have been proposed to improve equity of access to psychology services for children with long term conditions.

125. Design of a Paediatric Network was completed in January 2018, with a view to establishing a Child Health Partnership which would oversee strategy implementation, allocate resources, agree on the optimal configuration of services and ensure equity of provision across Trust boundaries. The programme manager for the partnership took up post in March 2019.

126. Implementation of the paediatric palliative care strategy is underway. A pilot, *Palliative and Life Limited Service (PALLS)* has been funded to base a specialist palliative care nurse in the Royal Belfast Hospital for Sick Children, and the Royal Jubilee Maternity Hospital since September 2018, as well as one additional bed in the Northern Ireland Children's Hospice since October 2018. The PALLS nurse works closely with teams across the HSC to identify infants, children and unborn babies who are life-limited or have palliative care needs, and put in place support and services, including advanced care plans.

127. Funding has been provided to give every Trust a named medical lead for children's palliative care.

128. Advanced nurse practitioner roles in children's nursing have also been developed with the first locally trained advanced nurse practitioners qualifying in 2019. The introduction of these new roles will serve to enhance the children's nursing workforce in the provision of high quality, safe and effective care to children and their families.

RECONFIGURATION OF PATHOLOGY SERVICES

129. Work is under way to develop a new regional management structure by 2021 for the delivery of modern, flexible and agile pathology services that can respond to changing demands arising from wider service reform.

130. Progress is also under way to enable significant modernisation by replacing current laboratory systems with a modern, single, regional Laboratory Information Management System by 2023.

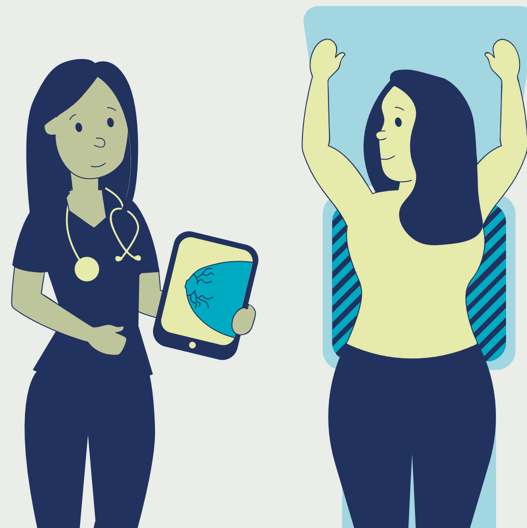
131. This new system will ensure ongoing and sustainable delivery of information management to HSC pathology services across the region, through provision of a modernised information technology (IT) solution. It will support and enable transformation of both HSC pathology services and wider HSC services, and reduce unnecessary variation in delivery of pathology services. It will also support improved clinical outcomes through enhanced integration and sharing of information.

RECONFIGURATION OF BREAST ASSESSMENT SERVICES

132. In the absence of change, waiting times for breast assessment are expected to worsen, with demand projected to increase in the years ahead. A public consultation was launched on 25th March 2019 with proposals for the future of breast assessment services in Northern Ireland. The public consultation proposes three breast assessment locations: Altnagelvin Hospital; Antrim Area Hospital; and a greater Belfast location, likely to be the Ulster Hospital. The aim is to establish a model of care which will ensure high quality, safe, sustainable, accessible and timely services. A centralised appointment booking system is also planned as part of the proposed reforms.

133. The future model of care will also include the establishment of a regional Breast Assessment Network to shape and support service provision. There are no plans to change the current breast screening arrangements.

134. The public consultation will run until 19th July 2019, and is available at: www.health-ni.gov.uk/consultations/reshaping-breast-assessment-services. A rapid review of breast surgery has also been initiated and will report by the end of 2019.



RECONFIGURATION OF URGENT AND EMERGENCY CARE (UNSCHEDULED CARE)

135. A review of urgent and emergency care – also referred to as unscheduled care - is now underway. The review aims to establish a new regional care model, giving specific consideration to the most appropriate arrangements for the assessment and admission of older people, as well as providing the best appropriate care for people of all ages.

136. A project has now been established to take this work forward, with initial engagement activity and information gathering underway. The proposals arising from this work will also be subject to public consultation in due course.

137. This review follows completion of a 'Public Health Needs Assessment for Urgent and Emergency Care' commissioned by the Department of Health and which is available to view at: www.health-ni.gov.uk/publications/northern-ireland-needs-assessment-urgent-and-emergency-care.

138. Later this year, the first 10 locally trained emergency care advanced nurse practitioners will take up permanent posts within Emergency Departments, fulfilling a vital function in the assessment, diagnosis, treatment, referral and discharge of patients.

139. This work will link closely with reforms in primary care, including testing new models for early evening care, and the development of multi-disciplinary teams.

RECONFIGURATION OF PLASTICS AND BURNS SERVICES

140. The Regional Plastic Surgery and Burns Project Board continues to make good progress to identify a future service specification for the service in 2019.

141. A needs assessment is completed or is substantially underway in a number of sub specialist areas including orthoplastics, skin cancer, hand and upper limb, breast and burns. The Belfast Health and Social Care Trust is also finalising its self-assessment against the National Burn Care Standards.

142. To date one additional plastic surgeon has been appointed. Commitment has also been given for two more plastics surgeons, one with a sub specialism in orthoplastics and the second with a sub specialism in sarcoma and skin cancer. Investments are also planned in paediatric burns for nursing and psychology and for AHP hand therapists.

RECONFIGURATION OF CANCER SERVICES

143. Work is underway on a review of oncology services to understand how the HSC can best meet patients' needs so that they can receive the most appropriate care in the most appropriate place.

144. New treatment pathways are being developed, involving those with lived experience of cancer services, and staff, to provide treatments closer to home where possible, and centralised where necessary. In future patients will be able to have more systematic anti-cancer therapy (chemotherapy) treatments in their local cancer unit.

145. To improve sustainability, work is ongoing to set out developments needed within the nursing, pharmacy, radiography and medical physics workforce to enable them to deliver some less complex activities in patient treatment.

146. This will result in medical staff time being made available for patients who require more complex treatments. These developments will improve the access and experience of care for many patients, particularly when there is a predicted significant rise in the population who will experience cancer in the future.

147. The Department of Health has also announced that it is to commission a new cancer strategy for Northern Ireland. The central goal of the new strategy will be to identify new ways of working to secure further advances across cancer care, working with patients, staff and cancer charities in its development. Decisions on the implementation of a new strategy would be for a future health minister.

RECONFIGURATION OF NEUROLOGY SERVICES

148. In response to service pressures, the Department of Health announced a review of neurology services in July 2018. A *neurology review team* has been established to identify the optimal service specification for neurology services for the next 10-15 years. This will include the development of principles and standards, the design of improved pathways for patients and measures to address workforce pressures. An interim report will be published shortly, with a final report later in 2019.

NEW CLINICAL RESPONSE MODEL FOR THE NORTHERN IRELAND AMBULANCE SERVICE

149. Recognising the pressures on services, the Northern Ireland Ambulance Service developed a new Clinical Response Model for public consultation. The next steps in this process are now under consideration.

150. In the short-term, a number of measures have been introduced to reduce pressures. Transformation Funding is currently being used to train student paramedics, emergency medical technicians and ambulance care attendants in the full range of clinical skills which will support the ambulance service to deliver its vital services.

151. In the longer term there are proposals for further paramedic training. A 10 year forward plan is being progressed that will include a programme of innovative projects.

ORGANISING OURSELVES TO DELIVER:

152. We continue to implement the decision to close the Health and Social Care Board (HSCB), and put in place new organisational arrangements which will see the Department of Health take firmer strategic control of the health and social care system, with clearer accountability and reduced complexity.

153. A new operating model has been agreed, and detailed design is underway. All changes are being developed in the context of supporting the new models of care and the broader transformation agenda as set out in *Delivering Together*.

SECTION 5: ENABLING TRANSFORMATION

ENABLING TRANSFORMATION:

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

PARTNERSHIP WORKING

154. Significant progress has been made to enable better partnership working with those who use and deliver our services. A key step in this work has been the formation of a *co-production working group*. Led by the Chief Nursing Officer, and involving people with a vast range of relevant experience, this group developed a co-production guide to support partnership working across health and social care.

155. Launched in August 2018 the guide is a living document that provides underpinning principles for co-production; providing definitions of key terms, and giving practical guidance.

156. Building on this the focus now is on embedding these new ways of working through amongst other things a series of co-production implementation discussions and planning events for the health and social care system and its partners.

157. In addition, work continues on the development and procurement of an online Real Time User Feedback System.

IMPROVE QUALITY

158. *Delivering Together* outlines that, in the design and delivery of health and social care, quality and safety will always be a fundamental priority. It outlines the need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. Working on the principles of: Learn together, Share together, Improve together, the Health and Social Care Quality Improvement team (HSCQI) is focused on building relationships and connections across system and professional boundaries.

159. Since its launch in April 2019, HSCQI has begun to provide greater focus on delivery of its main objective – providing co-ordinated regional support for the spread of specific quality improvement initiatives to build on what already exists; by connecting improvement activity and people together, to deliver regional improvement.

160. HSCQI communities of practice have been established to share and promote collective approaches to practice across organisational boundaries. Each community of practice has a different focus, in areas such as workforce, innovation, and evaluation.

161. To inform HSCQI development and its operation, an improvement prototype has been identified to test scale and spread through extending the work of the safety forum on sepsis management.

162. 26 participating units have been identified across all HSC Trusts encompassing Emergency Departments, Acute Medical and Acute Surgical Units and a Critical Care Unit. This prototype will seek to improve compliance on sepsis across Northern Ireland.

163. For more information go to: http://qi.hscni.net/.

INVEST IN OUR WORKFORCE

164. The HSC Workforce Strategy[7] has been developed by organisations across the health and social care sector in close co-operation with trade unions and other key stakeholders. It includes a detailed look at the workforce challenges and was produced following significant engagement with the workforce.

165. The strategy considers areas such as retention and recruitment of staff, opportunities for introducing new job roles and upskilling initiatives. It also focuses on ensuring that health and social care is a rewarding and fulfilling place to work and train.

166. Early work is now underway on a plan to establish a HSC careers service to promote health and social care careers and allow returners to the service to easily re-engage with the system.

167. Paramedics are now formally members of the allied health professions, and a paramedic science foundation degree began in January 2019, with 48 students taking place, in preparation for the commissioning of a Bachelor of Science course.

168. Work is also well underway on the single lead employer project for doctors and dentists in training, with the initial tranche to transfer by 1st August 2019.

7. https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

169. Significant developments have also been made in recruitment, with, for example, 11 new physician associates placed in March 2019, a further 20 trainees now engaged in training, and 99 additional nursing and midwifery places taking the total nursing and midwifery students to over 1000; the highest level ever educated in Northern Ireland.

170. The implementation of the *Retain Scheme* – a project focused on nursing staff working in ten older peoples' wards across the five HSC Trusts - has resulted in improved retention of nursing staff with up to a 66% improvement in nursing vacancies in these wards. Also proving successful is the *GP Retainer Scheme*, designed to assist in the retention of GPs in primary care, with 11 places available due to Transformation Funding support.

171. The *GP Induction and Refresher Scheme* is another investment in our workforce, which provides an opportunity for GPs who meet the required criteria to safely return to general practice following a career break or time spent working abroad. This scheme is also supporting the safe introduction of overseas GPs and provides support to GPs returning to or entering clinical practice. At March 2019, seven doctors were completing the scheme, with six already completed.

172. Health literacy is about giving health professionals the skills to explain medical issues in a way that people can understand and empower them to better manage their own health or medical condition. *Making Every Contact Count* training has been provided alongside health literacy to give staff the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them.

173. As part of the development of primary care, multi-disciplinary team training is being delivered to a wide range of primary care professionals including community pharmacists and GPs to help them improve health literacy.

174. Work is also underway on the development of a long-term training and development strategy, a review of medical school places has been published, and work is ongoing on criteria for prioritising workforce reviews, to populate the proposed optimum workforce model.

PLACE A STRONG FOCUS ON COLLECTIVE LEADERSHIP

175. The implementation and embedding of the HSC Collective Leadership Strategy is now being mobilised. Launched in October 2017 it sets out the framework for creating a leadership culture based on the principles of quality, continuous improvement, compassionate care and support.

176. The development of the strategy embodied a partnership approach. The work was led by a core group with a wide membership, including representatives from across the health and social care system, the Department of Health, trade unions, clinicians, service users and the voluntary and community sector with over 400 people contributing to its development through engagement events.

177. Work is advanced on the delivery of the actions as set out in the strategy. A set of core values and behaviours have been developed for the health and social care system and will be launched later in 2019.

178. In 2019/20, baseline information will be gathered through a regional staff survey and a cultural assessment tool. This information will be used to monitor the outcomes and review the implementation of the collective leadership strategy.

179. For more on the new HSC values and behaviours, and on collective leadership in action, go to the Interactive Delivering Together Progress Report at: https://www.health-ni.gov.uk/progressreport2019.

FOCUS ON MAKING BETTER USE OF TECHNOLOGY AND DATA (eHEALTH)

180. The eHealth and Care Strategy sets out the HSC's approach to technology focussed on better supporting people, sharing information and fostering innovation in order to support change. An important element of this work will be the modernisation of outdated systems and hardware. Delivering this strategy is essential if we are to deliver on the ambitious aims set out in *Delivering Together*.

181. The continued roll-out of eTriage is speeding up referrals to hospitals and reducing unnecessary paperwork. This system will also allow hospital doctors to give written advice to GPs to help them manage patients. As part of this roll-out a new approach to dermatology referrals has been trialled which uses technology in GP practices to take images and transfer them safely to hospital clinicians for assessment. This has resulted in a 59% downturn in the most urgent 'red flag' demand and a 30% decrease in patients requiring an outpatient appointment so far.

182. Northern Ireland already has an award winning clinical portal, the Northern Ireland Electronic Care Record (NIECR) which allows clinicians in different settings to see and record key information about patients improving safety and supporting better care. This system continues to be developed, widening access to community pharmacists and optometrists, for example, to help improve the accuracy of prescriptions and support the provision of more tailored advice to patients.

183. While the NIECR continues to help transform care, it has to draw on a large number of separate systems to present key summary information to clinicians and other professionals. *The Encompass programme* is intended to deliver an integrated electronic health and care record across our acute and community services – replacing the myriad of separate systems currently in place. It will remove the need for many paper based processes which are currently required, freeing up professionals to spend more time providing direct patient care - and it will improve patient safety by allowing all professionals involved in a patient's care to view the same information, improving treatment plans.

184. Having *Encompass* in place will underpin transformation and help ensure service users receive the best possible care whichever location they are in. *Encompass* will enable data to be used more pro-actively to predict where we can make interventions before people need hospital care, and to work more closely with service users to help them manage their own care.

185. A new platform for sharing information about patients in general practice – the *General Practice Information Platform* – which is currently being rolled out, will support GPs to provide this proactive and preventative care for their patients.

186. Alongside *Encompass* the systems used to support the work of our HSC laboratories, who complete vital tests to help clinicians diagnose and manage care, and the system used to capture images such as x-rays and computerised tomography (CT) scans, which are equally critical to diagnosis and condition management will be replaced. Both these programmes will consolidate existing systems, make it easier to share information across sites, and underpin change and transformation in these service areas.

187. Supporting people to manage their own health and wellbeing is at the centre of *Delivering Together* and a continued investment in technology will give people access to their health and care record to allow them to do that. A patient portal pilot, *'My Care Record'* provides secure on-line access to the health and care electronic records for both patients and carers. The first group of patients and carers using the system are those living with, or caring for those, with dementia. Both the functionality and the availability to other patient groups will expand over time.

188. To further support people to self-manage their own health and wellbeing a new on-line A-Z symptom search facility is now available on the nidirect website at: www.nidirect.gov.uk/information-and-services/health-and-wellbeing/illnesses-and-conditions .

189. In addition telecare services have been successful in enabling people to lead independent lives and remain in their own home for longer.

190. Technology has never been so important in underpinning transformation. It is therefore important that these new uses of technology are built on firm foundations, with the right technical infrastructure in place, and reassurance that our systems are secure. Investment continues in cyber-security and technical infrastructure. The recent appointment of a new Chief Digital and Information Officer at the Department of Health provides a single point of leadership to help ensure best use of technology and our rich data sources in order to enable transformation.

SECTION 6: SUMMARY

191. Two and a half years – a quarter of this 10 year journey – have now passed, with health and social care transformation well underway.

192. Solid foundations have been laid, in the shape of new multi-disciplinary teams, and day case surgery hubs, which are directing the flow of patients away from under pressure hospitals and emergency departments, and supporting primary care colleagues to better manage the needs of local people.

193. The Confidence and Supply Transformation Fund has allowed many initiatives to get underway in 2018/19, that would not otherwise have been able to do so; and the recruitment that this has supported, into vital roles across the system, will make a significant difference in terms of the capacity to progress new, transformative ways of delivering services.

194. The work being undertaken to review and reconfigure important services, such as urgent and emergency care, cancer, pathology, stroke and breast assessment services, will build on progress to date, and see new ways of working introduced and – importantly informed, by those who use, and deliver them.

195. There is no doubt that there is much more to do.

196. It is widely accepted that transformation of HSC services is a complex, long-term ambition dependent on a wide range of enablers, including political leadership and additional investment.

197. However, the clear direction of travel, set out within Health and Wellbeing 2026: *Delivering Together*, continues to guide the changes which need to be made and represents the only long-term answer to the significant challenges currently faced by the Health and Social Care system here.

APPENDIX 1:

MEMBERS OF THE TRANSFORMATION ADVISORY BOARD:

- Minister of Health (Chair)
- Rafael Bengoa (Chair of Expert Panel)
- John Patrick Clayton (Trade Union representative)
- Seamus McAleavey (Voluntary and Community sector representative)
- Mairead McAlinden (Expert Panel member)
- Brian O'Hagan (Co-chair of the regional PPI forum)
- Richard Pengelly (DoH Permanent Secretary and Chair of the Transformation Implementation Group)
- Maria Somerville (Person with caring experience)

MEMBERS OF THE TRANSFORMATION IMPLEMENTATION GROUP:

- Richard Pengelly (Permanent Secretary, DoH; Chair)
- Michael Bloomfield (Chief Executive, NIAS)
- Shane Devlin (Chief Executive, SHSCT)
- Martin Dillon (Chief Executive, BHSCT)
- Sharon Gallagher (Deputy Secretary, DOH)
- David Gordon (Director of Communications, DoH)
- Neil Guckian (Interim Chief Executive, SEHSCT)
- Sean Holland (Chief Social Services Officer, DoH)
- Jackie Johnston (Deputy Secretary, DoH)
- Anne Kilgallen (Chief Executive, WHSCT)
- Charlotte McArdle (Chief Nursing Officer, DoH)
- Michael McBride (Chief Medical Officer, DoH)
- Liam McIvor (Chief Executive, BSO)
- Deborah McNeilly (Deputy Secretary, DoH)
- Tony Stevens (Chief Executive, NHSCT)
- Alan Stout (General Practitioner)
- Mark Taylor (Consultant in General and Hepatobiliary Surgery, BHSCT)
- Valerie Watts (Chief Executive, HSCB and Interim Chief Executive, PHA)
- Dan West (Chief Digital Information Officer, DoH)

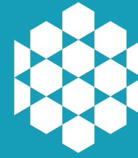
APPENDIX 2: The table below sets out an update on the 18 priority actions within *Delivering Together.*

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work the Health and Social Care Board, as well as the recommendations from the Expert Panel	January 2017	Complete - Elective care plan published.	
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: • increased GP training places; • continued investment in practice based pharmacists; • ensuring every GP practice has a named district nurse, health visitor and social worker to work with; • supporting the development of new roles such as physician associates and advanced nurse practitioners; and • further rollout of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	March 2017	Complete - Multi-disciplinary teams are being rolled out in three areas, with a focus now on practice based social workers. Consideration is being given to consultation on GP Federations in the absence of a minister.	
3	Bring forward proposals relating to the extension of placement options for **Looked after Children**.	October 2017	Complete - A consultation analysis will be published in the coming weeks.	
4	Following the completion and evaluation of a pilot project, roll out access to the NIECR to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists**.	October 2017	Complete – Access for independent optometrists is now available. Roll out to community pharmacies is ongoing.	
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	November 2016	Complete - A contractual framework has been developed.	

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	November 2016	Complete - Criteria for service reconfiguration published. Programme of service reconfiguration reviews underway.	
7	Following extensive review and engagement, launch a public consultation on proposals to modernise and transform **pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future	November 2016	Complete - Consultation completed in February 2017.	
	Move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups.	November 2016	Complete - Diabetes Strategic Framework published November 2016.	
	Launch and commence implementation of the **paediatric strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families.	November 2016	Complete - Paediatric strategies published in November 2016.	
	Launch a public consultation on proposals to develop sustainable **stroke** services and further improve the standard of treatment and care provided to stroke patients.	February 2017	Complete - A consultation on reshaping stroke care was launched on 26th March 2019.	
	Following a recent review, launch a public consultation on the configuration of **imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice.	February 2017	Complete - Public consultation launched 26th October 2017.	

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres**.	October 2017	Complete - Work concluded in November 2017 with delivery of a Task and Finish Group report.	
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	March 2017	Complete - Operating model agreed.	
10	Identify current ***innovative HSC projects*** at a local level and develop a rolling programme and implementation plan to scale up these projects across the region.	April 2017	Complete - Programme of innovative projects agreed.	
11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	November 2016	Complete - Engagement launched by minister.	
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	November 2016	Complete - Oversight structures in place.	
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the longer term sustainability of the adult social care system.	April 2017	Complete - Consultation complete.	
14	Design complete and procurement in progress for a **new user feedback platform** open to all those who both use and deliver our services.	October 2017	Complete – Design complete and procurement in progress.	
15	Complete the initial design work for the **Improvement Institute**.	February 2017	Complete - Initial design work completed by February 2017.	
16	Develop a **workforce strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	May 2017	Complete - Workforce strategy agreed.	

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
17	Develop an **HSC-wide leadership strategy**, to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	May 2017	Complete - Strategy agreed August 2017.	
18	Expand the range of information and interaction available to citizens on-line and development of a **patient portal** for dementia patients.	October 2017	Complete - Symptom Checker available on nidirect in January 2019. A patient portal went live in December 2018.	



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HEALTH AND WELLBEING 2026 DELIVERING TOGETHER

PROGRESS REPORT – 2021

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SECTION 1: MINISTERIAL FORWARD

'Health and Wellbeing 2026: Delivering Together" was published in 2016 in response to huge strategic challenges, including an ageing population, increasing demand, long and growing waiting lists, workforce pressures, the emergence of new and more expensive treatments, and ongoing budget constraints. The strategic direction sought a transformed health and social care service, both in delivery and in planning.

Since becoming Health Minister, I have repeatedly expressed a wish to continue the journey to improve our health and social care services. I am determined to strengthen the health outcomes for our population by making our system better.

This is particularly relevant considering the current context when our services are under considerable pressure. Whilst the pressures were present before the pandemic, they have only increased since March 2020. In my time as Health Minister I have therefore continued with the improvement journey started in Delivering Together. Even whilst in the grips of a pandemic almost £100m of transformational projects were delivered in 2020/21 further improving outcomes through new, innovative, working.

The impressive progress outlined in this report highlights the effects of a dedicated workforce, who are committed to always improving the outcomes for the whole population of Northern Ireland.

I would like to thank all those who have been involved in planning and delivering these projects. You deserve full recognition and admiration. With your help and support to continue to strengthen our health and social care service we are undoubtedly in a better place than we would have been without the successful delivery of the projects. By doing this we can collectively ensure that Northern Ireland continues to improve our health and social care services to deliver the best outcomes for everyone in society.

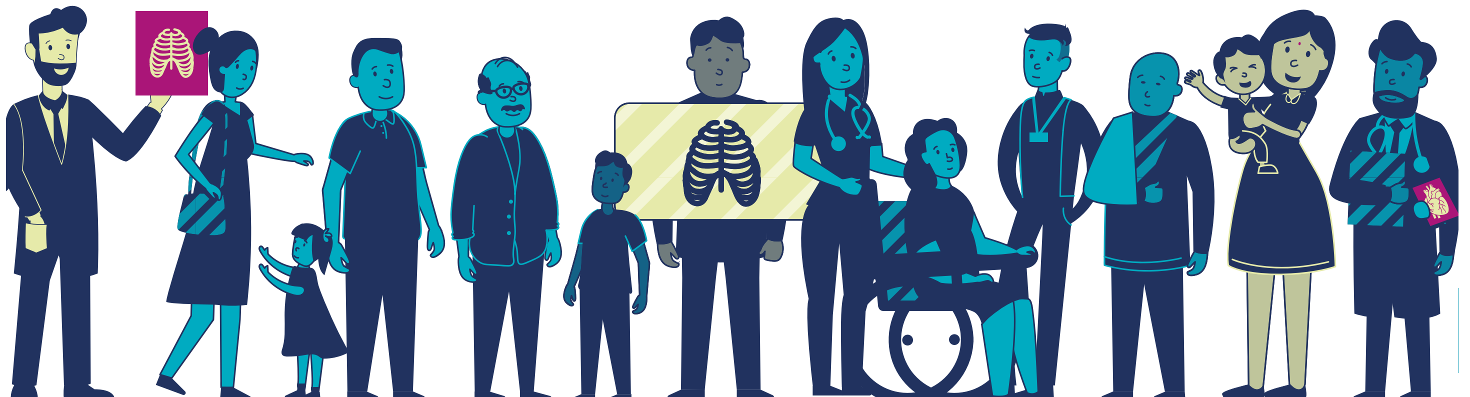
This reports outlines the progress made by projects on the ground across a broad range of critical areas – amongst many other initiatives – the reconfiguration of existing services, improved capacity and flow of patients through hospitals, supported and expanded primary care services, strengthened the workforce, invested in e-health, innovation and leadership and developed new practises in social work.

The evidence contained within this report confirms that this programme of activity has been hugely successful in stabilising, reconfiguring and improving our health and social care services.

I am delighted to publish this third progress report which provides an update on the extensive activity undertaken during 2020/21 to help realise the complex long term ambition to improve our health and social care system as detailed in Delivering Together.

Robin Swann, MLA
Minister of Health

SECTION 2: AMBITION



SECTION 2: AMBITION

Since the advent of 'Health and Wellbeing 2026: Delivering Together' in October 2016, it has been recognised that the journey of Transformation would be an iterative one. And this has been the case.

As was clearly set out in Delivering Together, we faced huge strategic challenges prior to Covid-19. These included an ageing population, increasing demand, long and growing waiting lists, workforce pressures, the emergence of new and more expensive treatments, and ongoing budget constraints.

In just under four and a half years, an extensive catalogue of initiatives - spanning the length and breadth of the HSC - has been progressed which has both challenged and supported the system.

The process of transformation has supported the stabilisation of services and laid important cornerstones in services - such as acute care at home and ambulatory care - which have become integral to the effective running of the system.

It has significantly tested our appetite and ability to reconfigure services in areas such as Stroke and Urgent and Emergency Care, and shone a light on the system's capacity, capability and willingness to truly transform through the creation of new care pathways in Primary Care Multi-Disciplinary Teams and through Day-Case Elective Care Centres.

It has also supported a much needed focus on workforce, and re-emphasised the importance of this most valuable asset in creating a sustainable system for the future.

SECTION 3:
LEADING & SUPPORTING CHANGE

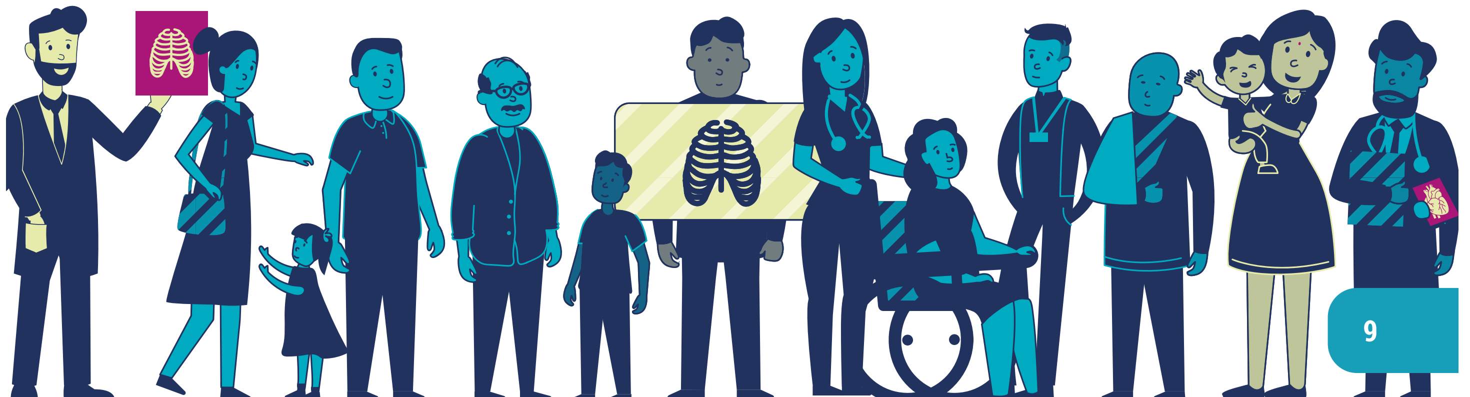
SECTION 3: LEADING AND SUPPORTING CHANGE

The governance arrangements for the Transformation of Health and Social Care services initiated by Health and Wellbeing 2026: Delivering Together had two elements; the Transformation Implementation Group which provided strategic leadership for the Transformation programme, and the Transformation Advisory Board, whose role was to act in an advisory capacity to oversee the direction of reform and complement the work of the Transformation Implementation Group.

In response to the COVID-19 pandemic the Strategic Framework for Rebuilding HSC Services was published on 9 June 2020. A new Rebuilding Management Board was established to oversee the Department's work on Rebuilding. The Rebuilding Management Board, subsumed the role of the Transformation Implementation Group and took on responsibility for consideration of key strategic Transformation decisions, in the context of rebuilding.

The Transformation Advisory Board will continue as a forum for engagement on the approach to transformation within the broader strategic context.

SECTION 4: PROGRESS AGAINST OUR AMBITIONS



SECTION 4: PROGRESS AGAINST OUR AMBITIONS

Delivering Together committed to transforming the whole HSC, as one system, by:

- Building capacity in communities and in prevention
- Providing more support in primary care
- Reforming our community and hospital services
- Organising ourselves to deliver
- Enabling transformation

This section of the report details the funding allocations made to and progress made by 92 Transformation projects which were on the ground in the 2020/21 financial year.

IMPLEMENTING A DIABETES PREVENTION PROGRAMME FOR AT RISK PEOPLE IN NORTHERN IRELAND

Objective

To introduce and evaluate a diabetes prevention programme in Northern Ireland.

Total Investment

£1,613,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementing a diabetes prevention programme for at risk people in Northern Ireland	253	558	802	1,613

Regional Project

Yes.

Progress

An evidence based diabetes prevention programme has been introduced across Northern Ireland.

After its first year of operation the project demonstrated evidence of lifestyle changes within those patients taking part in the programme, including reduction in weight and a reduction in HbA1c levels which will reduce the risk of the development of Type 2 diabetes.

There have been 107 diabetes prevention programmes with 2120 participants commenced between April 2019 and March 2020. Positive early outcomes, for those completing the programme over a nine month period: include 63% reduced HbA1c, 29% no longer within pre-diabetic range, and 25% remaining the same (delayed onset).

For the first year of the programme, an evaluation plan was developed and operationalised with data evidencing that the service was acceptable from both the perspective of those taking part, and from primary care teams making referrals to the service.

The impact of COVID-19 meant that the programme became virtual in the second year of operation, demonstrating its adaptability.

A further 54 virtual programmes began in 2020 hosting 578 participants and whilst it is too early to ascertain what the retention rates are with this virtual programme, 80% of participants remain engaged.

In total, of the 1,064 participants who have completed the programme to date (as at November 2020):

- 72.6% had reduced HbA1c
- 59.8% are now within a normal range
- 12.6% had no change in HbA1c – a positive outcome as no progression
- 15% of participants had an increased HbA1c
- There was an average 4.4kg weight loss
- There was an average weight loss of 5.7% of body weight

Strategic Importance

Type 2 diabetes is one of the most common long-term health conditions in Northern Ireland, associated with significant morbidity, mortality and healthcare costs. Delivering Together aims to manage the ageing population with long term conditions. It is estimated that by 2027 there will be a further 45,000 cases of Type 2 diabetic patients across Northern Ireland.

In addition, NHS England and Diabetes UK have summarised their findings on the links between COVID-19 related deaths and diabetes stating that of all COVID-19 hospital deaths in England between March and May 2020, a third of these deaths happened in people with diabetes.

TRANSFORMATION OF HEALTH CARE IN THE CRIMINAL JUSTICE SYSTEM

Total Investment

£1,588,000

Objective

To improve access and the quality of health care in the Northern Ireland prison system in line with the strategic direction set out in the Joint Department of Justice / Department of Health Action Plan.

In addition, in terms of the wider criminal justice pathway, to pursue the partnership working between the Department of Justice and the Department of Health to roll-out nurse led provision in custody suites across Northern Ireland.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Prison Healthcare	142	333	350	825
Piloting a nurse-led on-site police custody healthcare service	290	220	253	763
	432	553	603	1,588

Regional Project

Yes. The South Eastern HSC Trust (SEHSCT) provides healthcare for the whole of Northern Ireland's prison population.

Progress

The SEHSCT have progressed five projects in relation to prison healthcare that have been assessed by HSCB and PHA professionals, as delivering real benefits to the prison population across all prison settings.

Allied Health Practitioners have provided new services across a range of areas, for example, dietetic practitioners have supported over 200 men with advice and courses, such as the expansion of the Cook It programme via the training of 12 new tutors.

Physiotherapists have held over 85 new clinics, seeing over 580 clients for Chronic obstructive pulmonary disease related issues, with 275 GP appointments released as a result of this work.

Additional pharmacy capacity within prisons has improved medicines management along with the promotion of the physical health benefits to prisoners with regard to smoking cessation. Between April 2019 and March 2020, 34 prisoners participated in smoking cessation activities.

A peer support worker initiative has assisted in addressing the high levels of mental health and anxiety

within the prison population. Peer support workers provide both group, and one-to-one interventions, and hold a case-load of 10 individuals at any one time.

Nursing Assistants were introduced to offer skills mix and ensure nursing time was used effectively. In addition, these nursing assistants are now in a position to be accepted on to the Open University's Nursing Programme and to work towards professional registration.

In respect of the provision of health care in police custody suites, this joint initiative with the Department of Justice was established as a pathfinder in Musgrave Street Police Station, Belfast.

Such has been the success of this pathfinder that, in May 2020, the Police Service of Northern Ireland (PSNI) and Public Health Agency (PHA) submitted a joint business case for its roll out across all PSNI custody suites. The business case detailed monetary and non-monetary benefits including that since the introduction of the nurse led model, there has been a significant reduction in detained persons being referred for treatment in hospital emergency departments as they are now able to receive appropriate treatment within the custody suite. The number of referrals to hospital dropped by 42% from December 2018 – November 2019, compared to the previous year. Since the business case was submitted the custody pathfinder has also embarked on a pilot to screen for Blood Bourne Viruses (BBV), commenced a Clean Needle Provision Service and administers Covid-19 screening to help limit the spread of the virus in police custody. The roll-out of the scheme has been delayed but it is envisaged that it will be operational in Antrim Custody Suite by the end of 2021/22.

Strategic Importance

These initiatives support delivery of the, Improving Healthcare within the Criminal Justice Strategy and Action Plan, Health and Wellbeing 2026: Delivering Together, and the draft Programme for Government for Northern Ireland in that they are helping to address inequalities in Northern Ireland.

This is also further reflected in Making Life Better, and also in New Decade, New Approach, which reiterates the Northern Ireland Executive's intention to 'Delivering a fair and compassionate society that supports the most vulnerable'.

IMPLEMENTING A NEW METHOD OF CARDIAC REHABILITATION DELIVERY, OUR HEARTS, OUR MINDS PROJECT

Objective

To help individuals across the cardiovascular disease spectrum by implementing an innovative evidence-based, community preventive cardiology programme delivered by a multidisciplinary team.

Total Investment

£1,697,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementing a new method of cardiac rehabilitation delivery, Our Hearts, Our Minds	199	758	740	1,697

Regional Project

No. Project delivered within Western HSC Trust only.

Progress

A total of 990 patients have taken part in the programme which is now well established and has shown substantial improvements across all the domains of cardiovascular health including:

- A reduction of 54% in smoking status;
- Improvement in adherence to a cardio-protective diet, evidenced by an increase of three units in the Mediterranean Diet Score. To put this in context, an increase of 1.5 units is associated with a 30% relative risk reduction in cardiovascular disease events;
- Improvement in physical fitness as evidenced by an increase in METs (a ratio of your working metabolic rate relative to your resting metabolic rate) from 6 - 7.5. To put this in context, one MET increase is associated with an 8-17% reduction in all-cause mortality;
- A reduction in weight by 3.2kg in those who had a BMI greater than 25kg/m2, as well as reductions in central obesity – i.e. waist circumference reduced by 5cm;
- Overall achievement of blood pressure and cholesterol targets of 89%, and prescription of statins and Angiotensin-converting enzyme (ACE) inhibitors of 98% and 96% respectively at the end of the programme.

In May 2020, in response to the Covid-19 pandemic, the programme transitioned rapidly to a virtual platform which included assessment via video/telephone, group virtual education sessions and the provision of a Fitbit smartwatch to patients.

The Western Trust is to become the first healthcare institution in the world to offer its cardiovascular patients a Fitbit smartwatch in combination with an app to detect atrial fibrillation through the programme. The Trust is reporting adherence and attendance rates being extraordinarily high and demonstrating a decrease of 9% in re-admission rates compared to the same period the previous year.

Strategic Importance

The Our Hearts Our Minds project contributes to the Delivering Together aim of Building Capacity in Communities and in Prevention. The outcomes for the project will be used to inform the future delivery of cardiac rehabilitation across Northern Ireland. A cardiac rehabilitation needs analysis is due to be carried out across all Trusts from March 2021 to assist with this.

COMMUNITY DEVELOPMENT FRAMEWORK IMPLEMENTATION

Objective

To implement the Community Development Framework through the development of a capacity building programme, ELEVATE, and the establishment of a governance structure, the Implementation and Innovation Board.

Total Investment

£649,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Community Development Framework implementation	113	350	186	649

Regional Project

Yes.

Progress

The ELEVATE programme was established to build the capacity of individuals and organisations to use community development approaches as a way to reduce health inequalities.

Significant progress has been made including:

- Establishment of an online Community Development Portal that has seen almost 6,000 users this year;
- Building sustainable resilient communities through positive collaboration mentoring of organisations / groups via the development of a community mentorship programme, with five mentor organisations (one per Trust area) supporting a total of 34 organisations in 2020/21.
- Online training has been delivered to 201 participants this year, from a range of sectors including the community and voluntary, HSC Trusts, Allied Health Professionals, GPs, and other Government Departments.
- Developing and refining an evaluation framework to demonstrate the impact of Community Development. To date 38 participants have received training on the framework, which will be piloted by the Public Health Agency from April 2021.

In addition to the ELEVATE programme, a Community Development Implementation and Innovation Board (IIB) has been established to support the delivery of ELEVATE and embed effective community development practice across health and social care and wider statutory and community based organisations.

The programme adapted very quickly and moved online in response to the pandemic, with feedback from participants positive throughout. To date this year, all 20 of the planned training workshops have been carried out with 201 participants while a waiting list for further training has been established.

An early evaluation completed in March 2020 by Community Evaluation NI, highlighted that the programme has been welcomed across the wider health and social care system and community and voluntary sector, and demonstrates enhanced skills and knowledge regarding community development approaches to tackle health inequalities as a result of the training.

The project is playing a vital role in supporting the most vulnerable by equipping grass roots community development organisations, practitioners and volunteers with the tools, knowledge and resources to identify, and take collective action on root causes of health inequalities.

In addition to the successes noted above, the IIB and the ELEVATE programme have also been supporting a number of other key transformational projects including an Integrated Care Partnership workshop with a subsequent health inequality pilot currently underway within the South Eastern Health and Social Care Trust (SEHSCT).

The long term aim of the project is to upskill community development practitioners with the knowledge, resources and support to engage with their local communities to identify local priorities, and to work in partnership with statutory providers to tackle the root causes of health inequalities. The project is assisting local communities to identify and find solutions to improving their own health and wellbeing outcomes and doing so with maximum economy

Strategic Importance

Community Development has a strong contribution to make to achieving health and wellbeing outcomes. The health and social care system, irrespective of how effective and efficient it can be can only ever address a limited dimension of health. It is the intrinsic resources of communities - their strengths, knowledge and skills that the Community Development Framework is harnessing. The project is aligned to a number of strategic plans including the draft Programme for Government, Making Life Better, Delivering Together and Community Planning Processes. The project contributes to the Delivering Together aim of Building Capacity in Communities and in Prevention.

DYSPHAGIA NI:

A PARTNERSHIP APPROACH TO SUPPORTING EATING, DRINKING AND SWALLOWING DIFFICULTIES FOR ADULTS IN NORTHERN IRELAND

Objective

To develop a partnership approach to support the eating, drinking and swallowing (dysphagia) needs of adults in Northern Ireland and enable an integrated approach to supporting improved access to services, early identification and prevention, learning from patient experience and improving the safety of people with swallowing difficulties.

Total Investment

£1,905,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Dysphagia NI	131	930	844	1,905

Regional Project

Yes.

Progress

A mandated safety programme has been implemented across Northern Ireland to improve the safety of adults and children with eating, drinking and swallowing difficulties and as a result, the eating and drinking care plans for 1,300 service users has been reviewed.

A regional eLearning programme has also been developed to support health care workers' knowledge, identification and management of people with swallowing difficulties. Within six weeks of the launch of this programme, 390 staff members had completed this online training and received certification. In addition, approximately 2,500 face-to-face dysphagia awareness training sessions have been provided across the HSC, including Trusts and independent care homes.

Work has also been progressed to improve the identification and management of dysphagia and to work towards regional consistency including; the introduction of a regional swallowing difficulties observational checklist; health professional access to dysphagia friendly medication information; and regional priorities and guidance documentation available on a single online platform.

With COVID-19 acting as a catalyst for the need to move to digital engagement, in this and many other services, a regional TeleEDS pilot was progressed.

This pilot has allowed clinical consultation via teleconferencing, improving access to services for care home residents, and providing professional support for staff managing people with swallowing difficulties.

As a result of this service redesign there has been a 91% reduction in waiting times for a routine swallowing assessment in care homes from 52 weeks to an average of 4.7 weeks. 109 patients were assessed and treated as part of the initial pilot phase.

As part of this pilot 1,550 dysphagia menus in residential care homes and acute care were audited to ensure suitable eating and drinking plans were in place, and a regional scoping exercise was carried out, with 120 service users, 74 stakeholders and 62 speech and language therapists consulted, to put people's voices at the heart of system change.

Work has also been progressed to raise public awareness of swallowing difficulties through GPs, pharmacies, and HSC Trusts. A regional partnership has been established between HSC Trusts, the HSCB, and PHA to collect and share Dysphagia data. Dysphagia guidance packs - sharing links to online information - were sent to 249 nursing homes, and 234 residential care settings during the pandemic.

Strategic Importance

The project is aligned to a number of strategic plans including Delivering Together which aims to build capacity in communities and in prevention, reform community and hospital services, and organise ourselves to deliver.

DEVELOPING A MULTI-DISCIPLINARY IN-REACH SUPPORT FOR NURSING AND RESIDENTIAL CARE HOMES

Objective

To enhance and expand the knowledge and skill of care home staff to meet the urgent and critical care needs of residents with the aim of reducing avoidable attendance at emergency departments, admission to hospital, and the appropriate use of out-of-hours services.

Total Investment

£1,917,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a Multi-disciplinary In-reach Support for Nursing and Residential Care Homes	240	879	798	1,917

Regional Project

Yes.

Progress

Multi-disciplinary Care Home Support Teams have been established in each Health and Social Care Trust area with a total of 23 staff including nursing, social work, physiotherapy and dietetic professionals working across five teams.

All Care Home Nursing Support Teams have been enhanced to respond to COVID-19, and became the single point of contact with care homes during the pandemic. These teams, provide updates / support in relation to the ever-changing guidance including e-learning links, Infection, Prevention and Control (IPC) guidance, swab testing, face fit testing and, COVID-19 testing. They also provide clinical care support to meet the needs of those communities of critically vulnerable people living in care homes.

Since 2018, the Care Home Nursing Support Team in the Belfast Health and Social Care Trust has placed emphasis on upskilling nursing home staff to develop clinical skills by undertaking routine catheterisations, gastrostomy tube changes, and managing syringe pumps independently. The result is that nursing teams now rarely have to provide this service.

In the Northern Health and Social Care Trust in 2019/20, as a result of the work of the Care Home Nursing Support Team, the number of referrals to the hospital diversion team reduced from a peak of 12 per month, to a maximum of two per month.

The overall complaints and incidents reported by care homes to the South Eastern Health and Social Care Trust have reduced since the Care Home Nursing Support Team has been established. The number of complaints has reduced from just under 40 in the first quarter of 2018/19 to five in the same period for 2020/21. The number of incidents has also dropped from over 2,000 per quarter, to less than 500 over the same time period.

In the Southern Health and Social Care Trust, support from physiotherapy through the Care Home Nursing Support Team has raised awareness of fall prevention techniques, utilising technology to keep residents safe, and supported care home staff to deliver individualised care to residents with complex moving / handling needs.

The Western Health and Social Care Trust Care Home Nursing Support Team has delivered bespoke training, with 32 sessions delivered to 302 attendees up to March 2020. Since the onset of COVID-19 bespoke training has been delivered in nine training sessions, with 100 attendees.

Strategic Importance

This project supports delivery of the aims of both Delivering Together – reforming our community and hospital services - and Making Life Better by improving the health of our people; improving the quality and experience of care, and by ensuring sustainability of our service by measuring, monitoring and evaluating the care delivered in care homes.

SUICIDE PREVENTION - TOWARDS ZERO SUICIDE

Objective

To improve patient safety and outcomes, and reduce suicides in mental health patients.

Total Investment

£1,361,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Suicide Prevention - Towards Zero Suicide	127	615	619	1,361

Regional Project

Yes.

Progress

This project is running to timescale, with early set-up targets realised and quality improvement testing rolled out as planned. Work was stalled due to COVID-19 pressures from March – September 2020 but quickly reconvened.

Work to date has included the establishment of a multi-professional, five HSC Trust collaborative team of work streams that includes prison health care. A systematic review of adult mental health services has been conducted against the National Confidentiality Inquiry into Suicide and Self Harm Recommendations for Safe Services to identify new opportunities to improve patient safety, focused on suicide intervention and management.

As a result, six quality improvement projects are now in place and a learning partnership has been secured with Mersey Care NHS Trust including;

1. Co-production – work involving people with lived experience, carers and bereaved families in shaping suicide prevention interventions and priorities;

2. Workforce Learning & Development – producing a learning plan aligned with suicide prevention and self-harm competencies and roles, and developing local capacity to deliver on same, including the development of online training accessible to all HSC staff;

3. Collaborative Safety Planning QI Project- Final implementation testing of two safety planning models for regional use, and a six month spread and scale plan will follow to support consistent evidence-based safety planning practice across services and prisons;

4. Minimising Restrictive Practice (MRP) QI Project - Drawing on Trauma informed practice, service user feedback and evidence-based practice, this work aims to reduce the use of Restrictive Practices by 30% in identified wards in each Trust by the end of December 2021 through MRP project teams established in each Trust;

5. Suicide Prevention Care Pathways (SPCP) QI Project – Approval has been obtained to pilot a SPC Pathway in pilot sites in Adult Mental Health in Northern, South Eastern, Southern and Belfast Health and Social Care Trusts and in Northern Health and Social Care Trust Child and Adolescent Mental Health Service (CAMHS).

6. Early Post-discharge appointments – A new work stream has recently been set up to explore the safety benefits and resource/service changes required in order to offer earlier post discharge follow up to inpatient mental health care.

Significant work has also been progressed in the areas of safety planning, minimising restrictive practice in line with the ongoing Mental Health Action Plan Review of Restraint and Seclusion, three day follow-up, and the learning plan.

Strategic Importance

Northern Ireland has the highest prevalence of mental health problems in the UK. The legacy of the Troubles is also recognised as having an impact on mental health in Northern Ireland with 39% reporting experiencing a traumatic event relating to the Troubles.

This project aligns with the aims of the Department's Protect Life 2: A strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024, the Department's Mental Health Action Plan (2020), and Mental Health Strategy 2021-31.

It also aligns with the NI Executive's renewed commitment to transformation which focusses on well-being and support for mental health services, through both Delivering Together, and New Decade New Approach.

SUICIDE PREVENTION - PROTECT LIFE 2

Total Investment

£176,000

Objective

The project objectives are to:

- Support responsible media reporting on suicide by promoting the use of, and compliance with, media guidelines and promoting best practice guidelines on memorials and social media gatherings.
- Support the development and implementation of local Protect Life 2 action plans across the region.
- Build knowledge and awareness of the function and role of local Protect Life 2 Implementation Groups, in meeting community needs.
- Build knowledge and awareness of mental health / suicide prevention services.
- Support and inform the commissioning of community-based suicide prevention services by the Public Health agency.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Suicide Prevention- Protect Life 2	0	0	176	176

Regional Project

Yes.

Progress

The project has supported responsible media reporting on suicide by promoting the use of, and compliance with, media guidelines and promoting best practice guidelines on memorials and social media gatherings through the delivery of a series of engagement workshops and interviews with persons with lived experience and stakeholders to test and evaluate the pilot concept and the development of a web platform.

Each of the five Protect Life 2 Implementation Groups have developed local action plans which are currently being delivered in each of the five HSC Trust areas across NI. These plans are addressing unmet needs within local communities to either support those that are awaiting services to ensure that they do

not escalate, or to provide a support to individuals to help keep them from requiring access to services by promoting resilience and emotional wellbeing. The delivery of the action plans also builds knowledge and awareness of the function and role of local Protect Life 2 Implementation Groups, in meeting community needs.

Delivery of the action plans were completed by the end of March 2021 with approximately 11,000 people benefiting from this work. It is anticipated that the outcomes from the delivery of the action plans will include increased awareness of prevention and post-event services and how these can be accessed; increased hope and resilience; improved collaboration; and enhanced community capacity to prevent and respond to suicidal behaviour within communities.

To inform and support the commissioning of community based suicide prevention services, a specially appointed facilitator has held two engagement events with five individuals bereaved through suicide, with twelve community and voluntary sector organisations, ten statutory organisations, and academia including Ulster University and Queens University Belfast, Barnardo's, YEHA (Youth Education Health Advice), Family Forum, Families Voices Forum, Papyrus, Extern, PSNI, various local councils and members of HSC Trusts. One to one interviews have also been carried out with five people with lived experience of suicide ideation, or who have been bereaved through suicide to inform this important work.

Strategic Importance

This project links directly to actions outlined within, Protect Life 2 (PL2): A strategy for Preventing Suicide and Self Harm in Northern Ireland 2019 -2024.

It also supports the aim of Delivering Together to build support in communities and in prevention.

DEVELOPING A MULTI-AGENCY TRIAGE TEAM

Total Investment

£754,000

Objective

This initiative enables the Police Service of Northern Ireland, Northern Ireland Ambulance Service, and Belfast and South Eastern Health and Social Care Trusts' mental health professionals to work collaboratively, to ensure the most appropriate care possible for people when concerns about their mental wellbeing are reported via the 999 and 101 systems.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a Multi-Agency Triage Team (MATT)	0	577	177	754

Regional Project

The initiative is currently delivered in the Belfast and South Eastern Health and Social Care Trusts areas only.

Progress

Progress: The Multi Agency Triage Team (MATT) is a service of mental health professionals working alongside dedicated police officers and paramedics. It has been proven through this initiative that both users and those delivering the service consider MATT to be a positive alternative to the existing services for those experiencing a mental health crisis out of hours.

Prompt response times, the reduced need to attend / wait in emergency departments and the reduction in incidences of arrest have been welcomed by both users and staff, e.g. in 300 cases who would normally have been taken to emergency departments this was prevented in 238 cases, representing a 79% reduction.

In addition, 123 referrals would have been considered for the use of an Article 130 of the Mental Health (NI) Order 1986 and due to MATT input this was prevented in 114 instances, indicating a 93% reduction of involving potentially stigmatising legal processes whilst still providing the most suitable care for the individual. In over half of the referrals during the evaluation period the immediate crisis was de-escalated (n=225); in 72 of these instances referrals to mental health and substance misuse services were made to address the person's issues comprehensively and without having to use the emergency department route.

Strategic Importance

This initiative supports the delivery of a number of key strategies including Making Life Better and Delivering Together and No More Silos. In addition to supporting the delivery of targets in the Joint Commissioning Plan and Commissioning Plan Direction on reducing conveyancing rates and ED presentations, the programme also supports the delivery of the Protect Life 2 Strategy which identifies the need for early intervention to promote emotional resilience and frontline intervention for those in crisis.

DEVELOPMENT OF DERRY COMMUNITY CRISIS INTERVENTION SERVICE

Total Investment

£107,000

Objective

To respond to individuals observed to be in distress and potentially vulnerable and who would in all likelihood come to significant harm through self-harm and/or suicidal behaviour.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of Derry Community Crisis Intervention Service	20	27	60	107

Regional Project

Project delivered in the Western Trust area only.

Progress

The project commenced in January 2019 and is operational three nights per week over the weekend period in the Londonderry/Derry area. In 2019 the scheme had 212 interventions and in 2020 had 431. The majority of those helped by the service were in suicidal crisis, or there was a significant risk of loss of life as a result of the presenting crisis.

The service, which is provided by Extern, delivers a non-clinical community response within 30 minutes to individuals experiencing social, emotional or situational crisis. Individuals are offered a short term solution which includes risk assessment, de-escalation, support and identification of personal support options from friends or family. The service will also identify appropriate onward referral and signposting, advising the service user on how to avail of the appropriate service.

Strategic Importance

The objectives of this initiative align with the Protect Life 2 Strategy, Delivering Together which aims to build more capacity in communities and in prevention, and New Decade, New Approach which reaffirms the NI Executive's commitment to transformation and which includes a greater focus on mental health and wellbeing.

DEVELOPING AN EARLY INTERVENTION SUPPORT SERVICE

Total Investment

£1,779,000

Objective

To provide an evidenced based regional coherent offer of early intervention family support for children, young people and families to support families when problems first emerge before the need for statutory involvement.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing an Early Intervention Support Service	518	831	430	1,779

Regional Project

Yes.

Progress

The Early Intervention Support Service (EISS) has been established and tested as a new family support regional service model supporting circa 600 families annually working closely with the Family Support Hub network. A coherent regional evidenced informed family support model has been developed. One third of the 7,590 families identified annually through Family Support Hubs across NI with emerging vulnerability have access to an evidenced informed EISS.

EISS is monitored on a quarterly basis and report cards are produced annually. In 2019/2020, 720 families were referred to the service with 581 families receiving support.

Outcomes Star™ is the assessment tool used to establish an initial base line and to measure progress by families during and at the end of the intervention. 93% of families showed improvement in at least one of the outcome areas including; improved parenting skills/capacity; improved family relationships; increased participation/involvement in education/training/employment or improved emotional wellbeing.

An evaluation of the EISS completed by Queen's University Belfast (QUB) indicated that EISS is an extremely well received service that is clearly addressing unmet need.

Strategic Importance

EISS contributes to the Delivering Together, Health and Wellbeing 2026 commitment to give every child and young person the best start in life, and to increase the support provided to children, young people and families from before birth to adulthood. It also supports the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

Delivering together has committed to build on the success of the Early Intervention Transformation Programme and enhance early intervention services. By increasing early support to families the need for later intervention will be reduced, such as the need for children to come into care. This is consistent with New Decade, New Approach commitment to maintain the transformation agenda.

EISS will be particularly relevant and important in supporting the implications of disruption and pressure on families in the context of COVID-19 which has created very specific challenges to the psychological health and wellbeing of the whole population. The pandemic has brought increased pressure to children, young people and families in Northern Ireland.

HIV / PRE-EXPOSURE PROPHYLAXIS (PREP) SERVICE

Total Investment

£1,233,000

Objective

A Risk Reduction Clinic was introduced in Northern Ireland in July 2018. The clinic offered interventions aimed at reducing unsafe sexual behaviour, along with PrEP (Pre-exposure prophylaxis), to patients meeting risk-based criteria. PrEP is the use of antiretroviral drugs to protect individuals at risk of acquiring HIV.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
HIV/PrEP Service	210	620	403	1,233

Regional Project

Yes.

Progress

The PrEP service was established three years ago in 2018/19 with the use of transformation monies into both the Belfast and Western Trust. In 2020/21, due to Covid related pressures the Belfast service ceased at the end of March 2020 with staff being transferred to support COVID-19 related pressures. All patients were advised they could be repatriated to their Trust of residence as of November 2020. The Belfast clinic is not anticipated to be fully operational until April 2021. The WHSCT service continued to accept patients from across Northern Ireland throughout 2020/21 and from the monitoring information available we can see that against a target of 720 client/patient visits that there were 773 client/patient visits with 308 patients established on PrEP since the commencement of the WHSCT PrEP service in September 2019.

This PrEP service, in conjunction with the online testing service has the potential to increase sexual health testing and to detecting and treating more Syphilis, Chlamydia and Gonorrhoea infections, thereby reducing their onwards transmission. Trusts are working with the HSCB/PHA to provide the necessary monitoring information to reflect the project delivery period within each Trust.

The use of PrEP is worldwide and it has been deemed as a "miracle drug" in the fight against AIDS/HIV. It is already available through the NHS in England, Scotland and Wales. Much has been written about the use of PrEP, its efficacy and cost effectiveness. The establishment of a PrEP clinic in each Trust area is truly transformational within Northern Ireland and is widely supported by patients and clinical teams – it is fully endorsed as a necessary and strategic way forward.

In addition, for those at sexual risk of HIV and who are aware of PrEP and willing to take it, HIV is almost completely preventable with appropriate access to this service. Failure to continue to provide a recommended intervention will leave NHS clinics open to complaints, as well as possible legal recourse should a patient become infected with HIV as a result of not being able to continue to access appropriate PrEP services.

It is acknowledged that the availability of PrEP clinics is meeting a previously unmet need of at-risk clients to the service for HIV testing and STI ((Sexually Transmitted Infection) screening, who have never previously attended clinics or been tested. From the latest PHA figures we can see a clear decline in the number of new HIV diagnoses among MSM. This suggests that at least 20 new infections were prevented in the first year of PrEP clinics being made available

Strategic Importance

The development of a Northern Ireland PrEP service is enshrined within the ethos of the Delivering Together vision as it seeks to radically reform the way services are designed and delivered with a focus on person centered care and to build capacity in communities and in prevention to reduce inequalities.

While PrEP represents an important new method of preventing HIV transmission, it is part of an overall prevention strategy which includes HIV testing, risk-reduction counselling, condoms, sexually transmitted infection management and viral suppression through treatment of those infected with HIV. England, Scotland and Wales have already commissioned a HIV PrEP service as a core standard of care within their Sexual Health services.

DEVELOPING HEALTH AND SOCIAL CARE SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS IN NORTHERN IRELAND

Objective

To continue and develop health and social care services for people experiencing homelessness in Belfast and establish appropriate services in other Trusts on a sustainable and equitable basis.

Total Investment

£1,146,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing health and social care services for people experiencing homelessness in Northern Ireland	225	507	414	1146

Regional Project

Yes. Homelessness services are now available in all HSC Trusts.

Progress

Many elements of a comprehensive homelessness service have been established on a pilot basis in Belfast. This includes GP sessions for previously unregistered patients, additional general nursing care, specialist mental health support, dentistry, podiatry and enhanced hostel and hospital liaison. Ongoing evaluation by service users and colleagues has been excellent, for example feedback from 35 service users was over 90% positive in terms of accessibility, being comfortable to attend, and feeling that the service catered to their needs. Feedback in relation to the GP service from 50 service users was also more than 90% positive.

In Belfast the number of patients accessing GP, nursing, podiatry and dental services in dedicated premises are detailed in the table below:

Summary of activity - Belfast Inclusion Health Service, January – December 2019

Activity	Number
New registrations with GP	359
Consultations with GP	700
Active Nursing case-load	606
Nursing consultations	1966
Nursing interventions	4200
Triage calls (mostly from hostels)	1010
Blood-borne virus screens	360
Follow-up of people who did not wait at Emergency Department (high-risk)	55
Flu vaccinations	345
Podiatry new patients (part-year)	145 5% - high risk
Dental new patients (part-year)	272 99.7% requiring treatment

There was a reduction of 23% in attendance at emergency departments (ED) in the 4 months before and after follow-up of attenders at EDs who did not wait to be seen. For example, a patient who attended ED 18 times, and was also admitted to hospital 9 times during a two month period was subsequently linked with more appropriate services by a multi-disciplinary intervention provided by the project. Such patients are considered high-risk for adverse outcomes. Following this intervention, the patient attended the ED twice and was admitted four times to hospital in the next nine months. Multidisciplinary team meetings continue to ensure that the most appropriate services are provided to patients who are considered high-risk.

During COVID-19, this project liaised with those experiencing homelessness, hostels, the Northern Ireland Housing Executive and other relevant agencies to ensure that plans were in place to identify people experiencing symptoms of the virus, and that testing, isolation and care were available. This was very successful in preventing outbreaks of COVID-19 within this vulnerable population with no cases or outbreaks confirmed in those experiencing homelessness in Belfast during the first wave. A survey of 218 clients, using swab tests for active virus and blood tests for antibody levels, following the first wave, yielded no positive results, confirming the success of the prevention measures. Assessment of clients over 50 years of age regarding the need for shielding was also completed and appropriate shielding arrangements put in place for clients.

Pilot projects in other Trusts have also been established to provide nursing and enhanced GP provision to the homeless.

Strategic Importance

This project links with the recommendations in New Decade, New Approach and the Nursing and Midwifery Task Group Report to maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

The PHA and HSCB, in partnership with a number of key stakeholders across General Practitioner Services (GPS), produced a General Practice Nurse Framework for Northern Ireland 'Now and the Future' (2016). This initiative aims to provide guidance to support systems and processes that are required for the development of The General Practice Nurse workforce. The recommendations of the Framework have contributed to the DoH recommendations for GP-led services across Northern Ireland in respect of the development of structures and nursing teams to support GPs (2016).

The Delivering Together aims include enabling people to stay well and to deliver services in the community where appropriate, which is congruent with the project's objectives and achievements. People experiencing homelessness have some of the worst health outcomes and lowest life expectancy in Northern Ireland. They have higher rates of physical and mental ill-health, and addiction issues, but experience more difficulties with access to appropriate health and social care services leading to more ill-health and high emergency department attendance. The project also contributes to the draft Programme for Government objectives on decreasing preventable mortality, living healthy active lives, and decreasing numbers in absolute or relative poverty.

GENERAL PRACTICE NURSE DEVELOPMENT

Total Investment

£295,000

Objective

To address the need for access to appropriate structured and validated education and training for GP nurses. This will provide appropriate and consistent training to meet the requirements for the complex and changing service needs for patients in primary care settings.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
GP Nurse Development	145	70	80	295

Regional Project

Yes.

Progress

GP Nurses require a depth and breadth of knowledge across a variety of clinical therapeutic areas. This project is providing appropriate structured and validated education and training. The range and type of education is varied e.g. standalone modules in non-medical prescribing at Queens or Ulster University, mandatory 3 yearly update for cervical cytology to ensure that the requirement listed in the Northern Ireland Standards for Nurse and Midwife Education Providers: Cervical Screening Sample Taking (PHA 2016) are met.

General practice nurses/healthcare assistants identified the topics which they believed where required to ensure their practice was safe, effective and up to date. Topics covered included management of long term conditions, awareness and management of sepsis and antimicrobial resistance and awareness of safeguarding, record keeping, consent and mental health issues in general practice. In addition, the Royal College of Nursing (RCN) facilitated the regional network for practice nursing and nursing assistants across four localities in Northern Ireland to which all practice nurses were invited as part of professional development and governance arrangements. A range of induction programmes and therapeutic clinical updates on core topics and bespoke education programmes for general practice nurses/healthcare assistants are being delivered, with almost 300 training programmes being delivered.

The training provided through this project will be completed at the end of March 2021. Interim feedback from nurses who have completed the courses and through their contribution to service delivery has indicated that the training has been beneficial.

Strategic Importance

This project links with the recommendations in New Decade, New Approach and the Nursing and Midwifery Task Group Report to maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

The PHA and HSCB, in partnership with a number of key stakeholders across General Practitioner Services (GPS), produced a General Practice Nurse Framework for Northern Ireland 'Now and the Future' (2016). This initiative aims to provide guidance to support systems and processes that are required for the development of The General Practice Nurse workforce. The recommendations of the Framework have contributed to the DoH recommendations for GP-led services across Northern Ireland in respect of the development of structures and nursing teams to support GPs (2016).

PRIMARY CARE MULTI-DISCIPLINARY TEAMS (MDT)

Total Investment

£29,496,000

Objective

The rollout and implementation of MDT services of practice-based physiotherapists, mental health workers and social workers to GP practices; these MDT members will work alongside GPs and practice staff with the aim of better meeting the needs social, physical and mental health wellbeing of the local population. This model also includes significant investment in additional nursing specialist roles such as health visiting and district nursing.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Primary Care Multi-Disciplinary Teams (MDT)	1,488	10,234	17,774	29,496

Regional Project

Yes.

Progress

The MDT programme has been fully rolled out in the Down area and is progressing towards completion in Derry, West Belfast, Causeway and Newry area & District. Proactive planning is now underway to develop a road map for rollout across all 17 GP Federation areas. Staff in post as of December 2020 is as follows:

Across all the MDTs the following core staff are in post:

- Social Worker: 53 wte;
- Social Work Assistant: 23.5 wte;
- Mental Health Practitioner: 44 wte;
- Physiotherapist: 37.3 wte.

In addition the following nursing staff are supporting MDTs:

- District Nursing: 66.5 wte;
- Health Visiting: 34.5 wte.

By March 2021, this will be supplemented by the following additional staff:

- Social Worker: 10 wte;
- Social Work Assistant: 6.4 wte;
- Mental Health Practitioner: 10.8 wte;
- Physiotherapist: 10.2 wte.
- District Nursing: 8 wte;
- Health Visiting: 6 wte.

This means that, in the region of 600,000 people in Northern Ireland have access to an element of a Multi-Disciplinary Team within their GP practice with the overwhelming majority having access to a practice based mental health practitioner.

Strategic Importance

The MDT Project builds on the commitments in Delivering Together to invest in primary care to ensure there is a multidisciplinary team focused on the patient. New Decade, New Approach has committed to the ongoing roll out of Multidisciplinary Teams to build capacity in General Practice.

The Department of Health, Mental Health Strategy identifies the need for better mental health care and treatment in the primary care setting. It supports the roll out of further mental health workers as the key delivery measure. The Strategy also highlights the role Multi-Disciplinary Teams have in early intervention and prevention. The roll out of primary care multi-disciplinary teams, including mental health workers, will provide better access to mental health support in an easily accessible format where people need it. This will lead to quicker access to services, less referrals and better outcomes for people.

The MDTs remain a key priority within the health and social care transformation programme, helping provide more care closer to people's homes and improving access for practice populations. Evidence suggests that this approach will see patient issues resolved more quickly, for instance by reducing the need for referrals and appointments elsewhere, easing demand and pressure on hospitals.

COVID Work

Mental health and social work services have played a key role in the COVID-19 response by pro-actively engaging with the most vulnerable in our society. For example, social workers contacted vulnerable patients during the first wave of the pandemic and, working with statutory services and the local community, put in place in excess of 3,500 support packages.

Ongoing Evaluation

The Q3 Evaluation Report from RSM has highlighted the following promising signs of early impacts across the HSC during 2019/20:

- Whilst the number of GP referrals (per 1,000 patients) of Musculoskeletal (MSK) has decreased at a faster rate than in non MDT areas, referrals in MDT areas were broadly in line with the NI average in 2017/18. In Down and West Belfast, were the First Contact Physio (FCP) role within the MDT was fully in place during 2019/20, the reduction has been even more pronounced.
- There has been a decrease in the number of patients on waiting lists for imaging (14.7%) and physiological measurement (10.1%) in MDT areas between October 2019 and March 2020; and
- The average length of stay for chronic Ambulatory Care Sensitive (ACS) conditions (all ages) was considerably lower in the MDT areas than non-MDT areas, however, the time series trends across the MDT areas are not consistent.

As more patients self-refer to the new MDT roles, this will in turn release more GP time to better manage the more complex practice patient cohort. This ‘Releasing Time to Care’ approach will improve outcomes for these patients and further reduce demand to secondary care, for those who can now be safely managed in practices with this increased capacity.

These potential benefits and impacts will be closely monitored going forward but it is too early to make a definitive statement on them.

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MULTI-DISCIPLINARY TEAM (MDT) EVALUATION

Total Investment

£173,000

Objective

To undertake an independent evaluation of the Multi-Disciplinary Team model that will help shape and improve the model as it is expanded across the remaining GP Federations, bringing benefits to patients and the wider HSC.

Regional Project

Yes (initially the scope of the evaluation is the 5 current MDT areas Down, Derry, West Belfast Causeway and Newry & District).

Progress

Having gathered primary and secondary care data (from 2019/20 returns), the MDT evaluation partners, RSM Consulting have completed the quarters 1 and 3 reports as required. The quarter 2 report was deferred due the impact of COVID-19 on data collection.

The Quarter 3 report provides an overview of the evaluation plan, baseline data on a range of healthcare indicators (collected Sept-Dec 2020), learnings from international case studies where MDTs have been successfully implemented (conducted Summer 2020), findings of MDT strategic stakeholder interviews, who expressed their views and opinions on the design, implementation, roll-out and impact of the primary care MDT model in NI (conducted Summer 2020). This report also provides findings from surveys with both service users and MDT staff, to capture their perceptions of the MDT model, its operation and its impacts on service users, staff and health services (undertaken Nov-Dec 2020).

The report contains the following analysis, including a range of positives, which support the current MDT model:

- A literature review has been undertaken which includes interviews with Nuka, PORT Germany, Primary Care Clinic for Integrative Health at Witten/ Herdecke University Germany, Ontario & Dudley. Key learning from these interviews highlighted the importance of team meetings, co-location, early engagement with professionals, formal links to secondary care and robust data collection.

- 26 Strategic stakeholder interviews have taken place with stakeholders from various organisations across the health and social care sector. There was a high level of enthusiasm amongst stakeholders for the MDT model, and all stakeholders felt that the model would positively impact upon care.

Areas identified by these stakeholders for further discussion included a training needs assessment of the staff within MDTs, guaranteed funding for the model and detailed workforce modelling and projections across primary and secondary care.

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Service user and staff surveys closed on the 4 January 2021 with 195 and 216 responses respectively. Analysis of the survey results indicates a high level of patient satisfaction reported by patients with 89% satisfied or very satisfied with the service received and 78% feeling that the care received at their local practice had improved by the introduction of the expanded team.

In addition, 91% of staff surveyed, agreed/strongly agreed that the MDT has impacted positively on the health and wellbeing of service users. 81% agreed/strongly agreed that the MDT makes effective use of GP time and 75% agreed/strongly agreed that it has increased the sustainability of primary care. 78% agreed/strongly agreed that it has reduced referrals to secondary care.

To support the evaluation, additional work is ongoing to quality assure the primary care 2020/21 activity data extracted from the GP Intelligence Platform.

Strategic Importance

The development and implementation of Primary Care MDTs and this evaluation project will help shape and improve the MDT model which contributes to the Delivering Together theme of 'Providing more support in primary care'. It also supports the other Delivering Together themes:

- Building capacity in communities and in prevention;
- Reforming our community and hospital services; and;
- Organising ourselves to deliver.

PRIMARY CARE ELECTIVE REFORM IN NORTHERN IRELAND

Total Investment

£5,030,000

Objective

To improve access to services for patients, their families and carers and to place elective care on a sustainable footing, resulting in improved waiting times, in line with Delivering Together: Elective Care Plan.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Primary Care Elective Reform in Northern Ireland	1,094	2,981	955	5,030

Regional Project

Yes.

Progress

A range of pathways have been designed to facilitate patients being managed more appropriately in primary care without the need to refer to secondary care. Beyond primary care capacity, they support an improved approach to demand management via peer support, peer review, peer education, self-management and self-directed care at a population level within GP Federations.

Current priorities across GP Federations are the implementation and delivery of primary care services in the following specialties, thus reducing the requirement to refer to secondary care:

- Dermatology: to safely manage a range of routine dermatological conditions in a primary care setting. At the end of January 2021 a total of 4,052 (including dermatology surgery) patients had been seen face to face plus a further 933 patients managed remotely;

- Gynaecology: to safely manage a range of routine gynaecological conditions (Coil fitting) in a primary care setting. A total of 2,538 patients were seen and treated and a further 1,007 remote consultations provided;

- Vasectomy: to safely deliver non-scalpel procedures in a primary care setting. A total of 1,479 patients were treated;

- MSK/Pain: to safely manage a range of routine MSK conditions in a primary care setting; A total of 2,302 were seen in clinic and a further 233 patients managed remotely;

- Minor Surgery: to safely manage a range of routine minor surgical procedures (lipoma excisions, sebaceous cysts, dermatofibroma, excisions for diagnostic purposes) in a primary care setting. A total of 548 patients were treated.

Planning is currently underway to introduce new pathways in specialties such as Cardiology and Dementia in 2021/22.

Strategic Importance

Delivering Together, commits to the development of a comprehensive approach for addressing elective care waiting lists on a sustainable basis. The Elective Care Plan which sets out the plan for the Transformation and Reform of Elective Care Services has 6 key objectives. Objective 3 is to Expand capacity and capability in primary care.

The continued development pathways and services within primary care delivered by this project are therefore strategically important in the management of waiting lists.

TRANSFORMATION OF PRIMARY CARE IN NORTHERN IRELAND

Total Investment

£5,955,000

Objective

To assist in transformation of Primary Care. Develop innovative primary care based models to build capacity in networks and build on GP Practice capabilities.

Development of Multi-Disciplinary Teams, GP Federations working with Primary and Secondary care professionals to provide integration of services which are patient focused and orientated around population health.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Advanced Nurse Practitioners (ANP)	682	1,113	1,852	3,647
GP Federations to develop crisis response	0	271	889	1,160
GP Federations Core funding	285	283	285	853
Trial a GP Hub model for providing early evening services	40	0	60	100
Primary Care GP Development	0	86	109	195
	1,007	1,753	3,195	5,955

Regional Project

Yes.

Progress

Progress against each of the services currently being provided by the GP Federations is as follows:

Advanced Nurse Practitioners

ANPs are now embedded within Practice teams including in Derry, Armagh & Dungannon, Down, East Belfast and Mid Ulster GP Federation areas and are making valuable contribution to the delivery of primary care services. There are 34 trained / trainee ANPs working across the five Federation areas.

Crisis Response

The Crisis Response team provide a regional service to all practices that are experiencing difficulty with recruitment and with management of the practice. Urgent support is available, especially for those rural and single-handed practices. During the year ending December 2020 a total of 241 sessions were provided

by the GP Crisis Response team to practices at risk. The Crisis Response Team has been involved with 45 practices during this time (37 practices now stable with ongoing support provided to the remaining 8 practices).

Core Funding

Eastern, Northern, Southern and Western Federation Support areas each have staff employed to support the 17 GP Federations. Development of the administration function across these areas is underway, aiming to provide dedicated finance, HR and administrative support within each area. Four Federation Support Units (FSU) have been established to provide support to the GP Federations as follows:

- Northern FSU supports four GP Federations (73 Practices)
- Southern FSU supports three GP Federations (73 Practices)
- Eastern FSU supports eight GP Federations (133 Practices)
- Western FSU supports two GP Federations (48 Practices)

Trial GP Hub

This funding will assist 'Out of Hours' (OOH) providers in moving towards new ways of dealing with OOH services in the overall transformation. The funding supports the transition from GP OOH to a new Urgent & Unscheduled Care Service model in line with No More Silos.

Primary Care GP Development

With respect to funding for Primary Care GP Development, the allocation was used to fund GP Mentoring Scheme, Retainer Scheme and Practice Manager Training:

- GP Mentoring Scheme – A total of 20 GP Mentors have been trained in delivering mentoring support to the GPs on the Northern Ireland Performers List;

- Retainer Scheme – This scheme is designed to assist in the retention of GPs in Primary Care. It aims to provide the retainer with stable work in a practice and some Out of Hours sessions. During the current financial year 25 retainers have been recruited into General Practice and a waiting list (five) has also been created for those interested in joining the scheme.

- Practice Manager Training provides an accredited training course to a number of GP Practice Managers across Northern Ireland. The course has been provided to 32 Practice Managers to date.

Strategic Importance

This project contributes to the Delivering Together commitment to improving access and resilience within primary care and to supporting the development of new models of care, which will include the development of MDT's, introducing more skill mix, including practice pharmacists and Advanced Nurse Practitioners.

In 2019/20 HSCB committed to providing more support in primary care, including multi-disciplinary teams, increasing skill mix across GP Practices and rolling out new initiatives to all 17 Federations to further enhance the integrated approach to provision of services. This project contributes to the achievement of this commitment.

NEIGHBOURHOOD DISTRICT NURSING (NDN)

Total Investment

£1,220,000

Objective

The Neighbourhood District Nursing (NDN) model aims to improve safety, quality and experience by developing a 'one team' approach, provided by a 24 hour NDN team within a designated community and aligned to the GP Practice, with the ethos of home being the best and first place of care. To do this, the team work in partnership with patients, carers and their families, General Practitioners, and other health and social care professionals as part of a wider multidisciplinary team.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Neighbourhood district nursing	73	735	412	1,220

Regional Project

Yes.

Progress

Progress has been made against a number of key objectives including:

Test a new model of District nursing linked to Primary Care Multi-Disciplinary Teams

Five district nursing teams, one in each HSC Trust area, started to test the model in summer 2019. Enhancement to existing district nursing teams meant that almost 4% of the district nursing workforce aligned to 3% of the GP population tested in the model. A Quadruple Aim approach was used in the evaluation. Quarter 3 2019/20 showed a total working caseload of 819 people, average 17 patients per whole time equivalent (WTE) which is higher than the regional average of 13.

Improve patient care through proactive management of population health

A structured local population health needs assessment informed the development of community health improvement plans and Quality Improvement (QI) projects e.g. the Ballycastle team undertook a Palliative Care QI project which indicated that 18% of people died in hospital compared with the Northern Ireland average of 48%. This quality improvement project was primarily focused on improving the patient experience however there was also an indirect cost impact.

Promote a new public health model for District Nursing

In Quarter 3 (2019/20) 59 patients were supported to self-manage in areas of diabetes, continence, medicines and weight management. Individuals were provided with the skills that increased their confidence to take control of their own health and wellbeing and make better lifestyle choices.

Test a coaching model for district nursing

Teams were allocated a coach to test the new model of district nursing services. Five Nurse Coaches were appointed and all were supported to undertake the Institute of Leadership and Management (ILM) Level 5 Coaching qualification, developed and delivered by the HSC Leadership Centre.

Develop self-organised teams under a collective leadership model

In order to measure the people impacts of the intervention, the project team utilised the engagement measurement methodology from the HSCNI employee survey. This methodology utilised three Key Findings (KFs) consisting of nine questions in total which when analysed provides a single index measure of engagement out of a total of 5.0 The overall staff engagement score was 4.39 from 29 respondents.

Whilst these results allow for an initial benchmark they also compare favourably with HSCNI (2019) engagement levels which were 3.78.

Patient and client experience is recognised as a key element in the delivery of quality healthcare. A 10,000 More Voices survey indicated that 83% of respondents rated their experience as strongly positive thus building on public confidence.

The Neighbourhood District Nursing Interim Report December 2020 confirms that the model is a proof of concept and the principles of the model will be integrated into the strategic direction for the District Nursing service in NI and the Primary Care MDTs.

Strategic Importance

This project contributes to the Delivering Together commitment to further develop primary care ensuring that every GP practice has a named District Nurse assigned. The NDN model has strengthened named District Nurse alignment and partnership working within the MDTs.

The DoH District Nursing Framework 2018-2026 (DoH 2018) is the strategic direction for district nursing services in Northern Ireland and advocates that district nurses will be instrumental in population health management. Care will be integrated and population based. One outcome is to develop a regional community nurse-led model of care prototype and then to determine the scale and spread of the model.

New Decade, New Approach has committed to further rollout of primary care multi-disciplinary teams (MDTs).

The Nursing and Midwifery Task Group (DoH 2020) highlights significant transformation of nursing and midwifery services is essential to the stability and sustainability of the Northern Ireland HSC system.

PRACTICE NURSING

Total Investment

£1,672,000

Objective

To progress over the next 5/6 years the recruitment of additional general practice nursing workforce across GP federations to ensure that the NI benchmark (1:2222) is in keeping with national recommendations and to incorporate a phased approach with GP Federations and GP practices to implement the recommendations of the review of the pre-school vaccination delivery model.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Practice nursing	181	404	1,087	1,672

Regional Project

Yes.

Progress

In 2020/21 this project has enabled the recruitment of an additional 28 post registration trainee General Practice Nurses (GPN), across five GP Federations including: Ards, Antrim / Ballymena, Armagh/ Dungannon and South West and West Belfast. These nurses are currently completing the GPN training scheme and will be employed on a permanent basis within the five federation areas as Practice Nurses from September 2021.

The implementation of the recommendations from the review of the pre-school vaccination delivery model continue to be progressed on a regional basis. Pilot sites in the South West and West Belfast Federations continue to progress and monitor the uptake of vaccinations by 0-4 year olds. Project activity has also progressed across the five GP Federation areas with 32,085 vaccinations delivered.

Strategic Importance

The project links to New Decade, New Approach which committed to building capacity in General Practice and to the Delivering Together commitment to invest in primary care to ensure there is a multidisciplinary team focused on the patient. General practice nurses are an essential part of that team.

The General Practice Nursing Framework (PHA 2016), Phase 7 Delivering Care Policy framework and the Nursing and Midwifery Task Group Report, recommends the development of a system for workforce planning at a strategic level for General Practice Nursing which is linked to population needs and meets the requirements of patients in Primary Care and in addition can act as a catalyst for delivery on population based health initiatives including childhood immunisations.

PHOTO TRIAGE

Total Investment

£169,000

Objective

To continue with implementation of dermatology photo-triage service across Mid-Ulster and South Belfast GP practices as pilot areas in the first instance, prior to regional roll-out in 20/21.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Photo Triage	0	65	104	169

Regional Project

Yes.

Progress

Progress in the two pilot areas of the Mid-Ulster and South Belfast GP practices has been positive with 16% of referrals not needing to be seen in outpatients and a further 15% bypassing outpatients and going straight to surgery. As well as reducing demand for outpatient Dermatology services, patients being referred straight to surgery removes a step from the pathway, which ultimately ensures patients are treated quicker.

Photo triage is delivered in line with NICE COVID-19 guidance and safety recommendations to enable efficient planned care while minimising the risk of COVID-19. It is managing the care of elective patients who would not otherwise have access and/or have lengthy delays for assessment and treatment throughout and beyond the pandemic.

The success of the pilot has informed the full rollout of photo triage across all GP practices in NI and a project team is in the process of being recruited to support the roll out. A Hub model to help address the dermatology waiting list has been implemented in East Antrim and Mid Ulster and work is ongoing to further develop the Hub model which has been instrumental in the management of demand for dermatology services during the COVID-19 pandemic.

Work has commenced on reconstituting a project board and a full end to end review of the pathway has been completed with a list of enhancements agreed to improve the pathway for all users. The development of an electronic document transfer of the appointment outcome letters and image back function is underway. A minimum dataset and dashboard to capture and present the outcomes and uptake to the pathway has been agreed which will provide robust performance monitoring of the objectives of the project. Qualitative data will also be captured throughout the project which includes the capture of patient feedback on their experience of the pathway. A patient information leaflet has been developed in partnership with the PPI representative on the project team. The Project Team, have developed a Project Initiation Document, a project plan, communication and engagement plan and Terms of Reference for

both the Project Board and the Project Team. A review of the original modelling assumptions has been undertaken as part of the development of the project plan and it is anticipated that the pilot will be rolled out to eight or nine GP Federation areas in 2021. This will include the provision of training and awareness sessions to GPs and the deployment of the relevant equipment to support the pathway.

Strategic Importance

Delivering Together commits to the development of a comprehensive approach for addressing elective care waiting lists on a sustainable basis. The Elective Care Plan sets out six key objectives and associated actions for the Transformation and Reform of Elective Care Services in line with Delivering Together. The Photo Triage project contributes to the achievement of actions 1, to reduce waiting times; 3, to expand capacity and capability in primary care; 4, to improve direct access between primary and secondary care reform; and 5, modernisation.

DEVELOPING A NEW CANCER STRATEGY FOR NORTHERN IRELAND

Total Investment

£321,000

Objective

To develop a new Cancer Strategy for Northern Ireland for the period 2020 to 2030 which provides direction and coordinated action, across a wide range of fronts, and enables a comprehensive refresh of the HSC's approach to preventing and treating cancer.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a new Cancer Strategy for Northern Ireland	0	167	154	321

Regional Project

Yes.

Progress

The new Cancer Strategy phases one and two were developed by June 2020 with phase three recommendations subsequently completed following a short delay due to the impact of COVID-19. The draft strategy was developed in the context of a rapidly changing landscape of prevention, diagnosis and treatment options, workforce gaps and opportunities for change. The recommendations contained in the strategy will be costed and subject to review to ensure they provide a quality service and value for money. The implementation of the recommendations will be subject to ongoing monitoring and reporting.
The commitment to co-production underpinning the new Cancer Strategy will continue in the next stage through extensive use of consultation. This will ensure that the recommendations made meet the needs of all stakeholders and that the strategy outcomes continue to focus on quality and value for money.

It is envisaged that the strategy will go out to formal consultation at the end of June 2021 before being presented to the Minister for Health. This timeline is however dependent on the continuing engagement of HSC staff and the impact of COVID-19 on the provision of services.

Strategic Importance

The new Cancer Strategy for Northern Ireland for the period 2020 to 2030 contributes to the Delivering Together theme 'Reforming our community and hospital services' and the key enabler to 'Improve Quality'. The project also links to the Rebuilding HSC focus on rebuilding cancer services.

New Decade, New Approach outlined a commitment that the Executive would produce a new 10 year Northern Ireland Cancer Strategy. The strategy produced by this project will set the direction of travel and support the transformation of the current model of cancer service provision to ensure less people contract cancer and more patients recover from it.

REVIEW OF URGENT AND EMERGENCY CARE – NO MORE SILOS

Total Investment

£1,011,000

Objective

To review models of provision for urgent and emergency care across Northern Ireland to ensure that services are designed effectively to meet current and future needs.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Review of Urgent and Emergency Care – No more silos (NMS)	0	84	927	1,011

Regional Project

Yes.

Progress

The report on the review of Urgent and Emergency Care is due to be published summer 2021. The review of urgent and emergency care informed the DoH COVID-19 Urgent and Emergency Care Action Plan, No More Silos. This Action Plan brings together key leaders in primary and secondary care to implement the 10 key actions to improve the provision of unscheduled care service provision across the HSC.

Key Action 1

Urgent Care Centre (UCC) to be operational in Royal Victoria Hospital. Craigavon centre has opened, providing a limited service due to COVID pressures. An interim UCC solution at Downe Hospital has been developed as capital works at the Ulster site are due to complete autumn 2021.

Key Action 2

Keep Emergency Departments (ED) for emergencies. NMS Programme Team have developed a draft dashboard to monitor outcomes.

Key Action 3

All HSC Trust areas are developing rapid access pathways with supporting Clinical Communication Gateway electronic referrals for common clinical presentations. These pathways are fundamental to providing ED alternatives, for scheduling referrals from General Practice, Phone First and Urgent Care Centres.

Key Action 4

Regional Phone First model is now operational in Northern, Southern and Western HSC Trust areas. A local service model is operational in Downe Hospital and Belfast HSC Trust is planning a pilot with the Mater hospital.

Key Action 5

Scheduling Unscheduled Care – All HSC Trusts will have systems in place to schedule unscheduled care. This enables patients to wait at home before attending their scheduled appointment thus reducing congestion in ED and reducing risk of nosocomial infection.

Key Action 6 & 7

Anticipatory Care / Acute Care at Home - The NMS Network continues to work closely with Department of Heath senior nursing colleagues to ensure regionally consistent models for these services including standards and specifications.

Key Action 8

Ambulance Handover Zones – The BHSCT handover zone is now open. Handover zones will open in other Trusts areas by the end March 2021 with the exception of SEHSCT area which is scheduled to open in autumn 2021.

Key Action 9

Enhanced Framework for Clinical and Medical Input to Care Homes - HSCB Integrated Care have developed a model of care for enhanced Practice support for care homes, this has been issued to GP practices.

Key Action 10

Timely Discharge - Local Implementation Groups have been tasked to deliver additional domiciliary support to facilitate timely discharge including Enhanced Direct Payments. Pilots have been established in WHSCT and SHSCT areas with plans in place to roll out the service to all areas. NMS Network is engaging with the Regional Discharge Group to establish priority discharge.

Strategic Importance

Although the review of Urgent and Emergency Care is not yet complete, the move to implement the 10 key No More Silo's actions is already achieving the four aims of Delivering Together.

INTERMEDIATE CARE

Total Investment

£6,426,000

Objective

This transformation proposal was informed by the Northern Ireland findings of the National Audit of Intermediate Care (NAIC) 2017 and developed as an enhancement to a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Intermediate Care	500	3,067	2,859	6,426

Regional Project

Yes.

Progress

Trust Intermediate Care implementation plans have continued to develop at varying pace, partly influenced by different starting positions. The project specification outlined the need for a 'home first' ethos (similar to work in Wales and England) and that is progressing within HSC Trusts and aligning with other regional Discharge to Assess (D2A) work for example one Trust demonstrated a 115% increase from 2018/19 to 2019/20 and another Trust reported an 8% reduction in rehabilitation bed days used which equates to 4,018 less bed days. User and '10,000 more voices' carer stories (unique to the Northern Ireland Intermediate Care approach) have helped drive further change through HSC Trust improvement plans.

These Intermediate Care local plans have focused on locality specific issues including reducing bed base, improving response times and accessibility over six or seven days. Support worker roles have been implemented in some HSC Trusts as substitution for workforce challenges. Project performance is monitored using digitalised community information systems.

During the COVID-19 surge, Intermediate Care services have been prioritised by HSC Trusts to maintain hospital flow and admission avoidance in line with the UK approach.

Strategic Importance

The work of this project contributes to a number of strategic drivers including:

- Delivering Together - Building Capacity in communities by using the knowledge gained from NAIC to focus on the enhancement of home-based intermediate care to standardise provision, through adopting a defined service specification which was to:

    - Embed a 'home first' (D2A) ethos;
    - Focus on rehabilitation and independence; and;
    - Begin to rebalance bed-based usage to align with national figures.

- Northern Ireland's "Intermediate Care Guidance" published by DoH in 2007.

- NICE guideline 74 'Intermediate care including reablement' in September 2017 (adopted in Northern Ireland);

- The new Rebuild Management Board (RMB) project "Intermediate Care Services for Northern Ireland - A Regionalised Approach" approved in December 2020.

DEVELOPMENT OF AN NORTHERN IRELAND WIDE ACUTE CARE AT HOME SERVICE

Objective

To provide Acute Care at Home in all areas in order to avoid unnecessary attendances at and admissions to hospital for the frail elderly.

Total Investment

£7,216,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of an Northern Ireland wide Acute Care at Home Service	752	3,360	3,104	7,216

Regional Project

Yes.

Progress

The development of an Acute Care at Home service in all HSC Trust areas in Northern Ireland continues to progress. The service is now fully operational and available to all residents in the Southern and Belfast HSC Trusts. A variation known as Enhanced Care at Home is available to all residents in the South Eastern HSC Trust. In the Northern HSC Trust, a Hospital Diversion Nursing Team is operational across the Trust area, in addition to an Enhanced Support for Care Homes project and the development of Direct Assessment Units at Antrim and Causeway hospitals. In the Western HSC Trust, Acute Care at Home is available in the northern sector and has recently been extended into the southern sector.

A regional Acute Care at Home Model is being developed as part of the No More Silos initiative in partnership with the Regional Management Board "Intermediate Care – A regionalised approach" project. Local variations in the developments within each HSC Trust will be adapted to conform to this regional model.

Strategic Importance

Delivering Together committed to rolling out Acute Care at Home to the whole population within three years and to better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. It has also been identified as a key action from the Urgent and Emergency Care Review and is being implemented as part of the No More Silos Programme, particularly in supporting the frail elderly in care homes.

AMBULATORY CARE

Total Investment

£5,230,000

Objective

To make significant changes in the management of unscheduled care patients, whose condition can be managed in ambulatory pathways, by both scaling up existing models, creating new pathways and changing working patterns.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Ambulatory care	754	2,219	2,257	5,230

Regional Project

Yes.

Progress

Overall the project objectives have either been met or partially met on a regional basis. This project helps to support the response to the COVID-19 pandemic by reducing hospital admission at a time when hospitals in Northern Ireland are under extreme pressure. In addition, patients needing unscheduled care are also higher risk patients and treatment outside of hospital may reduce their risk of also contracting COVID-19 which could impact on their recovery.

Each HSC Trust is focussed on different priorities:

- SHSCT implemented a respiratory ambulatory service. From May 2019 to January 2020, 95 patients were accepted on to an ambulatory pathway and given an appointment at the Respiratory Ambulatory Clinic. A further 47 patients from other wards and clinics were treated at the Respiratory Ambulatory Clinic at that time;
- NHSCT established a Programmed Treatment Unit which managed, on an ambulatory basis, those patients who would otherwise have had to be admitted as an inpatient for specific programmed treatments/interventions. Between April 2019 and March 2020 an average of 114 patients were treated each month;
- SEHSCT used the transformation funding to enhance and develop a number of established ambulatory pathways. This led to significant growth in the numbers of patients routed through ambulatory clinics. In 2019/20, 3,407 patients were managed at these clinics;
- WHSCT established ambulatory clinics in the South West Acute Hospital. Patients were referred by their GP or diverted from emergency departments. From January 2019 to March 2020, 877 patients were seen in ambulatory care;
- Building on the success of ambulatory pathways in the Royal Hospital, BHSCT established a clinical assessment unit in the Mater Hospital. In 2019/20, 5,332 patients were treated at the unit.

Strategic Importance

The management of unscheduled care patients whose condition can be managed in ambulatory pathways, is critical to the effective flow of patients through the hospital systems. The importance of this is highlighted in three documents:

- COVID-19 Urgent and Emergency Care Action plan 'No More Silos' Oct 2020, where they contribute to points 5, 7 and 10;
- National Priorities for Acute Hospitals 2017, Good Practice Guide, Focusing on patient flow, and;
- Delivering Together.

BREAST ASSESSMENT SERVICE

Total Investment

£222,000

Objective

To develop advanced practice radiographers within breast assessment services in order to reduce the reliance on radiologists and to enable the service to continue to meet the increasing demand and maintain acceptable access times.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Breast Assessment Service	14	73	135	222

Regional Project

Yes.

Progress

Advanced practice roles have been introduced in two HSC Trusts, which have been able to demonstrate a positive impact.

SEHSCT - The investment in a full time principal radiographer has driven forward the breast interventional service. The post holder delivers a range of advanced procedures with a reduced reliance on consultants. This has included an expansion of the stereotactic vacuum biopsy service to include seven gauge therapeutic biopsy, which helps to avoid the need for surgery. The Trust also provides stereo-localisation using magnetic seeds which has led to improved patient flow.

SHSCT - Between November 2019 and March 2020 the Trust appointed two principal radiographers, each working 16 hours per week. These roles enabled the Trust to enhance clinic throughput seeing an additional 300 patients between November 2019 and March 2020, and to stabilise the breast two week wait. Due to staff turnover the Trust is currently looking at succession planning and hope to have appropriately skilled staff ready to take up post from September / October 2021.

Strategic Importance

This project contributes to the Delivering Together theme; Investing in our Workforce and the need to upskill staff to meet the workforce challenges.

New Decade, New Approach also commits to improving breast assessment as the demand for breast assessment continues to grow year on year. In light of the ongoing shortage of radiologists at national level it is essential that NI invests now to develop a 4 tier radiography service which supports the development of advanced practice roles thereby reducing the reliance on consultants and creating additional capacity within teams to meet the growth in demand.

DELIVERY OF THE DIABETES STRATEGIC FRAMEWORK

Total Investment

£9,746,000

Objective

To deliver against the priorities set in the Diabetes Programme (2020-2026) to support effective treatment and care for people living with diabetes as outlined in the Diabetes Strategic Framework (2016).

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Diabetes Strategic Framework	1,832	3,681	4,233	9,746

Regional Project

Yes.

Progress

The project has made progress across a range of activities, despite COVID-19 challenges including:

Structured Diabetes Education: effective investment has been used to drive down waiting lists and enable a regional approach to education.

Diabetes in Pregnancy: a service model, reflecting NICE guidance is being effectively delivered to support diabetes antenatal service and systems to support women with gestational diabetes, which is growing exponentially. The service has been successfully reorganised to provide flexible high quality 52 week care pre and post pregnancy. This level of provision is essential to meet additional demands within the service and support growing patient numbers through a safe and effective delivery. Trusts have been delivering virtual review clinics with expectant mothers to reduce significant hospital attendance and associated travel for expectant mothers (pre COVID-19). Both patients and health care professionals reported satisfaction with this approach.

Foot care: the project ensures that each person living with diabetes in Northern Ireland can receive the right foot care, at the right time in the right place with equitable service provision across the region through this clinical pathway.

Inpatients: the project enables HSC Trusts to appoint staff dedicated to inpatient diabetes care. The project has improved diabetes knowledge and understanding of insulin prescribing and administration across medical and nursing staff in inpatient services including those people living with diabetes, particularly those requiring complex treatment and care.

New Models of Care: these were explored by individual HSC Trusts in varying ways with a degree of success. This area is a priority within the refreshed Diabetes work programme. The potential to build on the Northern Ireland Prototype risk stratification and utilise opportunities to work in the intermediate space are areas for development. The focus will be on the development of the Type 2 pathway, an understanding of where care is delivered and by whom to identify new ways of working and the 'right patient, right place' ethos of Delivering Together.

Network infrastructure: this supports the delivery of the Diabetes Programme of work. Funding supports continued momentum and delivery, stabilisation of the staff team and secure retention of knowledge and relationships. The Network has developed a new programme architecture with a membership of over 150 people across the clinical, lived experience, voluntary community and health service network. This comprehensive architecture supports eight active working groups, a collective of Task and Finish Groups and Clinical Working Groups, as well as Locality, Primary Care and Communication's functions. People living with diabetes are represented at every level and within every group across the Network and within a Service User Reference Group which is administered by Diabetes UK as Network Partners.

Strategic Importance

The Diabetes Network was established in 2016 to support the implementation of the DoH Diabetes Strategic Framework (2016) as set out in Delivering Together. The framework was sponsored by the then Health Minister and is a priority work stream overseen by Chief Medical Officer (CMO) under unique management arrangements.

The Northern Ireland Diabetes Network takes responsibility for population needs assessment, service planning, resource allocation and service evaluation. Built on a collective leadership ethos in partnership with HSC, Public Health Agency and Diabetes UK, the network has formalised a new programme architecture. This effectively aligns primary and secondary care to support diabetes treatment and care as per the Department of Health Rebuild agenda. This fulfils the direction of the Regional Management Board with opportunities to support the wider strategic 'No More Silos' agenda.

IMPLEMENTING THE STRATEGY FOR PAEDIATRIC HEALTHCARE SERVICES PROVIDED IN HOSPITALS AND IN THE COMMUNITY (2016-26) AND THE STRATEGY FOR CHILDREN'S PALLIATIVE AND END OF LIFE CARE (2016-26)

Objective

To progress the implementation of the Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community 2016-26 and the Strategy for Children's Palliative and End of Life Care 2016-26.

Total Investment

£5,291,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementing the Paediatric Strategy and Strategy for Children's Palliative and End of Life Care (2016-26)	477	2,218	2,596	5,291

Regional Project

Yes.

Progress

The HSCB and PHA have worked collaboratively with all of the HSC Trusts to progress the implementation of the Paediatric Strategies. The Child Health Partnership has been established and a range of project activity has been prioritised across the HSC Trusts including:

Paediatric Palliative Care Strategy

A regional Paediatric Palliative Care Network has steered progress on the implementation of the Strategy. Three projects have been taken forward: The Paediatric and Life Limited Service (PALLS) has delivered a dedicated specialist nurse working alongside families of babies and children at the end of their short lives to provide access to a bed in the Children's Hospice or the child's own home. A dedicated regional paediatric palliative care consultant has been appointed and is currently in training in Great Ormond St Hospital in London. Appointment of paediatric palliative care leads across the Trusts have brought a much greater focus to the co-ordination of services to drive forward improvements to pathways for this cohort of children.

Paediatric Strategy for healthcare services

Age appropriate care has seen investment in clinical staff to ensure children up to their 16th birthday can be appropriately managed in paediatric wards. This is a key recommendation of the Report of the Inquiry into Hyponatraemia related deaths. All HSC Trusts ensured that they had the appropriate trained staff in place to manage this cohort of patients in age appropriate settings;

A Child Health Partnership Network has been created drawing representation from across the HSC Trusts and supported by the HSCB and PHA which will drive forward the implementation of the Paediatric Strategies.

Additional psychology support for children with chronic conditions has been made available. The service has been used by over 900 children and their families who are living with a range of conditions.

Admissions alternative schemes have supported paediatric ambulatory pathways to ensure children can be managed more appropriately. HSC Trusts used different metrics to measure the impact: WHSCT, for example, witnessed a reduction of 560 in paediatric admissions from 2017/18 to 2019/20. Other HSC Trusts achieved a reduction in their paediatric unplanned attendances of between 2-5%.

GP paediatric hubs have been established with visiting paediatricians meeting regularly with GPs and other practice staff to review and discuss paediatric cases which would otherwise have resulted in a referral to secondary care. This has led to the upskilling of GPs to manage a wider range of paediatric issues within primary care and is modelled on similar initiatives in England which have led to a reduction in paediatric referrals to secondary care. This was a very small scale initiative to test the model and to give confidence to GPs and paediatricians about the merits of this approach. In the SHSCT, 91 paediatric patients were discussed at multidisciplinary team meetings involving practice staff and a paediatric consultant. As a result, 18 children were referred to hub clinics and 8 referred onwards to secondary care.

Feedback from all of the project activity indicates that the objectives are being met.

Strategic Importance

Implementation of the Paediatric Strategy is a key priority in Delivering Together. This strategy has reached the halfway point in its lifetime and there is a need to accelerate implementation to ensure that all objectives can be achieved within the strategy's lifespan. A very solid foundation has been established with the creation of the Child Health Partnership and the collaboration between HSC Trusts and practitioners has been pivotal in terms of agreeing a system-wide paediatric response to the COVID-19 surges. In addition, objectives such as the provision of age appropriate care are mandated by the Hyponatraemia report and are critical to ensuring safe and appropriate care for all children and young people.

TRANSFORMING STROKE SERVICES

Total Investment

£4,061,000

Objective

To put in the place key building blocks for Reshaping Stroke Services out with the Minister's consultation, in line with the commitment in New Decade, New Approach to improve stroke services.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Transforming Stroke Services	625	1,705	1,731	4,061

Regional Project

Yes.

Progress

The transformation of Stroke Services has been progressed through project activity focused on increasing the uptake of thrombectomy across all areas of NI, establishing a 24/7 on call rota for thrombolysis, establishment of a stroke trainee consultant programme to sustainable workforce, introducing early supported discharge to a further 2 Trusts and strengthening the performance network.

The expansion of thrombectomy has increased numbers of patients across Northern Ireland benefiting from the procedure and thereby reducing mortality and long term disability. In terms of progress, thrombectomy procedures carried out by Belfast HSC Trust have increased from 79 in 2017/18 to 118 in 2019/20 and 123 in 2020/21. This expansion has benefitted stroke patients from all HSC Trust areas.

Prior to 2019, NI was the only UK Region without a sub-specialist stroke training programme, impacting on workforce capacity. Transformation funding has enabled the establishment of a Stroke Trainee post. The NIMDTA (Northern Ireland Medical and Dental Training Agency) was allocated £103k to appoint a Stroke Specialist Registrar to the Stroke Training programme for 1 year commencing in February 2019.

This post is vital to the delivery of thrombectomy services for NI as a region and more importantly to the establishment of an adequately trained sub-specialist consultant workforce for the future in NI.

ESD (Early Support Discharge) services provide patients with rehabilitation at home at the same intensity of inpatient care. They are commissioned to improve transfer of care arrangements, offer client choice, deliver efficiencies in acute bed usage and deliver improved clinical and wellbeing outcomes. The establishment of an ESD service in WHSCT and SHSCT has improved the equity of service provision. Four Trust areas (Belfast, South Eastern, Southern and Western) can now offer ESD to stroke patients. There is a proposal to extend to NHSCT subject to securing a funding source.

The Stroke Network has been strengthened through the appointment of a support team which has focused on performance monitoring the improvement of services against national standards. Service users and voluntary organisations are being engaged in the development of a long term support pathway.

Strategic Importance

This project contributes to the Delivering Together commitment to further improve the standard of treatment and care provided to stroke patients.

New Decade, New Approach committed to improving Stroke services by the end of 2020. In 2019 the Department carried out a public consultation, Reshaping Stroke Care – Saving Lives, Reducing Disability.

CANCER TRANSFORMATION: ONCOLOGY PROTOTYPES & HAEMATOLOGY

Objective

To stabilise and modernise oncology and haematology services through the investment in multidisciplinary teams and advanced practice roles.

Total Investment

£2,101,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Local Haematology	37	333	363	733
Specialist Haematology Service	62	395	505	962
Oncology Prototypes	0	81	325	406
	99	809	1,193	2,101

Regional Project

Yes.

Progress

In relation to oncology, South Eastern and Southern HSC Trusts have each successfully appointed a full-time Advanced Nurse Practitioner (ANP) and a full time speciality doctor. Both roles are providing valuable extra support at oncology clinics. The ANP is delivering non-medial prescribing clinics and, on completion of specialist training in 2021, will commence delivery of nurse-led follow up clinics. Belfast HSC Trust have also appointed advanced practice radiographers. Post holders are about to commence the delivery of radiographer-led clinics for consent and palliative mark-up, freeing up valuable consultant time to meet the growth in demand.

All HSC Trusts have made progress and while not all of the haematology transformation posts were appointed, HSC Trusts have significantly benefited from the investment.

Strategic Importance

This project activity contributes to the DoH Rebuilding and Stabilisation Plan and the commitments within New Decade, New Approach and with the new Cancer Strategy. This investment responds to significant growth in service demand and increasing concern about the resilience of services. It seeks to expand capacity through an expansion of multi-disciplinary teams whilst ensuring a focus on skills mix and advanced practice to support the modernisation of care pathways.

CANCER TRANSFORMATION:
INVESTMENTS INTO SPECIALIST SERVICES WITHIN BHSCT (MOHS, PARTIAL NEPHRECTOMY AND LYNCH TESTING)

Total Investment
£1,480,000

Objective

To invest in a number of specialist services within Belfast with a view to:

- Enhancing regional capacity for Mohs surgery for basal cell carcinoma;
- Centralisation of partial nephrectomy provision;
- Introduction of testing for Lynch Syndrome.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Consolidation of partial nephrectomy treatment	45	342	236	623
Basal Cell Carcinoma (MOHs Surgery)	31	177	292	500
Lynch Syndrome	31	135	191	357
	107	654	719	1,480

Regional Project

Yes.

Progress

The regional capacity for Mohs surgery for basal cell carcinoma has been enhanced by the recruitment of 7 staff (5.1WTE) in the Belfast Health and Social Care Trust (BHSCT). Despite delays with recruitment to the nursing post and a 4 month pause in provision due to COVID-19, the number of patients waiting has reduced from 150 to 38 between March 2019 and September 2020.

The centralisation of partial nephrectomy has progressed with the availability of an additional surgeon from another Trust providing a weekly surgical list. This has enabled BHSCT to expand its radiofrequency ablation (RFA) service. The project has increased the RFA capacity from 34 to 41 cases per annum. In 2019/20, an additional 35 cases were provided for, although the number of cases was affected by the onset of the COVID-19 pandemic in March 2020. Despite the on-going impact of the pandemic in April and May 2020, 31 cases had been provided for by October 2020 which is satisfactory progress given COVID-19 challenges.

Lynch testing is performed on patients with a confirmed diagnosis of colorectal cancer. The Lynch testing service provision commenced in November 2019 and from then to January 2020 212 tests were delivered which was in excess of the anticipated testing levels. The impact of COVID-19 on cancer referrals and diagnostic and treatment pathways has meant that the system is around 21% behind the expected number of colorectal cancer diagnoses for 2019/20 compared to previous years. While this has inevitably resulted in reduced Lynch testing activity in year; the testing service is now established and able to provide testing at the commissioned level once normal service provision resumes in 2021.

Strategic Importance

This project activity contributes to the Delivering Together commitment to ensuring the sustainability of the service including clinical quality and resilience. MOHs surgery is the gold standard treatment for patients with a basal cell carcinoma of the head or neck as it optimises outcomes and reduces scarring when compared to standard excision. The service was provided by two part time clinicians. The waiting list had extended beyond 100 patients with many waiting over a year. Investment was needed both to increase capacity and improve service resilience.

Waiting lists

RFA is an alternative to surgery as a first definitive treatment for patients with smaller renal tumours. This additional capacity is critical in terms of being able to deliver reasonable waiting times for patients with renal cancer. Cancer Improving Outcomes Guidance recommends that partial nephrectomy surgery should be centralised in one place. Provision in Northern Ireland is currently happening across 3 sites with the single surgeon who provided surgery within Belfast having gone on a career break. Cancer Peer Review highlighted the need to centralise the provision of surgery to the specialist centre. This investment was intended to support that centralisation and to provide increased capacity to meet the increase in patient numbers.

Lynch testing supports the implementation of NICE Diagnostics Guidance DG27- Molecular testing strategies for Lynch syndrome in people with colorectal cancer. It identifies people at high risk of developing colorectal and gynaecological cancers and enables active surveillance, earlier detection and treatment and improved outcomes.

PATHOLOGY TRANSFORMATION

Total Investment

£1,794,000

Objective

To establish a new regional pathology service management structure, ensure the independent Laboratory Information Management System (LIMS) programme successfully achieves its objectives, and oversee delivery of a range of complementary regional projects necessary to address existing service challenges and deliver service transformation.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pathology Transformation	162	730	902	1,794

Regional Project

Yes.

Progress

The project continues to make progress against the following five objectives:

- The programme has been set up and terms of reference have been agreed;
- Regional standardisation and implementation of new technologies is well underway including:
    - Establishing the Pathology Network project to standardise technical data, business processes and develop regional Standard Operating Procedures (SOPs) to support new LIMS implementation;
    - The roll out of new blood analysers in all HSC laboratories;
    - The implementation of a regional digital pathology solution;
    - Regional point of care equipment roll outs and the development of regional policies to support these new technologies;
    - Work is ongoing to plan regional cellular pathology equipment procurement to deliver maximum standardisation and coordinate activity alongside significant wider service changes;
    - Rolling out new rapid COVID-19 testing technologies supported by regional Standard Operating Procedures.

- Implementation of Workforce audit recommendations underway to address workforce gaps; for example:
  - The Pathology Network has approved training for advanced and expert practitioners in specimen dissection. This investment will help address gaps in the consultant workforce which cannot be filled through recruitment;
  - Training delivered in advanced Biomedical Science (BMS) dissection is ongoing to address gaps in consultant histopathology;
  - Regional recruitment of band 5/6 Biomedical Scientists has streamlined processes, and reduced duplication for the region by having one annual regional recruitment event and waiting list rather than 6 individual ones;
  - Work is underway to define the training requirements for consultant clinical scientists and reporting biomedical scientists in histopathology;
  - Input has been provided to the new Cancer Strategy on pathology cancer diagnostics, workforce, and training.
- Continued focus on quality, productivity and regulatory compliance; for example:
  - Continued participation in national benchmarking by all HSC laboratories;
  - Ongoing maintenance of United Kingdom Accreditation Service (UKAS) accreditation;
  - Provision of advice to Expert Advisory Group on COVID-19 testing, as well as DoH and HSCB Commissioners.
- New regional testing services have been setup, with some services redesigned to offer better quality and greater value for money and any service that is no longer clinically relevant stopped. For example:
  - Regional H-Pylori testing service established;
  - Regional faecal calprotectin testing service established;
  - Regional Faecal Immunochemical Test (FIT) testing established to support bowel cancer screening programme, and work underway to establish FIT testing in Primary Care to replace Faecal Occult Blood (FOB) testing in line with NICE guidance;
  - New process in place for introduction and funding of new technologies into pathology services (COVID-19 testing – range of platforms in first instance);
  - Plan in place to establish Network Clinical Approval Board during 2021/22;
  - Molecular diagnostics business case approved (BHSCT);

- Work underway to define the remit and membership of a regional molecular diagnostics forum;

- Continuing work to establish regional (single integrated) haematological malignancy diagnostic service.

Strategic Importance

Systems not Structures: Changing Health and Social Care' (2016) identified Pathology as one of the specialties in most need of reform. Delivering Together committed to a public consultation to modernise and transform Pathology services to improve service and workforce sustainability, ensuring a high quality pathology service for the future. This consultation was completed in 2016. The pathology transformation programme represents the out workings of that process.

The Pathology Network, which coordinates pathology transformation programme delivery, also coordinates SARS-CoV-2 testing delivered in Pillar 1. This has impacted on the timeline for programme delivery. The programme's link to 'Rebuilding' is that rebuilding plans must recognise that COVID-19 testing capacity is managed as a regional resource, and may impact diagnostic testing for non-COVID-19 service delivery.

UNSCHEDULED CARE (EX-AMBULATORY)

Total Investment

£8,414,000

Objective

This project's objectives were to make significant improvements in the management of unscheduled care patients across NI, and improve patient flow focusing on three areas:

- The control room function;
- Seven day working in base wards;
- Outpatient Parenteral Antibiotic Therapy (OPAT).

This project was developed due to growing pressures in the provision of unscheduled care along the patient pathway from attendance at emergency departments through to discharge into the community.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Unscheduled Care (ex-Ambulatory)	938	3,587	3,889	8,414

Regional Project

Yes.

Progress

Project progress is as follows:

- All HSC Trusts have put control rooms in place which have reduced in-patient admissions, length of stay, and patients who are experiencing delayed discharge. These have been particularly important in helping Trusts to manage the significant challenges of COVID-19.

- Seven day working has been introduced for social work and allied health professionals and is having a positive impact across hospital sites in managing in-patient flow. This is enabling discharge planning to commence early in the patient journey and so contributes to reduced length of stay and improved flow through the system.

- Patient flow has been significantly improved by OPAT which is facilitating admission avoidance and reduced length of stay. It has allowed a number of medically stable patients requiring antibiotic therapy, who had been cared for in acute hospitals, to be discharged and managed in the community.

Strategic Importance

This project contributes to the achievement of the New Decade, New Approach commitment to reconfigure hospital services to deliver better patient outcomes with improvements in urgent and emergency care as a key focus. This project is also a core component of the COVID- 19 Urgent and Emergency Care Action plan ‘No More Silos’. It also significantly contributes to the Delivering Together theme – reforming our community and hospital services.

PALLIATIVE CARE IN PARTNERSHIP PROGRAMME

Total Investment

£3,580,000

Objective

The Palliative Care in Partnership programme objectives are to:

1. Improve the early identification of patients with palliative care needs (i.e. those likely to be in their last year of life) in order to provide appropriate support and services to enable them to die in their preferred place.
2. Scale and spread the Marie Curie Rapid Response Service to cover Out of Hours periods in all localities.
3. Enhance the specialist palliative care workforce to support people with complex care needs in all care settings.
4. Promote a programme of palliative care awareness across HSC and with the general public.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Palliative Care	702	1,715	1,163	3,580

Regional Project

Yes.

Progress

There has been significant progress across the four key objectives including:

Early identification:

- The Early Identification Local Enhanced Service, to promote the use of the AnticiPal screening tool in general practice has been developed and rolled out in 57 GP practices and has facilitated monthly palliative care multi-disciplinary team meetings.
- The AnticiPal algorithm was also developed for use on the web clinical system and work continues to encourage the inclusion of the AnticiPal algorithm within the General Practice Improvement Programme (GPIP).

Marie Curie Rapid Response Service:

- The expansion of the Marie Curie Rapid Response Service has provided equity of service to patients living in the South Eastern, Belfast, and southern sector of the Western Health and Social Care Trusts. It has also supported an increase in provision to the existing services in Southern and Northern Health and Social Care Trusts.

Enhancing the specialist palliative care workforce:

- Fifteen full-time specialist palliative care professionals (allied health professionals and social workers) are now in post across the five HSC Trusts to complement existing multi-disciplinary teams. This addition to the workforce is supporting the complex needs of patients being cared for in their own homes and in care homes as they approach the end of their lives.

Raising awareness of palliative care:

- 25,000 copies of the Your Life, Your Choices: Planning Ahead booklet have been distributed across NI including to all care homes and community pharmacies.

- A Palliative Care in Partnership website (www.pcip.hscni.net) has been developed to provide support and resources for HSC professionals and for people with palliative care needs and those important to them.

- A Palliative Care in Partnership "Voices4Care" reference group for service users and carers has been facilitated.

- To progress the planned activities in the regional palliative care work plan two events and three workshops have taken place. This has included members and stakeholders of the Palliative Care in Partnership programme.

Strategic Importance

- The Palliative Care in Partnership programme supports the strategic direction as set out in; Delivering Together's commitment - building capacity in communities and in prevention;

- New Decade New Approach which commits to delivering service developments in palliative and end of life care;

- The Specialist Palliative Care Workforce Review to explore the workforce requirement to meet the NI population needs to 2024.

- Department of Health Living Matters, Dying Matters: Palliative and End of Life Care Strategy (2010).

In addition, the impact of COVID-19 has brought into sharp focus the need for additional capacity in palliative care services to meet the increasing need of people being cared for at the end of their lives in their own homes and care homes.

COVID-19 TRAINING IN CARE HOMES

Total Investment

£100,000

Objective

To enhance the delivery of safe, effective, compassionate care to service users living in care homes across Northern Ireland.

Regional Project

Yes.

Progress

Training was developed for Care Home nursing staff to respond to identified COVID-19 and Non COVID-19 related needs. A bespoke training programme 'Leading in Crisis' was developed and delivered to 100 staff to enhance clinical leadership and management capability within care homes. Access to e-learning for care home staff was also provided. A total of 127 training and engagement sessions were delivered with 4,225 participants.

Strategic Importance

This project contributes to the Delivering Together ambition of reforming our community and hospital services and the key enabler of investing in our workforce. Training and development of care home staff has enhanced the confidence and competence of nursing staff to meet the care needs of people living in nursing and residential care homes. This has resulted in direct care delivery to meet the increasing acuity, care and support needs of patients and residents, improving the quality and experience of care and reducing reliance on both primary and secondary care services.

All Trust Care Home Support Teams have been up-skilled to respond to the COVID-19 pandemic. The provision of regional training and development has improved access to training and supported a consistent regional approach to ensure that care home staff are equipped with the skills to recognise, prevent and treat COVID-19.

TRANSFORMING CHILDREN'S SERVICES- ADOPTION AND FOSTERING SERVICES

Total Investment

£4,788,000

Objective

To Transform Fostering and Adoption Services through (a) promoting mother and baby fostering, (b) adopting a regional approach to recruitment of foster carers, (c) recruiting more specialist foster carers and (d) developing post adoption support.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Establish a Mother & Baby Foster Placement Scheme for vulnerable mothers	84	288	350	722
Increased capacity to recruit specialist foster parents	0	237	100	337
Recruiting more Specialist Foster Carers	0	1,207	555	1,762
Looked After Children – Post Permanence placement support team	200	860	907	1,967
	284	2,592	1,912	4,788

Regional Project

Yes.

Progress

10 Specialist foster placements including placements for mothers and babies have been recruited to offer placements to vulnerable children and young people.

In terms of Mother and Baby fostering, 10 new carers have been recruited and there has been an increase in;

- Resources available for recruitment and training
- Uptake of training by foster carers and social workers
- Rehabilitation of parent and child together
- Planned permanency with parents understanding the rationale for the care plan and assisting with its arrangements

The post permanence support ensures that adopters continue to be supported to prevent adoption breakdowns. 17 new social work and 9 social care staff are all in place and are delivering services to adoptive children and families across the HSC Trust areas. These services include support for direct and indirect birth family contact and therapeutic interventions at both an individual child and family level. Social work staff across all HSC Trusts have availed of additional training to enable them to provide these interventions where appropriate.

The Regional Recruitment team has worked to promote fostering to the wider community through engagement such as the development of social media campaigns and use of marketing expertise.

Strategic Importance

All of the project activity contributes to the following strategies:

- The Delivering Together commitment to expand foster placement options.
- The Department of Health A Life Deserved: A Strategy for Looked after Children.
- The Children and Young People's strategy 2019-29 priority to secure stability for Looked after Children.
- The New Decade, New approach priority for post permanence support.

SERVICE REFORMATION FOR CHILDREN WITH SPECIAL EDUCATIONAL NEEDS (SEN)

Objective

To develop a consistent and standardised approach for the provision of HSC advice for children under-going Statutory Assessment to ensure compliance with the 6 week timeframe.

Total Investment

£989,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Service Reformation for Children with Special Educational Needs (SEN)	175	452	362	989

Regional Project

Yes.

Progress

Health and Social Care advice for Children and Young People (CYP) undergoing Statutory Assessment has been standardised and reformed across Paediatrics, Occupational Therapy, Physiotherapy and Speech and Language Therapy. Performance across these professions in respect of the 6 week timeframe for statutory assessments has increased from 49% in December 2019 to 90% compliance as a result of this project. Project progress includes;

- Successful implementation of an electronic information exchange system across the health and education sectors has been successfully implemented.
- There has been enhanced compliance with HSC advice for children undergoing statutory assessment with the Education Authority through training, the establishment of standard pro-forma and consistent pathways.
- There is enhanced working between HSC staff, the Education Authority and schools to ensure the requirements of the Children's Services Co-operation Act Northern Ireland (2015) are met.
- There is early identification of children with Special Educational Needs (SEN) through timely provision of advice reports as part of the Statutory Assessment process. This helped ensure timely intervention for children and subsequently enhanced outcomes for children and their families.

Strategic Importance

This project contributes to the achievement of the New Decade, New Approach commitment to addressing the issues highlighted as part of the Northern Ireland Audit Office (NIAO) review into SEN.

The NIAO report (2017) identified that only 21% of Statements of SEN were completed within the 26 week statutory time limit and the Education Authority have stated that the majority of delays were primarily relating to delays in receiving advice reports from a HSC Trust.

This project has supported Trust adherence to requirements within the Children's Co-operation Act (2015) and the Special Educational Needs and Disability Act (2016).

TRANSFORMING CHILDREN'S SERVICES - COURT BASED SOCIAL WORK (CARE PROCEEDINGS PILOT)

Objective

To transform children's court based social work.

Total Investment

£288,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Court based Social Work (Care Proceedings Pilot)	64	107	117	288

Regional Project

No. This is not a regional service although there is interest from the other Trusts.

Progress

The Care proceedings pilot has been fully introduced as a practice model in WHSCT and SEHSCT.

In both Trust areas there has been positive feedback from the Judiciary regarding the improved standard of Trust reports being submitted to court and the valuable role of the Court Liaison Officer in Court. This view is also echoed by the Trusts legal representatives in the Directorate of Legal Services. Social Work teams have also expressed their appreciation for the Court Liaison Officer as they are not required to attend Court for long periods of time. For each review saving valuable social worker time Progress includes:

- Improvement in the quality of social work assessments and analysis by the Court Liaison Officer;
- Development of consistent and improved quality in court;
- Provision of training programmes and increased social work confidence.

Strategic Importance

This project contributes to the achievement of the Delivering Together theme of reforming community services. The Northern Ireland Access to Justice Review Report (2011) recommended a fundamental review of family justice in Northern Ireland and highlighted a number of major systemic and policy issues with an impact on the quality and cost of access to justice. In December 2015 the Department of Health and the Department of Justice launched the Care Proceedings Pilot aimed at promoting good decision making and minimising unnecessary delay for children subject to care proceedings.

TRANSFORMING CHILDREN'S SERVICES - EARLY INTERVENTION APPROACHES

Objective

To transform Early Intervention Approaches.

Total Investment

£2,532,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Enhancing Family Support Hubs	485	862	610	1,957
The PAUSE project	63	119	393	575
	548	981	1,003	2,532

Regional Project

Yes.

Progress

PAUSE aims to reduce the number of children being removed into care by working directly with women who have previously had children removed into care. Following initial implementation in the Northern Health and Social Care Trust (NHSCT) it was rolled out to the other Trust areas. In NHSCT the following was achieved:

- A scoping study was completed to establish the level of need for mothers in recurrent Care Proceedings and those with children placed outside of their parents' care e.g. Kinship placements;
- Using co-production a bespoke Northern Ireland PAUSE Model was developed;
- The PAUSE Model is being delivered to 24 parents.

The PAUSE project has been expanded to the other Trust areas where the infrastructure and initial work has been established. PAUSE projects were established in Belfast, South Eastern, and Western Health and Social Care Trusts to test the need for the project resulting in staff being recruited and women identified and engaged with.

Family Support Hubs coordinate statutory and early intervention services to support vulnerable families and divert them from statutory services. The project enabled the Hubs to expand their work to include outreach to families. In 2019/20, 7,590 families were referred to Hubs, 453 more than previous year. 21% of referrals were from families with a child with a disability. The Hubs also dealt with 2,909 telephone query/advice calls.

A survey conducted between March and June 2020 confirmed that all 29 Hubs continued to operate during the first lockdown period. Hubs noted a rise in referrals for food, fuel and practical help including managing the behaviour of children, particularly those with an ASD or ADHD presentation.

Strategic Importance

This project contributes to the Delivering Together commitment to enhance the capacity of Family Support Hubs (FSH) as part of building capacity in communities and in prevention. It also contributes to the Families Matter support strategy and aligns with the New Decade, New Approach commitment to maintain the transformation agenda.

The Outcomes Delivery Plan (2019) includes an action under outcome 12 to deliver the PAUSE pilot, contributing to the Looked After Children (LAC) strategy by reducing admissions to care from a very vulnerable cohort of mothers.

TRANSFORMING CHILDREN'S SERVICES - SUPPORT TO CHILDREN AND YOUNG PEOPLE IN THE LOOKED AFTER SYSTEM

Total Investment

£7,757,000

Objective

To transform outcomes in the Looked After Children (LAC) system through;

(a) Development of Peripatetic Support Teams;

(b) Putting a LAC Interface Worker in each HSC Trust;

(c) Developing a Regional Chair post to manage access to secure care and;

(d) Developing a new solution for homeless young people.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Outworking from service review of children's residential care - peripatetic support	218	1,808	1,791	3,819
Testing a new housing solution for 16/17 year olds presenting as homeless	295	300	300	895
Transformation of regional facilities for children and young people	241	1,486	1,316	3,043
	754	3,594	3,409	7,757

Regional Project

Yes.

Progress

A regional chair post for overseeing a multi-agency panel for access to secure care has now been developed, replacing five HSC Trust panel members.

LAC Interface workers are now working in each of the five HSC Trusts improving the interfaces between services. Based on a cohort of 43 children across HSC Trusts, the interface workers have identified and addressed issues relating to:

- Accessibility and timeliness of interventions;
- Barriers and constraints to children in care accessing the care services they need;

- Seamless transitions across children and adult services, in particular related to Child and Adolescent Mental Health (CAMHs), adult mental health services, children with disabilities, and adult disability services.

Delivery of the LAC interface worker against specified objectives was overseen by a regional project group. In July 2020, a review of the project identified a number of findings and recommendations which confirmed that this role effectively supported, tracked and examined the pathways of Looked After Children with highly complex needs. Impacts include:

- Ability to improve cross agency / disciplinary collaboration and the development of approaches to youth homelessness. The second phase of the evaluation was completed in early 2021.

Peripatetic Support Teams are working to support young people in existing residential placements. In May 2020, an interim evaluation provided evidence (quantitative and qualitative) of progress towards delivery against objectives. However this early evidence is caveated with an acknowledgement that longer timeframes are required to fully assess and evidence effective delivery.

This evaluation was completed by the HSCB in conjunction with Social Care Institute for Excellence (SCIE) and the HSC Trusts. It confirmed that there was early quantitative data which indicated a reduction in placement moves and a reduction in young people being reported missing. It is also found that from September 2019 there were indicators of positive relationships being established between young people and those delivering the service.

Strategic Importance

This project contributes to Delivering Together's commitment to further support young people and children in the looked after system, the regional review of residential facilities supported by DoH and DoJ, and the Children and Young People's strategy 2019.

REFORM OF ADULT SOCIAL CARE

Total Investment

£485,000

Objective

To improve the social wellbeing of citizens who require social care services so that they live safely and well; improve quality and experience for people receiving care and support in their own home, ensure sustainability of services within local communities, and support and empower front line staff in both the statutory and independent sectors to deliver high quality services.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Reform of Social care – Power to People	0	0	485	485

Regional Project

Yes.

Progress

This project has made progress in a number of key areas:

- A new model of delivery for care and support at home has been developed and aspects of that reformed model have been tested across the HSC system for potential upscaling.
- The benefits of the new model are currently being rolled out across the South Eastern Health and Social Care Trust (SEHSCT). While this is providing significant evidence of modernisation, there is a need to "scale up" the provision of the new approach across all five HSC Trusts so that the benefits of the new approach can be fully realised.
- Roll out of Self Directed Support (SDS) approaches which enabled all service users and carers to be assessed or reassessed and offered the choice to access direct payments, a managed budget, HSC Trust arranged services, or a mix of those options, to meet any eligible needs identified.
- Supported Northern Health and Social Care Trust (NHSCT) front line staff to prepare for change through a project which assessed and tested the preparatory work required to equip the homecare workforce to implement a new model of care and support at home. Provision of a winter pack ensured that staff felt valued and supported during the difficult winter months. Items in the pack also supported and equipped staff in the delivery of care, thus contributing to an improved working experience and improving staff morale, health and well-being. Additionally, NHSCT hosted 8 engagement sessions for domiciliary care staff to enable staff to contribute to the development of a new model of care and support at home. This has provided a good practice model for other Trusts and providers;

- 3,499 front line HSC staff were provided with enhanced training through the Northern Ireland Social Care Council (NISCC). This aspect of the project was shortlisted by the European Social Network for the Collaborative Practice Award.

Strategic Importance

This Project is integral to the implementation of the recommendations contained in "Power to People: Proposals to reboot adult care and support in Northern Ireland" (2017).

REFORM OF ADULT SOCIAL CARE - SOCIAL CARE WORKFORCE STRATEGY

Objective

To support the development of a career structure and CPD framework for the social care workforce, and to inform a cohesive approach to workforce development across the HSC and Independent Sector.

Total Investment

£171,000

Regional Project

Yes.

Progress

This project has made progress with the development of a standardised continuous professional development framework with four workshops held and a benchmarking exercise (against Wales) completed. A career structure and CPD framework have also been progressed with consultations with qualifications panels and workforce sub groups taking place. £47,000 has also been directly invested in workforce training for staff in HSC and the independent sector. This training enabled 50 members of staff to attain a Diploma in Health and Social Care at Levels 2, 3 or 5 and included areas such as management and leadership in residential, adult and children's services.

The 'Social Care – Making a Difference' campaign has been developed by the Northern Ireland Social Care Council (NISCC) on behalf of the Department of Health as part of its ongoing work to reform Adult Social Care. The campaign highlights that social care staff are an integral and valued part of the health and social workforce and their work is critical to the sustainable provision of social care services now and in the future.

Strategic Importance

This project contributes to the achievement of the New Decade, New Approach priority focused on the Reform of Adult Social Care.

Project activity also aligns with the wide reaching reform and transformation of the adult social care sector in Northern Ireland guided by the 'Power to People' report.

In addition, the project also contributes to the achievement of the Social Care Strategy objective to support staff through direct training and skills building to enhance support service delivery. This strategy will raise the profile of social care as a profession and improve workforce retention while also increasing recruitment of staff to support the rebuilding of services.

REFORM OF ADULT SOCIAL CARE - MY HOME LIFE (MHL) PROGRAMME

Total Investment

£96,000

Objective

To meet the unique needs of care home managers by supporting them to improve quality of life for residents, relatives and staff.

Regional Project

Yes.

Progress

The My Home Life programme project commenced as planned in October 2020 despite the challenges of the COVID-19 global pandemic. Fourteen Care Home Managers have participated in the programme to date. Feedback from participants indicates that it has been a positive experience and has helped to improve the quality of life for residents, relatives and staff by applying the relationship centred course learning to all aspects of service delivery.

The course itself is a one year academic course with continued in work learning. The roll out of the programme to the 400 plus Care Home Managers will take 4 years to complete.

Strategic Importance

The My Home Life Programme project contributes to the Delivering Together recognition that increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. The Minister for Health has given his support for the MHL Leadership programme as one of the training and career pathway options to help recognise the skills, values and attributes of people who work in adult social care in Northern Ireland. The MHL Leadership training provides Care Home Managers with a programme which is underpinned by relationship-centred care that recognises the importance of seeing the care home as a 'community' where the quality of life of staff, family, friends and residents are all crucial to improvements in practice.

The My Home Life Programme project will contribute to the rebuilding of HSC services for those residing in a care home setting.

REFORM OF ADULT SOCIAL CARE - OPEN UNIVERSITY NORTHERN IRELAND PROVISION OF THE DEGREE IN SOCIAL WORK

Total Investment

£144,000

Regional Project

Yes.

Objective

To commission 15 places for social care workers on the OUNI Degree in Social Work programme.

Progress

15 places for social care workers were commissioned on the Open University Degree in Social Work in October 2020 and filled by November 2020.

Strategic Importance

This project contributes to many of the ambitions identified in Delivering Together including improving the skills and quality of the HSC workforce, providing career development opportunities for the largest staff grouping within HSC and ultimately enhancing service user experience. It will also support most of the Delivering Together key enablers particularly partnership working.

MENTAL HEALTH RECOVERY MODEL & CO-PRODUCTION

Total Investment

£607,000

Objective

To support the ongoing development of mental health recovery and co-production through peer support groups for service users and family carers, and Recovery Colleges.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Mental Health Recovery Model & Co-production	151	320	136	607

Regional Project

Yes.

Progress

The mental health recovery and co-production project activity in all Trusts enables individuals with lived experience to take responsibility for managing their own health and wellbeing. The project works in partnership with clinicians, professionals and other service providers to help individuals develop the knowledge, skills and motivation to engage in civic life, work and education. This project is a real example of how specifically the HSC has embedded the Department of Health Co Production Guide (2016) and how Mental Health Services (MHS) in general, have been leading by example to ensure that the legal requirement around personal and public involvement (PPI) are complied with. It has focused on informing, involving and including individuals with lived experience in all aspects of service development and commissioning. Each HSC Trust has employed staff to support co-production and recovery.

Progress also includes commissioning the external evaluation, the introduction of the outcomes tool and the availability of the Outcomes Star.

A service user consultant is a member of the Belfast Trust Mental Health collective leadership team and is integral to the setting of direction for all services. Belfast Trust currently employs 10 peer support workers. There are an additional 6 vacant positions for which a recruitment process is currently underway. The recovery college employs, 3 staff with lived experience and in 2020/21 ran 39 courses which reached 2100 people.

Co-production is the cornerstone of the Belfast Trust Recovery College. It is at every level and stage of planning, development, curriculum and quality assurance. All courses are co-facilitated by service users, carers and mental health staff. The Belfast Trust also have independent peer advocates that attend management meetings. They are also part of QI (Quality Improvement) projects and are part of the training and development of clinical teams and services.

The South Eastern Trust employs a number of people with lived experience in a range of roles, including a Service User Consultant. The Trust also employs Peer Workers in Inpatient, Addictions, Personality Disorder Services, Wellness Recovery Network and the Recovery College. The Trust has also commenced recruitment for two further posts through which individuals with lived experience will support people discharged from hospital in making the transition home.

The South Eastern Trust's future direction in building lived experience capacity and involvement will be outlined within a strategy which they aim to have available this year.

The Southern Trust employs 5 peer support workers across mental health and supports a number of ad hoc peer trainers to work within the Recovery College.

To drive forward the Mental Health Recovery Model and promote coproduction, the WHSCT appointed a 'lived experience' Service User Consultant (Band 7) for adult mental health in 2019. This post has now become a permanent role within the Senior Management Team. The recruitment of the peer consultant has led to a significant increase in coproduction activity within adult mental health services in the Western Trust. As part of the Delivering Value: Improving Quality and Safety Big Programme of Work, the Service User Consultant has created opportunities for people with lived experience of using WHSCT mental health services to directly participate in the design and delivery of services. Currently, service users are engaged in coproduction work streams with Trust staff in the following areas: a review of the ED Pathway for clients; evaluating access to psychological therapies; assessing the experience of clients using Paediatric Intensive Care Unit, and reviewing the engagement of families in the Severe Adverse Incidents process.

To promote coproduction further and to create opportunities for clients to build capacity and experience, the Service User Consultant has created a Virtual Reference Group (VRG), where people with 'lived experience' can come together and learn about coproduction activities within the Trust. The VRG was established in response to the challenges to face-to-face working presented by the Covid pandemic. The VRG has been very successful and has proved to be a starting point for service users embarking on a recovery journey and who wish to develop their coproduction skills. The Service User Consultant has also been instrumental in establishing an annual award celebrating Trust activity that promotes coproduction. Following the appointment of the Service User Consultant, Mental Health services in the WHSCT expanded its cohort of 'lived experience' roles with the appointment of 1wte permanent Lead Peer Trainer (Band 5) within the Recovery College. The Lead Peer Trainer supervises a cohort of volunteer peer trainers, however work has commenced around the potential recruitment of a further three part-time, permanent Peer Trainers (Band 4) to work in conjunction with the Recovery College and Mental Health teams.

To further drive forward the Mental Health Recovery Model and to promote coproduction the Service User Consultant has presented to all of the adult mental health teams on the topic of the values and principles of the You in Mind Mental Health Care Pathway (2014). Staff have been engaged in discussion

around the importance of working in partnership with service users and carers – and to promote hope, opportunity and control at all times. Regular meetings have also been established with carer and service user advocates, and these advocacy representatives have been invited on to several coproduction work streams.

To ensure that recovery principles are applied across all aspects of Mental Health services, all WHSCT inpatients at the point of discharge are given the opportunity to express an opinion about their treatment. Clients are asked if they felt involved in their care and whether their families/friends felt involved in their care. This data is analysed systematically and the results are shared with senior management and ward managers and teams on a monthly basis. This continuous survey was designed by the Service User Consultant with the aim of ensuring that clients feel a sense of partnership with Mental Health staff during their care. The continuous survey has now been extended to capture the views of clients using the Crisis Response Home Treatment teams.

As in other Trusts the pandemic resulted in face-to-face services moving to an online presence. Service user views on this period of the Covid crisis were captured by the Service User Consultant as part of the 10K More Voices project.

The Covid pandemic inevitably meant that users of WHSCT MH day centres experienced reduced access in terms of hours each week. At the same time, however, staff trained in the use of the Recovery Star wellbeing tool reported that they were able to engage in more focused, person-centred and recovery oriented work on a one-to-one basis with clients.

Recovery and co-production remains a key priority for MHS in all HSC Trusts which each have an active Recovery College, with a dedicated Recovery Co-ordinator. The HSC Trusts deliver an Annual Prospectus of co-produced and co-facilitated courses concentrating on recovery focused practise while the project funded 150 annual courses at each of the Recovery Colleges. The Process Evaluation of Mental Health Recovery Colleges in Northern Ireland Report (2019) found that the co-production model runs through the ethos of all the Recovery Colleges.

This project activity is building on the success of the peer led initiatives in recovery focused practice across MHS. The project's peer led recovery groups support individuals to positively engage in active care and treatment and to develop interests and activities that will enable them to sustain their health and wellbeing post treatment.

The Covid pandemic has had some impact on project progress in 2020-21, as many mental health services were transferred to online support and remote working, and the timelines for recruitment and selection of additional staff for face to face contact with patients and clients was affected.

Strategic Importance

This project supports the Department of Health Mental Health Action Plan – Action 5 objective to enhance the involvement of people with lived experience, including service users and carers in service delivery and service planning and action 13.2 to review and create a regional protocol for peer support workers including clear governance structure and role subject to funding.

It is also critical to the two key actions set out in the Department of Health Mental Health Strategy 2021-31; Action 16 to further develop recovery service, including Recovery Colleges, to ensure that a recovery focus and approach is embedded in the whole mental health system; and Action 33 to create a peer support and advocacy model across mental health services. The Recovery College model and peer support workers employed as part of this project will directly support these developments going forward. The underlying principle in mental health recovery, no decision about me without me, as reflected in the Regional You in Mind Care Pathway (2014) continues to guide Mental Health Services across Northern Ireland. Both the recovery colleges and the peer support model are key components of this recovery focused practice model and remain fundamental to the provision of high quality mental health care.

ENHANCED MENTAL HEALTH LIAISON SERVICE (MHLS)

Objective

To provide greater access in acute general hospitals to mental health services for patients and staff.

Total Investment

£3,102,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Enhanced Mental Health Liaison Service	227	1,198	1,677	3,102

Regional Project

Yes.

Progress

This project has enabled each HSC Trust to provide Emergency Department (ED) and acute hospital patients and staff with greater access to 24 hour rapid access to specialist mental health assessments (within 2 hours and 24 hours respectively).

The project has achieved the following progress:

- BHSCT – 24/7 coverage and service, covers both the Royal Victoria Hospital and Mater Hospital Emergency Departments. A two hour target is achieved 85% of the time and acute hospital ward referrals are all seen within 24 hrs, providing: timely assessment, onward referral and information advice offered.
- NHSCT – 24/7 coverage and service to ED (2 hrs) and acute hospital wards (24 hrs); Timely assessment, onward referral and information/advice offered. The Mental Health Liaison Service has been fully operational since 2015 and continues to provide a fully enhanced model of liaison care across both hospital sites.
- SEHSCT – Ulster Hospital site only, 24/7 only in ED (2hrs), no night time cover on wards. Repeat attenders policy in place and effective meetings held between services;
- SHSCT – 7 days per week, 9am-9pm, across all sites, ED (2hrs) and wards (24hrs);
- WHSCT – In September 2019 a MHL pilot commenced to cover the inpatients wards in AAH (Altnagelvin Area Hospital) but was suspended due to Covid-19 and staff returned to their substantive posts in March 2020. Following the recruitment of staff the MHLS commenced in South West Acute Hospital in September 2020 and January 2021 in AAH. The service currently operates Monday to Friday 9.00am – 5.00pm in both sites with out of hours crisis assessments being completed by the Crisis Team. As this service is only in its infancy these operational hours will be subject to change.

Strategic Importance

This project contributes to the New Decade, New Approach commitment to increase the focus on mental health and wellbeing.

The project also contributes to the achievement of the Mental Health Strategy 2021-31 Action 27 which calls for the creation of a Regional Mental Health Crisis Service that is fully integrated in mental health services which will provide help and support for persons in mental health or suicidal crisis. Minister Swann published the new, regional mental health, Crisis Service Review Report on 24 August 2021. The new Regional Crisis Service was developed together with the authors of the review, and reflects the recommendations in the review. The Policy outlines what the crisis service will look like and provides 10 actions to make this a reality.

It also contributes to realising the Mental Health Strategy 2021-31 theme of providing the right support at the right time, which includes appropriate crisis support. This results in quicker access to appropriate services without multiple onward referral processes which the MHLS offers currently in both general acute wards and ED services.

ESTABLISH ELECTIVE CARE CENTRES FOR TREATMENT OF CATARACT

Objective

To establish prototype for Elective Care Centres for the treatment of Cataract.

Total Investment

£2,514,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Establish Elective Care Centres for treatment of Cataract	311	1,155	1,048	2,514

Regional Project

Yes.

Progress

The Elective Care Centres for the treatment of Cataract commenced in December 2018.. In 2020/21 a total of 3,373 cataract procedures were carried out which represented a decrease against 2019/20 (6,370).

This decrease can be attributed to the incremental approach to new ways of working, ramping up theatre sessions and lists gradually growing in the three regional cataract elective care/day procedure centres but principally due to the profound effects of COVID-19 and the impact on elective procedures and clinical and nursing teams.

The anticipated introduction of a region-wide electronic patient record system (Medisoft) will facilitate lists being populated from a regional pool, working across Trust boundaries to maximise capacity and resource.

Pre-COVID-19, the progress trajectory was improving, with theatre lists and sessions across all three centres increasing. The COVID-19 pandemic has had a significant impact on cataract waiting lists.
Theatre activity in 2021/22 stands at 4,009 procedures at end of October 2021. An additional 1,058 procedures have been carried out via the Independent Sector in-reach to Downe Hospital Cataract Day Procedure Centre (DPC).

The centres continue to operate as resources for the region for pre-assessments and post-operative review, although a new care model introduced in October 2021 will see an increasing number of post-operative reviews delivered by primary care optometrists, freeing capacity in secondary care. This pathway approach complements existing commitments in Minister's Elective Care Framework (June 2021) which has seen the establishment of additional cataract pre-assessment mega-clinics in Q2 2021/22.
It is anticipated that the progress trajectory will be scaled up when COVID-19 pressures allow.

Strategic Importance

This project contributes to the achievement of the Delivering Together commitment to develop Elective Care Centres and has helped to inform the development of Day Procedure Centres and wider strategic reform.

It also contributes to the Elective Care Plan - Transformation and Reform of Elective Care Services (2017) Commitment 6 which states that: "Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties." Cataract waiting lists represent treatable sight loss in the population and is therefore a top priority.

The provision of Elective Care Centres is a priority for the Minister. In June 2021 the Elective Care Framework was published. The Framework sets out firm, time bound proposals for how HSC will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how HSC will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed. There are a number of actions in the Framework on the development of the Elective Care Centre model.

DAYCASE ELECTIVE CARE CENTRES (DECC) - PHASE 2

Objective

To develop a regional service delivery model for Day Procedures Centres in Northern Ireland.

Total Investment

£210,000

Regional Project

Yes.

Progress

The Lagan Valley Hospital Day Procedure Centre (DPC) has been established and is currently providing much needed support to other Trusts in response to the downturn in elective services during the COVID-19 pandemic, particularly for regional cancer diagnostic work. Plans are in place to develop the DPC at Lagan Valley in the longer term with a view to tackling the lengthy waiting lists for day procedures. A clinically led Day Procedure Network has been established to develop and expand this model of service delivery.

At 12th February 2021, 216 patients from across the Northern Ireland have had urgent procedures completed in the DPC including Gynaecology, Colorectal, Breast, Plastics, Urology and Ear, Nose and Throat (ENT) specialties. In addition, a successful inguinal hernia pilot (56 patients) has also been carried out at the DPC and plans are in place to roll this out to the region.

As services are rebuilt, DPCs will play a vital role in tackling waiting lists, tackling equity of access, maintaining infection control and delivering value for money.

Strategic Importance

This project is a commitment set out in Delivering Together and New Decade, New Approach. Delivering Together noted that elective care centres would be established to provide a dedicated resource for less complex planned surgery and other procedures. The Department of Health subsequently published the Elective Care Plan which included a commitment to establish elective care centres to provide a dedicated resource for less complex planned surgery and other procedures.

The project also contributes to the achievement of the Establishment of a Regional Service Delivery Model for Daycase Elective Care Centres in Northern Ireland. The DPC at Lagan Valley Hospital was established to maintain robust infection control preventative measures at this site and enable day-case procedures to continue during the pandemic.

In June 2021 the Elective Care Framework was published. The Framework sets out firm, time bound proposals for how HSC will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how HSC will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed. There are a number of actions in the Framework on the development of the Elective Care Centre model.

ESTABLISH AN ELECTIVE CARE CENTRE FOR TREATMENT OF VARICOSE VEINS

Objective

To establish a prototype Elective Care Centre for the treatment of Varicose Veins.

Total Investment

£1,328,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Establish Elective Care Centres for treatment of Varicose Veins	180	873	275	1,328

Regional Project

Yes.

Progress

The Elective Care Centres for the treatment of varicose veins were fully operational by February 2019. In 2019/20 a total of 1,541 patients were treated which is a productivity increase of over 45% against the base year of 1,034 in 2017/18. There was also a significant reduction in both the number of patients waiting for treatment and in the waiting times with the number of patients waiting reduced from 1,417 in September 2018 to 1,092 by March 2020 and in that same period the number of patients waiting over 1 year reduced from 568 to 177.

As with other parts of the HSC system, progress has been impacted by Covid-19 as staff have been re-deployed to support urgent and critical care.

Strategic Importance

This project contributes towards the achievement of the Delivering Together commitment to develop Elective Care Centres requiring the Department to "bring forward proposals for the location and service specification for Elective Care Centres."

It also contributes to the Elective Care Plan - Transformation and Reform of Elective Care Services (2017) Commitment 6 which states that: "Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties."

The provision of Elective Care Centres is a priority for the Minister. In June 2021 the Elective Care Framework was published. The Framework sets out firm, time bound proposals for how HSC will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how HSC will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed. There are a number of actions in the Framework on the development of the Elective Care Centre model.

IMAGING REVIEW – OBSTETRIC AND PAEDIATRIC STRANDS

Objective

To implement the Imaging Strategy with regard to Obstetrics and Paediatrics.

Total Investment

£183,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Imaging Review – Obstetric and Paediatric Strands	48	135	0	183

Regional Project

Yes.

Progress

The Strategic Framework for Imaging Services (2018) recommends a regional approach to planning and delivering imaging services, with distinct recommendations for obstetric and paediatric imaging. New clinical groups have been established to take forward these important agendas to drive forward the improvements required across Obstetrics and Paediatrics. Critical to the success of these groups is the appointment of a Clinical Lead for both Obstetric and Paediatric imaging to provide the leadership, expertise and experience required. A clinical lead for obstetric imaging has been appointed and an interim clinical lead is in place for paediatric imaging.

Strategic Importance

Delivering Together places a high priority on planning and delivering imaging services. Imaging spans most service areas and the Strategic Framework highlights the need for a more strategic, uniform and joined up approach to imaging matters to ensure the priority afforded in Delivering Together is realised.

DEVELOPMENT OF THE NORTHERN AREA PATHFINDER

Total Investment

£563,000

Objective

To establish an approach to developing a Population Health Improvement Plan including a proposal for an Integrated Care System (ICS) which can offer a new regional approach.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of the Northern Area Pathfinder	0	374	189	563

Regional Project

This project was developed in the Northern Trust area and has helped inform the development of an Integrated Care System (ICS) model in Northern Ireland which is in the process of being developed and established on a regional basis by the Department.

Progress

The Northern Area Trust/GP Partnership, which is at the core of this prototype, has brought together a range of organisations including HSCB Local Commissioning Groups, PHA, NIAS, the Community and Voluntary sector, local Councils with the Northern Trust, GPs and locally based Integrated Care Partnerships. This partnership working and the relationships which have been established are essential to the achievement of the project's objectives. The Trust/GP Partnership creates an integrated/ cross organisational senior team that acts as a core HSC partner organisation to engage and involve other partners.

It is planned to now embed an Integrated Care System within the Northern Area which aligns with the model set out in the Integrated Care System NI draft framework and which builds on the existing structures that have been developed in the prototype including: the Northern Area Partnership working at an Area level, Integrated Care Partnerships and GP Federations at locality level and community based work around GP practices and neighbourhoods. This will see the Northern HSC Trust and local GPs and others working together on an ongoing basis, in a new way of working.

Whilst the Covid pandemic has impacted on the planned objectives and work of the Prototype taking it in an unforeseen direction, the strength of the already established Partnership supported a joined up Northern Area response.

The Prototype has:

- Built an effective partnership between the Northern Trust and General Practice in the Northern Area which created an opportunity for positive change in particular around dermatology services and waiting lists, phlebotomy services, Treatment room services, Anticipatory Care, the response to Covid and the Covid vaccination programme, and Phone First.

- Proposed and part tested a model for an integrated health and social care system with shared accountability, while maintaining existing architecture – this is in keeping with the 'Delivering Together' strategy and the Bengoa report.
- Developed a methodology for co-producing a population health management plan that can be supported by the HSC, it's partners and empower communities (included a co-produced Workshop on 25 Feb 2020 to provide information relating to population data and trends to a wide range of participants). Following discussion and analysis, five shared population health issues were identified with partners as priorities in the Northern area including obesity, diabetes, mental health, frailty and end of life care. This will form the basis for beginning to build a Population Health Improvement Plan, which will be tested and address the Mental Health priority first. This focus on the development of a Mental health population health plan was temporarily interrupted by the Covid pandemic when partnership efforts were diverted to other Covid related projects.
- Covid related Partner initiatives included the setting up of the Partnerhub in the Northern area. This is a single point of contact for Trust partner organisations, including Care Homes, Independent Sector, Domiciliary Care Providers, GPs, Community Pharmacies and Community and Voluntary organisations. The Partnerhub offered support and advice in the early days of the pandemic and continues to do so. Feedback regarding the Partnerhub from Partner organisations has been extremely positive.
- Covid related projects led by the Prototype included the Ballysally Outreach Covid vaccination clinic. This project used data to determine the low vaccine uptake in the most deprived Super Output area in the Northern Trust, Ballysally. This pilot influenced the roll out of pop-up clinics across the region regarding vaccine uptake in deprived areas. Community Pharmacy, Community and Voluntary organisation, Council and Trust partners worked together to successfully create a model that was further replicated across the region.
- The Prototype worked with PHA to develop a data analytic tool that will inform and shape services.
- Prototype work streams have taken early results from designing and testing a number of new service models –including Diabetes and services for residents of Nursing Homes –these give insight to the benefits of using data to inform and drive service models, keeping service user at the centre.
- Prototype provided leadership for the Phone First model.
- Prototype work streams were developed to take forward population health improvement initiatives that were aligned to local and area priorities. These included diabetes, frailty and musculoskeletal. An Anticipatory Care pilot involving 3 care homes demonstrated reduced ED attendances, reduced repeat ED attendance, reduced ambulance transfers and reduced hospital admissions.

Strategic Importance

This Northern Area Prototype ICS was established to test a new model for planning and delivering health and social care services and was endorsed by the Transformation Implementation Group in February 2020 as the roadmap for developing a new ICS model in Northern Ireland. The Prototype embraces the recommendations of Systems, Not Structures report building on the foundations of GP Federations, ICPs and system wide commitment to co-production. Work is now progressing to develop new systems to replace the existing commissioning functions of the HSCB. This project is key to the development of new and reformed systems.

This model aligns with Systems, Not Structures and also Delivering Together which detailed the need to design new partnership approaches to the planning and management of HSC services which move away from competition towards collaboration, integration and improvement.

DEVELOPMENT OF THE DAISY HILL PATHFINDER

Total Investment

£5,283,000

Objective

To improve unscheduled and acute medical services on the Daisy Hill Hospital (DHH) by:

- Increasing medical and nursing capacity in the emergency department;
- Strengthening the High Dependency Unit (HDU);
- Developing a Direct Assessment Unit (DAU);
- Improving quality and safety across the site.

This is a five year project and as such the final deadlines for achievement stretch into 2022.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of the Daisy Hill Pathfinder	500	1,715	3,068	5,283

Regional Project

SHSCT only

Progress

There has been satisfactory progress in all areas, with the recruitment and retention of a number of new senior medical and nursing. The ongoing step wise approach to recruitment has become ever more challenging over the last nine months due to the pandemic and the temporary closure of the Emergency Department in Daisy Hill Hospital between April and October 2020.

Increasing medical and nursing capacity in the emergency department of the planned 16.9 WTE staff to be appointed in both year 1 and 2, 15.74 WTE staff were appointed and in post with remaining 1.16 WTE to be appointed by 2022/23.

Strengthen the High Dependency Unit (HDU) Progress has been made on the recruitment of non-medical staff and in working towards achievement of training targets for nursing staff in line with project programme. The increases are in these areas:

- Nursing support Band 3 = plus 1.94 WTE

- Nursing Bands 5 – 7 = plus 5.82 WTE (skill mix change improves service)

- Enhanced Nurse Practitioners = plus 2.00 WTE

- Non-medical staff Bands 2 – 4 = plus 4.93 WTE

- Additional Consultant Intensivists have been appointed at Craigavon Area Hospital (CAH) which means there are seven consultants now in place.

- Eight Consultant Intensivists are required for CAH ICU/HDU and it is planned, that as numbers increase over time, the Trust will be able to move towards achieving standards through an Intensivist run service in DHH HDU. The SHSCT has developed a phased approach to create a rota of 8 WTE specialty doctors to cover bank holidays and weekends.

Develop a Direct Assessment Unit (DAU) The DAU provides clinical assessments to 10-14 patients per day. Telephone advice is also available to GPs and NIAS with direct access. Due to the direct assessments only 3-4 % of patients are admitted.

Improve quality and safety across the site During the COVID-19 pandemic the ED and DAU were relocated to the Craigavon Hospital, this has adversely impacted on progress with the implementation of this objective. Nevertheless, a reduction in cancelled operations and improvement in patient flows has been partially achieved.

Strategic Importance

The impact of COVID-19 on DHH as an acute provider at the time of this assessment is highly significant. The pathfinder has enjoyed success because of co-production with the local community and its commitment to long term sustainability and Delivering Together.

DEVELOPING A HEALTH & SOCIAL CARE INFRASTRUCTURE FOR QUALITY IMPROVEMENT AND INNOVATION (HSCQI)

Objective

To implement a Regional Quality Improvement and Innovation System (HSCQI) based on the outcome of the prototyping work as stated in Delivering Together - actions 10 and 15 to better align current resources devoted to safety and quality improvement.

Total Investment

£2,104,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a Health & Social Care infrastructure for Quality Improvement and Innovation (HSCQI)	943	1,002	159	2,104

Regional Project

Yes.

Progress

The Health & Social Care infrastructure for Quality Improvement and Innovation (HSCQI) project was established as a Hub and Spoke network in April 2019. The Director of HSCQI and the Communications and Engagement Lead were appointed by September 2019. Progress with individual project activities includes:

- The development of the HSCQI website.
- On-going development of a Quality, Improvement and Innovation Communications strategy.
- Development of a web based QI repository.

A HSCQI Network of Quality Improvement (QI) leads consisting of the HSCQI Hub team (Legacy Safety Forum Team), QI leads working across other parts of the system (mainly Trusts and Primary Care) and a service user has been created. A regional HSCQI supporting Alliance has also been established and membership includes representatives from Trusts and Departmental Chief Professional Officers, Primary Care and service users.

The HSCQI work plan initially focussed on legacy HSC Safety Forum QI collaboratives i.e. Maternity, Paediatrics and Mental Health. In keeping with its design intent, HSCQI subsequently led on the scale and spread of 4 regionally agreed QI initiatives: (i) Antimicrobial Stewardship (ii) Sepsis Care Bundle (iii) Safety Planning in Mental Health and (iv) Safeguarding. HSCQI delivered this programme of work from September 2019 to March 2020 until COVID-19 pandemic began. Evaluation of this programme of work in July 2020 indicated that all of these scale up initiatives had made good progress and all four had the potential for even greater scale up success should this work re-commence.

In partnership with Healthcare Improvement Scotland (HIS), HSCQI supported the delivery of two regional cohorts of the Scottish Improvement Leaders course (SCiL), resulting in an additional 60 staff from across the system being trained to level 3 QI training criteria as stated within the HSC Attributes Framework.

During the COVID-19 pandemic, HSCQI established a regional COVID-19 Learning System by applying a 90 day learning cycle approach. This resulted in the identification of three regionally agreed key COVID-19 learning themes - the use of technology to support virtual visiting; the use of technology to support virtual consultations; and interventions used to support staff health and well-being. Three HSCQI Learning System subgroups have been established to scale and spread examples of key learning within each of these themes.

Strategic Importance

The establishment of HSCQI fulfils the commitments outlined within the following strategic documents:

Delivering Together (2016)
Action Point 10: Identify current innovative HSC projects at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.
Action point 15: Complete the initial design work for the “Improvement Institute”.

Systems, Not Structures (2016)
Rec 4 - Transforming the NI HSC system by the “Aggressive scale up good practice”; Rec 8 - “The system should identify and scale up at least 2 innovative projects per year where there is clear evidence of improved outcomes for patients and service users”.

The Right Time, The Right Place (2014)
Rec 7, - the NI HSC system should establish a “Northern Ireland Patient Safety Institute”. HSCQI is the realisation of that Institute.

The HSCQI project has responded positively to the emergency response to the COVID-19 pandemic and the subsequent ongoing rebuilding of services by supporting the PHA/HSCB communication and governance response and aligning the HSCQI Learning System programme of work with the HSC Service Delivery Innovation Rebuild work stream.

INFORMATION ANALYSIS - COST PERFORMANCE TO SUPPORT SERVICE IMPROVEMENT

Total Investment

£126,000

Objective

To support the optimisation of performance and embed the principles of reform into measurable improvements –

- Potential for an Integrated Performance Dashboard (IPD)
- Acute Capitation Review
- Patient Level Information and Costing System (PLICS)
- Reference Costs
- Pilot Integrated Performance Dashboard
- Activity Based Funding Model

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Information Analysis - cost performance to support service improvement	0	20	106	126

Regional Project

Yes.

Progress

- A stocktake of existing activity, performance and information sources has been undertaken and a proof-of-concept paper has been written on the potential for an Integrated Performance Dashboard with a pilot IPD now initiated This pilot has been designed for stroke services and full implementation is underway, timetabled for completion by March 2022. Adaptation of the stroke IPD to form a template for data processing and dashboard design that can be applied to other key business areas for performance monitoring and service improvement is timetabled for completion in summer 2022.

- Collation and harmonisation of available Acute Capitation Review data has been completed and its use in benchmarking between HSC Trusts is ongoing.

- A paper on the feasibility of introducing Patient Level Information and Costing System (PLICS) to NI has been approved, with work on acute activity roll-out commencing in February 2021 and timetabled for completion in March 2022.

- Delivery of Northern Ireland reference costs for 2019/20 was completed and published on schedule in April 2021.

- Analysis of an Activity Based Funding model is up-to-date in the current annual cycle.

Strategic Importance

This project contributes to the Delivering Together organising ourselves to deliver theme and supports the development of the Delivering Together key enabler of improving quality. The project is contributing to service improvement across the HSC.

The project also links to the Rebuilding HSC Services work stream , service delivery innovation by demonstrating the potential for design, development and use of Integrated Performance Dashboards to support service improvement and performance monitoring.

FUTURE NURSE FUTURE MIDWIFE

Total Investment

£677,000

Objective

To ensure a co-ordinated and planned approach to the implementation of transformational change associated with the Nursing and Midwifery Council's new Standards for pre and post registered Nursing and Midwifery training education across a range of practice and service settings.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Future Nurse Future Midwife	101	324	252	677

Regional Project

Yes.

Progress

Progress has been made in respect of all the project objectives and milestones. The Future Nurse Future Midwife project's overall implementation timeline was in line with or in advance of that anticipated, recognising that timescales for implementation of new education standards for nursing and midwifery were September 2020 and September 2021 (respectively). Curricula have been developed to meet the new Nursing Midwifery Council (NMC) standards across midwifery and the four areas of Practice within nursing. A Northern Ireland Practice Assessment Document (NIPAD) has been developed and is being utilised by all nursing students studying at local universities. A range of products and resources to support the nursing and midwifery workforce have been provided, including an e-learning programme to support upskilling and preparation to undertake new roles.

A new engagement and communication strategy has been implemented which enabled accurate, timely, relevant and reliable communication in a range of formats which is accessible to all nurses and midwives in Northern Ireland. Face to face and e-learning preparation programmes have been delivered from May 2020. To date approximately 10,000 staff have completed the preparation programme.

Also, through the project a work-stream was established to maximise and expand existing practice placements to increase capacity in the September 2020 intake by 300 additional pre-registration students to 1,325, a year on year increment of 29%, working towards an additional total of 900 students over 3 years. This enabled agreement to be reached on the specific nursing practice learning profiles, maximised learning opportunities across every practice placement and supported the additional 300 student places from September 2020.

These activities have been related to the NMC approval process and as such were critical to regulatory requirements.

Strategic Importance

The Future Nurse Future Midwife project contributes to the Delivering Together commitment to support our workforce and fulfils a regulatory requirement to transform Nursing and Midwifery Education into the future.

This project also supports the development of the Delivering Together 'Improve Quality' enabler.

It also links directly to the Rebuilding HSC Services Work-stream 'Safe Staffing' by ensuring that the nursing and midwifery workforce meets its regulatory requirements to support students undertaking pre-registration undergraduate training to successfully complete their programmes and join the workforce as registrants.

PRE-REGISTRATION NURSING PROJECT

Total Investment

£2,936,000

Objective

To put in place 75 pre-registration nursing students, starting September 2018, with the anticipated completion of training by August 2021.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pre-registration Nursing Project	587	1,006	1,343	2,936

Regional Project

Yes.

Progress

In September 2018, 75 nursing students commenced their pre-registration training. The nursing students completed their training in August 2021. The Pre-registration Nursing Project has provided funding for additional nursing and midwifery training places, to ensure the supply of new professional nursing and midwifery graduates is maintained to support the workforce, and for the continued safe delivery of services.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation. It also aligns with the Workforce Stabiliation strategic theme of the Nursing and Midwifery Task Group Report.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also supports the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

DIRECT ENTRY MIDWIFERY PROJECT

Total Investment

£820,000

Objective

To put in place 15 direct entry midwifery students in September 2018 with the anticipated completion of training in August 2021.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Direct Entry Midwifery Project	135	231	454	820

Regional Project

Yes

Progress

15 midwifery students commenced their Direct Entry Midwifery training in September 2018. The student midwives completed their training in August 2021. The project provides funding for additional midwifery training places, in response to predicted service demand.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity terms of numbers, expertise, motivation and skills. It also aligns with the Workforce Stabilisation strategic theme of the Nursing and Midwifery Task Group Report.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also support the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

SHORTENED MIDWIFERY COURSE PROJECT

Total Investment

£267,000

Objective

To put in place a cohort of 10 midwifery students to commence the shortened Midwifery course in September 2018, with anticipated completion of training in August 2020.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Shortened Midwifery Course Project	56	96	115	267

Regional Project

Yes

Progress

In September 2018, 10 midwifery students commenced their shortened midwifery course. The midwifery students completed their training in August 2020. The Shortened Midwifery Course Project provides funding for additional midwifery training places in response to predicted service demand.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, expertise, motivation and skills. It also aligns with the Workforce Stabilisation strategic theme of the Nursing and Midwifery Task Group Report.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also support the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

ADDITIONAL 900 NURSING PLACES PROJECT

Total Investment

£2,398,000

Objective

To provide an additional 300 pre-registration training places, year on year for three years, commencing in September 2020, with 900 Nursing and Midwifery training places complete by August 2025.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Additional 900 Nursing Places Project	0	0	2,398	2,398

Regional Project

Yes

Progress

300 nursing and midwifery students commenced their pre-registration training in September 2020. These students are on target to complete their training by August 2023. The second cohort of 300 students are due to commence their training in September 2021. The Additional 900 Nursing and Midwifery Places Project is a specific objective of the New Decade New Approach Agreement. It provides funding for additional nursing and midwifery training places, to ensure that the supply of new professional nursing and midwifery graduates is maintained to support the workforce, and for the continued safe delivery of services.

The benefits of these additional training places will start to be realised from autumn 2023 when the first cohort of 300 additional students complete their degree course and take up posts within the HSC.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

PRE-REGISTRATION PHYSIOTHERAPY PROJECT

Total Investment

£369,000

Objective

To provide 10 additional physiotherapy degree course places from September 2018.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pre-registration Physiotherapy Project	53	90	226	369

Regional Project

Yes

Progress

10 additional students commenced their Pre-registration Physiotherapy degree in September 2018. The physiotherapy students completed their degree in August 2021. These additional training places, which are required on a recurrent basis, will ensure that the necessary supply of trainee physiotherapists are in place to meet future workforce demands.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also supports the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

PRE-REGISTRATION DIAGNOSTIC RADIOGRAPHY PROJECT

Total Investment

£352,000

Objective

To provide 10 additional diagnostic radiography degree training places from September 2018.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pre-registration Diagnostic Radiography Project	61	105	186	352

Regional Project

Yes

Progress

10 additional students commenced their Pre-registration Diagnostic Radiography degree in September 2018. The diagnostic radiography students completed their degree in August 2021. The Pre-registration Diagnostic Radiography Project has provided funding to support the necessary additional training places in response to predicted service demand.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also supports the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

ADDITIONAL MEDICAL SPECIALTY TRAINING PROJECT

Total Investment

£1,661,000

Objective

To provide additional medical specialty training programmes in response to workforce planning recommendations, which confirm that Radiology, Intensive Care Medicine, Paediatrics, Urology, Trauma and Orthopaedics and Irish Clinical Academic Training (ICAT) Programme training places should be extended.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Additional Medical Specialty Training Project	400	601	660	1,661

Regional Project

Yes.

Progress

The Additional Medical Specialty Training Project has provided funding for additional specialty medical training places to ensure that the professional healthcare skills necessary for the continued safe delivery of services are in place and to meet predicted service demand. Since the project began in 2018, it has provided the following additional specialty medical training places;

- 5 Radiology places
- 4 Urology places
- 6 ICM places
- 4 Paediatrics places
- 2 ICATs places
- 1 Trauma and Orthopaedics place

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also support the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

They also support the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

NIAS CLINICAL RESPONSE MODEL AND PARAMEDIC TRAINING

Total Investment

£11,120,000

Objective

To carry out the preparatory work to develop a new Clinical Response Model (CRM) for Northern Ireland which will change the way in which calls made to NIAS are categorised, ensuring that the sickest patients are identified and dealt with quickly.

1. To transform the approach to the delivery of paramedic education and deliver a comprehensive workforce plan.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
NIAS Paramedic Training	1,670	3,410	5,000	10,080
Clinical Response Model	0	500	540	1,040
	1,670	3,910	5,540	11,120

Regional Project

Yes.

Progress

The project objectives for preparatory work on the development of the new CRM have been fully met. The key product of this was to introduce the CRM Code Set which was achieved to specification, on time and within budget. The Strategic Outline Case (SOC) has been submitted to the Department of Health to secure the resources to implement the model.

The paramedic education project objective has also been achieved on time and within budget.
Progress against the paramedic education objective is as follows:

- Successful development and delivery of a new Paramedic Foundation Degree in partnership with Ulster University.
- Delivery of training courses for the following workforce groups:
  - Ambulance Care Attendants (ACA): 182 students successfully completed the course.
  - Emergency Medical Technicians (EMT): 161 students successfully completed the course.
  - Paramedics: 81 students successfully completed the course and qualified as registered paramedics.

Strategic Importance

The development of a new Clinical Response Model and the training for EMT's, ACA's and Paramedics is consistent with Delivering Together in terms of investing in our workforce and ensuring that NIAS has the most effective clinical response model in place to ensure that people are treated in the right place at the right time.

SPECIALTY AND ASSOCIATE SPECIALIST (SAS) DOCTOR DEVELOPMENT PROJECT

Objective

The purpose of this project is to ensure that SAS doctors have the resources and support in place they need to meet the challenges of this role.

Total Investment

£509,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Specialty and Associate Specialist (SAS) Doctor Development Project - DoH	0	0	308	308
Specialty and Associate Specialist (SAS) Doctor Development Project - HSCB	22	74	105	201
	22	74	413	509

Regional Project

Yes.

Progress

While this project is at an early implementation stage it is positively contributing to the development of the clinical and non-clinical skills and knowledge of the SAS workforce by providing increased access to personal and professional development. All five HSC Trusts have appointed SAS leads who are supporting the work of the Regional Lead and the SAS Development Programme. Surveys (to identify issues relating to morale/access to training/resources) and a training needs analysis have been completed to identify gaps in SAS doctor's training.

Strategic Importance

This project contributes to the achievement of the Delivering Together enabler which established that investment in the HSC workforce is critical to HSC Transformation. It supports the professional and personal development of SAS doctors through the recruitment of SAS leads, and a Regional Associate Dean.

This project also supports the Rebuilding of HSC Services and Safe Staffing as SAS doctors are responsible for the delivery of direct patient care, and provide consistency to the medical and dental workforce.

ENHANCE LEVELS OF SENIOR NURSING STAFF ON DESIGNATED WARDS

Objective

To enhance levels of senior nursing staff on designated wards in phase 1 of delivering care in, RETAIN Wards, Older People's Wards, Stroke, Rehab and Psychiatry of Old Age Wards.

Total Investment

£3,543,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Enhance levels of senior nursing staff on designated wards in phase 1 of delivering care	518	1,381	1,644	3,543

Regional Project

Yes.

Progress

This project enables the existing workforce to be retained and senior nursing posts to be filled by uplifting a number of Band 5 posts to Band 6 posts across the five HSC Trusts. A total of 185 uplifts to Band 6 have been supported.

This project has ensured that there is senior nursing cover for a larger proportion of the 24/7 period and has enabled the ward sister/charge nurse to fulfil the complete supervisory role. This has also helped to increase the presence of senior nurse decision makers and retention of nurses in the designated areas. The project has improved the career pathway opportunities for nurses.

Strategic Importance

This project contributes significantly to the transformation of health and social care as set out in Delivering Together and the Nursing & Midwifery Task Group (NMTG) report which provides direction in achieving world class nursing and midwifery services in a reconfigured HSC system over the next 10-15 years. It specifically relates to the NMTG Strategic Theme 2 focused on maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred care.

It also contributes to the achievement of Delivering Care: a Framework for Nursing and Midwifery workforce Planning to support Person Centred Care in Northern Ireland (DoH 2014) which seeks to develop recommended safe staffing levels across nursing care environments and to create a platform for ensuring that nurse staffing is based on the patient needs (acuity) and best evidence available.

FAMILY NURSE PARTNERSHIP FOR NORTHERN IRELAND

Total Investment

£1,213,000

Objective

To increase the Family Nurse Partnership (FNP) capacity by two family nurses per HSC Trust. The overall objectives of FNP are to:

1. Improve pregnancy outcomes and maternal health;
2. Improve child health and development;
3. Improve economic self-sufficiency.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Extension of family nurse partnership	195	515	503	1,213

Regional Project

Yes.

Progress

Two new family nurses have been working within each HSC Trust since October 2018. Full capacity was reached within one year of appointment in line with FNP National Unit Guidance. This project has enabled 179 additional vulnerable young mothers and their families to receive intensive support which could not be provided by current services.

The level of support provided by the project to vulnerable young mothers ensures that a wide range of public health issues related to perinatal health, including smoking cessation, drugs, alcohol, healthy diet, infant attachment, domestic violence, safeguarding children and access to healthcare are being addressed.

Evidence of public health outcomes are starting to emerge such as an increase in breast feeding initiation rates to 44% compared with 17% for non-FNP teenage mothers in Northern Ireland. There is also evaluation evidence of improved educational attainment and employment for the young mothers and their children. Other socio-economic improvements include reduced hospital admission due to injury or ingestion. Children between 12 and 24 months in FNP have an admission rate of 0.02 and there is a 98% vaccination uptake by the time the children reach 24 months.

Strategic Importance

This project contributes to the Delivering Together commitment to give every child and young person the best start in life and to increase the support provided to children, young people and families from before birth to adulthood. It also supports the implementation of the Public Health Framework Making Life Better and its ambition to give every child the best start.

ENCOMPASS PROJECT

Total Investment

£1,800,000

Objective

To deliver the digitally enabled transformation of Health and Social Care Northern Ireland, including a whole system approach to digitisation.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Encompass Project	0	1,000	800	1,800

Regional Project

Yes.

Progress

This project is an integral part of the Encompass initiative which aims to deliver the digitally enabled transformation of Health and Social Care Northern Ireland over the next seven years. It funds the salary costs for staff in training roles and the Encompass licences. This project has enabled the identification of best practices in training and initiated the groundwork necessary to provide relevant training on a large scale across HSCNI. This will underpin the accelerated achievement of the overall Encompass initiative objectives, primarily the provision of a strategic whole system approach to digitisation; and improved patient safety and quality of care.

The funding of Encompass licences is of significant benefit to HSCNI as it decreases future revenue commitments, enables access to specialist advice from the supplier and provides support for new recruitment in line with the wider Encompass initiative objectives.

Strategic Importance

The wider context for the Encompass initiative is laid out in Delivering Together. This project contributes to the Delivering Together 'Organising ourselves to deliver' theme and supports the development of the Delivering Together key enabler of 'Improving Quality and Safety and eHealth'. The project will contribute to service improvement across the HSC.

When fully implemented Encompass will make a significant contribution to rebuilding HSC services through greater access to virtual platforms for service users and health professionals; replacement of existing disparate systems and functionality; a single patient record; and enhanced data analytics and reporting to provide accurate, real-time reporting and dashboards.

ADVOCACY SUPPORT FOR PATIENTS AND FAMILIES OF MUCKAMORE ABBEY HOSPITAL

Objective

To provide additional advocacy support to patients and families and ensure that the voice of all patients, carers and families with an interest in Muckamore Abbey Hospital are represented throughout the implementation of the Departmental Assurance Group action plan.

Total Investment

£89,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Advocacy Support for Patients and Families of Muckamore Abbey Hospital	0	25	64	89

Regional Project

No.

Progress

This project provides a dedicated advocacy resource to Muckamore Abbey Hospital in response to the Departmental Assurance Group's action plan. The Patient Client Council (PCC) has appointed a specialist advocate for Muckamore Abbey Hospital who is engaging directly with other advocacy organisations and family groups. This engagement is positive and is building trust between the families, the PCC and other stakeholders. Three engagement events with approximately 55 families occurred in December 2020 and a report has been prepared as a precursor for the public inquiry.

Strategic Importance

This project contributes to Delivering Together by providing a voice for service users and carers.

PATIENT CLIENT COUNCIL (PCC) MEMBERSHIP SCHEME

Objective

To support the drive to an active involvement of service users and carers in key decisions about Health and Social Care in Northern Ireland.

Total Investment

£177,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Patient Client Council (PCC) Membership Scheme	0	76	101	177

Regional Project

Yes.

Progress

Three Involvement Officers are now in post and are providing and promoting opportunities for the active involvement of service users and carers in key decisions about Health and Social Care in Northern Ireland through PCC social media channels. 35 training sessions have been completed to support and mentor 519 members of the public on specific programmes of work in readiness for their involvement.

The PCC play a critical role in how the HSC embeds partnership working, bringing people into the decision-making process by working across organisational boundaries; ensuring people are well informed to help reduce knowledge gaps and addressing power imbalances between participants.

Strategic Importance

The work of this project has supported the development of key enablers identified within Delivering Together; partnership working and improving quality. It has provided opportunities for individuals to become involved in programmes of work, for example, the Cancer Strategy, Being Open, Gender Identity, and Elective Care.

PARTNERSHIP WORKING, PERSONAL AND PUBLIC INVOLVEMENT (PPI) AND CO-PRODUCTION

Objective

To drive forward a cultural change within the HSC where service users, carers and their advocates are regarded as partners in the commissioning, planning and delivery of services.

Total Investment

£840,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
PPI and Co Production and capacity building	17	86	53	156
Partnership Working Officers	97	245	205	547
Building Co-Production HSC Training and Capacity Build Programme	0	0	50	50
10 WTE service user / peer user	0	0	87	87
	114	331	395	840

Regional Project

Yes.

Progress

Significant progress has been made in ensuring that the awareness and understanding of PPI, co-production and partnership working has been raised within the HSC and the agreed project objectives achieved.

As part of this project, six Partnership Working Officers have become an integral element within the HSC Trusts and PHA. They lead on the operational aspects of work to embed PPI and co-production methodologies across the System.

These officers ensure organisations are able to meet their statutory duty and policy obligations in relation to PPI and co-production and have encouraged greater partnership working since taking up post. They have encouraged consistency of practice and compliance with regionally agreed approaches and standards. All Trusts have now delivered introductory awareness training on involvement and co-production to an estimated 9,000 staff.

HSC staff have also provided targeted education and training with approximately 970 participants having engaged to date in training and development through webinars on consultation, involvement and co-production.

The PHA has also commissioned, designed and co-delivered a range of related training programmes to 120 participants in the last year. In addition, the Leading in Partnership Programme, was delivered to 130 participants (a quarter of which were service users and carers) since its inception in 2019/20. This is an intensive training initiative, during which each participant undertakes 50+hours of direct training and development.

These specialist education and training programmes have built a critical mass of people with experience, knowledge and expertise in relation to PPI, co-production and partnership working that is bringing about the cultural change which is required.

A Peer Mentor programme is also been developed to enhance and embed involvement, co-production and partnership working within the HSC. 10 Peer Mentors have been recruited and trained with further developmental work required to enable this programme to be delivered. To this end, research has been undertaken in highly complex areas such as the remuneration of service users and carers and the impact of such remuneration on benefits.

This research is advancing the HSC understanding of the challenges and difficulties faced in engaging people in peer mentoring, while balancing this with perhaps a long standing health condition or caring responsibilities. So far, approximately 90 people have directly availed of training related to peer mentoring and a lead officer from the PHA will continue to progress the delivery of the peer mentor programme.

Strategic Importance

Delivering Together outlined the importance of partnership working as being one of the five key enablers of HSC Transformation. This project contributes to the Delivering Together commitment to HSC involvement and co-production, strengthening partnership working within and across the health and social care system.

There is also a legislative imperative on the HSC to deliver on its statutory responsibilities in respect of PPI.

IMPLEMENTATION OF ONLINE USER FEEDBACK SYSTEM IN NORTHERN IRELAND

Objective

The overall aim of the project is to use learning from patient experience, through the implementation of an Online User Feedback System (OUFS), to inform commissioning which delivers better outcomes and value for money in how services are delivered.

Total Investment

£868,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementation of Online User Feedback System in Northern Ireland	74	429	365	868

Regional Project

Yes.

Progress

Significant progress has been made in the delivery of this project. Phase 1 (2018-2020) involved engaging and preparing stakeholders to promote, implement and manage the Online User Feedback System. This involved establishing a Regional Implementation Group to support implementation across the Health and Social Care System. All Trusts have a local implementation group to drive forward this project. The new OUFS "Care Opinion" website was launched in Northern Ireland on 3 August 2020 marking the end of Phase 1 of the Project Implementation Plan.

Phase 2 (Aug 2020-March 2021) focuses on story generation and ongoing promotion and active engagement of Care Opinion with the wider HSC system. To date 523 stories of patient experiences have been shared on the website and these have been viewed over 42,000 times.

74% of these stories have been positive and reach out to say thank you to HSC staff. As a result of these shared patient experiences 31 local changes have been planned or made. This clearly demonstrates how the feedback has informed and influenced the delivery of HSC services.

In addition, Care Opinion is informing regional work in relation to the COVID-19 response and rebuilding of HSC services through the development of specific plans in relation to District Nursing Strategy, No More Silos and the Regional Nightingale Rehabilitation Services.

All HSC Trusts have now implemented Care Opinion and have developed processes to collect and utilise the information they receive. 994 members of staff are now registered as subscribers to Care Opinion with 86% working as responders and 14% working as readers of stories, thus ensuring that stories are responded to within 7 day of publication. So far, 94% of patient experience stories have received a response within the 7 day period.

Engagement is ongoing with Primary Care, Community and Voluntary Sector organisations, RQIA and PCC in order to support a system wide approach to embedding an OUFS into the HSC System as a whole. This work is evaluated through an impact and improvement strategy, which reflects upon 10 key measures to meet the objectives of the project. To date the evaluation has been positive highlighting monthly increases in story generation and engagement with the public. There is also a growing dataset on the changes identified which is available for shared learning across Northern Ireland.

Strategic Importance

This project links to the Delivering Together action to consult on a proposal for and design of a new user feedback service. The primary driver for Online User Feedback is the Programme for Government (PFG), which includes a focus on gathering, and learning from lived experience through Outcome 4, Indicator 5 – "Improve the quality of the healthcare experience – percentage of people who are satisfied with the health and social care based upon their recent contact."

The need for an OUFS also links closely with recommendation 63 included in the report on the Inquiry into Hyponatraemia-Related Deaths.

OUFS is integral to the learning from the COVID-19 pandemic providing contemporary feedback on services. It has also contributed to the rebuilding of services through No More Silos, Regional Nightingale Rehabilitation Services, and District Nursing.

SECTION 5:
SUMMARY

The investment of almost £300 million since 2018, has provided a significant opportunity to stabilise, reconfigure and transform our services in a way that has brought tangible benefits to our population and importantly provided a solid bedrock upon which to build the HSC's emergency pandemic response.

The many challenges facing the HSC system as outlined within Delivering Together were seen first-hand in the work to drive forward the transformation agenda. Increasing demand for services, the need to reconfigure how we deliver these, workforce shortages and the lack of long-term recurrent investment challenged the delivery of this important programme.

And indeed the impact of COVID-19 exacerbated these challenges. However, in recognition of the importance of long-term transformation, the existing transformation projects and funding to support them, was protected throughout the pandemic to retain the important progress already made.

The projects outlined within this report have made significant progress in achieving their objectives or in progressing substantial work towards these.

A number of transformation projects carried out specific pieces of work to inform future plans, including reshaping Stroke Care, reforming Adult Social Care and Support, reviewing Urgent and Emergency Care and developing a New Cancer Strategy for Northern Ireland. These projects all directly contribute to the actions and commitments within Delivering Together and New Decade, New Approach.

Significant progress has been made on the implementation of the New Diabetes Strategic Framework to support effective treatment and care for people living with diabetes. In addition progress has also been made on the implementation of the Paediatric Strategies which are designed to modernise and improve treatment and care for children and their families.

Similarly, proposals to transform and improve services for Looked After Children have shown considerable benefit and there have been some excellent initiatives which are improving access and resilience within primary care.

The need to build resilience and capacity within our workforce now more than ever, is a key factor in our rebuilding agenda. Transformation has enabled commitments made to provide extra nursing, midwifery, physiotherapy, radiotherapy and medical places to commence. This – amongst many other projects outlined within this report – has helped address the workforce challenges and provide more stability in our services.

Positive progress has been made in the establishment of two Daycase Procedure Centre prototypes which has proven that the concept can standardise treatment, consolidate services, reduce waiting times, and ensure equity of access to patients.

Through the development of primary care elective care services, over 13,000 patients who would have been referred to secondary care have had their treatment in primary care. The development of Multi-Disciplinary Teams (MDTs) in primary care has been a flagship initiative to build capacity and capability

with pharmacists embedded in all GP practice teams and by co-locating mental health practitioners, social workers and physiotherapists in GP practices and ensuring that health visiting and district nursing support is enhanced. With over 600,000 people now having access to MDTs in primary care this has been a significant success to date.

The transformation programme supported the development of a range of services that were later included in commissioning plans for community pharmacy, successfully optimising the sector's contribution to population health by ensuring the public had continuous access to medicines, pharmaceutical advice, medicines optimisation and medication safety support.

Ambulatory project pathways, have kept patients out of hospitals when the need to do so was greatest and are helping to improve the management and flow of patients through the HSC system.

How we organise ourselves to plan and deliver services has also been an important factor in delivering successful and sustainable change. The Northern Area Pathfinder was established to test a new model for planning and delivering HSC services. The prototype embraces the recommendations of the Bengoa Report, building on the foundations of GP Federations, Integrated Care Partnerships (ICPs) and the system wide commitment to co-production. Work is now progressing to develop a new system to replace the existing commissioning functions of the HSCB with a focus on local population need and an integrated approach.

From the evidence contained within this report, there is no doubt that the Transformation programme has been hugely successful in stabilising, reconfiguring and transforming HSC services.

There is much learning that can be gleaned from progress to date and in how transformation supported the HSC system to respond quickly and effectively during the greatest ever stress test, the COVID-19 pandemic. As we enter the next iteration of our transformation journey; Rebuilding Better, we must continue to deliver together, building on the firm foundations that have been laid and integrating these new successful ways of working.

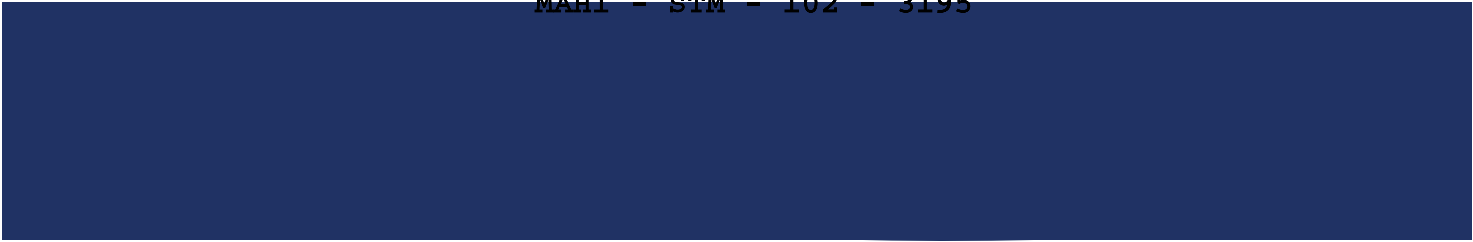
GLOSSARY

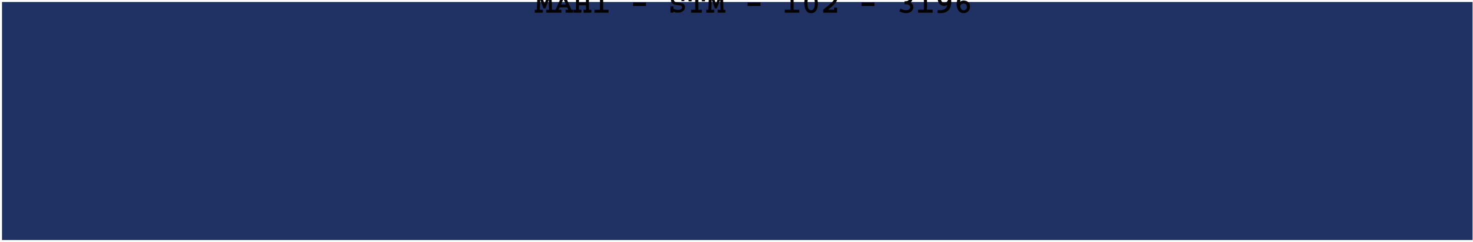
ACA	Ambulance Care Attendants
AHP	Advanced Health Practitioners
A&E	Accident and Emergency
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CAMHs	Child and Adolescent Mental Health services
CCIS	Community Crisis Intervention Service
CHST	Care Home Support Teams
CMO	Chief Medical Officer
CPD	Continuing professional development
CRM	Clinical Response Model
CYP	Children and Young People
D2A	Discharge to Assess
DAU	Direct Assessment Unit
DECC	Daycase Elective Care Centres
DHH	Daisy Hill Hospital
DNS	Diabetes Nurse Specialist
DOE	Department of Education
DOH	Department of Health
DOJ	Department of Justice
ED	Emergency Department
EIF	European Investment Fund
EISS	Early Intervention Support Service
ELEVATE	Capacity building programme
ESD	Early supported Discharge
EMT	Emergency Medical Technicians
FIT	Faecal Immunochemical Test

FNP	Family Nurse Partnership
FOB	Faecal Occult Blood
FSU	Federation Support Units
GMS	General Medical Services
GP	General Practitioner
GPICRT	General Practice Improvement and Crisis Response Team
GPN	General Practice Nurses
GPS	General Practitioner Services
HCPC	Health and Care Professions Council
HDU	High Dependency Unit
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCQI	Regional Quality Improvement and Innovation System
ICAT	Irish Clinical Academic Training
ICPs	Integrated Care Partnerships
ICS	Integrated Care System
IDDSI	International Dysphagia Diet Standardisation Initiative
IIB	Community Development Implementation and Innovation Board
LAC	Looked After Children
LIMS	Laboratory Information Management System
LOS	Length of stay
MATT	Multi-Agency Triage Team
MDT	Multi-Disciplinary Teams
MH	Mental Health
MHLS	Mental Health Liaison Service

MHS	Mental Health Services
MSK	Musculoskeletal
NAIC	National Audit of Intermediate Care
NAs	Nursing Assistants
NDN	Neighbourhood District Nursing
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
NICCY	Northern Ireland Commissioner for Children & Young People
NICE	National Institute for Health and Care Excellence
NIHE	Northern Ireland Housing Executive
NISCC	Northern Ireland Social Care Council
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NMC	Nursing and Midwifery Council
NMTG	Nursing & Midwifery Task Group
OBA	Outcomes Based Accountability
OOH	Out of Hours
OPAT	Outpatient Parenteral Antibiotic Therapy
OU	The Open University
OUFS	Online User Feedback System
PALLS	Paediatric and Life Limited Service
PAS	Patient Administration Systems
PCC	Patient Client Council
PHA	Public Health Agency
PL2	Protect Life 2
PLIGs	Protect Life Implementation Groups
PPE	Personal Protective Equipment
PPI	Personal and public involvement

PrEP	Pre-exposure prophylaxis
PSNI	Police Service of Northern Ireland
PSS	Peripatetic Support Services
QI	Quality improvement
QUB	Queen's University Belfast
RCN	Royal College of Nursing
REaCH	Responsive Education and Collaborative Health
RMB	Rebuild Management Board
RQIA	Regulation and Quality Improvement Authority
RSM	RSM UK Consulting LLP
SALT	Speech and Language Therapists
SAS	Specialty and Associate Specialist
SCIE	Social Care Institute for Excellence
SDE	Structured Diabetes Education
SEHSCT	South Eastern Health and Social Care Trust
SEN	Special Educational Needs
SHSCT	Southern Health and Social Care Trust
SOC	Strategic Outline Case
SOPs	Standard Operating Procedures
TZS	Towards Zero Suicide
UKAS	United Kingdom Accreditation Service
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent





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HEALTH AND SOCIAL CARE WORKFORCE STRATEGY 2026

DELIVERING FOR OUR PEOPLE

HSC
Nurse

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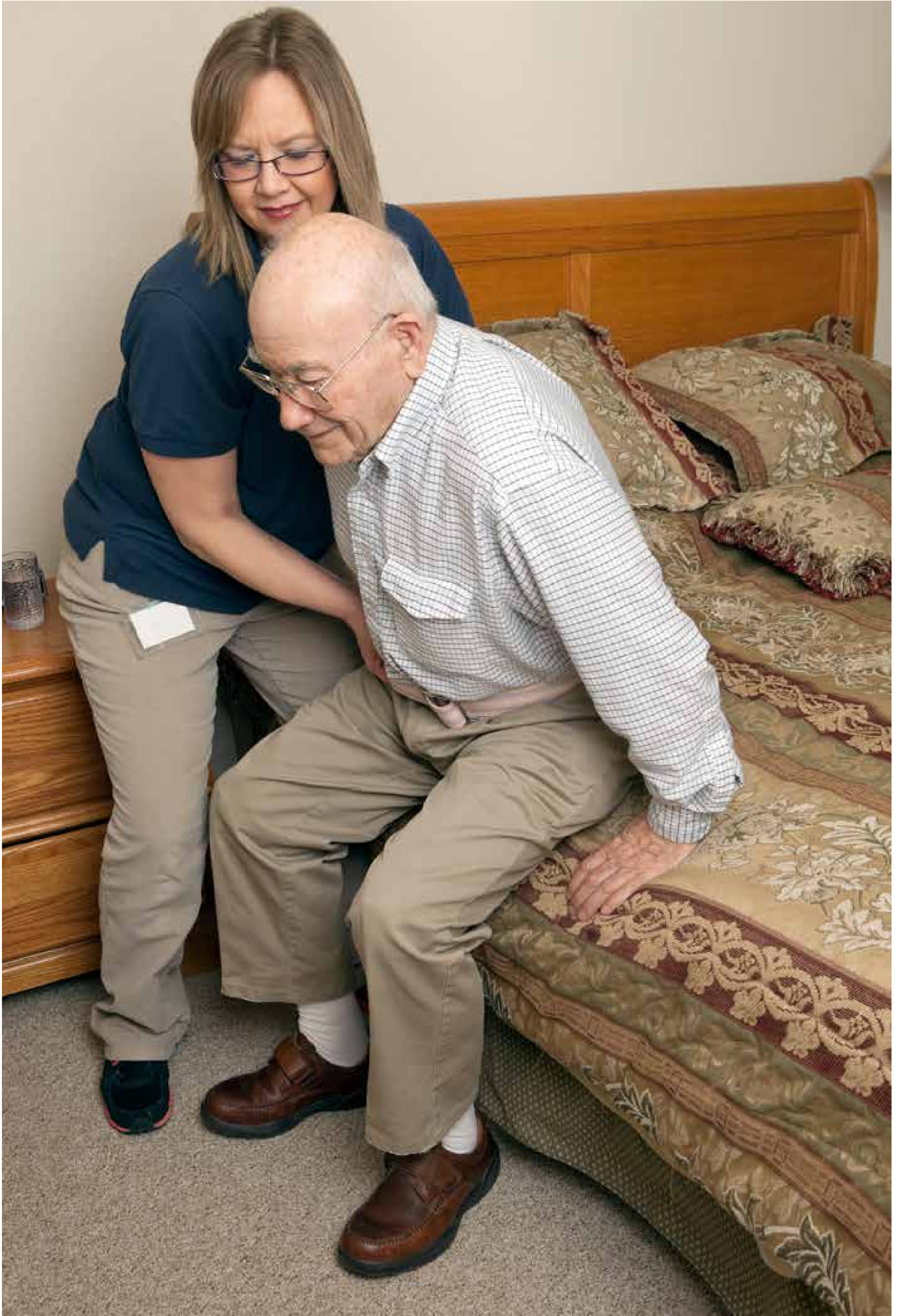


FOREWORD

Health and Wellbeing 2026 – Delivering Together, was the outworking of the recommendations of the Expert Panel on transforming health and social care, chaired by Professor Rafael Bengoa. It acknowledged that our health and social care services were designed to meet the needs of the 20th century population, and therefore transformation of health and social care services is essential if we are to meet the challenges of the future.

The people who work in health and social care – whether employed by the statutory Health and Social Care (HSC) organisations, independent contractors, or as our partners in the voluntary and community sector – are the system's greatest strength, working ever harder to provide the care needed by patients and service users. The system could not run without the skill, dedication and commitment of our talented, hard-working colleagues, across all disciplines, professions and levels.

We therefore owe it to them, and to the people of Northern Ireland, to address the workforce issues that need to be fixed, in order to transform health and social care. These issues place additional pressure on an already hard-working workforce, which has resulted in an increasing use of unsustainably expensive locums and agency workers. But recruiting additional people alone to prop up outdated service models is not the answer.

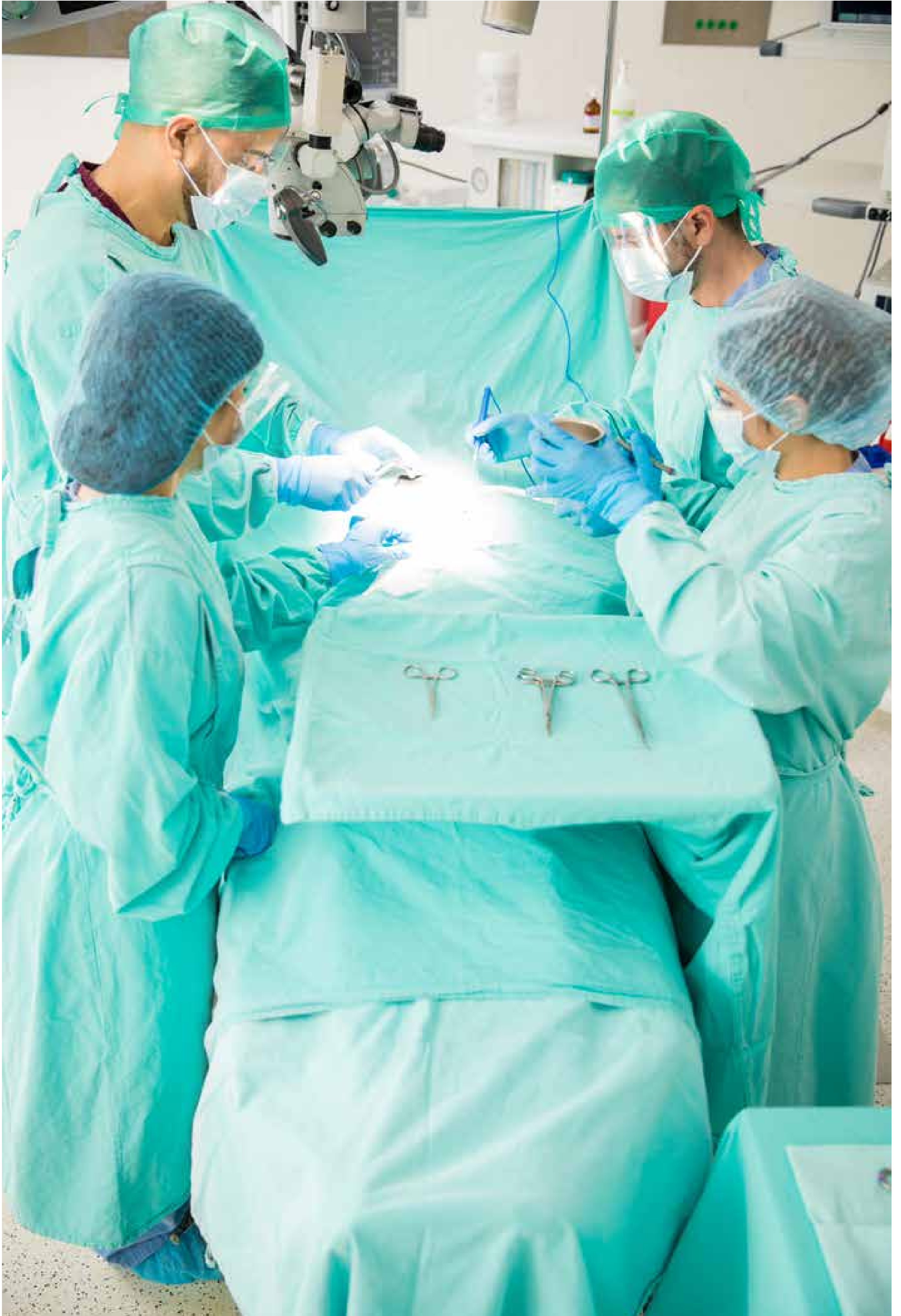
Instead, we need to resolve fundamental problems with supply, recruitment and retention of the health and social care workforce. We need to recognise that our highly-trained, skilled people are much sought-after across the world. We need to up our game as employers, to attract and retain the best talent.

Colleagues across health and social care need the opportunity to develop skills and expertise, whilst maintaining the provision of personalised, compassionate care. We need more investment in people, and effective workforce engagement and planning. We need to support our people.

This strategy has been developed through detailed engagement with colleagues across health and social care sectors. It reflects their views on how to create an environment in which excellent, high-quality care can continue to be provided. Skills development, career pathways, increased numbers of trainees, the development of new roles, investment in the wellbeing of the workforce and empowering and supporting the workforce to do what they do best, were all identified as necessary if we are to make employers within the local health and social care system the first choice for the best people.

This workforce strategy outlines a number of actions which, when implemented, will support our people to deliver world class health and social care.

The Transformation Implementation Group



INTRODUCTION

There is no option but to transform how we deliver health and social care in Northern Ireland.

Demand for services has never been so high, and will only increase. Our population is growing. Thanks to healthier lifestyles, and advances in medical science and technology, people are living longer. Increasing numbers of people are living with more than one health condition.

As the system is currently structured, funding levels cannot keep pace. If we accept a conservative estimate of inflation at 1%, new medical developments at 1% and demand rising at 4%, then the health and social care system as currently configured would require at least a 6% budget increase each year simply to stand still.

This workforce strategy is just one of the components required for successful transformation; central to it will be how services are reconfigured. Other workstreams within the transformation process will play their role in moving towards a sustainable health and social care system for the 21st century.

This strategy needs the commitment and engagement of workers and management across all health and social care providers to implement change successfully.

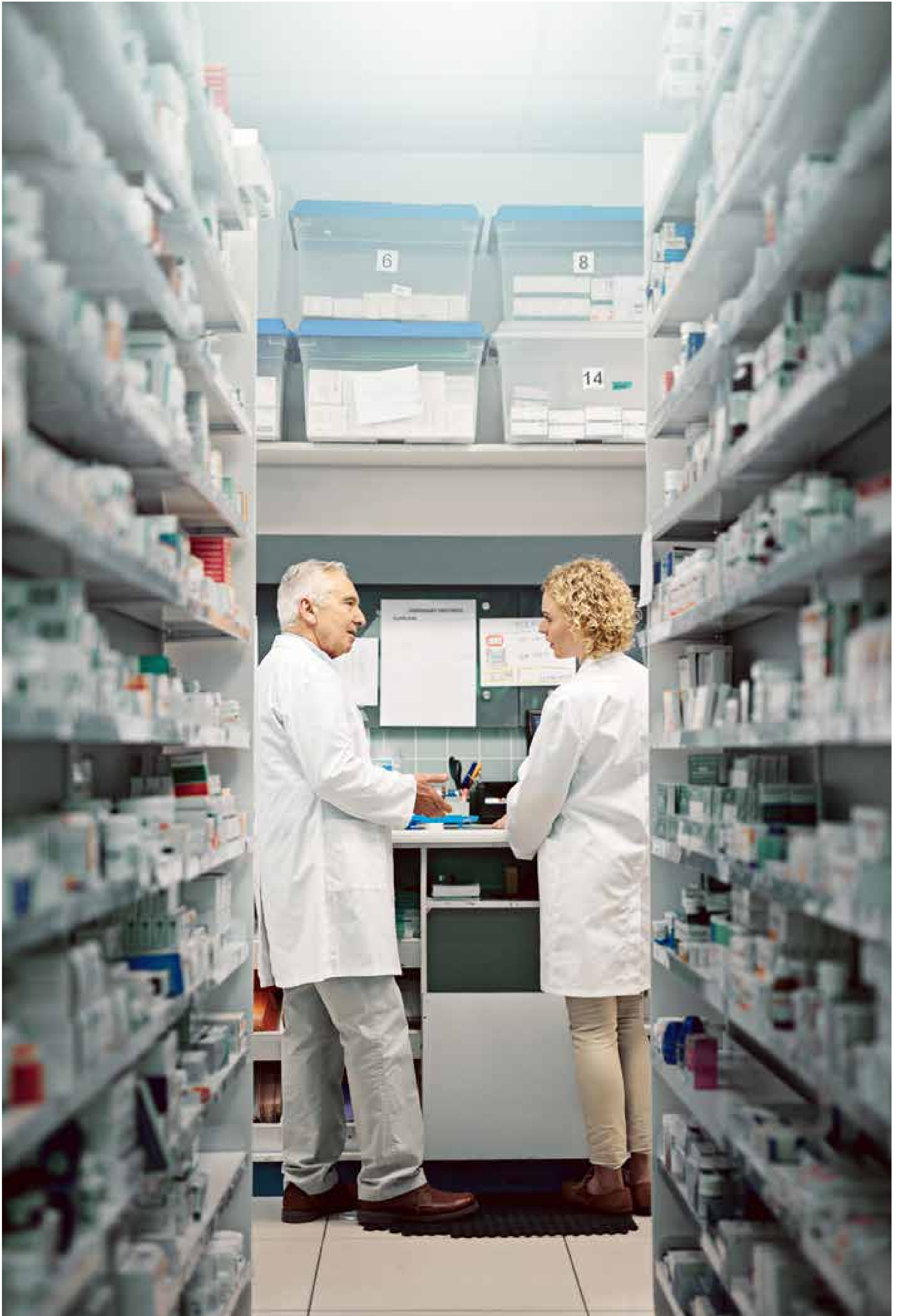
Ultimately, our aim is, by 2026, to meet our workforce needs – and the needs of our workforce.

In this document, we set out details about:

- our current workforce;
- the aim and objectives of the strategy;
- achieving our objectives and meeting our aim;
- the first of three action plans 'Action plan 2018-20';
- conclusion and;
- appendix: Current problems and future challenges.

We are also publishing alongside this document:

- an analysis of the workforce (https://www.health-ni.gov.uk/publications/workforce-strategy-workforce-information); and
- a report of the engagement process leading to this strategy (https://www.health-ni.gov.uk/publications/workforce-strategy-initial-engagement-findings).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The Department of Health is required by law to provide, or secure the provision of, health and social care in Northern Ireland. This strategy therefore includes those who are directly employed by HSC organisations, and those employed as and by independent contractors such as general practitioners (GPs), dentists, pharmacists and ophthalmic practitioners. It also recognises the contribution, challenges and future needs of the independent and voluntary health and social care sectors which support the HSC, and without which, it could not function.

As at March 2017, the Northern Ireland Statistics and Research Agency estimated the total size of the 'human, health and social work activities' sector at 122,560 jobs, covering public and private sectors (includes those known as independent and voluntary sectors).[1]

The public sector covers those directly employed by the 16 HSC bodies, namely the:

- Health and Social Care Trusts – Belfast, Northern, Southern, South Eastern, Western and Ambulance Service; and
- the Public Health Agency, Health and Social Care Board, Business Services Organisation, Regulation and Quality Improvement Authority, Patient and Client Council, Social Care Council, Medical and Dental Training Agency, Blood Transfusion Service, Guardian Ad Litem Agency, and Practice and Education Council for Nursing and Midwifery.

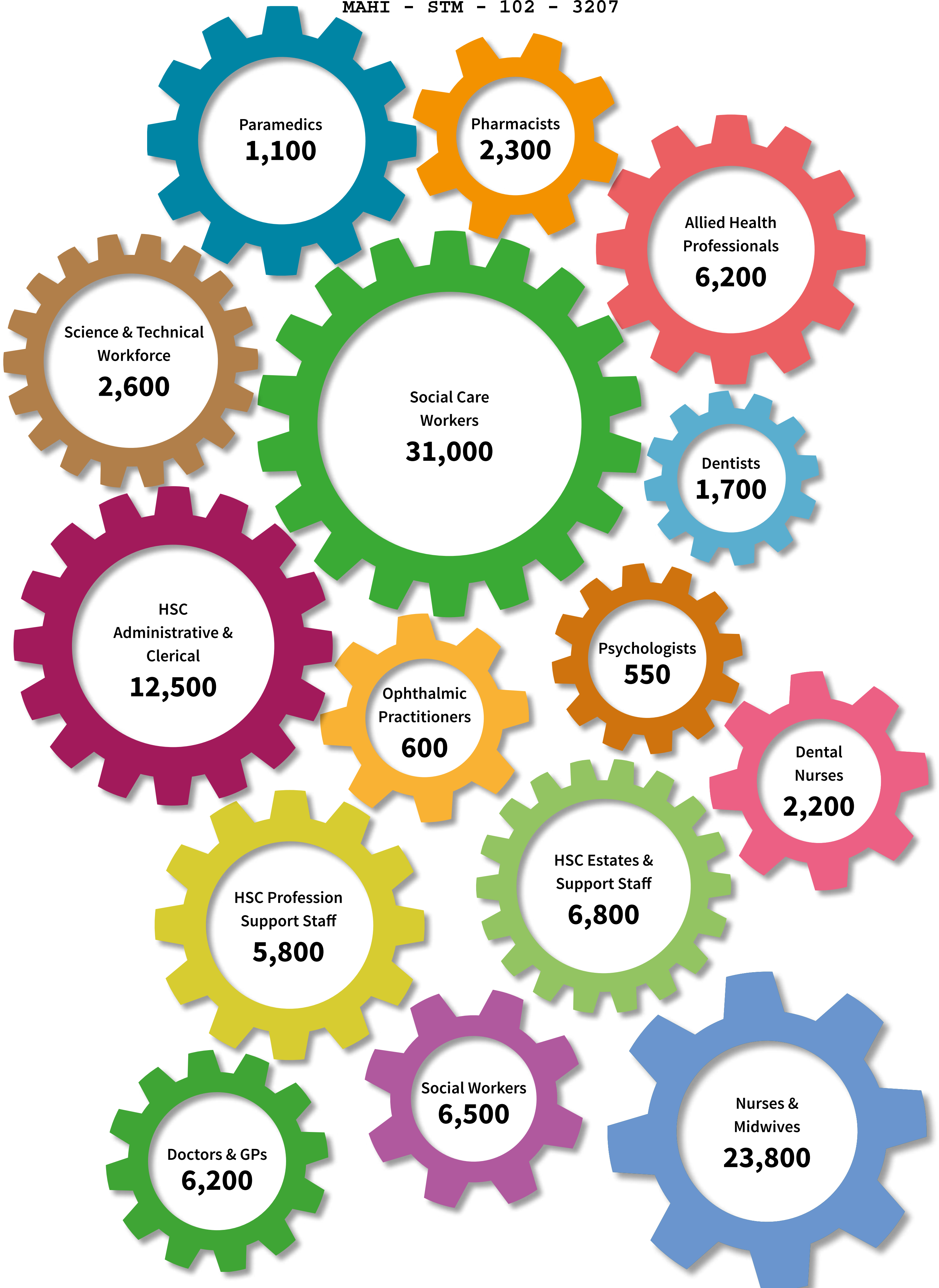
Further information about each organisation can be found at https://www.health-ni.gov.uk/

The Department also secures the provision of health and social care services from independent contractors, including GPs, dentists, pharmacists and ophthalmic practitioners, which are collectively known as Family Health Services or Primary Care Services.

Social care and health care have been integrated in Northern Ireland for decades. A large proportion of social care is delivered by independent and voluntary sector organisations.

The workforce that the Department knows most about is the one directly employed by the HSC organisations. Combining this information with other sources, such as professional regulation registers, gives an overview of the majority of the whole health and social care sector.

1. Quarterly Employment Survey March 2017.


Paramedics
1,100
Pharmacists
2,300
Allied Health Professionals
6,200
Science & Technical Workforce
2,600
Social Care Workers
31,000
Dentists
1,700
HSC Administrative & Clerical
12,500
Psychologists
550
Ophthalmic Practitioners
600
Dental Nurses
2,200
HSC Estates & Support Staff
6,800
HSC Profession Support Staff
5,800
Social Workers
6,500
Doctors & GPs
6,200
Nurses & Midwives
23,800

- We know there are over 31,000 social care workers registered in Northern Ireland, with the majority working in the independent sector (adult residential care, day care and domiciliary care for example) in the areas of older people's services, children's services, learning disability services, physical disability services and mental health services. Social care services are therefore reliant on the independent sector for the delivery of effective and efficient social care. In addition, there are 6,500 registered social workers, around two thirds of which work for HSC organisations. *Source: NI Social Care Council*

- There are over 23,800 nurses and midwives registered, mostly employed by the HSC Trusts but also in the independent sector in the likes of nursing homes, hospices and GP practices. *Source: Nursing & Midwifery Council*

- The number of doctors licensed to practice is over 6,200. The majority are employed by the HSC Trusts, but around 1,700 are GPs (with most working as independent contractors). *Source: General Medical Council*

- There are 1,700 dentists registered, with around two thirds providing at least some HSC general dental services and there are 2,200 dental nurses. *Source: General Dental Council*

- We have over 2,300 pharmacists registered in Northern Ireland, with a majority working in local pharmacies, around 580 working in HSC Trusts, but now also a growing number employed in general practices. *Source: Pharmaceutical Society of NI*

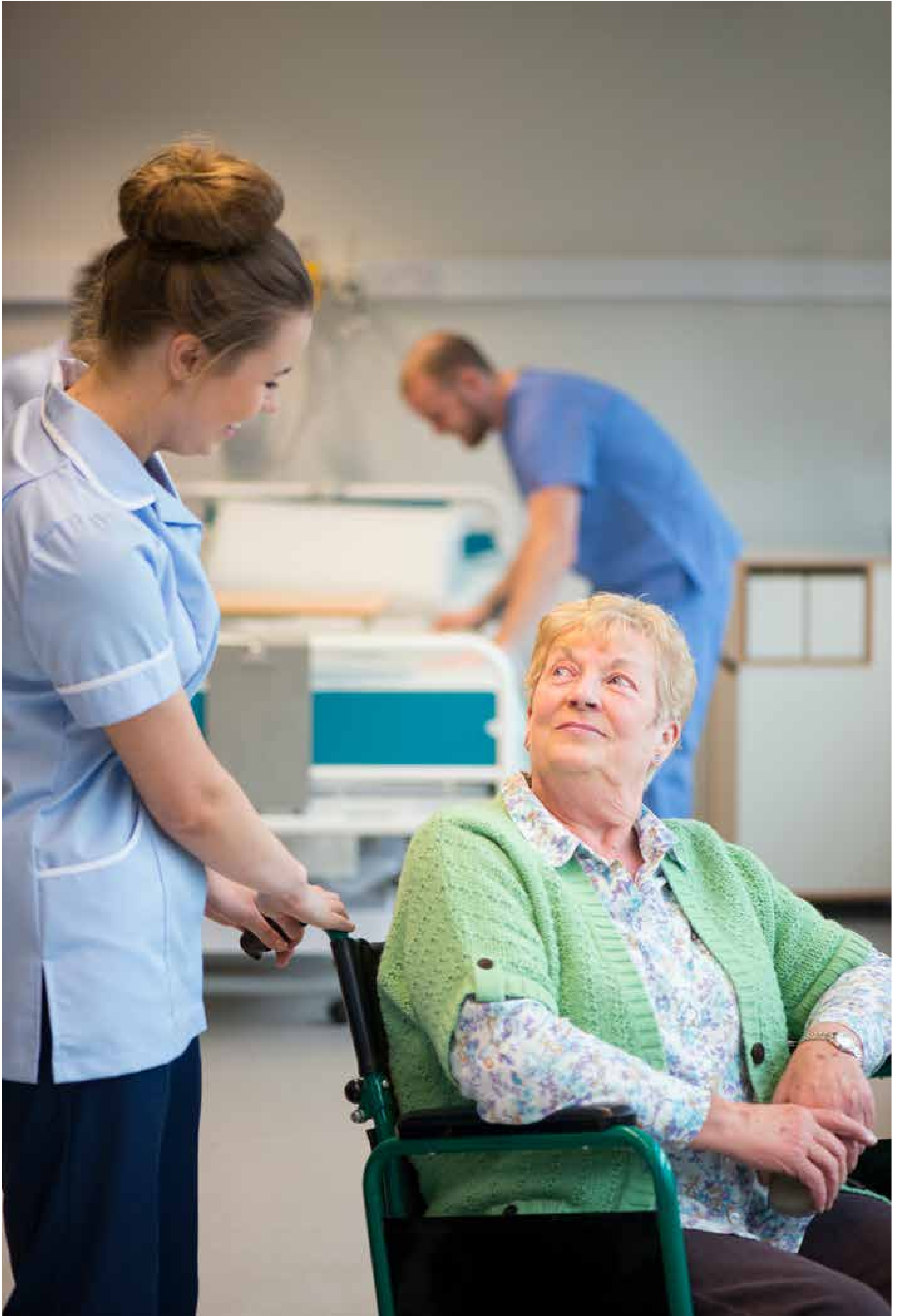
- There are 600 ophthalmic practitioners (optometrists and dispensing opticians) working as or for independent practitioners and providing HSC services. Around 6,200 people are registered as allied health professionals (AHP), with around 70% working for HSC Trusts. *Source: General Optical Council and Health & Care Professions Council (HCPC)*

- Almost 2,600 people are registered clinical scientists and biomedical scientists or HSC-employed medical technical officers, assistant technical officers or science support staff. *Source: General Optical Council and Health & Care Professions Council (HCPC)*

- There are around 550 registered practitioner psychologists with over 60% working for HSC Trusts. In HSC organisations, the administrative and clerical workforce is over 12,500 and the estates and support services workforce is almost 6,800. *Source: HCPC and HRPTS*

- There are many other support staff, with HSC-employed nursing/midwifery support numbering just under 5,000 people and over 800 HSC-employed AHP/psychology support staff. *Source: HRPTS*

- The total number of paramedics plus other NI Ambulance Service roles (e.g. emergency medical technician, control staff and ambulance officers) is over 1,100 workers. *Source: HRPTS*



Brief profile of the workforce

- Overall, the health and social care workforce is predominately female, though some staff groups have a majority of male employees.
- The average age of directly employed HSC staff has increased slightly in the last 10 years from 40 years to 43 years.
- Some of the HSC staff groups with younger and majority female profiles also show high levels of maternity leave.
- There are also HSC staff groups with older age profiles who therefore experience higher leaving rates.
- Around 40% of the HSC workforce are part-time staff.

Apart from age and gender profiles, workforce intelligence on the working patterns, leave and absence profiles of all of the independent sector workforce are not centrally available. Workforce diversity across all dimensions should be encouraged and understood, not only for the purposes of understanding the needs of staff and workforce planning, but also to ensure that the benefits associated with having a diverse workforce in place are realised.

Expenditure

Information on workforce expenditure is most readily available for HSC organisations, which spent over £2.3 billion on directly employed staff in 2015/16 and an additional £92 million on agency workers to fill HSC posts.

Areas of pressure

Sickness absence remains a priority area of focus, with mental health and musculo-skeletal issues being the largest contributing factors.

Addressing the HSC's increasing use of agency workers/locums is also a priority area. HSC expenditure on agency workers has doubled in the last five years. The largest proportion of agency worker expenditure is on doctors.

Whilst overall workforce numbers have been increasing in recent years, there is still a need for additional people. The March 2017 HSC vacancy rate (of posts being actively filled) was around 5% for posts currently in the system. Drilling down into this figure highlights key areas of concern, including within nursing, midwifery and medical staffing.

A more detailed workforce profile is available at:
https://www.health-ni.gov.uk/publications/workforce-strategy-workforce-information

O2 MASKS
AMBULANCE

The World Health Organisation[2] highlights the importance of developing workforce strategies:

> ***"Health systems can only function with health workers; improving health service coverage and realising the right to the enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality. Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the population, and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage."***

The workforce is also the most valuable asset in social care, and can, at its best, be at the forefront of empowering people's independence and choice and improving their social inclusion, participation and social wellbeing. Delivering this vision requires a confident, capable and well-trained workforce.

This strategy sets the objectives and actions to ensure that in Northern Ireland, we **meet our workforce needs – and the needs of our workforce.**

First, however, it is worth setting the workforce challenges in context.

Strategic issues in Northern Ireland

Inevitably, any discussion on reform of health and social care begins with the amount of money invested in the system. At present, over £5 billion is spent on commissioned health and social care services in Northern Ireland, with £2.3 billion of this on directly employed HSC staffing. Whilst total cash spending continues to increase every year, significant unmet need remains.

We must ensure that the resource we spend on the workforce is spent in the best way possible, not only with an emphasis on value for money, but also on improving services and achieving better outcomes for patients and service users. This strategy does not automatically assume that a certain amount of new money will be needed for it to succeed, although a number of proposals are being taken forward under Transformation funding. In addition, we will make the best use of the money we already have, and when new needs are identified over the course of implementing the strategy, we will make the best case possible for these to be funded, in line with other strategic reforms.

The future

We must also take into account the future shape of health and social care provision. Delivering Together set out a number of actions to stabilise, reconfigure, change services in, and transform the HSC. These include actions to address waiting lists, make significant investment in primary care, carry out a number of service configuration reviews, and bring forward proposals for Elective Care Centres. We do not yet know how

2. Global Strategy on Human Resources for Health: Workforce 2030

the system will be configured by 2026 in terms of sites and models of care; nor can we fully anticipate the technological advances that will happen by 2026.

Future e-Health solutions will both improve patient and client experience and make life easier for our workforce. This will include significant investment in mobile working solutions which will allow those on the frontline to work more effectively, spending more time working directly with patients and clients.

As we consolidate the different IT solutions used across the wider health and social care sector it should be easier for staff to view a joined-up care record, to move between different sites and different providers, and to draw out information to help improve the services we provide. The Encompass programme, which will be replacing the core patient administration systems and a number of other key systems, will be central to driving this consolidation.

Technology

The support that technology can provide to people who work in health and social care will continue to grow. In the best health and care systems, health analytics are shaping and improving the way services are delivered, while those working on the frontline are using IT systems which provide decision support tools, helping to improve the quality of clinical and professional decision making. In time, artificial intelligence is likely to make a significant impact in health and social care. Technology can provide a rich source of information to health and social care professionals – for instance with telemonitoring solutions supporting early intervention and prevention and allowing for more refined diagnoses.

Technology can also form part of the solution where individuals need treatment or support to live independently in their own homes – with apps and wearable technology helping individuals to understand and monitor their health. All of these developments will have an impact on the way that health and social care professionals do their jobs in the future.

We have taken care in this strategy to ensure that we are not trying to solve the problems of 2006 or 2016. Instead, the strategy identifies the objectives which need to be achieved to ensure that we have the optimum number of the workforce, with the best mix of skills, for the issues that will exist in 2026. The objectives therefore allow for flexibility in how they will be implemented over the next nine years.

Policy and planning

In line with the draft Northern Ireland Programme for Government, this strategy focuses on outcomes which set a clear direction of travel, enable continuous improvement, and depend on collaborative working between organisations and groups, whether in the public, voluntary, or private sectors.

The outcomes-based approach of the draft Programme for Government 2016 -2021, recognises that health and social care services do not operate in isolation. Workers regularly operate across a variety of settings that require collaboration, with a wide-range of bodies, spanning sectors such as education, housing, the emergency services and the criminal justice system. As such, the development of the performance indicators for each of the actions within this strategy will give due regard to the need for cross-sectoral and cross-government working.

Policy decisions and planning exercises must be based on robust evidence. Improving and acting upon the workforce intelligence gathered is therefore a key area of focus within this strategy. For example, previous nursing and midwifery workforce planning exercises have identified the need for baseline information on the independent nursing sector. The same could be said for all private, voluntary and community sectors, on which we rely to provide health and social care services. The final stage of the rollout of registration of social care workers with the Social Care Council will help provide more accurate information about the profile of the social care workforce across all sectors.

Other reports and strategies

The outcomes in the strategy will ultimately be focused on the health and wellbeing of our population, and these have obvious workforce implications. The King's Fund report, Population health systems – going beyond integrated care (February 2015) states that: "population health means different things to different people, but can be broadly defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group[3]".

"While access to traditional health and care services plays an important part in determining the health of a population, evidence suggests that this is not as important as lifestyle, the influence of the local environment, and the wider determinants of health – that is, the conditions in which people are born, live and work[4]. This means that improving population health requires efforts to change behaviours and living conditions across communities. It also means that accountability for population health is spread widely across these communities, not concentrated in single organisations or within the boundaries of traditional health and care services."

There is also a series of other Departmental strategies, for example, the Quality Strategy 2020 (a 10-year strategy designed to protect and improve quality in health and social care in Northern Ireland), Making Life Better 2012–2023 (a 10-year public health strategic framework), and Improving and Safeguarding Social Wellbeing 2012–2022 (a 10-year strategy for social work), which run concurrently with this workforce strategy, the purposes and aims of which must be taken into account throughout the transformation process.

Early intervention

The workforce strategy also needs to take account of the continuing drive for early intervention and prevention. It needs to enhance ongoing multidisciplinary efforts to

3. Kindig and Stoddart 2003
4. Canadian Institute for Advanced Research et al, cited in Kuznetsova 2012; Booske et al 2010; Marmot et al 2010; McGinnis et al 2002; Bunker et al 1995

BT Mod 4 Witness Stmt 6 Apr 2023 Statement & Exhibit Bundle Index & Exhibit Bundle (11891 pages)

ensure that a flexible workforce specialising in public health is trained, developed and strengthened to meet the health needs of employers and the population of Northern Ireland in the future, and ensure that core public health competencies are embedded in undergraduate and postgraduate training.

Mental health

We must also continue to recognise that we are not simply talking about physical health care. The Department is committed to moving towards parity of esteem for mental health. This is not a call for 50/50 funding between the two; rather, that mental health should receive its fair share of health education, attention and resource, including staffing.

Achieving parity of esteem for mental health will require sustained investment in care and the development of a flexible, fit-for-purpose mental health workforce to deliver modern effective care. The establishment and integration of multi-disciplinary teams and the development of integrated practice models for all condition-specific and high-intensity teams will be important.

Social care

In December 2017, the report of the Expert Advisory Panel on Adult Care and Support was published, 'Power to People: proposals to reboot adult care and support in NI'. It outlines a broad programme of reform, with specific proposals relating to the terms, conditions and status of the social care workforce. Implementing these proposals will have significant workforce impacts.

Approximately 31,000 people in Northern Ireland are registered social care workers, including 12,000 domiciliary care workers. An estimated 75% of the workforce is employed by the independent sector, with 25% employed by HSC Trusts. The Northern Ireland Social Care Council estimates that an additional 1,400 care workers are needed every year to meet growing demand.

However, recruitment and retention are major challenges. We will need to ensure that there is a sense that social care is a profession with clearly developed and recognised career pathways so that we have the workforce to match the very challenging nature of demand in that sector and the increasing levels of complex need in the community.

Brexit

Finally, we need to be aware that the potential effects from the UK's exit from the European Union, scheduled for March 2019, are still being defined, and are subject to the provisions of any exit agreement to be negotiated by the UK and the EU. However, we know that there are potential impacts on workforce supply from EU countries into Northern Ireland, particularly health and social care workers who live and work

around the Irish border and with the mutual recognition of professional healthcare qualifications. The workforce strategy will need to be flexible to take account of the emerging picture.

What the workforce thinks

To understand the concerns and issues facing the health and social care workforce in Northern Ireland, we gathered feedback from across the HSC, independent practitioners, the independent, voluntary and community sectors, trade unions and employer organisations.

Full details of the engagement process are available at https://www.health-ni.gov.uk/publications/workforce-strategy-initial-engagement-findings, but in summary, the consistent messages we heard were:

- **Recruitment challenges**, in terms of the numbers of training places available, planning for retirements, and the processes by which vacancies are managed.
- **Increasing workloads**, and in particular administrative tasks being transferred to frontline workers.
- The need for job plans and roles which reflect an **ageing workforce**, in response to increases in State Pension Age and the desire of individuals to work longer.
- The need to consider different **skills mixes and different roles** for the workforce of the future, taking changes in the complexity of conditions and patient outcomes into account.
- A workforce increasingly seeking **flexible working patterns**, for a variety of generational and practical reasons.
- The importance of having clearly defined **career pathways** for all workforce groups.
- The increasing attractiveness of **agency work** de-stabilises teams, and can have a demoralising impact upon the directly employed permanent workforce.

Other issues raised

Those who deliver health and social care also raised the following issues:

- Innovation should be actively encouraged more, or recognised, for example by sharing the learning from positive changes across organisations.

- Frustration with the differences in pay across the UK, and that this contributed to the appeal of agency work to augment pay and provide more flexible terms and conditions.

- Frustration at a perceived lack of communication about ongoing reform.

- A desire for more upskilling opportunities, and the ability to use newly acquired skills after training.

- There is a perceived lack of information gathered from those leaving the system, and suggested that an independent third party carrying out exit interviews would encourage open and honest discussions.

- There are potential opportunities to advertise health and social care services more effectively, and raise awareness amongst young people in particular, for example by offering more volunteering and work experience placements to those at GCSE level.

- A frustration at perceived lack of opportunities for people living in rural locations to gain employment in local HSC organisations, and also with the perception that rural services were struggling to continue to provide the depth of training and work required to sustain services.

- Frustration about being expected to navigate several software packages at once to access one set of patient records, and staff felt that they were not properly engaged during development.

- A desire for a more long-term, consistent view of HSC transformation taken by decision-makers, with a balance struck between political/public expectation and what was realistically deliverable in the context of resourcing pressures.

- It was questioned whether the guidelines issued by royal colleges on staff-patient ratios were relevant for the system of today, and some suggested that these ratios might have frustrated innovation and multi-disciplinary working.

- Concern was expressed that the health and well-being of the workforce was not properly addressed and supported by existing occupational health policies, which could be more person-centred and less focussed on managing attendance.

- It was suggested that health and social care workforce could receive ‘fast-track’ health and social care to help them to recover more quickly from illness or injury, which may result in them being able to return to work as soon as possible, thereby cutting sickness leave rates and agency and locum costs.

AIM AND OBJECTIVES OF THE STRATEGY

The **aim** of this strategy is that **by 2026, we meet our workforce needs – and the needs of our workforce.**

To achieve this aim, we need to meet three **objectives:**

1. **By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.**

2. **By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported.**

3. **By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.**

Thanks to the involvement of colleagues working across health and social care, we have a good understanding of the main themes that the workforce strategy needs to tackle. They are outlined below.

1. **Attracting, recruiting and retaining**
    - Attracting people from an early age to want to pursue a career in health and social care.
    - Recruiting enough of the right people, with the right skills, into health and social care.
    - Ensuring that they want to keep working in health and social care.
    - Provide opportunities to return to work for experienced colleagues who have left service.

2. **Sufficient availability of high-quality training and development**
    - Development opportunities are properly planned and sustainably provided.
    - Training needs are recognised as dynamic and constantly need to be reviewed at a strategic level.

3. **Effective workforce planning**
    - Have an optimum workforce model developed, agreed and in place.
    - Have optimum numbers of appropriately skilled people working in every setting and in every specialty, now and in the future to populate the model.
    - All necessary posts and vacancies are filled quickly.

4. **Multidisciplinary and inter-professional working and training**
    - Health and social care teams have the right skills mix to provide the right care and support efficiently, effectively and with compassion.
    - Successful multidisciplinary working can be promoted by effective multidisciplinary training.
    - Each profession recognises the value and contribution of other professions to health and wellbeing.
    - Postgraduate healthcare education forum.

5. **Building on, consolidating and promoting health and wellbeing**
    - Promoting support.
    - Developing occupational health services for health and social care workers, which can be used as a model for the rest of the Northern Ireland workforce.

6. **Improved workforce communication and engagement**
    - Between strategic bodies and delivery partners.
    - Between management, the workforce and workforce representatives.
    - Between the HSC, independent and voluntary sectors.

7. Recognising the contribution of the workforce

- Valuing the contribution that all make to delivering excellent, compassionate care and to improving the health, quality of life and wellbeing of the people of Northern Ireland.
- Protecting and developing terms and conditions in a time of reform.
- Devolving decision-making to the appropriate levels, including locally where possible.

8. Work-life balance

- Recognising that people have different needs and obligations outside of work, whilst balancing service needs.
- Responding to the changing needs and expectations of the workforce over time.

9. Making it easier for the workforce to do their jobs

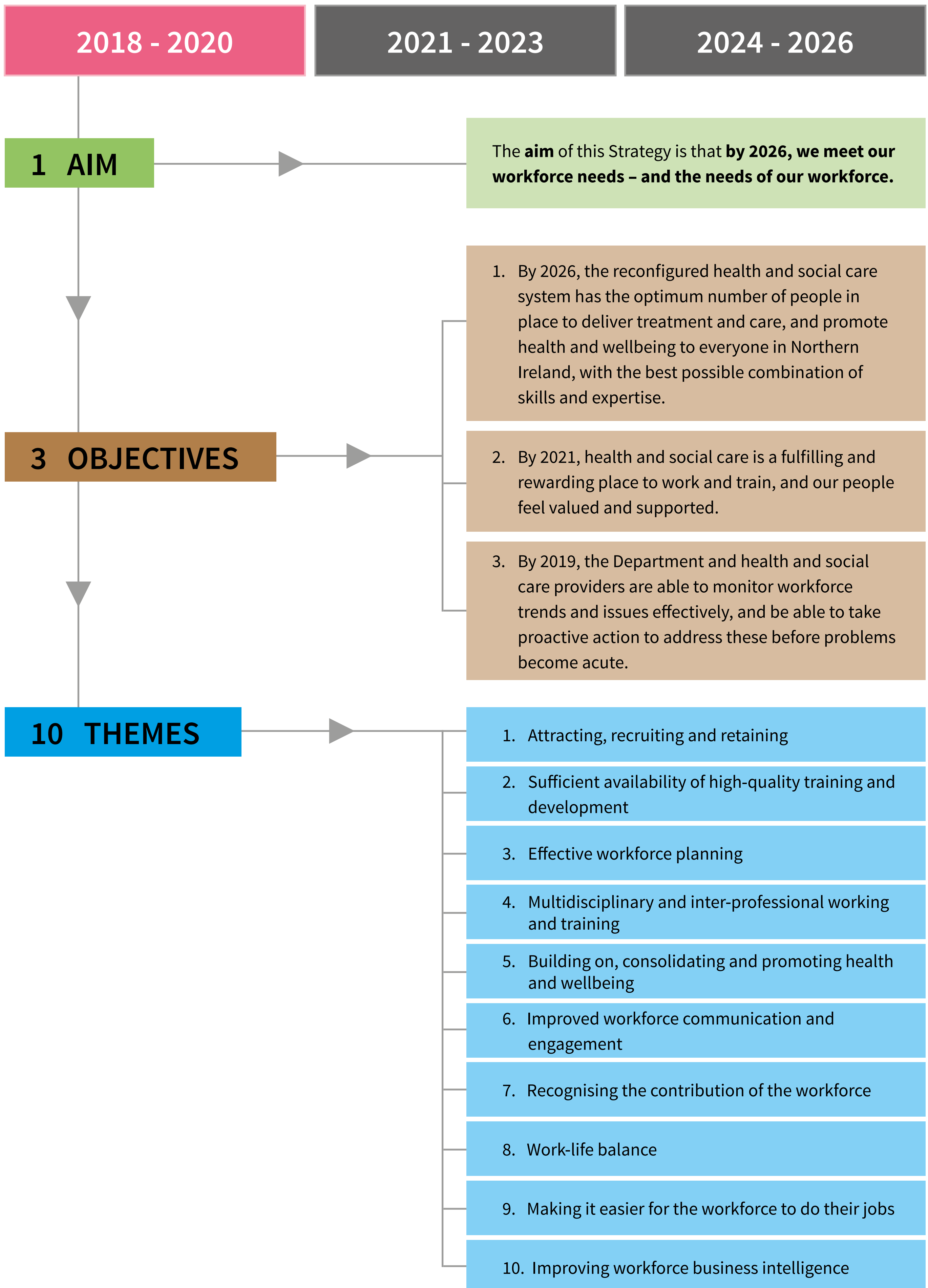
- Simplifying the employment relationship.
- Eradicating unnecessary duplication and bureaucracy.
- Improving IT infrastructure and staff capacity.

10. Improving workforce business intelligence

- Identifying and addressing gaps in workforce data/intelligence/statistical information, thereby improving the ability to take proactive action using business intelligence findings

These ten themes fit within one or more of the three objectives.

Action Plans



Action plans

This is a long-term strategy, to be implemented over a nine-year period. The eventual configuration of health and social care in Northern Ireland is not yet known. It is impossible in 2018 to be definitive about the impact of technological advances in 2026. The shape of the UK's exit agreement from the EU has, at this point, to be determined.

This strategy therefore needs to be flexible. That is why we propose **three** consecutive action plans over the life of the strategy, for:

- **2018-2020;**
- **2021-2023; and**
- **2024-2026.**

This will allow for formal review of progress every three years, to take account of global, national and local developments - political, economic, social and technological - and chart a path of cumulative action to achieving our objectives.

The draft action plan for 2018-2020, which is subject to further co-production and Departmental approval, is included in this document.

Oversight and accountability

- A programme board will be established by the Department of Health to plan and formally monitor and manage implementation. Progress will be informally reviewed periodically.

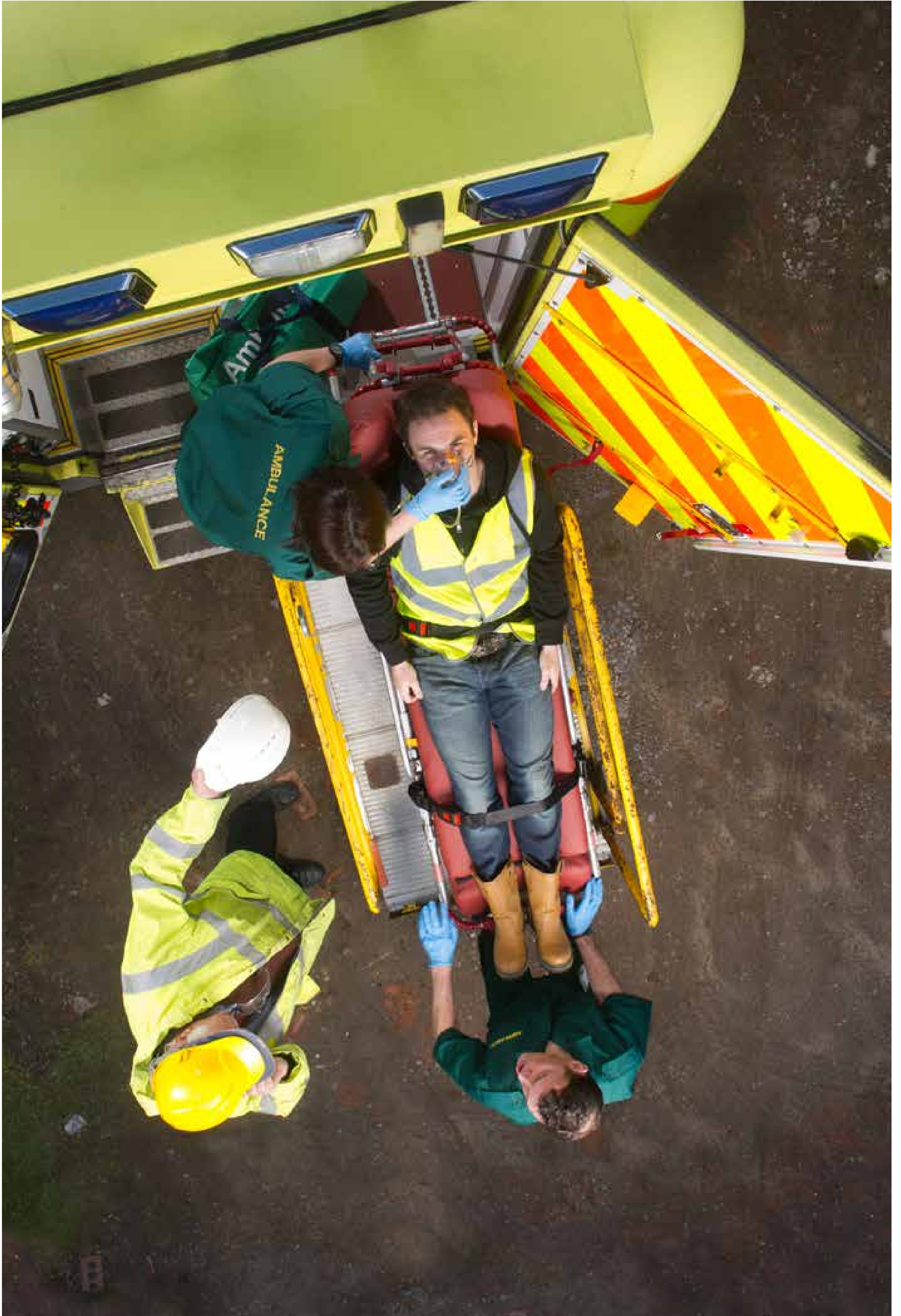
- A reference group, with representation from relevant employers, trade unions and others will provide advice and assurance to the programme board on progress, and act as the key body for resolution of any issues.

- Individual project teams and/or task and finish groups will be commissioned by the programme board, with input from the reference group, to take forward certain tasks.

Measuring success

Achieving the actions in each action plan will be a good indicator of success in meeting our aim and objectives. But we must also take an evidence-based approach. The first task and finish group to be set up will therefore produce and agree the performance indicators for the strategy.

This work will be completed by the end of June 2018. The performance indicators may include a mix of quantitative evidence, such as reductions in job/training vacancy rates and agency/locum spend, and qualitative measures such as those in staff surveys, etc.


AMBULANCE

OBJECTIVE 1

By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.

THEME 1

Attracting, recruiting and retaining

ACTION 1

Set up and roll out a regional health and social care careers service targeted at the existing workforce, young people from the age of 14, and possible returners to service.

WHY?

- To help ensure a good supply of people in the future.
- To inform and excite people on the range of jobs and professions.
- To publicise health and social care as a career option, with properly mapped career pathways, developed in partnership with existing members of the workforce.
- Focus on the skills developed within areas and locations which have recruitment difficulties.
- To provide volunteering and work experience opportunities.
- Will act as a single point of contact for new recruits and experienced returners.

OUTPUT

By 31/12/2020

Regional Health and Social Care careers service established.

ACTION 2

Explore and establish non-salary incentive programmes as a means of recruiting and/or retaining people and/or dealing with pressures in less popular specialties and locations.

WHY?

- We are experiencing difficulties in filling certain posts.
- Need new innovative ways to recruit and retain.
- Addressing supply and location issues should ultimately reduce reliance on agency and locum workers.
- Such a policy can be linked to return of service obligations – establishing a new two-way commitment between HSC employers and trainees.

OUTPUT

By 31/12/2020

Non-salary incentive programmes finalised for various professions in health and social care.

THEME 2

Sufficient availability of high-quality training and development

ACTION 3

Commissioning of sustainable training programmes that are aligned to meet current and future health and social care requirements for multidisciplinary service delivery.

ACTION 4

Commissioning of time-protected, appropriately located, sustainable post-registration training programmes, and development opportunities for more experienced people, including consideration of preceptorship arrangements to smooth the transition from training into practice.

WHY?

- Values the needs of students and workers.
- We need a sustainable approach to planning for, and funding, training for pre-registration students, to ensure that health and social care is fit for purpose by 2026.
- This will take account of revisions to the various curriculums – for example, resulting from findings of the Nursing and Midwifery Task Group in relation to mental health nursing.
- Smooth the transition from education environment to the realities of delivering health and social care, and the characteristics/skills required to do so.
- Reduce reliance on agency and locum workers.
- We need a sustainable and transparent approach to planning for, and funding, training for post-registration students, to ensure that health and social care is fit for purpose by 2026.

OUTPUT
By 31/12/2020

Rolling, prioritised programme of workforce plans aligned to health and social care service delivery requirements.

Policy on departmental commissioning of training and development for health and social care.

Multidisciplinary working and training to be a key principle.

Align to Leadership Strategy.

THEME 3

Effective workforce planning

ACTION 5

Develop and, by 2026, sustainably fund, an optimum workforce model for reconfigured health and social care services.

WHY?

- We need a strategic, coherent, dynamic workforce model that clearly outlines the people and skills required to meet service and population needs across the region in 2026. This should take account of population needs and demographic trends.
- We need a product that collates and coordinates the findings from the various prioritised workforce reviews that are regularly carried out for every profession and discipline. The optimum workforce model will be this product.
- We can also take account of, for example, the findings of the Nursing and Midwifery Task Group which is due to report in 2018.
- The optimum workforce model will adopt a number of key principles, including the need for multidisciplinary and inter-professional working.

OUTPUT
By 31/12/2020

Review of required medical training places completed by June 2018.

Progression of all recommendations arising from workforce planning reviews.

Optimum Workforce Model framework in place, co-designed with clinical leads, which will take account of reconfiguration plans, current and future drivers and pressures.

ACTION 6

By fully implementing and embedding the Regional HSC Workforce Planning Framework (six-step methodology), ensure that this is supported by necessary resources and underpinned by a multidisciplinary ethos across all providers.

WHY?

- Consistent, evidence-based regional approach to workforce planning.
- Need to review adequacy of training across all HSC providers.

OUTPUT
By 31/12/2020

By re-establishing a group to take forward regional workforce planning to ensure that the six-step methodology is fully embedded into workforce planning practices, including use of population health, disease profile data etc.

THEME 3

Effective workforce planning

ACTION 7

We take account of, and plan for, the workforce implications arising from the UK's exit from the EU and the subsequent implications for the EU/EEA and non-EU/EEA workforce

WHY?

- Need to take account of the implications for workforce supply, frontier workers, mutual recognition of professional qualifications, international recruitment, borders agency, immigration quotas and shortage occupation lists.

OUTPUT
By 31/12/2020

Terms of reference for EU exit workforce group, comprising (among others) worker and management representation to be agreed.

Regular meetings in 2018-19.

THEME 4

Multidisciplinary and inter-professional working and training

ACTION 8

Planning for and introducing new roles.

WHY?

- Need to develop and integrate new ways of working and jobs across health and social care.
- Need to ensure that the appropriate skills mix is in place.
- New roles need to be evidence-based, with clarity on outcomes of what new roles will contribute and achieve.

OUTPUT
By 31/12/2020

Needs analysis of new roles required.

Pilot and evaluation of physician associate (PA) students trained at Ulster University.

Recruitment of PAs into newly created posts.
Ongoing training programme in Northern Ireland to provide a supply of PAs into HSC.

Assess actions for other potential new roles.

THEME 4

ACTION 9

Multidisciplinary and inter-professional working and training

Develop multi-disciplinary, cross-sector working that will characterise the delivery of collective, compassionate care in the future

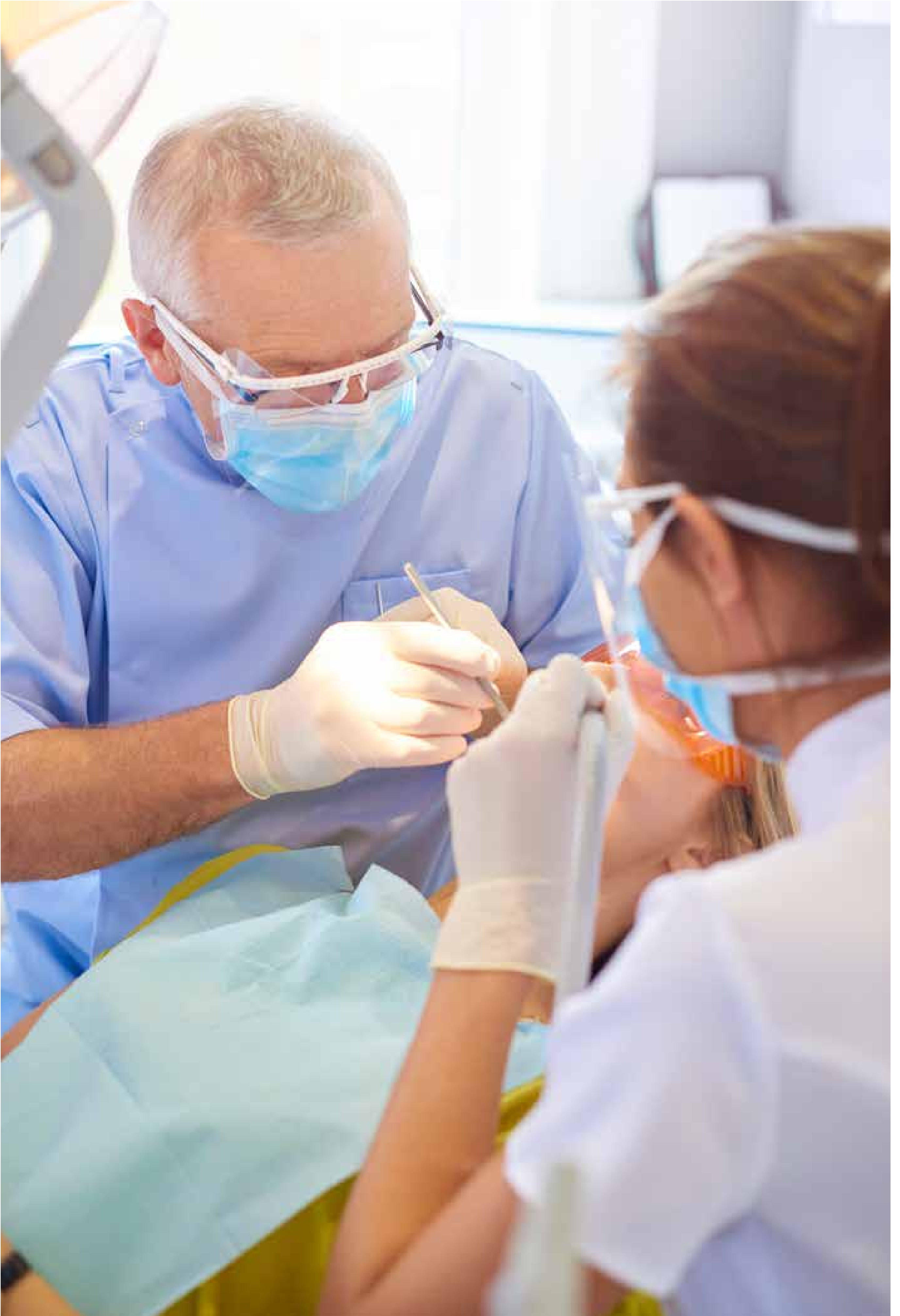
WHY?

- Effectively utilising skills and resources.
- Streamlining care pathways across locations and teams.
- Addressing increasing incidence of co-morbidities in an ageing population.
- Need to ensure that role of multidisciplinary teams in transformation of delivery of health and social care services is clear and embedded in all undergraduate health and social care courses.

OUTPUT
By 31/12/2020

Cross reference the work of and seek input from (among others):

- **Postgraduate Health and Social Care Education Forum**
- **Nursing Strategic Workforce Development Group**
- **Primary Care Multi-disciplinary Working Group**
- **Paramedic Steering Group**
- **Imaging Review**
- **Adult Social Care Review**
- **Assistive technology commitments, learning and development programmes.**



OBJECTIVE 2

By 2021, health and social care is a fulfilling and rewarding place to work, and our people feel valued and supported.

THEME 5

Building on, consolidating and promoting health and wellbeing

ACTION 10

Working with employers, and all those who work in the health and social care sector and trainee representatives, the Department and commissioners will produce an HSC staff health and wellbeing framework, with the aim of assisting staff to remain resilient, and physically and mentally well at work.

WHY?

- Investment in health and wellbeing services for the workforce reduces sickness absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure).

OUTPUT
By 31/12/2020

Audit of existing services and procedures.

Adopt and roll out new regional staff health and wellbeing policy.

ACTION 11

Commissioning and establishment of sustainable occupational health services.

WHY?

- Investment in occupational health services for the workforce reduces sickness absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure).
- This will also act as a model for new occupational health services for use by the wider public and private sectors.

OUTPUT
By 31/12/2020

Audit of existing services.

Completion and implementation of multidisciplinary occupational health workforce plan.

Establish group to appraise options for the more effective delivery of occupational health services to the wider health and social care sector, and subsequently other Northern Ireland industry sectors.

THEME 6

Improved workforce communication and engagement

ACTION 12

Establish processes and procedures to ensure that information flows freely across organisations/systems and that employees are kept abreast of developments.

WHY?

- Addresses concerns raised in previous staff surveys and in the fieldwork for this strategy.
- Allows for staff networks/forums to discuss such matters which are common across all sectors and bands.
- Allows for coherent messages on health and social care developments, including transformation and industrial relations.

OUTPUT
By 31/12/2020

Audit of existing services.

Processes and procedures co-produced and fully embedded.

ACTION 13

Co-produced staff appraisal and engagement project, and rollout of recommendations.

WHY?

- Allows for coherent action to address staff concerns in relation to:
  - Team working
  - Appraisal
  - Personal development
  - Knowledge and Skills Framework
  - Organisational / leadership culture (address high pressure cultures and how these can create high stress cultures and ultimately low morale).

OUTPUT
By 31/12/2020

Audit of existing services.

Completion and rollout of project and recommendations.

THEME 6

Improved workforce communication and engagement

ACTION 14

Design and implementation of co-produced policy on recognition initiatives.

WHY?

- Supporting the workforce to achieve success, and to feel valued and supported.
- Allows for coherent action on possible introduction/use of:
  - Advanced Information and Communication Technology
  - Co-production leading to greater staff involvement in decision-making.
  - Sufficient freedom to display initiative and make decisions.
  - Proper supervision.
  - Opportunities for training and development at all grades, and not just tied to promotion.
  - Agreed job rotation.
  - Opportunities for educational leave, etc.

OUTPUT

By 31/12/2020

Audit of existing services.

Completion and rollout of agreed co-produced policy.

ACTION 15

Working with employers, and the workforce and trainee representatives, the Department and commissioners will produce a set of standards that all HSC staff can expect in terms of facilities.

WHY?

- Addresses staff concerns in relation to food/drink/rest break facilities.

OUTPUT

By 31/12/2020

Agreed and updated HSC staff facility policy.

Recognising the contribution of staff

THEME 7

ACTION 16

Recognising the contribution of the workforce

Develop a regional system of workforce recognition, based on the policy developed under action 14 and existing areas of best practice.

WHY?

- Valuing the contribution that all make to delivering excellent, compassionate care.
- Devolving decision-making to the appropriate levels, including locally where possible.

OUTPUT
By 31/12/2020

Policy published by 31 December 2018.

THEME 8

ACTION 17

Work-life balance

Co-produce a regional work-life balance policy for health and social care workers.

WHY?

- Recognises the needs of the workforce such as those with dependent relatives and/or caring responsibilities, whilst balancing the requirements of the service.
- Support the workforce to access their work remotely where appropriate.
- Also will provide clarity around working time regulation/sleepover duties/working hours in 24-hour service.

OUTPUT
By 31/12/2020

Regional policy design group established and work under way.

THEME 9

Making it easier for the workforce to do their jobs

ACTION 18

Simplification of employment arrangements, for example, explore whether a single employer for all HSC staff is feasible and will produce benefits for staff/patients/ clients.

WHY?

- To provide clarity and remove duplication and possibility for error/confusion in relation to payroll, generic training, etc.

OUTPUT
By 31/12/2020

Completion of lead employer project for doctors in training.

Learning from doctors in training, lead employer project applied to planning for possible single HSC employer.

ACTION 19

Continue to develop workforce engagement projects for the introduction of new technologies and systems, including e-health initiatives, Encompass, etc. , which are designed to support the workforce in doing their jobs.

WHY?

- Some parts of the workforce do not feel sufficiently involved in design and roll-out of new technology and systems.

OUTPUT
By 31/12/2020

Comprehensive workforce engagement plans to be developed as part of design and implementation of new technologies and systems.

ACTION 20

Develop a policy which more effectively outlines a process for devolving the selection of 'new team members' to line management/team members (with support of central HR function) who have knowledge of the skills/attributes and individual qualities required for the post.

WHY?

- Eradicate unnecessary delays in filling vacancies

OUTPUT
By 31/12/2020

Policy in place by 31 Dec 2018, with first two-year evaluation about to begin in January 2021.

OBJECTIVE 3

By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.

THEME 10

Improving workforce business intelligence

ACTION 21

Department to oversee and monitor exercise to examine where current gaps exist. This will involve collaboration with the relevant bodies to introduce data collections that we know to be missing e.g. gather more primary care workforce data, independent sector, etc.

WHY?

- We have a number of gaps in our business intelligence, which if closed will allow us to monitor workforce trends and issues effectively, and be able to take proactive action in the future.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

ACTION 22

Align staff survey with workforce strategy to ensure information is available to measure progress against intended outcomes

WHY?

- We need better business intelligence from this source.
- Need to maximise response rate.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

THEME 10

Improving workforce business intelligence

ACTION 23

Roll-out of exit interviews for all staff leaving the HSC.

WHY?

- Results of detailed and meaningful exit surveys can be monitored and fed into workforce planning processes and decision-making.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

ACTION 24

Explore workforce data systems and analytics software to inform more evidence-based decision making and solve problems.

WHY?

- We need better business intelligence.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

CAUTION
WET FLOOR

CONCLUSION

This is a deliberately ambitious strategy. We do not underestimate the task at hand. In the first half of this strategy we set out the significant challenges facing health and social care in Northern Ireland. These combine to create a complex environment in which to transform.

However, there are already very positive examples of the fantastic work carried out by the health and social care workforce on a daily basis to transform and improve services, which showcase the dedication, innovation and caring approach so evident to anyone in Northern Ireland.

Perhaps more fundamentally, they offer evidence that the wide-ranging transformation envisaged by this strategy can be achieved. A selection of these examples can be found at: https://www.health-ni.gov.uk/topics/health-policy/transformation-programme#toc-0.

The strategy seeks to contribute to deep and wide transformation of health and social care in Northern Ireland by establishing a long-term, sustainable and sensible approach to meeting our workforce needs, and the needs of our workforce. The success of the strategy will rely on cooperation between employers and workers, professions and disciplines, and across all sectors.

The consequences of failure to achieve the aims and objectives of this strategy are grave. The already unsustainable rate of agency and locum expenditure will continue to increase. Waiting lists for treatment will continue to rise. Health and social care services will become unsustainable, and the longer this continues, the more difficult it will be to transform these services.

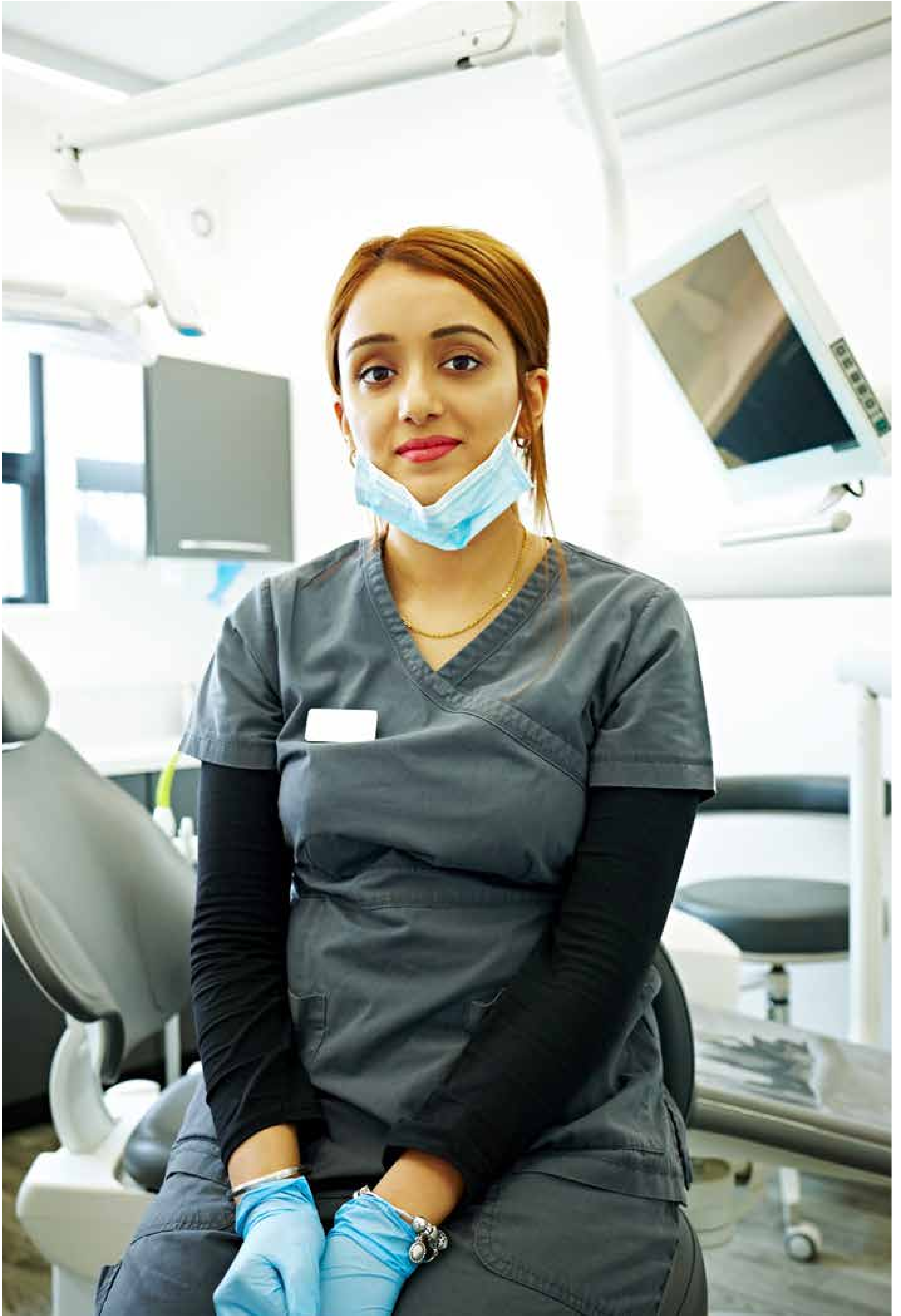
This strategy not only seeks to tackle issues in the present, but looks forward to health and social care as it will be in 2026. It is designed to be flexible enough to respond to issues that will arise in the future.

To make sure the strategy achieves its objectives, the Department will develop three consecutive action plans, with oversight mechanisms (programme board, reference group and project teams) designed to hold the Department accountable for their success. Annual progress updates will be published on the Departmental website, along with regular highlight reports showing the progress of each action.

The first task and finish group to be set up under the strategy will determine and agree the performance indicators to measure success. This work will be completed by the end of June 2018.

This strategy is not an isolated document. Many of the actions contained in the plan will be dependent on a number of other enablers and actions on the health and social care transformation agenda.

Throughout the development and co-production of this strategy, the most important focus has been to ensure that everyone has the opportunity to have their say, and shape policy for the next decade. We look forward to working together to ensure that we meet our workforce needs, and the needs of our workforce.



APPENDIX

CURRENT PROBLEMS AND FUTURE CHALLENGES

SOCIAL CARE

There can be considerable differences between the terms and conditions of employment for social care workers in statutory organisations and those employed within the independent sector. Lower pay, less favourable conditions, temporary or zero-hours contracts and a perceived lack of recognition of their value to society, have all contributed to low morale and a high turnover of the workforce.

Investment in learning and improvement for social care workers tends to be more limited in the independent sector. There are also fewer promotion opportunities in some areas of social care such as domiciliary care which may also discourage people from choosing social care as a long-term employment option.

The domiciliary care workforce needs should be an early priority in recognition of the particular vulnerabilities we face in social care. The Department is finalising a domiciliary care workforce review which has demonstrated that services at present are stretched, with the result that there is already a gap in the supply and demand chain, with unmet need already existing.

There is a need to build in robust and cohesive systems of communication, analysis and joint workforce planning between social care and nursing for example, and between the HSC and independent social care sectors. Analysis needs to look not only at spend, but also output and efficiency.

For the first time, anywhere in the UK, Northern Ireland social care workers are now required to register with the Northern Ireland Social Care Council, which is responsible for the regulation of the social work and social care workforces. Regulation requires social workers and social care workers to maintain the skills they need to perform their tasks effectively with the support of their employers.

Alongside this, a code of practice and code of conduct has been introduced for all social care workers, together with common induction standards and a regional framework for the delegation of tasks to social care workers. A continuous learning and development framework is also under development.

SOCIAL WORK

At present, there are significant pressures on social workers in several areas within HSC, including adult mental health, child protection and services for looked-after children. Other factors which will increase the demands on social work services in the coming years include the Northern Ireland Executive's target to improve social wellbeing through person-centred care, community development, self-directed support and co-production.

New legislation such as the Mental Capacity Act and the Adoption and Children's Bill will also mean additional statutory roles and responsibilities for social workers in the future. In the next five to 10 years, social workers will be expected to have more specialist knowledge and skills.

MEDICAL WORKFORCE

Upon graduation, provisionally registered doctors enter a two-year foundation programme, becoming fully registered at the end of year one. Effectively, all local graduates enter the UK programme and all but a small number complete it, making them eligible for the next stage of medical training.

The next stage of training is specialty training (core training, higher specialty training or run through training). A number of vacancies exist at this level, particularly in core medical training and emergency medicine. There are multiple factors that impact on trainee medics' career choices, including location of posts, work-life balance and career prospects.

This is compounded by the fact that posts are sometimes designated as training posts when they should more appropriately be service posts. Medical trainees also have concerns[5] about:

- staff shortages and resultant pressure on the workforce;
- high workloads and emotional demands;
- lack of autonomy and appreciation of their role;
- emphasis on service provision at the expense of training;
- too frequent job rotation;
- unsustainable and expensive locum positions;
- irregular working hours impacting on work-life balance;
- lack of social and supervisory support;
- disconnect between trainees and management; and
- uncertainty over the junior doctor contract.

Medical vacancies

In addition to the existing vacancies in the NI training programmes, the HSC has been experiencing a growing number of medical vacancies at consultant and specialty doctor/associate specialist level. Whilst a small number of specialties feature on the UK shortage occupation list, a growing number of grades and specialties not on this list are being reported as 'hard to fill'. This not only has an impact on waiting lists, but also on the overall cost of elective care.

Postgraduate training

There is also a differential pattern of recruitment at specialty training level. Ideally all recruitment into specialty training should be into programmes (i.e. a series of postings leading to the completion of specialty training). However, approximately a fifth of training posts are of one year duration and these are continually difficult to recruit into.

Some training programmes are becoming more difficult to recruit into, most notably in the medical specialties. This impacts on the availability of consultant applicants, both now and in future years, in areas such as general and acute medicine, cardiology, diabetes, gastroenterology, rheumatology and oncology.

5. HSC/NIMDTA Valued Strategy 2016

Specialty and associate specialty (SAS)

Specialty and associate specialist (SAS) doctors can play a key role in delivering the aspirations of Health and Wellbeing 2026 – Delivering Together, through leadership and developing innovative solutions, if the right support is put in place. Motivated SAS doctors, with the requisite planned training will continue to be able to work at a consistently high level, contributing clinically, educationally, in management, clinical governance, appraisal and innovation.

An infrastructure is required with accountability and support to ensure that a SAS doctor role is an attractive role and one which makes a significant contribution to the delivery of high-quality patient care. The Department continues to work with the BMA and HSC employers to support and develop the role of SAS doctors as a valued and vital part of the medical workforce.

Consultants

There remain significant consultant vacancies in some specialties, notably radiology; not as a result of recruitment issues to the training programme but rather the output from the programmes does not meet the current and future service demand for consultants.

The inability to recruit to postgraduate training programmes in NI, as outlined above, will result in increasing levels of locum cover being required to meet the service demands of a consultant led service.

Medical workforce representatives state that a combination of lower remuneration, workload, lack of autonomy and underinvestment in services has made working as a consultant a less attractive role in Northern Ireland than in other parts of the UK and Ireland.

General Practice

Demand for services led by GPs has increased significantly recently – with a 76% rise between 2004 and 2014 in consultations and a 217% rise in test results being dealt with over the same period.

At the moment, 39% of the GP workforce in general practice is aged 50 and over. There is anecdotal evidence of a shift towards more part-time working in the general practice workforce and of a preference for portfolio careers mixing a range of roles with an increasing emphasis placed on work-life balance.

Anecdotally we have heard of an increasing preference for salaried GPs, though surveys by BMA in recent years have indicated that younger GPs are more likely (73%) to say they envisage looking for a GP partnership in the future.

Premises infrastructure limitations are a real barrier to the utilisation of skills mix opportunities (the funding schemes for premises are no longer attractive to some).

For some GPs, they consider that the role is at 'tipping point' – the job has become undoable; expectations are too high, with too much to do in too little time.

Work is ongoing to deliver multidisciplinary primary and community care teams.

PHARMACY

The pharmacy workforce is expanding, with a range of careers for pharmacists, pharmacy technicians and other pharmacy staff. This reflects the increasing need for pharmaceutical expertise within multi-professional teams in all settings, helping to optimise the benefits of medicines and transform services.

Medicines

Medicines are the most commonly used healthcare intervention within health and social care. Increasing demands present challenges in terms of affordability and complexity of care. The current cost of medicines within HSC is £600 million however, despite this significant expenditure, medicines are over used, under used and misused to the extent where outcomes are sub-optimal.

There is therefore a need to secure the important contribution that pharmacy professionals bring to the transformation of health and social care in the areas of improved quality in (a) patients' outcomes, (b) valued interventions and (c) effective integration.

Challenges

By 2026, we need to deal with the following workforce challenges:

- the professional development of the clinical prescribing role of pharmacists in general practice. While all general practice pharmacists train as prescribers, it is important that they are supported in their ongoing professional development. For example, they should have the opportunity to develop in line with the advanced practice framework;
- embedding clinical leadership in the profession through the recruitment of consultant and specialist pharmacists in hospital and federation leads in primary care. However, it is recognised that leadership applies at all levels and this should be embedded in career development frameworks;
- the continued development of clinical pharmacy services and consultant roles in secondary care;
- the integration of prescribing skills into the roles of clinical pharmacists in all settings;
- the regulation of pharmacy technicians and development of the workforce to provide a better skill mix, particularly in community pharmacy. This is an important factor to increase capacity, if pharmacists are to deliver more clinical service;
- the expansion of the role of pharmacy workforce in all settings, and
- embedding of seven-day working.

Future developments

Enhanced deployment of pharmacists' clinical skills and collaborative working with other health and social care professionals should support patients' appropriate, safe and efficient use of medicines, improve economic health gain and reduce pressures on health care systems.

Emerging new models of care and new technologies will support people to manage their own health and gain the optimal benefit from treatment with medicines. Such system redesign and scale up should be underpinned by foundation and advanced postgraduate training to support inter-professional working and professional leadership. These are standard training pathways for secondary care pharmacists, which should be replicated in the primary care and community pharmacy sectors.

DENTAL WORKFORCE

General dental practitioners, as independent contractors, spend almost three quarters of their time on health service dentistry. However this has been decreasing in recent years, leading to a corresponding increase in private dentistry.

Dental nurses

Turnover of dental nurses can be high and there is little or no career progression currently available. There is a reliance on the availability of relevant courses through the network of Further Education colleges. The current experience within the dental workforce is that the courses necessary to train dental nurses are becoming difficult to access due to lack of availability.

Community dental service

The Community Dental Service, which is the main provider for special needs groups, has reported challenges in filling posts, particularly in the western region. Also, significant numbers of the most experienced community dentists are approaching retirement, with up to 40% reported to be potentially retiring by 2025.

Dental hospital/school

The Dental Hospital/School has reported some challenges in filling posts for particular dental specialties and it is understood that this is a problem in other parts of the UK too as the market is competitive for the relatively small numbers who have completed training.

Providing work experience for young people is much harder to do nowadays, with increased insurance costs, complex administration and onerous patient permission processes. Access NI checks for new staff can take up to 10 weeks (although this time period is quite variable). Practice owners are finding that there are additional costs associated with dental nurses due to indemnity and General Dental Council registration fees.

There is a recognised tendency for new graduates to remain close to the city in which they trained. This makes it harder to recruit to rural practices.

The dental technician workforce is ageing and unless new workers are attracted we will soon run out of skilled technicians, particularly those who are able to make dentures.

The ongoing Dental Services Workforce Review is considering these issues.

CLINICAL PSYCHOLOGY

There has been an unprecedented increase in recognition of the relevance and need for psychological interventions in health and social care. This is reflected in NICE guidance for physical, as well as mental, health presentations and in numerous regional and national strategies in relation to particular population and service needs.

Psychological interventions have been recognised as not only relevant to improved health and well-being, but as beneficial from a healthcare economics point of view in reducing costs associated with disability, healthcare dependence and social exclusion. Future legislative and associated policy changes, such as the implementation of the Mental Capacity Act, will also impact on demand for clinical psychologists within the health and social care workforce.

Clinical Psychologists are employed in a range of specialisms including adult mental health, adult physical health, neurology services, learning disability, children's mental health, paediatrics and child disability, autism services for adults and children, services for looked after children, older adult, forensic and addiction services.

Over recent years, consistent with NICE guidelines, there has been an increased diversification of the areas of employment and especially within staff wellbeing, Autistic Spectrum Disorder services, health, disability and early intervention services. Northern Ireland has the lowest rate of clinical psychologists per head of population across the four nations of the UK and in comparison with the Republic of Ireland.

Clinical Psychologists are trained through a doctoral clinical psychology training programme and contribute to the HSC workforce throughout training. NI has the lowest number of training commissions per head of population across the UK and Ireland. There is a 100% employment rate for graduates of the regional training programme currently delivered at Queen's University Belfast with approximately 19% of the workforce being recruited from outside Northern Ireland.

The British Psychological Society 2015 Workforce Review identified a 19% vacancy rate across Trusts with supply of clinical psychology graduates not keeping pace with need and demand. Regional priorities for new psychological services and the increased role of clinical psychology in governance and training of others, means that demand for clinical psychologists continues to grow.

Moreover, the profession is a female dominated profession (77%) and part-time working has increased from 25% in 2008 to 39% in 2015. This demography and pattern of working has created significant workforce pressures especially in the absence of any viable locum pool to cover maternity leave and family friendly work policies. 17% of the Clinical Psychology HSC workforce are over 50 years of age with early retirements available through mental health officer status for this cohort.

Following on from the DHSSPS Strategy for the Development of Psychological Therapy Service (June 2010) there have been very significant developments in recruitment of other professions, across a skill mix, into psychological services. These include psychological therapists, behaviour support workers, autism workers and rehabilitation assistants.

Effective governance arrangements are required for these other professionals delivering psychological or psychology informed interventions. Clinical Psychologists are well placed to contribute to the transformation agenda by supporting the development of psychological mindedness across the workforce and delivering a safe, effective and well governed stepped care approach to the provision of psychologically informed health and social care.

NURSING AND MIDWIFERY

Nurses and midwives are critical to health service delivery, accounting for 35% of the HSC workforce. They have the most contact time with patients and service users, and provide a diverse range of services across all settings. As members and coordinators of inter-professional teams, they help promote and maintain health and wellness, bringing person-centred care closer to communities, and improving outcomes.

Challenges and opportunities

The professions have embraced the challenges and opportunities placed on their practice by growing demands and changing service needs with a corresponding increase in workforce knowledge, skills and expertise. There is significant evidence that the development of innovative new roles such as advanced nurse practitioners and consultant nurses and midwives have advanced autonomous practice and embedded strong clinical leadership.

The potential of these roles needs to be maximised. Family nurse partnerships are an example of early intervention models that deliver positive outcomes.

The development of clinical specialisms, and treatment advances, have increased demands on the specialist nursing workforce, in particular cancer specialists. Further examples of nurse-led initiatives include nurse endoscopists and models involving minor surgery (such as dermatology).

Rising demands on community and primary care services, and the prevalence of long-term conditions, have placed a significant burden on community nursing services. Alongside the focus on advanced and specialist practice, is the need for adequate investment in post-registration education and development of the generalist nursing workforce.

In response to 'Delivering Together' and the increasing demands on the workforce, a Nursing and Midwifery Task Group was established to identify how the contribution of nurses and midwives can be maximised to improve population health outcomes. The task group's work is underpinned by a public health approach that promotes health and wellbeing.

It will identify best practice, evidence-based innovations which build on work already undertaken here. Indications emerging from extensive engagement with the workforce include a concerning picture of a pressurised, under-resourced service, curtailing the capacity to deliver safe, effective care.

Recruitment and growth in demand

The nursing and midwifery workforce has risen by 8% since 2008 but this has not kept pace with demand, and there is a significant shortfall in the number of nurses available to take up vacant posts in both the statutory and independent sectors. The same picture is emerging for midwifery, and the independent sector.

The impact of vacancies is compounded by high levels of maternity leave and sick absence in some areas. Maintaining service delivery incurs high bank and agency costs. Continued growth in demand has impacted on Trusts' ability to recruit at entry level.

There is a global shortage of registered nurses and midwives, and this impacts on Northern Ireland. Contributory factors include demographic changes with rising healthcare needs, changing service requirements, growth in nursing and midwifery-led services, and the expanding scope of practice with new roles emerging.

A further significant local factor is that investment in pre-registration nurse training between 2010 and 2015 did not keep pace with demand, resulting in a significant shortfall of nurses and midwives to fill vacancies. The Department has increased investment in undergraduate nurse training, commissioning an additional 100 places each year from 2016/17 and a further 100 new places for 2017/18. To help maintain safe staffing levels, an international nurse recruitment campaign commenced in 2016 as a short-term measure.

The implementation and progression of Delivering Care: Nurse Staffing in NI has highlighted the disparity that exists between current staffing levels across a range of specialities and those needed for optimum delivery of safe, effective care. Phase 1 investment has strengthened the workforce in acute medical/surgical areas.

Children's nursing

Advances in care and technology mean that many more children are living better, or more comfortably, with complex health care needs. Children's nurses have the expertise to care for and support children and their families in a variety of settings, both community and hospital based.

The intention with A Strategy for Children's Palliative and End of Life Care 2016–26 is to improve children's lives in real terms. The children's nursing workforce has to reflect changing population health needs, increasing complexities of conditions, the opportunities of innovation in healthcare alongside similar demographic workforce issues to the other fields of nursing.

Mental Health nursing

A mental health nursing review is underway, to enhance the contribution of mental health nurse to population outcomes. As the largest mental health workforce, mental health nurses are a core asset in the delivery of services and are central to workforce development.

There is a need to revise the mental health nursing undergraduate curriculum, strengthen the provision of psychological therapies and promote the development of advanced practice roles. All nurses and advanced nurse practitioners will have a critical role to play with the implementation of the Mental Capacity Act.

Learning Disability nursing

'Strengthening the Commitment' sets the strategic direction for learning disability nursing and recognises the important contribution learning disability nurses make in providing effective person and family centred care.

Recruitment, retention and replacing vacant posts are challenges, and it is within this context that a new career framework is being developed to further enhance the roles of learning disability nurses.

The aim is that they will be able to make a more significant contribution in improving physical, psychological, behavioural and social outcomes across primary care, community care, and acute and specialist learning disability services. This will also include the development of advanced and nurse consultant roles including specialist practice roles in Forensic Care Services.

Nursing Assistants

The current HSC nursing workforce model, where a Band 2 and 3 nursing assistant works under the delegated supervision of a registered nurse, is optimal in delivering safe, effective nursing care across all clinical settings. This skill mix model provides clarity and distinction between the role of a registered graduate nurse and that of a nursing support worker/assistant.

Development of the Band 3 role, with a wider skillset, has proved invaluable in supporting the graduate workforce to deliver effective care.

The Department has launched mandatory Standards for Nursing Assistants and other linked resources, including an Induction and Development Pathway, to endorse and strengthen the vital role undertaken by this cohort of staff.

The resources recognise and value the important contribution to nursing care made by Nursing Assistants and further enhance governance, oversight and patient safety.

New legislation such as the Mental Capacity Act will also mean additional statutory roles and responsibilities for nurses and midwives in the future.

Midwifery

The scope of practice of the midwife is clearly described and demarcated. The role has developed to meet changing population needs and the changing context of healthcare delivery. The birth rate in Northern Ireland has stabilised at approximately 24,500 births per year, however the complexities surrounding women giving birth has increased.

Evidence shows that it is in the interests of women to receive the majority of their care from a small group of midwives they know and trust, and the principle of “right care for the right woman in the right place by the right professional” is key.

Current service developments are in line with the 2012 Maternity Strategy, and include the development of midwifery-led care services, the acquisition of enhanced skills and competencies and development of maternity support workers.

Midwives have increasingly taken a major role as the lead professional for straightforward pregnancies, whilst developing roles as the key coordinator of care within the multidisciplinary team for complex cases. There is increasing recognition of the impact on the workforce of increasing midwife-led care, the shift to community based services and the development of freestanding birth centres.

The wide-ranging scope of midwifery practice to include increased safeguarding measures and public health responsibilities, and the impact of new initiatives such as the Early Intervention Transformation Programme adds strain to the service.

Changes to superannuation schemes and the potential impact of revalidation mean it is likely that a significant proportion of those eligible will chose to leave the service over the next five to 10 years. Current data indicates that in 2017, 21% of midwives in Northern Ireland are over 55 and eligible to retire.

The loss of more experienced midwives will potentially result in a skill mix imbalance in some areas. As younger midwives enter the profession, the challenges will relate to part-time working and maternity leave needs.

ALLIED HEALTH PROFESSIONALS[6]

Key to successful innovation and modernisation will be capitalising on the knowledge, expertise and professional experience of the AHP workforce, and communicating and sharing good practice, particularly in areas such as public health, diagnostics and re-ablement. Demand for AHP services continues to rise and this requires a review of the current workforce including supply and demand pressures.

There are several significant challenges for AHP recruitment and these vary across the professional groups. Regional recruitment for HSC Band 5 posts is coordinated through BSO for several of the professions. This requires further development to ensure a responsive recruitment process.

Further work is required to support the development of advanced practice across the AHP professions, as some professionals have highlighted issues with succession planning for the future at higher bands. An advanced practitioner framework is being developed to support this practice.

The services of all AHP professions are under pressure with capacity and high levels of maternity leave. This impacts on services and reduces the ability to respond to waiting lists in a timely way.

Temporary staffing is difficult to address through regional recruitment or agency working as there are not the clinical skills available for specific roles.

Due to the very diverse nature of clinical areas there is not the ability to use a bank system to backfill some posts.

There are many opportunities for the skills of AHPs to contribute to the transformation agenda, but this requires specific specialist training and competences. In respect of upskilling, for example, AHP staff have received training to allow them to act as independent prescribers.

However, issues exist with executing this role after training as operational matters need to be addressed to maximise the new skills into clinical practice.

6. The AHP (allied health professional) workforce group encompasses a variety of roles under the umbrella term. Seven of the AHP professions (speech and language therapists, physiotherapists, radiographers – diagnostic and therapeutic dieticians, occupational therapy, podiatrists and orthoptists – are directly employed through HSC and the five other professions (art drama and music therapists, orthotists and prosthetists) are subcontracted into Trusts through various local arrangements.

SCIENTIFIC SPECIALISMS

Scientists work across health and social care in life sciences, physical sciences, physiological sciences and clinical bioinformatics. They deliver care directly to patients and also provide essential supporting and diagnostic services. Over 50 separate scientific specialisms are recognised nationally.

Increasing demand for healthcare science work has led to challenges in managing workloads in many areas. There is almost no area of clinical care which does not rely on scientific support for the delivery of services.

Scientific advances are a key driver of innovation in health and social care, leading to improved patient outcomes. It is essential to have a fully trained and sufficient scientific workforce in all areas to ensure that these benefits can be delivered in a timely way, particularly in the face of continued growth in demand.

Genomics will impact on a number of disciplines in the future. There will be a need for highly trained biomedical scientists and clinical scientists to implement and run the technology, and for bioinformaticians to interpret the results.

Best practice elsewhere points to the need for the development of regional subspecialist teams supported by effective technology, such as digital imaging. However, separate consideration will need to be given to the evolving roles of each specialism when developing a future workforce plan.

Pathology is one of the key areas in need of reform, as the current pathology service model does not lend itself to effective regional workforce planning. The lack of medical and scientific staffing in some Trusts, disparity in resource across the HSC pathology service and variable distribution of workload across the region, all present a risk to provision of equitable health services across the region including delays in the provision of cancer pathology diagnostics.

New technology, for example digital pathology can help alleviate problems with consultant shortage as part of a wider strategy and should be adopted by the HSC.

There is a need for new expert, advanced and consultant-level scientific roles for clinical and biomedical scientists to alleviate the pressure caused by consultant shortages and to maximise new technology; new training programmes are required to facilitate this. Northern Ireland currently has no funded training programme for clinical scientists, advanced biomedical scientists, or epidemiologists in public health.

OPHTHALMIC SERVICES

Throughout the UK, ophthalmic hospital departments are struggling to provide the service required by their population. Around a half of the units have unfilled consultant and/or SAS positions.

Over 90% are undertaking waiting list initiative surgery or clinics, with a similar proportion estimating that they require between one and five additional consultant ophthalmologists over the next two years.

The Royal College of Ophthalmologists predicts a 20–30% increase in workload over the next 10 years for the common ophthalmic conditions of the elderly. Ophthalmology is a high demand specialty, typically accounting for 10% of all outpatient and 5% of all inpatient/day case activity.

This demand is particularly susceptible to demographic pressures, new and emerging treatments and technologies, and a historical reliance on additional in-house and independent sector activity.

The Health and Social Care Board and Public Health Agency have undertaken exploratory discussions around ophthalmology workforce planning, intended to reflect significant developments in service provision, including the expansion of capacity and capability in primary care (optometry), already evidenced in community-based acute eye and glaucoma referral refinement schemes, and the expanded use of multi-disciplinary teams in secondary care.

AMBULANCE SERVICE

Annual turnover of Emergency Medical Technicians (EMTs) and trainees, and ambulance care attendants and trainees has traditionally been low, but is beginning to rise. External application rates for non-registered trainee posts are healthy, with no associated recruitment difficulties.

However, external application rates for registered posts (i.e. HCPC qualified paramedics) are relatively low. While the majority percentage of staff in paramedic and rapid response vehicle paramedic posts are currently below the age of 55, a significant percentage of paramedic line managers are 55 or over.

The Northern Ireland Ambulance Service HSC Trust (NIAS) has partnered with the Ulster University to develop a paramedic education programme of a level 5 Foundation degree in Paramedic Practice, with an anticipated commencement for the first cohort of October 2018. Initially, this programme will draw on existing NIAS EMTs as candidates. The Trust will continue to work with DoH in respect of the further developments in Paramedic Education which may potentially include a BSc qualification.

Consideration is also being given to the impact of the publication of a new Agenda for Change national profile for the role of Paramedic which reflects developments in the role in recent years.

Paramedics

There has been significant development in the Paramedic role including in terms of additional clinical skills and decision making. Paramedics make a valuable contribution to the wider health and social care system including through the introduction of Alternative Care Pathways, where patients may be referred to a more appropriate alternative path to transportation to Emergency Departments.

In continuing to transform and modernise its service, NIAS has also introduced new Paramedic services and roles including:

- The creation of a Clinical Support Desk, staffed by Paramedics, within Emergency Ambulance Control to triage lower acuity calls in order to consider suitability for emergency ambulance response or an appropriate alternative.
- The creation of HEMS (Helicopter Emergency Service) Paramedic roles for Paramedics who operate alongside clinicians on the new Northern Ireland Air Ambulance.
- The piloting of a new Community Paramedic role.

There are also potential opportunities for further benefits to be derived from Paramedics working in other settings such as emergency departments, out of hours centres, GP surgeries, in minor injury/illness centres, in remote medicine and a varied range of other environments.

Workforce Review

Workforce considerations for Paramedics and other ambulance roles will be considered in the DoH, newly initiated Workforce Review for the service, established in partnership with trade unions.

Ambulance response times

A demand and capacity review has been undertaken to determine the underlying capacity required to deliver ambulance response time performance for Northern Ireland, designed to meet Ministerial targets and the Trust's own performance objectives.

The review was structured to include the identification of internal efficiencies designed to optimise performance using existing resources against an accurate demand analysis projected forward to 2020. The review also considered detail on the optimal rostering and deployment of that additional resource.

The modelling assessed the best performance that can be achieved with existing resource against current and projected response targets. After the consideration of all efficiencies, the remaining gap was identified and a detailed examination given of the resource required to bridge that gap.

This identified a requirement to significantly increase the numbers of Paramedics and EMTs, which in turn will have a significant impact on recruitment and training needs in the short term. The results of the demand and capacity analysis are now being considered by NIAS in partnership with Department of Health and Commissioners.

HSC ADMINISTRATIVE AND CLERICAL WORKFORCE

Administrative and clerical staff occupy roles both in direct and indirect frontline services, for example reception services, patient records and business support functions such as finance, HR and IT. Within HSC organisations this group of staff is often targeted with regard to efficiency savings and therefore, despite increases in most other HSC staff groups to meet increased demand for services, staff numbers had changed little in recent years.

As with many other staff groups, administrative and clerical staff report not being able to meet the conflicting demands of their work. A high portion of administrative and clerical staff also report working additional unpaid hours. At March 2017 HSC organisations had around a 4% vacancy rate in the administrative and clerical workforce and, as such, agency workers are being utilised.

HSC ESTATES AND SUPPORT SERVICES

Estates services staff (e.g. electricians, plumbers, engineers etc.) are a mostly male (97%) workforce, with little part-time working currently and over half aged 50+. The staff survey responses highlight issues with lack of appraisals and feedback from managers, not feeling valued, conflicting demands of work, issues of having inadequate materials and supplies to do their jobs and not having enough staff in teams. This staff group also report a high proportion working additional paid and unpaid hours.

The Support Services staff (e.g. catering, cleaning, drivers, porters etc.) are comprised of around 60% females and 40% males, with almost half aged 50+. Two thirds work part-time. This workforce also experiences high levels of sickness absence with injury, fracture and musculoskeletal issues being prevalent reasons for absence. Staff survey results also highlight low levels of appraisals, management feedback and engagement with staff about decision-making.

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Health and Social Care Workforce Strategy 2026 - Delivering for our People

Second Action Plan (2022-23 to 2024-25)

The 'Health and Social Care Workforce Strategy 2026 – Delivering for our People' was published in May 2018. It acknowledged that the people who work in Northern Ireland's health and social care system – whether employed by the statutory Health and Social Care (HSC) organisations, independent contractors, or as our partners in the voluntary and community sector – are the system's greatest strength, working ever harder to provide the care needed by patients and service users.

The experiences of the last two years has demonstrated to me that the system simply could not function without the skill, dedication and commitment of our talented, hard-working colleagues, across all disciplines, professions and levels.

The aim of the Workforce Strategy is that by 2026 "we meet our workforce needs, and the needs of our workforce". In practice, this means ensuring that a transformed health and social care system has the right numbers of appropriately-trained staff, with the right skills mix; and that the Department and employers create the conditions so that health and social care becomes an employer, and a trainer, of choice.

The Strategy's first action plan, while impacted by the pandemic, has delivered significant progress in a range of areas. However many of the challenges previously identified remain and further challenges have emerged as a result of the pandemic's effects. This second action plan, covering the three year period from 2022/23, has been developed in partnership with colleagues and stakeholders from across the health and social care system. It seeks to address our workforce challenges through an ambitious series of actions that will be taken forward over the next three years.

I have often said that an increased and sustained investment is necessary to support our ambitions for the health and social care workforce and to ensure full implementation of this second action plan. The Department of Health currently faces a very challenging financial position and I am on record as warning that funding pressures in health may be significant by the second half of 2022/23 with the

financial situation undoubtedly being constrained whatever the final budget settlement.

My ability to plan strategically is being significantly impaired by the ongoing budgetary uncertainty and my Department does not currently have the funding necessary to deliver all of the actions which have been identified as necessary by stakeholders. My Department will continue to do the best it can to deliver on these actions with the resources available, however, in the absence of significant additional funding a further process to identify actions of the highest priority for progression will be required.

Health Minister Robin Swann

Introduction

The 'Health and Social Care Workforce Strategy 2026: Delivering for Our People' was published in May 2018. The aim of the Strategy is that '**by 2026, we meet our workforce needs and the needs of our workforce'.**

To achieve this aim, we need to meet three objectives:

1. The reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise;
2. Health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported; and
3. The Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.

The Strategy was developed by the Department of Health through detailed engagement with colleagues from across the HSC and independent, voluntary and community sector healthcare providers and trade unions, and covers the period 2018 to 2026.

To enable flexibility in delivery over the life of the Strategy, three consecutive action plans will be developed. The first action plan which covered the period 2018 to 2020, despite being impacted by the pandemic, delivered progress in a number of significant areas. These included:

- commissioning by the Department of the highest ever number of pre-registration nursing and midwifery places at 1,325;
- delivery of an international nurse recruitment process which by December 2020 had recruited a total of 647 nurses, of which 593 remain in post;

- the delivery of an ongoing programme of workforce reviews, each utilising the Regional HSC Workforce Planning Framework six step methodology;
- the move to a Programme of Care approach to workforce planning in these reviews;
- the introduction of the Physician Associate role across the HSC;
- delivery of measures by each HSC Trust to support health and wellbeing of staff;
- movement of doctors in training to a single employer arrangement;
- introduction of processes that have reduced the time taken during recruitment from point of receipt into the HSC Recruitment Centre until final offer; and
- alignment of the HSC staff survey with the Workforce Strategy to ensure information is available to better measure progress against intended outcomes.

Our response to the pandemic has delayed the formal development of the second action plan with the Department completing an internal review of progress in the autumn of 2020 which identified a series of actions for progression from the beginning of 2021 with a view to them being incorporated into the formal second action plan.

The Department has worked collaboratively with colleagues from across the health and social care sector in recent months in the development of this second action plan with a particular focus on:

(i) building on the first action plan, continuing to address issues contained in the first action plan that remain relevant while ensuring these are refreshed where necessary to accurately address the current situation;
(ii) considering new actions specifically arising from the experiences of the pandemic; and
(iii) assessing additional actions relevant to an ever evolving health and social care system.

The result of this collaborative engagement is the second action plan outlined below which identifies actions for delivery over the next three years (2022/23 to 2024/25).

The second action plan identifies an ambitious range of strategic actions for progression over the next three years which is reflective of the breadth and content of feedback received from stakeholders, providing the mechanisms, strategic context and flexibility within which the objectives of the Strategy can be progressed.

It is recognised that the full implementation of this second action plan will require additional funding over the next three years at a time when we face a very challenging financial position. Securing this funding will not be easy or straightforward but the Department is committed to exploring every opportunity going forward to secure additional funding as the costs of implementation become clearer.

Health and Social Care Workforce Strategy: Delivering for Our People – Second Action Plan (2022-23 to 2024-25)

Timescales for delivery	2022/23	2023/24	2024/25
	Ongoing actions to be delivered across the period to 31/03/25		

Objective 1 - The reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise

Theme/Action	Outputs	Lead organisation	Funding position
Theme 1 – Attracting, recruiting and training Action 2.1 - Invest and establish a robust infrastructure within the HSC which promotes health and social care careers and supports future workforce planning WHY? • To help ensure a good supply of people in the future. • To inform and excite people on the range of jobs and professions. • To publicise health and social care as a career option, with properly mapped career pathways, developed in partnership with existing members of the workforce. • Focus on the skills developed within areas and locations which have recruitment difficulties. • To provide volunteering and work experience opportunities. • Will act as a single point of contact for new recruits and experienced returners.	HSC organisations will work collaboratively with schools and the further education sector with a prime aim to actively promote and encourage students to join the HSC family and become our workforce for the future. This will be achieved by:	HSC Employers	
	(i) using a blended approach including showcasing HSC at targeted career related events/conferences and campaigns including the use of virtual platforms (ongoing to 31/03/25)		can be partially implemented but will also require additional funding to ensure full implementation
	(ii) development and roll out of an agile marketing campaign with consistent HSC wide branding [Approximately 6 months from funding being identified to development of campaign]		requires additional funding
	(iii) developing links with other interested partners and stakeholders in the use of their digital space and develop profession specific materials and resources to increase awareness		can be partially implemented but will also require additional funding to ensure full implementation

	and promotion of the wide range of HSC roles (ongoing to 31/03/25)		
	(iv) investing further in the development of jobs.hscni.net to enhance its presence and improve the impact [Approximately 12 months from funding being identified to implementation of this output]		requires additional funding
Theme 1 – Attracting, recruiting and training Action 2.2 - Development and rollout of specific campaigns to showcase particular professions and support recruitment WHY? • To promote opportunities within specific professions that require focussed recruitment initiatives.	Focussed campaigns to showcase and support recruitment into a career in social care including healthcare support workers [Approximately 9 months from funding being identified to implementation of this output]	Social Care Directorate (DoH) / NI Social Care Council	requires additional funding
	Focussed campaign to support recruitment into Children and Family social work as a way of addressing the increasing challenges of recruiting and retaining social workers within this sector [Approximately 12 months from funding being identified to implementation of this output]	Social Care Directorate (DoH) / NI Social Care Council	requires additional funding
	Identify other professions suitable for similar focussed campaigns through recommendations arising from workforce reviews (ongoing to 31/03/25)	Workforce Policy Directorate (DoH) and Chief Professional Officers (DoH)	can be partially implemented but will also require additional funding to ensure full implementation

Theme 1 – Attracting, recruiting and training Action 2.3 – Explore new and alternative opportunities that may provide a recruitment and training pathway to a career in the health and social care system WHY? • To broaden the potential supply of people. • To provide career progression and development pathways to both new recruits and also existing HSC staff.	Convene cross HSC apprenticeship working group to scope health and social care and business support professions and roles that may be suitable for (i) Level 2/3 and (ii) Higher Level Apprenticeship programmes with view to also establishing career development pathways (by 30/06/22)	HSC Employers	can be fully implemented without additional funding
	Liaise with relevant stakeholders to explore most appropriate funding models for HSC apprenticeship programmes (by 31/03/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Scope potential application of existing apprenticeship frameworks i.e. pharmacy services, dental nursing and social care (by 31/03/23)	HSC Employers	can be fully implemented without additional funding
	HSC apprenticeship working group to engage with Healthcare Sectoral Partnership established by DfE to develop new (i) apprenticeship frameworks and (ii) apprenticeship programmes for identified professions, subject to appropriate funding models being established [Ongoing development once funding secured]		requires additional funding
	Develop proposals to harness the supply of psychology graduates to support the Clinical Psychology workforce (by 31/03/23)		can be partially implemented but will also require additional funding to ensure full implementation
	Examine opportunities to support and utilise employability academies		can be fully implemented without additional funding

	designed to facilitate the recruitment of staff i.e. social care (by 31/03/23)		
	Examine opportunities to develop and utilise existing trainee schemes to provide Level 1 entry into healthcare and business support professions with view to establishing career development pathways (by 31/03/23)		can be fully implemented without additional funding
	Develop a social work trainee scheme [Approximately 24 months from funding being identified to implementation of this output]	Social Care Directorate (DoH)	requires additional funding
Theme 1 – Attracting, recruiting and training Action 2.4 – Develop innovative approaches to support the recruitment and retention of social workers to address the workforce challenges within this sector WHY? • We need to deliver sufficient numbers of social workers to meet identified demand and ensure compliance with statutory functions. • Recruitment pressures within Children and Family social work services remain acute, impacting upon the delivery of delegated statutory functions. • There is a need to create adequate capacity within front line teams to meet increasing demands for services.	Establish a Social Work Workforce Implementation Board to progress initiatives to support the recruitment and retention of social workers (ongoing to 31/03/25)	Social Care Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Develop a strategy to secure and retain a stable, skilled and motivated Children and Family social work workforce to ensure the appropriate mix of staff with the appropriate skills to deliver safe and high quality social work services (ongoing to 31/03/25)	Social Care Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation

Theme 1 – Attracting, recruiting and training Action 2.5 – Establish structures to oversee the implementation of recommendations arising from workforce reviews WHY? • Ensures focus is retained on recommendations arising from workforce reviews with view to developing implementation frameworks for delivery.	Oversee implementation of the recommendations of the 2020 Pharmacy Workforce Review (ongoing to 31/03/25)	Pharmaceutical Advice and Services Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Establish structures to oversee recommendations arising from rolling programme of workforce reviews (ongoing to 31/03/25)	Chief Professional Officers (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.6 – Explore opportunities to recruit health and social care professionals from other jurisdictions WHY? •Provides an additional source of registered health and social care professionals.	Undertake international nurse recruitment programme to complement workforce (ongoing by 31/03/25)	Business Services Organisation	can be partially implemented but will also require additional funding to ensure full implementation
	A project to scope potential for international recruitment in other health and social care and social work professions including Pharmacy, Allied Health Professionals and Children and Family social workers [Project will complete within 12 months once funding is identified]		requires additional funding
	Develop initiatives to attract NI domiciles trained in GB to pursue a career in the HSC [Project will complete within 12 months once funding is identified]	Workforce Policy Directorate (DoH)	requires additional funding
	Scope feasibility of a streamlined	Strategic Planning and	can be fully implemented

	process for recently trained GPs from ROI obtaining entry onto the NI Primary Medical Performers List (ongoing to 31/03/25)	Performance Group (DoH)	without additional funding
	Developing an agreed regional process, including guidance documentation, to facilitate the creation of an approved employer to enable retention of recently qualified international GP graduates (ongoing to 31/03/25)	Strategic Planning and Performance Group (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.7 – Provide opportunities for former staff to return to the HSC WHY? •Provides an additional source of registered health and social care professionals.	Establish focussed process to facilitate recruitment of staff returning to the HSC (by 31/12/23)	Chief Professional Officers (DoH) / Strategic Planning and Performance Group (DoH) / HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.8 – Explore and establish non-salary incentive programmes as a means of recruiting and/or retaining and/or dealing with pressures in less popular specialties and locations WHY? • We are experiencing difficulties in filling certain posts. • Need new innovative ways to recruit and retain. • Addressing supply and location issues should ultimately reduce reliance on agency	Undertake focussed consultation with HSC staff to establish non-salary incentives attractive to specific professions and locations (by 31/03/23)	Workforce Policy Directorate (DoH) / HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation
	Utilise the findings of the above consultation to explore feasibility of implementing identified non-salary incentive programmes [Project will complete within 9 months once funding is identified]		requires additional funding
	Development of Return on Service obligation initially for BSc paramedics course with extension to other professions (commencing with an		can be fully implemented without additional funding

and locum workers. • Such a policy can be linked to return of service obligations – establishing a new two way commitment between HSC employers and trainees.	assessment of the feasibility of a Return on Service commitment for doctors) (by 31/03/23)		
	Cross HSC working group to develop agile, flexible and hybrid working people strategies (by 31/12/23)		can be fully implemented without additional funding
	Continued engagement on Agenda for Change terms and conditions (ongoing to 31/03/24)		can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.9 – Explore and establish incentive programmes as a means of recruiting and retaining across health and social care with a particular emphasis on less popular specialties and locations WHY? • We are experiencing difficulties in filling certain posts. • Need new innovative ways to recruit and retain. • We need to provide a particular focus on our existing staff with view to creating the conditions that maximise retention.	Establishment of a Fair Work Forum for Social Care which will consider how pay and conditions of the social care workforce can be improved across all sectors (by 31/12/22)	Social Services Policy Group (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Develop & deliver initiatives to support the specific retention of experienced health and social care professionals [Project will complete within 12 months once funding is identified]	Workforce Policy Directorate (DoH) / HSC Employers	requires additional funding
	Develop initiatives to support retention within all health and social care professional groups [Ongoing initiatives once funding is identified]	Workforce Policy Directorate(DoH) / Chief Professional Officers (DoH) / HSC Employers	requires additional funding
Theme 2 – Sufficient availability of high-quality training and development Action 2.10 - Commissioning of sustainable training programmes that are aligned to meet current and future health and social	Undertake a review of funding arrangements required to support workforce reviews undertaken to inform the process of strategic workforce planning (by 31/12/22)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Undertake review of Supplement for		can be fully implemented

care requirements for multidisciplinary service delivery; and Action 2.11 - Commissioning of time-protected, appropriately located, sustainable post-registration training programmes, and development opportunities for more experienced people, including consideration of preceptorship arrangements to smooth the transition from training to practice WHY? • Values the needs of students and workers. • We need a sustainable approach to planning for, and funding, training for pre-registration students, to ensure that health and social care is fit for purpose by 2026. • This will take account of revisions to the various curriculums. • Smooth the transition from education environment to the realities of delivering health and social care, and the characteristics/skills required to do so. • Reduce reliance on agency and locum workers. • We need a sustainable and transparent approach to planning for, and funding, training for post-registration students, to ensure that health and social care is fit for purpose by 2026.	Undergraduate Medical and Dental Education (31/12/23)		without additional funding
	Ongoing development and delivery of a rolling, prioritised programme of workforce reviews to inform the process of strategic workforce planning with an increased focus on planning by Programme of Care and integrated care pathways aligned to the health and social care Transformation Programme. This should address multidisciplinary and inter-professional aspects of service delivery and training, including paramedics, with costed implementation plans for recommendations (ongoing to 31/03/25)		can be partially implemented but will also require additional funding to ensure full implementation
	Produce a policy on departmental commissioning of training and development for health and social care (i) with emphasis on the requirement for multi-disciplinary service delivery and (ii) within a three year training budget plan (by 31/03/24)		can be fully implemented without additional funding
	Undertake review of medical training places (by 31/12/23)		can be fully implemented without additional funding
	The Department will undertake a review of post registration education and training arrangements to include Medical, Pharmacy, Social Work, Nursing and Midwifery and Allied Health Professionals (by 31/03/23)		can be fully implemented without additional funding
	Produce a costed implementation plan		can be partially

	for recommendations contained within existing workforce reviews with view to commissioning (i) additional pre-registration training programmes and (ii) additional post-registration and Medical Specialty Training within a three year training budget plan (by 31/03/23)		implemented but will also require additional funding to ensure full implementation
	Working with employers, the Department will review the potential of maximising the contribution of vocational learning, commencing with the existing nursing and social care workforce, to ensure the workforce develop and retain necessary skills (ongoing to 30/06/24)		can be partially implemented but will also require additional funding to ensure full implementation
	Examine the feasibility of developing preceptorship arrangements within professions (ongoing to 31/03/24)	Chief Professional Officers (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Continue to align and support a collective leadership culture within the HSC through the full implementation of the HSC Collective Leadership Strategy (ongoing to 31/03/25)	HSC Employers	can be fully implemented without additional funding
Theme 2 –Sufficient availability of high–quality training and development Action 2.12 – Develop a system-wide innovative approach to enhance the attractiveness of the HSC medical education programmes as a way of addressing the increasing challenges of	Undertake assessment of attrition rates from medical foundation training to medical specialty training in Northern Ireland (by 31/12/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Working with employers and medical training partners, the Department will develop innovations to make the HSC an attractive place to train and remain		requires additional funding

attracting doctors into specialty training programmes after completion of their foundation training WHY? •We need to ensure there are sufficient doctors available to meet identified demand across all specialties and services.	[Ongoing initiatives once funding is identified]		
	Develop focussed initiatives to attract Northern Ireland domiciled students who have completed undergraduate training elsewhere to return for post graduate training [Ongoing initiatives once funding is identified]		requires additional funding
	Undertake review of GP training programme with view to enhancing retention of trainees in Northern Ireland (by 31/12/23)		can be fully implemented without additional funding

Theme 3 – Effective Workforce Planning Action 2.13 – Develop, and by 2026 sustainably fund, an optimum workforce model for reconfigured health and social care services that utilises the findings of our strategic workforce planning to provide a system wide view of workforce requirements WHY? •We need a strategic, coherent, dynamic workforce framework that clearly outlines the people and skills required to meet service and population needs across the region in 2026. This should take account of population needs and demographic trends. • We need a product that collates and coordinates the findings from the various prioritised workforce reviews that are regularly carried out for every profession and discipline and as part of transformation initiatives that are ongoing. The optimum workforce model will be this product. • The optimum workforce model will adopt a number of key principles, including the need for multidisciplinary and inter-professional working.	Working with clinical leads and other relevant stakeholders, the Department will design a robust methodology for an Optimum Workforce Model. This will utilise outputs from the workforce reviews undertaken for the purposes of strategic workforce planning to provide a system wide view of workforce requirements across the reconfigured health and social care system (ongoing to 31/12/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Utilise outputs from the prioritised workforce reviews undertaken for the purposes of strategic workforce planning on an ongoing basis to populate the agreed Optimum Workforce Model with view to developing a system wide view of workforce requirements (ongoing to 31/03/25)	Workforce Policy Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 3 – Effective workforce planning Action 2.14 - By fully implementing and embedding the Regional HSC Workforce	Continue to ensure that the six-step methodology is fully embedded into workforce planning practices, including use of population health, disease profile	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

Planning Framework (six-step methodology), ensure that this is supported by necessary resources and underpinned by a multidisciplinary ethos across all providers WHY? • Consistent, evidence-based regional approach to workforce planning. • Need to review adequacy of training across all HSC providers.	data etc. (ongoing to 31/03/25)		
Theme 3 – Effective workforce planning Action 2.15 – Development of proposals to reduce agency dependency across the HSC WHY? •Reduce reliance on agency/locum workers leading to reduced agency/locum expenditure. •Redirect resources to the delivery of permanent HSC staff.	Implement a new procurement framework for agency staff (by 30/9/2022)	Business Services Organisation (BSO)	can be fully implemented without additional funding
	Working with HSC employers and stakeholders, the Department will identify a range of additional mechanisms to support a significant reduction in 'off contract' agency expenditure (by 30/9/2022)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Implement agreed mechanisms with a view to these activities contributing to a commencement of savings (from October 2022)	Organisations across HSC	can be partially implemented but will also require additional funding to ensure full implementation
Theme 3 – Effective workforce planning Action 2.16 – Development of legislation and consider the resource required to ensure safe staffing within health and social care settings	The Department in partnership with Trade Unions and Key Stakeholders to discuss and agree appropriate legislative options including appropriate primary legislation for safe staffing across all Health and Social Care settings (by 31/12/22)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

WHY? •Ensure safe staffing levels are maintained across all health and social care settings including paramedics. •Provide increased assurance for patient safety.	Develop a safe staffing policy that is inclusive for those working in Health & Social Care settings including the NI Ambulance Service (by 30/06/23)	Workforce Policy Directorate (DoH) / Chief Professional Officers	can be fully implemented without additional funding
	Develop appropriate secondary legislation including staff calculation methods that can be implemented in specific Health & Social Care settings (by 30/06/24)		can be partially implemented but will also require additional funding to ensure full implementation
Theme 3 – Effective workforce planning Action 2.17 - We take account of, and plan for, the workforce implications arising from the UK's exit from the EU and the subsequent implications for the EU/EEA and non-EU/EEA WHY? •Need to take account of the implications for workforce supply, frontier workers, mutual recognition of professional qualifications, international recruitment, borders agency, immigration quotas and shortage occupation lists.	Consider appropriate arrangements for the regulation of healthcare professions delivering services or undertaking training on the island of Ireland (by 31/12/23)	Workforce Policy Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 4 – Multi- disciplinary and inter-professional working and training Action 2.18 - Planning for and introducing new roles WHY?	Support UK wide work to secure statutory regulation and prescribing rights for Physician Associates (by 31/03/24)	Workforce Policy Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Complete full review of the Physician Associate pilot programme (by 31/12/23)		can be fully implemented without additional funding

• Need to develop and integrate new ways of working and jobs across health and social care. • Need to ensure that the appropriate skills mix is in place. • New roles need to be evidence-based, with clarity on outcomes of what new roles will contribute and achieve. • Strategic development of new roles facilitates transfer of best practice across professions.	Develop of a NI-wide strategy for utilisation of Physician Associates, along with the associated funding stream (by 31/12/24)		can be fully implemented without additional funding
	Support UK wide work to secure statutory regulation and prescribing rights for Pharmacy Technicians (by 31/03/24)		can be partially implemented but will also require additional funding to ensure full implementation
	Cross HSC working group to develop a formal process and criteria for the identification and development of new roles (by 31/12/22)	Workforce Policy Directorate (DoH) and Chief Professional Officers (DoH)	can be fully implemented without additional funding
	Undertake a needs analysis of new roles required across all health and social care professions commencing with Advanced Practitioner (Paramedic), Assistant Practitioner (Radiography) and Social Work Assistant (by 31/12/23)		can be fully implemented without additional funding
	Development of appropriate models for delivery of recruitment, training and practice frameworks for identified new roles, including identification of associated funding [Ongoing development once funding secured]		requires additional funding
Theme 4 – Multi- disciplinary and inter-professional working and training Action 2.19 - Develop multi-disciplinary, cross-sector working that will characterise the delivery of collective, compassionate	Cross reference the work of and seek input from relevant forums, working groups and reviews being undertaken in this area across health and social care to ensure alignment with the Workforce Strategy (among others):	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

care in the future WHY? • Effectively utilising skills and resources to deliver collective compassionate care. • Streamlining care pathways across locations and teams. • Addressing increasing incidence of co-morbidities in an ageing population. • Need to ensure that role of multidisciplinary teams in transformation of delivery of health and social care services is clear and embedded in all undergraduate health and social care courses.	- Reshaping Stroke Care - Review of Neurology Services - Review of Urgent and Emergency Care - Regional Medical Imaging Board - Mental Health Strategy - Future Planning Model - Cancer Strategy for NI - Children Services Review (ongoing to 31/03/25)		
Objective 2 - Health and social care is a fulfilling and rewarding place to work, and our people feel valued and supported			
Theme 5 - Building on, consolidating and promoting health and wellbeing Action 2.20 - Working with employers and all those who work in the health and social care sector and trainee representatives, the Department and commissioners will produce an HSC staff health and wellbeing framework, with the aim of assisting staff to remain physically and mentally well at work	Complete audit of existing health and wellbeing services and procedures (by 31/09/22)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Establish working group, aligned to the Regional Health and Wellbeing Network to produce a HSC staff health and wellbeing framework that will support employers in planning and implementing effective processes and resources for improving staff health, wellbeing and safety at work (by	HSC Employers / Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

WHY? • Investment in health and wellbeing services for the workforce reduces sick absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure).	31/12/22)		
	Ongoing development and implementation of initiatives to proactively support staff across health and social care to remain physically and mentally well at work (ongoing to 31/03/25)	HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation
	HSC Employers will work to develop and support sustainable initiatives to build a diverse and inclusive workforce where all colleagues are valued, listened to and through active involvement can contribute to decision making (by 31/12/23)		can be partially implemented but will also require additional funding to ensure full implementation
	HSC employers will work with Trade Unions to co-produce a regional policy for dealing with disciplinary matters in accordance with a just culture approach (by 31/12/22)		can be fully implemented without additional funding
Theme 5 - Building on, consolidating and promoting health and wellbeing Action 2.21 - Commissioning and establishment of sustainable occupational health services WHY? • Investment in occupational health services for the workforce reduces sickness absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure). • This will also act as a model for new occupational health services for use by the	Complete audit of existing occupational health services (by 30/09/22)	Workforce Policy Directorate (DoH) / Chief Nursing Officer	can be fully implemented without additional funding
	Complete an occupational health workforce review with view to the creation and implementation of a multidisciplinary occupational health workforce plan across the HSC that addresses the impact and learning from the Covid 19 pandemic (by 31/03/23)		can be partially implemented but will also require additional funding to ensure full implementation
	Re-instate the occupational medicine speciality training programme [Project will complete within 12 months once funding is identified]		requires additional funding
	Scope the requirements for an occupational nurse training programme		requires additional funding

wider public and private sectors.	[Project will complete within 12 months once funding is identified]		
	Establish working group to appraise options for the more effective delivery of occupational health services to the wider health and social care sector, and subsequently other Northern Ireland industry sectors (by 31/12/24)		can be fully implemented without additional funding
Theme 6 – Improved workforce communication and engagement Action 2.22 - Establish processes and procedures to ensure that information flows freely across organisations/systems and that employees are kept abreast of developments WHY? • Addresses concerns raised in previous staff surveys and in the fieldwork for this strategy. • Allows for staff networks/forums to discuss such matters which are common across all sectors and bands. • Allows for coherent messages on health and social care developments, including transformation and industrial relations.	Complete audit of existing processes for communication with staff across the HSC (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Processes and procedures co-produced and fully embedded (by 31/12/24)		can be partially implemented but will also require additional funding to ensure full implementation
	HSC organisations will co-produce formal mechanisms with staff and Trade Unions to ensure consistent communication and engagement mechanisms embedded across the HSC (by 30/06/24)		can be fully implemented without additional funding
Theme 6 – Improved workforce communication and engagement Action 2.23 - Co-produced staff appraisal and engagement project and rollout of recommendations	Complete audit of existing staff appraisal and engagement processes (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Working with staff and Trade Unions, HSC organisations will undertake a review of staff appraisal and engagement practices with view to		can be fully implemented without additional funding

WHY? • Allows for coherent action to address staff concerns in relation to: -Team working -Appraisal -Personal development -Knowledge and Skills Framework -Organisational / leadership culture (address high pressure cultures and how these can create high stress cultures and ultimately low morale).	developing and implementing a regional staff appraisal and engagement framework that formally incorporates health and wellbeing within the appraisal process (by 31/12/23)		
Theme 6 – Improved workforce communication and engagement Action 2.24 - Working with employers and the workforce and trainee representatives, the Department and commissioners will produce a set of standards that all HSC staff can expect in terms of facilities WHY? • Addresses staff concerns in relation to food/drink/rest break facilities.	Develop and implement an updated HSC staff facility policy [Policy will be developed within 12 months once funding is identified. Implementation of policy will be dependent on funding being available]	Infrastructure and Investment Directorate (DoH) and HSC Employers	requires additional funding
Theme 7 – Recognising the contribution of the workforce Action 2.25 - Design and implementation of	Complete audit of existing recognition initiatives (31/12/22)	HSC Employers	can be fully implemented without additional funding
	Working with staff and Trade Unions, HSC organisations will develop and		requires additional funding

co-produced policy on recognition initiatives WHY? • Valuing the contribution that all make to delivering excellent, compassionate care. • Devolving decision-making to the appropriate levels, including locally where possible. • Supporting the workforce to achieve success, and to feel valued and supported. • Allows for coherent action on possible introduction/use of: -Advanced Information and Communication Technology. -Co-production leading to greater staff involvement in decision-making. -Sufficient freedom to display initiative and make decisions. -Proper supervision. -Opportunities for training and development at all grades, and not just tied to promotion. -Agreed job rotation. -Opportunities for educational leave, etc.	implement a regional framework on recognition initiatives [Development will complete within 12 months of funding being identified; implementation of framework will be dependent on funding]		
Theme 8 – Work-life balance Action 2.26 – As part of a four nations approach, HSC organisations will carry out a HSC wide review of flexible working practices in Northern Ireland, in partnership with staff and Trade Unions WHY?	Adopt Section 33 Agenda for Change Handbook arrangements within HSC (from 01/04/22)	Workforce Policy Directorate (DoH) / HSC Employers / Trade Unions	can be fully implemented without additional funding

• Recognises the needs of the workforce such as those with dependent relatives and/ or caring responsibilities, whilst balancing the requirements of the service. • Support the workforce to access their work remotely where appropriate. • Also will provide clarity around working time regulation/sleepover duties/working hours in 24-hour service. • There is a need to develop working patterns which are reflective of the demographics of the workforce.			
Theme 9 – Making it easier for the workplace to do their jobs Action 2.27 - Simplification of employment arrangements, for example, explore whether a single employer for all HSC staff is feasible and will produce benefits for staff/patients/clients WHY? • To provide clarity and remove duplication and possibility for error/confusion in relation to payroll, generic training, etc.	Completion of lead employer project for doctors in training (by 31/03/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	The Department and relevant stakeholders will complete a formal evaluation of the lead employer project for doctors in training and produce recommendations on the feasibility of creating a single HSC employer for doctors (by 31/12/23)		can be fully implemented without additional funding
	Produce a costed implementation plan for recommendations contained within evaluation [Plan will be developed within 3 months once funding is identified]		requires additional funding
	Scope feasibility of a possible single HSC employer [Project will complete within 12 months once funding is identified]		requires additional funding
Theme 9 – Making it easier for the	Comprehensive workforce engagement	Business Services	can be fully implemented

workplace to do their jobs Action 2.28 - Continue to develop workforce engagement projects for the introduction of new technologies and systems, including e-health initiatives, Encompass etc., which are designed to support the workforce in doing their jobs WHY? • Some parts of the workforce do not feel sufficiently involved in design and roll-out of new technology and systems.	plans to be developed as part of design and implementation of new technologies and systems (ongoing to 31/03/25)	Organisation / Project Leads	without additional funding
Theme 9 – Making it easier for the workplace to do their jobs Action 2.29 – Establish processes and procedures to ensure the design and delivery of learning, development and training in a comprehensive, accessible and timely manner WHY? • Ensure modern technologies are utilised in the delivery of comprehensive and accessible learning, development and training to staff across all HSC settings.	Establish a cross HSC working group to scope the feasibility of developing a new Learning Management System, utilising learning from the pandemic and modern learning technologies, to deliver modern and responsive learning and training needs across the HSC (by 31/03/23)	HSC Employers	can be fully implemented without additional funding
	Produce a costed implementation plan for recommendations [Plan will be developed within 9 months of resources being identified]		requires additional funding
Theme 9 – Making it easier for the workplace to do their jobs Action 2.30 – Establish processes and procedures to ensure safe recruitment practice is managed in as short a time as possible engaging the candidate throughout	Cross HSC working group to develop and design a replacement for the HRPTS system (EQUIP programme) ensuring the HSC adopts best practice and fully utilises modern technology opportunities (ongoing to 31/03/25)	Business Services Organisation (EQUIP)	can be partially implemented but will also require additional funding to ensure full implementation
	HSC Employers and BSO Shared	HSC Employers /	can be fully implemented

the journey WHY? Eradicate unnecessary delays in filling vacancies.	Services will complete a full review of the HSC recruitment model and process to scope the opportunities for improvement and inform the subsequent implementation programme. This review will align and support the business change required to support implementation of the EQUIP Programme (by 31/12/22)	Business Services Organisation	without additional funding
	Develop and progress the implementation plan for improvement of the HSC recruitment model and process to achieve an improved experience for candidates and recruiting managers (by 31/12/24)		can be partially implemented but will also require additional funding to ensure full implementation
	Scope and procure necessary adaptions required to enhance existing HRPTS system in line with identified actions to improve timeliness and maximise candidate experience of the recruitment journey [Ongoing development once funding secured]	HSC Employers	requires additional funding
	Continue to develop streamlined approaches to recruitment of Health and Social Work students on the basis of learning acquired from pilot exercises completed during 2021 (ongoing to 31/03/25)	HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation

Objective 3 – The Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.			
Theme 10 – Improving workforce business intelligence Action 2.31 - Department to oversee and monitor exercise to examine where current gaps exist. This will involve collaboration with the relevant bodies to introduce data collections that we know to be missing e.g. gather more primary care workforce data, independent sector, etc. WHY? • We have a number of gaps in our business intelligence, which if closed would enhance workforce planning, allowing us to monitor workforce trends and issues effectively, and be able to take proactive action in the future.	Establish cross HSC working group to undertake audit of existing workforce data provision necessary for effective workforce planning across the health and social system (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Where data gaps are identified, scope the feasibility of introducing the recording and reporting of data (by 31/12/23)	HSC Employers / IAD (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 10 – Improving workforce business intelligence Action 2.32 - Explore workforce data systems and analytics software to inform more evidence-based decision making and solve problems WHY? • We need better business intelligence.	Utilise opportunities arising from the EQUIP programme to deliver enhanced, regionally consistent and interactive workforce analyses to stakeholder audiences enabling effective benchmarking and evidence based decision making with regard to workforce planning (ongoing to 31/03/25)	HSC Employers / Business Services Organisation (EQUIP)	can be partially implemented but will also require additional funding to ensure full implementation
	Explore opportunities arising from data systems and software across other health and social care areas to enhance workforce planning capabilities (ongoing to 31/03/25)	HSC Employers / IAD (DoH)	can be partially implemented but will also require additional funding to ensure full implementation

Theme 10 – Improving workforce business intelligence Action 2.33 - Align staff survey with workforce strategy to ensure information is available to measure progress against intended outcomes WHY? • We need better business intelligence from this source. • Need to maximise response rate.	HSC staff survey management group will meet regularly to develop and evaluate regular HSC staff surveys (ongoing to 31/03/25)	HSC Employers	can be fully implemented without additional funding
	Deliver HSC staff surveys aligned with the workforce strategy to provide data necessary to monitor intended outcomes [Surveys developed and delivered within 9 months of resources being identified]		requires additional funding
Theme 10 – Improving workforce business intelligence Action 2.34 - Roll-out of exit interviews for all staff leaving the HSC WHY? • Results of detailed and meaningful exit surveys can be monitored and fed into workforce planning processes and decision-making.	Establish cross HSC working group to develop a regional process and reporting mechanism for exit interview for staff leaving the HSC (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Develop implementation plan for the roll-out of exit interviews for all staff leaving the HSC including processes for utilising feedback to inform service design and retention initiatives [Plan can be developed within 9 months of resources being identified; implementation will follow]		requires additional funding

Oversight and Accountability

Oversight and accountability of the Workforce Strategy continues to be provided by a Programme Board which was established in 2018. The Workforce Strategy Programme Board is supported in this function by the Workforce Strategy Reference Group, with representation from relevant employers, trade unions and others, which provides advice and assurance to the Programme Board on progress.

During 2021 a new Workforce Strategy Unit was created within Workforce Policy Directorate in the Department. This Unit will be responsible for co-ordinating the Strategy with additional arrangements for the management and monitoring of implementation incorporated into the second action plan.

This will focus on the Workforce Strategy Unit working closely with stakeholders to identify and allocate leads for each action contained within the second action plan. Dedicated working groups, with appropriate representation from across the health and social system, will be convened with delivery plans and timeframes for implementation agreed for each output.

There is also a need for a consistent focus on the implementation of this action plan. A process of regular monitoring and reporting of progress against each identified output will also be undertaken by a focussed implementation group.

Together with continued input from the Reference Group, this process will enhance the Programme Board's ongoing management of the Strategy.

Funding

This second action plan has identified an ambitious and challenging range of actions and outputs for progression over the next three years. Many of the commitments can be taken forward without additional funding. Indeed, as a first step, many of the identified actions and outputs are to undertake scoping work to identify the most appropriate mechanisms for delivery, including costed implementation plans.

For other actions such as the commissioning of pre-registration and post-graduate training, the Department will continue to provide ongoing funding though it is recognised significant additional funding will also be required to grow our workforce to the required levels identified by our strategic workforce planning.

However, it is recognised that significant, additional, multi-year funding will be required to deliver the full challenging series of actions and outputs identified and the Department is committed to exploring all options to fund this second action plan, including the release of resources through service efficiencies and through seeking additional funding from the Executive. While this may have an impact on the pace of delivery, the Department believes it is right to be ambitious and, working with colleagues from across health and social care, we are committed to the implementation of this second action plan at the earliest opportunity.

Measuring Success

Achieving the actions in this action plan will be a good indicator of success in meeting our aim and objectives. But we must also take an evidence-based approach. A dedicated working group will be set up to produce and agree the performance indicators for the strategy, with this work to be completed by the end of September 2022. The performance indicators may include a mix of quantitative evidence, such as reductions in job/training vacancy rates and agency/locum spend, and qualitative measures such as those in staff surveys etc.

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

A Partnership for Care

Northern Ireland Strategy for Nursing and Midwifery

2010 - 2015

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A Message from the Minister

As Minister for Health and Social Care I have had many opportunities to witness first hand the immense impact that nurses, midwives and support workers have on the delivery of care across a range of settings. Traditionally nurses and midwives are seen as the guardians of care, working closely with patients/clients and their families twenty four hours a day, leading, managing and working in teams, advocating for patients and facilitating change and reform. It is this central role that is so vital to our health and social care system.

Nurses and midwives teach, support and nurture the professionals of tomorrow and remind us of the importance of the person, the patient and community that must be central to our services.

All of us, whether as patients or staff, want to be treated courteously, with dignity, respect, sensitivity and compassion. How we work and interact can have a real impact upon the experience of those who use our services, creating an environment where we can all take pride in the services that we offer. A considerable amount of progress has been made with the launch in 2008 of the patient experience standards, but we cannot be complacent, which is why I am delighted to see the needs of patients/clients reflected throughout this strategy.

I recognise that in health and social care our staff are the most important resource. While no one can deny that the current economic climate will present difficult choices and decisions I am optimistic that through working in partnership we will face these challenges together to improve the health and well being of the population in Northern Ireland.

Michael McGimpsey, MLA
Minister for Health, Social Services and Public Safety

Foreword by Chief Nursing Officer

Whatever your role within the family of nursing and midwifery this strategy is for you, it sets out our priorities for the next five years as we progress with drive and enthusiasm to achieve our vision of working in partnerships to meet the health and social care needs of our population.

In my role as Chief Nursing Officer I am fortunate to be able to spend time with members of the nursing and midwifery family throughout Northern Ireland observing the excellent work they do caring for patients and clients.

As nurses, midwives and support workers what we do affects every single person in our community. We welcome life, help people to make healthy choices, support those with a disability or chronic disease, and care for those who are terminally ill. In the past few years we have seen fundamental changes to the way our health and social care services work, with the establishment of the new Trusts, the Health and Social Care Board, Public Health Agency, Business Services Organisation and Patient Client Council. These organisational changes are designed to put the patient/client at the centre of our services and secure good health for the whole population.

The next five to ten years will bring an ever greater pace of change, and difficult choices – rather than wait passively for the tough choices to emerge, we must look ahead, act now and prepare for the future.

Martin E. Bradley

Martin Bradley
Chief Nursing Officer

Our Strategy

This strategy is the culmination of a range of work which has been undertaken in Northern Ireland in response to the Modernising Nursing Careers agenda and supports the Midwifery 2020 initiative. It has been developed in consultation with members of the nursing and midwifery family and patient representatives through a series of engagement workshops. Its development has been overseen by a steering group chaired by the Chief Nursing Officer.

This strategy has been developed under the four strategic themes of:

- **Promoting Person Centred Cultures**
- **Delivering Safe and Effective Care**
- **Maximising Resources for Success and**
- **Supporting Learning and Development.**

Based on the information obtained during the engagement workshops three key perspectives have been identified under each of the strategic themes. These will be used as lenses through which to view the strategy and achieve the vision. Each of the key perspectives is articulated at strategic, organisational and individual level to ensure that every nurse, midwife and support worker has a place in this strategy and can clearly see what it means for them.

Strategy Development

Trust Strategies

Reflected within the strategy are the themes contained within each of the five Health and Social Care Trust nursing and midwifery strategies which have been published during 2008/09, namely

Western Trust - Nursing ...Making a Difference – 2008 – 2012

Northern Trust – Our Futures, our journey – 2008 – 2012

South Eastern Trust – Nursing and Midwifery Strategy 2008 – 2011

Southern Trust – A passion for care – compassion for people 2009 - 2014

Belfast Trust – Striking the balance – 2009 – 2012

This strategy should be seen as a high level road map to guide the family of nursing and midwifery over the next five years. It is based on the principle that the contribution of every nurse, midwife and support worker is valued and has a part to play in ensuring the delivery of high quality safe and effective care to patients/clients. The strategic themes capture both the enduring values of nursing and midwifery as well a vision for the future.

This strategy will generate local action plans from each of the HSC Trusts, the Public Health Agency and DHSSPS and will also be adopted by the independent and voluntary and community sector.

The Strategic and Policy Context

It is an exciting and challenging time to be part of the nursing and midwifery family in Northern Ireland. The restoration of devolved government and the implementation of the Review of Public Administration have reshaped organisational and management structures. Throughout this unprecedented period of change the delivery of safe, high quality, effective and compassionate care has relied upon the family of nurses and midwives working across a diverse and wide range of settings with the aim of providing person centred care 24 hours a day 365 days of the year.

In addition to improved social conditions and public health successes, new drugs and technologies have contributed to the population living longer with people increasingly living with one or more chronic condition. Many of these conditions, such as cardiovascular disease, cancer, diabetes and chronic respiratory disease are linked by common preventable risk factors. Smoking, prolonged unhealthy nutrition, physical inactivity, and excess alcohol use are major causes of ill health within the population. As members of integrated, multidisciplinary teams nurses and midwives have important roles to play in working with patients/clients and their families in the prevention, treatment and management of chronic diseases from preschool through to old age.

The establishment of the new Public Health Agency, Health and Social Care Board and the Patient Client Council in April 2009 was driven by the need to improve the health and wellbeing of the people of Northern Ireland and reduce inequalities; as such the health and social care system should be proactive in working towards, anticipating and preventing health and social care problems rather than merely reacting to them. To achieve this there will be an increased focus on anticipatory care that crosses organisational boundaries. A self care approach will be adopted which will allow people with long term conditions to have access to improved information, education and support, as well as new technology aimed at enhancing home-based care. Similarly, health and social care organisations, local government and the independent, voluntary and community sectors will work together to ensure the person is placed at the centre of decision making processes and that safe and effective care services are increasingly delivered in the individuals home.

Changes in demographic trends and the aging population mean that increasingly more of the nursing workforce is employed in the independent / voluntary and community sectors. The review of the nursing and midwifery workforce conducted in September 2008 indicated that between 2000 and 3000 qualified nurses are currently employed within these sectors. It is therefore important that we recognise the knowledge; skills and experiences attained within these settings and cultivate a highly skilled and flexible workforce for the future.

The monitoring and inspection of the availability of health and social care services, including those within the independent sector is undertaken in Northern Ireland by the Regional Quality Inspection Authority (RQIA) who examine all aspects of the care provided and work to ensure public confidence in these services. In addition with the transfer of duties from the Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009, RQIA undertakes a range of responsibilities for people with a mental illness and those with a learning disability.

In Northern Ireland a range of policy initiatives, launched since 2002, have reflected the changing context of Health and Social Care and set the direction for future service delivery, namely:

- Developing Better Services: Modernising hospitals and Reforming Structures;
- Investing for Health;
- A Healthier Future: A Twenty Year Vision for Health and Wellbeing;
- Caring for People Beyond Tomorrow;
- The Review of Public Administration;
- Changing the Culture;
- The Bamford Review;
- Patient Client Experience Standards.

A summary of these documents is attached at **Appendix 1**

These policy documents and initiatives reflect the changing face of health and social care in Northern Ireland. Nurses and midwives must embrace the future opportunities and challenges that the professions face and exercise the direction outlined in this strategy to help shape the future.

Nursing and Midwifery in Northern Ireland

Nurses and Midwives are registered with the Nursing and Midwifery Council, with nursing subdivided into the four areas of adult, mental health, learning disability and care of children.

Pre–Registration Education

The students of today are the registrants of tomorrow. Effective educational programmes and mentorship will support and develop nurses and midwives for the future.

In Northern Ireland pre registration education is delivered by Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. Further information on these courses can be found on the relevant websites outlined below.

Queens University
www.qub.ac.uk/schools/SchoolofNursingandMidwifery

University of Ulster
www.science.ulster.ac.uk/nursing

Open University
www3.open.ac.uk/study/undergraduate/health-and-social-care/nursing/index.htm

Post Registration Practice

Consolidation period Post Registration - Guidance from the NMC recommends that all new registrants be afforded protected time in their first year of practice with the support of a preceptor. For midwives this period of consolidation culminates in a review process at which the progression from AfC band 5 to AfC band 6 takes place.

Career Progression

Following the consolidation period some practitioners will choose to specialise in a particular area of practice, whereas others will maintain a wider general focus. Both routes are of equal value. As nurses and midwives progress in their careers they will amass a portfolio of knowledge, skills and attributes with an emphasis on advanced decision making, advanced clinical skills, research, leadership and management.

Healthcare Support Workers

Health Care Support Workers are an important and valued part of our workforce and they play a key role in the delivery of safe and effective care across a range of settings.

In considering the roles and responsibilites of support workers there is more work required to obtain consensus on a number of areas including a common title for support workers at AfC bands 2 and 3, establishing a common level of educational attainment for entry into posts, new roles such as the maternity support worker and learning and development opportunities consistent with and supportive of the Knowledge and Skills Framework.

This will offer opportunities within the needs of service to further careers at a pace appropriate to abilities, skills and aspirations with the potential to progress to pre registration education.

Work in this area will be undertaken as part of the Central Nursing and Midwifery Advisory Committee (CNMAC) workforce planning and development and modernisation subgroup.

Our Vision

A Partnership For Care

To achieve this vision we will maximise the effectiveness of the nursing and midwifery contribution to improving health and social wellbeing and tackling inequalities for the popluation of Northern Ireland.

To support this vision nurses, midwives and support workers will:

- have the patient and families as their primary concern, reducing inequalities and working in partnership with individuals, communities and the public for improved health and social outcomes;
- work with other professional groups, agencies, patients and communities to maximise the use of everyone's talents and skills;
- be accountable, skilled and flexible, always striving to work effectively and efficiently to provide safe, accessible and equitable care acting as the patient/client advocate;
- practise in an atmosphere of continual learning and development, demonstrating their commitment to continuous quality improvement and an ability to learn from experiences and accredited sources of evidence and contributing to that evidence.

Our Values

The underpinning values of the nursing and midwifery family are the principles and beliefs that guide the choices and daily practice of individuals. These are relevant to any system, care setting or career structure. For nurses and midwives these principles are embodied within the Nursing and Midwifery Council Code: Standards of Conduct Performance and Ethics (2008). These values articulate the manner in which they work and the passion they have for care. These need to be at the core of our practice and support person centred care.

The family of nursing and midwifery will:

- treat people with **care and compassion**, with **dignity and respect** and with **impartiality**;
- work in **partnership and collaboration** with patients, clients, carers and colleagues in the interests of providing high quality care;
- be **accountable** for their actions;
- provide **leadership** to ensure safe and effective care;
- maintain **ongoing competence** throughout their working careers.

These vision and values statements are an integral part of the ways of working, regardless of the setting. Every member of the nursing and midwifery family has a personal responsibility to express these values in the way they interact with patients and clients and each other. These values should underpin every professional decision and are reflected throughout this strategy.

The Strategy for Nursing and Midwifery

Promoting Person Centred Cultures

Delivering Safe and Effective Care

Supporting Learning and Development

Maximising Resources for Success

A Partnership for Care

A Partnership for Care

Promoting Person Centred Cultures

“Being person centred requires the formation of therapeutic relationships between professionals, patients/clients and others significant to them in their lives and that these relationships are built on mutual trust, understanding and a sharing of collective knowledge”
(McCormack & McCance, 2006)

Through the development of Person Centred Cultures the nursing and midwifery family aim to ensure that the patient/client is an equal partner with the nurse/midwife. Assessing, identifying options for and delivering the most appropriate care for the individual. This involves sharing information on all aspects of the patient/client needs and available services. This requires mutual respect and courtesy.

Effective care, values the rights and needs of individuals and is accessible, responsive and promotes health and wellbeing.

To achieve this we will focus on three key perspectives:

- **ENSURING PERSONAL AND PUBLIC INVOLVEMENT**
- **IMPROVING THE PATIENT/ CLIENT EXPERIENCE**
- **WORKING TOGETHER FOR POSITIVE OUTCOMES**

ENSURING PERSONAL AND PUBLIC INVOLVEMENT (PPI)

Engagement with individuals and communities should be an integral part of service planning, commissioning and delivery. It means discussing with those who use our services and the public: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.
(HSC circular (SQSD) 29/07)

At a Strategic Level

- The Director of Nursing in the Public Health Agency (PHA) and the Directorate of Nursing and Midwifery within DHSSPS, in conjunction with the Patient and Client Council, will ensure the voice of the citizen is heard by supporting the involvement of patients and the public in shaping health policy and influencing service redesign leading to a partnership approach to better health.

- The commitment to PPI will be reflected in the leadership and accountability arrangements within HSC organisations. The nursing and midwifery elements of involvement will be coordinated and monitored by the Director of Nursing within the Public Health Agency in conjunction with the Trust Directors of Nursing, in line with regional strategy.

At an Organisational Level

- Directors of Nursing will adopt a systematic approach to PPI that links corporate decision making to local communities.

- Directors of Nursing will work with PPI leads to ensure a co-ordinated and equitable approach to involvement across the HSC and where relevant the independent, community and voluntary sectors.

At an Individual Level

- Each nurse and midwife will recognise that PPI is part of their responsibilities and demonstrate an individual contribution at their performance review.

- Nurses, midwives and support staff will use every opportunity to put patients, clients and the public in the lead for managing their care through a process of shared decision making.

"If the acquisition of PPI knowledge and skills becomes part of everyone's personal development plans, it will enhance practice, service and also inculcate a sense of ownership of the PPI agenda." (*Nurses and PPI, 2009*)

IMPROVING THE PATIENT/CLIENT EXPERIENCE

Patients and clients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained. This principle should be supported by all health and social care organisations and professional bodies, enabling staff to provide a quality service.
(Improving the Patient and Client Experience, 2008)

At a Strategic Level

- The Chief Nursing Officer (CNO) in partnership with the Director of Nursing at the PHA will oversee the regional implementation and monitoring of the "Improving the Patient and Client Experience" standards.
- A regional working group will develop appropriate measurement methodology that will generate evidence of achievement against the patient and client experience standards.

At an Organisational Level

- Directors of Nursing will ensure that organisational policies have due regard to the implementation of the patient and client experience standards.
- Directors of Nursing, ward sisters and their senior teams will act as inspirational role models providing visible leadership throughout their organisations acting on identified aspects of poor practice.

At an Individual Level

- Nurses and midwives will demonstrate through their behaviour, their role as advocates of quality care through the implementation of the patient and client experience standards and adherence to their code of conduct.
- Nurses, midwives and support staff will proactively seek and act upon a range of feedback to evaluate the impact of the patient and client experience standards.

"Good quality care is everyone's business; it requires champions in the boardroom and at the bedside." (*M Bradley, 2008)*

WORKING TOGETHER FOR POSITIVE OUTCOMES

Health and social care is a complex business; collaborative working, coordination and teamwork are necessary to achieve the positive outcomes nurses and midwives seek for patients and clients.

At a Strategic Level

- Nurses and midwives will work collaboratively within a multi-agency environment to put public health and social well being at the core of the health and social care system.
- The family of nursing and midwifery will secure an integrated and person centred approach to the development of services, within the existing and developing service frameworks.

At an Organisational Level

- Effective commissioning requires effective population needs assessment. Directors of Nursing will support nurses and midwives to work in partnership with community groups, statutory and voluntary agencies to compile and/or contribute to health and social care profiles of local populations to inform the commissioning process.
- Directors of Nursing will work collaboratively to enhance and sustain effective environments that value and support the contribution of nurses and midwives working together with a range of disciplines to achieve positive outcomes.

At an Individual Level

- Nurses and midwives will work in partnership with their patients and clients, in therapeutic relationships, supporting them to make informed choices about their care and treatment.
- Nurses, midwives and support staff will work closely with and value the contributions of the multi-disciplinary team, actively seeking positive outcomes for patients/clients.

"Understand the contribution that effective interdisciplinary team working makes to the delivery of safe and high-quality care...........work with colleagues in ways that best serve the interests of patients."
(GMC,Tomorrow's doctors, 2009)

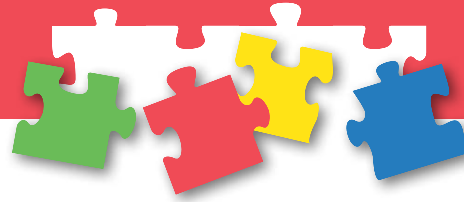
Delivering Safe and Effective Care

"The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.
(Quality Standards for Health and Social Care, 2006)"

The delivery of safe and effective care is the responsibility of all staff within the health and social care system including the independent, voluntary and community sectors. Nurses and midwives must recognise their personal responsibility and accountability for the delivery of evidenced based care. They will do this through competent decision making and the effective identification and management of risk, recognising and acting on areas of poor practice to ensure the best outcomes for patients and clients.

To achvieve this the family of nursing and midwifery will focus on three key perspectives:

- **BEING ACCOUNTABLE FOR CARE**
- **MANAGING RISK**
- **DELIVERING EVIDENCE BASED CARE**



BEING ACCOUNTABLE FOR CARE

Accountability is integral to professional practice. Nurses and midwives make decisions that effect patient/client care in a wide variety of circumstances and environments based on professional knowledge, judgement and skills. Accepting responsibility and being accountable for such decisions is an essential part of delivering safe and effective care.

At a Strategic Level

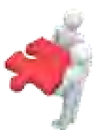
- The CNMAC will work with the CNO and senior colleagues to develop a regional accountability framework for nurses and midwives.
- The Local Supervising Authority Midwifery Officer at the PHA will act as a point of contact for supervisors of midwives and provide leadership, support and guidance on a range of matters.

At an Organisational Level

- Directors of Nursing will exercise their executive power and influence from ward to board, acting in the best interests of patients and clients.
- Directors of Nursing will monitor the implementation and maintenance of supervision processes against the regional standards through the annual report submitted to the CNO.
- Midwifery supervision is a statutory function. Supervisors of midwifery will provide a mechanism of support and guidance which will protect women and babies by actively promoting safe standards of care.

At an Individual Level

- Nurses and midwives will demonstrate through their actions understanding of their accountability to patients/clients, employers and the Nursing and Midwifery Council.
- Nurses, midwives and support staff will take ownership for quality care, holding themselves and others to account for the highest standards of care, acting to escalate concerns and address poor standards.



"As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions."
(Nursing & Midwifery Council, 2008)

MANAGING RISK

To ensure the delivery of safe and effective care nurses and midwives must be able to manage risk, embrace accountability, and meet the demands of governance. By adopting an anticipatory approach nurses and midwives can act proactively to minimise risk and provide a high quality service that meets patient/client needs and act on lessons learnt to drive improvements in the quality and safety of services ensuring that practice is informed and improved.

At a Strategic Level

- The Director of Nursing at the PHA will lead on a regional approach to learning from incidents, accidents and reviews including the establishment of a Regional Adverse Incident and Learning (RAIL) system.

- The Directorate of Nursing and Midwifery within DHSSPS will ensure that learning outcomes are fed back into all training and development activities to maximise the learning and reduce the risk of reoccurrence.

At an Organisational Level

- Directors of Nursing will exercise their executive power and influence informing, advising and assisting colleagues at board level to understand how strategic decisions may affect the quality and safety of patient care and the wider patient experience.

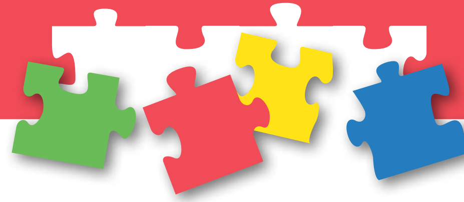
- Directors of Nursing will provide active leadership within a governance framework to enable risk to be assessed and managed effectively.

At an Individual Level

- Nurses, midwives and support staff will have access to and work within established risk management policies and processes.

- Nurses and midwives will be able to comprehensively assess and proactively respond to service users' individual needs and identified risks within their sphere of practice.

"…..Hospitals should do the sick no harm."
(F Nightingale, 1820 – 1910)



DELIVERING EVIDENCED BASED CARE

As professionals nurses and midwives must be able to demonstrate the effective integration of evidence, including research findings, into their clinical decision making processes to ensure the delivery of safe and effective care. Evidence based care must therefore be a core component of contemporary nursing and midwifery practice.

At a Strategic Level

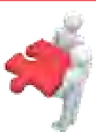
- The nursing and midwifery directorate within DHSSPS will ensure professional expertise is fully integrated into decision making processes at policy level.
- The CNMAC Research and Development subgroup will provide leadership and strategic direction for nursing and midwifery research and development in order to improve patient/client experience and outcomes.

At an Organisational Level

- Directors of Nursing will ensure the dissemination of evidenced based policies, procedures, standards and guidelines for nursing and midwifery practice. These will be supported by a dynamic programme of audit to monitor practice and highlight concerns at an early stage.
- Directors of Nursing will support practitioners to develop research expertise and utilise these skills within the healthcare settings.

At an Individual Level

- Nursing and midwifery decisions will be made through a process of critical analysis, characterised by compassion, respect and dignity.
- Nurses and midwives will utilise practice development, research and benchmarking to integrate evidence based care into their practice and will contribute to the development of that evidence.



"The translation of discoveries into interventions that deliver benefits for patients and the public requires the involvement of many different disciplines."
(A Shared Vision for UK Health Research, 2010)

Maximising Resources for Success

> Nursing innovations are key to improvement and progress in health systems worldwide.
> ***(International Council for Nurses, 2009)***

Individuals and organisations need to ensure that public resources are fully utilised and focused to meet the needs of patients and clients, providing and improving health and social care.

This strategy encourages entrepreneurship and innovation balanced with the need to maintain the safety of patients and clients. It recognises that nurses and midwives need to take appropriate actions to maximise the available resources and respond to the needs of patients and clients to ensure the best possible outcomes.

To achieve this the family of nursing and midwifery will focus on three key perspectives:

- **RESPONDING TO NEED**
- **IMPROVING OUTCOMES THROUGH INNOVATION**
- **WORKFORCE PLANNING**

RESPONDING TO NEED

Nurses and midwives are ideally placed to assist in identifying the needs of their patients and clients and to develop new and innovative ways to deliver quality care across a range of settings. New and expanding roles require additional skills and competencies building upon the solid foundations of existing practice and placing patients and clients at the centre of care.

At a Strategic Level

- The changing context of health care delivery will require the focused review of nursing and midwifery practice areas to ensure they are fit for purpose and meeting the needs of patients and clients.
- The CNO and Director of Nursing at the PHA will champion the development of new and innovative ways of delivering high quality, compassionate care.

At an Organisational Level

- Directors of Nursing will adopt the use of service improvement methodologies to design systems and processes which respond to the needs of patients/clients, avoid duplication and maximise the use of resources.
- Directors of Nursing will lead on the assessment of need and development of enhanced roles for nurses and midwives which improve the patient/client experience.

At an Individual Level

- Nurses, midwives and support staff will recognise their unique contribution to improving the health and wellbeing of the population and will work with others to meet the needs of patients/clients.
- Nurses, midwives and support staff will strive to protect and secure optimum independence and self determination for each individual patient/client and their family.

"Every system is designed to achieve exactly the results it gets....if you don't like the results, change the system."
(Don Berwick, Institute of Health care Improvement, 1996)

IMPROVING OUTCOMES THROUGH INNOVATION

Those who deliver care are best placed to make improvements in that care. In Northern Ireland nurses and midwives are at the forefront of service re-design, pushing the boundaries and challenging traditional practices. The adoption of a transformational leadership approach will encourage innovation in the development of nurse, midwife and healthcare support roles which harness and develop individual talents to improve outcomes for patients and clients.

At a Strategic Level

- The Directorate of Nursing and Midwifery within DHSSPS will support initiatives such as the Florence Nightingale foundation travel scholarship to enhance nursing and midwifery practice, service delivery and improve patient/client care.

- The Directorate of Nursing and Midwifery within DHSSPS and the Research and Development Office of the PHA will promote access to research opportunities to enhance practice and ultimately improve outcomes for patients and clients.

At an Organisational Level

- Directors of Nursing will promote a “can do” culture within organisations supporting ward sisters/charge nurses/team leaders, individuals and teams to challenge traditional practices to improve patient client care.

- Directors of Nursing will encourage staff to celebrate and share validated innovations and research findings and where appropriate adopt and sustain new ways of working for the benefits of patients/clients.

At an Individual Level

- Nurses, midwives and support staff will identify opportunities for practice/ service improvements and communicate these to line managers.

- Nurses, midwives and support staff will spread and embed innovation and research findings to improve outcomes for patients and clients.

“Society and the health care system will value nurses and midwives not only as clinicians, but also as managers, teachers, researchers, activists, thinkers and policy-makers.”
(Commission on the Future of Nursing and Midwifery in England, 2009)

WORKFORCE PLANNING

The management of people and finance go hand in hand. To maximise resources and ensure best possible outcomes for patients and clients the nursing and midwifery family will ensure the right people are in the right place with the right skills at the right time. Effective workforce planning leads to the recruitment and retention of a flexible, responsive and high performing workforce who can meet the needs of service delivery.

At a Strategic Level

- The CNO will task CNMAC to establish a regional workforce planning, development and modernisation subgroup which will advise DHSSPS on a Northern Ireland wide approach to the effective management of supply and demand within the nursing and midwifery professions.

- The Director of Nursing at the PHA in collaboration with Directors of Nursing will build a workforce planning toolkit to ensure the right people with the right skills in the right job. This will include assessment of population health needs, knowledge of current nursing and midwifery staff, their skill-mix, and data on other healthcare professionals.

At an Organisational Level

- Directors of Nursing will be proactive in identifying future nursing and midwifery workforce requirements. This intelligence will influence workforce commissioning to ensure the future needs of patients and clients are met.

- Directors of Nursing will focus on the values and worth of nursing and midwifery, highlighting the strengths and advocating the professions as top careers for the future.

At an Individual Level

- Nurses, midwives and support staff will recognise their skill sets both transferable and specialist to enable them to move flexibly between different environments of care.

- Nurses, midwives and support staff will work with and support one another to help achieve a balance between work and personal life.

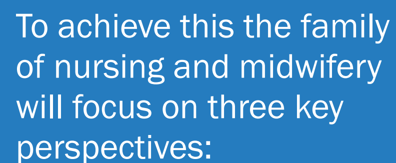
"Effective workforce planning in nursing has a profound impact on patient care – directly effecting factors such as mortality and failure to rescue."
(Professor Anne Marie Rafferty, 2009)

Supporting Learning and Development

> Lifelong learning and development for staff in the Health and Social Care is key to delivering a modern patient and client focused service. It is important that DHSSPS, working with its partners and related sectors, develops and equips staff with the skills they need to support changes and improvements in patient and client care.
> ***(DHSSPS, Workforce Learning Strategy 2009 – 11)***

Nurses, midwives and their support staff can only deliver high quality care if they maintain and develop their knowledge and skills, working together respecting one another and communicating effectively. Given the pace of change in the delivery of health care and the rise in public expectations the principles and values of lifelong learning are increasingly important to all members of the nursing and midwifery family.

This strategy will ensure that within supportive culture, learning and development will continue to contribute to a knowledgeable and dynamic workforce, supported by strong and visible leadership at all levels.



To achieve this the family of nursing and midwifery will focus on three key perspectives:

- **PROMOTING A LEARNING CULTURE**
- **DEVELOPING THE WORKFORCE**
- **DEVELOPING LEADERSHIP**

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PROMOTING A LEARNING CULTURE

A culture of learning does not necessarily develop spontaneously; it has to be nurtured, supported and developed over a period of time. Within a culture of learning the family of nursing and midwifery will create, acquire and transfer knowledge enabling staff to reflect upon practice and with new knowledge and insights improve outcomes for patients and clients.

At a Strategic Level

- Based on the learning needs analysis of nursing and midwifery the Education Commissioning Group will work in partnership with service and education providers to commission courses and development opportunities based on the needs of patient/clients. The impact of this learning will be evaluated to determine its bearing on practice.

- The CNO in association with NIPEC will adopt a regional approach to knowledge management through the practice and quality development database which will spark innovation, operational improvement and enhanced care.

At an Organisational Level

- Directors of Nursing will embrace the principles of a learning organisation ensuring that a learning and development action plan is implemented in each organisation and its impact evaluated.

- Directors of Nursing will promote fair and equitable access to learning and development. This will support the Knowledge and Skills Framework and the appraisal/personal development process to meet training needs and demonstrate learning outcomes.

At an Individual Level

- Nurses, midwives and support staff will take responsibility for their personal development and career plan maximising formal, informal and experiential learning opportunities.

- Nurses, midwives and support staff will actively participate in practice development opportunities and share the learning with others to improve outcomes for patients and clients.

"In a learning organisation people continually expand their capacity to create the results they truly desire, new and expansive patterns of thinking are nurtured, collective aspiration is set free, and people are continually learning to see the whole together." (*Peter Senge, 1990)*

DEVELOPING THE WORKFORCE

Within health and social care the workforce is the greatest resource and asset. In a context of continuing change and developments in people's health and social care needs, advancing technology and rising public expectations the pattern of practice and the organization of care delivery creates both challenges and opportunities for nurses, midwives and support staff in working towards improvements in care.

At a Strategic Level

- The CNMAC workforce planning, development and modernisation subgroup will review the outcomes of the Modernising Nursing Careers and Midwifery 2020 initiatives and advise on new ways of working including the role of nurse consultants and health care support workers.
- Building on the work already undertaken in the development of a post registration career framework we will adopt a skills escalator approach to support flexible career paths.

At an Organisational Level

- Directors of Nursing will encourage and promote confidence in staff to develop new skills and knowledge supporting the development of new roles which will improve patient/client care.
- Directors of Nursing will embed the practice education coordinator and facilitator roles, to support learners in practice.

At an Individual Level

- Nurses, midwives and support staff will engage in continuing development that will enhance practice and meet career aspirations.
- Nurses and midwives will facilitate the professional and personal development of others, demonstrating leadership, reflective practice, supervision, quality improvement and teaching skills.

"Health care provision requires that practitioners possess the knowledge and skills to respond and adapt to current and future health care priorities and needs." (*WHO, Strategic Directions for Nursing and Midwifery, 2002)*

DEVELOPING LEADERSHIP

Leadership in nursing and midwifery is crucial to the quality of patient/ client care and to the development of the professions. Leaders need to be confident, competent, well motivated, self aware, and socially skilled. They need to be team players who are able to work with others across professional and organisational boundaries. In short good leaders make positive, tangible changes to the delivery of care.

At a Strategic Level

- The CNO working with the Director of Nursing at the PHA will provide professional leadership to the family of nursing and midwifery, working closely with statutory bodies, professional and staff associations, HSC Trusts and the voluntary and independent sectors.

- Nursing and midwifery will adopt a succession planning approach to leadership development, identifying and nurturing leaders of the future in a commitment to ensure continuous, seamless leadership transition.

At an Organisational Level

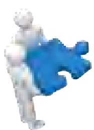
- Directors of Nursing will provide strategic leadership and act as role models to ensure safe and sustainable services.

- Ward Sisters, Charge Nurses and Team Leaders will provide leadership to frontline teams ensuring the delivery of safe, effective compassionate care.

At an Individual Level

- Nurses, midwives and support staff will set an example of excellence for others.

- Each nurse and midwife will be prepared to lead and be accountable for improvements in patient care.



“The ability of midwives to be strategic leaders in service, policy and higher education requires that these roles are there to start with; and that midwives have the expertise, credibility and leadership skills to represent the profession and its contributions.” (*Delivering high quality midwifery care, 2009)*

Where do we go from here

This strategy outlines a strategic vision for the family of nursing and midwifery in Northern Ireland. Each of our strategic themes of Prompting Person Centred Cultures, Delivering Safe and Effective Care, Maximising Resources for Success and Supporting Learning and Development have identified three perspectives through which together we will achieve our vision.

At an individual level each nurse, midwife and support worker has a responsibility to embrace the perspectives expressed in this strategy.

At an organisational level Executive Directors of Nursing will develop action plans that will bring forward the implementation of this strategy and its key perspectives.

At a strategic level the CNO and the Director of Nursing in the PHA will support and monitor the progress of this strategy.

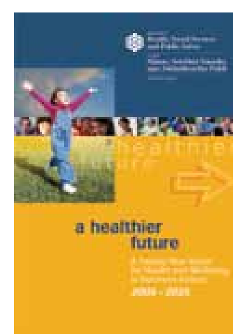
Appendix 1 – Summary of Policy Documents

Developing Better Services; Modernising Hospitals and Reforming Structures - published in June 2002 this document contained a range of proposals for modernising acute hospital services, building on the recommendations from the Acute Hospitals Review Group report of 2000. The key areas addressed were the future configuration of hospital services; future organisational structures and workforce. These issues have subsequently been largely subsumed by the Review of Public Administration and the introduction of Agenda for Change.

Investing for Health – also published in 2002 this document presented a cross-departmental, multi-sectoral framework for action to improve health and wellbeing in Northern Ireland by setting out how the Northern Ireland Executive plans to achieve its aim of 'working for a healthier people'.

The strategy recognises the important contribution made by members of statutory and non-statutory groups and identifies the principles and values that should guide future action to improve health highlighting the cost of poor health to the individual, families and to the economy.

A review of the investing for health strategy is underway and is due to be concluded by mid 2010.



A Healthier Future - this regional strategy for health and wellbeing was published in December 2004.The strategy is a vision for health and wellbeing in Northern Ireland over the next twenty years and intends to give the direction of travel for health and social services.

The strategy places a strong emphasis on:

- promoting public health;
- engagement with people and communities to improve health and wellbeing;
- the development of responsive and integrated services which will aim to treat people in communities rather than in hospital;
- new, more effective and efficient ways of working through multi-disciplinary teams;
- measures to improve the quality of services; and
- flexible plans, appropriate organisational structures and effective, efficient processes to support implementation of the strategy.

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Appendix 1 – Summary of Policy Documents

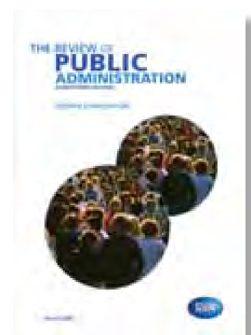
In April 2009, the Minister launched the new Public Health Agency. This saw a range of functions in Health and Social Care brought together to focus on improving the health and wellbeing of everyone in Northern Ireland. This restructuring is an opportunity to create a system for health and social care services and health promotion that can deliver more effectively on the vision, strategic themes and policy directions set out in A Healthier Future.

Caring for People Beyond Tomorrow published in October 2005 is a primary health and social care strategic framework for individuals, families and communities in Northern Ireland. This strategy sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

Key aspects of the Strategic Framework are:

- A service focused on providing comprehensive person centred care;
- A first point of contact that is readily accessible and responsive to meet people's needs day or night;
- A co-ordinated, integrated service employing a team approach with multi-agency linkages;
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered;
- A focus on prevention, health education and effective self-care.

The Review of Public Administration (RPA) was launched by the Northern Ireland Executive in June 2002 with the final outcome announced by the Secretary of State in November 2005. Its purpose was to review Northern Ireland's system of public administration with a view to putting in place modern, accountable and effective arrangements for public service delivery in Northern Ireland. It allowed for joined up thinking and the promotion of key cross cutting values such as efficiency, equality, accountability and co-terminosity.



Within Health and Social Care there were two major phases for implementation of the RPA. The first phase involved the establishment of the 5 new integrated HSC Trusts and the retention of the NI Ambulance Trust with effect from 1 April 2007. The second phase completed in April 2009 witnessed the establishment of a Health and Social Care Board, a new Public Health Agency and a Patient Client Council to replace the previous four boards and health and social services council structure.

Changing the Culture published in 2006, sets out a three year action plan to minimise Healthcare Acquired Infections. The key areas within the document are as follows:

- Organisation and culture;
- Education, training and practices;
- Governance, accountability and audit;
- Surveillance;
- Patient and public partnerships.

Since the publication of this document a range of activities have been undertaken, including a full review of the action plan entitled Changing the Culture 2010.

The Bamford Review published in 2007 is a series of eleven reports which outline a strategic direction for Northern Ireland to modernise and reform mental health and learning disability policy and service provision. The reports set out a clear vision on how an excellent service for those with mental health and or learning disabilities and their families can be provided, with the service user experience at the heart of any improvement.

The Bamford Action Plan (2009 – 2011) sets out the governments commitment to improving mental health and wellbeing of the population of Northern Ireland and to driving service improvement for those with a mental health need or a learning disability.

Improving the Patient, Client Experience Standards published in 2008, sets out the five standards relating to respect, attitude, behaviour, communication, privacy and dignity describing what the public should expect from staff in the health service.

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Llywodraeth Cymru
Welsh Government

The Scottish Government

Strengthening the commitment

The report of the UK Modernising Learning Disabilities Nursing Review

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Foreword

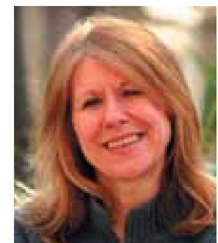
My professional commitment to learning disabilities nursing is long standing. It emerged from a personal insight early in my career into the vital role that learning disabilities nurses play in the lives of people with learning disabilities, their families and carers, the very complex and high-level competences they possess, and the advocacy, passion and dedication they show. I am therefore proud, and delighted, to be introducing this report of the UK Modernising Learning Disabilities Nursing Review on behalf of my fellow government chief nursing officers.

The role and profile of learning disabilities nursing has changed significantly over the last three decades. The wholesale shift from institutionalised care to a social model of provision based on independence, inclusion and empowerment has improved significantly the lives of people with learning disabilities, but has served to reduce demand for learning disabilities nursing as a specialism. As a result, the learning disabilities nursing workforce today is smaller and more widely distributed across the health and social care sector than ever before; and while some occupy specialist learning disabilities nursing roles, many others have more generic care or managerial roles.

This has resulted in a lack of focus and direction for learning disabilities nursing, fragmentation of the learning disabilities nursing community and, potentially, a loss of core nursing and specialist learning disabilities nursing skills to the system at a time when demand (which is already growing) is likely to increase. More and more children born with learning disabilities are now surviving into adolescence, adulthood and into older age, with the complex range of medical and health problems that brings: they require specialist learning disabilities nursing support across the lifespan.

In initiating the review, the UK chief nursing officers sought to bring this issue to the forefront for people with learning disabilities, their families and carers, policy-makers, commissioners, services, professional leaders and the learning disabilities workforce so that together we can prepare for the challenges and opportunities ahead. At the same time, we wanted to remind everyone of the very proud tradition that underpins learning disabilities nursing and of the importance of their contribution and commitment in a changing world.

The four countries are now invited to consider the report's recommendations and progress then as appropriate within their own contexts.



Ros Moore
Chief Nursing Officer, Scottish Government

Foreword by the Modernising Learning Disabilities Nursing Review Co-production Steering Group

We are the Co-production Steering Group for the UK Modernising Learning Disabilities Nursing Review and we are people with learning disabilities, people with autism and family carers. We all have experience of learning disabilities nursing and want to see it improve and develop. This should be consistent across the UK.

It has been enjoyable working on this and putting forward our ideas. We can see our ideas in the report but this is only the first step. The implementation stage will be even more important as this will lead to the goal of good outcomes for people. We want to see people with learning disabilities, people with autism and family carers meaningfully involved throughout all this work.

Our hopes are that the recommendations will develop a better future of nursing care for people with learning disabilities throughout their lifespan. People are complex and learning disabilities nurses need to find accessible ways to share information and work with people with learning disabilities to ensure good quality holistic health care. People are the experts on their life, health and care.

We want to see decision-makers buying into these recommendations and committing to budgeting to take them forward. As a group, we value the report and feel that it is important that the recommendations are carried out.

Executive summary

The issue

There are approximately 1.5 million people in Britain living with learning disabilities.[A] That number is likely to grow by 14 per cent between 2001 and 2021[B] as advances in science and care mean many more children with learning disabilities live longer, more fulfilled lives than has ever been the case before and the increasing adult population of people with learning disabilities grows into older age. While this is very welcome, the governments of the four countries of the UK must be sure their health and social care systems are ready for the changing health needs of people with learning disabilities.

Learning disabilities nursing has always had a major input into the health of people with learning disabilities, their families and carers, and demand is likely to grow. However, as a result of changes in societal attitudes to people with learning disabilities and to their care, learning disabilities nurses have become geographically dispersed within a range of public and independent sector providers and are employed in a variety of roles. The overall number of learning disabilities nurses has consequently decreased over time, with many now nearing retirement.

What we want to achieve

The UK Modernising Learning Disabilities Nursing Review wants to ensure that people with learning disabilities of all ages, today and tomorrow, will have access to the expert learning disabilities nursing they need, want and deserve. That requires a renewed focus on learning disabilities nursing and may require service and strategic investment in building and developing the workforce. The review aims to set the direction of travel for learning disabilities nursing to ensure we can meet current and future demand and that the workforce is ready and able to maximise its role throughout the entire health and social care system. We also want to ensure the best staff experiences and career opportunities for learning disabilities nurses and, most importantly, the best experience of support and care for people with learning disabilities, their families and carers.

The review makes a number of detailed recommendations (seen throughout this report and summarised in Table 2) that are about “strengthening the commitment” to learning disabilities nursing across the public sector. Underlying them are four clear organising principles for supporting reform.

Strengthening capacity

Accurate information on where learning disabilities nurses are working both within and outside the NHS is important for workforce planning and to ensure education programmes remain relevant. Further work is required across the four countries to scope the workforce, including those working in the independent/voluntary sector and in social care, so that strategic workforce development plans are developed and enacted. There should be a clear statement about what we want from learning disabilities nurses going forward and

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[A] Source: Mencap (www.mencap.org.uk/all-about-learning-disability/information-professionals/more-about-learning-disability).

[B] **Emerson E, Hatton C (2008)** *Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England.* Centre for Disability Research: Lancaster.

they should be enabled to plan their career development to meet the needs of people with learning disabilities now and in the future.

Strengthening capability

The values base for learning disabilities nursing remains strong and we should ensure that systems retain and reinforce attitudes and abilities to deliver person-centred and strengths-based approaches. At the same time, skills, knowledge and competencies are changing and must be extended to reflect the changing needs of people with learning disabilities.

Evidence clearly shows that people with learning disabilities have poorer health than the general population. In addition, many have difficulties accessing and using general health services. Learning disabilities nurses have an important role to play in supporting timely access to services, as well as contributing to preventative and anticipatory care.

Strengthening quality

All four countries are currently engaged in significant programmes of system transformation, efficiency and quality improvement. Learning disabilities nurses must embrace that movement and consider how they can demonstrate impact through measurable outcomes and evidence-based interventions that improve safety, productivity and effectiveness alongside traditional person-centred approaches.

A well-prepared, developed and supported workforce at all levels (including nonregistered staff) is essential to the delivery of quality health care for people with learning disabilities and education and training throughout the career pathway is key to achieving this.

Strengthening the profession

Strong leadership will be crucial to ensuring the recommendations from this report are taken forward and that existing networks for learning disabilities nurses across the UK continue to provide a powerful platform from which to celebrate, promote and develop their unique contribution. These have tended to be developed mainly for NHS staff, so a key step is for the learning disabilities nursing profession to embrace members from all sectors to create a critical mass of leaders working together to effect change and advocate for the profession and those they serve.

The way forward

We do not underestimate the challenge this will present. All this will take place in a time of recession, uncertainty and increasing diversity across the four UK health care systems. However, the demographic factors set out above cannot be ignored, and that's why high levels of commitment and engagement from key players are needed. UK government health departments, employers, educators, people with learning disabilities, their families and carers, learning disabilities nurses and wider health and social care staff are all crucial to its success.

Introduction

Health and social care systems across the UK continue to face significant strategic, structural and economic change, with an increased focus on localism and integration, changes in commissioning structures and a strong emphasis on outcomes and transparency. Learning disabilities nursing must adapt to meet the demands of this change.

The UK Modernising Learning Disabilities Nursing Review aims to ensure the best possible services are provided to people with learning disabilities, their families and carers now and in the future and that we have a valued and thriving learning disabilities nursing profession.

Health and social care challenges

Population

The population of people with learning disabilities is increasing across the UK and internationally. Demographic projections suggest that the numbers of people with learning disabilities will increase by 14% between 2001 and 2021 (1), with rises at both ends of the age spectrum linked to better survival rates in premature babies and improvements in health care and general standards of living (2,3).

Health inequalities

The number of individuals with complex needs, including co-morbid health problems and behaviours perceived as challenging, is increasing across the UK (4). A third of people with severe and profound learning disabilities also have an associated autism spectrum disorder (5). People with learning disabilities often experience health and social problems associated with ageing earlier than the general population and there is a higher than average incidence of dementia within some groups (6).

There is evidence showing that many physical, sensory and mental health needs of people with learning disabilities go unrecognised and unmet by services, with consequent negative impacts on their quality of life, life chances, life expectancy and experience of services.

Evidence also demonstrates the increased susceptibility of people with learning disabilities to discrimination and to potential violation of human rights within care settings (7,8).

These compounding issues can lead to people with learning disabilities being at higher risk of poor physical and mental health and to early mortality. If these issues aren't addressed, all services, be they specialist or general, can expect to experience greater demands from people with learning disabilities, their families and carers in the future (9).

Policy shift
Service modernisation initiatives across the four countries are similar in direction of travel, although they may differ in detail. They all aim to:

- promote independence, social inclusion and citizenship;
- develop a service ideology influenced by the social model of disability and values-based, rights-based, person-centred approaches;
- progress the integrated services agenda;
- promote community-based services; and
- ensure equitable access to health care for people with learning disabilities, their families and carers.

Examples of specific policies across the four countries are cited in Appendix 1.

Current position

Learning disabilities nurses remain important in the eyes of stakeholders
In the past, there was some debate about the relevance of learning disabilities nursing in the context of the shift to a social model of provision. Other countries have moved to a workforce with generically prepared registered nurses, or to training more closely aligned to social work or social education. The UK, however, has retained specific preparation towards registration as a Registered Nurse Learning Disabilities for over a century. Some countries are now reconsidering the benefits of having specifically prepared nurses for people with learning disabilities. More recently, there has been recognition that learning disabilities nursing continues to play a crucial role in moving the care of people with learning disabilities from an institutional setting to communities, in championing health improvement and working to tackle the health inequalities experienced by those they work for.

Learning disabilities nursing has a strong values base
Learning disabilities nurses respond to individuals with learning disabilities, their families and carers in a creative, flexible and effective manner, ensuring that interventions are informed by the most recent evidence- and values-based practice. They have a commitment to lifelong learning and promote the empowerment of people with learning disabilities, their families and carers in all aspects of care.

The values base for learning disabilities nursing (see Box 1) is strong and remains the key element underpinning practice. We have built on this base to develop a modernised vision of learning disabilities nursing across the four countries of the UK.

[C] "Carer" refers to: *"... someone who looks after a partner, husband or wife, son or daughter, relative or friend with a disability or illness. Many carers live with the person they care for, but many look after someone who lives independently, in supported accommodation, in hospital, or in a care home … Carers are family members or friends who look after someone without pay or financial reward. They are sometimes known as 'informal' carers or more frequently as unpaid carers."* Source: Scottish Government (2011) The Future of Unpaid Care in Scotland: headline report and recommendations [online]. Available at: www.scotland.gov.uk/Publications/2006/02/28094157/0

Box 1

The values base for learning disabilities nursing

Learning disabilities nursing is based on clear values that include placing individuals at the centre of care and ensuring they are fully involved in all aspects of planning and intervention. It also acknowledges the critical contribution of family and informal carers.[C] Central to this are the following underpinning principles that guide learning disabilities nursing practice.

Human rights
Placing the individual at the centre, valuing choice, inclusion, citizenship and social justice. Incorporates equality, individuality, person-centred and strength-based approaches, empowerment, self-determination, dignity and anti-oppression.

Personalisation
Supporting the individual's control and choice over their own life and services through empowering people with learning disabilities, their families and carers and relinquishing "control".

Equality and inclusion
Recognising diversity and challenging inequality and inequity by supporting people with learning disabilities to use the same services and have the same opportunities and entitlements as anyone else.

Person-centred
Meaningful engagement with people to identify goals significant to the person.

Strengths-based
Focusing on existing strengths, skills, talents and resources and increasing personal competence.

Respect
Valuing the whole person and the diversity of people who support and sustain him or her. Appreciating the contribution of families and carers and, where possible, enhancing the contribution of others.

Partnerships
Recognising that health and social outcomes are interdependent.

Health-focused
Focusing on the individual's health and well-being to enable inclusive lifestyles.

Current role of learning disabilities nurses

Learning disabilities nurses work with people, families and carers with a wide range of abilities and needs and within a diverse range of settings, providing both generalist and specialist nursing care. Consequently, they require a wide range of skills (including "traditional" skills such as care planning and "non-traditional" skills such as accessible communication[D]) alongside specific clinical, behavioural and psychological interventions.

[C] "Carer" refers to: *"... someone who looks after a partner, husband or wife, son or daughter, relative or friend with a disability or illness. Many carers live with the person they care for, but many look after someone who lives independently, in supported accommodation, in hospital, or in a care home … Carers are family members or friends who look after someone without pay or financial reward. They are sometimes known as 'informal' carers or more frequently as unpaid carers."* Source: Scottish Government (2011) The Future of Unpaid Care in Scotland: headline report and recommendations [online]. Available at: www.scotland.gov.uk/Publications/2006/02/28094157/0

[D] Accessible communication means designing information that is easier for everyone to use. This may mean producing material in a specific format such as large print, audio or Easy read. (Source: www.romathomas.co.uk/articles/index.php/accessible-communications)

Central roles of learning disabilities nurses can be summarised as:

- effectively identifying and meeting health needs;
- reducing health inequalities through the promotion and implementation of reasonable adjustments; and
- promoting improved health outcomes and increasing access to (and understanding of) general health services, consequently enabling social inclusion.

They also have an increasingly important role in helping to keep people safe and in supporting decision-making around capacity to consent and best interests.

These strengths provide a solid foundation for the development of learning disabilities nursing within the current demographic and policy context.

The UK Modernising Learning Disabilities Nursing Review

Learning disabilities nurses have been at the forefront in introducing and leading new ways of working to support reform, service modernisation and redesign initiatives, but an accountable and forward-thinking profession must future-proof itself.

The UK Modernising Learning Disabilities Nursing Review was commissioned and led by the Chief Nursing Officer for Scotland on behalf of the chief nursing officers across the UK. It reflects a four-country commitment to gathering and considering evidence on the current and future contribution of learning disabilities nursing. At the heart of the review is the commitment to supporting people with learning disabilities, their families and carers to achieve and maintain good health.[E]

The review does not stand alone: it is part of an ongoing consultative programme of work (see Box 2).

Box 2

Ongoing consultative programme of work

The programme aims to:

- set out the value that learning disabilities nurses bring;
- identify and share good practice in learning disabilities nursing;
- assess regional recruitment and retention issues;
- prioritise areas for development that reflect future models of care and population trends within specialist and generic services;
- consider what improvements can be made in areas such as education, careers, leadership, research, outcome indicators, public health and workforce; and
- identify the organisational, education and development strategies that will support and enable the learning disabilities nursing profession to realise its full potential.

[E] Within this report, "health" is viewed as encompassing physical, social and psychological conditions that enable individuals to achieve their potential (10). Recognising that each person's potential will differ, the role of learning disabilities nurses is in advising against, preventing and/or removing obstacles that limit the extent to which people with learning disabilities are able to achieve their individual potential.

Each country has involved people with learning disabilities, families and carers in a range of ways, either as members of steering groups or through focus groups and meetings with local organisations. In addition to hosting the UK Co-production Steering Group for people with learning disabilities, their families and carers, the Scottish Consortium for Learning Disability held focus groups for children and young people and people receiving support from forensic services.

The review was supported by a national programme manager reporting to the UK Programme Board, with four country-specific steering groups (Appendix 2).

Review processes included literature reviews, the collection of positive practice examples and visits to practice and education settings. Nurses were involved through workshops, conferences and information in the professional press, and focus groups were held for student nurses. In addition, a consultation was carried out with learning disabilities nursing students across the UK via two facilitated sessions using Facebook webchat, and two UK-wide events were held (one for learning disabilities nursing educationalists and one for professionals working in the independent/voluntary sector).

The review also worked closely with the Royal College of Nursing (RCN) to explore student aspirations and careers and to take forward work on image and recruitment.

Overview of the report

This report is relevant to all who design, develop, commission or deliver services for people with learning disabilities, their families and carers. This includes those working in the non-statutory sector, acknowledging their important role in improving outcomes and experiences.[F]

We recognise that people with learning disabilities, their families and carers already benefit from a raft of socially progressive legislation and policy throughout the UK, targeting their needs in areas such as health, social care, transport, housing and benefits. The recommendations consequently build on and support these national and local initiatives.

A fully accessible version of this report is being prepared for people with learning disabilities, their families and carers.

The report is structured around four chapters based on the four key themes set out in the executive summary with sections linking directly to the headings from *Modernising Nursing Careers* (11). Each chapter offers a brief narrative setting out key issues and recommendations for action. Positive practice examples collected through the review processes feature throughout, and the report ends with a conclusion and next steps.

The report's recommendations are also set out in Table 2, where the role of key players is proposed.

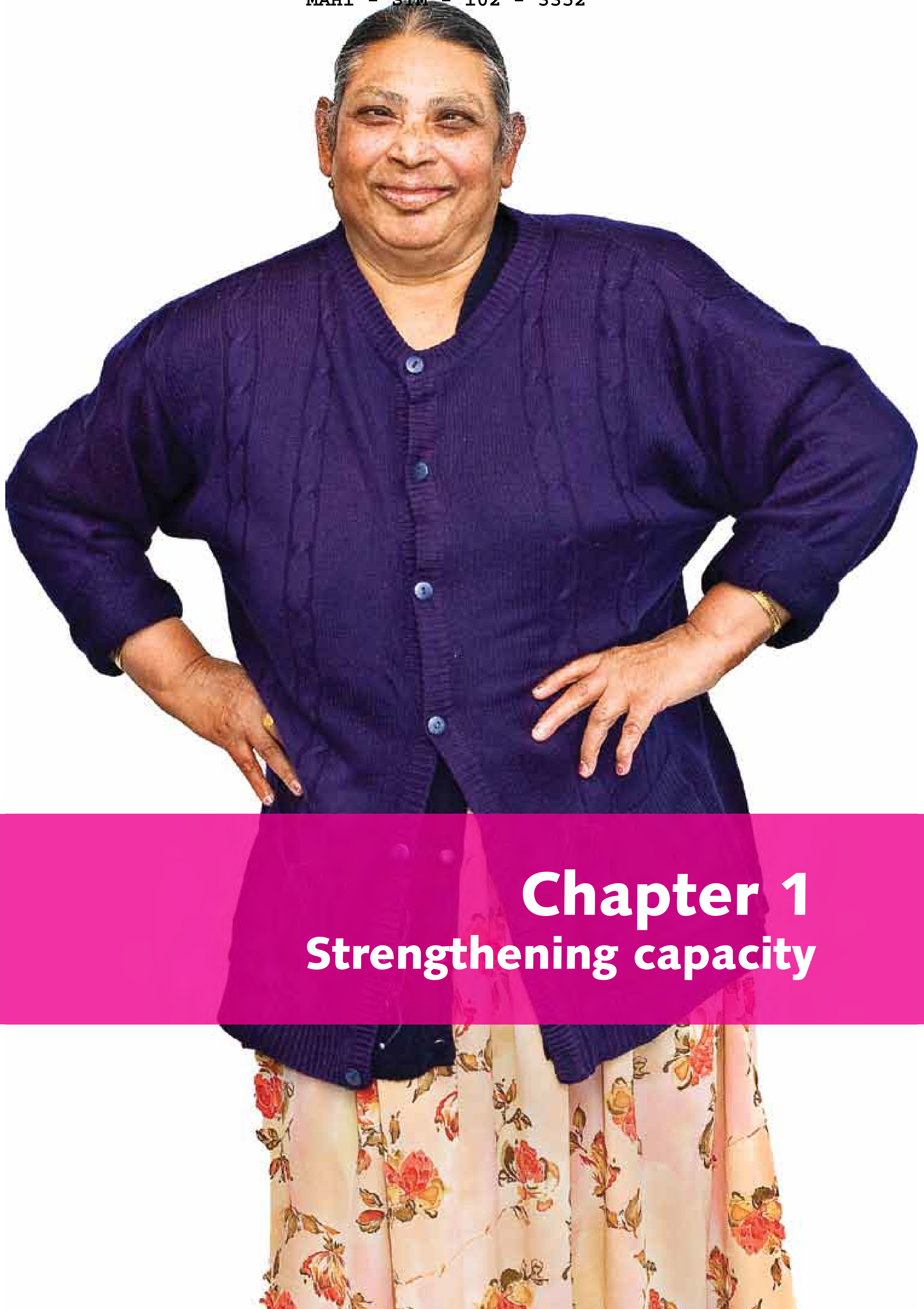
[F] NHS provision may include partly or fully integrated health and social care structures/services.

"I'm going into hospital soon and I'm not frightened anymore because [learning disabilities liaison nurse based in the hospital] will be there to make sure I'm all right."

Person with learning disabilities

"I believe learning disabilities nurses have helped support and move supporting people with profound and multiple learning disabilities onto people's agenda."

Senior community resource worker



Chapter 1
Strengthening capacity

Chapter 1. Strengthening capacity

This chapter addresses some of the key considerations underpinning efforts to strengthen capacity through developing the learning disabilities nursing workforce in relation to:

- **location and employment**
- **strategic workforce planning and development**
- **new ways of working and new roles**
- **career choices.**

1.1 Location and employment

Where we are now

Learning disabilities nurses work in a diverse range of settings, including assessment and treatment services, community teams, the independent/voluntary sector, the criminal justice system and the education sector, providing generalist and specialist nursing care.

Changing patterns of service provision mean that most nurses now do not work in institutions. Instead, they work within geographically dispersed, interdisciplinary and interagency community-based models. Some have strong links to, or are even located within, primary, secondary, mental health or acute services, though this is not common.

The independent/voluntary sector has increased its contribution to service delivery, becoming major employers of learning disabilities nurses in the process, although the precise extent of independent/voluntary sector involvement varies among the countries of the UK.

In some cases, learning disabilities nurses are employed in generic caring or managerial roles. This can lead to the loss of their specialist nursing skills to the service and disadvantage those nurses wishing to progress within appropriate career frameworks.

Where we want to be

Given the demographic and policy challenges highlighted in the introduction, there is a compelling case to assess the learning disabilities nursing workforce required to meet needs within general health services. This may include nurses working in health facilitator roles, in mental health or prison health services or in providing specialist input on a consultancy basis. Learning disabilities nursing skills and knowledge should also be valued in independent/voluntary settings.

In circumstances where nurses are employed in generic caring roles, consideration should be given to how the individual's range of nursing skills and expertise can be utilised to best effect to ensure good health outcomes for people with learning disabilities, their families and carers. In addition, nurses working outside the NHS and their employers should give serious consideration to the benefits of maintaining their professional registration.

Positive practice example

Positive behaviour support in community settings

The Richmond Fellowship Scotland is a social care provider supporting people throughout Scotland with a range of needs, including learning disabilities, autism, forensic needs and mental health difficulties.

The positive behaviour support team was set up in recognition of the fact that many individuals displayed behaviours perceived as challenging and that the organisation needed expertise and skills to support individuals effectively and train staff appropriately. The team comprises a manager and six behaviour support advisors from a range of backgrounds and includes staff with a learning disabilities nursing background. The team carries out functional assessments and, following this, behaviour support plans are developed for the local staff team to implement with support. This direct work with staff and people with learning disabilities is a key factor in successful implementation of the approach.

The model includes proactive and reactive strategies such as teaching new skills, developing communication, using reinforcement strategies and making adjustments to the environment as necessary. A periodic service review is implemented as an ongoing quality assurance tool; outcomes from this are graphed and fed back to staff teams to promote their commitment and involvement. Outcomes for people with learning disabilities are demonstrated by improvements in quality of life and reductions in behaviours perceived as challenging. Changes to staff attitudes and approaches are also evaluated.

For further information, contact Anne MacDonald

Recommendation 1

The four UK health departments and the independent/voluntary sector should establish a national collaborative to enable better understanding of, and planning for, a high-quality and sustainable registered learning disabilities nursing workforce across all sectors.

1.2 Strategic workforce planning and development

Where we are now

There are over 21 000 learning disabilities nursing registrants in the UK (see Table 1). Not all of these will be in current employment.

Table 1

Learning disabilities nurses on the NMC register, 2011

Country	Total number of registered nurses	Number of registered learning disabilities nurses
England	533 205	17 458
Scotland	66 750	1913
Wales	33 416	1030
Northern Ireland	22 564	722
Totals	**655 935**	**21 123**

Source: Nursing and Midwifery Council

New registrant numbers have slowly reduced over the last 10 years, and the numbers employed by the NHS have also fallen. Questions on the viability of some pre-registration education programmes across the UK have arisen as a consequence.

We have tried to establish where these registrants are working as part of the review, but this has proved difficult, even within NHS settings. A number of factors could account for this, including learning disabilities nurses moving to employment in the wider health and social care sectors. As a result, we are unable to effectively plan for the future.

It is also worth noting that the current learning disabilities nursing workforce is ageing, with the potential for a significant gap in the workforce as experienced nurses retire or leave the profession.

Where we want to be

Further work is required to collect accurate data in relation to the size, location and setting of the current workforce to effectively plan for the future and to monitor progress with the modernisation of learning disabilities nursing. Systems are needed within each country to enable robust and sophisticated assessments of workforce requirements and enable appropriate responses, such as appropriate levels of education provision with comparisons across the UK. This must be taken forward in a partnership involving the statutory and independent/voluntary sectors to ensure a clearer understanding of future workforce requirements across all sectors and promote collaboration and integration.

Effective planning and the development of flexible working patterns will help to ensure valuable experience is maintained within the workforce.

Recommendation 2

Systems to collect workforce data are required in each country, with links across the UK, for workforce planning for future provision of learning disabilities nursing. These should be able to capture information on service provision, educational and research requirements and should cover the independent/voluntary sector.

1.3 New ways of working and new roles

Where we are now

Learning disabilities nurses are highly valued by people with learning disabilities, their families and carers. Compassion, respect and human-rights based values and attitudes are the core skills people with learning disabilities, their families and carers look for in learning disabilities nurses and in all health professionals. They have told us throughout the review that we are doing well in the following areas:

- encouraging empowerment and participation;
- promoting communication skills, including accessible communication;
- carrying out health checks, supporting access to hospital or primary care, helping with behaviour and teaching people about health;
- helping people to keep healthy and live in the community;
- supporting access to general health care (liaison roles are highly valued); and
- raising awareness around learning disabilities through education and training for all health professionals.

However, they also told us that we need to do better in a number of areas. These are reflected in our recommendations and include the following.

- Some people with learning disabilities do not have good experiences in specialist assessment and treatment services. Learning disabilities nurses need to involve people more in their assessment and treatment in these settings and avoid restrictive practices (linked to Recommendation 8).
- Children with very complex needs who are being excluded from education – learning disabilities nurses could support services to manage this better (linked to Recommendation 6).
- Consistency is important: where possible, people prefer to have the same nurse/named nurse (linked to Recommendation 5).
- Nonregistered workers should have a more robust training in learning disabilities (linked to Recommendation 13).

Where we want to be

Going forward, people with learning disabilities, their families and carers have told us that we should keep on doing the things we do now, but reduce the variability they experience and start to extend the role in the following areas.

- Supporting transition from children's to adult services continues to be problematic and carers would value more involvement from learning disabilities nurses (linked to Recommendation 6).
- Learning disabilities nurses could develop their role around discharge planning (linked to Recommendation 7).
- Learning disabilities nurses need to take time to get to know people, build trust and recognise that the person is the expert (linked to Recommendation 5).
- People with learning disabilities, their families and carers would like to be more involved in the selection of learning disabilities nurses, including students and the nonregistered workforce (linked to recommendations 5 and 11).
- People with learning disabilities, their families and carers could be more involved in nurse education for all fields of nursing. Other nurses still need more knowledge and skills in working with people with learning disabilities (linked to Recommendation 11).
- Nurses could expand their role into other areas, such as mental health and prisons (linked to Recommendation 4).

The potential for learning disabilities nurses to undertake new, advanced and extended roles should be developed in line with advances in other fields of nursing. Evidence collected throughout the review would support particular attention being paid to the development of competence around non-medical prescribing, psychological therapies, telehealth, and new roles supporting children and families (see Chapter 2) and people with learning disabilities within the criminal justice system. Some of these are considered in more detail below.

Criminal justice system

A high proportion of people with learning disabilities (7%, compared to 2.5% in the mainstream population (12)) travel through the criminal justice system as victims or perpetrators of crime, in police custody or within courts and prisons. It is essential to ensure that sufficient numbers of learning disabilities nurses work in these services, utilising their specialist skills in assessment, planning, diversion (where appropriate) and liaising with different agencies within custodial settings and after release.

Non-medical prescribing

Non-medical prescribing offers opportunities to improve access to medicines and reduce waiting times and is positively viewed by people who have experienced it as part of their care (13). The potential for extending roles through non-medical prescribing for learning disabilities nurses should be explored, particularly in relation to epilepsy and mental health care.

Positive practice example

Non-medical prescribing

An epilepsy nurse specialist in Northern Ireland is demonstrating the benefits to people with learning disabilities of undertaking a non-medical prescribing course.

The epilepsy specialist nurse role is varied in that it involves clinical management, education and training, and practice development. The post-holder recognised opportunities to provide advice to people with learning disabilities, their families and carers on medication changes rather than them having to wait for the medical clinician, enabling a timely, effective treatment regime to be initiated and reducing risks by preventing seizures and/or adverse effects.

As a result, the nurse sought to further her knowledge and skills to support competency in prescribing and titrating antiepileptic drugs and her understanding of pharmacokinetic properties and interactions. She successfully completed the non-medical prescribing course and an epilepsy nurse prescribing pathway was agreed within service.

She is now in a position to advise people with learning disabilities, their families and carers on medication changes promptly, based on assessed need. As is the case with the medical consultant who reviews the client's epilepsy at outpatient clinics, she will recommend medication changes to the client's GP, enabling the person's electronic record to be updated and the necessary medication to be provided for the long term. She also provides expert knowledge around epilepsy in people with learning disabilities to support GPs.

For more information, contact Edna O'Neill at

Psychological therapies

A growing evidence base around psychological therapies and their benefits for people with learning disabilities supports the development of relevant skills by learning disabilities nurses (14,15). Nurses are encouraged to maintain and practice psychological interventions, supported by effective supervision. The ethos behind this process is to enable nurses to deliver approaches in line with a stepped-care framework, ensuring assessment and treatment delivery at the earliest opportunity and linking with other parts of the care system to reduce hospital admissions.

Telehealth

The increasing use of telehealth and telemonitoring across the UK has the potential to advance the personalisation, strengths-based and assets-focused agenda for people with learning disabilities, their families and carers. Learning disabilities nurses need to explore this potential within the systems in which they work.

Recommendation 3

The development of new, specialist and advanced role opportunities should be considered in light of workforce planning, service development and education provision. In particular, this should focus on the roles of non-medical prescribing, psychological therapies and telehealth and in specific settings such as the criminal justice system, mental health services (particularly dementia) and autism services.

1.4 Career choices

Where we are now

The range of statutory and non-statutory employment opportunities, alongside the integration of health and social care services, means that career choices are not always clear and career options can be limited by a lack of transferability between sectors and employers.

Where we want to be

Career pathways and progression should be clear across all services and settings to allow learning disabilities nurses to plan their career development. *Modernising Nursing Careers* (11) introduced the notion of structured career planning for nurses to enable them to develop knowledge and skills within existing roles that would also allow progression to more senior roles. Many initiatives relating to different levels of the NHS career framework have subsequently been advanced throughout the UK.

Education and training elements at all levels of the NHS career framework should be further developed to outline the knowledge, skills, attitudes and values required by the learning disabilities nursing workforce, including those in specialist practice and consultant nurse roles. This would enable the planning of education to meet workforce development needs, better meet the needs of people with learning disabilities, their families and carers, and act as the foundation for informing future developments in post-registration learning disabilities nursing education, research and scholarly activity. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework.

Positive practice example

Supporting reasonable adjustments

Working as a consultant nurse and senior lecturer, Jim Blair has a remit to lead the delivery and development of clinically effective, safe, lawful and appropriate practice within acute services for people with learning disabilities. The following examples show how the consultant nurse has been able to drive reasonable adjustments in hospitals to enhance the care and treatment experienced by people with learning disabilities.

Katherine has severe learning disabilities and her passport* says she is allergic to eggs. After reading this, the ward sister telephoned Katherine's home to clarify whether she experienced anaphylactic reactions or a rash. This was a precautionary measure, rather than a response to anything that had happened.

Vivek's passport stated that he "bubbles up liquids and regurgitates food". A doctor noted this and knew that this could indicate dysphagia, which can result in a person choking. Dysphagia is more common in people with learning disabilities, so it is vital to look for indications, as there were in Vivek's case, and quickly identify how to ensure optimum nutrition.

Without hospital passports, serious issues may be missed or left unaddressed. Clinicians at St George's Hospital in London were able to act on the information in the passports and to alert colleagues about the issues, resulting in effective care and treatment for both individuals.

Core reasonable adjustments at St George's

The following are standard for people with learning disabilities, their families and carers in St George's Hospital to help reduce anxiety, permit experts (such as family) to provide emotional and advocacy support, and to enable professionals to treat people in an efficient and timely way.

- No fixed visiting times for family, carers and friends of people with learning disabilities is general policy, so they can be with them for as long as they want.
- Food and drink is offered to family and carers to ensure they can be with the person they support at any time.
- The first or last appointment of the day should always be offered, so people who find it traumatic to wait do not have to do so.
- Double appointments are helpful because they permit a fuller assessment of people's needs, which is likely to result in more effective treatment and outcomes.
- A bed and/or chair are provided for a family member or carer.

For care and treatment to be equitable, adjustments need to be made so that the health care experiences and outcomes of people with learning disabilities in hospital are improved. An example of reasonable adjustments at St George's involved Trevor, a man who had capacity to consent to have dialysis but who pulled out the tubes after 30 minutes because he was unable to judge how long the procedure had taken and wanted to leave. The reasonable adjustment in his case was to provide a health care assistant to be with him throughout the four-hour treatment to talk with him and encourage him to complete dialysis. Over time, he stopped needing to have someone with him and now has dialysis by himself.

For further information, contact Jim Blair at [redacted]

*A hospital passport is a guide to the individual's health and well-being that is completed in advance of the hospital visit so that hospital staff have an accurate record of key information relating to their health and medical history (source: [redacted]

Recommendation 4

Each of the four countries should consider aligning their existing post-registration career frameworks for learning disabilities nursing to clearly articulate the knowledge and skills required by learning disabilities nurses at all levels and across all settings. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework.

Chapter 2
Strengthening capability

"Learning disabilities nursing is vital for ensuring people with learning disabilities and their carers get access to general health care in the same way as you or I do. They help people navigate the NHS system to ensure people with learning disabilities, their families and carers get the best health outcomes and support possible. They also support other health professionals to modify their delivery care models to best suit the client's circumstances and enable the delivery of true person-centred care."

Deputy director of nursing, general hospital

Chapter 2. Strengthening capability

This chapter outlines key considerations underpinning efforts to ensure a competent and flexible learning disabilities nursing workforce for the future by:

- **maximising the contribution of learning disabilities nursing**
- **working with people of all ages**
- **addressing health needs**
- **providing specialist services.**

2.1 Maximising the contribution of learning disabilities nursing

Where we are now

The Royal College of Nursing (16) defines nursing as:

> *"The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems and to achieve the best possible quality of life whatever their disease or disability, until death."*

Learning disabilities nurses are the only professional group specifically prepared to work with people with learning disabilities. This level of preparation, currently provided at degree level, alongside the breadth of biopsychosocial skills, competence and knowledge they develop, makes them a unique and critical component of the delivery of comprehensive services.

Too often in this review examples were cited of how learning disabilities nursing is being under-utilised. Considering the small pool of registered learning disabilities nurses available across the UK and the workforce challenges ahead, it is essential that their expertise is used to best effect for the populations they serve.

Where we want to be

A central requirement for the transformation agenda across the four countries and across all organisations is the need to target the skills, knowledge and competencies of learning disabilities nurses to the right people, in the right places and at the right times.

Positive practice example

Prescriber nurse-led clinics – a community model for people with learning disabilities and epilepsy

A community learning disabilities nurse in Gloucestershire has developed a nurse-led service to enhance epilepsy care for people with learning disabilities, reducing the risk of sudden unexpected death in epilepsy (SUDEP).

Regular appointments, partnership working and training have led to improved recording and medication concordance. This has enabled effective evidence-based nurse prescribing to rationalise people's medication. Reasonable adjustments have also been made by strengthening links and providing relevant data to support access to generic services.

Health outcomes have included:

- 75% seizure reduction;
- 33 people on the epilepsy care pathway with history and medication timeline;
- 9 people accessed a bone density scan, with 7 bone disorders identified (2 results pending);
- 5 women on long-term valproate medication accessed ultrasound scans, with 4 ovarian conditions identified (1 outcome awaited); and
- 544 hours of epilepsy training delivered to carers, empowering people to manage their condition.

The following have been implemented to reduce the risk of SUDEP:

- 17 epilepsy night bed monitors
- risk management plans
- protocols for all people prescribed rescue medication.

Quality, innovation, productivity and prevention savings have also been realised, including:

- reduced unscheduled hospitalisation and emergency calls through improved seizure control, risk management plans and prevention of fractures;
- reduced fuel and travel costs to complement the organisation's Green policy;
- improvements in training, appointment attendance, monitoring and medication concordance, with rationalisation of therapy;
- auditable outcomes using the National Institute for Health and Clinical Excellence's (NICE's) epilepsy-adapted learning disability tool;
- reduction in "did not attends" (13 of 412 consultations); and
- the nurse achieving up to 83 quality monthly contacts (working 22.5 hours/week).

For further information, contact Penny Shewell at [redacted]

Recommendation 5

Commissioners and service planners should have a clear vision for how they ensure the knowledge and skills of learning disabilities nurses are provided to the right people, in the right places, and at the right time in a way that reflects the values- and rights-based focus of learning disabilities nurses' work.

2.2 Working with people of all ages

Where we are now

Learning disabilities nurses already make a key contribution to quality nursing service delivery across the lifespan. This includes contact and interventions with babies and children, during school years, at transition to and throughout adulthood and, increasingly, in the later years to end of life. The skills and competencies of learning disabilities nurses must be available at these key life stages.

Where we want to be

Early years

Learning disability nurses should give specific and conscious attention to ensuring the health needs of children and young people with learning disabilities are appropriately prioritised and addressed. Their skills, knowledge and expertise must be maximised to ensure high-quality services and interventions for children with learning disabilities and their families (17).

Not all children with learning disabilities will require support from learning disabilities nurses, and it is essential that the shift towards improving access to general health services for children continues. Learning disabilities nurses nevertheless possess specific knowledge and competencies that can bring added value, particularly to those with the most complex needs, and they must be a central component of services that deliver care to this population in areas such as skills development, mental health and emotional well-being, behavioural management, complex physical health needs and family-focused intervention and support.

Positive practice example

Supporting parents with learning disabilities – new ways of working

The special parenting service in Cornwell provides assessment of parenting skills for people with learning disabilities who are expecting a baby. Areas where support or teaching is required are identified following assessment of knowledge on all aspects of parenting. The service also provides support, advice and consultation to statutory agencies, midwives and health visitors.

Following birth, the nurses work with all agencies involved to ensure that parents can provide "good enough" parenting, ensure that safeguarding issues do not arise and provide follow-up support to parents at identified key developmental stages. The *Parent Assessment Manual* is used as an initial assessment tool: this is designed to assess parenting ability for those with mild learning disabilities. Following assessment, interventions can include solution-focused therapy, video interaction guidance therapy, family therapy and skills teaching. Outcomes include:

- enabling clients to gain the knowledge and skills required for successful parenting
- raising confidence and self-esteem levels
- ensuring good attachment
- reducing family members' concerns about the parents' ability to succeed
- empowering the parents to feel confident to access universal services
- reducing the number of referrals to children's social care over safeguarding issues.

Next steps for the service are to:

- work in collaboration with universal services, midwives and health visitors to promote early referral to special parenting;
- collate evidence from the early intervention project to identify the effectiveness of current interventions; and
- be aware of current evidence-based practice and best-practice guidance to ensure that standards are maintained at the highest level.

For further information, contact Jan Line at [redacted] and Paul Thomas at [redacted]

Older age

Learning disabilities nurses must be prepared for the continuing rise in the number of older people with learning disabilities. These individuals are at risk of a range of physical and mental health conditions and may be frequent users of health and care services and other related agencies. In addition, some people with learning disabilities may be at risk from conditions that are similar to those experienced by older people (such as dementia), but may be too young to access generic older people's care services.

Recommendation 6

Commissioners and providers of health and social care should ensure the skills, knowledge and expertise of learning disabilities nurses are available across the lifespan. This should be enabled through effective collaborative working across health and social care structures.

2.3 Addressing health needs

Where we are now

There is strong evidence that people with learning disabilities have poorer physical and mental health and greater health needs (including needs related to behavioural difficulties) than the general population. In addition, many have difficulties accessing and using general health services. Learning disabilities nurses have expertise in facilitating and supporting access to general health care services.

The Nursing and Midwifery Council (NMC) standards for pre-registration nursing education (18) reflect the health role and function of learning disabilities nurses, stating:

> *"Learning disabilities nurses must have an enhanced knowledge of the health and developmental needs of all people with learning disabilities, and the factors that might influence them. They must aim to improve and maintain their health and independence through skilled direct and indirect nursing care. They must also be able to provide direct care to meet the essential and complex physical and mental health needs of people with learning disabilities."*

The contribution of learning disabilities nursing in addressing health needs within the social model of disability has been the source of some confusion. It is important that learning disabilities nurses and services recognise that poor health (in its widest context) limits participation in society.

Where we want to be

As the Learning Disability Consultant Nurse Network (19) states:

> *"The primary focus of learning disabilities nursing interventions within the social model of disability is upon reducing or eliminating barriers to good health and thereby increasing social inclusion."*

Learning disabilities nurses and their employers should recognise their crucial responsibility in improving health and well-being and reducing inequalities and should engage actively in commissioning, designing, monitoring and delivering services to ensure their accessibility.

A partnership approach across the lifespan involving primary care, child health, mental health, secondary care and specialist learning disabilities health services is essential.

Learning disabilities nurses are ideally placed to contribute to the preventative, early-intervention, strengths-based and public health approaches that are increasingly being applied to the general population to address health needs. While health promotion activity has been at the forefront of learning disabilities nurses' practice for many years, other more proactive preventative and public health approaches to addressing health needs have been less visible in their day-to-day work.

This broader holistic approach to addressing health needs will:

- ensure preventative action and early intervention is a core component of assessment and care planning;
- encourage people with learning disabilities, their families and carers to take a more active role in controlling their own health; and
- support strengths- or assets-based approaches to care and interventions.

There is a clear need for public health interventions to meet the needs of people with learning disabilities, their families and carers and for learning disabilities nurses to engage with colleagues within public health, primary care and other relevant health and cross-sectoral agencies, such as criminal justice and homelessness services.

A proposed model for addressing health needs in the context of learning disabilities nursing is set out in Fig. 1.

Fig. 1

Proposed model for addressing health needs in the context of learning disabilities nursing

Context		Nursing roles/interventions		Outcomes
Working with children	→	Family support. Early intervention. Skills teaching.	→	Maximised potential of the child. Improved interagency working. Reduced incidence of long-term health issues.
Inequalities in health	→	Health screening/facilitation. Health action planning/ interventions. Improving access. Education of others. Policy-influencing. Advocacy.	→	Healthier lifestyles. Reduced morbidity and mortality. Reduced risk for patients in generic services. Social inclusion.
Working with parents and families	→	Supporting parents and siblings of people with learning disabilities. Supporting parents with learning disability. Family therapy. Education/awareness.	→	Family-orientated service delivery. Reduced safeguarding issues. Improved family health and lifestyle.
People facing additional risks	→	Targeting relevant public health needs (e.g. mental health, drugs/alcohol and sexuality). Group interventions. Strengths-based approaches.	→	Enhanced self-care, peer support and independence. Reduced risk and safeguarding issues. Reduced self-harm and distress.
Commissioning	→	Caseload/population needs assessment.	→	Improved and informed commissioning of services.

Positive practice example

Health facilitation

The health facilitator role focuses on ensuring people with learning disabilities live healthier lives and enjoy better health. A significant number of adults with learning disabilities are not receiving a service from community learning disabilities teams but are known to GP practice staff.

A database is presently being constructed in the Southern Trust region of Northern Ireland to provide accurate figures. All practices have been visited by the health care facilitator who will:

- meet with the practice manager to cross-reference names of adults with learning disabilities with practice population lists;
- deliver an education session to GPs, practice nurses and reception staff on health needs and barriers to meeting need;
- encourage practice staff to establish clinics and complete a thorough health check on each individual;
- explain the requirements of the direct enhanced services (DES); and
- agree dates for clinics with GPs and advise on how to ensure good uptake of appointments.

Figures from primary care show that 932 health assessments were carried out in 2009 and 904 in 2010. GPs and practice nursing staff appreciate clinical input and support to develop understanding about people with learning disabilities, especially around behaviour management, communication difficulties, consent issues and health needs. Analysis to date suggests that practices with the health facilitator on site are more likely to meet the requirements of the DES.

A large number of health issues have been identified, including obesity, diabetes, hypertension, lack of medication review and lack of electrocardiograms for people on anti-psychotic medication. Many of these health issues have previously been undetected and unaddressed. GPs and practice staff have developed a rapport with people with learning disabilities, their families and carers, and practice staff have a better understanding of their health issues.

For further information, contact Brea Crothers at [redacted] or Marie Loughran at [redacted]

Recommendation 7

Commissioners and providers of health and social care should ensure that learning disabilities nurses are able to collaborative effectively with general health services, including mental health services, to address the barriers that exist for people with learning disabilities to improving their health. This should include proactive health improvement, prevention, whole-family and public health approaches.

2.4 Providing specialist services

Where we are now

Existing specialist services, when appropriately deployed, provide early intervention, crisis resolution and outreach that can reduce unnecessary admissions to hospital through expert assessment, care planning, interventions and evaluations for individuals and their families.

The need for specialist nursing skills in these areas is already significant and is likely to grow in the future. Learning disabilities nurses working within specialist services should possess, or be working towards developing, the appropriate specialist skills and should be able to demonstrate higher levels of judgement, discretion and decision-making in clinical care (20) relevant to their role.

Where we want to be

Evidence collected by the review suggests that assessment and treatment services could further develop and use a range of therapeutic interventions that have positive outcomes for people with learning disabilities. This would require further support and investment in education and development. The specialist role of learning disabilities nursing within assessment and treatment services must therefore be supported through the development of appropriate models of care and provision of relevant education support.

Health care providers and commissioners should review the needs of their populations and make provision to ensure delivery of specialist learning disabilities nursing skills where needed. This may involve reviewing their current workforce configuration and increasing collaboration with education providers.

To ensure that people with learning disabilities and their families receive the best holistic care, skills traditionally associated with acute and community nursing will need to become a core part of learning disabilities nurses' "toolkit".

Positive practice example

Specialist services

A low-secure unit that provides assessment and treatment for men with learning disabilities and forensic issues in Northern Ireland has developed group work and 1:1 therapeutic work for individuals who exhibit behaviours (or who are at risk of committing behaviours) that are sexually harmful to others.

The assessment and treatment programme initially implemented for this group was the Home Office accredited "Adapted Sex Offender Treatment Programme". Prior to implementation, two nursing staff were required to undertake intensive accredited training in advanced group work delivery and complete a period of secondment with probation services, delivering programmes and compiling risk assessments and management plans for offenders. Further training was then completed to deliver treatment specifically to those with learning disabilities.

The programme was based on the cognitive behavioural therapy model, giving individuals the opportunity to take responsibility for their offending behaviour and work towards skills development that would help them identify their specific areas of dynamic risk and formulate relapse-prevention strategies to lower their risk of reoffending.

The work was acknowledged in 2008 when two nurses from the hospital were granted the RCN Nurse of the Year for Northern Ireland award in recognition of setting up and facilitating a programme of treatment that at the time was unparalleled in Northern Ireland.

Nursing staff are providing consultancy on facilitation techniques, programme content and delivery. It is envisaged that nurses who are already qualified to deliver advanced group work will also become involved in training other staff to deliver the new programme. This will lead to a core group of nurses within the hospital who are able to work as therapists, delivering treatment within group work and 1:1 settings and compiling risk assessments and management plans in partnership with people with learning disabilities to facilitate return to community living in the most appropriate and safest way.

For further information, contact Rhonda Scott at

Recommendation 8

Commissioners and service providers should ensure that specialist learning disabilities services for complex and intensive needs (including assessment and treatment services across all sectors) employ sufficient numbers of appropriately prepared and supported registered learning disabilities nurses. This highlights the need to support and develop the availability of specialist and advanced clinical skills and knowledge of learning disabilities nurses in all settings.

"I had concerns about the [learning disabilities nurse] student being there… they were completely dispelled… His understanding and natural affinity for dealing with difficult situations mean if he is an example of the future we have no issues."

Family carer

Chapter 3
Strengthening quality

"Learning disabilities nurses listen to you and make sure I have a say about what happens to me."

Person with learning disabilities

ABERCROMBIE
18
92
YORK
ABERCROMBIE AND FITCH

Chapter 3. Strengthening quality

This chapter addresses some of the key considerations underpinning quality. Clearly, the appropriate preparation and development of learning disabilities nursing will contribute to all chapters of this report, but in this case has been linked to quality in relation to the following issues:

- **demonstrating quality outcomes**
- **quality improvement**
- **preparing and developing learning disabilities nurses**
- **maximising recruitment and retention**
- **developing workforce knowledge and skills for the future**
- **accessing supervision.**

3.1 Demonstrating quality outcomes

Where we are now

Demonstrating the quality, effectiveness and impact of learning disabilities nursing through outcome measurement presents a range of challenges, not least of which is the fact that learning disabilities nurses' work is often placed within a wider interdisciplinary and interagency team context that makes it difficult to identify their particular contribution to achieving outcomes.

Where we want to be

Positive health outcomes not only improve people's health status and quality of life, but also contribute to the achievement of organisational and policy drivers such as person-centredness, safety, effectiveness and efficiency through improving access to general health services, preventing admissions to hospital and securing early discharge.

A measurement framework of outcomes and outcome indicators would allow learning disabilities nurses to demonstrate their effectiveness in assessments, care planning and nursing interventions at individual and service levels within a multidisciplinary context. The potential for such measurement frameworks to be adapted and used across sectors to support health and social care integration should be explored.

A measurement framework should focus on effective assessment, care planning, intervention and evaluation. All interventions by nurses, individually or as part of a wider team, should be based on a competent and structured nursing assessment of the abilities and needs of the person with learning disabilities. Person-centred objectives for nursing interventions with identified timescales for evaluation should then be clearly written within nursing care plans.

An agreed set of indicators developed in collaboration with nurses and people with learning disabilities, their families and carers would allow the contribution of learning disabilities nurses to be evidenced and measured. This is particularly important given the current emphasis on efficiency, effectiveness and added value.

A range of outcomes and outcome indicators can identify effective and high-quality nursing care related to specific roles and practice settings. Examples may include:

- improvements in health status
- increasing access to general health services
- promoting independence and social functioning
- improving nutrition
- enhancing psychological and emotional well-being
- reducing seizures.

A more targeted and specific approach to outcome measurement dependent on role, function and setting may also be necessary. Role-specific indicators (for learning disabilities nurses employed, for example, as health facilitators or those working in acute liaison roles or within forensic services), condition-specific indicators (such as for epilepsy nurses), patient experience and quality-of-life outcome measures (via service user questionnaires and surveys, complaints and compliments, for example) and inclusion of learning disabilities in measurement of generic key performance indicators at service or policy level or via established rating scales (such as the Health of the Nation Outcome Scales for People with Learning Disabilities (HONOS-LD) (21)) will be required.

It is important that people with learning disabilities, their families and carers are involved in determining the outcomes.

Positive practice example

Developing behavioural family therapy

A specialist learning disabilities nurse in Lothian has worked with other clinicians in adapting and delivering behavioural family therapy (BFT) for people with learning disabilities and has trained 18 nurses to use the approach. The service now has three BFT trainers who specialise in learning disabilities and has developed close links with general mental health clinicians and trainers.

The approach is being implemented within several community learning disabilities teams. Clinicians now routinely use a series of outcome measures to monitor its effectiveness, with the client completing the Clinical Outcomes in Routine Evaluation – Learning Disability (CORE-LD) assessment and family members completing the Caregiver Strain Questionnaire (CGSQ) and the Family Functioning Questionnaire (FFQ). Care agency staff also complete an adjusted FFQ.

A successful case study demonstrating a reduction in carer stress for a family member and an increase in functioning for support staff and the family member was presented at the British Association of Behavioural and Cognitive Psychotherapy conference in 2011. A case series of five families was presented at the Seattle Club conference on research in intellectual and developmental disabilities in 2011. The results demonstrated a decrease in family stress on the CGSQ over the five cases, with family functioning improving in all members. There was a decrease in levels of distress in three of the four people with learning disabilities who completed the CORE-LD. It is noteworthy that services had been involved over a prolonged period of time for all five cases, suggesting that their problems were longstanding and that other treatment approaches had not been effective.

Learning disabilities nurses have increased knowledge and confidence following BFT training. The training has also given clinicians a clear structure to deliver the approach. Regular supervision has helped to maintain delivery while maintaining clinician confidence. Plans to further develop this work include:

- continuing to develop the evidence base evaluating the efficacy of the approach;
- expanding the BFT training to all community learning disabilities teams in NHS Lothian and continuing to expand the supervision network;
- developing better pathways for referrals and level of intensity of BFT based on the complexity of mental health issues;
- extending the BFT training to social work, allowing better joint working between health and social care; and
- establishing links with NHS Education for Scotland with a view to developing the approach for nurses on a wider scale.

For further information, contact Keith Marshall at [redacted]

Recommendation 9

Learning disabilities nurses, their managers and leaders should develop and apply outcomes-focused measurement frameworks to evidence their contribution to improving person-centred health outcomes and demonstrating value for money. This may require a specific piece of work to scope current frameworks.

3.2 Quality improvement

Where we are now

Learning disabilities nurses embrace the wider drive for evidence-based practice and improvement, but their contribution could be enhanced. Transformational work is currently being undertaken across the UK under patient safety programmes and work to drive quality, innovation, productivity and prevention. Elements of learning disabilities nursing practice may benefit from the systematic application of productivity tools like the Productive Series/Releasing Time to Care and robust improvement science.

Where we want to be

Learning disabilities nurses should increase their involvement in the range of transformational work, productivity, improvement and practice development.

Recommendation 10

Learning disabilities nurses should strengthen their involvement and links to transformational work, productivity improvement and practice development.

3.3 Preparing and developing learning disabilities nurses

Where we are now

A well-prepared, developed and supported workforce at all levels is essential to the delivery of quality health care for people with learning disabilities, and education and training throughout the career pathway is key to achieving this.

People with learning disabilities, their families and carers should be involved in all aspects of curriculum design, development and delivery.

Person-centred care (22) should be the foundation of learning disabilities nurse education. It has been defined as:

> *"... the delivery of a healthcare experience that recognises and responds flexibly to each person as a unique individual, builds trust and empathy, and engages them in decisions that affect their healthcare and wellbeing. Person-centred care is an approach which recognises that the quality of communication and human engagement with the person receiving healthcare will underpin the effectiveness of the clinical encounter, and therefore impact on the person's healthcare experience and outcomes."*

This means working alongside people to identify meaningful goals that fit with their aspirations and the outcomes they want to achieve, rather than focusing on what health and social services think people need.

Where we want to be

Pre- and post-registration education programmes should be designed to reflect issues such as person-centred care and the personalisation agenda and the more complex care needs that are now presenting within the population.

This review focuses on learning disabilities nurses, but the importance of all nursing students at undergraduate level developing core knowledge and skills to work with people with learning disabilities, their families and carers cannot be ignored. This has been emphasised with the NMC standards for pre-registration nursing education (20) and the Michael Report into access to health care for people with learning disabilities (23).

Positive practice example

Supporting the development of skills and knowledge in other fields of nursing (percutaneous endoscopic gastrostomy (PEG))

People who are reliant on their nutrition, hydration and medication being administered via PEG can experience difficulties when their devices block or are removed. This can result in attendance at accident and emergency departments. Community learning disabilities nurses in Swansea work in collaboration with the accident and emergency liaison nurse, specialist nutrition nurse and hospital nurse practitioners to develop individual pathways for direct access to intervention. The outcomes of this work include:

- clear and safe pathways to access secondary care
- reduced risk of invasive interventions such as surgery or endoscopic procedures.

The nurses also identified that people with learning disabilities who had enteral feeding needs were sometimes having to access nursing home facilities for respite care, were relying on registered nurse home visits for domiciliary care, and were unable to access day services unless registered nurses were available. The community learning disabilities nurses worked in partnership with a wide range of organisations to develop a programme of training for independent sector care providers and social services to enable individualised person-centred care plans to be devised, meaning people no longer have to access nursing environments for respite and day services or be reliant on district or continuing care nursing services to deliver support. This process entailed seamless joint working and planning to minimise the identified risks to individuals and those involved in their care, while promoting person-centred services.

For further information, contact Helen Lewis at [redacted]
or Paula Phillips at [redacted]

Recommendation 11

Those who commission, develop or deliver education should ensure that all learning disabilities nursing education programmes reflect the key values, content and approaches recommended in this report. They should also ensure that nurses in other fields of practice develop the core knowledge and skills necessary to work safely and appropriately with people with learning disabilities who are using general health services.

3.4 Maximising recruitment and retention

Where we are now

As we noted previously, the number of providers of pre-registration learning disabilities nursing education has reduced over the years. This will need to be addressed to reflect population and workforce planning needs.

Access to learning disabilities nurse preparation can be problematic for students in some parts of the UK, including remote and rural areas where no learning disabilities nursing education programmes are available locally. High attrition rates are a problem on some pre-registration programmes and the changing face of service provision for people with learning disabilities requires higher education institutions to develop a range of options for clinical placements that support the attainment of competences required by the NMC.

Throughout the review, students said that they feel more valued and better supported where there is strong mentorship in practice placements and close collaboration between practice and education settings. There are opportunities for learning disabilities nursing to trailblaze new models of delivery in education programmes that strengthen work-based support for students and enhance partnership working between education and practice settings.

Where we want to be

New approaches to identify and engage with potential recruitment pools, particularly existing nonregistered staff and students undertaking higher national certificate (HNC) programmes in further education colleges, are required. These opportunities are currently underexploited. The use of IT and social media may offer a route to accessing these groups.

The development of a wider range of accelerated routes and award models could further maximise potential to recruit from existing groups, including nurses on other parts of the register and people wishing to change their careers.

The wide range of educational technology now available provides more flexible options in relation to delivery of education programmes. Flexible and sustainable models of pre-registration curriculum development offer the most positive options for future progression in learning disabilities nursing, and the NMC standards promote these kinds of approaches. Models that support flexibility and sustainability, such as hub and spoke, blended learning approaches and disseminated models, should be considered to support effective delivery of pre-registration education across the UK. Innovative approaches to programme design and delivery that involve people with learning disabilities and families, promote rights-based and person-centred approaches and review options in interprofessional education must be more widely explored.

Recommendation 12

Updated strategic plans for pre- and post-registration learning disabilities nursing programmes are necessary for each country of the UK to support flexibility and ensure an efficient and sustainable model of delivery for the long term. This highlights the need for appropriate numbers of places on pre-registration learning disabilities nursing programmes to meet future workforce requirements.

3.5 Developing workforce knowledge and skills for the future

Where we are now

Post-registration education and continuing professional development (CPD) options are restricted by the relatively small learning disabilities nursing workforce. In addition, data on education needs and development opportunities, including those at post-registration level, are not easily available.

The skills profile of learning disabilities nursing is changing, with greater emphasis being placed on meeting complex health needs and employing specific interventions such as psychological therapies; some learning disabilities nurses are also assuming prescribing responsibilities. There are opportunities for higher education institutions and CPD providers to respond to these changes in the development and delivery of their programmes.

Nonregistered staff already play a vital role, which will change as the role of registered nurses develops. It is important that service providers build an educational infrastructure that meets the needs of this group.

Where we want to be

Creative opportunities for the development of education programmes include blended learning approaches, collaborative working across education providers and across sectors and further development of interprofessional education opportunities.

Positive practice example

Collaborative curriculum design and delivery

The learning disabilities team at Edinburgh Napier University has worked with people with learning disabilities, their families and carers, mentors and other stakeholders for a number of years to influence, design and deliver pre-registration nurse education for learning disabilities. People with learning disabilities, their families and carers and learning disabilities nurses are involved in the selection and interview of students and in developing learning materials, delivering sessions in the classroom, online and in the clinical skills labs, and assessing students in practice.

This partnership approach is central to education provision. In addition to a wide group of people who work as associate lecturers, a learning disabilities nursing development group and stakeholder group meet regularly to review and develop joint initiatives such as creating new modules, expanding the use of educational technology, supporting practice learning environments and promoting practice-based projects. The content of the learning materials has application to practice and the involvement of experts in delivery ensures students experience a strong focus on person-centred, family-centred health care that is relevant to practice.

With the move to increasing use of online technologies, a strategy is being developed to support people with learning disabilities, their families and carers and mentors to develop skills and competence in using technologies such as Elluminate Live and online discussion forums. This work has been commended by NHS Education for Scotland and the agency undertaking revalidation work for the NMC.

For further information, contact Janet Smith at [redacted]

Recommendation 13

Education providers and services must work in partnership to ensure that educational and developmental opportunities for nonregistered staff are developed and strengthened and their benefits are evidenced through appraisal systems, and that educational and development opportunities are available for registered learning disabilities nurses to support their ongoing development, reflecting the needs of people with learning disabilities.

3.6 Accessing supervision

Where we are now

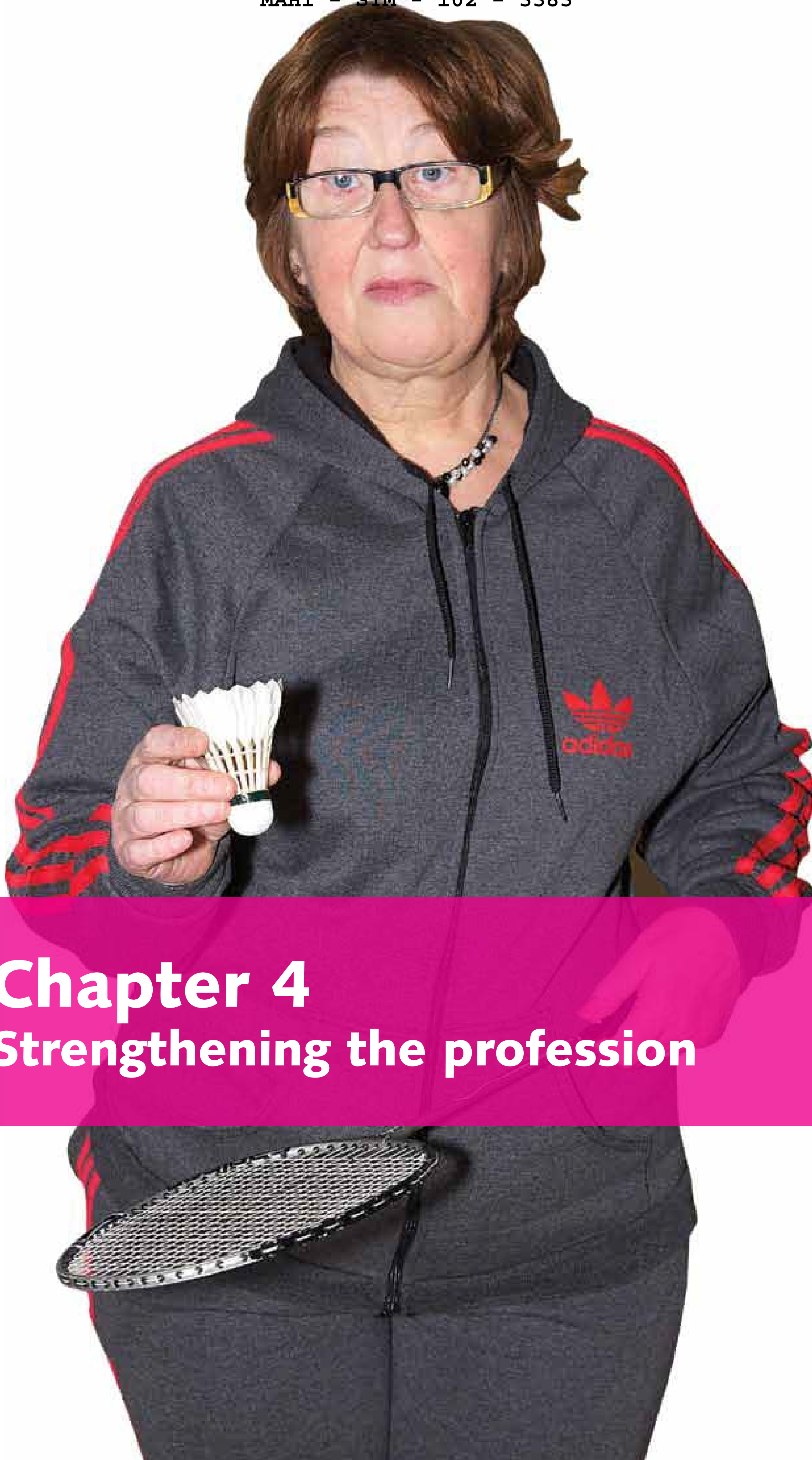
Clinical supervision is recognised as a supportive way to enable learning from experience with the aim of developing knowledge and improving care (24). It was evident through the review processes that learning disabilities nurses engage in supervision at a number of levels and with a variety of professionals during their careers. Engagement with clinical supervision nevertheless varies throughout the UK and possibly between sectors.

Where we want to be

Given the link between effective supervision, reflective learning and safe person-centred practice, supervision should be viewed as essential to contemporary learning disabilities nursing practice and must be supported by employers and nurses. They can demonstrate its value by creating and maintaining protected time and support for clinical supervision and by seeking to illustrate the outcomes of supervision in a way that demonstrates improvements in care.

Recommendation 14

Services should provide systems to ensure that learning disabilities nurses have access to regular and effective clinical supervision and that its impact is monitored and evaluated on a regular basis.



Chapter 4
Strengthening the profession

"Learning disabilities nurses listen to us and respect us as adults."

Person with learning disabilities

"My eyes have been opened to the world of adults with learning disabilities by the learning disabilities nurse. Delivering teaching sessions about young people and transition together has been an invaluable learning experience for us both."

Consultant paediatrician

Chapter 4. Strengthening the profession

This chapter addresses some of the key considerations underpinning modernising the learning disabilities nursing workforce in relation to:

- **leadership and management**
- **promoting the profession**
- **research and evidence.**

4.1 Leadership and management

Where we are now

Health and social care structures often bring together learning disabilities, mental health and/or community services, which means there may not be a senior learning disabilities nurse in a leadership role to ensure that learning disabilities nursing issues are identified and addressed. This local situation is reflected at national level: devolution in the UK has led to differences in policy and service provision across the four countries, which impacts on how leadership is defined nationally. There may not always be clear opportunities for learning disabilities nurses to demonstrate political leadership at this level.

There has been a lack of investment in some areas in leadership roles at senior level, including consultant nurse and advanced nurse practitioner roles, despite changing patterns of need giving rise to a requirement for strong leadership to drive the development of appropriate service provision.

Changing patterns of service provision and organisational structures have had an impact on the scope of management roles, affecting managerial responsibilities, accountability lines and supervision and appraisal mechanisms. Learning disabilities nurses working in multidisciplinary teams often manage, and/or are managed by, other professions.

The demographic profile of the profession indicates that many managers will be retiring from services over the next decade, resulting in a need for sophisticated workforce and succession planning.

Where we want to be

Strong leadership in learning disabilities nursing is essential, given the challenges set out in earlier chapters. Leadership is also important to drive forward the profession and to ensure a modernised workforce is in place to meet current and future needs. Learning disabilities nurses need to continue to acknowledge and develop their clinical leadership responsibilities and demonstrate and develop strong professionalism.

The leadership role should be supported through the development of clear career pathways, succession planning and leadership "champions" in all areas and through the creation of consultant nurse posts in key areas where there currently are none.

The need for a dynamic career and development framework to support learning disabilities nurses to become the leaders and managers of the future has been covered in Recommendation 4.

Positive practice example

Leading and influencing services (palliative care)

Community learning disabilities nurses in Bridgend, Wales demonstrated leadership in service development through making links with local palliative care services to increase their knowledge base and to "map out" services. Working collaboratively with these services, it became evident that individuals with learning disabilities within the locality rarely accessed palliative care services, which reflects the wider picture nationally.

The learning disabilities nurses identified resources to support people with learning disabilities, their families and carers and took measures to raise awareness of their needs for palliative and end-of-life care through an initiative called "Living Well, Dying Well." This and other measures were presented at a national palliative care conference in 2011.

The awareness-raising has led to requests to provide advice and support, creating opportunities to forge closer links with other services to meet the needs of people with learning disabilities, their families and carers. This work is continuing, with learning disabilities nurses:

- investigating systems to identify individuals with learning disabilities who have a life-limiting condition (this database will enable health professionals to strategically plan person-centred care for their future palliative and end-of-life care needs);
- continuing to work collaboratively with palliative care services to improve experiences of life and death; and
- continuing to contribute to the evaluation of the palliative care and end-of-life pathway with the aim of improving its efficiency.

For further information, contact Sharon Dixon at [redacted]
or Claire Jenkins at [redacted]

Recommendation 15

Leadership in learning disabilities nursing needs to be strengthened in practice, education and research settings with robust, visible leadership at all levels, including strategic and national levels. Services must ensure all learning disabilities nurses in clinical practice have access to a dedicated professional lead for learning disabilities nursing. In addition to existing leadership and development programmes, a UK-wide cross-sector project to nurture and develop aspiring leaders in learning disabilities nursing will be led by the four UK health departments.

4.2 Promoting the profession

Where we are now

Learning disabilities nursing has traditionally had a low profile among the general population and has received less focus than other nursing fields in policy over recent years. The demographic and policy challenges described throughout this report nevertheless mean that raising the profile of learning disabilities nursing is now more important than ever.

Learning disabilities nurses have historically embraced networking, and the strong existing networks for learning disabilities nurses across the UK provide a powerful platform from which to celebrate and promote their unique contribution.

Where we want to be

It is important that the profession is promoted to ensure all sectors are aware of the unique contribution and added value that learning disabilities nurses offer and that learning disabilities nursing is presented as a positive and rewarding career choice.

Promoting the image of the learning disabilities nursing profession therefore has an important part to play in encouraging recruitment, but it goes further than that. It is also about demonstrating to people with learning disabilities, their families and carers, the wider public, fellow professionals and policy-makers the advantages that learning disabilities nurses bring and developing their understanding of what they can deliver.

As part of that endeavour, partnership working with the RCN focusing on how the profession can be promoted to wider professional and lay audiences is being progressed, with a promotional resource under development. This work is expected to be completed in 2012.

The health and social care agenda provides further opportunities for developing networks that could strengthen partnership working across the profession in all sectors. Investment in forward-thinking, high-quality networks could support many of the initiatives outlined in this report.

Positive practice example

Managed Knowledge Network Learning Disability Portal, NHS Education for Scotland (NES)

The Managed Knowledge Network (MKN) Learning Disability Portal, supported by NES Knowledge Services, supports the health and social care workforce working with people with learning disabilities.

The MKN portal provides a sustainable, flexible and responsive means of ensuring that contemporary information on health needs and learning disabilities is available to the workforce quickly and efficiently, providing a platform for sharing best practice, promoting educational opportunities and hosting resources. The link to the Knowledge Network allows access to online journals and 500 bibliographic databases.

The portal also serves to bring together organisations and people with a common interest in finding, sharing and using knowledge to support people with learning disabilities. It includes online opportunities for accessing and sharing knowledge alongside support for development of skills and behaviours in finding and sharing knowledge effectively.

The development of the portal provides a unique opportunity for learning disabilities nursing to engage across all areas of practice and specialties and interface with other professional groups. The rapidly changing health and social care environment requires the learning disabilities nursing workforce to be responsive to change in practice, service alignment and integration.

The portal is designed for workforce use, but it also allows people with learning disabilities, their families and carers to access information and contribute to debates, helping to build confidence and influence in developing practice. The interactive model requires and encourages learning disabilities nurses to take ownership, engage and develop new initiatives and discussions, creating communities of practice.

This developing portal has the ability to network and engage across the UK, consequently linking national initiatives and helping translate them into local practice. The portal can respond, grow and adapt to changing technology, practice and policy.

For further information, contact Tommy Stevenson at [redacted]
The portal can be accessed at **www.knowledge.scot.nhs.uk/learningdisabilities**

Recommendation 16

Learning disabilities nurses need mechanisms to share best practice and develop the evidence base to continue to advance as a profession. Services must support learning disabilities nurses to participate in appropriate networks. A UK academic network for learning disabilities nursing will be created to support this drive.

4.3 Research and evidence

Where we are now

While the amount of research concerning learning disabilities nursing is increasing (25), there is still scope to further develop robust evidence. Learning disabilities nursing therefore requires support for:

- research activity
- research training
- implementation of research findings in practice.

Clinical–academic research careers have been promoted as one approach to developing partnerships between education and practice. A greater orientation towards evidence-based and evidence-informed practice can be achieved where educationalists have a clinical commitment within their portfolios and clinicians retain a strong education and research focus in their practice. Clinical–academic posts can promote greater integration between practice, education and research by supporting the enhancement of the evidence and education focus of practice and promoting a strong practice orientation in education and research. Currently, however, there are inconsistencies in the development and appointment of learning disabilities clinical–academic posts across the UK.

Where we want to be

Exciting opportunities nevertheless exist within the NHS and independent/voluntary sector to develop a broader range of clinical–academic roles that would strengthen and sustain practice, education and research provision. These roles should include researchers and educationalists maintaining links with clinical practice through clinical work, supervision of practitioners and joint working on particular practice development projects, and practitioners linking into education and research through teaching, research and initiatives that support education in practice. Clear organisational commitment is required to create models to develop sustainable roles such as these.

Research activity should be directly related to informing the practice of learning disabilities nursing and should focus on areas that add value and provide clear benefits to people with learning disabilities, their families and carers. Collaborative research studies involving higher education institutions that cover a range of geographic areas are required to facilitate larger-scale and comparative studies that can highlight differences and similarities in terms of need and developments. Existing links within the learning disabilities research community in the UK and internationally should facilitate this.

Most important, collaborative working with people with learning disabilities is essential to ensure that research is relevant to their needs and experiences. Learning disabilities nursing already has some good examples in this area and could lead on engaging, enabling and facilitating people with learning disabilities, their families and carers to participate in research.

Positive practice example

Learning disabilities nurses' involvement in research

The Confidential Inquiry into Deaths in People with Learning Disabilities is a three-year research study funded by the Department of Health and the Learning Disability Public Health Observatory in England. It is led by the Norah Fry Research Centre at the University of Bristol and is being carried out across Avon and Gloucestershire. The Inquiry is investigating all deaths among people with learning disabilities over the age of four years with the aim of adding to the current limited body of evidence, detecting any potentially avoidable and modifiable features involved in deaths and learning from positive practice.

The Mencap report *Death by Indifference* (7) highlighted the importance of involving families when evaluating care. In designing the Inquiry, the research team wanted to enable carers to be included and acknowledged that appropriately skilled staff were required to ensure that their views on the deceased were sought, understood and appropriately recorded. At the same time, it was important that their needs, as grieving carers, were also sensitively met.

As person-centred practitioners skilled in communicating with families and possessing sound understanding of the systems of care and complex health problems experienced by people with learning disabilities, a team of 11 learning disabilities nurses, supported by a lead nurse, were recruited to work part time as members of the Inquiry team. The nurses are seconded from their substantive posts to work with families of people who have died, conducting interviews, supporting them and signposting them to bereavement support agencies, if required. In addition, they advocate for the families at multi-agency local review panels held to discuss all death investigations.

For further information, contact Lesley Russ at

Recommendation 17

Learning disabilities nursing research should be extended to ensure practice now and in the future is evidence based and the impact of interventions can be demonstrated. Services and education providers must ensure that all existing and future schemes for clinical–academic careers have appropriate representation of learning disabilities nursing.

"The learning disabilities nurse has always been aware of the needs of the whole family and the fact that it continued from childhood into adulthood is very reassuring."

Family carer

Conclusion and next steps

Conclusion and next steps

The UK Modernising Learning Disabilities Nursing Review involved wide engagement with key stakeholders. It heard the hopes, aspirations and concerns of practitioners, managers, educators and researchers and, most importantly, it heard what qualities people with learning disabilities, their families and carers value most in nurses.

While this report could never capture all the learning that emerged from the engagement process, it has attempted to focus on actions that will have the greatest positive impact for people with learning disabilities, their families and carers, the nurses who care for them and the services who support them.

The foundation for these actions and the developments they represent is the underpinning principles and values base of learning disabilities nursing. It is these principles that have served learning disabilities nursing well and which are cherished by people with learning disabilities, their families and carers.

Learning disabilities nurses now have an opportunity to take their services forward to a new level.

This report has set out recommendations across a wide range of areas that reflect the complexity and the importance of modern learning disabilities nursing. The four countries are now invited to consider these recommendations and progress them as appropriate within their own contexts. Some of the recommendations will benefit from implementation at UK level, and a UK Implementation Group is being set up to support the groups that will be established at country level to oversee the development of action plans and onward progression.

The recommendations are set out in Table 2, which shows which agencies/individuals need to take account of, and respond to, each recommendation.

It is important to stress that while the recommendations are central to the modernisation of learning disabilities nursing in the UK and consequently may receive heightened attention, readers should engage fully with the whole report – there are many key messages that should be considered in addition to the recommendations.

Table 2

Recommendation summary

Recommendation	Action at UK level	Action at country level	Action at service level	Action at education level	Action at commissioning level	Action at individual practitioner level
1. The four UK health departments and the independent/voluntary sector should establish a national collaborative to enable better understanding of, and planning for, a high-quality and sustainable registered learning disabilities nursing workforce across all sectors.	√		√		√	
2. Systems to collect workforce data are required in each country, with links across the UK, for workforce planning for future provision of learning disabilities nursing. These should be able to capture information on service provision, educational and research requirements and should cover the independent/voluntary sector.		√	√	√	√	
3. The development of new, specialist and advanced role opportunities should be considered in light of workforce planning, service development and education provision. In particular, this should focus on the roles of non-medical prescribing, psychological therapies and telehealth and in specific settings such as the criminal justice system, mental health services (particularly dementia) and autism services.		√	√	√	√	
4. Each of the four countries should consider aligning their existing post-registration career frameworks for learning disabilities nursing to clearly articulate the knowledge and skills required by learning disabilities nurses at all levels and across all settings. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework.		√	√			
5. Commissioners and service planners should have a clear vision for how they ensure the knowledge and skills of learning disabilities nurses are provided to the right people, in the right places, and at the right time in a way that reflects the values- and rights-based focus of learning disabilities nurses' work.			√		√	√
6. Commissioners and providers of health and social care should ensure the skills, knowledge and expertise of learning disabilities nurses are available across the lifespan. This should be enabled through effective collaborative working across health and social care structures.		√	√		√	
7. Commissioners and providers of health and social care should ensure that learning disabilities nurses are able to collaborative effectively with general health services, including mental health services, to address the barriers that exist for people with learning disabilities to improving their health. This should include proactive health improvement, prevention, whole-family and public health approaches.			√		√	√

Recommendation summary

Recommendation	Action at UK level	Action at country level	Action at service level	Action at education level	Action at commissioning level	Action at individual practitioner level
8. Commissioners and service providers should ensure that specialist learning disabilities services for complex and intensive needs (including assessment and treatment services across all sectors) employ sufficient numbers of appropriately prepared and supported registered learning disabilities nurses. This highlights the need to support and develop the availability of specialist and advanced clinical skills and knowledge of learning disabilities nurses in all settings.			√		√	√
9. Learning disabilities nurses, their managers and leaders should develop and apply outcomes-focused measurement frameworks to evidence their contribution to improving person-centred health outcomes and demonstrating value for money. This may require a specific piece of work to scope current frameworks.			√			√
10. Learning disabilities nurses should strengthen their involvement and links to transformational work, productivity improvement and practice development.			√			√
11. Those who commission, develop or deliver education should ensure that all learning disabilities nursing education programmes reflect the key values, content and approaches recommended in this report. They should also ensure that nurses in other fields of practice develop the core knowledge and skills necessary to work safely and appropriately with people with learning disabilities who are using general health services.			√	√	√	
12. Updated, strategic plans for pre- and post-registration learning disabilities nursing programmes are necessary for each country of the UK to support flexibility and ensure an efficient and sustainable model of delivery for the long term. This highlights the need for appropriate numbers of places on pre-registration learning disabilities nursing programmes to meet future workforce requirements.		√	√	√		
13. Education providers and services must work in partnership to ensure that educational and developmental opportunities for nonregistered staff are developed and strengthened and their benefits are evidenced through appraisal systems, and that educational and development opportunities are available for registered learning disabilities nurses to support their ongoing development, reflecting the needs of people with learning disabilities.			√	√		
14. Services should provide systems to ensure that learning disabilities nurses have access to regular and effective clinical supervision and that this its impact is monitored and evaluated on a regular basis.			√			√

Recommendation summary

Recommendation	Action at UK level	Action at country level	Action at service level	Action at education level	Action at commissioning level	Action at individual practitioner level
15. Leadership in learning disabilities nursing needs to be strengthened in practice, education and research settings with robust, visible leadership at all levels, including strategic and national levels. Services must ensure all learning disabilities nurses in clinical practice have access to a dedicated professional lead for learning disabilities nursing. In addition to existing leadership and development programmes, a UK-wide cross-sector project to nurture and develop aspiring leaders in learning disabilities nursing will be led by the four UK health departments.	√		√	√		√
16. Learning disabilities nurses need mechanisms to share best practice and develop the evidence base to continue to advance as a profession. Services must support learning disabilities nurses to participate in appropriate networks. A UK academic network for learning disabilities nursing will be created to support this drive.			√	√		√
17. Learning disabilities nursing research should be extended to ensure practice now and in the future is evidence based and the impact of interventions can be demonstrated. Services and education providers must ensure that all existing and future schemes for clinical–academic careers have appropriate representation of learning disabilities nursing.			√	√		

Appendix 1. Key policy and professional drivers within the four countries

England

Department of Health (2001)
Valuing People: a new strategy for learning disability for the 21st century - a White Paper.
London: Department of Health.

Department of Health (2002)
Action for Health, Health Action Plans and Health Facilitation: detailed good practice guidance on implementation for learning disability partnership boards.
London: Department of Health.

Department of Health/Department for Children, Schools and Families (2003)
Together from the Start: practical guidance for professionals working with disabled children (birth to third birthday) and their families.
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Good Practice in Learning Disability Nursing.
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Healthcare for All: report of the independent inquiry into access to healthcare for people with learning disabilities.
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World Class Commissioning for the Health and Wellbeing of People with Learning Disabilities.
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Healthy Lives, Brighter Futures. The strategy for children and young people's health.
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Northern Ireland

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A Healthier Future: a twenty year vision for health and well being in Northern Ireland 2005–2025.
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The Bamford Review of Mental Health and Learning Disability (NI): forensic services.
Belfast: DHSSPS.

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Complex Needs – the nursing response to children & young people with complex physical healthcare needs.
Belfast: DHSSPS.

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Delivering the Bamford Vision. The response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability action plan (2009–2011).
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2009)
Integrated Care Pathway for Children & Young People with Complex Physical Healthcare Needs.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2009)
Autism Spectrum Disorder (ASD) Strategic Action Plan 2008/09–2010/11.
Belfast: DHSSPS.

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Department of Health, Social Services and Public Safety (2010)
Living Matters, Dying Matters – a strategy for palliative and end of life care for adults in Northern Ireland.
Belfast: DHSSPS.

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Improving Dementia Services in Northern Ireland: a regional strategy.
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Department of Health, Social Services and Public Safety (2010)
A Partnership for Care: Northern Ireland strategy for nursing and midwifery 2010–2015.
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Learning Disability Service Framework. Consultation document.
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Guidelines and Audit Implementation Network (2010)
Guidelines: caring for people with a learning disability in general hospital settings.
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Health Needs Assessment Report: people with learning disabilities in Scotland.
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The Healthcare Quality Strategy for NHSScotland.
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Learning Disability Implementation Advisory Group and Welsh Assembly Government (2011)
Practice Guidance on Developing a Commissioning Strategy for People with Learning Disabilities.
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Statement on Policy and Practice for Adults with Learning Disabilities.
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Welsh Assembly Government (2009)
A Community Nursing Strategy for Wales.
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Welsh Assembly Government (2009)
Post Registration Career Framework for Nurses in Wales.
Cardiff: Welsh Assembly Government.

Welsh Assembly Government (2009)
We Are on the Way. A policy agenda to transform the lives of disabled children and young people.
Cardiff: Welsh Assembly Government.

Welsh Assembly Government (2010)
Setting the Direction. Primary and community services strategic delivery programme.
Cardiff: Welsh Assembly Government.

Welsh Government (2011)
Together for Health. A five year vision for the NHS in Wales.
Cardiff: Welsh Government.

Appendix 2. Steering group memberships

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Lorraine MacKenzie, West Dunbartonshire

Rona Membury, Highland

Ian Stones, Aberdeen

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Alison Armstrong, Director of London Wide Programmes (Mental Health, Prison Health and Substance Misuse)

Amanda Platts, Self Advocate

Geoff Hodgson (supporting Amanda Platts), Supporter Centre Events

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Professor Ben Thomas, Professional Advisor, Department of Health

Daniel Marsden, Practice Development Nurse for Patients with Learning Disabilities, East Kent Hospitals University NHS Foundation Trust

Deborah Hussey, Lincolnshire Partnership NHS Foundation Trust
Team Leader, Learning Disability Services

Felicity Howdle, Information Analyst, Centre for Workforce Intelligence (CfWI)

Gweneth Moulster, Nurse Consultant, Haringey Learning Disability Partnership

Helen Laverty, Lecturer, Nottingham University

Helen Mycock (representing Mencap until January 2012)

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Jean Willson OBE, family carer

Joanna Goddard, Specialist Midwife for Safeguarding Children and Vulnerable Women

Susan Bernhauser, Dean of the School of Human and Health Sciences, University of Huddersfield

Lisa Gregg Herrett, Assistant Director Quality and Staff Development, Choice Support

Marc Pratt, Intensive Health Outreach Team, NHS Gloucestershire

Matthew Hoghton, Champion in Learning Disabilities, Royal College of General Practitioners Clinical Innovation and Research Centre

Paula Brayinon, Director of Operations and Nursing, Calderstones

Peter Hasler, Deputy Director of Nursing, South London and Maudsley NHS Foundation Trust

Professor Robert Gates, Professional/Academic Lead, University of Hertfordshire

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Steven Hardy, Training and Consultancy Manager, Estia Centre

Steven Rose, Chief Executive, Choice Support

Sue Hudson, Practice Development Lead, Suffolk Mental Health Partnership

Sue Turner, Improving Health and Lives Project Lead, National Development Team for Inclusion

Sue Beacock, Associate Dean Learning and Teaching, Hull University

Terri Dorman, Practice Development Nurse, Bedfordshire & Luton Partnership NHS Trust

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Vicky Stobbart, Service Manager - Learning Disability, Southwark

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Barry Mills, Clinical & Therapeutic Service Manager, Belfast Health & Social Care Trust

Claire Knox, carer

Damian McAleer, Nurse Education Consultant, Beeches Management Centre

Donna Morgan, Locality Manager & Lead Nurse, Northern Health & Social Care Trust

Fiona Rowan, carer

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Garvin McKnight, Staff Nurse, Muckamore Abbey Hospital, Belfast Health & Social Care Trust

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Glynis Henry, Chief Executive, Northern Ireland Practice & Education Council (NIPEC)

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Hazel Powell, Programme Manager, NHS Lothian

Hugh Masters, Nursing Officer (Mental Health and Learning Disabilities), Scottish Government

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June Brown, Nurse Consultant Learning Disabilities/Clinical Lead for Learning Disability Services, NHS Grampian

Linda Allan, Nurse Consultant Learning Disabilities, NHS Greater Glasgow and Clyde

Margaret Serrels, Clinical Services Development Manager, NHS Lanarkshire

Mark Gillespie, Nurse Consultant Forensic Mental Health and Learning Disabilities, NHS Greater Glasgow and Clyde

Melanie Hornett (Chair), Nurse Director, NHS Lothian

Michael Brown, Nurse Consultant and Reader in Health and Social Care, NHS Lothian/ Edinburgh Napier University

Rosemary Duffy, Scottish Prison Services

Selina Clinch, Programme Manager, Healthcare Improvement Scotland

Susanne Forrest, Programme Director, NHS Education for Scotland

Tommy Stevenson, Educational Project Manager, NHS Education for Scotland

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Sharon Williams, Assistant Head of Specialist Services, Learning Disabilities Directorate, Aneurin Bevan Health Board

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Modernising Learning Disabilities Nursing Review Strengthening the Commitment

Northern Ireland Action Plan

March 2014

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A MESSAGE FROM THE MINISTER

Ensuring that we deliver the best possible care to people with a learning disability is a key priority for the Department of Health, Social Services and Public Safety (DHSSPS). There is no doubt that we have made many significant improvements in how we deliver services to people with a learning disability, but more needs to be done in achieving our progressive and sustainable vision for learning disability.

To achieve the high quality, modernised and community based services, competent and skilled registered nurses – learning disability are a core ingredient for success. This action plan provides a road map to guide the delivery of learning disability nursing throughout Northern Ireland, ensuring that this small, specialist and very precious resource is used to the best effect within our health and social care system. We know that the learning disabled population in Northern Ireland are increasing year on year and that more children, born with a learning disability, are surviving into adulthood and old age. That in itself is a good thing, but as a consequence, it brings a range of physical and psychological health complexities, highlighting the need for highly skilled nursing across the lifespan.

I commend this Action Plan to all who have responsibility for the delivery of learning disability nursing in Northern Ireland.

Edwin Poots MLA
Minister of Health, Social Services and Public Safety

FOREWORD FROM THE CHIEF NURSING OFFICER

We are all acutely aware of the pace of change in today's HSC system. Within Northern Ireland we are currently working hard to implement the principles and requirements of Transforming your Care (DHSSPS 2011) which demands a wide ranging shift in the delivery of care, the commissioning of services, the regulation process and the culture of all organisations and agencies involved in the delivery of Health and Social Care to our local population.

As a consequence, health and social care services, professional groups and individual practitioners across Northern Ireland will be required to review current ways of working and adapt, modify and adjust accordingly.

When I consider the above, alongside the very significant current and emerging demographic changes within the population of people with learning disability, the high prevalence of physical and mental health needs and the high number of recent UK inquiries and reviews that have identified significant service and system failures, I believe it is very timely that we are taking forward an action plan to ensure that learning disabilities nursing in Northern Ireland is the best that it can be.

The following action plan reminds us all of the crucial and key role that registered nurses - learning disabilities have to play, now and in the future, in ensuring that people with learning disabilities receive safe and high quality care across all sectors involved in care delivery. The ultimate aim is to set a clear direction of travel for registered nurses - learning disabilities in Northern Ireland, one that is sustainable and one that has quality, safety and inclusion at its heart.

I therefore urge all relevant stakeholders across all agencies to actively contribute during the implementation of this action plan and by doing so; achieve even higher levels of excellence in the delivery of learning disabilities nursing in Northern Ireland.

This action plan has been influenced by many and I would like to express my thanks to all. However, a particular thank you to NIPEC for the leadership and coordination they have provided in developing this document.

Charlotte McArdle
Chief Nursing Office

INTRODUCTION AND BACKGROUND

In February 2011 the four Chief Nursing Officers from the United Kingdom commissioned a UK wide project that aimed to reflect upon, review and shape the future of the learning disabilities nursing profession. The project, which follows directly from recommendations of the existing four country policy 'Modernising Nursing Careers' (2006), was led by Ros Moore, CNO Scotland, and aims to maximise the contribution of the learning disabilities nursing profession across the UK to improve the experience of people with a learning disability and to improve outcomes for people with a learning disability and their families and carer's. This work fully acknowledges and recognises the multi-professional and multi-agency context within which registered nurses - learning disability work.

The UK Modernising Learning Disabilities Nursing Review, titled "Strengthening the Commitment" aims to ensure that people with learning disabilities of all ages, today and tomorrow, will have access to the expert learning disabilities nursing they need, want and deserve. That requires a renewed focus on learning disabilities nursing as a service and strategic consideration in building and developing the workforce. The review has set the direction of travel for registered nurses-learning disabilities across the United Kingdom, to ensure they can meet current and future demand and that the workforce is ready and able to maximise its role throughout the entire health and social care system.

Following the launch of the review in Edinburgh on 25 April 2012, a UK Steering Group was established (June 2012), in which each of the four countries is represented. Through the Group it was agreed that each of the four countries should produce its own Action Plan to take forward the recommendations of the Report *Strengthening the Commitment,* for local implementation.

This action plan has been developed by Northern Ireland Practice and Education Council (NIPEC), on behalf of and in partnership with the Department of Health Social Services and Public Safety (DHSSPS). This action plan reflects the expert opinion of key stakeholders within Northern Ireland who either work or have an interest in learning disabilities nursing policy, practice and education and has been further refined and enhanced following a 3 month period of consultation. It has been produced in response to and should be read in conjunction with *Strengthening the Commitment, the UK Modernising Learning Disabilities Nursing Review,* which can be accessed at http://www.scotland.gov.uk/Resource/0039/00391946.pdf

Currently, Health and Social Care in Northern Ireland is in a process of transforming the commissioning and delivery of services in order to better meet the needs of the population it serves. Therefore this action plan has taken into account the recommendations of a number of strategic direction policy documents namely:

- Equal Lives DHSSPS (2005); Guidelines on Caring For People with a Learning Disability in General Hospital Settings, GAIN (2010)
- Quality 20/20 (DHSSPS 2011)
- Transforming Your Care, DHSSPS (2011)
- The Learning Disability Service Framework, DHSSPS (2012)
- Fit and Well: Changing Lives: A Public Health Strategy for N. Ireland: Consultation document (DHSSPS 2012)
- The Bamford Action Plan 2012 - 2015 (DHSSPS 2013)

Registered nurses-learning disabilities play a key role in supporting people with a learning disability to achieve and maintain optimum health and well being. They deliver care within a context of numerous professional, economic, practice; social and policy drivers which are reflected within the following action plan.

This action plan aims to support and develop learning disabilities nursing in the context of an evolving learning disability service agenda. The action plan will be implemented and monitored by a regional implementation group who will report to the office of the Chief Nursing Officer on an annual basis.

STRENGTHENING CAPACITY

This section of the action plan addresses some of the key considerations underpinning efforts to strengthen capacity through developing the learning disabilities nursing workforce in relation to location and employment; strategic workforce planning; new ways of working; new roles and career choices.
Recommendations from National Report: Strengthening the Commitment
1. *The four UK health departments and the independent/voluntary sector should establish a national collaborative to enable better understanding of, and planning for, a high-quality and sustainable registered learning disabilities nursing workforce across all sectors.* 2. *Systems to collect workforce data are required in each country, with links across the UK, for workforce planning for future provision of learning disabilities nursing. These should be able to capture information on service provision, educational and research requirements and should cover the independent/voluntary sector.* 3. *The development of new, specialist and advanced role opportunities should be considered in light of workforce planning, service development and education provision. In particular, this should focus on the roles of non-medical prescribing, psychological therapies and tele-health and in specific settings such as the criminal justice system, mental health services (particularly dementia) and autism services.* 4. *Each of the four countries should consider aligning their existing post-registration career frameworks for learning disabilities nursing to clearly articulate the knowledge and skills required by learning disabilities nurses at all levels and across all settings. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework.*
The following actions will be taken in Northern Ireland to support these national recommendations
A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will: • Produce a workforce review/plan for registered nurses - learning disabilities in Northern Ireland that will consider all sectors and locations where these nurses work and will include nursing support staff. As part of this work, a data set, identifying the location of employment of registered nurses - learning disabilities in N. Ireland will be developed and will help inform decision making in a number of different contexts and levels such as: - succession planning - appropriate staffing levels/skill mix - pre-registration nursing programme recruitment • Identify the need for and support the development of extended specialist and advanced roles for registered nurses - learning disabilities, to ensure an expert skills base is available and responsive to the current and emerging needs of people with learning disabilities. As a consequence of the Transforming Your Care agenda, it will be a priority to examine the community nursing infrastructure to assess the level and type of nursing support available to people with a learning disability in a range of community settings. Other priority areas in this regard include: acute liaison, challenging behaviour, mental health, epilepsy, forensic care, crisis support, psychological and physical health needs/interventions.

- Contribute to and provide a learning disabilities nursing perspective to the regional Career Pathway Project, being facilitated by NIPEC and in doing so, assist health and social care service providers and learning disabilities nurses to identify/consider/pursue the range of career progression pathways that are available to them.

- Examine the potential for and the impact of, the transferability of the skills and competencies of registered nurses - learning disabilities throughout the health and social care system. This has particular relevance for acute liaison, mental health, CAMHS, prison settings and in dementia services.

  This work will include a separate examination of the roles undertaken by Registered nurses - learning disabilities in social care settings such as supported living environments.

Lead: N.I. Learning Disabilities Nursing Regional Collaborative

Time Scale: Prioritisation of actions and timeframes to be agreed by the NI Collaborative

STRENGTHENING CAPABILITY

This section outlines key considerations underpinning efforts to ensure a competent and flexible registered nurse-learning disabilities workforce for the future by maximising their contribution: working with people of all ages; addressing health needs and providing specialist services.

Recommendations from National Report: Strengthening the Commitment

5. *Commissioners and service planners should have a clear vision for how they ensure the knowledge and skills of learning disabilities nurses are provided to the right people, in the right places, and at the right time in a way that reflects the values - and rights - based focus of learning disabilities nurses' work.*

6. *Commissioners and providers of health and social care should ensure the skills, knowledge and expertise of learning disabilities nurses are available across the lifespan. This should be enabled through effective collaborative working across health and social care structures.*

7. *Commissioners and providers of health and social care should ensure that learning disabilities nurses are able to collaborate effectively with general health services, including mental health services, to address the barriers that exist for people with learning disabilities to improving their health. This should include proactive health improvement, prevention, whole-family and public health approaches.*

8. *Commissioners and service providers should ensure that specialist learning disabilities services for complex and intensive needs (including assessment and treatment services across all sectors) employ sufficient numbers of appropriately prepared and supported registered learning disabilities nurses. This highlights the need to support and develop the availability of specialist and advanced clinical skills and knowledge of learning disabilities nurses in all settings.*

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- As roles and locations of employment expand, develop a specific and targeted suite of competencies that clearly articulate the knowledge, values and skills required by registered nurses - learning disabilities in specific aspects of care.

- Ensure that the specific nursing skills and competencies of registered nurses - learning disabilities workforce are utilised appropriately and to best effect across the range of settings within which they work. It is particularly important that the nursing expertise of these Registrants is fully maximised and that an increasing emphasis is given to preventative and proactive health improvement approaches as core day to day nursing practice. This is relevant across the lifespan but is particularly necessary during early years and adolescence.

- Ensure that registered nurses - learning disabilities who work in in-patient and/or assessment and treatment services, with those with the most intensive and complex needs, are equipped with the appropriate staffing levels, skills and competence to ensure the highest possible standard of patient safety and experience in these "high risk". The NI Collaborative will give particular focus to:

    - Introducing patient-centred service improvement practices and cultures that ensure that positive therapeutic relationships and effective communication with people with learning disabilities and carers are at the heart of nursing practice.

- A targeted drive to ensure that registered nurses - learning disabilities are adequately prepared, equipped and supported in a) the management of violence and aggression, b) current risk assessment and management processes and c) effective responses to safeguarding incidents (children and adult). - Contributing to the achievement of a workplace culture that supports the reporting of incidents and concerns, learning from things that go wrong and contributing to the implementation of action plans arising from incidents. - The development of beacon wards/centres of nursing excellence in such settings.
Lead: N.I. Learning Disabilities Nursing Regional Collaborative
Prioritisation of actions and timeframes to be agreed by the NI Collaborative

STRENGTHENING QUALITY

This section addresses some of the key considerations underpinning quality in relation to demonstrating quality outcomes; quality improvement; preparing and developing registered nurses-learning Disability; maximising recruitment and retention; developing the workforce and accessing supervision.

Recommendations from National Report: Strengthening the Commitment

9. *Learning disability nurses, their managers and leaders should develop and apply outcomes-focused measurement frameworks to evidence their contribution to improving person-centred health outcomes and demonstrating value for money. This may require a specific piece of work to scope current frameworks.*

10. *Learning disabilities nurses should strengthen their involvement and links to transformational work, productivity improvement and practice development.*

11. *Those who commission, develop or deliver education should ensure that all learning disabilities nursing education programmes reflect the key values, content and approaches recommended in this report. They should also ensure that nurses in other fields of practice develop the core knowledge and skills necessary to work safely and appropriately with people with learning disabilities who are using general health services.*

12. *Updated, strategic plans for pre and post registration learning disabilities nursing programmes are necessary for each country of the UK to support flexibility and ensure an efficient and sustainable model of delivery for the long term. This highlights the need for appropriate numbers of places on pre-registration learning disabilities nursing programmes to meet future workforce requirements.*

13. *Education providers and services must work in partnership to ensure that educational and developmental opportunities for non registered staff are developed and strengthened and their benefits are evidenced through appraisal systems, and that educational and development opportunities are available for registered learning disabilities nurses to support their ongoing development, reflecting the needs of people with learning disabilities.*

14. *Services should provide systems to ensure that learning disabilities nurses have access to regular and effective clinical supervision and that this impact is monitored and evaluated on a regular basis.*

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- Develop and agree a process of measuring and demonstrating the outcomes of nursing practice.

- Link with the Regional Key Performance Indicators (KPIs) project to consider the introduction of relevant KPIs within settings where registered nurses - learning disabilities work.

- Ensure that key themes and issues identified via patient experience measures (locally and regionally) inform, improve and develop the practice of registered nurses - learning disabilities.

- Collaborate and link with HSC Trusts, other employers of registered nurses - learning disabilities and education providers, to ensure that registered nurses - learning disabilities are enabled to access post- registration education and training that is reflective of current

and emerging strategic policy, demographic changes and professional developments.

- Collaborate and link with HSC Trusts, other employers of registered nurses - learning disabilities and education providers, to ensure that pre-registration students of learning disabilities nursing have access to effective and appropriate practice learning and mentorship.

- Collaborate and link with HSC Trusts, other employers of registered nurses - learning disabilities and education providers, to ensure that newly qualified registered nurses - learning disabilities have access to effective preceptorship.

- Support and advice upon the provision of robust professional governance and accountability structures for learning disabilities nursing within all HSC Trusts and those who work in the independent and voluntary sector.

- Ensure that all registered nurses - learning disabilities actively participate in and have access to, professional advice and professional nursing supervision from a suitable registered nurse - learning disabilities who practise in the field of learning disabilities nursing.

- Encourage, support and enhance the educational and developmental opportunities which should be available for non-registered nursing support staff.

Lead: N.I. Learning Disabilities Nursing Regional Collaborative

Prioritisation of actions and timeframes to be agreed by the NI Collaborative

STRENGTHENING THE PROFESSION

This section addresses some of the key considerations underpinning modernising the Registered Nurse-Learning Disabilities workforce in relation to; leadership and management; promoting the profession and research and evidence.
Recommendations from National Report: Strengthening the Commitment
15. Leadership in learning disabilities nursing needs to be strengthened in practice, education and research settings with robust, visible leadership at all levels, including strategic and national levels. Services must ensure all learning disabilities nurses in clinical practice have access to a dedicated professional lead for learning disabilities nursing. In addition to existing leadership and development programmes, a UK-wide cross-sector project to nurture and develop aspiring leaders in learning disabilities nursing will be led by the four UK health departments. *16. Learning disabilities nurses need mechanisms to share best practice and develop the evidence base to continue to advance as a profession. Services must support learning disabilities nurses to participate in appropriate networks. A UK academic network for learning disabilities nursing will be created to support this drive.* *17. Learning disabilities nursing research should be extended to ensure practice now and in the future is evidence based and the impact of interventions can be demonstrated. Services and education providers must ensure that all existing and future schemes for clinical−academic careers have appropriate representation of learning disabilities nursing.*
The following actions will be taken in Northern Ireland to support these national recommendations
A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will: • Enhance professional leadership capacity and potential within registered nurses - learning disabilities in Northern Ireland. • Explore and commission, models and approaches to leadership and practice development, to support the development of current and aspiring clinical leaders of learning disability nursing in Northern Ireland across all sectors. • Ensure that Northern Ireland is represented on the national initiative to enhance leadership potential in final year learning disabilities nursing students and to take steps to build on this locally. • Take steps to ensure that Northern Ireland is represented at the national UK academic network and that there is local involvement on and contribution to relevant national initiatives. • In collaboration with the Royal College of Nursing, establish a Regional Professional Development Network for learning disabilities nurses to include HSC Trusts, the education sector and the independent/voluntary sector. • Encourage and support registered Nurses - learning disabilities to access and take up nursing research activity including awards, scholarships and publications. Such activity should be encouraged in the aspects of clinical practice, policy and strategic direction and regional level concerns.
Lead: N.I. Learning Disabilities Nursing Regional Collaborative
Prioritisation of actions and timeframes to be agreed by the NI Collaborative

CONCLUSION AND NEXT STEPS

The development of this Northern Ireland Action Plan to take forward the recommendations within the National UK Strengthening the Commitment Review, has involved wide engagement with a range of key stakeholders in the local Northern Ireland context.

This engagement has informed the range of key actions that will have the greatest positive impact for people with learning disabilities, their families and carer's who receive services from learning disabilities nurses.

Registered nurses - learning disabilities now have the opportunity to ensure that the services and nursing care they deliver is the best that it can possibly be.

It is important to stress that while the actions are central to the modernisation of learning disabilities nursing in Northern Ireland, readers should engage with the full UK report, which outlines in more detail the rationale behind the actions that have been prioritised for Northern Ireland. The full UK report also has many key messages that can and should be considered in addition to the actions in this document.

To lead, drive, support, monitor and deliver this action plan the DHSSPS will:

- **Establish a N.I. Learning Disabilities Nursing Regional Collaborative by May 2014 to support delivery of the actions. The group should have representation from service user groups; the independent sector; all five of the health and social care organisations; educational providers, NIPEC; the Health and Social Care Board, Public Health Agency and take into account other stakeholders as necessary.**

- **Require that the Regional Collaborative reports on progress to the Office of the Chief Nursing Officer on an annual basis.**

- **At the end of a 3 year period, DHSSPS will formally review progress on the recommendations and consider the need for further developments.**

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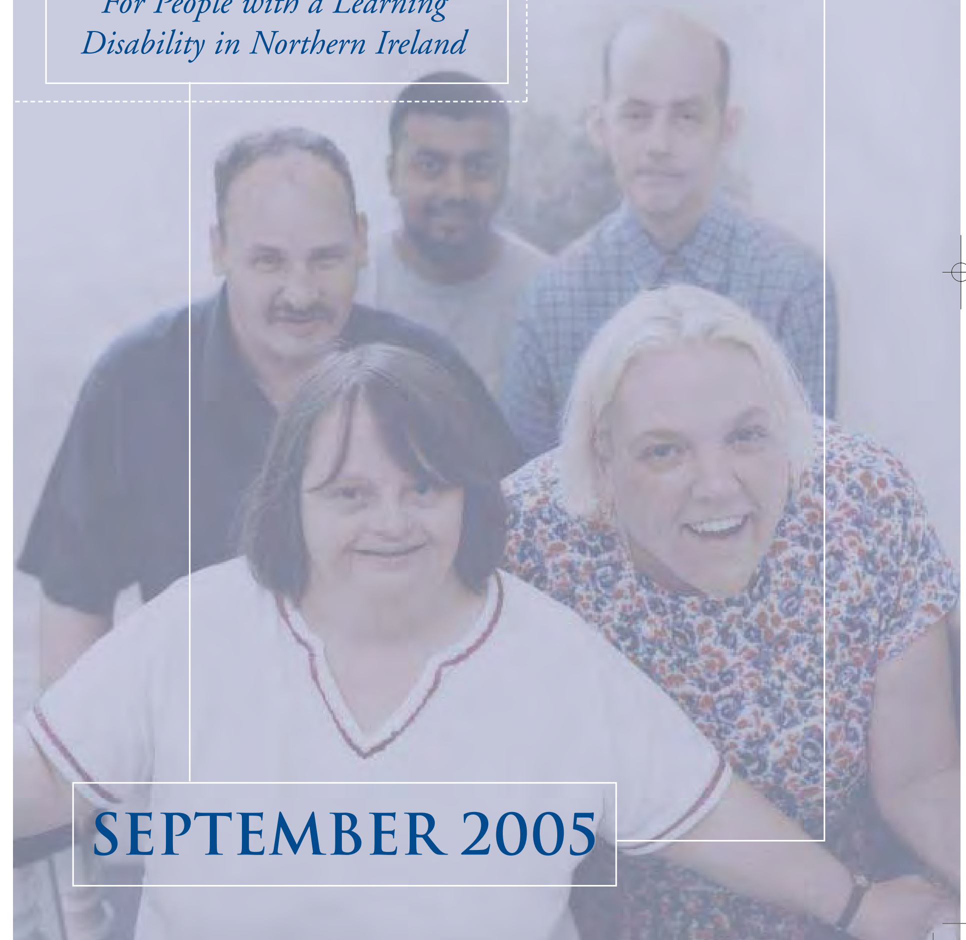
REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY

(NORTHERN IRELAND)

EQUAL LIVES:

Review of Policy and Services For People with a Learning Disability in Northern Ireland



SEPTEMBER 2005

EQUAL LIVES[1]

Explanation

Figures in bold in brackets refer to references to show where we got the information from. The details are given in Annex E at the back of the report.

Words that are underlined refer to words that are explained in the Glossary at Annex D.

The Glossary also lists all abbreviations that are used in this report.

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September 2005

[1] During the Review we met every month with the Equal Lives Group; men and women with a learning disability who advised us on the work. They said that the Review should focus on ensuring that people with a learning disability have equal chances and choices to other people in Northern Ireland. We have called this report *Equal Lives* to reflect their priorities.

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FOREWORD

In the summer of 2002, I was invited to chair the independent Review of Mental Health and Learning Disability, commencing in October of that year. By March 2003 it was clear that the work consisted of several interlinked reviews under one overarching title, and encompassing policy, services and legislation.

The Review Steering Committee has presided over the work of 10 major Expert Working Committees. In consultation with Government, we agreed to produce our reports on a phased basis.

Equal Lives is the second report from the Review. It sets out a compelling vision for developing services for men, women and children with a learning disability for the next 15 to 20 years.

The Equal Lives Review has adopted an evidence-based approach, drawing upon existing relevant information and research, and where necessary commissioning research. Exemplars of best practice local, national and international, have informed the debate. Widespread consultations with stakeholders, in particular people with a learning disability and their families and carers, have endorsed our vision and the strategic direction of the Equal Lives Review.

The Equal Lives Review has concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else.

The success of implementing the Equal Lives recommendations depends on the contribution of many stakeholders, but most of all Government, who must give a lead on implementing the process of change. We fully recognise the resource implications and urge Government, in particular the Department of Health, Social Services and Public Safety, to begin the necessary process of reform and modernisation of these services immediately.

Professor Roy McClelland, deputy Chairman of the Review, and I thank Siobhan Bogues, who chaired the Learning Disability Working Committee, and all involved in the Equal Lives Review for their efforts and their commitment.

Professor David R Bamford
Chairman

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20:20 VISION

Chapter 1

We hope the Review makes sure that people with a learning disability get the same chances and choices as everyone else. **Equal Lives Group**

Show us respect by giving us the support and information we need. **Family Carer**

About the Review of Mental Health and Learning Disability (Northern Ireland)

1.1 In October 2002 the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent review of law, policy and service provision affecting people with mental health needs or learning disability in Northern Ireland. The Review of Mental Health and Learning Disability (Northern Ireland) could be described as having 3 distinct strands:

- a review of policy and service provision for people with a learning disability
- a review of policy and service provision for people with mental health problems
- a review of the Mental Health (Northern Ireland) Order 1986.

1.2 While there are overlaps between each of these strands there are clear distinctions and in particular, the Review of Mental Health and Learning Disability (the Review) recognises that learning disability and mental health problems are very distinct and separate conditions.

1.3 This is reflected in the way in which the Review is being carried out. An overall Steering Committee, whose terms of reference are shown at Annex B, manages the Review. They are guided by inputs from Expert Working Committees[2], each of which is examining a particular area:

- Adult Mental Health
- Child and Adolescent Mental Health
- Forensic Issues
- Mental Health Promotion
- Dementia and Mental Health Issues of Older People
- Social Justice and Citizenship
- Legal Issues
- Needs and Resources

The areas being covered by each Working Committee are given at Annex C.

[2] Words that are underlined refer to items that are explained in the Glossary at Annex D at the back of the report

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1.4 This report summarises the findings of the Learning Disability Working Committee and presents a wide range of proposals for improving the lives of people with a learning disability and their families by developing responses that are based on the key values of:

- Citizenship
- Social Inclusion
- Empowerment
- Working Together
- Individual Support.

1.5 The Review Steering Committee agreed the following Terms of Reference for the Equal Lives Review:

Terms of Reference

- To carry out a review of policy and services for children and adults with a learning disability
- To take into account the evidence base, national and international, for best practice in the assessment of need, the planning of supports, effective means of delivering services and the empowerment of people with a learning disability
- To comprehensively research the significant issues for consideration in future policy, utilising all reliable, valid and up-to-date evidence and to take account of local initiatives and needs
- To work collaboratively and consult widely with all relevant stakeholders both within and outside the health and personal social services sector
- To liaise as necessary with colleagues on the other Expert Working Committees on interface issues
- To bring forward to the Steering Committee a comprehensive and prioritised set of recommendations giving due consideration to cost, workforce issues and infrastructure needs.

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How Did We Carry Out the Equal Lives Review?

1.6 The Equal Lives Review is based on an extensive range of consultations, research and analysis, carried out over the last year that included:

- establishing a Learning Disability Working Committee that managed the Equal Lives Review
- setting up the Equal Lives Group, which was made up of 16 men and women with a learning disability from different parts of Northern Ireland who met with us every month and gave advice on issues that they felt should be addressed
- meeting on 6 occasions with a group of family carers who gave feedback on ideas coming out of the Equal Lives Review
- holding 6 public meetings with men and women with a learning disability who talked about what they thought needed to change to make their lives better. Their views were collected by Equal Lives Group members and published in a separate report called We Have a Dream... (1)
- holding 5 public meetings for carers in different parts of Northern Ireland to share their concerns and suggestions. The issues raised at these meetings were published in a separate report - Focus on Families. (2)
- meetings with a group of young people who told us about the specific things they want us to address
- consultation with men and women who have complex health needs and/or a profound learning disability and their carers. The issues raised at these meetings were published in a separate report called Challenges of Complexity. (3)[3]
- setting up 6 Task Groups with various stakeholders to examine issues identified by the Committee as being particularly significant in relation to improving the lives of people with a learning disability - refer to Annex F for membership of the Equal Lives Review groups:
  - Support for Children and Young People and Their Families
  - Accommodation and Support
  - Day Opportunities
  - Ageing
  - Mental Health
  - Physical Health
- setting up a free phone line to provide an opportunity for people to share their views in a confidential manner. This service was designed for those who could not, or were unwilling to, attend meetings and to ensure that people from all over Northern Ireland could have their voices heard.

[3] These reports are available on the review web-site www.rmhldni.gov.uk

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- inviting people to make presentations to the Learning Disability Working Committee and Task Groups. Men and women with a learning disability, family carers and staff from a wide range of agencies all took this opportunity to tell us what is working well and what needs to change.
- inviting individuals and organisations to provide written comments. Many people took this opportunity to express their concerns and ideas to the Learning Disability Working Committee.
- holding conferences and seminars on particular issues attended by over 400 people so that new developments in services nationally and internationally could be presented and recommendations for local services identified:
  - day opportunities
  - lessons from Sweden
  - physical and mental health
  - lessons from other reviews on implementation
  - staffing and workforce issues
  - growing older
  - education
  - youth
  - family support
  - play
  - promoting equality
  - early intervention
- finding out what has happened in other countries and locally by reading policy documents and commissioning research from the University of Ulster. This research focused on 4 areas:
  - creation of a directory of research studies into learning disability undertaken in Northern Ireland[4]
  - strategic review of learning disability policy and service provision
  - reports on the 6 topics studied by the Task Groups
  - study of organisational arrangements and how they may develop in the future.
- 2 seminars for political representatives
- circulation of a consultation report to a wide range of individuals and organisations which resulted in over 70 written responses

[4] This directory is stored on a cd-rom and is available free-of-charge from Room 12J10, School of Nursing, University of Ulster, Newtownabbey, Northern Ireland BT37 OQB

- an independent facilitator was commissioned to run a series of meetings with family carers and men and women with a learning disability to secure feedback on the draft Equal Lives report
- detailed consideration of all responses received and redrafting to produce this final report.

How Does Our Work Fit in With the Rest of the Review of Mental Health and Learning Disability?

1.7 The fact that the Equal Lives Review was conducted within a wider review of legislation, policy and services relating to mental health and learning disability had a number of advantages. First, it has meant that we have been able to inform the work of other Expert Working Committees, which will also address the mental health issues affecting people with a learning disability. Second, we have been able to liaise with the Expert Working Committees that are concerned with learning disability and mental health matters in equal measure, i.e. Legal Issues, Social Justice and Citizenship, and Needs and Resources. Third, we have been able to contribute to the current Department of Health, Social Services and Public Safety review of workforce in learning disability and mental health along with Review colleagues from other Committees. These Committees will produce separate reports, each of which will highlight issues and actions to be taken which should contribute to an overall improvement in the lives of men, women and children with a learning disability in Northern Ireland, albeit within the broader context addressed by that Committee. The Learning Disability Working Committee has highlighted the factors that we believe should be considered by these committees in their work. This report provides the overall context in which further recommendations from the various Working Committees will be placed. Their reports will be produced during 2005 to 2006.

1.8 However, we recognise that there are two main disadvantages of this approach. First, coupling learning disability with a mental health review may create confusion about the nature of mental ill health and learning disability, which are two very distinct conditions. In particular learning disability is usually present from birth, it is a life-long condition that cannot be cured and people with a learning disability require educational and social supports as well as health and social services. We would recommend that in future such an approach to addressing needs should be avoided.

1.9 Second, concern has been expressed about the fact that other committees are addressing some of the specialised areas of policy and service development that will affect people with a learning disability. This includes child and adolescent mental health, adult mental health services, services for offenders and the mental health needs of older people. The Review has sought to address this in a number of ways:

- the Steering Committee has met monthly throughout this process to provide an opportunity for an exchange between committees on developments and to formulate an overarching vision and strategic direction
- the Steering Committee gave a clear direction from the outset that all Expert Working Committees must address fully the needs of people with a learning disability as they relate to their particular area of focus
- members of the Learning Disability Working Committee have been members of the other committees where possible to ensure that overlapping issues are addressed
- the conveners of each of the separate Expert Working Committees have met regularly to identify and agree mechanisms for addressing concerns as to the interface issues

- members of the Expert Working Committees have been invited to participate in seminars and events across the Review to enable sharing of ideas and developments
- draft copies of the Equal Lives Review were shared with conveners of the other committees at various stages to facilitate a read across from this report to those that are being produced by the other committees.

1.10 We recognise that concern persists about separate areas of policy being addressed in different reports. In response to these concerns we have highlighted at relevant sections of this report the areas that we expect will be addressed in other reports. In addition the Learning Disability Working Committee will continue to meet throughout the life of the Review to consider emerging reports and offer guidance where necessary on the links between those reports and the Equal Lives Review.

How Do We See the Way Ahead?

1.11 People with a learning disability in Northern Ireland do not enjoy equality of opportunity and are often excluded from the opportunities that other citizens enjoy. Their families frequently suffer high levels of social disadvantage and their caring responsibilities can place them under almost unbearable levels of stress. There is evidence of progress having been made, but in order to fully tackle these difficulties there is a need for major co-ordinated developments in support and services and a continuing change in attitudes over at least the next 15 years.

1.12 We believe this will be best achieved through the adoption of a shared value base, a focus on shared core objectives and rigorous efforts across Government departments and agencies in the community to implement the change agenda that is detailed in the Equal Lives Review.

Equal Lives Values

1.13 The Equal Lives Review is based on 5 core values with which all policy and service developments must be underpinned. These values offer guidance for future developments and should be enacted for all people with a learning disability irrespective of age, gender, severity of disability or complexity of needs.

Citizenship

People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.

Civil and human rights must be promoted and enforced. Government policy emphasises the importance of all citizens playing a role in civic society. People with a learning disability must be supported to be fully engaged in this agenda and their ability to exercise their rights and responsibilities needs to be strengthened. Citizenship recognises the unique contribution of each individual to their family and wider society and that the diverse strengths, needs and aspirations of people with a learning disability must be respected.

Social Inclusion

People with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community.

Inclusion recognises both people's need for individual support and the necessity to remove barriers to inclusion that create disadvantage and discrimination. Inclusion is only possible on the basis of equality of opportunity to access and to participate in

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education, employment, leisure and other aspects of community life. Inclusion is more likely to be achieved if people's connections are maintained at a local level through involvement in local schools, housing, employment, etc.

Empowerment

People with a learning disability must be enabled to actively participate in decisions affecting their lives.

Historically people with a learning disability have been excluded from decision-making processes and efforts must now be directed to affording opportunities to help them to learn how to participate effectively. They must be supported to have control, to have their voices heard, to make decisions about how they lead their lives and about the nature of support that they receive. Families and other carers need to be supported to enable people with a learning disability to take managed risks and lead more independent lives. It is recognised that some individuals with severe learning disability have particular difficulties with decision-making. For these individuals society needs to have robust arrangements in place to allow for substitute decision-making where required. The development of Mental Capacity legislation in Northern Ireland is ongoing through the Office of Law Reform and the Legal Issues Committee. We hope that this ensures transparent systems, based on promoting the human and civil rights of the individuals concerned.

Working Together

Conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability.

People with a learning disability must be central to planning and decision-making processes. The role of family carers as partners in these processes should be recognised and valued. A wide range of Government departments and agencies in the community, voluntary, statutory and private sectors will need to work together to meet their responsibilities to people with a learning disability. Making change happen requires those with a responsibility for education, housing, health, employment, leisure and social services to be fully committed and involved.

Individual Support

People with a learning disability will be supported in ways that take account of their individual needs and help them to be as independent as possible.

Service systems that are based on group approaches need to be remodelled to more fully recognise people's individual strengths and needs. In particular people with a learning disability who have additional complex needs and their families may require highly individualised supports. Individual support will take a wide range of forms including staff, expertise, information and practical assistance. Individual support will also need to take account of the vulnerability of some people with a learning disability. Person centred planning will need to take account of this and ensure that appropriate risk assessments are completed as required. Where abuse or potential for abuse is identified, agency policies and procedures on the protection of vulnerable adults should be followed in the case of adults. Where the concern relates to children and young people the relevant sections of the Children (Northern Ireland) Order 1995 and associated multi agency child protection protocols should be followed. This approach will assist in managing the inevitable tension between the aspiration to accord full rights of citizenship to people with a learning disability and additional vulnerability that may be present as a consequence of the disability.

1.14 These values are a challenge to policy and practice, but are in keeping with recent legislative changes. The implications of these changes have not yet been fully realised in services, which traditionally have been based more on separation and dependency.

Equal Lives Objectives

1.15 We propose that future policy for improving the lives of people with a learning disability is directed toward attaining 12 core objectives over the next 15 years.

Objective 1 To ensure that families are supported to enjoy seeing their children develop in an environment that recognises and values their uniqueness as well as their contributions to society.

Objective 2 To ensure that children and young people with a learning disability get the best possible start in life and access opportunities that are available to others of their age.

Objective 3 To ensure that the move into adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.

Objective 4 To enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.

Objective 5 To ensure that all men and women with a learning disability have their home, in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need.

Objective 6 To ensure that an extended range of housing options is developed for men and women with a learning disability.

Objective 7 To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.

Objective 8 To ensure that men and women with a learning disability are supported to age well in their neighbourhoods.

Objective 9 To enable people with a learning disability to have as much control as possible over their lives through developing person centred approaches in all services and ensuring wider access to advocacy and Direct Payments.

Objective 10 To ensure that health and social care staff are confident and competent in working with people with a learning disability.

Objective 11 To ensure that staff in other settings develop their understanding and awareness of learning disability issues and the implications for their services.

Objective 12 To promote improved joint working across sectors and settings in order to ensure that the quality of life of people with a learning disability is improved and that the Equal Lives values and objectives are achieved.

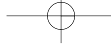
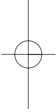
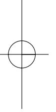
Making Change Happen

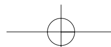
1.16 Twenty-first century services will need to attune to a changed perception of what it means to have a learning disability. Many people with this disability are capable of doing more themselves. Their needs and aspirations cannot be met solely by health and social services - they need support from education, housing, leisure, employment agencies and others.

1.17 We recognise that achieving these objectives will require a major programme of work that will include:

- changes to how funding is allocated
- securing additional resources to achieve key outcomes
- closer interdepartmental and interagency working
- significant attention to developing and reconfiguring the workforce
- setting up robust arrangements for ensuring the implementation of recommendations
- commitment and effective leadership from key decision makers, planners and managers.

1.18 We will set out in the chapters that follow a series of concrete recommendations that should be implemented to support the achievement of the Equal Lives objectives. These recommendations fit together like a jigsaw and provide a coherent framework for guiding the delivery of the change programme.



MESSAGES FROM PEOPLE WITH A LEARNING DISABILITY AND THEIR FAMILIES[5]

Chapter 2

See Me, Hear Me

We hope the Review will make sure that there are more advocacy groups and more chances for people to speak out and be listened to. We do not think this happens enough and that is why things go wrong. (1)

2.1 Throughout the Equal Lives Review we have listened carefully to the views of men, women and young people with a learning disability. Often we were told that they are not listened to or given a full chance to have their views heard by those who are making decisions about them. We heard a very strong message that change is needed to the way that decisions are taken and the approach taken to respond to people's needs, wishes and aspirations.

Chances and Choices

We want the same chances as everyone else. Why is this such a problem?
Equal Lives Group Member

2.2 Many people told us about the different activities in which they are involved, but a lot of difficulties were also highlighted when people with a learning disability tried to make use of the same opportunities as others. Problems described included:

- difficulties for children in using the play opportunities that their peers enjoy
- serious problems in getting out and about because of a lack of suitable transport locally
- many men and women described how lonely they feel especially at weekends and the evenings when they have nowhere to go
- bullying was a big problem for many of the people we talked to. Some told us how unsafe they feel in their own homes and others described how they had been subjected to regular verbal abuse because of their learning disability.

[5] Fuller details of these messages are contained in the reports of 3 of the consultations carried out as part of the Equal Lives Review. These reports can all be obtained from the Review website www.rmhldni.gov.uk.

- some of the men and women we met were keen to work or do further training but a lot of barriers were put in their way, including lack of opportunities, the perceptions of employers that they would not be able to do the jobs and the negative impact on their social security and other benefits if they took up employment.

I am ready to work but doors are always closed in my face because I have epilepsy and a learning disability. People don't want to know. Employers can't be bothered to have people with a learning disability. (1)

2.3 Many people who attended the public meetings described how important it was to them to have friends who were not family members or staff. Lack of information about personal relationships and restrictions placed on such relationships were highlighted at each meeting.

2.4 For those who had been successful in accessing a range of leisure or work opportunities the benefits were huge.

They gave my son a life - he goes to the local youth club and joins in a lot of clubs just like any teenager. **Mother**

Getting the Right Support

2.5 The importance of staff attitudes and skills was a recurring theme in all the meetings. When staff displayed knowledge about disability and sensitivity in their approach it had a very positive effect on the lives of both people with a learning disability and family carers.

My life has been totally changed lately. I got a new social worker a few months ago and suddenly I am getting a lot more help in the house. I got my first break ever a couple of weeks ago. **Mother**

2.6 Families were very appreciative of many of the services they received. Feedback from parents whose son or daughter had profound disabilities or complex needs stressed the value of the support they received.

Trustworthy, familiar staff make my daughter feel confident. **Parent** (3)

Work with the professionals at the day centre has definitely increased his life expectancy and improved his quality of life. **Parent** (3)

2.7 Although there were some conflicting views among carers as to the type of services they wanted, they frequently described their efforts to get the right support as a battle. We were told that parents were often worn out and very fearful about the future for their sons or daughters. The concrete steps that would make a difference to family carers included:

- easier access to information about the help available to them and how to access it
- flexible breaks from their caring role and emergency support especially outside of normal office hours in the event of a family crisis
- more support in the home
- better training for staff and staff approaches that are based on respecting the expertise of the family carer and their central position in the life of their son or daughter
- improved access to practical changes to the home environment and provision of practical aids
- immediate implementation of the right to a Carer's Assessment and more tangible responses to the needs identified in those assessments
- better access to Direct Payments that meet both their needs and the needs of their relative in order to give them greater control in the nature of support provided
- planning processes that embrace the expertise of family carers and most importantly that lead to action being taken in response.

The parents are getting older and tireder, the children are getting older and lonelier, the pile of public sector strategies, plans, reviews and academic studies is getting higher and higher, meanwhile plus ça change plus c'est la meme chose. There's an industry of officials and professionals out there, supposedly supporting our kids but fellow stressed-out parents and the man who invented Playstations have probably done more for my child than the lot of them put together. That makes me mad, and sad. (4)

2.8 The Equal Lives Group report clarifies what they believe is important in relation to support from staff. They want staff who:

- listen well
- know what they are supposed to do
- understand what to do in an emergency
- know a lot about learning disability.

They also stressed the importance of staff not wrapping them up in cotton wool and listening and acting on what they (the man or woman with a learning disability) felt was important.

Challenges of Complexity

2.9 Family members who care for a relative with complex needs had some very particular concerns. The complex needs related to those with an Autistic Spectrum Disorder (ASD) and learning disability, those with severe learning and/or physical disability, those with complex health needs and those with challenging behaviours. For many of these parents real concerns were expressed that the move towards social inclusion will lead to an even greater marginalisation of their family members. They were anxious that the social inclusion and equality agendas might not be open to addressing their concerns or meeting the needs and aspirations of their family members. It was noted that full involvement in community life is limited by the few facilities that are accessible and the negative attitudes of members of the public.

People stare all the time. **Parent (3)**

Public and some professional attitudes need to change. **Parent (3)**

2.10 Parents involved in the Challenges of Complexity (3) consultation made a number of suggestions:

- appropriate financial assistance to meet their accommodation needs
- improvements to day care to enable more sensory based activities and a wider range of activities
- communication training for all staff
- financial assistance to enable families to purchase a suitable vehicle
- changes in attitudes from all people to ensure all those with a learning disability, including those with very complex needs, can enjoy a full and meaningful life in their community.

2.11 The powerful messages we received from people with a learning disability and family carers have made an immense contribution to all our work on producing this report. This process of consultation and participation should be echoed throughout the work that will be required to implement the Equal Lives Review recommendations.

SETTING THE SCENE

Chapter 3

Modern Thinking About Disability

Persons with disabilities are members of society and have the right to remain within their local communities. They should receive the support they need within the ordinary structures of education, health, employment and social services. (5) **United Nations (UN)**

3.1 In order to provide a context for understanding the issues which impact upon the lives of people with a learning disability this chapter will address a number of broad themes viz:

- rights and the law
- policy changes
- defining and assessing learning disability
- prevalence of learning disability
- the impact of the troubles
- service provision and funding
- inequalities and human rights.

Rights and the Law

3.2 The quotation from the UN typifies the radical shift that has occurred over recent years in how society perceives people with a disability. This shift has been demonstrated by a growing recognition in legislation and social policy that people with a disability are people first and foremost. The previous focus on what people cannot do is being replaced by an emphasis on how the impact of their disability might be reduced through appropriate support and the removal of barriers to their full participation in society.

3.3 Developments in Northern Ireland legislation have reflected these trends. The Northern Ireland Act (1998) states that *a public authority shall, in carrying out its functions in Northern Ireland, have due regard to the need to promote equality of opportunity between persons with a disability and persons without.*

3.4 Further legal entitlements of people with a learning disability and carers have been set out in legislation, which is summarised in Annex G. Recent legislation largely serves two main purposes.

- First, it ensures that people with a disability have access to the same range of opportunities as their age peers and that they are not discriminated against.

- Second, it should provide people with a disability with the additional services and supports they require to assist them to achieve a better quality of life and social inclusion.

The Legal Issues Working Committee

3.5 The Learning Disability Working Committee is aware of the current detailed work of the Legal Issues Working Committee, much of which impinges on the lives of many people with a learning disability. Issues such as guardianship, capacity and incapacity, compulsory admission for assessment and treatment, the Mental Health Review Tribunal, advocacy, legal representation, are all matters which clearly connect with this report. Issues around inheritance, eligibility to vote, to marry and to engage in sexual activities will also need to be considered, along with finding effective ways of helping people with a learning disability to exercise their rights. It is our view that the future legislation will need to address these issues fully. This may require 2 separate pieces of legislation - one of which would address issues of mental capacity and decision-making and the second of which would address the legal issues for people with severe mental illness, irrespective of whether or not they have a learning disability. Learning disability interests are represented on the Legal Issues Working Committee and continue to be regularly articulated there.

Policy Changes

3.6 Changes in societal perceptions of disability are also reflected in the policy aspirations that underpin much of current service planning and delivery. These changes are clearly seen in the recent reviews of learning disability services undertaken in these islands over the past 15 years.

- The 1990 review of services in the Republic of Ireland was based on a philosophy that every one with a learning disability has the right to *as fulfilling and normal a life as possible.* (6)

- The last review of policy for people with a learning disability in Northern Ireland that was conducted by the Department of Health and Social Services in 1995 stated that *the aim of Government policy for people with a learning disability should be inclusion ... which stresses citizenship, inclusion in society, inclusion in decision-making, participation so far as is practicable in mainstream education, employment and leisure, integration in living accommodation and the use of services and facilities, not least in the field of health and personal social services.* (7)

- The Scottish Review - The Same as You? (2000) (8) - and the English Review - Valuing People (2001) (9) - were underpinned by a commitment to social inclusion, enabling people with a learning disability to have more control over their lives and securing equality of opportunity in accessing services in local communities. In 2001 the National Assembly of Wales set out the principles underpinning their framework for services for people with a learning disability in Wales, which similarly reflected a concern to secure equality, citizenship and improved quality of life for people with a learning disability. (10)

3.7 Over recent years the 4 Health and Social Services Boards in Northern Ireland have issued policy statements to guide their commissioning of services, each of which has echoed similar themes namely:

- inclusion within society as a right and the use of <u>mainstream</u> community services

- support to individuals that will reduce the impact of the disability on their lives

- focus on individual needs and aspirations and hence the provision of choices

- empowerment of people with a learning disability to make decisions
- partnerships are required to make these a reality. (11, 12, 13, 14)

3.8 These changes are also echoed in policy changes in relation to education, social security, children and family issues. All have been underpinned by aspirations to tackle inequality and open access to the opportunities that are available to other citizens in Northern Ireland.

3.9 It should be noted, however, that much of the evidence presented to the Learning Disability Working Committee indicates that these aspirational statements have not fully been translated into practice. In particular the Review of Policy and Services for People With a Learning Disability (1995) (7) pointed the way towards many of the changes that we are again highlighting in this report. The failure to fully implement the recommendations of that review appears to stem from a combination of the following factors:

- insufficient resources to build up the community infrastructure including community based alternatives to hospitals required to deliver on the strategic intent
- the lack of robust implementation mechanisms to hold all Government departments and agencies to account for their actions in implementing the recommendations
- the continued perception that the needs of people with a learning disability can be met solely by health and social services
- an underdeveloped culture of involving people with a learning disability and family carers in determining the services available to them.

3.10 The challenge for the future will be to build on the direction of travel that has been established in these legislative and policy developments and to learn from lessons of previous reviews to ensure that these aspirations become a reality within the next 15 years.

Defining and Assessing Learning Disability

Terminology

3.11 We considered the terminology that should be used to describe this condition, which included consultation with the Equal Lives Group to hear their views on the most acceptable approach. We recognise that the term *learning disability* has potential for confusion with the broader and educationally focused term *learning difficulty*. We also recognise that there is no universally acceptable term that defines people who have such diverse characteristics. Of greater significance will be the degree to which in the future those with a responsibility to reduce the negative impact of the disability address people's unique individual talents, needs and aspirations. We have decided to accept at this stage the advice of the majority of Equal Lives Group members who expressed a preference, if a term must be used, for *learning disability*. This will no doubt be the subject of ongoing debate as society continues to respond to the aspirations of those most affected by the implications of the term.

3.12 Learning disability is not easy to define. However, we recognise that in order to ensure that people with a learning disability qualify for the individual supports, protection and services they require, some form of working definition is required. Annex H summarises the definitions used nationally and internationally. Many of these focus solely on an individual's impairments and social

functioning. Having examined a range of definitions we have adopted the definition used in Valuing People (9) and recommend the adoption of this form of words in future policy developments i.e.

3.13 ***Learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development.***

3.14 In keeping with the Equal Lives model it is essential that account must also be taken of the person's social circumstances and the supports they require when applying these definitions.

Perceptions of Disability

3.15 Historically, definitions of disability, professional practice, and service delivery to people with a learning disability have been based upon a Traditional (Medical) Model of disability which suggests that it is primarily the individual's impairments that render them incapable of participating fully within society, and does not give adequate attention to the barriers imposed by society that exclude disabled people from participation and inclusion. During the past two decades however, the Traditional (Medical) Model of disability has been challenged and criticised on a number of fronts.

3.16 This has resulted in the development of what has become known as the Social Model of disability, which places a greater focus, or emphasis, on wider aspects of people's lives, including access to education, employment, health care, transport and housing, and the disabling nature of the barriers people face, in trying to access normal living.

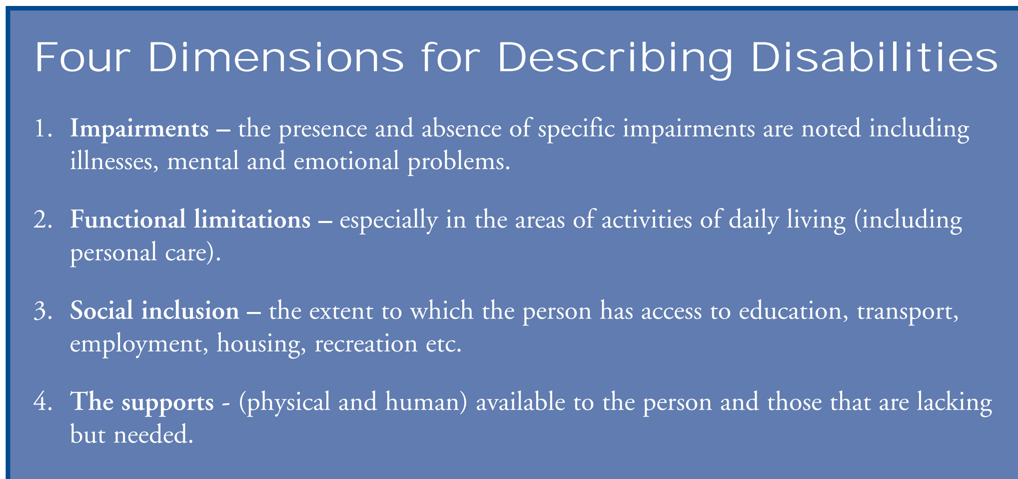
3.17 However, we recognise that people with a learning disability are not a homogenous group, and that the needs of individuals can vary considerably. Therefore, it is our view that all services, across all sectors, should aspire towards a holistic, or bio-psycho-social model, encapsulated by inclusive and person centred approaches. This model allows for the holistic view of an individual's needs, implied by the core values of the Equal Lives Review.

3.18 This model includes the following:

- focus on the person and not the disability
- focus and emphasis on environmental and societal barriers that exclude people with a learning disability from society
- acknowledgment of the need for informed medical diagnosis and health care support
- can be applied across the range of learning disability
- use of a common and acceptable language to all
- forging professional and agency togetherness rather than divisiveness
- challenging segregated service provision and paternalistic practice.

3.19 Within this model there are four basic dimensions in describing the disabilities experienced by the person with a learning disability. These are depicted in Figure 1.

Figure 1



Four Dimensions for Describing Disabilities

1. **Impairments –** the presence and absence of specific impairments are noted including illnesses, mental and emotional problems.
2. **Functional limitations –** especially in the areas of activities of daily living (including personal care).
3. **Social inclusion –** the extent to which the person has access to education, transport, employment, housing, recreation etc.
4. **The supports** - (physical and human) available to the person and those that are lacking but needed.

3.20 Assessment on all 4 dimensions gives a more complete picture of the person, their life-style and needs. Equally 4 different terms (or more) should be used to locate the person within subgroups such as: *a 20 year old man with Down's Syndrome who has a severe hearing impairment, with significantly low scores on a test of intellectual disability and who requires assistance with all personal care needs; living in a residential home with 30 other residents.*

Defining Learning Disability

Why Assess?

3.21 A person needs to be assessed to establish if they have a learning disability for different reasons:

- to determine if they are eligible for services specially provided for people with a learning disability
- to find out if they qualify for legal protection accorded to people with a learning disability
- to make an assessment of the particular help or support they require because of their disability.

3.22 The assessment of a person's eligibility to services needs to be reconceptualised. The person's needs for services can be multi-dimensional as noted earlier. No longer is it reasonable to think in terms of one service; rather people may avail of many different services. Thus assessments of eligibility for services are rarely done on a once-off basis.

3.23 However, people with a learning disability do not need to be specially assessed to determine their eligibility for services that are available to the wider population as long as they meet the same criteria as their fellow citizens. We anticipate that this truism will have growing significance in future years.

3.24 In order to determine a person's needs for specific services, including provision for protection, that arise from their learning disability, the essential requirement is to specify the person's needs and vulnerabilities rather than their disability per se. In the past a low IQ alone was used to categorise

persons deemed to have similar needs, but this is now being considered in tandem with an assessment of social functioning and a crude approach based solely on IQ should have no place in modern service provision.

3.25 The onus is on the service to precisely define the criteria that make a person eligible for the special service. Each defined service needs to produce and publicise the criteria for admission, especially for those services where demand exceeds supply, such as the provision of respite (short-term) breaks or attendance at day centres. The assessment of the person then becomes one of whether or not they meet the criteria for entitlement. This recognises the reality that everyone with a learning disability does not require every service. It also means that as people's needs change over time, they may become eligible for services; hence re-assessments of needs are required.

3.26 We view assessment of learning disability as an interactive process in which the person and their family carers are fully engaged with professional staff. This will necessitate services specifying more precisely their aims and criteria for admission while developing suitable and transparent means of assessing an individual's needs. There are encouraging signs that this is starting to happen in services, but it requires sustained attention in the coming years.

3.27 It is vital to ensure that a separate assessment of the needs of carers is conducted.

3.28 Until such times as present laws change, it is likely that thorough and precise assessments of intelligence and adaptive functioning will be required to determine if a person has either a significant or severe mental impairment as defined in legislation. However, this requirement need not carry over into definitions regarding eligibility for service provision for the reasons noted earlier. We anticipate that the Review's Expert Working Committee on Legal Issues will make further recommendations on this issue.

How Many People with a Learning Disability are there in Northern Ireland?

Prevalence

3.29 We have experienced some difficulty in securing accurate information on the prevalence of learning disability owing to the way in which such information is gathered in Northern Ireland. However, a recent study based on information held by Health and Social Services Trusts estimated the numbers as shown in Table 1. (Data from the Republic of Ireland are provided as a comparison). (15)

Table 1: Prevalence Rates (per 1,000) (15)

Age Bands	Mild/Moderate	Severe/Profound	Total	Overall Prevalence	RoI Prevalence(16)
0-19	6432	1718	8150	16.30	7.69
	39.3%	10.5%	49.8%		
20-34	2504	1047	3551	10.16	9.59
	15.3%	6.4%	21.7%		
35-49	1489	949	2438	7.04	7.81
	9.1%	5.8%	14.9%		*(35-54 yrs)*
50+	1473	753	2226	4.54	3.62
	9.0%	4.6%	13.6%		*(55+ yrs)*
Totals	**11,898**	**4468**	**16,366**	9.71	7.35
	72.7%	**27.3%**	**100%**		

3.30 These data suggest that many more children in Northern Ireland are recorded as having a learning disability than in the Republic of Ireland. However, in the latter, the figures are based on children in receipt of, or requiring, special services. In Northern Ireland many of the children classed as *possibly having learning disability* in the Child Health System may not be making any demands on special services. The prevalence figures for people aged 20 years and over are broadly comparable. The decrease in numbers of people by age reflects the shorter life expectancy of this group in the past. However, this is changing due to medical advances.

3.31 There is a small, but growing population of people from minority ethnic communities in Northern Ireland. Data is not available from present data systems, although under Section 75 of the Northern Ireland Act (1998) it should be recorded as these individuals and their families may have particular needs that are not currently addressed.

3.32 Finally, these numbers represent people known to services at a particular point in time. It is possible that the actual numbers of people with a learning disability are higher and they may come close to the often quoted figure of 2% of the population having a learning disability. This is especially so when those with milder forms of impairments, but allied with poor social circumstances, are included.

3.33 This would indicate that there is an unrecognised population of people with a learning disability of approximately 16,000 people who are currently not known to services.

Future Indications of Population

3.34 All the indications are that there will be increased numbers of people with a learning disability in the next 15 years. (17) This results from:

- increasing life expectancy - it is now thought that most adults with a learning disability in developed nations who live beyond thirty are likely to survive into old age and experience the normal ageing process
- people with more complex health needs are living into adulthood due to advances in medical care
- more mothers giving birth later
- increased survival rates of at risk infants due to improved healthcare
- the bulge in the numbers of children with a learning disability born in the 1950s and 1960s is now working its way through into the 50 plus age group
- a higher birth rate among ethnic minorities along with an associated higher rate of learning disability in these populations could also result in increased numbers.

3.35 There are some trends that may result in decreasing numbers or degree of disability:

- better pre-natal care for all pregnant mothers including increasing availability of pre-natal screening for congenital and other abnormalities
- improved health care and early intervention for at risk infants leading to fewer becoming learning disabled
- the advent of gene therapy to correct or ameliorate congenital abnormalities.

3.36 Overall it is impossible to predict the impact of these opposing influences. In England, a presumed growth of 1% per year for the next 15 years was made of people with moderate to severe learning disabilities. This figure may need to be higher for Northern Ireland as we have had a higher birth rate until comparatively recently and limited access to terminations of pregnancies. Even so a 1% increase per annum in the present adult population of 8,200 would mean an adult population of 9,500 by 2019. A 1.5% increase per annum would result in 10,200 people. It might also be that numbers would continue to rise for a further 15 years, up to 2034 before deaths matched births.

3.37 However, it is likely that higher proportions of these individuals would have increased support needs due to old age or additional complex needs and the impact on resources required to meet their needs would be in excess of a 15% - 25% growth in service provision based solely on the number of service users.

3.38 These factors indicate the increased demands that will be placed on existing pressurised services and the need to significantly develop community services to meet increased need into the future.

3.39 There may be increasing numbers of people from ethnic minority communities if immigration increases in Northern Ireland as it has done in the Republic of Ireland and Great Britain.

Links with Social and Economic Deprivation

3.40 Internationally there is clear evidence for a link between higher prevalence rates of mild/moderate learning disability and poorer socio-economic status and unstable family backgrounds. (18) This link with a severe learning disability is less clear-cut, but more recent research internationally does suggest a link with socio-economic status. (19)

3.41 Research in Northern Ireland has identified a significant association between the indicators of socio-economic measures of deprivation and the prevalence of people with a learning disability recorded on service information systems irrespective of the severity of their disability. (20) This is based on a small area analysis of the characteristics of people living within each electoral ward (i.e. around 2,500 persons) as ascertained by the national census or other form of surveys using representative sampling.

3.42 In Northern Ireland the association is best captured by three indicators of deprivation, namely there tend to be more people with a learning disability in wards that have:

- higher proportions of people aged 16 to 74 with no educational qualifications
- higher proportions of children in households with job seekers allowances
- higher proportion of adults with a limiting, long-term illness.

3.43 However, families who have a member with a learning disability may be poorer for other reasons (refer to Chapter 4). Therefore, many people and families are disadvantaged not only because of the disability, but also because of social and economic deprivation.

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The Impact of the Troubles

3.44 It is notable that in many of the studies done on the impact of the Troubles on individuals and families, people with a learning disability do not feature. In part their invisibility may result from their small numbers, but more likely it is because of the presumption that their disability negates them from being influenced by the same factors that afflict their non-disabled peers. Indeed this presumption may well explain why in the midst of a segregated educational system, the only schools attended by children from both communities over the past 20 years were mostly special schools. Likewise much of the service provision for men and women is non-denominational although the balance of attendees from one rather than another community can be determined by its geographical location. (21)

3.45 In common with other public institutions in Northern Ireland, special schools and services seem to have been silent about issues of division, conflict and sectarianism. (22) There appears to be limited engagement in any reconciliation initiatives.

3.46 The findings from studies undertaken with other populations in Northern Ireland are also likely to mirror the experiences of at least some people with a learning disability. These have been summarised in terms of impacts that are more frequently experienced and less visible, to those that are less frequently experienced but highly visible. (23) These include:

- the risk of straying into areas where they did not feel safe
- getting stopped and searched by security forces
- sectarian verbal abuse
- parents having to take extra security precautions to secure home or workplace
- knowing victims of punishment attacks
- young people pressurised to engage in sectarian activities
- involvement in paramilitary activity
- member of family killed.

3.47 The clinical experience of professionals suggests that people with a learning disability were recruited by paramilitaries and that some were subsequently involved in serious offences.

3.48 More generally though, family carers were reluctant for their family member with a learning disability to travel independently and opportunities for social, employment and educational activities across the community divides were severely restricted. There are indications from local research that this social isolation may be one of the most widespread and lasting legacies of the Troubles.

3.49 However, it is impossible to generalise about the overall impact that the Troubles have had on this client population as no systematic studies have been undertaken and even when these have been done for the wider population, the results are difficult to interpret given the presence of other confounding variables such as socio-economic deprivation and lack of contrast groups from outside Northern Ireland.

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3.50 Possibly the more important lesson is for the future and to ensure that people with a learning disability and service staff are fully involved in all initiatives to promote greater understanding and respect for the 2 main cultural traditions in Northern Ireland.

Service Provision

3.51 There is no accurate record of all services provided under the learning disability programme of care either by a Health and Social Services Trust or by a subcontractor in the private or voluntary sector. Nor are there accurate records of the number of people availing of them.

3.52 However, it is very apparent that over the past 20 years in Northern Ireland there have been major changes in service provision and an expansion in the range of services on offer. In particular:

- the 3 hospitals for people with a learning disability have reduced considerably in size and are evolving from providing long-term residential care towards the provision of short-stay assessment and treatment services
- in some areas there has been a shift in the provision of children's services from a learning disability programme of care to the generic family and child care programme and child health
- there has been a major growth in the provision of residential homes and nursing homes for people with a learning disability by a range of independent sector providers. Latterly increasing numbers of people have their own homes with staff providing support as required.
- there has been an increase in the range and quality of child care places but data available does not allow us to identify the extent to which children with a learning disability have benefited
- a wider range of day centres is available along with vocational training and employment services provided largely by the voluntary sector
- the provision of education for children with a learning disability has become the responsibility of Education and Library Boards and increasing numbers of these students go on to attend Further Education (FE) Colleges
- the health aspect of Early Intervention is now led by paediatric services with support from learning disability specialists
- a network of personnel from different disciplines and therapies are providing services to people with a learning disability living alone, at home and in community residential facilities
- a variety of different services have evolved to provide support to families and hardly any child or teenager now lives away from a family
- there is a growing appreciation of the need to facilitate and provide increased access to mainstream health, social services and education for people with a learning disability.

3.53 The result is a greater diversity of services with a wide range of personnel employed in them, which has produced a complex web of services spanning all sectors and a wide range of settings. However, this complex web of service provision has created its own particular difficulties including:

- family carers complain that they are not given information about all the services and help that is available (24)
- families may have to work with various different specialists who may give conflicting advice. The concept of a named or key worker for the family is not well established. (25)
- there is likely duplication within and across services in terms of record keeping, assessments and staff roles
- the full range of services is not available as often, new services have been developed in an area at the instigation of particular individuals or as a result of special project based funding. This produces inequalities within and across areas, a pattern that has been referred to as being a postcode lottery for support.

3.54 The need for joined-up working across different Government departments, statutory agencies and other service partners is very evident in the field of learning disability. It has received scant attention in Northern Ireland, although it is being actively promoted in Great Britain.

3.55 In recent years, increasing attention is being given to creating more person centred approaches in service delivery. Latterly Person Centred Planning (PCP) has been promoted as producing more effective outcomes for people with a learning disability in new styles of community-based services. However, recent research has indicated that PCP on its own may be ineffective unless the cultures of organisations change radically to create a shift in the power relationships between staff and the people they are working with and changes are made in funding arrangements and staff training and supervision. (26, 27)

3.56 In subsequent chapters we will address these and other issues through a series of recommendations.

Funding

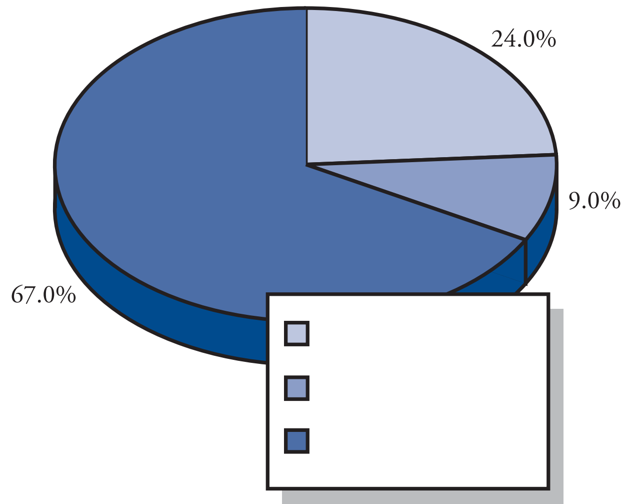
Health and Social Services Funding

3.57 The learning disability programme of care currently accounts for 7.6% of Health and Social Service Board expenditure (£136.4 million at 31 March 2003). This equates to approximately £80 per person of the total population. (28)

3.58 In the period 1997 to 2003 health and personal social services (HPSS) spending on the learning disability programme of care rose from £89.2 million to £136.4 million; an increase of 53%, although the later figure includes a substantial transfer of former social security payments to the HPSS. The share of the total HPSS spend also rose from 6.9% to 7.6%. (28) A detailed breakdown by key service area and by Health and Social Services Trust of the total learning disability expenditure for the latest available year (2002/2003) is given in Annex I.

3.59 The proportions of revenue monies spent in the HPSS learning disability programme of care as at 31st March 2003 are shown in Figure 2.

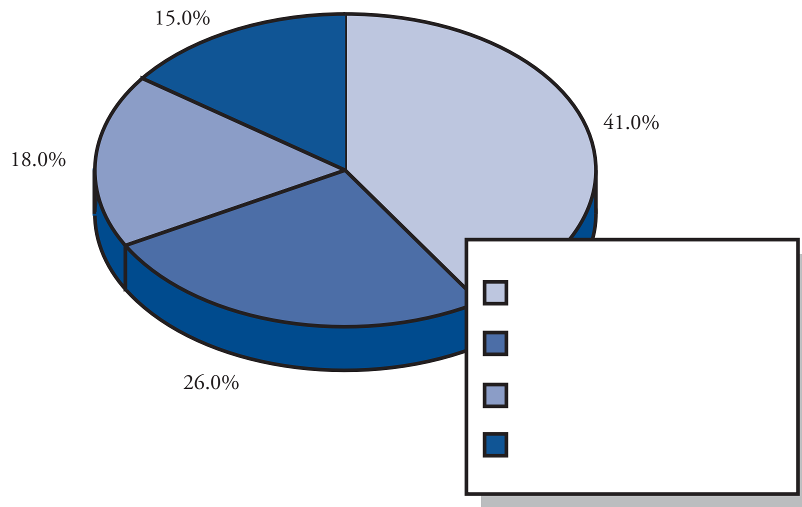
Figure 2: The proportions of monies spent in the Learning Disability Programme of Care - year-end 31 March 2003 (Total £136.4 million) (28)



3.60 There is a mismatch between the proportions of monies spent on hospital provision with the numbers of people in hospital settings (24% versus 4%). This can be explained to some extent in that the hospitals are funded to provide short-term assessment and treatment services for people in residential and family settings as well as for the people who live in hospitals. Total hospital expenditure has shown an increase of 9% over the 7-year period from 1997 - 2003. The overwhelming majority of hospital expenditure recorded for the learning disability programme of care is for inpatients with just over 1.5% relating to outpatients and 2% to day patients. However, all the costs of specialist medical and psychiatric services and some other services are presently costed to hospitals although they also serve people living in community settings.

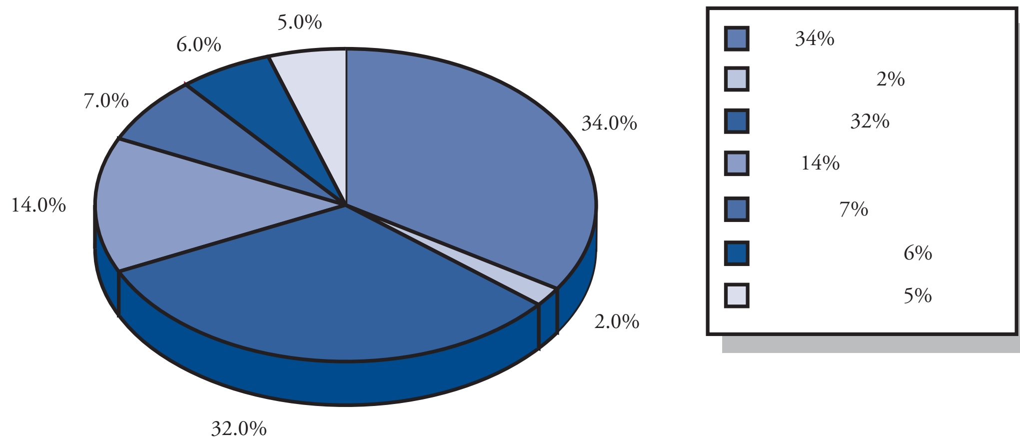
3.61 Community health expenditure has shown a 40% increase in the past 7 years, with the 2003 figure totalling £12.2 million (Figure 3). Expenditure on Allied Health Professionals includes speech and language therapy, physiotherapy, occupational therapy, etc as detailed at Annex D.

Figure 3: Learning Disability Community Health Expenditure 2002/2003 (Total £12.2 million) (28)



3.62 In personal social services (PSS) the largest items of expenditure recorded are residential homes/supported and other accommodation and day services as depicted in Figure 4. From 2002 onwards this received a major increase with the transfer of former social security payments to the HPSS. This was around £24 million but did not represent new monies, rather a reallocation of funds across Government departments.

Figure 4: Learning Disability PSS Expenditure 2002/2003 (Total £91.2 million) (28)



Funding From Other Sources

3.63 It has been difficult to obtain precise figures for the amount of monies spent by other Government departments on people with a learning disability. This will include:

- **Department of Education (DE):** on statutory assessments and statementing; the provision of learning support in mainstream schools and special schools
- **Department for Social Development (DSD):** social security benefits such as Disabled Living Allowance and Mobility Allowances plus contributions to Supporting People and the capital costs of special needs housing
- **Department for Employment and Learning (DEL):** further education costs, vocational training, Disablement Advisory Service and career guidance
- **European monies** have provided funding towards various learning disability services, although it is anticipated that these will end in 2006 or soon after.

Variation in Costs

3.64 To date there has been relatively little research into the costs of learning disability services and in particular into the value-for-money offered by different service models.

3.65 Most research in Great Britain has focused on different forms of residential care and found that costs vary dramatically within all forms of residential services. There can be a 4-fold difference in costs of these services and similarly a 3-fold difference has been reported for day services. (29) The level of dependency of the residents accounts for a proportion of the variation. However, once this is taken

into account, there appears to be little association between the size of the home and costs. Larger is not necessarily more cost-effective.

3.66 Newer community based services are generally more expensive than support provided in older style accommodation, although this largely results from compensating for the inadequacies of these services rather than inherent economies of scale in larger establishments.

3.67 A Northern Ireland study into the costs of providing residential services for people relocated from a long-stay hospital found similar wide variation in costs as in Great Britain with the highest median costs being in registered residential care homes which cost £36,000 per annum (range £16,000 to £41,500) with costs generally lowest in registered nursing homes: median of £19,000 (range £11,000 to £36,000). **(30)**

3.68 Another study into the costs of supported living reported a wide variation in weekly costs, which were on average lower than figures cited for similar schemes in England, although some of these services employed waking night staff, which increases costs markedly. **(31)**

Inequalities and People with a Learning Disability

3.69 There is ample evidence to demonstrate that people with a learning disability do not have access to the same range of services and opportunities as other people in Northern Ireland.

3.70 The table, which follows, gives some examples of the inequalities that have been highlighted to the Equal Lives Review.

Table 2:	Inequalities Linked to Learning Disability
Children, Young People and their Families	Many children are unable to access mainstream play and leisure activities. (32)
	Access to preschool facilities for these children is curtailed.(33)
	Mothers are less likely to be in employment.(34)
	Mothers are more likely to report symptoms of ill-health such as depression. (35)
	The burden of caring is more likely to fall on the mother. (32, 36)
	Families of disabled children face financial burdens that are not always met by disability benefits and due to reduced income they are more likely to experience social deprivation. (37)
	Siblings of severely learning disabled children may also face inequalities with many having less contact with friends and increased levels of anxiety compared to other children. (38)
	Transition from school to adult services is a particular area of concern for parents. In the past commissioners and service providers have failed these children by not providing the same range of services and choices that are open to non-disabled young people, such as career guidance, further education, work experience and vocational training. (39)
Adult Life	People with a learning disability do not have the same opportunities in employment, further education, leisure, social life and personal relationships. Poverty contributes to some of these.
	Fewer people with a learning disability achieve accredited qualifications.
Health and Wellbeing	There are high levels of unmet health needs among people with a learning disability in Northern Ireland. (40, 41)
	Some may have a higher incidence of physical health problems. (41, 42)
	A person who displays challenging behaviours[6] is more likely to be socially isolated and excluded not only because of the behaviour they display, but also due to the barriers to their social interaction skills and development that challenging behaviours create. (43)
	Those with the most severe behavioural problems are also more likely to be excluded from day opportunities such as day care or school. (44)
	People who challenge services are frequently the last people to move out of institutional care (45) and the ones most likely to be admitted to hospitals for specialist assessment and treatment. (46, 47)

[6] The term challenging behaviour as used here refers to people who challenge either due to behavioural causation (learned behaviour); mental health problems or both.

People who commit offences may not come before the courts but will have to live in more confined and highly supervised settings, often long-stay in hospitals. (48)

Growing Older

Many older people with a learning disability are at particular risk of neglect, poor access to health care and marginalization within society. (49, 50)

Some people with Down's Syndrome age prematurely and life longevity is reduced for many people with severe and profound disabilities. (49, 50)

Human Rights and Discriminatory Practices

3.71 People with disabilities may face more fundamental inequalities, foremost of which is the right to life. The European Convention for the Protection of Human Rights and Fundamental Freedoms is enshrined within the Human Rights Act (1998). At the centre of the human rights agenda is the fundamental principle that human beings have value and should be treated equally based on the fact that they are human beings first and foremost; human worth is not based on either capacity or incapacity. (51,52) These rights include the right to life, the right to liberty and security and the right to respect for a private and family life. These rights should never be restricted solely on the basis of the presence of a learning disability.

3.72 Questions do need to be asked however with regard to the inequalities that may exist in Northern Ireland detailed in Table 2. For example are statutory services in breach of the Disability Discrimination Act and Human Rights Act if they:

- fail to provide adequate community support for a person with challenging behaviours?
- exclude a person from day facilities or school because they do not have a nurse to care for his or her complex health needs?
- maintain a person in hospital because they do not have a facility in the community for a client to resettle to?
- deny access to health screening and treatment for a person by virtue of inaccessibility or exclusionary practice?
- do not have in place services to adequately meet the needs of older people with a learning disability?
- fail to provide family support, for example, respite?

3.73 Future legal challenges may test the legality of failure to provide adequate services in relation to the issues identified above.

Addressing Human Rights Issues

3.74 If institutionalised discrimination against people with a learning disability is evident in practice there remains an onus on Government and through them service commissioners and providers to address human rights and equality issues. It is our belief that in order to effectively address these issues services should be guided in future by the 5 values on which the Equal Lives Review is based: social

inclusion, citizenship, empowerment, working together and provision of individual support. In addition efforts must be harnessed to change the attitudes and mind sets that support such discrimination and inequality. Various writers have noted that legislative implementation needs to be combined with:

- education of service staff who may discriminate against people with a learning disability
- moving forward the inclusion agenda by providing more integrated housing, education and day opportunities
- learning disability awareness raising through schools as evidence suggests negative attitudes are formed early in life, and when developed such attitudes are extremely difficult to change
- use of various local and mass media to raise the equality agenda for people with a learning disability
- raising awareness across agencies of the need to counter inequality
- raising awareness within associated services e.g. general hospitals, mental health services regarding countering inequality for people with a learning disability
- involving people with a learning disability in the design, delivery and management of services.

Possible Inequities in Service Provision

3.75 There are difficulties in comparing service provision between one area and another because of the limited information available, the lack of reliable research studies in this area and differences in the way services are provided. Despite this caution there do appear to be some marked differences in Northern Ireland service provision when compared with other countries e.g.:

- Northern Ireland has the highest proportion of people resident in long-stay hospitals:
  - 15 places per 1 million population in England and Wales (9)
  - 163 places per 1 million in Scotland (8)
  - 222 places per 1 million in Northern Ireland (15)
- There are many more places provided (or to be provided) in Northern Ireland hospitals for assessment and treatment admissions:
  - estimated 203 places presently available in Northern Ireland/ 11.9 per 100,000 population reducing to 146 (excluding forensic and children's places) (based on figures supplied by HSS Boards)
  - 3.98 per 100,000 population in Scotland (53)
- In Northern Ireland over one quarter of people with a learning disability surveyed lived in nursing homes. The proportion of nursing home places is higher here than in England and Wales, where in 1997 just 7% of their places were in nursing homes. However, the proportion of nursing home places varied within Northern Ireland; the Northern Health and Social Services Board (NHSSB) having the highest proportion (46%) and the Western Health and Social Services Board (WHSSB) the lowest (21%).

- The proportion of people in supported housing within Northern Ireland is lower than Great Britain, although there is wide variation across the four Boards; with the Eastern Health and Social Services Board (EHSSB) having the highest proportion (31%) and the Southern Health and Social Services Board (SHSSB) and WHSSB the lowest (4%).

- None of the Health and Social Services Trusts in Northern Ireland achieve the minimum number of funded accommodation places that the Department of Health has suggested for England and Wales, namely 15.5 places per 10,000. Again there is wide variation across the 11 community Health and Social Services Trusts from 6.8 places per 10,000 to 13.8 places per 10,000.

- More people with a learning disability attend day centres in Northern Ireland (23.5 per 10,000 of total population) than in Scotland (15.1 per 10,000) and England (12.0 per 10,000). (54) This may be viewed positively in that larger numbers of people have access to day centres and may redress the imbalance in the provision of residential places noted above. On the other hand, it could be that people in Northern Ireland have less access to further education, supported employment and ordinary leisure opportunities in comparison to people in Britain.

- In Great Britain not only do more people with a learning disability attend FE colleges (5.7% compared to 4.1% in Northern Ireland in 1999), but more are enrolled on a full-time basis (45% compared to 11%). (55) More recent figures supplied to the Equal Lives Review by the Department for Employment and Learning indicate that in 2002/03, 5.3% of all enrolments in FE colleges were for people with any form of learning difficulty or disability but this ranges from 1% to 13% across the 16 colleges in Northern Ireland.

- Although there are no centrally collated statistics in Northern Ireland, there appear to be more opportunities for people with a learning disability to be in supported employment in Great Britain and the Republic of Ireland. (16, 54, 56)

Future Prospects

3.76 It is important to end this chapter by highlighting the many positive achievements that have occurred within services for people with a learning disability in Northern Ireland over the past decade which have included:

- an increase of 53% in health and social services spending on people with a learning disability since 1997

- the increased resources provided by Education and Library Boards to special schools and units, and in support of children with statements of special educational needs in mainstream schools

- the increased number of children with a learning disability attending mainstream preschools, nursery and primary schools

- the increase in the number of Allied Health Professionals and other staff working with children and families

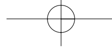
- the wider range of short-break options available to families and the reduced use of hospital provision to meet this need

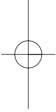
- the reduction by 300 in the numbers of people living in long-stay hospitals since 1994

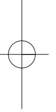
- the increase in expertise and support services that have enabled people with a learning disability and challenging behaviours to live in the community

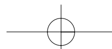
- the increased diversity of accommodation and support options available to people with a learning disability and the numbers with tenancy agreements to their accommodation
- increased availability of further education, vocational training and employment options through European funding allied with Government funding
- the improved range and level of social security benefits available to people with a learning disability and their carers
- the wider range of innovative day opportunities that has been developed
- the greater acceptance by society of the rights of people with a learning disability and their willingness to include them in community life.

3.77 These improvements demonstrate that change is possible. They are also a reminder that the changes required in the future are but a continuation of what has largely begun. The foundations have been laid for the proposals for change that follow. It will be essential that data be collected to monitor these changes across all public services. This is already a requirement under Section 75 of the Northern Ireland Act 1998.









CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES

Chapter 4

The challenge to the Review is to get beyond the rhetoric and the research to recommendations that will get us closer to the vision of a world in which children with a learning disability will have equal choices and equal value. **Children and Young People's Task Group.** (57)

Objective 1	To ensure that families are supported to enjoy seeing their children develop in an environment that recognises and values their uniqueness as well as their contributions to society

4.1 Recent trends in Government policy and legislation have emphasised the rights of children and the need to ensure equality of opportunity for all children. We have taken full account of the proposed children and young people's strategy for Northern Ireland and its welcome emphasis on including all children. However, frequently the particular needs of children and young people with a learning disability have tended to appear as a footnote in the initiatives that have emerged, but these are overshadowed by the numbers and needs of other groups. Children and young people with a learning disability have not benefited as they should from initiatives to improve children's experiences, or from measures focused on learning disability issues. We are proposing that there is an urgent need to address this situation in the firm belief that investment in children and young people is the most effective means of changing the experiences of people with a learning disability and their families.

Issues and Concerns

4.2 Many children and young people in Northern Ireland suffer from poverty and social disadvantage; these factors are increased where a family member has a learning disability. In Northern Ireland:

- 27% of the population is aged under 18 (58) making Northern Ireland the most youthful region in Europe yet we spend 25% less proportionately than England on children's services (59)
- 6.3% of children under 16 years live on family farms with an increased risk of isolation for all children and presenting serious challenges to families and services when a child has mobility problems (58)
- 29% of households are defined as poor with a further 12.1% vulnerable to poverty owing to low income. Half of these households include at least one member with long-term illness or disability (60)

- bullying is a significant cause for concern and unhappiness for children and young people with a learning disability. (61)

4.3 The views of children and young people with a learning disability are not routinely sought. When this is done it emerges that they share similar hopes and fears with their non-disabled peers, but also have additional specific concerns including difficulty having friendships, experience of bullying, isolation and barriers to play and leisure opportunities. (59, 62, 63)

Family Support

4.4 All children have the potential to bring to families great joy and equivalent levels of stress. Families are important to all of us, more so to the person with a learning disability. Families of people with a learning disability provide care and support well beyond what is normally expected and over a longer period of time. Families of children with a learning disability will at times report experiencing increased family harmony and cohesion, and higher levels of empathy among family members. For many other families however there can be preponderance of more negative experiences that drain the parent's or other main carer's ability to function as both an individual and as a long-term carer. (64)

4.5 The risk of experiencing such negative emotions is increased significantly for families:

- where the child has additional complex needs e.g.
  - children with multiple physical and sensory disabilities
  - children with an Autistic Spectrum Disorder
  - children who display high levels of challenging behaviours or mental health problems
  - families with more than one child with a significant disability
  - children whose disability is not easily identified and who don't look disabled
  - families where a parent has a learning disability
- at times of transition or change for the family e.g.
  - at the time of diagnosis
  - starting school
  - leaving school
  - transition to adulthood
  - leaving the family home. (65)

4.6 Children with a learning disability can display a range of special needs which require family members to fulfil a diverse range of roles and functions: parent, educator, communication facilitator, behavioural specialist, emotional confidant, advocate. Few carers could innately possess such a range of skills and, as such, need support and opportunity to acquire such skills. (66)

4.7 Positive developments in the support provided to parents over recent years include:

- increase in the number of Allied Health Professionals

- development in some areas of community based provision that facilitates access by children with a learning disability to community social and leisure opportunities
- the wider range of short-break options available to families and the reduced use of hospital provision to meet this need.

4.8 However, practical and emotional support to families tends to be fragmented and patchy. Although examples of good practice were presented to the Equal Lives Review, there was no evidence that such practice is consistent across Northern Ireland. Recurrent concerns presented to the Equal Lives Review included:

- Respite is currently defined as *placements, which are usually planned in advance, where a child moves out of the family home for a short break.* Provision is variable in Northern Ireland and parents frequently complained about their inability to access this provision particularly in emergencies.
- Provision of childcare has improved overall since the Government launched its most recent childcare strategy for Northern Ireland, Children First. (67, 68)
- The need for additional support for children with an Autistic Spectrum Disorder and/or multiple disabilities was highlighted to the Equal Lives Review.
- In addition there is an emerging need for additional provision after school and for older children.

4.9 Family support is not just about more services of whatever type being delivered to families in the hope that the cumulative effect will be helpful. Evidence has emerged in recent years both from outcome based research and families' own views that there are key elements of a Family Support model, which are crucial to successfully helping families cope. (65, 69)

Growing Areas of Need

4.10 There will be a number of growing areas of need over the next 15 years, which include:

- children who are technology dependant, an increasing number of whom are surviving into adulthood
- children with a learning disability who also have an Autistic Spectrum Disorder. Autism is a complex developmental disability of lifelong duration. The majority of those with an Autistic Spectrum Disorder do not have a learning disability and 75-90% are within the average or above average range of intellectual ability. (70) There is increasing evidence of the real life challenges experienced by these individuals who are often caught between learning disability, mental health and child health programmes of care. For those children with both an Autistic Spectrum Disorder and learning disability there is a need for appropriately skilled diagnosis and assessment and individual supports that take account of their particular needs. A ten year strategy to address the educational needs of children with Autistic Spectrum Disorders was detailed in the Task Force on Autism report. (71) Implementation of its recommendations requires close cooperation between the wider education sector and health and social services agencies.
- children with multiple severe and profound disabilities who require 24-hour personal care and increasingly intensive nursing care
- the numbers of children from minority ethnic communities are increasing

- increasing number of parents with a learning disability who may require additional supports to enable them to meet their parenting responsibilities. A survey in one Health and Social Services Trust found that 11% of families known to the children's disability team had 2 or more children with disabilities and for 5% of families one or both parents had a learning disability themselves.
- the nature of the family is changing. There are more lone parents caring for children with special needs. (72, 8)

Looked After Children

4.11 Children and young people grow and develop best in their natural families. Where the family can no longer provide the care or where the risks associated outweigh the benefits, this is not the case. Data are not available for all of Northern Ireland on the numbers of children with a learning disability who are looked after away from their natural families.

- A survey in the EHSSB found that 53 children with a learning disability were living in some form of residential accommodation (N=31) or with foster carers (N=22). (73) This represents 0.28 per 1,000-child population or 3.3% of children with a learning disability in the Board. If these figures were projected to Northern Ireland as a whole, this suggests that around 140 children live away from their natural families. Most of the children in residential accommodation were 14 years and over.
- In the Republic of Ireland, twice as many children (7%) live in some form of residential accommodation with an unknown number in foster care arrangements. (16)
- However, the study in the EHSSB area found that an additional 16 places were required to meet the needs of those young people presently living with families and that a further 14 places are also needed for those inappropriately residing in hospital or adult residential accommodation. If the figures for increased needs were projected to Northern Ireland as a whole, an additional 75 places are required for young people who need to live away from the family home in settings appropriate to their needs. Many of these young people have severely challenging behaviours and/or an Autistic Spectrum Disorder. They are difficult to foster because of their complex behavioural problems or health needs and they cannot be accommodated in mainstream children's homes. The lack of appropriate community provision results in some of these children being admitted to adult wards in learning disability hospitals and the lack of adequate provision makes it difficult to discharge them.
- Mainstream children's homes have difficulties supporting children with a learning disability, but where for an individual child it is appropriate that they do, staff require additional training and support to carry out this role.
- The lack of residential and foster placements is a recognised problem for all children. In a Social Services Inspectorate report in 2003, 95% of respondents reported a shortage. Social workers surveyed said that 17% of children with a disability always/nearly always did not have their needs met. Multiple care placements were identified as a serious challenge. (74)

Action Required

4.12 We propose that support to families with a child with a learning disability be remodelled to develop responses that are:

- more family directed
- continuously identify the needs and wishes of the family
- empower staff to support families in a more family directed, purposeful way
- able to direct resources flexibly.

4.13 In order to develop a more co-ordinated approach and to overcome many of the difficulties associated with families not knowing what support is available to them, a key worker should be appointed as soon as possible after diagnosis. This role has been recommended in other recent reports but as yet remains to be implemented in any consistent manner across Northern Ireland. It is imperative that a key worker be identified who will be linked with the family early and assume primary responsibility for co-ordinating service intervention and delivery. The key worker will be drawn from existing professionals such as social work, nursing or allied health professionals. The key worker will ensure that a Family Support Plan is agreed in partnership with the family that clarifies the support the child and family requires and how it will be delivered. The family and key worker should review the Family Support Plan annually. **(Recommendation 1)**

4.14 Respite services need to be developed in a manner that moves away from an over reliance on inflexible residential provision to the provision of a menu of short break services that include home based support, community based activity, family placements and residential options. The range of responses must take account of the intensive or specialist support needs of some children.

4.15 Children's Services Plans must detail how they will address the growing needs identified above with particular reference to deficiencies in short break provision, childcare and support in the home of families of children with Autistic Spectrum Disorders, complex health needs and/or multiple disabilities. **(Recommendation 2)**

4.16 It is vital that families have easily identifiable and accessible points of contact at different stages of their child's life. In the coming years, multi-agency centres should be developed to act as a focus for both generic and some specific services. These could be established from existing service sites, such as family centres, large primary care practices, community centres, nurseries or schools, but their existing remit would be widened through the addition of other information, support personnel and services. The goal would be to create a hub for supporting families so that help can be wrapped around the child and the family. This one-stop shop would also act as a common point of contact for children, their families and the staff who support them and would help to build clear referral pathways to further help and support and provide better co-ordinated responses. Children's Services Planning should be charged with developing this proposal in that such centres would be designed for all children in need and not just those with a learning disability. The evaluations of Children's Centres in England and the Wraparound Pilot in Northern Ireland provide models of service and evidence of the factors that contribute to success. (75, 76) **(Recommendation 3)**

4.17 As noted above we recommend that family support including planned breaks and emergency care in and away from home be prioritised in order to minimise family breakdown. To meet the needs for additional placements for looked after children specialist fostering and adoption should be further developed to ensure targeted recruitment of and enhanced support for foster and adoptive parents. Places for young people with a learning disability and complex needs aged 14 - 18 years who cannot be placed in a family situation should be provided in ordinary domestic settings and with regard to the principles of individual support, continuity and security of tenures of the supported living model. **(Recommendation 4)**

4.18 In order to address the complex and particular needs of children and young people with challenging behaviours and/or severe mental health problems community based assessment and treatment services need to be further developed. **(Recommendation 5)** The Child and Adolescent Mental Health Working Committee will make further recommendations in relation to children and young people with mental health problems. The interface between these services will be a key implementation issue.

4.19 Objective 1	**Recommendations**
Recommendation 1	Each Trust should have established arrangements for the development of Family Support Plans, which must be delivered through a co-ordinated strategy that monitors outcomes and identifies unmet needs.
Recommendation 2	Over the next 5 years providers should be resourced to extend the volume and range of emotional and practical help to support families. Their proposals should be considered within the context of Children's Services Planning and be aimed at assisting the maximum number of families. An ear-marked fund of up to £2 million recurrent each year for 5 years should be made available to fund proposals that best meet the Equal Lives values and objectives. The outcomes from this Family Support Fund should be carefully evaluated and used to inform future commissioning decisions in support of family carers.
Recommendation 3	Health and Social Services Trusts in partnership with Education and Library Boards and the community and voluntary sector should establish multi-agency centres, which provide a clear pathway to help for parents of children with a learning disability.
Recommendation 4	By March 2006 each Health and Social Services Board should identify the need for permanent placements for children and young people with a learning disability and produce strategies to address them. While the focus should be on innovative means of developing and supporting specialist fostering, it may be necessary to commission intensive care provision for small numbers of children who can not be placed in family settings.
Recommendation 5	Community based assessment and treatment services should be developed for children and young people with severe challenging behaviours and/or mental health problems. The service should encompass a small short-stay residential provision and community behavioural support services that provide outreach to families, schools and community based agencies.

Objective 2 To ensure that children and young people with a learning disability get the best possible start in life and access opportunities that are available to others of their age.

4.20 Energies need to focus increasingly on directly meeting the individual needs of babies and young children in a co-ordinated manner. As they grow older barriers to their inclusion in play and leisure opportunities enjoyed by their peers must be removed.

Issues and Concerns

Early Intervention

4.21 The value of early intervention with children with a learning disability has been well recognised, but the problems and challenges that exist are evident: (64, 68, 70, 77, 78)

- professional efforts are often not co-ordinated
- parents complain of having to manage multiple appointments and receiving at times conflicting advice
- long delays are reported for appointments to specialists
- key services are understaffed (79, 80)
- not all children with a learning disability receive a clear diagnosis despite the presence of complex needs. This can result in children losing out as service responses are often linked to diagnosis.
- families report that lengthy multiple assessments can often result in little direct therapeutic or education intervention
- parents also report great difficulties in accessing the information they need to fulfil their parenting responsibilities including information on support, benefits and their child's condition.

Play

4.22 To play is one of the fundamental rights as stated in Article 31 of the UN Convention on the Rights of the Child. There is an urgent need to address the invisibility of disabled children in almost all the forms of play provision. For many children with a learning disability current provision is still too often inaccessible, unwelcoming and fails to meet their needs. Attitudinal or logistical barriers often currently exclude children with severe and profound disabilities, an Autistic Spectrum Disorder, severe communication difficulties or challenging behaviours, from almost all forms of publicly funded play. (81)

4.23 Play provision using the child's home as the base can build the confidence of both child and parent to use the other forms of play provision. Toy Libraries, Sure Start and outreach from Child Development Clinics have the potential to enhance the quality of children's play at home. Home visiting services have demonstrated their value in promoting the importance of play to parents and developing parents' play skills in the early years. (82)

4.24 Policy and provision to promote play needs to take sufficient account of the very different role and form of play in the lives of children at different stages of their childhood. Many children with profound and multiple disabilities or complex health needs spend significant periods of time in hospital. Disabled children also spend time away from home using short break services and again the emphasis is all too often on care rather than play. All of these services used by children with a learning disability would benefit from more focus on play. (64)

Young People

4.25 Young people with a learning disability express the same aspirations as other young people to independence, work, learning, friends, marriage and a home.

- The experiences of young people with a learning disability are characterised by isolation and lack of social opportunities, creating over-reliance on families.
- Youth services identify the inclusion needs of young people with a learning disability as an equality issue but lack the resources to take forward the recommendations of pilot studies. (83)
- The vulnerability of these young people to mental and physical health problems, sexual exploitation and crime as both perpetrators and victims is well documented but little preventative or reparative work is done. (61)
- In learning disability services youth can get forgotten between children's and adult services. In mainstream services young people with a learning disability have difficulty getting heard. Young

people with complex needs are further excluded. There is a need for agencies to come together to address these issues across sectors and other administrative divides.

- Young people need to be supported to engage with the authorities to ensure their views are heard. The Interdepartmental Group that has been established by the Department of Education and Department of Health, Social Services and Public Safety to develop the range of support for children with special needs is an opportunity to ensure the broader agenda of young people's issues are addressed.

Action Required

4.26 In order to address the pressing need for information Health and Social Services Trusts should engage with partner agencies to develop accessible and timely information. This should be sensitively communicated to families at the point of diagnosis and at other major transition points. **(78)** There may be merit in exploring the feasibility of developing this at a regional level. **(Recommendation 6)**

4.27 In order to ensure that the needs of individual children are addressed in a more co-ordinated and effective manner the Family Support Plan should be complemented by the development, following diagnostic and assessment processes, of an agreed multi-agency Early Intervention Plan that is child centred. **(Recommendation 7)**

4.28 To address the current duplication and confusion about professional roles and boundaries and to support the development of key workers and effective Early Intervention Plans the Department of Health, Social Services and Public Safety and Department of Education should produce a comprehensive Early Intervention strategy that will:

- clarify pre-school years areas of responsibility between health and education
- consider how early intervention can be developed across all sectors including the training and research required in this area and also links within schooling
- review current provision models and resourcing
- extend and integrate the models of service that are currently being established for children with an Autistic Spectrum Disorder and which apply equally to children with other developmental disabilities. **(71, 84, 85) (Recommendation 8)**

4.29 The Department of Education and Department of Health, Social Services and Public Safety have a key role in ensuring equality of opportunity and addressing the needs of children with a learning disability. In order to achieve the objectives of the Equal Lives Review there will be a need for closer working and shared planning and funding where necessary. **(Recommendation 9)**

4.30 Children and younger people with a learning disability should have equal access to and benefit from play and leisure opportunities including sports and the arts. The Equal Lives Review has been encouraged to learn of initiatives in each of these areas that have included children and young people with a learning disability in community based play groups, after school clubs and youth services. However, there remains a lack of locally based accessible provision particularly for children and young people with profound and multiple disabilities. This needs to be addressed by ensuring that key agencies implement plans to reach children and young people with a learning disability. Public bodies should, therefore, require that the sports, leisure and recreational services for which they have responsibility evidence that they have been inclusive by monitoring uptake of their schemes and use of their facilities. **(Recommendation 10)**

4.31 In addition the Youth Service should mainstream the lessons learned from the pilot projects on inclusion and provide the support to ensure that young people with a learning disability get involved in decision-making processes in youth and other civic activities. **(Recommendation 11)**

4.32 Greater attention needs to be paid to addressing the increased vulnerability of children and young people with a learning disability to abuse and exploitation. The school curriculum for these pupils should encompass personal safety and personal relationship issues. **(Recommendation 12)**

4.33 The appointment of a Commissioner for Children and Young People in 2003 was a welcome development and the proposed children and young people's strategy should harness the efforts of a wide range of Government departments and other agencies towards achieving equality of opportunity for all children in Northern Ireland. The Commissioner could play a key role in ensuring that all agencies meet their inclusion objectives for children and young people with a learning disability. **(Recommendation 13)**

4.34 Objective 2	**Recommendations**
Recommendation 6	Each HSS Trust should set in place mechanisms to ensure that information on services and how to access them, benefits and support groups and other sources of help is automatically supplied to families at diagnosis/birth of their child.
Recommendation 7	Each HSS Trust should establish arrangements for the development of an Early Intervention Plan, which includes details of a key worker, for each child with a learning disability at his/her birth/diagnosis.
Recommendation 8	By June 2007 the Departments of Education and Health, Social Services and Public Safety should develop a regional strategy for early intervention.
Recommendation 9	By January 2007 joint planning and bidding mechanisms should be developed by the Departments of Education and Health, Social Services and Public Safety for services for children and young people with a learning disability.
Recommendation 10	The Department of Culture, Arts and Leisure, Arts Council, Sports Council, Education and Library Boards, Youth Council and District Councils should produce clear statements outlining how they are targeting provision for play, sports, arts and leisure opportunities for children and young people with a learning disability.
Recommendation 11	The Youth Service should mainstream the lessons learned from the pilot projects on inclusion and provide the support to ensure that young people with a learning disability get involved in decision-making processes in youth and other civic activities.
Recommendation 12	The Department of Education and Education and Library Boards should review the effectiveness of the programmes of learning for children and young people with special educational needs in relation to issues of personal safety and personal relationships. This should be supported with awareness programmes for parents and for others involved with children and young people.
Recommendation 13	The Commissioner for Children and Young People should be requested to monitor the effectiveness of all authorities in meeting their inclusion objectives. To facilitate this, the relevant departments should produce an Annual Report on the implementation of action plans.

FULLER LIVES

Chapter
5

I want my son to have a chance at education, to have friends, to get a job that he enjoys. Isn't that what you want for your children? Why should we be any different?
Mother

5.1 Ensuring that men and women with a learning disability are able to actively participate in their communities and afforded opportunities to meet their aspirations for meaningful day-time activities, friendships, employment, education and leisure was a key area of concern to all those who contributed to the Equal Lives Review. This chapter explores some of the issues highlighted and outlines a strategy for improvement that will require the active commitment of a range of Government departments and more effective working together between agencies, men and women with a learning disability and family members.

5.2 There is a pressing need to reform outdated policies and practices that are based on a belief that these issues should be addressed within the context of health and social services provision. An alternative model is required that challenges the social exclusion of men and women with a learning disability from mainstream services and proactively ensures their access to the same range of education, employment, personal relationships and leisure opportunities, whilst ensuring that individual support is available where required. Linkages with the revised anti-poverty strategy and actions are essential if we are to overcome social disadvantage and exclusion.

Objective 3	To ensure that the move into adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.
Objective 4	To enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.

Issues and concerns

5.3 The key issues may be summarised as relating to:

- the transition to adulthood
- supporting men and women with a learning disability who have complex needs

- further education
- day services
- employment
- transport
- leisure
- personal relationships.

Transitions

5.4 Education and Library Boards have key duties in planning for a young person's transition into adult life and are required under the Education Order (NI) 1996 to :

- inform Health and Social Services Trusts up to a year in advance of a young person with a statement of Special Educational Needs leaving school
- prepare a Transition Plan to allow for the coherent transition of the young person to adult life in partnership with parents and other agencies.

5.5 However, despite evidence of excellent practice including innovative initiatives in partnership with the voluntary sector, the experiences of many young people leaving school have been unsatisfactory.

- Various studies have documented the various difficulties that parents and young people have encountered during the transition years. (39, 63)
- Much of the planning occurs in the last year at school, which is too late to ensure that a range of options are sampled or explored.
- Careers advice is available to young people with a learning disability through the Careers Advisory Service. Input to individual schools varies but is better where good relationships have developed between the Careers Officers and the teachers.
- There is a striking contrast between the expectations of parents and young people and the lack of options that are available to them after school. (63)
- There are examples of good practice throughout Northern Ireland where partnerships between the voluntary and community sector and schools have resulted in positive outcomes, but there is no consistent access to such initiatives across Northern Ireland.

Complex Needs

5.6 There are a growing number of men, women and young people with a learning disability who have complex needs and multiple disabilities.

- Parents report that access to the services of Allied Health Professionals reduces upon leaving the special school.
- A growing number of young people who challenge services, some with a history of school exclusion.

- A few will commit offences and therefore come into contact with the criminal justice system.
- There are increased numbers of school leavers with a learning disability and an Autistic Spectrum Disorder.
- There is increasing evidence of dementia and Alzheimer's Disease amongst older men and women with a learning disability.

Further Education

5.7 There is scope for development of opportunities for men and women with a learning disability within Further Education (FE) in Northern Ireland.

- Significant variation exists across colleges in the number of students with a learning disability enrolled as a proportion of the student body ranging from 1% - 13% in 2002. **(86)**
- Average level of enrolments appears to be lower in Northern Ireland, 4.1% in 1999, as compared with 5.7% in England. **(55)**
- The number of students enrolled on full-time courses is also lower, 32% in 2002 in Northern Ireland (ranging from 10% to 67% across the Colleges) as compared with 45% in England in 1999. **(Department for Employment and Learning and 55)**
- Concerns exist about the lack of progression from FE provision; students not able to gain accredited awards from their study; the lack of links with job training and work experience; students repeating the same course content in subsequent years.
- It is encouraging that studies in Northern Ireland have highlighted a range of initiatives that are affording positive opportunities for young people with a learning disability to be involved in activities within the FE sector. This provision points the way towards the positive outcomes that might be achieved if such opportunities were more widespread and consistently available. **(55, 87, 88)**

Day Services

5.8 Traditionally the majority of school leavers from Severe Learning Disability (SLD) schools have been placed in day centres commissioned by health and social services agencies. The model of such provision has evolved over the years from an industrial/workshop philosophy to a social education model, which emphasises the development of social and life skills. More recently some centres are moving towards becoming resource centres where in-house attendance is combined with involvement in community activities. Concerns about the place of day centres in the service framework of the future led to the 4 Health and Social Services Boards to commission a wide-ranging review, the outcomes of which have informed the Equal Lives Review. **(56)** The main issues and concerns are:

- in 2002 an estimated 4,000 people were registered with day centres/training centres and workshops. This represents around 70% - 75% of men and women with a learning disability who live in their own accommodation or with family carers.
- 77 centres in Northern Ireland provide a service to men and women with a learning disability aged between 16 and 87 years. The profile of those using the centres includes people with

profound disabilities, those with an Autistic Spectrum Disorder, people with severe challenging behaviours and a growing number of individuals with dementia.

- demand for places exceeds supply. An estimated 180 children with severe and profound learning disabilities leave school each year. If all were to be accommodated in day centres an increase of around 20% in places would be required over the next 5 years with an additional cost of approximately £5.5 million.

- day centres have provided a valuable service to carers who have welcomed the respite for them and the opportunities provided for their son or daughter. However, they have also identified inadequacies including shorter opening hours, transport problems, and the need for more individualised planning.

- day centres can heighten the exclusion of men and women with a learning disability and reduce their engagement with the wider community.

Employment

5.9 Many men and women with a learning disability aspire to having a job and increasing numbers of parents share this aspiration for their teenage sons and daughters. The development of vocational training and the introduction of Supported Employment to Northern Ireland have opened up new possibilities for achieving these aspirations.

- Department for Employment and Learning's Disablement Advisory Service provides assistance to people with a disability to access employment. Programmes on offer include Access to Work, Employment Support, Job Introduction Scheme and New Deal for Disabled People. Mainstream

programmes like Jobskills and Worktrack are also available. Significant numbers of young people with a learning disability enter the Jobskills Programme.

- Access to these programmes can be limited by factors such as admission criteria, outcomes required, duration of the programme and the pattern of provision.

- There has been considerable growth in Supported Employment in Northern Ireland over the last decade. The Northern Ireland Union of Supported Employment has over 15 non-statutory agencies in its membership and many other day centres are involved in this work. A number of other approaches to securing paid work have also developed including vocational training and social enterprises. Evaluations of such schemes have evidenced the benefits to individual participants although few of the trainees had made the transition to paid work. **(89, 90)**. European monies from either the Building Sustainable Prosperity or Peace programmes have funded most of this provision. Urgent consideration needs to be given to mainstreaming the funding and the learning.

- A range of external factors impinge on the potential for men and women with a learning disability gaining employment including inflexible rules in relation to benefits, absence of clear intra-agency partnership, low expectations and a disparate reliance on health and social services funding. Difficulties in the reinstatement of benefits and the fact that wages earned may be lower than benefits received means that people may be reluctant to seek paid employment. This was seen as a major barrier to people with a learning disability accessing employment.

- The Department for Social Development has a role in clarifying what currently exists and considering how to make realistic alternatives to benefits work for people with a learning disability.

Transport

5.10 Issues and concerns have been raised to the Equal Lives Review about barriers to work and leisure opportunities arising from inadequate transport provision. This includes:

- the particular transport needs of people with a learning disability in rural areas

- the introduction by the Department for Regional Development (DRD) of reduced charges on public transport for people with a learning disability is a very welcome development. Similar reductions for their supporters are being considered.

- provision of transport within health and social services day services consumes over 25% of the total budget. As a consequence of the locations of many day centres, individuals can spend very lengthy periods being transported to/from centres with only 20% of centres able to transport most of their attendees from home to centre in less than 30 minutes.

- given the emphasis on facilitating people to use transport and enabling people with affordable, accessible transport, there also needs to be an emphasis on accessible transport for those with significant needs/complex needs. The cost of buying a suitable vehicle with appropriate modifications to enable a person with a learning disability to travel whilst seated in their wheelchair, whether through Motability or privately, is prohibitive for many families.

- a number of services have developed innovative independent travel training schemes, which have increased the capacity of individuals to make fuller use of public transport.

Leisure

5.11 Many people with a learning disability live lonely lives. Most of their free time is spent in home-based pursuits such as watching television and listening to music with few friends of their own age.

- In a study in 2003 the researchers interviewed the parents of over 50 school-leavers from 2 special schools for pupils with severe learning disabilities in Northern Ireland. Three in five of the young people (58%) were reported to have no friends of their own. In all 90% of parents would like their son or daughter to be more involved with friends of their own age and they mentioned the need for more clubs and for more sports and leisure activities. (63)

- A similar picture emerges for adults. In a 2002 study over 2 in 5 people reported having no friends outside of the day centre they attended and 4 was the most that anyone reported. The

most common activities undertaken with friends were going to discos and social clubs, but most of these were organised specifically for people with a learning disability, such as Gateway Clubs. (91)

- A study of 65 persons resettled from a long stay hospital in Northern Ireland into nursing home and residential care found that only 14 people (21%) had regular or frequent contact with friends outside of the residence. This included contact with people in day centres. Only 5 people were reported to meet their friends away from the centres; through visits to the residence (4) or going out with them socially (2) or for shopping (1). Overall, the mean number of different leisure activities residents had engaged in during the past 4 weeks was 5.6. However, people living in nursing homes had a significantly lower mean score (3.1 activities) than those in residential (5.8 activities) or community homes (7.4 activities). (92)

- Overall people with a learning disability tend to lead more sedentary lifestyles than the general population, performing significantly less than the minimum levels of physical activity recommended by the Department of Health. Levels of obesity appear to be rising among adults with a learning disability in Northern Ireland. (93)

- People with a learning disability often express dissatisfaction with their community, recreation and leisure activities. They mention in particular the need for more evening and weekend activities and greater opportunities to take part in community events. Among the obstacles they currently experience are the lack of public transport and the prohibitive costs of taxis, problems with physical access to premises such as cinemas, nightclubs, bars and restaurants and the lack of a companion - befriender - to accompany them. (1)

- Many family carers are also concerned about the lack of leisure opportunities. (56) Among the suggestions they made were:
  - drop in centres and more social clubs
  - weekend or short breaks away
  - befriending schemes with long-term commitments
  - education of the general public about learning disability
  - Community Access/Support Workers to allow individuals to attend events/concerts rather than depending on their ageing parents/carers to take them
  - day centre facilities utilised in the evenings.

- Relatively little monies have been expended by social services in promoting the social and leisure lives of people with a learning disability. Often this has been left to charitable groups (often led by parents and relatives) and they continue to be the main provider of leisure opportunities outside working hours with a heavy reliance on volunteers.

- The main service innovations in this area have revolved around the concept of befrienders; ideally a person of similar age, background and interests recruited to share some of their leisure time with a chosen partner. A Northern Irish survey identified this as the fifth most popular form of voluntary activity with an estimated 80,000 people involved across all client groups. (94)

- A number of dedicated befriending schemes have been set up by a range of agencies in Northern Ireland mostly in the non-statutory sector although as yet there has been no evaluation undertaken of their impact and sustainability.

5.12 Despite the fact that access to social and leisure opportunities is extremely limited for many men and women with a learning disability relatively few resources have been expended in this area. Greater attention to developing people's social networks could pay dividends in other ways by reducing the possible consequences of social isolation including challenging behaviours and depression.

Personal Relationships

5.13 Meaningful relationships, including marriage, and expression of one's sexuality contribute greatly to people's quality of life. The sexual expression and developing sexuality of people with a learning disability is often seen as problematic and not a normal part of growth and development. This ignores the person's rights and the benefits to be gained.

- The subject of relationships and sexuality and the social skills required to form appropriate relationships receive insufficient attention at home, at school and in other service settings.
- The changes in the life stages of people with a learning disability are often not recognised. There is a marked lack of sex education for men and women with a learning disability and lack of guidelines for staff who provide sex education.
- Life stages and general sexual and reproductive health care is not provided. For women in particular issues are not adequately addressed in relation to premenstrual syndrome, cervical and breast screening, sexual health screening, menopause.
- Sexual orientation and preferences often go unnoticed and undetected or attributed to lack of experience, choice or environmental influences.

5.14 Staff members who participated in a consultation exercise as part of the Equal Lives Review highlighted a number of issues pertinent to supporting sexual expression that they feel unable to resolve because of lack of clear legislation, policy and guidelines. These included:

- participants working in residential care settings who expressed feelings of frustration around being willing to support clients in their sexual expression but being hampered by how current legislation is interpreted and implemented through policy
- a perceived need for greater clarity between the Mental Health Order, Sexual Offences Act and Human Rights Act, in relation to service users' rights around sexual expression and the process used to assess capacity to consent
- a need for ongoing training, supervision and support to develop understanding and competencies at different levels of intervention, mostly around inappropriate touch/abusive behaviours
- policies are now more likely to acknowledge the rights of people with a learning disability around their sexuality and sexual expression, however, there is a lack of clarity around whether service users' rights are prioritised above parents' rights and the legal position regarding parents' rights i.e. if there is a clash between the individual's wishes and parents' wishes, whose views should be prioritised?
- balancing rights, responsibilities, vulnerabilities and risk in this area is complex and hampered by apparent lack of clear direction as to the parameters within which staff should work at a practice level.

5.15 We anticipate that the ongoing work of the Legal Issues Committee and of the Office of Law Reform on mental capacity will assist in resolving some of these issues.

5.16 There is a lack of support, education and training for parents, to enable them to identify emergent issues and gain knowledge and skills in supporting their children. Many parents struggle with their own values and beliefs around sexual expression and the desire of young people and adults with a learning disability to form sexual relationships. The following issues have been expressed by parents:

- fears and concerns around lack of support for children particularly when, during times of transition from primary to post primary education, they are seeking to keep their children in mainstream education
- education around appropriate sexual expression. Parents often feel unable to discuss problems with others and are unable to identify appropriate means of support.
- accessing appropriate information to support them to provide sex education for their sons or daughters.

Action Required

5.17 To address the wide-ranging concerns that have been identified a strategy is required that reduces the barriers to community integration and ensures equity of opportunity and social inclusion. Given its responsibility to promote lifelong learning, further education and increased employability the Department for Employment and Learning has a key role in developing such a strategy.

5.18 In Chapter 12 we set out proposals for new organisational arrangements that should oversee the implementation of these recommendations at both a regional and a local level.

5.19 The starting point for improvement must be the work undertaken at the transitions phase. It is alarming to note that despite effective transition planning being a mandatory requirement, so many young people have unsatisfactory experiences during the move from school towards adulthood. This is a key period when opportunities exist for pioneering a new style of service for a young generation of people rather than pursuing an automatic progression from special school to day service. Parents and young people should be targeted and offered a co-ordinated transitions programme that prepares for the transition to adulthood. This must be accompanied by a transitions plan that outlines the individual's interests and needs including vocational training, education and employment, health profile, social supports, leisure, friendships and social development. Transitions planning should begin at 14 years of age and if required appropriate transitions support available until 25 years. In order to achieve this it is recommended that a Transitions Service is developed for each population of 100 - 120,000 which will work with approximately 60 young people to ensure that the transitions programme and plan are addressed by relevant agencies. **(Recommendation 14)**

5.20 It is clear that transitions planning should not occur in isolation of other initiatives designed to increase opportunities for employment, education and other meaningful daytime activities, if we are to avoid falsely raising expectations. Transition Workers will require close working relationships with a number of agencies including schools; special education officers; the Careers Service; vocational training and employment service providers; the volunteer bureaux; voluntary and community groups, as well as employers and the business community. Current work by the Inter Departmental Group on Transitions will provide a positive steer in this regard. The key will then be local arrangements that are robust and reflect shared planning and ongoing monitoring of provision.

5.21 Provision in FE colleges needs to be fundamentally reviewed and tailored better to meet the need of students with a severe learning disability. Education providers must meet their obligations under the Special Educational Needs and Disability Order (SENDO) to ensure that existing policy, teaching, curriculum and facilities ensure that young people with a learning disability are treated as favourably as others in relation to accessing provision. This includes ensuring that there is a culture of inclusion; that prospectuses and other information produced is accessible and that appropriate learning and financial support is available. In addition it is recommended that the FE sector develop new programmes specifically designed to meet the Lifelong Learning needs of men and women with a learning disability. Particular attention needs to be paid to school leavers amongst whom the specific needs of those leaving at 16 should be noted. We suggest that around 270 fulltime places are required in future years for school-leavers and we recommend a further 300 whole-time equivalent places for older students. **(Recommendations 15, 16)**

5.22 There is a need for a radical reconfiguration of existing day service provision based on a progressive shift towards a resource model. As alternative provision develops there should be a reduction in the numbers of people who attend day centres on a full-time basis. It is anticipated that centres will in future be providing a service to men and women with increasingly complex needs who should also be enabled to access opportunities for community integration. Day centres will need to explore the need for developing sites for meeting the particular needs of people with an Autistic Spectrum Disorder and older people. We believe that the potential for day centres to be used as resources to the community is particularly underachieved at present. Partnership with community and voluntary groups should be explored particularly for the development of evening and weekend access to the centres to facilitate other services and community groups.

5.23 The modernisation of day centres will require reallocation of existing resources and additional investment in physical infrastructure and human resources. In order to stimulate the modernisation agenda each day centre should be required to produce a development plan in partnership with attendees, family carers and potential provider partners. The development plan should address as a minimum issues of:

- location
- buildings
- service functions and activities
- people served
- staffing
- transport
- payments made
- developing links to community and other providers
- provision for people with complex needs.

5.24 Future Department of Health, Social Services and Public Safety investments in day services should be targeted at the development of other supported placements including voluntary work and leisure opportunities. There are different models of achieving this and diversity of provision should be encouraged to promote innovative and creative approaches. **(Recommendation 17)**

5.25 In order to enable the proposed reconfiguration of day services and to promote access to the labour market for men and women with a learning disability it is recommended that supported employment services are developed across Northern Ireland. The Disablement Advisory Service should take the lead in reviewing the existing specialist employment provision including the use of its disability programmes by people with a learning disability. In particular the aim should be to have such services available in each area serving a population of 100-120,000 persons. We welcome the recent initiative of the Department for Employment and Learning to reviewing its employment services for persons with disabilities, including those with a learning disability. **(Recommendation 18)**

5.26 The public sector is a major employer in Northern Ireland. Public bodies could play a key role in addressing the barriers to employment experienced by men and women with a learning disability. Attention should be directed towards the process of recruitment for posts in the public sector including the routes into work, reviewing job descriptions, creation of more part-time posts, process used to attract individuals to apply for a vacancy and selection and interview processes.

5.27 The development of policies and practice in these areas in terms of making reasonable adjustments as defined in the Disability Discrimination Act 1996 would help promote equality of opportunity in a most positive manner. **(Recommendation 19)**

5.28 Mainstream vocational training provision could do more to accommodate the needs of school leavers and adults with a learning disability wishing to enter the labour market. The impact of admissions criteria, course content and outcome related funding on access by people with a learning disability should be examined. Improvements should be made in support provided to participants and the training of staff. **(Recommendation 20)**

5.29 The limitations posed by existing transport provision have curtailed access to educational, employment and leisure opportunities. A determined effort is required to ensure that these barriers are removed. There is scope to more actively promote independent travel on public transport and on foot. This should be planned with the support of the family and must feature in schools and college curricula as well as in other support services. In addition those charged with responsibility for public transport must ensure that the particular needs of men and women with a learning disability are incorporated in their strategies. **(Recommendations 21, 22).**

5.30 With the emphasis on facilitating people to use transport and enabling people with affordable, accessible transport, there also needs to be an emphasis on accessible transport for those with significant needs/complex needs. The Motability Scheme requires reviewing to ensure an appropriate, affordable solution for those who need to travel in their wheelchair along with other family members. **(Recommendation 23)**

5.31 Leisure and recreation schemes should be promoted and co-ordinated at District Council level. An audit should be commissioned of leisure and recreation facilities, societies and clubs within their area that serve the wider community as well as people with disabilities. This Directory should be maintained by District Councils and widely circulated to all service providers (including residential services) and family carers. A central point should be created or identified for recruiting volunteer helpers and drivers. Different schemes within District Councils should have shared access to a minibus or people-carriers. Seed monies should be available to initiate new schemes. **(Recommendation 24)**

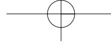
5.32 Now that all services are expected to have policy guidelines in place on sexuality and personal relationships, there needs to be concerted efforts across all services to make available opportunities

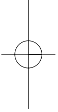
for education on these issues and on sexual health. This should be done with the knowledge and support of family carers, but they should not have a sanction on their relative's participation if that is his or her wish. (**Recommendation 25**)

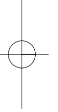
5.33 The issue of bullying that is commonly reported by self-advocates needs to be proactively addressed both in specialist services and the wider community. In the latter instance, the greater involvement of people with a learning disability in educating senior pupils in primary schools and secondary school students has increased the students' awareness of the hurt they cause. Equally people with disabilities should be encouraged to exercise their rights to make complaints to the police or other relevant authority. It should be noted that the draft Criminal Justice Order includes disability within its definition of the grounds for hate crimes. (**Recommendation 26**)

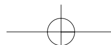
5.34 Objectives 3 and 4	**Recommendations**
Recommendation 14	That Transition services are established for all young people who have a statement to support parents and young people to develop a transitions plan and ensure recommendations are carried through. Careers advice restructuring should support this proposal and provide an ongoing support to 22 years.
Recommendation 15	The Department for Employment and Learning will ensure that revised funding arrangements are in place so that FE Colleges are able to increase significantly the number of full-time places available to students who have a Statement of Severe Learning Disability, to undertake a 3 year accredited course.
Recommendation 16	In order to afford lifelong learning opportunities the Department for Employment and Learning should ensure that revised funding arrangements will enable more part-time places to be created in FE for older students. Access to FE by people with a learning disability should be monitored and we welcome the intention of the Department for Employment and Learning to do so.
Recommendation 17	By March 2007 each Health and Social Services Trust should have produced a costed Development Plan for each day centre they provide or commission.
Recommendation 18	The Department for Employment and Learning, in consultation with other relevant Departments, should promote the introduction of dedicated Supported Employment services across Northern Ireland.
Recommendation 19	Public sector employers should review their recruitment practices, as required by equality legislation to open up employment opportunities for men and women with a learning disability.
Recommendation 20	Department for Employment and Learning should review the use of its employment, skills and disability programmes by people with a learning disability to remove structural barriers to participation and identify how they could promote better outcomes.
Recommendation 21	Department of Education and Department of Health, Social Services and Public Safety should ensure that young people with a learning disability are equipped with skills to use public transport where possible through appropriately targeted independent travel training programmes. Where possible these should become part of the curriculum and continuing education plans for young adults.

Recommendation 22	Department for Regional Development should ensure that the regional transport strategy ensures that people with a learning disability can access local transport.
Recommendation 23	The Motability Scheme requires reviewing to ensure an appropriate, affordable solution for those who need to travel in their wheelchair along with other family members.
Recommendation 24	Access to local leisure and recreational services should be promoted and co-ordinated led by District Councils.
Recommendation 25	Personal relationships education should be available in all services for people with a learning disability with training offered to staff and support to parents.
Recommendation 26	OFMDFM should co-ordinate a policy initiative to reduce the likelihood of bullying experienced by people with a learning disability, both in specialist settings and the wider community, notably schools. The development of anti-bullying strategies would be a positive first step.









ACCOMMODATION AND SUPPORT

Chapter 6

Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative and recreational activities. If the stay of a disabled person in a specialised establishment is indispensable, the environment and living conditions therein should be as close as possible to those of the normal life of a person of his or her age. **UN Declaration on the Rights of Disabled Persons 1975 (51)**

6.1 Shelter and care are basic human needs. Where we live and with whom we live, help to define us as individuals and give us status. The location of our homes often determines the extent of social inclusion that we experience. During much of the last century those people with a learning disability who could not live with their families had to live on a long-stay basis in hospital accommodation or residential facilities. The most recent Review of Policy for People with a Learning Disability (7) clarified as a Government priority, the need to resettle people who were living in hospital. In many cases the accommodation that replaced the hospitals retained many of their features; most obviously sizeable groups of people who were unrelated to each other living together in hostels, care homes and nursing homes with little engagement with local communities. More recently a wider range of housing options have been developed based on more individual responses and located in ordinary buildings in the community. However, the emphasis on resettlement in Government policy has resulted in an imbalance between efforts to secure alternative housing for people living in hospital and the lack of development of supports to those living with their families. Future housing strategy must take account of population trends that evidence that a growing number of people will require alternative housing options and the need to alleviate pressures on family carers who currently provide accommodation for the majority of people with a learning disability in Northern Ireland.

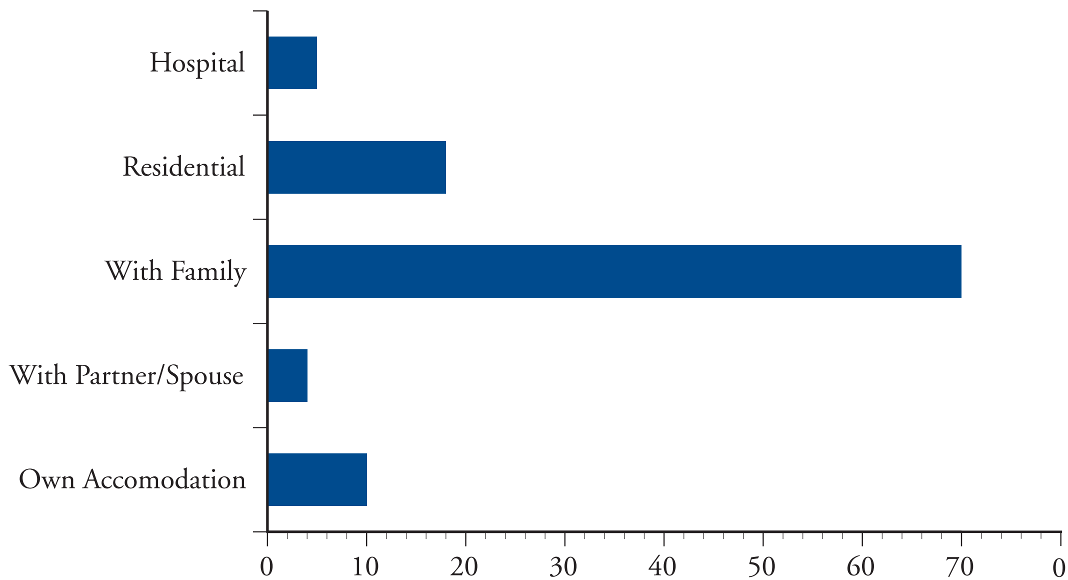
Objective 5	To ensure that men and women with a learning disability have their homes in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need.
Objective 6	To ensure that an extended range of housing options is developed for men and women with a learning disability.

Where Do People with a Learning Disability Live?

6.2 Nearly all children (up to 19 years of age) live in family homes either with natural, adoptive or foster parents. (15) Accurate figures are not available for all of Northern Ireland, but in a study in the EHSSB area 34 children were living in some form of residential accommodation and 26 in foster care arrangements. Together these represent 2% of all children known to Health and Social Services Trusts in that area. (73)

6.3 Figure 5 shows where men and women with a learning disability are living.

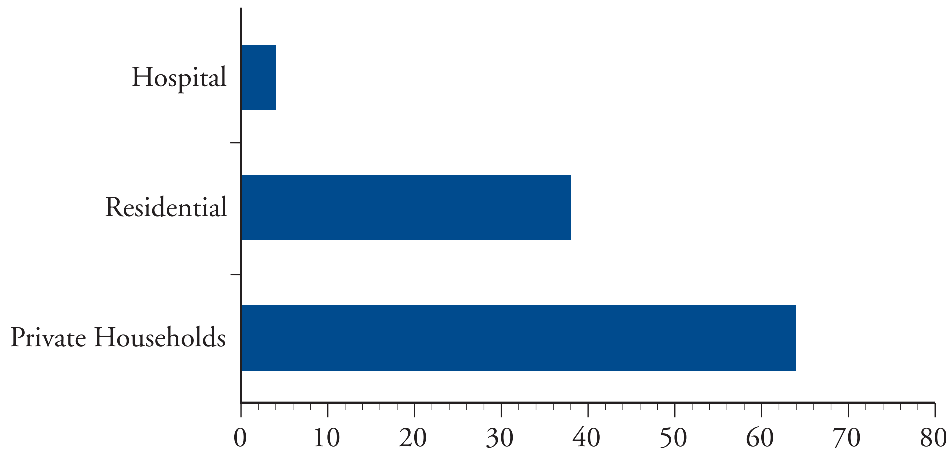
Figure 5: Percentage of adults in different forms of accommodation in Northern Ireland in 2003 (N=7,970) (15)



6.4 As figure 5 shows the majority of people live with family carers although a small proportion have their own accommodation. Around 450 live in hospitals and on average will have lived there for 20 years. Nearly 1900 persons are in some form of residential provision and have lived there for around 8 years on average.

6.5 Comparable figures for Great Britain are given in Figure 6.

Figure 6: Percentage of adults in different forms of accommodation in Great Britain in 1999 (95)



Issues and Concerns

6.6 The main concerns with current arrangements that were highlighted to the Equal Lives Review relate to the position of men and women with a learning disability living long-stay in hospitals, the reliance on large group living arrangements, pressures on family carers and the barriers to developing an appropriate range of housing options.[7]

- Although the number living in learning disability hospitals has been declining since the 1980s, in 2003 it was estimated that 455 men and women with a learning disability had no home outside a hospital: Muckamore Abbey Hospital 300, Longstone Hospital 115 and Stradreagh Hospital 40. (15) This is in spite of the fact that hospital resettlement has been the cornerstone of Government policy in Northern Ireland since 1995. The average age of people living in hospital in Northern Ireland is 49 years. Many have a severe learning disability and more complex needs. They typically live in ward-style accommodation. Few have their own bedroom.

- Research into the resettlement programme has highlighted that people were relocated largely into large group settings with little use being made of more individualised options, such as supported living options. There is also growing concern about what has been termed the *new long stay population* namely those men and women with a learning disability admitted to hospital for assessment and treatment, but who have remained in hospital owing to the absence of a suitable community alternative. Studies have placed this group at between 11 and 15 % of those admitted. (46)

- Approximately half of the remaining men and women with a learning disability who live outside the family home live in registered residential care homes (950 individuals). On average the homes

[7] Unless otherwise stated the evidence cited in this section is drawn from a series of reports prepared for the Northern Ireland Housing Executive and the 4 HSS Boards by Professor Roy Mc Conkey and colleagues (96, 97, 98, 99)

accommodate 20 individuals. A further 29% live in registered nursing homes. Recent research indicates that approximately 220 men and women might be more appropriately accommodated in supported living options.

- A growing number of people (19%) do live in supported living arrangements where typically they have tenancy agreements and live on their own or with one or two other persons and have support from staff including 24-hour cover if needed. Of those living in these 3 forms of accommodation, the majority came to their present home from living in a hospital (42%) and a further 25% from another residential facility. Only 34% came from the family home.

- Concern has been expressed at the lack of consistency across Northern Ireland in terms of the types and level of provision, which may indicate service inequities. The Northern Health and Social Services Board had the highest proportion of people in nursing home accommodation (46%) as compared with 22% in the Eastern Health and Social Services Board. The Eastern Board had the highest level of people in supported living arrangements (31%) as compared with only 4% in the Western Board and 3% in the Southern Board.

- Most people live with family carers; usually their parents. Nearly one third presently live with a single carer and over 25% with carers aged over 65 years. Around one in 6 carers were rated as being in poor health. These are all risk factors that make present care arrangements vulnerable.

- Families with a disabled member experience far greater problems with their housing than families with non-disabled members. In one study 9 out of 10 families reported at least one difficulty with their housing and many reported multiple problems. **(100)** Families on low incomes experienced most problems. These include the need for better bathroom facilities and requirements for extra storage space. The report noted that only 10% of families had received assistance from statutory agencies in order to address their housing needs. Families find the process of obtaining grants to improve their homes is complex and time-consuming and often the monies made available are insufficient to cover the cost of the adaptations that are required.

- Carers of people with complex physical and health needs felt particularly unsupported with very limited opportunities for respite breaks and a lack of choice as to alternative care arrangements when they can no longer cope. (2)

- Only a small proportion of people have their own house (around 10%) or live with a spouse/partner (3%).

- More recently a small number of agencies have developed Adult Placement Schemes where families are actively recruited, supported and paid to provide short breaks or long-term homes for selected individuals. Whilst these developments have to date been used successfully in Northern Ireland primarily for short breaks, there is room for further development of the model for the provision of permanent homes. **(101, 102)**

Futures Planning

6.7 The Equal Lives Review has also been presented with a number of issues and concerns linked to planning for future provision that will need to be incorporated in housing strategies developed to address emerging and current needs.

- To date most of the planning has related to the resettlement of people from long stay hospitals. This will continue to be an issue with over 400 people still requiring a move to accommodation in the community. However, the predominance of the resettlement agenda over recent years has had adverse effects in terms of the lack of attention paid to planning for the future housing needs

of those who live with families, many of whom are in housing arrangements that are vulnerable to breaking down owing to illness or family crisis. In addition, the type of accommodation favoured during the resettlement programme is not suitable for future needs as men and women with a learning disability increasingly aspire to accommodation arrangements that are more independent and closely integrated into their communities. Large scale, group environments will not meet these aspirations, which will increasingly in the future be driven by awareness of human rights and concepts of social inclusion.

- In addition to those currently living in hospital it is estimated that approximately 1600 persons may require alternative accommodation and/or support arrangements in the coming 5 to 10 years. Of these around 170 are likely to be required in the next 2 years with half of this figure needed in the Eastern Health and Social Services Board area. The amount and type of support varies across individuals, but could involve assistance with personal care, medication, household activities, community participation, budgeting, inter-personal relationships and behaviour management.

- We have identified a number of issues with current administrative systems that threaten the development of more appropriate housing and support options for people with a learning disability:

  - there has been a lack of bridging finance to the same extent as was available in Great Britain to enable people to be resettled from hospitals

  - as yet no commitment has been given to the resettlement of all long-stay patients by a designated date

  - dowry systems are not in place so that the money can follow the resettled person in perpetuity

  - care management procedures as they presently operate, coupled with lack of finance and community options, constrain staff from promoting options for more independent living arrangements and planning for them over a longer time frame

  - men and women with a learning disability, irrespective of where they presently live, are not encouraged by their carers to have their name placed on the waiting lists for public sector housing if a change in accommodation is likely to be required

  - the Equal Lives Review has been made aware that the Common Selection Scheme now operated by the Northern Ireland Housing Executive could make it more difficult for people with a learning disability to access housing that is appropriate to their needs

  - revenue costs for complex needs housing schemes must be secured at the same time as capital costs are committed. This will guarantee that the places are allocated to the persons for whom they were planned. However, revenue allocations by both the Department of Health, Social Services and Public Safety and the Department for Social Development (DSD) are done on an annual basis which prevents planning commitments being given for capital developments that may take up to 3 years to complete.

Action Required

6.8 We propose that the following service principles and aspirations should guide the development of future housing and support options for people with a learning disability. They arise from existing legislation, recent research findings undertaken with this client group and recognised good practice already taking place in Northern Ireland and elsewhere in these islands. They also take cognisance

of recent and future legislative changes such as the Disability Discrimination Act and the proposed introduction of a Bill of Rights.

- People with a learning disability have the right to the same range and standards of accommodation that is available to their non-disabled peers.
- They have the same rights as other citizens in obtaining tenancies in public housing, in buying and inheriting houses and in claiming housing and other support benefits to which they are entitled. This includes access to Direct Payments and the Independent Living Fund.
- At present, families provide homes and support for the great majority of people with a learning disability in Northern Ireland. Moreover it is the wish of many people to continue living within the family. Hence families should be supported in continuing to provide housing and support to their relatives as long as both parties wish this to happen. This support should include the provision of housing adaptations, of domiciliary supports and of short breaks.
- People with a learning disability should be enabled to remain in their neighbourhoods if they want to when family carers are no longer able or available to look after them. They should be assisted to continue living in the family home by having tenancies transferred to them; participating in the right-to-buy schemes or the ownership of the house being passed over to them. Domiciliary supports should be made available to the person with a learning disability as well as to family carers.
- Meeting the accommodation and support needs of people with a learning disability is not just the responsibility of health and social services. Hence Health and Social Services Boards and Trusts must work in partnership with a range of statutory and non-statutory housing and social care agencies in order to fulfil these needs.
- A range of different types of accommodation and support services should be available within Northern Ireland so that services can be better tailored to the needs of individuals and to provide for an increased element of choice. People with a learning disability, their relatives and paid carers should be informed about the range of accommodation and support options that are available. This should be done in accessible formats.
- When demand for accommodation and support services exceeds supply, the allocation of these services should be done in a transparent and equitable manner. Applicants, their family carers and advocates must be kept fully informed throughout.
- People should not live in hospital accommodation. Some may have to be admitted for short periods (of up to 6 months) of acute assessment and treatment, but no one should remain there for long periods (12 months+) due to their specialist needs. Everyone should have a home address to which they will be discharged.

6.9 Resettlement of long-stay patients from hospitals within the context of supported living principles must be progressed as rapidly as possible. By June 2011, all people living in a learning disability hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011. **(Recommendation 27)**

6.10 In order to address the concerns raised about the potential for developing a new long stay hospital population all commissioners should ensure that they have arrangements in place to provide emergency support and accommodation for persons with a learning disability. Learning disability hospitals should not provide this service from 1 January 2007. **(Recommendation 28)**

6.11 Objective 5 Recommendations

Recommendation 27	By June 2011, all people with a learning disability living in a hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011.
Recommendation 28	With immediate effect, all commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability. Hospitals will not provide this service from 1st January 2008.

6.12 In line with the thrust towards more normal, individualised housing options for men and women with a learning disability there is a need for both a wider range of supported living provision, to include adult placement services, and to address the deficiencies identified in large-scale group living environments. New care standards coming into force over the next 3 years will require upgrading of much current provision. This is not only to improve the quality of life of existing residents, but also to secure better quality provision for future users of these accommodation options. We propose that in future all new-build accommodation provided for people with a learning disability should be for no more than 5 individuals - preferably less - within the same building. This accommodation should take the form of lifetime, barrier-free homes, i.e. homes that can provide security of tenure for the tenants and be designed in such a way as to be suitable for meeting the needs of current and potential physical disabilities. In order to assure equity of provision it is also proposed that by January 2013 all accommodation provided for men and women with a learning disability and aged under 60 should be in households of 5 or less individuals. **(Recommendations 29, 30)**

6.13 In order to meet the emerging needs identified an additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings. **(Recommendation 31)**

6.14 These proposals will require close collaboration with the NI Housing Executive, Department for Social Development and health and social services agencies. There should also be active engagement with personnel from the Social Security Agency at both regional and local levels. Mechanisms should be put in place to engage with District Councils, Local Health and Social Care Groups and community organisations in the development of local initiatives. In particular funding mechanisms and planning cycles urgently need to be addressed in order to enable the extensive programme of work that is required. The capital and revenue cycles of both Department of Health, Social Services and Public Safety and Department for Social Development need to synchronise for Supporting People schemes. **(Recommendation 32)**

6.15 In particular when considering the needs of people with more profound and multiple disabilities the potential for technological advancements in maximising opportunities for independence needs to be more fully harnessed. Housing planners and service providers should improve their awareness of such developments and their application within future housing strategies. **(Recommendation 33)**

6.16 The Equal Lives Review has highlighted the low level of home ownership amongst men and women with a learning disability in Northern Ireland. It should be clarified if Supporting People monies can be used to support people who are owner-occupiers. There is considerable scope for meeting at least some of the emerging housing needs through Supporting People to either purchase their own homes or to take over the ownership of property left to them by families. **(Recommendation 34)**

6.17 Improved supports need to be given to family carers to enable people to continue living with their families. This includes improved short break provision; extension of home based, floating support

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services to maintain people in family homes; support for other family members to take over the caring role from ageing parents if they wish to and improvements to the process of accessing housing adaptation grants. **(Recommendation 35)** The Department for Social Development and the NI Housing Executive should ensure the increased use of floating support linked to an individual's needs rather than overly relying on accommodation based schemes. This would make it easier for people to move to more suitable accommodation as their needs change. **(Recommendation 36)**

6.18 Objective 6	**Recommendations**
Recommendation 29	With immediate effect, all new housing with support provision for people with a learning disability should be for no more than 5 individuals with a learning disability - preferably less - within the same household.
Recommendation 30	By 1 January 2013 all accommodation for people with a learning disability under 60 years of age should be for no more than 5 people.
Recommendation 31	An additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings.
Recommendation 32	Department for Social Development and Department of Health, Social Services and Public Safety should develop clear assessments of future housing needs for people with a learning disability including those who currently live with their families and agree a continuous 3 year funding strategy to resource housing and support arrangements.
Recommendation 33	Housing planners should accumulate and disseminate detailed knowledge on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community.
Recommendation 34	A strategy should be developed by the Department for Social Development to increase opportunities for people with a learning disability to own their own homes where this is a safe and appropriate option.
Recommendation 35	Procedures and criteria for applying for Disabled Facilities Grants should be revised to tackle inconsistencies, reduce bureaucracy and reduce the hidden costs to carers.
Recommendation 36	Department for Social Development and the NI Housing Executive should establish mechanisms to ensure the increased use of floating support linked to an individual's needs rather than overly relying on accommodation based schemes.

HEALTH AND WELL BEING

Chapter
7

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity **World Health Organisation 1946 (103)**

Health is a fundamental human right **DHSSPS 2002 (104)**

7.1 An increasing number of people with a learning disability are living longer and healthier lives. Greater numbers of children with complex health needs and multiple disabilities are surviving into adulthood. Increasingly people with a learning disability who experience mental health problems are living in local communities rather than having their homes in specialist hospitals.

7.2 In order to ensure that people with a learning disability enjoy the benefits of such changing circumstances, commissioners and service providers will need to actively ensure that there is equity of access to the full range of healthcare provision enjoyed by the general population. This is now clearly enshrined in human rights and equality legislation. Evidence presented to the Equal Lives Review demonstrates that there are both high levels of unmet health needs and deficiencies in the current systems for ensuring that the physical and mental health needs of people with a learning disability are effectively addressed.

7.3 In this chapter we will outline the key issues and concerns relating to the physical health of people with a learning disability. A coherent strategy is then proposed to address the concerns based on the Equal Lives Values and those principles that currently inform public health policy. Chapter 8 will address issues related to mental well-being and challenging behaviours.

Objective 7 To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.

Issues and Concerns

7.4 Research has consistently confirmed that the life expectancy of people with a learning disability has increased markedly over the last 60 years. One study reported an increase in the average age of death between 1931 and 1995 of 53 years for men (from 14.9 - 67.2 years) and 47 years for women (from 22 - 69.2 years). **(105)**

7.5 However, the research evidence also indicates that people with a learning disability have higher mortality rates than people in the general population. **(106, 107)**

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7.6 Some people with a learning disability are at higher risk of physical ill health arising from problems associated with particular conditions or syndromes: (42, 108, 109, 110)

- physical and sensory impairments are more frequent amongst people with a learning disability
- they may also develop further difficulties related to cardiovascular problems, resistance to infections and their immune systems
- there is an increased prevalence of physical and sensory impairments amongst people with a learning disability
- there is an increased prevalence of epilepsy which occurs within 25% of people with a learning disability and 1/3 of people with profound learning disability
- there are significantly higher levels of obesity
- increasing numbers of people with a learning disability require intensive nursing care and technological support owing to complex health needs, have higher risk of infection or respiratory difficulties.

7.7 On occasions individuals may be so vulnerable and have such complex needs that they lack full insight into the degree of support required to keep themselves physically and mentally well. The Legal Issues Committee is addressing this issue in detail in the context of capacity.

7.8 Northern Ireland studies were at the forefront in identifying the high levels of undetected health problems amongst people with a learning disability, some of which are easily remedied such as impacted ear wax. Often the problems remain undetected for long periods until they become serious and more obvious.

7.9 The oral health of people with a learning disability is worse than the general population with poorer oral hygiene, higher untreated diseases and more extractions. (111, 112) This was an area of particular concern to family carers during consultation events (2) and is the subject of a separate review being undertaken by the Department of Health, Social Services and Public Safety.

7.10 In December 2004 the Disability Rights Commission launched a formal investigation into health inequalities experienced by people with long-term mental health problems and people with learning disabilities in England and Wales. The investigation, which is titled Equal Treatment - Closing the Gap, has been launched because of the overwhelming weight of evidence pointing to disparities in health outcomes amongst people with learning disabilities and people with long-term mental health problems. Put simply, a lot of evidence points to the fact that these groups of people have higher morbidity and mortality rates than the overall population, and not always due to reasons related to their disability. Therefore the Disability Rights Commission has decided to use its powers to undertake formal investigations to instigate a comprehensive enquiry into this issue.

My daughter has been waiting since January (11 months) to get 2 bad teeth removed. No reasons have been given to me to explain why the delay. She is suffering and in constant pain. She should not have to go through this. (2)

7.11 Primary care services are the first point of contact for many family carers and people with a learning disability in seeking help with health concerns. For many the family GP has a very significant role. Where a GP has a good relationship with families, s/he can have a very positive influence on the

healthcare experiences of both the family and the individual with a learning disability. (2) However, while this is the case in many instances, a number of concerns have been identified.

- Many people with a learning disability make less use of their GP. (113) In a study in the Western Health and Social Services Board area 44% of GPs and 63% of nurses reported that people with a learning disability used the practice less often than other patients. (114)

- GPs can have limited confidence about their role in meeting the health needs of people with a learning disability. (113, 115)

- There is a limited uptake of health screening by people with a learning disability. (116, 117)

- Difficulties have been reported in attempts to identify people with a learning disability on general practitioner registers for the purpose of health screening, as no system exists for such purposes. In a survey in the WHSSB area 51% of GPs reported that they could not easily identify people with a learning disability. (114)

- Confusion exists about the roles and responsibilities between specialist learning disability services and mainstream health services in relation to the health care of people with a learning disability. However, where they do work together health status can be improved. (113)

7.12 In the past people with a learning disability who required hospital treatment arising from a physical health problem were sometimes admitted to specialist learning disability hospitals. The inappropriateness of this practice was recognised and Government policy now emphasises the rights of all to access mainstream health services including acute hospitals. The Equal Lives Review was informed about a number of positive initiatives in Northern Ireland acute hospitals to facilitate people with a learning disability including one hospital making arrangements to reduce waiting times in hospital and the provision of accessible information in another. However, consistent feedback from our consultations indicated that in many instances acute hospital staff require staff from the learning disability service or a family member to be present all the time on the ward when the patient is in hospital. As yet there has been limited study of the extent of contact that people with a learning disability have with acute hospitals or the quality of their experiences.

7.13 Findings from a study in Northern Ireland provide some indication of the position: (118)

- people with a learning disability have regular contact with acute general hospitals
- limited use is made of opportunities for the use of pre-appointment/pre assessments and advance planning
- at admission time limited steps are taken to accommodate the individual abilities and the needs of the person with a learning disability
- people with a learning disability are often excluded from key discussions and decisions about their care
- further training is required by hospital staff in relation to requirements for obtaining informed consent from people with a learning disability
- nursing staff have limited knowledge and skills in relation to communicating and managing people with a learning disability
- the majority of parents and carers perceived the need to remain in hospitals for the duration of contact in order to ensure the person with a learning disability received adequate care and supervision
- acute hospitals may need to provide ongoing support if treatment is to be completed successfully and to avoid premature discharge
- more effective liaison arrangements between acute hospitals and learning disability services need to be put in place
- there is a need for further training of staff to work with people with a learning disability in acute hospital settings.

7.14 These findings are similar to others, which have been reported by people with a learning disability and family carers from elsewhere in Northern Ireland. (1, 2, 119)

7.15 During the Equal Lives Review we also learnt of many excellent initiatives in Northern Ireland designed to improve the health status of people with a learning disability. These include research, health screening projects, production of accessible health information and health promotion initiatives.

7.16 Unfortunately many of these initiatives have been ad hoc, project based and time limited owing to funding constraints. Therefore, while they have benefited local groups, they have had limited impact on the regional health status of people with a learning disability. (40, 41, 42)

7.17 Despite increased emphasis on health promotion issues in Government and health service policies there is little evidence of specific targeting of people with a learning disability within Northern Ireland. This contrasts with the position in England, Scotland and Wales where specific guidance and policy has been produced. (120, 121)

Access to Specialist Services

7.18 People with a learning disability should have access to the wide range of specialist health care services available in the community including neurology services, epilepsy nurse specialists and diabetes nurse specialists.

7.19 The creation of Health Facilitator posts in England has enabled more people with a learning disability to have access to this range of services while supporting such services to develop the necessary skills to meet their needs. Although the term is new, Health Facilitation is not a new concept and can be used to describe anyone who is assisting a person with a learning disability to achieve and maintain good health. Indeed Health Facilitation is a central component of each professional working in any field. However the formal recognition that named Health Facilitators are receiving is new, together with the opportunity to act on a strategic as well as a local level. Health Facilitation evolved from roles developed by carers, practitioners and others who were concerned about improving the health of people with a learning disability through the NHS in order to access the best and most appropriate health care.

Aids To Daily Living

7.20 Evidence presented throughout the Equal Lives Review confirms that there will be a marked increase in the number of children, men and women with complex physical health needs and disabilities.

- Timely access for necessary equipment must occur to prevent long waiting times that often cause extreme physical hardship.
- On average each disabled child in Northern Ireland uses three pieces of specialist equipment each day as an aid to daily living. Families often report long waiting times between assessments and delivery, problems with repairs and needs changing over time not being assessed. Much energy is expended by families in accessing these vital practical aids which can lessen burdens associated with mobility, continence, feeding and sleeping. The absence of these at the right time increases stress on the family unnecessarily. (79)

Action Required

7.21 In 2002 the Ministerial Group on Public Health launched a new public health strategy Investing for Health, which sets out the way forward in making improvements to the health of the population in Northern Ireland. (104) Investing for Health adopted 4 key values:

- health is a fundamental human right
- policies should actively ensure equality of opportunity and promote social inclusion

- individuals and communities should be included fully in decision-making on matters relating to ill health
- all citizens should have equal rights to health, and fair/equitable access to health services and health information according to their needs.

7.22 Whilst the specific health needs of people with a learning disability receive limited attention, it is noted that people with disabilities are entitled to the same access to opportunities as their non-disabled peers. In order to ensure that the outcomes of Investing for Health benefit people with a learning disability, determined action will be required to reduce the inequalities in health and service provision that currently exist.

7.23 An effective strategy should include the following:

- a priority theme of ensuring that the health needs of people with a learning disability are better served by mainstream health services in the first instance
- improving collaboration between primary health care staff and learning disability services
- optimising the contributions of learning disability expertise in achieving health gains but reshaping their contribution to achieve improved health outcomes and access to mainstream services. The role of professionals in learning disability services should develop to enable them to build new relationships with mainstream colleagues, improve the knowledge base of mainstream staff and reshape their contribution to service provision.
- ensuring that the small number of individuals with complex health needs and additional disabilities whose needs cannot be effectively managed by mainstream services receive ongoing and intensive support from specialist professionals to ensure their needs are met
- reshaping the workforce and meeting a wide range of staff training and development needs (This will be explored further in Chapter 11).

7.24 Despite the clear evidence on unmet health needs amongst people with a learning disability limited attention has been paid to these issues in either Departmental or Health and Social Services Board/Trust policy documents. This fails to acknowledge the particular support needs of many people with a learning disability in relation to accessing health care services and health promotion initiatives.

7.25 In order to make a long-term and sustained improvement to the health status of people with a learning disability there is a need for a regional approach to health improvement. This is particularly crucial in view of the evidence that where targeted action has been taken in specific localities, positive outcomes have been demonstrated.

7.26 It is recommended that the Department of Health, Social Services and Public Safety establish a regional framework for sustained health improvements of the learning disabled population. **(Recommendation 37)** The regional framework should include:

- clear statements on the rights of people with a learning disability to have equality of access to health care under recent legislation and Government policy directives
- specific targets in relation to registration of people with a learning disability with general practices and other relevant family practitioners e.g. dentists

- expectations of health checks and health screening for people with a learning disability with particular reference to key areas that have particular risks e.g. cervical/breast screening, thyroid function tests for people with Down's Syndrome
- specific health promotion initiatives and interventions that focus on improving the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and dental health
- requirements in relation to production of Health Action Plans
- requirements for health promotion initiatives to take account of the particular difficulties experienced by people with a learning disability in accessing information.

7.27 It will be necessary for each Board to review existing Health Improvement Plans for people with a learning disability to ensure that they translate the regional framework at a local level.

7.28 In order to redress the lack of attention given to the particular health issues in policy documents it is recommended that all generic health strategies make specific reference to the needs of and impact on people with a learning disability alongside other minority groups. **(Recommendation 38)**

7.29 In order to support the major practice, organisational and cultural changes required it is recommended that the new role of Health Facilitator be created. The primary role and function of Health Facilitators would be to drive and champion the implementation of the regional framework, support work to achieve the local targets and establish Health Action Planning processes for priority groupings within the population of people with a learning disability. **(Recommendation 39)**

7.30 The Health Facilitator's role would embrace both physical and mental health needs and ensure that people with a learning disability gain full access to the healthcare they need for both primary care and acute hospital services.

7.31 In order to ensure that the specific individual health needs of people with a learning disability are identified and addressed it is proposed that arrangements be set in place to ensure that all are offered a personal Health Action Plan. Health Action Plans detail the actions that are required to maintain and improve the health of people with a learning disability . They encompass a personal plan that outlines the help needed to enable a person with a learning disability to stay healthy, responsibility for which will rest with a named Health Facilitator working in partnership with primary health care staff. Health Action Plans involve people with a learning disability and their family carers in effective multi-agency and multi-disciplinary care planning prepared with and for the individual concerned. The Health Action Plan where possible should form part of a Person Centred Plan. In order to reduce the inconsistencies that can result from local initiatives it is recommended that the broad format for the Health Action Plans be agreed at a regional level. **(Recommendation 40)**

7.32 Health Action Plans should include details of the need for health interventions, oral health, fitness and mobility, emotional needs and records of screening tests. They should also identify clearly who is responsible for taking action.

7.33 Further action is required to raise awareness with primary care services and acute general hospitals of the health issues faced by people with a learning disability. In order to clarify arrangements and ensure that roles and responsibilities are clearly set out between mainstream and specialist learning disability services it is recommended that each general practice and acute general hospital develop clear arrangements to facilitate equality of access for people with a learning disability. **(Recommendation 41)**

7.34 As noted earlier identification of people with a learning disability at primary care level is problematic. Without such identification targeted efforts to improve involvement in health screening and planning for provision is not possible. It is therefore recommended that improvements be made in how people with a learning disability are identified within GP practices (e.g. use of standardised diagnostic codes throughout Northern Ireland). This would have a number of benefits including:

- raising awareness of poor health status and consequent need for practices to focus attention on them
- identification of specific physical and mental health issues that might be targeted locally
- provision of a basis for target setting, monitoring and evaluation. **(Recommendation 42)**

7.35 It is recognised that GPs and other practice staff may require support from specialist learning disability professionals to assist them in providing sensitive and appropriate services. There is a need for Community Learning Disability Teams to more closely align themselves with primary care colleagues. We propose that this be achieved by the development of having a named professional from the Community Learning Disability Teams linked to each GP practice. The link person may be able to resolve some of the common problems experienced by individual people with a learning disability in using primary care services including long waiting times, medication management, communication difficulties. The link person could have a role in:

- practice training sessions in health centres to improve knowledge of learning disability and physical/mental illness
- developing effective partnership work between primary care and learning disability services
- assisting in health promotion initiatives provided for people with a learning disability. **(Recommendation 43)**

7.36 An essential component of supporting optimum physical health is adequate management of associated physical disabilities. To meet the increasing quantity and complexity of needs high specification equipment must be available. The range of wheelchairs and aids available through the Regional Disablement Service should be appropriate to individual need and the budgets will need to be reviewed to reflect the anticipated increase in demand. **(Recommendation 44)**

7.37 Objective 7 Recommendations

Recommendation 37 The Department of Health, Social Services and Public Safety should produce a Regional Framework for Health Improvement of people with a learning disability providing clear direction including targets and timescales. Each HSS Board should review their Health Improvement Plans to ensure that they translate the regional framework at a local level to support improved health outcomes for children, men and women with a learning disability.

Recommendation 38 All generic health strategies, published at Department, Board and Trust level, should make specific reference to the needs of and impact upon people with a learning disability.

Recommendation 39 By December 2009 resources should be made available from within primary care to appoint within primary care a Health Facilitator for each 110- 120,000 population.

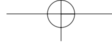
Recommendation 40 By December 2008 a Health Action Plan will be developed, as a part of the Person Centred Planning process, which is to be set in place for all those with a learning disability in contact with health and social services agencies.

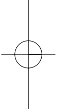
Recommendation 41 With immediate effect each general practice facility and acute general hospital within Northern Ireland should have clear and formalised arrangements in place to facilitate equity of access to services for people with a learning disability.

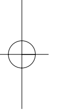
Recommendation 42 Each general practice should establish robust medical records and health data about people with a learning disability on their practice register.

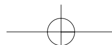
Recommendation 43 With immediate effect each general practice should have an identified link person within their local Community Learning Disability Team with whom they work collaboratively to facilitate better access for people with learning disability within primary care settings.

Recommendation 44 Equipment and wheelchair provision budgets should be increased to meet significant additional demand. This will require an increase of the proportion available to people with a learning disability.









MENTAL HEALTH AND CHALLENGING BEHAVIOURS

Chapter 8

Mental Health is the emotional and spiritual resilience, which enables us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own worth and others' dignity and worth **HEA 1998 cited in Promoting Mental Health DHSSPS (2003) (122)**

8.1 Promotion of mental health is of particular importance for people with a learning disability. Mental health problems are much more frequent among people with a learning disability. The presence of a mental health problem combined with a learning disability makes it even more difficult to cope independently and to make balanced decisions about life and care. In this chapter we will focus on the mental health needs of people with a learning disability and the action required to address them in order to fully achieve Objective 7.

Objective 7 To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.

Issues and Concerns

8.2 People with a learning disability can experience the same range of mental heath problems as the rest of the population and there is evidence that they are more prevalent amongst this group. (123, 124)

8.3 Reported prevalence rates vary widely, for example, schizophrenia is three times more common than in the general population. (125)

8.4 There are difficulties in recognising that a person with a learning disability has a specific mental illness and underreporting of mental health problems can occur. (126)

8.5 Within Northern Ireland there is expertise in assessing and treating mental illness in people with a learning disability. This is best evidenced where a number of professionals can work in an inter-disciplinary way. This presently occurs in the three specialist hospitals. There has been limited development of this comprehensive approach in community settings. Access by people with a learning disability to mainstream mental health services is extremely limited. An unhelpful barrier based on IQ currently determines an individual's access to services.

8.6 Many community residential facilities in Northern Ireland have difficulty in providing the specialist support required by people with complex mental illness. They rely on the expertise of outside

professionals and admissions to specialist hospitals are higher from these settings than from people living with family carers. (46, 47)

8.7 Health and social services are only in the early stages of developing specific community based services within learning disability services to support people who develop major mental health problems, although some professionals have developed a high degree of specialism while addressing the needs of individuals with whom they work. (127)

8.8 Improved collaborative planning or joint work between specialist hospitals and community based services is a priority.

Challenging Behaviours

Severely challenging behaviour refers to culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities. **Emerson (128)**

8.9 Challenging behaviours may be associated with a mental health problem. They may also be used by an individual:

- to indicate pain or distress
- as a means of communication
- to avoid stressful situations
- as learned behaviours triggered by specific contexts.

8.10 Challenging behaviours can present major difficulties within services and potentially are a significant obstacle to securing the inclusion of individuals in community based opportunities. It is difficult to be certain about the number of people with a learning disability who display severe challenging behaviours largely because of different definitions that have been used. However, research conducted in Northern Ireland indicates that it is a major issue in both community and hospital services.

- Behavioural management was reported as being the third most frequently reported role of community nurses for people with a learning disability. (129)
- Another study of caseloads of all community nurses for people with a learning disability in Northern Ireland found that 28 % of people they work with were reported to have challenging behaviours. (130)
- 70% of people admitted to Longstone hospital over an 18-month period were noted to have challenging behaviour. (127)
- In a study of 154 people admitted to Muckamore Abbey hospital the most common reason for admission was that of a wide range of challenging behaviours (69%). (131)

8.11 The consequences of challenging behaviours can be serious in terms of impact both on the individual involved and on others including:

- people who display challenging behaviours may suffer severe harm due to self-inflicted behaviours

- people with challenging behaviours are more likely to be socially rejected and excluded. This is particularly the case for people with communication difficulties for whom social integration is further reduced. (132)
- parents of children with a learning disability and challenging behaviours have high levels of personal stress and increased social isolation (133)
- sleep disturbance has been reported in 88% of children with challenging behaviour (134)
- staff in services in Northern Ireland have cited issues related to challenging behaviour as a key unmet training need and have highlighted their disquiet at the lack of clear guidance on appropriate methods of working with people whose behaviour is challenging (135, 136)
- the individual may come into contact with the police and criminal justice system.

8.12 There is expertise in the assessment and management of challenging behaviours within hospitals and in community teams. Strategies that have proven successful in addressing challenging behaviours include:

- Applied Behavioural Analysis
- manipulation of the living environment
- education for carers and families.

Action Required

8.13 In addition to the action detailed in Chapter 7 with regard to health promotion, health facilitation and primary care services, we believe that a new model based on community provision is required to address the needs of men and women with a learning disability who have mental health problems and/or display challenging behaviours.

8.14 Other Expert Working Committees of the Review of Mental Health and Learning Disability (NI) will address:

- **forensic issues** especially the interface between mainstream forensic mental health services and specialist learning disability provision in the areas of prevention, continuity of care as well as in specialist assessment and treatment. Individuals with a learning disability can be particularly vulnerable when in contact with the criminal justice system. This can occur in police stations, when attending court, in prison and young offenders centres and on probation. There must be a full range of inpatient care, including high, medium and low security services. In addition there is a need for Community Forensic Services to support the full range of people with a learning disability in the community, including those who have been discharged from hospital or released from prison. Detailed consideration of the needs of people who require the support of specialist forensic services will be included in a separate report.
- **child and adolescent mental health.** We anticipate that mainstream services will take the lead role for those with a mild and moderate learning disability with joint working becoming more common for those with a more severe learning disability.
- **alcohol and substance misuse.** Amongst people with a learning disability who have problems with substance misuse or alcohol problems, most will have a mild learning disability. The combined problems of substance misuse with a learning disability, possibly with an additional

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mental health problem, greatly increases concerns regarding vulnerability and the capacity to make informed life choices. Mainstream addiction services require an individual to have a high level of motivation and a desire for change to benefit from treatment. People with a learning disability need particular support to assist them to take part in such treatment when their capacity to make informed life choices is impaired. Specific recommendations regarding development of this aspect of the service are contained in the report from the Alcohol and Substance Misuse Committee.

- **mental health promotion.** It is clear that both children and adults with a learning disability are exceptionally vulnerable to mental health problems and as a result of this vulnerability, there has been an impetus towards detecting, assessing and treating mental health problems in this population. Such an impetus, whilst very necessary, is reactive by its nature, and a key message is that little attention has been given to the development of robust proactive and preventative strategies that build resilience and protect people with a learning disability from the development of mental health problems. Emphasis should be given within all relevant sectors to building positive mental health from childhood onwards. Schools and colleges in particular have immense potential to contribute to and enhance young people's emotional development.

- **mental health issues in old age and dementia.** Service developments and provision that have been found to be helpful with the general population need to be applied within learning disability services. We anticipate joint working arrangements to be common practice.

- **legal issues.** Issues such as guardianship, capacity, compulsory admission for assessment and treatment, the Mental Health Review Tribunal, advocacy, legal representation, indeed what type of legislation should replace the existing Mental Health Order (NI) 1986 are all matters which clearly affect people with a learning disability and will be addressed by the Legal Issues Committee.

8.15 The Expert Working Committee on Adult Mental Health has incorporated proposals for addressing the mental health needs of people with a mild learning disability in mainstream mental health services which supports the model of provision which follows.

8.16 Simply having a learning disability has been enough to exclude people from accessing services. We suggest that a collaborative system of care between mental health and learning disability services will best meet the needs of this most vulnerable group. Historically in Northern Ireland more individuals with mild/borderline IQ levels did access mainstream services. However over recent years this practice has been diminishing.

8.17 A significant proportion of adult admissions to specialist learning disability hospitals are people with a mild/moderate learning disability. Many of these admissions could be prevented if appropriate community supports were in place. People with a mild learning disability should be able to access mainstream mental health services where these services are appropriate to meet their needs. Mainstream services include child and adolescent mental health services, mental health services for adults of working age, mental health services for older people, forensic mental health services, substance misuse services, brain injury services etc. The benefits of this approach include facilitating access to a wider range of expertise and increased access to local services. It is recognised that achieving this shift may initially give rise to clinical concerns about the quality of the experience for the individual. However, these concerns will be reduced if adequate energies are directed towards increasing the collaboration between learning disability services and mainstream services and to developing protocols whereby the skills of learning disability specialists are appropriately shared across programmes. **(Recommendation 45)** In order to achieve this it would be necessary to greatly strengthen links between learning disability services and mainstream mental health services. **(Recommendation 46)**

8.18 In order to address the low level of community provision and the consequent over dependence on hospital based interventions it is proposed that community based assessment and treatment services be further and more robustly developed. These should be built on existing professional expertise. Training that involves the sharing of skill and knowledge across the range of professionals can enhance expertise.

8.19 A model for community service would include community assessment and treatment teams who would be competent in addressing mental health problems and challenging behaviours. Crucially the teams should provide an outreach service to homes and services in the community and be available outside of normal office hours. Such a community service would include a range of accommodation options providing a variety of supports. It is proposed that such services be developed incrementally in order to enable an appropriate remodelling of current hospital provision and the development of appropriately piloted protocols, eligibility criteria and operational systems. The regulatory status of this provision will also need to be clarified, as it will be a new service model that does not readily fit with current regulation categories.

8.20 Outcomes and benefits of this model are:

- a local, safe, secure alternative to acute hospital admission
- easement on demand for hospital admission
- reducing length of stay of hospital admission
- continuity of normal lifestyle pattern through continued community integration
- maintenance of family and/or current placement links
- reducing numbers of hospital re-admissions
- facilitating time out of home without using a hospital place
- fewer obstacles to communication because of closer geographical base
- review assessment and alteration of medication through local psychiatry input
- less traumatic experience for the individual
- more appropriate targeting to meet specific needs
- more person centred approach
- greater continuity/stronger links to local learning disability supports
- better use of acute scarce resource
- local services encourage care and resolution to the individual's difficulties
- effective and co-ordinated liaison and integration with other local services. **(Recommendation 47)**

8.21 As a consequence of the development of community based assessment and treatment services, admission to specialist hospitals solely for people with a learning disability will become increasingly less frequent. DHSSPS should commit to reviewing and evaluating the developing community services and the need for continuing specialist hospital provision. Ultimately it is hoped that there may not be a need for specialist hospitals for assessment and treatment solely of those with a learning disability.

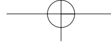
8.22 In order to enable community provision to develop there is a need for clarity about the shift in resources and the additional funding that will be required. This should be agreed at a regional level in order to avoid perpetuation of service inequities and to address the complex issues involved in commissioning this level of specialist provision. This should take account of the training requirements for the recognition of mental health and challenging behaviour problems across the whole range of people providing care and support. **(Recommendation 48)**

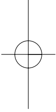
8.23 A small number of people with a learning disability have severe challenging behaviour or mental illness that is liable to relapse. Staff and carers must be alert to warning signs of a recurrence and share information about such signs. To encourage better liaison and clarity of roles and responsibilities between specialist and community services in relation to such people, Health and Social Services Trusts should ensure that protocols are agreed for proactive approaches to intervene in a systematic way should there be warning signs of recurrence. **(Recommendation 49)**

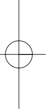
8.24 There is a significant level of concern raised by staff about the lack of guidance on the appropriate management of challenging behaviours and the complex legal, human rights and practical issues involved. It is recommended that a regional approach be adopted to developing clear guidance in this area for all learning disability services in Northern Ireland. Similar initiatives in England have assisted in providing a framework in which both people with a learning disability and their carers can be supported and the required training strategies developed. **(Recommendation 50)**

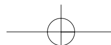
8.25 Objective 7	**Recommendations**
Recommendation 45	As a matter of urgency the Department of Health, Social Services and Public Safety should consult with all 4 Health and Social Services Boards about their present and future plans for specialist assessment and treatment services for men and women with a severe learning disability with a view to greater sharing of existing and planned resources and the development of new forms of community based services.
Recommendation 46	By the end of the Review period people with high levels of adaptive functioning/mild learning disability who require therapeutic intervention as a result of mental health problems should be able to access mainstream mental health services. Support from dedicated learning disability services should be available if required.
Recommendation 47	Community based assessment and treatment services should be developed on an incremental basis to provide assessment and treatment of men and women with a learning disability who have specific mental health needs and/or challenging behaviours. The community based assessment and treatment services will encompass behaviour support expertise that will provide outreach to individuals, families and community services and short-term intensive treatment to those within a residential facility which may be approved to treat people under mental health legislation.
Recommendation 48	As a consequence of the other mechanisms being recommended the Department of Health, Social Services and Public Safety should establish a regional plan that sets targets for the reallocation of existing resources and the securing of additional resources to enable the community services to be established.
Recommendation 49	Some people with a learning disability are at increased risk of recurrent severe challenging behaviours and/or mental illness. Health and Social Services Trusts should ensure that protocols are agreed so that a proactive approach can be taken to systematic intervention should there be signs of recurrence.

Recommendation 50 By December 2006 the Department of Health, Social Services and Public Safety should produce in partnership with service providers regional guidelines on the management of challenging behaviours within services.









GROWING OLDER

Chapter 9

One of the great social achievements of the 20th century has been increased longevity of people with learning disabilities due to advances in medical care and social support. (137)

9.1 The life expectancy and number of older people is increasing across most developed countries. Most people with a learning disability who survive beyond 30 years will have average life expectancy and experience normal ageing processes. Many will experience a long and healthy old age. Growing older is also likely to include a number of additional challenges for people with a learning disability owing to the impact of their disability. The Equal Lives Review found limited evidence of strategic planning, specific policy or changing practices that will meet the emerging needs associated with increased numbers and needs of older men and women with a learning disability or their family carers in Northern Ireland.

Objective 8 To ensure that men and women with a learning disability are supported to age well in their neighbourhoods.

Issues and Concerns

Difficulty in Definition

9.2 Old age is a relative concept, the definition of which is affected by social, psychological and biological factors. Therefore, being old might be defined by social benchmarks such as retirement age, physical signs of ageing, or the degree to which one feels old.

9.3 Men and women who have a learning disability may experience each of these quite differently. The degree to which many men and women with a learning disability have been excluded from the social opportunities and life chances available to others means that society's benchmarks may be applied less satisfactorily, as typified by the question posed to us by a man with a learning disability at a meeting, *Am I ever going to be allowed to retire from my day centre?* The physical signs of ageing may affect some people with a learning disability at an earlier age. (50) There is limited evidence on how well men and women with a learning disability cope psychologically with ageing. It could be that due to cognitive limitations some people find difficulty understanding the ageing process. This may be worsened by the fact that many individuals with a learning disability are prevented from experiencing normal life events e.g. they may be hindered in the acceptance of mortality, as they are frequently not exposed to rituals such as funerals in an attempt to protect them from unpleasant events. (49)

9.4 Owing to these factors and the potential additional supports that may be required, it has been proposed that planning to meet the ageing needs of men and women with a learning disability should begin at an earlier stage and no later than 50 years.

Impact of Ageing

9.5 As noted there may be significant differences in the impact of ageing for men and women with a learning disability as compared with other people in Northern Ireland.

- A number of different types of dementia exist, but the most significant and prevalent is Alzheimer's Disease. The neurological effects of this disorder are devastating for the person who develops it and for his/her family. It leads to deterioration in function in virtually all aspects of life, a disintegration of the affected person's personality and eventually death. Research evidence indicates that people with Down's Syndrome show neurological changes resulting from Alzheimer's type dementia at a much younger age than others, and in addition virtually all people with Down's Syndrome who live long enough will develop this type of dementia. (138)

Table 3: Percentage of people with Down's Syndrome affected with Alzheimer's Disease (139)

Age in years	Rate %
30-39	0-10%
40-49	10-30%
50-59	20-55%
60-69	30-75%

- Men and women with a learning disability may also develop what are known as syndrome-specific conditions including congenital heart defects/visual and hearing disorders (Down's), musculo - skeletal problems (Fragile-X) and obesity related diabetes (Prader-Willi). (138, 140-144)

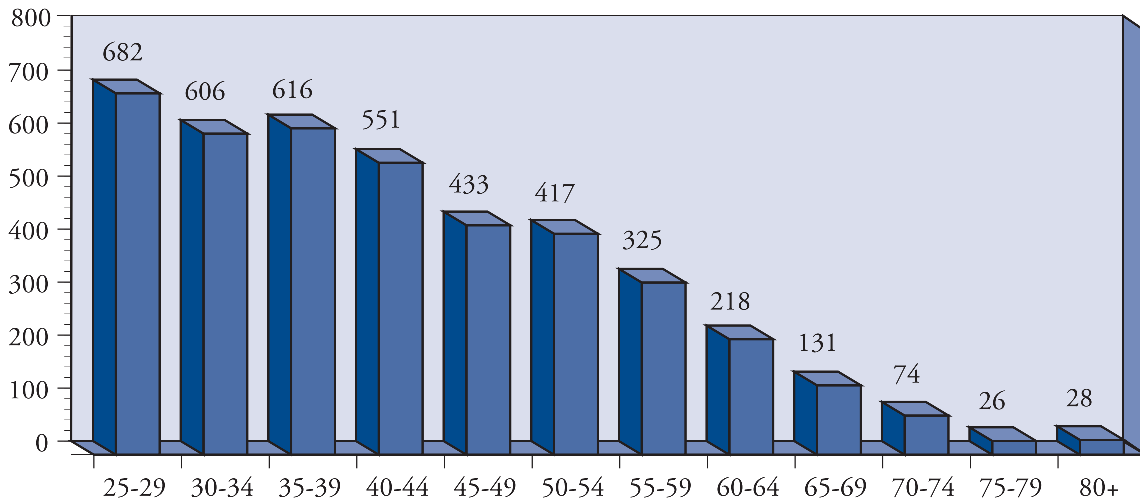
9.6 Between 20-40% of older men and women with a learning disability are liable to have a mental health problem. (145)

Numbers

9.7 There is clear evidence of the increased numbers of older men and women with a learning disability in Northern Ireland.

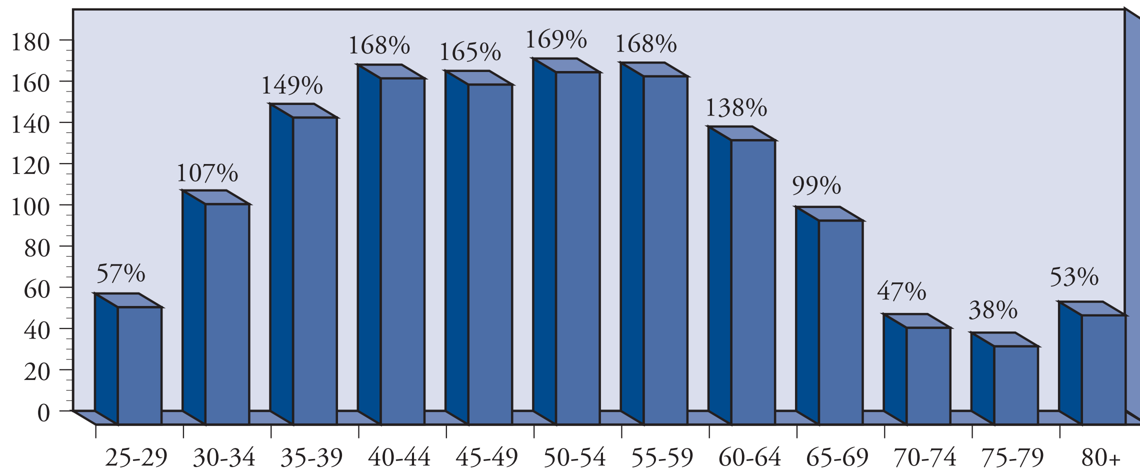
- The prevalence study of people with a learning disability in Northern Ireland (15) identified that out of 4,107 people with a learning disability living in ordinary homes 477 (12%) are aged over 60 years of age (Figure 7). If we applied the definition of old age as starting at 50, then 1219 (30%) people could be considered to fall within the older adult population.

Figure 7: The number of people living in community settings (i.e. with family carers; own accommodation) in 5-year age bands. (N=4107) (15)



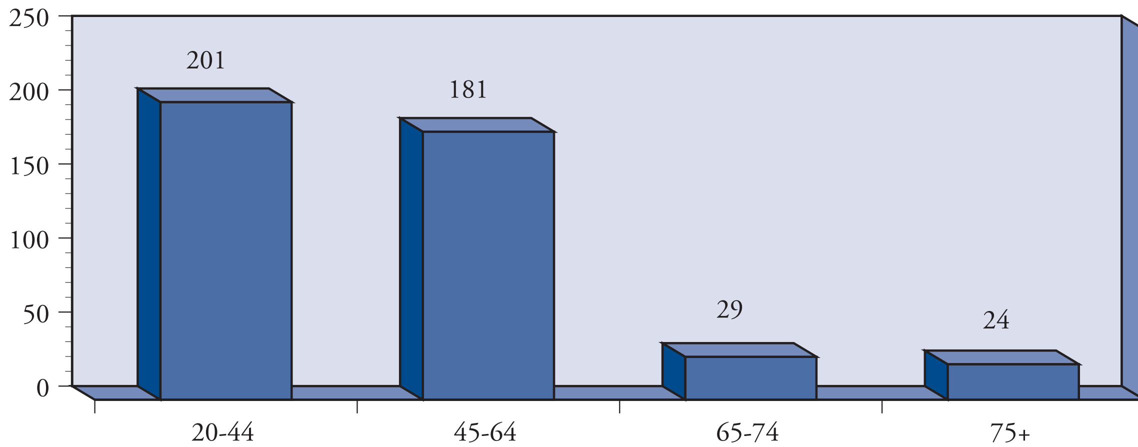
- This study also identified the number of people with a learning disability living in residential or supported living. These figures show that of 1,358 people in supported/residential living, 375 (28%) were over 60 years of age and 712 (52%) were aged over 50. (Figure 8)

Figure 8: The number of people living in residential and supported living settings in 5-year age bands (N=1358) (15)



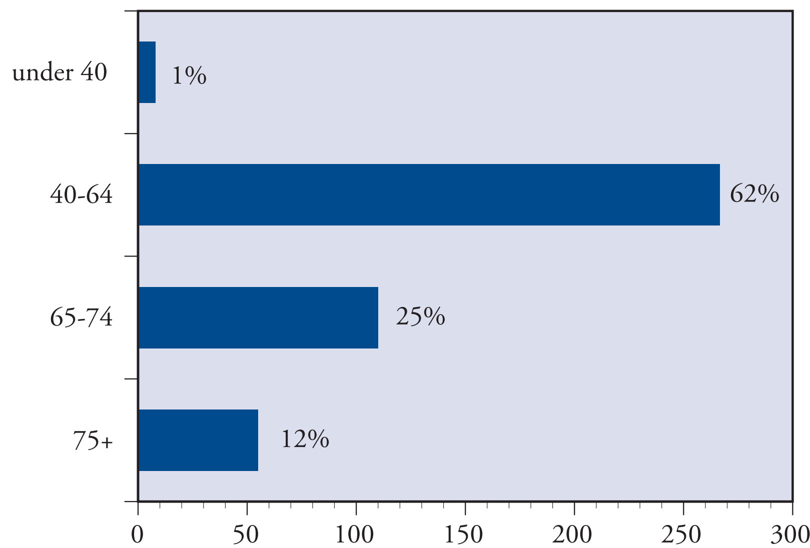
- Of the 435 men and women with a learning disability who had been in a hospital for more than one year, 53 (12%) were aged 65 years and over and over half of the hospital residents (234, 54%) were aged 45 years and older. (Figure 9)

Figure 9: The number of in-patients in hospitals greater than 366 days in age bands (N=435) (15)



- In another study in Northern Ireland that investigated future housing needs in one Board area, 37% of family carers were over 65 years old. The report author projects this to the other data presented and estimates that nearly 500 men and women with a learning disability live with a carer aged over 75 years, and a further 1,000 people live with a carer aged over 65 years.

Figure 10: The number and percentage of primary carers by age bands looking after people with a learning disability aged 25 years and over in EHSSB area (N=436) (99)



Family Carers

Over the last few months I have been to three funerals of adults with a learning disability. Each time I hugged the mother and told her now you can let go. Parents worry so much what will happen to their children after they die that they pray that their son or daughter dies first so they will not be left to fend for themselves. (2)

9.8 Family members continue to provide the bulk of caring as men and women with a learning disability grow older. For many this can be a positive experience and a preferred choice over other options because of a number of factors:

- parents self-select to care for their son/daughter rather than having them placed in care
- after many years of caring parents adjust and accommodate to the caring role
- parents build a long-term relationship with their son/daughter and do in fact gain and feel they have a purpose in life fulfilling the caring role. (146, 147)

9.9 However, there are a range of issues relating to the role of family carers as they and their relative get older including:

- older family carers are under greater physical and mental pressures because of their age and the frailty this often brings; and as they age, they become increasingly anxious about the future
- because of the duration of the caring relationship, which is often life-long, they are likely to have a particularly intense, interdependent relationship with the person they are supporting
- they are more likely to be caring alone
- they have smaller support networks as parents, partners and friends age and die
- they have a very different experience of the service sector from new generations of carers. They were often advised to forget or reject their child, encouraged to have very limited expectations of his or her life expectancy or abilities and usually had to fight very hard for any support from the statutory sector.
- older family carers are often very reluctant to seek help. Reasons for this include past negative experiences of the paid service sector, and a fear that by seeking help they are admitting their own diminishing capacity and that they will lose control. (146)

9.10 Similar issues have been described in the limited research in Northern Ireland on the experiences of older people with a learning disability or their carers e.g. one study in a Health and Social Services Trust found that:

- deterioration in mobility of their ageing relative was the most common problem reported by family carers followed by the onset of epilepsy, reported by 45% and 33% of carers respectively
- most of their support came from social workers and GPs but rarely more than a visit once every 6 months to one year. (147)

9.11 Despite the fact that family carers are entitled to a separate assessment of their needs we found that there was a very limited awareness or uptake of this amongst family carers in Northern Ireland. (2)

Futures Planning

9.12 During the consultation for the Equal Lives Review family carers frequently raised their concerns about the future and a wish for workers to support them to make plans for when they may no longer be able to meet the care needs. However, they noted how difficult this was and that on occasions an apparent refusal to look towards the future was a reflection of the pain involved in contemplating their own mortality and the consequences for their son or daughter. (2) Carers were particularly concerned that futures planning should address issues of capacity and consent, to ensure that this responsibility was appropriately placed in the absence of the main carer. There are few precedents for older people with a learning disability remaining in the family home in the absence of the main carer. This offers considerable scope for extending the range of housing options available to older men and women with a learning disability.

9.13 There has been a serious dearth of service planning to meet the future needs of men and women with a learning disability as they age. This is reflected in the very limited local research, absence of a departmental steer on expectations of services to develop appropriate responses, confusion about the interlinking roles of learning disability, older people and dementia services and an apparent failure to recognise the potential pressures arising from the increased numbers and needs on future service provision. One result has been that older men and women with a learning disability are being moved from their accommodation, and often their familiar day supports, at extremely vulnerable periods in their lives.

Ageing Well

9.14 In contrast with developments for older people generally there has been little emphasis on health and well being for people with a learning disability. Ageing well has not been actively encouraged or supported by services to date. The consequences of this are now becoming evident in our population of older people with a learning disability.

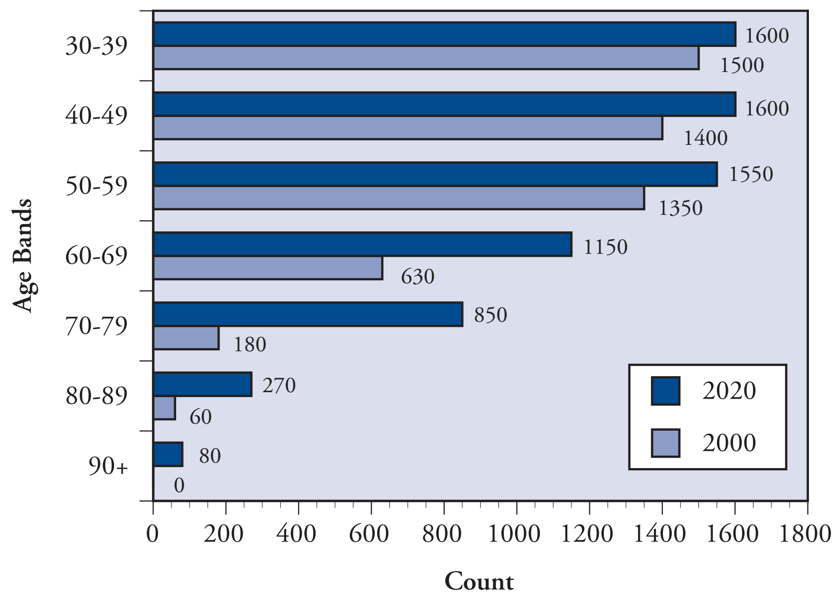
- Older men and women with a learning disability have few opportunities to take part in leisure pursuits. (148) This is due to the health problems they face, perceptions of them as a lower social status group, exclusion rather than inclusion within their community and lack of support to access leisure activities. (149)

- In line with the general population, issues around diet and exercise are coming to the fore and are generally exacerbated for people with a learning disability due to many factors, not least their poor access to primary care services. (150, 151, 152)

Action Required

9.15 Over the next 15 years using predictions for the wider population, we estimate that the number of men and women with a learning disability in contact with health and social services who are aged over 50 years will rise from around 2,200 in 2000 to 3,900 as Figure 11 shows; a predicted increase of 81%. The figure of 3,900 represents around 0.58% of the predicted population of people aged over 50 in 2020 (672,000) and 1.23% of the predicted population aged 65 years and over (319,000).

Figure 11: Projected increase in the number of people with a learning disability from 2000 to 2020.



9.16 In order to remedy the serious lack of strategic planning to address the particular issues associated with ageing there is an urgent need for focused planning and reconfiguration of service delivery in this area.

9.17 As the ageing process for some men and women with a learning disability may begin much earlier, planning for them should begin much earlier. Planning for those people aged 50+ should be prioritised immediately, and should be developed in conjunction with people with a learning disability. As PCP is progressed with all people, planning for the future will naturally happen from an earlier age. We suggest that it includes those aged 50 and upward, which would mean that:

- monitoring would allow early identification of potential problems and thus improved planning to meet this growing need
- potential crisis management could be avoided especially following the death of a sole carer
- service user and family education and preparation for growing old could be planned for earlier and therefore be more effective.

9.18 Redefining ageing in this manner would necessitate revised arrangements for the allocation of resources to meet the needs of this group. In particular the interface between funding for elderly services and that for learning disability services would need to be reviewed and more flexible connections between both programmes facilitated. **(Recommendation 51)**

9.19 An ageing in place culture should be facilitated by support services if, through PCP, men and women with a learning disability and family carers reveal that this is their preferred option. Research indicates that this is most likely to be the case and is certainly the most cost-beneficial option for HPSS services. This raises fundamental questions about the most appropriate service model(s) to meet the needs of both family carers and older people with a learning disability.

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We are not sure whether we should be valuing our elderly clients by regarding them as people with unique needs or valuing them by treating them no differently from anyone else. **Moss (152)**

9.20 There are potentially a number of models that might be developed including:

- developing expertise within learning disability services to enable them to meet the needs associated with ageing
- ensuring that older men and women with a learning disability can access supports from services for older people and possibly before 65 years of age
- developing clear linkages between specialist learning disability services and older people's services to ensure that skills are shared between both groups but facilitating greater choice by men and women with a learning disability so that they can age in place if desired.

9.21 Applying the Equal Lives Values and in particular the requirement to individualise support planning, it is evident that within future provision there may be a need for not one, but several models. Clearly this would require greater cross-programme and multi-disciplinary co-operation. There will also be a need for a more flexible approach to resource allocation to meet the joint needs of both the individual and their elderly family carer. The interdependence of both must be recognised.

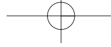
9.22 Given the absence of coherent work in Northern Ireland to address these issues we believe that a regional approach should be adopted to develop clarity about the strategic direction to be taken and the changes to organisational structures and systems that should ensue. This work should be led by the Department of Health, Social Services and Public Safety and involve the development of a regional network wherein knowledge and expertise about ageing issues might be further researched, shared and developed. The outcome should be a regional framework that addresses at least the following:

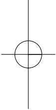
- values and principles derived from the Equal Lives values as they apply to the ageing population of people with a learning disability
- information audit of need
- creation of a policy framework
- development of local partnerships between learning disability services and the elderly programme of care
- human resource implications in both of the above sectors
- strategy for optimising health
- involving older people with a learning disability in decision-making
- promoting positive lifestyles for older men and women with a learning disability through voluntary and community organisations
- forward planning[8]. **(Recommendation 52)**

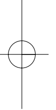
[8] Adapted from the checklist for action in Preparing for a Positive Future (153)

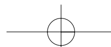
9.23 There is a need for a complementary process to be undertaken to address the issues for men and women with a learning disability who develop dementia including those who are younger. These issues are currently under consideration by the Expert Working Committee on Dementia and Mental Health Issues in Older People of the overall Review. We recommend that the framework that is developed ensure that men and women with a learning disability who develop dementia should be enabled to access support and expertise from mainstream dementia services in their locality. This will require close cooperation between learning disability specialists and those who have expertise in dementia. **(Recommendation 53)**

9.24 Objective 8	**Recommendations**
Recommendation 51	The Department of Health, Social Services and Public Safety should review funding allocations to ensure that the projected increase in numbers of older people with a learning disability is reflected in the allocations to the learning disability programme. This shift will take cognisance of the fact that people with a learning disability may experience the effects of ageing at an earlier age.
Recommendation 52	The Department of Health, Social Services and Public Safety and Health and Social Services Boards should produce a strategic plan to address current deficiencies in services and future service provision for older people with a learning disability and their families.
Recommendation 53	Arrangements should be developed to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services. This will include mechanisms to provide a skills boost between dementia services and dedicated learning disability services.









ENSURING PERSONAL OUTCOMES

Chapter 10

We hope that the Review will make sure that there are more advocacy groups and more chances for people to speak out and be listened to. We do not think this happens enough and that is why things go wrong. (1)

10.1 The Equal Lives Review has concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve:

- developing responses that are person centred and individually tailored
- ensuring that people have greater choice and more control over their lives
- services becoming more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important
- increased flexibility in how resources are used
- balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

10.2 In this chapter we will outline the issues that support or impede this direction of travel and the specific actions that are required to achieve it.

Objective 9	To enable people with a learning disability to have as much control as possible over their lives through developing person centred approaches in all services and ensuring wider access to advocacy and Direct Payments.

Issues and Concerns

Person Centred Approaches

10.3 Throughout the Equal Lives Review process it was evident that many services in Northern Ireland are seeking to develop a greater focus on meeting individual needs and aspirations through person centred approaches to planning and support.

10.4 However, PCP appears to have been the result of determination on the part of individuals or groups within services to transform working methods rather than a consequence of a shift in strategic direction within organisations. Therefore, as in other areas of practice, the likelihood of being offered the opportunity to participate in a PCP process depends more on where you live rather than on the degree to which you might benefit. (1)

10.5 There is some confusion about the terms in use, which we seek to clarify here.

PERSON CENTRED APPROACHES

…ways of commissioning, planning, and organising services that are based on listening actively to what people want and tailoring services to individual needs rather than fitting people into available services.

PERSON CENTRED PLANNING (PCP)

…a process for continual listening and learning focusing on what is important to someone now and in the future and acting on this in alliance with their family and friends. (154)

PERSONAL OUTCOMES

…the effects of an intervention that focus on the issues that matter most to people in their lives and checking to ensure that they are being met.

10.6 Developing a person centred approach within existing service agencies will require cultural and organisational changes and fundamental shifts in the ways in which decisions are taken and implemented.

10.7 Throughout the Equal Lives Review people expressed considerable support for PCP to be made available to all people with a learning disability. This support was voiced at presentations to the Learning Disability Committee, at meetings with the Equal Lives Group and carers and by each of the 6 Task Groups. Future energies will need to focus on ensuring that where person centred plans are developed, sufficient attention is given to their implementation to ensure that they result in better outcomes for the individual.

Direct Payments

10.8 The Carers and Direct Payments Act (NI) 2002 makes provision for people to have increased control over the services they receive and for carers to have their needs recognised formally. The Act:

- requires Health and Social Services Trusts to inform carers of their right to an assessment
- gives carers a statutory right to assessment of his/her ability to provide and continue to provide care for the person cared for
- places a duty on Trusts to supply services that meet the personal needs of carers as well as the person they care for
- enables carers to purchase, through a Direct Payment, the services they require to meet their own assessed needs.

10.9 There was a low level of awareness about these provisions amongst the carers who attended the Equal Lives Review meetings. Concern was also expressed about the length of time taken to complete these procedures and the level of support that was offered as a result. (2)

10.10 The Community Care Direct Payments Act (1996) made it possible for disabled people, including those with a learning disability, to have a Direct Payment from Health and Social Services Trusts to pay for their community care services. The individual can use the money to buy or organise the kind of support that best suits them rather than use services provided by Trusts or other organisations on their behalf. There has to date been a very low uptake of Direct Payments by people with a learning disability in particular but also among others with a disability. At March 2004, out of 107 people in receipt of Direct Payments in Northern Ireland, 12 had a learning disability. (155) The Belfast Centre for Independent Living has established an advice and support service in Direct Payments which to date has had limited requests from people with a learning disability or their family carers.

Advocacy and Information

10.11 Current Government policy stresses the importance of people being able to have a say about how services are run and for services to be more user-led. Yet many people with a learning disability find it hard to make their voices heard. Advocacy can help people let others know what is important to them and have influence over decisions, which affect them.

10.12 Compared with England, Scotland and Wales, the range and volume of advocacy services for people with a learning disability in Northern Ireland is low. There are examples of good practice throughout Northern Ireland, but these are sporadic and often groups are relying on unpredictable funding and volunteer support to keep them going. Very few people that we met during the Equal

Lives Review meetings had access to an independent advocate or to opportunities for support in self-advocacy. (1) There is no regional forum of people with a learning disability.

10.13 Between 50% and 90% of people with a learning disability have some communication difficulties (depending on the definitions used and the survey population). Four out of 5 people with severe/profound learning disabilities have no effective speech, although they will demonstrate what they want to communicate by other means. (156) This places an onus on agencies to ensure that people with a learning disability are informed about issues that will affect them in a way that takes account of their communication needs. Agencies also need to hear what people say and adapt their processes to ensure that people are listened to.

Quality

10.14 As noted above the benefits of PCP were regularly highlighted to us during the Equal Lives Review. However, we are concerned to ensure that PCP is not viewed as an end in itself. Rather it is the first step in the process of ensuring that people with a learning disability and family carers achieve personal outcomes through their involvement with support services. To us this is the core definition of a quality service.

10.15 Key drivers for measuring and assuring that this happens are the commissioning processes of funders and the monitoring of standards by regulators. There are currently no agreed systems for assessing the quality of life and personal outcomes for people with a learning disability across the full range of services on offer to them. Much current regulation of residential and nursing homes focuses on issues of physical structure and process rather than on measuring the impact on people's lives through determining what the individual regards as important. Growing emphasis on health and safety legislation has created further pressures to institutionalize services in order to meet stringent standards.

10.16 The Government is engaged in a series of initiatives that are designed to improve quality in services. A key element of this is the establishment of the Health and Personal Social Services Regulation and Improvements Authority (HPSSRIA), which will inspect care services against a set of national care standards. This development has the potential to support the increasing emphasis that we feel is needed in all services for people with a learning disability on personal outcomes. However, a number of people who contributed to the Equal Lives Review raised concern that unless the care standards are based around promoting person centeredness in services the opportunity for them to support the inclusion and individualised aspirations of service beneficiaries will be lost. More worryingly, this development will run counter to the values underpinning the Equal Lives Review.

10.17 This emphasis on personal outcomes is equally applicable in specialist assessment and treatment services relating to a person's physical and mental health, or their challenging behaviour. It is imperative that the contribution of these services is closely aligned to the broader PCP for the person.

Research and Information Needs

10.18 In order to raise the quality of supports it is necessary to have a sound evidence base on which to base recommendations for change, development or maintaining existing practices. As part of the Equal Lives Review an audit of learning disability research was commissioned and disseminated on the Review website. This audit highlighted the value of such concrete links between research and

policy formulation and practice. It also raised a number of issues that need to be considered in ensuring that the implementation of the Equal Lives Review's recommendations is supported by a coherent research strategy. Further research on the assessment of personal outcomes and the impact of person centred planning should be a key area for research and development during the first 5 years of the implementation of the Equal Lives Review.

10.19 We have highlighted the deficiencies that exist related to information and research on issues relevant to learning disability. The audit of learning disability research undertaken for the Equal Lives Review has identified key research findings that service providers and commissioners need to address along with the significant gaps in our knowledge. The list below is not exhaustive, but is included to highlight the significant gaps that exist in terms of meeting the change agenda detailed in the Equal Lives Review:

- the socio-educational outcomes for children, families and schools when pupils with a learning disability attend mainstream schools compared to special schools
- meeting the personal support needs of family carers at different stages of their son or daughter's life cycle - new born; transition to adulthood; maturity - and as they, as parents, approach old age
- the benefits systems and the impact on poverty in families and people with a learning disability
- tracking young people through different transition routes to understand better the outcomes of various options open to them - college, employment, and day centre attendance
- evaluating ways of increasing the social connectedness of teenagers and adults with a learning disability
- the contribution of productive work - paid and unpaid - in the lives of people with a learning disability
- exploring the obstacles to self-advocacy and how they are best overcome
- ensuring equality of access to healthcare in all its forms for people with a learning disability
- reducing obesity among people with a learning disability
- establishing the outcomes of various accommodation and support options for people with a learning disability, who also have challenging behaviours/mental health problems
- supporting people with a learning disability who have dementia in community settings
- promoting the engagement of volunteer helpers in learning disability services
- evaluating the role of community development agencies in promoting the social inclusion of people with a learning disability.

Action Required

10.20 In order to ensure that people with a learning disability and their family carers have a greater say in decisions that affect them and to support the development of more person centred approaches, there is a need for radical shifts in how organisations operate and opportunities available for participation and influence. We will develop this theme further in Chapter 12.

10.21 The cornerstone of this work will be embedding PCP throughout services and ensuring that all those individuals in contact with health and social services are enabled to have a PCP developed with them if they so choose. This plan will be co-ordinated by the lead worker from the agency that is identified by the person and their support staff as being best placed to do so and the PCP would be held by the individual but shared with their permission with all agencies and personnel involved with the individual.

10.22 At various stages in the Equal Lives Review we have proposed that PCP is particularly important at the point of discovering that a child has a learning disability, in preparing for the transition to adulthood, and in enabling people to plan for the future as they get older. In addition priority should be given to developing a PCP with individuals with complex needs including those who may have particular difficulties in communicating their needs and aspirations as a result of having an Autistic Spectrum Disorder or severe learning disability. Achieving this will require organisations to work collaboratively and to undertake reviews to their current practices especially to enable the shift in attitude and culture that effective PCP requires. **(Recommendation 54)**

10.23 Direct Payments have the potential to be highly effective in giving people control over their lives. Supporting people to purchase the support they need to fit their own unique circumstances should be a key driver towards helping them achieve personal outcomes. Even a modest increase in the uptake of Direct Payments by people with a learning disability and family carers of 10% per annum over the next 15 years would result in around 1,000 beneficiaries (Based on people aged over 20 and children with severe/profound disabilities). There is clearly a need to more widely promote this option and to create more flexible resource allocation to enable it to be taken up by those who wish to do so. However, all these costs could not be met from within existing HPSS budgets as only a small proportion of present funding is spent on variable costs. Thus in England, the Department of Health announced an additional £9million over 3 years to boost Direct Payments for people with a learning disability. A similar initiative is required in Northern Ireland in order to support the uptake of Direct Payments. **(Recommendation 55)**

10.24 In order to ensure that people are supported to have their views heard and acted upon there is a need to address the underdevelopment of independent advocacy services in Northern Ireland. Advocacy can take many forms including group advocacy, self-advocacy and citizen advocacy. In all cases advocacy services should fulfil 3 roles: educational - raising awareness about the strengths, needs and aspirations of people with a learning disability within the community at large; bringing about change to the way that systems work with individuals; and creating collaborative links between people with a learning disability and other groups/organisations in the wider community. The extension in range and volume of advocacy services should be a key priority for planners in the future if more person centred outcomes are to be attained. The development of advocacy services will also facilitate the establishment of a Regional Forum of People with a Learning Disability that we believe is an integral component of implementation arrangements for the Equal Lives Review. **(Recommendation 56)**

10.25 In Chapter 4 we recommended that steps be taken to address the gaps that exist in ensuring that information is available that meets the needs of people with a learning disability and their families. We believe that in addition to this specific measure there is a need to encourage all those who provide services to people with a learning disability to take steps to ensure that they produce information in accessible ways that are tailored to meet the needs of the specific individuals with whom they work. **(Recommendation 57)**

10.26 In order to ensure that the Government's drive to improve quality is meaningful there is a need to develop measures that address the effectiveness of organisations in delivering personal outcomes. This will mean that systems have to be more responsive to the fact that desired outcomes of

support are highly individualised and that the focus needs to be on the issues that matter most to the individual who is being supported. If standards are developed that effectively measure personal outcomes in this way, regulators and service commissioners will have a key role to play in promoting person centeredness in services with correspondingly less emphasis on setting standards to be applied uniformly across a diversity of service responses. **(Recommendations 58, 59)**

10.27 It is proposed that the research requirements identified are addressed through the development of an agreed learning disability research strategy, which will encompass the following elements:

- development of links between Northern Ireland researchers and other national and international researchers in learning disability in order to access more research funding
- consideration of the uptake of existing research findings and their use in decision-making
- the participation of stakeholders in deciding on research questions
- the development of researcher-practitioners
- boosting the amount of resources available for research and development within Northern Ireland
- instigating and managing cross-national research projects.

10.28 In conducting the Equal Lives Review we have highlighted difficulties in accessing accurate information on the numbers, needs and services available to people with a learning disability and on the amounts of funding being invested in services for them. In order to accurately evaluate the impact of the implementation of the Equal Lives Review recommendations and to plan more effectively there is a need to establish better systems for tracking people and funding and assessing outcomes. In particular new systems should provide information on services and supports needed by individuals as well as those they are receiving. These records should allow for better integration of information that to date is held separately in education, health, social services or housing systems, taking account of the Data Protection Act. Experiences in England, Scotland and Republic of Ireland would help to inform the development of an appropriate data set. **(Recommendation 60)**

10.29 Objective 9 Recommendations

Recommendation 54 By 1 January 2009 the opportunity to have a PCP should be in place for all persons with a learning disability who are in contact with HPSS agencies. From 2006 priority should be given to:

- developing Family Support Plans based on person centred principles that cross disciplines and agencies
- developing an Early Intervention Plan for children at the point of diagnosis
- ensuring that all young people with a learning disability have an effective Transitions Plan based on PCP principles in place from 14 years of age
- ensuring that all persons living with a sole family carer and/or those aged over 50 years have been offered the opportunity to have a Futures Plan agreed based on PCP principles. In addition a plan for meeting the needs of carers should be prepared. This invitation should be re-issued to family carers and the person they care for on a regular basis and no less than every 3 years.

Recommendation 55 The use of Direct Payments should be widely promoted and additional revenue monies of up to £300,000 per annum over the next 3 years ear-marked by the Department of Health, Social Services and Public Safety for the development of increased uptake of Direct Payments.

Recommendation 56 An independent advocacy service should be in place for each area serving a population of 100,000 - 120,000. A Regional Forum for People with a Learning Disability should be established with representatives drawn from local advocacy services. Both initiatives should be grant-aided through Office of the First Minister and Deputy First Minister (OFMDFM), so that they can cover all services and not just those provided by the Department of Health, Social Services and Public Safety.

Recommendation 57 A commissioning requirement of any service that includes people with a learning disability must be the evidence from providers across departments and agencies of how information will be provided in an accessible format appropriate to the needs of the individuals being supported.

Recommendation 58 Health and Social Services Boards should be required, within a regionally agreed framework, to establish mechanisms in partnership with their service providers for monitoring the degree to which Person Centred Planning is appropriately implemented and delivers on positive personal outcomes for individuals with a learning disability.

Recommendation 59 The Health and Personal Social Services Regulation and Improvement Authority should include measurement in the standards against which learning disability services are inspected of the processes used in service delivery to secure positive personal outcomes.

Recommendation 60 A commissioned programme of research and service evaluation to support the implementation of the Equal Lives Review should be established in collaboration with the Research and Development Office.

ENABLING CHANGE: STAFFING

Chapter 11

All staff who work with people with a learning disability should get special training so that they understand how to respect people and know what to do to support people with a learning disability. (1)

11.1 The biggest single contributor to quality services is the competence of the staff, both paid and unpaid, who are employed in them. Throughout the Equal Lives Review we have heard how people's lives have been enhanced by the relationships they have formed and the support they have received from the staff with whom they have come in contact. Since the last review of policy in 1995 there have been considerable changes that impact on developing a competent workforce in health and social care services:

- the volume and range of services has expanded creating a need for an extension to the workforce within and beyond health and social services
- an increase in the input of Direct Support Workers and an expanded range of roles that they undertake
- an increase in the numbers of Direct Support Workers employed on a part-time basis
- new or increasing demands arising from the changing demography and complex needs of people with a learning disability including:
  - addressing issues associated with working with an ageing population
  - increasing numbers of people with both an Autistic Spectrum Disorder and a learning disability
  - growth in number of children and adults who have complex physical health care needs.

11.2 Consultation conducted as part of the Equal Lives Review highlighted a range of positive characteristics in relation to developments in the workforce in response to these changes.

- Staff are increasingly developing approaches based on working with rather than for people with a learning disability and their families.
- There is now a higher profile for learning disability services, which has contributed to raising the confidence and status of staff in these services.
- The new and changing roles have created new opportunities for staff and have in many cases resulted in innovative service responses to staff training and development.

- The introduction of the Learning Disability Awards Framework (LDAF) has offered a coherent learning pathway for many Direct Support Workers in residential and day services in the WHSSB and in a growing number of voluntary agencies in Northern Ireland.
- Many individuals reported that there has been skills improvement amongst staff in learning disability services and an increased focus on their training.

11.3 The availability and retention of an appropriate range of qualified and competent staff will be crucial to the successful implementation of the Equal Lives Review. In this chapter we will explore the key factors that will impact on achieving this and outline our recommendations on the action required to build on the significant strengths that are currently in place amongst those who work with people with a learning disability and their families.

Objective 10	To ensure that health and social care staff are confident and competent in working with people with a learning disability.
Objective 11	To ensure that staff in other settings develop their understanding and awareness of learning disability issues and the implications for their services.

Issues and Concerns

User Involvement

11.4 Potentially one of the most powerful ways of raising awareness of the needs and aspirations of people with a learning disability and their family carers is to ensure their involvement in staff recruitment and development.

- During the Equal Lives Review we learned of a number of initiatives in this area, albeit that they are occurring in isolation from broader workforce strategies.
- Our understanding of the issues was greatly informed by the many presentations we heard from people with a learning disability and family members.
- This is an area that should be promoted more widely in agencies.

Recruitment and Retention

11.5 The recruitment and retention of staff is a key challenge for services both in Northern Ireland and throughout the United Kingdom.

- There is a lack of accurate data on either the current workforce or future workforce requirements on which to effectively develop strategies to address recruitment and retention difficulties.
- Staff in existing learning disability hospitals will have an important role to play within community based settings as the number of people living in hospitals reduce.
- Whilst several professional groups have published their standards for staffing levels in relation to the population size covered, limited information appears to be published in relation to the current level of recruitment among the different professional groups and the present level of

unfilled posts. However, there appears to be a general consensus that recruitment of Allied Health Professionals - notably speech and language therapists - is difficult in Northern Ireland at present. This may be because they are able to work in a wide range of settings and learning disability may not be presented as an attractive career pathway. Similarly difficulties appear to exist in recruiting staff to clinical psychology posts. Applications to learning disability nurse training have been reducing and by tradition there have always been fewer recruits to this branch of the profession.

- No clear and concise information is currently compiled at a Northern Ireland level on the difficulties being experienced in recruiting qualified and unqualified staff into statutory or independent learning disability services and the factors thought to be contributing to these difficulties.

- There are clear benefits in achieving a cohesive and experienced staff group. These include increased continuity within services; a growth in staff skills and knowledge with experience and it offers a greater return on the investment in training and reduced costs of recruitment. (157)

- The most comprehensive review of literature relating to the retention of staff within community based services for people with a learning disability within the United Kingdom and the USA identified 8 key factors that have been consistently reported as contributing to staff turnover in learning disability services. (158) These factors were:

  - characteristics of staff (younger people, those with higher education and those on shorter contracts moved on more frequently)
  - lower income/less satisfaction with income
  - mismatch between expectations and actual job
  - lack of commitment to the organisation or general type of work
  - lack of support from other staff
  - the availability of alternative employment
  - high job stress
  - low job satisfaction.

11.6 A wide range of factors have been highlighted that contribute to staff remaining in services, awareness of which can inform the development of a strategy to address retention difficulties. Key factors include effective stress management in the workplace, enabling a good work/life balance, effective support from managers and clarity about roles and responsibilities. (157, 158)

Volunteers

11.7 A much-neglected area of study is the role that unpaid volunteers play in supporting people with a learning disability.

- The invaluable contribution made by family carers who still provide the vast majority of support has been highlighted throughout the Equal Lives Review. Although it is impossible to accurately assess this financially, when it has been done for all carers in Northern Ireland (159) and then pro rated for those likely to be caring for a child or adult with a learning disability, the total

amount is in the order of £170 million per year which exceeds that spent by health and social services.

- Moreover as British surveys have shown, parents of people with a learning disability are more often likely to be engaged in voluntary work to assist others than are other parents. **(160)**

- Volunteers who give freely of their time to support people with a learning disability make a significant input particularly in the area of leisure and sporting activities e.g. approximately 4,000 men, women and children with a learning disability participate in leisure clubs in Northern Ireland such as Gateway and Special Olympics, which are staffed mainly by volunteers. (56)

- There will be an increased need for volunteer involvement as a consequence of the rise in advocacy and befriending services anticipated in the Equal Lives Review.

- The distinction between volunteers and paid staff can be blurred in fostering and family placement schemes in which a host family looks after a person with a learning disability in their home. Payments are made to cover the extra expense this entails although there is criticism of the low rates of pay on offer. However, most volunteers in these schemes do not want to make money but continue because of the satisfaction and enjoyment they get from it. **(101)**

- A common outcome is the way the experience enriches the lives of the volunteers. A study of over 200 volunteers who supported athletes at the World Games of Special Olympics in Dublin identified 4 main outcomes; it was an enriching and worthwhile experience; they gained a greater understanding of people with a learning disability; it contributed to a national event in the life of the country and it emphasised people's talents not their disabilities. **(161)**

- In sum, volunteers are in danger of being overlooked as services become more professionalised. Yet this is one of the proven means of reducing the social exclusion of people with a learning disability and for increasing the quality of their lives. Increased resources and efforts are required to sustain and expand schemes that support volunteers.

Changing Nature of Services

11.8 The changing nature of services detailed at paragraph 11.1 creates challenges and opportunities for workforce development including a trend towards smaller staff teams in services, an increase in lone working, a requirement that staff develop their understanding of the impact of Autistic Spectrum Disorder on people who have a learning disability and the need for training to enable staff to provide highly specialist health interventions.

- The increase in the number of people with a learning disability with additional complex health needs has created a need for additional supports and services if people are to be able to avail of the service provision. Increasing complexity of need in community care with added chronic disease management is currently placing under resourced community health services under great pressure.

My daughter is profoundly disabled and needs 24-hour care. The agency that provides respite in my house has been told their staff are not allowed to give her medication. I have to come home while they are there to give her the medicine so I don't really get the break at all. (2)

- In many special schools this issue has been addressed by having more nurses on site during school time, which has been well received by education staff. **(162)** In day centres some nurses have been employed in other roles but until recently most centres have relied on inputs from nurses on the Community Learning Disability Teams. However, at least one Health and Social Services Trust has appointed a nurse to the day centre staff team; as yet there is no evaluation of the outcomes of this approach.

- Professionals are increasingly undertaking more specialist functions in services which requires them to move into new areas of work, new structures and new working methods for which training and staff support needs are particularly crucial.

- The concept of a Community Learning Disability Team has been a feature of learning disability services in the UK since the 1970s. The form and function of these teams varies widely and there has been very little research undertaken into the effectiveness of the various models despite the fact that they are an expensive component of health and social services provision. The structure of community teams providing services to people with a learning disability is changing across Northern Ireland. Many Trusts have moved away from the formally structured Community Learning Disability Team that provided services to children and adults with a learning disability. A number of different team structures now exist, including Children's Disability Teams, Adult Disability Teams supporting people with all disabilities (but with some team members only supporting people with a learning disability), separate Community Nursing Teams and Community Social Work Teams for people with a learning disability (with varying degrees of collaborative working).

- Whilst considerable literature exists about the requirements for effective team work **(163, 164)**, at present there is no clear evidence on the impact of different team structures in support of people with a learning disability, nor conclusive evidence on the most effective team structure within community learning disability services.

- Responses to consultation confirmed that there is a very variable pattern with some respondents indicating that they did not work in teams but rather as groups of professionals working alongside each other. Consultation feedback also confirmed the need for greater clarity about the composition and function of community teams and the changing role they should play in the future as a consequence of implementation of the Equal Lives Review.

- Ensuring the inclusion of people with a learning disability in community facilities will mean that some staff who support people with a learning disability will have to develop increased knowledge and skills in community profiling, community development and networking.

- As access to Direct Payments increases a larger number of individuals will be directly employing staff to meet their support needs creating new challenges in relation to meeting the training needs of both the employer and employees.

Staff in Mainstream Health Services

11.9 Despite the fact that inclusion has been a policy aim in Northern Ireland since 1995 (7), people with a learning disability continue to encounter persistent difficulties in gaining equity of access to mainstream services as noted earlier. In particular, difficulties have been reported in accessing primary care and acute general hospital services within Northern Ireland. To a large extent these stem from the attitudes of staff in these sectors.

- The views of professionals in primary care towards people with a learning disability and their limited skills in communication, limited preparation or specific training have been identified as

factors influencing the service provided to people with a learning disability. Research evidence also shows that people with a learning disability often do not avail of other health services within community settings (eg dentist, optician, audiologist, speech and language therapist, dietician - refer to Chapter 7).

- It is recognised that nurses within acute hospitals also report experiencing difficulties in working with people with a learning disability. Indeed, the National Patient Safety Agency has recently highlighted the seriousness of this situation and after a comprehensive process of consultation within England has identified the care of people with a learning disability in general hospitals as one of their top priority issues. **(165)**

- Studies consistently report limited confidence and uncertainty about what to do in working with people with a learning disability. Acute care nurses often reported limited knowledge, skills and experience towards caring for people with a learning disability. Likewise a study undertaken in Northern Ireland, which included 167 student therapists (mainly physiotherapists and occupational therapists) reported that they had significantly less confidence and felt more unprepared to work with people with a learning disability than people with a physical disability. **(166)**

- Evidence is available from within Northern Ireland to show that when primary care and specialist learning disability staff work collaboratively, the health status of people with a learning disability can be improved.

11.10 It will be equally important that staff in mental health services become more skilled in supporting people with a learning disability.

Training and Development

11.11 Whilst many people consulted during the Equal Lives Review highlighted an increase in the range of training and development opportunities available, concern was expressed about the patchy nature of such provision and the relevance of current qualifications to those supporting people with a learning disability.

11.12 Surveys of managers in learning disability services in Northern Ireland have consistently highlighted challenges for them in meeting the training and development needs of Direct Support Workers. Specific training gaps cited include staff training on sexuality and personal relationships, Autistic Spectrum Disorder and addressing challenging behaviours. **(135, 136, 167)** While the value is acknowledged of National Vocational Qualifications (NVQ) in assessing competence, shortcomings have been identified with current training requirements that focus solely on NVQ attainment without ensuring adequate provision of a coherent learning pathway for staff working with people with a learning disability. The introduction of LDAF has enabled agencies to begin to address this gap and initial evaluations of pilot projects using this framework are promising. **(168)**

11.13 The only dedicated professional training courses in learning disability are in nursing and psychiatry. Other professionals may take a number of modules or only parts of a module on learning disability as part of their initial training. The University of Ulster has recently introduced a Higher Certificate in Health and Social Care (Learning Disability Studies) although this is primarily intended for staff without formal professional training. There is a need to develop trans-disciplinary postgraduate modules or courses in the field of disability generally or learning disability in particular in order to increase the expertise of professionals working in dedicated learning disability services. The University of Ulster has recently introduced two such courses, one focusing

on learning disability and challenging behaviours and the other on learning disability and mental health needs.

Action Required

11.14 The challenges to developing the workforce that will be required to achieve the Equal Lives objectives may be summarised as building a workforce that:

- meets the needs of people with a learning disability and their families
- recognises cultural shifts in services towards supporting people in ways that are person centred, more flexible and based on the Equal Lives values
- addresses problems in staff recruitment and retention
- is sensitive to the particular issues in working with people from ethnic minority communities
- comprises staff who are skilled, confident, competent and well supported by their employers
- develops the capacity of staff in learning disability services to provide leadership within and between a wide range of agencies.

11.15 The perceptions and needs of staff within non-learning disability services must be considered and action taken to provide the support needed for inclusion to become an accepted aim of these services. To be effective collaborative working must go beyond providing information to primary care and acute general hospitals services about what needs to be done; it needs to include practical support, training and sharing of information with staff in these sectors.

11.16 Such collaborative arrangements should be evaluated against the degree to which they result in an increased capacity among mainstream services to support people with a learning disability and must replace families of people with a learning disability or staff in learning disability services providing parallel services to those provided to the wider population.

11.17 The collaborative developments noted above in relation to primary and acute care services will also be necessary for staff in a wide range of other services, such as employment support, further education and housing services; the key point being that the Equal Lives objectives will never be achieved if the knowledge, skills and values are not in place within all mainstream services.

11.18 Health and Social Services Boards and Trusts need to develop greater clarity about the coordination of community learning disability professionals. There is a confused picture at present, which does not form a viable basis for meeting the Equal Lives objectives. In particular for developing the revised working practices that will deliver the new styles of services envisaged in this report. The functions and coordination of community learning disability professionals should therefore be reviewed in light of the proposals in this review by December 2006. **(Recommendation 61)**

11.19 As a matter of urgency the Department of Health, Social Services and Public Safety should develop a regional development strategy for the learning disability workforce. This short-life review should be completed by April 2007. We believe that this strategy should:

- involve all key stakeholders including those in the independent sector
- review the remuneration of staff in relation to other service sector occupations, such as the hospitality industry

- seek to address the needs of small-scale isolated providers
- ensure that the current and future needs of the workforce are addressed particularly the implications for staff in addressing the direction of travel envisaged in this review
- promote increased joint working in addressing training and development needs
- promote the involvement of people with a learning disability and family carers in staff recruitment, training and development
- gather robust data on the workforce including current staff, qualifications held and identification of gaps in the knowledge and skills
- explore the potential application of LDAF for providing a learning pathway that complements NVQs and for up-skilling the learning disability workforce and staff in other settings. **(Recommendation 62)**

11.20 The Department of Health, Social Services and Public Safety currently operates the Training Support Programme (TSP), which provides funding for employers of social care staff in the statutory and voluntary sectors to enable them to meet the training requirements of Government policy. TSP has considerable potential to be used to support the training and development issues for these staff that have been highlighted in the Equal Lives Review. However, criteria for accessing this funding is rigidly linked to attainment of qualifications as determined by the Social Services Inspectorate and the Northern Ireland Social Care Council (NISCC). As has been noted these rigid qualification targets are seen as not being effective in meeting the full range of training challenges that exist in services and that will be exacerbated by the demands of the Equal Lives Review. The role of TSP needs to be revised, the budget available needs to be increased and the criteria for the funding revised in order to support the extensive workforce development challenges we envisage.

11.21 In order to support the involvement of service users in training those in receipt of TSP funding should be required to report on the degree to which they are developing mechanisms for securing the involvement of people with a learning disability in the design and/or delivery of training programmes. **(Recommendation 63)**

11.22 The training needs of family carers and volunteers have not been well met by existing arrangements. It should be incumbent upon those in receipt of TSP funding that mechanisms are set in place to open up access to this provision for these groups where possible. **(Recommendation 64)**

11.23 Finally there needs to be a time limited initiative to promote the leadership and managerial capacity of staff that will be crucial to the implementation of the Equal Lives Review. Priority should be given to proposals for initiatives that will be jointly planned across sectors and settings. **(Recommendation 65)**

11.24 In order to achieve a baseline level of knowledge that may be expected of all Direct Support Workers in adult learning disability services in Northern Ireland, it is recommended that the induction and foundation standards that have been produced by the NISCC become a mandatory requirement of all new entrants to this workforce. In order to ensure that the knowledge base is

sensitive to the needs of men and women with a learning disability the attainment of these standards should be assessed through successful completion of LDAF induction and foundation standards as these have been developed with this aim in mind.[9]

11.25 From 1st January 2007 all new Direct Support Workers in learning disability services should be required to meet NISCC standards on induction and foundation within the 6 months of appointment. It is anticipated that this will normally be evidenced by completion of assessment to LDAF standards and be subject to inspection by Health and Personal Social Services Regulation and Improvement Authority (HPSSRIA). **(Recommendation 66)**

11.26 In order to produce health gains for people with a learning disability, to promote improved access to mainstream health and social services and to address the deficiencies that have been highlighted in professional training, we recommend that professional training is required to ensure that generically trained health and social services professionals (medicine, Allied Health Professionals, nursing, social work) should receive a minimum of awareness raising training on learning disability issues during their pre-qualification education. **(Recommendation 67)**

11.27 In order to enhance the status of working with people with a learning disability as a positive career choice and to encourage recruitment in the paid workforce, volunteering and community service, a publicity strategy should be developed and implemented that promotes the positive features of working with people with a learning disability. **(Recommendation 68)**

11.28 As has been noted throughout the Equal Lives Review successful community integration will require that members of the public and staff in agencies beyond health and social services develop a greater understanding of the strengths, needs and contribution that people with a learning disability can make to community life. In order to stimulate the development of such an understanding it is proposed that Department for Social Development, Department of Education and Department for Employment and Learning identify tangible action that they can take to promote joint training and awareness raising amongst the agencies that are accountable to them. **(Recommendation 69)**

11.29 Objectives 10 and 11	**Recommendations**
Recommendation 61	HSS Boards and Trusts should agree the role, composition, configuration and functions of Community Learning Disability Teams in light of the proposals in the Equal Lives Review by December 2006.
Recommendation 62	By April 2007 a regional workforce development strategy should be produced in partnership with employers from the independent and statutory sectors that identifies the workforce implications of the Equal Lives Review and sets out a clear strategy for addressing them.
Recommendation 63	All service providers who receive funding from the Department of Health, Social Services and Public Safety Training Support Programme should be required to evidence how people with a learning disability have been involved in the design, delivery and/or evaluation of training programmes provided on learning disability specific issues.

[9] Work is ongoing on extending the LDAF to children's services. It will be necessary when this work is completed to consider its relevance and application to children's services in Northern Ireland

Recommendation 64 Service providers who receive Training Support Programme funding should be required to demonstrate that arrangements are in place to open access to the training provision to family carers, volunteers and people with a learning disability where possible.

Recommendation 65 Funding should be allocated to the Review Implementation Steering Committee for a Leadership Innovation Fund to which all agencies and professions might apply, designed to promote interagency initiatives that develop the leadership and managerial capacity in organisations to deliver on the new vision in the Equal Lives Review.

Recommendation 66 From 1 January 2007 all new Direct Support Workers in learning disability services should be required to meet the Northern Ireland Social Care Council standards on induction and foundation within the first year of appointment. It is anticipated that this will normally be evidenced by completion of assessment to LDAF standards and be subject to inspection by the Health and Personal Social Services Regulation and Improvement Authority.

Recommendation 67 All generically trained health and social services professionals (medicine, Allied Health Professionals, nursing, social work) should receive at a minimum awareness raising training on learning disability.

Recommendation 68 A publicity strategy should be developed and implemented that promotes the positive factors of working with people with a learning disability and encourages greater participation in volunteering and community service.

Recommendation 69 Department of Education, Department for Social Development and Department for Employment and Learning should develop measures to encourage awareness raising and improved training on learning disability amongst agencies that they fund to support equity of access by people with a learning disability to their provision. These measures should include the development of joint training opportunities with health and social services agencies.

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MANAGING CHANGE: IMPLEMENTATION

Chapter 12

Improved inter-agency working would result in better service provision to those with a learning disability and an enhancement of their opportunity and quality of life.
Manager of a Citizens Advice Bureau.

12.1 The Equal Lives Review sets out an ambitious change programme that will require commitment and leadership at all levels in organisations throughout Northern Ireland. We anticipate that the implementation of the recommendations of the Equal Lives Review will involve a fundamental shift towards more person centred ways of working and a determined effort to remove barriers to inclusion in existing structures, systems and working practices. The Equal Lives Review has concluded that many of the aspirations in the 1995 Review were appropriate and that it can usefully be built upon to deliver on the Equal Lives objectives. However, our consultation indicates that major weaknesses in the 1995 Review included:

- the absence of transparent resource commitments to implement the Review's recommendations
- the lack of a robust implementation process
- the continuation of organisational impediments to progress.

12.2 Many of the needs of people with a learning disability and their family carers are best met at an individual, face-to-face level. However, the way in which these services are delivered is heavily influenced by the organisational structures in which they are provided. Different organisations can be involved in attempting to meet the diversity of needs and aspirations. Agencies have different funding sources as well as different management and staffing structures and contrasting ways of working. Therefore, it can be difficult for them to co-ordinate their services even when they are working in the same geographical area. These difficulties are further compounded when service priorities are set and service planning is undertaken without consultation with potential partner agencies.

12.3 In this chapter we will highlight issues and concerns relating to organisational arrangements in support of people with a learning disability and outline our proposals for supporting the implementation of the Equal Lives Review.

Objective 12	To promote improved joint working across sectors and settings in order to ensure that the quality of lives of people with a learning disability is improved and that the Equal Lives values and objectives are achieved.

Issues and Concerns

Organisational Structures

12.4 There is a wide range and growing number of organisations that work to support citizens in Northern Ireland. Many of these organisations are for everyone and therefore, they should be open to supporting people with a learning disability. Others are specific to people with a learning disability and in recent years their number has also grown significantly.

12.5 Some organisations have a regional remit in that they cover all of Northern Ireland. Others are responsible for designated geographical areas such as Health and Social Services Boards, while others cover particular districts, such as Health and Social Services Trusts or District Councils. Finally there are others, which work at a more local level, such as a special school or a day centre.

Present Service Structures For People With A Learning Disability

12.6 All Government departments have responsibilities to people with a learning disability just as they have to all other citizens. This responsibility was reinforced by Section 75, Northern Ireland Act (1998), which placed a duty on public authorities to have *due regard to the need to promote equality of opportunity between persons with a disability and persons without.* The Department of Education and Department of Health, Social Services and Public Safety have traditionally taken a leading role in addressing the needs of people with a learning disability for whom they have specific legal responsibilities. On occasions this has had an adverse effect in terms of limited impetus in other Departments to ensure that their activities effectively targeted people with a learning disability.

12.7 While a number of voluntary organisations also operate at a regional level there are no regional organisations led and managed by people with a learning disability.

12.8 The Department of Health, Social Services and Public Safety and Department of Education oversee the work of 4 Health and Social Services Boards and 5 Education and Library Boards at an area level. Unfortunately the geographical areas covered by these sets of Boards are not the same. Within Health and Social Services Boards, there are a number of programmes of care, of which learning disability is a distinct programme. However, other programmes of care also have some responsibility for people with a learning disability as they do for all other citizens although this is often not well defined. Likewise, each Education and Library Board has a senior manager with responsibility for Special Educational Needs.

12.9 The Boards act largely as planning and commissioning bodies; contracting with local agencies - that is Health and Social Services Trusts and Schools - to directly provide services.

12.10 Health and Social Services Trusts in turn may contract with voluntary and private sector providers for the delivery of certain services that usually cover a particular locality. Some of these agencies also work in different Trust and Board areas.

12.11 A number of organisations exist to further collaboration and co-ordination among the voluntary sector throughout Northern Ireland. These include the Association of Real Change (ARC), Children in Northern Ireland and Northern Ireland Council for Voluntary Action (NICVA).

Participation by People with a Learning Disability or Carers in Service Planning and Provision

12.12 There are few formal organisations to represent the views of people with a learning disability or family carers. Consequently there is little tradition of service providers working jointly with people with a learning disability or family carers in the provision of services.

- There is general agreement that greater participation in the planning of learning disability services would result in better services.
- There is a greater emphasis on consultation rather than participation, where consultative processes are separated out from Trust business planning arrangements.
- The value of integrating consultative processes with policy development mechanisms has been evidenced by the role played by Equal Lives group members in the Equal Lives Review, which clearly demonstrated their capacity to be active participants in the process with strongly held views on topics that may receive less attention from professionals. (1)

Reform of Public Administration in Northern Ireland

12.13 A major Review of Public Administration (RPA) commenced in June 2002. The RPA has highlighted a common concern about

a continuing growth in the number of organisations involved in public administration, which not only absorbs resources, but makes it more difficult for the public to identify and contact the appropriate source of advice and support and a lack of co-ordination between sectors and organisations at all levels where there is a need to work together on specific issues or personal cases. (169)

12.14 The RPA team has published its final stage consultation document. A two-tier model is proposed, with a regional tier encompassing the Assembly, Government departments and regional authorities. The second, sub-regional tier covers organisations that would ideally have the same boundaries, including councils, health bodies, other sub-regional bodies and sub-regional delivery units of regional bodies. There is also support for an enhanced role for both the private sector and the voluntary and community sectors. Given the significant changes to the structure of the public sector in Northern Ireland, that are proposed by the RPA, we consider it premature to recommend far reaching changes at this stage. Rather we will set out considerations that we hope will help inform the future reform process.

Developing Policy for Learning Disability Services in Northern Ireland

12.15 Despite the growing emphasis on joint working in Government policy statements, the main method of service planning and delivery in support of people with a learning disability remains that of independent working by different agencies.

12.16 In the 1995 Review of Policy for People with a Learning Disability, it was noted that other Government departments and agencies have a lead role to play, such as housing, further education, training for and support in employment, and leisure. It recommended

Good liaison arrangements between all of the agencies involved are necessary both at the strategic planning level and at the point of service delivery to ensure the development and implementation of compatible and co-ordinated strategies. (7)

12.17 As has been noted throughout this report the Equal Lives Review has identified serious shortcomings in achieving this aim.

12.18 In recent years the Department of Health, Social Services and Public Safety has identified the need for inter-departmental working to meet a range of Government policy objectives in the broad field of health and various interdepartmental working groups have been set up in furtherance of these aims; most notably the Ministerial Group on Public Health. (170) However, formal interdepartmental working appears not to have occurred to any great extent in learning disability, although there have been positive developments in relation to interdepartmental groups on Early Years and Transitions, which have addressed the needs of young people and children with a disability.

12.19 Since the last Review of Learning Disability Services all 4 Health and Social Services Boards have produced policy statements on service provision. All Boards endorsed the need for inter-sectoral working with voluntary and statutory providers and also for consultations and planning to be done with service users and family carers.

12.20 A study carried out by the University of Ulster for the Equal Lives Review confirmed that joint working is happening to some extent on the ground. The benefits were seen to outweigh any potential drawbacks and they centred mainly on the gains for people with a learning disability in getting better co-ordinated services. This implies recognition that services working independently of one another are providing a poorer quality of service than they could be delivering.

12.21 The research study confirmed the messages from other submissions made to the Equal Lives Review that there will need to be a determined and committed effort to ensure that joint working is an essential feature of future service provision in Northern Ireland. In addition, our review of work undertaken to implement changes to policy affecting people with a learning disability elsewhere in the UK and the Republic of Ireland confirms that robust implementation arrangements are essential if the changes are to succeed.

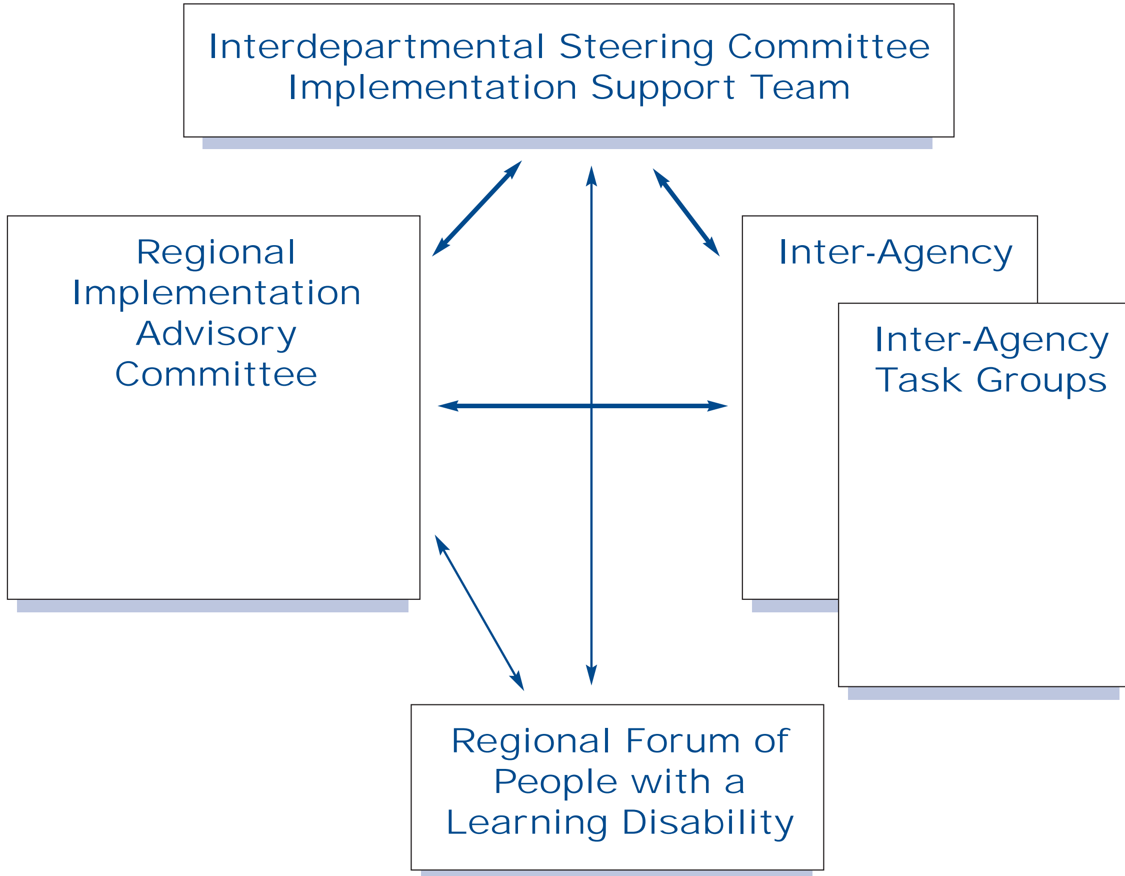
12.22 The proposals that follow acknowledge that, in the context of the RPA, there is a need for us to highlight principles that should underpin any future restructuring to ensure that the needs of people with a learning disability and indeed other minority groups are addressed. These proposals are, therefore, offered to inform the ongoing work of the RPA unless accompanied by a specific recommendation that we believe should be enacted regardless of the nature of restructuring that will follow the outcomes of the RPA.

Action Required

Review Implementation Arrangements

12.23 The Equal Lives Review has highlighted a need for a major development of services and some reconfiguration of existing provision. In Figure 12 we outline the structures that we believe are required to ensure that this happens effectively and in accordance with the core values of the Equal Lives Review. This model aims to facilitate the processes of consultation, co-ordination and implementation, which arguably are missing in existing structures.

Figure 12: Proposed Implementation Arrangements



12.24 Particular efforts need to be made to promote the meaningful involvement of people with a learning disability in future arrangements. At present the number of organisations doing this is small, as is the development of advocacy in its various forms. There is no regional forum for people with a learning disability in Northern Ireland and very limited public money is spent on the promotion of advocacy and in supporting people with a learning disability to participate meaningfully in planning groups and committees. Moreover there is a need to promote advocacy at a more local level as well, so that people with a learning disability have increased opportunities to access mainstream as well as specialist services.

12.25 The involvement of carers is arguably further advanced in service planning, but this is variable across Northern Ireland. When it has occurred, the outcomes are broadly positive, which should encourage provider and commissioning agencies to expand their engagement with carers. This can be achieved by ensuring they are represented alongside professionals in committees and working groups. It is vital though that these representatives are assisted in ensuring the broader population of carers are informed of these processes and that mechanisms are in place to reflect their views.

12.26 There are a number of clear messages to emerge from the Equal Lives Review about how joint working can be promoted. These are already operational in Northern Ireland, albeit in contexts other than learning disability, but they do have the support of the agencies consulted as part of the Equal Lives Review. We anticipate that there is a need for 2 levels of joint working: inter-departmental and local inter-agency. This simple structure should suffice given the size of Northern Ireland and the small number of people with a learning disability.

12.27 Moreover it is important that these structures incorporate the 3 processes of consultation, co-ordination and implementation.

12.28 There is widespread agreement on the benefits of having an Interdepartmental[10] group to take forward the recommendations emerging from the Equal Lives Review. Membership of this Interdepartmental Steering Committee would comprise representatives from each relevant Government Department. The Minister should chair the meetings of the Interdepartmental Steering Committee on 4 occasions per annum. **(Recommendation 70)**

12.29 The Interdepartmental Steering Committee would also have responsibility for advising Departments on the commissioning of both existing and new learning disability services. In doing so they would be informed by representatives of users, carers, local Inter-Agency Task Groups and service providers who would comprise a Regional Implementation Advisory Committee. The Regional Implementation Advisory Committee would provide an opportunity to identify common issues across Northern Ireland, as well as sharing in good practice initiatives. It would monitor the work of the local Inter-Agency Task Groups as well as provide a forum for debate on controversial issues and on the development of new service initiatives envisaged by the Equal Lives Review. The work of the Regional Implementation Advisory Committee should be supported by a Development Fund to stimulate change and innovation in the implementation of the Equal Lives Review.

12.30 Both committees would need to be serviced by a small team of full-time staff - an Implementation Support Team - preferably to include staff seconded from agencies outside of the Civil Service, who have particular experience and expertise in assessing and meeting the needs of people with a learning disability and who can provide credible advice and guidance to local groups in the production and implementation of local plans and change initiatives. **(Recommendation 71)**

12.31 There may also be some value in designating one person with lead responsibility for the operations of this team, who is accountable (has direct access) to the Minister chairing the Interdepartmental Steering Committee.

12.32 The Regional Implementation Steering Committee and Implementation Support Team would liaise closely with a Regional Forum for People with a Learning Disability. They would produce accessible annual reports and meet the Forum at least annually to plan the programme of work for the coming year. **(Recommendation 72)**

12.33 The Implementation Support Team could be time-limited appointments for a 5-year period in order to establish the new structures and to help them to bed down. The ultimate goal would be for these new arrangements to become embedded into mainstream structures, although the need for an interdepartmental group would probably continue as would the Regional Forum for people with a learning disability.

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[10] At a minimum this should consist of DHSSPS, DENI, DEL, DSD, OFMDFM and Department of Culture, Arts and Leisure (DCAL).

12.34 These joint working arrangements should be replicated at a local level. Inter-Agency Task Groups should be set up at an agreed local level. Initially we propose that 4 Task Groups be established possibly based on existing Health and Social Services Board areas, which may sub-divide for particular purposes such as supporting the production of Day Care Development Plans. **(Recommendation 73)**

12.35 The Inter-Agency Task Groups' remit would be to review existing provision in their area and to plan the range of services available to people with a learning disability and their families within the context of the Equal Lives values and objectives. These groups could cover the full age range of people with a learning disability, although they will need to liaise with the 4 area inter-agency groups that are already operational for children's services if they continue in operation.

12.36 The Inter-Agency Task Groups should have representatives of existing statutory, voluntary and private agencies and would include Health and Personal Social Services, Education and Library Boards, Further Education Colleges, Department for Employment and Learning, Northern Ireland Housing Executive, Community Education and Leisure Services of District Councils, along with user and carer representatives and their advocates. Initially they would be convened and supported by Health and Social Services Boards, but within 1 year, the groups will have identified the means for achieving co-ownership.

12.37 The groups would be required by the Interdepartmental Steering Committee to prepare Joint Learning Disability Service Plans along the lines of those required in Great Britain and the Republic of Ireland. These will form the basis of funding bids and the commissioning of local services. They would also inform the form, role and location of specialist learning disability provision and access to other special needs services.

12.38 The proposed Implementation Support Team and the Regional Implementation Advisory Committee would have a major role to play in establishing and supporting these groups.

North-South and East-West Relationships

12.39 This proposed structure would also facilitate greater linkages with learning disability interests elsewhere in these islands; notably between the Governmental Interdepartmental Groups and between the different national fora for people with a learning disability.

12.40 Indeed it could be argued that the lack of these structures within Northern Ireland has contributed to the relative isolation of learning disability services here from elsewhere in these islands.

Specific Focus on Learning Disability

12.41 There has been a long history in Northern Ireland of ring-fencing public funding to services specifically for people with a learning disability. Ring-fenced funding can be justified on various grounds. The needs of this population are complex and life-long even though the numbers are relatively small. Moreover they are distinctive when taken as a whole especially from other disabling conditions and mental health needs. Services are still under-developed and development monies are more easily targeted if they have a specific focus. Major changes in policy are more easily implemented within a distinct domain.

12.42 We recommend that ring-fenced funding continues within the Department of Health, Social Services and Public Safety and Department of Education, even though the way in which these

monies are spent could change radically in the coming years as they have done in the past. This also necessitates having transparent accountability systems in place to demonstrate that the monies are spent on the purposes for which they were given and the outcomes achieved.

12.43 There is also logic in extending this concept to other funding departments, especially in the light of Section 75 duties placed upon public bodies. At a minimum this would demonstrate that these citizens are getting at least their fair share, but also make more transparent the contribution they are making to positively responding to the particular needs of these citizens. **(Recommendation 74)**

12.44 This is not to imply that these funding streams should be managed separately. Indeed the evidence suggests that local services can be more efficiently delivered if they are jointly commissioned using pooled funding, as is the case in Great Britain. This is starting to happen with the new Supporting People arrangements in Northern Ireland and this model could be extended to other aspects of people's lives such as transition planning, training and employment services, and leisure initiatives.

12.45 In view of the negative impact that the absence of robust implementation structures had on the success of the 1995 Review, it is the view of the Learning Disability Working Committee that work on implementing each of the following recommendations has to be commenced immediately if the objectives of the Equal Lives Review are to be achieved.

12.46 Objective 12	**Recommendations**
Recommendation 70	An Interdepartmental Steering Committee should be established by January 2006 to promote joint working and oversee the implementation of the Equal Lives Review recommendations.
Recommendation 71	An Implementation Support Team should be established by November 2005 to support work being undertaken to implement the Equal Lives Review.
Recommendation 72	A Regional Forum for People with a Learning Disability should be established by January 2006.
Recommendation 73	Inter-Agency Task Groups should be established by June 2006 to drive change at a local level and produce local plans in accordance with the Equal Lives values and objectives.
Recommendation 74	Ring-fenced funding continues within Department of Health, Social Services and Public Safety and Department of Education and the potential is explored for extending this to other departments to underpin the implementation of the Equal Lives Review.

Prioritisation of Other Recommendations

12.47 This report has highlighted that people with a learning disability in Northern Ireland do not enjoy equality of opportunity and that they are often excluded from the opportunities that other citizens enjoy. As has been shown some progress has been made but in order to resolve fully the difficulties outlined there will be a need for a major and co-ordinated development programme over the next 15 years.

12.48 The Equal Lives report has made 74 recommendations to take forward its vision for the future. Full implementation of these recommendations will cost approximately £175 million additional

over the change period. (171) It is recognised that these large sums of money are not immediately available and accordingly this section of the Equal Lives report will set out some immediate and medium -term objectives. While change will be costly and will take time there must be an immediate and ongoing commitment to making financial resources available if the change process is to be real. While the report recognises the need to reconfigure and better target existing resources, the level of change and modernization envisaged will not happen without this commitment.

12.49 To maximise the impact of change it will be essential to progress each of the report objectives in tandem. While some recommendations will not require funding they will require considerable investment of planning time from staff and will also have to be incrementally introduced.

12.50 It is now intended to order each of the Equal Lives Review recommendations placing a priority rating against them. Priority ratings agreed were as follows:

i. Pre-Implementation Support

ii. Immediate Planning - to be started forthwith

iii. Immediate Resourcing - 2006 - 2012

iv. Medium-term Resourcing - 2012 - 2020.

Principles Guiding Prioritisation Process

12.51 Recommendations will be prioritised if they:

i. provide support for family carers

ii. maximise HPSS and other public funding streams e.g. Supporting People

iii. show that they can prevent inappropriate hospital admissions

iv. release money from current services which are considered to be no longer fit for purpose

v. promote effective access to all services across Northern Ireland

vi. maintain and build upon existing interagency collaborations.

12.52 It is clearly acknowledged that the recommendations are not mutually exclusive and therefore planning for delivery of all the recommendations must commence immediately. The Learning Disability Working Committee accept that implementation of all the recommendations by necessity will be incremental in nature.

Pre-Implementation Support

- Appointment of Implementation Support Team by November 2005
- Establishment of Interdepartmental Steering Committee by January 2006
- Establishment of Regional Forum for People with a Learning Disability by January 2006
- Establishment of Inter-Agency Task Groups by June 2006

- Agreement that ring-fenced funding continues within Department of Health, Social Services and Public Safety and Department of Education and the potential explored for extending this to other departments. **(Recommendations 71,70,72,73,74)**

Immediate Planning

12.53 Those recommendations that fit into Immediate Planning are as follows:

- Development of joint planning and bidding mechanisms by the Departments of Education and Health, Social Services and Public Safety for services for children and young people with a learning disability by January 2007
- Development of a regional strategy for early intervention by the Departments of Education and Health, Social Services and Public Safety by June 2007
- Promotion of Supported Employment Services by Department for Employment and Learning
- Clear assessments of future housing needs for people with a learning disability completed and agreement reached on a 3 year funding strategy to resource housing and support arrangements by Department for Social Development and Department of Health, Social Services and Public Safety
- Detailed knowledge accumulated and disseminated on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community by housing planners
- Development of a strategy to increase opportunities for people with a learning disability to own their own homes by the Department for Social Development
- Revised procedures and criteria for applying for Disabled Facilities Grants
- Mechanisms established to ensure the increased use of floating support by the Department for Social Development and the NI Housing Executive
- Review completed of the Motability Scheme
- Regional Framework for Health Improvement of people with a learning disability produced by the Department of Health, Social Services and Public Safety
- Equipment and wheelchair provision budgets increased to meet significant additional demand
- Health Improvement Plans reviewed by HSS Boards
- Specific reference to the needs of and impact upon people with a learning disability within all generic health strategies, published at Department, HSS Board and Trust level
- Awareness raising and improved training on learning disability in place amongst agencies funded by the Department of Education, Department for Social Development, and Department for Employment and Learning
- Commissioned programme of research and service evaluation established in collaboration with the R & D Office

- Identification of the need for permanent placements for children and young people with a learning disability and production of strategies by Health and Social Services Boards to address them by March 2006
- Costed Development Plans for day centres produced by each Health and Social Services Trust by March 2007

(Recommendations 9, 8, 18, 23, 32, 33, 34, 35, 36, 37, 38, 44, 68, 60, 4, 17)

Immediate Resourcing

12.54 The following recommendations have been agreed as falling within this area:

- Opportunity to have a PCP which incorporates Heath Action Planning is in place for all persons with a learning disability who are in contact with HPSS agencies by January 2009
- Arrangements in place from January 2006 to prioritise person centred planning concerned with:
  - development and delivery of Family Support Plans
  - development and delivery of Early Intervention Plans
  - Transitions Plans
  - Futures Plans
- Establishment of independent advocacy services
- Establishment of Family Support Fund and extension of range and volume of support available to families
- Development of community based assessment and treatment services for children and young people with severe challenging behaviours and/or mental health problems
- Mechanisms in place to ensure that information on services, benefits and other sources of help is automatically supplied to families at diagnosis/birth of their child
- Commissioning requirement in place detailing that providers of any services evidence how information will be provided in an accessible format appropriate to the needs of the individuals being supported
- Establishment of Transition Services for all young people who have a statement
- Personal relationships education available in all services for people with a learning disability with training offered to staff and support to parents
- Development of community based assessment and treatment services for men and women with a learning disability who have specific mental health needs and/or challenging behaviours
- Production of regional guidelines on the management of challenging behaviours within services by December 2007 by the Department of Health, Social Services and Public Safety in partnership with service providers
- All people with a learning disability living in a hospital relocated to the community by June 2011

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- Funds provided to ensure that on average 80 people are resettled per annum over the 5-year period from 2006 to 2011
- Resourced and implemented arrangements in place to provide emergency support and accommodation for persons with a learning disability by January 2008
- Mechanisms in place to ensure that all new housing with support provision for people with a learning disability is for no more than 5 individuals with a learning disability within the same household
- Additional 100 supported living places per annum developed for the next 15 years to enable people to move from family care without having to be placed in inappropriate settings
- Clear and formalised arrangements set in place by each General Practice facility and Acute General hospital to facilitate equity of access to services for people with a learning disability
- Link person identified within Community Learning Disability Teams to work with each General Practice
- Establishment by General Practices of robust medical records and health data about people with a learning disability on their practice registers
- Strategic plan produced by the Department of Health, Social Services and Public Safety and HSS Boards to address current deficiencies in services and future service provision for older people with a learning disability and their families
- Development of arrangements to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services
- £300,000 per annum ear-marked by the Department of Health, Social Services and Public Safety between 2006 and 2009 to increase uptake of Direct Payments
- Policy initiative from OFMDFM in place to reduce the likelihood of bullying experienced by people with a learning disability
- Agreement reached by HSS Boards and Trusts on the role, composition, configuration and functions of Community Learning Disability Teams by December 2006
- Production of a regional workforce development strategy by April 2007
- Establishment of a Leadership Innovation Fund by the Interdepartmental Steering Group
- Arrangements set in place for all new Direct Support Workers in learning disability services to meet the Northern Ireland Social Care Council standards on induction and foundation evidenced by completion of assessment to LDAF standards by January 2007
- Mechanisms set in place for young people with a learning disability to be equipped with skills to use public transport where possible through appropriately targeted independent travel training programmes by Department of Education and Department of Health, Social Services and Public Safety
- Arrangements set in place to ensure that the regional transport strategy ensures that people with a learning disability can access local transport by the Department for Regional Development
- Arrangements set in place to ensure that access to local leisure and recreational services is promoted and co-ordinated led by District Councils

- Clear statements produced on targeting provision for play, sports, arts and leisure opportunities for children and young people with a learning disability by the Department of Culture, Arts and Leisure, Arts Council, Sports Council, Education and Library Boards, Youth Council and District Councils
- Review completed of the effectiveness of programmes of learning for children and young people with special educational needs in relation to issues of personal safety and personal relationships by the Department of Education and Education and Library Boards
- Arrangements made for mainstreaming lessons learned from the pilot projects on inclusion by the Youth Service
- Arrangements made for monitoring the effectiveness of all authorities in meeting their inclusion objectives for children and young people with a learning disability by the Commissioner for Children and Young People
- Revised funding arrangements set in place by Department for Employment and Learning so that FE Colleges are able to increase significantly the number of full-time places available to students who have a Statement of Severe Learning Disability, to undertake a 3 year accredited course
- Review completed of the use of employment, skills and disability programmes by people with a learning disability by Department for Employment and Learning
- Review completed by public sector employers of recruitment practices to open up employment opportunities for men and women with a learning disability

(Recommendations 54, 40, 56, 1, 2, 5, 57, 6, 7, 14, 25, 27, 47, 28, 29, 31, 41, 42, 43, 50, 52, 53, 55, 26, 61, 64, 65, 21, 22, 24, 10, 12, 13, 11, 15, 20, 19)

Medium term resourcing

12.55 The recommendations that fall into this area are:

- Establishment of multi-agency centres, which provide a clear pathway to help for parents of children with a learning disability by Health and Social Services Trusts in partnership with Education and Library Boards and the community and voluntary sector
- Revised funding arrangements set in place by the Department for Employment and Learning to enable more part-time places to be created in FE for older students
- Arrangements secured for all accommodation for people with a learning disability under 60 years of age to be for no more than 5 people by January 2013
- Resources made available from within primary care to appoint a Health Facilitator for each 110-120,000 population by December 2009
- Arrangements secured for the majority of referrals, because of mental health problems, of people with high levels of adaptive functioning/mild learning disability to access, with support from dedicated learning disability services if required, mainstream mental health services by December 2010
- Arrangements set in place by the Health and Personal Social Services Regulation and Improvement Authority to measure delivery of positive personal outcomes by services

- Arrangements set in place for all generically trained health and social services professionals to receive awareness raising training relating to people with learning disability during their pre-qualification education

(Recommendations 3, 16, 30, 39, 46, 59, 66)

Conclusion

12.56 We have set out an ambitious programme for change in the Equal Lives Review, which we believe sets out a clear policy direction for people with a learning disability. The Equal Lives values and objectives should form the benchmarks by which future policy and service developments are measured.

12.57 The objectives and recommendations that we have made cannot be met within current resources and organisational systems. There is a need to change both the use of existing resources and to secure additional funding if the Equal Lives objectives are to be achieved. In addition all those who work with people with a learning disability in both specialist and mainstream settings will need to review how they work, and where necessary, to develop new styles of working that are based on ensuring that the voices of people with a learning disability and their family carers have a greater influence and improved approaches to working in partnership.

12.58 The enthusiasm and dedication that has been evident from the many hundreds of people who have participated in the Equal Lives Review demonstrates that there is a strong commitment to improve the quality of lives of people with a learning disability and their families. The challenge now will be to ensure that the aspirations contained in this Review are translated into action across Northern Ireland in a way that ensures that people with a learning disability really can experience equal lives in the future.

OBJECTIVES AND RECOMMENDATIONS

OBJECTIVE 1 **To ensure that families are supported to enjoy seeing their children develop in an environment that recognises and values their uniqueness as well as their contributions to society.**

Recommendation 1 Each Trust should have established arrangements for the development of Family Support Plans, which must be delivered through a co-ordinated strategy that monitors outcomes and identifies unmet needs.

Recommendation 2 Over the next 5 years providers should be resourced to extend the volume and range of emotional and practical help to support families. Their proposals should be considered within the context of Children's Services Planning and be aimed at assisting the maximum number of families. An ear-marked fund of up to £2 million recurrent each year for 5 years should be made available to fund proposals that best meet the Equal Lives values and objectives. The outcomes from this Family Support Fund should be carefully evaluated and used to inform future commissioning decisions in support of family carers.

Recommendation 3 Health and Social Services Trusts in partnership with Education and Library Boards and the community and voluntary sector should establish multi-agency centres, which provide a clear pathway to help for parents of children with a learning disability.

Recommendation 4 By March 2006 each Health and Social Services Board should identify the need for permanent placements for children and young people with a learning disability and produce strategies to address them. While the focus should be on innovative means of developing and supporting specialist fostering, it may be necessary to commission intensive care provision for small numbers of children who can not be placed in family settings.

Recommendation 5 Community based assessment and treatment services should be developed for children and young people with severe challenging behaviours and/or mental health problems. The service should encompass a small short-stay residential provision and community behavioural support services that provide outreach to families, schools and community based agencies.

OBJECTIVE 2	**To ensure that children and young people with a learning disability get the best possible start in life and access opportunities that are available to others of their age.**
Recommendation 6	Each HSS Trust should set in place mechanisms to ensure that information on services and how to access them, benefits and support groups and other sources of help is automatically supplied to families at diagnosis/birth of their child.
Recommendation 7	Each HSS Trust should establish arrangements for the development of an Early Intervention Plan, which includes details of a key worker, for each child with a learning disability at his/her birth/diagnosis.
Recommendation 8	By June 2007 the Departments of Education and Health, Social Services and Public Safety should develop a regional strategy for early intervention.
Recommendation 9	By January 2007 joint planning and bidding mechanisms should be developed by the Departments of Education and Health, Social Services and Public Safety for services for children and young people with a learning disability.
Recommendation 10	The Department of Culture, Arts and Leisure, Arts Council, Sports Council, Education and Library Boards, Youth Council and District Councils should produce clear statements outlining how they are targeting provision for play, sports, arts and leisure opportunities for children and young people with a learning disability.
Recommendation 11	The Youth Service should mainstream the lessons learned from the pilot projects on inclusion and provide the support to ensure that young people with a learning disability get involved in decision-making processes in youth and other civic activities.
Recommendation 12	The Department of Education and Education and Library Boards should review the effectiveness of the programmes of learning for children and young people with special educational needs in relation to issues of personal safety and personal relationships. This should be supported with awareness programmes for parents and for others involved with children and young people.
Recommendation 13	The Commissioner for Children and Young People should be requested to monitor the effectiveness of all authorities in meeting their inclusion objectives. To facilitate this, the relevant departments should produce an Annual Report on the implementation of action plans.

OBJECTIVE 3	**To ensure that the move into adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.**
OBJECTIVE 4	**To enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.**
Recommendation 14	That Transition services are established for all young people who have a statement to support parents and young people to develop a transitions plan and ensure

recommendations are carried through. Careers advice restructuring should support this proposal and provide an ongoing support to 22 years.

Recommendation 15 The Department for Employment and Learning will ensure that revised funding arrangements are in place so that FE Colleges are able to increase significantly the number of full-time places available to students who have a Statement of Severe Learning Disability, to undertake a 3 year accredited course.

Recommendation 16 In order to afford lifelong learning opportunities the Department for Employment and Learning should ensure that revised funding arrangements will enable more part-time places to be created in FE for older students. Access to FE by people with a learning disability should be monitored and we welcome the intention of the Department for Employment and Learning to do so.

Recommendation 17 By March 2007 each Health and Social Services Trust should have produced a costed Development Plan for each day centre they provide or commission.

Recommendation 18 The Department for Employment and Learning, in consultation with other relevant Departments, should promote the introduction of dedicated Supported Employment services across Northern Ireland.

Recommendation 19 Public sector employers should review their recruitment practices, as required by equality legislation to open up employment opportunities for men and women with a learning disability.

Recommendation 20 Department for Employment and Learning should review the use of its employment, skills and disability programmes by people with a learning disability to remove structural barriers to participation and identify how they could promote better outcomes.

Recommendation 21 Department of Education and Department of Health, Social Services and Public Safety should ensure that young people with a learning disability are equipped with skills to use public transport where possible through appropriately targeted independent travel training programmes. Where possible these should become part of the curriculum and continuing education plans for young adults.

Recommendation 22 Department for Regional Development should ensure that the regional transport strategy ensures that people with a learning disability can access local transport.

Recommendation 23 The Motability Scheme requires reviewing to ensure an appropriate, affordable solution for those who need to travel in their wheelchair along with other family members.

Recommendation 24 Access to local leisure and recreational services should be promoted and co-ordinated led by District Councils.

Recommendation 25 Personal relationships education should be available in all services for people with a learning disability with training offered to staff and support to parents.

Recommendation 26 OFMDFM should co-ordinate a policy initiative to reduce the likelihood of bullying experienced by people with a learning disability, both in specialist settings and the wider community, notably schools. The development of anti-bullying strategies would be a positive first step.

OBJECTIVE 5	**To ensure that all men and women with a learning disability have their home, in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need.**
Recommendation 27	By June 2011, all people with a learning disability living in a hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011.
Recommendation 28	With immediate effect, all commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability. Hospitals will not provide this service from 1st January 2008.
OBJECTIVE 6	**To ensure that an extended range of housing options is developed for men and women with a learning disability.**
Recommendation 29	With immediate effect, all new housing with support provision for people with a learning disability should be for no more than 5 individuals with a learning disability – preferably less - within the same household.
Recommendation 30	By 1 January 2013 all accommodation for people with a learning disability under 60 years of age should be for no more than 5 people.
Recommendation 31	An additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings.
Recommendation 32	Department for Social Development and Department of Health, Social Services and Public Safety should develop clear assessments of future housing needs for people with a learning disability including those who currently live with their families and agree a continuous 3 year funding strategy to resource housing and support arrangements.
Recommendation 33	Housing planners should accumulate and disseminate detailed knowledge on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community.
Recommendation 34	A strategy should be developed by the Department for Social Development to increase opportunities for people with a learning disability to own their own homes where this is a safe and appropriate option.
Recommendation 35	Procedures and criteria for applying for Disabled Facilities Grants should be revised to tackle inconsistencies, reduce bureaucracy and reduce the hidden costs to carers.
Recommendation 36	Department for Social Development and the NI Housing Executive should establish mechanisms to ensure the increased use of floating support linked to an individual's needs rather than overly relying on accommodation based schemes.

OBJECTIVE 7 **To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.**

Recommendation 37 The Department of Health, Social Services and Public Safety should produce a Regional Framework for Health Improvement of people with a learning disability providing clear direction including targets and timescales. Each HSS Board should review their Health Improvement Plans to ensure that they translate the regional framework at a local level to support improved health outcomes for children, men and women with a learning disability.

Recommendation 38 All generic health strategies, published at Department, Board and Trust level, should make specific reference to the needs of and impact upon people with a learning disability.

Recommendation 39 By December 2009 resources should be made available from within primary care to appoint within primary care a Health Facilitator for each 110- 120,000 population.

Recommendation 40 By December 2008 a Health Action Plan will be developed, as a part of the Person Centred Planning process, which is to be set in place for all those with a learning disability in contact with health and social services agencies.

Recommendation 41 With immediate effect each general practice facility and acute general hospital within Northern Ireland should have clear and formalised arrangements in place to facilitate equity of access to services for people with a learning disability.

Recommendation 42 Each general practice should establish robust medical records and health data about people with a learning disability on their practice register.

Recommendation 43 With immediate effect each general practice should have an identified link person within their local Community Learning Disability Team with whom they work collaboratively to facilitate better access for people with learning disability within primary care settings.

Recommendation 44 Equipment and wheelchair provision budgets should be increased to meet significant additional demand. This will require an increase of the proportion available to people with a learning disability.

Recommendation 45 As a matter of urgency the Department of Health, Social Services and Public Safety should consult with all 4 Health and Social Services Boards about their present and future plans for specialist assessment and treatment services for men and women with a severe learning disability with a view to greater sharing of existing and planned resources and the development of new forms of community based services.

Recommendation 46 By the end of the Review period people with high levels of adaptive functioning/mild learning disability who require therapeutic intervention as a result of mental health problems should be able to access mainstream mental health services. Support from dedicated learning disability services should be available if required.

Recommendation 47 Community based assessment and treatment services should be developed on an incremental basis to provide assessment and treatment of men and women with a learning disability who have specific mental health needs and/or challenging behaviours. The community based assessment and treatment services will

encompass behaviour support expertise that will provide outreach to individuals, families and community services and short-term intensive treatment to those within a residential facility which may be approved to treat people under mental health legislation.

Recommendation 48 As a consequence of the other mechanisms being recommended the Department of Health, Social Services and Public Safety should establish a regional plan that sets targets for the reallocation of existing resources and the securing of additional resources to enable the community services to be established.

Recommendation 49 Some people with a learning disability are at increased risk of recurrent severe challenging behaviours and/or mental illness. Health and Social Services Trusts should ensure that protocols are agreed so that a proactive approach can be taken to systematic intervention should there be signs of recurrence.

Recommendation 50 By December 2006 the Department of Health, Social Services and Public Safety should produce in partnership with service providers regional guidelines on the management of challenging behaviours within services.

OBJECTIVE 8 **To ensure that men and women with a learning disability are supported to age well in their neighbourhoods.**

Recommendation 51 The Department of Health, Social Services and Public Safety should review funding allocations to ensure that the projected increase in numbers of older people with a learning disability is reflected in the allocations to the learning disability programme. This shift will take cognisance of the fact that people with a learning disability may experience the effects of ageing at an earlier age.

Recommendation 52 The Department of Health, Social Services and Public Safety and Health and Social Services Boards should produce a strategic plan to address current deficiencies in services and future service provision for older people with a learning disability and their families.

Recommendation 53 Arrangements should be developed to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services. This will include mechanisms to provide a skills boost between dementia services and dedicated learning disability services.

OBJECTIVE 9 **To enable people with a learning disability to have as much control as possible through developing person centred approaches in services and ensuring wider access to advocacy and Direct Payments.**

Recommendation 54 By 1 January 2009 the opportunity to have a PCP should be in place for all persons with a learning disability who are in contact with HPSS agencies. From 2006 priority should be given to:

- developing Family Support Plans based on person centred principles that cross disciplines and agencies
- developing an Early Intervention Plan for children at the point of diagnosis

- ensuring that all young people with a learning disability have an effective Transitions Plan based on PCP principles in place from 14 years of age
- ensuring that all persons living with a sole family carer and/or those aged over 50 years have been offered the opportunity to have a Futures Plan agreed based on PCP principles. In addition a plan for meeting the needs of carers should be prepared. This invitation should be re-issued to family carers and the person they care for on a regular basis and no less than every 3 years.

Recommendation 55 The use of Direct Payments should be widely promoted and additional revenue monies of up to £300,000 per annum over the next 3 years ear-marked by the Department of Health, Social Services and Public Safety for the development of increased uptake of Direct Payments.

Recommendation 56 An independent advocacy service should be in place for each area serving a population of 100,000 – 120,000. A Regional Forum for People with a Learning Disability should be established with representatives drawn from local advocacy services. Both initiatives should be grant-aided through Office of the First Minister and Deputy First Minister (OFMDFM), so that they can cover all services and not just those provided by the Department of Health, Social Services and Public Safety.

Recommendation 57 A commissioning requirement of any service that includes people with a learning disability must be the evidence from providers across departments and agencies of how information will be provided in an accessible format appropriate to the needs of the individuals being supported.

Recommendation 58 Health and Social Services Boards should be required, within a regionally agreed framework, to establish mechanisms in partnership with their service providers for monitoring the degree to which Person Centred Planning is appropriately implemented and delivers on positive personal outcomes for individuals with a learning disability.

Recommendation 59 The Health and Personal Social Services Regulation and Improvement Authority should include measurement in the standards against which learning disability services are inspected of the processes used in service delivery to secure positive personal outcomes.

Recommendation 60 A commissioned programme of research and service evaluation to support the implementation of the Equal Lives Review should be established in collaboration with the Research and Development Office.

OBJECTIVE 10 **To ensure that health and social services staff are confident and competent in working with people with a learning disability.**

OBJECTIVE 11 **To ensure that staff in other settings develop their understanding and awareness of learning disability issues and the implications for their services.**

Recommendation 61 HSS Boards and Trusts should agree the role, composition, configuration and functions of Community Learning Disability Teams in light of the proposals in the Equal Lives Review by December 2006.

Recommendation 62 By April 2007 a regional workforce development strategy should be produced in partnership with employers from the independent and statutory sectors that

identifies the workforce implications of the Equal Lives Review and sets out a clear strategy for addressing them.

Recommendation 63 All service providers who receive funding from the Department of Health, Social Services and Public Safety Training Support Programme should be required to evidence how people with a learning disability have been involved in the design, delivery and/or evaluation of training programmes provided on learning disability specific issues.

Recommendation 64 Service providers who receive Training Support Programme funding should be required to demonstrate that arrangements are in place to open access to the training provision to family carers, volunteers and people with a learning disability where possible.

Recommendation 65 Funding should be allocated to the Review Implementation Steering Committee for a Leadership Innovation Fund to which all agencies and professions might apply, designed to promote interagency initiatives that develop the leadership and managerial capacity in organisations to deliver on the new vision in the Equal Lives Review.

Recommendation 66 From 1 January 2007 all new Direct Support Workers in learning disability services should be required to meet the Northern Ireland Social Care Council standards on induction and foundation within the first year of appointment. It is anticipated that this will normally be evidenced by completion of assessment to LDAF standards and be subject to inspection by the Health and Personal Social Services Regulation and Improvement Authority.

Recommendation 67 All generically trained health and social services professionals (medicine, Allied Health Professionals, nursing, social work) should receive at a minimum awareness raising training on learning disability.

Recommendation 68 A publicity strategy should be developed and implemented that promotes the positive factors of working with people with a learning disability and encourages greater participation in volunteering and community service.

Recommendation 69 Department of Education, Department for Social Development and Department for Employment and Learning should develop measures to encourage awareness raising and improved training on learning disability amongst agencies that they fund to support equity of access by people with a learning disability to their provision. These measures should include the development of joint training opportunities with health and social services agencies.

OBJECTIVE 12 **To promote improved joint working across sectors and settings in order to ensure that the quality of lives of people with a learning disability are improved and that the Equal Lives values and objectives are achieved.**

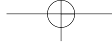
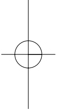
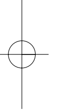
Recommendation 70 An Interdepartmental Steering Committee should be established by January 2006 to promote joint working and oversee the implementation of the Equal Lives Review recommendations.

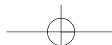
Recommendation 71 An Implementation Support Team should be established by November 2005 to support work being undertaken to implement the Equal Lives Review.

Recommendation 72 A Regional Forum for People with a Learning Disability should be established by January 2006.

Recommendation 73 Inter-Agency Task Groups should be established by April 2006 to drive change at a local level and produce local plans in accordance with the Equal Lives values and objectives.

Recommendation 74 Ring-fenced funding continues within Department of Health, Social Services and Public Safety and Department of Education and the potential is explored for extending this to other departments to underpin the implementation of the Equal Lives Review.



REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY (N. IRELAND)

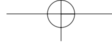
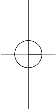
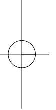
TERMS OF REFERENCE

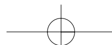
1. To carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986.

2. To take into account:

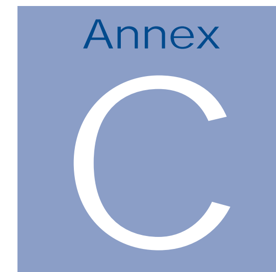
   - the need to recognise, preserve, promote and enhance the personal dignity of people with mental health needs or a learning disability and their carers;
   - the need to promote positive mental health in society;
   - relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity;
   - evidence - based best practice developments in assessment, treatment and care regionally, nationally and internationally;
   - the need for collaborative working among all relevant stakeholders both within and outside the health and personal social services sector;
   - the need for comprehensive assessment, treatment and care for people with a mental health need or a learning disability who have offended or are at risk of offending; and
   - issues relating to incapacity.

3. To make recommendations regarding future policy, strategy, service priorities and legislation, to reflect the needs of users and carers.



EXPERT WORKING COMMITTEES



FIRST WAVE

- **Social Justice and Citizenship:**

  Convenor: Bill Halliday, Equality Commission for Northern Ireland

  To consider relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity; and how best to promote the social inclusion of people with a mental health problem or learning disability and their carers, taking account of employment, housing, education, social security, personal finance and other social issues.

- **Legal Issues:**

  Convenor: Master Brian Hall, Office of Care and Protection

  To include a review of the Mental Health (N Ireland) Order 1986; the Mental Health Commission; the Mental Health Review Tribunal; the procedures for the transfer of patients to and from N Ireland; issues relating to people who are not able to look after their own property and affairs as a result of a mental health problem or learning disability; and issues relating to people with a mental health problem or a learning disability who are in contact with the criminal justice system.

- **Learning Disability:**

  Convenor: Siobhan Bogues, Manager, ARC (NI)

  To review policy and services for children and adults with learning disability.

- **Adult Mental Health:**

  Convenor: Professor Roy McClelland, Deputy Chair of the Review

  To include consideration of primary care provision, acute services, rehabilitation and community care for adults with a mental health problem.

SECOND WAVE

- **Mental Health Promotion:**

  Convenor: Professor Alan Ferguson, Chief Executive, NI Association for Mental Health

  To include consideration of how best to promote positive mental health in society, with particular reference to the impact of the recently-published Mental Health Promotion Strategy, and how best to meet the needs of people at risk of suicide.

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- **Child and Adolescent Mental Health:**

  Convenor: Moira Davren, Royal College of Nursing

  To include consideration of primary care provision, acute services, rehabilitation and community care for children and adolescents.

- **Dementia and Mental Health Issues of Older People:**

  Convenor: Nevin Ringland, Chief Executive, PRAXIS Care Group

  To include consideration of primary care provision, acute services, rehabilitation and community care for older people with dementia or a mental health problem.

- **Alcohol and Substance Misuse:**

  Convenor: Dr Diana Patterson, Shaftesbury Square Hospital

  To include consideration of the links between mental health and alcohol and substance misuse, and the provision of the most appropriate assessment, treatment and care for those involved.

- **Forensic Services:**

  Convenor: Dr Fred Browne, Chair, Northern Ireland Division, Royal College of Psychiatrists

  To consider the assessment, care and treatment of people with a categorical mental illness, severe personality disorder or who engage in dangerous or persistently challenging, aggressive behaviour, and who may be in contact with the criminal justice system.

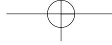
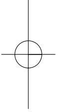
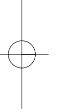
- **Needs and Resources:**

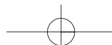
  Convenor: Glenn Houston, Chief Executive, Craigavon and Banbridge Health and Social Services Trust

  To support other working committees in assessing the financial implications of their recommendations.

THE REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY (NORTHERN IRELAND)

COMMITTEE STRUCTURE



GLOSSARY

Annex D

Allied Health Professionals	These include physiotherapists, speech and language therapists, occupational therapists, podiatrists, radiographers, and dieticians
Challenging Behaviour	When someone is behaving in a way that might cause harm to themselves or to other people. Services are challenged to find a way of managing the behaviour so the chance of harm is reduced
Citizenship	People with a learning disability are treated as equal citizens
Domiciliary Support	Support provided to a person in their own home
Empowerment	People with a learning disability are supported to take a full part in decisions affecting their lives
Expert Working Committee	A group including carers, men and women with a learning disability and staff who were asked by the Review to find out what needs to be done to make things better for people in the future
Forensic Issues	Issues for people with a learning disability who commit offences whether or not they come in contact with the criminal justice system or who are at risk of offending
Inter-agency	Links between organisations that have responsibility for either the commissioning and/or the delivery of services
Intra-agency	Subsections within the one agency working together more closely
Inter-departmental[1]	Government departments working together
Inter-disciplinary/ Inter-professional	Staff in services from different professions working together with an individual service user, or in the planning and delivery of services to groups of service users and carers. E.g. nurses, social workers, teachers, allied health professionals, clinical psychologists and psychiatrists
Inter-sectoral	Working together between the statutory sector (bodies that are directly managed by government) and the independent sector (voluntary organisations, community groups and the private sector)
Legislative	To do with the law
Mainstream	Generally available to everyone in the community

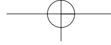
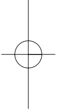
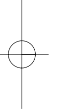
[1] Other terms are sometimes substituted such as cross departmental or pan–agency working. These are taken to mean the same as inter as in inter-departmental

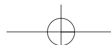
Multi- Agency Centres	A one-stop shop for children, their families and the staff who support them where staff from a range of organisations are in the one place to offer support, advice and information
Prevalence	Working out how many people in a community have a learning disability
Primary Care Services	Health and social services that are generally available directly to everyone e.g. dentist, GPs
Revenue Allocations	Money allocated for daily costs like staff salaries or rent
Sensory Impairments	A loss of sight and/or hearing
Social Inclusion	When people with a learning disability feel part of the community that they live in
Supported Employment	Helps people with a disability to get a job by giving the right help and support
Terminology	The names we use for different things
Transition	A time in people's lives when big changes are happening, like leaving school or getting old

Abbreviations

ARC	Association for Real Change
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DHSSPS	Department of Health, Social Services and Public Safety
DRD	Department for Regional Development
DSD	Department for Social Development
EHSSB	Eastern Health and Social Services Board
FE	Further Education
HPSSRIA	Health and Personal Social Services Regulation and Improvement Authority
HPSS	Health and Personal Social Services
HSS	Health and Social Services
LDAF	Learning Disability Award Framework
NHSSB	Northern Health and Social Services Board

NICVA	Northern Ireland Council for Voluntary Action
NISCC	Northern Ireland Social Care Council
NVQ	National Vocational Qualification
OFMDFM	Office of First Minister and Deputy First Minister
PCP	Person Centred Planning
PSS	Personal Social Services
RPA	Review of Public Administration
SHSSB	Southern Health and Social Services Board
SLD	Severe Learning Disability
TSP	Training Support Programme
UN	United Nations
WHSSB	Western Health and Social Services Board



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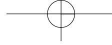
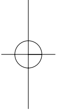
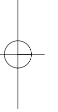
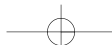








COMPOSITION OF EQUAL LIVES REVIEW WORKING GROUPS

Learning Disability Working Committee

Andrew Bailey	PSNI
David Bamford	Chair Mental Health and Learning Disability Review
Siobhan Bogues	ARC
Maurice Devine	Down Lisburn Health and Social Services Trust
Kieran Downey	Sperrin Lakeland Trust
John Hunter	Department of Education Northern Ireland
Mary Lunny	Parent
Agnes Lunny	Positive Futures
Roy McConkey	University of Ulster at Jordanstown/ Eastern Health and Social Services Board
John McEleney	Foyle HSS Trust
Catherine McGuigan	Equal Lives Group
Joan McGuinness	Longstone Hospital
Colin McMinn	DHSSPS
Brendan Mullen	Ulster Community & Hospitals HSS Trust
Marian Nicholas	Parent
Maureen Piggot	MENCAP
Moira Scanlon	Occupational Therapist
Oliver Shanks	Psychiatrist
Eileen Sherrard	Clinical Psychologist
Tom Smith	Southern Health and Social Services Board
Miriam Somerville	North & West Belfast HSS Trust
Nigel Stratton	Homefirst Community Trust

Equal Lives Group

Orlagh	Cassidy
Joe	Coyle
Hilary	Gammon
Alan	Henry
Gerald	Maguire
John Paul	McCusker
Catherine	McGuigan
Cathy	McKillop
John	Mullan
Patrick	Hill
Nigel	Reid
Trevor	Rhodie
Nora	Smith

Advisers to Equal Lives Group

Paul	Roberts
Siobhan	Wylie
Judith	Skates (secretary)

Carers Advisory Group

Sam	Bell
Anne	Blake
Colm	Callon
Briedge	Campbell
Derek	Doherty
Sharon	Doherty
Mary	Duffin
Maureen	Gribben
Carol	Ince
Colette	Jones

Siobhan	Lappin
Mary	Lunny
Anne	Mallon
Valerie	Martin
Pat	McAlister
Teresa	McDonagh
Nuala	McGarry
Seana	McQuade
Cowan	Reid

Accommodation and Support Task Group

John Black	DHSSPS
Tony Brady	Carer
Agnes Lunny	Positive Futures
John Mc Cart	North & West Belfast HSS Trust
Roy Mc Conkey	University of Ulster at Jordanstown/ Eastern Health and Social Services Board
Colin Mc Minn	DHSSPS
Brian O' Kane	Supporting People
Tom Smith	Southern Health & Social Services Board

Ageing Issues Task Group

Kate Comiskey	Blair Lodge
Chris Conliffe	Scientist Practitioner
Peter Deazley	DHSSPS
Margaret Maybin	Training and Practice Development Team
Janet MacPherson	North & West Belfast HSS Trust
Moira Scanlon	Craigavon & Banbridge HSS Trust
Kay Trolan	Parent
Vivienne Williamson	St Luke's Hospital

Children and Young People Task Group

Margaret Black	Northern Health and Social Services Board
Oscar Donnelly	North & West Belfast HSS Trust
Pauline Ferguson	Positive Futures
Hilary Harrison	DHSSPS
Nan Hill	South & East Belfast HSS Trust
John Hunter	Department of Education Northern Ireland
Goretti Horgan	Parent
Mandy Irvine	North & West Belfast HSS Trust
Rosemary Kilpatrick	Institute of Child Care Research
Mary Lunny	Parent
Pat McAlister	Parent
Alison McCullough	South & East Belfast HSS Trust
Aidan Murray	Eastern Health and Social Services Board
Michael Palframan	Barnardos
Maureen Piggot	MENCAP

Day Opportunities Task Group

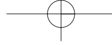
Alison Anderson	Skill Northern Ireland
Liam Burns	MENCAP
Damian Cassidy	The Appleby Trust
Kieran Downey	Sperrin Lakeland Trust
Edyth Dunlop	Northern Ireland Union for Supported Employment
Ian Hayes	Service User
Brendan Linton	MENCAP
Roy Mc Conkey	University of Ulster at Jordanstown/ Eastern Health and Social Services Board
Barry Mc Menamin	MENCAP
Colin Mc Minn	DHSSPS
Eilish Rehill	FACT
Jude O'Neill	Western Health & Social Services Board

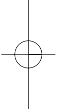
Physical Health Task Group

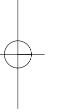
Owen Barr	University of Ulster at Magee
Maurice Devine	Thompson House Hospital
Sean Donnelly	Clifton Street Surgery
Lucy Finnegan	South & East Belfast HSS Trust
Therese Kane	Albert Street Healthy Living Centre
Neil Kelly	South & East Belfast HSS Trust
John McEleney	Foyle HSS Trust
Margaret Mc Elroy	Carer
Eveline Milne	Longstone Hospital

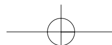
Mental Health Task Group

Owen Barr	University of Ulster at Magee
Don Bradley	Ulster Community & Hospitals HSS Trust
Petra Corr	North & West Belfast HSS Trust
Maurice Devine	Thompson House Hospital
Ian Mc Master	DHSSPS
Joan Mc Guinness	Longstone Hospital
Brendan Mullen	Ulster Community and Hospitals HSS Trust
Marion Nicholas	Parent
Oliver Shanks	Psychiatrist
Irene Sloan	Challenge
Miriam Somerville	North & West Belfast HSS Trust









LEGISLATION IN NORTHERN IRELAND

Most of the recent legislation in Northern Ireland has followed on from Parliamentary Bills first introduced at Westminster and this is usually done by Orders in Council. The main extant Orders (arranged by date order) affecting people with a learning disability are:

Chronically Sick and Disabled Persons (NI) Act 1978

This provides for the identification of people with a disability for the purpose of providing welfare services under the Health and Personal Social Services (NI) Orders 1972. It also provides for the laying before the NI Assembly of two reports, one on the placement of people under 65 in a hospital mainly for the care of elderly people (Section 12 report) and the other on the placement of people under 65 in premises for people over that age (section 13 report).

Mental Health (NI) Order 1986

Under this Order people with a learning disability (referred to in the Order as mental handicap/mental impairment) can be detained in hospital for assessment and treatment if they are suffering from a mental disorder, the nature and degree of which presents a substantial risk to themselves, and when failure to detain them creates a substantial likelihood of serious physical harm to themselves or others. The Order also allows for people to be received into guardianship to ensure that the person receives the care and protection he or she needs. The Order also allows steps to be taken to manage the property and affairs of people who cannot do so for themselves.

Education and Libraries Boards (NI) Order 1986 and Education (NI) Order 1996

Under these Orders, Education and Library Boards have a duty to identify and assess children in their area who have special education needs and children who they think have, or will have, special education needs. If the assessment finds that a child has special education needs, the Education and Library Board must issue a statement explaining these needs which must also detail the special arrangements being made by the Education and Library Board to meet those needs.

The 1996 Order provides a legal framework for the assessment and development of special education needs. It is accompanied by a Code of Practice on the Identification and Assessment of Special Education Needs (Department of Education for Northern Ireland, 1997), based on its equivalent developed in England and Wales (DfEE, 1994). This code provides detailed guidance on five stages of assessment.

Disabled Persons (NI) Act 1989

The Chronically Sick and Disabled Persons (NI) Act 1978 was amended by the Disabled Persons (NI) Act 1989. The 1989 Act, in addition to the provisions in the 1978 Act, requires Health and Social Services Trusts to assess young people with disabilities, at the time they leave school, for a range of welfare services as outlined in the Chronically Sick and Disabled Persons (NI) Act 1978. The Trusts are also expected to give appropriate advice about matters such as employment and further education.

Section 5 of the Disabled Persons (NI) Act 1989 requires Education and Library Boards to notify the relevant Trust at the time of the first annual review of a statement following the child's 14th birthday, or at a time of a reassessment after that birthday, whichever is earlier. This notification is required in order for Trusts to consider the young person's needs for social services after they have left school. Education and Library Boards are also required to notify the Trust between twelve and eight months before the actual date of ceasing full-time education.

The Disabled Persons (NI) Act 1989 also gives disabled people rights to representation, to assessment of their needs, and to information and counselling. The statutory provisions relating to representation are provided in Sections 1 and 2 of the 1989 Act and intended to give the same rights to disabled people in Northern Ireland as that given in Great Britain by the Disabled Persons (Services, Consultation, and Representation) Act 1986. For example, Section 2 requires Boards or Trusts to make arrangements for social services to meet the needs of disabled people, including practical assistance in the home, transport arrangements to and from home, home adaptations, holidays and help obtaining a telephone. However, ten years on, these two sections have not yet been implemented in N. Ireland.

Carers of disabled people, including those caring for disabled young people, have the right to have their ability to care taken into account (section 8) and the right to ask for an assessment of the needs of the disabled person (section 4).

Health and Personal Social Services (NI) Orders 1991 and 1994

Under these Orders, Health and Social Services Boards are responsible for assessing the health and social welfare needs of their resident population (including disabled young people and adults) and for commissioning services to meet these needs.

These Orders brought about the purchaser/provider split in the organisation of health and personal social services, with Health and Social Services Boards "purchasing" services for their resident population and HSS Trusts "providing" services, which were agreed through contracts with Health and Social Services Boards. The Trusts may in turn sub-contract with private and voluntary organisations for services.

The Children Order (NI) 1995

This Order was made in March 1995 and most of its provisions commenced in November 1996. It brings together most public and private law relating to children and establishes a new approach to services provided by Health and Social Services Trusts for children and their families.

The Children (NI) Order 1995 provides a legal framework for the provision of social care services for disabled children and their families and seeks to ensure the integration of these services. They are to be recognised as children first with the right to have their particular needs met by the provision of services.

Young people with disabilities, up to the age of 18 (or 21 in some circumstances), are included in the Order's definition of "children in need" (Article 17).

The Order defines a child as disabled if he or she is:

"blind, deaf, dumb or suffering from mental disorder of any kind or substantially or permanently handicapped by illness, injury or congenital deformity or such other disability as may be described."

The language used is archaic and may be seen as stigmatising, but it is the legal definition to be adhered to by Trusts providing services and assessing the needs of disabled children. Disabled children, as children in need, are entitled to services necessary to safeguard and promote their welfare. Trusts are required to take reasonable steps to identify children in need in their area and to assess the needs of such children.

Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 states:

"A public authority shall, in carrying out its functions to Northern Ireland, have due regard to the need to promote equality of opportunity-

Between persons of different religious belief, political opinion, religious group, age, marital status or sexual orientation;

Between men and women generally;

Between persons with a disability* and persons without; and

Between persons with dependants and persons without".

**Disability has the same meaning as in the Disability Discrimination Act 1995 (see below).*

Following on from Section 75, public authorities must now undertake Equality Impact Assessments. An Equality Impact Assessment (EQIA) is a thorough and systematic analysis of a policy. The purpose of carrying out an EQIA is to identify whether there are differences in the way a policy impacts upon the nine categories stipulated under Section 75 and whether these differences are adverse i.e. do they have a negative impact on any of the equality categories. If there are negative impacts then the public body must consider how these should be addressed. This may involve developing new measures to reduce the negative impact or developing new measures that more effectively promote equality of opportunity.

This Act also established the Equality Commission for Northern Ireland which subsumed the Northern Ireland Disability Council and which undertakes the same functions as the Disability Rights Commission in Great Britain.

Other UK legislation:

Three further pieces of legislation also have implication for services:

Carers Recognition and Service Act 1995

This requires HSS Trusts to undertake an assessment of carers' needs; to provide information about services and arrange means whereby their needs can be met.

Community Care Direct Payments Act 1996

This Act which is mandatory in N. Ireland from 1998, makes it possible for disabled people, including those with a learning disability, to have a Direct Payment from HSS Trusts, to pay for their community care services. The individual can use the money to buy or organise the kind of support that best suits them rather than use services provided by Trusts or other organisations on their behalf.

Disability Discrimination Act 1996

This Act aims to ensure that disabled people have equal opportunities in terms of access to employment, buildings, and goods and services. It also requires schools, colleges and universities to provide information for people with disabilities and make suitable accommodation for their needs. There was initial debate about what constituted 'services' but parliamentary challenges have led to the affirmation that services include health and social services. Under the DDA it is illegal to discriminate by any of the following:

- refusal to provide a service
- treating a person less favourably in the standard of service, or how a service is provided
- providing a service in less favourable terms (e.g. failure to provide access for disabled people).

Under the DDA disabled people are defined as follows:

- must have a physical or mental impairment
- the impairment must adversely affect the individual's ability to carry out normal daily activities
- the adverse effect must be substantial
- the adverse effect must be long term.

Under the Act the term impairment is defined as relating to the following aspects: mobility, dexterity, physical condition, continence, ability to lift, speech hearing or eyesight, cognition (memory, concentration and learning) and perception of risk. There seems little doubt that many people with a learning disability are 'disabled' under the DDA definition. It therefore follows that people with a learning disability should be protected under the DDA.

SELECTED DEFINITIONS OF LEARNING DISABILITY

International definitions of what is known as 'learning disability' include three elements all of which must be present:

- significant impairment of intelligence that includes a reduced ability to understand new or complex information, and to learn new skills;
- deficits in social functioning or adaptive behaviour and a reduced ability to cope independently; and
- the disability started before adulthood and has a lasting effect on development.

However the precise terminology used in definitions varies and there are significant problems in operationalising these definitions so that people can be reliably and validly classed as 'learning disabled.'

Northern Ireland

In Northern Ireland there has been relative consistency in the definitions used although the terminology is not always consistent. For example, mental handicap is defined in the Mental Health (NI) Order 1986 as:

"A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning."

(The Order also defines 'severe mental handicap' in similar terms by substituting the word 'significant' with 'severe')

However this definition omits a key feature included in all international definitions, namely that the disability or impairment is present from childhood. Moreover the term 'development of mind' is impossible to define accurately (Foundation of People with Learning Disabilities, 2001).

Great Britain

The Scottish Review of Learning Disability Services (Scottish Executive, 2001) considered it important for any definition to give an appropriate and meaningful description of the services and supports individuals may need. Hence they state:

People with learning disabilities have a significant life-long condition that started before adulthood, that affected their development and which means they need help to understand information; learn new skills; and to cope independently (p.3).

Likewise the English Review (Department of Health, 2001) gave this definition:

Learning disability includes the presence of:

- *a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with*
- *a reduced ability to cope independently (impaired social functioning)*
- *which started before adulthood with a lasting effect on development.*

European Union

The EU Monitoring and Advocacy Program of the Open Society Institute (2003) defined intellectual disability (also described as learning disability or mental retardation) as:

A lifelong condition, usually present from birth or which develops before the age of 18; is a permanent condition that is characterized by significantly lower than average intellectual ability; results in significant functional limitations in intellectual functioning and in adaptive behaviour as expressed in conceptual, social and practical adaptive skills.

They go on to note that "a person with intellectual disability usually requires support in three or more of the following areas of major life activity: self-care, receptive and expressive communication, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency. People with intellectual disabilities generally need a combination of special, interdisciplinary or generic services, individualized support, and other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated".

United States of America

DSM-IV Diagnostic and Statistical Manual of Mental Disorders

The American Psychiatric Association in their diagnostic classification defines mental retardation as:

(a) *significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually measured administered IQ Test*

(b) *concurrent deficits or impairments in present adaptive functioning (i.e. the person's effectiveness in meeting the standards expected of his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home-living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety*

(c) *the onset is before age 18 years.*

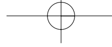
The American Association on Mental Retardation (2002) has been an international leader in defining and assessing people with 'mental retardation'. They define mental retardation as:

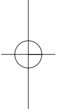
A disability characterized by significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social and practical adaptive skills. This disability originates before 18 years of age.

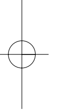
They go on to note five assumptions that are essential to the application of this definition:

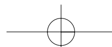
1. "Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.

2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor and behavioural factors.
3. Within an individual, limitations often co-exist with strengths.
4. An important purpose of describing limitations is to develop a profile of needed supports.
5. With appropriate personalized supports over a sustained period, the life functioning to the person with mental retardation generally will improve".









HPSS EXPENDITURE ON LEARNING DISABILITY PROGRAMME

Annex I

By Trust 2002/03

HSS Trust	Hospital £'000	Community £'000	PSS £'000	Total £'000
Armagh & Dungannon	8375	1354	6596	16325
Causeway	150	546	4565	5261
Craigavon & Banbridge		791	5204	5995
Down Lisburn		1793	10300	12093
Foyle	2908	1313	7302	11523
Green Park	698			698
Homefirst	97	2604	15826	18527
Newry & Mourne		845	5921	6766
North & West Belfast	20734	1198	11284	33216
South & East Belfast		522	9760	10282
Sperrin Lakeland		330	6922	7252
Ulster Community and Hospitals		873	7555	8428
United		85		85
TOTAL	**32962**	**12254**	**91235**	**136451**

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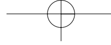
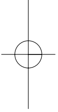
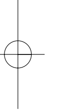

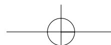

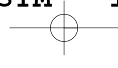

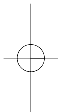

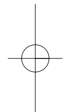

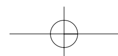

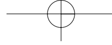
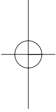
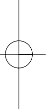

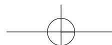

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SERVICE FRAMEWORK FOR LEARNING DISABILITY

Working for a Healthier People

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Foreword

As Minister for Health I am determined to protect and improve the quality of health and social care services and ensure that these are safe, effective and focussed on the patient. Driving up the quality of services and outcomes for people will be my underlying priority. I am committed to working, not only to improve health but to tackle inequalities in health.

I am particularly pleased, therefore, to launch the Service Framework for Learning Disability for implementation. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

Service Frameworks aim to set out clear standards of health and social care that are both evidence based and measurable. They set out the standard of care that service users and their carers can expect, and are also to be used by health and social care organisations to drive performance improvement through the commissioning process. The Service Framework for Learning Disability is one of five Frameworks to be issued for implementation to date and, that focus on the most significant causes of ill health and disability in Northern Ireland, namely: cardiovascular disease, respiratory disease, cancer, mental health and learning disability. Two further Frameworks, for children and young people and older people are currently at various stages of development.

This latest Framework has been developed actively involving a wide range of people across all aspects of health and social care including, patients, clients and carers, all of whose support has been invaluable. I would like to convey my sincere thanks, to you all, for your immensely important contribution.

Edwin Poots MLA
Minister for Health, Social Services and Public Safety

SERVICE FRAMEWORK FOR LEARNING DISABILITY

Summary of Standards

Safeguarding and Communication and Involvement in the Planning and Delivery of Services

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 1 (Generic): All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.	1. All HSC organisations and organisations providing services on behalf of the HSC have a **Safeguarding Policy** in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc.) The Safeguarding Policy is supported by robust procedures and guidelines.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.
	2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.
	3. All HSC organisations and organisations providing services on behalf of the HSC have **safeguarding champions** in place in order to promote awareness of safeguarding issues in their workplace.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 2: People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services, unless there are explicit and valid reasons to the contrary agreed with the person.	1. Evidence that people with a learning disability their family and carers have been involved in making choices or decisions about their individual health and social care needs.	Establish baseline March 2015. Performance levels to be determined once baseline established. March 2016.
Standard 3 (Generic): All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.	1. Percentage of job descriptions containing PPI as responsibility March 2015: senior and middle management March 2016: designated PPI leads at all levels of HSC organisations March 2017: all new job descriptions 2. Percentage of patients and clients expressing satisfaction	Establish baseline and set target March 2014. Monitor progress March 2015. 100% in all new job descriptions March 2016. Establish baseline and set target March 2014. Report percentage increase of patient and client satisfaction March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 3 (Generic): (continued)	3. Percentage of staff who have gained PPI training (details to be agreed for 2015/2016)	Report percentage increase of patient and client satisfaction March 2016. Conduct training needs assessment for PPI, commission design of PPI training programme March 2014. Establish baseline and set target March 2015. Monitor percentage of staff trained at different levels in PPI March 2016.
Standard 4: Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.	1. Develop and agree a regional training plan that ensures that relevant HSC staff are trained in consent and capacity issues. 2. Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC	All HSC organisations March 2016. Development and implementation of SAAT March 2015. Performance level to be determined based on outcomes of SAAT March 2016.
Standard 5 (Generic): All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.	1. Percentage of patients and clients expressing satisfaction with communication	Establish baseline March 2014. Report percentage increase of patient and client satisfaction with communications March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 5 (Generic): (continued)		Report percentage increase of patient and client satisfaction with communication March 2016.
Standard 6: People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care	1. Percentage of people with a learning disability who do not use speech as their main form of communication who have been supported to establish a functional communication system.	Develop and implement SAAT March 2015. Performance levels to be determined based on outcomes of SAAT March 2016.
	2. Develop and agree a regional training plan for staff in both HSC and services commissioned by HSC to raise awareness of communication difficulties and how they may be addressed.	Regional Training Plan in place. March 2015. Training is delivered in accordance with Regional Training Plan. March 2016.
Standard 7: People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.	1. All HSC organisations should provide evidence that they are making information accessible to people with a learning disability.	Development and implementation of SAAT March 2015. Performance levels to be determined once baseline established March 2016.
	2. Each person with a learning disability can access a named person who can signpost them to relevant services.	Establish baseline of information provided March 2016. Performance levels to be determined once baseline established.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 8: People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.	1 Evidence of provision of accessible information on Direct Payments within HSC organisations.	Develop and implement SAAT March 2015. Establish performance levels based on outcomes from SAAT March 2016.
	2 Percentage of requests for Direct Payments from people with a learning disability that were approved.	Develop and implement SAAT March 2015. Establish performance levels based on outcomes from SAAT March 2016.
	3 Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%).	Performance levels to be determined based on available resources and included in final Framework.
	4 Number of children with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 3.50%).	Performance levels to be determined based on available resources and included in final Framework.
	5 The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff.	HSC Board and all Trusts March 2017.
Standard 9 (Generic): Service users and their carers should have access to independent advocacy as required.	1. To be determined	To be determined.

Children and Young People

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 10: From the point at which concerns are raised that a child or young person may have a learning disability, there is an action plan in place to determine the nature and impact of the learning disability	1. Percentage of parents who express satisfaction with the assessment process and how the outcomes were conveyed.	Establish baseline of information provided March 2016. Performance levels to be determined once baseline established March 2017.
Standard 11: Children and young people should receive child-centred and co-ordinated services through assessment to ongoing care and support from the point at which a determination has been made that they have a learning disability.	1 Percentage of children and young people with a learning disability and carers who have been offered an annual assessment either under the Family Health Needs Assessment or UNOCINI Assessments. 2 Percentage of children and young people who have an agreed care plan detailing a pathway to receiving appropriate care and support	Establish baseline March 2016. Performance levels to be determined once baseline established March 2017. Establish baseline March 2016. Performance levels to be determined once baseline established March 2017.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 12: HSC services should respond to the needs of children and young people who have a learning disability and complex physical health needs in a manner that is personalised, developmentally appropriate and which supports access to appropriate care.	1 Percentage of parents whose child has a learning disability and complex physical health needs who have an identified key worker with co-ordinating responsibility.	Scope requirements and produce audit plan March 2015. Audit 50% of information available March 2016. 100% March 2017.
	2 Percentage of children and young people with complex physical health needs who have effective transition arrangements in place between hospital and community.	Develop and implement SAAT March 2015. Performance level to be determined based on SAAT outcomes March 2016. Fast Track arrangements for access to hospital/community services to be audited following establishment of baseline.
	3 Percentage of children with a learning disability and complex physical health needs who have received a multi-professional assessment as per regional integrated care pathway.	90% March 2015. 95% March 2016. 98% March 2017.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 13: Any child or young person who cannot live at home permanently should have their placement/ accommodation needs addressed in a way that takes full account of their learning disability.	1 Percentage of looked after children or young people with a learning disability who cannot live with their families who have a Permanency Plan.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Entering Adulthood

Standard 14: Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.	1. Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school. 2. Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services.	Develop and implement SAAT March 2016. Performance levels to be determined based on SAAT outcomes March 2017. 90% March 2015. 95% March 2016. 98% March 2017.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 15: People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.	1. Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach. 2. Trusts to facilitate appropriate training for staff. 3. Trusts to facilitate appropriate training for service users and family carers. 4. Increase in the number of people with a learning disability accessing sexual health and reproductive healthcare services.	HSC Board policy developed and agreed March 2015. 40% March 2016. 80% March 2017. Level to be established pending development of regional policy March 2017. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.

Inclusion in Community Life

Standard 16: Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.	1. Percentage of school leavers with a learning disability who access work placements or employment within one year of leaving school (as percentage of total learning disabled school leaving population). 2. Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 17: All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.	1. Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings, outside of their building based service. 2. Percentage of adults with a severe or profound learning disability receiving support in a building based service, who express satisfaction with the opportunity to experience day opportunities.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.
Standard 18: All parents with a learning disability should be supported to carry out their parenting role effectively.	1. Develop and agree a regional protocol between children's and adult services for joint working and care pathways. 2. Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment. 3. Percentage of parents with a learning disability involved in child protection or judicial processes who have received locally based skills training. 4. Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	HSC Board in collaboration with all Trusts March 2015. Establish baseline March 2016. Performance levels to be determined once baseline established March 2017. 85% March 2015. 90% March 2016. 95% March 2017. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Meeting General Physical and Mental Health Needs

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 19: All people with a learning disability should have equal access to the full range of health services including services designed to promote positive health and wellbeing.	1. All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	All HSC Trusts establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	2. Percentage of GPs who have a system for identifying people with a learning disability on their register.	Baseline as per learning disability DES March 2015. Performance levels to be determined once baseline established March 2016.
	3. Each GP practice has a designated link professional within local learning disability services.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	4. Evidence of reasonable adjustments by health service providers.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 20 (Generic): All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well-developed specialist smoking cessation services.	1. Number of people who are accessing Stop Smoking Services 2. Proportion of the smoking population who are accessing Stop Smoking Services. 3. Number of people using stop smoking services who have quit at 4 weeks and 52 weeks.	Baseline 2011/12 = 39204. - 4 % year on year increase March 2014 – March 2016. Baseline 2011/12 =10.8%. NICE guidance and the ten year tobacco strategy call for a target of over 5% of the smoking population to be reached, hence target to maintain at >/= 5% March 2014 – March 2016. Baseline 2011/12 = 20,299 for those quit at 4 weeks and 5,889 for those quit at 52 weeks. Target 4% increase in respective numbers year on year March 2014 – March 2016.
Standard 21: All people with a learning disability should be supported to achieve optimum physical and mental health.	1. The PHA and each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs. 2. Percentage of adults with a learning disability who have an annual health check. 3. Percentage of adults with a learning disability, who have an up to date and active Health Action Plan (HAP) following the annual health check.	All Trusts have in place a health improvement strategy for people with a learning disability March 2015. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 21:(continued)	4. Percentage of people with a learning disability who have been examined by a dentist in the past year. 5. Percentage of females with a learning disability who access cervical and breast screening services. 6. Percentage of people with a learning disability who have a sight test with an optometrist in the past year.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
Standard 22: All people with a learning disability who experience mental ill health should be able to access appropriate support.	1. A regional protocol is developed to ensure that people with a learning disability can access mainstream mental health services. 2. Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies where indicated in their treatment plan. 3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion.	Protocol in place March 2015. Establish baseline March 2016. Performance levels to be determined once baseline established March 2017. Establish baseline. March 2015. Performance levels to be determined once baseline established March 2016.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 23 (Generic): All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.	1. Percentage of people eating the recommended 5 portions of fruit or vegetables each day.	Baseline for 2011/12 = 32% overall, 26% for males and 36% for females. Target: maintain or at best increase percentage by 1% year on year March 2014 – March 2016.
Standard 24 (Generic): All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.	1. Percentage of people meeting the recommended level of physical activity per week.	New physical activity guidelines were launched in 2011 and as such a new suite of questions to establish the percentage of people meeting the recommended level of physical activity per week has been integrated within the 2012/13 Northern Ireland Health Survey. It is anticipated these new baseline results will be available in Nov / Dec 2013 March 2014. Performance level to be agreed thereafter.
Standard 25 (Generic): All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.	1. Percentage of people who receive screening in primary care settings in relation to their alcohol consumption.	Establish baseline March 2014. Performance level to be determined once baseline established March 2015.

Meeting Complex Physical and Mental Health Needs

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 26: All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.	1. Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in place that detail actions to be undertaken in the event of their challenging behaviours escalating.	Develop and implement SAAT March 2015. Performance level to be determined based on SAAT outcome March 2016.
	2. Where challenging behaviours present a significant risk to the individual or others or a risk of breakdown in accommodation arrangements, a specialist assessment has been completed within 24 hours.	Develop and implement SAAT March 2015. Performance level to be determined based on SAAT outcome March 2016.
	3. Where challenging behaviours present a significant risk to the individual, a Management Plan has been developed and implemented within 48 hours.	Develop and implement SAAT March 2015. Performance level to be determined based on SAAT outcome March 2016.
	4. Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases.	All HSC Trusts March 2016.
	5. Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/treatment service.	Develop and implement SAAT March 2017. Performance level to be determined based on SAAT outcomes.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 27: All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.	1. Evidence that the HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and co-ordinated approaches to working with people with a learning disability who have offended or are at risk of offending.	Protocols in place March 2015.

At Home in the Community

Standard 28: HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.	1. Percentage of support plans that take account of people's aspirations in relation to future accommodation needs, including independent living. 2. Percentage of adults who are living with a single carer or where there are 2 carers and the primary carer is aged over 65 who have a futures plan in place. 3. Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability. 4. Percentage of people leaving learning disability hospital within one week after treatment has been completed.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. 95% March 2015 97% March 2016 100% March 2017.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 29 (Generic): All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed.	1. Number of front line staff in a range of settings participating in Carer Awareness Training Programmes 2. The number of carers who are offered Carers Assessments 3. The percentage of carers who participate in Carers Assessments	20% March 2015. 50% March 2016. Improvement targets set by HSC Board in conjunction with Carers Strategy. Implementation Group. Reviewed annually. Improvement targets set by HSC Board in conjunction with Carers Strategy. Implementation Group. Reviewed annually.
Standard 30: All family carers should be offered the opportunity to have their needs assessed and reviewed annually.	1. Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Ageing Well

Standard 31: All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.	1. Percentage of people whose care plan has been reviewed taking account of issues associated with ageing. 2. Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015 Performance levels to be determined based on SAAT outcomes March 2016.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 32: All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.	1. Percentage of people with a learning disability and dementia who can access appropriate dementia services as required. 2. Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis. 3. Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Develop and implement SAAT March 2016. Performance levels to be determined based on SAAT outcomes March 2017. Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.

Palliative and End of Life Care

Standard 33 (Generic): All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care	1. Percentage of the population that is enabled to die in their preferred place of care. 2. Percentage of population with an understanding of advance care planning	Establish baseline March 2014. Performance levels to be determined once baseline established March 2015. Establish baseline March 2014. Performance levels to be determined once baseline established March 2015.

STANDARD	KEY PERFORMANCE INDICATORS	ANTICIPATED PERFORMANCE LEVEL
Standard 34: All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.	1. Palliative care services have mechanisms to identify whether people have a learning disability. 2. Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016. Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.

A NOTE ON TERMINOLOGY

The following terms will be used throughout this document:

> ‘carer’ will be used to describe a family member including children and young people or informal carers
>
> ‘HSC organisation’ will be used to describe a variety of health and social care providers, such as, the HSC Board, HSC Trusts and the Public Health Agency.
>
> ‘service user’ will be used to describe those who use learning disability services

A glossary of terms used is provided in Annex A

SECTION 1: INTRODUCTION TO SERVICE FRAMEWORKS

Background

The overall aim of the Department of Health, Social Services and Public Safety (DHSSPS) (the Department) is to improve the health and social wellbeing of the people of Northern Ireland (NI).

In support of this the Department is developing a range of Service Frameworks, which set out explicit standards for health and social care that are evidence based and capable of being measured.

The first round of Service Frameworks focuses on the most significant causes for ill health and disability - cardiovascular health and wellbeing; respiratory health and wellbeing; cancer prevention, treatment and care; mental health and wellbeing; and learning disability. Work has also commenced to develop Service Frameworks for children and young people and older people.

Service Frameworks have been identified as a major strand of the reform of health and social care services and provide an opportunity to:

- strengthen the integration of health and social care services;
- enhance health and social wellbeing, to include identification of those at risk, and prevent/ protect individuals and local populations from harm and /or disease;
- promote evidence-informed practice;
- focus on safe and effective care; and
- enhance multi-disciplinary and inter-sectoral working.

Aim of Service Frameworks

Service Frameworks will set out the standards of care that service users, their carers and wider family can expect to receive in order to help people to:

- prevent disease or harm;
- manage their own health and wellbeing including understanding how lifestyle affects health and wellbeing including the causes of ill health

and its effective management;

- be aware of what types of treatment and care are available within health and social care; and
- be clear about the standards of treatment and care they can expect to receive.

All Service Frameworks incorporate a specific set of standards that are identified as Generic[1]. These, essentially, are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping. These include:

- safeguarding (Generic Standard 1);
- involvement (Generic Standard 3);
- communication (Generic Standard 5);
- independent advocacy (Generic Standard 9);
- smoking prevention & cessation (Generic Standard 20);
- healthy eating (Generic Standard 23);
- physical activity (Generic Standard 24);
- alcohol (Generic Standard 25);
- carers (Generic Standard 29); and
- palliative care (Generic Standard 33).

These Generic standards reinforce the holistic approach to health and social care improvement and reflect the importance of health promotion in preventing medical or social care issues occurring in the first place. Their inclusion ensures:

- equality of opportunity for all;
- the communication of consistent messages to service users and providers of HSC; and
- a consistent approach in the design and delivery of services.

[1] Generic Standards updated following CMO letter of 29 May 2013

Service Frameworks will be used by a range of stakeholders including commissioners, statutory and non-statutory providers, and the Regulation and Quality Improvement Authority (RQIA) to commission services, measure performance and monitor care.

The Frameworks will identify clear and consistent standards informed by expert advice, research evidence and by national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE). The auditing and measuring of these standards will be assisted by the Guidelines and Implementation Network (GAIN) which will facilitate regional audit linked to priority areas, including Service Frameworks.

The standards, in the context of the 10 year Quality Strategy[2], will aim to ensure that health and social care services are:

i. **Safe** – health and social care which minimises risk and harm to service users and staff;

ii. **Effective** – health and social care that is informed by an evidence base (resulting in improved health and wellbeing outcomes for individuals and communities), is commissioned and delivered in an **efficient** manner (maximising resource use and avoiding waste), is **accessible** (is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to need) and **equitable** (does not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status).

iii. **Person centred** – health and social care that gives due regard to the preferences and aspirations of those who use services, their family and

[2] Quality 2020: A 10-Year Quality Strategy for Health and Social Care in Northern Ireland

carers and respects the culture of their communities. A person of any age should have the opportunity to give account of how they feel and be involved in choices and decisions about their care and treatment dependent on their capacity to make decisions. In absence of the capacity to make decisions they should listen to those who know and care for the person best.

Involving and communicating with service users, carers and the public

The Department has produced guidance, "Strengthening Personal and Public Involvement in Health and Social Services"[3], which sets out values and principles which all health and social care organisations and staff should adopt when engaging with the public and service users. These include the need to involve people at all stages in the planning and development of health and social care services. This policy position has been strengthened by the introduction of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the statutory duty it places on HSC organisations to involve and consult with the public. (Art 19)

It is important that the views of service users and carers are taken into account when planning and delivering health and social care. The integration of the views of service users, carers and local communities into all stages of the planning, development and review of Service Frameworks is an important part of the continuous quality improvement and the open culture which should be promoted in HSC.

The Department is committed to involving those who use learning disability services (experts by experience), their carers and wider families. Through the proactive involvement of the service users and carers in the planning of Service Frameworks, it is hoped that concerns and ideas for improvement can be shared and that the standards developed in partnership with service users,

[3] DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07) http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

carers and the public will focus on the issues that really matter to them.

It is also important that Service Frameworks provide service users and carers with clear and concise information, which is sensitive to their needs and abilities, so that they can understand their own health and wellbeing needs. To facilitate this, easy access versions will be made available for all Service Frameworks. Service Frameworks will also be made available in various other formats e.g. Braille, large print and audio tape. The Department will also consider requests for other formats or translation into ethnic minority languages.

People are ultimately responsible for their own health and wellbeing and that of their dependents, and it is important that service users, their carers and wider family are made aware of the role they have to play in promoting health and wellbeing.

Involving other agencies in promoting health and wellbeing

Improving the health and wellbeing of the population requires action right across society and it is acknowledged that health and wellbeing is influenced by many other factors such as poverty, housing, education and employment. While Service Frameworks set standards for providers of health and social care services it is essential that HSC services work in partnership with other government departments and agencies both statutory and non-statutory to seek to influence and improve the health and social wellbeing of the public.

People who use health and social care services, including learning disability services, may have complex needs which require inputs from a range of health and social care professionals and other agencies.

The benefits of multidisciplinary team working and multiagency working, including voluntary and community organisations, are well recognised and it is a key component of decision making regarding prevention, diagnosis,

treatment and ongoing care. This will be a key theme underpinning the development and implementation of Service Frameworks.

Data Collection

As Service Frameworks are implemented it is important that timely, accurate information is available to support decision-making and service improvement.

To support this, data sources are identified, early in the development stage, to match the key performance indicator (KPI) data definitions. It is through the data source that progress can be monitored. Where robust baseline data is not available Frameworks will be looking to audits, including Self Assessment Audit Tools (SAATs), to gather information, establish baselines and set future performance levels.

Research and Development

It is important that Service Frameworks are based on valid, relevant published research, where available, and other evidence.

Education and Workforce

Education and workforce development occur at individual, team, organisational, regional and national levels: they are part of the drive to promote quality. The ongoing development and implementation of Service Frameworks will influence the education and training agenda and curricula content for all staff involved in the delivery of health and social care. This will require a commitment to lifelong learning and personal development alongside a focus on specific skill areas to ensure that newly qualified and existing staff are in a position to deliver on quality services.

Leadership

Effective leadership is one of the key requirements for the implementation of Service Frameworks and will require health and social care professionals from primary, community and secondary care to work together across organisational boundaries, including other governmental departments and the voluntary and community sectors. It is essential that Service Frameworks are given priority at senior, clinical and managerial level and implemented throughout all HSC organisations.

Affordability

Extensive discussions have been held with key stakeholders on the overall costs of delivering the Service Framework for Learning Disability in the context of the very significant challenges facing health and social care services. Many of the standards do not require additional resources and should be capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, performance indicators and targets will be reviewed and adjusted as necessary, in the light of the available resources in any one year.

Securing additional funding that may be needed to advance some standards will undoubtedly create challenges. However, Service Frameworks constitute the distillation of the best advice and guidance available and there is great value in setting out our aspirations to improve quality in the care of people with a learning disability, even if we cannot commit to achieving every standard fully or as quickly as we would like. Even in the most difficult of times we must continue to set challenging targets in an effort to improve services.

The Department will work closely with the HSC Board, and other stakeholders, in developing an achievable, prioritised implementation plan for this Service Framework that will deliver real benefits and improved quality of services.

SECTION 2: SERVICE FRAMEWORK FOR LEARNING DISABILITY

Introduction

The aim of the Service Framework for Learning Disability is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion, reducing inequalities in health and social wellbeing, and improving the quality of care.

The Service Framework for Learning Disability sets standards in relation to:

- safeguarding and communication and involvement in the planning and delivery of services
- children and young people
- entering adulthood
- inclusion in community life
- meeting general physical and mental health needs
- meeting complex physical and mental health needs
- at home in the community
- ageing well
- palliative and end of life care

The Service Framework for Learning Disability is initially for a three-year period from 2013 – 2016. It will be the subject of further review and continuing development as a living document as performance indicators are achieved, evidence of changed priorities emerge and new performance indicators are identified.

Process for developing the Service Framework for Learning Disability

The development of Service Frameworks is overseen by a multi-disciplinary Programme Board, which is jointly chaired by the Chief Medical Officer and the Deputy Secretary of the Department. The Service Framework for Learning Disability was lead by a Project Board who were accountable to the

Department's Programme Board for ensuring the completion of the project within agreed timescales and to DHSSPS guidelines. The Project Board was informed by a project team with representation from all aspects of the service including service users, carers, advocates and voluntary organisations. The full project membership is set out in Annex B.

In order to develop the standards, 5 working groups were established which ensured broader representation and expertise. These groups and their membership are set out in Annex C. These groups produced the preliminary reports that informed the development of the standards.

External quality assurance was provided by Mr Rob Greig, National Development Team for Inclusion (NDTi) and Dr Margaret Whoriskey, Scottish Executive.

Equality Screening

The Framework has been screened to take account of Section 75 of the Northern Ireland Act 1998 and any potential impact that the Framework might have on Human Rights. It is the recommendation of the Project Team that the Framework does not negatively impact on equality of opportunity and therefore does not require a full Equality Impact Assessment.

Values

The core values outlined in the Equal Lives Review (2005) have been adopted in full in the development of the Service Framework for Learning Disability. These core values when enshrined in practice will ensure that independence is promoted for all people with a learning disability. (Annexe D)

Policy and Legislative Context

The Service Framework for Learning Disability is congruent with the legal and policy context for the delivery of supports to people with a learning disability.

This has over recent years increasingly been underpinned by concepts of rights, inclusion and citizenship.

The onus on public authorities to promote equality of opportunity is also enshrined in the Northern Ireland Act (1998) which states that "*a public authority shall, in carrying out its functions in Northern Ireland, have due regard to the need to promote equality of opportunity between persons with a disability and persons without.*"

The Reform and Modernisation of Mental Health and Learning Disability Services Review (Bamford - May 2007)

A review of policy, practice and legislation relating to Mental Health and Learning Disability was commissioned by DHSSPS in October 2002. The Review concluded in August 2007 and produced ten reports (Annex E) that detailed the vision for supporting people with a learning disability, promoting mental health and wellbeing at all levels of society and for the delivery of specialist health and social care for everyone who needs it.

The DHSSPS response to Bamford, 'Delivering the Bamford Vision' (2008) (the Action Plan) states, "*the Northern Ireland Executive accepts the thrust of the recommendations*", and sets out proposals to take the recommendations forward over the next 10 – 15 years.

The Service Framework for Learning Disability builds on the approaches to supporting people with a learning disability proposed in the Bamford Review and the subsequent Action Plan.

Consistency with other documents

The Service Framework for Learning Disability has taken cognisance of reports and documents that have been or are being developed by DHSSPS and other regional groups, including:

- Transforming Your Care (DHSSPS, 2011)
- *Investing for Health* strategies;
- The Quality Framework – as outlined in *Best Practice Best Care (2001);*

- The *Reform and Modernisation* of HSC;
- Personal and Public Involvement (PPI) (DHSSPS, 2007)
- National Institute for Health and Clinical Excellence guidance (NICE)
- Social Care Institute for Excellence guidance (SCIE)

Human Rights and Social Inclusion

A key priority for health and social care services and the wider community is to tackle stigma, discrimination and inequality and to empower and support people with a learning disability and their families to be actively engaged in the process. This is underpinned by legislation from Europe and the United Kingdom (UK) as well as international law. A summary of all the relevant documentation can be found in "Promoting Social Inclusion" (including the UN Convention on the Rights of People with Disabilities[4] (UNCRPD)), The Reform and Modernisation of Mental Health and Learning Disability Services (Bamford - May 2007) and the "Human Rights and Equality" Report (Bamford - October 2006).

Human rights, as enshrined in the Human Rights Act (1998) UK, derive from the fundamental principles that:

- human beings have value and should be treated equally based on the fact that they are human beings first and foremost; and
- human worth is not based on either capacity or incapacity.

Human rights include the right to life, liberty and security and respect for a private and family life.

As this Framework also aims to address the particular issues facing children and young people with a learning disability and their family carers it is also underpinned by the four core principles of the UN Convention on the Rights of Children:[5]

- non-discrimination;

[4] UNCRPD http://www.un.org/disabilities/default.asp?id=150
[5] UNCRC http://www.article12.org/pdf/UNCRC%20Official%20Document.pdf

- devotion to the best interests of the child;
- the right to life, survival and development; and
- respect for the views of the child.

How to read the rest of this document

Each Service Framework follows an individual's journey from infancy through to end of life care taking into account the different health and social care needs of children, adults and older people. In the Service Framework for Learning Disability each standard is accompanied by a statement written from the perspective of a person with a learning disability, in order to make them more meaningful to those for whom the Framework is primarily aimed.

Each standard sets out the evidence base and rationale for the development of the standard, the impact of the standard on quality improvement as well as the performance indicators that will be used to measure that the standard has been achieved within a specific timeframe. Each standard is presented in the same way. Figure 1 shows the information that is included in each standard.

Explaining the Standards

<table>
<tr><td colspan="4">Overarching Standard
This is a short statement that outlines what will be delivered and includes a statement written from the perspective of a person with a learning disability</td></tr>
<tr><td colspan="4">Rationale
This is a short section that outlines why/how the standard will make a difference for people using learning disability services.

Evidence
This includes brief references for the research evidence or guidance that the standard is based on.</td></tr>
<tr><td colspan="4">Responsibility for delivery/implementation</td></tr>
<tr><td colspan="4">This lists the HSC organisations tasked with responsibility for delivering the standard. It will include partners in care such as other government departments and agencies and voluntary organisations and community groups that have contractual or service level agreements with health and social care organisations.</td></tr>
<tr><td colspan="4">Quality Dimensions</td></tr>
<tr><td colspan="4">The impact of the standard on quality improvement is identified in relation to the five core values outlined in the Equal Lives Review (2005) (Annexe D). These include:
• Citizenship
• Social Inclusion
• Empowerment
• Working Together
• Individual Support</td></tr>
<tr><td>Performance Indicator

This information will be monitored to show if the standard is being delivered.</td><td>Data Source

This identifies where the information will be derived from.</td><td>Anticipated Performance Level
This describes how well the service must perform against this indicator.</td><td>Date to be achieved by

This specifies when the anticipated performance level should be reached.</td></tr>
</table>

Figure 1

Many of the standards apply to both adult services and services for children and young people. Each standard has been colour coded for ease of reference. It should be noted that there are some standards that may apply to both adults and young people, for example, Standard 13 (meaningful relationships) but will continue to be colour coded for adult services.

Standard applies to children, young people and adults with a learning disability

Standard applies only to children and young people with a learning disability

Standard applies only to adults with a learning disability

The rest of this document is divided into the following Sections:

- **Section 3** sets out the rationale for developing a Service Framework for Learning Disability
- **Section 4** sets out the standards for safeguarding and communication and involvement in the planning and delivery of services
- **Section 5** sets out the standards for children and young people
- **Section 6** sets out the standards for entering adulthood
- **Section 7** sets out the standards for inclusion in community life
- **Section 8** sets out the standards for meeting general physical and mental health needs
- **Section 9** sets out the standards for meeting complex physical and mental health needs
- **Section 10** sets out the standards for at home in the community
- **Section 11** sets out the standards for ageing well
- **Section 12** sets out the standards for palliative and end of life care

SECTION 3: WHY DEVELOP A SERVICE FRAMEWORK FOR LEARNING DISABILITY?

Introduction

Learning disability may be defined as follows:

> *A learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development.* (Equal Lives, 2005)

Prevalence of Learning Disability

In determining the prevalence of learning disability in NI the Bamford Review (2005) cited a study based on information held by the former Health and Social Services Trusts, which estimated the numbers as shown in Table 1.

Table 1: Prevalence Rates (per 1,000) (15)

Age Bands	Mild/Moderate	Severe/Profound	Total
0-19	6,432	1,718	8,150
20-34	2,504	1,047	3,551
35-49	1,489	949	2,438
50+	1,473	753	2,226
Totals	**11,898**	**4,467**	**16,365**

However, the Review notes that these figures may be an underestimate as many people classed as *possibly having learning disability* may not be making any demands on health and social care services at present but could do so in the future.

Nonetheless, the overall prevalence rate of 9.7 persons per 1000 is higher than that reported for the Republic of Ireland (RoI) and for regions of Great Britain (GB).

The Review also anticipates that there will be increased numbers of people with a learning disability in the next 15 years. In addition, it notes the likelihood that higher proportions of these individuals will have increased care and support needs due to old age or additional complex needs.

Of particular importance to their quality of life is the need to promote their inclusion in society so that individuals with a learning disability can participate in the communities in which they live and access the full range of opportunities open to everyone else.

Developing a Service Framework for people with a learning disability serves a number of functions:

- For people with a learning disability, it details what it is they can expect in terms of care and support to meet their individual needs in ways that they understand and are accessible.
- For carers and families of people with a learning disability, it outlines what it is they can expect in terms of access to services for their family member and of their involvement as partners in the planning processes.
- For staff in front line service delivery, it enables them to communicate effectively in assisting people with a learning disability to access mainstream and specialist HSC services appropriately.
- For commissioners and those with responsibility for the delivery of services in the statutory and independent sectors, it assists them in achieving an integrated model of services and supports around the person in line with the expectations of service users and their families.

Relating the Service Framework for Learning Disability to other Service Frameworks

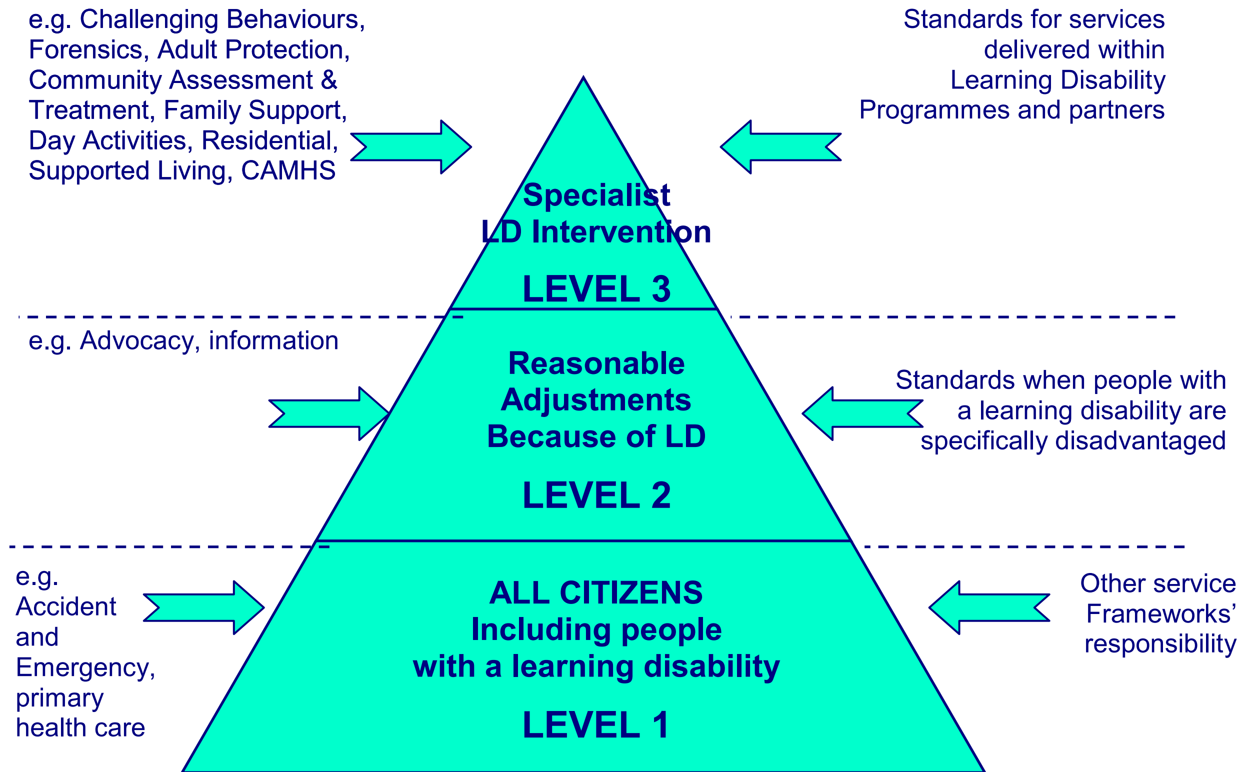

Figure 2

Figure 2 above describes the relationship between the Service Framework for Learning Disability and other service frameworks. Each service framework identifies standards related to a specific aspect of health and social care. The needs of people with a learning disability will also be addressed through these frameworks (Level 1).

In many instances HSC providers will need to make adjustments to the care and support they offer in order to make them accessible to people with a learning disability and their families. Current evidence indicates that these necessary adjustments are not consistently in place within HSC services. Standards in the Service Framework for Learning Disability will therefore require all HSC services to take the needs of people with a learning disability into account when designing and delivering services (Level 2).

While the basic premise of the Service Framework for Learning Disability is that people with a learning disability should access the same HSC services as other people, there are occasions when special expertise or support is required. As services become more inclusive it is anticipated that the volume and range of separate services will decrease as learning disability expertise is developed within mainstream HSC services.

The Service Framework for Learning Disability identifies a range of minimum standards that reflect the current service configuration in order to ensure that people with a learning disability and their families are clear about the care and support they can expect from these services (Level 3). Services provided through the non-statutory sector through contractual or service level agreements with HSC Trusts are also expected to meet these standards.

SECTION 4: SAFEGUARDING AND COMMUNICATION AND INVOLVEMENT IN THE PLANNING AND DELIVERY OF SERVICES

A wide range of people, for a variety of reasons, have been shown to be at risk of harm through abuse, exploitation or neglect. People of all ages, and from all social groupings, have the right to be safeguarded from such harm; to have their welfare promoted; and their human rights upheld. All HSC staff and staff providing services on behalf of the HSC have a dual responsibility with regard to safeguarding: (a) to ensure that all service users are treated with respect and dignity and are kept safe from poor practice that could lead to harm; and (b) that all staff are alert to the indicators of harm wherever it occurs and whoever is responsible; and know how and where to report concerns.

Effective communication is fundamental to the delivery of high quality health and social care. Without it there can be no meaningful partnership with service users and carers. Poor communication is often a significant contributory factor in complaints against HSC organisations and underpins many of the negative user experiences reported in research.

Involving people with a learning disability and their carers in the planning, delivery and monitoring of services helps to ensure that the care and support received meets their needs and aspirations. Involvement has to occur at all levels in HSC from ensuring service users' and carer's views are represented in organisational structures for the design and delivery of services, to securing a person-centred approach in all individual care and support arrangements.

There are particular challenges in meaningfully involving people with learning disability given the communication impairments they may experience and the legacy of discrimination which has served to exclude them from decision making fora in the past. Effective service user involvement needs to be underpinned by access to advocacy and information, alongside a clear understanding of issues related to capacity and informed consent.

Standard 1: (Generic)
All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.

Service user perspective:

"I am protected from harm"

Rationale:
A wide range of people, for a variety of reasons, have been shown to be at risk of harm through abuse, exploitation or neglect. People of all ages have the right to be safeguarded from such harm; to have their welfare promoted; and their human rights upheld. At the same time, they have the right to choose how to lead their lives, provided their lifestyle choices do not impact adversely on the safeguarding needs of others or, within the requirements of the law, of themselves. Decision making in this regard will have to pay due consideration to the age, maturity and capacity of the person. In this Standard, the term safeguarding is intended to be used in its widest sense, that is, to encompass both **preventive** activity, which aims to keep people safe and prevent harm occurring, and **protective** activity, which aims to provide an effective response in the event that there is a concern that harm has occurred or is likely to occur.

All HSC staff and staff providing services on behalf of the HSC have a dual responsibility with regard to safeguarding: (a) to ensure that all service users are treated with respect and dignity and are kept safe from poor practice that could lead to harm; and (b) that all staff are alert to the indicators of harm from abuse, exploitation or neglect wherever it occurs and whoever is responsible; and know how and where to report concerns about possible harm from abuse, exploitation or neglect whether these relate to the workplace or the wider community.

Effective safeguarding can ensure that people are safeguarded and their welfare promoted whether in their own homes; in the community; in families; and in establishments such as children's homes; secure accommodation; residential care and nursing homes; and hospitals. Through safeguarding, and in conjunction with positive engagement of individuals (and as appropriate their family and carers), effective prevention and potential for early intervention is enhanced and promoted and care and service plans are supported to deliver better outcomes. Where safeguarding is promoted, staff are empowered to act as advocates to safeguard vulnerable individuals and professional advocacy and counselling services are provided where required. A learning culture is also evident and staff are knowledgeable about safeguarding and keep abreast of local and national developments and learning, including enquiries, serious case reviews, case management reviews, inquiries and reports.

The quality of outcomes is more consistent, regardless of age, disability, gender, ethnic origin, religion, language, sexuality, political opinion, who pays for their care or their access to HSC provided or purchased services. Application in the wider community of knowledge and expertise gained in the

workplace serves to safeguard people more broadly and more generally. The cycle of abusive behaviour(s) and/or neglect is broken.

Evidence:

World Health Organisation (2011) European Report on Preventing Elder Maltreatment
http://www.euro.who.int/__data/assets/pdf_file/0010/144676/e95110.pdf

OFMDFM (2009) Report of the Promoting Social Inclusion Working Group on Disability
http://www.ofmdfmni.gov.uk/report_of_the_promoting_social_inclusion_working_group_on_disability__pdf_1.38mb_.pdf

DHSSPS (2008) Improving the Patient & Client Experience 5 Standards: Respect, Attitude, Behaviour, Communication and Privacy and Dignity
http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

The Joint Committee on Human Rights (2008) A Life Like Any Other? Human Rights of Adults with Learning Disabilities, Seventh Report of Session 2007-08 Volume 1
http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/40/40i.pdf

Council of Europe (2007) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse
http://conventions.coe.int/Treaty/EN/treaties/html/201.htm

OHCHR (2006) UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment http://www2.ohchr.org/english/law/cat-one.htm

OFMDFM (2005) Ageing in An Inclusive Society – Promoting the Social Inclusion of Older People (currently under review)
http://www.ofmdfmni.gov.uk/ageing-strategy.pdf

DHSSPS (2003) Co-operating to Safeguard Children
http://www.dhsspsni.gov.uk/show_publications?txtid=14022

United Nations (2000) The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children
http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf

European Convention on Human Rights http://www.hri.org/docs/ECHR50.html

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board & LCGs • Public Health Agency (PHA) • HSC Trusts • Primary Care	• PCC • RQIA • SBNI, NIASP & LASPs • PSNI • Other statutory agencies & voluntary, community & private sector

Quality Dimension
Citizenship People of all ages will be safeguarded from harm and have their welfare promoted and their human rights upheld. Safeguarding responses are non-discriminatory, and seek to ensure that people of all ages at risk of harm are offered support to keep them safe from harm and to protect them when harm occurs. **Empowerment** Safeguarding interventions must be tailored to the presenting circumstances and to the needs and choices of the individual (provided these do not impact adversely on the safeguarding needs of others or, within the requirements of the law, of him or herself) and his/her circumstance. Decision making in this regard will have to pay due consideration to the age, maturity and capacity of the person. **Working Together** Promotion of self-reliance and personal and professional safeguarding behaviours; builds personal and professional safeguarding capacity; promotion of the welfare of individuals; protection from mistreatment; impairment of health and development is prevented; and individuals are kept safe from harm. **Individual Support** Promotion of self-aware practice; supportive of person-centred engagement; fosters awareness and opportunity for early intervention in poor practice/potentially abusive dynamics; and promotion of individualised safety plans where these are indicated, thereby enhancing services and safeguarding awareness and responses

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. All HSC organisations and organisations providing services on behalf of the HSC have a **Safeguarding Policy** in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc). The Safeguarding Policy is supported	HSC and provider Organisation annual reports HSC Governance Reviews, e.g. Complaints; SAIs, etc HSC Statutory Functions Reports and Corporate Parent Reports SBNI, NIASP & LASP Annual Reports RQIA Reports &	Establish baseline Performance level to be determined once baseline established	March 2014 March 2015

by robust procedures and guidelines	Reviews Case Management Reviews (CMRs) Serious Case Reviews (SCRs)		
2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place	As above	Establish baseline Performance level to be determined once baseline established	March 2014 March 2015
3. All HSC organisations and organisations providing services on behalf of the HSC have **safeguarding champions** in place to promote awareness of safeguarding issues in their workplace	As above	Establish baseline Performance levels to be determined once baseline established	March 2014 March 2015

Standard 2:
People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. This needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services unless there are explicit and valid reasons to the contrary agreed with the person.

Service user perspective:

"I am involved as a matter of course in making choices or decisions about my health and social care needs."

"My family, other carers and advocates are involved as partners."

"Staff ask for my views and the views of family carers when they are planning and delivering services."

Rationale:
People with a learning disability and family carers report a lack of engagement and exclusion from the planning and decision-making processes, which can result in services being unresponsive to individual needs, strengths and aspirations. It is important to ensure that people with a learning disability and their families are involved as partners in their health and social care.

Services must be delivered in ways that appropriately manage risk for service users, carers and their families. It is acknowledged, however, that in some situations, living with an identified risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking (when it is appropriately managed) can be considered to be a positive action. HSC staff need to work in partnership with service users and carers to explore choices, identify and assess risks and agree on how these will be managed and minimised for the benefit of individual service users, their carers and families.

Evidence:
DHSSPS (2010) Care Management, Provision of Services and Charging Guidance http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Well

being in Northern Ireland 2005-2025
http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Trusts	• Other service providers • Advocacy organisations • Families and carers

Quality Dimension

Citizenship
Service users will be involved as partners in the planning and delivery of health and social care services.

Social Inclusion
Involvement will ensure that service users are enabled to access mainstream services and be fully included in the life of the community.

Empowerment
Involving service users in the design and delivery of HSC services ensures that their expertise effectively informs the development of appropriate services.

Working Together
Partnership with service users, their families and carers is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Person-centred support relies on individuals being supported to share their views, hopes and concerns. Involvement is a necessity for the development of person-centred approaches and planning.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Evidence that people with a learning disability, their family and carers have been involved in making choices or decisions about their individual health and social care needs.	HSC Trust reports (care plans)	Establish baseline Performance level to be determined once baseline established	March 2015 March 2016

Standard 3: (Generic)
All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.

Service user perspective:

"I will have an opportunity to be actively involved at all levels of health and social care."

Rationale:
Actively involving patients and the public in the planning and provision of health care in general has been noted to bring many advantages to both those who receive and those who provide care. These include:

- Increased patient satisfaction and reduction in anxiety with positive health effects
- Improved communication between service users and professional staff
- Better outcomes of care with greater accessibility and acceptability of services
- Bridging of the gap between those who avail of services and those who provide care
- Recognition of the expertise of the recipient of care developed through experience

Evidence:
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

NHS (2006) Healthy Democracy
http://www.nhscentreforinvolvement.nhs.uk/index.cfm?content=90

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Well being in Northern Ireland 2005-2025
http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • HSC Trusts • Primary Care	• Other Service providers • Advocacy organisations • Families & carers

Quality Dimension			
Citizenship Effective involvement ensures that the diverse needs of people with a learning disability are taken account of in service planning and delivery. The development of partnerships with service users and carers ensures that their views and aspirations are respected and valued. **Social Inclusion** Involvement helps to address the legacy of disadvantage for people with a learning disability which has led to their voices not being heard effectively in service planning. **Empowerment** Involvement gives a voice to the people most directly affected by decisions within health and social care. Involving them will enable them to have an influence over decisions made that affect their lives. **Working Together** Partnership with service users and carers is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes. **Individual Support** Person-centred support relies on individuals being supported to share their views, hopes and concerns. Involvement is a necessity for the development of person-centred approaches and planning.			
Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of job descriptions containing PPI as responsibility March 2014: senior and middle management March 2015: designated PPI leads at all levels of HSC organisations March 2016: all new job descriptions	Audit sample of job descriptions	Establish baseline and set target Monitor progress 100% - in all new job descriptions	March 2014 March 2015 March 2016
2.Percentage of patients and clients expressing	Patient & Client Experience monitoring	Establish baseline and set target	March 2014

satisfaction		Report percentage increase of patient and client satisfaction	March 2015
	Annual Accountability Report	Report percentage increase of patient and client satisfaction	March 2016
3. Percentage of staff who have gained PPI training (details to be agreed for 2014/2015)	Annual Accountability Report Training Report	Conduct training needs assessment for PPI, commission design of PPI training programme	March 2014
		Establish baseline and set target	March 2015
		Monitor percentage of staff trained at different levels in PPI	March 2016

Standard 4:
Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.

Service User Perspective*:*

"I am helped to give or refuse my consent when decisions are being made that will affect my health or well being"

Rationale:
Respecting peoples' right to determine what happens to them is a fundamental aspect of good practice and a legal requirement. Research shows that people with a learning disability are often denied this right. Health and social care staff report uncertainty about how to ensure capacity and informed consent. This covers a wide range of areas from managing personal finances to consenting to surgery and other medical interventions. A major legislative reform process is underway that will strengthen the legal framework for work in the area of mental capacity and consent. HSC organisations should be working within the spirit of this legislative direction.

Evidence:
DHSSPS (2009) Legislative Framework For Mental Capacity And Mental Health Legislation In Northern Ireland – A Policy Consultation Document www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf

Equality Commission Northern Ireland (2008) – A Formal Investigation under Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in NI for People with a Learning Disability www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

SCIE (2008) Healthcare for All: The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (The Michael Inquiry) Tizard Learning Disability Review, 13(4), December 2008, pp.28-34. http://www.scie-socialcareonline.org.uk/profile.asp?guid=4f9f7333-2539-4004-af21-26ed14db5f5d

Mencap (2007) Death by Indifference www.mencap.org.uk/case.asp?id=52&menuId=53&pageno

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

DHSSPS (2003) Reference Guide to Consent for Examination, Treatment or Care www.dhsspsni.gov.uk/consent-referenceguide.pdf

DHSSPS (2003) Seeking Consent: Working with People with Learning Disabilities: http://www.dhsspsni.gov.uk/consent-guidepart4.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary & Acute Care Teams	• DHSSPS • Independent sector • Service users, carers and families

Quality Dimension

Citizenship
The right to self determination is respected and capacity to consent is presumed to exist unless proven otherwise

Empowerment
Paying attention to correct processes for securing consent ensures that the views of people with a learning disability are adequately addressed in decision making.

Individual Support
All health and social care interventions are based on best practice in capacity and consent issues.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Develop and agree a regional training plan that ensures that relevant HSC staff are trained in consent and capacity issues.	HSC reports	All HSC Organisations	March 2016
2 Evidence that robust processes are in place where capacity has been judged to be an issue within HSC services or services commissioned by HSC	SAAT	Development and implementation of SAAT Performance levels to be determined based on outcomes of SAAT	March 2015 March 2016

Standard 5: (Generic)
All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.

Service user perspective:

"I am supported by staff who can communicate well with me."

Rationale:
Effective communication (clear, accessible, timely, focused and informative) has a significant impact on all aspects of care provision from disease prevention, to diagnosis, to self-management of long-term conditions.

Poor communication is a significant factor in most complaints against HSC organisations.

Evidence:
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

GMC (2013) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice.asp

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003: www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• DHSSPS • DE • Other service providers • Service Users & carers

Quality Dimension

Citizenship
As a universal requirement, good communication helps to ensure input by all service users on all aspects of the services they receive assisting in the highlighting of gaps in provision and areas for improvement.

Social Inclusion
Good communication helps to deliver and sustain appropriate patient/client/carer access to services and a clear understanding of the role and responsibilities of the service user in achieving health and care outcomes.

Empowerment
Good communication with patients/clients/carers enables adequate understanding of, consent to and compliance with treatment and care and contributes to audit and monitoring

Working together
Health and care outcomes themselves are enhanced through improved patient partnership and dialogue, including, but not limited to – diagnosis, self-referral, health promotion, disease prevention and management of long term conditions

Individual Support
Person-centredness cannot be delivered or claimed in the absence of good communication with service users. Good communication is a prerequisite of person-centredness.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of patients and clients expressing satisfaction with communication	Patient & Client Experience monitoring report Annual Accountability Report	Establish baseline and set target Report percentage increase of patient and client satisfaction with communication Report percentage increase of patient and client satisfaction with communication	March 2014 March 2015 March 2016

Standard 6:
People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care

Service user perspective:

"I am supported by staff who can communicate well with me."

Rationale:
Between 50% and 90% of people with a learning disability have some form of communication difficulty. Effective communication has a significant impact on all aspects of care and support provision across the full range of activities that promote health and social wellbeing. Poor communication is often a significant contributory factor in complaints against HSC organisations.

People with speech, language and communication needs, in addition to their learning disability, are amongst the most vulnerable and most in need of effective care and support to reach their potential. Early identification and effective intervention are essential. The current system is characterised by high variability and a lack of equity.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Equality Commission (2008) A Formal Investigation under the Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in Northern Ireland for People with a Learning Disability
http://www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

DSCF (2008) Bercow Report: A Review of services for children and young people (0-19) with speech, language and communication needs
www.dcsf.gov.uk/bercowreview/docs/7771-DCSF-BERCOW%20Summary.pdf

DoH (2008) Better Communication: Improving services for children and young people with speech, language and communication needs. Action Plan to the Bercow Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091972

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

GMC (2006) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• DHSSPS • DE • Other Service Providers • Service users and carers

Quality Dimension

Citizenship
Good communication helps to ensure input by people with a learning disability on all aspects of the services that they receive, assisting in the highlighting of gaps in provision and areas for improvement.

Social Inclusion
People with communication difficulties are supported to access mainstream leisure and social activities that promote their integration into mainstream community living and promote their psychological and emotional wellbeing.

Empowerment
Good communication with service users, carers and family enables adequate understanding of, and consent to, the care, support and treatment arrangements offered.

Working Together
There is evidence of good communication between professionals that can determine early identification of communication difficulties and planning to provide the necessary supports to the person with a learning disability, their carer and family and that this is reviewed regularly with particular attention at transition points.

Individual Support
Good communication is a prerequisite of person-centredness.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people with a learning disability who do not use speech as their main form of communication,	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016

who have been supported to establish a functional communication system.			
2 Develop and agree a regional training plan for staff in both HSC and services commissioned by HSC to raise awareness of communication difficulties and how they may be addressed	HSC reports	Regional Training Plan in place Training is delivered in accordance with Regional Training Plan.	March 2015 March 2016

Standard 7:
People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.

Service user perspective:

"I receive information about services and issues that affect my health and wellbeing in a way that my family and I can understand."

Rationale:
The particular communication difficulties experienced by many people with a learning disability create additional challenges in accessing information on which to make informed choices and access appropriate supports. Access to HSC services depends on people having information on what is available and how the care and support offered will impact on them. This places an onus on HSC organisations to ensure that people with a learning disability, their carers and their families are informed in a way that takes account of their particular circumstances.

This process will be enhanced by the availability of a named staff member to assist people in understanding the services available.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Equality Commission (2008) A Formal Investigation under the Disability Discrimination Legislation to Evaluate the Accessibility of Health Information in Northern Ireland for People with a Learning Disability
http://www.equalityni.org/archive/pdf/FormalInvestDisability(Full).pdf

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

Foundation for People with Learning Disabilities (2005) Communication for person-centred planning
http://www.learningdisabilities.org.uk/?view=Search+results&search=Communication+for+person-centred+planning

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board (including Commissioning Groups) • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DSD, DE, DEL, DoJ • Other service providers • Advocacy partners • Service users and carers

Quality Dimension

Citizenship
People with a learning disability can only exercise their rights as citizens if they have accessible information about entitlements and services offered.

Social Inclusion
A major barrier to inclusion is the lack of information on which to base informed decision making.

Empowerment
Access to information enables people to speak out about what they need and what is being offered.

Working Together
Provision of information in an accessible manner is a key step towards enabling effective partnership between those who work in services and those who use them.

Individual Support
The development of effective person-centred support relies on individuals being well informed about choices that are open to them.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 All HSC organisations should provide evidence that they are making information accessible to people with a learning disability	SAAT	Development and implementation of SAAT Performance levels to be determined once baseline established	March 2015 March 2016
2 Each person with a learning disability can access a named person who can signpost them to relevant services.	Sample survey of families and service users.	Establish baseline of information provided Performance levels to be determined once baseline established	March 2016

Standard 8:
People with a learning disability, or their carer, should be able to access self directed support in order to give them more control and choice over the type of care and support they receive.

Service user perspective:

"I, or my carer, can request self-directed support in order to give me more control and choice over the type of care and support I receive."

Rationale:
There is growing evidence of the positive outcomes that may be gained by people with a learning disability when they have direct financial control over their supports. Access to Direct Payments as a means of delivering social services in NI has been available since 1996 under the Personal Social Services (Direct Payments) (Northern Ireland) Order 1996. The Carers and Direct Payment Act (NI) 2002 extended access to a much wider group of people. Direct Payments increase choice and promote independence. They provide for a more flexible response than may otherwise be possible for the service user and carer. They allow individuals to decide when and in what form services are provided and who provides them, who comes into their home and who becomes involved in very personal aspects of their lives. Direct Payments put real power into the hands of service users and carers, and allow them to take control over their lives. Whilst uptake of this provision has been low, it has been steadily increasing over recent years.

In England, direct payments have paved the way for investigation into how individual budgets could work to promote choice and control for people using adult social care services. The introduction of individual or personal budgets is part of the wider personalisation agenda in adult social care. At the time of preparing the Service Framework for Learning Disability an equivalent policy directive relating to the use of individual budgets is not in place. However, DHSSPS have indicated its commitment, in the Bamford Action Plan, to exploring the benefits of increasing users' direct control over services. The implementation (and review) of this standard will, therefore, evolve alongside future policy developments in this area.

Evidence:
HSC Board/ PHA (2011) Draft Commissioning Plan 2011/12
http://www.publichealth.hscni.net/sites/default/files/Draft%20HSCB%20PHA%20Commissioning%20Plan%202011-2012_0.pdf

DoH (2009) New Horizons: A Shared Vision for Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)

http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2009) Research briefing 20: The implementation of individual budget schemes in adult social care. Published Jan 2007, Updated Feb 2009, Addendum 2009
http://www.scie.org.uk/publications/briefings/briefing20/index.asp

PSSRU (2007) Direct Payments: A National Survey of Direct Payments Policy and Practice http://www.pssru.ac.uk/pdf/dprla_es.pdf

DoH (2007) Valuing People Now: From Progress to Transformation – A consultation on the next three years of learning disability policy
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/LiveConsultations/DH_081014

DHSSPS (2005) Direct Payments: Policy and Practice Review Report
http://www.dhsspsni.gov.uk/direct_payments_policy_and_practice_review_report.pdf

Bamford (2005) Equal Lives (Section 10 - Ensuring Personal Outcomes): Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DoH (2005) Independence, Wellbeing and Choice: Our Vision for the Future of Social Care for Adults in England – Social Care Green Paper
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4116631

Joseph Rowntree Foundation (1999) Implementing Direct Payments for People with Learning Disabilities http://www.jrf.org.uk/sites/files/jrf/F349.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Welfare Rights Advisers • Advocacy organisations • DEL/DHSSPS/DCAL • Service users and carers.

Quality Dimension

Citizenship
Increased equity exists between service users and service providers where human rights have been respected.

Social Inclusion
Quality of life and wellbeing are improved through being able to have direct control over funding available to support social inclusion activities

Empowerment
Service users and carers experience more choice and control within processes and access services that they have requested and, where necessary, have the support of independent advocates.

Working Together
Change in attitudes and culture with renewed engagement between agencies on joint support planning providing greater flexibility in the way in which supports can be accessed.

Individual Support
People demonstrate improved health and wellbeing from having greater control over how they are supported and having their aspirations met in a more individualised way.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Evidence of provision of accessible information on Direct Payments within HSC organisations.	SAAT	Develop and implement SAAT Establish performance levels based on outcomes from SAAT	March 2015 March 2016
2 Percentage of requests for direct payments from people with a learning disability that were approved	SAAT	Develop and implement SAAT Establish performance levels based on outcomes from SAAT	March 2015 March 2016
3 Number of adults with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 2.25%)	HSC Board and Trust Reports	Performance levels to be determined based on available resources and included in final Framework	
4 Number of children with a learning disability in receipt of Direct Payments expressed as a percentage of those in contact with Trust (regional percentage is 3.50%)	HSC Board and Trust Reports	Performance levels to be determined based on available resources and included in final Framework	

5 The HSC Board and Trusts have plans in place to extend the range and scope of self directed support including how they will develop skills and expertise in relevant staff	HSC Board and Trust reports	HSCB and all Trusts	March 2017

Standard 9: (Generic)
Service users and their carers should have access to independent advocacy as required.

Service user perspective:

"I can get an advocate to support me to speak out about worries I have about the care and support I receive"

Rationale:
People engage with health and social care services at times in their lives when they might be vulnerable or in need of support and / or guidance in relation to decisions about their health and wellbeing. For a whole raft of reasons (age, disability, mental health issues, gender, ethnic origin, sexual orientation, social exclusion, reputation, abuse and family breakdown and living away from home or in institutions), they may also feel discriminated against or simply excluded from major decisions affecting their health and wellbeing. It is at such times that independent advocacy can make a real difference because it gives people a voice; helps them access information so that they can make informed decisions and participate in their own care or treatment.

Independent advocacy is also a means of securing and protecting a person's human rights; representing their interests; and ensuring that decisions are taken with due regard to a person's preferences or perspectives where, for whatever reason, they are unable to speak up for themselves. In strategic terms independent advocacy can contribute to increased social inclusion and justice; service improvements in health and wellbeing; reductions in inequalities across the health and social care sector; and enhanced safeguarding arrangements. Independent advocacy can be delivered in a number of different ways and people may need different types of advocacy at different times in their lives. The most common models are self/group advocacy; peer advocacy; citizen advocacy; and individual/issue-based advocacy (also known as professional advocacy).

In this context, independence means structurally independent from statutory department or agency providing the service. The advocacy provider must be free from conflict of interest as possible both in design and operation and must actively seek to reduce any conflicting interests.

Independent advocacy should be available throughout the care pathway and, in particular, should be available early in the process as this may prevent a crisis developing. An advocacy service should apply not just to service users but to their carers and families. To be effective users need to be aware of advocacy services. Therefore they need to be promoted through accurate and accessible information. Relevant health and social care staff should be aware of the benefits of independent advocacy and the particular importance of independence from service provision.

There is currently a proposal to introduce a statutory right to an independent

advocate in the proposed Mental Capacity Bill. Guidance on this right will be issued once the Bill has been finalised.

Evidence

DHSSPS (2012) Developing Advocacy Services – A Policy Guide for Commissioners
http://www.dhsspsni.gov.uk/developing-advocacy-services-a-guide-for-commissioners-may-2012.pdf

DHSSPS (2010) Advocacy Research: Summary Paper
http://www.dhsspsni.gov.uk/advocacy-research-summary-paper-of-advocacy-provision-october-2010.pdf

Knox, C. (2010) Policy Advocacy in Northern Ireland. University of Ulster, Jordanstown

Alzheimer's Society (2009) Listening Well http://www.alzheimers.org.uk

Horton, C (2009) Creating a Stronger Information, Advice and Advocacy System for Older People. London; Joseph Rowntree Foundation

SCIE (2009) At A Glance 12: Implications for Advocacy Workers available at http://www.scie.org.uk/publications/ataglance/ataglance12.asp

Seal, M. (2007) Patient Advocacy and Advance Care Planning in the Acute Hospital Setting – Australian Journal of Advanced Nursing Vol 24, No 4, pp29-36

Wright, M. (2006) A Voice That Wasn't Speaking: Older People Using Advocacy and Shaping it's Development, Stoke-on-Trent, OPAAL UK (Older People's Advocacy Alliance)

Bamford Review (2006) Review of Mental Health and Learning Disability (NI), Human Rights and Equality of Opportunity Available at www.dhsspsni.gov.uk/bamford

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts • Public Health Agency (PHA)	• Local Commissioning Groups • Primary Care Partnerships • GPs • Voluntary and Community Sector • Independent Sector • PCC

Quality Dimensions

Citizenship
An advocacy service can promote equality, social justice and inclusion of the most vulnerable and disadvantaged. Advocacy can enhance capacity building

at a community and individual level, which can ultimately reduce dependency on other health and social care services.

Empowerment
Advocacy services can enable individuals to access information, express their views and wishes and make informed choices about their own health and well being. The service is geared to needs of the individual. The service user will receive a service that best meets their needs at a time, which evidence shows, to be effective and to have maximum impact.

Individual Support
Advocacy services can safeguard users from abuse and exploitation by ensuring that their rights are upheld and their voice heard. An advocacy service can promote equality, social justice and inclusion of the most vulnerable and disadvantaged.

Performance Indicator	Data Source	Anticipated Performance Level	Date to be achieved by
To be determined			To be determined

SECTION 5: CHILDREN AND YOUNG PEOPLE

Work is ongoing in the development of a Children and Young People's Service Framework. It is anticipated that that Framework will address the universal needs of children and young people in Northern Ireland.

This Section aims to address the particular issues facing children and young people with a learning disability and their family carers and acknowledges the role played by schools and Education and Library Board in the assessment, intervention, support and onward referral of children & young people who may or do have a learning disability. This Section should be read alongside the other standards set out in this Framework.

Support to families tends to be fragmented and parents report difficulty in accessing services and understanding the range of roles and services that are in place.

It is crucial when concerns emerge that a child may have a learning disability, that a clear action plan is agreed as to how the concerns will be investigated. It is essential that planning and support systems are used to wrap around the child and family to ensure a seamless and co-ordinated approach. Where children have to live away from their family the arrangements in place must take account of their learning disability.

The Service Framework for Learning Disability reflects the fundamental position that regardless of diagnosis, a child/young person is a child/young person first, and that children and their families should be fully supported to participate in valued childhood experiences. They should also have access to the same opportunities, life experiences and services as other children and families.

Standard 10:
From the point at which concerns are raised that a child or young person may have a learning disability, there is an action plan in place to determine the nature and impact of the learning disability.

Service User Perspective:

Parents will have an action plan that clearly sets out the steps to be taken for discovering the nature and impact of learning disability their son or daughter may have.

Rationale:
Parents report dissatisfaction with the manner in which supports are organised when concerns begin to emerge that their son or daughter may have a learning disability. Professional efforts are often not well co-ordinated resulting in parents having to manage multiple appointments and, at times, conflicting advice.

Long delays are reported for appointments to specialists and parents can experience great difficulties in accessing the information they need and in understanding the roles that various professionals and organisations play.

Assessment needs to be timely, comprehensive and conducted in a co-ordinated manner.

Evidence:
Power, A (2008) 'It's the system working for the system': carers' experiences of learning disability services in Ireland: *Health and Social Care in the Community* (2008) http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2524.2008.00807.x/abstract

SCIE (2008) Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case reviews. www.scie.org.uk/publications/guides/guide24/index.asp

SCIE (2007) Knowledge Review 18: 'Necessary Stuff' – The social care needs of children with complex healthcare needs and their families. www.scie.org.uk/publications/knowledgereviews/kr18.asp

DHSSPS (2007) Complex Needs – The Nursing Response to Children & Young People with Complex Physical Healthcare needs. www.dhsspsni.gov.uk/complex_needs_report.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• Families • DHSSPS, DE • Early Years providers

Quality Dimension
Social Inclusion Assessment takes account of the need for the child or young person to have as normal a life as possible and be socially included within the communities in which they live. **Empowerment** Children, young people and their families receive co-ordinated essential information about the services they can expect to receive and the roles that professionals will have in delivering these services and have an identified link person to whom they can refer any problems and with whom they can develop effective relationships. **Working Together** Professionals work together with families to determine a child/young person's condition within a required timeframe and systems are put in place for effective ongoing communication and delivery of supports. **Individual Support** Assessments are co-ordinated effectively between professionals and families and parents are clear as to actions planned by HSC professionals.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of parents who express satisfaction with the assessment process and how the outcomes were conveyed.	Audit of sample family carers	Establish baseline of information provided Performance levels to be determined once baseline established	March 2016 March 2017

Standard 11:
Children and young people should receive child-centred and coordinated services through assessment to ongoing care and support from the point at which a determination has been made that they have a learning disability.

Service user perspective:

"My son or daughter receives services that are child-centred, appropriate and co-ordinated."

Rationale:
The Children Order (NI) 1995 outlines that a child is a 'child in need' by virtue of the fact that he/she is disabled (Art17(C)). Trusts and statutory bodies are required to comply with their statutory duties in respect of children in need, including those in relation to carers needs under this legislation.

Getting the right care and support for children, young people and their families makes a significant impact on positive outcomes in adulthood. A child's needs cover the whole range of public services and resources including play, leisure, housing and education. The involvement of all these interests is essential if we are to avoid confining the lives of children with a learning disability within the health and social care system.

Evidence:
DHSSPS (2009) NI Single Assessment Tool
http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-northern-ireland-single-assessment-tool.htm

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Integrated Care Pathway for Children & Young People with Complex Physical Healthcare Needs
http://www.dhsspsni.gov.uk/integrated_care_pathway-july09.pdf

DHSSPS (2008) UNOCINI Guidance
http://www.dhsspsni.gov.uk/microsoft_word_-_unocini_guidance_revised_june_2011_inc_mh_domain_elements.pdf

Black, LA *et al* (2008) Lifelines Report An Evaluation Report of the Impact of the Families Services delivered by Positive Futures in Rural and Urban Areas of Northern Ireland. http://www.positive-futures.net/sites/default/files/LIFELINES%20Full%20Report.pdf

Kenny, K and McGilloway, S. (2007) Caring for children with learning disabilities: an exploratory study of parental strain and coping, British Journal

of Learning Disabilities, p221-8.
http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2007.00445.x/abstract

SCIE (2007) Knowledge Review 18: 'Necessary Stuff' – The social care needs of children with complex healthcare needs and their families
www.scie.org.uk/publications/knowledgereviews/kr18.asp

DHSSPS (2007) Complex Needs – The Nursing Response to Children & Young People with Complex Physical Healthcare needs.
www.dhsspsni.gov.uk/complex_needs_report.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts/Children's Services	• Families • DHSSPS, DE, DCAL • Voluntary and community sector providers

Quality Dimension

Social Inclusion
Assessment and supports take account of the need for the child or young person to have as normal a life as possible and be socially included within the communities in which they live.

Empowerment
Children, young people and their families receive co-ordinated essential information about the services they can expect to receive and the roles that professionals will have in delivering these services and have an identified link person to whom they can refer any problems and with whom they can develop effective relationships.

Working Together
Professionals work together with parents as partners in developing family centred plans to meet the care and support needs of the child and his/her family. Plans must take account that the needs of children and young people with a learning disability cannot be met by health and social care alone and will involve close working with other interests including housing, leisure and education.

Individual Support
Supports are co-ordinated effectively between professionals and the family and the child/young person has a plan in place that is regularly reviewed to ensure that supports remain appropriate.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of children and young people with a learning disability and carers who have been offered an annual assessment either under the Family Health Needs Assessment or UNOCINI assessments.	Audit/Sampling	Establish baseline Performance levels to be determined once baseline established	March 2016 March 2017
2 Percentage of children and young people who have an agreed care plan detailing a pathway to receiving appropriate care and support.	Audit to include UNOCINI referrals and completed family support and Looked After Children (LAC) pathway assessments following initial referral	Establish baseline Performance levels to be determined once baseline established	March 2016 March 2017

Standard 12:
HSC services should respond to the needs of children and young people who have a learning disability and complex physical health needs in a manner that is personalised, developmentally appropriate and which support access to appropriate care.

Service User Perspective:

"If my son or daughter has complex physical health needs we will receive care and support in a flexible way through services that are age appropriate."

Rationale:
Current services often lack the responsiveness and flexibility required to ensure that children and young people with a learning disability enjoy equal access to the full range of supports that are required to effectively address the needs arising from additional health problems they have. This can result in them receiving care and treatment that is less than optimum, is poorly coordinated, and sometimes delivered in settings, which are not developmentally appropriate.

Children and young people with a learning disability benefit greatly from effective transitions between hospital and community services and sensitive, detailed assessment and care planning across the range of HSC professionals involved with the family.

Evidence:
DHSSPS (2009) Integrated Care Pathway for Children & Young People with Complex Physical Healthcare Needs
http://www.dhsspsni.gov.uk/integrated_care_pathway-july09.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Families Matter: Supporting Families in Northern Ireland
http://www.dhsspsni.gov.uk/families_matter_strategy.pdf

The Council for Disabled Children (CDC) (August 2009) The use of eligibility criteria in social care services for disabled children
http://www.ncb.org.uk/cdc/home.aspx

DHSSPS (2008) UNOCINI Guidance
http://www.dhsspsni.gov.uk/microsoft_word_-_unocini_guidance_revised_june_2011_inc_mh_domain_elements.pdf

DHSSPS (2007) Complex Needs – The Nursing Response to Children & Young People with Complex Physical Healthcare needs.
www.dhsspsni.gov.uk/complex_needs_report.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Beecham,J. et al. (2002) Children with Severe Learning Disabilities: Needs, Services and Costs *Children & Society* pp. 168–181
www.lse.ac.uk/collections/PSSRU/staff/beecham.htm

Sloper, P. (1999) Models of service support for parents of disabled children. What do we know? What do we need to know? *Child: Care, Health and Development*, 25 (2), 85-99. www.ncbi.nlm.nih.gov/pubmed/10188064

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts / Children's Services • Primary and Acute Services	• DHSSPS • Voluntary & Community Sector Providers • Families & carers

Quality Dimension

Citizenship
The rights of the child/young person/family are respected when assessing their needs and practical approaches are taken to meeting these needs that are equitable to the rest of the population.

Working Together
There is a coordinated approach to addressing health and social care needs where parents are clearly signposted to sources of care and support, particularly when the child/ young person moves between hospital and home.

Individual Support
Multi-disciplinary input is effective in providing assessment and supports that the child and family requires using person-centred and family centred approaches that are effective in maintaining, where possible, ordinary family life and are reviewed regularly or at least annually.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of parents whose child has a learning disability and complex physical health needs who have an identified key worker with co-ordinating responsibility	Annual Audit	Scope requirements and produce audit plan. Audit 50% of information available 100%	March 2015 March 2016 March 2017

2 Percentage of children and young people with complex physical health needs who have effective transition arrangements in place between hospital and community.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes. Fast track arrangements for access to hospital /community services to be audited following establishment of baseline	March 2015 March 2016
3 Percentage of children with a learning disability and complex physical health needs who have received a multi-professional assessment as per regional integrated care pathway.	Trust Reports	90% 95% 98%	March 2015 March 2016 March 2017

Standard 13:
Any child or young person who cannot live at home permanently should have their placement/ accommodation needs addressed in a way that takes full account of their learning disability.

Service User Perspective:

"If I cannot live at home permanently, my needs will be addressed in a way that takes full account of my learning disability."

Rationale:
A small number of children and young people who have a learning disability cannot live with their natural families. Many have severely challenging behaviours, specific health needs and/or Autistic Spectrum Disorders (ASD). They require support and living arrangements that are sufficiently expert to address their complex individual needs. Decisions about future care and support arrangements need to be taken in a timely manner and in a way that supports permanency.

Evidence:
DHSSPS (2009) Autism Spectrum Disorder (ASD) Strategic Action Plan 2008/09 – 2010/11
http://www.dhsspsni.gov.uk/asd_strategic_action_plan.pdf

DoH (2005) Valuing People: The story so far (p44)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4107059.pdf

McConkey *et al* (2004). The characteristics of children with a disability looked after away from home and their future service needs. British Journal of Social Work, 34 (4), 561-576. http://bjsw.oxfordjournals.org/content/34/4/561.abstract

Chadwick *et al* (2002) Respite Care for Children with Severe Intellectual Disability and their Families: Who Needs It? Who Receives It? Child and Adolescent Mental Health vol7 (2): 66-72.
http://onlinelibrary.wiley.com/doi/10.1111/1475-3588.00013/full

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• DHSSPS • Other Service Delivery Partners

Quality Dimension

Citizenship/Social Inclusion
Children & young people with a learning disability have their needs met within environments that promote social inclusion and full citizenship

Empowerment
Children, young people and their family members are supported to express their views on the care and support services that they require and are supported to maintain links with each other when a child/young person lives away from home.

Working Together
Professionals collaborate to provide responsive services through developing a person-centred Permanency Plan to meet the needs of the individual child/young person.

Individual Support
The Permanency Plan includes arrangements for specialist placements based on the short, medium and long term needs of the individual.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of looked after children or young people with a learning disability who cannot live with their families who have a Permanency Plan.	SOSCARE	Establish baseline Performance level to be determined once baseline established	March 2015 March 2016

SECTION 6: ENTERING ADULTHOOD

The manner in which young people are supported at the time of transition from adolescence to adulthood is a crucial component in determining the degree to which they are enabled to live full and valued lives in their communities.

Supporting effective transition is the responsibility, not only of HSC organisations, but also requires the effective engagement of other government departments, notably DEL and DE, and other agencies. There is scope for improvement in the quality of the transition experience. Many young people have unsatisfactory experiences during the move from school towards adulthood.

Parents and young people should be offered a transitions pathway that outlines their:

- individual interests;
- aspirations;
- strengths and needs including vocational training;
- education;
- employment;
- health profile;
- social supports;
- friendships (including meaningful relationships); and
- social development.

Standard 14:
Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.

Service User Perspective:

"I will have a transition plan in place before my 15th birthday."

"I will know the arrangements that are in place for when I leave school before my 18th birthday."

Rationale:
Effective transition planning at an early stage is vital if young people are to move successfully from school towards fuller adult lives. This is a statutory requirement under special education legislation and a recommendation of the Bamford Review. These arrangements should be made in partnership with the young person, their family/carers and adult learning disability services for transition to appropriate adult services in accordance with agreed transition protocols. The objective of this transition planning is to support people into the same life chances as other non-disabled young people e.g. a job, relevant education, positive relationships and the start of living independently.

It is noted that increased numbers of children with statements of special education needs, including those with disabilities are accessing mainstream education. Under the Special Educational Needs and Disability (NI) Order 2005 (SENDO) Code of Practice, transition planning in schools commences for 'statemented' pupils at the first annual review following the child's 14th birthday. The Education and Library Board's (ELB) Transition Service will ensure, in the most complex of cases, that appropriate advice givers will be present as part of the annual review process. Transition planning and services should be available, with young people and carers made aware of them, and able to access transition supports following post primary education with sufficient forward planning to minimise apprehension and stress for those young people and their carers.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2008) Getting a Life 2008-11 http://www.gettingalife.org.uk

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Special Educational Needs and Disability (NI) Order 2005 (SENDO)

Education (NI) Order 1996 and Code of Practice
http://www.deni.gov.uk/index/7-special_educational_needs_pg/special_needs-codes_of_practice_pg.htm

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DE (ELBs, schools and FE colleges), DEL • Education Transitions Co-ordinators • Voluntary agencies • Youth services • Councils • Independent providers • RQIA • Young people and their families • Advocacy organisations

Quality Dimension

Citizenship
A common assessment pathway will help to ensure equity of services for all.

Social Inclusion
Accessible information will be provided to allow young people, their carers and relevant others to participate fully in the development of a transition plan. Such information is available in a range of media and from a wide range of sources. Young people's involvement will create a move away from a narrow focus on services to a broader expression of aspirations for the future.

Empowerment
The process of preparing the Transitions Plan will place the young person and his/her family at the centre of planning for the future

Working Together
Decisions about eligibility for services will be the outcome of a multi-disciplinary assessment, and will be open and transparent for parents. The plan will be developed on a multi-disciplinary/multi agency basis with clear accountability lines for delivery by all the contributors.

Individual Support
A preliminary assessment will feed into an individualised transitions plan. Each plan will reflect the young person's aims and objectives in life including specific individual needs and interests, continuing education and training, employment, social and leisure activities and day opportunities.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of young people who express satisfaction that their transition plan has been implemented within 2 years of leaving school.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2016 March 2017
2 Evidence of transfer to DES, where appropriate, for health checks for children on transition to adult services	DES	90% 95% 98%	March 2015 March 2016 March 2017

Standard 15:
People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.

Service User Perspective*:*

"I will be supported to enjoy meaningful relationships."

Rationale:
The Bamford Review promotes the importance of people with a learning disability benefiting from meaningful relationships and the need to offer support, guidance, training and related services to ensure that this happens.

The Human Rights Act 1998 includes the right to respect for privacy and family life, freedom of expression, the right to marry and to found a family and the right not to be discriminated against in respect of these rights and freedoms. This has to be balanced with positive risk taking strategies. Safeguards need to be put in place, where necessary and appropriate, but within a framework that ensures the objective is to support people who are having positive relationships whenever possible.

People with a learning disability have a right to learn about sexuality and the responsibilities that go along with exploring and experiencing one's own sexuality. They have to know how to protect themselves from unplanned pregnancy, HIV and other sexually transmitted infections, and sexual and gender-based violence. Education programmes for people with a learning disability should begin during adolescence as part of their general education. The implementation of this standard will need to be supported by the provisions detailed in Standard 3 (Consent and Capacity).

Evidence:
DHSSPS (2010) Adult Safeguarding: Regional & Local Partnership Arrangements http://www.dhsspsni.gov.uk/asva-__2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2008) Sexual Health Promotion Strategy & Action Plan 2008-2013
http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf

Simpson, A et al (2006) Out of the shadows: A report of the sexual health and well being of people with learning disabilities in Northern Ireland. Newnorth Print Ltd.

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

SCIE (2004) The Road Ahead: Information for Young people with Learning Difficulties, their Families and Supporters at Transition
http://www.scie.org.uk/publications/tra/index.asp

The Human Rights Act, 1998
http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951

Responsibility for delivery/implementation	Deliver and Implementation Partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS, DE (Education and Library Boards and Schools) • Voluntary sector • Service Users • Families

Quality Dimension

Citizenship
The right to personal relationships is enshrined in Human Rights legislation. Meaningful relationships are a fundamental component of health and social wellbeing.

Social Inclusion
People will be supported to access social and leisure opportunities where friendships may be developed.

Empowerment
People will be supported to appreciate the rights, risks and responsibilities involved in personal relationships

Working Together
Staff and family carers will contribute to the development of policies and best practice guidelines in this area.

HSC Trusts will implement the Adult Safeguarding arrangements and staff will be trained appropriately to discharge it.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Regional guidelines on sexuality and personal relationships are developed to ensure a consistent approach	HSC Board Report	HSC Board policy developed and agreed	March 2015

2 Trusts to facilitate appropriate training for staff.	Trust Reports	40% 80%	March 2016 March 2017
3 Trusts to facilitate appropriate training for service users and family carers.	Trust Reports	Level to be established pending development of regional policy	March 2017
4 Increase in the number of people with a learning disability accessing sexual health & reproductive healthcare services.	SAAT	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

SECTION 7: INCLUSION IN COMMUNITY LIFE

Emotional and social wellbeing are directly related to the degree to which people are able to live valued lives and participate in community opportunities.

For people with a learning disability barriers can exist which prevent them from accessing the opportunities that are open to the rest of society. Many of these barriers do not relate directly to the disability, but rather are the result of discrimination and approaches based on a belief that social education and leisure opportunities need to be provided within the context of HSC provision. This has resulted in the social exclusion of people with a learning disability and the development of services that group people together on the basis of a shared learning disability, rather than addressing individual needs and aspirations.

The HSC has a role in working with others in employment, housing, leisure and education to maximise opportunities that enable people with a learning disability to actively participate in their communities and engage in meaningful daytime activities, friendships, employment and leisure.

The majority of men and women with a learning disability live at home with their families. Appropriate short breaks are often an important component in supporting these arrangements.

Increasingly people with a learning disability express an aspiration to have children. HSC services must work together to ensure that people who have a learning disability are appropriately supported in their parenting role.

Standard 16:
Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.

Service User Perspective:

"I will be able to get support to help me find and keep a job."

Rationale:
The Lisbon Agenda (2000) promotes the integration of people traditionally excluded from the labour market. The Bamford Review recommends that agencies should work in partnership to promote and deliver supported employment services. HSC Trust day opportunities strategies promote the development of supported employment as an integral part of service development.

A cultural shift away from a reliance on day centres should be encouraged, towards alternative options which enable individuals with a learning disability to participate in society through day opportunities and work placements that will improve their skills and allow them the opportunity to integrate with others. Those involved in person centred planning should actively consider employment as one of these options.

Evidence:
Beyer S, (2010) Using a Cost Benefit Framework for Supported Employment Policy and Practice: an analysis of 2 UK agencies Journal Appl Res Intellect, Volume 23, 5 (September 2010) pp.447-447
http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2010.00584.x/pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) Valuing Employment Now – Real Jobs for People with Learning Disabilities
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101401

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

DELNI (2008) Pathways to Work (New Deal)
http://www.delni.gov.uk/index/finding-employment-finding-staff/fe-fs-help-to-find-employment/stepstowork.htm (Accessed 15 April 2011)

OFMDFM Promoting Social Inclusion (PSI) Disability
http://www.ofmdfmni.gov.uk/index/equality/disability/disability-promoting-

social-inclusion.htm

Lisbon Agenda (2000) http://www.euractiv.com/en/future-eu/lisbon-agenda/article-117510

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• DEL, OFMDFM • Supported employment providers • Northern Ireland Union of Supported Employment (NIUSE)

Quality Dimension

Working Together
HSC staff, in partnership with DEL and others, will enable people with a learning disability to achieve and maintain employment opportunities with ongoing professional support.

Social Inclusion
Historically there have been barriers to opportunities for meaningful employment for men and women with a learning disability. Increasing such opportunities will be a key contributor to improving social inclusion.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of school leavers with a learning disability who access work placements or employment within one year of leaving school (as percentage of total learning disabled school leaving population).	ELB Transition Service	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
2 Percentage of adults with a learning disability who receive HSC support to help them secure employment (as a measure of those who request support).	Audit	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 17:
All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.

Service User Perspective:

"I will be supported to take part in a range of activities during the day"

Rationale:
There is a need for a radical reconfiguration of existing day service provision based on a progressive shift towards a resource model. As alternative provision develops there should be a reduction in the number of people who attend Adult Centres on a full-time basis. It is anticipated that these centres will, in the future, be providing a service to men and women with increasingly complex needs who should also be enabled to access opportunities for community integration. Adult Centres will need to explore the potential to develop sites for meeting the particular needs of people with more complex needs. The potential for Adult Centres to be used as a community resource is particularly under-utilised at present. Partnerships with community and voluntary groups should involve promoting the inclusion of people with a learning disability.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2007) Knowledge Review 14: Having A Good Day? A study of community-based day activities for people with learning disabilities
www.scie.org.uk/publications/knowledgereviews/kr14.asp

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

PCC (2011) My Day, My Way The Bamford Monitoring Group's Report on Day Opportunities
http://www.patientclientcouncil.hscni.net/uploads/research/My_Day_My_Way_FINAL.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • HSC Trusts	• Local community organisations • DHSSPS, DEL • FE providers • Local economy

Quality Dimension

Social Inclusion
Reconfiguration of day centres may reduce the number of days attended and an

expansion of wider community options for individuals.

Working Together
Each person will have a person-centred plan which will identify the multi-disciplinary and community inputs required to deliver on that plan. A lead person will be accountable for the delivery of the plan, which must be reviewed 6 monthly.

Individual Support
Admission criteria and processes in day centres will be in line with the standard and clear processes will be in place to consider intake and development of opportunities in local communities.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of adults with a severe or profound learning disability who have meaningful day opportunities in mainstream community settings, outside of their building based service.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016
2 Percentage of adults with a severe or profound learning disability receiving support in a building based service, who express satisfaction with the opportunity to experience day opportunities.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016

Standard 18:
All parents with a learning disability should be supported to carry out their parenting role effectively.

Service User Perspective:

"If I have children I will get support to be a good parent."

Rationale:
An increasing number of adults with a learning disability are becoming parents. In about 50% of cases their children are removed from them largely because of concerns about the children's wellbeing or the lack of appropriate support.

Barriers to the provision of appropriate supports include negative and stereotypical attitudes. Men and women with a learning disability have a right to be parents and where they choose to exercise this right, effective support should be in place to avoid adverse outcomes for them and their children.

If support is provided early it is more likely that the family unit will be successfully supported to stay together.

Evidence:
DoH (2009) New Horizons: A Shared Vision for Mental Health
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf

Aunos, M *et al* (2008) Mothering with Intellectual Disabilities: Relationship Between Social Support, Health and Wellbeing, Parenting and Child Behaviour Outcomes. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2008.00447.x/abstract

Tarleton, B *et al* (2006) Finding the right support? A Review of Issues and Positive Practice in Supporting Parents with Learning Difficulties and Their Children. The Baring Foundation
www.bristol.ac.uk/norahfry/research/completed-projects/rightsupport.pdf

IASSID Special Interest Research Group on Parents and Parenting with Intellectual Disabilities (2008) Parents labelled with Intellectual Disability. Position of the IASSID SIRG on Parents and Parenting with Intellectual Disabilities. Journal of Applied Research in Intellectual Disabilities, 21: 296–307. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2008.00435.x/abstract

Booth T *et al* (2006) Temporal discrimination and parents with learning difficulties in the child protection system. *British Journal of Social Work* 36(6), 997–1015. http://bjsw.oxfordjournals.org/content/36/6/997.abstract

SCIE (2006) Knowledge Review 11: Supporting disabled parents and parents with additional support needs.
http://www.scie.org.uk/publications/knowledgereviews/kr11.asp

CSCI (2006) Supporting Parents, Safeguarding Children: Meeting the needs of parents with children on the child protection register http://www.pmhcwn.org.uk/files/supporting_safeguarding.pdf (Accessed 15 April 2011)

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• DHSSPS • Community and voluntary sector providers • Advocacy services

Quality Dimension

Citizenship
Independent advocacy support is provided to enable parents with a learning disability to be involved in the decision making process within multi-disciplinary meetings and other decision making fora.

Social Inclusion
Supports provided promote and encourage the parents to become less isolated from the community in which they live.

Empowerment
More parents and their children will be receiving appropriate care and support resulting in a smaller percentage of children of parents with learning disabilities being subject to Care Orders.

Working Together
Professionals work collaboratively across children's and adult's services to provide effective support to the parent and work will continue to develop policy on positively supporting parents with a learning disability to continue caring for their children.

Individual Support
Parents will be better enabled to care for themselves and their children through having their needs properly assessed and being appropriately supported in their parenting role.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Develop and agree a regional protocol between children's and adult services for joint working and care pathways.	HSC Board Report	HSC Board in collaboration with all HSC Trusts	March 2015

2 Percentage of parents with a learning disability who have a multi-professional/agency competence based assessment and subsequently receive appropriate support services	Trust Report	Establish baseline Performance level to be determined once baseline established	March 2016 March 2017
3 Percentage of parents with a learning disability involved in child protection or judicial processes who have received locally based skills training.	Trust Reports	85% 90% 95%	March 2015 March 2016 March 2017
4 Percentage of parents with a learning disability involved in child protection or judicial processes who have access to the services of an independent advocate.	Trust Reports	Establish baseline Performance level to be determined once baseline established	March 2015 March 2016

SECTION 8: MEETING GENERAL PHYSICAL AND MENTAL HEALTH NEEDS

Physical and mental health are inextricably linked with each impacting upon the other. The World Health Organisation (WHO) gives equal value to physical and mental health in the definition of health as “a complete state of physical, mental and social wellbeing, not just the absence of disease and infirmity”. People with poor physical health are at higher risk of experiencing common mental health problems and people with mental health problems are more likely to have poor physical health. Many factors influence the health of individuals and communities. Whether people are healthy or not depends a great deal on their circumstances and the environment in which they live. The determinants of health and wellbeing include:

- social environment
- the physical environment
- the person’s individual characteristics and behaviour

Many of these factors of health are not under the direct control of the individual and therefore one person’s health may differ from another’s depending on their circumstances.

Evidence demonstrates that there are significant disparities in health outcomes for people with a learning disability. They experience higher levels of physical and mental ill health, yet have lower access to primary care services, health screening and health promotion activities.

People with a learning disability can experience difficulties when using general health services, hospitals and primary care services. There is a need to proactively ensure that there is equity of access to the full range of health care services enjoyed by the general population. This is enshrined in disability discrimination and human rights legislation.

Standard 19:
All people with a learning disability should have equal access to the full range of health services, including services designed to promote positive health and wellbeing.

Service User Perspective:

"I have equal access to the full range of health services as other people in the community."

Rationale:
It is known that people with a learning disability often experience difficulties when using health services and this can result in their health needs not being effectively assessed or met.

Most people with a learning disability do not require specialist services to address their health needs but many will require a range of reasonable adjustments to help them make use of generic health services such as primary care, acute hospitals and dentistry. Specialist learning disability services are a key resource to support mainstream health services develop the knowledge and skills to do this effectively.

Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as:

- longer appointment times
- offering the first or last appointment
- the provision of easy read information to enhance understanding
- close involvement and support of family carers
- appropriate waiting facilities
- pre-admission visits
- fast tracking arrangements when appropriate (e.g. in A&E Departments)

The standard links closely to Standards 4 and 5 (Communication and Involvement in the Planning and Delivery of Services).

Evidence:
Learning Disabilities Observatory: Improving Health and Lives (2010) Health Inequalities Report
http://www.improvinghealthandlives.org.uk/projects/particularhealthproblems

GAIN (2010) Guidelines: Caring For People With A Learning Disability In General Hospital Settings
http://www.gain-ni.org/Library/Guidelines/Gain%20learning.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and

Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Mencap (2007) Death by Indifference
www.mencap.org.uk/case.asp?id=52&menuId=53&pageno

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care (including pharmacy and dental)	• DHSSPS • Service users and carers

Quality Dimension

Citizenship
People with a learning disability are equal citizens and must be able to readily access the full range of services that support their health and social wellbeing as are available to the rest of the population.

Social Inclusion
Primary care services, acute hospital services and other specialist services, such as, palliative care should have knowledge of the specific issues for people with a learning disability accessing these services and make reasonable adjustments accordingly.

Working Together
All generic services should have knowledge of local learning disability specific services and how to access them when required. This includes access to advocacy services.

Individual Support
The provision of all services should be tailored to the individual needs of the person with a learning disability, and reasonable adjustments made accordingly. An individual with a learning disability should be able to make round the clock contact with services and receive the care needed to meet their needs.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 All acute hospitals should have an action plan for implementing the GAIN Guidelines for improving access to acute care for people with a learning disability and be able to demonstrate a clear commitment to the implementation of such a plan.	Trust report	All HSC trusts establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
2 Percentage of GPs who have a system for identifying people with a learning disability on their register.	DES	Baseline as per learning disability DES Performance levels to be determined once baseline established	March 2015 March 2016
3 Each GP practice has a designated link professional within local learning disability services.	Trust report as per GAIN Guidelines	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
4 Evidence of reasonable adjustments by health service providers.	Report from HSC Trust learning disability services	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 20: (Generic)
All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well developed specialist smoking cessation services.

Service user perspective:

"I will be advised on the dangers of smoking"

Rationale:
Smoking is a major risk factor for a number of chronic diseases including a range of cancers, coronary heart disease, strokes and other diseases of the circulatory system. Its effects are related to the amount of tobacco smoked daily and the duration of smoking.

A number of specialist smoking cessation services have been commissioned in a range of settings across Northern Ireland. These services offer counselling and support in addition to the use of pharmacotherapy by trained specialist advisors.

Evidence:
DHSSPS (2010) Tobacco Control Strategy for Northern Ireland
http://www.dhsspsni.gov.uk/tobacco-strategy-consultation.doc

NICE (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities http://www.nice.org.uk/Guidance/PH10

NICE (2006) Brief Interventions and Referral for Smoking Cessation in Primary Care and Other Settings http://www.nice.org.uk/Guidance/PH1

Responsibility for delivery/implementation	Delivery and Implementation Partners
• HSC Board • HSC Trusts • Public Health Agency (PHA) • Primary Care	• DHSSPS • Families & carers • Voluntary, education, youth and community organisations

Quality Dimension

Citizenship
People with a learning disability can exercise their rights as citizens if they have accessible information to inform decision-making.

Empowerment
All members of the public will benefit from access to public information and education campaigns that raise awareness of issues relating to tobacco use, such as, the health risks to smokers and non-smokers. People who are ready to stop smoking are able to access specialist smoking cessation services in a choice of settings.

Working together
Brief Intervention Training for Health and Social Care Staff will ensure patients and clients receive consistent and timely advice on smoking cessation. Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision. Provision of information in an accessible format is a key step towards enabling effective partnership between those who work in services and those who use them. HSC professionals should take account of what is important to the person, their relationships and activities in working with them to address issues around smoking. Brief Intervention training for HSC staff will ensure that service users receive consistent and timely advice.

Individual Support
Effective person-centred support should take account of balancing what is important to people with what is important to them in regard to their health and wellbeing. Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
Number of people who are accessing Stop Smoking Services	ELITE (PHA Stop Smoking Services Performance Report)	Baseline 2011/12 = 39204 4 % year on year increase	March 2014 March 2015 March 2016
Proportion of the smoking population who are accessing Stop Smoking Services.	ELITE (PHA Stop Smoking Services Performance Report)	Baseline 2011/12 =10.8%. NICE guidance and the ten year tobacco strategy call for a target of over 5% of the smoking population to be reached, hence target to maintain at >/= 5%	March 2014 March 2015 March 2016
Number of people using stop smoking services who have quit at 4 weeks and 52 weeks.	ELITE (PHA Stop Smoking Services Performance Report)	Baseline 2011/12 = 20,299 for those quit at 4 weeks and 5,889 for those quit at 52 weeks. Target 4% increase in respective numbers year on year	March 2014 March 2015 March 2016

Standard 21:
All people with a learning disability should be supported to achieve optimum physical and mental health.

Service User Perspective

I will be helped to stay as physically and mentally healthy as possible.

Rationale:
People with a learning disability are more likely to experience major illnesses, to develop them younger and die of them sooner than the population as a whole. They have higher rates of obesity, respiratory disease, some cancers, osteoporosis, sensory impairment, dementia and epilepsy. It is estimated that people with learning disability are 58 times more likely to die prematurely. However, even with such a dramatic health profile, the learning disabled population are less likely to get some of the evidence-based treatments and checks they need, and continue to face real barriers in accessing services. This contributes to preventable ill health, poor quality of life and potentially, premature death.

Effective screening and regular health checks help to identify unmet need and prevent health problems arising. People with a learning disability participate less in screening and regular health checks than the rest of the population. Information on, and activities in, health promotion can be difficult to access.

Evidence:

Learning Disabilities Observatory (2011) The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK
http://www.improvinghealthandlives.org.uk/publications/

DoH (2009) Improving the health and well being of people with learning disabilities: world class commissioning www.dh.gov.uk/commissioning

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) Valuing People Now: A new three-year strategy for people with learning disability
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377

DoH (2009) Health Action Planning and Health Facilitation for people with learning disabilities: good practice guidance
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096505

DoH (2009) Delivering Better Oral Health: An evidence- based toolkit for

prevention – second edition

DoH (2008) High quality care for all: NHS Next Stage Review Final Report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

DHSSPS (2007) Guidance on Strengthening Personal and Public Involvement in Health and Social Care (HSC (SQSD) 29/07)
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

DHSSPS (2007) Oral Health Strategy for Northern Ireland
http://www.dhsspsni.gov.uk/2007_06_25_ohs_full_7.0.pdf

Disability Rights Commission (2007) Equal Treatment: Closing the Gap: A Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and/or Mental Health Problems
http://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2006.00100.x/abstract

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Foundation for People with Learning Disabilities (2005) Communication for person-centred planning
http://www.learningdisabilities.org.uk/publications/communication-person-centred-planning/

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency (PHA) • Primary Care • HSC Trust (Learning Disability Teams)	• Families • Voluntary and Community providers

Quality Dimension

Citizenship
People with a learning disability are supported to access the full range of screening and health checks as the rest of the population of NI.

Social Inclusion
Screening and health checks are made accessible to people with a learning disability and they are facilitated to participate in these activities.

Empowerment/Individual Support
Individuals will be supported to have regular screening and health checks on all the major illnesses and facilitated to make lifestyle choices that promote their good health and have in place a Health Action Plan as part of their person centred plan.

Working Together
There should be effective liaison and evidence of advance planning between HSC staff and family carers to fully embrace people with learning disabilities into the system of regular screening and health checks and health promotion activities. This should incorporate the development of Health Action Plans which includes details of health interventions, oral health, fitness and mobility, emotional needs and records of screening tests and identification of those responsible for taking action.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 The PHA and each HSC Trust has a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs.	Public Health Agency/ Trust Reports (to include reports from voluntary and community organisations Trust has commissioned services from)	All Trusts have in place a health improvement strategy for people with a learning disability.	March 2015
2 Percentage of adults with a learning disability who have an annual health check.	GP Records Health Facilitator records	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
3 Percentage of adults with a learning disability who have an up to date and active Health Action Plan (HAP) following the annual health check.	GP records Health Facilitator records Learning Disability Teams	Establish baseline Performance levels to be determined once baseline is established	March 2015 March 2016
4 Percentage of people with a learning disability who have been examined by a dentist in the past year.	Audit	Establish Baseline Performance Levels to be determined once baseline established	March 2015 March 2016

5 Percentage of females with a learning disability who access cervical and breast screening services.	GP records Health facilitators	Establish Baseline Performance levels to be determined once baseline established	March 2015 March 2016
6. Percentage of people with a learning disability who have had a sight test with an optometrist in the past year.	Audit	Establish Baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 22:
All people with a learning disability who experience mental ill health should be able to access appropriate support.

Service User Perspective

"If I have mental illness I can get appropriate support."

Rationale:
People with a learning disability and mental health needs require a co-ordinated multi-disciplinary approach to having their needs met through integrated services responding flexibly to the demands of their conditions with clear pathways of care identified so that the most appropriate supports are immediately available to the person and their family carers when required.

Refer also to standard 56 in Service Framework for Mental Health and Wellbeing

Evidence:

DHSSPS (2011) Service Framework for Mental Health and Wellbeing Consultation Document
http://www.dhsspsni.gov.uk/service_framework_for_mental_health_and_wellbeing_-_consultation_version.pdf

DoH (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities A report by Professor Jim Mansell
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Emerson, E. and Hatton, C. (2007) The Mental Health of Children and Adolescents with Intellectual Disabilities in Britain. *British Journal of Psychiatry* 191, 493-499.
http://bjp.rcpsych.org/cgi/content/abstract/191/6/493

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

NHS QIS (2004) Learning Disability Quality Indicators
http://www.healthcareimprovementscotland.org/previous_resources/indicators/learning_disability_quality_in.aspx

Carpenter, B. (2002) Count Us In: report of the inquiry into meeting the mental health needs of young people with learning disabilities. London: Foundation for People with Learning Disabilities London:
http://www.learningdisabilities.org.uk/publications/count-us-in/

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts • RQIA	• DHSSPS • Other service providers

Quality Dimension

Citizenship
Addressing the mental health needs of people with a learning disability requires a combination of services that are consistently available to enable their full participation within the structures of society

Social Inclusion
The mental health needs of people with a learning disability are met in the most appropriate setting.

Empowerment/Individual Support
People with a learning disability and mental illness have person-centred plans in place with clear pathways of care identified and planned to enable them to lead as normal a life as is possible given the conditions of their illness. To involve the person, their parents or family carer in this process empowers the family and the person with a learning disability to make informed choices

Working Together
Services surrounding the person with a mental illness should be co-ordinated and resourced appropriately with a lead person identified to effectively manage and promote the mental health and wellbeing of the person requiring services.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. A regional protocol is developed to ensure that people with a learning disability can access mainstream mental health services.	HSC Board	Protocol in place	March 2015
2. Percentage of people with a learning disability and mental health needs who access mainstream mental health services e.g. psychological and talking therapies	Audit	Establish baseline Performance levels to be determined once baseline established	March 2016 March 2017

where indicated in their treatment plan.			
3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion	GP Records	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

Standard 23: (Generic)
All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.

Service user perspective:

"I will be provided with healthy eating support and guidance"

Rationale:
Reducing fat and salt in the diet and increasing fruit and vegetable consumption is associated with a reduction in the risk of cardiovascular disease and hypertension.

Having a well balanced and nutritious diet will also help prevent many diseases which are linked to being overweight and obese such as high blood pressure, heart problems, risk of stroke, some cancers and Type 2 Diabetes. In addition, an improved diet can also contribute to an improvement in an individual's mental health and wellbeing.

Evidence:
DHSSPS Draft Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2011-2021)
http://www.dhsspsni.gov.uk/showconsultations?txtid=44910

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

SCAN (2008) Scientific Advisory Committee on Nutrition. The Nutritional Wellbeing of the British population
http://www.sacn.gov.uk/pdfs/nutritional_health_of_the_population_final_oct_08.pdf

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Citizenship
People with a learning disability are provided with healthy eating support and advice as are the rest of the population.

Empowerment/ Individual support
Individuals will receive support and advice, appropriate to their needs, in a range of settings to develop skills for healthy eating and be facilitated to make lifestyle choices that promote their good health and wellbeing as part of person-centred planning.

Lifestyle issues including eating and physical activity choices should be explored through knowledge of what is important to the person. This should take account of what has worked and what has not worked in the past.

Working Together
There should be effective liaison and evidence of advance planning between staff and family carers to fully embrace people with a learning disability into the system of health promotion activities. All stakeholders should promote a consistent nutrition message by using the Eat Well – getting the balance right model. Training and education should be available for child carers / group care workers.

Schools / hospitals / residential care and nursing homes should be supported in the implementation of nutrition standards. Support and advice to develop skills for healthy eating in a range of settings should be available.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1. Percentage of people eating the recommended 5 portions of fruit or vegetables each day.	To be determined	Baseline for 2011/12 = 32% overall, 26% for males and 36% for females Target: maintain or at best increase percentage by 1% year on year	 March 2014 March 2015 March 2016

Standard 24: (Generic)
All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.

Service user perspective:

"I will be provided with support and advice on physical activity"

Rationale:
The National Institute for Health and Clinical Excellence (NICE) has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease. Lack of physical activity is associated with an increase in the risk of coronary heart disease.

The recently reviewed and updated UK Physical Activity Guidelines, supported by all four CMO's, provide advice and guidance on the recommended levels of physical activity throughout the life course. The report also presents the first time guidelines have been produced in the UK for early years (under fives) as well as sedentary behaviour, for which there is now evidence that this is an independent risk factor for ill health.

Evidence:
DHSSPS Draft Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2011-2021)
http://www.dhsspsni.gov.uk/showconsultations?txtid=44910

DoH (2011) New UK Physical Activity Guidelines
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

NICE (2006) Public Health Intervention Guidance No.2 Four commonly used methods to increase physical activity: Brief intervention in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling http://www.nice.org.uk/nicemedia/pdf/word/PH002_physical_activity.doc

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension
Empowerment People with a learning disability will benefit from access to appropriate information and advice on physical activity. **Working Together** HSC staff recognise their responsibility to ensure service users receive consistent and timely health promotion messages. Appropriate physical activity brief intervention training should be provided for HSC staff to ensure patients and clients receive consistent and timely advice. **Individual Support** Lifestyle issues including physical activity choices should be explored through knowledge of what is important to the person. Paying attention to what works best for the person in undertaking physical activity, working with their interests. This should take account of what has worked in the past and what does not work.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. Percentage of people meeting the recommended level of physical activity per week.	Northern Ireland Health Survey	New physical activity guidelines were launched in 2011 and as such a new suite of questions to establish the percentage of people meeting the recommended level of physical activity per week has been integrated within the 2012/13 Northern Ireland Health Survey. It is anticipated these new baseline results will be available in Nov / Dec 2013. Performance level to be agreed thereafter.	March 2014

Standard 25: (Generic)
All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.

Service user perspective:

"I will receive support and advice on the use of alcohol"

Rationale:
Excessive alcohol consumption is associated with many diseases such as cancers (oesophagus, liver etc), cirrhosis of the liver and pancreatitis. There are also direct effects of alcohol and an increased association with injuries and violence.

Excessive alcohol consumption can affect the cardiovascular system, and is associated with high blood pressure, abnormal heart rhythms, cardiomyopathy and haemorrhagic stroke.

Evidence:
DHSSPS (2006) New Strategic Direction for Alcohol and Drugs (2006-2011)
http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

SIGN (2003) Scottish Intercollegiate Guidelines Network The Management of harmful drinking and alcohol dependence in Primary Care No 74
http://www.sign.ac.uk/pdf/sign74.pdf

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • Public Health Agency (PHA) • HSC Trusts	• Primary care team, inclusive of social care

Quality Dimension

Citizenship
People with a learning disability and alcohol related issues should be able to access mainstream services. They are likely to require the support of learning disability personnel to utilise the services offered by the mainstream addiction teams.

Working Together
Appropriate alcohol brief intervention training should be provided for HSC staff to ensure patients and clients receive consistent and timely advice.

Individual Support
HSC staff should take account of what and who is important to the person now and in the future in relation to lifestyle and where alcohol fits in. Explore how alcohol can be managed in the person's life by taking account of what has worked and what has not worked in the past for this person.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of people who receive screening in primary care settings in relation to their alcohol consumption.	Northern Ireland Local Enhanced Service	Establish baseline Performance level to be determined once baseline established	March 2014 March 2015

SECTION 9: MEETING COMPLEX PHYSICAL AND MENTAL HEALTH NEEDS

Children and adults with a learning disability may experience significant additional, complex health needs. Complex physical and mental health needs may be defined as those requiring a range of additional support services beyond the type and amount required by people generally and those usually experienced by people with impairments and long-term illnesses. These needs require a high level of effective integration between specialised and general services.

Supports to children, young people and adults who have complex physical and mental health needs will be most effective if they are based on person-centred planning approaches and within an ethos of ensuring bridging between learning disability expertise and other service settings. (Standard 10 sets out the specific standard for children and young people with complex physical health needs).

Standard 26:
All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.

Service User Perspective:

I can get support locally from specialist learning disability services if my behaviour challenges services and/or my carers

Rationale:
Emerson (1995) defines 'challenging behaviour' as behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.

People who present behaviours that challenge services are generally well known to staff working within specialist learning disability services and they are therefore in a position to provide relevant information to other services and support the person and family carers to enable him/her to continue to access these services.

The specialist supports available should include social work, psychiatry, psychology, speech and language therapy, physiotherapy, nursing and any other relevant disciplines and these should be available 24 hours a day, 7 days a week. Should crises occur there needs to be the capacity to respond with appropriate interventions that maintain the person in the community/home in which he/she resides and/or short breaks that provides time out from the situation.

Whilst significant evidence exists as to the need for timely, flexible, home-based support to address challenging behaviours and to prevent unnecessary inpatient admission, work is not complete on the optimum service configuration and models required in Northern Ireland. To develop community based supports and move away from a traditional model of hospital admission will require resource investment and future detailed service planning.

Evidence:
NDTi (2010) Guide for Commissioners of Services for People With Learning Disabilities Who Challenge Services
http://www.ndti.org.uk/uploads/files/Challenging_behaviour_report_v7.pdf

DoH (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities A report by Professor Jim Mansell
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114346

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability

http://www.dhsspsni.gov.uk/equallivesreport.pdf

NHS QIS (2004) Learning Disability Quality Indicators
http://www.healthcareimprovementscotland.org/previous_resources/indicators/learning_disability_quality_in.aspx

Emerson, E (1995) Challenging behaviour - analysis and intervention in people with a learning disability Cambridge University Press

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• Commissioning organisations • HSC Trusts • RQIA	• DHSSPS • Family carers • Advocacy providers • Other service providers

Quality Dimension

Citizenship
Providing support to an individual who presents behaviours that are challenging to access mainstream health and social care services maintains their equity with the rest of the population of NI.

Social Inclusion
There are community-based services to meet the needs of people with challenging behaviour.

Empowerment
Incidents of challenging behaviours are reduced when appropriate support mechanisms are available so that they can continue to receive the community - based services they require.

Working Together
Mainstream and specialist services should be collaborating on the needs of people with a learning disability who present behaviours that challenge mainstream services so that the person can access the healthcare services they require and services comply with regional guidelines on the management of challenging behaviours.

Individual Support
Management and intervention for challenging behaviour is practised and the approaches used have proven evidence-based effectiveness and social validity.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of individuals with significant challenging behaviours who have a Behaviour Support Plan including advance directives in	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016

place that detail actions to be undertaken in the event of their challenging behaviours escalating.			
2 Where challenging behaviours present a significant risk to the individual or others or a risk of breakdown in accommodation arrangements, a specialist assessment has been completed within 24 hours.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016
3 Where challenging behaviours present a significant risk to the individual, a Management Plan has been developed and implemented within 48 hours.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2015 March 2016
4 Evidence that HSC has engaged with other relevant delivery partners in developing and implementing consistent approaches in individual cases.	Trust report Audit of voluntary/ community sector	All HSC Trusts	March 2016
5 Percentage of people labelled as challenging who are not living in a congregate setting described as a challenging behaviour or specialist assessment/ treatment service	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes	March 2017

Standard 27:
All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.

Service User Perspective:

I will get support If I come in contact with the police, courts or prisons

Rationale:
Men and women with a learning disability can come into contact with the Criminal Justice System in a range of different ways. They can be suspects, remandees, prisoners or indeed witnesses. However, people with a learning disability can be particularly vulnerable as they may not understand the processes involved, the information given to them, or their rights. The Reed Report (1992) highlighted the needs of mentally disordered offenders and recommended that, where appropriate, people with a learning disability who offend should be directed to HSC services, while emphasizing the need for services to be based on a multi-agency needs assessment.

It is vital that an offender with a learning disability does not go unrecognised and unsupported whilst in the prison system and that care pathways are established between primary care, learning disability services and Criminal Justice Services.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DoH (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

RCSLT (2009) Locked Up and Locked Out: Communication Is The Key
http://www.rcslt.org/news/events/Locked_Up_NI_post_event_report

Prison Reform Trust (2008) No-One Knows. Police Responses to Suspects Learning Disabilities and Learning Difficulties: A Review of Policy and Practice
www.prisonreformtrust.org.uk

DHSSPS (2006) The Bamford Review of Mental Health and Learning Disability (NI): Forensic Services
http://www.dhsspsni.gov.uk/forensic_services_report.pdf

Reed Report (1992) Review of mental health and social services for mentally disordered offenders and others requiring similar services: Vol. 1: Final summary report. (Cm. 2088) London: HMSO ISBN 0101208820

Responsibility for delivery/implementation	Delivery and implementation partners
• HSC Board • HSC Trusts • General Practitioners	• DHSSPS, DoJ • Police Service of Northern Ireland (PSNI) • Probation Board for Northern Ireland (PBNI) • NI Prison Service • NI Courts Service • Youth Justice Agencies • Voluntary and community providers

Quality Dimension

Citizenship
People with a learning disability going through the Criminal Justice System have the same rights as other members of society and there is evidence of good practice available to ensure that this is the case.

Social Inclusion
Offending behaviours have the potential to increase the person's social exclusion and measures must be evidenced within their person-centred plan (PCP) that promotes their social inclusion in mainstream activities upon discharge from any institutional setting.

Empowerment
Measures are in place to minimise the person's vulnerability when they are in contact with the Criminal Justice System

Working Together
There is evidence of multi-disciplinary working practices to ensure that people with a learning disability are supported within the Criminal Justice System.

Individual Support
Community based services are in place which support people, prevent admissions where possible, and facilitate discharge from inpatient and other secure settings. The least restrictive options for individuals should be available.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Evidence that HSC has engaged and developed local protocols with relevant delivery partners to achieve consistent and	HSC Board Report	Protocols in place	March 2015

coordinated approaches to working with people with a learning disability who have offended or are at risk of offending.			

SECTION 10: AT HOME IN THE COMMUNITY

To maximise their health and social wellbeing, people with a learning disability should be supported to live in the community close to family, friends and community resources. Where they currently live with family they (the family) should be supported to provide the necessary care and support.

A greater focus on 'purposeful lives' will support people with a learning disability to live as independently as possible. It is vital that people are supported to live in the community and that inappropriate admission to hospital is avoided. People with a learning disability who require hospital treatment should be speedily discharged when the treatment ends to community homes with appropriate care and support. Resettlement of long stay populations, the development of innovative approaches to prevent delayed discharges and the promotion of 'purposeful respite' will enhance outcomes for people with a learning disability, their families and carers.

Standard 28:
HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.

Service User Perspective:

"My accommodation needs will be met by staff from different agencies who work well together"

Rationale:
People with a learning disability aspire to have the same standard in living options that are available to their non-disabled peers.

In NI the majority of adult persons with a learning disability continue to live with family carers. As carers age, they may require extra support to maintain their caring role. In addition, people with a learning disability may need support to participate in community activities with their peers.

Person-centred support plans should identify the person's preferred living arrangements and these should be regularly reviewed. It is important that as family carers age they are supported to plan for the future to allow for a smooth transition to new care arrangements either within the family or in supported accommodation (refer to Section 12: Ageing Well).

Small-scale, supported living arrangements (5 persons or less) have been shown to offer a better quality of life for people with a learning disability as compared to congregated living arrangements.

People living outside of family care should have a tenancy or occupancy agreement to offer them security of tenure along with an agreement to the number of support hours available to them individually.

People should be involved in decisions about sharing their homes with others. As far as possible they should be offered a choice of accommodation in a locality of their choosing.

Evidence:
DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011)
http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

SCIE (2009) At a glance 8: Personalisation Briefing: Implications for housing providers www.scie.org.uk/publications/ataglance/ataglance08.asp

DHSSPS (2008) Residential Care Homes: Minimum Standards
http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

NDA (2007) Supported Accommodation Services for People with Intellectual Disabilities: A review of models and instruments used to measure quality of life in different various settings (Walsh, PN *et al*, 2007)
http://www.nda.ie/website/nda/cntmgmtnew.nsf/0/929ECD4441474CA280257872004B8619/$File/SupportedAccommodation.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

McConkey, R (2005) Fair shares? Supporting families caring for adult persons with intellectual disabilities. Journal of Intellectual Disability Research, vol 49, Issue 8, 600 – 612
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2788.2005.00697.x/full

NIHE (2003) Supporting People
http://www.nihe.gov.uk/index/sp_home/strategies/independent_living-2/supporting_people_strategy.htm

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts	• DSD • NIHE • Other service and housing providers

Quality Dimension

Citizenship
People with a learning disability have equity of access to housing options similar to the general adult population.

Social Inclusion
People with a learning disability are living in communities.

Empowerment
People with a learning disability are supported to access information and advice to exercise their preference of where they live and who they wish to live with, through the help of independent advocates where necessary and, tailoring support to people's individual needs to enable them to live full, independent lives.

Working Together
HSC professionals are involved in developing strategies, information and advice to housing providers on identified housing needs of people with a learning disability. Joint planning and partnership working is promoted towards meeting a person's housing need.

Individual Support
Support Plans are in place that support the person with a learning disability and their carers' independence. Funding sources are maximised that support this position and planning for the future is incorporated into this process.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of support plans that take account of people's aspirations in relation to future accommodation needs, including independent living	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016
2 Percentage of adults who are living with a single carer or where there are 2 carers and the primary carer is aged over 65 who have a futures plan in place	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016
3 Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016
4 Percentage of people leaving learning disability hospital within one week after treatment has been completed	PfA monitoring	95% 97% 100%	March 2015 March 2016 March 2017

Standard 29: (Generic)
All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed.

Service user perspective:

" My carer's needs will be considered and supported"

Rationale:
Carers are central to providing health and social care. People want to live in their own homes as independently as possible and family caring is critical in achieving this goal. Breakdown in caring has a major impact on readmission rates to hospital and unnecessary admissions to residential and nursing home care placements.

Caring is both a demanding and rewarding activity. Evidence shows that unsupported caring can have a negative impact on the physical, social and emotional well being of an adult carer. It is in everyone's interest to ensure that carers can continue to care for as long as they wish and are able to, without jeopardising their own health and wellbeing or financial security, or reducing their expectations of a reasonable quality of life.

Young carers (children and young people up to the age of 18 years who have a substantive caring role for a member of their family) often do not have an alternative but to be a carer. These children can be lonely, isolated, lose friendships and miss out on education and social activities. Young carers are frequently involved in activities that are developmentally inappropriate and the impact on their lives is unknown. Many young carers go unidentified. This highlights the need to identify young carers and provide support and assistance which will promote their health, development and inclusion in educational and social activities.

Early intervention, individually tailored to the needs of the carer and the cared for person, can be crucial in avoiding breakdown in the caring role. Forming meaningful partnerships with carers and making agreements with them about support to be provided is essential. Carers identify their requirements as respite care, information, personal care for the cared for person and practical and emotional support to continue in their role. This highlights the need for service planning and commissioning based on partnership working between statutory and independent sector and involvement of carers or their representatives to shape future services.

To enable carers to access the right information, support and services, current methods for identifying carers and encouraging them to acknowledge their caring role need to be enhanced. Under the Carers and Direct payments Act, all staff have a duty to inform carers. Staff should be particularly proactive in identifying the presence of younger and older carers.

One of the most important and far-reaching improvements in the lives of carers will be brought about by how health and social care staff view and treat them. Changes in staff knowledge of carers' issues could promote a more positive attitude to carers and this would make a significant difference to the lives of carers. Services should recognise carers both as individuals in their own right and as key partners in the provision of care and support.

Evidence:

PCC(2011) Young Carers in Northern Ireland: A report of the experiences and circumstances of 16 year old carers
http://www.patientclientcouncil.hscni.net/uploads/research/Young_carers_in_Northern_Ireland.pdf

Schubotz & McMullan (2010) The Mental and Emotional Health of 16-Year Olds in Northern Ireland: Evidence from the Young Life and Times Survey. Belfast: Patient and Client Council Report

DSD/ DHSSPS (2009) Review of Support Provision for Carers
http://www.dsdni.gov.uk/ssani-review-support-provision-carers.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool
http://www.dhsspsni.gov.uk/eccu2-09.pdf

DHSSPS (2008) Implementation of the Carers Strategy (Training for Carers)
http://www.dhsspsni.gov.uk/microsoft_word_-_circular_hss__eccu__3_2008_-_implementation_of_carers__strategy.pdf

Earley L *et al* (2007) Children's perceptions and experiences of care giving: A focus group study. *Counselling Psychology Quarterly.* 20. 1. pp.69–80

Evason, E. (2007) Who Cares Now? Changes in Informal Caring 1994 and 2006. Research Update 51. Belfast: ARK Publications www.ark.ac.uk

DHSSPS (2006) Caring for Carers Recognising, Valuing and Supporting the Caring Role http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

DHSSPS (2006) Implementation of the Carers Strategy (Identification of Carers) http://www.dhsspsni.gov.uk/hss__eccu__4-2006_carers_circular_-_signed.doc.pdf

SPRU (2004) Hearts and Minds: The health effects of caring
http://www.york.ac.uk/inst/spru/pubs/pdf/Hearts&Minds.pdf

Olsen R (1996) Young Carers: challenging the facts and politics of research into children and caring. Disability and Society, 11 (1), 41-54

Responsibility for delivery/implementation	**Delivery and Implementation Partners**
• HSC Board • Public Health Agency • HSC Trusts	• Primary Care – GPs, LCGs • Independent Sector • DSD, DENI

Quality Dimension
Citizenship Carers will feel valued and able to access the support they need. Staff will be facilitated to understand and value the role of carers. **Social Inclusion** Carers will be recognised as real and equal partners in the delivery of care. All carers, irrespective of age, who they care for or where they live will be directed toward appropriate agencies that can offer advice and support. **Empowerment** Carers will be encouraged to identify themselves as carers and to access information and support to protect and promote their own health and well-being and minimise the negative impact of caring **Working Together** Involving carers in the planning, delivery and evaluation of services improves outcomes for the carer and cared for person. Carers will be identified and supported best through partnerships between the statutory and voluntary sector and by good referral processes **Individual Support** Carers will be identified and signposted to help and support as early as possible in their journey and at times of crisis/transition.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. Number of front line staff in a range of settings participating in Carer Awareness Training Programmes	Trust Training Report (including Induction programmes)	20% 50%	March 2015 March 2016
2. The number of carers who are offered Carers Assessments	HSC Board/ DHSSPS returns	Improvement targets set by HSC Board in conjunction with Carers Strategy Implementation Group	Reviewed annually
3. The percentage of carers who participate in Carers Assessments	HSC Board/ DHSSPS returns	Improvement targets set by HSC Board in conjunction with Carers Strategy Implementation Group	Reviewed annually

Standard 30:
All family carers should be offered the opportunity to have their needs assessed and reviewed annually.

Service User Perspective:

"The needs of family members who care for and support me will be assessed and regularly reviewed"

Rationale:
The majority of people with a learning disability live with their families. Nearly one-third live with a single carer and over 25% live with carers aged over 65 years. The pressures of caring can cause stress and ill health. Family carers report difficulties in accessing breaks from their caring responsibilities. The types of short breaks valued by family carers and people with a learning disability are wide ranging and needs to be flexible and responsive to the individual circumstances. This should include adult placement, drop-in services for people with a learning disability and support for the disabled family member to access social and recreational opportunities. A move away from an over reliance on short breaks in residential facilities is therefore signalled. Short breaks should be a positive experience for the person with a learning disability, adding to their lives' experiences as well as giving the family member a break.

Evidence:
NDTi (2010) Short Breaks Pathfinder Evaluation Greig, R., Chapman P., Clayson A., Goodey C., and Marsland D. http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR223.pdf

DHSSPS (2010) Care Management, Provision of Services and Charging Guidance http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf

DHSSPS (2009) Delivering the Bamford Vision. The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan (2009-2011) http://www.dhsspsni.gov.uk/bamford_consultation_document.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool http://www.dhsspsni.gov.uk/eccu2-09.pdf

Black, LA *et al* (2008) Lifelines Report: An Evaluation Report of the Impact of the Families Services delivered by Positive Futures in Rural and Urban Areas of Northern Ireland. http://www.positive-futures.net/sites/default/files/LIFELINES%20Full%20Report.pdf

Kenny, K and McGilloway, S. (2007) Caring for children with learning disabilities: an exploratory study of parental strain and coping, British Journal of Learning Disabilities, p221-8.

http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2007.00445.x/abstract

DHSSPS (2006) Caring for Carers: Recognising, Valuing and Supporting the Caring Role http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability http://www.dhsspsni.gov.uk/equallivesreport.pdf

Bamford (2004) University of Ulster Audit of Learning Disability Research in NI http://www.dhsspsni.gov.uk/learning-disability-consultation

Mencap (2003) Breaking point: A report on caring without a break for children and adults with profound learning disabilities. Mencap. London. http://www.mencap.org.uk/campaigns/take-action/our-other-campaigns/breaking-point

Responsibility for delivery/implementation	Delivery Partners
• HSC Board • HSC Trusts	• DHSSPS, DSD • Other Service Providers

Quality Dimension

Citizenship
Family carers have a voice in the development of strategies that impact on their role and ability to continue caring for their child, young person or adult

Social Inclusion
Carers are not left in isolation to cope with their role of caring for their child, young person or adult

Empowerment
Carers are better informed of their entitlements through the support and information they receive from professionals and /or independent advocates.

Working Together
Carers are involved in working as equal partners with statutory/other agencies in planning services that are flexible and responsive to meeting their needs and the needs of the person with a learning disability.

Individual Support
Carers of a person with a learning disability will have their support needs assessed and be provided with the services that support the family and / or the individual carer.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1 Percentage of carers who express satisfaction at their annual review that their needs as identified in the carers' assessment have been met.	User and carer feedback	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

SECTION 11: AGEING WELL

Life expectancy for men and women with a learning disability has increased markedly over recent years. Growing older is likely to present additional challenges for people with a learning disability owing to the impact of their disability.

People with Down's syndrome are at high risk of Alzheimer's disease as they grow older and virtually all people with Down's syndrome who live long enough will develop this type of dementia. In addition, it is estimated that between 20% – 40% of older people with a learning disability are liable to have a mental health problem.

The number of older family carers is also increasing which can create particular challenges, for example, older carers:

- are under greater physical and mental pressures because of their age;
- may be particularly anxious about the future;
- are more likely to be caring alone; and
- may have smaller social support networks.

There has been little emphasis on health and wellbeing for older people with a learning disability or indeed their ageing carers. Ageing well has not been proactively encouraged by service providers. This is reflected in the low number of older people with a learning disability who participate in leisure activities and in concerns about unhealthy life styles.

Standard 31:

All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.

Service User Perspective:

"As I get older HSC staff will support me to plan for the future taking account of my age"

Rationale:
To avoid unnecessary anxiety to the person with a learning disability and their ageing family carer they both need to think about and plan for the changes that are likely to happen in their lives. Where this is done, crisis intervention should be eliminated in all situations where a person is known to social services and their needs met when there is a requirement to do so. At the same time, plans should also be considered for the family carer, in line with the statutory entitlement to an assessment of carer's needs (as with Standard 29).

People with a learning disability should be enabled to remain in their own home with their family carer for as long as possible with appropriate care and support to do so.

People with a learning disability have the same needs for autonomy, continuity of support, relationships and leisure as other older people.

Evidence:
The Alzheimer's Society (2011) Adaptations, improvements and repairs to the home www.alzheimers.org.uk/factsheet/428

DHSSPS (2010) Improving Dementia Services in NI: A Regional Strategy Consultation Document http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf

DHSSPS (2009) Regional Carer's Support and Needs Assessment Tool http://www.dhsspsni.gov.uk/eccu2-09.pdf

DHSSPS (2008) Standards for Adult Social Care Support Services for Carers http://www.dhsspsni.gov.uk/standards_for_adult_social_carer_support_services_for_carers.pdf

DHSSPS (2007) Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (Bamford) http://www.dhsspsni.gov.uk/living_fuller_lives.pdf

Tinker, Prof (1999) Ageing in place: What can we learn from each other? Kings College London www.sisr.net/events/docs/obo6.pdf

McQuillan *et al* (2003) Adults with Down's Syndrome and Alzheimer's Disease.

Tizard Learning Disability Review 8(4): 4-13.
http://pierprofessional.metapress.com/content/41u62857klh37m32/

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • HSC Trusts	• DHSSPS, DSD • Other service providers

Quality Dimension

Citizenship
People with a learning disability have the same right of access to Allied Health Professionals and specialist services, including equitable access to equipment aids and adaptations that assist daily living. They should not be discriminated against because of their learning disability.

Empowerment
People with a learning disability are facilitated to ensure that they have support to express their views and wishes as they plan for their future. People with a learning disability are provided with accessible information and support to understand and make their decisions about the future including information about age-related benefits.

Working Together
People with a learning disability have the right to a seamless transition towards increasing involvement and co-operation with services for older people and this should include any changes between programmes of care/team/Directorates in a pro-active manner.

Individual Support
Plans are in place and reviewed for the time when the carer is unable to continue to care, and is considered as part of the ongoing assessment of client and carers needs.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people whose care plan has been reviewed taking account of issues associated with ageing.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016

2 Percentage of carers aged 65 years and over receiving domiciliary or short break support services.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2015 March 2016

Standard 32:

All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.

Service User Perspective:

"I can get care and support from dementia services when I need it"

Rationale:
The early stages of dementia in people with a learning disability are more likely to be missed or misinterpreted – particularly if several professionals are involved in the person's care. The person may find it hard to express how they feel their abilities have deteriorated, and problems with communication may make it more difficult for others to assess change. It is vital that people who understand the person's usual methods of communication are involved when a diagnosis is being explored – particularly where the person involved does not use words to communicate. It is important that any prescribed medicine is monitored closely and that other ways of dealing with the situation are thoroughly explored.

People who have Down's Syndrome develop signs of dementia at a much younger age than others resulting in their needs being planned for much earlier.

Carers should be provided with information that helps them identify the earlier onset of dementia symptoms and be provided with appropriate support to continue to care for their adult with a learning disability. Carer's assessments should seek to identify any psychological distress and the psychosocial impact on the carer, including after the person with dementia has been provided with alternative care options.

Understanding a person's past history is crucial to providing person-centred care for someone with a learning disability and dementia.

Evidence:
DHSSPS (2010) Improving Dementia Services in NI: A Regional Strategy Consultation Document http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf

DHSSPS (2010) Adult Safeguarding in NI: Regional & Local Partnership Arrangements http://www.dhsspsni.gov.uk/asva-__2010.pdf

Brooker, D (2007) Person-centred Dementia Care – Making Services Better. http://books.google.co.uk/books?id=FQ3CdTblObwC&pg=Brooker+2007

NICE (2006) Clinical Guideline 42: Dementia - Supporting people with dementia and their carers in health and social care (Revised 2011)

http://www.nice.org.uk/nicemedia/live/10998/30317/30317.pdf

Regional Adult Protection Forum (2006) Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance
http://www.shssb.org/filestore/documents/Safeguarding_Vulnerable_Adults_-_3_Nov_06.pdf

Bamford (2005) Equal Lives: Review of Mental Health and Learning Disability
http://www.dhsspsni.gov.uk/equallivesreport.pdf

Alzheimer's Society (2011) – Learning Disabilities and Dementia
http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=103

An Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing TILDA. Measures will address health, cognitive status, activities of daily living, living situations, social life and overall quality of life within which a descriptive statistical picture of the life experiences of adult persons of ID will be developed. Prof. Mc Carron's research. Commenced September 2008. Due to complete in October 2011. http://people.tcd.ie/mccarrm

Responsibility for delivery/implementation	**Delivery and implementation partner**
• HSC Board • HSC Trusts Dementia Services • Primary Care • RQIA	• DHSSPS • Other service providers • Family carers

Quality Dimension

Citizenship
People with a learning disability and dementia should have the same access to dementia services as everyone else. People with a learning disability and those supporting them should have access to specialist advice and support for dementia. People with a learning disability and dementia should feel equally valued and should not experience barriers to person-centred care.

Social Inclusion
Every effort should be made to ensure people with a learning disability and dementia are cared for at home. When a move is necessary a specific care plan should be drawn up to ensure continuity of care and support for the person and successful transfer of expertise to the new service. People with a learning disability and dementia should not be excluded from services because of their diagnosis, age (whether regarded as too young or too old) or any learning disability.

Empowerment
Treatment and care should take into account each person's individual needs and preferences. Individuals must be given all available support before it is concluded that they cannot make decisions for themselves. Advocacy services and voluntary support should be available to people with a learning disability and dementia and carers separately if required.

Working Together
There should be sharing of skills and expertise between dementia services and learning disability services with equity of access to the most appropriate service delivery area. Referral protocols and pathways need to be clearly defined to facilitate people receiving the right care and attention in the right place at the right time.

Individual Support
Carers (family, staff, statutory and independent residential and nursing care providers) should be provided with information including inter-agency working, support and training to enable them to continue to care for the person with a learning disability and dementia. Care plans should incorporate individual person centred planning principles and should reflect individually assessed dementia care related needs.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Percentage of people with a learning disability and dementia who can access appropriate dementia services as required.	Trust generic dementia service	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016
2 Percentage of people with a learning disability and dementia who have received additional supports following a dementia diagnosis.	SAAT	Develop and implement SAAT Performance level to be determined based on SAAT outcomes	March 2016 March 2017
3 Percentage of HSC professionals and other support providers who have received awareness training on the needs of people with a learning disability and dementia	HSC Trust report	Establish baseline Performance levels to be determined once baseline established	March 2015 March 2016

SECTION 12: PALLIATIVE AND END OF LIFE CARE

Palliative and end of life care focuses on all aspects of care needed by patients and their families, physical, emotional and spiritual. It involves relief of symptoms, making thoughtful decisions, supporting families and providing ongoing care in the appropriate setting. It is important that people in the last phase of life get the appropriate care, at the right time, in the right place, in a way that they can rely on. The following standards are designed to improve the patient and family experience of palliative and end of life care through *holistic assessment* of need, improved coordination of care and a greater focus on choice at end of life.

Standard 33: (Generic)
All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care.

Service User Perspective*:*

"I will be supported in my end of life care needs"

Rationale:
Most people would prefer to die at home (including residential and nursing home where this is the person's usual home) where this is possible.

In order to support this, identification of the possible last year/months/weeks of life should take place. Evidence shows that when end of life care needs are identified there is improved quality of life and even prolonged life, compared to when this stage of illness is not identified, particular in non-cancer conditions.

Advanced care planning allows more informed choice of care and enables people to be more supported to die in their preferred place of care.

Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments. (WHO, 2002)

End of life care refers to the possible last year of life. It helps all those with advanced, progressive, incurable conditions to live as well as possible until they die. It enables the supportive and palliative care needs of both the patient and the family to be identified and met throughout the last phase of life and into bereavement. At this stage however it is often still appropriate to provide acute treatment in conjunction with palliative care, particularly in long term conditions. It includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support. (National Council for Palliative Care, Focus on Commissioning, Feb 2007).

Evidence:
NCPC (2012) Palliative Care Explained
http://www.ncpc.org.uk/sites/default/files/PalliativeCareExplained.pdf (as accessed on 26 September 2012)

NICE (2011) Chronic Obstructive Pulmonary Disease (COPD): Quality Standard
http://guidance.nice.org.uk/QS10

DHSSPS (2010) Living Matters: Dying Matters – A Strategy for Palliative and End of Life Care for Adults in Northern Ireland.
http://www.dhsspsni.gov.uk/855_palliative_final.pdf

NICE (2010) Chronic Obstructive Pulmonary Disease; Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care http://www.nice.org.uk/Guidance/CG12

Harrison , S et al, (2008), Identifying Alternatives to Hospital for People at the End of Life, The Balance of Care Group / National Audit Office http://www.balanceofcare.co.uk/previous_projects.html

Khan, SA; Tarver, K; Fisher S; Butler C (2007), Inappropriate Admissions of Palliative Care Patients to Hospital: A Prospective Audit, London, Pilgrims Hospices

Pleschberger, S, (2007), Dignity and the Challenge of Dying in Nursing Homes: The Residents' View http://ageing.oxfordjournals.org/content/36/2/197.short

DHSSPS (2006) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

NHS (England) (2006) Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. Prognostic Indicator Papers vs 2.25 http://www.endoflifecare.nhs.uk/eolc/files/GSF-Guide-Prognostic_Indicators-Jul06.pdf

NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer http://guidance.nice.org.uk/CSGSP

NICE (2004) Supportive and Palliative Care (CSGSP): Improving supportive and palliative care for adults with cancer http://www.nice.org.uk/Guidance/CSGSP

NHS Modernisation Agency (2004) Coronary Heart Disease Collaborative: Supportive and Palliative Care for Advanced Heart Failure http://www.improvement.nhs.uk/heart/Portals/0/documents/supportiveandpalliativecare.pdf

NICE (2003) Chronic Heart Failure; Management of Chronic Heart Failure in Adults in Primary and Secondary Care http://www.nice.org.uk/Guidance/CG5

Ellershaw & Wilkinson (2003), Care of the Dying: a Pathway to Excellence, Oxford University Press

Foote, C & Stanners, S, (2002), Integrating Care for Older People – New Care for Old – A Systems Approach, London, Jessica Kingsley

Responsibility for delivery/implementation	**Delivery and implementation partners**
• HSC Board • Public Health Agency (PHA) • HSC Trusts • Primary Care	• NICaN Supportive and Palliative Care Network • Primary care team, inclusive of social care • Voluntary palliative care

	organisations • Private nursing home and care providers

Quality Dimension

Citizenship
Earlier identification of palliative care needs and advance care planning will help improve quality of life and support a good death. Inappropriate admissions to hospital at the very end of life will be avoided.

Social Inclusion
People with non cancer conditions will have access to care and services traditionally available mainly to those with cancer conditions only

Empowerment
Involving service users, carers and families ensures that choices and preferences are taken into account in the planning and delivery of services

Working Together
HSC staff work in partnership with learning disability teams in order to ensure that appropriate reasonable adjustments are made to meet the specific needs of people with a learning disability.

Individual Support
Effective joint working between palliative care services and learning disability teams will ensure that the impact of learning disability is appropriately addressed in individual treatment plans.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
1. Percentage of the population that is enabled to die in their preferred place of care.	NISRA survey for baseline of the population's preference Registrar General and PAS information for actual place of death	Establish baseline Performance indicator to be determined when baseline established	March 2014 March 2015
2. Percentage of the population with an understanding of advance care planning	NISRA survey for baseline levels	Establish baseline Performance indicator to be determined when baseline established	March 2014 March 2015

Standard 34:
All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.

Service User Perspective*:*

If my health is getting worse and I need extra support towards the end of life staff will take into account my learning disability

Rationale:
Early identification of the supportive, palliative and end of life care needs of patients, their care-givers and family, through a holistic assessment, maximise quality of life for all in terms of physical, emotional, social, financial, and spiritual health and wellbeing.

People with a learning disability are entitled to the same services and respect throughout life as anyone else. Good palliative and end of life care is about enabling the individual to live out their potential when faced with an advanced progressive illness. By addressing the physical, emotional, spiritual and social issues which often make us fearful of death, it ensures that all individuals regardless of clinical diagnosis, get the appropriate care, at the right time, in the right place, in a way they can rely on.

Where necessary, reasonable adjustments should be made to take account of the impact of learning disability. Reasonable adjustments can be many and are wide ranging, but it is important to remember that they must be individualised to the person, and may include such things as:

- longer appointment times
- offering the first or last appointment
- the provision of easy read information to enhance understanding
- close involvement and support of family carers
- partnership working between learning disability services and other service providers.
- appropriate waiting facilities
- pre-admission visits
- fast tracking arrangements when appropriate (e.g. in A&E Departments)

Evidence:
Department of Health, Social Services and Public Safety (2010) *Living Matters: Dying Matters: A palliative and end of life care strategy for adults in Northern Ireland.* DHSSPS, Belfast.

Mencap (2008) Healthcare for All (The Michael Report) Report of the Independent Inquiry into access to healthcare for people with learning disabilities

National Institute for Clinical Excellence (2004) Improving Supportive and

Palliative Care for Adult with Cancer.
NHS (England) (2006) Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. Prognostic Indicator Papers vs. 2.25
http://www.endoflifecare.nhs.uk/eolc/files/GSF-Guide-Prognostic_Indicators-Jul06.pdf

NICE (2004) Improving Supportive and Palliative Care for Adult with Cancer. National Institute for Clinical Excellence: London
http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf

NICE (2004) Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care.
National Institute for Clinical Excellence: London
http://guidance.nice.org.uk/CG12

Responsibility for delivery/implementation	**Delivery and implementation partners**
• Primary Care • HSC Trusts • Public Health Agency	• Voluntary Palliative Care Organisations • Private nursing home and care providers

Quality Dimension

Empowerment
Involving service users, their carers and families ensures that their choices and preferences are taken into account in the design and delivery of services.

Working Together
Partnership with service users, their carers and families is only possible if they are proactively involved in decision-making processes. Effective partnerships will contribute to positive health and social care outcomes.

Individual Support
Effective person-centred support will ensure that individuals are appropriately assessed for supportive and palliative care.

Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
1 Palliative care services have mechanisms to identify whether people have a learning disability.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes.	March 2015 March 2016

2 Evidence of specific actions in service delivery that make reasonable adjustment for their learning disability.	SAAT	Develop and implement SAAT Performance levels to be determined based on SAAT outcomes.	March 2015 March 2016

ANNEX A

GLOSSARY OF TERMS

TERM	DEFINITION
Acute Care	Health care and treatment provided mainly in hospitals
Advocacy	A service that provides someone to represent your views or support you in expressing your own views
Allied Health Professionals	Allied health professionals (AHPs) work with all age groups and within all specialties. AHPs work in a range of surroundings including hospitals, people's homes, clinics, surgeries and schools.
Augmented forms of communication	Better more accessible communication
Autonomy	Freedom of will
Capacity (mental)	Being able to understand and use information to make a decision
Care order	Care order is a court order made on the application of a HSC Trust and granted where the court finds the child has suffered or is likely to suffer significant harm.
Care pathway	A plan for the care needed to help a person with a learning disability to move through the different services they may need.
Challenging behaviour	When someone is behaving in a way that might cause harm to themselves or other people. Services are challenged to find a way of managing the behaviour so the chance of harm is reduced.
Citizenship	People with a learning disability being treated equally with other people.
Commissioners	A term used to describe organisations or groups who have been given responsibility for purchasing of health and social services.

Community Care	Services provided outside the hospital setting by HSC professionals and other organisations in the community.
Competency – based	An ability to do something, especially measured against a standard
Crisis intervention	A situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid things getting much worse.
Cross-sectoral	Links between organisations managed by Government and voluntary/ community organisations and private business
Direct Enhanced Services	A Directly Enhanced Service is a specialised service provided by all GPs in N Ireland for adults with severe learning disability
Direct Payments	Direct Payments have been available since 1996 and aim to promote independence by giving people flexibility, choice and control over the purchase and delivery of services that support them. Individuals can opt to purchase services tailored to suit them by means of a Direct Payment from the Trust. From 19 April 2004 Direct Payments were extended to a wider range of service users under the Carers and Direct Payments Act (Northern Ireland) 2002 to include carers, parents of disabled children and disabled parents.
Disparities	A lack of equality between people or things
Domiciliary care	Support or care provided to a person in their own home
Dual diagnosis	Two different illnesses
Eligibility	To meet requirements for a certain criteria
Empowerment	Supporting people to take a full part in making decisions about their life.
Evidence-based practice	Doing things that have been shown to work
Health Action Plan	Describes the care and support you need to look after yourself and stay healthy.

Holistic care	Comprehensive care that addresses the social, psychological, emotional, physical and spiritual needs of the individual.
Independent sector	Organisations that are not managed by Government – includes voluntary organisations, community organisations and private business
Informed consent	Agreement by you to undergo treatment or care after being informed of and having understood the risks involved.
Integrated care pathway (ICP)	A multi-disciplinary outline of anticipated care which identifies how a patient with a specific condition will be supported by a number of professionals or agencies.
Integration	Equal access for all
Inter-agency	Links between different organisations
Legislative	To do with law
Mainstream Services	Services that anyone can use.
Methodologies	Different way of doing research.
Multi-Agency	Staff from different agencies, for example health and social care, education and employment, working together.
Multi-disciplinary	Staff from different professions, for example, nurses, doctors, social workers, working together.
Optimum	Most suitable
Palliative care	The active, holistic care of patients with advanced progressive illness. The goal of palliative care is to achieve the best quality of life for patients and their families.
Partnership working	Different organisations working together to achieve something
Person-Centred	The person and their family and friends are central and fully involved in all aspects of their care. The service, the organisation and its systems are focused on the needs of (what is important to) the individual.

Preliminary reports	Reports done at the start.
Prevalence	How many people in the population have a particular problem
Primary Care	Health and social care services that are generally available to everyone, for example, GP, dentist.
Reasonable adjustments	Actions that service providers should take to make sure people with a learning disability can use their services.
Respite	Support which gives carers a break from their usual caring roles and duties.
SAAT	Self Assessment Audit Tool – a performance management tool designed to measure the delivery of key objectives
Secondary Care	Health and social care services that help people with more complicated needs than those that primary care deal with, but mostly in the community.
Self-determination	A right to decide for self
Self-directed support	Helping people be in control of the support they need to live their life as they chose.
Service Framework	A document that sets out what people can expect the service to provide.
Service User	Anyone who uses, requests, applies for, or benefits from health and social care services.
Social inclusion	Making people with a learning disability feel part of the community they live in.
Statutory sector	Those organisations that are managed by government
Stereotypical	To categorise individuals or groups according to an oversimplified standardised image or idea
Transition	A time in a person's life when big changes are happening, for example, leaving school
Universal	Meaning all

ANNEX B

MEMBERSHIP OF PROJECT BOARD

Dominic Burke	Western Health and Social Services Board (Chair to 2009)
Fionnula McAndrews	Health and Social Care Board (Chair from April 2009)
Siobhan Bogues	Association for Real Change (Northern Ireland)
Dr Maura Briscoe	DHSSPS (to October 2009)
Peter Deazley	DHSSPS (from October 2009)
Paul Cavanagh	Western Health and Social Services Board (until 2009 and from September 2009)
Jim Simpson	Western Health and Social Services Board (to August 2009)
Aidan Murray	Health and Social Care Board (from September 2009)

MEMBERSHIP OF PROJECT TEAM

Siobhan Bogues	Association for Real Change (Northern Ireland) (Chair of Project Team)
Charles Bamford	DHSSPS
Orlaigh Cassidy	Service User
Edna Dunbar	Association for Real Change (Northern Ireland) (to September 2009)
Paula McGeown	DHSSPS (from September 2009)
Veronica Gillen	DHSSPS (to September 2010)
Rosaleen Harkin	Western HSC Trust
Sandra Harris	Equal Lives Action Group
Roy McConkey	Expert Board on Mental Health and Learning Disability
Bryce McMurray	Southern HSC Trust
Bria Mongan	South-Eastern HSC Trust
John Mullan	Service User
Jim Simpson	Western Health and Social Services Board (to August 2009)
Miriam Somerville	Belfast HSC Trust
Tom Smith	Southern Health and Social Services Board (until August 2009)
Pat Swann	DHSSPS
Sam Vallelly	Northern HSC Trust
Adrian Walsh	Eastern Health and Social Services Board
Aidan Murray	Health and Social Care Board (from October 2009)
Molly Kane	Public Health Agency (from September 2009)

ANNEX C

MEMBERSHIP OF WORKING GROUPS

ACCOMMODATION

Bryce McMurray	Southern HSC Trust (Chair of Accommodation Working Group)
Richard Black	Southern HSC Trust
Dessie Cunningham	Southern HSC Trust
Tony Doran	Southern HSC Trust
Janet McConville	Southern HSC Trust
Sinead McGeeney	Disability Action
Paul Roberts	Positive Futures
Moira Scanlon	Southern HSC Trust
Tom Smith	Southern Health and Social Services Board
Chris Williamson	NI Federation of Housing Associations

AGEING

Rosaleen Harkin	Western HSC Trust (Chair of Ageing Working Group)
Tony Brady	Carer
Raymond Boyle	Western HSC Trust
Dr Michael Curran	Western HSC Trust
Brendan Duffy	Western HSC Trust
Dr Jennifer Galbraith	Western HSC Trust
Lee McDermott	Western HSC Trust
Mr Brian McGarvey	Western HSC Trust
Pat McLaughlin	Western HSC Trust
Maureen Piggott	Mencap
Isobel Simpson	Western HSC Trust

CHILDREN AND YOUNG PEOPLE

Bria Mongan	South-Eastern HSC Trust (Chair of Children and Young People Working Group)
Sharon Bell	Parent
Dr Ann Black	South-Eastern HSC Trust
Gerry Campbell	NICCY
Heather Crawford	South-Eastern HSC Trust
Jennifer Creegan	South-Eastern HSC Trust
Maurice Devine	DHSSPS
Alice Lennon	South-Eastern Education and Library Board
Agnes Lunny	Positive Futures
Pauline McDonald	Belfast HSC Trust
Marian Robertson	South-Eastern HSC Trust
Colette Slevin	Mencap
Tracey Sloan	Parent

FULLER LIVES

Sam Vallelly	Northern HSC Trust (Chair of Fuller Lives Working Group)
Gareth Anderson	Northern HSC Trust
Ivan Bankhead	Northern HSC Trust
Mildred Bell	Northern HSC Trust
Pauline Cummings	Northern HSC Trust
Molly Kane	Northern Health and Social Services Board
Kate Kelly	Northern HSC Trust
Áine Lynch	North Regional College
Virgina Maxwell	Carer
Oonagh McCann	North-Eastern Education and Library Board
Oliver McCoy	Northern HSC Trust
Gerard McKendry	Service User (Compass Advocacy Group)
Donna Morgan	Northern HSC Trust
Judith Shaw	DEL
Bernie Doherty	DEL
Norman Sterrit	Triangle Housing Association

HEALTH

Miriam Somerville	Belfast HSC Trust (Chair of Health Working Group)
Kate Comiskey	Blair Lodge
Dr Petra Corr	Belfast HSC Trust
Maurice Devine	South-Eastern HSC Trust
Brian Irvine	Service User (Orchardville Training Centre)
Neil Kelly	Belfast HSC Trust
Rosalind Kyle	Belfast HSC Trust
Liz Leathem	Bryson Group
John McCart	Belfast HSC Trust
Dr Colin Milliken	Belfast HSC Trust
Mairead Mitchell	Belfast HSC Trust
Adian Murray	Eastern Health and Social Services Board
Fiona Rowan	Carer
Eilish Steele	Belfast HSC Trust

QUALITY IMPROVEMENT SUB-GROUP

Siobhan Bogues	Association for Real Change (ARC NI)
Edna Dunbar	Association for Real Change (ARC NI) (to September 2009)
Veronica Gillen	DHSSPS (to September 2010)
Seamus Logan	DHSSPS
Patrick Convery	Regulation & Quality Improvement Authority
Maureen Piggot	Mencap NI
Roy McConkey	University of Ulster
Jim Simpson	Western Health & Social Services Board (Until August 2009)
Stella Cunningham	Patient & Client Council
Molly Kane	Public Health Agency

COSTINGS SUB-GROUP

Adrian Walsh	Health & Social Care Board
Siobhan Bogues	Association for Real Change (ARC NI)
Veronica Gillen	DHSSPS (to September 2010)
Paula McGeown	DHSSPS (from September 2009)
Tracey McKeague	Health & Social Care Board
Bria Mongan	South-Eastern HSC Trust
Aideen O'Docherty	DHSSPS
Miriam Somerville	Belfast HSC Trust

ANNEX D

The five core values outlined in the Equal Lives Review (2005):

Citizenship	People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.
Social Inclusion	People with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community.
Empowerment	People with a learning disability must be enabled to actively participate in decisions affecting their lives.
Working Together	Conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability.
Individual Support	People with a learning disability will be supported in ways that take account of their individual needs and help them to be as independent as possible

ANNEX E

Bamford Review of Mental Health and Learning Disability Reports

- Mental Health Improvement and Wellbeing May 2006
- Child and Adolescent Mental Health July 2006
- Adult Mental Health June 2005
- Dementia and Mental Health of Older People June 2007
- Alcohol and Substance Misuse Dec 2005
- Forensic Services Oct 2006
- Learning Disability Sept 2005
- Promoting Social Inclusion Aug 2007
- A Comprehensive Legislative Framework Aug 2007
- Human Rights and Equality Oct 2006
- Delivering the Bamford Vision 2008

ANNEXE F

ABBREVIATIONS

A&E	Accident and Emergency
ASD	Autistic Spectrum Disorders
BMI	Body Mass Index
CSCI	Commission for Social Care Inspection (now Care Quality Commission)
CSR	Comprehensive Spending Review
DCAL	Department of Culture, Arts & Leisure
DE	Department of Education
DEL	Department of Employment & Learning
DES	Direct Enhanced Services
DfES	Department for Education and Skills (England)
DHSSPS	Department of Health, Social Services and Public Safety
DNAR	Do Not Attempt Resuscitation
DoH	Department of Health
DoJ	Department of Justice
DSCF	Department for Children Schools and Families (England)
DSD	Department of Social Development
ELB	Education and Library Board
FE	Further Education
GAIN	Guidelines and Audit Implementation Network
GMC	General Medical Council
GP	General Practitioner
HSC	Health and Social Care
IASSID	International Association for the Scientific Study of Intellectual Disabilities
LASPs	Local Adult Safeguarding Partnerships
LCG	Local Commissioning Group
NDA	National Disability Authority
NDTi	National Development Team for Inclusion

NHS	National Health Service
NIASP	Northern Ireland Adult Safeguarding Partnership
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health and Clinical Excellence
NIHE	Northern Ireland Housing Executive
NIUSE	Northern Ireland Union of Supported Employment
OFMDFM	Office of First Minister and Deputy First Minister
PBNI	Probation Board for Northern Ireland
PCC	Patient and Client Council
PCP	Patient-centred Plan
PfA	Priorities for Action
PHA	Public Health Agency
PPI	Personal & Public Involvement
PSNI	Police Service of Northern Ireland
QIS	Quality Improvement Scotland
RCSLT	Royal College of Speech and Language Therapists
RoI	Republic of Ireland
RQIA	Regulation & Quality Improvement Authority
PSSRU	Personal Social Services Research Unit
SAAT	Self Assessment Audit Tool
SACN	Scientific Advisory Committee on Nutrition
SBNI	Safeguarding Board for Northern Ireland
SCIE	Social Care Institute for Excellence
SENDO	Special Educational Needs and Disability Order
SIGN	Scottish Intercollegiate Guidelines Network
UNOCINI	Understanding the Needs of Children Northern Ireland
WHO	World Health Organisation

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DELIVERING THE BAMFORD VISION

The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability

ACTION PLAN 2012-2015

Integrated Projects Unit

November 2012

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Ministerial Foreword

The Northern Ireland Executive's response to the findings of the Bamford Review led to the publication in October 2009 of the 2009-2011 Bamford Action Plan. That plan contained agreed actions and timescales for Northern Ireland Government Departments and Health and Social Care sectors.

I am pleased to publish this follow-on 2012-2015 Action Plan that will continue to progress the enhancements to mental health and learning disability service started through the previous Plan.

The Evaluation of the 2009-2011 Action Plan, published in May 2012, establishes that over the last two years the joint working across Government Departments and the HSC sector has achieved much, and 80% of the actions have been delivered. It also highlights areas where services can still be improved and the need for more of a focus on outcomes rather than outputs.

The follow-on 2012-2015 Action Plan has been based on the lessons learnt from the 2009-2011 Evaluation, consultative workshops, new research and evidence based practice and the views of service users and their carers.

Government Departments have endorsed these actions which are to be delivered by end 2015. The Bamford Vision for these services though will only be fully realised through the commitment not just of health and social care staff, and an inter-governmental and agency approach, but also through the drive of service users, carers and the voluntary and community sectors.

The implementation of this Action Plan will continue to be monitored through the Interdepartmental Senior Officials Group on Mental Health and Learning Disability and monitoring reports will be published on a regular basis.

I believe it is important that Government and those who commission and deliver services are informed and guided by the views of those who use these services. The evaluation of this follow-on 2012-2015 Action Plan will therefore focus primarily on service user outcomes rather than outputs. An Outcome Evaluation Model for this Action Plan is being developed.

I would like to particularly thank the Bamford Monitoring Group of the Patient and Client Council for their invaluable assistance in the formulation of this Action Plan and their Outcomes Paper.

The Bamford Vision set out a 10-15 year timescale for the enhancement of mental health and wellbeing, and for learning disability services. A strong foundation has been established and a positive change is evident but we still have much to do in order to deliver that Vision.

I want to reiterate the commitment of the full Northern Ireland Executive to the ongoing development of mental health and learning disability services to meet the needs and expectations of those who use and rely on them.

EDWIN POOTS, MLA

Minister for Health, Social Services and Public Safety

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SECTION A

1 SETTING THE SCENE

The Bamford Review of Mental Health and Learning Disability

1.1 The Bamford Review of Mental Health and Learning Disability, an independent review of legislation, policy and service provision, concluded in August 2007. Broadly the Review called for:

- continued emphasis on promotion of positive mental health
- reform of mental health legislation
- a continued shift from hospital to community-based services
- development of a number of specialist services, to include children and young people, older people, those with addiction problems and those in the criminal justice system
- an adequate trained workforce to deliver these services.

1.2 The Review envisaged a 10-15 year timescale for full implementation of its recommendations.

Bamford Action Plan 2009-2011

1.3 The Northern Ireland Executive accepted the broad thrust of the Review's recommendations. The Executive's response to the findings of the Bamford Review, *Delivering the Bamford Vision*, was consulted on in 2008. This led to the publication in October 2009 of the Bamford Action Plan 2009 –2011.

1.4 The 2009-2011 Plan set out the Executive's commitment across Departments to improving the mental health and well-being of the population of Northern Ireland and to improving services for those with a mental health need or a learning disability in line with the policy articulated in *Delivering the Bamford Vision*. The Action Plan contained agreed actions with associated timescales to be taken forward by a range of Northern Ireland Government departments and agencies, in particular the Health and Social Care sector.

1.5 An inter-Ministerial group, chaired by the Minister for Health, Social Services and Public Safety, was established to oversee the work and structures put in place to support this group. The structures put in place also provide a formal forum for the voice of service users and carers through the Bamford Monitoring Group.

1.6 Departments other than DHSSPS continue to make a substantial contribution to progressing the Bamford Vision, as evidenced by the Action Plan in Section B. The structures supporting cross-sectoral work on Delivering the Bamford Vision are shown

below.

1.7 This Action Plan, covering the period 2012-2015, follows on from the 2009-2011 Action Plan. Some of the actions in this Plan continue work already started during 2009-2011, while others address issues raised by the Bamford Review which were not possible to progress during the 2009-2011 Plan. The plan also includes a number of issues which were not considered by the Bamford Review but which fall under the broader vision of the Review

1.8 In preparing this Action Plan, those who use the services and their families and carers have had opportunity to influence the Plan through:

- two initial workshops held in September 2011 to gather views on the key areas for renewed action;
- two workshops in March 2012 jointly hosted by the Inter-Departmental officials group and the Bamford Monitoring Group to consider how cross-sectoral working could be improved; and
- continued close working with the Bamford Monitoring Group.

Transforming Your Care

1.9 *Transforming Your Care*, TYC, – a review of health and social care in Northern Ireland published in December 2011 has many parallels with the Bamford Vision in respect of mental health and learning disability service provision and enhancement including;

- Early intervention and health promotion,
- A focus shift to community care,
- Promotion of recovery practices,
- Personalisation of care,
- Resettlement,
- Service user and carer involvement,
- Advocacy,
- Provision of clearer information, and
- Respite provision.

1.10 The Evaluation of the 2009-2011 Bamford Action Plan and the TYC Review both also acknowledge the many improvements in mental health and learning disability services over the last few years and the ongoing need to continue to drive forward more rapid progress.

1.11 The TYC Review reflects the Bamford Vision, with both committed to delivering the best outcomes, increasing independence, choice and service improvements for people with mental ill-health or a learning disability. This will enable accelerated service enhancement in line with the needs and expectations of service users and carers in a coordinated and consistent manner.

Bamford Implementation Structures 2012-2015

2 WHERE WE ARE NOW

The Bamford Vision

2.1 *Delivering the Bamford Vision* set out the broad direction in which mental health and learning disability priorities were to be addressed across Government and the health and social care sector in particular. The 2009-2011 Action Plan contained 80 mental health and 67 learning disability actions, with some actions common to both, to be undertaken over the period of the Plan. Many of the actions were supported by additional resources committed in the Comprehensive Spending Review for that period.

Evaluation

2.2 Progress on the Plan has been monitored on a regular basis and a more detailed evaluation carried out during 2011. This shows that about 80% of the actions committed to in the 2009-2011 Plan have been carried out. This was achieved despite a reduction in the anticipated allocations to the health and social care sector and the wider public sector in 2010/11 due to the generally worsening financial climate. The full evaluation report can be accessed at:

http://www.dhsspsni.gov.uk/show-publications?txtid=56444

2.3 The evaluation report acknowledges that some actions were preparatory steps in modernising and improving services, through developing strategies and new models of service delivery, and recognises that people who use the services may not yet have seen much difference in the actual provision of services.

2.4 Significant work and investment has however gone into:

- Inter-Departmental working across education, housing, training and employment, as well as within the health and social care sector, to ensure that as far as possible, people with a learning disability or a mental health need are supported within their communities;
- developing a range of strategies and plans for future service developments;
- improving mental health and learning disability services, with an emphasis on community based early intervention and a significant investment of new funding to support this;
- detailed preparations for the drafting of the new mental capacity legislation.

Learning

2.5 Despite this work and additional investment, there is still a long way to go in achieving the goal of improving the lives of people with a mental health need or a learning disability and their families and carers. Reports from the Bamford Monitoring Group, which was established to represent the views of these groups of

people, indicate that:

- generally, people recognise that the Bamford Vision is beginning to make a positive difference to their lives, but there is frustration with the slow pace of change.
- people are concerned that funding and the other resources necessary to realise the Bamford Vision may be reduced due to the financial cutbacks.
- there is a perceived major deficit, at a regional level, in the provision of advice and information services for those who use and rely upon mental health and learning disability services.
- people with mental health needs, learning disabilities, parents, carers and communities want to be involved in the planning, design, delivery and evaluation of services in Northern Ireland.
- service users and carers believe there to be a considerable lack of cross-sectoral working on realising the Bamford Vision. This has the potential to be a major barrier in the delivery of essential services and cause stress to individuals, families and carers.

2.6 Much, therefore, remains to be done and there are many challenges to be faced in a difficult financial environment.

3 THE CHALLENGES AHEAD

Challenges

3.1 In committing to the delivery of the first stage of the Bamford reforms through the 2009-2011 Action Plan, the Executive was aware of the challenges for the future that would have a major influence on the implementation of that plan and future plans. These included demographic change, particularly our longer life-spans with increasing complexity of needs, and the levels of public sector funding that could be directed towards supporting the reform and modernisation of mental health and learning disability services, taking account of all the other pressures on public sector funding.

Our Ageing Population

3.2 These challenges remain. Numbers of older people continue to increase, and this is addressed in this Action Plan for 2012-15 mainly through two strands of work on dementia services and on the needs of people with a learning disability as they and their carers grow older.

Finances

3.3 As a result of the 2008-2011 Comprehensive Spending Review DHSSPS allocated an additional £44m to mental health and learning disability services, as outlined below, with a further £3m made available to support mental health promotion and suicide prevention over the three year period.

DHSSPS proposed additional funding for mental health and learning disability 2008/09- 2010/11

3.4

	2008/09 £m	2009/10 £m	2010/11 £m	Total 3 year 2008/09 to 2010/11 £m
Learning Disability	7.00	2.00	8.00	17.00
Mental Health	12.75	1.85	12.40	27.00
TOTAL	19.75	3.85	20.40	44.00

3.5 The widespread constraints in public spending in 2010/11 impacted on the amounts planned for mental health and learning disability as set out in the table below. The amounts allocated were reduced from £27m to £17.1m for mental health and from £17m to £12.4m for learning disability.

DHSSPS actual additional funding mental health and learning disability

3.6

	2008/09 £m	2009/10 £m	2010/11 £m	Total 3 year 2008/09 to 2010/11 £m
Learning Disability	7.00	2.00	3.40	12.40
Mental Health	12.40	1.90	2.80	17.10
TOTAL	19.40	3.90	6.00	29.50

3.7 While these reductions, along with the general requirement to deliver annual efficiency savings, have had some effect on the Health and Social Care sector's ability to deliver on actions in the 2009-2011 Action Plan, the evaluation of the Action Plan shows that actual spending by the HSC Trusts on mental health and learning disability services increased between 2007/08 and 2010/11 by sums considerably more than those actually allocated as additional funding by DHSSPS.

3.8 By the end of 2010/11, expenditure on mental health services had risen by £32.31m from the baseline of £195.69m in 07/08

Mental Health Expenditure

3.9

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
Hospital	95.81	109.49	107.04	103.46
Community and Social Services	99.88	111.96	117.26	124.54
Total actual spend	195.69	221.45	224.30	228.00
Increase over 2007/08 baseline		25.76	28.61	32.31

3.10 Learning disability service data demonstrates corresponding increased resourcing over and above the Bamford CSR uplift. By the end of 2010/11, expenditure on learning disability services had risen by £39.88m from the baseline of £200.20m in 07/08.

Learning Disability Expenditure

3.11

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
Hospital	40.14	42.67	42.23	42.98
Community and Social Services	160.06	172.64	186.03	197.09
Total actual spend	200.20	215.31	228.26	240.08
Increase over 2007/08 baseline		15.11	28.06	39.88

3.12 A wide range of Departments and agencies also fund programmes and services which benefit people with mental ill-health or a learning disability. Most of these benefit a wider range of people; it is not therefore possible to identify how much of this funding directly impacts Bamford services.

3.13 Funding will continue to be a significant challenge in the period to 2015 and beyond. There is continuing pressure to achieve efficiencies. The only additional funding to the Health and Social Care sector earmarked for mental health and learning disability services over the budget period 2011-2015 is £9.20m - £2.80m for mental health and £6.40m for learning disability - to continue the resettlement programme. This contrasts sharply with the financial outlook at the start of the 2009-2011 Action Plan, when much more significant increases in funding were anticipated.

3.14 New actions or initiatives will require further financial analysis and their implementation will be subject to resource availability and prioritisation within the respective organisation(s). However, it is acknowledged that much can be achieved through reform, modernisation, and redesign of commissioning arrangements and service provision. In the context of health and social care services, such an approach is underpinned by *Transforming Your Care* (December 2011) and its associated consultation document *Vision to Action*[1].

New Challenges

3.15 A further challenge relates to emerging issues. It is now 10 years since the Bamford Review started its work. Over time service provision and inter-relationships between services change and evolve and the priorities attributed to particular issues by those who use the services, their families and carers and the general public change. Issues are emerging now which were not highlighted in the Bamford review, but need to be addressed. While not strictly a response to the recommendations of Bamford Review, actions proposed on such emerging issues will be taken forward in the broader framework of reform and modernisation envisaged by Bamford and in

[1] *Transforming Your Care*(December 2011) and *Vision to Action* - A consultation document(October 2012 – 15 January 2013)

keeping with the Bamford ethos of support and care which is person-centred and enabling.

4 THE WAY FORWARD

The Bamford Vision

4.1 The Executive's Vision for the Future set out in the 2009-2011 Action Plan remains valid today and will continue to guide the service improvements across Government.

THE BAMFORD VISION

To make the Bamford vision a reality, the NI Executive will promote the mental wellbeing of the population as a whole. The Executive will also promote the health and wellbeing, and maximise the independence and full participation of people of all ages with a mental health need or a learning disability, underpinned by legislation and public services to include reform and modernisation of mental health and learning disability services.

People with a mental health need or a learning disability using public services should expect to:

- *be encouraged and supported to look after their own health, both mental and physical, and build up emotional resilience;*
- *be supported, as far as possible, in their own homes and communities, making best use of self-directed help;*
- *be supported, through effective collaboration between Government Departments and their agencies, in their life choices and in day to day activities of engaging in education, training, work and leisure;*
- *be consulted on and be able to influence the provision of services to meet their needs;*
- *be encouraged to access help at as early a stage as possible; and*
- *be supported towards personal fulfilment and full citizenship.*

4.2 This is the vision for the future, supported by all Government Departments.

4.3 The actions in this Action Plan consist of:

- actions carried forward from the 2009-2011 Action Plan due to the work not

being completed;
- actions which are a consequence of the actions completed in the 2009-2011 Plan;
- new areas of work which had not been addressed in the previous Plan, some of which were highlighted in the 2008 consultation on the Executive's response to the Bamford review, but could not be made a priority in the 2009-2011 Plan.

4.4 As indicated earlier in Chapter 3, the actions in this Plan also take account of the financial outlook. Only actions which can be taken forward within the existing budgetary allocations are committed to in the Plan.

Work areas which support the Bamford Action Plan

4.5 The 2009-2011 Action Plan reinforced the message that mental health and learning disability issues are affected by actions much wider than just the provision of services which bear those labels. It was recognised, for example, that action in relation to tackling domestic and sexual violence contributes to the emotional wellbeing of many in our community. Work on promoting Personal and Public Involvement (PPI) throughout the health and care sector will promote the inclusion of people with a learning disability or a mental health need and improve services by making them more responsive to the needs of service users. Similarly work to support families and carers and the general drive to increase uptake of Direct Payments impact on people using mental health and learning disability services in parallel with other groups of people.

4.6 While work continues in all of the areas mentioned in 4.4, this new Action Plan does not include this work as specific actions in the Tables in Section B. The tables concentrate instead on actions which are focused on mental health and learning disability issues.

4.7 In addition many of the actions from the 2009-2011 Action Plan which were completed will continue to have an effect during the lifetime of this new Action Plan. These actions however are not repeated in this new Plan. For example, findings from the workforce study carried out as part of the 2009-2011 Action Plan will be taken forward as an integral part of the work to develop mental health and learning disability services in general as well as in actions relating to specific services being addressed within this new Plan.

4.8 Work which was carried out to improve information on the use of mental health and learning disability services will help those commissioning and providing services to improve service delivery. Further work is indicated in the Action Plan however in relation to provision of information for those seeking to access services; this has been highlighted by the Bamford Monitoring Group as an area where improvement is needed.

Criminal Justice Services

4.9 A High Specialist Support Services sub-group under the HSC Bamford Taskforce provides a coordinated approach across Health and Social Care and Criminal Justice Systems, CJS. The sub-group seeks to improve services provided to people with mental health and/or a learning disability who are, or have been, in recent contact with the CJS. Membership includes representatives from DOJ, DHSSPS, the HSC sector, PSNI and service uses and carers.

4.10 The cross sectoral working ethos of the sub-group has achieved much already and continues to focus on developing care pathways, quality and outcome measures, specialist learning disability services and a regional inter-agency training approach.

5 THEMES

5.1 The 2009-2011 Plan reinforced key Bamford messages by grouping the actions under five themes:

BAMFORD THEMES

1. *Promoting positive health, wellbeing and early intervention*
2. *Supporting people to lead independent lives*
3. *Supporting carers and families*
4. *Providing better services to meet individual needs*
5. *Developing structures and a legislative framework*

5.2 These will continue to be the themes within which the Bamford agenda will be progressed through this 2012-2015 Action Plan.

Promoting positive health and wellbeing

5.3 Promoting positive community and personal health and wellbeing was central to the Bamford Review's vision. DHSSPS continues to lead on the development of a new 5 year cross-sectoral Mental Health & Wellbeing Promotion Strategy to be issued for public consultation in late 2012. The new strategy for the period 2013 to 2018 will focus on building the mental and emotional resilience of the whole population and of specific "raised risk" groups. As with previous work on this issue, it will require effective collaboration across departments and sectors.

5.4 The new Mental Health and Wellbeing Promotion Strategy will have strong links with the Protect Life strategy on suicide prevention, which has been refreshed to run to March 2014. Action on these two strategies, with their emphasis on cross departmental/ sectoral commitment, will form a key strand of work within this Bamford Action Plan for the coming years.

5.5 The importance of promoting emotional wellbeing in children and young people, equipping them with coping skills and providing support where necessary, is recognised in a series of actions to be undertaken by Department of Education.

5.6 Helping people with a learning disability maintain their physical health is also recognised in this theme, through continued implementation of the Directed Enhanced Services and targeted action on dental services.

Supporting People to Lead Independent Lives

5.7 Leading a fuller life through active participation in the community and being able to engage in meaningful day-time activities was a key theme within the Bamford Review

reports, particularly the Equal Lives report on people with a learning disability. The Office of the First Minister and Deputy First Minister continues to lead cross-sectoral work on promoting social inclusion for people with a disability. Work also continues on improving access to work, on training for work and on access to public transport, recognising their role in helping people be more independent.

5.8 The Bamford Review called for a renewed impetus to resettle into the community the substantial number of people who remained unnecessarily in long stay mental health and learning disability hospitals. The resettlement programme will continue during the period of the 2012-15 Action Plan, supported by funding earmarked for that purpose. At the same time processes will continue to ensure that patients admitted to hospital in more recent times are discharged back into the community as soon as their assessment and/ or treatment is completed.

5.9 Direct Payments can be used to increase choice and promote independence. They provide for a more flexible response to meeting the needs of the service user as users can opt to purchase services themselves by means of a Direct Payment from the HSC Trust in order to tailor their support package to their individual needs.

5.10 It is still DHSSPS policy to offer Direct Payments as an alternative to direct service provision, but a recent court judgement means that there is no legal basis to enter into a direct payment arrangement with an individual who lacks capacity. It is the Department's intention to amend existing legislation to make provision for another individual to receive Direct Payments on behalf of a person with eligible needs who lacks capacity to consent to such payments. It may, however, take some time to effect the necessary legislative change, so arrangements are being put in place to ensure that Direct Payments can continue to be offered in the interim period.

5.11 Direct Payments can increase choice to some extent. Many people who use mental health and learning disability services have said that they would like to be given greater freedom to arrange a package of support and care that truly suits their individual needs and their family circumstances. While there may be benefits to those who use services, there may also be drawbacks which would not make personalisation suitable for everyone. Over the life of this Action Plan, DHSSPS will undertake work to consider how best the policy of "self directed support" or "personalisation" can be progressed in Northern Ireland. This is reflected in the Action Plan in Section B.

Supporting Carers and Families

5.12 The contribution made by many families and other informal carers in supporting people with a mental health need or a learning disability is immense. Work continues on the recommendations contained in the earlier Joint Review of Support Provision for Carers, including provision of information for carers, both in booklet form and on the NI Direct website, and promoting the use of the Carers Support and Needs Assessment component of NISAT. RQIA will commence a review of the implementation of the DHSSPS Standards for Adult Social Care Support Services for Carers across relevant HSC services in 2012, which will inform future work to support

carers. The work on personalisation referred to in paragraph 5.10 also has the potential to provide better support for families and carers.

5.13 Investment in respite services, with associated targets for increased provision in the 2009-2011 Action Plan, recognised the value of respite provision to carers and to service users. However attempts to monitor the targets highlighted difficulties with defining respite provision and with measuring consistently the extent of provision. The HSC Board has been engaged in a substantial exercise to bring fairer approaches to assessment for and provision of respite services. This work will continue during this Action Plan period and will take into account the issues raised in the recent Bamford Monitoring Group report on respite services.

5.14 Stakeholders have also highlighted that increased emphasis on managing mental health periods of crisis within the community puts an added burden on family and carers. Carers' needs have to be recognised and appropriate support and information provided as part of the further development of these services.

Providing Better Services

5.15 The publication of the mental health Service Framework in 2011 and the anticipated publication of the Service Framework for learning disability will serve to improve health and social care services through setting standards. Community mental health and learning disability services will continue to be built up, so that fewer people need to be admitted to hospital. Work will continue on many of the service improvement areas started in the 2009-2011 Action Plan:

- developing early interventions, including psychological therapies;
- building up specialist services, eating disorder, perinatal mental health and forensic services;
- ensuring timely discharge from hospital after assessment and treatment.

5.16 In view of the Bamford Monitoring Group's findings in relation to service users and carers being able to access information on services, work will continue on a service mapping project for mental health services with the aim of providing information to people who wish to access the services in their area. This project will then be extended to learning disability services.

Research

5.17 In 2011, 5 reviews of current research and research evidence were commissioned by HSC R&D Division in areas prioritised by key stakeholders including clinicians, commissioners, researchers and service users. The completed reviews were disseminated widely including a launch event in November 2011. Eight research questions, for which no robust evidence is yet available, led from these reviews and formed the basis of a further call for substantive research projects which closed in March 2012. Following the evaluation panel, five projects were funded. These projects, the titles of which are listed below, will run for a period of 18-36 months.

- A natural experiment investigating differences in how residential facilities support people with intellectual disabilities with challenging behaviour and/or mental health problems.
- Effective family support models during the transition of adults with intellectual disabilities (ID) into old age.
- Transitions & outcomes for care leavers with mental health and/or intellectual disabilities.
- Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of Family, Peer & School Processes, and
- Improving pathways and care for young people in NI with mental health problems in the transition from CAMHS to adult services (IMPACT).

Developing Structures and a Legislative Framework

5.18 The structures supporting work on Delivering the Bamford Vision as set out in Chapter 1 will remain in place. There is however a need to address the concerns expressed by the Bamford Monitoring Group and by other stakeholders that cross-sectoral working is not seen at local level and that lack of joined-up working causes frustration for those who uses the services and for families and carers.

Workshops

5.19 To inform preparation of this Action Plan, two workshops were held in March 2012 under the auspices of the Inter-Departmental Senior Officials Group, IDSOG, and the Bamford Monitoring Group, BMG, to consider how cross-sectoral working could be improved to benefit those who use mental health or learning disability services.

Workshop themes

5.20

5.21 In response to issues raised at these workshops the IDSOG will sponsor work on local level cross-sectoral issues, involving the relevant stakeholders along with representatives from the Bamford Monitoring Group. This is reflected in the Action Plan in Section B.

Children and Young People's Strategic Partnership

5.22 A new regional cross-sectoral group will also contribute to delivering the Bamford agenda for children and young people through the HSC Board. The Children and Young People's Strategic Partnership (CYPSP) was established in January 2011. The HSC Board has a statutory duty to establish and lead the CYPSP and publish a Northern Ireland Children and Young People's Plan; the first of these has been issued for consultation. The Partnership and its Plan is multi-agency and multi- sectoral. The purpose is integrated planning and commissioning to improve outcomes for our

children and young people, including those who have a disability.

5.23 Of particular relevance to the Bamford agenda will be three regional sub groups of the CYPSP:

1) children and young people with emotional and behavioural difficulties;
2) children and young people with disabilities;
3) transition for young disabled people from childhood to adulthood.

Mental Capacity Legislation

5.24 The need for new legislation was a key recommendation arising from the Bamford Review, which called for the development of a single legislative framework for the reform of the current Mental Health (NI) Order 1986 (the 1986 Order) and the introduction of new mental capacity legislation in Northern Ireland. The 2009-2011 Action Plan included an action to take forward work on new legislation, but recognised that it would be later than 2011 before new legislation could be introduced.

5.25 Preparation of a draft Bill is under way, with a previous intention of introducing the Bill into the Assembly in 2012 and enactment in 2013. A major element of this legislative reform will be to embed a set of principles in the legislation, as recommended by the Bamford Review. The Bill will also provide for substitute decision-making on behalf of those unable to make decisions for themselves provided safeguards set out in the Bill are engaged. However a recent decision by DHSSPS and the Department of Justice to extend the scope of the Bill to those subject to the criminal justice system has meant that the Bill's introduction to the Assembly is now scheduled for December 2013 with enactment following, at the earliest, in 2015.

5.26 The draft Bill will also include a new statutory right to an independent advocate in certain circumstances. To pave the way for this new right, draft policy guidance for commissioners of advocacy services was published earlier this year; further work on the new statutory right will be taken forward during the period of this Action Plan.

6 LEARNING DISABILITY

Core Values

6.1 The Bamford Review based its recommendations relating to people with a learning disability on 5 core values of:

- Social inclusion – people with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community;
- Citizenship – people with a learning disability are individuals and each has a right to be treated as an equal citizen;
- Empowerment - people with a learning disability must be enabled to actively participate in decisions affecting their lives;
- Working Together – conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability;
- Individual Support - people with a learning disability will be supported in ways that take account of their individual needs and helps them to be as independent as possible.

6.2 These core values will continue to influence the development of learning disability services as we move into this new Action Plan.

Service Framework

6.3 A Service Framework for Learning Disability, published in September 2012, sets out clear standards of care that people can expect. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

Children and Young People with a Learning Disability

6.4 Work will continue across the health and social care and education sectors to ensure that children with a learning disability are supported and encouraged to develop to their full potential and to participate as fully as possible in school. The Education and Library Boards have statutory responsibilities in this regard. Recognising that transition to adulthood can be a particularly daunting time for young people with a learning disability, work will continue across Departments and their agencies to support young people during this period of their lives. The transitions sub-group of the Children and Young People's Strategic Partnership will play a significant role in this work.

Older People with a Learning Disability

6.5 Equal Lives, the Bamford Review report on learning disability, recognised that increasing numbers of people with a learning disability were living to old age, but that this brought added challenges. Family carers also grow older and become unable to continue with the caring role. Accommodation and day time activities may no longer be suited to the person's interests and physical abilities. Dementia can start at an earlier age than for most other people. This Action Plan includes a commitment to develop a plan to support people with a learning disability who are living with elderly carers where there is a risk of that caring arrangement breaking down.

Resettlement

6.6 There are currently around 200 long-stay patients in learning disability hospitals who no longer require hospital treatment and who could be resettled into the community. As with mental health, work will continue over the period of this Action Plan to seek alternative care arrangements for as many of these people as possible with the current funding of £6.4m identified for this and to identify options to achieve the long term objective to complete the resettlement programme by 2015. The principle of betterment will continue to inform decisions.

7 MENTAL HEALTH

Community focus

7.1 The overarching vision of the Bamford Review that people with a mental illness should be treated in the community unless there is a clear clinical reason not to do so has been widely accepted by users and carers and by those who provide services to them. However, the reform and modernisation of mental health services needs continued impetus to ensure the necessary shift in investment from hospital based services to community based services is achieved. The objective of redirecting mental health spend so that 60% of total spend goes towards community based services was not achieved during the 2009-2011 Action Plan and will continue to be an objective in this Plan.

Supporting Recovery

7.2 Further development of a range of community mental health services is required to enable people to be treated close to family networks. This should be complemented by a smaller inpatient service. The full range of services needs to be firmly based in a recovery ethos, whereby people are rehabilitated to live as fulfilling and independent lives as possible, even with limitations caused by illness. Since those who use the services should determine their own recovery goals, full involvement of those who use the services and their families and carers is a key requirement to promoting a recovery ethos. Since recovery can mean many different things, some of which are not necessarily related to the complete alleviation of the symptoms of the illness, the voluntary and community sector is well placed to complement statutory health and social care sector provision in supporting people's recovery.

7.3 The Action Plan in Section B includes a commitment to undertake a programme of work that will facilitate an enhanced culture of recovery across all mental health services. This is likely to include, among other things, the development of training initiatives, establishing effective communication systems with service users and carers and audit and evaluation mechanisms.

7.4 Reflecting what recovery means to those who use mental health services will also be a major influence in the work to measure outcomes and evaluate the success of the Bamford Vision, as outlined at Chapter 8. There is a range of measures of recovery outcome. One of the rapid reviews under the research programme in the 2009-2011 Action Plan recommended a number of these for further consideration.

Service Framework

7.5 Implementation of the Service Framework for Mental Health and Wellbeing, published in 2011 will be instrumental over the period of this Action Plan in improving the mental health and wellbeing of the population of Northern Ireland, reducing inequalities and improving the quality of health and social care in relation to mental

health.

7.6 The Service Framework sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation of individuals and communities who currently have or are at greater risk of developing mental illness. The standards adopt a lifespan approach that will enable each individual to be seen in their own context at their own point in life.

Stepped Care

7.7 The stepped care model of providing the right level of services to the right people at the right time will continue to shape the development of mental health services. Early interventions in primary care will continue to be promoted, including better access to psychological therapies.

Resettlement

7.8 There are currently around 150 long-stay patients in psychiatric hospitals who no longer require hospital treatment and who could be resettled into the community. Work will continue over the period of this Action Plan to seek alternative care arrangements for as many of these people as possible.

7.9 A total of £2.8m has been allocated for the current spending review period, but the total cost to complete the mental health resettlement programme is significantly greater. Work will continue on options to achieve the long term objective to complete the resettlement programme by 2015.

7.10 The ongoing resettlement programme has also helped to identify an emerging group of people (about 100) in mental health inpatient facilities with quite challenging behaviours who require further longer term rehabilitation before they could be considered for community placement. These patients were identified in a review by the Department in 2010 which recommended 3 twenty bedded dedicated low secure units for Northern Ireland be established to facilitate such rehabilitation. Work will now be carried out to implement a regional approach to the provision of these facilities.

Children and Young People

7.11 In response to an RQIA review of Child and Adolescent Mental Health (CAMH) services, work is under way to develop policy guidance on a service model for these services. This policy guidance will confirm the preferred model for the organisation and delivery of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland and will also adhere to the overall strategic direction for CAMHS within the Bamford Review. A stepped model is proposed, building on the existing tiered approach, but making service delivery more user-centred. This is similar to the approach being adopted in adult mental health services. This stepped care approach will be more patient focussed and able to deliver the appropriate level of care that best meets the child or young person's assessed needs.

Older People

7.12 Work will continue to improve dementia services in line with the recent strategy, with its emphasis on ensuring that people with dementia are treated with awareness and respect, especially by those providing services, and that they are supported to maintain their independence for as long as possible. Older people with functional mental illness will benefit from the improvements being made to adult mental health services.

8 MONITORING AND EVALUATION

Evaluation of 2009-2011 Plan

8.1 The evaluation of the 2009-2011 Action Plan has shown progress, but recognises that much more needs to be done. The evaluation has also been mostly factual outputs – the actions were achieved or not achieved. It was also restricted in the extent to which it has been possible to reflect on whether those who use the services and their families and carers have seen any difference in the services delivered or in the way they are delivered to them.

Monitoring

8.2 The IDSOG will continue to monitor the implementation of the actions within this Plan. The Group will now publish its monitoring reports at regular intervals throughout the life span of this Plan in order that progress can be tracked by all stakeholders.

Outcomes over outputs

8.3 The qualitative/quantitative balance of the future evaluation of this Action Plan will reflect requests from those who use these services. The evaluation will therefore focus primarily on user outcomes over the more quantitative aspects of service delivery reflected in the monitoring reports.

8.4 The Bamford Monitoring Group under the Patient and Client Council has drafted a service user Outcomes Paper, enclosed at Annex A. This Paper is derived from the reports, feedback from conferences and workshops held by the group in the past 2 years and on the broad themes identified at the BMG/IDSOG Workshops in March 2012. The Paper proposes outcome measures for consideration within the context of the future evaluation of this Action Plan. These proposed outcome measurements should also enable the evaluation of this Plan to reflect more fully the views of those who use and rely on mental health and learning disability services.

8.5 This will be augmented by work being taken forward by the HSC Bamford Task Force to measure outcomes, and the development of indicators supporting Service Frameworks for both mental health and learning disability services.

8.6 All of this work will be underpinned by the principle that Delivering the Bamford Vision is about improving the lives of men, women and children who have a mental health need or a learning disability.

SECTION B

2012–2015 BAMFORD ACTION PLAN

In this Action Plan actions are shown within each of the 5 themes outlined at paragraph 5.1. Within each theme, actions which impact both mental health and learning disability services are shown first, followed by actions impacting only on learning disability and then actions which will impact only on mental health services.

HEALTH AND WELLBEING

Joint actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
1A	DHSSPS	Publish and Implement a revised cross-sectoral Promoting Mental Health Strategy	DHSSPS, with contributions from relevant Departments - led by DHSSPS Investing for Health Group	Publish a revised cross-sectoral Promoting Mental Health strategy, taking account of lessons learned from previous work	March 2013	Better mental wellbeing in the population
1B	DHSSPS		PHA	Implement Action Plan from Promoting Mental Health Strategy	Ongoing	
2	DE	Develop final proposals for Early Years Strategy	DE .	Early Years (0-6) Strategy implemented; early years providers deliver high quality experience for every learner.	November 2012	Children receive a high quality pre-school experience that promotes their healthy development and lays the foundations for the achievement of good outcomes in the longer term.

3	DCAL	Implement a 10 year Strategy for Sport and Physical Recreation	DCAL	A greater emphasis on the mental benefits of regular participation in sport and physical recreation	Ongoing	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation
4	DE	Promote an anti-bullying culture within schools in partnership with the NI Anti-bullying Forum	Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils and parents are confident that their concerns about bullying will be dealt with in an appropriate and timely manner

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
5	DHSSPS	Ensure that persons with a learning disability have equal access to the full range of primary health care services	HSC Primary Care, Acute Hospitals, Multi-Disciplinary Learning Disability Teams, Other Providers	Full implementation of Learning Disability Directed Enhanced Services across region	March 2015	Improve the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and mental health.

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
6A	DHSSPS	Progress the next phase of the suicide prevention strategy	DHSSPS	Carry out evaluation of the effectiveness of the implementation of the “Protect Life” strategy 2006, at both a local and regional level.	December 2012	Fewer people attempt to or take their own life
6B				Publish the next phase of the suicide prevention strategy, based on the latest available evidence and findings from the evaluation.	December 2013	

7A	DHSSPS	Develop and implement New Strategic Direction on drugs and alcohol Phase 2, and Strategy Evaluation	DHSSPS	Complete actions from NSD Phase 2 Implementation	December 2015	Reduce levels of harm related to Alcohol and Drug Misuse
7B				Undertake a regional commissioning framework across all four tiers of service delivery for young people, families and adults	March 2013	Consistent approach to service design and delivery
7C				Implement commissioning framework recommendations	December 2015	Evidence based services in place to meet regional and local needs

7D				Work in partnership with the Drug and Alcohol Co-ordination Teams to ensure a co-ordinated response to address current and emerging needs	Ongoing	Improved co-ordination through partnership working at locality and regional levels
8	DHSSPS	Respond to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland 2011	PHA	Implementation of recommendations	March 2013	Minimise occurrence of suicide and homicide by people who access mental health services in NI.

9	DETI	Specialist health and safety inspectors and business advisors to provide advice and, where necessary, enforcement in high stress risk work sectors	HSENI	Organisations in sectors, in which employees are at a high risk of suffering from workplace stress related ill health caused by or made worse by their work, provide appropriate support	Ongoing	Reduce stress-related ill-health and associated absenteeism in high stress-risk work sectors and increase productivity.
10	DE	Promote a focus on pupils' emotional health and wellbeing through a programme of awareness raising and staff capacity building for all schools	DE – Pupil Support Unit	All schools proactively promote pupils' wellbeing as part of their raising standards agenda.	Ongoing	A caring and supportive environment exists in all schools and all pupils and staff benefit from the active promotion of positive mental health.
11	DE	Maintain access to counselling support which is independent of the school for all pupils of post primary age	DE – Pupil Support Unit	Counselling support remains accessible in all secondary and special schools	Ongoing	All pupils of post primary age have access to counselling support which is independent of the school.

SUPPORTING PEOPLE

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
12	OFMDFM	Publish a strategy for the implementation of recommendations arising from the PSI report on Disability.	OFMDFM	Publish a strategy document based on the recommendations arising out of the PSI Report on Disability, taking into account each strategic objective in relation to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).	June 2013	Improved social inclusion of people with disabilities across a wide range of areas and activities examined by the PSI Group including:• Access to Employment;• Children, Young People and their Families;• Housing, Transport, Information and Access.
13	DHSSPS	Resettle long stay patients from learning disability and mental health hospitals	HSC DHSSPS DSD	Resettle all long stay patients	March 2015	More people able to live independent lives safely in the community

14	DSD	Scope existing supported housing capacity/suitability to maximise resources	NIHE	Commissioning programmes for new provision will consider examining capacity/suitability to maximise existing resources	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
15	DSD DHSSPS	Ensure new build supported housing programmes are "future proofed" to ensure longevity/sustainability in terms of the tenants	HSC DSD DHSSPS NIHE	Needs assessments to take into account longevity/sustainability	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
16	DEL	To support and develop the Employment Advisor Teams to deliver services to people with mental ill-health or a learning disability	DEL Disability Employment Service.	Pilot roll-out of Employment Service Pathway Teams	December 2012	To deliver a more individually tailored service to all ESA clients.

17	DEL	Maintain support arrangements and extended eligibility for participants with disabilities on the Training for Success programme.	DEL's Training Programmes Branch	Maintained access and support arrangements.	Ongoing	Support provided, as necessary, to those with disabilities to facilitate access to and participation in training.
18	DEL	Widen Participation in Higher Education Strategy	DEL's Higher Education Widening Participation Branch	NI Executive has agreed the Widening Participation Strategy. To commence action/projects in support of the WP initiatives targeted at students with disabilities.	Ongoing	Provision of targeted support at students with disabilities who are at risk of being excluded from higher education.
19	DEL	Establish and progress effective Partnership Agreements and joint working arrangements with post-primary schools, further education, training and apprenticeship providers, HSC Trusts and organisations who act as advocates for young people with a variety of barriers, including disabilities.	DEL's Careers Service	Improved to careers services leading to better outcomes for clients.	Ongoing	Improved careers decision making and increased participation in education, training and employment

20	DEL	Lead on the implementation of a cross-departmental Strategy - "Pathways to Success" - for those young people Not in Education, Employment or Training (NEET).	The NI Executive agreed a cross-Departmental Strategy. A NEET Advisory Group will be established comprising officials from the main Departments involved, representatives from the voluntary/community sector, education and health and social care sectors, local government and the business sector.	Subject to economic conditions, help to prevent young people falling into the NEET category; and help reduce the number of young people within the NEET category by, for instance, improving their opportunities to move out of poverty. . The Strategy has committed to put in place a system to scope and develop more robust measurement metrics in relation to those who are at risk of falling into or in the NEET category.	Tracking system in place by 2014.	A reduction in the number of young people most at risk of remaining outside education, employment or training (NEET); a group which will include those with mental health and learning difficulties.
21	DEL	To develop Careers Service delivery to support the above mentioned "Pathways to Success" Strategy (for NEETs).	DEL's Careers Service	Case management of 17/18 year olds	June 2013	Increased participation in education, training and employment by 16-24 age group

22	DEL DE	Continue to work in partnership with DE to increase the level of information sharing in respect of relevant pupil data being shared with DEL's Careers Service including electronic sharing of pupil data via C2K.	DEL's Careers Service in conjunction with DE.	Improved service to young people. Data Sharing Agreements in place with schools, data sharing delivered via C2K.	Ongoing	Improved information sharing should lead to more focused support for young people moving into education, training and/or employment.
23	DEL	Continue to provide specialist support, as appropriate, for young people considering participating in Training for Success (TfS).	DEL's Training Programmes Branch	Improved service to young people.	Ongoing	Ongoing provision of appropriate targeted support to enable young people with significant barriers to enter, engage and achieve the best possible outcomes.
24	DEL	Incorporate provision within the design of the new Work Connect Programme to meet the employment needs of those who are claiming Employment Support Allowance and who have mental ill-health and learning disability.	DEL's Disability Employment Service (DES)	To monitor and review the level of participation and success of the new Work Connect programme.	March 2013	Providing targeted support to enable adults with significant barriers to improve their employability and, if appropriate, enter employment.

25A	DHSSPS	To support the uptake of self-directed support and individual budgets in line with Transforming Your Care	DHSSPS	Produce a Departmental high level vision for self directed support	March 2013	People will have options to choose the most appropriate services for their needs
25B			HSC	Increase the number of people with self-directed support and individual budgets	March 2015	
26	DE	Take forward and implement Review of Special Educational Needs & Inclusion	DE	Following July 2012 agreement by the Executive of a Policy Memorandum: draft instructions for OLC for primary legislation; draft subordinate legislation for consideration by Education Committee; draft new statutory code of practice for consultation. Following commencement of new legislation, begin to implement agreed legislation and statutory code over a 5-year transitional period.	Ongoing from 2012 until legislation is commenced and transitional arrangements put in place	Pupils with special educational needs supported to achieve to their full potential through early identification of need and early intervention

27	DHSSPS	Implement "Developing Advocacy Services - A Policy Guide for Commissioners"	HSC	Implement Advocacy Services Action Plan	March 2013	Principles and standards which should lead to greater parity and consistency in the commissioning and delivery of advocacy services.
28A	DHSSPS	To support the employment of experts by experience in the commissioning and delivery of mental health and disability services.	HSC	To move to a position where service users and carers are employed in the commissioning and delivery of services	Ongoing	Services meet the needs and expectations of those who use and rely on them.
28B				To move to a position where service users and carers are involved in the process of recruitment and selection.		

Learning disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
29	DRD	Investigate how information provision on transportation issues can be improved for people with learning disabilities	DRD, Imtac Translink	Implement measures in the Accessible Transport Strategy (ATS) action plan 2012-2015 in relation to the provision of information for people with learning disabilities	March 2015	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability

30	DRD	Examine options for improving the provision of travel training schemes	DRD	Evaluate pilot scheme in Ards & North Down area and consider regional rollout of the scheme.	March 2015	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability
31	DRD	Review the training of staff to ensure that its content covers the needs of people with a learning disability.	DRD	Learning disability awareness training in place for: 1. DRD staff 2. PSV licence holders under the terms of the Certificate of Professional Competence. 3. All Translink (non-driver) staff	Ongoing	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
32	DHSSPS	Promote recovery orientated practice throughout all mental health services	HSC in collaboration with voluntary and community sector	Introduce a range of actions/initiatives to facilitate an enhanced culture of recovery across all mental health services (to include the development of training initiatives, effective communication systems with service users/carers and audit/evaluation mechanisms)	March 2015	An improved and consistent understanding of recovery throughout mental health services, ensuring that a recovery based approach becomes embedded in the value base of practitioners and services and enabling service users to maximise their abilities, independence and their general health.

33	OFMDFM	Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment	OFMDFM	Assessment of mental health needs for victims and survivors.	February 2013	Better planning of services for victims and survivors.
34	DEL	Continue to deliver specialist employment provision to address the employment needs of those clients who have disability related barriers to finding and sustaining work.	DEL's Employment Service, including the Disability Employment Service (DES)	Individuals with a disability, including mental ill health and learning disability are assisted via DEL programmes to enter and stay in work.	Ongoing	Increased participation on specialist programmes including Condition Management Programme, Work Connect, Workable and Access to Work, as well as local ESF Disability Employment projects.

35	DEL	Enhance and develop the services to assist clients who transfer from Incapacity Benefit to Job Seekers Allowance.	DEL's Employment Service, including the Disability Employment Service (DES)	To help ex- Incapacity Benefit clients to move towards and into employment through participating in the Condition Management Programme. To monitor and review the level of participation and success of the new Job Seekers Allowance clients .	March 2013	To assist clients with Mental Health conditions better manage these to improve their ability to participate on appropriate provision and to find and keep a job.
36	DCAL	"Health in Mind" programme to improve the quality of life of 25,000 adults affected by mental ill-health through the provision of information, learning and reading activities	DCAL (Libraries NI)	By project end: 40,000 people have accessed improved information about mental health; 20,000 people affected by mental ill health, their families and carers have improved knowledge and skills to enable them to access and use relevant information; 3.000	October 2014	People affected by mental ill health and their families have improved access to information and support

SUPPORTING CARERS

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
37	DHSSPS	Enhance the arrangements to meet demand for respite including emergency respite and short break care	HSC	Implement recommendation of HSCB Phase II respite report. Agreed description of respite and measurement and reporting mechanisms	March 2013	Enhanced flexibility of emergency respite and short break care targeted to meet specific, individual assessed need. Better range of options for short break/respite consistently across Trusts which meets assessed needs of individuals.
38	DHSSPS	To provide support to all carers in order that they may continue in their caring role	HSC	All carers offered carers assessment.	March 2015	The needs of the person cared for and the carer are identified through a carer-centred assessment process.

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
39A	DHSSPS	Carry out a scoping exercise to ascertain future caring requirements for people with a learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements	HSC	Report on the future caring requirements of people with learning disabilities who have elderly carers	March 2013	Identification of future service need/provision.
39B		Develop a rolling, costed plan to support those with learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements		Annual costed plan developed in each Trust.	September 2014	Arrangements in place to support and maintain existing community and family arrangements

BETTER SERVICES

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
40	DHSSPS	Monitor/review departmental capital budget	DHSSPS/HSC	Progress relevant business cases from Trusts to achieve future agreed pattern of provision	March 2015	People can access services in appropriate and fit for purpose buildings
41	DHSSPS	Complete research into priorities highlighted by Bamford rapid reviews	DHSSPS PHA HSC Universities	To improve services developed in priority areas	October 2015	To provide new and effective interventions relevant to Northern Ireland
42	DHSSPS	To ensure Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services in line with guidance.	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Evaluate and review leadership, accountability and monitoring arrangements	March 2013	Future policies and services will seek to address the needs and expectations of service users and their carers

43	DSD	To carry out a qualitative research study into our customers who have a disability to allow us to obtain an insight into the thoughts and behaviours of this specific group of customers	SSA	To gain an insight into our disabled customers in terms of the challenges they face and the impact that disability has on their lives.	Ongoing	Contribute to a greater understanding of the use and impact of disability benefits; Increase the understanding of the difference made to people's lives by receipt of disability benefits; Inform and support the development of policy and strategy relating to disabled customers.
44	DSD	To develop and implement a strategy for increasing the uptake of benefits	SSA	A benefit uptake strategy.	March 2015	To maximise the uptake of benefits by targeting those likely to be eligible for unclaimed benefit
45	DSD	To work in Partnership with organisations and government departments which are impacted by Universal Credit.	SSA	Information is shared and input sought	Ongoing	All impacted organisations attend various Universal Credit governance (e.g. Programme Board, Steering Groups, Checkpoint meetings etc). Impacted organisations are also involved in the development of customer journeys, migration planning, staff communications, etc and are embedded into the programme team working in the Design Centre.

46	DHSSPS	To improve access to advice and information on services and support available	HSC and PHA	Develop a central point of access for information	March 2015	People with mental health problems, learning disabilities and carers have access to information about services and support in their area
47	DHSSPS DE	Improve services for children with challenging behaviours and their carers	HSC Board	Implement regional guidelines on the management of challenging behaviours	March 2015	Consistent service provision across region.

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
48A	DHSSPS	Develop and implement a Service Framework for learning disability services	DHSSPS	Publish service framework.	December 2012	Improve the standards of care that people who use services, their family and carers can expect to receive against agreed performance indicators

48B	DHSSPS		HSC	Implementation of service framework	Ongoing from December 2012	
49	DHSSPS	Maintain direction of HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	At least 80% of HSC spend on learning disability services should be on community services	Ongoing	Community services will promote integration of individuals into society
50	DHSSPS DSD	Enhance provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community	DHSSPS HSC DSD (benefits)	Enhanced access to a range of opportunities in education, training, employment and social activity	Ongoing	Opportunities tailored to the needs of people with a learning disability promoting their inclusion in society Regional model produce by March 2013
51	DHSSPS	Complete and maintain a map of learning disability services across Northern Ireland	PHA/ HSC Board in collaboration with HSC and voluntary and community sector	Compile mapping information on all learning disability services provided	December 2013	New services can be better targeted and gaps in existing services can be filled

52	DE	Improve transitions planning for all children with statement of special educational needs	DE, Education and Library Boards, DHSSPS and HSC, CYPSP	A Transitions plan tailored to meet the needs of the young person. Collaborative working and multi agency planning to facilitate improved planning and delivery at local level.	Ongoing	Children and young people supported in making effective transitions, making good progress and achieving to their full potential.
53	DHSSPS	Development of UK wide framework for learning disability nurses	DHSSPS and other 3 UK Government departments	Publication of action plan	March 2014	Learning disability nurses utilise and develop their specialist knowledge and skills to ensure the best possible health outcomes for people with learning disabilities
54	DHSSPS	Develop a plan for community forensic learning disability services taking account of service to be provided with available resources and which makes full use of other forensic arrangements in place	HSC	Prioritised action plan to be taken forward within available resources	February 2013	Improved community forensic service for those with learning disability.

55	DHSSPS	Community Dental Service to undertake an annual oral health assessment for each L.D. client and produce an individual oral health plan, referring as appropriate for care.	HSC	LD clients regularly examined and treatment arranged	Ongoing	Oral health issues addressed and preventive strategies employed
56	DHSSPS	Community Dental Service to provide training/ training materials for staff in day care facilities re significance of oral health issues.	HSC	Deliver training interventions and educational resources.	Ongoing	Increased awareness of significance of diet, tooth brushing and use of Fluoride toothpaste
57	DHSSPS	Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines "Caring for people with a learning disability in general hospital settings"	HSC	Implement reasonable adjustments to support the pathway through acute care. Initiate staff training and development of easy read information. Develop coordinated links between hospital and community services.	March 2015	Improved delivery of safe and effective care within general hospital settings
58	DHSSPS	Implement a regional Bed Management Protocol for those with a learning disability.	HSC Board to lead in collaboration with HSC Trusts	Regional implementation of agreed Bed Management Protocol	March 2013	Safer and more effective access to inpatient care for those with a learning disability

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
59	DHSSPS	Re-direct HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	60% of HSC spend on mental health services should be on community services.	March 2015	Better services for those in need provided within their community
60	DHSSPS	Implement the Mental Health Service Framework across HSC:	PHA	Review HSC performance against proposed framework indicators - this should include service user/carer input in terms of both development of indicators and monitoring of actual service performance.	Ongoing	Agreed standards of care that people who use services, their family and carers can expect to receive. Develop service improvement plans where progress against performance indicators is measured
61	DHSSPS	Provide information on children's, adolescent and adult mental health services for use by the public, GPs and other clinicians.	PHA/ HSCB	Develop and publish IT based resource on all Trust websites	April 2013	Identification of all general and specific MH services available.

62	DHSSPS	Implement service model for CAMHS services	HSC	Implementation of CAMHS action plan	Ongoing	Young people are able to access consistent and appropriate services across NI
63	DHSSPS	Improve and harmonise model for crisis response and home treatment services	HSC	Implement agreed regional model for crisis response and home treatment	December 2012	People in crisis will be able to receive appropriate care and support to a consistent standard
64	DHSSPS	Enhance availability of psychological therapies	HSC	Implement enhanced services in line with published strategy and available resources.	Ongoing	Improved access to psychological therapies
65	DHSSPS	Improve access to computerised Cognitive Behavioural Therapy programmes	HSC Board in collaboration with HSC	Promote and increase uptake of CCBT programmes	Ongoing	Improved support for those with mild to moderate depression

66	DHSSPS	Introduce legislation to extend the provisions of the Mental Health (NI) Order 1986 to private hospitals	DHSSPS	Provision for private hospitals to treat detained patients	December 2012	People are able to be treated in the most appropriate facility to meet their needs
67	DHSSPS	Evaluate implementation of regional guidance on assessment and management of risk in mental health and learning disability services	DHSSPS, HSC and RQIA	RQIA to review and report on progress to implement regional guidance	December 2012	People who may pose a risk to themselves or to other people or who may be at risk from other people will have such risks assessed and managed in an appropriate way as part of their treatment and care plan.
68	DHSSPS	Enhance medicines management services for vulnerable patients with mental illness living in the community	DHSSPS HSC	Develop a pilot medicines management service	March 2014	Joint working across Mental Health Medicines Management and relevant healthcare providers to enhance pharmaceutical services through education, brief intervention, alert systems and compliance aids where appropriate.
69	DHSSPS	Enhance services for people with a personality disorder	HSC	Implement enhanced services in line with published strategy and available resources.	Ongoing	Better access to appropriate services for people with a personality disorder and support for their carers

70	DHSSPS	Maintain the provision of specific eating disorders in-patient service capacity within each Trust	HSC Board and PHA in collaboration with HSC Trusts	Provision of eating disorder inpatient services available within generic units with in-reach support from community eating disorder service.	Ongoing	Continuity of care from community services for those who need to be admitted to hospital. Fewer people will require admission to a facility outside Northern Ireland
71	DHSSPS	Ensure provision of appropriate low secure and community forensic services in line with 2011 Review	HSC	Develop costed action plan to be implemented as resources permit	March 2013	More appropriate levels of therapeutic support and rehabilitation provided in the least restrictive conditions for those who need forensic services.
72	DHSSPS	Take forward action plan to improve dementia services in line with NI strategy.	HSC with DHSSPS and voluntary and community sectors	Provide range of services advocated in N I Dementia Strategy and associated action plan as resources permit.	Ongoing	Improved services for people with dementia, their families and carers
73	DHSSPS	Improve Perinatal mental health services	HSC/PHA	Implementation of Perinatal Mental Health Regional Integrated Pathway and Training Strategy	March 2015	Better detection and treatment of mental illness during pregnancy and the post natal period

BETTER STRUCTURES

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
74	DHSSPS	Ensure relevant Inter-Departmental and cross sectoral structures are maintained	DHSSPS (with other Departments)	A co-ordinated approach to improve services in line with Bamford Vision	Ongoing	Better joining up of services across agencies
75	DHSSPS	Sponsor work on cross-cutting issues, involving the relevant agencies at local level along with service users and their carers.	Interdepartmental Group	Establish local-level cross-sectoral working groups under the IDG.	September 2013	To improve joining up of services for people with a mental ill-health or a learning disability.

76A	DHSSPS	New mental capacity legislation	DHSSPS DoJ	Preparation and consultation of draft Bill	October 2013	A consistent approach, with appropriate safeguards, to decisions - about care, treatment, property or assets – which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reasons.
76B				Introduction to NI Assembly	December 2013	
76C				Enactment	March 2015	

ANNEX A

Patient and Client Council/Bamford Monitoring Group Outcomes Paper

The Bamford Monitoring Group has reviewed the reports, feedback from conferences and workshops held by the group in the past 2 years to identify the key issues and recurring themes. These are the issues that are most important to people with mental health needs, learning disabilities, parents, carers and families and must be central to the Bamford Action Plan 2012 – 2015.

The key issues / themes are outlined below linked to user / carer defined outcomes and suggested outcome measures required to evidence if the outcomes are being achieved i.e. is the action plan making a positive difference to people's lives?

The Bamford Monitoring Group strongly believes that there is a need to be clear and specific by including outcome measures for outcomes. Outcomes in the 2009 – 2011 Bamford Action Plan were described as "too woolly" and it was often unclear if they were being achieved.

The Bamford Monitoring Group would emphasise several key points regarding the Bamford Action Plan 2012 – 2015 and process of its development:

- Service users and carers must be involved in developing the Bamford Action Plan from the outset. It has been a difficult task to develop the outcomes and measures below.
- It is essential to create a robust process for service users and carers participation in development of future action plans.
- Focusing on measuring outcomes that are relevant to and valued by service users is vital. This is in keeping with a recovery orientated approach and reflects the purpose of services.
- Identifying progress in achieving the Bamford Action Plan must be monitored from an outcomes basis.

Outcome	***Theme / Key Issue***	***User / Carer defined outcomes***	***Linkage to Action Plan Actions***	***User / Carer defined outcome measures*** *(Evidencing progress)*
1	***Joined Up Working***	Increase Government Department partnership working	***74, 75***	IDSOG to provide an annual report on specific Inter Departmental initiatives being taken forward under the Bamford review. These should evidence genuine participation and capacity building.
2	***Involvement***	Service users and carers are involved in developing the next Bamford Action Plan.	**42, 74, 75**	People with mental health problems, learning disabilities and carers are involved as partners in developing the next Bamford Action Plan.
3		Service user and carer participation on all Bamford related groups	**42**	IDSOG to initiate audit.
4		Service users and carers are involved in the design, delivery, management, review and development of mental health and learning disability services (across all Government Departments)	***27, 28, 42***	Tool that evaluates involvement and participation required Service users and carers groups / forum / networks in the development of strategy and policy Service User and carer-led evaluation of mental health and learning disability services Staff recruitment panels that include service users and carers. The process should be accessible for people with a learning disability. Service users and carers input into the whole process of recruitment and selection e.g. job description, short listing, and interviewing,

Outcome	Theme / Key Issue	User / Carer defined outcomes	Linkage to Action Plan Actions	User / Carer defined outcome measures (Evidencing progress)
				Service users and carers carry out training for non-service user and carer members of the interview panel. Service users and carers providing training for mental health and learning disability staff Advocates (Peer) employed in mental health and learning disability to support service users and carers.
5		Service users and carers are directly involved in all aspects of care.	**27, 32, 48, 50, 60, 67, 74**	People with mental health problems, learning disabilities and carers report positive experience of being involved in making decisions about their care and support. All people with mental health problems or a learning disability all have an individual care plan, which they hold personally. This care plan is subject to regular review.
6		All carers should be offered a carers assessment	**38**	Increased number of people supported to access Carer's Assessment All carers offered a Carers Assessment Increased number of people reporting positive experience accessing Carer's Assessment
7	***Information***	There is a central point of access for information and advice about all mental health and learning disability services and support available	**46, 51, 61**	Access to information should be readily available for people with mental health problems and learning difficulties. Increase the number of people with mental health problems, learning disabilities and carers reporting positive experience accessing information about services in their area Increase the number of people with mental health problems and learning disabilities are involved in the development of information about services in their area

Outcome	Theme / Key Issue	User / Carer defined outcomes	Linkage to Action Plan Actions	User / Carer defined outcome measures (Evidencing progress)
				People with mental health problems, learning disabilities and carers report that staff are able to give appropriate information about services in their area
8	***Employment***	Move to a position where 'experts by experience' are directly employed in commissioning and delivery of mental health and learning disability care.	**12, 16, 20, 21, 22, 28, 34, 35**	Increase the number of people with mental health problems and learning disabilities are directly employed by Government Departments and the HSC sector. Evidence of reasonable adjustment as required by section 75 of the Northern Ireland Order put in place to enable more people to take up employment Appropriate support must be provided to those employed as a service user / carer reps and people who are employed with mental health needs and learning disabilities. Increase the number of people with mental health problems and learning disabilities entering and/or retaining paid employment: Full Time (over 16 hours a week) and Part Time (under 16 hours a week)
9	***Housing***	People with mental health problems and learning disabilities are supported to live independently. People have a choice who to live with and where, in a safe supportive community.	**12, 13, 14, 15**	Increased number of people with mental health problems and learning disabilities living independently year on year. Increased in the amount of supported independent living accommodation available for people with mental health problems and learning difficulties Increased number of people with mental health problems and learning disabilities report positive experience planning and arranging independent living.
10	***Benefits***	The new Welfare Reform system meets the needs of people with mental health problems and learning disabilities ensuring access to appropriate benefits and support	**35, 44, 45**	People with mental health problems and learning disabilities receive appropriate benefits Increased number of people with mental health problems and learning disabilities reporting a positive experience of

Outcome	Theme / Key Issue	User / Carer defined outcomes	Linkage to Action Plan Actions	User / Carer defined outcome measures (Evidencing progress)
				accessing advice regarding their finances, benefits or debts. Increased number of people with mental health problems and learning disabilities reporting positive experience accessing benefits All benefits staff are trained in mental health and disability awareness Specialist staff receive dedicated specific training to provide appropriate support to people with mental ill-health or a learning disability.
11		People with mental health problems and learning disabilities have support when accessing benefits	**43**	People with mental health problems and learning disabilities have access to advocacy service during benefits assessments/interviews.
12	***Education***	Better and more consistent planning and support is available to support young people on transition from education to adult services, including all young people with a learning disability or mental health problem – not just those with a statement of special educational needs	**26, 52**	Evidence that young people are involved and their views taken into account in decision-making about transition. Evidence that parents are involved in the transitions planning process for their son / daughter. Young people and their families receive appropriate accessible information about: - the transitions process - the options and support available on leaving school This allows young people and their families to make informed choices about the future.

Outcome	Theme / Key Issue	User / Carer defined outcomes	Linkage to Action Plan Actions	User / Carer defined outcome measures (Evidencing progress)
13		People with mental health problems and learning disabilities are involved in making decisions about courses and subjects available in Further Education Colleges	**18, 19, 21, 22, 50, 52**	Evidence that there are increased numbers of courses for people with mental health problems and learning disabilities in Further Education Colleges Evidence that people with mental health problems and learning disabilities are involved in designing courses and subjects available in FE Colleges Evidence that people with mental health problems and learning disabilities are supported to find and participate in courses
14	***Self-directed Support***	People with mental health problems and learning disabilities have access to and control their own self-directed support.	**25**	Increased number of people with mental health problems and learning disabilities supported to access self-directed support. Increased number of people with mental health problems and learning disabilities supported to become more actively involved in decision making regarding their support. Increased number of people reporting positive experience accessing self-directed support.
15	***Transport***	People with mental health problems and learning disabilities are able to access transport to ensure their independence, choice and opportunity.	**12, 29, 30, 31**	Increased number of people reporting positive experience accessing transport

ANNEX B

Abbreviations

BMG	Bamford Monitoring Group
CYPSP	Children and Young People's Strategic Partnership
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DHSSPS	Department of Health, Social Services and Public Safety
DoJ	Department of Justice
DRD	Department for Regional Development
DSD	Department for Social Development
ELB	Education and Library Board
FE	Further Education
HSENI	Health and Safety Executive Northern Ireland
HSC	Health and Social Care
NIHE	Northern Ireland Housing Executive
NISAT	Northern Ireland Single Assessment Tool
OFMDFM	Office of the First Minister and deputy First Minister
PHA	Public Health Agency
RQIA	Regulation and Quality Improvement Authority

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GUIDELINES ON CARING FOR PEOPLE WITH A LEARNING DISABILITY IN GENERAL HOSPITAL SETTINGS

June 2010

FOREWORD

These guidelines have been published by the Guidelines & Audit Implementation Network (GAIN), which is a team of health and social care professionals established under the auspices of the Department of Health, Social Services & Public Safety in 2008. The aim of GAIN is to promote quality in the Health Service in Northern Ireland, through audit and guidelines, while ensuring the highest possible standard of clinical practice is maintained.

These guidelines address the needs of an important and vulnerable group in society and to further this aim we have included an example of a possible implementation plan which we hope will ease the adoption of these guidelines under most circumstances.

This guideline was produced by a sub-group of health care professionals from varied backgrounds and was chaired by Maurice Devine, Nursing Officer at the Department of Health, Social Services & Public Safety (Northern Ireland).

GAIN wishes to thank all those who contributed in any way to the development of these guidelines.

Tom Trinick

Dr T Trinick
Chairman of GAIN

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CARING FOR PEOPLE WITH A LEARNING DISABILITY IN GENERAL HOSPITAL SETTINGS

Introduction

Going into hospital for any reason is a time of anxiety and stress for any of us. People can find that they are in an unfamiliar environment, with unfamiliar people using unfamiliar language. Alongside this unfamiliarity the person may be suffering significant illness and/or pain and consequently, it is a time when people often feel vulnerable.

On such occasions, children, young people and adults with a learning disability may feel even more vulnerable for a range of reasons, including difficulties they may have in respect of communication, difficulties in expressing feelings of discomfort or pain, difficulties with self-management. In addition, a limited understanding of the needs of people with learning disabilities by the hospital staff caring for them increases their vulnerability. Other factors that add to this vulnerability are that the person may have additional health needs such as epilepsy, mental health issues, sensory impairment, compromised nutrition and be at increased risk of choking, all of which are more common in people with learning disabilities.

Current health and social care policy within Northern Ireland is underpinned by the recognition of people with learning disabilities as equal and valued citizens of the country (DHSSPS 2005). Despite this, a range of key publications discussed within the literature review of this document has highlighted the difficulties many people can encounter in accessing and using general hospital services, at times, with grave consequences for people with learning disabilities.

It is therefore intended that these guidelines for care delivery will enhance safe and effective care throughout the journey within the general hospital setting for people with a learning disability.

LITERATURE REVIEW

The next few pages provide a definition of the term 'learning disabilities' and an overview of the published literature on the difficulties people with learning disabilities may encounter when accessing general hospital services, alongside the published recommendations to improve the quality of services. The guidelines contained within this document have been developed in response to the evidence within the published literature.

What is Learning Disability?

The formal definition of people with a learning disability used within Equal Lives (DHSSPS 2005), is as follows:

Learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on development.

As a consequence, the individual is likely to experience difficulty in understanding new or complex information or learning new skills. The individual may also have difficulties with social and/or communication skills, with carrying out activities of daily living independently and may have associated physical and sensory disabilities.

Within N. Ireland, there is a population of approximately 26,500 people with a learning disability of whom about half are aged between 0 – 10 yrs (DHSSPS 2009). For a range of reasons people with learning disabilities are twice as likely to experience admission to general hospitals than the general population. These include higher rates of and vulnerability to, specific health conditions, increasing longevity and the inevitable diseases of "old age", and the increasing complexity of health needs. It has also been projected that the number of people with learning disability will increase by 1% each year over the next 15 years and that the number of children and older adults with complex physical health needs will both be large areas of growth (DHSSPS 2005). Against this backdrop, it is

clear that people with learning disabilities will increasingly require services within general hospitals.

People with Learning Disabilities and Contact with General Hospitals

It is the stated objective of Equal Lives (DHSSPS 2005) to 'secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services, that are as locally based as possible and responsive to the particular needs of people with a learning disability' (Objective 7). This objective is underpinned by 14 recommendations for service developments. Furthermore, legislation over the past decade including the Human Rights Act (1998) and the Disability Discrimination Act (1995), has highlighted the legal requirement of health services ensuring equality, dignity and autonomy. These laws require that reasonable adjustments are made in all their services to ensure they do not 'unlawfully discriminate' against people with learning disabilities and include the provision of accessible information.

Contact with general hospitals for people with a learning disability is a frequent occurrence, with people with learning disabilities being twice as likely to use general hospital settings, compared to the rest of the population (NPSA 2004). Services required can range from emergency care provision, outpatient appointments and day procedures through to the need for surgical intervention and repeated lengthy admissions due to complex health needs.

Contact by people with learning disabilities with the general hospital service is most often for investigation to assist the diagnosis of learning disabilities, to monitor development and to investigate the degree of development delay in areas such as vision, hearing and mobility. People with learning disabilities also make use of hospital services for medical and surgical interventions and may also need swift access to emergency services, either as a result of the exacerbation of a chronic condition such as epilepsy, respiratory disease or a gastrointestinal disorder or, as the result of an accident (Barr 2004).

Challenges in Accessing and Using General Hospital Services

Despite the above policy objectives, access to primary and secondary healthcare services for people with learning disabilities has been a growing concern over the past decade. This has been reflected in a number of reports and inquiries. These reports include The National Patient Safety Agency (NPSA 2004) report "Understanding the patient safety issues for people with learning disabilities" which highlighted that the care of people with a learning disability in general hospital was a major safety concern.

Following on from "Death by Indifference" (Mencap 2007), a campaign document by Mencap, which chronicled the deaths of six people with learning disabilities in general hospital settings, The Michael Inquiry (DH 2008) highlighted the difficulties people with learning disabilities can often have in accessing a range of general health services. This inquiry made a number of recommendations for improvement. The Parliamentary and Health Ombudsman's 'Six Lives' Report (TSO 2009) instigated by "Death by Indifference", found evidence of major failings in the care of the six people with learning disabilities and concluded that on one occasion and possibly a second, the deaths of the people with learning disabilities were avoidable.

Within Northern Ireland a number of research projects into access to general health care such as "Promoting Access" (Barr 2004) and "Patient People" (SHSCC 2008), together with research specifically into access to Accident and Emergency services (Sowney & Barr 2007), have also identified major challenges in access to general healthcare for people with learning disabilities.

The findings of the above research reports and independent inquiries have, in particular, highlighted the need to improve the access to and safety within general hospitals. A number of persistent difficulties encountered by people with learning disabilities, their families and staff within general hospital services has been documented. These include:

People with learning disabilities

- Experience difficulty in understanding what was happening.
- Are provided with limited information.
- Do not feel involved in the discussions and decisions which have taken place.
- Have a lack of accessible information for people with learning disabilities.
- Experience confusion and fear arising from limited explanation and uncertainty about what is happening.
- Experience insufficient attention being given to making reasonable adjustments – e.g. addressing communication problems, difficulty in understanding and anxieties and preferences.

Families and carers of people with learning disabilities

- Often find their opinions and assessments ignored by healthcare professionals. They struggle to be accepted as effective partners in care.
- Experience long waiting times often in inappropriate environments, with limited information prior to and during contact with the hospital.
- Perceive poor quality of care in relation to hygiene, nutrition and maintenance of the safety of the person with learning disabilities.
- Identify that there are limited opportunities for meaningful activities and the environment results in the person with learning disabilities often becoming bored and restless.
- Experience limited forward notice of discharge, poor co-ordination of discharge and little or no support after discharge has been reported.
- Perceive the need to stay in hospital during the period of contact, with little effort made to facilitate their stay in the hospital or make it comfortable.
- Experience negative attitudes and stereotypes about people with learning disabilities. This can result in diagnostic overshadowing where doctors and others make mistaken assumptions about people with learning disabilities resulting in failure to diagnose accurately or the misinterpretation of symptoms.

Staff in general hospitals

- Have limited relevant information available about the person with learning disabilities on admission.
- Have limited knowledge, skills, experience and confidence in supporting people

with learning disabilities and are not familiar with what help they should provide or from whom to get expert advice.
- Experience difficulties in achieving informed consent and the required level of co-operation.
- Receive limited training in the needs of people with learning disabilities.
- Perceive partnership working and communication (between different agencies providing care, between services for different age groups, and across NHS primary, secondary and tertiary boundaries) as being poor in relation to services for people with learning disabilities.

(Barr 2004; Sowney & Barr 2006; Sowney & Barr 2007; DH 2008; SHSSC 2008; Backer et al 2009; TSO 2009)

Consequences of Ineffective Hospital Services For People with Learning Disabilities
The consequences of ineffective general hospital services for people with learning disabilities can be major for them as individuals, for their families and for service providers. The impact of the limitations of services has been described as distressing, at the very least, for people with learning disabilities and for some people these limitations have been reported as causing or contributing to their avoidable death, leaving family members with many unanswered questions. The findings of the Parliamentary and Health Services Ombudsman's investigation (TSO 2009) into the deaths of six people with learning disabilities identified failures in services such as:

- One death was avoidable and another was likely to have been avoidable.
- Distress and suffering for those involved.
- Unnecessary distress and suffering for the families of the aggrieved, in particular about those failings which occurred for disability related reasons.
- Distress at unanswered questions of what difference would have been made if there had been no service failure or maladministration. Would the person concerned have lived longer? Could there have been some improved enjoyment in the last period of their life?
- Distress compounded by poor complaint handling leaving questions unanswered.
- Distress arising from a failure to live up to human rights principles.

The Need for Effective Health Services

As noted earlier, there are clear policy and legislative requirements that require people with a learning disability to have 'access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability' (DHSSPS 2005).

We recognise that a number of excellent initiatives have been developed in some Trusts to enhance the patient journey through general hospitals. However, these have mostly been project based and time limited with no dedicated and recurring resource to secure longevity. We trust that these guidelines are a helpful and informative step in assisting the process of improvement that is required.

STRUCTURE AND PURPOSE OF THE GUIDELINES

Within the GAIN document, there are 12 specific areas of improvement identified. These have been prioritised as the most pressing areas of need, based on a review of current published literature on this topic. The 12 priority areas for improvement focus on specific areas of the person's journey to and through the general hospital service (e.g. the journey through emergency care), transition processes (e.g. admission and discharge planning) and a number of clinical issues (e.g. nutrition and hydration). They are as follows:

- Attitudes and values;
- Communication;
- Training;
- Legal issues;
- Outpatients;
- The admission process and support during the hospital stay;
- Discharge planning;
- Emergency care;
- Support for carers;
- Nutrition and hydration;
- Pain;
- Children in hospital.

Each of these guidelines includes a best practice statement and a series of best practice indicators relevant to the particular area of improvement. It is important to recognise that the achievement of the best practice indicators is not solely the responsibility of staff working within general hospitals. It is apparent from reviewing the literature that improved quality and safety in the journey through general hospital settings will also be influenced by the recognition and implementation of the guidelines in partnership with local learning disability services, primary care, paid carers, family carers and managers of services. All have their part to play.

Many of the best practice initiatives that have been highlighted can be delivered through better individual care planning, together with improved communication and effective liaison within and between services. There will be some further resource implications in applying some of the best practice indicators and these may require more strategic planning. However, much progress can be made within existing resources through the actions of services and individual staff members, particularly in how they relate to people with learning disabilities and their families.

1. ATTITUDES AND VALUES

Best Practice Statement

Every individual with a learning disability using hospital services should have equitable access. Staff in a general hospital setting should demonstrate behaviours that are respectful, which include:

- Seeing the person not the disability;
- Ensuring that communication is sensitive to the needs and preferences of the person;
- Person centred care;
- Dignified, respectful and compassionate care;
- Non-judgemental attitudes.

Background

A central requirement in the provision of quality hospital care to people with a learning disability is underpinned by a philosophy that requires staff to recognise the human worth of a person with a learning disability and to adopt care practices that respect diversity. This creates new challenges for staff within hospital settings and one of the most important is to change attitudes towards patients with a learning disability.

Many of the issues that have been highlighted as poor practice are not resource dependent, but rather, they reflect attitudes that need to be changed. Improving the Patient and Client experience (DHSSPS 2008) identifies 5 overarching standards that will be central to the achievement of the best practice statements below. These include a focus being given to; respect, attitude, behaviour, communication and privacy/dignity.

Best Practice Indicators

1. **Equal does not mean the same:** Equality for a patient with a learning disability does not necessarily mean treating them in the same way. This may mean providing additional and alternative methods of support established with the patient and/or their families/carer in order to achieve a positive outcome.

2. **Autonomy:** All members of hospital staff should respect the wishes and choices of patients who have a learning disability. Patients must be actively involved in decisions regarding their care and steps should be taken to maximise their contribution to decision making (e.g. using pictures, information leaflets). This will require hospital staff to have a clear understanding of the law around capacity and consent.

3. **Contribution of Carers:** Families/carers have an important and unique contribution in the planning of the person's care and treatment. The importance of listening to the family/carers, recognising their particular knowledge of the patient with a learning disability and their ability to communicate with and understand responses, is significant. Often they are the only people who have a continuous relationship in the person's life; this contribution should be acknowledged, valued, listened to and acted upon.

4. **Advocacy:** Advocacy is the process whereby vulnerable people should be facilitated to have a voice and be heard. An advocate can be any "appropriate adult" for example, a family member/carer or friend or a link nurse within the hospital. It is important that the patient has a choice of someone they want and feel comfortable with. Identifying advocacy arrangements for the patient should be a core component of the assessment process in hospital, thereby promoting a person centred approach to care and treatment.

5. **See the person not the disability:** It is vital that health professionals look past the learning disability which can sometimes overshadow the presenting condition and may delay the investigation, diagnosis and treatment of their medical condition.

6. **Communication:** Establish, where possible, the patient's preferred method of communication. Staff should recognise the need to communicate directly with the patient with a learning disability at all times in the format they understand. Safe and person centred care is underpinned by effective and sensitive communication. "Clear communication means understanding and feeling understood." (DHSSPS 2008)

7. **Training:** All staff within general hospital services should receive training that increases their awareness of learning disability. Issues such as legal aspects, human rights, discrimination and the importance of good communication, attitudes and values should be included. In line with best practice, training on learning disability issues should also include people with learning disabilities and their family/carer as experts through experience.

8. **Don't make assumptions about the person's quality of life:** Hospital staff should ensure that they provide a balanced view of all treatment options available to patients with a learning disability. When major decisions around best interest need to be taken, there should be a clear understanding of the law and due regard must be given to the opinions and wishes of those closest to the patient. Everyday practice should place value on the quality of life of a patient with a learning disability.

Helpful Resources

http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf
DHSSPS Improving the Patient & Client Experience November 2008

http://www.dhsspsni.gov.uk/consent-guidepart4.pdf
DHSSPS Seeking Consent: Working with people with learning disabilities 2003

http://www.understandingindividualneeds.com/page.php?identity=health_and_wellbeing
Understanding Individual Needs, a web site that aims to help family, friends and professionals provide the best possible care and support to people with learning disabilities and ensuring they have a chance to lead a valued and fulfilling life.

http://www.mencap.org.uk/document.asp?id=6770
Mencap (2008) Getting it Right.

2. COMMUNICATION

Best Practice Statement

People with learning disabilities and their families/carers should experience effective and meaningful communication to support safe and person centred care.

Background

Safe and person centred care is underpinned by effective and sensitive communication. It is well established that the risk of harm increases if there is difficulty in communicating with the patient. Effective communication is multi-faceted and involves communication with the patient, communication with family/carers and communication between professional staff. Effective communication is supported by a number of key principles which include the understanding that:

- All people communicate using various means;
- People with learning disabilities communicate in a number of ways, both verbal and non-verbal;
- Behaviour is a means of communicating;
- The environment and how the person is feeling play a pivotal role in enhancing or limiting effective communication;
- It is the responsibility of hospital staff to understand, recognise, and take steps to address, the challenges of communication;
- A lack of clear and accessible information creates a barrier to accessing safe, effective and person centred healthcare;
- Effective communication may be facilitated by the involvement of family/ carers;
- Good listening skills and non-verbal communication are often the most important channels of communicating with people with learning disabilities.

Best Practice Indicators

1. An assessment of the person's preferred method of communication should be undertaken and staff should check if the patient has a document that highlights how they communicate (e.g. a health action plan, or hospital support plan. See helpful resources below).

2. The subsequent care plan should highlight the way(s) in which the person communicates specific needs/problems such as: hunger, thirst, toileting needs etc, or pain or distress.

3. Communication should always take place with the patient in the first instance, but staff should discuss (following consent/best interest decision) with family/ carers their role in facilitating communication with the patient. Staff should listen to and respect the advice/information given by the main carer, as they will have a detailed knowledge of the person with a learning disability.

4. Staff should adjust their verbal and non-verbal communication to meet the needs of the patient. Consider the following when communicating with patients who have a learning disability:
   - Address the person by their preferred name;
   - Speak slowly and don't shout;
   - Use very straightforward language and don't use medical jargon;.
   - Where appropriate the use of gestures, pictures, signs and symbols can help (see Hospital Communication Book in helpful resources section below);
   - The need for extra time to facilitate understanding. Make sure that the individual understands what you have said before moving on to the next topic;
   - Be aware that the patient may have additional hearing or visual impairments;
   - Pay attention to eye contact, body language, facial expression and contact via touch.

5. Staff should make use of and, where necessary, develop relevant resources, to assist in the provision of information. A range of easy read information sheets are available in a variety of formats to help patients understand what is going to happen during their stay in hospital. (See helpful resources section).

6. Staff should have regular training on communication skills, particularly centred on the challenges encountered when a patient has cognitive or other sensory impairments.

7. Trusts should develop a resource pack to support effective communication during the hospital journey. The Hospital Communication Book developed by The Learning Disability Partnership Board in Surrey, provides an excellent template for the development of such a resource.

8. Expressions of concern by individual patients or by family members or carers must be acknowledged and addressed immediately, using the proper and usual procedures. Complaints processes must be made accessible to patients who have learning disabilities and/or the family/carers. When concerns are addressed and openly discussed at an early stage, there is often no need for formal complaint processes.

9. Effective communication between professionals is central to the safe and effective delivery of care. This is particularly important at key stages during the hospital journey. For example, communication between nursing staff at handover, communication between consultants when a child is moving into adult services and communication between hospital and community professionals at discharge.

Helpful Resources

www.easyhealth.org.uk: a web site run by Generate, a charity working with people who have learning disabilities, provides very useful resources in terms of easy read information related to health issues.

www.easyhealth.org.uk/FileAccess.aspx?id=757: The Hospital Communication Book that is free to download and provides a comprehensive range of tools and advice to help people who have difficulties understanding and/or communicating get an equal service in hospital.

3. LEARNING DISABILITY TRAINING FOR GENERAL HOSPITAL STAFF

Best Practice Statement

Every individual with a learning disability has the right to receive care and services from knowledgeable, competent and skilled practitioners, in a timely, safe and caring environment that takes account of their specific needs. The training to support this care must be available to and accessed by all professional and non-professional staff who potentially deliver services to people with a learning disability, in the general hospital setting

Background

The health needs of people with learning disabilities are complex and their health care needs are often misunderstood by health care professionals. Evidence indicates that there is limited understanding and knowledge of the health problems they experience and the risk of harm to patients with a learning disability whilst in hospital (NPSA 2004).

A range of reports and inquiries has identified that training for staff in general hospital settings has been limited and patchy. This has resulted in uncertainty in providing safe, effective and appropriate care to people with learning disabilities when they require these services. Also, many staff still fail to understand their duties relating to the laws regarding disability, human rights and equality.

Respective professional Codes of Conduct and common law emphasise that it is every practitioner's responsibility to be knowledgeable, competent and safe in providing treatment and services for all users of that service.

The knowledge, skills, attitudes and values of staff can improve through specific training on learning disability and the involvement of people with a learning disability in the development and delivery of such training is recommended within the Michael Report (HMSO 2008).

Best Practice Indicators

1. Academic and professional institutions that provide both undergraduate and post graduate clinical training should incorporate Learning Disability Awareness training within their curricula.

2. Learning Disability Awareness Training should be mandatory for all hospital staff who have direct patient contact in order to enhance their knowledge and skills in providing safe and effective care to patients with learning disabilities.

3. All new staff within Health and Social Care (HSC) services should receive appropriate training in learning disabilities, to include disability equality training as part of their Corporate Induction Programme.

4. The training of staff should be designed and delivered in partnership with people with learning disabilities and/or their carers.

5. The Learning Disability Awareness Training should be competence based and include the following core elements:

- An overview of learning disability - definitions and concepts;
- The health issues affecting people with learning disabilities and the barriers experienced when accessing generic health services;
- Service users' and carers' perspectives of equitable access, including personal experiences and proposals for best practice;
- Effective Communication;
- Legislative requirements such as consent and capacity, Equality of Opportunity, Disability Discrimination Act, Human Rights Act;
- Influential inquiries and reports - Death by Indifference (Mencap 2007), Patient People (SHSSC 2008);
- The provision of reasonable adjustments in the general hospital setting;
- How to access support from local learning disability services.

6. Additional training should be provided to key staff identified from within each clinical area. This would help facilitate them in the role of a Learning Disability Link Nurse to champion the needs of patients with a learning disability in that specific clinical area.

7. The Learning Disability Link Nurse training objectives should incorporate:
    - A greater awareness of the needs of patients with a learning disability;
    - An understanding of the risks of harm posed by being in the hospital environment and knowledge of how these risks can be managed;
    - An understanding of the difficulties facing patients with a learning disability and their carers when using hospital services;
    - Knowledge and skills in caring for patients who have a learning disability and the promotion of person centred care processes at ward level;
    - The development of local action plans to improve practice.

Helpful Resources

www.gain-ni.org the Southern Trust Learning Disability Awareness Training Pack and The Southern Trust link Nurse Programme.

http://www.dhsspsni.gov.uk/consent-guidepart4.pdf DHSSPS (2003) Seeking Consent: Working with People with Learning Disabilities

http://www.rcn.org.uk/data/assets/pdf_file/0004/78691/003024.pdf RCN (2006) Meeting the health needs of people with learning disabilities. Guidance for nursing staff. London, Royal College of Nursing.

4. LEGAL ISSUES IN THE DELIVERY OF CARE TO PEOPLE WITH A LEARNING DISABILITY

Best Practice Statement

Staff working in general hospitals will understand and apply the relevant legal and professional framework(s) and principles in the delivery of care to children and adults with a learning disability, ensuring that care is delivered in a safe, effective, personalised and non-discriminatory manner.

Background

From the review of the literature and the various reports/inquiries that have identified failings in care delivery to people with learning disabilities within general hospital settings, three areas of concern have been frequently highlighted:

a) Human Rights: People with a learning disability are not being afforded the same **human rights** as everyone else, in respect of being treated with dignity, equity, respect and consideration of autonomy. As a result, individuals with a learning disability have been subject to, and are at risk of, prolonged suffering and inappropriate care.

b) Equality of Opportunity and Reasonable Adjustments: The literature review has highlighted that there have been significant failures on the part of hospitals to provide equality of opportunity and to make adjustments that take account of a patient's level of cognitive or communication needs. Under Disability Discrimination legislation (DDA 1995) and Section 75 of the Northern Ireland Act (1998), public health service providers have a duty to make **reasonable adjustments** and to ensure that their services are fully accessible to people with a learning disability.

c) Consent and Capacity: A number of recent reports have suggested that health professionals working in general hospital settings do not understand the law in relation to **consent and capacity** as it applies to people with a learning disability. Consequently, treatment may be delayed or denied (Mencap 2007).

Best Practice Indicators

1. Staff working in general hospitals should receive specific training on the Disability Discrimination Act (1995), with particular emphasis given to the making of reasonable adjustments (at a practice, policy and organisational level). Human rights and consent training is also vital, with emphasis given on its application to people with learning disabilities. This training needs to be provided for healthcare staff working in both children and adult settings.

2. Reasonable adjustments should be considered not only in terms of physical barriers such as ramps and wheelchair access. Other practice, policy and procedural adjustments may require to be made such as:

    - Providing information in a format that is most likely to aid understanding;
    - The provision of longer appointments (e.g. in outpatients);
    - Effective communication with the individual and/or carers;
    - Appropriate mechanisms in place to identify pain and/or distress;
    - Appropriate complaint handling;
    - The level and extent of involvement of others such as family/carers/advocate;
    - Identifying the reasonable adjustments that are required within the individual care/treatment plans.

3. For planned admissions, a pre-admission meeting involving the person with a learning disability and those close to them (family/carers/advocate) and perhaps local community learning disability services, will help to explore issues of consent, capacity, confidentiality and reasonable adjustments required.

4. Staff within general hospitals should make use of the skills and expertise of those who work in learning disability services and of advocates in situations where there is confusion/uncertainty.

5. Individuals with a learning disability should first and foremost be presumed to have capacity to make healthcare related decisions unless proven otherwise. Where there is doubt about capacity, this must be assessed by the professional responsible for the intervention. Family/carers should be involved in this process.

6. Where an individual is deemed **not** to have capacity, a best interests meeting should be convened to discuss specific decisions that need to be taken. However, in emergency/life threatening situations, health care staff can apply the doctrine of necessity which allows for immediate decision making that is deemed to be in the person's best interest.

7. Every hospital ward/clinical setting should have access to the document "Seeking Consent: Working with People with Learning Disabilities" (DHSSPS 2003).

8. For staff who work with children who have learning disabilities, the ward or clinical environment should have access to the document "Seeking Consent: Working with Children" (DHSSPS 2003).

9. With the agreement of the person with a learning disability, inform and advise carers (both paid and unpaid) fully in any discussions or decisions about care or treatment.

10. Treatment decisions must never be based on professional assumptions about the person's quality of life. This is of particular relevance if and when Do Not Resuscitate (DNR) decisions are being considered.

11. Do Not Resuscitate decisions must follow exactly the same legal and professional pathways for people with a learning disability as for everyone else.

Helpful Resources:

http://www.dhsspsni.gov.uk/consent-guidepart4.pdf
DHSSPS (2003) Seeking Consent: Working with People with Learning Disabilities

http://www.dhsspsni.gov.uk/consent-guidepart2.pdf
DHSSPS (2003) Seeking Consent: Working with Children

http://www.mencap.org.uk/document.asp?id=6770
Mencap (2008) Getting it Right.

5. PREPARING FOR AN OUTPATIENT APPOINTMENT

Best Practice Statement

All people with a learning disability who have an outpatient appointment at a general hospital will have an opportunity to be supported in preparing for this. Account should be taken of their abilities and needs, together with the implications of these to facilitate examination, treatment and care.

Background

The majority of contact patients have with hospitals is known about in advance and often relates to outpatient appointments for initial assessment, investigation or treatment.

It has been regularly noted within published literature that people with learning disabilities experience difficulties during their contact with general hospital services. This is often related to limited preparation that does not take full account of the abilities and needs of the patient and the implications of this for general hospital services.

Best Practice Indicators

1. When arranging an appointment the referrer should provide an indication of any additional support that may be required.

2. Managers of OPD Departments should take steps to facilitate contact for the person in advance of the appointment to discuss relevant details of the organisation and the nature of the appointment.

3. A structured approach in an agreed format (e.g. Traffic Light assessment or hospital passport. See helpful resources section) should be used to gather the information necessary to support the appointment. This should include key information about the patient's communication abilities, physical care needs, behaviour when distressed and other factors that may need to be considered in arranging the appointment time and the duration of the appointment.

4. Appointments should be planned to take account of the possibility that extra time may be required for explanation, discussion, providing reassurance and maintaining cooperation. Consideration should be given to offering the first or early clinic appointments.

5. All information about what to expect should be provided to people with learning disabilities and their family/carers in appropriate accessible formats, providing contact details for key staff who may be able to provide or organise support if required. Staff working in learning disability services will have a key role to play in the provision of this support.

6. Directions sent to the patient and signage within the hospital site should provide clear accessible information that will allow the patient to find the correct department easily.

7. There should be flexibility in the waiting arrangements that take account of the abilities and needs of the person. Specific consideration should be given to minimising distractions/noise, providing a quiet waiting area (e.g. a vacant consultation room), providing space to walk around, or leave the waiting area for short periods and be called back for their appointment.

8. The process of the appointment should be explained to the patient in plain language, outlining the sequence of events.

9. Throughout the appointment staff should monitor the person's level of comfort, anxiety, distress and understanding of what is happening.

10. At the end of the appointment staff should provide a clear explanation of the next steps in the process of care and should consider the need to liaise with local learning disability services.

Helpful Resources

http://www.nnldn.org.uk/a2a/: Access to Acute: a network for staff working with people with learning disabilities to support access to acute medical treatment.

www.easyhealth.org.uk: a web site run by Generate, a charity working with people who have learning disabilities, provides very useful resources in terms of easy read information related to health issues.

www.gain-ni.org The Traffic Light Assessment tool that has been developed by the Southern Trust provides important information about people with a learning disability to hospital staff.

www.healthpassport.co.uk/: This website provides a free downloadable version of a health passport used in Buckinghamshire. It was made by and for people with learning disabilities, and will help them access health appointments or when they need to go into hospital.

www.easyhealth.org.uk/FileAccess.aspx?id=2058 "Your next patient has a learning disability" can be accessed as an excellent resource leaflet for healthcare professionals who are unfamiliar with the needs of people with a learning disability.

http://www.hft.org.uk/Resources/Home%20Farm%20Trust/Family%20Carer%20Support/Documents/WorkingTogether.pdf Home Farm Trust (2008) Working together: easy steps to improving how people with a learning disability are supported when in hospital.

6. THE ADMISSION PROCESS AND SUPPORT DURING A HOSPITAL STAY

Best Practice Statement

When a person with a learning disability needs to be admitted to hospital, steps should be taken to prepare them, the hospital staff and the ward to ensure that they receive safe and effective care during their hospital stay.

Background

The changing patterns of morbidity among people with learning disabilities largely reflect the changes in the general population. Many people with learning disabilities also have additional health needs that may require an inpatient admission to hospital. The period of admission can range from a few hours (for day surgery) to several weeks. Often such admissions are known about in advance and this provides an opportunity for the preparation of people with learning disabilities and staff in the hospital to facilitate a safe journey.

Albeit that there are opportunities for planning admissions, there are some reported persistent limitations in the care of patients with learning disabilities which have resulted in unnecessary distress/suffering, discomfort and inequity and that may have had grave consequences for them.

Best Practice Indicators

1. People with a learning disability should have the opportunity for a pre admission meeting/ward visit prior to any planned admission. In this meeting, staff should make use of all available information, including any personalised health documents (Health passports, or Traffic Light assessments. See helpful resources section below) and the information available from family and members of the local learning disability services (day care/ community learning disability team).

2. In these planned circumstances local learning disability staff, in conjunction with family carers, should ensure that the relevant hospital staff are informed of key needs that the patient may have and hospital staff should ensure that

the clinical area is as prepared as possible for the person's admission. This preparatory phase should consider the possibility of the need for specific equipment to meet the person's needs.

3. There should be a coordinated approach in the handover of information to ward staff on admission and throughout the hospital stay. This may be provided by staff within local community learning disability service which should highlight the patient's abilities and needs and details of any additional support that may be required or any risks that may need to be managed. This information should direct subsequent care planning.

4. Each hospital ward should gather resources that can help when a person with a learning disability is admitted and ensure that this is accessible to all staff. For example, information regarding the contact points of local learning disability services, easy read information about the ward, the hospital and certain procedures such as blood tests and x-rays.

5. An up to date list of key contacts for staff in learning disability services should be available in all departments within general hospitals in order to facilitate prompt contact with these staff or services if required.

6. In wards that are frequently used by people with a learning disability, the hospital should identify staff to take on a link or champion role specific to the care of the person with a learning disability.

7. The individual patient should have an identified named nurse who is responsible for nursing care for the duration of their hospital stay.

8. Hospital staff should introduce themselves to the patient and their carers. People should be shown the ward layout, including toilet facilities, nurses' station and other important features of the ward. They should also be shown how to summon help if required.

9. The admission process and any planned investigation, treatment and care should be explained in plain language, outlining the sequence of events. This should include the opportunity to ask questions. A range of resources to help hospital staff provide understandable information can be accessed from the easy health website (see helpful resources section below).

10. All care should be provided in a manner consistent with the current Standards for Improving the Patient & Client Experience, ensuring the provision of respectful and dignified care (DHSSPS 2008).

11. Care should be taken to investigate fully the patient's presenting signs and symptoms and care should be taken to avoid the risk of "diagnostic overshadowing" which means not attributing the current condition to the presence of learning disabilities.

12. Medical and nursing care should be delivered on the basis of standard evidence, good practice and guidelines and in response to identified clinical need.

13. Hospital staff should continually explain procedures, changes in circumstances, medication etc. and ensure that the patient and carers understand what they have been told and have the opportunity to ask questions.

14. When the patient is required to undergo surgery particular activities should include a pre-operative visit by theatre/recovery nursing staff to the patient and their family at an agreed time. The theatre staff undertaking the pre-operative visit will discuss the following issues with the ward nursing staff, patient and main carer. If the patient is admitted on the day of the operation, the following information would need to be collected in another way:

    - The patient's previous experiences of anaesthesia and surgery;
    - How to manage the process of 'fasting';

- Any known behavioural patterns which may become evident when the patient recovers from the anaesthetic;
- The patient's communication needs;
- Whether the main carer wishes to accompany the patient to the anaesthetic room and/or to be present in the recovery room shortly after the patient recovers from the anaesthetic;
- Whether a ward nurse/carer needs to stay with the patient in the anaesthetic room until the patient is anaesthetised to provide continuity of care and support.

15. Hospital staff should consider the need for increased clinical observation of changes in the health condition of a patient with learning disabilities, given that some people may have less ability to articulate changes in how they are feeling. In such circumstances it is the responsibility of the ward staff to provide or commission additional resources to fulfil this need should it arise.

Helpful Resources

http://www.nnldn.org.uk/a2a/ : Access to Acute: a network for staff working with people with learning disabilities to support access to acute medical treatment.

www.easyhealth.org.uk: a web site run by Generate, a charity working with people who have learning disabilities, provides very useful resources in terms of easy read information related to health issues.

www.gain-ni.org The Traffic Light Assessment tool that has been developed by the Southern Trust provides important information about people with a learning disability to hospital staff.

www.healthpassport.co.uk/ : This website provides a free downloadable version of a health passport used in Buckinghamshire. It was made by and for people with learning disabilities, and will help them access health appointments or when they need to go into hospital.

www.easyhealth.org.uk/FileAccess.aspx?id=2058 "Your next patient has a learning disability" can be accessed as an excellent resource leaflet for healthcare professionals who are unfamiliar with the needs of people with a learning disability.

http://www.hft.org.uk/Resources/Home%20Farm%20Trust/Family%20Carer%20Support/Documents/WorkingTogether.pdf Home Farm Trust (2008) Working together: easy steps to improving how people with a learning disability are supported when in hospital.

http://www.rcn.org.uk/data/assets/pdf_file/0004/78691/003024.pdf
RCN (2006) Meeting the health needs of people with learning disabilities. Guidance for nursing staff. London, Royal College of Nursing.

Gates B, Barr O, (2009) Oxford Handbook of Learning and Intellectual Disability Nursing. London, Oxford University Press.

7. DISCHARGE PLANNING

Best Practice Statement

Individuals with a learning disability and where appropriate, their family/carers, will have a thorough and coordinated approach to discharge planning that meets their specific needs. Discharge planning will begin on the day of admission and will be evidenced within the patient's plan of care.

Background

People with learning disabilities access and avail of in-patient hospital services more often than the general population yet they are discharged from hospital more quickly. Evidence highlights that the discharge processes experienced by patients with a learning disability and their family often falls short of what would be regarded as good practice (Mencap 2007).

Issues such as untimely discharge (too early or delayed), inappropriate management of the process and discharge to unsafe environments are associated with a greater risk of harm to the individual (Mencap, 2007, Michael, 2008, Parliamentary and Health Service Ombudsman 2009).

Good discharge planning is known to reduce the length of hospital stay, reduce the likelihood of unplanned readmissions and achieve good patient outcomes and experiences (Shepperd et al 2004. See helpful resources below).

Best Practice Indicators

1. For planned admissions, the discharge process should be a partnership approach involving ward staff, the patient, their family/carer (where appropriate) and the Community Learning Disability Services and should commence prior to admission.

2. In the case of unplanned admissions, discharge planning should also be a partnership approach, beginning in the assessment period, then communicated and documented in the plan of care.

3. Where clinically appropriate, patients should be placed on the recognised care pathway related to their condition and a potential date of discharge should be communicated to the patient and family.

4. Staff also need to be aware of the potential distress that a patient with a learning disability (and particularly those with autism) may experience if an expectation of being discharged on a specific date does not become reality.

5. Staff should provide the patient with a clear explanation of the discharge process and respect the right of the patient to be actively involved in all decisions regarding their care.

6. As soon as is practically possible, a discharge planning meeting should be organised by the hospital staff, involving the patient and should include the family/carers and the relevant hospital and community/primary care staff to identify:

   - The potential date and time of discharge in order to plan the recommencing of normal daily activities, or recommended new care package;
   - Any potential difficulties the patient may experience on the day of discharge, such as waiting for lengthy periods in a discharge lounge;
   - The location and suitability of the environment to which the patient is being discharged;
   - Any other community/primary care staff who need to be informed of the patient's discharge;
   - The support that the patient and the family/carers may require to help the patient remain within their own home environment (wherever home is);
   - Where certain procedures need to be carried out in the home environment after discharge, competency based training for families or other essential carers should be initiated and overseen in hospital prior to discharge taking place.

NB. In some cases (e.g. following a short uncomplicated stay in hospital) it may be appropriate to proceed by telephone arrangement, particularly if convening a formal discharge planning meeting may delay discharge.

7. Prior to discharge, hospital staff should ensure that the patient and, where appropriate, the family/carers have been provided with clear, understandable information on the diagnosis, treatment given and any follow up treatment, appointments or specialist assessments that may be required. Of particular importance is information around medicines and the need to follow particular instructions such as bed rest, no lifting or any other requirements.

8. The above information must be communicated in a format that is understood. The easy health website (see helpful resources section) provides a wide range of information and booklets regarding health information and procedures that could be utilised.

9. Hospital staff should provide the patient with a contact number should they require further advice or information regarding their care following discharge.

10. Hospital staff should invite the patient, family/carers to provide evaluation or feedback of their experiences during their stay in hospital.

Helpful Resources

http://www.hft.org.uk/Resources/Home%20Farm%20Trust/Family%20Carer%20Support/Documents/WorkingTogether.pdf Home Farm Trust (2008) Working together: easy steps to improving how people with a learning disability are supported when in hospital.

Cochrane Database Systematic Review. Shepperd S, Parkes J, McClaren J, Phillips C.(2004) Discharge planning from hospital to home, 2004;(1):CD000313

8. ATTENDANCE AT EMERGENCY CARE SERVICES

Best Practice Standards

Every person with a learning disability using the emergency care service should receive timely, safe and effective care that takes account of their specific health needs.

Background

People with learning disabilities have greater health care needs than the general population, which increases their contact with the emergency care service.

Unlike planned admissions, these attendances often happen unexpectedly and the pace of work in this unfamiliar environment can increase anxiety and distress, adding to the patient's vulnerability. This fast moving environment creates the potential for limited information sharing and it is acknowledged that inadequate communication increases the risk of harm to the patient.

Best Practice Indicators

1. Staff within emergency care departments should develop a specific care pathway/protocol for identifying and caring for patients with a learning disability.

2. It is important for staff to assess the patient's needs and safety requirements. Fast tracking arrangements for all children and adults with a learning disability should be considered. Where fast tracking cannot be applied, emergency care staff should consider using quieter waiting areas.

3. Staff within emergency care departments should check with the patient or family/carer if they have documentation that identifies their individual method of communication and other relevant information that will be useful to support their assessment, investigation and provision of safe care (e.g. a health passport or traffic light assessment. See helpful resources section below).

4. During triage, staff need to allow extra time to assess the patient's needs in order to communicate effectively the proposed plan of care and to seek consent for examination, treatment and care. Where appropriate, support from the family/carers may be required to facilitate effective communication to help inform decision making.

5. Where possible, the same nurse should care for the patient throughout their journey within the emergency care department.

6. Staff should be aware that all behaviour is a means of communicating and that people with learning disabilities may express feelings of fear, anxiety and/or pain through odd or unusual behaviours.

7. All information on the diagnosis, investigations and care must be provided in a format that is understandable to the patient in the first instance. Health professionals can access a range of informative, easy to read leaflets that help explain procedures such as x-rays, blood tests and other procedures which are available from the easy health website (see helpful resources section below).

8. Careful consideration needs to be given to the admission/transfer/discharge planning, whether it is admission to a ward within the hospital, transfer to another hospital or discharge home. It is essential that time is taken to ensure that relevant information is passed on to other wards/departments/hospitals and healthcare professionals. Specific care needs to be taken to ensure that the individual and/or the carer(s) are familiar with and understand the discharge advice, including any medication, treatments or follow-up arrangements.

9. Staff within emergency care service should familiarise themselves with the contact information of their local Community Learning Disabilities Services. A referral can be made to the Community Learning Disabilities Services where the named nurse has any of the following concerns:
   a) the patient's safety;
   b) mental health and/or challenging behaviour;

c) the patient's ability to comprehend instructions or follow medication regimens.

10. If the individual is a frequent user of emergency care departments, planned preparatory work can be carried out by local Community Learning Disability Services to help emergency care staff understand specific needs when such circumstances arise.

Helpful Resources:

www.easyhealth.org.uk/FileAccess.aspx?id=757: A Hospital Communication Book that is free to download and provides a comprehensive range of tools and advice to help people who have difficulties understanding and/or communicating get an equal service in hospital.

www.gain-ni.org The Traffic Light Assessment tool that has been developed by the Southern Trust provides important information about people with a learning disability to hospital staff.

www.healthpassport.co.uk/ : This website provides a free downloadable version of a health passport used in Buckinghamshire. It was made by and for people with learning disabilities, and will help them access health appointments or when they need to go into hospital.

http:/www.mencap.org.uk/consent-guidepart4.pdf
Mencap (2008) Getting it Right.

http://www.dhsspsni.gov.uk/consent-guidepart4.pdf
DHSSPS (2003) *Seeking Consent: Working with People with Learning Disabilities*

http://www.dhsspsni.gov.uk/consent-guidepart2.pdf
DHSSPS (2003) *Seeking Consent: Working with Children*

9. SUPPORT FOR CARERS

Best Practice Statement

When a person with a learning disability is required to use the general hospital setting, carers should be engaged as healthcare partners throughout the pathway of care alongside, not instead of, healthcare staff.

Background

We know that people with a learning disability are vulnerable when they use hospital services and therefore, the involvement of those who are closest to the patient in their care will provide them with some reassurance during a time of anxiety, distress and upset. Family/carers can make a major contribution to the effectiveness of treatment and support by providing medical and other key information. For example, they are likely to possess skills that will enable the cooperation of the person to receive clinical or other nursing procedures. They can also identify risk areas in relation to aspects of care.

However, there can be a tendency for health care professionals to discount the involvement of carers and not to consult with them. Mencap (2007) highlighted this in their "Death by Indifference" report, suggesting that lack of involvement of families and carers can result in poor prognosis, wrong diagnosis and, potentially, avoidable deaths.

Alternatively, it is also too often expected or assumed by health care professionals that family/carers will continue their support and care delivery to people with learning disabilities when they go into hospital.

Family/carers and hospital staff should be working together, within the parameters of the patient's expressed wishes, his or her capacity and within the parameters of the law around consent and confidentiality, to achieve the best outcomes for patients with a learning disability.

If they decide to, the family/carers can also be involved in a range of helpful activities during the hospital stay such as, helping with meals, interpreting what the patient is trying to say and keeping the patient meaningfully occupied.

Best Practice Indicators

1. The crucial role that family/carers play is highlighted throughout all of the guidelines within this document and their involvement in the journey of care must be acknowledged, valued and listened to by hospital staff within the parameters of the patient's expressed wishes, his or her capacity and within the parameters of the law around consent and confidentiality. Doing so will help achieve the best outcomes for patients with a learning disability when they have to use general hospital services.

2. It is important that there is no expectation that family members and/or support staff from learning disability services are required to remain on the ward throughout the admission of a child or an adult with a learning disability and to provide direct care and support. First and foremost, the provision of direct care and support to the patient is the responsibility of the hospital staff. There will of course be circumstances when this additional support is provided (e.g. when the patient is a child, when the family carer chooses to do so, or in circumstances where the patient may have very specific needs related to their learning disabilities). It is therefore important that hospital staff establish at an early stage the role family / carers are able and willing to play in the provision of care and support during the patient's hospital stay.

3. All staff in the clinical area must be made aware of any additional support provided by family members or carers and should facilitate the presence of carers including agreed arrangements for visiting, breaks and refreshments. Staff should also remain alert to the fact that carers may also be concerned or worried about the patient.

4. The poor management of complaints has been highlighted in many of the reports and inquiries that have examined the care of people with learning disabilities in hospitals. When concerns are raised or complaints are made, steps should be taken immediately to make individual patients and/or their carers aware of the process and of their rights. Easy read information should be developed to support this. Effective and speedy investigation, empathetic and timely responses together with an apology where necessary, will help resolve concerns locally.

5. Family/carers could compile useful information in the form of a Traffic Light Assessment or Health Passport (see helpful resources), prior to admission. A copy of this can be held in the patient's medical record for future planned or unplanned admissions.

6. Family/carers have a key role to play in the process of effective communication and, in particular, in identifying or interpreting indicators of distress.

7. Hospital staff should also ask if independent advocacy is available for the patient who has a learning disability, particularly when there are difficult or contentious decisions. Although it is recognised that family and paid carers advocate strongly on behalf of the individual they provide care for, independent advocates have the potential to provide both the patient and their families and carers with additional support.

8. Family/carers and individuals with a learning disability themselves, should be involved in the provision of training to health care professionals.

9. Staff should consider whether family/carers would benefit from a carer's assessment.

Helpful Resources:

http://www.hft.org.uk/Resources/Home%20Farm%20Trust/Family%20Carer%20 Support/Documents/WorkingTogether.pdf Home Farm Trust (2008) Working together: easy steps to improving how people with a learning disability are supported when in hospital.

www.carersuk.org Carers UK is the voice of carers, and aim to improve their lives by providing advice, information and support and campaigning for change.

www.mencap.org.uk/page.asp?id=1946 Mencap helps people with a learning disability, and those that care for them to have their voices heard in decisions that affect their lives. They may be able to provide local advisors to provide independent advocacy support in a range of circumstances.

10. EFFECTIVE NUTRITION AND HYDRATION

Best Practice Statement

People with a learning disability will receive high quality nutritional care based on individually assessed needs, which may be additional and more complex than that required by the general population. Quality nutritional care will involve appropriate screening, assessment, planning, monitoring, serving and, where necessary, safe practical help with eating and drinking.

Background

The importance and effects of meeting (or not meeting) the nutritional needs of patients with a learning disability in general hospital settings have been highlighted in many reports and inquiries mentioned in the literature review of this document. It is recognised that good nutrition and hydration in hospital are as crucial to well being and recovery as the medicines and other treatments that patients may receive.

The nutritional needs of people with a learning disability vary depending on the severity of their disabilities and sometimes associated conditions. The challenges of meeting nutritional needs can be exacerbated by communication difficulties whereby the individual is unable to articulate their need for food or fluids, likes and dislikes of food and fluid or feelings of nausea and pain. People with a learning disability may also be unable to exercise real choice as they may not have the means or the opportunity to do so. Due to their learning disability and sometimes additional communication difficulties, their opinion on menu choice is at risk of not being sought.

The incidence of eating, feeding and swallowing problems is higher in people with learning disabilities than in other population groups, with at least half of the adults with learning disabilities suffering from dysphagia. This has been highlighted as a major patient safety issue in the care provision to people with a learning disability (NPSA 2004). Therefore, if nutritional needs are not assessed and managed effectively, this can have detrimental health consequences, especially when the individual's health is already compromised. The following best practice indicators are reflective of the "Get your 10 a day: Standards for Patient Food in Hospital" (DHSSPS 2007).

Best Practice Indicators

1. Staff within the hospital setting should ascertain if the person being admitted has a traffic light assessment/health action plan (which is likely to include details of the need for nutritional health interventions/support to the person with a learning disability). There may also be useful information from the Speech and Language therapist within the Local Community Learning Disability Service.

2. Family/carers (both formal and informal) should be recognised as having expert knowledge of the person. This knowledge should be incorporated in the individual's care plan and used to plan and implement care while the patient is in a general hospital.

3. All children and adults admitted to general hospital should be screened to determine their nutritional status.

4. Following screening by nurses, patients who are identified as malnourished or at risk of malnutrition will be referred for and receive a nutritional assessment appropriate to their level of need.

5. Patients who require support with eating and drinking should be clearly identified and receive safe assistance as required.

6. Staff should strive to promote independence with individuals with a learning disability who require aids whilst feeding, such as plate guards and non slip mats.

7. Specialist assessment by a dietician, support and monitoring will be required for those individuals who suffer from swallowing difficulties and/or require to be fed via enteral/parenteral routes.

8. Patients who have a learning disability should have their food and/or fluid intake monitored and have this activity carried out in a way that is informative, accurate and up-to-date.

9. Additional support may be necessary to assist patients with menu choice. Pictorial menu cards for patients with a learning disability who are unable to understand written menus should be available so that the individual can be helped to choose. Use of personal place mats (highlighting likes or dislikes, risks, nutritional and nursing support) will be beneficial in assisting patient choice.

10. Meals should be presented in an appealing and appetising manner with minimal disruption at mealtimes.

Helpful Resources:

http://www.bapen.org.uk/pdfs/must/must_full.pdf Malnutrition Universal Screening Tool (MUST)

DHSSPS (2007) Get your 10 a day: The nursing care standards for patient food in hospital. DHSSPS. Belfast.

11. THE ASSESSMENT AND MANAGEMENT OF PAIN

Best Practice Statement

People with a learning disability will be thoroughly assessed for pain, with attention focused on both verbal and non-verbal indicators of pain and/or distress. Their pain should be fully investigated and treated according to clinical need.

Background

First and foremost, it is important to dispel the myth that people with a learning disability have a higher pain threshold than the general population. This is untrue and there is no evidence base for this suggestion.

Many people with a learning disability will be able to describe their pain. However, some people, particularly those with severe and profound disabilities, may have difficulty verbalising their pain and therefore will use other means to communicate their pain. These signs and symptoms can include:

- Increased agitation;
- Constant or frequent crying;
- Withdrawal;
- Fidgeting and/or repetitive movements;
- Self injurious behaviour;
- Tensing or body bracing to achieve a pain easing posture;
- Increased sweating, heart rate or breathing;
- Changes in eating or sleeping habits;
- Changes in frequency and type of seizures;
- Inappropriate laughing;
- Other behaviours that may challenge staff.

What is also important to consider are those indicators that may infer that the individual feels well and is not experiencing pain, distress or discomfort.
These can include:

- The individual feeling and looking relaxed;
- The individual shows pleasure;
- The individual is alert and responsive;
- The individual responds to the company of others;
- The individual is eating and sleeping well;
- The individual is cooperative to the requests of others.

Best Practice Indicators

1. Staff should be aware of possible indicators and expressions of pain that may be different than those usually seen and are specific to the individual receiving care. This includes non verbal expressions of pain and changes in behaviour.

2. For planned admissions, a pre-admission meeting involving the person with a learning disability and those close to them (family/carers/advocate) and perhaps local community learning disability services, will help to consider and explore the assessment and management of pain and distress.

3. In accurately assessing pain, the combined use of careful history taking, close observation of the individual, accurate interpretation of the communicative behaviour and clinical judgement is vital.

4. Staff should consider using the pictorial formats available in The Hospital Communication Book to help them identify the presence, location and severity of the pain being experienced (See helpful resources below).

5. Hospital staff should utilise the skills and expertise of specialist pain nurses if they are available. This will be particularly important in circumstances such as treatment for cancer related disorders or palliative care.

6. Staff should directly communicate with the patient and use straightforward questions about the presence of pain. They should be aware that the patient may need more time for responses.

7. Staff must communicate with family/carers well known to the patient, paying particular attention to baseline indicators of comfort and contentment, descriptions of changes in behaviour or previous/similar episodes.

8. Investigate indicators of pain and distress fully. Do not assume that the patient is refusing to co-operate. Take time to explain any plans for investigations, familiarise the patient with the environment and consider the assistance of family/carers during investigations.

9. Staff should rule out physical causes (such as pain and/or distress) for behaviour changes before attributing these changes to other reasons that may be associated with the learning disability or mental health issues.

10. Consider the need for regular analgesia rather than 'as necessary'. Be watchful for a response to analgesia, looking for indicators of well being or a reduction in pain indicators.

11. Be aware of possible undesired effects of medication and observe for these. Some people with learning disabilities may be more susceptible to undesired effects and some may find this difficult to articulate. Some people may be taking other medication for other conditions and it is vital that possible drug interactions are considered.

12. During the assessment process it is vital that staff consider that the person may be indicating distress as a consequence of other emotional factors rather than physical pain.

13. Pain assessment tools, using self report or observational methods and proxy reports have been designed for young children (Wong 1998) and for adults with a learning disability (e.g. Disability Distress Assessment Tool (DISDAT) and staff should give consideration as to their benefit and utilisation in each individual circumstance (See helpful resources below).

Helpful Resources

www.easyhealth.org.uk/FileAccess.aspx?id=757 A Hospital Communication Book that is free to download and specifically designed to help people who have difficulties understanding and/or communicating get an equal service in hospital.

www.disdat.co.uk/ A distress assessment tool designed by St. Oswald's hospice designed to help health professionals assess and identify distress indicators in people who have limited communication.

http://www.painknowledge.org/physiciantools/opioid_toolkit/components/Wong-Baker_Scale.pdfThe Wong-Baker FACES rating scale has been developed for children over 3 years and is particularly helpful for patients who may be cognitively impaired. It offers a visual description for those who do not have the communication skills to explain their symptoms and how they feel.

12. IMPROVING THE EXPERIENCE OF CHILDREN WITH A LEARNING DISABILITY

Best Practice Statement

Children and young people with a learning disability who use general hospitals will receive coordinated, safe, effective and child/family centred services that are age appropriate and based on assessed needs.

Background

All of the other guidelines within this document will apply to children as well as adults, but there is a need to highlight a number of important best practice indicators that have particular relevance for children. Although it is recognized within policy and legislation that children with a disability should always be regarded as children first, children with any type of significant disability may require a range of additional support beyond the type and amount required by children in general. Children with a learning disability use general hospitals on a similar basis as other children (e.g. accidents, tonsillectomy, heart defects etc), but will often be frequent users as a consequence of complex physical healthcare needs. In these circumstances, all staff involved should refer to the document, "Developing Services to Children and Young People with Complex Physical Healthcare Needs." DHSSPS (2009).

The findings of the "Care at its Best" report (DHSSPS, 2005) should also be noted. This is the report of a Northern Ireland wide multidisciplinary inspection of the service for disabled children in hospital. The findings of the inspection informed the development of the document "Standards for the Care of Disabled Children in Hospital" (DHSSPS, 2010), which contains detailed standards covering key aspects of hospital care for disabled children regardless of the child's disability or the hospital setting. The "Improving the Experience of Children with a Learning Disability" best practice statement which is presented here should therefore be read in conjunction with these more detailed standards.

Best Practice Indicators

1. If at all possible, a pre-admission assessment should be completed which will involve the child, parents/carers and relevant hospital and community staff.

Important information should be collated at this stage (e.g. using the traffic light assessment format – see helpful resources) as this will help hospital staff to understand and effectively meet the child's needs.

2. There should be fast tracking procedures in place for learning disabled children who use hospital frequently or who have difficulty coping with prolonged waiting periods, particularly in departments such as Emergency Care and Outpatients' Departments.

3. Every child or young person who has a learning disability must have an agreed discharge/transition plan that starts on admission and involves hospital personnel, community services (specialist and universal services), the child and the family.

4. There should be an identified community key worker who will be the point of contact with the hospital staff during the period of admission. This is most likely to be a community children's nurse or a community learning disability nurse. This individual should provide an appropriate level of community in-reach to the hospital.

5. Parents/carers should be acknowledged as having expert knowledge of their child's needs. The child and their parents/carers should be involved in all assessment, care planning and discharge processes. They should be encouraged to ask questions and should receive relevant information in a format they can understand.

6. Families should be supported to maintain contact with their child in hospital. There should also be an appropriate level of support and provision for family members who need, or wish, to be with their child during the night.

7. Children and young people who spend extended periods in hospital should have access to a range of special provisions such as free access to television, therapeutic leisure activities and/or music and art therapy.

8. Where extended periods in hospital occur, the child should be enabled to engage in appropriate play and social activity programmes during their stay and, where appropriate, there should be adequate education provision delivered by relevant educational and/or hospital staff.

9. Where certain procedures need to be carried out in the home environment after discharge, competency based training for families or other essential carers should be initiated and overseen in hospital prior to discharge taking place.

10. Particular attention needs to be given at particular transition points such as the transition from general hospital to community services and transitions between child to adult services within general hospitals. Key standards for these circumstances are available in the document "Integrated Care Pathway for Children and Young People with Complex Physical Healthcare Needs" DHSSPS (2009).

11. All staff working within paediatric wards should have access to relevant training on learning disability with specific emphasis given to, communication skills, co-morbidity such as epilepsy and autism and key patient safety issues such as medicines' management, child protection and identifying deterioration.

12. The contact numbers of local Community Learning Disability Services should be provided to all paediatric wards within general hospitals.

Helpful Resources

www.gain-ni.org The Traffic Light Assessment tool that has been developed by the Southern Trust provides important information about people with a learning disability to hospital staff.

http://www.dhsspsni.gov.uk/developing services to children_july_2009.pdf
Developing Services to Children and Young People with Complex Physical Healthcare Needs. (DHSSPS 2009).

http://www.dhsspsni.gov.uk/integrated care pathway-july09.pdf
Integrated Care Pathway for Children and Young People with Complex Physical Healthcare Needs DHSSPS (2009)

IMPLEMENTATION AND AUDIT

Implementation of the Guideline will be driven by HSC Trusts. Clearly there will be a range of variance across trusts and consequently the approach to implementation will differ from trust to trust. GAIN is therefore not prescriptive in this regard. However, we have included at Annex 1 an example of a possible implementation strategy for consideration.

We recommend that Audit Departments within HSC Trusts audit the implementation of the guideline and may wish to use a rolling programme to audit specific components of the guideline. However, it is also intended that there will be discussions between GAIN and RQIA to consider a specific regional review of the guidelines within the next 3 years.

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Supported by:

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Sheila MComish	Services Manager

ANNEX 1

Example of a possible Implementation Strategy for consideration by HSC Trusts:

- An implementation steering group should be developed comprising senior hospital staff from nursing, medical and AHP backgrounds, senior staff from specialist community learning disability services, educational representation and service user and carer representation.

- Data analysis over the previous 5 years to identify within each general hospital the 'hot spots' where learning disabled clients are treated and cared for in order to localise the priority areas.

- There could be three strands to implementation which can be defined as follows; Corporate, Departmental and Individual which should include the 12 best practice statements outlined in the document.

- Operational action plans to be developed for each practice area within hospitals. Each action plan will be unique according to the particular area of practice There are areas within some general hospitals in N. Ireland that have developed successful strategies and these can be identified as examples of best practice and replicated elsewhere.

- Training programme to be developed considering existing programmes, for example, the existing equality and diversity training to incorporate the needs of the client group (see NB1 below).

- Development of a learning disability champions' network within hospital departments. It may be necessary to share champions within departments (see NB2 below).

- A communication strategy between hospital and specialist learning disability services should be developed.

- Development of a resource file in each practice area.
- Consider investment in a specialist learning disability link practitioner.
- Development of health passports and communication passports for clients.
- Incorporating the GAIN guidelines into the in-house audit programme.

NB1 General induction is required for all staff regarding the specific needs of this client group. Equality and Diversity training which is part of the Trust's induction programme could be developed further to include the issues for learning disabled clients. Discussions should also commence with medical staff so that learning disability issues are identified within the medical induction programme.

NB2 Develop a learning disability champions' network for both children and adults within specific departments of the hospital such as emergency care, day procedures, out patients. Staff will be identified within departments and could also be utilised within other departments where the client group is less visible (e.g. in maternity wards). These staff will require further in-depth training.

Copies of this Audit report may be obtained by either contacting the GAIN Office or by logging on to the website

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Delivering Care: Nurse Staffing in Northern Ireland

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

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

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

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Preface

A message from the Minister for Health and Public Safety

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

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

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

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

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

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report[1] (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

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

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

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

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

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

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

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

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

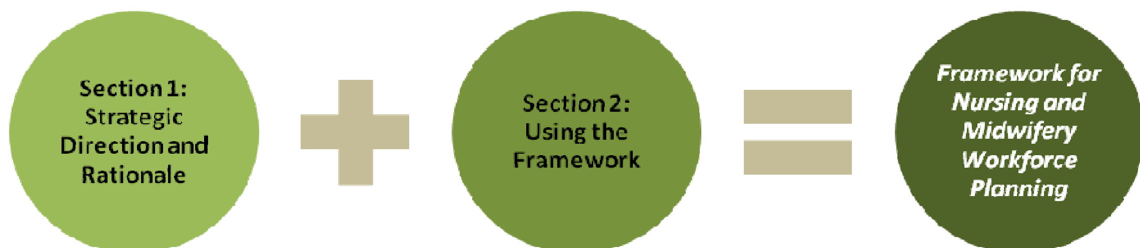
This document should now be shared with Health and Social Care Trust Boards and mechanisms established to ensure workforce planning processes are in place throughout Northern Ireland to support safe, effective, person centred care.

Chief Nursing Officer

Delivering Care: Nurse Staffing in Northern Ireland.

The framework is made up of the following constituent elements:

And is made up of two complimentary documents:



GLOSSARY OF TERMS

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

EXECUTIVE SUMMARY

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

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

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

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

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

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries[3].

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

Section 1: Strategic Direction and Rationale

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

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

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

[3] Please see pages 1 - 3 of this document.

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

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

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

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

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

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

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

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

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

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

SECTION 1: STRATEGIC DIRECTION AND RATIONALE

1.0 INTRODUCTION

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

1.2 The Independent Inquiry into the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust[4] highlighted the need for appropriate staffing levels to support safe, effective, person centred care.

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

> *"The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care."*
>
> *"The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff."*
>
> *"People must always come before numbers. Individual patients and their treatment are what really matters.......This is what must be remembered by all those who design and implement policy for the NHS."*

2.0 BACKGROUND AND CONTEXT

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

Regional Policy and Strategy

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

Transforming Your Care

The strategic review of Health and Social Care (HSC): *Transforming Your Care*[5] sets out the direction of travel for HSC services in Northern Ireland over the next five years. This is supported by the Commissioning Plan[6], which details year on year service provision, priorities and standards that services must meet. The implications of the changes to services in the next five years are significant, particularly in the development of new service models and the response the workforce will be required to make in support of these changes. Examples include:

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

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[4] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, HMSO.
[5] Department of Health Social Services and Public Safety/Health and Social Care Board. (2011). *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.
[6] Health and Social Care Board and Public Health Agency. (2011). *Commissioning Plan 2011/12*. Belfast, HSCB.

› Greater emphasis on the prevention of ill health.

Quality 2020

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

The People's Priorities

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

A Partnership for Care

The need to develop a framework to support effective workforce planning was identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[9] and as part of the Health and Social Care Board (HSCB)/Public Health Agency (PHA) Commissioning plan 2011/12[10].

Evidence Base Related to Staffing Levels and Patient Outcomes

2.3 Significant research has been undertaken into the issues of both nurse staffing levels and skill mix, thereby providing a wide literature base in relation to the association between lower numbers of registered nurses and significant reduction of the quality of patient outcomes[11]. Examples include:

› Fewer registered nurses, increased workload, and changing nursing teams in care environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units in a mixed method study combining longitudinal data (5 years) and primary data collection[12].

› Features of the hospital work environment, such as better staffing ratios of patients to nurses, nurse involvement in decision making, and positive doctor-nurse relations, are associated with improved patient outcomes, including mortality and patient satisfaction[13].

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

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

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

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

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

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

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

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

Evidence from Public Inquiries

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

Mid Staffordshire NHS Foundation Trust

The recommendations of the Francis Inquiry[16][17] identified the importance of including nursing staff at all levels in discussions related to standards of care and the resources required to deliver safe and effective, person centred care. Referring to the long term failures of the Trust, Robert Francis QC stated: *'The quality of nursing during that period suggested that staffing levels had been acknowledged to have been too low as long ago as 1998.'*[18]

Public Inquiry into the Outbreak of Clostridium Difficile

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

NHS Review

The NHS review into the quality of care and treatment provided by 14 hospital trusts in England[21] by Professor Sir Bruce Keogh recommended that '*nurse staffing levels and skill mix'* should *'appropriately reflect the caseload and the severity of illness of the patients they are caring for.'* This recommendation was made in light of the fact that the review teams found inadequate numbers of nursing staff in a number of ward areas, which was compounded by an over-reliance on unregistered support staff and temporary staff.

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[14] Cho, S.H., et al (2003). The effects of Nurse Staffing on Adverse Events: Morbidity, Mortality and Medical Costs. *Nursing research.* 52, pp 71-79.
[15] Health Care Commission. (2005). *Ward Staffing*. London, Health Care Commission.
[16] Francis, R. (2009). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*. London, TSO.
[17] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London, TSO
[18] *Op Cit*, n 16, page 396.
[19] Hine, D. (2011). *Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals.* Available for download at: http://www.cdiffinquiry.org
[20] *Ibid*, page 76.
[21] Keogh, B. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.* Available for download at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Why Develop a Range?

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

Aim

2.6 The overarching aim of the work was:

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

Scope and Objectives

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

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

Range not Ratio?

2.9 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio[22]. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.

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

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

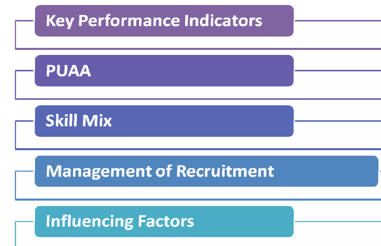
[22] Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies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

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

ASSUMPTIONS OF THE FRAMEWORK

3.0 Introduction

3.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.



3.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.

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

3.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of this document supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.

3.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

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

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

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

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

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

ASSUMPTION 2:
PLANNED AND UNPLANNED ABSENCE ALLOWANCE

3.5 Planned and Unplanned Absence Allowance (PUAA) refers to periods of absence from work, which can be described as anticipated and, therefore, must be factored into the workforce planning process. This comprises annual leave, sickness[23], and mandatory study leave. It was necessary, therefore, when describing nurse or midwifery[24] staffing to agree an allowance which could be factored in to any subsequently developed range.

Rationale

3.6 Telford (1979)[25] remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom. This methodology recognises the need for 'allowances and amendments for sickness, absence, holidays, in-service training and nursing education'[26] in any method of effective workforce planning.

3.7 In 2006, the Royal College of Nursing recommended a PUAA of 25%[27]. Similarly, the Healthcare Commission recommended a minimum of 24% in 2005[28], prior to the implementation of Agenda for Change[29].

3.8 Other professions have reflected a requirement to build in allowances for planned and unplanned leave. For example, the medical profession referred to the necessity of 'supporting professional activities' within the Consultant Contract Framework (2003)[30]. *Professional activities* were identified as: training, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local governance activities. Leave is also directed to be built into weekly job planning for consultant teams, including an average of 10 days per year of professional activity[31]. It should be noted that sickness absence was not accounted for within the Consultant Contract framework.

3.9 In 2002, the Auditor General for Scotland[32] identified a requirement for Planned and Unplanned Leave Allowance to be taken into account within nursing workforce planning processes, outlined in **Table 1**, page 7.

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23 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
24 It should be noted that this element of the assumptions of the framework is applicable to nursing and midwifery.
25 Telford, W.A. (1979). *A Method of Determining Nursing Establishments*. Birmingham, East Birmingham Health District.
26 *Ibid*, page 2 of the referenced document.
27 Royal College of Nursing Policy Unit. (2006). *Setting Appropriate Ward Nurse Staffing levels in NHS Acute Trusts*. London, RCN.
28 Health care Commission. (2005). *Ward Staffing*. London, Health Care Commission.
29 Department of Health. (2004). *Agenda for Change - Final Agreement*. Available for download at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099423.pdf
30 Department of Health, Social Service and Public Safety. (2003) *Consultant Contract Framework*. Available for download at: http://www.dhsspsni.gov.uk/scu-consultantcontract.pdf
31 Department of Health, Social Service and Public Safety. (2008). *Regional Guidance on Job Planning for Medical and Dental Consultants in Northern Ireland*. Available for download at: http://www.dhsspsni.gov.uk/regional-guidance-on-job-planning-for-medical-and-dental-consultants-in-northern-ireland.pdf Page 15 - 16.
32 Audit Scotland. (2002). *Planning ward nursing – legacy or design?* Edinburgh, Auditor General.

Table 1:

Planned and Unplanned Absence Allowance, Auditor General Scotland[32].

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

Annual Leave

3.10 The implementation of Agenda for Change[33] provided an increase from 25 to 33 days' leave for staff with a service record of 10 years or over. This substantial increase would, therefore, require that the allowance for annual leave calculated within PUAA is increased from that adopted in 2002. A reduction in the number of public holidays from 12 to 10 provided an overall net increase of 16%.

3.11 For the purposes of the framework, annual leave is calculated at the mid point of the Agenda for Change[34] leave allocation, which is 29 days + 10 days public holidays = 39 days. There are 260 working days per year for a full time/37.5hr person. This equates to 39/260 = **15%.**

Sickness Absence

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

Mandatory Study Leave

3.13 In response to the increased intensity and complexity of patient care and the need to support the continuing provision of safe, effective, person centred care, mandatory training needs have significantly increased for the nursing and midwifery workforce in the last 10 years from 2002. This includes regulatory requirements such as: meeting the Nursing and Midwifery Council (NMC) Standards for Learning and Assessment in Practice[36], statutory midwifery supervision and the Chief Nursing Officer's standards for supervision in nursing[37], as well as a range of clinical competencies which are required to comply with national and regional policy or standards. Examples of the types of training required for all staff and professional staff and associated hours required are outlined in **Table 2**, page 9. There is a regulatory requirement for professional updating, elements of which may be undertaken in a registrant's own time. As more robust revalidation models are progressed in light of the Francis Inquiry[38], it is essential that PUAA can accommodate this.

3.14 The nursing and midwifery workforce has a high percentage of individuals that choose part-time working arrangements - 56% full time, 44% part time[39]. Training must be provided on the basis of headcount as opposed to Whole Time Equivalents, which considerably increases the overall number of staff requiring training.

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

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

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

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

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

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

[39] *Ibid*.

Future Allowances

3.15 It was therefore proposed that the average level applied in 2002 of 22% should be reviewed to reflect the changes to annual leave allowances, and statutory and mandatory training requirements for professional and non-professional staff within a ward team.

3.16 The revised allowances, stipulated at **Table 3**, below, have been agreed by the Nursing and Midwifery Leaders in Northern Ireland, using those defined by the Auditor General (2002)[40] as a starting point, taking into consideration the elements mentioned in paragraphs 3.10 – 3.14, page 7. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods. The ranges incorporate a Planned and Unplanned Absence Allowance of 24%.

Table 3: Comparative Planned and Unplanned Absence Allowances

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

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

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

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

TABLE 2

EXAMPLES OF STATUTORY[41] AND MANDATORY[42] TRAINING FOR NURSING AND MIDWIFERY STAFF[43]

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

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

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

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

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

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

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

ASSUMPTION 3:
SKILL MIX

3.19 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[44], a skill mix comprising a higher level of unregistered staff may be appropriate. A level of skill mix will be determined regionally for a variety of care settings by the Nursing and Midwifery Leaders in Northern Ireland, based on best available evidence such as recognised workforce planning tools, related to the care setting under consideration. The skill mix relevant to a particular setting will be included within the subsequent '*Using the Framework for..*' sections. To reference the skill mix for general and specialist medical and surgical adult hospital care settings, please see page 3 of Section 2.

3.20 Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to '*fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.*'[45][46]

3.21 An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

ASSUMPTION 4:
MANAGEMENT OF RECRUITMENT

3.22 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.

3.23 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

- Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
- Avoidance of overuse of temporary staff, for example, bank and agency staff
- Matching of staff skill and band mix to patient acuity and dependency within approved guidelines[47]
- Timely and ongoing review of risk assessments linked to service reconfigurations.

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[44] For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.
[45] Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.
[46] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.
[47] For information related to skill mix for medicine and surgery, please see *Delivering Care* Section 2, page 3.

ASSUMPTION 5: INFLUENCING FACTORS

3.24 It is acknowledged that workforce planning for nursing staff is both complex and diverse[48]. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation[49] is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:

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

3.25 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a care setting. Further information on factors which influence workforce planning in medical and surgical settings can be found in Section 2, pages 7 - 13.

NURSE STAFFING RANGES

4.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery

MEDICINE

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

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

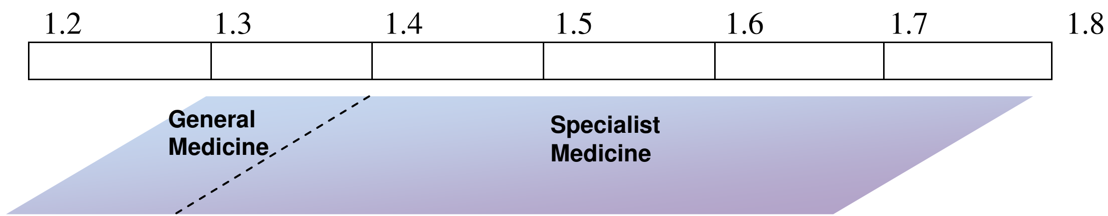
4.3 In some general ward areas, existing ***in both medical and surgical settings***, a cohort of dedicated beds for specialist services may exist, for example: 8 specialist respiratory care beds within a 24 bed general respiratory ward. As models of care for general medicine move towards specialisms,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

4.4 **Figure 1,** page 12, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and

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

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

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



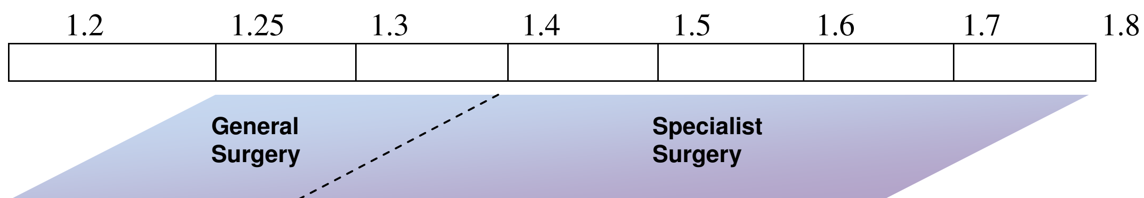
SURGERY

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

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

4.7 **Figure 2** below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for PUAA. For further information as to how the ranges were described and agreed, please go to page 19 of this document.

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



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

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

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

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

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

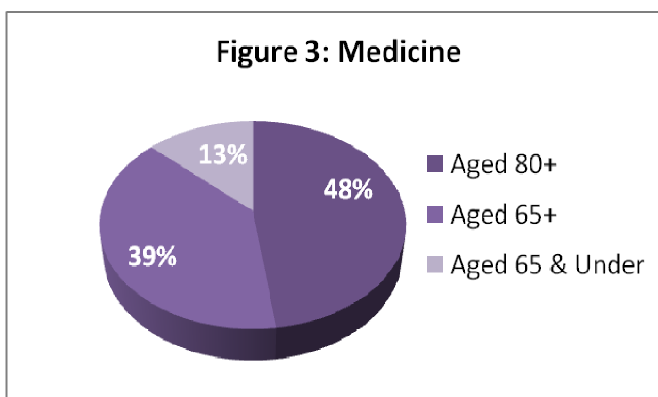
ILLUSTRATIVE EXAMPLE

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

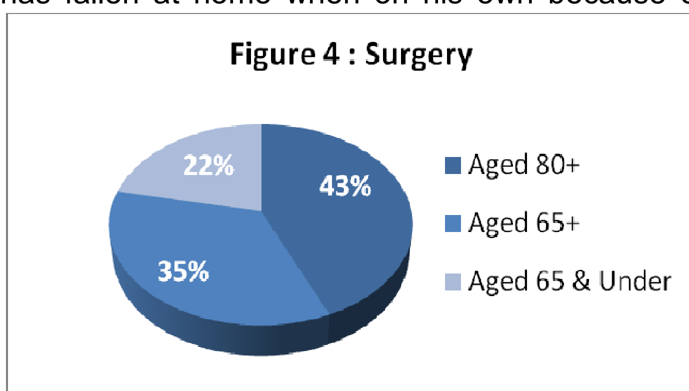
Along with an overview of activity within the snapshot, the numbers of staff that the range for general medical settings represents are described. It is also worthy of note that in addition to the demonstrated workload element, there are a number of activities which are part of the professional role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

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

Patient Profile



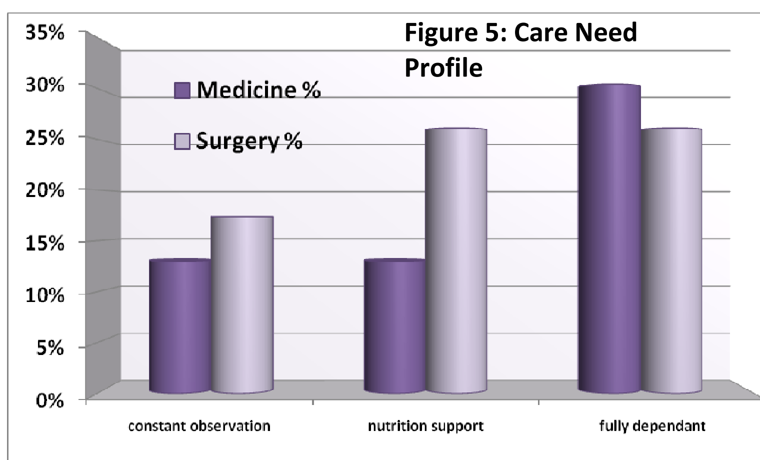
John's story is typical of someone who is being cared for within adult hospital-based acute medical services in Northern Ireland. John is 81 years old. He lives on his own and has recently been experiencing difficulty breathing. 17 years ago, he suffered a number of small strokes from which he fully recovered and he now remains on medication to prevent further deterioration. Two years ago he had his right kidney removed because a malignant tumour had been found. He is usually independent, but suffers from severe pain from osteoarthritis in both knees which means he walks with a stick. His mobility is quite limited as a result and recently he has been increasingly unsteady.



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

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

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



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

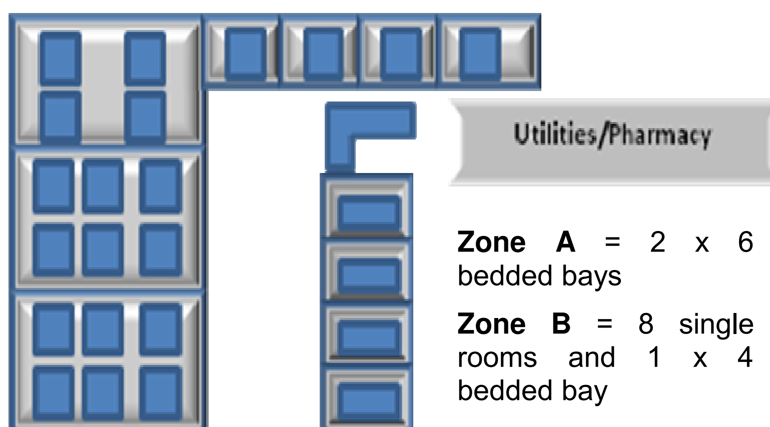
Northern Ireland has a population of approximately 1.8 million people and is the fastest growing population in the UK. The number of people over 85 years old is predicted to increase by 19.6% by 2014, and those over 75 years increasing by 40% by 2020. More people are living longer, with long term conditions and disabilities, which can be further complicated by more than one condition in some cases[50] and a requirement for complex drug regimen.

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

Environment

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

Diagram 1: Ward Layout.



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

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

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

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

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

Staffing Profile

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

Table 4: Staffing Complement

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

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

5.0 IMPLEMENTING AND MONITORING THE FRAMEWORK

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

6.0 CONCLUSION

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

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

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

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

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

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

Appendices

Appendix 1 - METHODOLOGY OVERVIEW AND PROCESS SUMMARY

Methodology Overview

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

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

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

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

Process Summary

Two time-limited literature reviews were undertaken to inform the work of the project. The first was conducted by the Business Services Organisation, Clinical Education Centre, and reviewed methodologies for defining staffing ranges in general care settings, which have been reported nationally and internationally. The conclusions from this review were that existing knowledge and practice in relation to staffing ratios and workforce planning remained relevant. In addition, there has been the recent development in England of an electronic tool to assist workforce planning – the Safer Nursing Care Tool[51]. The second literature review focused on available evidence-based staffing ranges or ratios, which have been developed for adult hospital medical and surgical specialties. This review, carried out by the PHA, confirmed that little work had been reported in relation to evidence-based staffing ranges/ratios for particular adult hospital medical and surgical specialties.

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

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

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

The ranges for the data refreshing exercise provided a continuum measurement from which a range might be set, based on existing staffing complements within Northern Ireland. It should be noted that HSC Trust organisations had previously reviewed funded establishments based on a range of workforce planning tools including Telford[52] and the Association of United Kingdom University Hospitals[53]. Given that Planned and Unplanned Absence Allowances (PUAA) were included in historical funding within legacy Health and Personal Social Services Boards of between 18% to 23%, ranges were set to reflect the recommended 24% PUAA (please see page 14 of this document).

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

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

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

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

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

[52] Telford, W.A. (1979). *A Method of Determining Nursing Establishments.* Birmingham, East Birmingham Health District.
[53] Association of UK University Hospitals (2009) *Patient Care Portfolio. AUKUH acuity/dependency tool: implementation resource pack*, London: AUKUH. Tool and related literature are available for download from www.aukuh.org.uk

APPENDIX 2 - MEMBERSHIP OF STEERING GROUP

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

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Steering Group are as follows:

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

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

APPENDIX 3 - MEMBERSHIP OF THE WORKING GROUP

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

Administrative Support: Mrs Linda Woods (NIPEC)

TERMS OF REFERENCE

Terms of Reference for the Working Group are as follows:

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

APPENDIX 4 - ABBREVIATIONS

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

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Delivering Care: Nurse Staffing in Northern Ireland

Section 2: Using the Framework for general and specialist medical and surgical adult in-hospital care settings

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

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

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Framework Outline
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Preface

A message from the Minister for Health and Public Safety

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

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

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

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

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

Edwin Poots, MLA
Minister for Health and Public Safety

Foreword and Acknowledgements

I am pleased to introduce *Delivering Care: Nurse Staffing in Northern Ireland* approved by Edwin Poots, Minister for Health, as the agreed policy direction for formulating the nursing profile of a unit or area. In the Nursing and Midwifery Workforce Planning Project report[1] (SEHDa, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. The approach is subjective and as other objective approaches become available they should be used in conjunction with the *Delivering Care* framework to provide further assurance that the right numbers of staff are available to deliver quality person centred care in Northern Ireland.

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

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

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

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

workforce must be ready to meet the challenges of Transforming your Care and I believe this framework will assist in those preparations.

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

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

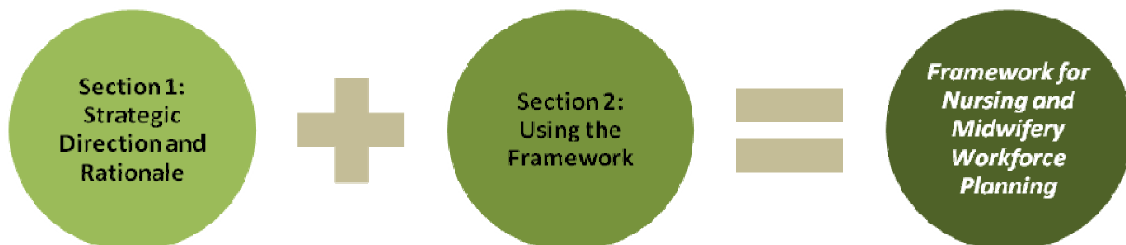
Finally, I would like to thank Professor James Buchan, School of Health, Queen Margaret University, Edinburgh, for reviewing the documents and providing valuable feedback to support the final production and publication of Sections 1 and 2 of the Framework.

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

Chief Nursing Officer

The framework is made up of the following constituent elements:

And is made up of two complimentary documents:



GLOSSARY OF TERMS

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

EXECUTIVE SUMMARY

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

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

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

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

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

The importance of this framework is underpinned by regional policy and strategy, evidence base related to staffing levels and patient outcomes, and evidence from public inquiries[3].

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

Section 1: Strategic Direction and Rationale

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

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

[2] Department of Health Social Services and Public Safety. (2010). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.
[3] Please see pages 1 - 3 of this document.

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

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

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

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

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

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

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

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

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

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

SECTION TWO: USING THE FRAMEWORK FOR MEDICAL AND SURGICAL CARE SETTINGS

1.0 INTRODUCTION

1.1 This document is the second section of *Delivering Care: Nurse Staffing in Northern Ireland.* It is designed to assist all staff, but particularly nurses, both in front line practice, management and commissioning, in the process of nursing workforce planning.

1.2 This section contains the following elements of the framework:

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

1.3 For further information relating to the background, context and process of the work surrounding the development of the framework please refer to Section 1 of *Delivering Care*.

Range not Ratio?

1.4 There are a number of questions which could arise in relation to the rationale for defining a range, rather than an absolute number or ratio[4]. This framework describes a range of nurse staffing which would normally be expected in specific specialities. It provides, therefore, a reasonable starting point for discussions about the appropriate staffing in a particular ward. **It does not** prescribe the staff numbers that should be on every ward and at every point in time, as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes. It is also important that planning processes will include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person centred care.

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

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

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

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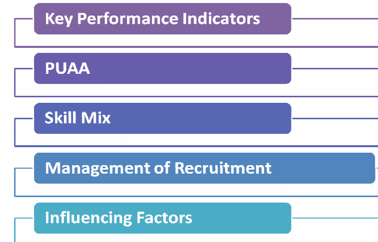
[4] Buchan, J. (2005). A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 10, 4: 239 – 244. This article reviews the strengths and weaknesses of using an absolute defined ratio, concluding that there are potential inefficiencies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

ASSUMPTIONS OF THE FRAMEWORK

2.0 Introduction



2.1 The framework refers to staffing ranges expressed as nursing: bed ratios reflecting the view that the family of nursing comprises both registered and unregistered staff, included collectively within the ratios.

2.2 A number of underpinning assumptions must be considered when understanding how a range is set and might be used within the context of this framework. These assumptions are outlined below.

ASSUMPTION 1:

ASSURANCE OF SAFETY, QUALITY AND EXPERIENCE THROUGH KEY PERFORMANCE INDICATORS

2.3 The first assumption underpinning the use of the framework is the requirement to provide assurance across a number of quality outcomes for people receiving care and treatment through Key Performance Indicators (KPIs) which have been regionally agreed as sensitive to nursing care. The evidence base referred to at paragraph 2.3, page 2, of Section 1, supports the view that the use of nursing sensitive KPIs can demonstrate either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement.

2.4 A regional Project Group in Northern Ireland has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains within which indicators have been presented for organisations to monitor: Organisational, Safe and Effective Care and Patient Experience. Many organisations in Northern Ireland are currently presenting some of this information via HSC Trust 'dashboard' systems, which allow data sets to be viewed collectively across all wards and departments. It is intended that as more indicators are agreed regionally, they will be added to the existing governance data systems in each Trust. Examples of the current indicators within each domain are:

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

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

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

It is recognised that such quality information, which is being continuously monitored, will demonstrate the efficacy of staffing levels in a particular clinical area. Where the staffing complement meets the demand of the service being provided, quality indicators should demonstrate that safe, effective, person centred care is being delivered. Should quality indicators begin to fall below the accepted level of

achievement, staffing levels should be reviewed as one of the lines of enquiry of attributable causes.

ASSUMPTION 2:

PLANNED AND UNPLANNED ABSENCE ALLOWANCE

2.5 The ranges incorporate a Planned and Unplanned Absence Allowance of 24%. This allowance refers to periods of anticipated absence from work and should, therefore, be factored into the workforce planning process. This includes annual leave, sickness[5], and mandatory study leave. This element is further defined in *Section 1* of the framework, page 6. It should be noted that the defined percentage will be subject to ongoing review and potential amendment by relevant professional forums, reflecting developments in training requirements and training delivery methods.

ASSUMPTION 3:

SKILL MIX

2.6 This term refers to the ratio of registered to unregistered nursing staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. The agreed skill mix for a particular clinical setting must be applied when using this framework. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[6], a skill mix comprising a higher level of unregistered staff may be appropriate.

2.7 The Nursing and Midwifery Leaders in Northern Ireland have defined skill mix for an adult hospital-based general medical or surgical care setting as 70:30 registered:unregistered staff, based on best available evidence such as recognised workforce planning tools, related to this care setting. Some flexibility within the stated skill mix in any given area will be tolerated, to maximise the use of support staff, where higher levels of dependency and lower levels of acuity exist and there is evidence to demonstrate that safe, effective, person-centred care is being provided. The skill mix should not, however, fall below 65:35 registered:unregistered staff.

2.8 Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to '*fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.*'[7,8]

An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of a senior decision maker(s) – Band 6 or above – over the seven day week.

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[5] 'Sickness' refers to both short and long term sick leave, with long term defined as 20 days or over and up to six months.
[6] For definitions of acuity and dependency please see Influencing Factors, *Delivering Care*, Section 2.
[7] Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN. P 18.
[8] Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*. London, TSO. Recommendation 195, p 106.

ASSUMPTION 4:
MANAGEMENT OF RECRUITMENT

2.9 It is recognised that due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained.

2.10 Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements:

- Maintenance of staffing levels, which support the delivery of safe and effective, person centred care
- Avoidance of overuse of temporary staff, for example, bank and agency staff
- Matching of staff skill and band mix to patient acuity and dependency within approved guidelines[9]
- Timely and ongoing review of risk assessments linked to service reconfigurations.

ASSUMPTION 5:
INFLUENCING FACTORS

2.11 It is acknowledged that workforce planning for nursing staff is both complex and diverse[10]. The application of processes or approaches to gauge the number of individuals required with the right level of competence, to provide the appropriate level of care for a particular patient/client group, can be a challenge to those tasked with accurately defining workforce requirements. Triangulation[11] is required of a number of relational factors which impact on the workforce, for example: patient/client dependency, environmental factors, proximity to other services. The Steering Group of the Staffing Ranges Project has defined these factors within four domains:

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

2.12 It is important, therefore, that these factors are taken into consideration when workforce planning discussions take place, to adopt an appropriate ratio within the defined range for a medical or surgical setting. The tables contained at pages 7 - 13 outline the Influencing Factors within the four identified domains, including the following descriptions:

- A definition of what the factor means in terms of using the framework
- An indication of how the factor impacts on staffing ranges, with related guidance
- A list of helpful resources in relation to the factors described.

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[9] For information related to skill mix please see assumption 3, page 3.
[10] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 6.
[11] *Ibid*.

5.4 The Influencing Factors should be used to inform service providers, commissioners, and Ward Sisters/Charge Nurses to set or review the point at which a facility falls within the continuum of a nurse staffing range. The factors presented will be used to influence the point at which a facility falls within the continuum.

5.5 Two practical examples of how the Influencing Factors might be used to guide workforce planning are included in this document at pages 15 - 16 and 19 - 20 of this document.

NURSE STAFFING RANGES

3.0 Nurse Staffing Ranges for General and Specialist Medicine and Surgery

MEDICINE

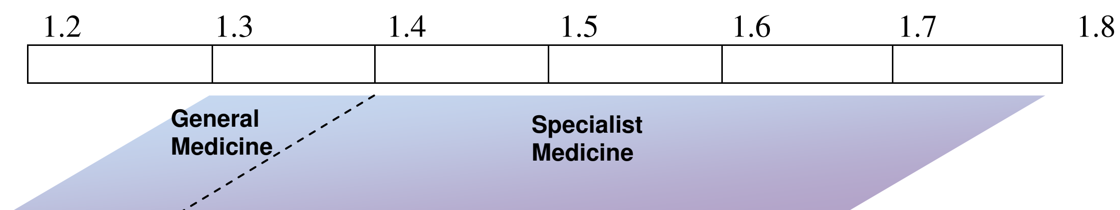
3.1 A **general medical care setting** is defined as comprising adult patients admitted for diagnosis, treatment and/or rehabilitation of medical conditions, including acute general medicine, general respiratory, cardiology, stroke, acute elderly medicine. This does not include, however, short-stay units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

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

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

3.4 **Figure 1**, below, pictorially represents the range for general and specialist medicine, the majority of general medical wards defined between 1.3 and 1.4, recognising that small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist medicine, fewer wards being defined at the top end of the range (1.8) and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care*, *Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care*, *Section 1*.

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



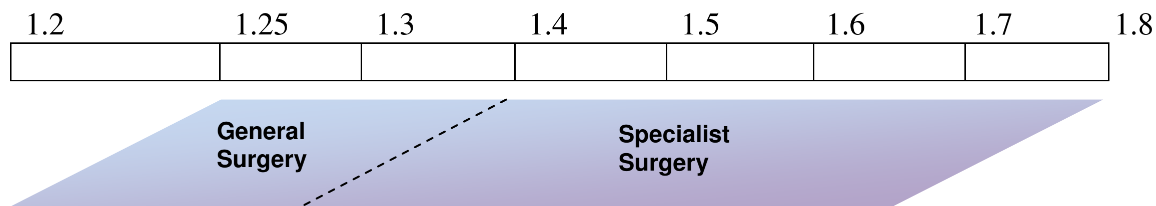
SURGERY

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

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

3.7 **Figure 2**, below, pictorially represents the range for general and specialist surgery, the majority of general surgical wards defined between 1.25 and 1.4, recognising that a small number may fall below 1.25 and similarly, a small number existing at the higher end of the range at 1.4. The same representation exists for specialist surgery, fewer wards being defined at the top end of the range and lower end of the range. The range stipulated includes an allowance of 24% for Planned and Unplanned Absence Allowance (please see page 6, *Delivering Care*, *Section 1*). For further information as to how the ranges were described and agreed, please go to page 19 of *Delivering Care*, *Section 1*.

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



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

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

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

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

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

INFLUENCING FACTORS

WORKFORCE

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	Rosters provide a structured process of matching available staff, and their skills, to the variations in workload to ensure patient safety. Within a roster system, the arrangement of start and finish times known as 'shifts', plus the sequence of working days available per staff members' contract over an agreed period of time, ensure that available numbers of staff are deployed to manage the workload demands.	Optimal rostering of staff supports effective management of the staffing resource available to a manager to deliver on the workload demands of a ward or department. An imbalance in the numbers and skills of staff available to meet the care demands of patients can present greater risks to patient safety. Appropriate shift patterns are key factors in delivering safe and effective care, and maintaining staff morale.
Planned and Unplanned Absence Allowance	Periods of absence from work, which are expected or unexpected and, therefore, factored into the workforce planning process. This includes sickness (both short and long term, with long term defined as 20 days or over and up to six months), study leave, as a minimum for mandatory training, non clinical working, e.g. management time.	Planned and Unplanned Absence Allowance acknowledges that staff have particular requirements and rights that render them unavailable to be rostered. This allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.
Ward Sister's/ Charge Nurse's time	An agreed allocation of 100% of a Ward Sister's/Charge Nurse's time to fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.	The absence of an agreed allowance of time for Ward Sisters and Charge Nurses to address the management and supervisory responsibilities of their role can result in such essential responsibilities being neglected and failure to provide leadership at ward level. Currently, a ward sister/charge nurse manages a staffing complement in excess of 32 staff with associated appraisal, supervision, regulatory, human resource responsibilities and budgetary management including salaries and wages and goods and services.
Skill mix	The percentage ratio of registered to unregistered nursing staff working within an individual care setting.	An inappropriate skill mix can result in a mismatch of duties and responsibilities to roles. This can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources.

Management of Recruitment	Due process of Human Resources policies and procedures requires a number of weeks to recruit staff. Notwithstanding this process, it is essential that nursing vacancies are filled within a prompt timescale to ensure staffing levels to support safe and effective, person centred care are maintained. Employers must ensure that a risk-assessed approach is adopted to managing recruitment, taking into consideration the following elements: › Maintenance of staffing levels, which support the delivery of safe and effective, person centred care › Avoidance of overuse of temporary staff, for example, bank and agency staff › Matching of staff skill and band mix to patient acuity and dependency within approved guidelines › Timely and ongoing review of risk assessments linked to service reconfigurations.	Vacancy rates must continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills.
Management of absenteeism/ sickness	The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable.	Effective approaches to the management of periods of staff absence support the continuity of services, provision of safe and effective person centred care, patient safety and good staff morale.
Competence skill set to work flexibly	The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of demands.	The absence of a core set of transferable skills can limit the capacity of staff to meet a broad range of demands in a given department. To ensure that the essential clinical skills are developed within a team demands careful identification of learning needs and development opportunities for all staff.

Helpful Resources:

The HSC Trust Roster Policy should provide information on appropriate rostering practice.

Planned and Unplanned Absence Allowance Guidance at page 6 of *Delivering Care*: *Section 1*.

RCN Publication: *Making the business case for ward sisters/ team leaders to be supervisory to practice*:
http://www.rcn.org.uk/__data/assets/pdf_file/0005/414536/004188.pdf

Royal College of Nursing. (2009). *Breaking down barriers, driving up standards*. London, RCN.
http://www.rcn.org.uk/__data/assets/pdf_file/0009/287784/003312.pdf

ACTIVITY

Term Used	What does this mean?	Impact?
Ward Attendees	Persons who attend a clinical setting for a planned or unplanned visit to seek advice, review or treatment e.g. wound review following surgery.	Ward attendees must be captured as a workload indicator at all times. Incremental growth in ward attendances can place increasing demands on ward nursing teams, without appropriate increases in staffing levels to manage same, and could potentially become an unfunded service development if not appropriately managed.
% Bed Occupancy	A measurement of the percentage of time that beds are occupied, measured at midnight. Day cases and ward attendees are excluded from the calculation. **Average Daily Occupied Beds** **--- x 100** **Average Daily Available Beds**	Capturing bed occupancy at 12.00 midnight only can result in substantial activity and workload being omitted. Comparing bed occupancy at 12.00 midday and 12.00 midnight can provide valuable management information. The Government's Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals, average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions[12].
Throughput	Is the average number of patients per bed during a calendar month. This can include deaths, discharges and transfers to other wards. Day Cases and ward attendees are excluded from the calculation. **Total Inpatients** **--** **Average Number of Available Beds**	With managed shorter lengths of stay in many hospital beds, throughput is an important workload indicator in the service. In settings where the admissions rate is high e.g. Acute Medical Admissions Units have a high, volume of people being admitted to the care setting, therefore, a high throughput, there is a requirement for higher numbers of staff to support the ongoing care needs.
Patient Dependency/ Acuity	An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	Appropriate workload measurement tools can lead to appropriate staffing levels for wards and departments, thus supporting safe and effective care.
Length of Stay	A measurement of the average length of time spent in hospital. Day Cases and ward attendees are excluded from the calculation. **Average Daily Number of Occupied Beds x Days in Year** **--** **Total Inpatients**	The trend in Health and Social Care services has been towards shorter lengths of stay. This also results in more complex discharge processes, as people are provided with ongoing treatment and care in the community setting. These factors ultimately contribute to an increase in the throughput and a resultant increase in the workload demand for staff.

Seasonal Variations	Patients commonly present with a range of conditions and chronic illnesses which may be dependent on the time of the year, or become exacerbated at certain times of the year. This provides a particular case mix of conditions and/or increased volume of admissions which may require more intensive nursing input due to the critical nature of the care required.	Seasonal variations are likely to present a greater workload burden on nursing staff. It is important that increased workload demands are supported by appropriate staffing levels.
Specialities/ Case Mix	The range and variation of patients' health conditions managed in a particular clinical setting	A broader range of specialties and case mix being managed in a care setting presents a greater demand on the nursing team in terms of knowledge, skills and complexity.
Number of Beds	The actual number of beds in a clinical setting.	The number of beds and design of a ward environment can have an impact on the efficiency of a ward or department. There would appear to be an optimal number of beds per ward to maximise efficiencies.
Assessment of Risk	Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care[13]. This includes, risk to people in their care, members of staff and other members of the public.	By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. Time is required from the nursing team for this activity to carry out ongoing risk assessments for people within their care environments.
Incremental Service Improvements / Development	This is activity concerned with testing ideas, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users. (Department of Health, 2008)[14].	Incremental service improvements are designed to implement improvements in patient care and/or outcomes. This can result in improved working conditions for staff. Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale.

[12] Department of Health (2000). *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services.* London, DoH.
[13] Department of Health Social Services and Public Safety. (2008). *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*. Belfast, DHSSPS.
[14] Department of Health (2008). *Making the difference: The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS.* London, DoH.

ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	The support provided within a clinical area by Information Technology and other mechanised systems and sufficient equipment maintained and stored appropriately which may assist registrants in caring for people.	Access to available software which links to a range of data systems can enable efficient transfer of information, which assists at many stages of the patient care pathway. Efficient systems may reduce workload requirement and conversely, inefficient systems may add to the workload e.g. staff spending time sourcing equipment.
Geographical Layout/ Room Structure	The arrangement of the physical clinical environment, including whether or not there are single roomed facilities. The physical arrangement of a clinical setting has an impact on workforce planning, in that it may require greater numbers of staff where there are areas of poor visibility or require staff to work in discrete teams.	A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements. Where single rooms restrict visibility and therefore compromise clinical and care observations this will have an impact on staffing levels in wards.
Ward Size	The 'average' 24-bedded[15] clinical area can be constructed of 24 beds, configured within a mixture of multiple bed areas and/or single rooms.	In clinical settings where the bed complement is substantially smaller, nursing: bed ratios will be significantly higher to support the provision of safe and effective care on a 24 hour basis. Similarly, where a ward is significantly larger than 24 beds, there will be a requirement for appropriate levels of senior staff to support the provision of safe and effective care on a 24 hour basis.
Departmental Adjacencies in relation to Areas for Patient Transfer	The physical distance required to be covered when escorting patients to and from other service areas, e.g. radiology, theatre(s). Where there is likely to be a significant number of patients requiring a nurse escort*, the workforce planning impact needs to be taken into account in determining staffing levels to support safe, effective person centred care.	Nursing staff may be required to escort patients to diagnostic testing/theatre, thus removing the member of staff from the team and the team ability to share the workload.
Supportive Staff Infrastructure	The support provided within a clinical area by other members of staff, who are not registrants or within the family of nursing e.g. administration or housekeeping staff.	There are a range of tasks which can be completed by individuals who are not identified as working within the family of nursing e.g. administrative staff, housekeeping staff.

****Escorting*** refers to the professional role of attending to a patient when in transit from one care environment to another (i.e. the patient requires care).

[15] Ball, J. (2010). *Guidance on Safe Nurse Staffing Levels in the UK*. London, RCN. Page 24. The 'average' NHS ward has 24 beds.

PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	This is activity which is linked with care delivery but is not a direct element of the process of care delivery, e.g. multi-professional case meetings.	The level of this activity and requirements for delivery of such can impact on the workload of nursing teams. This requires definition as to what elements are present within the nursing workload and how much time is expended on them.
Compliance with professional regulatory standards	This is activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a clinical environment, such as those for learning and assessment in practice/mentorship. This may include ongoing monitoring of these standards.	High ward activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards.
Supervision	This is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety. (NIPEC, 2007)	An element of the time required to train nurses and those within the family of nursing is included in the Planned and Unplanned Absence Allowance of 24%.
Accountability and governance requirements	The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services. Governance has been defined as ‘systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community, and partner organisations’ (DoH Integrated Governance Handbook 2006). Accountability embodies three key attributes: • recognisably high standards of care • transparent responsibility and accountability for those standards • a constant dynamic of improvement.	In order to provide safe, effective, person centred care, appropriate staffing levels are required to impact positively upon the professions’ ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators. This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires the time of the team to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care.

References and Helpful Resources:

Department of Health (2006). *Integrated Governance Handbook: A handbook for executives and non-executives in healthcare organisations.* Available for download at:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129615.pdf

Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS.

Northern Ireland Practice and Education Council (2007). *The Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS*. Belfast, NIPEC.

Department of Health Social Services and Public Safety. (2011). *Framework Document*. Available for download at:
http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

http://www.nmc-uk.org/Publications/Standards/

6.0 HOW TO USE THIS FRAMEWORK

6.1 This framework has been designed to promote a shared understanding of workforce planning principles associated with nurse staffing levels to provide safe effective, person centred care. As Trusts reform and modernise their services, the nurse staffing ranges and planned and unplanned absence allowance outlined in this document must be taken into account prior to releasing funding from nurse staffing for efficiency/productivity savings.

6.2 Use of the framework will inform both HSC Trusts and the Commissioner for a range of purposes, some of which are presented below:

HSC Trusts

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

Commissioner

- To promote a shared understanding between professional, management, finance and human resources colleagues of the essential components to set and review nurse staffing proposals for commissioning general and specialist services to provide safe, effective, person centred care.
- As a reference document when developing and agreeing the nurse staffing levels component within investment proposals.

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

6.4 Pages 15 - 20 contain a number of practical examples illustrating how to use the Framework to assist nursing workforce planning processes. There is also a worked example of a 'Telford Exercise' at page 17, using the Telford model of nursing workforce planning, which remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom[16].

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

Scenario No. 1

Preparing for a Discussion

A Ward Sister has been in post for 4 years in an acute adult in-hospital medical care setting in Northern Ireland Health and Social Care Trust (NIHSCT). During this time, the acuity and dependency of the patients her team cares for had increased, along with increased bed occupancy and decreased length of stay. The number of part-time staff within her team complement has also increased significantly.

Sister decides to use *Delivering Care* to have an informed, evidence-based discussion with her Line Manager, about the nurse staffing requirement for her ward to support the provision of safe and effective person centred care.

Steps for discussion:

1. This ward is an acute adult in-hospital medical care setting. Using the Staffing Range for medicine, the lower end of the ratios is 1.3.
2. Sister undertakes a 'Telford' exercise (please see page 17) using her own professional judgement and information from the day-to-day running of the ward, identifying when staff are required to manage optimally the service provided.
3. Sister then looks at the Influencing Factors, pages 7 - 13. Through reading the information, she realises that:
    - it would be helpful to have in place an e-rostering system to assist with the optimum management of the staffing resource
    - the sickness absence rate in the ward she manages is currently 6.5% excluding maternity leave.
4. In order to prepare for the discussion with her line manager, Sister contacts a colleague who contacted her recently to raise awareness regarding the implementation of the e-rostering system within NIHSCT. She is informed that her ward will be included in year two of implementation. She also has a discussion with colleagues within Human Resources and Occupational Health departments to identify if there are any further steps she might take to best manage the sickness absence rate in her ward team.
5. Having identified these areas for action, Sister has several other issues for discussion with her line manager arising from the Influencing Factors:
    - a review of the skill mix within the ward is required as currently it is 68:32 and not the recommended 70:30 registered: unregistered staff
    - the significant increase in part-time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements
    - shorter lengths of stay have increased the workload for nursing staff, particularly in relation to complex discharge planning
    - verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Meeting with Ward Sister and Line Manager.

Sister begins the meeting with her Line Manager by talking about the action she has taken in relation to the e-rostering system and enhanced management of sickness/absence rates in her ward as a starting point when considering the staffing complement. Having discussed these issues, the Line Manager identifies a number of other approaches which might help Sister to review the processes within the ward she manages, such as the Productive Ward[17], or Lean Thinking[18]. Sister agrees that further work could be done within the ward team, in relation to streamlining some of the processes.

She outlines that the ward, being an acute adult in-hospital medical care setting, starts at a ratio of 1.3, using the staffing range for medicine within *Delivering Care Section 2*. The 'Telford' exercise indicated that the complement of staff required was within the lower end of the range; the skill mix required, however, was 70:30, higher than what was currently included in Sister's Funded Establishment (FE). She also identifies that the significant increase in part time staff has a particular relevance in relation to training, as each member of staff, whether full or part-time, requires the same amount of training as regards mandatory and statutory requirements.

She also discusses that shorter lengths of patient stay have increased the workload for nursing staff, particularly in relation to complex discharge planning, and verbal feedback from her team within the last six months has indicated that staff are having difficulty on occasions in finding time to mentor pre-registration nursing students and in meeting the mandatory supervision requirements of two supervision sessions per nurse per year.

Sister and her Line Manager consult with the Assistant Director for Nursing and Midwifery Workforce within the Trust, to reach an agreement that the point within the range at which the FE currently falls: 1.3 is appropriate; there is, however, a question in relation to the skill mix of the FE. There are currently 24 beds in the ward.

This equates to 1.3 x 24 = 31.2 WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

31.2 x 0.7 = 21.84 registered

31.2 x 0.3 = 9.36 unregistered

Sister currently has 21.2 registered staff and 10.2 unregistered staff members as part of her team.

She agrees with her Line Manager and Assistant Director of Nursing and Midwifery Workforce that an additional 0.64 WTE registered staff should be added to her staff complement and 0.84 WTE unregistered staff be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Ward Sister leadership/supervisory role at the agreed set level of 100 % WTE of a Band 7; this brings the total funded establishment to be calculated at 32.2 WTE.

[17] The Productive Ward focuses on improving ward processes and environment to help nurses and therapists spend more time on patient care, thereby improving patient safety and efficiency. For further information, please go to: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

[18] Lean thinking is an approach which is about getting the right things to the right place, at the right time, in the right quantities, whilst minimising waste and being flexible and open to change. For further information, please go to: http://www.institute.nhs.uk/quality_and_value/lean_thinking/lean_thinking.html

Example Outline of a 'Telford' Exercise

Please note: the 'Telford' exercise outlined within these pages demonstrates the use of one workforce planning tool which involves a degree of professional judgement. A number of workforce planning tools exist, which use a range of different approaches to the activity, some of which have been referred to in *Delivering Care, Section 1*.

1. Define the length of the shift patterns over a 25 hour period, which includes one hour in total for handover (two half hour periods). For example: that the morning shift is 5 hours long, afternoon shift is 5 hours long, evening shift is 4 hours and night shift 11 hours. These hours are recorded in column **B** in **Table 1,** page 18.
2. Identify the number of registered and unregistered staff required for each shift based on professional judgement; regarding appropriate numbers to provide safe, effective, person centred care.
3. Add up the number of staff for each band to reach a total for the week for each shift – see column **A.**
4. Calculate the number of hours required for each staff group by multiplying columns **A** and **B** to reach the answer located in column **C.**
5. Add all the hours up in column C to provide a total number of staff hours. Multiply this number by 1.24 to add the required 24% Planned and Unplanned Absence Allowance.
6. Divide this number by 37.5 to reach the number of Whole Time Equivalents (WTE) required to staff the ward.
7. You will see from the three columns to the far right of Table 1, it is also possible to calculate numbers by band and therefore calculate skill mix using the same method of:

   Sub-total of hours x 1.24 / 37.5 = Number of WTEs
8. This example provides a total of 31.51 WTEs of all bands. This includes 22.25 of registered staff and 9.26 of unregistered staff. To calculate the skill mix:

   Total number of registered staff

   Total number of staff

   = 70.6%

   Total number of unregistered staff

   Total number of staff

   = 29.4%
9. Finally, to calculate the nursing to bed ratio, divide the total staff complement by the number of beds:

   31.51

   24

   = 1.31 nursing: bed ratio

10. It should be noted that these calculations do not include the allocated 100% of a Ward Sister's/Charge Nurse's time to fulfil his/her leadership/supervisory role within the care setting. Adding this allocated time brings the Funded Establishment to 32.51

Table 1

	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Total for week A	hours per shift B		Weekly hours per shift per level			
Morning											C	Registered	Band 3	Band 2
Registered	5	5	5	5	5	4	4	**34**	**5**		**165.00**	165.00		
Band 3	1	1	1	1	1	1	1	**7**	**5**		**35.00**		35.00	
Band 2	2	2	2	2	2	1	1	**12**	**5**		**60.00**			60.00
Afternoon														
Registered	5	5	5	5	5	4	4	**33**	**5**		**165.00**	165.00		
Band 3	1	1	1	1	1	1	1	**7**	**5**		**35.00**		35.00	
Band 2	1	1	2	2	1	1	1	**10**	**5**		**45.00**			45.00
Evening														
Registered	4	4	4	4	4	4	4	**28**	**4**		**112.00**	112.00		
Band 3	0	0	0	0	0	0	0	**0**	**4**		**0.00**		0.00	
Band 2	1	1	1	1	1	1	1	**7**	**4**		**28.00**			28.00
Night Duty														
Registered	3	3	3	3	3	3	3	**21**	**11**		**231.00**	231.00		
Band 3								**0**	**11**		**0.00**		0.00	
Band 2	1	1	1	1	1	1	1	**7**	**11**		**77.00**			77.00
										Sub total	953.00	673.00	70.00	210.00
										add 24%	228.72	161.52	16.80	50.40
										Total	1194.12	834.52	86.80	260.40
										WTE	**31.51**	22.25	2.31	6.94
								Total WTE			**31.51**	**22.25**		**9.25**
								Nursing To Bed Ratio			**1.31**			
									Total Beds	**24**				
Totals									**Skill Mix %**			**70.62**		**29.38**

Scenario 2

Preparing for a Discussion

The Assistant Director (AD) for Acute Services, Northern Ireland Health and Social Care Trust (NIHSCT), has been informed that one of the wards within his service group, an acute adult in-hospital general surgical care setting, will be closing 2 beds in the next financial year due to some of the surgical interventions previously carried out as in-patient procedures now being undertaken as day surgery admissions. In addition, two beds currently used for patients returning from surgery and staffed outside of the upper limits of the specialist end of the staffing ranges, are being stepped down to general surgical beds. The care of those patients will be moving to a newly configured unit located elsewhere in the Trust. The AD is aware that this will have an effect on the staffing complement within this ward and decides to use *Delivering Care Part 1* to have an informed, evidence-based discussion with the Lead Nurse for surgery and the Charge Nurse responsible for the ward.
Steps for discussion:

1. The Charge Nurse's ward is an acute adult in-hospital general surgical care setting. There are currently 26 beds, the staffing ratio currently set at 1.25 for 24 of the beds and 2.5 for two of the beds. The Funded Establishment (FE) in his clinical setting is 36.2 Whole Time Equivalents (WTE) with a skill mix of 70:30, registered:unregistered staff.
2. Using the staffing range for surgery, the lower end of the ratios is 1.25. It is likely that this will be applied to all 24 beds, following the service redesign and reconfiguration of bed usage.
3. The AD calculates that this would provide a FE of 30 WTE. Whilst reading through the framework document, he notes that there are a number of areas which need to be considered during the meeting with the Lead Nurse for surgery and the Charge Nurse. He raises the potential use of the framework to guide discussions with the Lead Nurse, and encourages her to have a conversation with the Charge Nurse to think about areas of preparation in advance of the meeting. He also contacts the NIHSCT Nursing and Midwifery workforce lead, to explore possibilities for reconfiguration of the ward team staffing complement using the Delivering Care Framework. Following that discussion, he asks the Workforce Lead to attend the meeting with the Lead Nurse for surgery and Charge Nurse.
4. The Lead Nurse for surgery and Charge Nurse discuss the framework document in order to prepare for the meeting. The Charge Nurse subsequently agrees to carry out a 'Telford' exercise (please see page 17) to estimate the likely need for staff at particular times of the week when the service in his ward area becomes particularly busy.
5. They also consider the Influencing Factors, pages 7 - 13. Through reading the information, they realise that:
    - 3 recently registered staff have joined the team in the last month; they need development of their skill set in relation to the type of service being provided in the ward, and a period of preceptorship
    - Over the last two years, the length of stay of patients in the ward has been decreasing and the throughput increasing
    - The geographical layout of the ward has always presented a difficulty for

- Staff have reported that Key Performance Indicator (KPI) scores collected for nursing and midwifery organisationally have recently fallen compared with previous scores across three out of the five measurements within AHSC Trust. Staff have also reported that there is difficulty in getting time to conduct audits for KPI measurement.

Meeting with Assistant Director for Acute Services NIHSCT, Assistant Director Nursing and Midwifery Workforce NIHSCT, Lead Nurse for surgery and Charge Nurse.

The AD begins the meeting by offering an opportunity to the Lead Nurse for surgery and Charge Nurse to present their thinking in relation to identified areas for discussion from *Delivering Care Part 1*. In terms of the geographical layout of the ward, Charge Nurse has identified a need to review the storage systems. The Lead Nurse has offered the opportunity to work with him to implement the Productive Ward[19], which has successfully helped other areas review ward-based systems and increase efficiency for the ward team.

Charge Nurse outlines the results of the 'Telford' exercise, which indicated that the complement of staff required was within the lower end of the range for general surgery. He acknowledges that the skill mix at which the ward operates is 70:30. The Lead Nurse and Charge Nurse discuss the impact of the decreased length of stay and increased throughput, coupled with a registered staff complement that has a proportion of recently registered staff, who are still within the requirements for induction and preceptorship. The impact of this increased workload on staff is demonstrated through the evidence provided in the falling KPI scores and anecdotal evidence that staff are finding it difficult to find time to collect audit information.

After much debate during the meeting, it is agreed to review the 'Telford' exercise, providing additional staff numbers at busy times in the working week to allow for the extra workload identified. It is agreed that this should be reviewed again in 6 months' time, during which staff will have been provided with some of the required development to build confidence/new competence to provide the service, thus reducing the requirement for extra staffing. When the 'Telford' exercise is repeated, the range is calculated at 1.3. It is also agreed that Charge Nurse will retain the existing Band 6 staff team members, who will not be redeployed in the first instance, to support the development of the ward team.

This equates to 1.3 x 24 = 31.2 WTE

Using the skill mix of 70:30 registered:unregistered staff, this is calculated as:

31.2 x 0.7 = 21.84 registered

31.2 x 0.3 = 9.36 unregistered

Charge Nurse currently has 24.5 registered staff and 10.5 unregistered staff members as part of his team.

He agrees with those attending the meeting that 2.66 WTE registered staff and 1.14 WTE unregistered staff should be redeployed to another ward area to provide safe, effective, person centred care.

Factoring in additional time for the Charge Nurse leadership/supervisory role at the agreed set level of 100% WTE of a Band 7, this brings the total funded establishment to be calculated at 32.2 WTE.

[19] *Op cit*, n 17.

ABBREVIATIONS

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

Delivering Care
Phase 2
Emergency Departments Staffing Model

A Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

Department of Health

HSC Health and Social Care

Introduction

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

Phase 2 of this work focuses on the Nurse staffing in core, Type 1 Emergency Departments (EDs).

This summary paper is intended to complement the Phase 2 framework policy document which provides a more detailed overview of the development of the staffing model for Emergency Departments in Northern Ireland (NI). This paper also seeks to provide an update on the progress to date for members of the Steering Group and Working Group to identify the current workforce baselines for ED Nursing and to identify workforce priorities for the next planning period.

It is also important that planning processes include the triangulation of findings from any recognised workforce planning tools alongside Key Performance Indicators (KPI's) for safe, effective, person-centred care. This work has been developed in the context of the principles of Quadruple Aim, which combines a focus on population health and wellbeing, safety, quality and experience, cost and value with experience of care givers.

Context

The subject of nurse staffing in EDs continues to be a matter for debate. Ensuring appropriate staffing has been referenced in inquiries and reviews, shown in research evidence and is viewed by patients and their carers as a key element in influencing the quality of care.

The second phase of the Delivering Care project builds on the methodologies and learning of the first Phase completed January 2014.

DOH policy sets out a strategic direction for services in NI, including principles for urgent and emergency care models for the future. The staffing model presented in this paper provides a flexible, considered approach to determining nursing staffing establishments for services within a changing model of provision.

The system of urgent care aims to ensure each community has local access to urgent health and social care services. Emergency care, specialist care and planned care services will be provided in hospitals for people whose health and care needs cannot be met in their own homes or their own communities. Triage services and patient transport will be critical to ensuring that individuals access the care appropriate to their needs on a timely basis.

The scope of Phase 2 was to: Develop a staffing ranges approach related to Type 1 Emergency Department care settings in Northern Ireland.

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It is recognised that it will take time and resources to implement some of the recommendations and associated actions.

Work within organisations in relation to the provision of community and ambulatory assessment services, specialist assessment and admission units and speciality assessment teams continue to assist the flow and efficiency of service through EDs in the region.

The total number of A&E attendances in NI has changed significantly over the last 5 years. Trends between departments vary year on year across NI, but the general trend has been one of increase in attendances and therefore requirement for additional nursing expertise.

The process for determining the appropriate staffing establishment of each Type 1 ED in NI has been agreed by the project groups of the Delivering Care Project. It includes a review of relevant data for each ED, which demonstrates activity levels and number of people attending the ED, staffing models for the clinical areas of the department and consideration of the leadership and experience profile required.

Evidence

There has been significant research undertaken into Nurse staffing levels and skill mix, which shows a clear association between lower numbers of registered Nurses and significant reduction in the quality of patient outcomes. However, the specific evidence relating to Type 1 core EDs is more limited.

Where evidence has been collected, it indicates an association between lower Nurse staffing levels in EDs and a negative impact on patient outcome measures including longer waits for treatment and an increase in the number leaving the department without being seen.

Drivers

In the development of this staffing model, a range of strategic and operational drivers have been considered including:

- Demographic data and total attendance patterns in geographical areas across NI.
- Geographical location of the department.
- Recommendations of RQIA and other reviews.
- Demand on emergency care departments and changing profile of urgent and emergency care services.
- Feedback from patients and their families through, for example, 10,000 voices.
- Outcome of the Unscheduled Care task groups to improve patient outcomes, patient flows.
- Specific requirements for children's and mental health services in an ED based on the type of nursing need which is being presented to the ED by the population that the Health and Social Care Trust (Trust) serves.

Benchmarking

Accessing benchmarking data to compare staffing arrangements within NI and across the UK is difficult as services vary considerably and data is not publically available.

Nonetheless, to support this work, information has been shared from two Trusts in the UK, and from a benchmarking analysis completed by Keith Hurst, a UK-based Independent Researcher, on attendances, throughput and workforce across 33 core Type 1 core EDs in England.

Assessment of the information and figures received showed a significant difference in Senior Clinical Nurse Presence (Band 6 and above) compared to all Level 1 core EDs in NI.

Emergency Department (Type 1) Nurse Staffing Range

On the basis of the Benchmarking exercise and detailed local assessment of recently commissioned core staffing requirements in two 2 NI Type1 core EDs, it has been concluded that staffing levels for Type 1 core EDs should be in the broad range **1:700 - 1:850** nurse to attendance ratio. **Table 1** shows the staffing ranges from the UK Benchmarking sites and the local NI sites.

Table 1

Site	Attendance (15/16)	WTE staff	Ratio
UK specific site	80,000	113	1:708
UK specific site	100,000	117	1:856
UK (33 SITES)	Variable	Variable	1:705 - 1:933
NI 1	89,000	119	1:747
NI 2	78430	97.6	1:803

However, it should be noted that this range is only a starter for discussion. **It is not the final** prescribed staffing numbers for every department as this must be developed in discussion with staff, managers and commissioners. This will also be dependent on a range of local factors which impact on the Emergency Department and should shape the planning processes. These factors, below, (in addition to attendances) will need to be considered in determining the target staffing numbers for individual departments:

- Site Locations within Trust to consider rural/urban.
- Geographical Distance from Regional Centre, which requires the availability of Nurses for transfers.
- Smaller Departments – despite having lower attendances, Out-of-Hours' still require staffing in preparation to respond.

- Large Footprint
- Building Design/layout.
- RQIA Acute Hospital Inspections and other local and National inquiries, in relation to recommendations, specifically regarding Nursing Workforce and Quality Indicators.
- NIAS Triage, Dedicated NIAS triage area and the availability of nursing staff has a direct influence on NIAS turnaround times and overall impact on Patient experience.
- Children's Services to consider availability/location of liaison services, ambulatory and inpatient children beds.

Discussions held around dependency measuring within EDs concluded that, whilst it is an important issue, acuity across sites would be comparable and therefore does not need to be considered as a separate influencing factor.

ED Target Staffing

Delivering Care seeks to address the association demonstrated between lower nurse staffing levels in EDs and a negative impact on patient outcome measures such as increased patient waiting times, increased number of patients leaving the department without being seen, time to triage, compliance with NEWS guidance, and administration/ assessment of effectiveness of pain relief.

The adoption of a model approach was agreed through which a number of tools and methodologies could contribute to the final determination of a target funded establishment for each Type 1 core ED in NI.

The approach is built on several components that are outlined in the main Phase 2 framework document which includes the range of Nurse to attendance ratio, key staffing requirements including appropriate skill mix and a number of influencing factors. Staffing levels can only be established when all three elements of this model are considered.

Senior Staffing Requirements

The benchmarking exercise indicated that the levels of seniority of Nursing staff in NI were lower than elsewhere in the UK.

Tables 2 and 3 below show a recommended, but not prescriptive, senior staffing requirement which will ensure that all key areas of the ED have an experienced nurse to provide expert clinical knowledge at all times to ensure that patient pathways function seamlessly throughout the department to improve patient safety and enhance their experience in the Department.

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The skill mix takes account of an allocation of 100% of a ward sister/charge nurse's time to fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the clinical environment and assume high visibility as a nurse leader for the Department (Delivering Care Phase 1, 2014), (RCN, 2009), (Frances, R, 2013).

Table 2

SMALLER EDs	WTE
1 Band 7 Supervisory Ward Sister/Charge Nurse	1.00
1 Band 7 12 hrs Day peak activity	2.80
2 Band 6 Daytime / 12 hrs	5.60
2 Band 6 Night time / 12hrs	5.60
TOTAL	**15.00**

Table 3

LARGER EDs	WTE
1 Band 7 Supervisory Ward Sister/Charge Nurse	1.00
1 Band 7 24/7	5.60
3 Band 6 x 12 hr daytime 2 Band 6 Night Duty	14.0
TOTAL	**20.6**

Non-registered staff

It is recommended that given the complexity of patient need and the skills and competence required to meet this need, the non-registered workforce should generally be working to a Band 3 Health Care Assistant role. It is accepted, however, that Trusts will continue to utilise their current Band 2 practitioners. Whilst this might cause initial inconsistencies, it is envisaged that this will improve when NIPEC completes their current work on the role of the HCA. The publication of the NIPEC project in 2016/17 will also inform any proposed review of recommendations on the Registered /non-registered skill mix ratio which is currently at **80/20.** The following **Tables 4 and 5** are the recommendations for the unregistered staff resource within larger and smaller EDs across NI.

Table 4

Larger EDs	WTE
Non-registered Staff:	
4 WTE 12hrs daytime 3 WTE night duty (7 WTE x 24/7)	11.11 8.33
Total (WTE)	**19.44**

Table 5

SMALLER EDs	WTE
Non-registered Staff:	
2 WTE Daytime / 12hrs 2 WTE Night duty	5.60 5.60
Total (WTE)	**11.2**

The Band 5 staffing requirement will be calculated by deducting the proposed Band 7 / 6 and 3 resource from the overall WTE required for the Department.

Influencing Factors

Workforce planning for nursing staff is both complex and diverse. The application of processes or approaches to determine the number of competent individuals required to provide the appropriate level of care for a particular client group can be a challenge. As part of the Delivering Care Framework, a number of factors that impact on the opportunity to deploy staff to provide safe and effective person centred care have been identified and will be considered to agree the final staffing model for each Type 1 core ED in each Trust.

Workforce

- Optimal rostering of staff shift patterns to deliver safe and effective care will require deployment of appropriate skill mix availability within the nursing workforce to match the variations in the workload.
- The 100% allocation of the Department sister/charge nurses time for overall responsibility of the Department.
- Management of recruitment and the management of planned and unplanned absence allowance to ensure effective deployment of staffing resources.

Environment and Support

- The geographical layout, location, including proximity to the regional trauma centre and size of the department and clinical environment, impacts on the provision of safe and effective person-centred care.
- In addition, the technology and support of admin and portering staff impacts on the supportive staff infrastructure and ability to streamline care appropriately.

Activity

- The planned /unplanned attendances and patient dependency influence workload requirements and are an important workload indicator which must be reviewed at regular intervals.
- Seasonal variations, service developments, quality and safety reviews, can result in shifting workloads.
- Trends in lengths of stay in the department will impact on staffing levels and therefore assisting the flow through the Department to reduce the time spent in the Department is a vital influencing factor.

Professional Regulatory Activity

- Revalidation and time allocated to support nurses in their practice, supervision and preceptorship are regulatory standards that are incorporated into the planned and unplanned absence allowance of 24 % for NI.

Monitoring

Implementation of the factors identified and local governance requirements to deliver on agreed key performance indicators requires a sufficient nursing workforce to deliver safe and effective care. On occasions when nurse staffing may be outside the policy range, the Executive Director of Nursing must provide assurances about the capacity of the workforce to provide quality Nursing care to patients, and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards.

Implementation

As with the Delivery Care Model the final staffing for each Type 1 core ED will be agreed following a discussion with the Trust Workforce Lead, the Trust Clinical Nurse Lead and the Commissioning Nurse Consultant.

Review

This model will be reviewed in 2019.

Delivering Care
Phase 3
District Nursing

A Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

Introduction

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

Phase 3 of this work focuses on District Nursing.

This summary paper is intended to provide an update on progress to date for Steering Group and Working Group members regarding the District Nursing capacity requirements, taking account of evidence available, benchmarking, key drivers and influencing factors.

It is recognised that workforce planning processes include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPI's) for safe, effective, person-centred care. This work has been developed in the context of the principles of Quadruple Aim, which combines a focus on population health and wellbeing, safety, quality and experience, cost and value with experience of care givers.

Context

A District Nurse is a registered nurse with a graduate level education possessing a specialist practitioner qualification recordable with the Nursing and Midwifery Council. The District Nurse leads a District Nursing team comprised of registered Nurses and Healthcare Assistants. The District Nurse is considered a lone worker who works autonomously and has a central and decisive role in the assessment, planning and delivery of care and treatment at home within community care settings (QNI 2009). Simultaneously the role also requires that the District Nurse works collaboratively and in partnership with statutory and non-statutory colleagues to co-ordinate care. They may work within Integrated Care Teams (Nurses, Social Workers and Allied Health Professionals).

The District Nurse has named responsibility for a designated population (caseload) in a GP Practice. The District Nursing service is mainly domiciliary based, providing a wide range of nursing interventions primarily for frail older people, people living with long term conditions, those who are palliative and end of life, and disabled adults. They play a key role in supporting independence, managing long term conditions and preventing and treating acute illnesses (King's Fund 2016).

In June 2014 a regional workshop was held with District Nursing staff to define the activities of the District Nursing service that needed to be factored into a workforce model. The 3 main components were divided into:

- Daytime
- Evening; and
- Night Service

In order to find a way forward to measure like-with-like across Trusts, it was agreed to define what 'core' District Nursing team activities would fall within each of the three specified units of time. It was also agreed that where a service did not currently exist within a Trust, e.g. night service, then broad activity was defined within each of the three areas (**Appendix 1**). The most distinct variance relates to blood transfusion management (not provided in SHSCT or BHSCT). Some Trusts run a separate infusion service that administer blood transfusions, platelets, intravenous/subcutaneous therapy and administer IV medication therapies.

District Nursing Funded Clinical Establishment

A regional summary of funded clinical Whole Time Equivalent (WTE) by Agenda for Change (AfC) banding for each HSC Trust is provided in **Table 1.** This summary table includes core daytime teams, and other teams within the District Nursing service, such as Rapid Response/Hospital Diversion and Evening service.

Belfast HSC Trust and South Eastern HSC Trust provide a night time service but related staffing has not been included in the Table below to enable some regional comparisons to be made. The remaining three Trusts do not currently provide a night time District Nursing service.

A number of investments have been processed in each Local Commissioning Group in the last two years, resulting in an increase of almost 70 WTE.

Table 1: Health and Social Care (HSC) Trust funded WTE by AfC Band (July 2016)

AfC Band	HSCT Trust WTE day and evening teams (night excluded)					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
7	0	35.40	2	0	33.4	**70.8**
6	59.61	4	42.99	59.11	2.53	**168.24**
5	114.66	164.60	128	122.92	129.63	**659.81**
3	44.49	62.32	30.42	24.53	27.82	**189.58**
2	0	0	6.13	0	0	**6.13**
Total	**218.76**	**266.32**	**209.54**	**206.56**	**193.38**	**1094.56**

Evidence

A literature review was carried out as part of the Phase 3 framework to ascertain the evidence base for District Nursing workforce planning. Thompson and McIlfactrick (University of Ulster, 2014) indicated that community nursing staffing levels are typically outlined either as a population ratio or through caseloads, i.e. the number of patients per District Nurse. They state that defining staffing levels in this way can be difficult as none of the parameters used are fixed.

The Queen's Nursing Institute review (QNI, 2014), commissioned by NHS England, reviewed workforce planning within District Nursing across the UK. The review identified a significant gap in the availability of workforce tools that enable and support strategic workforce planning. The review made a number of recommendations, including the need to develop a tool that provides operational and strategic information, a tool that is clinically driven and built in to existing systems and includes agreed standards of core activities.

QNI has just published a report *Understanding Safe Caseloads in the District Nursing Service (Sept 2016)* which describes the elements to be considered when planning safe caseloads.

In 2015 an electronic workforce tool was developed in NI based on the work of Dr Keith Hurst, who had acted as an expert advisor to the Working Group. Analysis of the data collection is ongoing.

The electronic Caseload Analysis Tool (eCAT) allows for some local demand management and regional trend analysis over time.

The Buurtzorg Nederland (home care provider) Model is also being explored, following a study visit in May 2016. This Model was founded in the Netherlands in 2006/07; Buurtzorg is a unique District Nursing system which has garnered international acclaim for being entirely nurse-led and cost effective.

Understanding Quality in District Nursing Services (King's Fund 2016) has identified evidence of a growing gap between capacity and demand in district nursing services creating pressures which can impact on the quality and safety of patient care and results in increasing task focused approaches and missed opportunities for prevention.

Key Drivers

In the development for this model, a range of strategic and operational drivers have been considered. These key drivers that will have a significant impact on the future District Nursing service include:

1. The DoH District Nursing framework currently being developed. The vision is to have a District Nursing Service that is provided 24 hours a day 7 days a week throughout Northern Ireland, and will be underpinned by the principles of person-centred care, integration, efficiency and expertise

2. Quality care - In addition to the Quality 2020 strategy the King's Fund (2016) sets out a framework for the components of good care for older people receiving a District Nursing service and identifies 3 characteristics of good care; caring for the whole person, continuity of care, and the personal manner of staff.

3. Population health - Increased focus on enabling health promotion, prevention and self-management. The "*Making Life Better" NI* Public Health framework (DHSSPS 2013) seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential and to reduce inequalities in health.

4. Care enabling technologies - Building on the "Regional eHealth and Care Strategy" (DHSSPS 2015). It is imperative that there are systems and processes to support timely and consistent sharing of patient information, with real time access to all relevant health and social care information for district nurses and all other relevant care providers to enable them to work effectively and safely with their patients. This will be achieved through the development and implementation of an electronic record in common for all citizens in NI over the next 5 - 10 years.

5. Palliative care - The Regional Palliative Care Programme recognises that the District Nurse will typically be the keyworker and key elements of this role include identification, co-ordination and contact and delivering care and support.

6. A commissioning priority for Unscheduled Care in 2016/17 is to have effective, integrated arrangements, organised around the needs of individual patients, in place in community settings to provide care for people at home, avoiding the need for hospital attendance/ admission and to support safe and effective discharge.

7. Increasing Demand - Due to the rapidly changing health and social care landscape increasing numbers of people with multiple and complex conditions are being cared for at home, which includes people living in deprivation and those living to a very old age.

   There has been an increase of some 120,000 District Nursing contacts between 2010/11 and 2014/15, equating to an increase of 10%.

8. Demography - The population of NI is increasing, and within this overall increase the size of the older population is increasing more quickly. **Table 2** illustrates the current and projected population by Trust area.

Table 2: Populations and percentage calculations across the HSC Trusts

Trust	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Population (all ages) (NINIS 2014)	351554	469051	352301	369391	298201	1,840498
% Total population	19.1%	25.5%	19.1%	20.1%	16.2%	100%
Population > 65 years (NINIS 2014)	53728	76845	60977	51556	42810	285916
% population > 65	15.3%	16.4%	17.3%	14%	14.4%	15.5%
% population projected change from 2014-2024 for > 65 years (NINIS 2014)	14.1%	26.2%	28.8%	29.8%	30.7%	25.8%
Projected population all ages (2024.)	364,281	486,877	371,577	408,410	307,570	1,938,175

The Northern HSC Trust has the greatest population, and South Eastern HSC Trust has the greatest percentage population > 65 years.

If the population change is projected to 2024 for those >65 years, the Western HSC Trust followed closely by Southern HSC Trust and South Eastern HSC Trust have the greatest increase.

The focus on the population > 65 is significant as District Nursing caseload analysis data (March 2015) indicates that 82.5% of patients on the caseload were in this age range.

Benchmarking

A benchmarking of District Nursing staffing levels as a population ratio in NI is presented in **Table 3**, which details the HSC funded establishment WTE by population size (total population and additionally > 65 years population). The District nursing ratio reflects the composition of the total District Nursing Team. This includes:

- District Nurses with specialist qualification
- Community Staff Nurses
- Non registered Health Care Assistant

Table 3: HSC funded establishment WTE by population size

Trust	Total WTE	Population (all ages) (NINIS 2014)	Population > 65 years (NINIS 2014)	Ratio of WTE per 10,000 head of population	Ratio of WTE per 10,000 head of population >65 years
BHSCT	218.76	351554	53728	6.2	40.7
SEHSCT	209.54	352301	60977	5.9	34.4
NHSCT	266.32	469051	76845	5.7	34.7
SHSCT	206.56	369391	51556	5.6	40.1
WHSCT	193.38	298201	42810	6.5	45.2

Simple analysis indicates:

- The HSC Trust District Nursing ratio of WTE per 10,000 head of population ranges from 5.6 – 6.5 (NI average 5.9)
- The ratio of WTE per 10,000 head of population >65 years ranges from 34.4 - 45.2 (NI average 38.0)
- Western HSC Trust has the highest ratio of District Nurses per 10,000 population over 65 years
- South Eastern HSC Trust has the lowest ratio of District Nurses per 10,000 population over 65 years.

The RCN survey of District Nurses and Community Nurses which was undertaken in 2013 in England (King's College London 2014) found that for the average population size of just over 5,000 people there were 10.9 WTE (7.8 WTE were registered). The authors of the RCN report highlight that a large number of participants did not know the population size (67%) and the variation in responses led to uncertainty regarding how the question was answered, and so did not use the population data in the analysis.

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The NHS National Community Services Benchmarking report (2015) provided outturn data for 2014/15 from 70 community services (no NI submissions) which indicates a mean of 52.4 (range 60.1 - 40.3) WTE per 100k population. This includes clinical and non-clinical Community/District Nursing Service and Community Matrons. Integrated Care Teams were excluded as it was not possible to distinguish the District Nursing WTE from the other professions. The report highlighted a mean average waiting time of 8.8 days for the District Nursing Service and 12.2 days for Community Matrons.

The Buurtzorg Nederland Model (one of the home care providers) consists of small self-managing teams. There are now approximately 850 teams employing a total of 10,000 nurses. Each team has a maximum of 12 staff who work in a neighbourhood of 10 – 20,000 population providing co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients.

In June 2016 a question was posed to District Nursing Leads in each HSC Trust to ascertain professional judgement about what a District Nursing team size should look like for a 10 - 20,000 population. Whilst not a scientific approach and cognisant that other teams such as infusional services, etc had not been included for a day and evening service (not night time service), the range was 5.75 - 7.50 WTE for a 10,000 population.

It has been difficult to benchmark against other District Nursing teams within and outside NI as the configuration of the service varies considerably in terms of structure and workload activity.

Staffing Model

In order for the District Nursing service to have sufficient capacity to address future service demands and implement key drivers, it is recommended that a range of 8 - 10 WTE which will incorporate appropriate skill mix is needed for a 10,000 population.

Influencing Factors

Workforce planning for nursing staff is both complex and diverse. The application of processes or approaches to gauge the number of individuals required with the right level of competence to provide the appropriate level of care for a particular client group can be a challenge. As part of the Delivering Care framework, a number of factors that impact on the opportunity to deploy staff to provide safe and effective person-centred care have been identified and will be considered to agree the final staffing model for each District Nursing team in each HSC Trust.

Workforce

- Optimal rostering of staff for day, evening and night time to deliver safe and effective care will require deployment of appropriate skill mix availability within the nursing workforce to match the variations in the workload.
- Annual review of the availability of District Nursing Specialist Practice Qualification education programme placements, and teacher practitioner requirements.
- Percentage supervisory role of the District Nurse team leader to be agreed.

- Skill mix for a day, evening and night time service (excluding infusional teams) should be 80% registered and 20% non-registered staff. It is acknowledged while non-registered staff provide a vital services both in hospital and community they are limited to the patients they can care for in their own home often due to patient complexity and clinical need.
- Management of recruitment factoring in demographics of the workforce.
- Management of planned and unplanned absence (24%).

Environment and support

Integrated Care Partnerships (ICPs) are a key element of Transforming Your Care and a new way of working for the health service in NI to transform how care is delivered. There are 17 ICPs serving local populations of approximately 100,000 people. The District Nursing WTE required per 10,000 population will be determined at ICP population level, and local influencing factors that will need to be considered to differentiate between ICPs are outlined below:

- The geographical location of the teams - rural/urban.
- Population profile - this will include demography, deprivation and disease risk factors.
- Geography - the geographical location of the teams will have an impact as it may affect travel times required between patient visits, other appointments and meetings. Geographical location may also impact on the feasibility to provide ambulatory care service in clinic settings, and cause reduced access to technology.

Impact of other services

- Other relevant services provided within the ICP area, e.g. Specialist Teams (Diabetes, Respiratory), Enhanced/Acute Care at Home models, Palliative Care.
- The number of GP practices (and GP registered patients) within each ICP area.
- The number of Nursing Homes and Residential Units in each ICP area and the extent to which they rely on District Nursing services.
- In addition, the technology and support of admin staff impacts on the supportive infrastructure and ability to stream line care appropriately.

Activity

- Workload analysis using tools such as eCAT to measure complexity/patient dependency and acuity, depth and breadth of care. eCAT data will provide local caseload analysis which will enable HSC Trusts to effectively manage and deploy staff appropriately.
- Analysis of planned and unplanned activity, including unmet need and care left undone.
- Face-to-face direct contact with staff.
- 24 hour District Nursing service provision.

Professional regulatory activity

- Revalidation and time allocated to support nurses in their practice, supervision and preceptorship. This is incorporated into the PUAA of 24% for NI.

Monitoring

Compliance in delivering on agreed key performance indicators requires a sufficient nursing workforce to deliver safe and effective care. On occasions when nurse staffing may be outside the policy range, the Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks.

The testing of new models of District Nursing service provision should incorporate a triangulation approach allowing for professional judgement.

Implementation

As with the Delivering Care model, the final staffing for District Nursing teams in HSC Trusts will be agreed following a discussion with the Trust Workforce Lead, the Trust District Nursing Lead and the Commissioning Nurse Consultant.

Review

This Phase will be reviewed in October 2019.

Appendix 1- District Nursing Activities by Specified Period of Time

<table>
<tr>
<td>Holistic Person Centred Assessment, Care Planning, Implementation and Evaluation
Support (Clinical) to Nursing Homes
Clinical interventions e.g. B/P, monitoring urine, BM, pre-treatment bloods, Doppler.
Education and support to carer’s formal and informal- e.g. teaching g re-training feeding, admin of meds etc.
Nursing Assessment and review including risk assessments, e.g. Braden, MUST, pain, bedrails.
Health Promotion/ education.
Nurse prescribing.
Administration of medication including flu vaccinations and chemotherapy.
IV & subcutaneous Infusion management.
Wound management e.g. ulcers, simple wounds and complex wounds, including all ranges of interventions.
Device management e.g. central lines, catheter, syringe pumps, abdominal catheters (ascites drainage), chest drains, tracheostomy, gastrostomy, PEG/enteral feeding tubes.
Continence assessment/review (urine and bowel), including ostomy care.
End of life care
Equipment assessment, prescribing, risk assessment and review.
Pressure ulcer prevention
Manual handling
Management of long term health conditions including support for patient self-management
Blood transfusions management. Platelet infusion management
Administration of IV medication
Urgent response crisis
Root cause activity
Management of Safeguarding issues.
Key worker role
Staff supervision and delegation.
Management of students.</td>
<td>Holistic Person Centred Assessment, Care Planning, Implementation and Evaluation
IV and Subcutaneous Infusion Management
Management of complex wound
Device management e.g. central lines, catheter, syringe pumps, abdominal catheters (ascites drainage), chest drains, tracheostomy, gastrostomy, PEG/enteral feeding tubes.
Continence management
End of life care
Manual handling
Clinical interventions e.g. B/P, monitoring urine, BM, venepuncture.
Support and supplementary education of carers, personal care.
Response to urgent ‘crisis’ calls.
Administration of medications.
Pressure ulcer prevention/ repositioning.
Administration of IV medication
Nurse Prescribing</td>
<td>Holistic Person Centred Assessment, Care Planning, Implementation and Evaluation
IV and Subcutaneous Infusion Management
Management of complex wound
Device management e.g. central lines, catheter, syringe pumps, abdominal catheters (ascites drainage), chest drains, tracheostomy, gastrostomy, PEG/enteral feeding tubes.
Continence management
End of life care
Manual handling
Clinical interventions e.g. B/P, monitoring urine, BM, venepuncture.
Support and supplementary education of carers, personal care.
Response to urgent ‘crisis’ calls.
Administration of medications.
Pressure ulcer prevention/ repositioning.
Administration of IV medication</td>
</tr>
</table>

Delivering Care Phase 4 Health Visiting

A Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

HSC Health and Social Care

Introduction

Delivering Care aims to support the provision of high quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. This paper provides a summary of Delivering Care Phase Four which focuses on the health visiting service.

The health visiting service is driven by the implementation of the Department of Health (DoH) Child Health Promotion Programme (CHPP). Health visitors work with families and communities using health promotion, prevention and early interventions in order to give every child the best start in life and address inequalities in health. The service works across all four thresholds of need as defined within the Hardiker Model:

- Level 1: Children aged 0-4 years in receipt of CHPP
- Level 2: Children and families who require additional support from the health visitor when a health need is identified
- Level 3: Identified as 'Children in Need' as defined within The Children (Northern Ireland) Order 1995
- Level 4: The most vulnerable children, ie on the Child Protection Register and/or Children 'Looked After'

Children may move across levels of need based on their vulnerability at a point in time. It is therefore necessary that health visitors have regular contact with families so that they can respond to identified health needs as early as possible.

Context

The Northern Ireland (NI) health visiting workforce currently does not have the capacity to deliver the full universal CHPP (See Table 1) to all pre-school children and priority is therefore given to contacts in the first year of life and responding to complex child and family health needs. The service is also challenged by an aging demographic with 18 predicted retirements over the next eighteen months.

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Table 1: The Universal Child Health Promotion Programme Contacts

CONTACT	AGE	VENUE
Ante natal visit	Post 28 weeks of pregnancy	Home
New Birth Contact	between 10-14 days (age)	Home
6-8 week contact	6-8 week contact	Home
12 14 weeks	12-14 weeks	Home
6-9 months	6-9 months	Home, clinic or community setting
1 year	1 year	Home
2-2.5 years	2 year	Home
over 3 years	3 year	Home, clinic or community setting
4 year pre-school	4 year	Telephone call, clinic or home visit

Indicator of Performance data (DoH June 2016) indicates that 14% of seven CHPP contacts (excludes antenatal and 3+ year contacts) are not being delivered and this has remained the case from March 2015-2016. Contacts are frequently delivered in clinics rather than home settings. Additional investment is required if the full delivery CHPP programme is to be delivered in keeping with DoH policy and professional quality standards and the broader role of health visiting in public health realised.

Regional health visiting capacity was increased in November 2015 by 34.9 WTE health visitors and 6.8 WTE supervisors as a result of £1.7m investment and the availability of 56 students completing their health visitor course. This achieved average health visiting caseloads of 1 health visitor per 250 children although workforce pressures including funded vacancies persist. Forty six students commenced training in September 2016.

Health visitors have three key areas of work:

1: Delivery of the Child Health Promotion Programme (CHPP) to all pre-school children and their families

All children and families are entitled to receive nine Level 1 CHPP health visiting contacts (Table 1) and additional interventions at Level 2 where a health need is identified, for example, in response to postnatal depression, parenting and child development concerns, challenging behaviour, breastfeeding, healthy weight and nutrition, infant jaundice, feeding difficulties, attachment and bonding problems.

Prevention and early interventions through the effective delivery of the health visiting can lead to a reduction of demand on high cost services including general practitioners, paediatrics, CAMHS and allied health professionals as well as multidisciplinary/agency services required at Level 3 and Level 4[1]. Prevention and early interventions by public health nurses improve the long term health outcomes for children[2].

[1] Department of Health, Sept, 2015, *Universal Health Visitor Reviews,* London DH
[2] Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. 1988. Improving the life course development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health, 78, 1436–1445*

2: Responding to the children and families with identified health needs, including safeguarding needs, in partnership with other disciplines and agencies

Responding to the health needs of children with complex and/or safeguarding needs is prioritised by health visitors given the detrimental consequences for those children with unresolved need or at risk of child abuse and neglect. The number of very vulnerable children and families requiring multidisciplinary support at Levels 3 and 4 has increased during the years when the health visiting workforce has reduced.

In 2015[3]:

- There were 23,834 children identified as 'in need' by social services childcare teams
- There were 28,420 domestic abuse incidents reported
- There were 2,875 children 'Looked After' of which 593 aged 0-4 years.

3. **Population Health and Wellbeing**

Participation in public health initiatives allows health visitors to promote health and wellbeing through community development initiatives, parenting programmes and public health campaigns. Health visitors, registered with the Nursing and Midwifery Council as specialist community public health nurses, have a key role in working with others to improve public health and address the challenges of disadvantage and inequalities. This is in keeping with the Northern Ireland's Executive vision articulated within the aim, principles and themes of the Making Life Better strategic framework.

Public health practice is responsive to local need and the views of the public. This includes partnership working with voluntary/community groups, Sure Starts and Family Support Hubs, as well as responding to emerging issues such as childhood obesity, child sexual exploitation and refugees. The public health role has been adversely affected by insufficient health visiting capacity and needs to be developed if key strategic population priorities in relation to prevention and early intervention are to be achieved.

Evidence

Determining an appropriate health visitor caseload size has been a complicated process due to the range of variables affecting children such as the child's developmental and health needs, environmental factors, parenting capacity, family and community resources and geographical factors.[4]

The limited research evidence available, and the views of health visitors and their managers across the five HSC Trusts, in relation to caseload size and skill mix, suggests that health visiting caseloads should vary depending on the level of need and inequalities

[3] Please see: https://www.gov.uk/government/collections/statistics-children-in-need
[4] National Health Service England, 2014. *National Health Visiting Service Specification 2014/15*, NHS England

experienced by those in receipt of the service. As a result of the deficit in health visitor numbers, 29% of health visitors report that caseloads are so large that they are losing track of vulnerable families[5].

The importance of home visiting and early intervention cannot be over-emphasised. Families value a relationship with a trusted health professional[6]. Dr David Olds et al[7] provides evidence that home visiting interventions provided by highly skilled nurses can result in better outcomes for children and families and, indeed, society. In a YouGov survey, 76% of parents stated they wanted support and advice on child health and development specifically from a trained health visitor with up-to-date health care knowledge[8].

A range of factors impact on demand for the health visiting service such as parenting styles and attitudes, increased caseload size, increasing levels of child and family poverty, family complexity, increasing mental health issues (infant, perinatal and adult) and families whose first language is not English.[9] There is strong evidence to support the important public health role that health visitors have in promoting child, family, community and population health[10].

Research evidence has highlighted that when families live in areas of poverty and deprivation there are lower levels of breastfeeding, increased levels of smoking, higher risks of chronic disease and reduced health outcomes for children and these families need an enhanced service[11]. Evidence also shows that young children who have poor quality maternal/child relationship have 2.5 times higher rates of adolescence obesity[12]. The cost of perinatal mental health problems in the UK is £8.1 billion each year with nearly 72% of the cost relating to adverse impacts on the child rather than the mother[13]. Evidence from the National Childbirth Trust suggests that approximately 32% of mothers experience bonding problems[14] and of the 25,273 births in 2011, 2,527 women developed postnatal depression, the majority of which are mild to moderate, and are supported by primary care services including health visiting[15].

[5] Family and Parenting Institute, 2008. *Health visitors – an endangered species*, London, FPI
[6] Regulation and Quality Improvement Authority, (2016*).Every Child Counts Regional Audit of the Child Health Promotion Programme,* Belfast RQIA
[7] Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. 1988. Improving the life course development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health, 78, 1436–1445*.
[8] YouGov survey on behalf of Family and Parenting Institute, 2007, ‘Parents of Under 5s’, The sample size totalled 5,422 respondents who were asked to tick all that applied for this question.
[9] Department of Health, 2011, *Health Visitor Implementation Plan 2011–15*, London DH
[10] Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. 1988. Improving the life course development of socially disadvantaged parents: A randomized trial of nurse home visitation. *American Journal of Public Health*, 78, 1436–1445
[11] HM Government, 2010, *Healthy Lives, Healthy People: Our strategy for Public Health in England*, HMSO
[12] Joseph Rowntree Foundation, 2007*. Parenting and Outcomes for Children*, Joseph Rowntree Foundation
[13] London School of Economics and Centre for Mental Health, Bauer, A. Parsonage, M. Knapp, M. Lemmi, V. Adelaja, B. 2014, *The costs of perinatal mental health problems*, London, Centre for Mental Health
[14] https://www.nct.org.uk/press-release/difficulties-baby-bonding-affects-third-uk-mums
[15] http://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016_0.pdf

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Key Drivers

The model proposed in this paper provides a flexible, considered approach to determining health visiting staffing establishments within a changing model of provision so as to achieve outcomes in keeping with the ***Transforming Your Care***[16], ***Making Life Better***[17] the Delivering Social Change **Early Intervention Transformation Programme** and ***Healthy Futures*** [18]strategies. These strategies and programmes place emphasis on the need to give every child the best start in life and the importance of encouraging and facilitating healthy living.

Benchmarking

Workforce benchmarking provides an opportunity to make comparison with workforces in other countries and health authorities. Relevant information has been taken from official government websites for England, Wales and Scotland in order to benchmark the NI health visiting service with other regions in the United Kingdom (UK) (July 2016). Benchmarking indicates that the NI health visiting service has a lower ratio of health visitors per 0-4 year old population than either England or Scotland.

Northern Ireland: The health visiting service following additional investment in November 2015 is commissioned on the basis of one health visitor WTE: 250 children

Scotland: 1 WTE : 221 children – there is an investment plan in place to achieve approximately 1:160 ratio (1316 WTEs for 291,174 0-4yrs + 2015 investment plan underway to achieve 500 additional HVs)[19]

England: 1 WTE : 238 with investment plan to achieve an additional 4200 HVs (11,955 WTE HVs: 2,847,332 births over 4 years 2011-14).

There is however significant regional variation[20]:

- Doncaster 1:160
- Sunderland 1:190
- Hull 1:199
- Manchester 1:225
- Surrey 1:570
- Coventry 1:597

Note that in relation to **Wales:** Information is not readily available on caseloads. However, it is understood that health visitors providing the Flying Start programme to vulnerable families should not have a caseload in excess of 110 children (Welsh Assembly)[21].

[16] Department of Health Social Services and Public Safety/Health and Social Care Board. 2011. *Transforming Your Care. A Review of Health and Social Care in Northern Ireland*. Belfast, DHSSPS.
[17] Department of Health Social Services and Public Safety/Health and Social Care Board*, 2014, Making Life Better 2013 – 2023,* Belfast, DHSSPS.
[18] Department of Health Social Services and Public Safety, 2010. *Healthy Futures 2010-2015,* Belfast, DHSSPS.
[19] http://news.scotland.gov.uk/News/500-new-health-visitors-ddc.aspx
[20] Conservative Research Department, 2011, Helping New Families
[21] http://www.childreninwales.org.uk/our-work/early-years/flying-start-network/

Staffing Model

Application of the Delivering Care Framework Phase 4, including benchmarking, the development of a caseload weighting system for health visiting service (eCAT) and CHPP compliance monitoring, has resulted in a recommendation that there should be a regional average one WTE health visitor per 180 children aged 0-4 years old with a skill mix of 90% registered staff and 10% non-registered staff. The proposed staffing ratio allows for one session per WTE health visitor to be allocated to public health activities over and above those required to deliver the core child health promotion programme.

Evidence from professional bodies in relation to caseload size and the opinion of health visitor service managers and practitioners in Northern Ireland suggests that universal health visiting caseloads should range from one WTE health visitor : 100 - 225 children. This range allows caseload sizes to vary in order that there is a higher level of health visiting contacts where demographic, deprivation, local challenges and specific health needs of families require this.

In 2009, a regional steering group was set up to develop, test and pilot a 'health visiting caseload weighting tool' in order to define a 'busy but fair' health visiting caseload. The development of this tool, including the electronic version eCAT, has been informed by the views of health visitors and health visiting service managers; evidence available on health visiting caseloads; the need for a caseload weighting system that is sensitive to the complexity of health visiting practice and demographic variables; the role of health visiting services across Hardiker levels of need; the views of national and local experts, and, the opinions and experiences of health visiting teams in all five Health and Social Care Trusts. The caseload weighting tool has been piloted and tested using all caseloads held by health visitors in NI and is considered by the workforce to be effective and useful.

The caseload tool uses a scoring matrix based on the Hardiker Level of Need and demand on the health visiting service and an optimal caseload weighting score. The most complex family circumstances requiring a frequent visiting pattern are allocated the highest score. Children receiving the core CHPP programme only receive the lowest score. To create a caseload score the total score allocated to children receiving the CHPP and families receiving additional interventions are divided by the health visitor's available caseload hours. **The optimal caseload score for a 'busy but fair' caseload is 16.** The appropriateness of this score is being tested during 2016/17.

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The average caseload score in Northern Ireland is 21.18 (April 2016) (see Table 2).

Table 2: Health Visitor Caseload Weighting Scores April 2016						
	HSCT A	HSCT B	HSCT C	HSCT D	HSCT E	Region
Caseload Score April 2016	20.7	20	24.2	20.5	20.5	21.18

The application of the caseload scoring matrix supports local management of a HSC Trust health visiting service. The size of any given caseload within an optimal score of 16 may fluctuate depending on the levels of need within the caseload.

Skill Mix

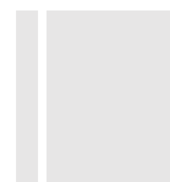
The Delivering Care Phase 4 Framework will facilitate a regional approach to the use of skill mix within health visiting teams. 90% of practitioners in the health visiting service will be registered nurses on the NMC register and 10% will be non-registered child health assistants.

The 90% of registered nurses will be made up of **a minimum of 85% health visitors** who are required to take responsibility for health visiting caseloads aligned to general practitioner practices and **a maximum of 5% Band 5 Public Health nurses** who will work with the supervision of a health visitor. This reflects the public and professional view that the CHPP offers an opportunity for parents to benefit from a relationship with a trusted and highly skilled public health practitioner who is accessible to them and that there is a need to develop an evidence base about the role and effectiveness of staff nurses within health visiting teams.

Child health assistants (Band 3) will deliver family health interventions delegated and supervised by a Health Visitor. They will also provide support to ensure the service is efficiently delivered and information for the purpose of an outcomes based accountability framework is available and reported.

One supervisory WTE team leader/manager (who does not hold a caseload) is required per 12 health visitors (WTE). Health visitors will provide supervision to non-registered staff.

One Band 7 practice teacher per 16 health visitors is required to teach up to two student health visitors on placement; to facilitate other student placements within the team/HSCT and to promote a learning culture within the health visiting service. The practice teacher will have their caseload reduced to reflect one day per week allocated to teaching and learning that is not available to working with children and families in their caseload.



Influencing Factors

There are a number of factors that need to be considered by service managers and teams when determining local health visiting staffing levels (Table 3).

Table 3: Influencing Criteria

Influencing Factors	**Impact of staffing**
Workforce	➢ Number of part time staff ➢ Availability of skill mix opportunities ➢ Recruitment affected by student HV numbers ➢ Age and experience profile – ratio of recently qualified and experienced HVs
Environment and support	➢ Geographical location (rural/urban) ➢ Clinic, school & community facilities ➢ GP alignment and local partnership arrangements ➢ Population profile (e.g. demography, deprivation, BME) ➢ Interface with other services e.g. FNP, Sure Starts, Family Support Hubs, Child Development Clinics, social work ➢ Lone working ➢ Team Size ➢ Access to technology
Activity	➢ All 4 Hardiker Levels of Need: Caseload Scoring Range 100-225 ➢ Uni-disciplinary, multi-disciplinary & interagency health plans ➢ Child Health Promotion Programme ➢ Population and public health initiatives ➢ Involvement in service developments and risk management ➢ Supporting pre/post-registration students
Professional regulatory requirements	➢ Delegation to Public Health Staff Nurses and Child Health Assistants ➢ Supervision of Public Health Staff Nurses and Child Health Assistants ➢ Mentorship and supervision including safeguarding children supervision ➢ Revalidation and time allocated to support HV in their practice, supervision, preceptorship are regulatory standards that are incorporated into the planned and unplanned absence allowance of 24% for N.I.

The final staffing for health visiting teams in each HSC Trust will be agreed following a discussion with the Trust Workforce Lead, Health Visiting Head of Service, Public Health Agency (PHA) Public Health Nurse Consultant and Commissioning Nurse Consultant.

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Implementation

Implementation will be directed and supported regionally by the HSCB/PHA commissioning/professional team and in keeping with health visiting workforce availability. The PHA will ensure a regionally consistent approach to implementation. Implementation Reports will be provided to Healthy Futures Programme Board on a three monthly basis.

Monitoring

The Executive Director of Nursing, in all cases, must provide assurances about the quality of care to families/children and the efficient use of resources through internal and external professional and other assurance frameworks, including KPI dashboards and other evaluative methods such as the 10,000 Voices work of the PHA in Northern Ireland.

Caseload data on eCAT will be updated at least monthly by health visitors. This data will be used by HSCTs and the PHA as part of the local and regional monitoring and quality assurance processes. Core qualitative and quantitative datasets will be agreed regionally with the PHA and will include information provided by service users.

Health visitor team leaders/managers/supervisors will ensure that the model is being applied consistently through practice supervision. Records will be audited against allocated scores awarded per child and families. Caseload data information will be shared and analysed at team meetings and this analysis will be used to inform managerial decisions including caseload allocation.

Information in relation to Key Performance Indicators (KPIs) including compliance with the CHPP will be collected three monthly as a minimum. Additional KPIs may be identified and will be agreed regionally.

The Outcomes Based Accountability framework developed as part of the Delivering Social Change Early Intervention Programme (Work Stream 1) will be implemented and developed. This includes feedback from service users and practitioners.

Review

The Delivering Care Phase 4 Model will be reviewed annually for the first three years, thereafter three yearly.

Delivering Care Phase 5A (Inpatients) Mental Health

As part of the Policy Framework for Nursing and Midwifery Workforce Planning in Northern Ireland

Introduction

Delivering Care aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of staffing models and ranges for the nursing and midwifery workforce within the Delivering Care policy framework.

Phase 5A and 5B of this work focuses on Mental Health Nursing in both inpatient (A) and community settings (B).

This paper is intended to build on the key principles and assumptions that have been agreed in previous phases for Delivering Care. This phase will reflect the methodology agreed with the regional Steering Group and governance arrangements for the overall project, as they relate to **Phase 5A inpatient environments**.

It is recognised that workforce planning processes include the triangulation of findings from recognised workforce planning tools alongside Key Performance Indicators (KPIs) for safe, effective, person-centred care. This work has been developed in the context of the principles of Quadruple Aim[1], which combines a focus on population health and wellbeing, safety, quality and experience, cost and value with added experience of care givers.

Context

The subject of nurse staffing continues to be a matter for debate. Ensuring appropriate nurse staffing is in place has been referenced in inquiries and reviews[2], highlighted in research and evidence[2] and is viewed by families and carers as a key element in influencing the quality of care[2]. Phase 5 (Mental Health Nursing, inpatient and community settings) of the Delivering Care framework builds on the methodologies and learning from previous phases.

The Bamford vision for Mental Health in Northern Ireland[3]

At the heart of the Northern Ireland (NI) Mental Health Strategy is the vision to deliver a service which gets the best results at the earliest opportunity.

The Bamford vision for Mental Health strongly supports the following principles:

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[1] Bodenheimer, T., (2014) From Triple to Quadruple Aim: Care of the Patient requires care of the Provider, Annals of Family Medicine, University of California
[2] Public Health Agency (2017) Delivering Care: A Literature Review for Workforce Planning for Mental Health Nursing In Northern Ireland, PHA
[3] Bamford Review of Mental Health and Learning Disability https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf

- Good Mental Health should underpin all aspects of health and wellbeing and should be everyone's responsibility.
- People with Mental Health needs should be valued. This includes the right to full citizenship, equality of opportunity and self-determination.
- There is a need for society to address the challenges facing people with Mental Health needs
- There should be a process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with Mental Health problems and to their carers and families.

Within Mental Health services, a person-centred approach is endorsed which is community and family-orientated with a recovery ethos as core to the vision for service development. The Bamford vision also provided a detailed framework for Mental Health promotion, suicide prevention and recovery, with users and carers at the centre. In addition, the strategic policy focus is on the development of leadership, teamwork, workforce and training, acknowledging that reform is dependent upon a sufficient and competent Mental Health workforce.

At all levels of the Bamford Mental Health Strategy there is a requirement for adequate resources, including support for recommended staffing levels to ensure the effectiveness of the Health and Social Care (HSC) workforce. This requirement will be progressed under the key work streams across Mental Health strategies to reform services into the future. Mental Health services incorporate a number of Nurse-led approaches to service delivery.

The key achievements of Bamford

Since the inception of the Bamford vision there have been a number of improvement initiatives, including practice development for staff, introduction of new services and ways of working and improved patient experience. Listed below are some of the key achievements of the Bamford vision:

- The resettlement of the majority of patients out of hospital to the community;
- The establishment of recovery-orientated practice and recovery service development;
- The establishment of a Mental Health "Stepped Care" model for services;
- The development of crisis resolution services and specialist Mental Health services including services for people with a Personality Disorder or an Eating Disorder;

- Improved Mental Health awareness throughout the community and investment in psychological therapies and suicide prevention measures;
- Emphasis on co-production practices and meaningful partnership working with service users with lived experience;
- Recommendations to increase participation of service users in employment programmes and the embedding of Mental Health promotion in schools.
- The development by the Public Health Agency (PHA), Health and Social Care Board (HSCB) and the Department of Health (DoH) of an education and learning framework for Mental Health professionals.

Key Drivers for the Future Mental Health Nursing Service

A range of strategic and operational drivers have been considered within this phase of Delivering Care that will have a significant impact on the future of Mental Health Nursing services. The following policy drivers have been considered:

- **Health and Wellbeing 2026: Delivering Together[4] -** This document was produced in response to the report by Professor Bengoa. Delivering Together puts people first and focuses on enabling people to stay well for longer. Where care or support is needed, it will be, wherever possible provided in a community setting.
- HSC (NI) **Workforce Strategy** 2018[5].
- **Quality Care[6]** -The Q2020 Strategy aims to protect and improve the quality of health and social care in Northern Ireland and to be recognised as a leader for excellence. Through its key strategic goal 'strengthening the workforce', the Q2020 strategy is committed to ensuring that we provide the right education, training and support to deliver a high quality service. This is fundamental to the delivery of safe and effective services.
- The **Bamford[7]** vision for Mental Health services, which called for continued emphasis on promotion of positive Mental Health, reform of Mental Health legislation and a continued shift from hospital to community based services with the development of specialist services.

[4] Department of Health (2016) Health and Wellbeing 2026 Delivering Together, DoH 2016
[5] Department of Health, Social Services and Public Safety (2015), Evolving and Transforming to Deliver Excellence in Care. A Workforce plan for Nursing and Midwifery in Northern Ireland (2015-2025) DHSS&PS
[6] Department of Health, Social Services and Public Safety, (2014) Quality 2020: An Attributed Framework for Health and Social Care, DHSS&PS
[7] Bamford Review of Mental Health and Learning Disability https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-action-plan-2012-15.pdf

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- The DoH Nursing and Midwifery Task Group / Mental Health Nursing Review (2018) aimed at improving the contribution of nursing across the life span.

- **Delivering Excellence, Supporting Recovery**[8] is the Department of Health's Strategy (2011-2016) for Mental Health Nursing.

- **Dementia Strategy**[9] **-** Recommendations aimed at improving the services and support arrangements currently available for people with dementia, their families and their carers, with an emphasis on early diagnosis.

- **Population health**[10] – Increased focus on enabling health promotion, prevention and self-management. The "Making Life Better" NI Public Health framework (DHSSPS 2013) seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of NI where all people are enabled and supported in achieving their full health and wellbeing potential and to reduce inequalities in health.

- **Care enabling technologies**[11] - Building on the "Regional eHealth and Care Strategy" (DHSSPS 2015) it is imperative that there are systems and processes to support timely and consistent sharing of patient information. This should include real time access to all Mental Health and social care information for all relevant care providers to enable them to work effectively and safely with their patients. This will be achieved through the development and implementation of an electronic record in common for all citizens in NI over the next 5 - 10 years.

- A priority for **unscheduled care**[12] in NI is to have effective, integrated arrangements, organised around the needs of individual patients, in place in community settings to provide care for people at home and in their local communities. The intention is to avoid the need for hospital admission for Mental Health services and to support safe and effective discharge planning arrangements when a period of hospital admission is required.

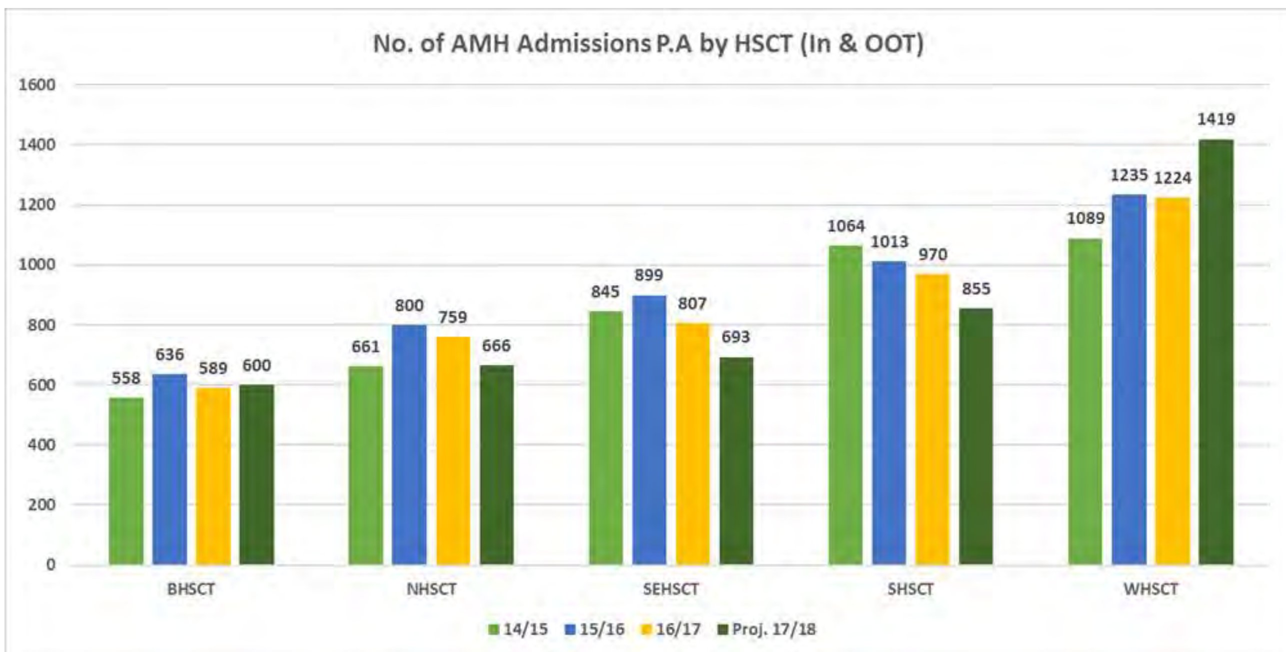
- **Demography** - The population of NI is increasing, and within this overall increase the size of the older population is increasing more quickly.

[8] Department of Health, Social Services and Public Safety (2011-2017) Delivering Excellence, Supporting Recovery, DHSS&PS
[9] Department of Health, Social Services and Public Safety (2011) Improving Dementia Services in Northern Ireland- A Regional Strategy, DHSS&PS
[10] Department of Health, Social Services and Public Safety (2014), Making Life Better 2012-2023, A Whole System Strategic Framework for Public Health, DHSS&PS (2002) Investing for health Strategy 2002-2012, DHSS&PS
[11] Department of Health, Social Services and Public Safety (2015) Regional eHealth and Care Strategy, DHSS&PS
[12] Department of Health (2016) Health and Wellbeing 2026 Delivering Together, DoH 2016

- **Increasing Profile of Demand** - Due to the rapidly changing health and social care landscape increasing numbers of people with Mental Health issues are being cared for at home, which includes people living in deprivation, increased referrals for young people and those living to a very old age. See **Figure 1** (NI Referral Rates).

Figure 1 Number of Acute Mental Health Admissions per annum demonstrates a snapshot of the changing profile of demand for Mental Health services in NI. This Table illustrates the increasing referral rates for inpatient admissions to Mental Health services from 2014/15 through to 2017/18 across all 5 Health and Social Care Trusts (HSC Trusts).

Figure 1: Number of Acute Mental Health Admissions per annum In & Out of Trust



Source : HSCB 14.03.2018

Current Services

Stepped Care model in Mental Health services

In October 2014 the HSCB and the PHA launched a Regional Mental Health Care Pathway for people who require Mental Health care and support. The purpose of the Care Pathway was to provide guidance on the steps of care to be delivered, enhance quality of service experience and promote consistency of service delivery across NI. It describes a Stepped Care approach consisting of 5 distinct steps. When service users are welcomed into the service, the Stepped Care approach means that care provision for any individual can be stepped up or down according to a person's needs.

A step up in care usually means that more intensive specialist support is required. Equally a step down in care means that a person needs less intensive input. This model impacts on the requirements of the nursing workforce. The five steps are illustrated in **Figure 2**, in relation to the types of support and clinical/care environments.

Figure 2: Regional Mental Health Care Pathway October 2014 HSCB/PHA

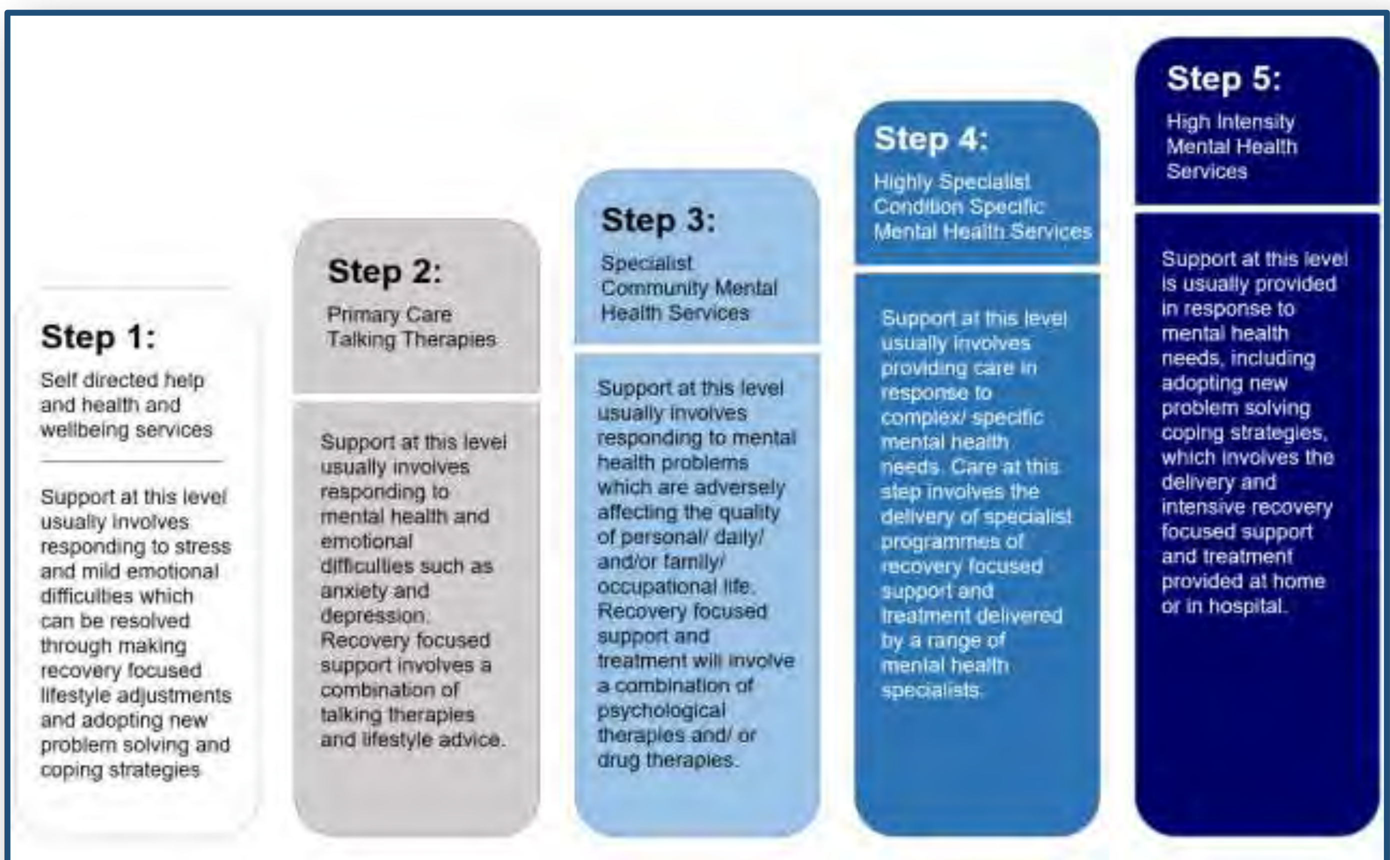


Image adapted from HSC's Regional Mental Health Care Pathway, 2014

Descriptors and category of care environments

Northern Ireland's Mental Health service is made up of hospital inpatient units and community Mental Health services. The inpatient services include acute admission units, dementia assessment, specific admission units for those who are over 65 years of age, addictions units, inpatients and psychiatric intensive care units. There are also low secure rehabilitation units. A regional medium secure unit and the Child and Adolescent Mental Health Service (CAMHS) unit are located in the Belfast HSC Trust. These services will be provided across Steps 4 to 5 in the Stepped Care model.

Within the community there are community Mental Health teams, which include specialist teams such as Addictions Teams, Personality Disorder teams, Eating Disorder teams and Community Forensic teams. Crisis Resolution/Home Treatment teams are based in the community and provide a gatekeeping role to inpatient beds. Day Hospital provision exists in some areas. These facilities are staffed by existing staff based in hospital or community teams. Mental Health services span across acute and primary care teams and across the age spectrum to include Mental Health teams for older people. These services will be provided across Steps 3 to 5 in the Stepped Care model.

There are also services which are situated within the community and other agencies which respond to stress and mild emotional difficulties offering self-directed help, encouraging adoption of new problem-solving techniques and coping strategies. These provide an opportunity for people to be helped within their own community. Finally, there are services which offer help for moderate Mental Health conditions, such as "talking therapies". These services are offered within Primary Care at Steps 1 and 2 of the Stepped Care model. The diagram, **Figure 3** on page 8 gives a description of the Categories of Care in the Stepped Care Model.

Inpatient units

Phase 5A will incorporate inpatient units across the 5 HSC Trusts. Patients admitted to these facilities require acute Mental Health care and support and will be cared for within a whole system approach which includes a Stepped Care pathway. For the purposes of this phase of Delivering Care, each inpatient unit will be described within the following categories of care environments.

Figure 3 Categories of Care Environments

Category 1. Acute admission, assessment and treatment wards are clinical environments where patients are admitted in the acute phase of an illness, or require an immediate Mental Health assessment and/or treatment. These wards are where patients can be treated in the least restrictive environment. Their condition is treated and stabilised with a view to discharge back to the community in as short a time as possible. These wards are used for admissions when it is no longer possible to maintain or treat the patient safely in the community or their place of residence. This may also include those patients who are over 65 and who have a functional illness and those who may need admission to an inpatient addiction service. The length of stay can range from 2-6 weeks. This category of care environment is **Step 4** within the Stepped Care model.

Category 2. Psychiatry of old age/dementia assessment wards a**re clinical environments where patients are admitted in the acute phase of their illness, or require further assessment**. They may or may not have already been given a diagnosis of dementia and may have further complex health issues and/or co-morbidities requiring a higher intensity of nursing care. This category of care environment is **Step 4** within the Stepped Care model.

Category 3. Psychiatric intensive care units/beds are clinical environments where patients are admitted due to increased acuity/need/risk with significant challenging behaviour which could not be managed in an admission or assessment unit. These units have a higher degree of security, safety/safeguarding to ensure patient safety and risk is managed effectively. Patients may be subject to assessment under the Mental Health (NI) Order 1986 before admission. The length of stay should be short within a 6 week timeframe with patients being discharged and/or transferred to a Mental Health care environment/service that meets their needs. This category of care environment is **Step 5** in the Stepped Care model. This Category may include inpatient Child and Adolescent Mental Health Services (CAMHS). These units deliver tertiary level care and treatment to young people with a range of mental disorders and complex needs (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder, severe psychosomatic disorders) associated with significant impairment and/or risk to themselves or others such that their needs cannot be met safely by Tier 3 community CAMHS . This includes young people with mild learning disability and Autistic Spectrum disorders who do not require Tier 4 CAMHS Learning Disability Services.

Category 4. Low secure units in Northern Ireland are clinical environments which provide a service for patients with a severe and enduring mental illness and who require high intensity rehabilitation. Due to the level of acuity and risk, these patients have not been able to be rehabilitated quickly to the community and normally remain detained under the Mental Health (NI) Order 1986 prolonging the length of stay. This category of care environment is **Step 5** of the Stepped Care model.

Category 5. Medium secure services provide therapeutic psychiatric services for individuals with a mental illness, who present a serious risk of harm to themselves and others, due to their condition. Patients being admitted must be detained under Mental Health (NI) Order 1986. The decision to admit to a secure unit will be based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed whilst in hospital. Many but not all of those admitted to secure services will have been in contact with the criminal justice system. This category of care environment is **Step 5** in the Stepped Care system.

Case studies for each category of care environment

In order to give some understanding of the types of patients and conditions admitted to the various inpatient Mental Health settings, a number of anonymised case studies can be found at ***Appendix 1.***

The Mental Health nursing workforce in Northern Ireland

Mental Health Nurses are the largest professional group within Mental Health and social care services in Northern Ireland (NI). They account for 70% of the total statutory workforce in Mental Health services and also have a significant presence in the independent, community and voluntary sectors.

Mental Health Nurses provide the majority of direct patient care in many settings. Currently, there are a reported total number of 1640 live registrants in Mental Health Nursing in Northern Ireland (*Source DoH March 2017).* It is noted that not all of those registrants may be practising in Mental Health care environments in NI. Commissioning of pre-registration Mental Health places by the Department is aligned with the Nursing and Midwifery Workforce Plan and reviewed annually.

A Mental Health Nurse is a Registered Nurse (RN) who is regulated by the Nursing and Midwifery Council (NMC), under Part (1) of the NMC Register. For the purposes of this paper, Phase 5 will include nurses who work in H&SC Trusts in hospitals (including acute admission wards, secure units, psychiatric intensive care units, psychiatry of old age, continuing care recovery and rehabilitation) and community services.

The Mental Health Nurse is uniquely placed to provide an integrated experience of care with and across a range of inpatient setting. Crucially this involves providing person and family centred care. Mental health Nurses remain the corner stone in the formulation of need, in managing risk and in delivering 24 hour therapeutic care including the delivery of a wide range of talking therapies and recovery based interventions. The Chief Nursing Officer for Northern Ireland has commissioned a review of Mental Health nursing with a view to enhancing and maximising the role Mental Health Nurse can play in delivering better outcomes. The output of this review will shape the future curriculum, the practice model and support the development of a career framework for Mental Health nursing across a range of settings.

The specific requirements of a workforce framework should consider the unique role and function of the Mental Health Nurse, where care of a psychological nature is as important as physical care. There is also a requirement to have an appropriate professional blend of senior nursing staff (Band 6/7) within Mental Health teams, to provide safe and effective skill mix and leadership and provide evidence based therapeutic interventions and care at all times.

The significance of the profile of the Mental Health Nurse

Nurses are a unique group of professionals within health care, not least because they constitute the largest group of staff in the HSC system. They are central to the provision of quality care and are highly valued by the public in NI, a view expressed in the *Patient and Client Council Report (2010).*[13]

Mental Health Nurses gain an in-depth knowledge of the clinical perspective of disease. This knowledge is gained through a 3-year graduate programme leading to NMC registration as a Registered Nurse Part 1 (Mental Health). The course equips the graduate nurse with the knowledge, skills and attitude to deliver high quality, complex Mental Health nursing. The modules cover the theory and evidence for person-centred nursing, providing a holistic assessment of health needs, including therapeutic relationships, bio-psycho-social assessment and risk assessment.

There are also modules in leadership and management, professional values and practice learning opportunities, in a range of Mental Health settings, with 50% practice learning and 50% theory. The NMC has recently published new education and proficiency standards[14] for undergraduate and registered nurses respectively. The NMC as the professional regulator exists to protect the public. The education framework contains the standards and requirements that together signify what effective professional education and training looks like. Similarly, the standards of proficiency reflect the anticipated future needs of the public for expert nursing care and provides guidance on what the newly registered nurse should know and be able to do at the point of registration in order to practise safely and effectively.

This range of learning experience gives Mental Health Nurses an all-round suite of skills in assisting patients in the Recovery process. They are adept at building psycho-social support systems. *(Foundation of Nursing Studies, Playing our Part, 2017)*[15]

Within a multi-disciplinary team, nurses are the professional group which spend the most time with patients. They form a therapeutic relationship with patients which creates a dynamic which cannot be under-estimated. Psycho-social and interpersonal skills used by Mental Health nurses are critical and central to delivery of care. Mental Health Nurses are able to provide high quality behavioural or psycho-dynamic interventions *(Devane, 1998)*[16] through the use of the therapeutic relationship. They also have a critical role in medicines management, administration and patient education and self-management.

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[13] Patient and Client Council (2010) The People's Priorities, A View from Patients, Service Users, Carers and Communities on Future Priorities for Health and Social Care in Northern Ireland
[14] Nursing & Midwifery Council (2017) Education Framework: Standards for Education and Training, NMC
[14] Nursing & Midwifery Council (2017) Standards of Proficiency for Registered Nurses, NMC
[15] Foundation of Nursing Studies (2017) Playing Our Part, The Work of Graduate and Registered Nurses, London
[16] Devane et al (2014) The Clinical Skills of Community Psychiatric Nurses Working with Patients Who Have Severe and Enduring Mental Health Problems: An Empirical Study. Journal of Advanced Nursing, Vol 27, No 2, pp 253-262

This therapeutic relationship also extends to include assessment, advice and support to family, carers and nominated friends in the care of the individual. These elements need to be recognised and valued as an integral part of the patient's recovery.

Evidence

Determining the appropriate skill mix and caseload size for all Mental Health nurses is a complicated process due to a range of variables that impact on health and social care needs. These include:

- Workforce;
- Environment;
- Activity (Clinical);
- Professional Regulatory Activity

These are further described as influencing factors in ***Appendix 2.***

Within Mental Health inpatient settings in NI, the current method that is used to calculate staff is the Telford method. This approach is underpinned by the clinical judgement and experience of registrants and is often used with other methods of workforce calculation in order to provide a degree of triangulation.

Within Community Mental Health Teams the capacity method that is used is a "workforce utilisation tool," the "Choice and Partnership Approach" (CAPA)[17]. This model combines collaborative and participatory practice with service users bringing together active involvement of patients, supporting the recovery ethos of care, essentially managing demand and capacity within the existing workforce. Further review of caseloads based on populations for NI will be explored in Phase 5B.

A literature review was carried out as part of the Phase 5 framework in 2017 to ascertain the evidence base for Mental Health workforce planning. The key findings are highlighted in ***Appendix 3***[18]***.***

Methodology

The methodology for this phase of Delivering Care follows on from the previous phases. This approach is based on a range of workforce intelligence information, best available evidence, literature reviews, benchmarking, application of the core assumptions of the framework and scoping exercises with Trusts. Engagement with key stakeholders on the proposed staffing recommendations for the current workforce requirements has been done in collaboration with the expert reference group, working group and steering

[17] York, A., & Kingsbury, S., (2013) The Choice and Partnership Approach: A Service Transformation Model, Short Run Press, Exeter

[18] Public Health Agency (2017) Delivering Care: A Literature Review for Workforce Planning for Mental Health Nursing in Northern Ireland, PHA

group. The methodology is aligned to the agreed governance arrangements for the project.

Approach

The approach is based on best evidence and promotes a quadruple aim methodology (see **Figure 4)**, and includes reference to recognised workforce planning tools.
The 'Triple Aim' was developed in 2008 to guide the redesign of healthcare systems with an emphasis on population health, patient experience of care and reducing costs. In recognising that the backbone of any effective healthcare system is an engaged and productive workforce, a 4th aim was added - *Improving the experience of providing care*.

This 4th aim holds particular importance within the delivering care process. Nurses are often central to the teams of health and social care professionals charged with delivering health and service improvements. Effective workforce planning is vital, not only in ensuring the availability of sufficient numbers of skilled staff but also in providing structures and support so that each member of the nursing workforce can realise the sense of accomplishment and success that results from meaningful work.

Figure 4 The Quadruple Aim Method

The outputs of the approach for Phase 5A have been produced in consultation with a wide range of key stakeholders including planners, service providers, professional managers, senior nurses and expert reference group. Following a review of baseline data, modelling the data during the development of Phase 5A, it has been proposed that the core elements will be the development of a guide for a nursing staff to bed (range)

for staff based across the categories of care environments, in inpatient settings in Mental Health services.

The financial analysis and data collection templates, for the recommended model follow the same methods as for previous phases. Each phase has a review date to ensure the framework is refreshed regularly.

Assumptions

The following assumptions of the framework are built into the principles of the recommended staffing range for Mental Health Nurses in inpatient settings. Outcome indicators for monitoring the Mental Health Nursing workforce have also been built on the assumptions of the framework.

a) Assurance of safety, quality and experience through the following key performance indicators (to be agreed regionally)

- Organisational; absence rates, vacancy rates, staff in post, skill mix via Delivering Care monitoring returns.
- Safe and effective care, e.g. incidence of SAIs which will be agreed regionally.
- Patient experience, e.g. involvement in person-centred decision making re: care needs and decisions in relation to treatments and direct patient contact.

b) Planned and unplanned absence allowance

Planned and unplanned absence allowance (PUAA) refers to periods of absence from work which can be described as anticipated and therefore must be factored into the workforce planning process. This includes annual leave, sickness and mandatory study leave. The allowance agreed for NI is set out in **Table 1**. It should be noted that the agreement throughout the phases of the policy for Delivering Care does not include a specific mandatory allowance for maternity leave.

Table 1: Percentage uplift for planned and unplanned absence

Annual leave	Sick leave	Study leave Mandatory	Total allowance NI
15%	5%	4%	24%

c) Skill mix

The skill mix refers to the ratio of registered to non-registered nursing staff working within Mental Health teams across inpatient and community settings. The level of skill mix may vary across both these settings. A level of skill mix has been recommended for the funded establishment of each category of care environment, based on best evidence and the use of recognised workforce planning tools. In addition, the skill mix should take into consideration the allocation of the 100% ward sister/charge nurse/nurse team leader role across all Mental Health settings. There is also a requirement to ensure that senior nursing posts make up part of the registered nurse skill mix requirement, in mental health care environments. These posts will ensure the delivery of nurse led, psychological therapeutic interventions and drive forward evidence based practices.

Following a review of evidence and current baselines and benchmarks, the proposed skill mix for inpatient units will range from 70:30 - 80:20.

d) Management of recruitment

Whilst there are recognised challenges around nurse recruitment in NI it will be essential that all Nursing vacancies across Mental Health services are filled within a prompt timescale by registered and unregistered nursing staff respectfully to ensure that Nurse staffing levels support safe and effective person-centred care as set out in the framework recommendations.

Employers must ensure that a risk-based approach is adopted to managing recruitment, taking into consideration the maintenance of safe nurse staffing levels against the recommended range within the framework. Every effort should be made to avoid the overuse of temporary, bank and agency staff. This is a regional priority across Northern Ireland.

Matching skill mix to band mix to patient acuity and dependency within recognised professional standards and guidelines will be a fundamental requirement to ensure that professional judgement is incorporated to reviewing required staffing levels.

The availability of senior nursing posts across inpatient units as part of the workforce requirements should support the proposed staffing model.

Benchmarking of Inpatient Nurse to Bed Ratios across the UK

In NHS England, the preferred model for inpatient workforce tools is based on the time spent on activity matched with the acuity of patients and recommends a set of best practice workforce guidelines for Mental Health nurses regarding staffing. It should be noted that the Grade Mix in England incorporates Band 2 and 4 and there is a slightly higher percentage of Band 6 posts that may, in some cases, sit outside some of the current establishments of inpatient units, which may cover Nurse Therapist posts and

other services i.e. Day Hospitals within some units. The skill mix varies across the inpatient environments reviewed from 58/42 to 70/30, in other countries in the UK. Band 7 posts exist as "supervisory" in some areas but not all. The model in England includes 22.5% uplift for planned and unplanned absences (PUAA). It should be noted that daily measurement of acuity of inpatients determines the recommended staff ratios across many Inpatient units in the UK. A review of Inpatient staffing levels was also sourced from NHS Scotland. **Table 2** below provides an example of the nurse to bed ratios (NTBR) reviewed as part of the benchmarking exercise across Mental Health inpatient environments in the UK.

Table 2: Benchmarking examples of staffing based on nurse to bed ratios from inpatient units reviewed in NHS **Scotland and NHS England**[19][20]

Ward Description	NTBR
Category 1 Acute Admission*	**1.5 - 1.92**
Category 2 Psychiatry of Old Age	**0.83 - 1.85**
Category 3 PICU*including CAMH's	**1.79 – 3.69**
Category 4 Low Secure* *(as with Cat 1)*	**1.80 - 1.92**
Category 5 Medium Secure	**3.26 - 4.26**

**In mainland UK, PICU and some inpatient admission and assessment units will have access to other services which provide a higher level of security, such as Low Secure and Medium Secure units, and in some cases flexible high dependency beds. In Northern Ireland, there are no low secure units as defined in England and one regional Medium Secure unit based within the Belfast Trust.*

In psychiatry of old age units there is a high incidence of enhanced care in place (Special Observations) and high bank expenditure, over and above the average nurse to bed ranges funded in these environments which is reflective of the NTBR in Category 2.

[19] NHS Mental Health Staffing Framework, UK Case Studies, 2014/15
https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/.../mh-staffing-v4.pdf

[20] Ayrshire Central Hospital, Irvine, Scotland NHS 2018 (aacpt)

Staffing Model – Phase 5A Inpatient Units

In order to provide good governance, a professional lead for Mental Health is recommended and should be identified in each HSC Trust within the organisational structures, within a collective leadership framework. The professional lead in each HSC Trust should provide leadership to all nursing staff in Mental Health, ensuring they are facilitated to deliver a service of high quality and safe, person-centred care in accordance with the NMC Code. In addition, it is recommended that the availability of senior nursing staff (Band 6) is prioritised as part of the blend of registered nursing staff to ensure the delivery of evidence based care and nurse led therapeutic interventions within inpatient environments on a 24 hour basis.

Based on the application of the assumptions/influencing factors, the Benchmarking information and a peer review of staffing levels, which included Telfords in each Trust for inpatient Mental Health Services, the recommended nurse to bed staffing ranges are outlined in **Tables 3a and 3b.**

Table 3a: Phase 5A Proposed Nurse to Bed Ratio / Range for Inpatient Units

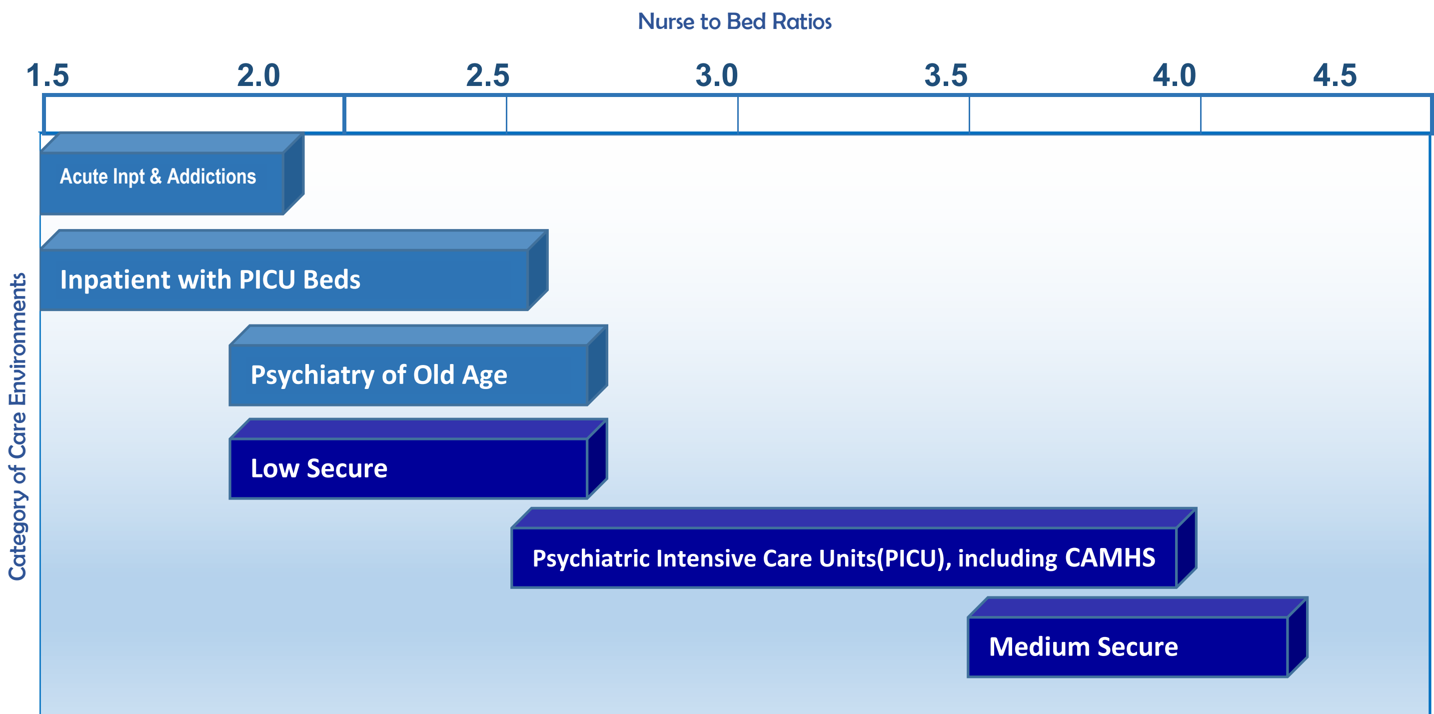

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Table 3b: Category of Care Environments Phase 5A

Category of Care Environment	Inpatient facility	Proposed Nurse to Bed Ratio Range	Proposed Skill Mix
1	**Acute Assessment & Treatment Units including Addictions** **For units with PICU beds and higher acuity patients**	1.5 – 1.8 1.5 – 2.6*	70/30 Minimum 70/30
2	**Psychiatry of Old Age** **Dementia Assessment Units**	1.8 – 2.5**	70/30
3	**Low Secure Units**	1.8 – 2.5	80/20
4	**Psychiatric Intensive Care Units and CAMHS**	2.5 – 4.0	80/20
5	**Medium Secure Units**	3.5 – 4.2	80/20

* For inpatient assessment units who have PICU beds or on occasions have to deal with patients of higher acuity

** For units that have patients who require enhanced care and have higher acuity e.g. Dementia, functional illness/healthcare needs

Monitoring

Compliance in delivering on agreed key performance indicators requires a sufficient Nursing workforce to deliver safe and effective care. On occasions when Nurse staffing may be outside the policy range, the Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks.

The testing of new models for Mental Health Nursing service provision and reform into the future should incorporate a triangulation approach allowing for professional judgement.

As with the Delivering Care approach, the final staffing ranges for Mental Health Nursing in Trusts will be agreed with reference to the recommended ranges set out in Phase 5A, following a discussion with the Trust Workforce Lead, the Trust Mental Health Nursing Lead and the Chair of the Working Group/ Steering Group. This may require a phased approach to implementation.

Review

This Phase will be reviewed in 2020/21.

Appendix 1

Case Studies for each Care Environment

Care Environment Category 1 Acute Admission

Harry's story is typical of an admission to an acute admission/assessment ward. Harry is 58 years old and has a diagnosis of Bi-Polar Disorder. His mood can fluctuate very quickly from a hypomanic state to a depressive state and is known as rapid cycling.

On admission Harry is usually elated, presenting as over active and over talkative, removing his clothes inappropriately and singing offensive songs. He would have increased thirst and would drink copious amounts of fluids, increasing his risk of hyponatraemia. At times he would also be doubly incontinent and would be aggressive both physically and verbally.

Nursing interventions would include protecting Harry's dignity and reducing his risk of aggression. This requires him to be nursed on 1:1 observations in a single room to reduce stimulation and ensuring Harry has a male member of staff with him at all times. If Harry is so over active that he could present as a danger to himself or others, detention under the Mental Health Order may be necessary. It is the nurse's responsibility to ensure that the detention process is completed in detail. Nurses will also provide care through monitoring Harry's physical well-being. He may need to have fluid intake monitored due to his excessive drinking and be encouraged to take his medication and have a referral to the dietician.

When Harry is aggressive he may require de-escalation and physical restraint. This will be carried out by nursing staff. This may require up to 6 staff at any one time.

At all times Harry's family will be kept informed of his care.

Care Environment Category 1 Addictions

Stephanie is a typical example of a patient admitted to an addiction unit as part of a treatment plan for detoxification and stabilisation.

Stephanie is a 28 year old with a history of substance misuse. She has been engaging with the community addictions service and has agreed with them that admission is appropriate. This is a planned admission.

Stephanie is inducted into the ward and detoxification is started. This will be undertaken by qualified nursing staff and the patient will remain under observation throughout the process. She will have daily medications administered and will collaborate with nursing staff to develop her nursing care plan, which will be reviewed weekly.

On admission Stephanie has various blood tests completed such as blood borne virus screening and a Hepatitis B vaccination will be administered by a nurse. Stephanie will also be encouraged to attend a group psycho-educational recovery focused programme on a daily basis. All physical health monitoring will be completed by a nurse and Stephanie's family and support network will be engaged in her treatment plan to promote successful after-care post discharge.

Discharge planning will commence on admission and a plan will be developed with the patient and nurse. On discharge Stephanie will be offered a 7-day follow-up appointment with the community team.

Care Environment Category 2 Psychiatry of Old Age (Functional Illness)

William's story is a typical example of an admission to a bed for patients who are over 65 and who have a functional illness. William is 91 and has had a 3-month history of increasingly out-of-character erratic behaviour. This includes disinhibition and inappropriate conversation and overspending. His daughter moved home from abroad in order to support him, but despite this his behaviour continued to deteriorate, requiring admission.

On admission he was agitated shouting loudly, describing panic attacks and behaving erratically. He was given a diagnosis of Bi-Polar Disorder. Nursing care provided was to preserve William's dignity, ensure his safety, ensure adequate food and fluid intake, reduce the frequency of disinhibited behaviour and any aggression, monitor medication and provide a low stimulus environment to help manage his symptoms. The therapeutic alliance with the nursing staff will be paramount in managing this gentleman's behaviour.

Care Environment Category 2 Psychiatry of Old Age Dementia Assessment

Roy's story is typical of an admission to a psychiatry of old age ward. He is 74 years old and has had a diagnosis of Alzheimer's disease since 2013. He was living at home with his wife prior to admission and required assistance with all activities of daily living.

He was admitted as a detained patient, due to a decline in his mental state over the preceding 8 weeks. He presented with increasing levels of agitation, particularly in the evening. There was increasing confusion regarding his surroundings and he had made several attempts to leave home in search of his childhood home. Medication compliance had declined and his sleep pattern had become disturbed. He also made many attempts to leave home to go to work. Roy would become distressed when his wife would not let him leave whereby he would hit out.

On admission following physical examination, blood tests and urine testing there were no abnormalities detected.

Nursing care would be required to stabilise Roy's condition, ensure his safety, review his medication, reduce his level of agitation and regulate his sleep. On occasions following appropriate risk assessment, Roy required enhanced care and one to one nurse supervision for long periods of time.

Care Environment Category 3 PICU

Barry is a typical example of a patient who requires to be admitted to a PICU.

Barry had been an inpatient in an acute admission ward for 6 weeks. His behaviour had been aggressive periodically for three days and he had been restrained on 4 occasions. His medication was reviewed and changed and he had been placed on continuous observation during the period of his disturbed behaviour.

Due to the rapid deterioration in his mood and behaviour, a multi-disciplinary meeting was convened and it was decided that for his own safety and the safety of others he met the threshold for admission to PICU. Nursing staff will co-ordinate this transfer making it as seamless as possible, providing information to the PICU staff about previous incidents and then completing the transfer to the new ward.

Once safely transferred Barry will have a higher ratio of staff to monitor and manage his behaviour with enhanced care and one to one supervision when required. If he requires restraint there are less staff and patients around thus preserving his dignity. There is also the option of seclusion or 'time out' where Barry can be more closely monitored in a room by himself, which provides less stimulus to help him reduce his anxiety and agitation.

PICU staff will meet regularly to discuss Barry's progress, with a view to moving him back to an admission ward within 6-8 weeks.

Care Environment Category 3 CAMHS

Sarah's story is an example of an admission to the regional CAMHS unit. She presented with low mood, self-harm and suicidal thoughts to her GP and has also taken overdoses in the past. Sarah has a belief that she has been told that she is beyond help. It was an overdose of medication that prompted her current admission.

Since admission Sarah has absconded from the ward and has made attempts to cut herself, placed ligatures around her neck, has continuously displayed risk taking behaviours and been physically aggressive to others and property.

She has had a history of low mood since primary school and poor concentration resulting in poor motivation engaging in therapeutic activities. There is a history of abuse of the female children in her family by their biological father. His subsequent conviction has had a profound impact on the family. Father subsequently committed suicide, which has resulted in Sarah experiencing feelings of guilt and responsibility.

Sarah has feelings of low self- esteem, high levels of anger and has experienced panic attacks. She experiences derealisation and displays a lack of concern regarding the impact of her risk taking behaviour. She also has reported feeling unsupported by her mother and describes having to be very independent. However, her mother is currently struggling to manage the demands of a large family. Sarah's mother also has hearing difficulties, making communication more challenging. It has been reported that her mother and her new partner are abusing substances and gambling causing financial worries.

Sarah's inpatient stay will be aimed at helping her understand her feelings and risk behaviours. It will provide a consistent and supportive environment where she can use therapeutic interventions to help her modify her behaviour and raise self-esteem and build emotional resilience.

Care Environment Category 4 Low Secure

John's story is typical of an admission into a low secure unit. He is 33 years old, detained under the Mental Health order, is deemed capable of managing his own affairs and has a diagnosis of schizophrenia. He has been in the low secure unit for 10 months.

He experiences paranoid thoughts and would resort to violence and aggression in response to his thoughts and what he believes to be true. He has made many attempts to leave the ward.

Historically, his mental state has deteriorated when he has been discharged into the community and he frequently would fail to attend outpatient appointments. At times there has had to be police involvement to manage his aggression in the community and in the past he has assaulted a member of staff in a hostel.

A few months previously, he was referred to the medium secure unit, but he was assessed as not requiring that level of security.

In the past 8 weeks his medication has been reviewed and changed and there have been no further physical assaults on staff, just a few verbal altercations.

Nursing care would be required to manage risk and ensure John's safety and the safety of others, review his medication and to engage him therapeutically in order to reduce his agitation and aggression. There would also be ongoing therapeutic input to hopefully prepare him for a return to the community, engaging with the community Mental Health team.

Care Environment Category 5 Medium Secure

Tim's story is an example of an admission to the regional medium secure unit. Tim is a 50 year old man, who is single and unemployed. He has been known to psychiatric services since 1977, when he was given a diagnosis of adjustment disorder. He was then diagnosed in 1994 with paranoid psychosis. Tim's first admission to hospital was in 2007 after being assessed in police custody following an alleged assault on a member of the public.

Tim has a forensic history of 39 convictions between 1975 and 1990. These were for 3 counts of riotous/disorderly behaviour, 6 counts of deception, 20 convictions for road traffic offences and other offences such as carrying weapons and a breach of the peace. He has served as a remand prisoner for an alleged sexual assault.

Tim is currently under police investigation facing a charge of actual or grievous bodily harm.

Tim's admission will provide him with treatment and care for his condition. He will be assessed and treated appropriately to his mental state. The admission also provides him and the general public with a degree of safety given his forensic history. He will be managed with a view to stabilising his mental state and to assisting him to be rehabilitated back into the community, when appropriate.

APPENDIX 2

INFLUENCING FACTORS FOR PHASE 5 MENTAL HEALTH NURSING

WORKFORCE

Term Used	What does this mean?	How does this impact on a Staffing Range?
Rostering and Shift Patterns	• Rosters are structured process matching staff skills to workload variations. • Shifts plus sequence of contracted working days per staff member = available numbers of staff to manage workload demand.	• Optimal rostering of staff **=** effective management manpower to deliver on workload demand. • Imbalance in the numbers available to meet demand can increase risk to patient safety. • Appropriate shift pattern key factor in delivering safe effective care and maintaining staff morale.
Planned and Unplanned Absence Allowance (PUAA)	• Periods of absence from work - expected or unexpected - factored into workforce planning. • (A) Sickness both short and long term, (long term = 20 days or over/up to six months). • (B) Study leave (as a minimum for mandatory training). • (C) Non-clinical working, e.g. management time.	• PUAA acknowledges staff have particular requirements and rights that render them unavailable to be rostered. • Allowance needs to be agreed and funded to ensure effective workforce planning and efficient deployment of staffing resources.
Department Sister's/ Charge Nurse's /team leader time	• Agreed allocation of 100% of ward manager's (WM) time to fulfil their leadership responsibilities. • Supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures. • Be a role model for good professional practice and behaviours; oversee the environment and assume high visibility as nurse leader.	• Absence of an agreed allowance of time for ward managers can result in essential responsibilities being neglected and failure to provide leadership at department level. • Currently WM's co-ordinate a significant staffing complement with associated appraisal, supervision, regulatory, HR responsibilities and budgetary management including salaries and wages and goods and services.

Skill mix	• Percentage ratio of registered to unregistered nursing staff working within an individual care setting. • Blend of multidisciplinary registered staff including Nurse Therapists that support the Mental Health workforce. • Clinical Leadership should be reflected in the skill mix of the nursing workforce	• Inappropriate skill mix can result in a mismatch of duties and responsibilities to roles, including clinical leadership/senior cover. • Can present greater clinical risks to patients or, conversely, inefficient deployment of expensive staffing resources. • Appropriate delegation of care to unregistered staff promotes good professional Governance. • Determination of % of nurses required to constitute a Community Mental Health Team.
Management of Recruitment	• HR policies and procedures take weeks to recruit staff. • Notwithstanding this process, it is essential that nursing vacancies are filled promptly (to ensure staffing levels for safe and effective, person-centred care). • Employers must ensure that a risk-assessed approach is adopted to manage recruitment.	• Vacancy rates should continue to be carefully managed to avoid destabilising a department or team and increasing the risk to patient care through inappropriate staffing levels and skills. • Recruitment and retention strategies need to be put in place to support and sustain the nursing workforce. • Absence rates should be monitored and managed accordingly at HSC Trust level. • Maintenance of staffing levels (which support delivery of safe and effective person-centred care) should be reported on at HSC Trust level. • Avoidance of overuse of temporary staff, eg bank and agency staff. • Matching of staff skill and experience and band mix to patient acuity and dependency within approved guidelines. • Timely and ongoing review of risk assessments linked to service reconfigurations.

		• Annual review of uptake of MH students. • Lack of forward planning will result in inadequate succession plans for post registration MH nursing.
Management of absenteeism/ sickness	• The management process through which periods of sickness/absence are managed for all employees, with the aim of maintaining the lowest level achievable (5% target).	• Effective approaches to the management of periods of staff absence support the continuity of services, provision of safe and effective person-centred care, patient safety and good staff morale.
Competence skill set to work flexibly	• The level to which the workforce has developed a knowledge base and transferable skill set to enable practice within a particular care setting and be capable of addressing a broad range of patient needs.	• The absence of a core set of transferable skills can limit the capacity of Mental Health nursing staff to meet a broad range of patient needs in a given care environment. • To ensure that the essential clinical professional nursing skills are developed within a Mental Health team demands careful identification of learning needs and development opportunities and identified roles for all staff including senior nurses, nurse therapists and unregistered nursing staff.

ACTIVITY

Term Used	What does this mean?	Impact?
Planned ward Attendances	• Persons who attend a clinical setting for a planned visit to seek advice, review or treatment.	• Planned attendances must be captured as a workload indicator at all times. • Incremental growth in these attendances can place increasing demands on nursing teams, without appropriate increases in staffing levels. • Could potentially become an unfunded service development if not appropriately managed.
% Bed occupancy	• A measurement of the percentage of time that beds are occupied measured at midnight. • Day attenders are excluded from this number. • Unplanned review attendances and planned review attendances.	• Capturing bed occupancy at 12 midnight can only result in substantial activity and workload being omitted. • Collection at other times of the day can assist with this measure. • The 24-hour, 7-day service needs to be factored into workforce requirements across Mental Health care environments where appropriate.
Patient Dependency/ Acuity	• An assessment of the care demands of each patient, incorporating physical and psychosocial needs, using a validated and credible tool.	• Appropriate workload measurement tools can inform the utilisation of appropriate staffing levels for departments and localities, thus supporting safe and effective direct and indirect care.
Demand, need and throughput	• Length of stay; • Caseload analysis; • Trends in increase in mental illness requiring assessment 24/7. • Referral rates	• Trend in H&SC services towards reducing the time spent in Inpatient units. • Increase in demand on services requires a capacity modelling tool (eg. CAPA). • Increased complex discharge processes, (ongoing treatment and care in community setting). • Increase in the throughput of patients and results in an increase in the workload demands for staff.

Specialties/ Case Mix	• Range and variation of patients' health conditions managed in a particular clinical setting/care environment, including the demand for psychological therapies.	• A broader range of specialties and case mix being managed in a care setting presents a greater demand on the Mental Health nursing team in terms of knowledge, skills and complexity.
Number of spaces for diagnosis and treatment	• There are a number of appropriate treatment areas within Inpatient units that can be used for assessment and management of patients' conditions.	• The number of spaces for diagnosis and treatment and design of a care environment can have an impact on the efficiency of the department, e.g. ECT suites and group therapeutic interventions.
Assessment of Risk	• Nurses must assess and manage risk within a clinical environment to ensure the delivery of safe and effective, person-centred care. This includes risk to people in their care, members of staff and other members of the public.	• By adopting an anticipatory approach nurses can proactively support the minimisation of risk and provide a quality service that meets patient/client needs. • Opportunities to act on lessons learned and drive improvements in the quality and safety of services ensure that practice is informed and improved. • Time is required from the nursing team for this activity to carry out ongoing risk assessments for patients within their care environments.
Incremental Service Improvements/ Development and Reform	• This is activity concerned with testing new ideas and ways of working, sustaining and sharing best practice to make a tangible difference in outcomes and experience for staff and service users.	• Incremental service improvements are designed to implement improvements in patient care and/or outcomes. • Can result in improved working conditions for staff. • Alternatively, unrelenting service improvements can also have a disruptive impact on individuals and contribute to low staff morale if not supported with appropriate workforce requirements. • Staff requirements should be factored into elements of reform agendas where appropriate.

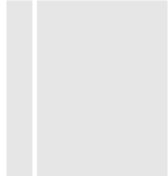
ENVIRONMENT AND SUPPORT

Term Used	What does this mean?	Impact?
Technological and Equipment Support	• Support provided within a clinical area by Information Technology and other mechanised systems eg ECR. • Sufficient equipment maintained and stored appropriately (which may assist nursing teams in caring for patients).	• Access to available software which links to a range of data systems (can enable efficient transfer of information which assists at many stages of the patient care pathway). • Efficient systems may reduce workload requirement. • Inefficient systems may add to the workload, eg staff spending time sourcing equipment.
Geographical Layout/ Room Structure	• Arrangement and layout of the physical clinical environment, including use of single rooms. • Impact of physical arrangement of clinical setting on workforce planning (may require more staff where there are areas of poor visibility or require staff to work in discrete teams).	• A well designed/engineered layout for a clinical environment, with optimal employment of relevant technologies, can support enhanced observation of patients and consequently decrease risks to patients/clients, thus reduce the impact upon staffing requirements. • Where single rooms restrict visibility and therefore compromise clinical observations, this will have an impact on staffing levels in care environments.
Population profile for MH services	• Demographic profile for the population of NI and the significance of incidence of mental illness. • Includes relationship to deprivation/ incidence of Mental Health risk factors.	• The demographic profile of any geographical area may determine the service profile and priorities for nurse staffing models required to meet the demand on Mental Health services, also population workforce profiles and community and voluntary sector support will need to reflect this.
Number of beds	• Number and type of beds will determine the range or ratio for staff in each care environment across Mental Health inpatient facilities.	• Additional beds to meet demands and acuity of patients may impact on the capacity of staff to provide person-centred care.

Departmental Adjacencies Escorting Patients	• Where there may be a number of patients requiring nurse escort, workforce planning impact needs to be considered re staffing levels to support safe, effective person-centred care.	• Nursing staff may be required to escort or transfer patients to other units thus removing the member of staff from the core team.
Supportive Staff Infrastructure	• The support provided within a care environment by other members of staff, who are not registrants or within the family of nursing, eg 'patient trackers', administration or housekeeping staff.	• There are a range of tasks which can be completed by individuals who are not identified as working specifically within the family of nursing, e.g. administrative staff, housekeeping staff. • The support provided by these staff members has an impact on the Mental Health nursing team to be able to deliver the care required. • Conversely, the absence of such members of staff should be highlighted where there is an indication that this support would be helpful to the nursing team to facilitate effective care delivery. • Additional nurse therapists and nurse specialists facilitate the delivery of patient centred care and can provide enhanced therapeutic interventions in a range of care environments. • These posts are **in addition** to the core requirements for inpatient workforce requirements but have a significant supportive role in Mental Health service provision.

PROFESSIONAL REGULATORY ACTIVITY

Term Used	What does this mean?	Impact?
Indirect care	• Activity linked with nursing care delivery but not a direct element of the process of care delivery, e.g. multi-professional case meetings, referrals to other agencies/services, resetting/restocking environments following use.	• Level of this activity and requirements for delivery of such can impact on the workload of nursing teams. • This requires definition as to what elements are present within the nursing workload and how much time is expended on them for their specific role.
Revalidation	• NMC introduced revalidation for Nurses and Midwives in October 2015. All nurses are required to revalidate to maintain their registration. • The allowance in the planned and unplanned allowance incorporates training.	• Nurses will have to be supported to revalidate every three years to demonstrate that they practice in accordance with the NMC code in their nursing role.
Compliance with professional regulatory standards	• Activity concerned with ensuring that professional standards issued by the NMC are embedded and maintained within a care environment, eg revalidation or learning and assessment and practice/mentorship. This may include ongoing monitoring of these standards.	• High activity levels without adequate staffing can negatively impact upon the ability of nurses to comply with regulatory standards. This is of particular importance with the introduction of revalidation.
Supervision	• Process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service user protection, quality and safety.	• An element of the time required to develop nurses and those within the family of nursing, including the time requirement for supervision processes, is included in the Planned and Unplanned Absence Allowance of 24% as endorsed in the Delivering Care policy framework (2014).



Accountability and governance requirements	• The impact of nurse staffing levels on the quality and safety of patient care is well documented. The Executive Director of Nursing is accountable for ensuring that nurse staffing levels are sufficient to deliver safe, effective, high standards of nursing care to all who use services. • Governance has been defined as 'systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, the wider community and partner organisations (DoH Integrated Governance Handbook 2006). Accountability embodies key attributes: • Recognisably high standards of care; • Transparent responsibility and accountability for those standards; • A constant dynamic of improvement.	• In order to provide safe, effective, person-centred care, appropriate staffing levels are required to impact positively upon the profession's ability to deliver effectively to governance requirements indicated through good performance in Key Performance Indicators agreed regionally. • This type of activity can include collecting information about the standard of practice and care through, for example, audit, complaint review, user engagement and benchmarking practice against an evidence base. Following such activity, action plans are required to enable development of nursing practice or service improvement work to ensure the ongoing delivery of safe, effective, person-centred care. All of this activity requires time for the Mental Health nurse to engage effectively and facilitate ongoing accountability, governance reporting arrangements and improvement of care in all settings

APPENDIX 3

Key Themes Highlighted in PHA Literature Review Mental Health Workforce Planning (2017)

- *"Mental Health Services require a higher proportion of interventions"*
- *"Interventions are often reactive and unplanned"*
- *"A higher proportion of service users are ambulatory rather than bed-based"*
- *"Length of stay in hospital tends to be longer for Mental Health patients"*
- *"Higher percentage of service users are detained rather than there by choice"*
- *"Around 50% of service users require a higher degree of security."*

The **key themes** that emerged from the literature review were as follows:

- The increase in incidence of Mental Health problems across Northern Ireland;
- The need for services to react accordingly;
- The significance of the role of the Mental Health nursing workforce and the requirement to meet the demands appropriately;
- The strength of the nursing role within this context, with nurses forming the largest group of staff within the NHS and with respect to the unique role and function of the Mental Health nurse;
- The requirement to shift from a paternalistic approach to a more inclusive approach to health care in order to support people to take control of their own lives (Making Life Better, 2012-2023);
- The challenge of supporting more people in the community;
- Significant challenges for sustaining and managing the numbers of nurses who will leave the service in the next 5 years due to Mental Health Officer status.

In addition, the Royal College of Psychiatrists (RCPsych), in an occasional paper OP 79, [21]created 10 standards for good practice on an acute Mental Health ward (refer to footnote below). Within a hospital ward, a professional blend of nursing staff provides care for a set number of patients. One of the recommendations was that the optimum number of beds would be 18. In 2006 the Royal College of Nursing in its policy document 15/2006 specified that the ratio of registered to non-registered nursing staff should not fall below 65:35 in general wards in mainland UK. It is accepted by the Royal College of Nursing that the ratio in acute Mental Health wards in Northern Ireland should be 70:30.[22]

[21] Royal College of Psychiatrists, OP79 Do The Right Thing: How to Just a Good Ward (June 2011) www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op79.aspx

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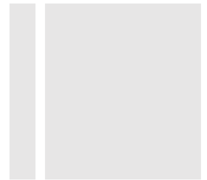

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Evolving and Transforming to Deliver Excellence in Care

A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2025) Updated May 2016

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

NIPEC

HSC

FOREWORD BY THE DHSSPS CHIEF NURSING OFFICER

It is vital that the Nursing and Midwifery workforce in Northern Ireland offers enough flexibility and innovation for future changes in service delivery models and public need.

To this end, this Workforce Plan for Nursing and Midwifery:

- Sets out clearly the education and training commissions we intend to make between 2015 and 2025;
- Explains the context and processes on which these decisions have been made;
- Provides the aggregate number of commissions and the trend increases and decreases within and between key groups and specialties;
- Highlights key trends and emerging themes from the wider health and social care system and other workforce plans that may have implications for service delivery in future years;
- Identifies key challenges that will need to be addressed if we are to make improvements in the workforce planning processes next year and beyond so that the investments we make better reflect the future needs of patients and clients.

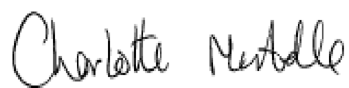
We appreciate that there is no exact science or agreed methodology for predicting or responding to future patient and client need. Therefore we must work closely with a wide range of stakeholders to help us make these difficult judgments, within a finite budget. This will require a culture of transparency and openness, where we can share and challenge each other's assumptions to ensure that the decisions we make result in safe, effective, person-centred and compassionate care with improved outcomes and positive patient and client experiences.

The recommendations for action contained within this Plan aim to lay the foundation for the development of a competent, confident, critical-thinking and innovative nursing and midwifery workforce in Northern Ireland for the future. To take this forward, I will ensure that the Regional Workforce Planning Group places this Plan on their agenda and work-plan to ensure robust multi-disciplinary workforce planning.

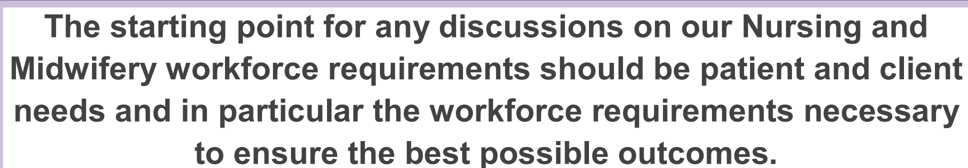
I would like to express my sincere thanks to the members of the Project Steering Committee who committed their time, energy and expertise to the development of this Workforce Plan. I would also like to thank all of the individuals across the HSC system who provided us with evidence and information and the wide range of stakeholder representatives who contributed to and participated in various meetings,

surveys, workshops, focus groups and interviews during this process. The Central Nursing Advisory Committee CNMAC have completed an indepth examination of Band 5 recruitment processes and this paper has also been drawn upon to include an updated position for 2016.

A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for project managing the development of this Plan and to Skills for Health for their permission to reproduce material from their Six Steps Methodology to Integrated Workforce Planning (2009).



Mrs Charlotte McArdle
DHSSPS Chief Nursing Officer



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EXECUTIVE SUMMARY

Evolving and Transforming to Deliver Excellence in Care has been developed to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to meet the health and care needs of the population in Northern Ireland over the next ten years, and beyond. A range of methods were employed between January and November 2014 including reviewing the international literature, gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups, interviews and meetings with stakeholders across the Health and Social Care system, including the independent sector, and reviewing relevant policies and strategies to identify proposed service developments or changes over the next ten years.

Throughout the project, participants repeatedly highlighted the challenges facing nurses and midwives during a period of transition from predominantly hospital-based to community settings. These include a growing number of older people, children and other vulnerable groups with complex needs in the community; the rise in the number of people with long-term conditions and co-morbidities requiring complex nursing care; the associated drive to prevent hospital admissions and to ensure end of life care at home; the requirement for specialist and advanced level practice and non-medical prescribing; the increase in the delivery of nurse and midwife led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, stakeholders reported a range of recruitment processes that have led to the perception of a developing culture of "*any nurse will do*". Nonetheless, an interest and enthusiasm to drive improvements in service responses and delivery to ensure safe, effective and person-centred care were evident during stakeholder engagement. It was clear throughout the project that all employers are starting to feel the effects of the well documented global shortage of Nurses.

A series of recommendations have been developed which command a consensus among stakeholders. Chief among them are:

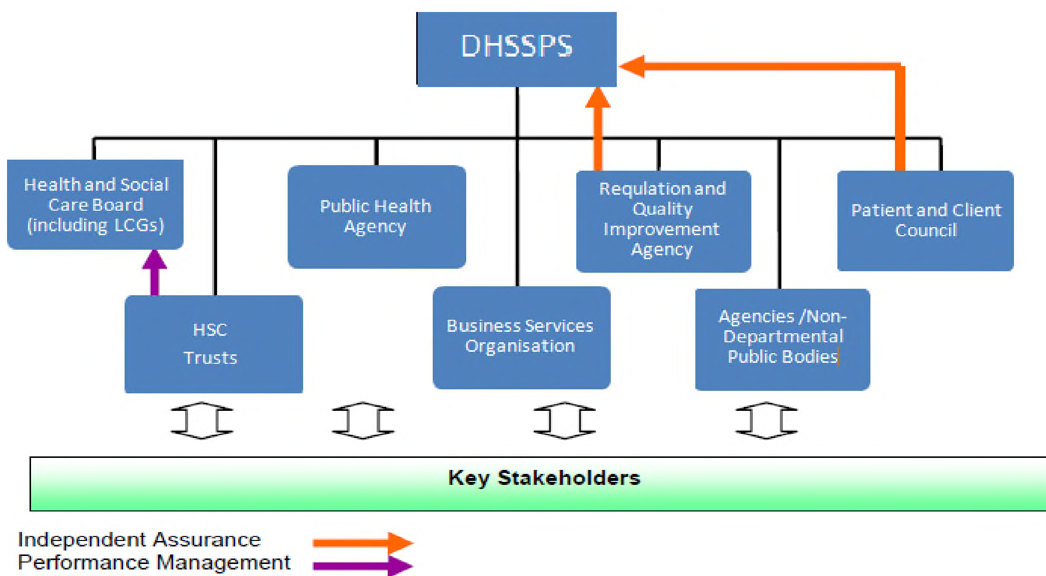
- the need for a strategic approach to the future supply and demand of Nursing and Midwifery to make Northern Ireland a destination Employer of Choice;
- a review of HSC Trusts' nursing and midwifery recruitment processes;
- a review of the nursing and midwifery workforce within the independent sector;
- implementation of pre and post registration education programme forecasts;
- the introduction of Advanced Practice Programmes across the statutory and independent sectors.

An action plan and structure for taking the work forward is proposed along with a monitoring process.

INTRODUCTION

Health and social care in Northern Ireland are provided as an integrated service with a number of organisations working together to plan, deliver and monitor health and social care (Figure 1):

Figure 1: Northern Ireland Health and Social Care Structure



Source: (DHSSPS, 2011a)

Nurses and midwives comprise the largest part of the Health and Social Care (HSC) workforce delivering services 24 hours a day, 365 days a year, designed to meet peoples' health and healthcare needs across the age spectrum and in every health sector (statutory and independent) including primary, secondary and tertiary care, and in schools, prisons and workplaces. While the role of the professions has always been highly valued, recent reports have highlighted the need to maximise and further release the potential of the nursing and midwifery workforce to provide safe, effective, person-centred and compassionate care (Francis, 2013; International Council of Nurses, 2014).

This is particularly relevant with the *Transforming Your Care* agenda (DHSSPS 2011b), driving the transition of service delivery from predominantly acute hospital based to community settings and other key policy directives (DHSSPS, 2011c; DHSSPS, 2012a; DHSSPS, 2012b; DHSSPS, 2013a; DHSSPS, 2014a). To support this, more nurses will be needed with skills in complex case management, advanced and specialist practice knowledge, and the confidence to work independently in community rather than acute hospital settings.

Workforce planning has become a key component of all health and social care planning as the impacts of demographic changes and a shrinking labour market are increasingly understood. Not only will the needs of patients and clients continue to change and demand for our services increase, but the workforce profile and characteristics of our staff will also change as our own workforce ages.

Workforce planning involves commissioning the services required to implement strategic priorities and the workforce to deliver those services. NHS England's (2014) recent publication *Five Year Forward View,* highlights that we can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.

To support this, the HSC system has a vital role to play in the commissioning of pre and post-registration nursing and midwifery education programmes. This requires partnership working between the DHSSPS, Health and Social Care Board (HSCB), HSC Trusts, Local Commissioning Groups (LCGs), Integrated Care Partnerships (ICPs) and the independent sector organisations. This is particularly pertinent to *Delivering Care* (DHSSPS, 2013b), the policy direction for agreeing nurse staffing levels in Northern Ireland. The first phase of this work is in the process of implementation and will require additional funding, during a period of significant financial constraints.

The last major *Review of the Nursing and Midwifery Workforce in Northern Ireland* was published by the DHSSPS in 2009. This included workforce projections up to and including 2013 therefore the production of this Workforce Plan is timely. During the period between 2009 and 2014, there has been a 4% (whole time equivalent) increase in the number of registered nurses and midwives, which includes student health visitors and midwives. We now have an ageing nursing and midwifery workforce with up to 46% eligible to retire over the next ten years in some practice areas, who will need to be replaced with the HSC system.

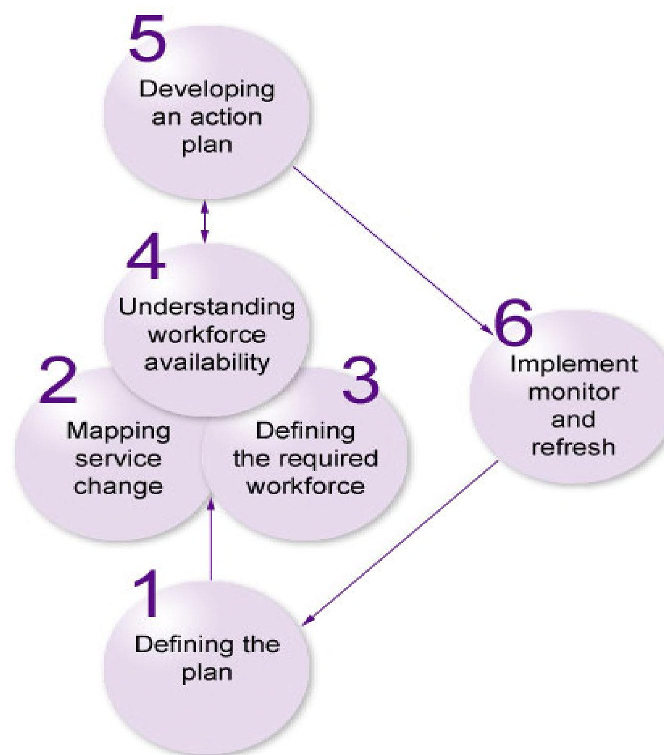
This Workforce Plan will support the needs of the nursing and midwifery workforce in an increasingly demanding working environment. It will assist the DHSSPS in the development of strategies to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to support the delivery of safe, effective and person-centred care and meet the needs of the service overall. The recommendations will also aim to lay the foundations for the development of a more systematic and standardised approach to nursing and midwifery workload and workforce planning processes to improve the current situation.

SIX STEP METHODOLOGY FOR WORKFORCE PLANNING

Effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, within the correct budget, delivering services to provide the best possible patient and client care. Workforce planning is complex and comprises of many elements.

The Skills for Health Six Steps Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this Workforce Plan (Figure 2):

Figure 2: Six Step Methodology to Integrated Workforce Planning (Skills for Health, 2009)



This high-level stepped approach has been endorsed by the health and social care workforce planning community across Northern Ireland. It has proven useful in supporting the establishment of information on the supply and demand factors relevant to the nursing and midwifery workforce.

This in turn has helped to inform decision-making on the number of nursing and midwifery education and training places to be commissioned between 2015 and 2025 and to develop an understanding of the issues impacting on recruitment, retention and career progression of those employed.

GUIDING PRINCIPLES OF THE WORKFORCE PLAN

The following principles were employed to guide the development of this *Workforce Plan for Nursing and Midwifery (2015-2025)*:

Guiding Principles

- ✓ The Nursing and Midwifery Workforce Plan is set within the wider context of the international perspective on workforce, education and training, legislative, professional and practice issues, taking into account and reflecting activity at national, regional and local levels;
- ✓ The Plan will take account of the demographics and health and care needs of the patient and client population in Northern Ireland, the services for which there is expressed demand, the profile and dynamics of workforce supply and availability, and assess the extent to which a balance of demand and supply can be achieved;
- ✓ The whole of the registered nursing and midwifery workforce is taken into account, including the numbers, skills and skill mix required;
- ✓ There is a willingness and commitment from health and social care organisations to share high level data;
- ✓ A person-centred approach is central to health and care delivery, treatment, outcomes and patient and client experience;
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required;
- ✓ Human resources and finance departments must be central to supporting the service delivery and planning agenda;
- ✓ Stakeholder engagement should be employed throughout the whole process of implementation;
- ✓ The Plan will include recommendations and actions to ensure it is integrated within the overall approach to service planning within the wider health and social care system.

ABBREVIATIONS

AfC	Agenda for Change
ANP	Advanced Nurse Practitioner
BSO	Business Services Organisation
CNMAC	Central Nursing & Midwifery Advisory Committee (DHSSPS)
DHSSPS	Department of Health, Social Services & Public Safety
ECG	Education Commissioning Group
GP	General Practitioner
HC	Headcount
HSC	Health & Social Care
HSCB	Health & Social Care Board
ICP	Integrated Care Partnership
Independent sector	Includes independent, voluntary and private sectors
ICN	International Council of Nurses
LCG	Local Commissioning Group
NMC	Nursing & Midwifery Council
NIPEC	NI Practice & Education Council for Nursing and Midwifery
NISRA	Northern Ireland Statistics and Research Agency
PHA	Public Health Agency
RCN	Royal College of Nursing
RCM	Royal College of Midwifery
RQIA	Regulation and Quality Improvement Authority
RWPG	Regional Workforce Planning Group (DHSSPS)
Staff in Post	The total number of staff employed (usually of a given group)
WTE	Whole Time Equivalent
WHO	World Health Organisation

STEP 1: DEFINING THE PLAN

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

1.1 Purpose

In December 2013, the DHSSPS Chief Nursing Officer commissioned the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) to manage a project to develop a Workforce Plan for Nursing and Midwifery.

The Project Objectives:

- Identify the profile and characteristics of the current nursing and midwifery workforce;
- Review the literature and relevant policies and strategies;
- Analyse recruitment and retention issues;
- Engage and consult with relevant stakeholders;
- Utilise a recognised workforce model to predict trends and requirements;
- Produce a final report with recommendations and an action plan to address these.

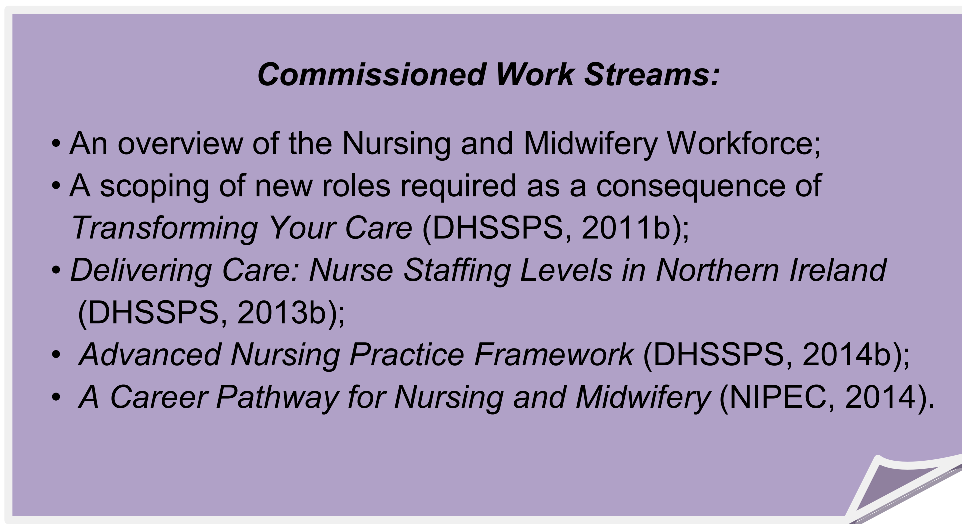
The primary purpose of this Plan is to support the forecasting of the number of Nursing and Midwifery Council (NMC) approved pre-registration nursing and midwifery and post-registration specialist nursing places to be commissioned on an annual basis over a ten year period (2015–2025).

This will enable relevant organisations to have a workforce pool to draw from in order to employ sufficient nurses and midwives who will deliver person-centred practice and, in partnership with the wider care delivery team, improve outcomes for patients, clients and their families.

The Plan will ensure:

- A clear understanding of the future direction of the nursing and midwifery workforce in Northern Ireland;
- An integration with service and financial strategies;
- A base of realistic and affordable assumptions;
- Short and medium term changes to service are taken account of;
- Engagement with clinical staff and wider stakeholders;
- A link to commissioning plans;
- The provision of an evidence base.

It will build on a range of significant work streams already commissioned, some of which have been completed.



Commissioned Work Streams:

- An overview of the Nursing and Midwifery Workforce;
- A scoping of new roles required as a consequence of *Transforming Your Care* (DHSSPS, 2011b);
- *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b);
- *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- *A Career Pathway for Nursing and Midwifery* (NIPEC, 2014).

All of the above work streams will, because of their focus on the development of the nursing and midwifery workforce, supplement the Plan which will be the umbrella document addressing the many issues currently facing the workforce.

1.2 Scope

Considering the wide range of health and healthcare services provided in Northern Ireland, this Plan is by necessity, broad in its scope, acknowledging that nurses and midwives deliver care 24 hours a day, 365 days a year, across the age spectrum. It has relevance to registered nurses and midwives employed within the statutory and independent sectors, taking account of primary, secondary and tertiary care settings and the major areas of practice to include: both the nursing and midwifery professions, the three parts of the NMC register and associated fields of practice and Agenda for Change (AfC) Bands ranging from Band 5 to Executive Nurse.

As the primary purpose of this Plan is to support the prediction of pre and post registration education places to be commissioned for nurses and midwives, health care support staff have not been included in this Plan.

Availability of nursing and midwifery workforce statistics relating for the independent sector were limited at the time of developing this Plan therefore it has proven difficult to include accurate, up-to-date figures. However, some important information obtained during stakeholder engagement has been included, particularly the need to strengthen reported recruitment issues. Nonetheless, work currently underway relating to nursing and midwifery within this sector will be taken into consideration during the implementation of the recommendations contained within this Plan.

A range of methods were employed between January and November 2014 to meet the project aim and objectives including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups and interviews with stakeholders across the HSC system and reviewing relevant policies and strategies to identify proposed capital and service developments or changes over the next ten years. The findings have been used to inform and shape the content and recommendations included within this Plan.

1.3 Ownership

The need to ensure the support and ownership of the health and social care system and the professions was considered critical in the development of this Plan. A Regional Steering Committee was therefore established to oversee the project, chaired by the Chief Nursing Officer, with representation from the DHSSPS, the five HSC Trusts, Public Health Agency, Business Services Organisation, Independent Sector and Professional and Trade Union organisations. Membership of the Project Steering Committee is listed in Annex A. Extensive stakeholder engagement and analysis of relevant statistical data was conducted and all relevant health policy documents were reviewed and a full list may be found in Annex B.

The Plan takes account of, and requires synergy with, the full range of legislative, policy and professional requirements and developments aimed at enhancing standards, care delivery and patient and client outcomes. It must also be considered in the multi-professional and inter-agency context of the settings in which nurses and midwives work. For this reason, it is important that it is linked with other relevant Workforce Reviews and Plans, in particular, the full range of Medical Workforce Reviews. The Plan will inform the education commissioning process in partnership with the Regional Workforce Planning Group (RWPG), as outlined in the monitoring process at point 6.2.

STEP 2: MAPPING SERVICE CHANGE

This is the first of three interrelated steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

2.1 Population and Health Profile

In Northern Ireland we have the fastest growing population of any country within the UK (DHSSPS, 2013a). The Northern Ireland Statistics and Research Agency (NISRA, 2014) reported that births in Northern Ireland have remained stable over the last 5 years with 25,300 live births registered during 2012. They also projected the population to rise from 1.79 million in 2010 to nearly 2 million in 2025 (an increase of almost 8 per cent).

There are 430,763 children and young people under the age of 18 in Northern Ireland (PHA, 2014). The number of people aged 65 and over is forecast to increase by 42 per cent, from 260,000 to 370,000. Significantly, though, the number of people of working age is only projected to increase by 1.4 per cent, from 1,109,000 to 1,124,000, by 2025. Over the same period, the number of people aged 85 and over will increase by 25,000 to 55,000.

In 2012, there were 14,756 deaths registered in Northern Ireland, an increase of 552 deaths (3.9%) compared to 2011. Of the 14,756 deaths registered in 2012, just under half (49%) of deaths occurred in hospital. A further 27% died in their own home, followed by 18% in a nursing home. The remaining 6% of deaths occurred elsewhere (NISRA, 2014). The average age at death has increased over the last 30 years from 70.1 years in 1982 to 76.4 years in 2012 (NISRA, 2014).

The main cause of death was cancer accounting for 28% of deaths in Northern Ireland. According to NISRA (2014), cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in Northern Ireland has increased from 18% in 1981 to 29% of all deaths in 2011. By way of contrast, deaths in 2011 due to ischemic heart disease decreased by 60% since 1981 from 4,909 to 1,966 (PHA, 2014).

Life expectancy across the region has improved by 8 years for females and 6 years for males since 1980/82. In 2008/10 males can expect to live to the age of 77.1 years and females to the age of 81.5 years. As overall life expectancy in Northern Ireland has continued to rise over the past 30 years (O'Neill et al., 2012), so has the likelihood of developing a long-term condition or experiencing co-morbidities (more than one long-term condition). A report by the Institute of Public Health in Ireland (2010) predicted that between 2007 and 2020 the prevalence of long term conditions amongst adults in Northern Ireland, namely Hypertension, Coronary Heart Disease, Stroke and Diabetes, is expected to increase by 30%.

The prevalence of long-term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2014). Across Northern Ireland the most prevalent long-term conditions are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

During 2011/12 long-term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 of the population (aged 18+).

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2014).

The number of alcohol related deaths has been increasing over the past decade. Since 2001, there has been a total of 2,785 alcohol related deaths, 68% of which have been deaths to males. Of this total, 854 or 31% were registered to Belfast Local Commissioning Group's (LCG's) area of residence (PHA, 2014).

The Health Survey Northern Ireland (DHSSPS, 2014c) indicated that three-quarters of children aged 2-10 years old (75%) were either underweight or normal weight, while a fifth (19%) were overweight and 6% were classed as obese. Overall, a quarter of adults (25%) were measured as obese with a further two-fifths (37%) classed as overweight. Males (69%) were more likely than females (57%) to be overweight or obese.

In Northern Ireland between 2001 and 2011, 37,500 people died prematurely of conditions which were potentially preventable. An additional 8,765 people died prematurely of conditions which, if diagnosed and treated early enough, might have been avoidable (PHA, 2014).

High levels of mental health problems, self-harm, suicide and alcohol and drug abuse are reported in the homeless population and an estimated 2/3 of prisoners have mental health problems (PHA, 2014). *Transforming Your Care* (DHSSPS, 2011b) highlighted that 24% of women and 17% of men in NI have a mental health problem – over 20% higher than the rates in England or Scotland. *The Service Framework for Mental Health and Wellbeing* (DHSSPS, 2011d) highlights that 10-20% of older people (aged 65 years or over) suffer from serious mental health problems. Similarly, *Healthy Child Healthy Future* (DHSSPS, 2010c) reported that the prevalence of mental health problems amongst children and adolescents is estimated at 20% and 'Looked After Children' are amongst the most socially excluded of our child population. In addition, children and young people with complex physical needs are increasingly being supported at home, including ventilated children (DHSSPS, 2011b).

The Dementia Strategy (DHSSPS, 2011e) indicates that levels of dementia are projected to increase to 60,000 by 2051 from 19,000 in 2010. Between 17-21% of the population have a physical disability, and around 37% of households include at least one person with a disability (NISRA, 2014).

2.2 Drivers for Change

The success of the *Transforming Your Care* (DHSSPS, 2011b) strategy, particularly in respect of the delivery of new service models, is significantly dependent on the development of an appropriately trained and competent nursing and midwifery workforce. The challenges facing nurses and midwives during this period of transition include a growing number of older people, children and other vulnerable groups requiring nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; high levels of mental health problems; the associated drive to prevent hospital admissions and to ensure end of life care at home; the development of eHealth technologies, including tele-monitoring; the requirement for advanced physical assessments and non-medical prescribing; the increase in the delivery of nurse led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, public expectations of health and social care are changing and patients and carers expect high-quality services to be delivered close to their homes.

To effectively meet emerging demographic, social and disease challenges and drive the transition of service delivery from predominantly acute-based to community settings, as outlined in *Transforming Your Care* (DHSSPS, 2011b), there is an increasing need for Specialist Nursing expertise particularly with skills in complex case management, advanced specialist practice knowledge, and the confidence to work autonomously in community rather than acute hospital settings.

A number of Specialist Nursing roles have already been developed in Northern Ireland, particularly in the areas of long-term conditions management, and increasingly in the management of conditions such as urology, dermatology, cancer, diabetes, Parkinson's disease, chronic heart failure and dementia. In many cases the involvement of a Specialist Nurse can prevent patients from being re-hospitalised (RCN, 2010).

The independent sector is becoming increasingly important in the delivery of care; mainly due to demographic changes and as our population continues to age. Increasingly more of the nursing workforce is employed within these sectors and it is important that the knowledge, skills and experiences attained within these settings are recognised and cultivated to ensure a highly skilled and flexible workforce for the future.

The demands for nursing and midwifery services will become greater as the health and social care landscape in Northern Ireland continues to evolve, during the shift from acute to community based services and given the recent onus on quality and patient safety highlighted in a range of recent regional and national strategies, reviews and public inquiries including:

- Quality 2020 Strategy (DHSSPS, 2011c)
- Public Inquiry into the Outbreak of Clostridium Difficile (Hine, 2011)
- Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)
- Independent Review into Healthcare Assistants and Support Workers (Cavendish, 2013)
- Winterbourne View Report (DH, 2013)
- Review into the Quality of Care (Keogh, 2013)
- Improving the Safety of Patients (Berwick, 2013)
- Management of Unscheduled Care Report (RQIA, 2014)

The need for investment in high quality, nursing and midwifery services has never been greater.

It is therefore important that consideration is given to ensuring that 'the right number with the right skills are in the right place at the right time with the right attitude, doing the right work, at the right cost, with the right work output (WHO, 2010), to achieve the quality goals set by health and social care organisations. To enable this we need to ensure that effective education and training and continuous professional development is available and ongoing to support the way forward. Ultimately, we want to assure our patients and clients that every service is safe and effective and provided by staff who are caring and compassionate.

2.3 Financial Challenges

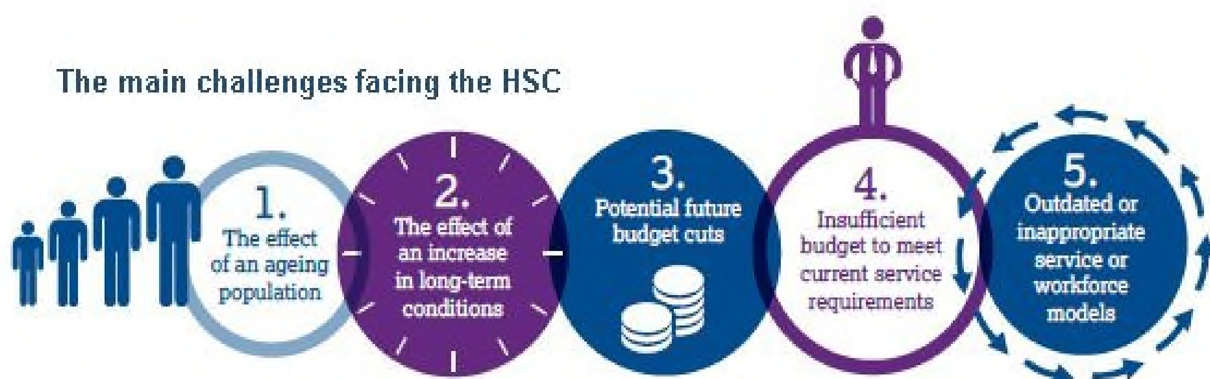
Although the HSC continues to face significant financial challenges it must play a full and active role in delivering the efficiencies required to reduce the expenditure set by the Northern Ireland Executive. The implications of the efficiency challenges facing the HSC workforce over the next ten years will be significant, particularly in relation to meeting existing commitments; irrespective of any modernisation, reform and improvement.

A key financial objective within the *Transforming Your Care* (DHSSPS, 2011b) reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. The *Transforming Your Care* report highlights the intention to shift approximately 5% (£83 million) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme. In order to affect this shift of care and funding out of hospital services and into the primary/community setting, the HSCB will commission services to be delivered in a different way.

2.4 Service Changes

2.4.1 Strategic Direction and Transformation

Although Northern Ireland differs from much of the rest of the UK, in having an integrated health and social care system, it faces many of the same challenges (outlined in the diagram below) and must deliver similar changes if it is to be successful and sustainable in the future.



Source: Adapted from the NHS Confederation (2014)

The demographic changes described previously demonstrate the need to preserve and sustain our health and social care services in the face of increasing demands and to meet the care needs of the population within a difficult financial climate.

2.4.2 Regional Reviews and Strategies

Successful outcomes in the provision of health care are linked to the broader public health agenda and require integrated working at local and regional levels. The HSC has begun to address the challenges it expects to face, commencing work on a number of initiatives aimed at continuously improving the quality of services. A number of reviews and strategies (Annex B) are at various stages of development and implementation. Key themes arising from which will have an impact on the Nursing and Midwifery workforce are identified below:

Healthcare Policy

- Focus on measuring effectiveness, reducing variations and improving productivity
- High profile for improving quality of care and safety
- Designing effective healthcare systems and structures
- Continuing effort to improve evidence-based decisions on provision of services
- Revision of pattern of hospital services, concentration of specialisms and more care closer to home
- Personal and public involvement (PPI)

Supply of Healthcare

- Growing role for the independent sector
- Substantial investment in information technology
- Increase in the use of telecare to support people at home

Demands for Healthcare

- Changing patterns of disease, shifting dependency ratios
- Changing modes of service delivery
- Financial constraints
- Continuing emphasis on health promotion and prevention
- Persistent health inequalities
- High priority on supporting self-care in long-term conditions
- Growing demand for patient choice
- Developments in technology
- Move to 7 day working to support Integrated Care Pathways
- Outpatient Reform
    - increased use of virtual clinics
- Enhanced Care at Home Models
    - enhancement of community nursing services
    - rapid response to patients out of hours suffering an acute episode
    - single gateway multidisciplinary approach
- Stroke Care
    - increase direct entry to stroke units from 70% to 90%
    - early supported discharge
- Older persons' assessment and liaison (OPAL) Teams
    - specialist geriatric assessment outside of care of elderly wards
    - daily in-reach to ED's for screening
    - rapid access to out-patient clinics
- Alternatives to admission -
    - Shifting of resource to the community

Step 3: Defining the Required Workforce

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

3.1 Workforce Projections

Significant workforce change and development is expected to support enhanced community and primary care services associated with the implementation of *Transforming Your Care* (DHSSPS, 2011b). This will result in substantial training, re-training and re-deployment of associated nursing and midwifery staff, creating significant pressure on the Education Commissioning Budget as community based specialist practice programmes are full-time and are among the most costly elements of the Education Commissioning budget to fund. Similarly, there are a range of *Hot Spot Areas* which will have an impact on the nursing and midwifery workforce projections over the next ten years, as presented below.

Add in action point

The full time nature of Specialist Practice Programmes should be reviewed and consideration given to delivering these programmes on a part time basis

3.1.1 Hot Spot Areas

Impact of a Global Shortage of Nurses and Midwives

A range of reports and studies warn that global shortages are placing the nursing and midwifery workforce under pressure and risking the quality of patient care (Kelly et al., 2011; Van den Heede & Aiken, 2013; Imison & Bohmer, 2013; ICN, 2014). In the UK, the Centre for Workforce Intelligence (2013) forecast a likely reduction of 63,800 nurses over the period 2013 to 2016. Similarly, an NHS Employers report (2014) highlighted that 83% of NHS Trusts in England are currently experiencing qualified nursing workforce supply shortages.

In addition, there has been an outward shift of many of the internationally recruited nurses who moved to Northern Ireland during the last decade, mainly among the

Filipino and Indian nursing community. This is particularly pertinent to the independent sector who report significant difficulties in attracting and retaining nurses, even from overseas, at a time when an increasing number of patients and clients are being cared for by this sector. Northern Ireland employers from all sectors are holding major Job Fairs in an attempt to recruit, retain and attract nurses and midwives to their organisation. Similarly, employers from outside Northern Ireland are offering competitive relocation packages and choice of specialty with enhanced training to attract nurses and midwives. The evidence suggests that the international shortage of nurses will continue to be an issue of particular importance for Northern Ireland during the period of this Workforce Plan. In CNMAC's paper December 2015 (Annex C) there is a recommendation that immediate steps be taken to support a regional international recruitment process from both EC and Non EU countries

Action Point: A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice.

Impact of Recruitment Processes for Nurses and Midwives

During the development of this Plan, stakeholders identified a range of recruitment issues within HSC Trusts relevant to nursing and midwifery. The current practice of recruiting to temporary posts and/or the development of long waiting lists for posts, whereby nurses in particular are offered posts which do not take into consideration areas of preference or alignment to knowledge and skills, has led to the perception of a developing culture of "*any nurse will do*". This practice is counter-productive and is not resulting in ensuring the right nurse is deployed in the right area.

Similarly, recruitment processes and methods employed to backfill maternity leave and sickness absence were reported by stakeholders as difficult and protracted, leading to staff being under extreme pressure and experiencing heavy workloads; resulting in increased levels of workplace stress and low morale impacting on patient care. The impact of regional recruitment was reported as further concern. The CNMAC paper December 2015 gives more detail on the issues surrounding recruitment of Nursing and Midwifery staff.

Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review.

Action Point: Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review to support the implementation of this Workforce Plan.

Impact from Other Professional Groups

Workforce planning is currently underway for the medical profession to determine both the required size and distribution, by specialty, across Northern Ireland. Whilst there has been some success in recruiting to medical vacancies during 2013/14, pressures still remain in the system at both Consultant and Specialty Doctor level (Emergency Departments and Medical Specialties). Filling General Practitioner (GP) Specialist training roles is also proving difficult which will impact on future GP recruitment. With proposed reductions in the number of trainees within medical specialties and difficulty recruiting to all junior medical posts, this Plan is anticipating greater medical workforce pressures especially in some key areas where there are existing recruitment issues.

During the course of developing this Plan and further to recommendations made by the College of Emergency Medicine, work is underway to consider where Advanced Nurse Practitioners (ANPs) may offer a solution to the recruitment difficulties being experienced within the medical profession and/or where their competencies can best meet service needs. Areas to date include Primary Care, Community Care, Emergency Departments and Urology and it is expected that there will be similar recommendations from the Medical Paediatric Review. The Northern Ireland *Advanced Nursing Practice Framework* (DHSSPS, 2014b) provides a mechanism for greater understanding of the definition, role and competencies required to practice at this level. The HSC Trusts must take the opportunity to link the development of new roles explicitly to the planning process and commission future training numbers based on such plans alongside developing funding streams. This may require additional funding or a re-profiling of overall staff budgets within these areas.

Action Point: Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.

Implementation of Delivering Care

Demand for nursing and midwifery in Northern Ireland is set to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). During a scoping exercise on implementation of the first phase, it was anticipated that an additional 284 (WTE) adult nurses would be required to meet the normative nurse to bed and skill mix ratio in acute and specialist medicine and surgery. This is also a policy direction in the other UK countries;

England now requires all hospitals to publish staffing levels on a ward-by-ward basis and guidance from NICE (2014) is likely to strengthen the demand for nursing and midwifery in many areas. Scotland and Wales are moving in a similar direction. It is anticipated that any recruitment exercise required to address implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

During the development of this Plan, stakeholders from the independent sector reported that they are forced to recruit from other countries due to the significant recruitment and retention issues within this sector. Therefore, in order to address any concern regarding instability of nurse staffing within the Independent sector consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within this sector.

Action Point: An infrastructure to support learning and assessment in practice and availability of a period of preceptorship must be available within the independent sector similar to that already available within the Statutory Sector to ensure adequate supervision, support and guidance to enable consolidation of nursing and midwifery training.

The second, third and fourth phases of *Delivering Care* are running concurrently at present and intend to replicate the methodology used during phase one to produce a range for staffing levels within Emergency Departments, District Nursing and Health Visiting teams.

These phases are due to report by the end of March 2015 and may have further implications for nurse staffing in those areas. The project will subsequently look at other areas such as mental health, learning disability, children's and midwifery however an agreed timeline is yet to be established for these areas.

Action Point: Ensure that as new and emerging evidence and developments become available from *Delivering Care* (DHSSPS, 2013b), these are reflected within the implementation, monitoring and refresh stage of the Workforce Plan.

Professional Issues for Nursing and Midwifery

As previously outlined at point 2.2 above, many factors will present challenges for the nursing and midwifery professions over the next ten years and beyond. Similarly,

a range of professional issues will have a significant impact on the nursing and midwifery workforce, including the following:

- A Revised NMC Code for Nurses and Midwives;
- A new NMC Model of Revalidation;
- Implementation of *Delivering Care: Nurse Staffing Levels* (DHSSPS, 2013b);
- Development of Advanced and Specialist Practice roles and implementation of the *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- Implementation of *Job Planning Guidance for Clinical Nurse Specialists* (NIPEC, 2012);
- Implementation of the *Preceptorship Framework* (NIPEC, 2013);
- Mentorship and practice training in community settings;
- Implementation of *Standards for Supervision for Nursing* (DHSSPS, 2007) and *Midwives Rules and Standards* (NMC, 2012);
- Nursing and Midwifery accountability and delegation of care;
- Implementation of a *Career Pathway for Nursing and Midwifery* (NIPEC, 2015).

Technology and Technical Skill Demands

Changes in technology continue and we wish to embrace these changes in order to reap the benefits that they will bring in terms of more efficient and effective working. Already facilities such as video conferencing, Apps, digital dictation, e-learning, electronic prescribing, use of tablets and remote working are starting to become a reality for some nurses and midwives and support staff. However, accessibility to information and communication technology facilities require further enhancement in many areas, particularly within community nursing.

Many nursing and midwifery staff encounter telehealth and telecare applications in their daily work and an increasing number are taking a lead role in telehealth and telecare programmes. By expanding access to specialist services, providing real-time health advice, and remotely monitoring both care environments and health status, telehealth and telecare programmes have the potential to reduce visits by patients to care providers (and vice versa), facilitate more localised care, provide more timely diagnosis and intervention, and even reduce costs (RCN, 2014).

It is difficult to comprehend how much technology might have changed by the end of this workforce planning period. However, in order to gain maximum benefit from future technological change the HSC will require a workforce with increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

Action Point: Provision of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.

This is a commissioning responsibility which must be addressed if we are to offer patients and clients a better quality service, with easier access to the services required and to ensure effective and efficient utilisation of this particular workforce.

STEP 4: UNDERSTANDING WORKFORCE AVAILABILITY

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

4.1 Workforce Figures (based on HRPTS data at March 2014)

Workforce data and information in relation to the overall workforce within the HSC sector in Northern Ireland are held and maintained on a new system, Human Resources, Payroll, Travel and Subsistence (HRPTS). This system was introduced using a phased approach during 2013 and 2014 and is now in use across all of the HSC organisations. The HRPTS data is continually updated and managed locally by the employer organisations. The DHSSPS produces a quarterly statistical summary report for the whole of the HSC workforce.

The data relating to the nursing and midwifery workforce available on HRPTS provides a reasonable baseline demonstrating the numbers presently employed within the HSC workforce. It should, however, be noted that some areas have been difficult to analyse using the data, due to the categorising of some staff and some inconsistencies in the core data provided from HSC Trusts. At present, HRPTS grades all such staff as acute nurses, and although detailed interrogation of the system may permit the identification of staff statistics by sub-specialty, this is not easily done and is not part of the routine quarterly reporting.

Similarly, although the strategic direction, outlined in *Transforming Your Care* (DHSSPS, 2011b), is to drive the transition of service delivery from predominantly acute-based to community settings, the number of District Nurses, who are key professionals in supporting this agenda, has reduced by 13% since the previous Workforce Review (DHSSPS, 2009). This would suggest that some HSC Trusts are categorising these nurses on HRPTS under other grades, for example, 'Specialist Nurses' as during the same timeframe, Specialist Nurses at Bands 5 and 6 increased by 104%. In addition, the coding of some Band 5 and Band 6 nurses as 'Specialist Nurses' needs to be addressed as Band 5 nurses do not practice at a

Specialist level. HSC Trusts' workforce plans should address these categorisation and coding issues.

Action Point: The HRPTS categorisation and coding of the workforce needs to be reviewed and addressed by the HSC Trusts, particularly in respect of District Nurses and Specialist Nurses.

The figures included within this Plan are reported as they have been recorded on HRPTS. To allow meaningful analysis, bank staff and staff on career breaks have been excluded. Where staff have more than one post in the same organisation, or even within a different organisation, each post will have been counted in the 'Staff in Post' headcount, but the whole-time equivalent (WTE) will reflect the proportion of standard hours that are worked in each post. Staff who are temporarily absent from their position, for example due to maternity leave or sick leave, have been included in the analysis. In contrast to previous Nursing and Midwifery Workforce Reviews, Prison Nurses, who are now employed by the South Eastern HSC Trust, have been included in the 2014 workforce figures (n=55.2 WTE).

The data obtained for the purpose of this Workforce Plan includes a breakdown of the current workforce figures, inter alia, by:

- **Employing organisation;**
- **Service area (e.g. acute, midwifery, mental health, etc);**
- **Age;**
- **Gender;**
- **Headcount (HC) and Whole Time Equivalents (WTEs);**
- **Full-time or part-time status.**

4.2 HSC Workforce Profile

At the time of developing this Plan, the most recent statistical report was for the workforce as at 31st March 2014, therefore this point in time has been selected as the baseline for analysis.

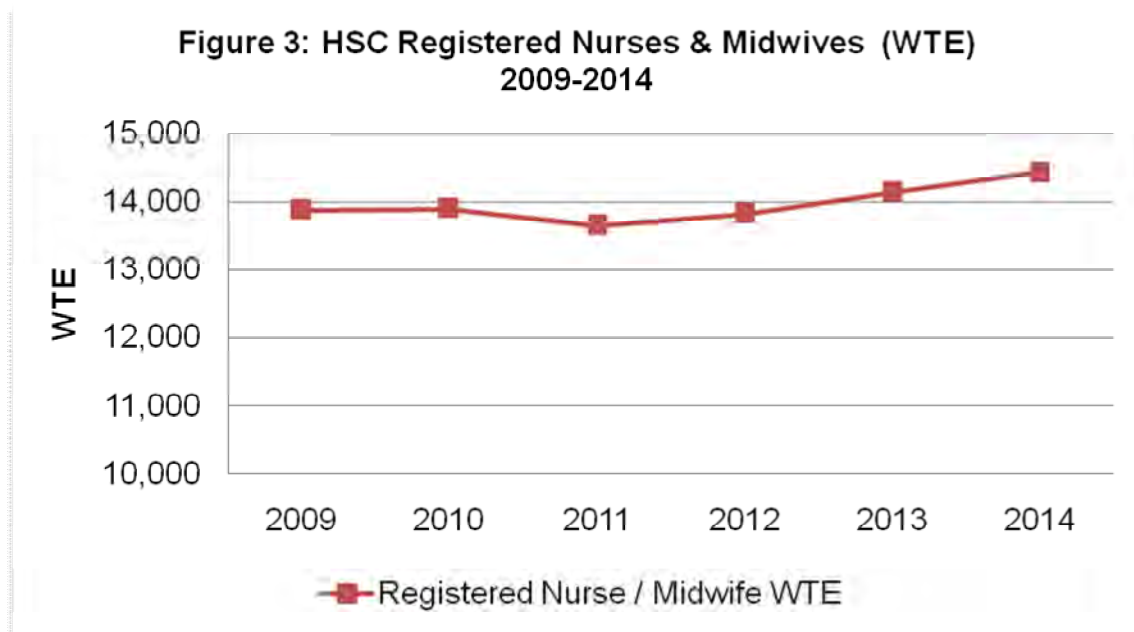
4.2.1 Composition of the Registered Nursing and Midwifery Workforce

The HSC employs 16,646 or 14,328.7 Whole Time Equivalent (WTE) registered nurses and midwives (excluding bank staff and career breaks) with a comprehensive range of skills geared towards meeting the needs of patients and clients (Table 1). It is the largest staff group within the HSC, accounting for around 27% of all staff.

Table 1: HSC Registered Nurses & Midwives as at 31st March 2014

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	**16,646**	**14,328.7**

Since the previous Nursing and Midwifery Workforce Review (DHSSPS, 2009), levels of registered nurses and midwives (including student midwives and health visitors for comparison) remained steady between 2009 and 2010, with a slight reduction in numbers during 2011 (Figure 3).



*includes student midwives and student health visitors for comparison with 2009 Review.

Table 2 demonstrates that overall, comparing 2014 with 2009, whole-time equivalent number of registered nurses and midwives have increased by 4%.

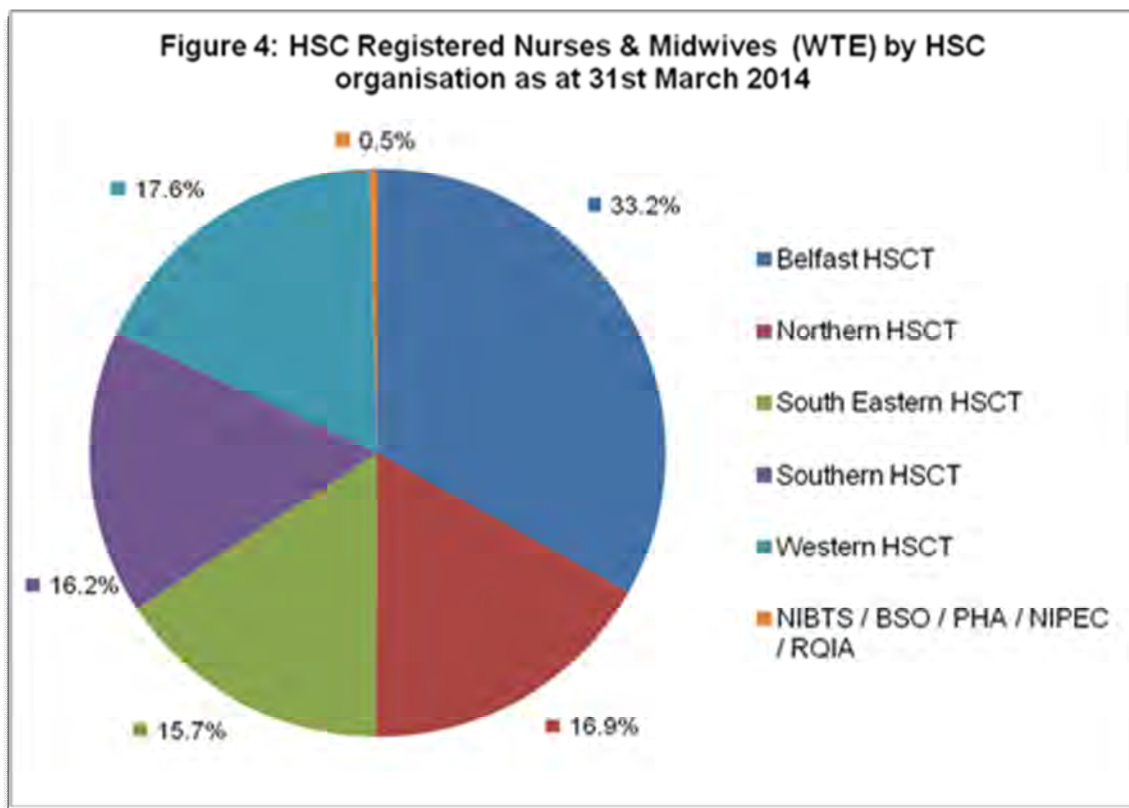
Table 2: Comparison of HSC Registered Nurses and Midwives (including post-registration students) 2009 and 2014

Combined Grades	2009		2014 *		% Change 2009-2014	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses / Midwives	16,251	13,875.9	16,646	14,328.7	3.1%	4.0%
Student Midwives / Student Health Visitors			105	99.8		
Total	16,251	13,875.9	16,751	14,428.5	3.1%	4.0%

*Figures include Student Midwives and Health Visitors for comparative purposes. The 2014 figures include Prison nursing staff (55.2 WTE).

4.2.2 Employing Organisation

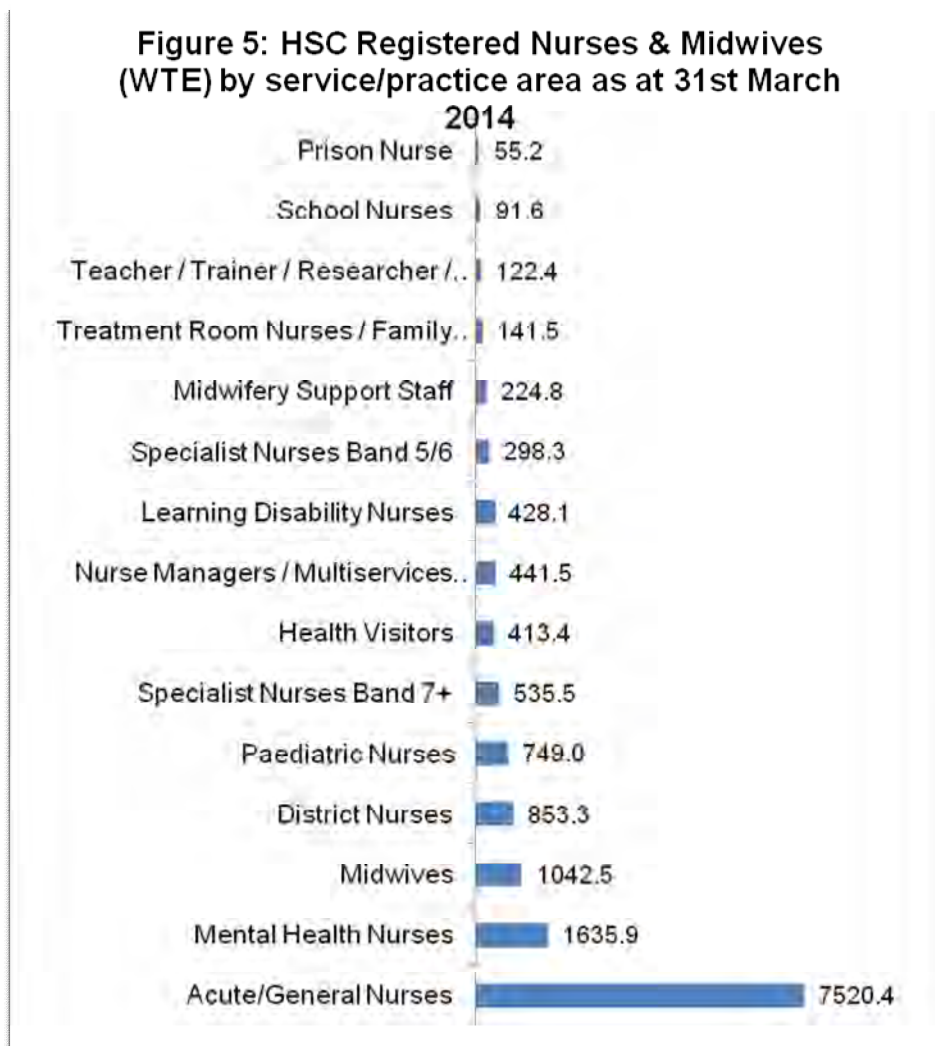
Belfast HSC Trust employs the largest percentage of the registered nursing and midwifery staff (33.2%), with the other HSC Trusts employing between 15.7% and 17.6% (Figure 4). However, it is important to note that the Belfast HSC Trust provides a range of regional services.



4.2.3 Registered Nurses and Midwives by Practice Area

Figure 5 below illustrates the number of registered nursing and midwifery staff by service/practice area. As previously highlighted, the data recorded on HRPTS by all HSC Trusts is not consistently coded to permit analysis of particular areas, such as, acute nurses working within specific wards, departments or sub-specialties.

Similarly, there appear to be some inconsistencies across all HSC Trusts in relation to how nursing staff are categorised on HRPTS, particularly District Nurses, who may, on some occasions have been categorised as other grades, for example, 'Specialist Nurses'. These issues present potential difficulties regarding the prediction of nursing and midwifery commissions within specific service/practice areas and will therefore be considered when discussing the predicted commissions over the next ten years within this Plan.

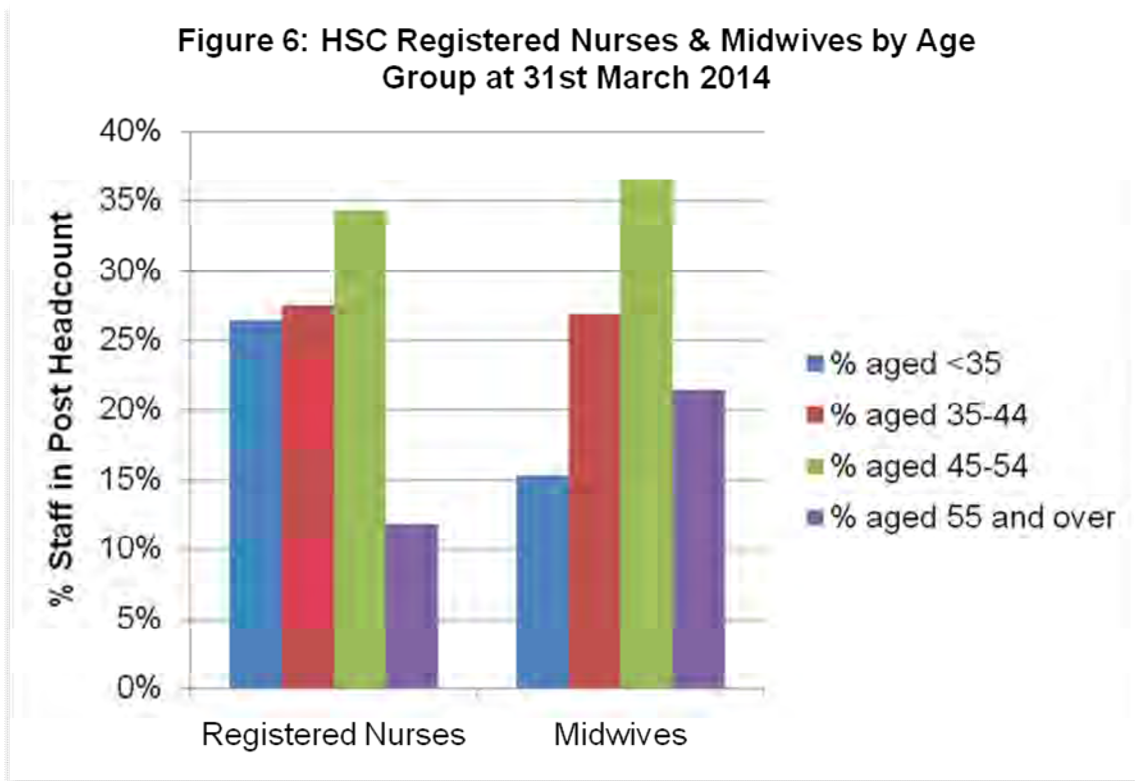


A more detailed illustration of the registered nursing and midwifery workforce by service/practice area within each HSC organisation has been included in Annex C.

4.2.4 Age of the Registered Nursing and Midwifery Workforce

Figure 6 presents (by staff category) the percentage of registered nursing and midwifery staff within each age category (using staff in post headcount). In terms of the 4 age categories presented, analysis shows that the highest proportion of staff within each category are aged 45-54. Midwives have the largest percentage of staff aged 45 and over (58%), followed by registered nurses (46%).

This compares with the 2009 Review which reported midwives had the largest percentage of staff aged 45 and over (54%), followed by registered nurses (39%).



Further analysis shows that the midwives category has the largest percentage of staff aged 55 and over (21%), compared to registered nurses (12%). This compares with the 2009 Review which reported that 13% of midwives were aged 55 and over and 8% of registered nurses were aged 55 and over. A more detailed illustration of the registered nursing and midwifery workforce by service/practice area and age has been included in Annex D.

Ensuring the health needs of our ageing workforce is essential, not least in recognising that some nursing, midwifery and support roles have a substantial physical element which may become more onerous, particularly with the transition of service delivery from predominantly acute-based to community settings (DHSSPS, 2011b), and the increase in patterns of lone working which this often entails. In

addition, the Health and Safety Executive (2013) identified differences in the sickness absence patterns between younger and older workers which need to be considered. Typically younger workers tend to be absent more often, but for shorter periods of time, whereas older workers are less likely to be absent less frequently but are more likely to have a longer period of absence.

The figures included in Annex E present the current numbers of staff aged 45 – 54 years who are likely to retire within the next five to ten years (or who may otherwise be more liable to leave the service for other reasons), particularly in the front-line service areas of mental health nursing (43%), district nursing (43%), health visitors (44%), school nursing (46%), specialist nursing (55%) and nurse managers (59%). Similarly, the numbers and the health and well-being of staff aged 55 or older, particularly in the front-line service areas of midwifery (21%), school nursing (21%), teaching and training (22%) will need to be considered. Furthermore, in other service areas, particularly acute nursing, where the age profile is generally younger and the workforce is predominantly female, the continuing incidence of part-time working and maternity leave is likely to prove challenging, particularly in respect of filling shifts which are relatively unpopular, including weekends and nights.

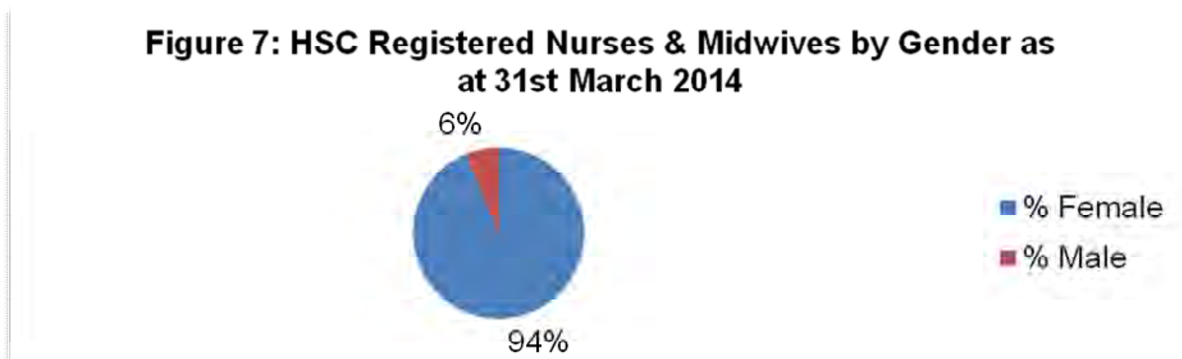
4.2.5 Registered Nursing and Midwifery Workforce by Gender

Table 3 demonstrates that 15,597 of the registered nursing and midwifery workforce are female with 1,049 being male.

Table 3: HSC Registered Nurses & Midwives by Gender (headcount)

Combined Grades	Female	Male	Total
Registered Nurses/Midwives	15,597	1,049	16,646

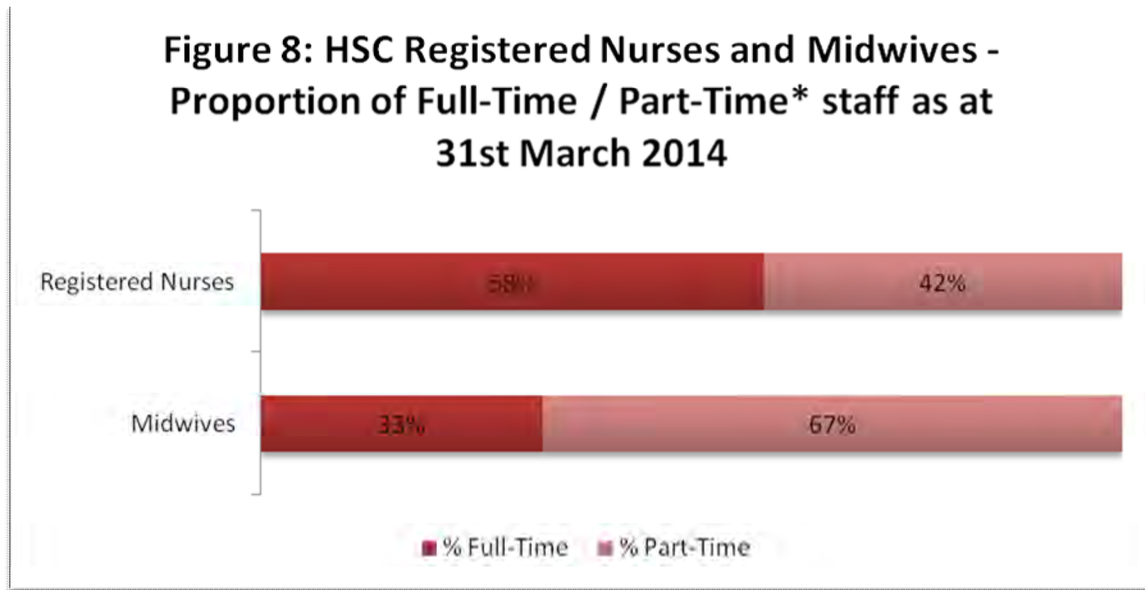
Figure 7 outlines that the figures are consistent with the 2009 Review which reported that 91.9% of the overall workforce was female and 8.1% male.



A detailed illustration of the registered nursing and midwifery workforce by service/practice area and gender has been included in Annex E.

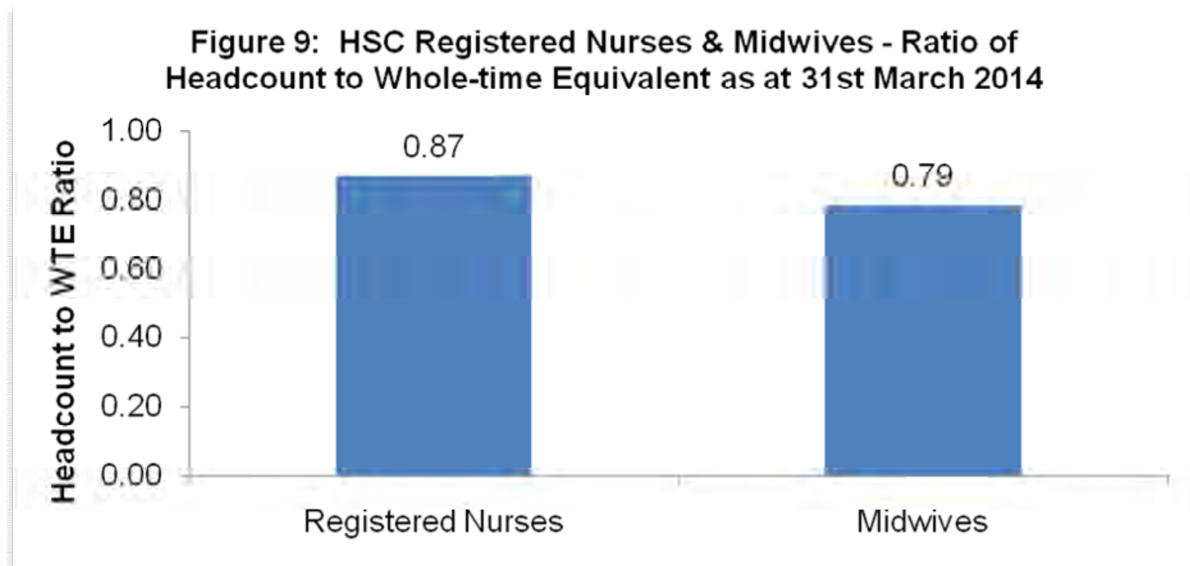
4.2.6 Registered Nursing and Midwifery Working Patterns and Conditions

In terms of contract type, analysis of registered nursing and midwifery staff whole-time equivalents (WTE) shows that the midwives category has a greater proportion of part-time staff at 67% compared to the registered nurses (42%): (Figure 8).

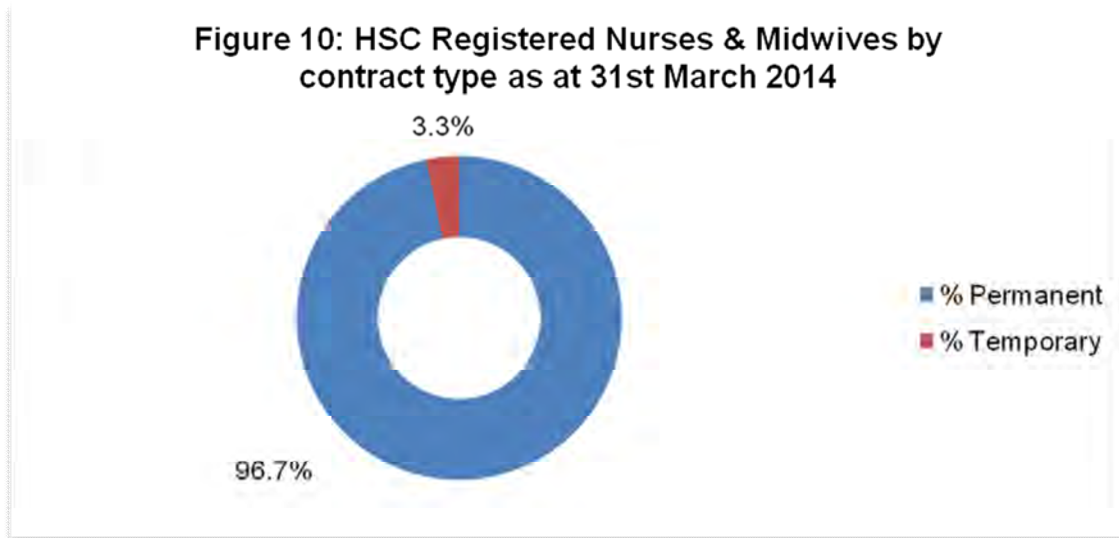


* Part-time is defined as anyone working less than full-time hours (i.e. 37.5 hours per week).

As demonstrated in Figure 9 below, although the midwives category shows a greater proportion of part-time staff, analysis of the overall headcount to whole-time equivalent ratio shows that they have a marginally lower ratio (0.79) compared to the registered nurses category (0.87).



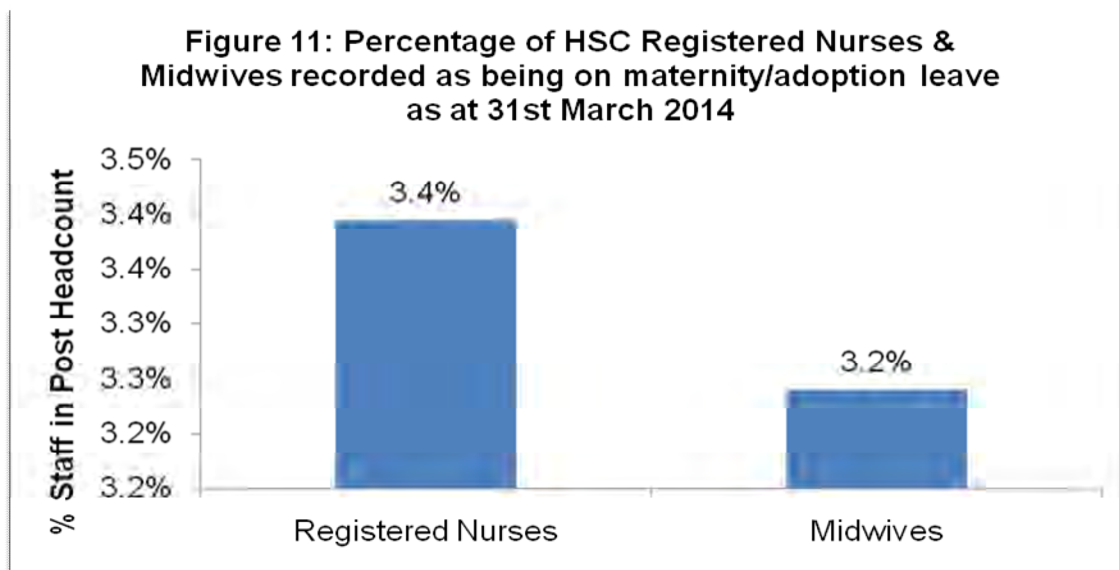
Analysis of contract type in HPRTS shows that the registered nursing and midwifery workforce consists of mostly permanent contracts (excluding bank), as presented in Figure 10.



The whole-time equivalent contribution of bank staff cannot currently be analysed, however, the majority of registered nursing and midwifery staff bank contracts held within HRPTS are for staff who also have a substantive post within HSC organisations (around 80%).

4.2.7 Registered Nursing and Midwifery Staff Maternity/Adoption Leave

Figure 11 below shows analysis of attendance/absence type in HRPTS and shows the percentage of staff recorded as being on maternity/adoption leave as at 31st March 2014.



A breakdown of registered nursing and midwifery staff recorded as being on maternity leave as at 31st March 2014 is presented in Table 4 below.

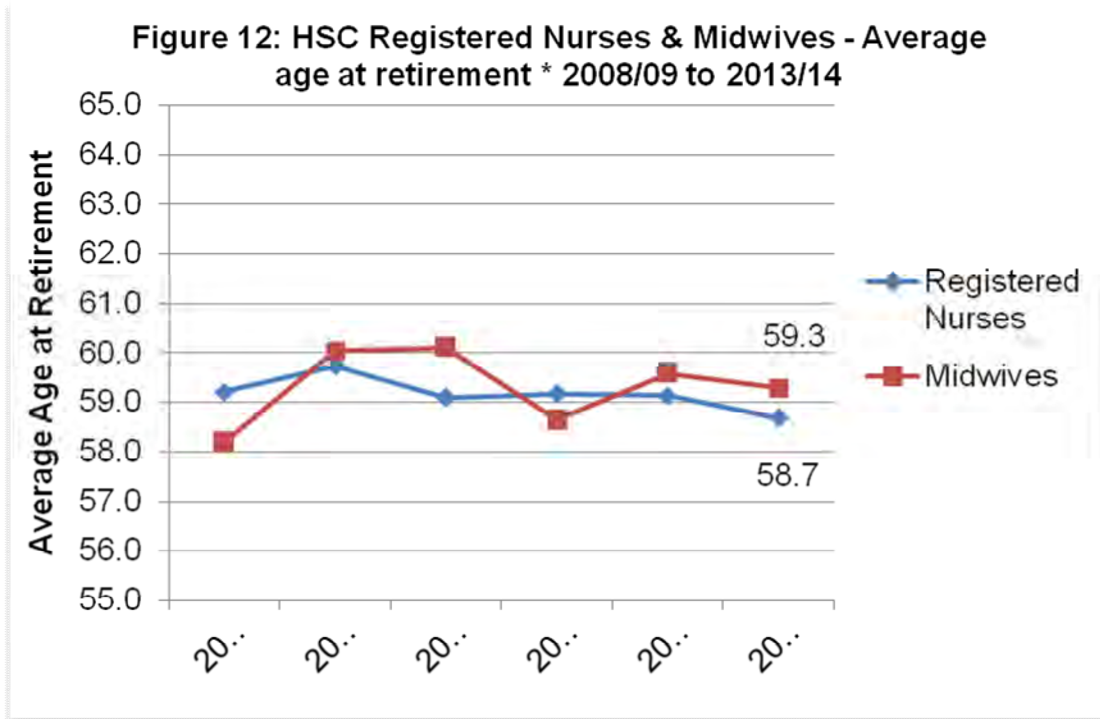
Table 4: Percentage of HSC Registered Nurses & Midwives recorded as being on maternity/adoption leave as at 31st March 2014 (Headcount and Whole-time equivalent)

Staff Category	Recorded as being on Maternity/ Adoption Leave		Total staff		% recorded as being on Maternity / Adoption leave	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses	520	464.0	15,319	13,286.2	3.4%	3.5%
Midwives	43	36.7	1,327	1,042.5	3.2%	3.5%

Although HRPTS high level statistics demonstrate that overall maternity rates are fairly low, representing 3.4% of registered nurses and 3.2% of midwives, at team level maternity absences can have a significant impact, for example, an Orthopaedic theatres team – 2 out of 10 staff on maternity leave = 20% or a Health Visiting team – 3 out of 16 staff on maternity leave = 19%.

4.2.8 Registered Nursing and Midwifery Staff Retirement Trends

Retirements present an opportunity for change and redesign of the workforce. However, it is worth noting that there is often a wealth of skills and experience embodied in these people, gained over many years of service, which will be lost to the HSC and will therefore take time to develop and re-establish. Eligibility for retirement can differ for specific grades of nurses and midwives or due to the pension scheme in question. Average age at retirement for registered nurses decreased slightly in 2013 but has ranged from 58.8 - 59.6 over the last 5 years. For midwives, average retirement age was increasing during the period 2008-2010, with a dip in 2011/12, followed by a period of increase in 2012/13 and 2013/14 (Figure 12).



*The above figures include those with 'Reason Left' recorded as Retirement, Ill Health Retirement or Voluntary Early Retirement (excluding bank staff), but only for those aged 55+.

It might be expected that retirements could be predicted with some degree of accuracy; however, this Plan is being written at a time when such predictions are more difficult due to the current economic climate and pension changes for staff. For instance, with effect from 1 April 2011 employers can no longer operate policies that include a compulsory retirement age. In addition, by 2015 the state retirement age for men and women will be 65 years. It could therefore be expected that women may reconsider the age at which they retire resulting in a gradual increase in age.

Similarly, it seems likely that public sector pension schemes will change during the period of this Plan, based on the Hutton Review of Public Sector Pensions (2011). The main changes will include linking the age at which the Occupational Pension is paid (based on a career average rather than a final salary scheme) to the age at which the State Pension is paid. The implications of these changes might be that staff will continue to work beyond the age at which they had previously planned to retire under the existing scheme, in order to match their existing pension or improve on this. Alternatively, the proposed changes may prompt staff to retire earlier than planned, prior to any definitive changes. Furthermore, *Mental Health Officer Status* is held by many staff which enables them to retire at the age of 55 years, without any reduction to their pension. This status is not available to staff who did not have it granted before 6 March 1995, so the numbers who fall into this category will be reducing during the timescale of this Plan.

The decision about when to retire will be a personal one, whether related to any or all of the above issues, the economy and how it impinges on people's lives or for other reasons. Predicting numbers that are expected to retire is not precise, but we can assume, based on historical trends, that staff will leave when they reach the current average retirement age for their group. Further work on the impact of the age profile and pension changes should be undertaken to support this Plan, particularly during annual reviews.

Action Point: The impact of the nursing and midwifery age profile and relevant pension changes should be undertaken to support the implementation of this Plan, particularly during annual reviews.

4.2.9 Registered Nursing and Midwifery Staff Health and Wellbeing

The DHSSPS collects high level sickness absence information from HSC organisations twice a year. HSC Trusts must continue to support in the best way possible, those of its staff who suffer ill health.

Figure 13 below shows the trend of sickness absence rates amongst registered nursing, midwifery and support staff, ranging between 6 and 6.6%.

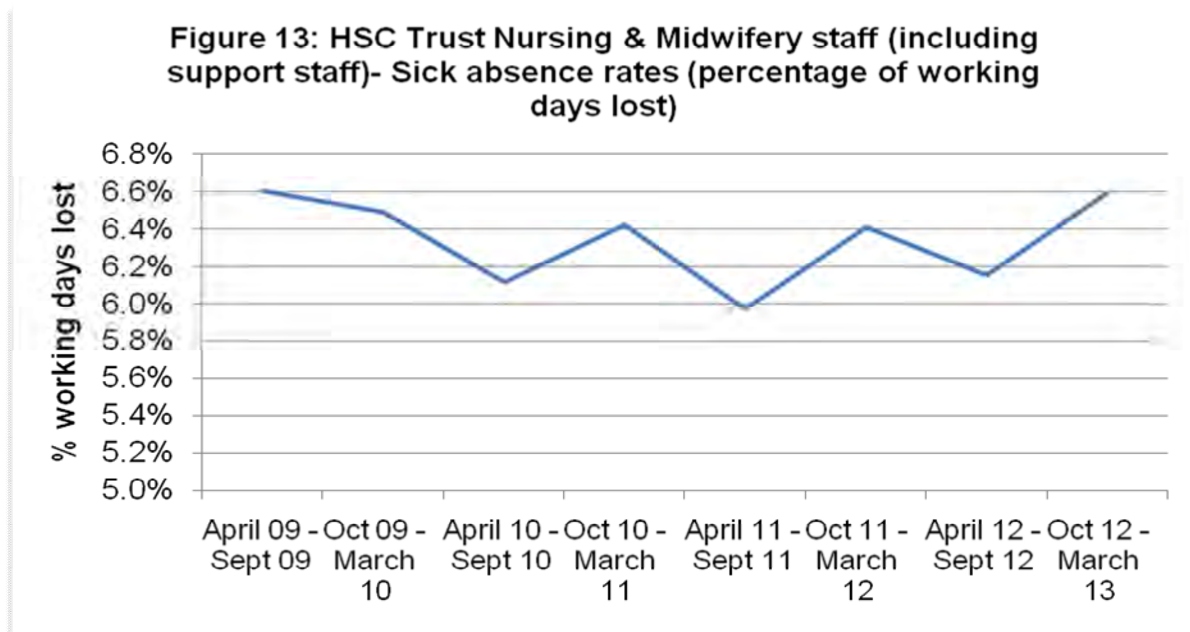
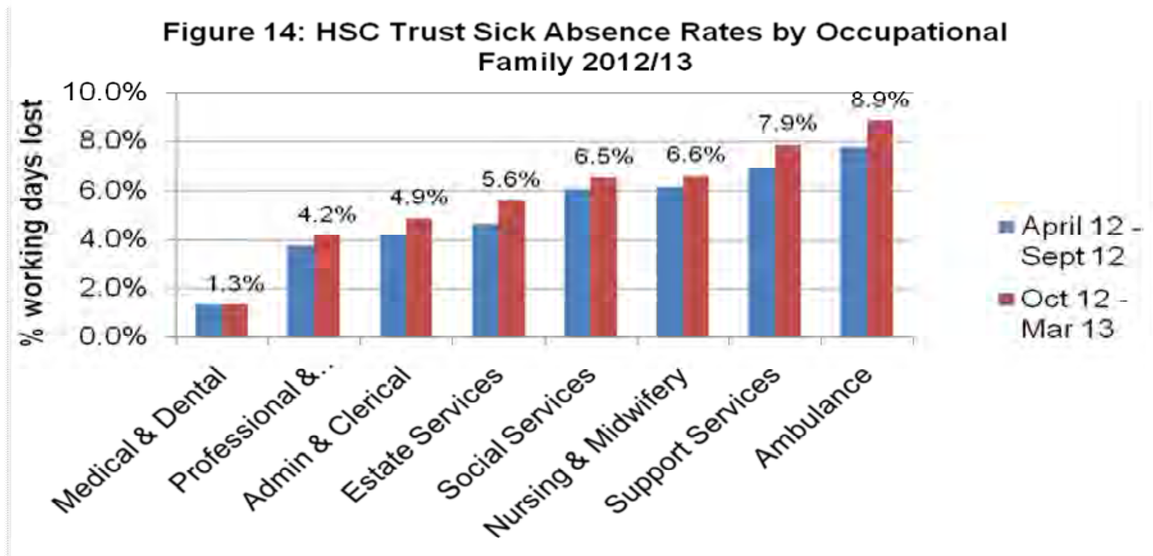


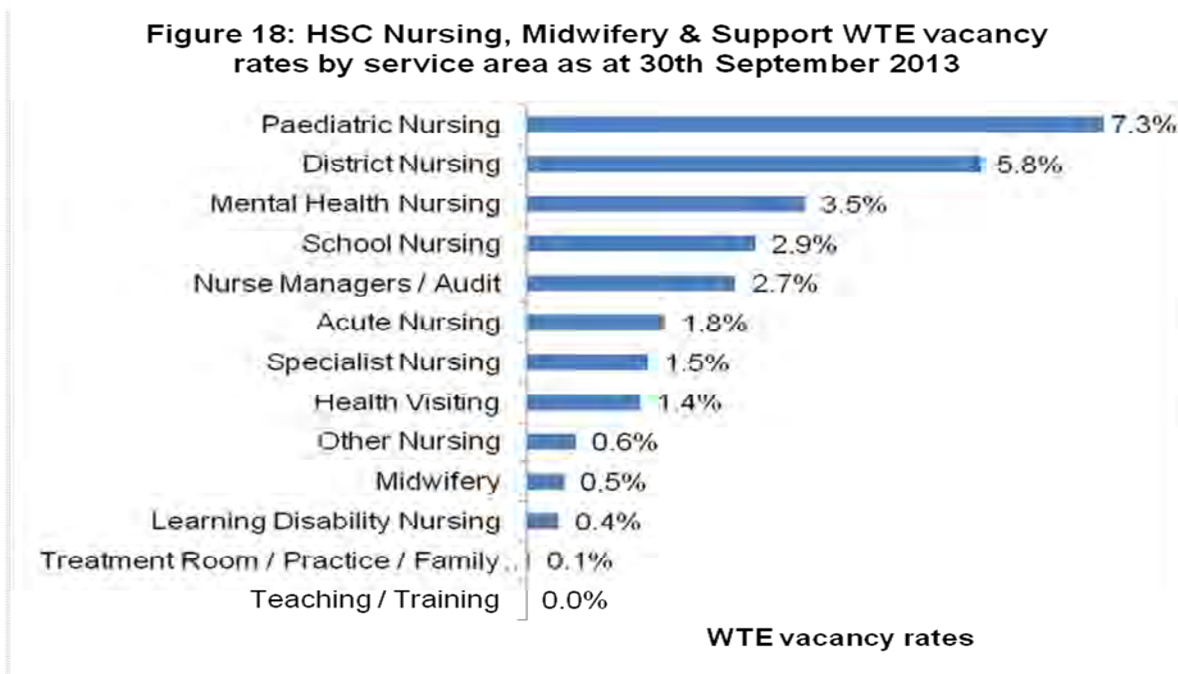
Figure 14 below shows a comparison of sickness absence rates in other occupational families for the two collection periods in 2012/13. The registered nursing, midwifery and support workforce had a similar sickness absence rate during 2012/13 to the social services workforce but not as high as support services or ambulance staff (note the percentage label in the chart relates to the period October to March).



Delivering Care (2013b) includes a 5% target for Sickness Absence. The regional average for the monitoring period October 2012 – 31 March 2013 is up from 6.41% last year to 6.6% therefore a significant reduction in sickness absence will be required to meet this target. The HSC Trusts should continue to seek to reduce sickness absence rates over the period of this Plan (2015-2025).

4.2.10 Nursing and Midwifery Vacancies and Supplemental Staffing

A vacant post is defined as a post '*actively being recruited to' (DHSSPS*). The DHSSPS collects data on vacancies via a survey twice a year. Figure 18 below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.



All HSC Trusts had varying levels of vacancies, at 30th September 2013, amounting to 470 (headcount) or 419.1 (WTE) vacant posts, representing a rate of 2.3% (based on WTE) across the HSC nursing & midwifery occupational family, with the highest vacancy rates in paediatric nursing (7.3%), district nursing (5.8%), mental health nursing (3.5%) and school nursing (2.9%) at that time. Vacancy numbers, rates, Agenda for Change bands and service areas across the HSC Trusts are presented in Annex F.

HSC Trusts operate their own staff banks or overtime system and/or utilise agency staff to supplement the nursing, midwifery and support workforce. This is normally in response to vacancies, planned and unplanned/sickness absence in order to minimise service disruption and ensure service standards are maintained. HRPTS figures demonstrate that the majority of bank contracts (around 80%) are held by registered nurses and midwives who already have a substantive post within the relevant Trust.

HSC Trusts' Financial Returns submitted to the DHSSPS (Table 5) demonstrate variations in the use of bank and agency staff.

Table 5: Bank/Agency Expenditure from DHSSPS Finance Directorate 2008-2013

Agency Staff – Nursing £s						
Year	**Belfast HSC Trust**	**Northern HSC Trust**	**South Eastern HSC Trust**	**Southern HSC Trust**	**Western HSC Trust**	**Total**
08/09	8,829,000	622,401	2,581,926	1,289,099	846,399	14,168,825
09/10	6,066,000	481,465	3,303,414	1,185,710	1,268,818	12,305,407
10/11	2,818,000	612,964	3,398,887	452,734	1,525,742	8,808,327
11/12	3,114,000	836,225	2,031,664	263,240	2,070,303	8,315,432
12/13	3,742,000	1,078,594	2,768,074	672,111	1,591,350	9,852,129
Total	**24,569,000**	**3,631,649**	**14,083,965**	**3,862,894**	**7,302,612**	**53,450,120**
Bank Staff – Nursing £s						
Year	**Belfast HSC Trust**	**Northern HSC Trust**	**South Eastern HSC Trust**	**Southern HSC Trust**	**Western HSC Trust**	**Total**
2008/09	6,957,000	7,059,211	494,641	2,732,462	3,046,598	20,289,912
2009/10	10,861,422	4,138,646	2,511,105	3,703,771	2,971,304	24,186,248
2010/11	12,833,926	4,684,905	2,847,489	4,097,985	3,891,876	28,356,181
2011/12	15,067,266	5,612,623	5,604,662	6,327,428	3,158,444	35,770,423
2012/13	16,664,000	6,242,135	6,207,717	7,825,280	4,774,951	41,714,083
Total	**62,383,614**	**27,737,520**	**17,665,614**	**24,686,926**	**17,843,173**	**150,316,847**

Source: Trust Financial Returns (TFR E&S)

It is important to note that HSC Trust data on bank and agency staff is primarily financial, and HRPTS does not record the use or deployment within specific service

areas of agency and bank staff, making it difficult to track the impact of their use. In addition, the whole-time equivalent (WTE) contribution of bank staff cannot currently be analysed by HRPTS.

This compares with the picture across Northern Ireland at the time of the previous review (DHSSPS, 2009), with 2006/07 returns for bank and agency nursing costs (Table 6) showing the following:

Table 6: Bank/Agency Expenditure from DHSSPS Finance Directorate 2006-2007

Bank and Agency Staff – Nursing £s						
Year	**Belfast HSC Trust**	**Northern HSC Trust**	**South Eastern HSC Trust**	**Southern HSC Trust**	**Western HSC Trust**	**Total**
2006/07	10,552,000	798,000	1,758,000	464,000	982,000	**14,553,000**

Source: Trust Financial Returns (Expenditure: Salaries and Wages)

The use of bank and agency staffing has more than doubled in the intervening years since the last nursing and midwifery workforce review (DHSSPS, 2009). As demonstrated in the Report into Mid-Staffordshire NHS Trust (Francis, 2013), there appears to be a clear link between temporary staff and poorer outcomes for patients and families.

The Keogh Report (2013) also noted a positive correlation between inpatient to staff ratio and a high hospital standardised mortality ratio (HSMR) score. Another key finding was that actual nurse staffing levels in the 14 Trusts were below those that had been reported in national indicators. High use of temporary staff, higher use of health care assistants, low levels of nurse staffing at nights and weekends, and relatively high levels of nurse vacancies were among key staffing issues.

One recommendation was that '*Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience*.' The Report also noted the National Quality Board's (2013) guide to nursing, midwifery and care staff capacity and capability and further guidance has recently been published by the National Institute of Clinical Excellence (2014).

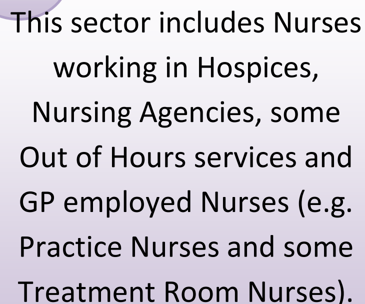
To support this, significant work is ongoing in Northern Ireland to address the use of bank and agency with mechanisms and processes in place within HSC Trusts to facilitate the use of the most cost effective supplementary staffing solution, be it bank

or overtime. In addition, the Nurse Leaders in Northern Ireland have agreed that as posts are filled via *Delivering Care*, the use of bank/agency/overtime must be reduced by 75% when the work has been completed. A Regional Initiative, led by the Chief Nursing Officer, *Evidencing Care through Key Performance Indicators for Nursing and Midwifery* will monitor compliance with the agreed 75% reduction, as a further assurance that the use of bank and agency staff will be minimised alongside a reduction in vacancies and absenteeism.

It is in the best interest of each employer, the staff and the patient to reduce to the lowest possible level the use of nursing and midwifery bank and agency staff within Northern Ireland. HSC Trusts must implement *Delivering Care: Nurse Staffing in Northern Ireland* (DHSSPS, 2013b) to reduce vacancies and the use of bank and agency staff to ensure safer patient and client care.

4.3 Workforce Figures for the Independent Sector

The independent healthcare sector refers to private, voluntary and not for profit establishments covering a wide variety of services and organisations (Skills for Health, 2011).



Historically it has proven difficult to obtain accurate, up-to-date workforce figures for nurses within the independent sector. This is mainly because no mechanism or process currently exists whereby independent sector employers are required to present their workforce data in a consistent manner and/or many employers in this sector may be concerned about commercial sensitivity and are not prepared to release workforce data.

This is consistent with attempts to gather data from this sector during the previous Workforce Review (DHSSPS, 2009) which suggested that the total number of nursing staff may be as low as 2,000 or well over 3,000. A UK wide *RCN Employment Survey* (2013a) indicated that 12.3% of Northern Ireland respondents (n=9,553) reported working within this sector. Comparing this with the NMC register at 31st March 2014, it appears that the number of nurses working within this sector ranges from 2,731 to 3,475.

Although the previous Review (DHSSPS, 2009) indicated that the Regulation and Quality Improvement Authority (RQIA), the independent HSC regulatory body for Northern Ireland, were seeking to gather workforce data from the independent sector, no data was available during our period of stakeholder engagement.

The independent sector providers are facing a growing complexity of care; some are delivering consultant lead intermediate care bed services, fracture rehabilitation services, assessment bed services, acute mental health and alcohol dependency services along with their nursing care and dementia care services. Their need for registered nurses is increasing as they respond to these demands yet they are unable to recruit sufficient numbers of nurses to meet demand and are currently recruiting extensively overseas.

This is supported by a recent report from the Care Quality Commission (CQC; 2014), the inspectorate for health and social care in England, which highlighted a severe shortage of nurses in nursing homes, made worse by the efforts of NHS hospitals to hire more staff following the Report into Mid-Staffordshire NHS Trust (Francis, 2013).

This sector has been lobbying to increase pre-registration nursing places in Northern Ireland throughout the compilation of this Nursing and Midwifery Workforce Plan. The Four Seasons Group alone recruited 209 registered nurses via European Union (EU) routes during 2014. They now have to recruit further afield and in December 2014 they undertook recruitment trips to Cochin in India and to Manila in the Philippines as they can no longer acquire the volume of nurses required through either local recruitment or the EU route.

The EU nurses recruited by the Independent Sector often move on to HSC posts within one year of coming to Northern Ireland as they will then have no work permit restrictions.

The new NMC registration process for non EU nurses is currently not clear due to the delay in UK Visas and Immigration (UKVI) making determination on the entry visa type for these NMC applicants. The NMC have been in discussion with UKVI and a decision on the change of policy is imminent. The Department of Health in England has been lobbying for a decision by UKVI due to the magnitude of the nursing shortages they are facing.

Action Point: A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.

Step 5: Developing An Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical.

5.1 Commissioned Nursing and Midwifery Student Places

Learning and development is an intrinsic element of workforce planning; necessary for the attainment and maintenance of professional registration, the further development of nursing and midwifery roles, competence and capability and, ultimately, the delivery of safe, effective and person-centred care.

5.1.1 Pre-registration Nursing and Midwifery Commissioning

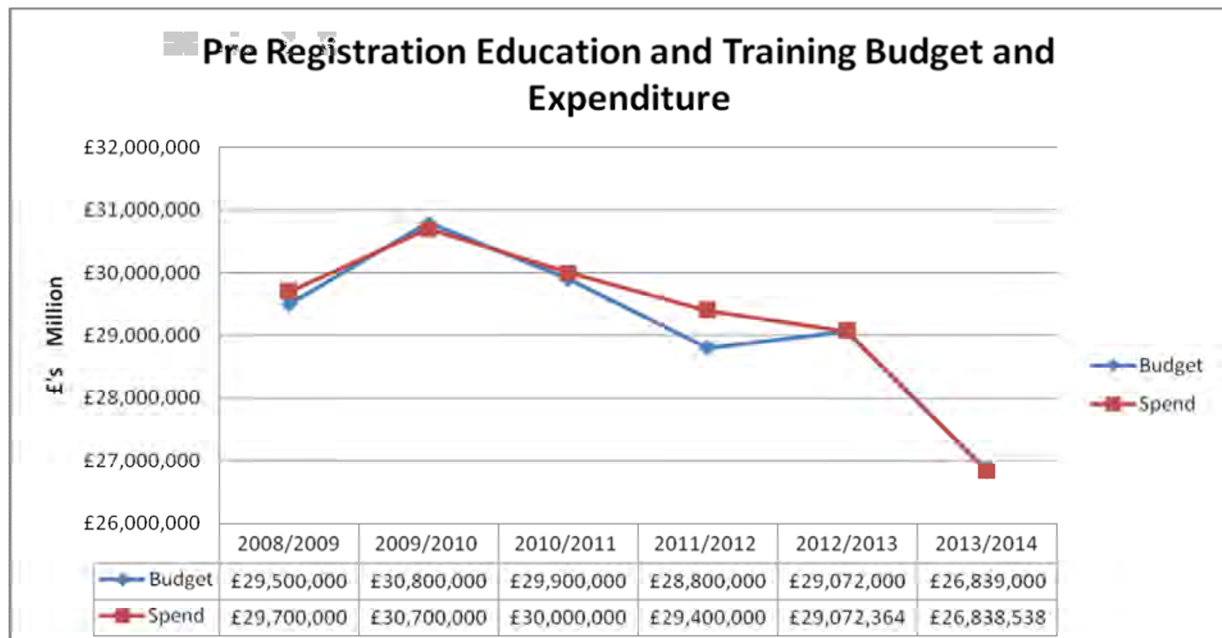
The DHSSPS commissions pre-registration nursing and midwifery education in Northern Ireland; delivered by three providers, namely Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. From 2011, Northern Ireland moved from diploma/degree to degree level only programmes, incorporating the Nursing and Midwifery Council (2010) requirements.

The commissioning profile should be continually assessed to ensure it meets the needs of service. Table 7 demonstrates that the number of pre-registration nursing and midwifery places commissioned has fallen in recent years from 792 in 2008/2009 to 685 in 2014/2015 despite reported difficulties in recruiting nurses to the Independent sector. As previously reported, this sector is continuing to recruit from overseas, however recruitment and retention difficulties exist.

Table 7: the number of pre-registration nursing and midwifery places commissioned

Branch	Pre-Registration Commissioned Places by Year						
	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Adult	525	535	471	471	444	444	444
Adult OU	0	18	0	9	9	7	9
Mental Health OU	36	18	18	9	9	18	16
Children's	55	60	60	60	55	55	55
Mental Health	99	99	99	99	96	96	96
Learning disability	15	30	30	30	30	30	30
Midwifery D/Entry	30	30	30	30	35	35	35
Midwifery, Additional Registration	32	35	35	35	25	25	0
Totals	**792**	**825**	**743**	**743**	**703**	**710**	**685**
Year of completion	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**

Figure 19 below shows that the Pre-registration Nursing and Midwifery Education Commissioning Budget has been significantly reduced from £29,500,000 in 2008/2009 to £26,839,000 in 2013/2014, representing a 9% reduction.



The RCN (2013b) in their publication '*Frontline Nurse: Nursing on Red Alert*', reported concerns about the reduction in training places as a key factor contributing

to an impending nursing shortage. As the nursing commissioning and education process takes at least three years it may be some time before we feel the full effects of this reduction in supply. It will then take several years to respond to a potential nursing shortage through the education system. England in particular is currently recruiting aggressively in Northern Ireland and offering relocation packages of up to £3,000 to new nurse graduates here. This is a trend that will continue until the education system can address the shortfall of nurses in the other three countries. England, Scotland and Wales have all increased pre-registration nurse training places in 2015/2016 due to the impact of nursing shortages. This Review recommends increasing Pre-registration numbers by at least 100 places.

5.1.2 Post-registration Nursing and Midwifery Commissioning

The DHSSPS also commissions post-registration education for nurses and midwives from a range of providers across Northern Ireland, which includes the three universities, independent providers, such as the Royal College of Nursing and the Clinical Education Centre and in some cases Universities outside Northern Ireland. Programmes are also funded for provision at local HSC Trust level.

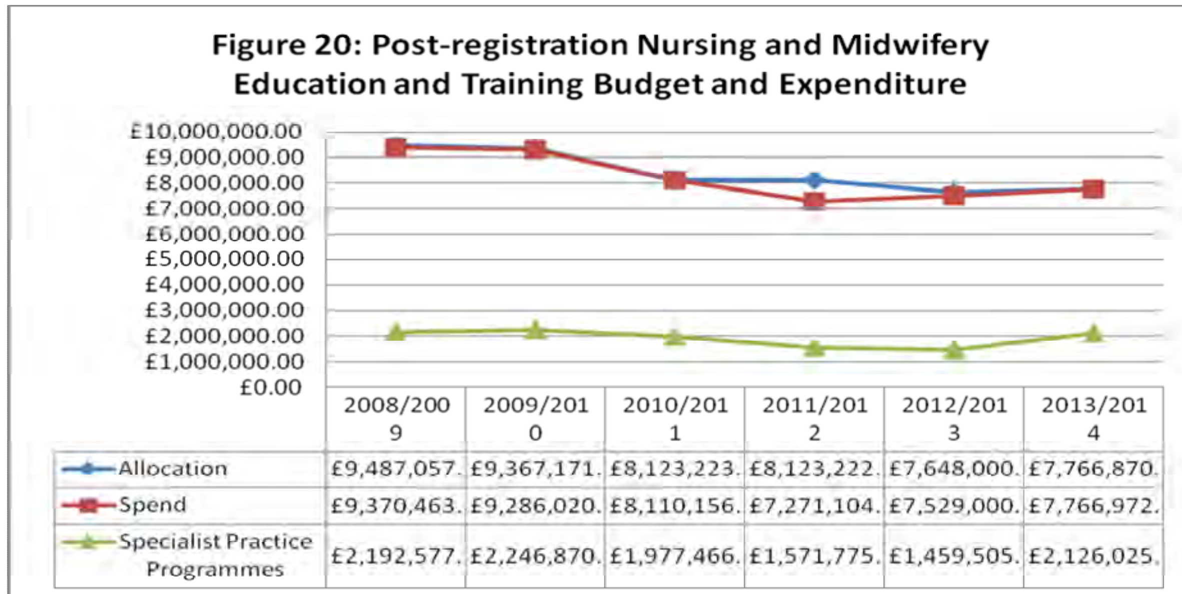
In addition, the DHSSPS commissions 32 *Return to Practice* programmes on an annual basis within the four fields of practice including Adult, Children's, Mental Health and Learning Disability Nursing. The University of Ulster reports that competition remains oversubscribed for these programmes with between 80-90 applications per year. Presently there is no pathway for NMC Part 3 registrants, including Health Visitors.

The commissioning process is currently managed through the DHSSPS Education Commissioning Group (ECG). Commissioned programmes include study days, stand alone modules and short courses leading to an NMC regulated programme such as Specialist Practice Qualifications.

Nursing and Midwifery post registration education is crucial to maintain competence and to develop new specialist skills for specialist roles, including District Nursing, Health Visiting, Infection Prevention, Neonatal Care, Respiratory Disease and Diabetes.

The nursing and midwifery post-registration education and training and expenditure budget from 2008/2009 to 2013/2014 is presented in Figure 20 below which demonstrates that the Post-registration Nursing and Midwifery Education Commissioning budget allocation has been significantly reduced since 2008/2009 by £1,720,187.00, representing a 19% reduction.

Figure 20: Nursing and Midwifery Education Commissioning Budget Allocation



	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Allocation	£9,487,057.	£9,367,171.	£8,123,223.	£8,123,222.	£7,648,000.	£7,766,870.
Spend	£9,370,463.	£9,286,020.	£8,110,156.	£7,271,104.	£7,529,000.	£7,766,972.
Specialist Practice Programmes	£2,192,577.	£2,246,870.	£1,977,466.	£1,571,775.	£1,459,505.	£2,126,025.

*Specialist Practice Programmes relate to Replacement Monies for staff back fill (based on full-time, midpoint Band 5)

5.1.3 Continuing Professional Development Commitments

NMC revalidation places a high degree of demand on nurses and midwives to demonstrate they remain fit to practice. Continuing professional development (CPD) is necessary for the maintenance of NMC registration, the delivery of high quality nursing care and the further development of nursing and midwifery roles. Lord Willis, speaking at the 2014 RCN Congress, argued that training for nursing should continue long after registration:

> *"I would like to look at continuous professional development (CPD) and preceptorship because when a nurse has finished training they are not the finished article and should continue to learn throughout their career. For that to happen we need a seismic change to CPD".*

During our discussions with stakeholders, a number of issues were identified:

- the increasing requirements for nursing and midwifery staff to undertake mandatory training restricts their ability to undertake some CPD pursuits. CPD represents a major resource commitment at service level, both in time required to be released from service delivery, and also in the provision of staff to *back fill*;

- the increasing complexity of patient and client clinical need in the independent sector requires nurses to up-skill to reduce reliance on the HSC Trusts' workforce to support the independent sector staff;

- supervision of staff/mentoring roles places a high degree of demand at service level this has been particularly emphasised by the Independent sector;

- training should be developed according to programmes of care;

- the annual appraisal system must be linked to the Education Commissioning Process to ensure that staff develop in a way that is consistent with HSC Trust Reform Plans, regional strategies and priorities;

- HSC organisations must embed succession planning and ensure strong and capable leadership at all levels within nursing and midwifery to develop practice, improve quality of care and optimise patient and client outcomes.

5.2 Risk Assessment

This Workforce Plan emphasises the importance of continuing to develop Key Performance Indicators linking workforce metrics, such as, vacancies, use of bank and agency staffing and absenteeism to quality metrics, for example, patient falls, pressure ulcers, omitted or delayed medication and patient experience data.

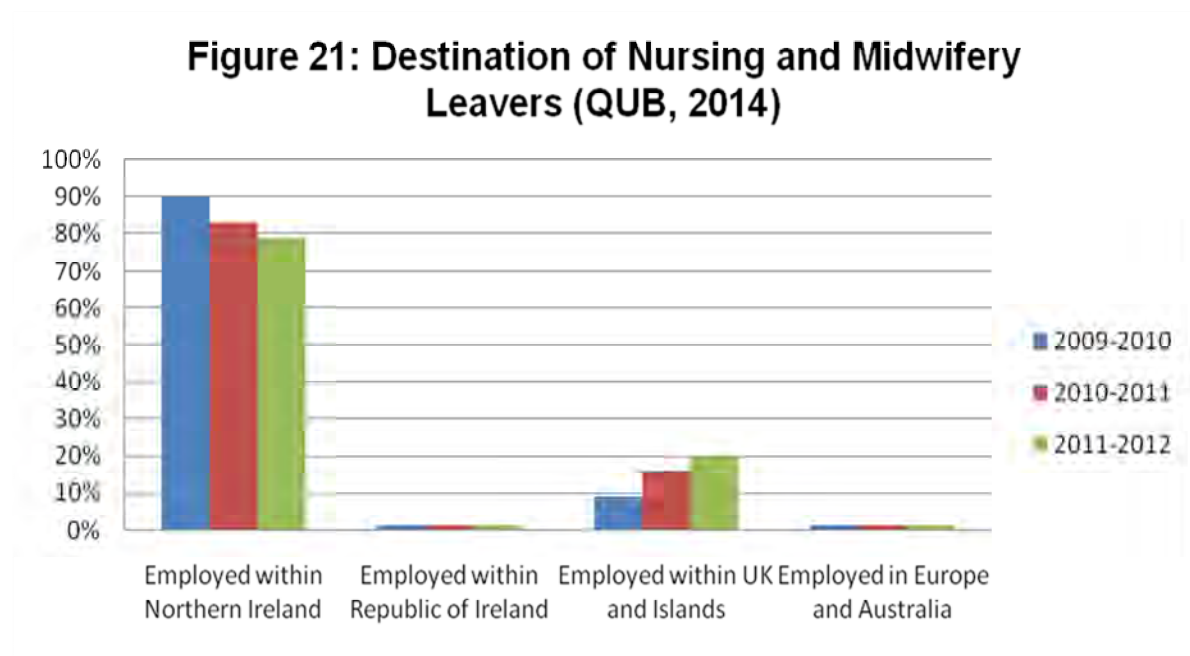
The HSC Trusts' Executive Directors of Nursing are responsible for the identification, mitigation and, where possible, avoidance of risks, including risks associated with the workforce. Risks should be recorded and managed through a robust corporate approach to Risk Management and monitored via accountability arrangements with the DHSSPS.

5.3 Student Nurses and Midwives

5.3.1 Destination of Student Nursing and Midwifery Leavers

Within recent years, countries such as the US, Canada and Australia have been offering generous salary and relocation packages, and fast-tracked residency status with the prospect of naturalisation, for example, the '*US Green Card*' system. Similarly, the transferability of the UK professional registration facilitates the free movement of both nurses and midwives currently working within the UK (including Northern Ireland).

Figure 21 below presents the findings from a survey conducted by Queen's University, Belfast. This demonstrates an increasing trend (currently 21%) for newly qualified nurses and midwives being employed outside Northern Ireland following completion of their programmes. It is important to note that those nurses and midwives *Employed within Northern Ireland* (Figure 21) include the independent sector who use the same *pool* as the HSC to recruit from.



At the time of developing this Plan, comparable destination figures were unavailable from the University of Ulster and Open University in Northern Ireland. However, the University of Ulster suggested that a lower number of student nurse graduates, representing approximately 7%, went to work elsewhere in the UK over the last four years, with no figures presented for other countries.

5.3.2 Attrition rates for Northern Ireland

The number of students leaving before completing their pre-registration training in Northern Ireland is provided below. The numbers provided are inclusive of students who have left midwifery training.

Academic Year	Total
2010/11	51
2011/12	80
2012/13	63
2013/14	46
2014/15	65

Trainee nurses and midwives are admitted to universities by academic year and therefore the information is available by academic year rather than financial year.

This loss represents almost 10% per year.

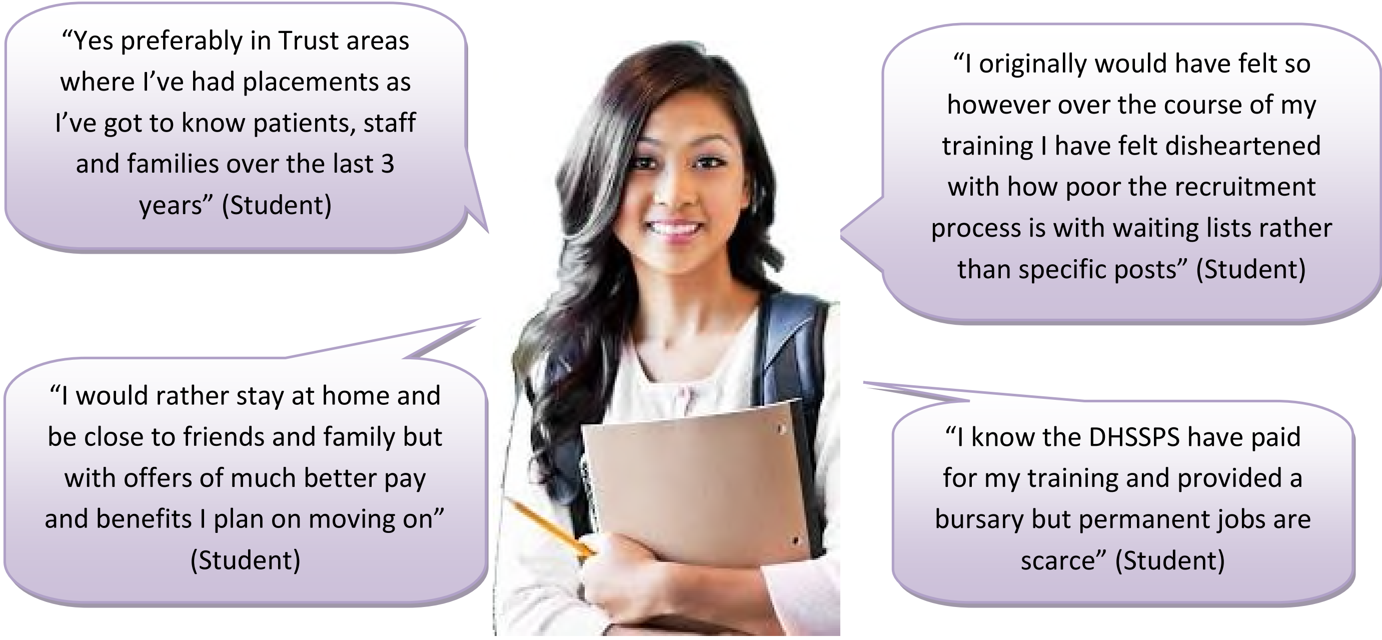
Action Point: Further work should be commissioned immediately to track destination and attrition rates for all Universities in Northern Ireland.

5.3.3 Perspective from Student Nurses and Midwives

As part of this Plan, final (3rd) year Student Nurses and Midwives (direct entry and additional registration programmes) were asked to participate in a survey to ascertain their views on taking up a post in Northern Ireland following completion of their educational programme and NMC registration.

Ninety six students commenced the survey with 87 (90.6%) completing it. The key findings are presented below.

Students were asked if they felt a sense of duty/responsibility to stay in Northern Ireland on completion of their programme. From a total of 85 respondents, 39% (n=33) reported that they did feel a sense of duty/responsibility to stay in Northern Ireland, however 61% (n=52) reported that they did not.



Students were asked "What would encourage you to take up a post in Northern Ireland". The main reasons reported from those who responded (n=90, 94%) include:

being close to home * good promotion opportunities * a supportive employer

good preceptorship programme * job security * choice to work in area of interest

familiar with the system * permanent post * early advertisement of posts

Students were asked "What would discourage you from taking up a post in Northern Ireland". The main reasons reported from those who responded (n=91, 95%) include:

temporary contract * lack of staff on wards * unsupportive working environment

poor preceptorship programme * waiting lists for jobs * placed in area I don't want

lack of opportunity to progress * working conditions putting registration at risk

The majority (67%, n=64) of those who responded reported that they would consider moving to another part of the UK or abroad when qualifying?

“Nurses seem to be held with a higher outlook in society in other countries and offered rotational programmes” (Student)

“Easier to obtain permanent jobs with better career opportunities and terms and conditions elsewhere” (Student)

“Higher standards of care, better staff working relationships” (Student)

“Elsewhere they give you an opportunity to work in your preferred area in nursing and opportunities for preceptorship” (Student)

Students were asked if they would consider a post in the independent sector on completion of their programme, with 58% (n=56) reporting Yes, 29% (n=28) reporting No and a further 13% (n=12) reporting they would, but only if they could not obtain a post within the HSC. From a total of 85 respondents, 60% (n=51) also agreed they would consider a rotational Graduate Scheme (across the statutory and independent sectors) at MSc level if they were unable to obtain a post following completion of their programme. The main reasons reported include:

beneficial to gain experience * great way to further education and develop skills

brilliant opportunity to transition and feel confident * gain insight into other areas

create better quality nursing care * increase suitability for different environments

5.4 Factors impacting on the Nursing and Midwifery Workforce

There are many factors impacting on the Nursing and Midwifery Workforce as discussed in the previous sections. The key factors which will have a significant impact on the demand and supply over the next ten years have been extrapolated from a variety of sources and include:
:

- impact of more nurses and midwives delivering care closer to and in the patient's/client's own home *(Transforming Your Care*; DHSSPS, 2011b);
- increasing numbers of patients being looked after in the independent sector, major recruitment issues and relying on recruiting overseas (stakeholder engagement);
- the impact of the independent sector, which include Practice Nurses and some Treatment Room Nurses, using the same *pool* as the HSC to recruit from;
- impact of rising numbers of the population over the age of 85 years and rising levels of long-term conditions (DHSSPS, 2013a);
- impact of the age profile and imminent high number of retirements, particularly in relation to the Health Visiting, District Nursing, Mental Health Nursing and School Nursing workforce (HRPTS);
- implementation of *Delivering Care* (DHSSPS, 2013b); the first phase (acute and specialist medicine and surgery) recommended an increase of 284 (WTE) registered nurses (adult) in addition to current staffing levels;
- impact of working patterns (94% female, 42% working part-time in some areas) and reported recruitment difficulties in covering maternity leave and sickness absence (HRPTS);
- impact of a global shortage of nurses with destination figures from Queen's University, Belfast demonstrating an increasing trend (21%) for employment of new nursing graduates outside Northern Ireland;
- impact of attrition rates of almost 10% in pre-registration training
- impact of regional recruitment (stakeholder engagement);
- reported recruitment issues of an attitude that *"any nurse will do*", management of long waiting lists with a lack of preference for nurses in where they choose to or are trained and experienced to work and holding of vacancies (stakeholder engagement);
- releasing staff to avail of further training and development opportunities due to difficulties in backfilling posts (stakeholder engagement);
- ensuring adequate programmes are in place to support CPD, mentorship, preceptorship and a career pathway for nurses and midwives (stakeholder engagement);
- increasing role of ICT and the impact of training and development and embedding such innovations in practice (stakeholder engagement).

5.5 Pre-registration Nursing and Midwifery Education Forecasts

5.5.1 Introduction

This section includes figures and tables relating to each of the Pre-Registration Branch programmes including Adult Nursing, Children's Nursing, Mental Health Nursing, Learning Disability Nursing and Midwifery.

Where relevant to the above Branches, Additional Registration and Community Nursing Programmes have also been included. The tables assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses and 59.5 years for midwives).

5.5.2 Pressures Points Identified for Education Commissioning

Significant pressures on the Nursing and Midwifery Education Commissioning Budget exist, particularly with regard to the community practice placements which are increasing due to policy direction of *Transforming Your Care* (DHSSPS, 2011b). HSC Trusts reported that the commissioning of Additional Registration programmes should also be considered carefully as under AfC terms and conditions, nurses with two such qualifications will attract a higher pay band; which has prevented advertisement of this type of position.

Additional Registration programmes do however have their place, particularly when shortages of nurses in specific practice areas exist, as training can be undertaken within a much shorter time frame. Similarly, some areas should support staff to undertake Additional Registration programmes, for example, Emergency Departments, Children's and Mental Health, where nurses require the knowledge and skills to treat a wider range of conditions and co-morbidities.

5.5.3 Adult Nursing

In addition to the main factors detailed previously, those impacting particularly on the Adult Nursing Workforce include:

- Impact of *Delivering Care (DHSSPS, 2013b)* on acute and specialist medical and surgical wards;
- Planned new builds (hospitals) all with single room accommodation;
- Difficulties in recruiting middle grade doctors particularly to Emergency Medicine and plans to introduce Advanced Nurse Practitioners;
- Impact of Reviews, Strategies and Service Frameworks;
- Implementation of the recommendations from the Francis Report (2013);
- Increased acuity in hospital, co-morbidities, high dependency patients within medical and surgical areas with no extra resource;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct care;
- Advances in technology and associated training and development needs;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns including high numbers of female (95.4%) and part-time staff (46%).

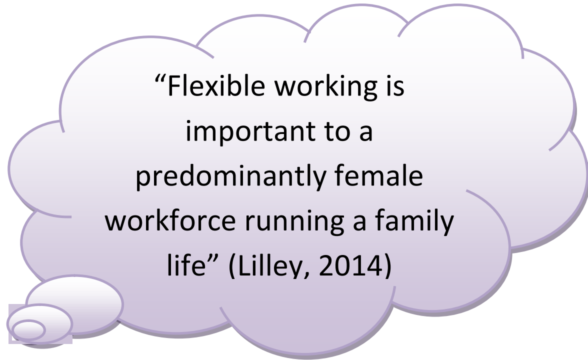


Table 8 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 – 59	60+	Total	% aged 55 and over
2015	2,933	1,214	1,375	1,358	1,441	761	337	9,419	12%
2020	***1,098***	2,933	1,214	1,375	1,358	1,441	761	9,419	23%
2025	***1,441***	***1,098***	2,933	1,214	1,375	1,358	1,441	9,419	30%
2030	***1,358***	***1,441***	***1,098***	2,933	1,214	1,375	1,358	9,419	29%

Table 9a below demonstrates the number of commissioned education places for adult nursing between 2008/09 and 2014/15.

Table 9a: Adult Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	**08 09**	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Direct Entry	559	570	489	489	462	469	469

Considering all of the above, the first reaction is to consider increasing the number of commissioned education places for adult nursing. However, we must keep in mind that Queen's University, Belfast report losing 21% of new graduates to positions outside of Northern Ireland. Focused work must take place to retain these newly qualified nurses and midwives as well as increasing Pre-registration Adult Nurse commissions by 100 places.

Taking factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%) and retirement and previous education commissions for this group into consideration, Northern Ireland must show a demonstrable improvement in employing these newly qualified nurses, however Adult Pre-registration Nurse places must be increased by at least 100 places as soon as possible. In addition, retirements over the next 10 years are expected to rise from the current 11% rate to 30%. Therefore proposed commission forecasts from 2015 - 25 are presented in Table 9b below:

Table 9b: Proposed Adult Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Proposed Places *	560	560	560	560	560	560	560	560	560	560

* These figures include Return to Nursing programmes

Northern Ireland must show an immediate and demonstrable improvement in employing their new graduate nurses as due to the three year lead in period, we cannot respond quickly enough to the demand discussed at length within this Workforce Plan.

5.5.4 Children's Nursing

In addition to the main factors detailed previously, those impacting particularly on the Children's Nursing Workforce include:

- Planned new builds (hospitals) and impact of the Regional Children's Hospital on recruitment in other HSC Trust;
- Difficulties in recruiting middle grade doctors to this speciality and plans to introduce Advanced Nurse Practitioners;
- Implementation of Paediatric, Neo-natal and Medical Reviews;
- Age appropriate settings for children up to the age of 18 years - requiring a significant workforce shift;
- Increase in the number of children with complex needs in the community and transitions required to support this;
- Reduction in the trend of filling children's nursing posts with general nurses and need to consider qualified skill mix;
- Difficulties in providing mentorship and preceptorship and a limited career pathway;
- A predominantly young, female (95.4%) workforce with 50% working part-time hours.

Table 10 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	351	128	105	123	126	42	11	886	6%
2020	***53***	351	128	105	123	126	42	886	19%
2025	***126***	***53***	351	128	105	123	126	886	28%
2030	***123***	***126***	***53***	351	128	105	123	886	26%

The HSC will lose up to 53 children's nurses to retirement imminently based on current retirement trends. Table 11a below demonstrates the number of commissioned education places for children's nursing between 2008/09 and 2014/15.

Table 11a: Children's Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	55	60	60	60	55	55	55
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	4	6	6	5	2	7	7
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	4	6	6	4	5	3	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends and previous education commissions for this group, alongside new build plans and increasing numbers of children with complex needs requiring care in the community this Plan would recommend an increase in pre-registration numbers (Direct Entry and Additional Registration programmes) as presented in Table 11b below.

Table 11b: Proposed Children's Nursing Commission Forecasts 2015/16 – 2024/25

Proposed Places	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	64	70	70	70	60	55	55	55	55
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	0	10	0	10	0	10	0	10	0	10
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	10	0	10	0	10	0	10	0	10	0

5.5.5 Mental Health Nursing

In addition to the main factors detailed previously, those impacting particularly on the Mental Health Nursing Workforce include:

- Mental health nurses being recruited to learning disability posts to fill deficits;
- Reform within mental health continues with the closure of long-stay wards by 2015 – need to consider future challenges associated with this;
- Planned new builds (hospitals) all with single room accommodation;
- Development of Advanced Nurse Practitioners/Consultant Nurses in condition specific/specialist need areas, i.e. addictions, eating disorders, dementia;
- Increasing nurse prescribing role;
- Increased care of patients with co-morbidities and complex care required;
- Implementation of pending Capacity legislation, the Service Framework for Mental Health and Well-being (DHSSPS, 2011d), Dementia Strategy (DHSSPS, 2011e), Bamford Action Plan (DHSSPS, 2012b) and Recovery Orientated Practice;
- Increase in public health and mental health prevention/early intervention roles;
- Issues related to availability of male staff particularly for acute and PICU settings;
- The need to strengthen the knowledge and skills in evidence based therapeutic interventions to support the implementation of the Psychological Therapies Strategy;
- The need to strengthen senior mental health nursing leadership to ensure nursing issues and needs are identified and addressed;
- Increasing age profile of this workforce and the impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (75.8%) and part-time staff (17%).

Table 12 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	318	212	258	375	362	142	53	1,720	11%
2020	***195***	318	212	258	375	362	142	1,720	29%
2025	***362***	***195***	318	212	258	375	362	1,720	43%
2030	***375***	***362***	***195***	318	212	258	375	1,720	37%

The HSC will imminently lose up to 195 mental health nurses to retirement. Table 13a below demonstrates the number of commissioned education places for mental health nursing between 2008/09 and 2014/15.

Table 13a: Mental Health Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	99	99	99	99	96	96	96
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	16	7	1	0	0	1	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	2	4	4	0	2	0	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan would recommend an initial decrease in pre-registration numbers with a subsequent increase as presented in Table 13b below.

Table 13b: Proposed Mental Health Nursing Commission Forecasts 15/16 – 24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	90	90	95	95	100	110	120	120	120	120
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	10	0	10	0	10	0	10	0	10	0

This Plan also recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. Similarly, increasing the length of the Mental Health Programme is recommended to ensure it includes an element of evidence based psychotherapeutic intervention training to best meet the new challenges this workforce is facing regarding early interventions.

Action Point: Review and future proof the Mental Health Nursing programmes to ensure the workforce are equipped to fulfill an increasing public health role, support co-morbidities and unmet physical needs and deliver evidence based psychotherapeutic interventions.

5.5.6 Learning Disability

In addition to the main factors detailed previously, those impacting particularly on the Learning Disability Nursing Workforce include:

- Difficulties experienced in recruiting learning disability nurses;
- Planned learning disability specialist nursing home for high complex needs within the Belfast HSC Trust;
- Increasing numbers of people with a learning disability and older people;
- More complex care in the community, increasing co-morbidities, challenging behaviour and unmet physical needs;
- Need for improved therapeutic interventions, crisis response, prevention of hospital admissions and early discharge;
- Strengthening knowledge and skills to work effectively with children and developing skills in traditional nursing procedures i.e. enteral feeding, catheterisation and medicines management;
- The need to strengthen senior learning disability nursing leadership to ensure nursing issues and needs are identified and addressed;
- The need for a clear service model for learning disability nurses to determine the future roles and skills required and impact of implementation of *Strengthening the Commitment* (DHSSPS, 2012d)
- Nurses increasingly working in service areas registered as social care settings including residential, domiciliary and day care;
- Issues related to availability of male staff (14.2%);
- Impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (85.8%) and part-time staff (25%).

Table 14 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	134	69	58	65	87	32	20	465	11%
2020	***52***	134	69	58	65	87	32	465	26%
2025	***87***	***52***	134	69	58	65	87	465	33%
2030	***65***	***87***	***52***	134	69	58	65	465	26%

The HSC will lose up to 52 learning disability nurses to retirement imminently based on current retirement trends. Table 15a below demonstrates the number of commissioned education places for learning disability nursing between 2008/09 and 2014/15.

Table 15a: Learning Disability Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	15	30	30	30	30	30	30
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	0	6	1	0	1	2	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	6	7	0	0	0	10	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan recommends maintaining training numbers, as presented in Table 15b.

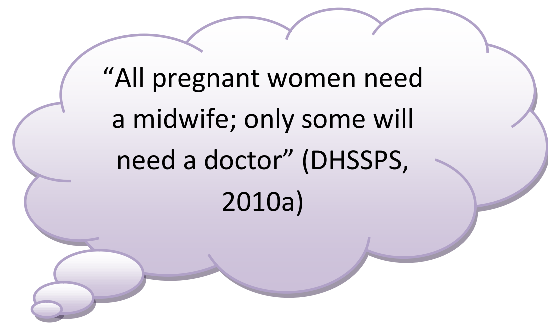
Table 15b: Proposed Learning Disability Nursing Commission Forecasts 15/16-24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	30	30	30	35	35	35	35	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	0	10	0	10	0	10	0	10	0	10

This Plan recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. A review of the Learning Disability programmes is recommended to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

Action Point: Review and future proof the Learning Disability Nursing programmes to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

5.5.7 Midwifery



In addition to the main factors detailed previously, those impacting particularly on the midwifery workforce include:

- A steadying birth rate (NISRA, 2013), with rising social and medical complexities;
- Major role in the promotion of normalising birth and as the lead professional for women with straightforward pregnancies (DHSSPS, 2012a);
- Key coordinator of care within the multidisciplinary team for complex pregnancies as highlighted in *Midwifery 20:20* (DHSSPS 2010a);
- Impact of a shift to community based care, increasing midwife led care in births and home births alongside free standing birthing centres;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns within this group including high numbers of female and part-time staff (67%);
- There are currently more midwives than there are jobs available.

Table 16 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	247	170	193	196	290	207	77	1,380	21%
2020	***284***	247	170	193	196	290	207	1,380	36%
2025	***290***	***284***	247	170	193	196	290	1,380	35%
2030	***196***	***296***	***284***	247	170	193	196	1,380	28%

The previous Review (DHSSPS, 2009) recommended that the number of commissioned places for midwifery should be increased, mainly due to the ageing profile. However, significantly lower numbers retired than expected therefore this workforce is now much older.

Furthermore, the projected retirements are expected to increase during this Review period from a current level of 21% to 35%. The HSC will lose up to 284 midwives to retirement imminently based on current retirement trends. Table 17a below demonstrates the number of commissioned education places for midwifery between 2008/09 and 2014/15.

Table 17a: Midwifery Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	30	30	30	35	35	36	35
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (18 mths)	32	35	35	30	25	25	20

Not all newly qualified midwives are being offered a post following completion of their programme. The cohorts of direct entry are obtaining posts in midwifery within a year of qualifying. There is an acknowledgment however of a loss back to nursing positions from the 18 month programme, due to a lack of available posts.

Taking this into consideration and based on the factors impacting on the workforce highlighted above, new mothers are becoming older and are increasingly presenting with co-morbidities which make the Addittional Registration Programme indispensable. Midwifery numbers commissioned should aim to meet those presented in Table 17b below.

Table 17b: Proposed Midwifery Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	35	35	35	35	30	30	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (18 mths)	20 per year up to 21/22 and then 15 from 22/23 onwards									

5.6 Post-registration Nursing Education Forecasts

5.6.1 Introduction

The areas in this section include figures and tables relating to the post-registration programmes (District Nursing, Health Visiting and School Nursing). These programmes refer to registered nurses who work in community settings. For the purpose of assessing demand and supply we have excluded some areas, for example, Mental Health, Learning Disability and Paediatric Nurses because they are predominantly supplied by pre-registration programmes, as previously highlighted.

These programmes (full-time) currently receiving Replacement Monies (based on Midpoint Band 5) include:

- District Nursing (10mths)
- Health Visiting (12mths)
- School Nursing (12mths)

The tables included in the sections below assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses).

5.6.2 District Nursing

In addition to the main factors detailed previously, those impacting particularly on the District Nursing Workforce include:

- Changing profile of district nursing including increased role in palliative care, intravenous infusions, rapid response, 24/7 working patterns;
- Implementation of Reform Plans and Integrated Care Partnerships;
- Changing demographics: increase in older people, long-term conditions, complex care in the community and acuity management;
- Implementation of various strategies and service frameworks;
- Registered nurse skill mix in district nursing teams will impact on the number required to be undertake the specialist practitioner programme which will be determined by the pending phase of *Delivering Care for District Nursing;*
- DHSSPS Guidance (2010d) on care management, assessment and care planning requirements;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct patient care;
- Impact of evolving futuristic technologies and training and development;
- Impact of the age profile and imminent high number of retirements related to the district nursing workforce;
- Impact of working patterns within this group including high numbers of female (97.5%) and part-time staff (53%);

Table 18 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	137	117	191	207	251	117	38	1,058	15%
2020	***155***	137	117	191	207	251	117	1,058	35%
2025	***251***	***155***	137	117	191	207	251	1,058	43%
2030	***207***	***251***	***155***	137	117	191	207	1,058	38%

The HSC will lose up to 155 district nurses to retirement imminently and this trend is set to more than double from 15% to 43% during the period of this Plan. Table 19a below demonstrates the number of commissioned education places for district nursing between 2008/09 and 2014/15.

Table 19a: District Nursing Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	18	12	9	9	17	26	23

Based on the significant factors impacting on this workforce, as highlighted previously and the Minister for Health's commitment to double the number of district nurses in training, this Plan would recommend increasing the commissioned numbers as presented in Table 19b below.

Table 19b: Proposed District Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Proposed Places	40	40	40	40	30	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for District Nursing* has been agreed.

5.6.3 Health Visiting

In addition to the main factors detailed previously, those impacting particularly on the Health Visiting Workforce include:

- Health Visiting is on the Risk Register of every HSC Trust and the Public Health Agency for risk associated with the delivery of the Universal Screening Programme and Safeguarding;
- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Increased role within Family Nurse Partnerships (Ministerial Target 2014/15);
- Increase in the black and minority ethnic population (BME) and the need for interpreters;
- Public health challenges: childhood obesity, peri-natal, infant, child and adolescent mental health, domestic abuse, child abuse, child sexual exploitation (CSE), deprivation and poverty;
- Increase in referrals from social services regarding children under 4 years old (5% between 2007 and 2012);
- *Delivering Care for Health Visiting* has not yet been published and will need to be taken account of when considering future commissioned education places;
- Impact of working patterns within this group including high numbers of female (99.7%) and part-time staff (48%);
- Impact of the age profile and imminent high number of retirements.

Table 20 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	84	62	76	117	122	62	18	541	15%
2020	***80***	84	62	76	117	122	62	541	34%
2025	***122***	***80***	84	62	76	117	122	541	44%
2030	***117***	***122***	***80***	84	62	76	117	541	36%

The HSC will lose up to 80 health visitors to retirement imminently and this trend is set to more than double during the period of this review from 15% to 44%. Table 21a below demonstrates the number of commissioned education places for health visiting between 2008/09 and 2014/15.

Table 21a: Health Visiting Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	29	26	24	18	25	37	61

Based on the factors impacting on this workforce as highlighted previously, this Plan would recommend the commissioned numbers as presented in Table 21b below.

Table 21b: Proposed Health Visiting Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	45	45	45	40	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for Health Visiting* has been agreed.

5.6.4 School Nursing

In addition to the main factors detailed previously, those impacting particularly on the School Nursing Workforce include:

- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Increase in students with chronic diseases, mental health issues and high-risk behaviours;
- Improving access to early prevention and support for children and families and help reduce the need for referral to social services;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Impact of working patterns within this group including high numbers of female (100%) and part-time staff (78%);
- Impact of the age profile and imminent high number of retirements.

Table 22 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 – 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	24	29	61	78	82	43	32	349	21%
2020	***74***	24	29	61	78	82	43	349	36%
2025	***82***	***74***	24	29	61	78	82	349	46%
2030	***78***	***82***	**74**	24	29	61	78	349	40%

The HSC will lose up to 74 school nurses to retirement imminently and this trend is set to increase incrementally throughout the period of this review from 21% to 46%. Table 23a below demonstrates the number of commissioned education places for school nurses between 2008/09 and 2014/15.

Table 23a: School Nursing Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	4	0	6	2	4	5	0

Based on the factors impacting on this workforce as highlighted previously, retirement trends**,** part-time working and low numbers commissioned since the previous Review (2009)**,** this Plan would recommend increasing the commissioned numbers as presented in Table 23b below.

Table 23b: Proposed School Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	20	20	20	15	15	15	20	20	15	15

5.6.5 Specialist Nursing

Specialist nursing has a key role to play in the delivery of *Transforming Your Care* (DHSSPS, 2011b) and education places need to be commissioned focusing particularly on Programmes of Care, for example, Frail Elderly, Respiratory, End of Life Care, Diabetes and Stroke. The current reliance on Learning Needs Analysis, as part of the Education Commissioning Process, needs to be strengthened and this Plan recommends the development of an Education Commissioning Direction Framework. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Plan well in advance of commissioning the new services.

Action Point: Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

Education Commissioning must set the direction of travel and focus both the strategic and service priorities. The current Education Commissioning Plan must be re-profiled and focus on strategic and service priorities rather than be based wholly on individual/personal development.

Specialist Nursing numbers have increased dramatically since the previous *Review of the Nursing and Midwifery Workforce* (DHSSPS, 2009) as presented in Table 24 below. It is believed that this is not an accurate picture as the numbers include AfC Band 5 nurses, however Band 5 nurses do not practice at a specialist nursing level. Conversely, the numbers of district nurses have reduced significantly. It is widely accepted by HSC Trusts that this increase is an HRPTS coding issue. The specialist nurse section of HRPTS should undergo a data cleanse exercise to better understand both specialist nursing and district nursing numbers.

Table 24: Comparison of Specialist Nurses and District Nurses (WTE) between 2009 and 2014 as recorded on HRMS and HRPTS

Categorisation/Year	2008	2009	2010	2011	2012	2013	2014
Specialist Nurses Bands 5, 6 & 7	386.4	425.8	495.7	687.7	752.7	807.6	787.6
Variance		+39.4	+69.9	+192	+65	+54.9	-20
District Nurses	972.6	932.9	902.0	823.5	833.7	860.3	850.4
Variance		-43.3	-30.9	-78.5	+10.2	+26.6	-9.9

5.7 Summary of Nursing and Midwifery Education Commissions 2015 - 2025

Table 25 below presents a summary of the proposed nursing and midwifery education commissions over the next 10 years, taking into account the factors impacting on the workforce as highlighted previously.

Table 25: Summary of Proposed Education Commissions 2015 - 2025

Programme	Commissioning Projections (all programmes must be reviewed on an annual basis to reflect changes in demand, attrition rates and destination figures)									
	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Adult Nursing	560	560	560	560	560	560	560	560	560	560
Children's Direct Entry	55	64	70	70	70	60	55	55	55	55
Children's Additional	0	10	0	10	0	10	0	10	0	10
Children's Community	10	0	10	0	10	0	10	0	10	0
Mental Health Direct Entry	90	92	95	95	100	110	120	120	120	120
Mental Health Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Mental Health Community	10	0	10	0	10	0	10	0	10	0
Learning Disability Direct Entry	30	30	30	35	35	35	35	30	30	30
Learning Disability Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Learning Disability Community	0	10	0	10	0	10	0	10	0	10
Midwifery Direct Entry	39	35	35	35	35	30	30	30	30	30
Midwifery Additional	25	20	20	20	20	20	20	15	15	15
District Nursing	40	40	40	30	30	30	30	30	30	30
Health Visiting	40	45	45	45	40	30	30	30	30	30
School Nursing	20	20	20	15	15	15	20	20	15	15

Action Point: Due to the huge reform agenda, all Nursing and Midwifery educational programmes at both pre and post registration level should have a taught element on Quality Improvement methodologies and ideally be required to identify and implement a quality improvement project.

Step 6: Implement, Monitoring and Refresh

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

6.1 Next Steps / Further Work to be Undertaken

The overall ambition of this Workforce Plan is to ensure we have a healthy, productive workforce, who are appropriately trained, and will provide the highest quality healthcare services at the right time in the right place. Change requires leadership and, in many health and care systems, it also requires improved opportunities for stakeholder involvement. "Top down" change is often unsustainable: the support of nurses and midwives is required, as is the active participation of other stakeholders (commissioners, education providers, professional and union organisations and other key professionals, particularly medical staff). The recommendations outlined in this Plan can support informed decision-making and prioritisation at a local and regional level.

To take this forward, the Regional Workforce Planning Group (RWPG) will oversee the implementation of the recommendations, underpinned by a robust implementation and monitoring strategy.

The following actions, to be undertaken include:

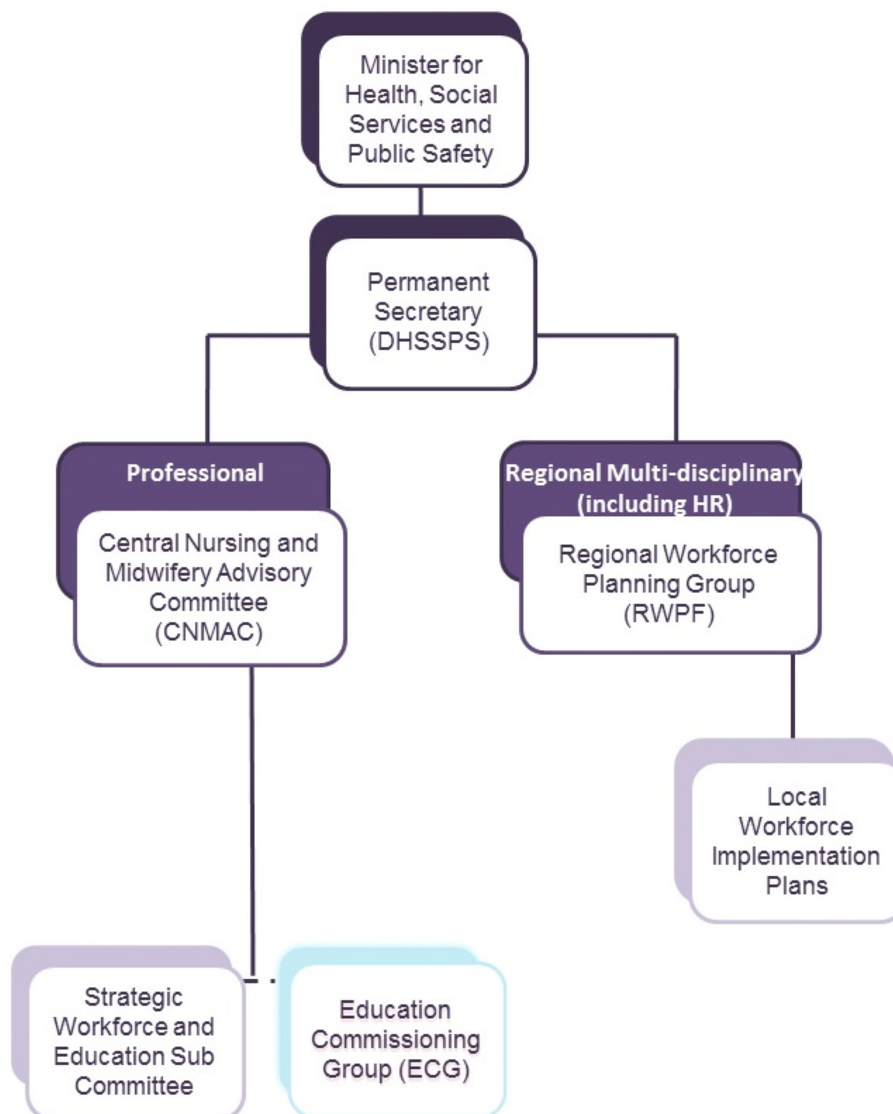
- Costing the Recommendations for consideration within this Plan
- Present the Plan and Recommendations to the DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) for professional approval
- Present the Plan and Recommendations to the Regional Workforce Planning Group for DHSSPS approval
- Once agreed, CNMAC's Workforce and Education Sub-Committee will be charged with overseeing and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews as at 5.5.6.

6.2 Monitoring Process

The monitoring of this Plan will sit in tandem with the Regional Workforce Key Performance Indicators currently being developed, particularly in relation to vacancy rates, bank and agency usage and associated improvements on recruitment processes, as presented in Figure 22.

The DHSSPS Chief Nursing Officer will include this information during mid and end of year Accountability Meetings.

Figure 22: Structure for implementation and monitoring of the Workforce Plan



CONCLUSION

Major workforce change is expected to support the many developments being undertaken in Northern Ireland over the next 5 to 10 years. There includes a shift of resource from acute hospital to community and primary care settings which will require substantial re-training and re-deployment of staff in nursing and midwifery. This will have a significant impact on the Nursing and Midwifery Education Commissioning Budget, however immediate steps should be taken to ensure this budget is delivering value for money before making projections on any additionality.

Demand for nursing and midwifery in Northern Ireland is likely to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). The second, third and fourth phases are due to report by the end of March 2015 however, no timeline has been agreed for areas such as mental health, learning disability, children's and midwifery. It is anticipated that any recruitment exercise required to address the implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

In addition, a range of reports and studies have highlighted the likelihood of a significant decline in the future supply of nurses in the UK (Centre for Workforce Intelligence, 2013; Imison & Bohmer, 2013; NHS Employers, 2014). This is already being felt in Northern Ireland and we are in the process of commencing our own international recruitment campaign during 2016 whilst we still face competition with other countries who are recruiting aggressively from within our universities. Employers in Northern Ireland must make themselves attractive to newly qualified nurses if they are to grow and maintain a steady workforce.

Whilst we have included the use of retirements to make our education commissioning forecasts, we must be aware of the needs of the independent sector as they will be using the same *pool* from which to recruit nurses in addition we are in an era of increasing demand This Plan recommends increasing training numbers at pre-registration level by at least 100 places.. The Plan also urges an immediate review of post-registration education programmes to ensure they are commissioned to meet regional strategies and priorities and to ensure best value for money.

Practitioners, managers, educationalists and commissioners will be required to interpret and apply the recommendations contained within this Plan, based on local circumstances. Similarly, organisational and corporate commitment will be required if it is to result in positive change and outcomes. The Regional Workforce Planning Group (RWPG) will oversee the implementation of this Plan to ensure a nursing and

midwifery workforce capable of meeting the health and care needs of the people of Northern Ireland over the next decade and beyond.

RECOMMENDATIONS

No	Recommendation
Theme: Future Supply and Demand of Nursing and Midwifery	
1	A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice including a radical review of the recruitment processes, methods and timescales used within HSC Trusts and categorisation and coding of nurses and midwives on HRPTS.
2	Destination and attrition rates for all Universities in Northern Ireland should be tracked on a yearly basis.
3	A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.
Theme: Supporting Nurse Training	
4	Consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within the independent sector.
Theme: Annual Review	
5	Ensure that emerging evidence from further phases of *Delivering Care* (DHSSPS, 2013b), additional registration programmes and the impact of the nursing and midwifery age profile and relevant pension changes, are reflected during annual reviews.
6	Commissioning of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.
Theme: Education Programmes and Commissioning	
7	Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.
8 9	Ensure that all pre and post registration Nursing and Midwifery educational programmes include a taught Quality Improvement methodologies element and ideally be required to identify and implement a quality improvement project. Review and future proof the Mental Health and Learning Disability Nursing programmes to ensure the workforce is equipped to fulfil an increasing public health role, manage and provide interventions to those with co-morbidities and/or complex physical and mental health needs. Consideration needs to be given to delivering the Specilaist Practice Community Programmes on a part time basis
10	Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

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ANNEXES

Annex A

Membership of Project Steering Committee (Working Group member)

Charlotte McArdle (Chair), Chief Nursing Officer, DHSSPS
Catherine Daly, Under Secretary, DHSSPS
Dr Paddy Woods, Deputy Chief Medical Officer, DHSSPS
Paula Smyth, HRD, DHSSPS
Caroline Lee, Nursing Officer, DHSSPS (Working Group member)
Dr Carole McKenna, Senior Officer, NIPEC (Project Lead) (Working Group member)
Alison Dunwoody, Deputy Principal Statistician, DHSSPS (Working Group member)
Angela McLernon, Chief Executive, NIPEC (from July 2014)
Dr Glynis Henry, Chief Executive, NIPEC (to June 2014)
Richard Cardwell, Assistant Statistician, DHSSPS
Damien McAllister, Director of HR, NHSCT
Joan Peden, Co-Director of HR, BHSCT
Ann McConnell, Assistant Director of HR, WHSCT
Myra Weir, Assistant Director of HR, SEHSCT
Monica Molloy, Senior HR Manager, BHSCT
Iain Gough, Senior HR Manager, SHSCT
Hugh McPoland, Director of HR, BSO
Nicki Patterson, Executive Director of Nursing, South Eastern HSC Trust
Olive Macleod, Executive Director of Nursing, Northern HSC Trust
Alan Corry-Finn, Executive Director of Nursing, Western HSC Trust
Brenda Creaney, Executive Director of Nursing, Belfast HSC Trust
Francis Rice, Executive Director of Nursing, Southern HSC Trust
Pat Cullen, Interim Director of Nursing and AHP, PHA
Janice Smyth, Director, RCN
Breedagh Hughes, Director, RCM
Kevin McAdam, HSC Representative, Unite
Anne Speed, HSC Representative, Unison
Carol Cousins, Independent and Voluntary sector representative (from August 2014)

Annex B

Northern Ireland Health Policy and Strategy Documents

Title	Published
A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland (DHSSPS, 2004)	Dec 2004
Improving the Patient and Client Experience (DHSSPS, 2008)	Nov 2008
Service Framework For Respiratory Health And Wellbeing (DHSSPS, 2009)	Jan 2009
Adult Safeguarding in Northern Ireland. Regional and Local Partnership Arrangements (DHSSPS, 2010)	Mar 2010
Living Matters Dying Matters. A Palliative and End of Life Care Strategy for Adults in Northern Ireland (DHSSPS, 2010)	Mar 2010
Improving Dementia Services in NI: A Regional Strategy, Consultation Paper (DHSSPS, 2010)	May 2010
Healthy Child, Healthy Future. A Framework for the Universal Child Health Promotion Programme in Northern Ireland (DHSSPS, 2010)	May 2010
A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery 2010-2015 (DHSSPS, 2010)	Jun 2010
A Strategy for the Development of Psychological Therapies Services (DHSSPS, 2010)	Jun 2010
Midwifery 2020, Delivering Expectations (DHSSPS, Welsh Assembly, DH, & Scottish Government, 2010)	Sep 2010
Delivering Excellence Supporting Recovery: Professional Framework for Mental Health Nursing 2011-2016 (DHSSPS, 2010)	Oct 2010
Safeguarding Children Supervision Policy for Nurses (DHSSPS, 2011)	Feb 2011
Service Framework For Cancer Prevention, Treatment And Care (DHSSPS, 2011)	Feb 2011
Service Framework For Mental Health And Wellbeing (DHSSPS, 2011)	Oct 2011
Quality 20:20, A 10 year Strategy to Protect and Improve Health and Social Care in Northern Ireland (DHSSPS, 2011)	Nov 2011
Improving Dementia Services in Northern Ireland. A Regional Strategy (DHSSPS, 2011)	Nov 2011
Transforming Your Care: A Review of Health and Social Care in NI (DHSSPS, 2011)	Dec 2011
Learning Disability Service Framework (DHSSPS, 2011)	Dec 2011
Strengthening the Commitment, the UK Modernising Learning Disability Nursing Review (DHSSPS, Welsh Assembly, DH, & Scottish Government; 2012)	Apr 2012
Promoting Good Nutrition. A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016 (DHSSPS, 2011)	Jun 2012

A Strategy for Maternity Care in Northern Ireland 2012-2018, (DHSSPS, 2012)	Jul 2012
Fit and Well – Changing Lives (DHSSPS, 2012)	Jul 2012
Service Framework For Learning Disability (DHSSPS, 2012)	Sept 2012
Delivering the Bamford Action Plan 2012-2015 (DHSSPS, 2012)	Nov 2012
Transforming Your Care: Vision to Action, A Post Consultation Report (DHSSPS, 2013)	Mar 2013
Transforming Your Care: Strategic Implementation Plan (DHSSPS, 2013)	Oct 2013
Service Framework For Older People (DHSSPS,2013)	Sept 2013
A Review of Paediatric Healthcare Services Provided in Hospitals and in the Community, Consultation Document (DHSSPS, 2013)	Nov 2013
A Review of Children's Palliative and End of Life Care in NI, Document for Public Consultation (DHSSPS, 2014)	Jan 2014
Strengthening the Commitment, One Year On, Progress Report on the UK Modernising Learning Disability Nursing Review (DHSSPS, 2014)	Apr 2014
Making Life Better. A Whole System Strategic Framework for Public Health (DHSSPS, 2014)	Jun 2014
Modernising Learning Disabilities Nursing Review Strengthening the Commitment. Northern Ireland Action Plan (DHSSPS, 2014)	Mar 2014
Service Framework for Cardiovascular Health and Wellbeing 2014 – 2017 (DHSSPS, 2014)	May 2014

Note: this is not an exhaustive list.

Annex C

HSC Registered Nurses & Midwives by HSC organisation and Service/Practice Area as at 31st March 2014 (HRPTS)

	Belfast HSCT		Northern HSCT		South Eastern HSCT		Southern HSCT		Western HSCT		NIBTS / BSO / PHA / NIPEC / RQIA		Total	
Combined Grades	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Acute/General Nurses	3,413	2,930.7	1,276	1,088.7	1,307	1,114.0	1,350	1,125.7	1,388	1,247.3			8,751	7,520.4
Mental Health Nurses	434	414.9	326	311.2	249	233.8	310	289.9	401	386.1			1,720	1,635.9
Learning Disability Nurses	212	198.2	30	27.4	35	30.3	113	100.1	75	72.2			465	428.1
District Nurses	200	170.4	226	172.4	222	172.1	187	148.2	223	190.2			1,058	853.3
Midwives	339	264.8	228	176.3	256	201.0	281	212.8	222	186.5			1,327	1,042.5
Health Visitors	77	65.1	118	98.1	84	73.6	118	98.4	92	78.3			489	413.4
Paediatric Nurses	384	320.8	139	119.0	104	79.6	124	105.3	135	124.3			886	749.0
School Nurses	31	23.5	24	16.4	20	13.9	29	19.4	21	18.5	37	34.0	125	91.6
Treatment Room Nurses / Family Planning Nurses	29	17.5	114	67.2	25	16.4	24	16.9	32	23.4			224	141.5
Specialist Nurses Band 5/6	98	81.0	120	99.8	50	42.3	30	22.8	60	52.4			358	298.3
Specialist Nurses Band 7+	157	143.4	119	113.2	91	83.6	105	96.5	94	89.7			575	535.5
Nurse Managers / Multiservices Manager / Non Acute Ward Sister /	113	103.9	109	106.1	128	121.0	67	60.3	41	40.2			468	441.5
Prison Nurse					56	55.2							56	55.2
Teacher / Trainer / Researcher / Counsellor	22	18.1	33	29.7	7	7.0	31	22.4	18	14.6	33	30.6	144	122.4
Total	5,509	4,752.3	2,862	2,425.5	2,634	2,243.8	2,769	2,318.7	2,802	2,523.8	70	64.6	16,646	14,328.7

Annex D

HSC Registered Nurses & Midwives by Service/Practice Area and Age (based on headcount) as at 31st March 2014 (HRPTS)

<table>
<tr><th>Combined Grades</th><th><25</th><th>25-29</th><th>30-34</th><th>35 - 39</th><th>40 - 44</th><th>45 - 49</th><th>50 - 54</th><th>55 - 59</th><th>60+</th><th>Total</th></tr>
<tr><td>Acute/General Nurses or Prison Nurses</td><td>438</td><td>1,136</td><td>1,336</td><td>1,172</td><td>1,274</td><td>1,183</td><td>1,268</td><td>685</td><td>315</td><td>8,807</td></tr>
<tr><td>Mental Health Nurses</td><td>33</td><td>111</td><td>174</td><td>212</td><td>258</td><td>375</td><td>362</td><td>142</td><td>53</td><td>1,720</td></tr>
<tr><td>Learning Disability Nurses</td><td>24</td><td>55</td><td>55</td><td>69</td><td>58</td><td>65</td><td>87</td><td>32</td><td>20</td><td>465</td></tr>
<tr><td>District Nurses</td><td>7</td><td>41</td><td>89</td><td>117</td><td>191</td><td>207</td><td>251</td><td>117</td><td>38</td><td>1,058</td></tr>
<tr><td>Midwives</td><td>6</td><td>54</td><td>143</td><td>167</td><td>189</td><td>194</td><td>290</td><td>207</td><td>77</td><td>*1,327</td></tr>
<tr><td>Health Visitors</td><td></td><td>16</td><td>44</td><td>53</td><td>66</td><td>111</td><td>119</td><td>62</td><td>18</td><td>*489</td></tr>
<tr><td>Paediatric Nurses</td><td>72</td><td>145</td><td>134</td><td>128</td><td>105</td><td>123</td><td>126</td><td>42</td><td>11</td><td>886</td></tr>
<tr><td>School Nurses /Treatment Room Nurses / Family Planning Nurses</td><td>0</td><td>10</td><td>14</td><td>29</td><td>61</td><td>78</td><td>82</td><td>43</td><td>32</td><td>349</td></tr>
<tr><td>Specialist Nurses Band 5/6</td><td colspan="2">13</td><td>48</td><td>49</td><td>63</td><td>92</td><td>63</td><td>23</td><td>7</td><td>358</td></tr>
<tr><td>Specialist Nurses Band 7+</td><td></td><td colspan="2">29</td><td>46</td><td>112</td><td>173</td><td>144</td><td>56</td><td>15</td><td>575</td></tr>
<tr><td>Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit / Researcher / Counsellor</td><td colspan="3">16</td><td>37</td><td>77</td><td>140</td><td>147</td><td>55</td><td>15</td><td>487</td></tr>
<tr><td>Teacher / Trainer</td><td></td><td></td><td>7</td><td>5</td><td>24</td><td>35</td><td>26</td><td>21</td><td>7</td><td>125</td></tr>
<tr><td>Total</td><td>581</td><td>1,584</td><td>2,085</td><td>2,084</td><td>2,478</td><td>2,776</td><td>2,965</td><td>1,485</td><td>608</td><td>16,646</td></tr>
</table>

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex E

HSC Registered Nurses & Midwives by Service/Practice Area and Gender as at 31st March 2014 (HRPTS)

Combined Grades	Female	Male	Total	% Female	% Male
Acute/General Nurses	8,352	399	8,751	95.4%	4.6%
Mental Health Nurses	1,304	416	1,720	75.8%	24.2%
Learning Disability Nurses	399	66	465	85.8%	14.2%
District Nurses / Treatment Room Nurses / Family Planning Nurses	1,250	32	1,282	97.5%	2.5%
Midwives / Health Visitors	1,810	6	1,816	99.7%	0.3%
Paediatric Nurses	874	12	886	98.6%	1.4%
School Nurses	125	0	125	100.0%	0.0%
Specialist Nurses Band 5/6	346	12	358	96.6%	3.4%
Specialist Nurses Band 7+	540	35	575	93.9%	6.1%
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit	425	43	468	90.8%	9.2%
Prison Nurse	42	14	56	75.0%	25.0%
Teacher / Trainer / Researcher / Counsellor	130	14	144	90.3%	9.7%
Nurse / Midwifery Support	4,023	625	4,648	86.6%	13.4%
Total	19,620	1,674	21,294	92.1%	7.9%

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex F

HSC Nursing, Midwifery and Support Staff Vacancies as at 31st March 2014

	Nurse Support		Qualified Nurses						
Pay band	1 - 4		5 - 7		8 - 9		TOTAL		Overall WTE Vacancy Rate *
Staff Group	HC	WTE	HC	WTE	HC	WTE	HC	WTE	
Acute Nursing	63	54.3	132	120.0	1	1.0	196	175.3	1.8%
Mental Health Nursing	7	7.0	74	71.9	0	0.0	81	78.9	3.5%
Learning Disability Nursing	0	0.0	3	3.0	0	0.0	3	3.0	0.4%
Midwifery	2	1.1	7	4.8	0	0.0	9	5.9	0.5%
Health Visiting	0	0.0	18	15.0	0	0.0	18	15.0	1.4%
District Nursing	7	5.6	41	33.6	0	0.0	48	39.2	5.8%
Paediatric Nursing	14	10.6	66	62.3	0	0.0	80	72.9	7.3%
School Nursing	3	2.3	1	0.7	0	0.0	4	3.0	2.9%
Treatment Room / Practice / Family Planning Nursing	0	0.0	1	0.1	0	0.0	1	0.1	0.1%
Specialist Nursing	0	0.0	16	12.7	1	1.0	17	13.7	1.5%
Nurse Managers / Audit	0	0.0	7	6.7	5	5.0	12	11.7	2.7%
Teaching / Training	0	0.0	0	0.0	0	0.0	0	0.0	0.0%
Other Nursing	0	0.0	1	0.5	0	0.0	1	0.5	0.6%
Total	96	80.8	367	331.3	7	7.0	470	419.1	2.3%
WTE Vacancy Rate		2.0%		2.3%		1.9%		2.3%	2.3%

* The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).

For further Information, please contact

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This document can be downloaded from the NIPEC website
www.nipec.hscni.net

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