Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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The Quality Standards for Health and Social Care

SUPPORTING GOOD GOVERNANCE AND BEST PRACTICE IN THE HPSS

March 2006

FOREWORD BY THE MINISTER

The people of Northern Ireland are entitled to the highest standards of health and social care. Having standards in place to ensure that people have the right care wherever they live in Northern Ireland is a fundamental principle of reform and modernisation of the health and social care system.

I am committed to putting patients, clients and carers first. The *Quality Standards for Health and Social Care* set out the standards that people can expect from Health and Personal Social Services (HPSS). In developing these standards, my aim is to raise the quality of services and to improve the health and social wellbeing of the people of Northern Ireland. At the heart of these standards are key service user and carer values including dignity, respect, independence, rights, choice and safety.

The standards have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

The publication of the quality standards is an important milestone in the process of putting patients first. They will be used by the new Regulation and Quality Improvement Authority to assess the quality of care provided by the HPSS. The new Authority will be looking to see how the HPSS provide quality services and will be reporting their findings both to the Department and to the public.

Given the rapidly changing environment in which the HPSS now operates including changes arising from the Review of Public Administration, it is important that these standards do not become outdated or serve to stifle innovation. Therefore, the standards will be reviewed by the end of 2008.

SHAUN WOODWARD MP
Minister for Health, Social Services and Public Safety

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Section 1: Introduction to the Development of Standards

1.1 Introduction

Almost 95% of the population of Northern Ireland makes contact with health and social services on an annual basis. This contact may be through primary care services, community care services or through hospitals. In all of these contacts, people are entitled to the highest standards of health and social care.

This document sets out clearly for the public, service users and carers, and those responsible for the commissioning, planning, delivery, and review of services, the quality standards that the Department considers people should expect from Health and Personal Social Services (HPSS). It represents a significant step in the process of placing the needs of the service user and carer, and the wider public, at the centre of planning, delivery and review of health and social care services.

1.2 Background to the development of standards

Quality improvement is at the forefront of the development of health and social care services in Northern Ireland. These improvements are centred around five main areas, which are an integral part of modernisation and reform:

- setting of standards – to improve services and practice;
- improving governance in the HPSS - in other words, the way in which the HPSS manages its business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they provide; and
- establishing a new, independent body to assess the quality of health and social care.

The consultation document “Best Practice – Best Care”, published in April 2001, sets out the detail of this framework to improve the quality of care. This included links to national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

1.3 Improving governance in health and social care

The outcome of the Review of Public Administration, announced in November 2005, signalled major changes to the structure and functions of HPSS organisations. Regardless of these changes there remains a statutory duty of quality on HSS Boards and Trusts. This means that each organisation has a legal responsibility for satisfying itself that the quality of care it commissions and/or provides meets a required standard. This requirement is just as important as the responsibility to demonstrate financial regularity and propriety. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. This process is known as *Governance*.

1.4 The setting of standards

In addition to drawing on national and professional standards, a range of local standards is being developed to enhance governance arrangements in the HPSS. These include controls assurance standards, so that by 2006-07, there will be a comprehensive set of specific assurance standards, which the HPSS can use to assess compliance against the required attainment levels. In addition, a number of care standards have been developed to facilitate the inspection and regulation of specific health and social care services provided by the HPSS and the independent sector. These care standards are specified in legislation and will be inspected, regulated and monitored by a new organisation called the Health and Personal Social Services Regulation and Improvement Authority (the Regulation and Quality Improvement Authority - RQIA).

The development of the *Quality Standards for Health and Social Care*, as outlined in this document, is intended to complement standards already issued or currently in development. Consequently, evidence of compliance with existing or new standards, such as professional standards, charter standards, controls assurance and/or care standards will form part of the evidence of practitioner or organisational commitment to these new quality standards.

1.5 What is a standard?

A standard is a level of quality against which performance can be measured. It can be described as ‘essential’- the absolute minimum to ensure safe and effective practice, or ‘developmental’, - designed to encourage and support a move to better practice. The *Quality Standards for Health and Social Care*, which are contained in this document, are classed as essential.

Given the rapidly changing environment in which the HPSS operates, it is important that standards do not become outdated or serve to stifle innovation.

To prevent this, standards need to be regularly reviewed and updated. It will be the Department's responsibility, drawing on the best evidence available, including advice, reports and/or information from the RQIA, to keep the quality standards under consideration, with a formal review being completed by the end of 2008.

1.6 Why are standards important?

Raising and maintaining the quality of services provided by the HPSS is a major objective for all involved in the planning, provision, delivery and review of health and social care services. Currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery and ease of access.

In order to improve the quality of these services, change is needed, underpinned and informed by a more cohesive approach to standards development.

Standards:

- give HPSS and other organisations a measure against which they can assess themselves and demonstrate improvement, thereby raising the quality of their services and reducing unacceptable variations in the quality of services and service provision;
- enable service users and carers to understand what quality of service they are entitled to and provide the opportunity for them to help define and shape the quality of services provided by the HPSS and others;
- provide a focus for members of the public and their elected representatives, to consider whether their money is being spent on efficient and effective services, and delivered to recognised standards;
- help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- promote compliance, and underpin the regulation and monitoring of services to determine their quality and safety and to gauge their continuous improvement.

By promoting integration, these *Quality Standards for Health and Social Care* will contribute to the implementation of clinical and social care governance in the HPSS and will be used by HPSS and other organisations, service users and carers, the wider public and the RQIA to assess the quality of care provision.

1.7 The five quality themes

There are five quality themes on which the standards have been developed to improve the health and social well-being of the population of Northern Ireland. These themes have been identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes are:

1. Corporate Leadership and Accountability of Organisations;
2. Safe and Effective Care;
3. Accessible, Flexible and Responsive Services;
4. Promoting, Protecting and Improving Health and Social Well-being; and
5. Effective Communication and Information.

1.8 Assessing quality

The RQIA was established by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and began work on 1 April 2005. It has two main functions:

- inspection and regulation of specified health and social care services provided by the HPSS and the independent sector; and

- inspection and review of the services provided by the HPSS in Northern Ireland.

The RQIA has a general duty to encourage improvements in the quality of services commissioned and provided by HPSS and other organisations. It will promote a culture of continuous improvement and best practice through inspection and review of clinical and social care governance arrangements.

The RQIA has taken over responsibility for the registration, inspection and regulation of providers of care, for example, residential care, nursing homes and day care facilities. On a phased basis, the RQIA will assume further responsibilities over the coming years, including reporting on the quality of care provided by the HPSS. Where serious and/or persistent clinical and social care governance problems come to light, it will have a key role to play, in collaboration with other regulatory and inspectoral bodies, in the investigation of such incidents. It will report on its findings to the Department and to the public.

1.9 How will the standards be used to measure quality?

The RQIA, in conjunction with the HPSS, service users and carers, will agree how the standards will be interpreted to assess service quality. It is envisaged that specific tools will be designed to allow the RQIA to measure that quality and to assist the HPSS in assessing themselves. Once developed, not only will these tools assess HPSS structures and processes but they will also contribute to the assessment of clinical and social care outcomes.

Whilst it is for the RQIA to provide guidance on what assessment methods it will use, it is recognised that collecting the evidence to demonstrate that relevant standards have been successfully achieved may be a time consuming process for the HPSS. Therefore, information that is currently compiled on existing standards will also be able to be used to contribute to the demonstration of achievement for these standards.

The RQIA will commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five themes contained within this document. RQIA will report on the quality of care provided by the HPSS following its review. This approach will promote quality improvement across organisations.

Section 2: Values and Principles Underpinning the Standards

2.1 Introduction

There are three key premises, which underpin these quality standards and are central to all aspects of planning, provision, delivery, review and improvement of the HPSS. They are that:

- people in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, delivery and evaluation of, services;

- clinical and social care governance in the HPSS must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments;

- service users and carers should be fully valued by HPSS staff who, in turn, should be valued by service users, carers and others.

2.2 The values underpinning the Standards

The quality of a service provided is dependent on managers and HPSS staff basing their practice on the following values and principles; these complement those already outlined in the care standards for independent agencies, establishments and certain other services provided by HPSS organisations.

They are:

DIGNITY AND RESPECT	The uniqueness and intrinsic value of the individual is acknowledged and each person is treated with dignity and respect. This is applicable to service users, carers, staff and others who come in contact with services.
INDEPENDENCE	A balance between the promotion of independence and risk taking is needed. Service users have as much control as possible over their lives. Service users are informed about risk whilst being protected against unreasonable risks.
PROMOTION OF RIGHTS	In the context of services delivered to them, the individual and human rights of service users are promoted and safeguarded. Where necessary, appropriate advocacy arrangements are put in place.
EQUALITY AND DIVERSITY	Equality of opportunity and positive outcomes for service users and staff are promoted; their background and culture are valued and respected.
CHOICE AND CAPACITY	Service users are offered, wherever possible, according to assessed need and available resources, the opportunity to select independently from a range of options based on clear and accurate information, which is presented in a manner that is understood by the service user and carer.
PRIVACY	Service users have the right to be free from unnecessary intrusion into their affairs and there is a balance between the consideration of the individual's safety, the safety of others and HPSS organisational responsibilities.
EMPOWERMENT	Service users are enabled and supported to achieve their potential in health and social well-being. Staff are supported and developed to realise their ability and potential.
CONFIDENTIALITY	Information about service users and staff is managed appropriately and everyone involved in the service respects confidential matters.
SAFETY	Every effort is made to keep service users, staff and others as safe as is possible. In all aspects of treatment and care, service users are free from exploitation, neglect or abuse.

2.3 The principles underpinning the Standards

The following principles are fundamental to the development of a quality service.

PUBLIC AND SERVICE USER INVOLVEMENT	The views and experiences of service users, carers, staff and local communities are taken into account in the planning, delivery, evaluation and review of services. Service users and carers, wherever possible, are involved in, and informed about, decisions made when they seek access to or receive services during their treatment or care.
SAFETY AND EFFECTIVENESS	Systems are in place to ensure that the safety of service users, carers, staff and the wider public, as appropriate, underpin all aspects of health and social care delivery. For example, the imperative to protect children and vulnerable adults may take precedence over the specific wishes of the service user and their carers. In addition, the protection of staff may need to be balanced with the specific wishes of service users, carers, families and friends. Quality systems are in place to enable staff to play a full and active role in providing effective and efficient health and social care services for all who use these services. Staff are fully supported, regularly supervised and appropriately trained and educated, to provide safe and effective health and social care services.
ROBUST ORGANISATIONAL STRUCTURES AND PROCESSES	Robust organisational structures and processes are in place, which are regularly reviewed to promote safe and effective delivery of care. Timely information is shared and used appropriately to optimise health and social care.
QUALITY of SERVICE PROVISION	Policies, procedures and activities are in place to encourage and enable continuous quality improvement. Service developments and provision are based on sound information and knowledge of best practice, as appropriate.

Section 3: Format of the Standards

3.1 The five quality themes

The five quality themes are applicable to the whole of the HPSS, including those services, which are commissioned or provided by HPSS organisations and family practitioner services. They are underpinned by the duty of quality on HSS Boards and Trusts. Where care is commissioned outside Northern Ireland, commissioners must ensure that the quality of care is commensurate with these and other associated standards.

The five quality themes, encompassing the standards, are set out in sections four to eight of this document. These are:-

- Corporate Leadership and Accountability of Organisations (Section 4);
- Safe and Effective Care (Section 5);
- Accessible, Flexible and Responsive Services; (Section 6);
- Promoting, Protecting and Improving Health and Social Well-being (Section 7); and
- Effective Communication and Information (Section 8).

3.2 Format of the standards

Each theme has a **title**, which defines the area upon which the standard is focused. Then, a **standard statement** will explain the level of performance to be achieved. The reason why the standard is seen to be important will be covered by the **rationale**. The standard statement will then be expanded into a series of **criteria**, which will provide further detail of areas for consideration by the HPSS and by RQIA.

Section 4: Corporate Leadership and Accountability of Organisations (Theme 1)

4.1 Standard Statement

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

4.2 Rationale

The HPSS must provide effective leadership and a clear direction to make the most of its resources (people, skills, time and money), and to deliver high quality services to the public in as safe an environment as is possible. The aim is to ensure a competent, confident workforce and an organisation that is open to learning and is responsive to the needs of service users and carers. This will facilitate staff in the organisation to take individual, team and professional responsibility in order to promote safe, sustainable and high quality services. The organisation needs to maintain and further enhance public confidence.

4.3 Criteria

The organisation:

a) has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

k) undertakes robust pre-employment checks including:

- qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body;
- police and Protection of Children and Vulnerable Adults checks , as necessary;
- health assessment, as necessary; and
- references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

Section 5: Safe and Effective Care (Theme 2)

5.1 Standard Statement

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.2 Rationale

A quality service is one which is safe, effective and sustainable. Diminished standards on safety reflect a poor quality of service. The provision of health and social care is complex and will never be one hundred percent error-free. However, more can always be done to avoid injury and harm to service users, from the treatment and care that is intended to help them. This is an integral part of continuous quality improvement. Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence.

It is acknowledged, however, that in some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking can be considered to be a positive action. Health and social care staff need to work in partnership with service users and carers to explore choices and agree on how risk can be managed and minimised for the benefit of individual service users, carers, families and communities.

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.

This theme of “Safe and Effective Care” has been subdivided into three areas:

- ensuring safe practice and the appropriate management of risk;
- preventing, detecting, communicating and learning from adverse incidents and near misses; and
- promoting effective care.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;

b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;

c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

d) promotes effective interagency working in relation to raising awareness of the risk factors associated with abuse, including domestic violence and in the promotion of effective interagency responses;

e) has a safety policy in place which takes account of the needs of service users, carers and staff, the public and the environment; and

f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure:

- efficacy and comparability of outcomes in health and social care;
- compliance with professional and other codes of practice;
- effective and efficient procedures for obtaining informed consent for examination, treatment and/or care;
- accurate, timely and consistent recording of care given or services provided and associated outcomes;
- protection of health, welfare and safety of staff;
- awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light;
- there is choice where food and/or fluid is provided, which reflects cultural and spiritual preferences and that procedures are in place to promote the safe handling of food and a healthy diet;

- safe practice in the selection, procurement, prescription, supply, dispensing, storage and administration of medicines across the spectrum of care and support provided, which complies with current medicines legislation;

- promotion of safe practice in the use of medicines and products, particularly in areas of high risk, for example:

    - intrathecal chemotherapy;
    - blood and blood products;
    - intravenous fluid management;
    - methotrexate;
    - potassium chloride; and
    - anticoagulant therapy.

- risk assessment and risk management in relation to the acquisition and maintenance of medical devices and equipment, and aids and appliances across the spectrum of care and support provided;

- promotion of general hygiene standards, and prevention, control and reduction in the incidence of healthcare acquired infection and other communicable diseases;

- appropriate decontamination of reusable medical devices;

- safe and effective handling, transport and disposal of waste, recognising the need to promote the safety of service users and carers, staff and the wider public, and to protect the environment;

- interventional procedures and/or any new methods undertaken by staff are supported by evidence of safety and efficacy;

- address recommendations contained in RQIA reports (when available), service and case management reviews; and

- participation in and implementation of recommendations contained in local or national enquiries, where appropriate, e.g. National Confidential Enquiries.

5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

The organisation:

a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;

b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;

c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and

d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.

5.3.3 Promoting Effective Care

The organisation:

a) provides relevant, accessible, information to support and enhance service user and carer involvement in self-management of their health and social care needs;

b) promotes a person-centred approach and actively involves service users and carers in the development, implementation, audit and review of care plans and care pathways;

c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;

d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems;

e) uses recognised clinical and social care standards and outcomes as a means of measuring health and social care quality;

f) promotes the implementation of evidence based practice through use of recognised standards and guidelines including guidance from the Department, NICE, SCIE and the National Patient Safety Agency (NPSA);

g) has in place systems to promote active participation of staff in evidence based practice, research, evaluation and audit;

h) has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate;

i) provides regular reports to the organisation's executive and non-executive board directors on clinical and social care governance arrangements and continuous improvement in the organisation; and

j) promotes the involvement of service users and carers in clinical and social care audit activity.

Section 6: Accessible, Flexible and Responsive Services (Theme 3)

6.1 Standard Statement

Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources.

Each organisation strives to continuously improve on the services it provides and/or commissions.

6.2 Rationale

To meet the needs of local communities and to narrow inequalities in health and social well-being, services should take account of the current and anticipated needs of the local community. Service users, carers, front line staff and the wider public should be meaningfully engaged in all stages of the service planning and decision-making cycle. Assessment of need should be undertaken in partnership with the statutory, voluntary, private and community sectors. This should be informed by the collation and analysis of information about the current health and social well-being status of the local population, unmet need, legislative requirements, and evidence of best practice and review of current service provision. Service planning should also take account of local and regional priorities and the availability of resources.

In order to promote systematic approaches to the development of responsive, flexible and accessible services for the local population and for individuals, this theme has been sub-divided into two main areas:

- service planning processes; and
- service delivery for individuals, carers and relatives.

6.3 Criteria

6.3.1 Service Planning Processes

The organisation:

a) has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives;

b) integrates views of service users, carers and local communities, and front line staff into all stages of service planning, development, evaluation and review of health and social care services;

c) promotes service design and provision which incorporates and is informed by:

- information about the health and social well-being status of the local population and an assessment of likely future needs;
- evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
- principles of inclusion, equality and the promotion of good relations;
- risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
- current and/or pending legislative and regulatory requirements;
- resource availability; and
- opportunities for partnership working across the community, voluntary, private and statutory sectors.

d) has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities;

e) has standards for the commissioning of services which are readily understood and are available to the public; and

f) ensures that service users have access to its services within locally and/or regionally agreed timescales.

6.3.2 Service Delivery for Individuals, Carers and Relatives

The organisation:

a) ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators;

b) has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision;

c) ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:

- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary;

d) incorporates the rights, views and choice of the individual service user into the assessment, planning, delivery and review of his or her treatment and care, and recognises the service user's right to take risks while ensuring that steps are taken to assist them to identify and manage potential risks to themselves and to others;

e) ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially;

f) promotes multi-disciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff; and

g) provides the opportunity for service users and carers to provide comment on service delivery.

Section 7: Promoting, Protecting and Improving Health and Social Well-being (Theme 4)

7.1 Standard Statement

The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social well-being, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation.

7.2 Rationale

Individuals, families and carers have a major part to play in their own and their dependents' health and social well-being. Although many factors influence the health and social well-being of individuals, many of these factors are societal issues and are outside the control of individuals. Examples include poverty, social exclusion, poor education, unemployment, crime, and poor housing. Resolving these issues requires a broad-based approach and concerted action by a wide range of people and agencies including the statutory, voluntary, community and business sectors. The HPSS, working in partnership with these other agencies and community groups, should actively seek to influence and support better decision-making, and establish systems to promote and improve the health and social well-being of the public and to reduce inequalities. The goal is to improve the health and social well-being of the population of Northern Ireland, by increasing the length of their lives, improving the quality of life through increasing the number of years spent free from disease, illness, or disability, and by providing better opportunities for children and support for families.

7.3 Criteria

The organisation:

a) has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities;

b) actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities;

c) is committed to human rights, as identified in human rights legislation and United Nations Conventions, and to other Government policies aimed at tackling poverty, social need and the promotion of social inclusion;

d) actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the Northern Ireland Act 1998;

e) promotes ownership by service users, carers and communities to enable service users and the public to take responsibility for their own health, care and social well-being, and to participate as concerned citizens in promoting the health and social well-being of others;

f) collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities;

g) has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance;

h) has processes to engage with other organisations to reduce local environmental health hazards, as appropriate;

i) has evidence-based chronic disease management programmes and health promotion programmes and, as appropriate, community development programmes, which take account of local and regional priorities and objectives;

j) has systems to promote a healthier, safer, and “family friendly” workforce by providing advice, training, support and, as appropriate, services to support staff;

k) has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public;

l) uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services; and

m) provides opportunities for the use of volunteers, as appropriate.

Section 8: Effective Communication and Information (Theme 5)

8.1 Standard Statement

The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

8.2 Rationale

Good communication and effective use of information are the basis for decision-making by individuals, the public and organisations. They ensure that all relevant facts are collated and used to inform treatment and care, and the assessment, planning, service delivery and resource allocation processes. For information to be useful, it needs to be in an understandable format, accessible to those who need it and readily available. The communication and information management processes within an organisation must take account of the needs of service users and carers, staff and the public and the media, and any legislative or regulatory requirements. Protecting personal information and confidentiality are important to ensure that information is appropriately communicated to those who need to know and effectively used to inform any decisions made. The HPSS should be sensitive to the range of information needs required to support individuals, communities and the organisation itself.

8.3 Criteria

The organisation has:

a) active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public;

b) an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation;

c) an effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services;

d) system(s) and process(es) in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness;

e) clear communication principles for staff and service users, which include:

- openness and honesty;
- use of appropriate language and diversity in methods of communication;
- sensitivity and understanding;
- effective listening; and
- provision of feedback.

f) clear information principles for staff and service users, which include:

- person-centred information;
- integration of systems;
- delivery of management information from operational systems;
- security and confidentiality of information; and
- sharing of information across the HPSS, as appropriate;

g) the organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media;

h) effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation;

i) procedures for protection of service user and carer information which include the timely sharing of information with other professionals, teams and partner organisations as appropriate, to ensure safe and effective provision of care, treatment and services, e.g. in relation to the protection of children or vulnerable adults, and the safe and efficient discharge of individuals from hospital care;

j) effective and efficient procedures for obtaining valid consent for examination, treatment and/or care;

k) an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery; and

l) a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.

APPENDIX 1

GLOSSARY OF TERMS

Adverse incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Carer	Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.
Care plan	The outcome of an assessment. A description of what an individual needs and how these needs will be met.
Care Standards	Care Standards are service specific standards currently being developed. They will cover a range of services provided by public, voluntary and private organisations such as nursing homes, residential homes, independent clinics etc.
Clinical and Social Care Governance	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Community care	Health and social services aimed at supporting individuals to remain safely in their own homes for as long as possible.
Community development	Consultation with, and involvement of local communities and groups in improving health and social well-being of the community.
Controls Assurance Standards	These standards focus on key areas of potential risk and help HPSS organisations demonstrate that they are doing their reasonable best to manage themselves and protect stakeholders from risk. They support effective governance.
Equality impact assessment	Consideration of a policy having regard to its impact on and the need to promote equality of opportunity between: persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation, men and women generally, persons with a disability and persons without and between persons with dependants and persons without.
Evidence based practice	Provision of services which are based on best practice as proven by research findings, scientific knowledge and evaluation of experience.
Family Practitioner Services (FPS)	The principal primary care services i.e. family doctors, opticians, dentists and pharmacists.
HPSS (Health and Personal Social Services)	An organisation which either commissions or provides health and social services, e.g. HSS Boards, Strategic Health and Social Care Authority, a Trust providing hospital and community services, a local commissioning body, and Family Practitioner Services.

NPSA	The National Patient Safety Agency promotes safe practice in clinical care and supports the development of solutions and the cascade of learning to reduce areas of high risk.
Person-centred assessment	An assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs.
Primary care	The many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals e.g. family doctors, pharmacists, nurses, allied health professionals (physiotherapists, psychologists, dieticians etc) social workers, care assistants, dentists, opticians and so on.
Secondary care	Specialist services usually provided in an acute hospital setting following referral from a primary or community healthcare professional.
Statutory duty	A legal responsibility.
Statutory sector	Government-funded organisations e.g. HSS Boards, Strategic Health and Social Services Authority, Trusts, Special Agencies and Local Commissioning Groups.
Tertiary care	Highly specialised services usually provided in an acute hospital setting by medical and other staff with expertise in a particular medical specialty.

APPENDIX 2

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THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)

FORENSIC SERVICES

October 2006

THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY (NORTHERN IRELAND)

FORENSIC SERVICES

CONTENTS

FOREWORD

The Bamford Review of Mental Health and Learning Disability consists of a number of interlinked reviews under one overarching title and encompasses policy, services and legislation.

The Review Steering Committee presides over the work of 10 major Expert Working Committees, 4 of which commenced their work by April 2003 and the remaining 6 by November 2003.

In consultation with Government we have agreed to produce our reports separately in a phased manner.

This report represents the first major review of Forensic Mental Health and Learning Disability Services in Northern Ireland. Although there have been some welcome improvements in services in recent years, current services in Northern Ireland fall very substantially below those available in other parts of the United Kingdom. In producing this report Fred Browne and his committee have integrated evidence and experience from a very broad range of stakeholders. I am grateful for all their hard work.

All of our committees have adopted an evidence-based approach, drawing on existing relevant information and research and, where necessary , commissioning research. Exemplars of best practice from local, national and international sources are informing our reports.

We have maintained a clear vision for Mental Health and Learning Disability services in Northern Ireland. Widespread consultation with stakeholders has endorsed our vision and the strategic direction of the Review. A feature of the Review process is the contribution of service users and carers across both Mental Health and Learning Disability; their insights, advice and guidance continue to be invaluable.

As Chairman of the Review I wish to thank all who have contributed to the preparation of this report.

Roy McClelland (Professor)
Chairman

October 2006

Executive Summary

This report makes detailed recommendations on the development of Forensic Mental Health and Learning Disability Services in Northern Ireland. The report is interlinked with the other reports of the Bamford Review of Mental Health and Learning Disability (Northern Ireland). It shares the values and principles that are common to the whole Review and it takes account of the needs of all the interested parties, including forensic service users and their carers, service commissioners, providers and the wider public. At its heart the report is concerned with the development of services for mentally disordered offenders and others with similar needs. Most of the recommendations stem from 2 underlying themes:

1. **People who are subject to the Criminal Justice System (such as prisoners, people who are on pr obation, on bail or attending court or police stations) have high levels of mental disorder . Curr ently the services to meet the needs of these people ar e inadequate. These members of our society should not be deprived of assessment, treatment or care for their mental disorders because they are subject to the Criminal Justice System. Rather they should have access to services that ar e equivalent to those available to the r est of our society. Where people ar e subject to the Criminal Justice System, services should be provided in co-operation with the Criminal Justice Agencies.**

2. **The majority of people in our society who suf fer from mental disorder pose no increased risk of causing harm to others. However , some people suf fer from mental disorder that is associated with significant risks of causing serious harm to others. It is in the inter ests of these individuals and the wider society that they ar e pr ovided with evidence-based tr eatment and car e that helps minimise the risks. The Health and Personal Services (HPSS) should pr ovide services to identify and assess people suffering fr om such disorders, whether they ar e curr ently in hospital, in prison, in police stations or in the community and the HPSS should pr ovide these individuals with appropriate treatment, care and safeguards. Where such individuals are subject to the Criminal Justice System a joint co-operative approach is required between the HPSS and the Criminal Justice Agencies.**

This report examines these and related issues in detail and makes a series of recommendations. Implementation of these recommendations will lead to important changes in peoples' lives, including the following:

- People who suffer from mental disorder and who are subject to the Criminal Justice System or whose disorder poses significant risks of serious harm to others will have their needs identified more ef fectively and they will be provided with timely access to assessme nt, support, treatment and care, for example:

  - Prisoners suffering from major mental illness will no longer have to wait in prison for lengthy periods of up to several years before they can be transferred to hospital to receive the treatment they require;

  - It will become possible for unsentenced prisoners and other individuals to be admitted to a high security hospital facility for detailed assessment so that properly informed decisions can be made about further placement, treatment and care;

- Service users will receive appropriate psychotherapeutic treatments;

- Mentally disordered people in police stations will have access to a range of mental health and learning disability services;

- People who have so far not received adequate services, such as those sufering from personality disorder and other developmental disorders, will have access to assessment and evidence-based treatments;

- People will no longer receive treatment in conditions of security and restriction which is greater than their condition and circumstances require.

- Service users will find that services are of high quality and that service providers work effectively together to assess and meet their needs, for example:

  - Services will be based on agreed values, principles and purposes and will be developed through joint planning between the relevant parties, including service users and carers;

  - Services will be evidence-based and developed to meet assessed needs;

  - Services will establish appropriate arrangements for information sharing, joint working, continuing improvement and mental health promotion.

- Carers will experience services that are developed and delivered to take account of their needs, for example carers of mentally disordered prisoners will receive appropriate information and support.

- The public will be better informed about mental disorder and the relationships between mental disorder and risk. They will be assured that services work together ef fectively to identify and minimise the risks associated with mental disorder and also that services are efficient and provide value for money.

- Staff will be recruited in accordance with workforce plans that meet the needs of services. Staff will be appropriately trained and supported.

In order to achieve these outcomes the Review makes the following r ecommendations:

A Regional Forensic Network

A Regional Forensic Network should be established to co-ordinate the planning and delivery of forensic services at regional and local levels.

Police Stations

The Review Implementation Team should lead the co-ordination of planning and developing mental health and learning disability services to police stations in liaison with the Regional Forensic Network.

Courts

Service commissioners should commission a full range of statutory and independent mental health and learning disability services to meet the needs of mentally disordered people attending courts.

In Year 5, when forensic mental health and learning disability services in Northern Ireland have increased in size and capacity according to the schedule proposed in Chapter 12, a detailed option appraisal should be undertaken to consider the provision of assessments and other services for the courts by alternative means, including by service level agreements.

Prisons

The project overseeing the transfer of lead responsibility for prison healthcare to the NHS must ensure that joint working arrangements with all relevant mental health and learning disability service providers are agreed and published beforeApril 2007. It must be demonstrated that service providers have sufficient resources and capacity to meet the identified needs.

The Review supports the recommendations made by Professor McClelland and colleagues (2005)[13] in relation to the assessment, treatment and care of prisoners on committal to prison.

A multi-agency consortium should be formed to promote the development of psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. The lead should be taken by Department of Health, Social Services and Public Safety (DHSSPS) with input from criminal justice agencies and the relevant health sector bodies.

Probation

Probation Board for Northern Ireland (PBNI), the Regional Forensic Network and the Implementation Team should agree joint arrangements to assess and monitor the needs and should provide services for individuals, their carers, their representatives, service providers and the wider community.

Secure Inpatient Services

The current arrangements for high secure services for people in Northern Ireland have unacceptable gaps in service provision. The Department of Health, Social Services and Public Safety (DHSSPS) must take the lead in ur gently finding solutions to the current obstacles to treatment and care in conditions of high security.

The Review recommends the provision of an additional secure facility in Northern Ireland to meet the identified high and medium secure needs of service users. The regional high and medium secure facilities should be complemented by local low secure facilities and community facilities to form a range of short, medium and longer stay facilities that meet the needs of forensic service users. In particular the DHSSPS must plan and develop long stay medium secure services and step-down low secure and community services.

Community Forensic Services

The 5 Community Forensic Teams that are currently partly staf fed and funded require the necessary funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity and supported by appropriate facilities in the community . Community forensic services should be further developed to meet assessed need.

Forensic Learning Disability Services

Co-ordinated services must be planned and developed to meet the short, medium and longer term needs of service users at high, medium and low levels of security and in the communityA regional inpatient and community forensic learning disability service should be developed immediately which supports the further development of 5 localised and regionally co-ordinated teams.

The DHSSPS must urgently address the current obstacles to service users with learning disability receiving inpatient care, including the lack of step-down services at low security and in the community.

Risk Assessment and Management

The DHSSPS, Northern Ireland Of fice and relevant others should produce a comprehensive interagency and community response to help of fenders reduce their risks of of fending and to provide protection to the public from high risk sexual and violent offenders, irrespective of whether or not they suffer from mental disorder.

Personality Disorder

The DHSSPS should ensure that assessment and treatment services are made available to offenders suffering from personality disorder along with support for their carers. Services should be provided in prisons and in the community. Services in the community should comprise outpatient, day patient and therapeutic community services. In the prisons outpatient and day patient services should be provided. A residential secure service should also be developed. Services should be evidence-based or, where there is inadequate evidence, they should be established in a way which gathers and contributes to the evidence.

Offending by Adults with Asperger's Syndrome or High Functioning Autism (AS/HFA)

The Regional Forensic Network should co-ordinate a programme of training for staff in the identification, assessment, treatment and care of people suffering from AS/HFA.

Services for Women

Service commissioners and providers must ensure that services are gender sensitive. The DHSSPS should consider whether a separate low secure facility is more appropriate to the needs of women service users than the current provision in Shannon Clinic. Community services should be provided individually to male and female users on the basis of individual needs and must be gender sensitive.

Forensic Psychotherapy

The DHSSPS, the Regional Forensic Network, service commissioners and providers must ensure that planning and development of all inpatient and community mental health and learning disability forensic services incorporate and integrate a range of multi-disciplinary psychotherapeutic approaches. All clinical staff working in forensic services must be provided

with the appropriate opportunities and support to develop high levels of psychotherapeutic knowledge and skill. The planning and delivery of forensic services must also include the provision of services by specialist Psychotherapists and Forensic Psychotherapists.

Regional Guidance and Procedures

The DHSSPS should establish reviews including:

- assessment of fitness for interview, fitness to attend court and related matters;
- the appropriate adult scheme; and
- the Discharge Guidance.

Quality Assurance

Standards and mechanisms for assuring the quality of mental health and learning disability services must be developed by the relevant regional body with responsibility for quality assurance, service commissioners, providers and by the Regional Forensic Network.

Mental Health Promotion

Service commissioners, providers, the Regional Forensic Network and the regional body with responsibility for mental health promotion should identify opportunities for mental health promotion within the Criminal Justice System and forensic mental health and learning disability services and ensure that appropriate services are provided and their impact evaluated.

The DHSSPS should lead the establishment of a Regional Prison Mental Health Promotion Group to address mental health promotion and suicide prevention.

Research and Assessment of Need

Research should be commissioned to assess and monitor the needs for forensic services of people in the Criminal Justice System, in inpatient settings and in the community . The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high, medium and low security and in community facilities. The assessment should include people suf fering from mental illness, severe mental impairment and from personality disorder and other developmental disorders. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

The joint DHSSPS/Northern Ireland Prison Service (NIPS) project to transfer responsibility for prison healthcare to the National Health Service (NHS) must ensure that a detailed assessment of the needs of mentally NHS disordered prisoners and their carers is carried out. An assessment should also be commissioned to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements.

The NIPS should commission research on the feasibility of reducing the number of mentally disordered people in prison by providing a broader range of facilities in the community, including lower security placements for mentally disordered women.

Research should also be commissioned to evaluate the methodology of assessing people in police stations and prisons with a view to ensuring the accurate identification of specified forms of mental disorder and need.

Information Systems

The DHSSPS should ensure that development of Information Systems within the HPSS takes full account of the need to provide health and social care for people subject to the Criminal Justice System. Where appropriate, health and social services systems should link with Criminal Justice Systems in support of joint working.

Learning and Development

The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders in the Criminal Justice System and in health and social services.

Training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development, closely integrating training with clinical practice.

Recruitment and Retention

The DHSSPS must ensure that development and maintenance of forensic services is supported by robust workforce planning.

Funding

Current services are under-developed. Funding is required for the development of mental health and learning disability inpatient services at high security , long stay medium security and low security. There are also needs to provide accommodation and day facilities in the community , mental health and learning disability community teams, services for mental health and learning disability services to the prisons, and to support people in police stations, in courts and in contact with probation. Funding is also required to develop comprehensive personality disorder services and psychotherapy services.

Conclusion

The Review believes that all of these recommendations and the others detailed in this report are necessary and realistic and that the objectives are achievable over the next 15 years through a planned and co-ordinated approach that involves all the relevant parties working together to meet the needs. An implementation plan is included to assist with the sequencing and prioritisation of the recommendations.

Finally it must be acknowledged that the development and provision of services for mentally disordered offenders and others with similar needs is a highly emotive topic. Perhaps the greatest challenge that we all face is to recognise our capacity for prejudice, discrimination and rejection of these disadvantaged individuals, to acknowledge their legitimate needs and to make the necessary and sustained commitments to action, as described in this report.

CHAPTER 1

THE NEEDS OF SERVICE USERS, CARERS AND SERVICE PROVIDERS

1.1 People in need of forensic services are some of the most mar ginalised, stigmatised, vulnerable and poorly understood individuals in Northern Ireland and the services to meet their needs are some of the least developed. This report reviews mental health and learning disability services for mentally disordered of fenders and others with similar needs in Northern Ireland. The report makes recommendations for action in relation to specialist Forensic Services and also the range of other mental health and learning disability services. This report should be read in conjunction with the other reports from this Review. McCall[1] has also completed a literature review and needs assessment of forensic services in Northern Ireland.

1.2 While forensic service users have features in common, each person must be respected as a unique individual. Many have experienced multiple disadvantages during childhood such as frequent family separations, physical, psychological and emotional abuse and neglect, lack of close, confiding and supportive relationships, inconsistent parenting and alienation from school and community. As a consequence, many have personality difficulties such as chronic low self esteem, lack of empathy for others, dif ficulties in relationships with authority and poor impulse control. Many have resorted to abuse of alcohol and other substances which appear to of fer temporary relief from mental distress, but which contribute further to disturbance of mood and behaviour and to social alienation. Abuse of substances may precipitate the onset of mental illness or aggravate established illness. Those who develop mental illness may be further distressed by severe disturbances of thought, perception and mood. Major illnesses often impair the capacity to appreciate the illness and the need for treatment. Of fending behaviour may occur as a consequence of a chaotic and disintegrated phase in the life of the individual. The combination of some or all of these elements often leads to of fending behaviour and societal reactions that include fear, rejection and discrimination.

1.3 The needs of forensic service users are not just narrowly confined to the amelioration of symptoms of mental disorder . Services responding to therapeutic and care needs must address the wide range of problems specific to each individual with the aim of helping him or her integrate into society . Where the individual has behaved in a violent or dangerous manner this must include careful assessment of risk.

1.4 The needs of carers must also be addressed. Carers may have experienced dif ficulties understanding the nature of the service user's problems and providing appropriate support. They may have been traumatised or become alienated. Carers of forensic service users require assessment of their own needs and provision of the necessary information and support.

1.5 Staff who work with forensic service users and carers must have the understanding and ability to deal with the wide range of problems that present. They must possess the abilities

to work in partnership with users, carers and many others and to view situations from many different perspectives. Work of this nature generally evokes a wide range of emotions and staff require training and support to help them respond appropriately . Staf f providing forensic services encounter 2 systems, the Criminal Justice System and the Health and Social Services. These 2 systems have dif ferent purposes and cultures and it is inevitable that tensions will arise. Staf f working across these interfaces must be sensitive to the ethical and practical problems that can arise for service users and carers and must be able to help negotiate solutions. Staff must be alert to the restrictions and controls that may be placed on service users that create an imbalance in power between staf f and service users and may render service users liable, often in subtle ways, to infringement of their rights. Service users may be subject to discrimination from other service providers such as over - emphasising of risks to others related to mental disorder or by reluctance to of fer appropriate community services.

1.6 Because of their multiple disadvantages service users often have dif ficulty identifying and articulating their needs. At present advocacy services are at early stages of development. Forensic service users and their carers do not at present come together as groups to voice their needs for improved services. These factors in turn make service users and their carers particularly vulnerable to receiving inadequate care. Stigma and discrimination may influence Government and commissioners of services, for example by failing to take adequate account of the needs of forensic service users and by failing to safeguard proper provision for them.

1.7 The challenges for the decision makers and for the rest of society are to recognise and respect service users and carers as fellow members of our society , to ensure that they receive appropriate therapeutic interventions and care which facilitate their journey towards productive and satisfying lives and their integration within society .

CHAPTER 2

INFORMATION, VALUES, PRINCIPLES AND STANDARDS

INTRODUCTION

2.1 It is essential that during the planning and delivery of Forensic Services full account is taken of the available information and evidence. Values and principles are also essential in directing our goals. A vision for services that combines an evidence-based approach and a values-based approach is essential[2]. There must be arrangements to take information from and contribute to the "evidence cycle" that gathers and evaluates the available evidence, identifies gaps in information, prioritises and implements research and generates and disseminates evidence. There must also be explicit statements of the values and principles upon which the development and delivery of future services should be founded. Both must be integrated into the planning of services and their delivery.

EVIDENCE

2.2 The need for local research and development has been identified in the Report by the Adult Mental Health Working Committee[83] (chapter 7.21) which has proposed a Northern Ireland Research and Development Strategy. That strategy must encompass forensic services. Priorities for Research and Development in Forensic Services are identified in subsequent chapters in this report.

VALUES AND PRINCIPLES

2.3 The vision of this Review is:

- valuing those of us with mental health needs, including rights to full citizenship, equality of opportunity and self-determination;
- addressing the challenges facing people with mental health needs; and
- 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.

2.4 The values of the Review state that people with mental health needs and their carers should receive services which:

- offer proper treatment and care to facilitate their journey towards productive and satisfying lives and their integration into our society;
- respect them as individuals – through openness in the providing of information, respect and courtesy in individual interactions with service users, true partnership and empowerment in service planning and provision – with Government, providers and the wider society each accepting their respective responsibilities; and

- demonstrate justice and fairness – resources for services should be allocated and managed according to criteria which are transparent, and which demonstrate equity

2.5 The principles for the Review's Strategic Framework are:

- partnership with users and carers in the development, evaluation and monitoring of services;
- partnership with users in the individual assessment process and all therapeutic interventions of care and support;
- delivery of high quality, effective therapeutic interventions, care and support;
- equity of access and provision of services, including the needs of people from minority cultures, people with disabilities, people subject to the Criminal Justice System;
- provision of services which are readily accessible;
- delivery of continuity of care and support for as long as is needed;
- provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;
- taking account of the needs and views of carers, where appropriate, in relation to assessment, therapeutic interventions, care and support;
- provision of comprehensive and equitable professional and peer advocacy , where required or requested;
- promotion of independence, self-esteem, social interaction and social inclusion through choice of services, facilitation of self management, opportunities for employment and social activities;
- promotion of safety for service users, carers, providers and members of the public;
- provision to staff of the necessary education, training and support; and
- services subject to quality control, informed by the evidence.

PRINCIPLES FOR FORENSIC SERVICES

2.6 The principle that people who are subject to the Criminal Justice System should have equity of access and provision of services adopted elsewhere has been referred to as the "Principle of Equivalence"[3]. It is of fundamental importance to service users, carers and service commissioners and providers. People who are in police stations, on bail, attending

court, in prison, on probation or otherwise subject to the Criminal Justice System must have equity of access and provision of the full range of statutory mental health and learning disability services. This principle creates a substantial agenda for change.

2.7 The Review recommends that 4 additional principles should be adopted in relation to forensic services:

1. there should be joint co-operative planning between the Criminal Justice Agencies and the Health and Personal Social Services (HPSS) and joint delivery of services in order to best meet the needs of service users and carers.

Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

2. as far as possible in the community, rather than in inpatient settings;

3. under conditions of security and restriction no greater than as is justified by the degree of danger they present to themselves or others; and

4. open, accountable and subject to external review.

STANDARDS FOR THE DEVELOPMENT AND DELIVERY OF FORENSIC SERVICES

2.8 The Review has developed the following 10 interconnected Standards that it believes should be applied to guide the planning and delivery of Forensic Mental Health and Learning Disability Services in Northern Ireland:

Standard 1. A Co-Ordinated Joint Strategic Approach

2.9 The development and delivery of comprehensive Forensic Mental Health and Learning Disability Services require contributions from many sources including service users and carers, commissioners and providers of services, representatives from forensic mental health and learning disability services, from Criminal Justice Agencies in the statutory, voluntary and community sectors and from the wider community. A shared approach must be adopted that respects the contributions of each organisation and each individual and co-ordinates service development and delivery at regional and local levels.

Standard 2. Evidence, Principles and Purposes

2.10 Forensic services should take account of the available evidence on efficacy of service models and interventions and contribute to the generation of further evidence. They should operate in accordance with explicit values and principles and have clear purposes. Forensic services should be developed and delivered in response to need. There must be robust mechanisms to assess and meet the needs of each individual, his or her carers and representatives, service providers and the wider community. There must also be mechanisms to assess the impact of service developments on need.

Standard 3. Organisational Structures and Interconnections

2.11 Forensic services comprise a range of components, such as services to people in prison, community forensic services and secure inpatient services. All components must have clear or ganisational structures, accountability and governance arrangements. Each component must be co-ordinated at regional and local levels to work together with all other interconnecting services in an ef ficient and ef fective manner. Forensic services should work flexibly in partnership and in support of interconnecting health and social services providers and with Criminal Justice Agencies in the statutory, voluntary and community sectors.

Standard 4. Comprehensive and Accessible Services

2.12 Forensic services should be comprehensive to include the provision of timely , accessible and high quality assessment of needs, treatment and care for service users and support for their carers with continuity of services for as long as required. Services should assess the full range of needs (physical, psychological and social) and should provide services to meet those needs in accordance with best practice. Forensic Services should be developed and delivered in a manner that promotes openness and good communication between all relevant people, while respecting the rights of the individual for privacy and confidentiality. Information sharing protocols and joint working protocols should be developed between the Criminal Justice System and mental health and learning disability services.

Standard 5. Risk Assessment and Management

2.13 Forensic services should assess and manage the risks for which they have responsibility . They should make all reasonable ef forts to reduce the relevant risks with the resources at their disposal but there must also be widespread recognition that risk is inherent in the work of forensic services and cannot be eliminated. The work of forensic services should be supported by the development of interagency and multi-disciplinary risk assessment and management protocols and procedures.

Standard 6. Quality Assurance

2.14 Forensic services must have robust and demonstrable quality assurance mechanisms that include setting standards and assessing the performance and quality of services. These should include internal mechanisms such as audit and also external review.

Standard 7. Mental Health Promotion and Education

2.15 Promotion of mental health is essential to prevention and reduction of need. Forensic services must help develop understanding of the routes whereby an individual may become a mentally disordered of fender and the interventions that could be made to produce more favourable outcomes. Forensic services should liaise closely with the regional body responsible for mental health promotion[84]. In addition, forensic services should contribute

to public education to promote understanding and help prevent stigmatisation and discrimination.

Standard 8. Information, Research and Innovation

2.16 Forensic services should have information strategies that include contributing to evidence-gathering and research. Services should promote enquiry and innovation. Information Technology should be used where appropriate to enhance service quality and efficiency.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

2.17 The development and maintenance of forensic services must be supported by a workforce planning strategy that ensures the recruitment and retention of staff who are equipped with the appropriate personal qualities and professional qualifications. There must be a Learning and Development strategy to provide staff with the necessary knowledge, skills and support throughout forensic services and the interconnecting health and social services and in Criminal Justice Agencies. Service users and carers have learning and development needs that should be addressed.

Standard 10. Sustainable and Transparent Funding

2.18 The development and maintenance of forensic services requires appropriate funding from the relevant sources. Funding should be delivered in accordance with long term plans that ensure sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

ORGANISATIONAL STRUCTURES TO SUPPORT THE CO-ORDINATED PLANNING AND DELIVERY OF FORENSIC SERVICES

2.19 This Report makes recommendations for the development and delivery of forensic services in Northern Ireland over the next 15 years. Services must be provided to meet the needs of all service users and demonstrate efficient use of resources. Those who are charged with the duty of planning, implementing and delivering forensic services bear a heavy burden of responsibility to all the stakeholders including service users and carers, the wider public and staff in the Health and Social Services and in the Criminal Justice System.

2.20 The purpose of this Review is to provide a vision for the development of forensic and other mental health and learning disability services in Northern Ireland. It is essential that arrangements are established to revise and update plans in response to changing circumstances, while maintaining an overall strategic direction. The Review believes that strategic planning of services must be an ongoing process with the continuing development of strategic plans for short, medium and long time frames.

2.21 A Forensic Regional Advisory Group was established in 2005 to co-ordinate the development of forensic services in Northern Ireland. The Review welcomes this

development. Chapter 12 gives further details of the Review' s recommendations on implementing the necessary changes to support the planning and development of forensic services. These include regional and local co-ordination through the formation of a Regional Forensic Network.

Recommendations

1. A Regional Forensic Network should co-ordinate and lead the strategic planning of forensic services in Northern Ireland.

2. Strategic planning must be guided by evidence and by values and principles. The Regional Forensic Network must establish systems of gathering the necessary information and evidence to inform the further development of services.

3. The Regional Forensic Network should establish explicit values and principles to guide the planning and development of forensic services. The values and principles adopted by this Review (see 2.3 - 2.5) are recommended. In addition the following principles are recommended for forensic services:

   i. there should be joint co-operative planning between the Criminal Justice Agencies and the Health and Personal Social Services and joint delivery of services in order to best meet the needs of service users and carers;

   Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

   ii. as far as possible in the community, rather than in inpatient settings;

   iii. under conditions of security and restriction no greater than as is justified by the degree of danger they present to themselves or others; and

   iv. open, accountable and subject to external review.

4. The planning and development of forensic services should take full account of the 10 Standards identified in this Report.

CHAPTER 3

POLICE STATIONS

INTRODUCTION

3.1 The police service is a major agency in contact with mentally disordered people in the community. It acts as an important 'gatekeeper' to the mental health and learning disability services, especially in relation to situations that arise in public places.

3.2 In police stations there are two main ethical reasons to ensure that individuals who are suffering from mental disorder are identified:

- the individual may be suf fering from a mental disorder that interferes with his or her capacity to protect his or her rights and best interests while in the police station; and
- the individual may require treatment for his or her condition.

3.3 Thus services are required at police stations to:

- identify and assess the needs of people who are suspected or confirmed as suffering from mental disorder;
- offer appropriate support, treatment and care to service users;
- provide appropriate information and support to carers; and
- advise the Criminal Justice System, where appropriate, on the implications of the service user's condition.

CURRENT SERVICES

3.4 Police stations are provided with medical services by Forensic Medical Of ficers (FMOs) most of whom are general practitioners and who conduct most of the assessments of individuals suspected of suf fering from mental disorder. In 1998 a police liaison scheme for Mentally Disordered Of fenders (the "MDO Scheme") was established in Musgrave Street Police Station in Belfast. Two community mental health nurses are employed to screen custody records, carry out mental health assessments on selected individuals, provide health promotion and liaise with the appropriate agencies to arrange treatment and support. They also provide advice to FMOs, courts, legal representatives and others. In addition the nurses provide training to police to help them understand the nature of mental disorders and the problems experienced by those suf fering from mental disorder . This MDO Scheme has remained in place and is expected to become part of the Eastern Health and Social Services Board Community Forensic Service. It remains confined to the Belfast area.

3.5 Key findings from the MDO Scheme[4] were:

- 16% of custody records met one or more assessment criteria for mental disorder;
- 91% of those who underwent assessment were judged to have a mental health problem;
- typically these were single unemployed males in their early 30s and living alone;
- two thirds had a history of having been in one or more health, social services or criminal justice institutions, 47% had received inpatient care; and
- almost half had been in prison.

3.6 The most commonly recorded diagnoses were:

- depression (44%);
- substance misuse (15%);
- schizophrenia/paranoid psychosis (11%); and
- anxiety (11%).

3.7 No information is available in relation to mentally disordered of fenders presenting to police stations in other parts of Northern Ireland.

3.8 Users and carers made positive comments in relation to the MDO Scheme. Comments also included lack of understanding of mental health problems and the stigma associated with police escort. Other key issues highlighted in consultation with stakeholders were:

- the MDO Scheme was generally regarded as beneficial;
- the scheme was considered to be under-resourced;
- there were communication problems between organisations and difficulties sharing information;
- there was uncertainty in defining fitness for interview and the roles of appropriate adults;
- there were dif ficulties in managing people viewed as suf fering from personality disorder; and
- there were difficulties admitting to hospital people who were suffering from temporary disorders.

3.9 The literature review by McCall[1] provides details of the characteristics of people detained in police stations and those placed in hospital as a place of safety the use of the appropriate adult scheme, the needs of carers, police liaison schemes and the use of educational interventions for police officers. There is evidence to indicate that police liaison schemes and education of police officers are effective interventions.

STANDARDS

Application of Standards

3.10 The 10 standards identified in Chapter 2 have been applied to the consideration of planning and delivery of services in police stations.

Standard 1. A Co-Ordinated Joint Strategic Approach

3.11 There must be ef fective co-ordination between Criminal Justice and Health and Social Services Organisations and equity of access and provision of services for people subject to the Criminal Justice System. Mental health and learning disability services such as Community Mental Health Teams, Crisis Resolution Services, Community Forensic Teams, Learning Disability and Alcohol and Substance Misuse Services are being developed across Northern Ireland. It is essential that these developing services are co-ordinated at local and regional levels to provide a full range of mental health and learning disability services for mentally disordered people in police stations.

Recommendations

5. Service commissioners must commission a full range of statutory mental health and learning disability services to meet the needs of mentally disordered people detained in police stations.

6. Providers of statutory , voluntary and community mental health and learning disability services must ensure they provide equity of access and provision of services for people detained in police stations.

7. Mental health and learning disability services to people detained in police stations should be provided locally and co-ordinated regionally . The Department of Health, Social Services and Public Safety (DHSSPS) should lead this co-ordination in liaison with the Regional Forensic Network.

Standard 2. Evidence, Principles and Purposes

3.13 The planning of services requires good quality evidence and explicit principles and purposes. Although valuable information has been obtained from the MDO Scheme there remain substantial gaps in our knowledge of the needs of mentally disordered people and their carers in police stations throughout Northern Ireland.

3.14 The principles of this Review include the provision of advocacy services. At present there are various people who may adopt an advocacy role for service users in police stations,

including lawyers, appropriate adults, health, social services staff, probation staff and members of voluntary organisations. However, there is no-one specifically charged with the responsibility for acting as an advocate for mentally disordered service users within police stations. It is recommended that the advocacy services attached to community mental health and learning disability services should be extended to include police stations.

Recommendations

8. Research should be commissioned to assess the needs of mentally disordered people and their carers in police stations throughout Northern Ireland. This research should include recommendations leading to the establishment of systems to monitor ongoing need and the impact of services on need.

9. Advocacy services associated with community mental health and learning disability services should be extended to include police stations.

Standard 3. Organisational Structures and Interconnections

3.15 Mental health and learning disability services to police stations must have clear organisational structures, accountability and governance arrangements. Each component must be co-ordinated at regional and local levels to work together with all other interconnecting services in an efficient and effective manner. Statutory mental health services should work in partnership with voluntary and community sector providers. It is likely that different patterns of service delivery will be required to meet the different needs in individual police stations throughout Northern Ireland, for example, the model that has been developed for a large city centre police station in Belfast may not be appropriate for a smaller rural station.

Recommendation

10. Clear organisational structures, accountability and governance arrangements must be agreed for mental health and learning disability services to police stations.

Standard 4. Comprehensive and Accessible Services

Assessment of Health Needs

3.16 It can be a difficult task for the FMO to assess an individual in a police station. For example there may be very little background information available and the individual may be intoxicated, unco-operative, violent or emotionally disturbed by the circumstances that have brought him or her to the police station. Not all people are registered with a general practitioner, but for those who have current health records it would be helpful if these were accessible to the FMO. Ultimately it is expected that information technology systems will be developed throughout the National Health Service (NHS) that can provide appropriate access to staff providing assessment and healthcare in police stations, however, these systems may take a number of years to develop. In the interim it is essential to review and improve the existing systems.

Recommendation

11. Service providers should develop information systems that enable FM0s and staff working in mental health and learning disability services to gain appropriate access to the health records of people detained in police stations.

3.17 The current accuracy of the systems in police stations for identifying mental disorder and mental health needs is unknown. The arrangements depend upon police, lawyers, users, carers and others raising the suspicion of mental disorder and then the FMO, perhaps with the assistance of mental health staff, correctly identifying the mental disorder or need. At present there is very little scientific evidence to inform practitioners on the most ef ficient and effective methods of assessing suspects in police stations for the presence of mental disorder. Screening procedures should be directed towards explicit objectives such as identifying mental disorders that may place the individual at risk of causing harm to themselves or others or being unable to protect their best interests. Screening tools must be evidence-based for the environment of a police station. Research should be commissioned to establish an appropriate evidence base.

Recommendation

12. Research should be commissioned to evaluate the methodology of assessing suspects in police stations with a view to ensuring the accurate identification of specified forms of mental disorder and need.

Fitness for Interview

3.18 FMOs are frequently asked to determine whether an individual is fit to be interviewed.The Code of Practice for the Police and Criminal Evidence (Northern Ireland) Order 1989[5] acknowledges that a person may be unfit to be questioned on account of being under the influence of drink or drugs, but it does not address the needs of people who may be unfit for interview on account of mental disorder.

3.19 The Association of Forensic Medical Of ficers of Northern Ireland and the Association of Forensic Physicians in England, Scotland and Wales have agreed to work on the basis that, for a person to be fit to be interviewed he or she must:

- able to understand the questions that are being put to them;
- understand why particular questions are being put to them, and to understand the nuances behind the questions; and
- be able to give a good account of themselves in their answer .

3.20 FMOs and Forensic Physicians have defined unfitness for interview as follows:

'A detained person may be unfit for interview when conducting an interview could worsen any existing physical or mental illness to a significant degree, and/or anything said or done by the detained person at the time of interview may be considered unreliable in subsequent court proceedings, because of the physical or mental state of the detainee.'

3.21 There is a need for clear and approved guidance on this issue of fitness for interview and related issues such as:

- the appropriate disposal(s) for an individual found unfit to be interviewed;
- whether a person may be deemed permanently unfit for interview; and
- whether a person who is being charged without interview may be unfit to be charged.

Recommendation

13. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to produce guidance on assessment of fitness for interview and related matters.

The Appropriate Adult Scheme

3.22 When a police officer has any suspicion that a person due to be interviewed as witness, victim or suspect may be mentally disordered, he must contact an appropriate adult[6]. The appropriate adult scheme provides certain safeguards for mentally disordered people in police stations. However, a number of concerns have been raised about the scheme. These include:

- the criteria for suspected mental disorder are potentially very broad and do not appear to be adequately targeted at those who are most vulnerable;
- research[7] has indicated that in practice there is a failure by police to identify mental disorder and this implies that the interests of mentally disordered people have not been demonstrably safeguarded;
- there are difficulties in finding people to act as appropriate adults. Social workers may perform this function, but Trusts have not been provided with the resources to meet these considerable potential demands;
- in Northern Ireland there is a lack of detailed guidance for those acting as appropriate adults;
- there has been insufficient training for staff acting in the role of appropriate adult; and
- an appropriate adult may be a parent, guardian or relative or other person responsible for the care or custody of the person who is suspected of suffering from mental disorder. However, concerns have been expressed that relatives and carers may not be best placed to represent the interviewee.

Recommendation

14. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising representatives of all the relevant stakeholders to review the appropriate adult scheme. The group should consider the effectiveness, efficiency and practical working of the scheme, including the criteria invoking the use of appropriate adults.

Assessment and Management of Mentally Disordered People in Police Stations, Including Those with Behaviour Disorder

3.23 Joint protocols should be developed for the arrangements to assess and manage mentally disordered people in police stations. Particular problems can arise with individuals whose behaviour is disturbed, for example those who are violent or who harm themselves. These behaviours may be related to factors such as intoxication, negative attitudes towards the police or emotional distress at the circumstances that have brought the individual to the police station. Such behaviours do not automatically or necessarily indicate the presence of mental disorder that requires admission to a psychiatric hospital. Behaviourally disturbed individuals may also have physical health needs, but nurses and other staff in Accident and Emergency departments understandably do not feel they should be subjected to violence or abuse. Police officers are not trained as nurses and there are very real concerns that someone may become seriously ill or die in police custody despite the efforts of those concerned to help them. The safe and appropriate care of such individuals is a major challenge. At present each case is dealt with on an individual basis, but there remain concerns that the situation is unsatisfactory.

3.24 In Queensland, Australia, Mullen and Chettleburgh (2002)[8] recognised a similar problem and recommended liaison between police and health services and consideration of a short-term assessment and detoxification centre co-located with a general hospital. The Review recommends that there should be discussions between the relevant stakeholders to consider the services that should be put in place and to ensure that agreed protocols are developed for the management of intoxicated and disturbed individuals in each locality.

Recommendations

15. Commissioners should commission services for the safe assessment, treatment and care of mentally disordered offenders in police stations.

16. Service providers and other stakeholders should agree joint protocols for the assessment and management of mentally disordered people in police stations, including those whose behaviour is disturbed.

Advice to Police

3.25 Where it appears to police that a person is suffering from mental disorder and that he or she has committed a minor criminal offence, police may exercise their discretion not to proceed further with the matter. Offending behaviour may be a manifestation of a relapse in illness and require treatment or it may be that the most appropriate response is for the individual to take responsibility for his or her behaviour. It is important that in such situations police should have ready access to advice from a suitably qualified health professional.

Recommendation

17. Commissioners should commission services that provide police with ready access to advice from suitably qualified health professionals.

Standard 5. Risk Assessment and Management

3.26 There are many risks associated with mentally disordered people in police stations. A co-ordinated risk assessment and management framework should be developed that extends across the Criminal Justice System and the HPSS. This should include the assessment of both individual and or ganisational risks and the development and implementation of risk management strategies. Key stakeholders should be involved in the development and implementation of this framework, including its application to the assessment, treatment and care of mentally people in police stations.

Recommendation

18. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in police stations.

Standard 6. Quality Assurance

3.27 In view of the potentially high vulnerability of mentally disordered people in police stations it is essential that quality standards are developed and audited.

Recommendation

19. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services must ensure that quality standards are developed for mental health and learning disability services in police stations and that services are audited and subject to external independent inspection.

Standard 7. Mental Health Promotion and Education

3.28 People are often brought to police stations at times of crisis in their lives, for example a pattern of substance abuse may bring individuals into conflict with the law and may cause them to re-evaluate their behaviour . These occasions may , therefore, represent opportunities for the promotion of good mental health. Brief, but timely intervention may itself have therapeutic effect or it may direct the individual to another source of help where his problems can be addressed in more depth. A number of so-called arrest referral schemes have been established[9]. There are two main approaches. In one, police of ficers provide information about drug and other relevant services to those who have been arrested. In the other, mental health staff have access to prisoners in custody suites and provide either an assessment on site or at a subsequent meeting.

Recommendation

20. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion within police stations and ensure that appropriate services are provided and their impact evaluated.

Standard 8. Information, Research and Innovation

3.29 Detailed information was gathered on the functioning of the MDO Scheme[4]. There remains a need for basic epidemiological research and also for gathering information on the functioning and ef ficacy of mental health and learning disability services to police stations.

3.30 Information systems are currently being developed within the HPSS. These developments should take account of the need to provide health and social services to people in police stations.

Recommendations

21. The DHSSPS should ensure that research programmes are commissioned to examine the efficacy of different models of services to mentally disordered of fenders in police stations with a view to informing further service planning.

22. The DHSSPS should ensure that development of Information Systems within the HPSS takes account of the need to provide health and social services to people in police stations.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

3.31 Service planning should consider the workforce requirements to deliver services to mentally disordered people in police stations. Training needs assessment should consider the needs of all stakeholders including, police, FMOs, lawyers and health and social services staff.

Recommendations

23. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including police, FMO's, lawyers and health and social services staf f.

24. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

Standard 10. Sustainable and Transparent Funding

Recommendation

25. The development and maintenance of services for mentally disordered people in police stations across the province requires appropriate funding from the relevant sources. Funding should be delivered in accordance with a long term plan that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

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CHAPTER 4

BAIL

INTRODUCTION

4.1 A person may be released on bail by police after being charged with an offence or may be granted bail by a court. Mentally disordered offenders have the same rights as others to be considered for bail. Conditions may be attached to bail such as residence in an approved bail hostel.

CURRENT SERVICES

4.2 There are no specific services for those on bail with mental health problems. It is assumed that most service users obtain mental health services through primary and community services, both statutory and non-statutory.

NEEDS ASSESSMENT

4.3 There is a lack of information on the mental health problems experienced by those on bail, how effectively they avail of services and how effectively these services meet their needs. Some mentally disordered prisoners are granted bail subject to certain conditions such as having appropriate accommodation. Inability to meet such conditions may result in the individual having to remain in custody . Anecdotal evidence suggests there is a lack of suitable accommodation available for mentally disordered people who have been granted bail, leading to unnecessary imprisonment. In particular the provision in the community of a wider range of bail facilities with joint input by Criminal Justice staff and health and social services staff could offer different levels of supervision and therapy. Such facilities may be suitable for people with various mental health and learning disability problems including personality problems and alcohol and substance misuse problems. These could have the potential to significantly reduce the numbers on remand in prison. Facilities of this type may also be suitable for step-down of pre-release sentenced prisoners. At present, however, it is unknown how many mentally disordered people could be placed in such statutory services.

APPLICATION OF STANDARDS

4.4 In view of the lack of information on mentally disordered people on bail and the lack of specific services, the 10 Standards identified in Chapter 2 have not been considered in detail. As information becomes available and services develop the standards should be taken into full account.

Recommendation

26. The Northern Ireland Prison Service (NIPS) should commission research on the feasibility of reducing the number of mentally disordered people in prison by providing a broader range of facilities in the community . The research should address the mental health and social needs of male and female remand prisoners as well as the requirements of the Criminal Justice System. It should consider the potential utility of facilities with joint input by Criminal Justice staf f and health and social services staf f to of fer dif ferent levels of supervision and therapy for a wide range of mental disorders including mental illness, learning disability, personality disorders and alcohol and substance misuse.

CHAPTER 5

COURTS

INTRODUCTION

5.1 Services are required at court to:

- identify and assess the needs of people who are suspected or confirmed as suffering from mental disorder;
- offer appropriate support, treatment and care to service users;
- provide appropriate information and support to carers; and
- advise the Criminal Justice System, where appropriate on the implications of the service user's condition.

CURRENT SERVICES

5.2 The MDO Scheme operates an open referral system and provides assessment and advice in Belfast Magistrates Court. There is no similar service to other courts in Northern Ireland.

5.3 McCall[1] found that user and carer views were generally positive in relation to the MDO Scheme, particularly in relation to solicitors and judges having an understanding of mental illness although some views were expressed that few solicitors had experience in dealing with mental health issues.

5.4 There is no formal psychiatric liaison service to the courts in Northern Ireland, nor any duty psychiatrist service to provide ur gent assessments. Most psychiatric and psychological reports are requested by solicitors acting for the defence and only a few reports (0-5 reports *per annum* in Northern Ireland) are requested directly by the courts. Concerns have been raised that reports prepared on behalf of the defence may be limited in a number of respects, for example the remit given to the author of the report may be restricted and the report may not include important details such as the risks associated with any identified mental disorder. In many cases the author of the report may make recommendations in relation to the management of the of fender but assumes no responsibility for providing services. Concerns have also been raised that the advice offered to the courts appears to be of variable quality.

5.5 Article 22 of the Criminal Justice (Northern Ireland) Order 1996[10] states that in any case where the of fender is or appears to be mentally disordered, the court shall obtain and consider a medical report before passing a custodial sentence other than one fixed by law . It is not known whether the current systems ef fectively identify those suf fering from mental disorder. Article 22 (5) requires that the report is prepared by a medical practitioner approved for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986[11].

5.6 There are concerns that certain potentially useful court disposals are substantially under - used, such as probation orders with conditions of psychiatric treatment (Chapter 7 - Probation).

5.7 The international literature on the prevalence of mental disorder among those appearing before the courts is very limited and probably has little direct relevance to the current situation in Northern Ireland[1].

5.8 Birmingham (2001)[9] reviewed psychiatric court liaison schemes in England and Wales and concluded that the following were features of successful schemes:

- owned by mainstream general or forensic services;
- staffed by senior psychiatrists;
- nurse-led and closely linked to local psychiatric services;
- good working relationship with magistrates and the prosecution;
- good methods for obtaining health, social services and criminal records;
- access to suitable interview facilities;
- use of structured screening assessments;
- direct access to hospital beds;
- ready access to secure beds; and
- access to specialised community facilities.

APPLICATION OF STANDARDS FOR THE DEVELOPMENT AND DELIVERY OF FORENSIC SERVICES

5.9 The lack of information on mental health and learning disability services to the courts and the paucity of court liaison services means that it is dif ficult to apply the full detail of the standards identified in Chapter 2 to the existing services. However, the standards can still serve to guide future service developments.

Standard 1. A Co-Ordinated Joint Strategic Approach

5.10 While there is some information available on the MDO Scheme in Belfast, little is known about the ef ficiency or ef fectiveness of the current systems in the remainder of courts in Northern Ireland as regards their capacity to detect mental disorder or arrange appropriate services to meet the needs of mentally disordered people. There is a need to study these arrangements and to consider the strategic options that would be suitable for the courts.

5.11 It is a fundamental principle of this review that people who are subject to the Criminal Justice System should have equity of access and provision of services. Thus health and social services commissioners must commission a full range of statutory , voluntary and community sector mental health and learning disability services to meet the needs of mentally disordered people attending courts. Providers of community mental health and learning disability services must ensure they provide equity of access and provision of services for people attending courts.

5.12 It is expected that as mental health and learning disability services are developed for offenders, the courts will increasingly wish to receive information primarily from those who are involved in assessing and treating the individual. As mental health and learning disability services develop increased capacity the Court Service may wish to make service level agreements with health and social services providers to include, for example the provision of assessments, the availability of staf f to act as appropriate adults and the provision of training to court staff.

Recommendations

27. Service commissioners should commission a full range of statutory , voluntary and community mental health and learning disability services to meet the needs of mentally disordered people attending courts.

28. Providers of community mental health and learning disability services should ensure they provide equality of access and provision of services for people attending courts.

29. In Year 5, when forensic mental health and learning disability services in Northern Ireland have increased in size and capacity , a detailed option appraisal should be undertaken to consider the provision of assessments and other services for the courts by alternative means, including by service level agreements.

Standard 2. Evidence, Principles and Purposes

5.13 Future court liaison schemes should be developed in response to assessed need. They should have explicit purposes and operate in accordance with agreed principles.

Standard 3. Organisational Structures and Interconnections

5.14 There is a need to ensure that there is appropriate liaison between courts and mental health and learning disability services. At present mentally disordered prisoners may be discharged at court without the necessary arrangements being made to ensure the provision of services in the community. This issue is considered further in Chapter 6 – Prisons.

Standard 4. Comprehensive and Accessible Services

5.15 The following issues have arisen in relation to current court procedures:

- Fitness to Attend Court;
- Prisoners Attending Court; and
- Court Procedures.

Fitness to Attend Court

5.16 Psychiatrists and others may find themselves being asked whether a witness in a criminal case is fit to attend court. There are established legal criteria to assist doctors in determining whether an accused person is fit to plead at court or fit to be tried. In practice these legal criteria may cause dif ficulties for doctors because there is little guidance on their exact medical meaning. However , there are no legal criteria at all to assist a doctor in determining whether a person is fit to attend court to give evidence. In Chapter 4 it was recommended that guidance should be developed on the assessment of fitness for interview in a police station and related matters. It would seem appropriate for the issue of fitness to attend court to be considered as part of that same process.

Recommendation

30. The DHSSPS in partnership with Criminal Justice Agencies should establish a group of relevant stakeholders to produce guidance on the assessment of fitness to attend court.

Prisoners Attending Court

5.17 Not infrequently, prisoners who are attending court complain of medical symptoms and ask to see a doctor. It can be difficult for doctors in such situations to know how to respond to the individual' s complaints, particularly when the doctor does not have access to the healthcare records held in prison. A system should be devised whereby doctors placed in this situation can have appropriate access to the relevant information.

Recommendation

31. Service providers must ensure that healthcare staff assessing and treating prisoners attending court have ready and appropriate access to existing healthcare information

Court Procedures

5.18 The procedures for the making of certain mental health disposals such as hospital orders involve the co-ordination of a number of dif ferent elements such as ensuring there is the requisite written or oral evidence from two appropriately qualified medical practitioners, ensuring that the receiving Trust has been given an opportunity to make representation to court and that a suitable place is available in hospital. In practice dif ficulties often arise because one or more of the necessary elements is missing or delayed.

5.19 Concern has also arisen that on a number of occasions individuals have continued to be treated in hospital as if they remained the subject of a Restriction Order , yet the court had dealt with the legal case and terminated the Restriction Order, but this information had not been communicated to the Responsible Medical Officer.

5.20 There is also a need to review policies and procedures in relation to escorting service users between court and mental health and learning disability facilities, including the use of video link facilities.

Recommendation

32. The DHSSPS should establish a group with the Court Service and other relevant stakeholders to review and develop procedures and protocols in relation to mentally disordered offenders to ensure efficient and effective operation.

Standard 5. Risk Assessment and Management

5.21 The courts often require information in relation to the assessment and management of risk related to mental disorder. There is a need to develop accredited standards in relation to risk assessment and management. This issue is discussed further in Chapter 11.

Standard 6. Quality Assurance

5.22 Court liaison schemes should develop robust performance, quality assurance and clinical governance mechanisms.

5.23 Secure inpatient forensic services should develop joint protocols and procedures in relation to escorting service users to and from court. These should be subject to audit.

Recommendation

33. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services should ensure that quality standards are developed for mental health and learning disability services in courts and that services are audited and subject to external independent inspection.

Standard 7. Mental Health Promotion and Education

5.24 The MDO Scheme provides an opportunity to promote mental health among mentally disordered offenders. Future court liaison schemes should incorporate mental health promotion.

Recommendation

34. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion at courts and ensure that appropriate services are provided and their impact evaluated.

Standard 8. Information, Research and Innovation

5.25 Further information is required about the mental health needs of people attending court.

5.26 The use of technology such as video-links may help reduce the number and expense of escorted visits to court by service users in secure forensic services.

Standard 9. Recruiting, Retaining and Developing a Skilled Workforce

5.27 There is a need to provide interagency training that ensures that staff working in the health and social services have a good understanding of court procedures and that staff in the court service understand the needs, and respond appropriately to, individuals suffering from mental disorder.

Recommendations

35. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including court staff, lawyers, judiciary and health and social services staff.

36. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

Standard 10. Sustainable and Transparent Funding

Recommendation

37. The proposed review of options for mental health and learning disability services to the courts should include consideration of funding mechanisms.

CHAPTER 6

PRISONS

INTRODUCTION

SERVICE USERS AND CARERS AND THEIR NEEDS

6.1 It is a major challenge to provide effective healthcare within a prison environment. Life in prison is very different from life in the community or in hospital[12]. Many prisoners have emotional difficulties and may have been subjected during their earlier lives to trauma and neglect. In adult years they may have dif ficulty coping, have impaired relationships and poor integration into society arising from underlying personality dif ficulties or disorders. Alcohol or other substance misuse, self-harm and frequent previous contact with mental health and learning disability services are common.

6.2 Imprisonment inevitably entails loss of liberty , autonomy and right to self-determination. Some prisoners will experience withdrawal from substances they had previously abused or they may be exposed in prison to further substances of abuse. Prisoners may find themselves placed in the company of others they would not normally choose and they may be subject to bullying and harassment, perhaps from sectarian, paramilitary or racist elements. They may find particular dif ficulty coping with loss of contact with their families and children and they may find themselves lonely and isolated. Prisoners will also have to deal with the stresses related to the circumstances that have placed them in prison, including, for those not yet sentenced, the uncertainty of their disposal at court. Some may find that imprisonment provokes them to examine their previous lifestyle and the behaviours that led to their imprisonment and they may experience a range of emotions including anger, guilt, remorse or self-pity.

6.3 Understandably, most inmates resent being in prison. There is a lack of purposeful and satisfying activities and many prisoners are confined to their cells for prolonged periods. The high turnover of prisoners may make it dif ficult to establish supportive relationships with other inmates. It can also be dif ficult for staff and inmates to establish constructive relationships with each other. Staff may feel their systems of working do not support the development of such relationships and they may not feel adequately trained or supported. It can be dif ficult for staff to maintain good morale. Staf f may consider the dif ficulty of their job is not appreciated or understood by wider society and that they may be too easily subjected to criticism. Some staff may reflect the antagonistic views towards prisoners that can readily be found elsewhere in our society.

6.4 Carers also experience a range of emotions and dif ficulties related to imprisonment. Relationships are often strained and carers may feel excluded.

6.5 McClelland and colleagues conducted a Review of Non-natural Deaths in Northern Ireland Prison Service Establishments (2005)[13]. They identified unique features of the Northern Ireland Prison Service (NIPS) in 2004. These included the separation of paramilitary affiliated prisoners; the threats, attacks and murder of staff during the course of the

Troubles; the severe industrial relations climate; antiquated staf fing practices in comparison to other UK prison systems; high staf f to prisoner ratios and the apparent parochial nature of the prison service. They considered that the management of vulnerable prisoners was not high enough on the agenda of NIPS and that the prison regimes appeared to be over controlled and therefore negatively impacting on the mental health and care of vulnerable offenders.

6.6 McClelland and colleagues also noted that since the reviews in 2004 a number of relevant initiatives had been taken and commitments to action made by both NIPS and DHSSPS. These developments were welcomed by the McClelland Committee.

6.7 This chapter examines in more detail the needs of mentally disordered adult prisoners. Improvement of the mental health of prisoners must comprise 2 elements: both

- creation of a prison environment that actively promotes mental health; and
- provision of a range of mental health and learning disability services.

6.8 These elements must be delivered by a partnership between NIPS and the HPSS which supports a joint co-operative approach. In addition to measure to promote mental health, prisoners require regular input from primary care services, general adult psychiatry , learning disability , psychotherapy , forensic services, adolescent and addiction services. Additional recommendations are made in Chapter 10 in relation to learning disability services. Chapter 1 1 also elaborate on services for women, people suf fering from personality disorder and from Autistic Spectrum Disorder and also the assessment and management of risk. Recommendations are also made in the reports by the Alcohol and Substance Misuse Committee and the Child and Adolescent Mental Health Committee which are relevant to people in prison.

CURRENT SERVICES

The Prison Estate

6.9 The prison state in Northern Ireland comprises:

- Maghaberry;
- Magilligan;
- Hydebank Wood;
- Prison Service College, Millisle; and
- Prison Service Headquarters.

6.10 Maghaberry is a high secure prison housing adult male long-term, sentenced and remand prisoners, both in separated and integrated conditions. Maghaberry also has responsibility for male immigration detainees who are accommodated in a facility at Belfast prison. The overall responsibility for immigration detainees rest with the Immigration and Nationality Department of the Home Office.

6.11 Magilligan is a medium security prison, housing shorter -term sentenced adult male prisoners. It also has low security accommodation for selected prisoners nearing the end of their sentence who are being prepared for return to the community .

6.12 Hydebank Wood is a young of fenders centre and prison for male remands and sentenced young offenders between the ages of 17 and 21, in some circumstances up to age 23, and all female prisoners including young of fenders and female immigration detainees. Sometimes young offenders under 17 are sent to Hydebank because of the lack of services elsewhere.

6.13 The average daily population in the Northern Ireland prisons has varied considerably over the past 35 years and currently is close to 1,400 with a total throughout per year of approximately 5,000. Further details can be found at www.niprisonservice.gov.uk

Mental Health in Prisons

6.14 Mental health problems, and mental illness, are the most prominent single health challenge in the prison environment. In a recent study by Blaauw 2004[14], an estimated 63% of prisoners had a psychiatric disorder, compared with 16% of the general population. These disorders included af fective disorders, anxiety , psychosis, alcohol and substance misuse and personality disorder. Although no comprehensive similar study has been carried out in Northern Ireland, the evidence suggests that if anything the figure is even higher. There is an urgent requirement for detailed assessment of mental health needs of prisoners in Northern Ireland.

CURRENT MENTAL HEALTH AND LEARNING DISABILITY SERVICES IN NORTHERN IRELAND PRISONS

6.15 In Northern Ireland prisons, primary care services are provided by nurses, healthcare officers and medical officers (who are mostly general practitioners) who refer to secondary psychiatric and psychological services. Prisoners under go an initial nursing and medical assessment on committal to prison and those with identified mental health problems are referred for comprehensive mental health nursing assessment. Prisoners may subsequently refer themselves or be referred to a range of mental health care services.

6.16 Specific provision is made for mental health services by sessions from a Forensic Psychiatrist, a General Adult Psychiatrist with an interest in substance misuse, two recently appointed Mental Health Nurse Therapists, an Occupational Therapist from an HSS Trust, and from mental health nurses and psychologists employed by NIPS. Counselling services are provided by voluntary or ganisations such as the Samaritans and are accessed by a confidential phone line. A listener service has been established in Magilligan.

6.17 Prisoners receive treatment in normal prison location and in prison healthcare centres. There is an inpatient psychiatric unit in Maghaberry . Prisoners with mental illness or severe mental impairment may be transferred to health service facilities under the provisions of the Mental Health (Northern Ireland) Order 1986[11]. There are, however, legal problems which currently make it impossible to transfer unsentenced prisoners to high

secure hospitals. Moreover , there are no dedicated treatment facilities for prisoners with personality disorders.

6.18 One of the key areas of recent development in NIPS has been the development and implementation of the Multi-Agency Prisoner Resettlement Strategy . A key issue in the Strategy is 'Promoting a healthier and pro-social lifestyle'. This will involve agencies within and out, with the prison working in close partnership to address issues which impact on mental health and well-being such as housing and employment.

SERVICE DEVELOPMENT

6.19 Various reviews have contributed to the growing body of evidence and opinion that prison healthcare should no longer be the sole responsibility of the NIPS:

- Review of the Provision of Healthcare Services to Prisoners (2002)[15];
- Healthcare Needs Assessment (2004)[16];
- Human Rights Commission Report on Women Prisoners (2004)[17];
- HM Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland Report on Female Prisoners at Ash House, Hydebank Wood Prison (2004)[18]; and
- Review of Non-natural Deaths by Professor McClelland and colleagues (2005)[13].

6.20 The Review of the Provision of Healthcare Services to Prisoners 2002[15] stated that it was satisfied that healthcare standards in Northern Ireland prisons were broadly comparable to those in prisons elsewhere throughout the United Kingdom.

6.21 Since 2000, Her Majesty's Prison Service and the Department of Health in England have been working in formal partnership to improve health services for prisoners[19], culminating in the transfer of commissioning responsibility for those services to the NHS.

6.22 In the light of this, and the various Review recommendations, the then Health and Prisons Ministers accepted a joint NIPS and DHSSPS submission inApril 2005 recommending the transfer of lead responsibility for prisoner healthcare from the NIPS to the DHSSPS by April 2007. A project management framework has been established with responsibility to achieve this objective, taking account of the needs of Northern Ireland prisoners and experience in other jurisdictions. This transfer is thus an important development with major implications for DHSSPS and for the NIPS.

STANDARDS

Standard 1. A Co-ordinated Joint Strategic Approach

6.23 Many of the organisational difficulties experienced over the years in attempting to provide healthcare within the prison environment have been related to the separating of prisoners from the health services in the rest of the community and to the creation of separate health services for prisoners. The transfer of responsibility to DHSSPS should help ensure that prisons are not viewed as being separate from the communities in which they are situated.

6.24 The decision to transfer responsibility is fully consistent with the principle of this Review that people subject to the Criminal Justice System should have equity of access and provision of services. There are many potential advantages to this arrangement, for example it should of fer to prisoners the full range of statutory , voluntary and community sector services available in the community, including assessment and treatment services. It should assist information sharing, ensure that services come under similar quality assurance and governance arrangements and facilitate the use of shared risk assessment and management systems and the extension of Health and Social Services information technology services to prisoners. It should support common approaches to research, to workforce planning, staff training and development.

6.25 It is essential that these arrangements for service provision are taken forward jointly by NIPS and DHSSPS working in partnership. Commissioners of services must understand the needs of people within prison environments and service providers must be enabled to develop sufficient capacity to provide the full range of services required. Services must work together in an integrated manner to meet the needs of service users and carers. There must be robust quality assurance mechanisms including independent external review .

6.26 The Review recommends that planning the future of mental health and learning disability services for prisoners is integrated with the planning of mental health and learning disability services throughout Northern Ireland, including the joint strategic approach co-ordinated by the Regional Forensic Network.

Recommendations

38. Improvement of the mental health of prisoners requires a partnership between the DHSSPS and the NIPS to ensure:

- development of a prison environment that actively promotes mental health and well-being; and
- provision of a comprehensive range of mental health and learning disability services which address the needs of prisoners and are integrated with other community and prison services to ensure ef fective through care.

39. The Review welcomes the decision to transfer responsibility for the healthcare of prisoners to DHSSPS and emphasises that it must be supported by robust quality assurance mechanisms and by sufficient resources to meet the needs.

40. The Review recommends that planning the future of mental health and learning disability services for prisoners is integrated with the planning of mental health and learning disability services throughout Northern Ireland including the joint strategic approach co-ordinated by the Regional Forensic Network.

Standard 2. Evidence, Principles and Purposes

Assessment and Monitoring of Need

6.27 Effective service planning requires detailed information in relation to the needs of prisoners and their carers. This is an essential component of the project overseeing the transfer of responsibility. The assessment of need must take account of the full range of mental disorders. It should also consider the need to support the work of criminal justice staff, for example, by assessing and providing appropriate treatment and care for people engaged in offending behaviour programmes.

Recommendations

41. The joint DHSSPS/NIPS project to transfer responsibility must ensure that a detailed assessment of the needs of mentally disordered prisoners and their carers is completed by the end of 2006. The assessment of need must encompass all those suffering from mental disorder including mental illness, learning disability, personality disorder and alcohol and substance misuse. It must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff.

42. The needs assessment must lead to the provision for service commissioners of systems to monitor and evaluate in an ongoing manner the needs of service users and carers and the impact of services on need.

Values, Principles, Culture and Ethos

6.28 The Review recommends that, following joint consultation, explicit values and principles are agreed for prison mental health and learning disability services that link with those for other prison staff and community health services. These values and principles should guide the creation of prison environments that promote mental health and they should also guide the development and delivery of mental health and learning disability services. It will be essential that these values and principles are developed jointly by the DHSSPS and by the NIPS and that they are placed at the heart of all developments to promote mental health within the prison environment and to deliver a range of mental health and learning disability services. Thus the principles and values should form the centre of induction and training for all staff and they should be translated rigorously into the day-to-day activities of the services to help create a culture and ethos that supports mental well-being.

Recommendations

43. The DHSSPS and NIPS in partnership should develop explicit values and principles for mental health and learning disability services and Criminal Justice Services for prisoners that guide the development of a prison environment that actively promotes mental health and well-being and that provides a comprehensive range of mental health and learning disability services.

44. The DHSSPS and NIPS in partnership should agree arrangements to develop strong and cooperative working relationships between prison staff, health and social services staff, and Criminal Justice Agencies at operational and managerial levels. These should include the supporting or ganisational structures, training and the development of joint policies, protocols and procedures.

Involvement of Service Users, Carers and the Provision of Advocacy

6.29 The principles of this Review require the involvement of service users and carers in service development and delivery. There is also a need for the provision of advocacy services.

6.30 Those who currently advocate for service users include legal representatives, the Prisoner Ombudsman, members of the Independent Monitoring Boards, chaplains, probation officers, mental health and learning disability service providers and others. Advocacy services and complaints procedures can be an important safeguard for service users and a driver for change in attitudes, practice and culture. These services are an essential component of in-reach mental health and learning disability services.

Recommendations

45. Commissioners of mental health and learning disability services in prisons must ensure that service users and carers are involved in the development, delivery and monitoring of services.

46. Commissioners of mental health and learning disability services in prisons must ensure that advocacy services and complaints procedures are developed for service users in prisons, building on those already in place.

Standard 3. Organisational Structures and Interconnections

6.31 Organisational structures must support the delivery of the full range of mental health and learning disability services in a multi-disciplinary and interagency manner . Regular input is required from statutory , voluntary and community sector providers of forensic, adult mental health, alcohol and substance misuse, learning disability and adolescent services with ready access to other mental health services that are more specialised or less frequently required. Services must be configured in ways that support key objectives, for example, there should be close linkages between Maghaberry and the regional secure unit to support the early identification of prisoners who require inpatient treatment in conditions of medium security and to facilitate their transfer at the earliest possible opportunity There should be linkages between prison and the community that maximise continuity of treatment, care and support. It is essential that these services are planned carefully by the transfer project in a coherent and strategic manner rather than being allowed to develop in an in an unco-ordinated way. They will require consultation and co-ordination with a wide range of service providers.

6.32 The DHSSPS has published guidance on “Dischar ge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of

Serious Physical Harm to Themselves or Others" (May 2004) [20]. Paragraph 12 states that when a person suffering from mental disorder, including personality disorder and who could represent such a risk, is discharged from prison a clear duty rests with NIPS to ensure that the relevant Health and Social Services Trust is notified so that arrangements for the service user's care in the community can be put into effect without delay. However, currently there are not sufficiently detailed information systems, nor are there enough services in the community, particularly for those suffering from personality disorder, to be satisfied that there are adequate arrangements to provide appropriate support, treatment and care for mentally disordered prisoners on their discharge from prison.

Recommendation

47. The project overseeing the transfer of lead responsibility must ensure that joint working arrangements with all relevant mental health and learning disability service providers are agreed and published before April 2007. It must be demonstrated that service providers have sufficient resources and capacity to meet the identified needs, including the needs of prisoners and discharged prisoners who are suffering from mental illness, learning disability, personality disorder and alcohol and substance misuse. The arrangements must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff in relation to prisoners and discharged prisoners.

Standard 4. Comprehensive and Accessible Services

Assessment on Committal to Prison

6.33 Assessment of the physical and mental state and the needs of each individual on committal to prison is conducted by nurses and medical officers. Professor McClelland and colleagues (2005)[13] in a report on six non-natural deaths in prison have identified a number of improvements that need to be made to the process of receiving prisoners into custody and assessing their health needs. The Review fully supports those recommendations. The NIPS is implementing a Practice Development Programme at Maghaberry with support from the Royal College of Nursing and the University of Ulster to improve committal services. The transfer project should ensure that these changes continue and are further developed as necessary following transfer of responsibility.

Recommendation

48. The Review supports the recommendations made by Professor McClelland and colleagues (2005)[13] in relation to the assessment, treatment and care of prisoners on committal to prison. The transfer project should ensure that work continues as quickly as possible to address these recommendations and that arrangements are made to complete any outstanding work following transfer of responsibility.

Assessment and Management of People Suffering from Personality Disorder

6.34 Personality disorder is a major issue for the NIPS, the wider Criminal Justice System, the HPSS and for society generally . A full range of appropriate interventions is required. Services should be evidence-based. Where there is inadequate evidence on the effectiveness, research should be incorporated into services to add to the available evidence. The Review recommends that the following services should be developed:

- a range of therapeutic interventions, including the development of therapeutic community approaches, both in secure settings and in the community;
- day patient and outpatient services provided by forensic and other mental health and learning disability services; and
- input from forensic and other mental health and learning disability services to the assessment and management of prisoners attending offender behaviour programmes.

6.35 The services required for prisoners suf fering from personality disorder are considered further in Chapter 11, but the following recommendations are made here:

Recommendations

49. Commissioners of mental health and learning disability services for prisoners must ensure that services provide assessment, treatment and care for all people suf fering from mental disorder including those suffering from personality disorder.

50. DHSSPS should take the lead in developing, in partnership with the Criminal Justice Agencies, an inclusive model of assessment, treatment and care of people suffering from personality disorder.

Healthcare Centres and Mentally Disordered Prisoners

6.36 There are healthcare centres in each prison establishment which admit prisoners with physical and mental healthcare needs, including people with complex mental health needs who have been accepted and are awaiting transfer to a high or medium secure hospital. However, some patients with mental disorders who are admitted to these units would not meet the criteria for admission to a psychiatric hospital; instead, if they were outside prison, they would receive treatment and care in the community . It appears that some prisoners could be supported in ordinary prison location by in-reach mental health services working in partnership with prison staff.

6.37 The Review considers that a range of measures including diversifying ordinary prison accommodation, supporting mentally disordered prisoners in ordinary location and rapidly transferring to secure inpatient services those who require such placement may provide more appropriate services to service users and also reduce the need for places in healthcare centres. Over the years prisons have found the healthcare centre environment useful in the management of people suffering from a wide range of disorders such as those undergoing

detoxification from drugs and alcohol, those suf fering from stress reactions and other neurotic disorders and those awaiting transfer to outside hospitals. As more appropriate services are developed, the need for health centre places and mental illness beds should be reduced, as in the Scottish Prison Service, although it is unlikely that the need for mental illness places could be eliminated altogether, at least not in the short term. It may also be appropriate to centralise the main healthcare centre facility in one establishment.

6.38 It is recommended that a specific mental health needs assessment is conducted to consider the needs of service users and the need for healthcare beds in prison.

Recommendation

51. A specific mental health needs assessment should be commissioned as part of the programme of the transfer of lead responsibility to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements. This should be completed by the end of 2006.

The Needs of Women Prisoners

6.39 Women prisoners often demonstrate high levels of mental health problems. For the small numbers of women prisoners with continuing behavioural disturbance there are particular needs for joint co-operative interagency working. It is imperative to identify better arrangements to provide alternatives to custody. The NIPS has commissioned an assessment of the needs of women prisoners. This should consider alternative placements including those at lower levels of security.

Recommendations

52. Services should be commissioned for women prisoners that are gender sensitive and that have the capacity to respond appropriately to the range of their mental health and learning disability needs, including substance misuse and personality disorder.

53. NIPS should commission a research project into alternatives to prison for mentally disordered women, including placements at lower levels of security.

The Needs of Young Offenders

6.40 The male and female young of fenders' centres at Hydebank admit young of fenders between the ages of 17 and 21 and these detainees may remain there until the age of 23. There is a need to ensure the provision of adolescent mental health and learning disability services to those who are under the age of 18 and to ensure the appropriate transfer to adult services of all relevant information and the treatment and care of individuals who attain the age of 18. Joint management plans should be agreed in the case of each individual suffering from mental disorder.

Recommendations

54. A full range of mental health and learning disability services including adolescent, psychotherapy and personality disorder , alcohol and substance misuse should be commissioned. Community service providers must ensure that a full range of co-ordinated services is developed and provided to those who are under the age of 18, and DHSSPS must play its part in ensuring adequate provision of the necessary expertise.

55. Service providers must develop protocols and procedures so that management plans are jointly agreed in the case of each adolescent suffering from mental disorder when transferring to adult prison services or healthcare services in the community.

On-call Services

6.41 The principles adopted by this Review require that there should be equity of access and provision of services to prisoners; there should therefore be formal on-call arrangements for each prison establishment to deal with out of hours mental health emergencies.

Recommendation

56. The transfer project team should define requirements and, together with service commissioners and providers, put such arrangements in place before April 2007.

Treatment Issues

6.42 Mentally disordered prisoners should have access to treatment and care from a range of statutory and voluntary services. In a prison environment certain circumstances arise that require further consideration.

(a) Providing treatment to mentally disordered prisoners who lack capacity

6.43 Most mentally disordered prisoners have the mental capacity to decide whether or not to accept any treatment that is of fered to them. However , some prisoners may be suf fering from or may develop severe mental disorder that renders them incapable of deciding whether or not to accept treatment. Such individuals should, if they satisfy the relevant criteria, generally be transferred to a HPSS hospital under the provisions of Part III of the Mental Health (Northern Ireland) Order 1986[11] ("the Order"). However , there may be delays in transfer caused, for example, by the dif ficulties in transferring remand prisoners to high security, the lack of availability of a bed in hospital or the delays inherent in current assessment and transfer procedures. The healthcare centres in the prison establishments are not recognised as hospitals under the Order , and people cannot be detained there and given treatment under the provisions of the Order . People who are suf fering from severe mental disorder and who are not receiving appropriate treatment may pose a serious risk of harm to themselves or others. Such individuals may be treated under common law in emergency situations. Earthrowl and colleagues (2003)[21] have proposed guidance on providing courses of treatment to prisoners who lack mental capacity, however these measures do not negate the underlying imperative that such prisoners should be transferred to hospital.

6.44 The Review does not recommend powers to permit compulsory treatment of mentally disordered people in prison without their consent. The Review believes that such cases must be addressed by the provision of adequate resources and procedures that ensure timely transfer to hospital of those who require such treatment.

(b) Transfer of Prisoners to Inpatient Hospital Services

6.45 It should be noted that when a person outside of prison is suf fering from severe mental disorder and requires admission to a psychiatric hospital he or she is generally admitted without delay, usually on the same day as the decision has been made to admit. The same standard should apply to prisoners.

6.46 When prisoners require transfer from prison to hospital to receive inpatient treatment for mental disorder they generally require secure inpatient services. There are gaps in current provisions resulting in unacceptable delays. At present mentally disordered prisoners remain in prison when they should be in hospital.

6.47 There are particular dif ficulties in obtaining inpatient treatment for mentally disordered prisoners who are on remand and who require treatment in a high security facility . These difficulties, and options to address them, have been considered more fully in Chapter 8 and by the Forensic Sub Committee of the Legal Issues Committee.

6.48 For those prisoners who require treatment in conditions of medium security it will be important to develop close working links between the prisons and the Regional Secure Unit and to ensure that high priority by management of the Regional Secure Unit is given to the transfer of prisoners. In order to ensure that places are made available to prisoners it will be essential to ensure that there are adequate long–stay medium secure places, low secure places and step-down facilities in the community.

Recommendations

57. People who require admission to hospital for assessment or treatment under the provisions of the mental health legislation must have equal access and priority whether they originate in prison or in the community . The application of this standard in practice should be subject to external audit by the appropriate health care inspection body .

58. The transfer project should ensure that specific joint working arrangements between service providers, the Prison Service and the DHSSPS are agreed and published before April 2007.

Standard 5. Risk Assessment and Management

6.49 There are currently no standardised risk assessment and management systems in routine clinical use in the mental health and learning disability services within the prisons. It is recommended that a multi-disciplinary and interagency operational group should identify policies and procedures. These policies and procedures should encompass risk assessment and management for service users in prison and also for the discharge of individuals to the community.

6.50 The operational group should also identify or ganisational risks and liabilities through its clinical governance mechanisms and should formulate and implement appropriate plans to address them.

6.51 The development of risk assessment and management systems for mentally disordered prisoners should proceed in consultation with criminal justice agencies, taking account of recent and proposed developments such as the extension of MASRAM to include violent offenders.

Recommendation

59. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in prisons. The framework must not discriminate unjustifiably against people suffering from mental disorder.

Standard 6. Quality Assurance

6.52 The Review has recommended the principle that services should be open, accountable and subject to external review. It is essential that the services available for mentally disordered people in prisons have robust clinical governance and internal quality assurance mechanisms and are subject to external independent inspection and review .

6.53 Measures of service quality may include assessment and monitoring of need, the capacity of the services to identify and respond to the needs of individuals with mental disorder, the capacity to transfer to outside hospitals those who require such treatment and the capacity to work in a joint interagency manner to address problems such as behavioural disturbance and offending behaviour.

6.54 It is also important to identify and remedy obstacles to performance such as delays for visiting staff in gaining access to prisoners and inadequate interview facilities.

6.55 Where adverse or untoward incidents or events occur , these should be investigated by methods, which not only establish the facts of what happened, but also examine the underlying processes, procedures and systems. The National Patient Safety Agency favours the use of root cause analysis in this regard. Robust mechanisms must be put in place to ensure there is learning from such incidents and that this learning is translated into relevant practical changes. Serious untoward incidents should be independently reviewed.

Recommendation

60. Mental health and learning disability services and Criminal Justice Agencies should develop joint co-ordinated interagency standards that encompass both the creation of a prison environment that promotes mental health and the provision of a full range of mental health and learning disability services. These standards should be supported by clinical governance arrangements, internal quality assurance mechanisms, external independent inspection and systems of learning from adverse events. NIPS and DHSSPS should jointly set up an effective operational group in 2006.

Standard 7. Mental Health Promotion and Education

6.56 The World Health Organisation (WHO) Regional Office for Europe produced a Consensus Statement on Mental Health Promotion in Prisons (1998)[22]. It recognised that although most mental disorders may have been present before imprisonment these disorders could also be made worse by the conditions of imprisonment and thus prison has the potential to cause significant mental harm. It agreed that the fundamental rights of prisoners entailed the provision of preventive treatment and healthcare equivalent to those provided in the general community, that the concept of care, positive expectations and respect should permeate all prisons and that the promotion of the mental well-being of prisoners and prison staff is vital in prisons. In addition to its detailed statement, the WHO also produced a management checklist to assist mental health promotion in prisons[23].

6.57 Health promotion initiatives are being undertaken jointly by the Prison Services and the National Health Service in Scotland[24] and in England and Wales[25]. The Healthcare Needs Assessment (2004)[16] recommended development of Health Promotion in the Northern Ireland prisons, and limited progress has been made.

6.58 It is essential that Health Promotion initiatives include specific measures to promote mental health and well-being that become instilled within the culture and ethos of the prison establishments. They cannot be seen as the sole preserve of Mental Health and Learning Disability Services, but rather they must be owned and led in partnership with the body with regional responsibility for mental health promotion, the wider health sector bodies and the Prison Service and developed in partnership with a range of users' and carers' representatives, voluntary and community sector and statutory Mental Health and Learning Disability services.

6.59 It is recommended that a Regional Prison Mental Health Promotion group is established that is centrally led and co-ordinated and that is sensitive to the circumstances of each prison establishment. This group should liaise closely with the regional body with responsibility for mental health promotion. The group should identify the needs in Northern Ireland and the efficacy of developments elsewhere and it should formulate and implement a range of proactive measures for prisoners as well as providing education, training and support for prison and healthcare staff. There should be evaluation of the impact of the group's activities.

Suicide and Other Self-Harm

6.60 Suicide and self-harm are major concerns in prison, as in the rest of society . Prisoners show high rates of mental health problems and are subject to the stresses related to offending behaviour and imprisonment. It is imperative to ensure that measures are put in place to address the identified suicide risks. The WHO[22] (2000) has produced guidance on the prevention of suicide in prisons. The Royal College of Psychiatrists (2002)[26] has published a Council Report on Suicide in Prisons, which made 26 recommendations and provided guidance on the assessment of prisoners. These include recommendations on resources, services, and procedures for assessment and staff training. Although the Report

relates primarily to the situation in England and Wales, its recommendations are highly relevant to Northern Ireland.

6.61 The NIPS has introduced a suicide and self-harm policy in 2004, which has been a positive step. The report by Professor McClelland and colleagues (2005) [13] reviewed 6 non-natural deaths in prison prior to that policy and made additional recommendations which are supported by the Review.

Recommendation

61. The DHSSPS, involving the body with regional responsibility for mental health promotion, in partnership with NIPS, service providers and representatives of users and carers should establish a Regional Prison Mental Health Promotion group to address mental health promotion and suicide prevention. The group should build upon the existing policy and formulate a strategy that sets explicit standards. It should seek to establish a culture and ethos in the prisons that promotes mental health and well-being for prisoners and staff and that further reduces the risks of suicide. The goal should be for the initial strategy to be implemented by 2007. Work should continue in conjunction with the regional body with responsibility for mental health promotion and should include evaluation of its effects.

Standard 8. Information, Research and Innovation

6.62 In order to work in an ef ficient co-ordinated multi-disciplinary and interagency manner , mental health and learning disability services in the prisons must have comprehensive information strategies that include, for example, the gathering of information on need, service performance and quality . There is a need to develop Information Technology systems that are integrated with the HPSS systems and that support service delivery . Consideration should be given to co-ordination with relevant components of criminal justice information systems.

Recommendations

62. The transfer project should ensure that information systems are established before April 2007 to meet the needs of mentally disordered prisoners. Information systems for prisoners should integrate and evolve with the HPSS systems and should be developed, where appropriate, to integrate with criminal justice systems in support of joint working.

63. The DHSSPS should commission and promote ethically approved research in relation to the needs and services for mentally disordered prisoners, for example research should be undertaken into the needs for healthcare centre places, the transfer of prisoners to Health Service, bail and community step-down facilities, the efficacy of offender management programmes and the efficacy of mental health promotion strategies.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

6.63 Workforce planning strategies and processes that are supported by both the Health and Social Services and by the Criminal Justice System must support the development and

maintenance of the required range of mental health and learning disability services. These must ensure the recruitment and retention of staff. There must also be Learning and Development arrangements to provide staff with the necessary knowledge, skills, support and opportunities for further learning and personal development. The needs for Learning and Development include not only staff working in prison mental health and learning disability services, but also other staff working in interconnecting health and social services and in criminal justice agencies. There is a need for interagency training to help promote understanding of the different, but interconnected roles. In addition service users and carers have learning and development needs that should be addressed. Consideration should also be given to the emotionally demanding nature of much of the work in prisons and the consequent needs of staff for psychological support.

6.64 There is a particular need, for all agencies, to develop expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. All of these services require close and co-operative working relationships between criminal justice staff, forensic and other mental health and learning disability services, supported by flexible working patterns, joint policies, procedures and protocols, agreed standards, joint research and audit, and shared learning and development. It is proposed that a Consortium is developed to bring together Criminal Justice Agencies, health and social services agencies and the prisons, to link community services and develop expertise in the psychotherapeutic aspects of assessment, therapy and risk management.

6.65 Learning and development mechanisms must be closely aligned to service development. Robust systems must be put in place to ensure there is learning from adverse incidents and that this learning is translated into relevant practical changes.

Recommendations

64. The DHSSPS must ensure that development and maintenance of services for mentally disordered prisoners are supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

65. Service providers must ensure that learning and development strategies for all staff are closely linked to service development and to governance arrangements.

66. A multi-agency consortium should be formed in 2006 to promote psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. The lead should be taken by DHSSPS with input from criminal justice agencies and the relevant health sector bodies.

Standard 10. Sustainable and Transparent Funding

6.66 The transfer of lead responsibility for prisoner healthcare to DHSSPS by April 2007 will include transfer of current funding from NIPS. In England the similar transfer of responsibility was accompanied by substantial additional funding (an increase of approximately 40%).

The current Review is highlighting major current under -funding of mental health and learning disability services throughout the HPSS and is recommending additional resources. Additional funding is highly likely to be required to ensure both the development of services on the basis set out in this Review and their ef fective delivery.

Recommendation

67. The strategic development of mental health and learning disability services for prisoners requires sustainable additional funding. Funding arrangements must support the joint co-ordinated multi-agency planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

44

CHAPTER 7

PROBATION

INTRODUCTION

7.1 The Probation Board for Northern Ireland (PBNI) has a statutory responsibility for assessing and supervising of fenders in the community in order to protect the public from risk of harm and to rehabilitate of fenders. Many of these of fenders have one or more mental health needs related to mental illness, learning disability , personality disorder and alcohol and substance misuse. There are, therefore, clear overlaps between the work of PBNI and mental health and learning disability services and thus, in accordance with the principles proposed in Chapter 2, there should be joint co-operative planning and delivery of services in order to best meet the needs of service users and carers. People who are on probation must have equity of access and provision of mental health and learning disability services.

7.2 This chapter considers the relationship between PBNI and mental health and learning disability services for adults with mental illness, personality disorder and learning disability and it makes recommendations for the future development of services. Additional recommendations in relation to learning disability are contained in Chapter 10 and further recommendations on specific issues including personality disorder, risk and the Multiagency Procedures for the Assessment and Management of Sex Of fenders (MASRAM) are contained in Chapter 1 1. Interfaces with Alcohol and Substance Misuse Services, with Child and Adolescent Mental Health Services and with Legal Issues are addressed in the respective reports of this Review.

BACKGROUND

Probation Services

7.3 Since the introduction of the Criminal Justice (Northern Ireland) Order 1996, the of fender population supervised by PBNI has not only increased, but the crime profile has shifted towards more serious, difficult and potentially dangerous and disturbed of fenders. On 31 March 2005 PBNI supervised 1,253 Probation Orders, 804 Community Service Orders, 803 Custody Probation Orders and 31 Supervised Life Licensees. Probation staf f conduct thorough risk assessments during each stage of contact with the of fender, including the preparation of Pre-Sentence Reports, case management and programme delivery . Often this work is conducted in the absence of involvement of health and social services agencies. Sentences such as the Custody Probation Order (introduced 1 January 1998) have led to PBNI supervising of fenders previously given custodial sentences.

7.4 During 2004/05 the courts requested 8,228 Pre-Sentence Reports from PBNI. A review in 2004 of Pre-Sentence Reports over a 6 month period found that 60% of these reports were written for offenders where the index offence was one of violence. More than half of those reports written on violent offenders were for an offence of Assault Occasioning Actual Bodily Harm or a more serious violent offence. In addition 42% of these offenders had 3

or more previous convictions, indicating a pattern of ongoing of fending behaviour rather than an isolated incident. Some of these individuals were not engaged with or had been excluded from primary care, mental health and learning disability services, social services and housing authorities and were deemed unsuitable for safe supervision by probation alone. Concerns have been raised that such patterns of exclusion and mar ginalisation by services may be associated with increased risks of self harm and further of fending.

7.5 There are also concerns that currently there are not suf ficient mental health and learning disability services working with PBNI to contribute to assessment of individuals and their mental health needs, to advise criminal justice agencies and to arrange or provide treatment and care.

7.6 As regards supervision of of fenders by probation, current standards require that of fenders are supervised according to their likelihood of re-of fending as well as the level of risk of harm they pose to the public. Of fenders on community supervision orders are required to report to a probation of ficer in accordance with instructions and to notify any change of address. At 31 March 2005, PBNI managed 330 of fenders in custody on Custody Probation Orders, which was one third of the prison population and 473 in the community Many of these of fenders had committed serious of fences of violence and sexual violence, and had previously had contact with psychiatric and psychological services. Many also had serious personality deficiencies and dif ficulties. However , there was a lack of joint working between PBNI and mental health and learning disability services. At 2005 there were 115 PBNI "listed cases" which were deemed to pose a high risk of potential harm to the public. Analysis of these cases indicated that one third had convictions of a sexual nature, including rape, unlawful carnal knowledge, gross indecency and abduction, one third had convictions for violence, including Assault Occasioning Actual Bodily Harm, Grievous Bodily Harm and use of a firearm and the convictions of the remaining one third included burglary, robbery, arson and motoring of fences.

7.7 PBNI programmes are delivered throughout Northern Ireland for of fenders who commit serious violent of fences including sexual of fences and domestic violence. A new community programme commenced in January 2006 to address serious violent of fending, for example, at the PBNI Integrated Supervision Unit, Alderwood House, Belfast, probation staff deliver sex offender treatment programmes, domestic violence programmes and other programmes, again with limited input from mental health and learning disability services.

7.8 There are currently 4 probation hostels in Northern Ireland that allocate beds to bailees. McCall (2005)[1] found that unmet need had been identified in theWestern Health and Social Services Board where there were 12 beds in a community supervised hostel, but it was considered that a minimum of 24 beds was required to meet the current needs. There are significant and well established working partnerships with voluntary agencies in Northern Ireland. These services provide accommodation, vocational training, skill development and employment opportunities for offenders with mental health problems, learning disabilities and personality disorders.

7.9 McCall (2005)[1] found little information about mentally disordered offenders on probation. The main findings were:

- male probationers had higher death rates and suicide rates than the general population (1 cohort study);
- the majority of referrals from a probation hostel to a forensic psychiatry department were for complaints of depression and concerns regarding self-harm; and
- the quality of probation of ficer-probationer relationships can colour the use of strategies to monitor and enforce treatment compliance. A respectful, personal approach was perceived as being more effective than those that were more authoritarian.

STANDARDS

Standard 1. A Co-Ordinated Joint Strategic Approach

7.10 Current experience indicates that many service users in contact with probation welcome a joint and co-ordinated approach between probation and mental health and learning disability services that addresses both the mental and the criminal justice needs of the individual and his or her carers. In order to ef fectively carry out their functions probation staff should be aware of the presence and nature of any mental health needs that are relevant to:

- the risks of harm the individual poses to him or herself or to others, including the risks of reoffending; and
- the monitoring, supervision and rehabilitation of the individual.

7.11 Probation staff require access to timely assessment, advice, treatment and care provided by mental health and learning disability services. These services are required when individuals are under going assessment for the courts or for the Life Sentence Review Commission or when individuals are subject to Probation Orders and Custody Probation Orders. The sources of assessment and advice must be independent – psychological or psychiatric assessments commissioned by the defence may be given a limited and incomplete remit, for example they may not adequately address issues of risk.

7.12 Mental health and learning disability services may also benefit from information from probation services, for example, to help understand the legal circumstances of service users. There are opportunities for service providers to jointly address identified problems.

7.13 At present mental health and learning disability services are neither configured nor resourced to provide the services that are envisaged and there are a number of perceived or actual obstacles to joint approaches. Joint strategies must address these issues.

Recommendations

68. Strategies should be developed to ensure effective joint working between PBNI and the full range of mental health and learning disability services in relation to the assessment, treatment and care of mentally disordered people who are under going assessment by Probation or are subject to a Probation Order.

69. The Regional Forensic Network should co-ordinate the development of services at the interfaces between PBNI and:

- community forensic mental health and learning disability services;
- prison forensic services; and
- inpatient secure services.

70. The DHSSPS should, in partnership with PBNI, co-ordinate the development of services at the interfaces between PBNI and other mental health services.

Standard 2. Evidence, Principles and Purposes

7.14 There is a need for more detailed information on the mental health needs of service users and carers in contact with probation services and the Review recommends that detailed needs assessments should be commissioned. However , the current service needs are so substantial that the results of a full needs assessment are not required before service development can begin.

7.15 The joint services should have clearly defined purposes, should contribute to evidence gathering and should be consistent with the values and principles advocated by the Review These services should assess the needs of each individual, his or her carers, their representatives, service providers and the wider community. The services should not only seek to identify , assess and provide treatment and care for those with mental health problems, but they should also target those causing greatest concern, developing particular expertise in relation to the assessment and management of problems and needs related to personality disorder.

Recommendation

71. PBNI, the Regional Forensic Network and the DHSSPS should agree joint arrangements to assess and monitor the needs of mentally disordered individuals, their carers, their representatives, service providers and the wider community. The results of ongoing assessment should inform service planning.

Standard 3. Organisational Structures and Interconnections

7.16 In these joint services staf f should work flexibly in partnership with each other and in support of interconnecting health and social services providers and with criminal justice agencies in the statutory, voluntary and community sectors. The services should develop

models of good practice, including clear or ganisational structures and lines of accountability and also policies, protocols and procedures for joint working and information sharing.

Recommendation

72. PBNI, the Regional Forensic Network and the DHSSPS should agree joint purposes, clear organisational structures and lines of accountability and should develop policies, protocols and procedures for joint working and information sharing.

Standard 4. Comprehensive and Accessible Services

7.17 Comprehensive services should be developed jointly by PBNI and forensic and other mental health and learning disability services to provide timely, accessible and high quality assessment of needs, treatment and care for service users and support for their carers with continuity of services for as long as required. Arrangements for joint working must address the full range of biological, psychological and social needs and in particular services should be developed in a manner that promotes openness and good communication between all relevant people, while respecting the rights of the individual for privacy and confidentiality.

Recommendation

73. PBNI, the Regional Forensic Network and the DHSSPS should develop comprehensive and accessible joint services to assess and provide treatment and care for mentally disordered people in contact with probation. There are particular needs to develop joint psychotherapeutic approaches.

Standard 5. Risk Assessment and Management

7.18 The pilot services should contribute to the assessment and management of risk, including the development of joint policies, protocols and procedures.

Recommendation

74. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people undergoing assessment by Probation or subject to a Probation Order.

Standard 6. Quality Assurance

Recommendation

75. PBNI, the Regional Forensic Network and the DHSSPS should agree standards for joint working. Services should be subject to internal and external evaluation of performance and quality.

Standard 7. Mental Health Promotion and Education

7.20 There are substantial opportunities to promote the mental health of those in contact with probation. The joint services should examine the services that may be developed and the potential benefits, including promoting continuity of mental health promotion when individuals are discharged from prison to the community.

Recommendation

76. PBNI and mental health and learning disability services should identify opportunities for mental health promotion and agree appropriate services.

Standard 8. Information, Research and Innovation

7.21 The needs assessment and joint services should add to the available information and should indicate future directions for research. Services should explore the possible uses of information technology including possible interfaces between mental health information systems and criminal justice information systems such as Causeway.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

7.22 There are needs to ensure that mental health and learning disability staf f become familiar with the work of probation and that probation staf f develop their capacities in recognising and responding to mental health needs. Following assessment of needs, inter -agency learning and development should be established for professionals working with of fenders with mental illness, learning disability , personality disorder and alcohol and substance misuse.

7.23 Workforce planning is essential to ensure that developments in Forensic Services are supported by the recruitment and retention of appropriate numbers of staff.

Recommendation

77. Inter-agency learning and development arrangements should be established to support joint working between PBNI and forensic and other mental health and learning disability services.

Standard 10. Sustainable and Transparent Funding

7.24 **Recommendation**

78. The development of forensic and other mental health and learning disability services to support the work of PBNI requires sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

CHAPTER 8

SECURE INPATIENT SERVICES

INTRODUCTION

8.1 Inpatient services are essential components in the range of Forensic Services. Service users should have timely access to safe inpatient environments that provide treatment and care to meet the needs of each individual thus maximising his or her prospects of experiencing improvement in mental health and a safe return to the community .

8.2 Inpatient forensic services are stratified according to the risk the service users present[27]. Security is considered according to environmental, relational and procedural aspects and is often described as comprising high, medium and low levels of security .

These levels of security have been described as follows[28]:

*"**High Security** is the level of security necessary only for those patients who pose a grave and immediate danger to others if at large. Security arrangements should be capable of preventing even the most determined absconder. High secure services should only be provided in secure hospitals with a full range of therapeutic and recreational facilities within the perimeter fence, acknowledging the severe limitations on the use of outside services and facilities.*

***Medium Security** is the level of security necessary for patients who represent a serious but less immediate dang er to other s. Patients will often have been dealt with in the Cr own Courts and pr esent a serious risk to other s combined with the potential to a bscond. Security should therefore be sufficient to deter all b ut the most determined. A good range of therapeutic and recreational facilities should be availa ble within the perimeter fence to meet the needs of patients who are not ready for off-site parole, but with the emphasis on graduated use of ordinary community facilities in rehabilitation whenever possible.*

***Low Security** is the le vel of security deemed necessary f or patients w ho pr esent a less serious physical danger to others, often dealt with in the Magistrates Courts and identified by court assessment/diver sion sc hemes. Security meas ures are intended to impede r ather than completely prevent absconsions, with greater reliance on staffing arrangements and less reliance on physical security measures."*

8.3 Inpatient services can be further subdivided according to length of stay, for example into the following classification (adapted from Kennedy 2002[27]):

- High security;
- Medium term medium security;
- Long term medium security;
- Acute/medium term low security; and
- Long term low security.

8.4 Although these descriptions help give some understanding of the dif ferent levels of security there is a need to develop more objective criteria based on the characteristics of service users and their needs.

8.5 Work has progressed to set standards for the care of service users in secure facilitiesx [29]. It is essential that services are person-centred, of high quality and that they have internal quality assurance mechanisms and independent external scrutiny.

8.6 All the services at different levels of security must work in concert with each other and with interconnecting forensic and other mental health and learning disability services. It is essential that services have the capacity to admit each service user in a timely manner to a facility that meets his or her needs and that service users are not subject to any greater restriction than their condition or legal status requires.

8.7 It has been demonstrated that well developed adult mental health services, including low secure services, correlate with reduced demand for services at higher levels of security[30]. Secure places inevitably entail restriction of the liberty of service users as well as significant financial costs for society. The Review believes that secure inpatient services are necessary and that places must be made available to all who require them. Investment in interconnecting and step-down mental health and learning disability services is required to help keep the total number of such secure places at a minimum.

8.8 This chapter considers primarily the secure inpatient needs of adults with mental illness. The needs of those with learning disability are considered in Chapter 10, those with personality disorder in Chapter 11 and the needs of children and adolescents are considered in the report by the Child and Adolescent Mental Health Committee[86].

HIGH SECURE SERVICES

Introduction

8.9 There is no high secure hospital in Northern Ireland. The State Hospital, Carstairs, Scotland, has provided most of the care and treatment in conditions of high security for adults from Northern Ireland with mental illness or severe mental impairment who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting.

8.10 Service users have been transferred to the State Hospital from hospitals in Northern Ireland and some of these service users have originated from the courts and prisons. Once it is agreed that a service user has made suf ficient progress at the State Hospital he or she generally returns to the referring hospital in Northern Ireland. Until Shannon Clinic, Northern Ireland's Regional Medium Secure Unit, was opened in April 2005 there was a gap between the high security provision at the State Hospital and the low security of the Psychiatric Intensive Care and other units in Northern Ireland. This meant that patients in the State Hospital needed to have made suf ficient improvement to be returned to a low security environment before they were likely to be accepted back to Northern Ireland. It will be essential that any service users who have been transferred to facilities outside Northern Ireland are returned at the earliest appropriate opportunity. Current capacity must be further developed to meet this objective.

BACKGROUND

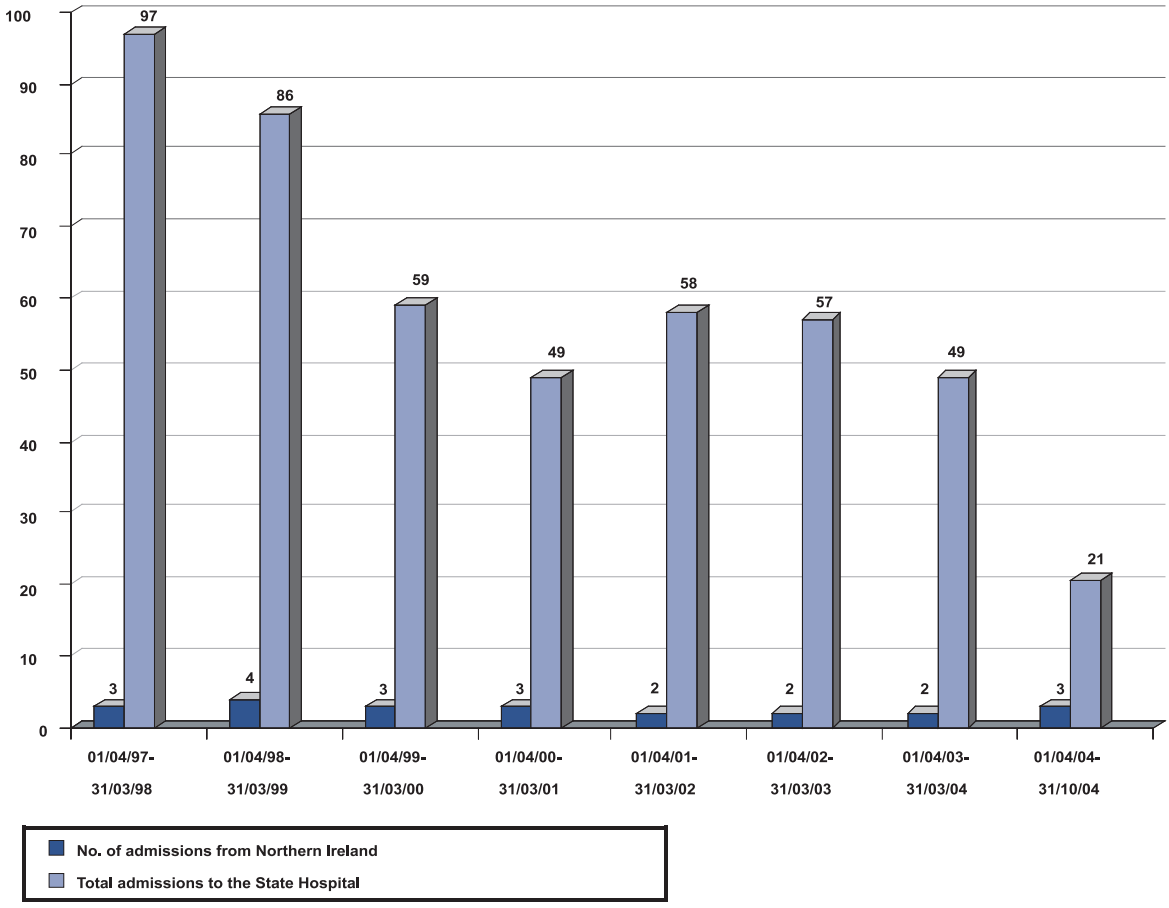
8.11 McCall (2005)[1] has reviewed the literature in relation to high secure services. Badger (1999)[31] found that there were about 33 patients in special hospitals per million of the

population in Britain, with 4 times as many men as women. The average age was in the 30's but with a wide age range. About two thirds of patients were legally classified as mentally ill and a one quarter had a personality disorder The average length of stay was 8 years with rather longer periods of stay for women. About two thirds of patients had an index offence of violence against the person, with about a quarter of all patients having committed homicide. Substantial ethnic dif ferences have been observed among admissions [32]. It has been estimated that at least half of the patients in special hospitals do not require the highest level of security. The average length of stay at the State Hospital between 1992-1997 was 5 years with a readmission rate of 22.3%, mostly due to violence[33].

CURRENT NEEDS AND SERVICES

8.12 The State Hospital provides care and treatment for around 240 patients from Scotland and Northern Ireland.

Admissions from Northern Ireland to the State Hospital, 2004



8.13 The State Hospital rarely admits patients with a primary diagnosis of personality disorder[34].

8.14 The number of mentally ill patients in the State Hospital who originated from Northern Ireland reduced substantially following the opening of the Shannon Clinic Regional Secure Unit in April 2005.

8.15 Northern Ireland has traditionally admitted fewer patients to high secure care than Scotland and England despite a lower resource base. These low numbers of admissions to the State Hospital from Northern Ireland may be an indicator that need is not being adequately met.

8.16 There are substantial obstacles to admission to the State Hospital for service users from Northern Ireland. Currently people who are remanded to prison and who are suf fering from mental disorder that warrants transfer to a high secure service cannot be remanded to a hospital outside the Northern Ireland jurisdiction and thus cannot receive appropriate treatment in conditions of high security until their case has been dealt with by the courts. The provision of psychiatric treatment in prison is strictly limited, for example, a prisoner who is so mentally ill that he or she does not appreciate the need for treatment cannot be given treatment in prison under the protection of mental health legislation. Such a prisoner may have to remain on remand in prison for a prolonged period, perhaps a year or more, without receiving adequate treatment. Similarly individuals whose circumstances may warrant an interim hospital order to the State Hospital cannot be transferred outside of the Northern Ireland jurisdiction. Section 81 of the Mental Health (Scotland) Act 1984[35] (as amended by The Mental Health (Northern Ireland) (Consequential Amendments) Order 1986[36] specifically excludes people subject to remand for assessment or treatment or to an interim hospital order (Articles 42, 43 and 45 of the Mental Health (Northern Ireland) Order 1986) from the arrangements for removal to Scotland of patients in Northern Ireland. It is a highly unsatisfactory situation that service users from Northern Ireland are unable to have access to treatment and care in conditions of high security when their condition requires it.

8.17 Obstacles have also arisen to the return to Northern Ireland of service users whose diagnosis has changed while under going assessment and treatment in Scotland. Uncertainty has arisen in relation to the meaning of the term “severe mental handicap” in the Mental Health (Northern Ireland) Order 1986[11]. These issues are discussed further in Chapter 10 and in the report on Legal Issues by this Review.

APPEALS AGAINST LEVELS OF SECURITY

8.18 Provisions are included in the Mental Health (Care and Treatment) (Scotland) Act 2003[37] to allow for appeal against detention in conditions of excessive security . Service users from Northern Ireland who are detained inappropriately in conditions of excessive security at the State Hospital will be able to avail of the provisions in the Scottish legislation when they come into effect in May 2006. This is likely to result in pressure to admit to Shannon Clinic service users whose requirements are for longer term medium security rather than the medium term treatment, for which the Shannon Clinic was originally planned. If such service users are admitted to Shannon Clinic, the capacity of the clinic to respond to service users who need short and medium term care will be reduced.

WOMEN IN HIGH SECURE SERVICES

8.19 Historically very low numbers of women service users from Northern Ireland have required treatment in conditions of high security. At the time of writing this Report there

are no women service users from Northern Ireland in the State Hospital. A report for the Forensic Mental Health Services Managed Care Network in Scotland [38] has recommended that dedicated multi-disciplinary teams responsible for providing forensic psychiatry services for women should be established within local forensic services across Scotland. It also recommended that until Secure Services for Women are available Scotland-wide, the Women's Service at the State Hospital should continue and that only once there is clearly no need for the service should it be closed.

NEEDS OF USERS AND CARERS

8.20 The State Hospital has introduced a number of measures to improve the experiences of service users and carers such as improvements in information and communication, the implementation of Integrated Care Pathways, the provision of a Patients'Advocacy Service and the formation of a Patient Partnership Forum and a Carers' Reference Group[39].

STAKEHOLDER VIEWS AND USER/CARER VIEWS

8.21 McCall (2005)[1] found mixed views in relation to the service provided by the State Hospital for service users and carers in Northern Ireland. There were concerns about the geographical distance and separation from families and also, about the secure environment, but there was also appreciation of the treatments and facilities available there.

STANDARDS

Standard 1. A Co-Ordinated Joint Strategic Approach

8.22 At present, in the absence of more suitable alternative provision, service users in Northern Ireland continue to require high secure services from the State Hospital in Carstairs. While these arrangements continue Forensic Services in Northern Ireland should co-ordinate with Forensic Services in Scotland, both in relation to the provision of effective clinical services and also in relation to sharing and developing best practice. This co-ordination should occur through various mechanisms such as regular liaison between the Northern Ireland Forensic Managed Network and the Scottish Forensic Mental Health Services Managed Care Network and between Shannon Clinic and the State Hospital. Arrangements should be put in place to ensure that co-ordination occurs between all relevant parties, including multi-disciplinary staff and user and carer advocates.

Recommendation

79. The Regional Forensic Network should promote co-ordination of forensic service provision for the people of Northern Ireland, including with high security services at the State Hospital, Carstairs, Scotland.

Standard 2. Evidence, Principles and Purposes

8.23 The principles of this Review require that all service users have ready access to high quality care. It is, therefore, essential that all service users have access to assessment,

treatment and care in conditions of high security if their condition requires it. However, certain service users are denied this option, namely prisoners on remand and people who may benefit from assessment and treatment in a high secure service while the subject of an interim hospital order. There are substantially fewer admissions to high secure services from Northern Ireland than from other jurisdictions in the United Kingdom. Certain service users in Northern Ireland remain inappropriately placed in prison when they should be in hospital. The Review considers that the current arrangements are highly unsatisfactory. It strongly urges that a solution is found urgently and as a matter of priority.

8.24 The Review has discussed a number of ways in which this situation might be resolved. These options include:

(i) arrangements to "fast-track" the legal cases of mentally disordered people;

(ii) changes in the legislation to enable people whose condition requires treatment in high security to receive such treatment either in Scotland or elsewhere;

(iii) changing the use of the Shannon Clinic Regional Secure Unit so that in some circumstances it provides treatment and care in conditions equivalent to high security; and

(iv) building a high secure hospital in Northern Ireland.

8.25 Option 1 the "fast-tracking" of legal cases would require agreements with the Public Prosecution Service and the Court Services to process more speedily cases where it appears that the accused is suffering from mental disorder and cannot be provided with appropriate treatment while in prison. Such arrangements may help shorten the period an individual may spend in prison on remand or awaiting sentencing, but these periods are still likely to remain unacceptably long. Such arrangements could not offer the individual the benefit of being assessed and treated in hospital before disposal by the courts. Therefore, this option is unlikely to present a complete or satisfactory solution to the identified problem.

8.26 Option 2 involves changes in primary legislation to facilitate transfers to high secure services in Scotland or other jurisdictions. There are likely to be substantial legal and practical difficulties in transferring service users outside of the jurisdiction while they are still subject to the Northern Ireland courts. It should also be noted that there are high secure services in England and in the Republic of Ireland. The current mental health legislation allows for transfer of service users between Northern Ireland and other parts of the United Kingdom, but there is currently no reciprocal mental health legislation that allows transfers between Northern Ireland and the Republic of Ireland. There are substantial potential opportunities for the development of forensic services on an all-Ireland basis.

8.27 Option 3 was considered by the DHSS/NIO review of secure provision (1994)[30]. It debated whether Northern Ireland should manage all its patients, including those requiring high security facilities, but it decided that the services at the State Hospital would continue to be required. It suggested the Regional Secure Unit could have its security level upgraded at a later stage. However, the building was specified and designed as a medium secure unit and is likely to require very substantial modification to upgrade it to high secure levels, if indeed that is feasible. The Regional Secure Unit was also specified at a level of 20 beds per million of the population, which is lower than the levels subsequently recommended elsewhere. The

lack of provision for service users requiring long stay medium security and the lack of 'step-down' facilities from Shannon Clinic are likely to create a very high demand for the places in the Clinic. Converting part of the unit to high secure usage would compromise the capacity of the Unit to provide the medium secure service that was originally intended.

8.28 Option 4 involves building an additional secure facility in Northern Ireland to accommodate service users who require treatment and care in conditions of high security. On the face of it this option may not seem feasible on account of the small numbers of service users from Northern Ireland who are currently in high security. However, it should be noted that the numbers of service users from Northern Ireland who are receiving treatment in conditions of high security are substantially lower than in other jurisdictions. Current usage of high secure services does not reflect actual need because the legal and other obstacles prevent service users gaining access to the high security conditions they require.

8.29 At present there are a number of major gaps in high and medium secure provision for service users in Northern Ireland:

- unsentenced prisoners sufering from mental illness or severe mental impairment are denied the treatment they require as they cannot be transferred to a high security service;
- there is no provision for long stay medium secure places leading to inefficient usage of resources at Shannon Clinic;
- facilities for women at Shannon Clinic are limited. Women would benefit from a separate facility and the places at Shannon Clinic could be used by men;
- there is a need to provide treatment in conditions of high security for individuals suffering from personality disorder (see Chapter 11); and
- there are no secure facilities for adolescents.

8.30 An additional secure facility could provide a comprehensive solution to the high and medium secure needs of service users from Northern Ireland. Consideration should be given to providing these specialist services within an all-Ireland framework.

Recommendations

80. The current arrangements for high secure services for people in Northern Ireland have unacceptable gaps in service provision. All people in Northern Ireland must have access to high secure services when they require them. The DHSSPS must take the lead in urgently finding solutions to the current obstacles to treatment and care in conditions of high security.

81. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high and medium security. The assessment should include people suf fering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

82. This assessment of high and medium secure needs should be combined with an assessment of the needs for low secure and step-down community services (Chapter 9) and the needs for forensic learning disability services (Chapter 10).

83. The Review recommends the provision of an additional secure facility in Northern Ireland to meet the identified high and medium secure needs of service users. The regional high and medium secure facilities should be complemented by local low secure facilities and community step-down facilities to form a range of short, medium and longer stay facilities that meet the needs of forensic service users.

Standards 3-9

8.31 In developing new secure services consideration should be given to each aspect of the care standards proposed in Chapter 2 including the development of policies, procedures and protocols, risk assessment and management, quality standards and assurance mechanisms, the development of information systems, joint research and contributions to mental health promotion and public education. There are also many opportunities for sharing of good practice, for example, in relation to advocacy and clinical services, and there are opportunities for innovation such as the use of video-links to improve contact between carers and service users. In addition, consideration should also be given to developing joint training between Northern Ireland Forensic Services and those available in adjacent jurisdictions.

Recommendations

84. New secure services should be developed in accordance with the standards proposed by this Review.

85. The Regional Forensic Network should explore the range of opportunities to co-ordinate training for staff in Forensic Mental Health and Learning Disability Services in Northern Ireland with the training available in adjacent jurisdictions.

MEDIUM SECURE SERVICES

Introduction and Current Services

8.32 The Shannon Clinic Regional Secure Unit (the Clinic) at Knockbracken Healthcare Park, Belfast, was opened in April 2005. When fully operational it will provide 34 medium secure places for the assessment and treatment of adults suf fering from mental illness. Shannon Clinic takes admissions from prisons, courts, high secure services and other mental health services. Admissions generally warrant detention under the Mental Health (Northern Ireland) Order 1986[11] and comprise individuals who are a serious and enduring risk to others and prisoners who are mentally ill and require treatment in a medium secure setting. The Clinic primarily takes admissions ranging from several weeks to approximately 2 years. There is currently no provision in Northern Ireland for service users requiring longer stay treatment in conditions of medium security.

8.33 Facilities are available in Shannon Clinic for a small number of women to reside in part of a ward area that is separate from the facilities for men, but with access to shared activities and rehabilitation facilities.

8.34 The Clinic has an established a model of care that guides its activities and operations:

- A Bio-Psycho-Social Model;
- Patient Centred Approach;
- Multi-disciplinary Team Approach;
- Supports Patient Recovery;
- Safe, Secure and Therapeutic Environment;
- Promotes a Learning Ethos for Staff and Patients; and
- Involving Patients and Families in the Care Planning Process.

8.35 Service users and carers are also supported by user and carer advocates.

8.36 The Clinic has formulated many policies, procedures and protocols and is developing integrated care pathways, needs assessment, care planning, risk assessment and management procedures, standards, audit and quality assurance systems. The Clinic is also using computerised notes and records and video-links.

8.37 The Clinic has developed networks with interconnecting services and has also established an extensive staff training programme.

8.38 This chapter considers the future development of medium secure services for mentally ill adults in Northern Ireland.

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

8.39 The development of the Clinic has been overseen by a regional project board. It is expected that the function of regional co-ordination will be adopted by a Regional Forensic Network which will have links to the Scottish Forensic Mental Health Services Managed Care Network.

Recommendation

86. The Regional Forensic Network should promote the development and delivery of regional medium secure services and their co-ordination with interconnecting services.

Standard 2. Evidence, Principles and Purposes

8.40 The Clinic has been commissioned as a short and medium term facility for adults with mental illness, providing assessment and medium term treatment for periods of up to 2 years. The capacity of the Clinic to effectively provide this service will depend heavily on

the provision of interconnecting services throughout Northern Ireland to act in concert with the Clinic by providing long term medium secure services and step down low secure and community forensic services. Unless these facilities are made available there is a very real danger that service users will spend longer in the Clinic than is clinically necessary and that the Clinic will not be able to offer places to those in urgent need such as mentally ill people in prison. Such an outcome would also represent an inef ficient use of the taxpayers' investment in this facility.

8.41 Kennedy[27] has stated that "Patients who are failing to progress despite appropriate trials of treatment need not continue to occupy scarce intensive therapeutic placements." He has suggested that such individuals may become frustrated by their lack of progress and that after detailed review of treatments and needs these individuals should be allocated to a long term placements where they are kept under regular review and may from time to time benefit from a return to a more intensive treatment setting.

8.42 It is essential that a detailed assessment of need is carried out and that adequate long term medium secure, low secure and community services are provided to support the ef ficient functioning of the Clinic.

8.43 In addition to the detailed needs assessment exercise the Clinic should contribute to the understanding of the needs for service provision by analysing both the needs of each service user and also the constraints on their progress. The Clinic should explore the development of a standardised Analysis of Constraints methodology[41] to identify the obstacles that are blocking the progress of each service user towards reduced restriction and greater autonomy. Identified constraints might include, for example, specific features of the service user's mental condition and lack of services to meet the identified needs.

8.44 The Regional Forensic Network should establish systems to monitor ongoing need for forensic services, including places in conditions of medium security . This information should inform planning for high, medium and low secure services and step-down community services for service users with short, medium and longer stay needs. The aim must be to create detailed information systems that inform the planning and delivery of an interconnected range of secure inpatient and community services to meet the needs of service users.

Recommendations

87. The DHSSPS must take account of the assessment of need for secure services and it must plan and develop long stay medium secure services and step-down low secure and community services.

88. In order to inform service planning and development Shannon Clinic staf f should analyse the needs of each service user and the constraints on his or her progress.

89. The Regional Forensic Network should establish systems to monitor ongoing need for high, medium and low secure services and step-down community services for forensic service users with short, medium and longer stay needs. This information should contribute to the planning and delivery of forensic services.

Standard 3. Organisational Structures and Interconnections

8.45 The service based at the Clinic is closely connected to community forensic services which are at an early stage of development. Staf f work across or ganisational boundaries to promote co-ordination. The Clinic has also been working in close collaboration with the State Hospital. It is essential that similar close connections are established between the Clinic and the prisons. These should be agreed at an early stage to ensure that robust systems are put in place to identify and transfer mentally ill prisoners in need of assessment and treatment in conditions of medium security . Previous experience in the Northern Ireland prisons demonstrated the benefits of staf f working jointly between an inpatient hospital unit and the prison healthcare centre – greater numbers of transfers to hospital occurred and in shorter periods of time, compared with other parts of the province that did not operate such an arrangement.

Recommendation

90. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer to hospital of mentally disordered people who require treatment in conditions of medium security.

Standard 4. Comprehensive and Accessible Services

8.46 Comprehensive arrangements have been made at the Clinic to assess and meet the needs of service users and carers. Partnerships have been developed with many relevant parties and joint protocols are being produced in partnership with Criminal Justice Agencies. A range of psychotherapeutic approaches is being developed including group and individual therapy and staff supervision and support.

Standard 5. Risk Assessment and Management

8.47 Each mental health and learning disability service must develop risk assessment and management systems that are generically similar and that are tailored to the needs and circumstances of the individual service user. The Clinic is developing expertise, policies, procedures and protocols. These should draw upon best practice.

Recommendation

91. Service providers should develop regional expertise at Shannon Clinic in the assessment and management of risk in relation to service users who require assessment, treatment and care in conditions of medium security.

Standard 6. Quality Assurance

8.48 The Clinic is introducing systems to assess performance and assure quality and clinical governance.

8.49 One of the criteria used to assess the ef ficacy of the Clinic should be its capacity to take service users at short notice, including mentally ill prisoners in need of assessment and treatment in conditions of medium security . This criterion is not under the control of the Clinic service alone – it will depend heavily on the ability of interconnecting services throughout Northern Ireland to act in concert with the Clinic by providing long term, step-down and community forensic services.

Recommendation

92. Shannon Clinic should develop explicit quality standards and quality assurance mechanisms, including audit and independent external inspection by the relevant regional body.

Standard 7. Mental Health Promotion and Education

8.50 The Clinic is developing arrangements to promote the physical and mental health of service users and has also contributed to public education.

Recommendation

93. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure inpatient services to mental health promotion and public education.

Standard 8. Information, Research and Innovation

8.51 The Clinic has sought to develop an ethos of enquiry that promotes information-gathering and research and this ethos is supported by internal or ganisational structures. It will be important to develop a research strategy that includes links with relevant research bodies.

8.52 Information Technology systems have been introduced to the Clinic and are undergoing further development as part of a wider project.

Recommendations

94. The Regional Forensic Network should develop information and research strategies and promote the involvement of secure inpatient services.

95. The Regional Forensic Network should promote the integration of InformationTechnology systems between medium secure services and interconnecting services to help ensure the effective transfer of information.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

8.53 The Clinic has developed an extensive learning and development programme that is closely related to clinical practice. This should be developed further by increasing links with

universities and other training organisations and by working with other developing forensic services and the Regional Forensic Network.

8.54 Staff working with mentally disordered of fenders also require psychotherapeutic support and arrangements have been made to provide psychotherapy services.

8.55 At the time of writing this Report, shortages of key trained staf f have prevented the Clinic from opening to full capacity and they have impeded the development of community forensic services. These obstacles demonstrate the crucial importance of developing workforce strategies to ensure the recruitment, training and retention of all the necessary staff to support service developments.

Recommendations

96. The model used by Shannon Clinic of closely integrating training with clinical practice should extended to other forensic services.

97. The DHSSPS must ensure that development and maintenance of secure inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

8.56 The further development of medium secure services to meet the needs of service users for short, medium and long stay treatment and care will require appropriate funding in accordance with a long term plan.

Recommendation

98. The development and maintenance of medium secure services requires appropriate funding in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

LOW SECURE SERVICES

Introduction

8.57 Low secure services include Psychiatric Intensive Care Units, challenging behaviour wards and acute and longer term forensic low secure units.

8.58 The DHSS/NIO Review of Secure Provision[40] noted there were then 150 locked ward (low secure) beds in Northern Ireland. The Review recommended building a Medium Secure Unit for the province and rationalising locked ward provision.

8.59 The Northern Ireland Hospital Advisory Service inspected the 6 Psychiatric Intensive Care Units in the mid 1990's. It found substantially different practices in these units.

8.60 The Report of the Adult Mental Health Services Committee [83] (Chapter 4.125) has recommended, as part of a comprehensive package of services, that there should be 25 challenging behaviour beds per 250,000 of the population, which equates to a total of 170 for the province.

8.61 Low secure services are essential to support users in community and inpatient adult mental health services, to provide step-down facilities for service users in medium and high security and to provide support to users of community forensic services. Low secure services must function in a co-ordinated manner with all other interconnected services in order to meet the needs of service users. Inadequate capacity in low secure services may have a number of knock-on effects on interconnected services, for example, if a low secure place is unavailable to a service user in medium security he or she may be forced to spend a longer period than necessary at that higher level of security and may render that place unavailable for other service users in urgent need.

BACKGROUND

Current Services

8.62 The table below shows current provision of low secure beds in Northern Ireland. There are 6 Psychiatric Intensive Care Units (PICUs) which have provided a number of dif ferent functions including the short, medium and longer term treatment of mentally ill adults. In some cases these units have provided care for some mentally ill adolescents and accepted transfers from prisons and high secure services.

8.63 There are also challenging behaviour wards which typically provide for longer stay patients and where the emphasis is on rehabilitation.

Current provision of low secure beds in Northern Ireland

Hospital	Number of PICU beds	Number of long stay on locked/lockable wards	Total beds on locked/lockable wards
Knockbracken	16	24	40
Downshire	16	0	16
Holywell	18	22	40
Tyrone and Fermanagh	10	0	10
Gransha	8	0	8
St Lukes	13	17	30
Total	81	63	144

8.64 There are substantial variations in provision between dif ferent geographical areas. Many wards are in old buildings and offer dormitory accommodation and limited facilities and activities.

Literature Review

8.65 McCall (2005)[1] has reviewed the limited literature on the ef ficacy of low secure units and the epidemiological features of patients in low secure care. The main findings were as follows:

- wide variation in the provision and nature of low secure care reflecting idiosyncratic and localised development of services;
- almost complete lack of research evidence on the ef ficacy of low secure care for particular types of patients and problems;
- offenders were significantly less likely to be aggressive to others than non-offenders, but significantly more likely to self-harm, however , treatment outcomes were similar for both groups (results of 1 study[42]); and
- enhanced availability of local low secure reduces demand for medium and high secure services[30].

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

8.66 Low secure services are essential components of adult mental health and forensic services and must work in co-ordination with interconnecting services. It is essential that future services are planned jointly by all relevant parties.

Recommendation

99. The DHSSPS should ensure the development and delivery of low secure forensic services including step-down rehabilitation and long-stay services.

Standard 2. Evidence, Principles and Purposes

8.67 There is a lack of detailed information on the needs of service users in Northern Ireland for low secure accommodation. There is a requirement for a needs assessment and service mapping exercise. This should consider the needs of service users who are currently in low secure accommodation and those who may require low secure accommodation, for example, some service users in high and medium security , in prison, in acute admission wards, in longer stay wards and in the community . The exercise should take account of different admission criteria to current low secure services. Having identified the detailed needs of service users, options for services should be considered that will ensure adequate capacity to meet current and projected future needs. The appropriate occupancy rates should be calculated that will meet needs and ensure availability of places when required. The assessment of needs for low secure places should be integrated with assessment of need for medium and high secure places. Low secure services will also require linkages to accommodation and services in the community to ensure these are available once service users are ready to move there.

8.68 Options for the future development of low secure services should consider the quality of the services that are required, including the standard of physical accommodation and the levels of therapy and care. If service users spend significant periods in locked or restricted accommodation there is a clear need to provide a wide range of facilities such as therapeutic, occupational, recreational and outdoor activities. Other factors to be considered include:

- the number of categories of low secure services;
- the specific needs of certain groups such as women; and
- the key linkages of services, for example, PICU' s may be more closely linked to admission units and low secure forensic units may be more closely linked to forensic services. It is generally inappropriate to place in PICU' s individuals who require rehabilitation in a secure and low stimulus environment.

8.69 Different arrangements may be developed in dif ferent localities, but the essential features are that services should be developed in partnership with all the relevant parties and they should provide the number of places and quality of services required to allow service users to be placed in good quality accommodation and according to their needs rather than according to the availability or otherwise of a place. Substantial new provision of low secure inpatient facilities is likely to be required to meet current and projected needs.

Recommendations

100. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of low security The assessment should include people suf fering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

101. The needs assessment should consider the optimal configuration of low secure services, including the needs of specific groups such as women.

102. The needs assessment should lead to the development of low secure services that are fit for purpose. This is likely to require substantial new provision.

Standards 3-10.

8.70 Future low secure services should be developed following assessment of need and in accordance with the principles advocated in this report.

Recommendation

103. It is recommended that future low secure services, including low secure forensic services are developed in accordance with the standards advocated in Chapter 2.

CHAPTER 9

COMMUNITY FORENSIC SERVICES

INTRODUCTION

9.1 Community Forensic Services are an essential component of co-ordinated regional forensic services. They provide a range of community resources for service users and carers, the Criminal Justice System and for other mental health and learning disability services.

9.2 The sources of referral may include:

- inpatient forensic services;
- other inpatient and community mental health and learning disability services;
- police stations and courts;
- prison services; and
- probation services.

9.3 Community forensic services have crucial roles in meeting the needs of service users and carers, for example, in supporting the timely dischar ge of service users from secure inpatient services to appropriate accommodation in the community, in providing follow-up treatment and care for mentally disordered people dischar ged from prison or in providing assessment and therapeutic support to probation or to other mental health and learning disability services.

9.4 This Chapter primarily considers the service arrangements for adults with mental illness or severe personality disorder. Services for women and for people with learning disability are considered in greater detail in Chapter 11 and Chapter 10 respectively.

THE SERVICE USERS

9.5 The DHSSPS (2003)[43] proposed that the client group for community forensic services would be defined as:

"People with a cate gorical mental illness, se vere personality disor der or w ho eng age in dangerous or persistently challenging, aggressive behaviour and who may be in contact with the Criminal Justice System."

9.6 A submission to the Forensic Mental Health Services Managed Care Network in Scotland[44] has proposed the following definition:

"People suffering, or appearing to suf fer, from a major mental disor der whose behaviour brings them into the Criminal Justice System and are a cause for concern; either because

of the seriousness of the offence or their potential dangerousness. In addition the service will also offer input to those with severe mental disorder who pose a risk to the safety of others, but may not necessarily have been convicted of an offence".

9.7 It is apparent from definitions such as these that there can be no precise or exact cut-off point between those service users who may fall within the remit of community forensic services and those who fall within the remit of other interconnected services. There is a need for local agreement between service providers that takes account of the functions and capacities of the relevant services and ensures that the needs of service users are met.

BACKGROUND

9.8 Two models of community forensic services have been described[45] - the integrated model (forensic specialists working within community mental health teams) and the parallel model (forensic specialists working on a separate specialist team). Characteristics of both models are shown in the Table below.

Characteristics of parallel teams	Characteristics of integrated teams
Own team base Separate referral meetings Specialist management line Specialist supervision Protected funding Forensic psychology Good links with Criminal Justice Systems Capped caseloads	Close links with community mental health services Acceptance of more referrals from primary care

9.9 In practice many services have developed features of both parallel and integrated models.

Current Services

9.10 Until 2003-4, Community Forensic Services in Northern Ireland were very limited - they have been described by McCall (2005)[1]. In 2004 funding was allocated for the partial development of community forensic services in each of the 4 Health and Social Services Boards. It was recommended that the Community Forensic Teams ('CFTs') would work in a 4 level model:

"Level 1 - a one off assessment/consultation with the CFT;

Level 2 - a short period of assessment by the CFT with the referring team retaining responsibility;

Level 3 - a agreed period of shared responsibility - (a) to assess risk, (b) to evaluate interplay/operation of known risk factors, and (c) to assess efficacy of risk reducing strategies;

Level 4 - CFT taking full responsibility for duration of need;

It would be assumed that the majority of CFT's work would be at level 1 with only a small minority at level 4".

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

9.11 As with other components of Forensic Services it is proposed that community forensic services should be developed in a planned strategic manner by partnerships comprising service users and carers, commissioners and providers of services, representatives from forensic and interconnecting mental health and learning disability services and from Criminal Justice Agencies in the statutory, voluntary and community sectors, and also representatives from the wider community. It is expected that the Regional Forensic Network will lead and co-ordinate the planning and development of community forensic services.

9.12 The development of capacity to meet the needs of service users in the community must include both supporting and building upon the capabilities of current services, as well as developing and integrating new specialist services.

Recommendation

104. The Regional Forensic Network should lead and co-ordinate the planning and development of community forensic services. It should both support and build upon the capabilities of current services as well as developing and integrating new specialist services.

Standard 2. Evidence, Principles and Purposes

9.13 It will be essential to ensure that the plans for community forensic services have explicit purposes that take full account of the needs of all the interested parties, including the needs of service users and carers, other mental health and learning disability services and also the Criminal Justice System. Community forensic services must be planned on a multi-disciplinary and interagency basis and their purposes should include:

- assessing local referrals to secure inpatient services;
- supporting the discharge of service users from inpatient secure services to the community, facilitating self management, opportunities for employment and engagement in social activities;
- working jointly with other mental health and learning disability services to provide consultation, assessment, and support and, in some cases, shared or sole treatment and care;
- liaison with police stations and courts;
- in-reach to prisons and support of discharged prisoners with mental disorder;
- assessments at the request of probation;

- input to offender therapy programmes; and
- supporting the work of the Multiagency Procedures for the Assessment and Management of Sex Offenders (MASRAM) or its successor.

9.14 The current information on need is inadequate and systems must be devised to regularly assess need as well as the performance of services and their impact on need. The DHSSPS[43] noted in 2003 that comprehensive assessment of need *"would….be time consuming, and for the purpose of consideration of service model proposals any benefits that would be achieved over using …..(current) estimates ….. may not outweigh the delays incurred, especially as starting from such a low baseline service any developments may well be incremental and thus offer the opportunity for more accurate ongoing assessment of service demand."*

9.15 At the time of writing this Report the CFT's are not fully staffed or developed. The Review supports the current DHSSPS plans to initially develop 5 CFT's in Northern Ireland which equates to approximately one CFT per 350,000 of the population (in one or more cases 2 teams may amalgamate to form one enlarged team). It is recommended that these teams are supported by workforce planning and funding that they can reach full operating capacity as soon as possible.

9.16 It is recommended that the Regional Forensic Network commissions assessments of need to guide further planning and development. In particular it should be noted that the need for forensic services is recognised to be substantially greater in urban rather than rural areas[27]. Further developments are likely to require that services are aligned more closely to need rather than being provided on a simple *per capita* basis. The assessment of need must include not only the staffing requirements, but also resources such as accommodation suitable to meet the needs of service users. There is a need to assess the types of accommodation required and also the most appropriate locations to best meet the needs and wishes of service users and carers.

Recommendations

105. The 5 CFT's that are currently partly staffed and funded require the necessary funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity by 2010. Thereafter teams should be developed in response to need to ensure that they have capacity to fulfill the range of services required by service commissioners and service users.

106. Commissioners must commission a full range of community forensic services with the following purposes:

- assessing local referrals to secure inpatient services;
- supporting the discharge of service users from inpatient secure services to the community, facilitating self management, opportunities for employment and engagement in social activities;
- working jointly with other mental health and learning disability services to provide consultation, assessment, and support and, in some cases, shared or sole treatment and care;

- liaison with police stations and courts;
- in-reach to prisons and support of discharged prisoners with mental disorder;
- assessments at the request of probation;
- input to offender therapy programmes; and
- supporting the work of the MASRAM or its successor.

107. The CFT's should produce information on their workload and performance which, combined with needs assessments should help guide the future planning of CFTs including suitable accommodation in the community.

Standard 3. Organisational Structures and Interconnections

9.17 Community forensic services will need to work closely with other forensic services, with primary care services and with all other mental health and learning disability services including particularly:

- adult mental health including Community Mental Health Teams, Home Treatment/Crisis Resolution services and Assertive Outreach services, the psychotherapy services and the special needs services;
- alcohol and substance misuse;
- learning disability; and
- child and adolescent mental health services.

9.18 It will be important to consider the key linkages between the developing CFT's and secure inpatient forensic services in order to maximise joint working and to facilitate timely discharge of service users to the community.

9.19 In addition community forensic services will need to establish appropriate linkages with components of the Criminal Justice System such as:

- Police stations;
- Courts;
- Prison;
- Probation; and
- MASRAM or its successor (see Chapter 11).

9.20 Community forensic services will require a range of suitable accommodation to meet the needs of service users. These will include[27]:

- 24-hour nursed care;
- Hostel; and
- Independent community placements.

9.21 In addition there will be a requirement for day care facilities to provide a range of therapies and activities to ensure the provision of a purposeful day.

Service Models

9.22 The model currently being implemented in Northern Ireland is of CFTs working according to the model described at 9.10.

9.23 The Review places emphasis on flexible and dynamic groups of statutory , voluntary and community sector services being formed or dissolved in accordance with the needs of service users and carers. Services must work across or ganisational boundaries to address needs rather than being structured rigidly into or ganisational groupings.

9.24 All staff will require the ability to work in complementary and often overlapping roles. While emphasising the need for staff to work flexibly in response to need, there must also be careful co-ordination between CFT members to ensure there is clear agreement on the roles, responsibility, accountability and lines of communication of each member of staf f.

9.25 The development of these services will require improvements in inter -agency communication and co-working to ensure that staf f understand their respective roles and responsibilities and that they co-ordinate their efforts to meet the needs of service users and carers. There will be a need for joint policies, protocols and procedures on issues such as working in partnership and information sharing. There may also be a need for shared or interconnected information technology systems.

Service Capacity

9.26 It will be important to agree with all relevant parties the expected workload and capacity of each CFT . It would be easy for CFT s to become overwhelmed by lar ge numbers of referrals from the many potential sources so that they became unable to provide the quality of service required.

9.27 It is proposed that the CFT s will spend a substantial proportion of their time working in support of other services and that the numbers of individuals for whom the CFT s have primary responsibility for treatment and care will be kept small.

Recommendation

108. Community Forensic Services should develop specific service models and structures and agreed methods of working with interconnecting services.

Staffing

9.28 It is recognised that the exact remit and workload of CFT's will vary with local circumstances. Nevertheless, the Review recommends the following as an appropriate typical composition for a CFT, as an indication of the resources required.

Recommendation

109. A CFT should comprise a range of staff with the necessary skills to meet the needs of users and carers. The following is considered representative of the skills and funding levels required:

1 Consultant Forensic Psychiatrist
1 Consultant Chartered Forensic Psychologist
1 Forensic Psychologist
1 Psychotherapist
2 Social Workers
1 Occupational Therapist
5 Nurses
2 Administrative Staff
User and carer advocacy services

The composition of CFTs should be adjusted in response to information on need and service performance.

Standard 4. Comprehensive and Accessible Services

9.29 As community forensic services develop they will need to agree arrangements for their core activities such as the gathering of information, assessment of needs, the assessment and management of risk and the provision of a range of therapies. There are particular needs to develop and maintain psychotherapeutic expertise in the assessment and treatment of these challenging service users. It is recommended that the Regional Forensic Network facilitates co-ordination of these developments, both within Northern Ireland and with other similar services outside the province.

Recommendation

110. The Regional Forensic Network should co-ordinate the development and delivery of community forensic services, including the development of policies, procedures and protocols.

Standard 5. Risk Assessment and Management

9.30 Community forensic services should develop risk assessment and management policies, procedures and protocols that should draw upon best practice and co-ordinate with the arrangements of interconnecting services.

Recommendation

111. The Regional Forensic Network should co-ordinate the development of risk assessment and management policies, procedures and protocols by community forensic services.

Standard 6. Quality Assurance

9.31 Community forensic services must have robust and demonstrable quality assurance mechanisms that involve service users and carers and include setting standards and assessing the quality of services. These should include internal mechanisms such as audit and also external review. Performance standards should include the quality of information-gathering, compliance with values and principles, and capacity to meet the needs of service users and carers, other mental health and learning disability services and Criminal Justice Agencies.

Recommendation

112. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

Standard 7. Mental Health Promotion and Education

9.32 Community forensic services should contribute to wider programmes of mental health promotion and public education.[84]

Recommendation

113. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic services contribute to mental health promotion and public education.

Standard 8. Information, Research and Innovation

9.33 Community forensic services should develop information strategies that include contributing to evidence-gathering, research and innovation. Information Technology should be used where appropriate to enhance service quality and delivery.

Recommendation

114. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

9.34 Staff will require training to ensure a broad range of relevant competencies to meet the needs of service users and carers and to comply with agreed policies, protocols and procedures. There are needs to develop skills in forensic psychotherapy, in offender

therapies and in risk assessment and management. There are also needs for interagency training.

9.35 At the time of writing this Report, shortages of key trained staf have prevented community forensic services from developing to full capacity , thus demonstrating the crucial importance of developing workforce strategies to ensure the recruitment, training and retention of all the necessary staff to support service developments.

Recommendation

115. The DHSSPS must ensure that development and maintenance of community forensic services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

9.36 The development and maintenance of community forensic services requires appropriate funding from the relevant agencies in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

Recommendation

116. The development of community forensic services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

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CHAPTER 10

FORENSIC LEARNING DISABILITY SERVICES

INTRODUCTION

10.1 People with learning disability are among the most vulnerable individuals who come into contact with the Criminal Justice System and the Mental Health and Learning Disability Services. These individuals may experience fundamental dif ficulties in comprehending and communicating effectively with the world around them. Some individuals also present substantial risks of causing serious harm to themselves or to others.

10.2 Despite these vulnerabilities and risks, dedicated forensic services for people with a learning disability in Northern Ireland are very limited and those services that are available are primarily inpatient based.

10.3 Recommendations in relation to forensic services for people with a learning disability have been included in Chapter 3 (Police Stations), Chapter 4 (Bail), Chapter 5 (Courts), Chapter 6 (Prisons) and Chapter 7 (Probation). In addition Chapter 1l (Specific Issues) also relates to forensic service users with a learning disability . The current Chapter relates primarily to the provision of specialist Forensic Learning Disability Inpatient and Community Services. This Chapter should also be read in conjunction with the Equal Lives Report[85] which gives broader recommendations on services for people with a learning disability .

10.4 It is dif ficult to estimate the prevalence of of fending by people with a learning disability with any degree of accuracy. Walker and McCabe (1973)[46] indicated that, as a result of deficits in intelligence and social skills, people with a learning disability are probably more likely to be apprehended by the police than other of fenders. Generally, however, studies show large variations in rates depending on inclusion criteria, types of assessment, sample type, study design and methodology . Additionally it is not clear whether people with learning disability are over or under represented in the of fender population, or indeed if offending is more prevalent among people with a learning disability than in the general population (Davy, 1993[47]; Simpson and Hogg, 2001[48]).

INPATIENT SERVICES

INTRODUCTION

10.5 Recent research (Slevin et al, 2005[49]) conducted in Northern Ireland has shown that up to 65% of admissions to a learning disability hospital had been attributable to some form of severe challenging behaviour. Whilst not all this behaviour would be classified as offending behaviour a significant proportion is likely to fall into this category.

CURRENT SERVICES

10.6 Northern Ireland is served by 3 learning disability hospitals. The Northern & Eastern Health and Social Services Board areas are served by Muckamore Abbey Hospital, the

Southern Board by Longstone Hospital and the Western Board by Lakeview Hospital. Muckamore Abbey Hospital provides an inpatient forensic service mainly to the Eastern and Northern Boards, although historically it also has a regional inpatient function of admitting patients who are subject to Part III of the Mental Health (Northern Ireland) Order 1986[11]. However, there are currently marked difficulties in obtaining places at Muckamore Abbey Hospital due to a lack of rehabilitation services and supporting community services that would promote the return of service users to the community . This situation is highly unsatisfactory as it results in some service users being denied admission to the service they require and other service users being kept in hospital and unduly restricted longer than their condition requires.

10.7 A 19 bed dedicated inpatient forensic unit will open at Muckamore Abbey Hospital in 2006. The unit will provide medium and low secure services. Currently there are no low secure beds on the other learning disability hospital sites.

10.8 Service users with learning disability who require treatment in conditions of high security are transferred to the State Hospital, Carstairs, although there are currently unacceptable delays in the transfer of unsentenced prisoners (see Chapters 6 and 8).

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

10.9 The development and delivery of comprehensive forensic learning disability services requires contributions from many sources including service users and carers, commissioners and providers of services, representatives from forensic and interconnecting mental health and learning disability services and from Criminal Justice Agencies and both the statutory and non-statutory sectors, and also representatives from the wider community . A shared strategic and proactive approach must be adopted that ensures that needs for high, medium and low levels of security are met by the provision of a range of services. It is recommended that services are co-ordinated by the Regional Forensic Network and the Learning Disability Implementation Group. These bodies should co-ordinate with other forensic services outside of the province such as the Scottish Forensic Mental Health Services Managed Care Network and with the State Hospital, Carstairs.

Recommendation

117. The Regional Forensic Network should lead the development of forensic learning disability services in Northern Ireland, in co-ordination with the Learning Disability Implementation Group. Forensic Learning Disability Services should link with forensic services outside the province, including the State Hospital Carstairs and the Scottish Forensic Mental Health Services Managed Care Network. Co-ordinated services must be planned and developed to meet the short, medium and longer term needs of service users at high, medium and low levels of security.

Standard 2. Evidence, Principles and Purposes

10.10 It is essential that all service users have access to assessment, treatment and care in conditions of high, medium or low security as their condition requires. At present, however, there are restrictions on the transfer of certain patients from Northern Ireland to conditions of high security (see Chapters 6 and 8). Similarly the lack of rehabilitation and "step down" services results in service users staying for longer periods in conditions of higher security than their clinical condition requires. A needs assessment and service mapping should be commissioned to examine the requirements for secure provision for forensic service users with learning disability . The results of this exercise should lead to the construction of a plan for a comprehensive range of forensic learning disability services at high, medium and low levels of security for service users with short, medium and longer term needs. The plan should take account of both current and future needs and should allow for the placement of service users in the most appropriate facility in accordance with their need, rather than being constrained or delayed by the lack of available places. Rehabilitation of service users will also require the provision of a range of community facilities including day care services.

Recommendations

118. The needs assessment and service mapping exercise advocated at 8.28 and 9.17 should include a detailed assessment of the needs for forensic learning disability services. This should lead to the development of a comprehensive plan and the development of a full range of inpatient and community forensic learning disability facilities and services. The Review advocates the provision of additional high and medium security services for people with learning disability in the proposed new unit (Recommendation 83). There is also a need for local low security services and community forensic learning disability services.

119. The forensic learning disability services in Northern Ireland are currently so patently inadequate that their initial development does not need to await the completion of a needs assessment exercise. A regional forensic learning disability service should be developed immediately which supports the further development of 5 localised and regionally co-ordinated teams.

Standard 3. Organisational Structures and Interconnections

10.11 The secure inpatient services at Carstairs and Muckamore Abbey Hospital must co-ordinate closely with other inpatient learning disability services, with community forensic learning disability services, with mental health services and with the prisons, probation and other components of the Criminal Justice System. There are particular needs to identify prisoners who are suf fering from learning disability and who require transfer to inpatient facilities. At present there are substantial obstacles to the transfer of prisoners with learning disability to inpatient facilities. Uncertainty about the meaning of the term "severe mental handicap" under the Mental Health (Northern Ireland) Order 1986[11] has led to service providers in Scotland becoming reluctant to accept service users from Northern Ireland in case they cannot be returned at a later date. The lack of step-down facilities to support secure inpatient services in Northern Ireland has led to places becoming unavailable to other service users in acute need, including individuals who are inappropriately placed in prison.

Recommendations

120. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer of people who require assessment, treatment and care in forensic learning disability inpatient services.

121. The DHSSPS must address the current obstacles to service users with learning disability receiving inpatient care, including uncertainty over the definition of the term "severe mental handicap" and the lack of step-down services at low security and in the community.

Standard 4. Comprehensive and Accessible Services

10.12 Forensic services for people with learning disability should assess the full range of biological, psychological and social needs and should provide services to meet those needs in accordance with best practice. There are particular needs to develop psychotherapeutic approaches. Services should be developed and delivered in a manner that promotes openness and good communication between all relevant people, while respecting the rights of the individual for privacy and confidentiality. Appropriate information should be provided to service users and carers. Information sharing protocols and other joint working protocols should be developed between forensic learning disability services, the Criminal Justice System and other mental health and learning disability services.

Recommendation

122. The Regional Forensic Network should promote the development of joint working policies, procedures and protocols between forensic learning disability services and interconnecting mental health and learning disability services and services in the Criminal Justice System.

Standard 5. Risk Assessment and Management

Recommendation

123. The Regional Forensic Network should promote the development by forensic learning disability inpatient services of risk assessment and management polices, procedures and protocols that co-ordinate with mental health services and with the Criminal Justice System (see Chapter 11).

Standard 6. Quality Assurance

10.13 Forensic learning disability inpatient services should develop robust systems to assess performance and assurance quality and clinical governance. One of the criteria used to assess the efficacy of forensic learning disability inpatient services should be their capacity to take service users at short notice, including prisoners in need of assessment, treatment and care. Services should analyse the constraints to the progress of service users and should formulate plans to remove or overcome the obstacles that are identified.

Recommendation

124. The Regional Forensic Network should co-ordinate the development of robust systems to assess performance and assure quality and clinical governance for forensic learning disability inpatient services.

Standard 7. Mental Health Promotion and Education

Recommendation

125. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure forensic learning disability inpatient services to mental health promotion and public education.

Standard 8. Information, Research and Innovation

10.14 Services should develop an ethos of inquiry that promotes information gathering, research and innovation. They should be supported by internal or ganisational structures. Information technology systems should be developed to support service planning and delivery and co-ordination of information sharing.

Recommendations

126. The Regional Forensic Network should co-ordinate the development of information systems and research in forensic learning disability services.

127. The Regional Forensic Network should promote the integration of InformationTechnology systems between forensic learning disability services and interconnecting services to help ensure the effective transfer of information.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

10.15 The development and maintenance of forensic learning disability services must be supported by workforce planning strategies and mechanisms that ensure the recruitment and retention of staf f who are equipped with the appropriate personal qualities and professional qualifications. There must be learning and development arrangements to provide staff with the necessary knowledge, skills, support and opportunities for further learning, professional and personal development. The needs for learning and development include not only staf f working in forensic learning disability services, but other staf f working in interconnecting health and social services and in Criminal Justice Agencies. Forensic learning disability services must co-ordinate with other services to meet their general and specific learning and development needs.

Recommendation

128. The DHSSPS must ensure that development and maintenance of forensic learning disability inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

Recommendation

129. The development and maintenance of forensic learning disability services requires appropriate funding from the relevant sources. Funding should be delivered in accordance with long-term plans that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

COMMUNITY FORENSIC LEARNING DISABILITY SERVICES

CURRENT SERVICES

10.16 At present there are no dedicated forensic services for people with learning disability in the community in Northern Ireland. For those individuals whose needs have been identified and who are currently receiving services, they may receive them from various sources including Community Learning Disability Teams (CLDT's), Behaviour Support Services (BSS), psychology services or from Autistic Spectrum Disorder (ASD) services for adults.

Standard 1. A Co-Ordinated Joint Strategic Approach.

10.17 The development of capacity to meet the needs of service users in the community must include both supporting and building upon capabilities of current services as well as developing and integrating new specialist services. As with other components of forensic services, community forensic learning disability services should be developed in a strategic manner through inclusive partnerships. It is proposed that the Regional Forensic Network, in partnership with the Learning Disability Implementation Group, co-ordinates the planning and development of community forensic learning disability services. Service providers will need to develop and maintain specialist expertise in assessing and providing treatment to forensic service users with learning disability. This will require and, at times, joint working with community forensic service providers.

Recommendation

130. The Regional Forensic Network should liaise with the Learning Disability Implementation Team and take the lead role in promoting the planning and development of community forensic learning disability services.

Standard 2. Evidence, Principles and Purposes

10.18 Community forensic learning disability services should be developed in accordance with the principles advocated by this Review and services should have clear explicit purposes. Service planning must be informed by detailed assessment of need.

Recommendation

131. The proposed needs assessment and service mapping exercise (Chapter 8) should include the gathering of information to guide the further development of community forensic learning disability services, following the initial development of a regional service.

Standard 3. Organisational Structures and Inter-Connections

10.19 Community forensic learning disability services must work closely in co-ordination with all interconnecting services including inpatient services, Criminal Justice Agencies and mental health services. Community forensic learning disability services will need to develop close connections with police stations, courts, prisons, probation and MASRAM. Community forensic services will require a range of suitable accommodation to meet the needs of service users, including:

- 24 hour nurse care;
- hostels; and
- independent community placements.

10.20 Services will also require a range of day care facilities.

10.21 As with community forensic services, it is expected that community forensic learning disability services will adopt a tiered approach. It will be important to agree with all relevant parties the expected workload and capacity of each team.

Recommendation

132. Immediate measures should be taken to create a regional community forensic learning disability service linked to an inpatient assessment and treatment service.This regional service should support the development of 5 locally based and regionally co-ordinated community forensic learning disability teams. These teams must have suf ficient capacity to fulfill the same purposes as those identified for other community forensic services (Chapter 9).

Standard 4. Comprehensive and Accessible Services

10.22 Community forensic learning disability services should co-ordinate with interconnecting services to provide a comprehensive range of timely , accessible and high quality services that assess needs and provide treatment and care for service users and support for their carers with continuity of services for as long as required.

Recommendation

133. Community Forensic Learning Disability Teams must be developed with the necessary staffing levels and range of skills to meet the needs of users and carers. The proposed regional team is likely to require similar staf fing levels and resources to the Community Forensic Teams proposed at Chapter 9, with the addition of access to speech and language therapy services.

Standard 5. Risk Assessment and Management

Recommendation

134. The Regional Forensic Network should ensure that community forensic learning disability services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the arrangements of interconnecting services.

Standard 6. Quality Assurance

Recommendation

135. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic learning disability services and ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

Standard 7. Mental Health Promotion and Education

Recommendation

136. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic learning disability services contribute to mental health promotion and public education.

Standard 8. Information, Research and Innovation

10.23 Community forensic learning disability services should contribute to evidence gathering and promote research and innovation. Information technology should assist the development and delivery of services and should co-ordinate with interconnecting services.

Recommendation

137. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic learning disability services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

10.24 As with other forensic services, community forensic learning disability services require robust recruitment and retention procedures and learning and development systems that ensure the provision of a skilled workforce.

Recommendation

138. The DHSSPS must ensure that development and maintenance of community forensic learning disability services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

Recommendation

139. The development of community forensic learning disability services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

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CHAPTER 11

SPECIFIC ISSUES

INTRODUCTION

11.1 This Chapter examines 5 further issues that have been identified as requiring particular attention in order to promote the development of comprehensive forensic services in Northern Ireland. These are:

(i) The Assessment and Management of Risk;
(ii) Personality Disorder;
(iii) Autistic Spectrum Disorder;
(iv) Services for Women; and
(v) Forensic Psychotherapy.

11.2 It is recognised that potentially a great number of other special groups could be considered, such as Forensic Service Users with eating disorders, acquired brain injury , deafness or adult Attention Deficit and Hyperactivity Disorder. Ultimately each forensic service user is an individual with unique needs. Thus the Review has recommended a flexible model of services that is built upon assessing the needs of each individual service user and his or her carers and then providing services to address those needs. As forensic services are developed and new scientific discoveries are made, there will be a continuing need to review services to ensure they properly meet the needs of individual and groups of service users and carers.

THE ASSESSMENT AND MANAGEMENT OF RISK

1) Introduction - Developments in Forensic Services and Criminal Justice

11.3 The assessment and management of risk is one of the central activities of forensic mental health and learning disability services and of the Criminal Justice System. In Northern Ireland and other parts of the United Kingdom there have recently been important developments in Criminal Justice in relation to the management of risks posed by violent and sexual offenders. These developments in Criminal Justice extend beyond the remit of the Review , which is concerned with making recommendations in relation to people suffering from mental disorder, but they are relevant to the assessment and management of some mentally disordered offenders and also to the development of interagency practices at the interfaces between criminal justice and health and social services agencies.

i) Multi-Agency Public Protection Arrangements (MAPPA)

11.4 In England and Wales, the Criminal Justice and Court Services Act (2000)[50] established the Multi-Agency Public Protection Arrangements (MAPP A) which were re-enacted and strengthened by the Criminal Justice Act (2003)[51]. These require the police, prison and probation services to work together to assess and manage the risks posed by sexual and violent offenders. Multi-Agency Protection Panels (MAPPs) have 4 main functions:

- identification of mappa offenders;
- sharing of relevant information;
- assessment of risk of serious harm; and
- management of risk of serious harm.

ii) Multi-agency Procedures for the Assessment and Management of Sex Offenders (MASRAM)

11.5 In Northern Ireland Multi-agency Procedures for the Assessment and Management of Sex Offenders (MASRAM) were launched in 2001. At present MASRAM is an interagency response to sex of fending that comprises four core agencies – the Police Service, the Probation Board, the Prison Service and Social Services. It is an administrative arrangement and does not have a statutory basis. The Criminal Justice Inspection (Northern Ireland) reviewed MASRAM (2005)[52] and recommended that it should be placed on a statutory footing with guidance to underpin its activity , that its remit should be extended to include violent offenders and that it should organise its activities to target those posing the highest levels of risk. The report also recommended that the process for discharging restricted hospital patients should incorporate a thorough criminal justice risk assessment and plan for appropriate post-discharge support.

iii) Review of the Sentencing Framework in Northern Ireland

11.6 The Northern Ireland Office has published a consultation document on the Review of the Sentencing Framework (2005)[53]. Options discussed include wider use of compulsory supervision following custody, a discretionary release to ensure that dangerous of fenders are not released until their risk is such that they can be safely supervised in the community and mechanisms to ensure that a released of fender can be rapidly recalled to prison if he either causes harm or evidences the likelihood that he will cause harm.

iv) Life Sentence Review Commission

11.7 In Northern Ireland, the Life Sentence Review Commission is an independent judicial body which considers the release of life sentence prisoners once the tarif f period is completed. Prisoners must satisfy the panel that it is no longer necessary for the protection of the public from serious harm that he or she is confined. It must be established that the risk of the prisoner committing serious harm if released on licence is no more than minimal. The panel may make recommendations about licence conditions attached to the prisoner's release.

v) Risk Management Authority (RMA) and Order for Lifelong Restriction (OLR)

11.8 In Scotland there is no equivalent of MASRAM or MAPPA. The Report of the Committee on Serious Violent and Sexual Offenders chaired by Lord MacLean[54] made a series of recommendations in relation to the assessment and management of 'high risk of fenders'. These included the establishment of a Risk Management Authority (RMA) and the introduction of a Risk Assessment Order that enables a formal risk assessment to be

conducted after conviction and before sentencing. A new sentence, the Order for Lifelong Restriction (OLR) may be imposed on certain of fenders who are assessed as presenting a substantial and continuing risk to the public. Such of fenders are supervised and managed in accordance with a Risk Management Plan.

11.9 The RMA was established by the Criminal Justice (Scotland) Act 2003[55]. The remit of the RMA includes:

- developing policy and carrying out research into the risk assessment and risk management of offenders whose liberty presents a risk to the public at lar ge;
- setting standards for and issuing guidance to those involved in the assessment and management of risk; and
- accrediting practitioners and risk management plans and monitoring risk management plans for those offenders who receive an OLR sentence from the High Court.

2) Some Concepts in Relation to the Assessment and Management of Risk in Mentally Disordered Offenders

11.10 Forensic services are concerned with mentally disordered offenders and others with similar needs. Service users pose risks of harm to themselves and others that will vary in nature and degree at different times and in different circumstances. Service providers must ensure that arrangements are put in place to identify and respond appropriately to these risks. These responses must also take into account the mental capacity of the individual and his or her responsibility and rights to self-determination.

11.11 The varying risks posed by forensic service users must be placed within the broader context of the risks posed by many other individuals in our society . There must be consistent approaches across society that identify and respond to risk, but do not discriminate unjustifiably against those suffering from mental disorder.

11.12 Risk assessment and management procedures must be evidence based and fully acknowledge the considerable limitations of current risk prediction methods. The failure to correctly predict harm ("false negative" prediction) results in missed opportunities to prevent harm if the prediction methods had been more accurate. The prediction of harm when, in fact, it would not have occurred ("false positive" prediction) can result in service users being unnecessarily restricted, for example, by being kept in hospital for longer than required[56]. Such false positive predictions may also incur unnecessary and substantial public financial expenditure.

11.13 There are dangers that a 'culture of blame' will lead to an unwarranted preoccupation with risk that discriminates those with mental disorder and makes service providers reluctant to take even small risks. The concepts of risk taking and risk appetite are of fundamental importance. HM Treasury (2004)[57] has stated:

"The resources available for managing risk are finite and so the aim is to achieve an optimum response, prioritised in accordance with an evaluation of the risks. Some amount of risk taking is necessary – the only way to avoid risk is to do nothing at all which is guaranteed to ensure that nothing is achieved. The amount of risk which is judged to be tolerable and justifiable is the "risk appetite".

11.14 The risk appetite of our society will be a significant influence on the overall size of developing forensic services. A relatively small risk appetite could result in the development of large forensic services, high financial costs for society and high personal costs for service users who will be subject to greater restriction and deprivation of liberty. A relatively large risk appetite would result in substantially lower public expense, service users would be rehabilitated more quickly and they would be subject to less restriction. There may be some increase in incidents of harm, although the small contribution of mental illness to the overall levels of offending indicates that the total number of such incidents is likely to be small.

11.15 Increasingly adverse incidents have come to be viewed as the outcome of a number of influencing and causal factors within systems of care. Rather than automatically blaming or scapegoating the individual service provider who last had contact with the perpetrator before an incident was committed, approaches such as root cause analysis attempt to identify and improve underlying systemic factors such as service organisation and workload, training, policies and procedures. Robust quality assurance and clinical governance mechanisms must be developed that take a proactive and systemic approach to risk assessment and management and that incorporate learning from incidents and "near-miss" events.

3) Approaches to Risk Assessment and Management

i) The Care Programme Approach and Discharge Guidance

11.16 Systematic approaches to risk assessment and management have been adopted in England and Wales and in Scotland through the Care Programme Approach[58] and the Enhanced Care Programme Approach[44]. Essentially these processes bring together the relevant parties (users, carers and service providers) at Care Programme meetings to agree the identified needs and risks and to develop co-ordinated care plans and risk management plans. The outcome of these meetings is documented and circulated to all relevant parties to ensure that there is clarity in relation to the roles, responsibilities and actions to be taken to support the treatment and care of the service user.

11.17 In Northern Ireland, the Department of Health and Social Services introduced guidance entitled "Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others". The guidance was introduced in 1996 and revised in 2004[20]. The guidance seeks to improve standards of care and has similarities to the Care Programme Approach. Although the guidance has a number of commendable features concerns have been raised that it does not adequately respect the autonomy of individual service users, that it stigmatizes those with mental disorder, that it places unrealistic expectations on

service providers and that it places liability on service providers for the actions of some people who are mentally competent to take responsibility for themselves. Unlike the Care Programme Approach, it has been introduced without additional resources or training to support implementation.

ii) Clinical Practice

11.18 In practice forensic services in the rest of the United Kingdom and elsewhere have developed risk assessment and management procedures and protocols that include:

- information gathering;
- information sharing;
- risk evaluation; and
- risk management plans.

11.19 Procedures often include the systematic use of risk assessment tools that combine actuarial and clinical features and are relevant to the context of the service user. Psychodynamic assessments also assist in understanding the individual and his or her characteristic patterns of thoughts, feelings and behaviours.

4) Discussion

The Assessment and Management of High Risk Offenders

11.20 Recent developments within the Criminal Justice System have supported an interagency approach to the assessment and management of risk of violent or sexual of fending. This Review seeks to promote interagency co-operation at the interfaces between Criminal Justice and Mental Health and Learning Disability Services. The Review also supports approaches to risk assessment and management in the Criminal Justice System that are applied equitably across the population and do not discriminate unjustifiably against those suffering from mental disorder.

11.21 The Review supports the development of a risk assessment and management framework to help of fenders reduce their risks of of fending and to protect the public from high risk offenders while restricting the freedoms of such individuals no more than is necessary in the public interest. This risk assessment and management framework should apply to all offenders who pose the prescribed level of risk and irrespective of whether these individuals suffer from mental disorder such as mental illness, severe learning disability or personality disorder, or whether there is no such mental disorder.

11.22 Such a framework is likely to interface with the work of other bodies such as MASRAM, the Life Sentence Review Commission, the proposed Parole Board and, in relation to Restriction Order patients, the Northern Ireland Office and the Mental Health Review Tribunal.

11.23 These issues relate to many areas of the Criminal Justice System and encompass many individuals who do not suffer from mental disorder. Thus they extend substantially beyond the remit of this Review . Similarly , although the Criminal Justice Inspectorate made helpful recommendations in respect of many aspects of the assessment and management of the risks posed by of fenders, the remit of its inspection of the MASRAM process did not include the full range of issues identified by this Review . Likewise the Review of Sentencing Framework has considered some issues such as sentencing options for dangerous offenders, but these have not been integrated into a comprehensive framework for Northern Ireland. This Review recommends that these elements are drawn together by another body which comprises the relevant stakeholders and considers the range of options and measures required to produce a comprehensive interagency and community response to help of fenders reduce their risks of of fending and to provide protection to the public from high risk sexual and violent of fenders.

11.24 The Review supports the creation of a service, run jointly by the Criminal Justice System and the HPSS the assessment and management of high risk of fenders. It envisages a joint co-operative response to of fenders that assesses the needs of each individual, his or her carers and also takes account of the needs of the public for protection. The Review recognises that in order to reduce the risk to the public to acceptable levels there may be a requirement for some offenders to be treated, managed or placed in specialised institutional settings. The Review envisages a range of services including a high secure facility, one of more facilities at lower levels of security and also services in the community . Of fenders would be admitted to such facilities not primarily on the basis of mental disorder, but rather because of the risk they pose to public safety. These services would be similar to the pilot therapy programmes that have been developed for high risk of fenders in England.

Recommendation

140. The DHSSPS and the Northern Ireland Of fice and relevant Criminal Justice Agencies should produce a comprehensive interagency and community response to help of fenders reduce their risks of offending and to provide protection to the public from high risk sexual and violent offenders, irrespective of whether or not they suffer from mental disorder. This Risk Assessment and Management Framework should include:

- the legislative framework, including options to provide courts with risk assessments such as a risk assessment order and sentencing options such as an order for lifelong restriction;
- processes, methods and standards of risk assessment, risk management and offender therapy programmes;
- interagency strategies and working arrangements, including information sharing and other joint protocols and procedures;
- development of best practice, guidance and quality assurance mechanisms;
- training in risk assessment, risk management and offender therapy methods;
- accreditation of practitioners;
- the services required for the assessment and management of risk and the provision of of fender therapies, including specialist facilities in conditions of security and in the community;
- the development of research strategies and methods of research and evaluation; and
- assessment of the workforce requirements and the provision of appropriate workforce planning and funding to meet the identified needs.

The Assessment and Management of Mentally Disordered Offenders

11.25 Forensic Mental Health and Learning Disability Services in Northern Ireland should develop standardised risk assessment and procedures and management protocols in relation to:

- information gathering;
- information sharing;
- risk evaluation; and
- risk management plans.

11.26 These should be co-ordinated by the Regional Forensic Network and integrate with the proposed Risk Assessment and Management Framework and with local clinical governance arrangements. They must recognise what can reasonably be achieved within the resources available and set standards that are monitored.

Recommendations

141. The Regional Forensic Network should ensure that all inpatient and community forensic services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the Risk Assessment and Management Framework.

142. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for risk assessment and management by forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external review.

143. The DHSSPS should revise current Discharge Guidance to ensure that it is compatible with the principles recommended by this Review and is supported by training and other appropriate resources.

PERSONALITY DISORDER

Introduction

11.27 Personality disorder is a major source of suffering for individuals and those in contact with them. It is also perhaps the most controversial, emotive and poorly understood issue at the interface between the Criminal Justice System and the Health and Social Services. The recommendations in this section interlink with those contained in many other parts of this Report but, it was considered fundamentally important to focus specifically on the issue of personality disorder in order to promote a positive and coherent vision for the future development of services, based on a partnership approach.

Definitions

11.28 The World Health Organization (WHO) (1992)[59] has defined personality disorder as:

> *"Deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual of a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance".*

11.29 The WHO (1992)[59] has classified specific personality disorders into:

- Paranoid;
- Schizoid;
- Dissocial;
- Emotionally unstable – impulsive type;
- Emotionally unstable – borderline type;
- Histrionic;
- Anxious (avoidant);
- Anankastic;
- Dependent; and
- Others.

11.30 The majority of specific personality disorders are not related to an increased likelihood of offending. Rates of personality disorder are high among certain groups of offenders, for example Singleton (1998)[60] found that 78% of male remand prisoners had personality disorder.

11.31 Mental illness is diagnosed on a separate axis or dimension from personality disorder. There is no objective measure of personality disorder and no clearly defined cut-off between normal and abnormal personality. An individual can be diagnosed as suffering from several personality disorders. Combinations of diagnoses are not uncommon in forensic practice, for example an individual may be diagnosed as suffering from schizophrenia, dissocial personality disorder and alcohol dependence syndrome.

11.32 In order to make a diagnosis of personality disorder a detailed process of assessment is required that considers the account and presentation of the individual and also generally additional information from other sources, for example, family members, health and social services and Criminal Justices Agencies. Structured and standardised psychological assessment may aid the diagnostic process. Personality disorder should not be diagnosed on the basis of specific behavioural problems alone, but rather there must be detailed consideration of the individual's characteristic patterns of perceiving, thinking, feeling and relating to others. In current clinical practice in Northern Ireland a lack of standardised approaches to the diagnosis of personality disorder means that the diagnosis may be made

without adequate information or the diagnosis may be missed, for example when personality disorder is present in addition to other mental disorders such as mental illness or substance misuse.

11.33 It is generally considered that personality disorder is caused by a combination and interaction of genetic propensities and adverse early experiences such as abuse and neglect. Adverse experiences in adult life may also contribute to personality deterioration. Personality disorders are by definition deeply ingrained, enduring and stable and thus they are not readily amenable to change. It is, therefore, important that research is commissioned into understanding how personality disorders develop and the most effective ways of preventing them. Forensic Services should contribute to those efforts.

11.34 In Scotland the Committee on Serious Violent and Sexual Offenders[54] noted that there are many types of personality disorder , the majority of which are not related to an increased likelihood of offending. The Committee emphasised the importance of the identification and management of high risk offenders, whether personality disordered or not.

The Committee stated that:

"Present understanding does not support compulsory hospitalisation and medical treatment for severe anti-social personality disorder."

11.35 In many respects the concept of personality disorder has limited utility . The term is so broad and the different types of personality disorder may have such different manifestations that the term "personality disorder" by itself conveys little meaning. It is often more appropriate to take a problem-orientated approach, in other words, an approach that seeks to identify and modify specific behaviours or behavioural deficiencies rather than attempting to change the whole personality of the individual. Such an approach also generally reflects the wishes of service users who tend to present to services complaining of specific problems or difficulties rather than "personality disorder".

Current Services

11.36 There are no specific services for forensic service users in Northern Ireland that are dedicated to the assessment and treatment of personality disorder - there are no residential facilities such as therapeutic communities, special prison units or secure hospital units, nor are there dedicated services in the community.

11.37 Thompson and colleagues[34] have described the current situation in Scotland where "At the present time it is routine psychiatric practice in Scotland **not** to admit individuals with a primary diagnosis of personality disorder to forensic psychiatric units". Although personality disorder is specifically included in the Mental Health (Care and Treatment) (Scotland) Act 2003[37], detention under that Act requires that an individual has significantly impaired ability to make decisions about treatment. Generally people with a primary diagnosis of personality disorder are considered not to have such impairment and thus they are not considered detainable for treatment under the Scottish mental health legislation. Although community forensic mental health service provision is rudimentary in most parts

of Scotland, most forensic psychiatrists have a small cohort of outpatients with a primary diagnosis of personality disorder.

11.38 In England personality disorder has been rejected as a diagnosis of exclusion [61] and there has been substantial financial investment in forensic services for people suf fering from personality disorder.

11.39 The pilot schemes in England are being closely evaluated[34]. These include:

- the development of pilot inpatient and community forensic personality disorder services;
- the development of pilot units to treat people with "Dangerous and Severe Personality Disorder" - 2 units in prison and 2 units in high security hospitals; and
- the continuing use of HMP Grendon as a therapeutic community for prisoners with challenging behaviours within the prison service.

STANDARDS

Standard 1. A Co-Ordinated Joint Strategic Approach

11.40 The Review recommends a combined approach by the Criminal Justice System and Health and Social Services to the assessment and management of of fenders who suf fer from personality disorder. This approach must recognise the huge morbidity associated with personality disorder and the legitimate wishes of those with personality disorder and their carers to have access to assessment and treatment services.

11.41 People with personality disorder who are subject to the Criminal Justice System should not be excluded on the basis of that diagnosis from assessment or from receiving clinically appropriate therapeutic interventions by mental health and learning disability services. Similarly people with personality disorder who are subject to the Criminal Justice System should not be excluded from Criminal Justice Services, nor should assessment and management of their problems and needs be regarded as the sole responsibility of mental health and learning disability services.

11.42 The approach should ensure that the unique contributions of forensic mental health and learning disability services are utilized in assessment and treatment. The Criminal Justice System must also accept its major role in the management of of fenders with personality disorder as these individuals are almost invariably considered to have criminal responsibility for their actions.

Recommendation

144. The DHSSPS and NIPS must ensure that services are developed for people with personality disorder , including of fenders. The services require co-ordinated joint approaches by both the Criminal Justice System and the Health and Social Services. Service users, carers and their advocates must be involved in service planning and delivery.

Standard 2. Evidence, Principles and Purposes

11.43 The Review urges an explicit ethical basis to the assessment, treatment and care of people suffering from personality disorder . Evidence based services should be of fered to individuals who wish to avail of them, whether or not they are subject to the Criminal Justice System. The Review does not consider it is ethical for mental health legislation to be used to enforce compulsory treatment on individuals who are mentally competent to refuse it.

11.44 The issue of personality disorder should not be confused with the issue of of fenders who are at high risk of committing serious violent or sexual of fences. The Review recognises the wishes of society to receive protection from high risk of fenders and it has supported the development of a comprehensive interagency and community response, irrespective of whether or not such high risk of fenders suffer from mental disorder . Society should not discriminate unjustifiably against those who suf fer from mental disorder , for example, it should not introduce compulsory powers against high risk of fenders who suf fer from mental disorder that are more restrictive than the powers against offenders who pose an equally high level of risk, but do not suffer from mental disorder.

Standard 3 and Standard 4. Organisational Structures and Interconnections and Comprehensive Accessible Services

11.45 The Review envisages the provision of the following services for Northern Ireland:

In the community:

- residential therapeutic community facilities for forensic service users in Northern Ireland;
- day patient and outpatient services provided by each community forensic service; and
- input from each community forensic service into offender therapy programmes led by probation.

In the prisons:

- day patient and outpatient services provided in by prison forensic services; and
- input from prison forensic mental health and learning disability services to the assessment and management of prisoners attending the of fender therapy programmes.

11.46 In addition consideration should be given to the development of a secure service for the management of prisoners whose personality disorder makes them unmanageable in an ordinary prison environment and those who would benefit from management in a therapeutic community. It is proposed that the Criminal Justice System and the Health and Social Services would jointly develop this service. It would offer detailed interagency and multi-disciplinary assessment, including:

- history of the individuals' life experiences;
- needs;
- mental state;
- psychological assessment;
- functional assessment;
- medical diagnoses;
- mental capacity; and
- risk assessment.

11.47 The service would require clear criteria for admission and discharge that would be subject to appeal. The service should offer a therapeutic ethos, including evidence-based therapies that are linked to research on therapeutic efficacy. The service should not offer perverse incentives to prisoners to behave in a disturbed manner with a view to securing admission to a more favourable service than the ordinary prison environment. The service would require one or more new facilities, both at high security and at lower levels of security with linkages to community services. The Review has noted the probable need for additional secure provision and this proposed new service for offenders may form a component of this additional provision. The service would need to be linked to a robust risk management framework operate according to explicit standards and be open to external inspection. The service would require high levels of psychotherapeutic input combined with high levels of training and support for staff.

11.48 At present there is not sufficient information on needs to make detailed recommendations on the size of these services.

Recommendations

145. The DHSSPS should ensure that assessment and treatment services are made available to offenders suffering from personality disorder along with support for their carers. Services should be provided in prisons and in the community . Services in the community should comprise outpatient, day patient and therapeutic community services. In the prisons outpatient and day patient services should be provided. A residential secure service should also be developed.

146. The DHSSPS should commission a detailed assessment of needs to inform the planning of services for offenders with personality disorder.

Standard 5. Risk Assessment and Management

11.49 It will be essential to support the development of these services by explicit policies on risk and responsibility. Within the current 'culture of blame'[62] guidance from the DHSSPS places responsibility on mental health and learning disability services for the actions of individuals who are mentally competent to make decisions for themselves. These obstacles to service delivery must be removed. Risk assessment and management arrangements for mentally disordered offenders should co-ordinate with those for other offenders and must not discriminate unjustifiably against those suffering from mental disorder. Also policies, procedures and protocols should be developed to take account of the needs to preserve medical confidentiality and to share information.

Recommendation

147. Service providers must ensure that services for the assessment and management of personality disorder are supported by the development of policies, procedures and protocols that recognise the respective responsibilities of all key stakeholders and that co-ordinate with the proposed Risk Assessment and Management Framework.

Standard 6. Quality Assurance

11.50 Forensic services must have robust and demonstrable quality assurance and governance mechanisms that include setting standards and assessing the quality of services. These should include internal mechanisms such as audit and also external review.

Recommendation

148. The commissioners and providers of services for offenders with personality disorder must ensure that services have strong quality assurance and governance arrangements including internal audit and independent external inspection and review.

Standard 7. Mental Health Promotion and Education

Recommendation

149. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that forensic services for people with personality disorder contribute to mental health promotion and public education, including contributing to understanding of the development of personality disorders and the most effective ways of preventing them.

Standard 8. Information, Research and Innovation

Recommendations

150. The Regional Forensic Network should promote the development of information and research strategies for forensic services for people with personality disorder . Research should be conducted into the needs of of fenders with personality disorder and into the efficacy of therapeutic interventions.

151. The Regional Forensic Network should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

Recommendation

152. The DHSSPS must ensure that robust workforce planning systems are developed to ensure the recruitment, training support and retention of suitable staff to support the development of services for offenders with personality disorder.

Standard 10. Sustainable and Transparent Funding

Recommendation

153. The development and maintenance of forensic services for the assessment and treatment of high risk of fenders and individuals suf fering from severe personality disorder requires appropriate funding from the relevant agencies. This should be delivered in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

OFFENDING BY ADULTS WITH ASPERGER'S SYNDROME OR HIGH FUNCTIONING AUTISM (AS/HFA)

INTRODUCTION

11.51 Current trends in prevalence[63] confirm an increase in the number of individuals in the general population receiving a diagnosis of an ASD, including Asperger's Syndrome or High Functioning Autism (AS/HFA). Recommendations for services for these individuals are contained in the Strategic Framework for Adult Mental Health Services[83]. Professionals in forensic services are increasingly likely to encounter individuals with AS/HFA. There is a need to increase our understanding of the relationship between AS/HFA and offending and to improve the identification and assessment of such individuals and their management within the Criminal Justice and Health and Social Services Systems.

Prevalence of AS/HFA within Forensic Services

11.52 While the majority of persons with AS/HFA are scrupulously law abiding[64], a small subset does come into contact with the legal system. Those with AS/HFA may behave in socially deviant and destructive ways with consequent police involvement. Due to poor diagnostic expertise in many countries, it is not clear how commonly violent and potentially criminal behaviour occurs by people with AS/HFA. Kohn et al (1998)[65] suggested that the prevalence of aggression in the population of AS/HFA persons is around 20% with many cases not being reported to police authorities.

11.53 A study of 135 young of fenders assessed by the Forensic Psychiatry Department in Stockholm[66] found 30% with probable AS/HFA and a strong association with arson. Scragg and Shah (1994)[67] screened the entire population of Broadmoor Hospital, finding a rate for AS/HFA of 2.3% In 1999 the National Autistic Society[68] screened 1305 patients (96% of the total population) in three Special Hospitals in England and identified 31 cases (2.4%).

There were a further 31 'equivocal' cases who displayed some features of AS/HFA, but for whom the screening process was insufficient to be definitive and they would have required a full diagnostic evaluation to obtain a certain diagnosis. Wing (2003)[69] also reported 2.4 – 5.3% prevalence in a Special Hospital population, with over half of these having a co-morbid diagnosis of schizophrenia. The prevalence of adults with AS/HFA within the prison system or detained under the mental health legislation is unknown, as is the prevalence of females with AS/HFA involved with forensic services.

11.54 In a local community service for adults with AS or HFA, 18% of the individuals had been involved with the police and/or court services for of fences including stalking behaviour , sexual offences, theft, fire setting and anti-social behaviour[70]. Of the Trust's sample, 25% of individuals known to the service had been detained in a psychiatric hospital under the Mental Health (Northern Ireland) Order 1986 at some time. Out of the 6 individuals with a forensic history, 5 had been admitted, 2 of who were formally detained - but not necessarily as a direct result of their offending behaviour. None had received a prison sentence.

Relationship between AS/HFA and Offending

11.55 Direct relationships between the of fending behaviour and the clinical features of the disorder have been identified, particularly deficits in social relatedness or rigidity in thought and behaviour[71]. Case reports have noted connections between of fending behaviour and core impairments of AS/HFA including:

- deficient empathy and consequent failure to recognise the impact of behaviours on others;
- problems with social understanding such as reacting negatively to actual or perceived rejection and bullying;
- an over sensitivity to sensory stimuli leading to a violent reaction;
- having a rigid interpretation of rules; and
- an obsessional pursuit or interest.

11.56 Also highlighted by Wing (1997)[72] is the social naivety and lack of common sense often seen in individuals with AS/HFA, which can make them easy targets for being manipulated by others with criminal intentions and malice. Such conspicuous interpersonal idiosyncrasies make those with AS/HFA particularly vulnerable to victimisation[73].

11.57 Murrie et al (2002)[74] observed that those with AS/HFA may have little or no experience with alcohol or drugs, little previous criminal contact and may be quick to confess to the police. They stated that this last aspect reflected a variety of traits from deficient shame, poor judgement, lack of experience, or an impaired appreciation of the social and legal consequences of a confession, to simple forthrightness, rule-abiding behaviour or honesty.

11.58 Murrie et al (2002)[74] emphasised the need for full assessment of AS/HFA and its legal implications so that courts could make properly informed decisions on issues such as treatment and disposal.

Need for Services

11.59 Although in the minority of people diagnosed with AS/HFA, those who are within the forensic system "represent a highly unique population with specialised needs"[75].

11.60 The Reed Report (1992)[76] devoted a volume to the special needs of mentally disordered offenders with AS/HFA and the services required to meet those needs. The Scottish Executive Development Centre for Mental Health (2004)[77] has published an extensive document on the needs of people with Learning Disabilities and/or Autistic Spectrum Disorders in secure, forensic and other specialist settings. Recommendations common to both were that:

11.61 Agencies should take account of the specialised and varying needs of of fenders with autism, including the importance of co-operation between dif ferent services:

- such agencies should train their staf f to recognise and, where possible, respond to the special challenges presented by people with autistic disorders; and
- research is required into meet the needs of autistic people who of fend or have severe behavioural problems.

11.62 The National Autistic Society[78] made a series of recommendations including:

- changes to definitions in mental health legislation;
- early assessment of cases suspected of having an autistic spectrum disorder where the police have arrested an individual;
- a code of practice or guidelines on evidence-based intervention, including medication, for individuals with autistic spectrum disorders; and
- the introduction of an enforceable legal right to an independent advocate for all patients formally and informally detained.

11.63 There are substantial deficiencies in the provision of Forensic Services for individuals with autistic spectrum disorders in Northern Ireland. This reflects the low levels of forensic services and also the shortfall in the provision of adequate and appropriate services for adults with AS/HFA in the general population[79]. There is only a limited number of specialised units in the UK.

11.64 There should be individual assessment of the needs of forensic service users with AS/HFA and their carers, followed by combining the available resources in a flexible manner to address those needs. Those resources are likely to include staff with appropriate expertise in Forensic Services and in assessing and managing AS/HFA. Good communication, co-ordination and co-operation between service providers is essential.

Recommendations

154. The Regional Forensic Network should co-ordinate a programme of training for staff in the identification, assessment, treatment and care of people suffering from Asperger's Syndrome or High Functioning Autism (AS/HFA) in Forensic Mental Health and Learning Disability Services and the Criminal Justice System.

155. The DHSSPS in partnership with Criminal Justice Agencies should commission a regional needs assessment to ascertain the prevalence of AS/HFA within the Criminal Justice and Forensic Services in Northern Ireland and to assess the needs of users and carers.

156. The DHSSPS should promote research into AS/HFA, including its relationship with offending behaviour, the effectiveness of specific psychological and environmental interventions, the development of models of service models and the definition of acceptable outcomes.

SERVICES FOR WOMEN

11.65 The Criminal Justice System and mental health and learning disability services must be gender sensitive and recognise the specific needs of both male and female service users. People who are subject to the Criminal Justice System and the users of forensic mental health and learning disability services are predominantly male and thus there are particular dangers that the specific needs of women are not adequately addressed.

11.66 The Department of Health in England reviewed many issues relating to women's mental health[80]. As regards women offenders it was noted that:

- men commit more crime than women; less than 5% of the prison population are women;
- men start their criminal careers at an earlier age than women and are more likely than women to have lengthy criminal careers;
- women are more likely than men to commit acquisitive offences and are less likely to commit arson, violent or sexual offences;
- women are more likely than men to say that financial hardship, particularly in relation to their children, contributed to their crime;
- there has been a recent dramatic rise in the number of women in prison compared to men; and
- women in prison have experience of high levels of violence and abuse as children and as adults.

11.67 Women prisoners are:

- twice as likely as men to have received help for a mental/emotional problem in the 12 months before entering prison;
- less likely than men to receive a diagnosis of antisocial personality disorder and more likely to receive a diagnosis of borderline personality disorder;

- more likely to have severe mental illness;
- twice as likely as men to have symptoms associated with post-traumatic stress disorder; and
- more likely than men to have a history of self harm.

11.68 The Department recommended that the following principles should apply across all service settings:

- access to a same sex member of staff;
- access to a female doctor for physical healthcare;
- physical examinations to be undertaken by a female member of staff or with a female chaperone present;
- a female member of staff present if restraint is used;
- access to women-only therapy groups, particularly for issues such as violence and abuse;
- access to women-only social activities; and
- acknowledgement of caring responsibilities, for example through provision of childcare facilities, transport and flexible appointment times.

11.69 It also advocated the provision of single-sex forensic units, predominantly at medium and low security. In addition it recommended training for mental health practitioners on gender-related issues.

11.70 In England, a number of separate women's secure services have been developed. In Scotland it has been proposed that comprehensive Forensic Psychiatry Services forWomen should be provided in each of the 4 regional groupings that would meet all the treatment needs of women service users. These services would comprise dedicated multi-disciplinary teams with access to secure beds and easy progression to non-secure inpatient facilities or community services.

11.71 In Northern Ireland, there are no dedicated forensic mental health and learning disability services for women. The transfer of female prisoners from Mourne House, Maghaberry to Ash House at Hydebank Wood in June 2004 has been criticised [81]. An inspection of facilities at Ash House in November 2004 led to recommendations for a policy and strategic plan for the treatment of women in custody based on a full assessment of their specific needs. A separate prison was recommended for women in Northern Ireland and also the development of separate policies specific to women, the provision of therapeutic responses to self-harm and increased constructive activity. McClelland and colleagues (2005)[13] praised improvements in the services for women in Ash House. A full health needs assessment of the women in Ash House was completed in 2005.

11.72 At the time of writing this Report there are not known to be any women from Northern Ireland who are receiving treatment in high secure inpatient facilities, either in Northern Ireland or in other parts of the UK. Shannon Clinic provides accommodation that may be

used by women and is partly separate from the facilities used by men, but with access to shared activities and rehabilitation facilities. There are no separate community forensic mental health and learning disability services for women.

DISCUSSION

11.73 The Criminal Justice System and mental health and learning disability services must be gender sensitive and recognise the specific needs and preferences of both male and female service users.

11.74 Several facilities for female forensic service users from Northern Ireland provide substantial or significant separation from male service users – the prison, Carstairs and Shannon Clinic.

11.75 There is a need to work closely with female service users and their advocates and carers to gain greater understanding of their needs and preferences and to develop and deliver services that are sensitive to and that respect these needs and wishes. It is particularly important to be clear about the reasons to either separate or integrate male and female service users. For example, much of the therapeutic work to address the ef fects of sexual abuse and trauma may be better carried out in a single sex environment. In other situations an integrated environment may facilitate work on social skills. Policies on these issues should be developed in all forensic services.

11.76 The relatively small numbers of women forensic service users may limit the range of facilities that can realistically be made available locally . In other regions it has been suggested that services should be combined, for example, at low and medium levels of security. There may also be benefit in providing services jointly with other service providers, for example, with Scotland or the Republic of Ireland.

11.77 Women forensic service users from Northern Ireland can generally receive assessment and treatment in a single sex environment in Carstairs and in the prisons. Shannon Clinic of ers a degree of separation, combined with opportunities for integration. The assessment of the future needs for secure provision may well indicate that a separate low secure facility is more appropriate to the needs of women service users.

11.78 The Review has considered the provision of a separate community forensic service for women service users. Current needs would probably require a regional service to meet the needs of women service users. The Review considers that the individual needs of service users, both male and female, should be met by local community forensic services and that all such services should be gender sensitive.

11.79 Training should be provided for all staff in Forensic Services to ensure gender sensitivity.

Recommendations

157. Service commissioners and providers must ensure that services are gender sensitive. Planning and development of forensic services must take account of the needs and wishes of service users, their advocates and carers.

158. The Regional Forensic Network should co-ordinate the development of gender sensitive policies in all forensic services.

159. The proposed assessment of needs for secure provision (Chapter 8) should consider options to meet the needs of service users in a manner that is gender sensitive. This should include consideration of whether a separate low secure facility is more appropriate to the needs of women service users than the current provision in Shannon Clinic.

160. Community services should be provided individually to male and female users on the basis of individual needs and must be gender sensitive.

161. Service providers must ensure that staff in all Forensic Services receive training to ensure that services are gender sensitive.

FORENSIC PSYCHOTHERAPY

11.80 In order to provide comprehensive assessment, treatment and care, Forensic Services should take account of biological, psychological and social factors. Psychotherapy Services are particularly poorly developed at present and require specific consideration because of their fundamental importance in understanding and responding appropriately to the problems and needs of service users and their carers. There is a need to develop knowledge and skills in many areas of psychotherapy such as group analytic, family , systemic and individual psychoanalytical and cognitive behavioural approaches. Knowledge of the following should be developed:

- understanding the need for psychotherapeutic intervention as an important element in the treatment of psychosis and chronic mental disorders, including personality disorder, particularly where service users are in an institution or receiving other treatment and care for a long period of time;
- developing an understanding of the nature of personality disorder , particularly when there is a history of antisocial and criminal activity;
- awareness of the importance of personality disorder in service users with a diagnosis of major mental illness who have committed criminal acts;
- developing an understanding of the ef fects of psychopathology on abnormal and criminal behaviours, particularly aggression and sexual violence;
- understanding of group and institutional processes and the dynamics of the institutions involved in forensic settings including prisons and secure inpatient facilities;
- recognition of the personal impact of working with forensic service users and thus moderating the potential for a negative impact on clinical practice, management and multi-disciplinary working;
- recognition of the impact of of fending and abusive experiences on service users, their victims and the institutions in which they are housed;
- understanding of criminological issues, including ethnicity, gender and culture; and
- aiding risk assessment and management by understanding the meaning of criminal activity to service users.

11.81 Forensic Psychotherapists require a wide range of skills including the following:

- expertise in assessment for Psychotherapy;
- expertise in one or more branches of Psychotherapy and knowledge of other branches of Psychotherapy, including the indications and contraindications in order to match therapy to the needs of service users;
- expertise in the use of security as part of treatment;
- understanding of the nature of risk and dangerousness and risk management, including appropriate communication with professional colleagues;
- expertise in the rehabilitation of service users who present potential risk to others;
- the ability to formulate problems from a systemic and or ganisational viewpoint, including understanding the effect of particular behaviours and teams and systems;
- expertise in clinical supervision;
- ability to evaluate the outcome of therapies; and
- the ability to formulate and communicate opinions clearly.

11.82 The Review recommends development of a range of multi-disciplinary therapeutic services that are integrated within Forensic Services. All staff working in Forensic Services should aim to develop high levels of knowledge and skill. They should be supported by specialist practitioners who have developed further knowledge and skills of psychotherapeutic practices and they should have strong links with psychotherapy departments.

11.83 Psychotherapeutic services should be provided to a broad range of forensic settings including high, medium and low secure inpatient facilities, prisons, community and outpatient facilities including therapeutic communities, hostels and community offender programmes.

11.84 Chapter 6 has noted the need for the DHSSPS to take the lead, in partnership with Criminal Justice Agencies to form a multi -agency consortium to promote psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour.

Recommendations

162. The DHSSPS, the Regional Forensic Network, service commissioners and providers must ensure that planning and development of all inpatient and community mental health and learning disability forensic services incorporate and integrate a range of multi-disciplinary psychotherapeutic approaches.

163. All clinical staf f working in forensic services must be provided with the appropriate opportunities and support to develop high levels of psychotherapeutic knowledge and skill.

164. The planning and delivery of forensic services must also include the provision of services by specialist Psychotherapists and Forensic Psychotherapists.

165. The DHSSPS must ensure that development and maintenance of forensic mental health and learning disability inpatient and community services is supported by robust workforce planning that takes account of the need to recruit and retain specialist Psychotherapists and Forensic Psychotherapists and to provide supervision, support and training to staff working in forensic services.

CHAPTER 12

IMPLEMENTING CHANGE

CO-ORDINATING DEVELOPMENTS AT REGIONAL AND LOCAL LEVELS – A REGIONAL FORENSIC NETWORK

12.1 Forensic Services in Northern Ireland must be developed to meet the needs of service users and carers at a local level and they must be co-ordinated across the region. The Review does not propose a fully detailed and prescriptive plan, but rather it advocates a process that is dynamic and interactive and which co-ordinates planning and development in an ongoing and strategic manner . It is proposed that Forensic Services should develop through partnerships between a regional co-ordinating group which sets the overall directions, priorities and sequence of change and local groups which implement change and ensure its integration with related services.

12.2 In recent years a number of or ganisational structures referred to as Managed Clinical Networks[82] have been developed to address problems similar to those faced by Forensic Services in Northern Ireland. These networks are regional or national or ganisations that bring together the key stakeholders to work in partnership to promote service development. Examples include the Northern Ireland Cancer Network and the Scottish Forensic Mental Health Services Managed Care Network.

12.3 In Scotland the national development of Forensic Mental Health Services is co-ordinated by a Managed Care Network Advisory Board which is chaired by the Head of the Mental Health Division in the Health Department. The Board comprises representatives from all the key or ganisations and provides dedicated time to its Chief Executive and Lead Clinician. The Advisory Board relates to the State Hospital and 4 regional groups which in turn relate to local services. The Board has commissioned a number of working groups to produce regional guidance and is developing regional multi-agency structures with links to NHS Regional Planning Groups. Thus the Scottish Network is an or ganisation with representation from the key stakeholders and with the capacity to co-ordinate functions at national, regional and local level.

12.4 The Review considers that a Northern Ireland Forensic Services Managed Network would be a logical development to advance the development of Forensic Services in Northern Ireland in accordance with the principles espoused by this Review . This Network would not only link together the developing services in Northern Ireland, but it could also establish useful connections with other developing forensic services in the rest of the United Kingdom, Ireland and further afield. Such external connections could, for example, lead to the sharing of service plans, experiences of service delivery and also staff training and development.

PURPOSES OF THE REGIONAL FORENSIC NETWORK

12.5 It is envisaged that the Forensic Services Managed Network (the Network) would have the following purposes:

> to plan, implement and evaluate the development and delivery of co-ordinated statutory and independent mental health and learning disability services for mentally disordered offenders and those with similar needs and to contribute to the prevention of mental disorder and associated harm.

12.6 It is considered essential that the remit of the Network should not focus narrowly or exclusively on the development and delivery of specialised Forensic Services. Instead it should be explicitly acknowledged that many service users with forensic needs currently have those needs met by a range of interconnecting services in primary and secondary care. There is a need both to support and develop these interconnecting services and at the same time to develop specialised forensic services. The Network should actively pursue both purposes in order to increase the capacity to meet needs and to enhance the quality of the services that are delivered.

THE REGIONAL FORENSIC NETWORK BOARD

12.7 The Network Board (the Board) should have appropriate accountability to Government and authority to resolve conflicts where these arise. The membership of the Board should comprise relevant commissioners and providers of mental health and learning disability services, representatives of service users and carers and associated or ganisations such as the Probation Board, the Police Service, the Prison Service, Housing and the Courts. The Board should include user and carer representation. Consideration should also be given to developing links with other developing forensic services outside Northern Ireland.

12.8 The functions of the Board should include:

- strategic planning;
- promoting and co-ordinating the development of systems to assess need and gather the information and evidence required for service planning;
- promotion of values and principles;
- promotion and development of comprehensive interconnected services;
- overseeing the development of co-ordinated systems of risk assessment and management;
- overseeing the development of quality assurance mechanisms that include setting and auditing standards and assessing the performance and quality of services;
- co-ordinating contributions to mental health promotion and education;
- co-ordinating developments in information systems and promoting research and innovation; advising the DHSSPS on recruitment and retention;

- promoting a co-ordinated approach to learning and development; and
- advising the DHSSPS on funding requirements.

12.9 The Board will require resources such as a Chair and Project Manager to carry out its tasks.

12.10 The Review envisages that the Regional Forensic Network will be part of the regional mental health and learning disability implementation process chaired by a Regional Director. In view of factors such as the specialised nature of the services, the potential high costs of some elements and the need to provide equity , the Review strongly favours the regional commissioning of forensic services.

Recommendations

166. The Review recommends the establishment of a Regional Forensic Network to co-ordinate the planning and delivery of Forensic Services at regional and local levels.

167. Forensic Services should be commissioned on a regional basis.

DEVELOPING CO-ORDINATED FORENSIC SERVICES

12.11 Although this Report has considered in separate chapters the services that should be delivered at different locations, it is essential that services are developed in a co-ordinated manner. Staff must work across locations in a manner that best meets the needs of service users and carers and supports the development of therapeutic relationships and continuity of care. For example, some staf f will work both in inpatient settings and in community services; community forensic teams may provide in-reach forensic services to prisoners including preparation for return to the community and support following dischar ge from prison. As services grow and develop their structures will change, for example, it is proposed that community forensic learning disability services should begin as a regional service and then, following further assessment of needs and as resources become available, services should become more locally based and more closely integrated with other local services. Staf f must work flexibly and co-operatively to support the growth and differentiation of services. At times staf f will need to come together to learn from each other, to share information and resources such as protocols and training.At times there will be a need to pool all the relevant and available expertise, for example, in the assessment and management of particularly problematic or difficult cases. Forensic Services will also need to develop in an open manner , recognising and supporting the invaluable work of many other services in supporting mentally disordered of fenders. Services must share information on service performance and quality and they must not become fragmented or isolated because of the high risks that can develop in those situations. Forensic services should also contribute to wider developments in the HPSS and in the Criminal Justice System.

12.12 Forensic Services in Northern Ireland are at the start-up of a process that will continue to evolve over many years. At this early stage, even though there is a great lack of information about the detailed needs of service users and their carers, there is an obvious and compelling case to urgently provide a number of components of a regional forensic

service, as has been recommended in this Report. These initial developments should not be delayed by procedures to assess the needs, but nor should these initial developments distract from the underlying requirement to assess and monitor need and service performance. Thus the first phase of developing forensic services must include both the initial development of services and the detailed assessment of needs. After this initial phase, further developments must increasingly take account of assessed need and service performance. Services should continue to be developed to meet the needs, however , Forensic Services should not expand indefinitely and unthinkingly . Research must be conducted into the routes whereby individuals become mentally disordered of fenders or forensic service users. Where possible, preventive measures should be introduced that help promote mental health and wellbeing. If our society is to address the challenges posed by mentally disordered of fenders it must invest in the necessary long-term research and preventive strategies.

12.13 Thus the Review envisages an iterative process of development of Forensic Services, driven by assessed need, guided by principles and values, delivering quality-assured services to meet the needs and contributing through research to the reduction of need.

WORKFORCE PLANNING

12.14 The development of Forensic Services must be supported by effective workforce planning. This element is so fundamental to the successful development of services that its importance could hardly be overstated. A Workforce Strategy must be developed for Forensic Services that is similar to and co-ordinated with that for Adult Mental Health Services[83]. The workforce plan must address the recruitment and retention of staf f in Forensic and interconnecting services.

12.15 There must also be learning and development strategies to provide staff with the necessary knowledge and skills. There must be arrangements for the training of new staf f and the continuing professional development of existing staff. The training needs of staff working in Forensic Services and in interconnecting services must be analysed and training strategies devised to meet the needs. Users and carers should also be included in a comprehensive learning and development strategy, both to help in the training of staf f and to meet their own needs. Training should be closely linked to the needs of the developing services. There are particular needs to provide training in psychotherapy and also psychotherapeutic support for staff who are working in this emotionally demanding field. Services should work together co-operatively to share training locally and regionally.

INFORMATION SYSTEMS

12.16 Similarly the Adult Mental Health Services Report[83] has identified the need for comprehensive and integrated information systems. The arrangements for information systems must extend across mental health and learning disability services encompassing Forensic Services and making the necessary links with the Criminal Justice System.

RESEARCH AND DEVELOPMENT

12.17 The development of Forensic Services must be supported by a Research and Development strategy. Priorities include:

- an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high, medium and low security and in community facilities should be commissioned by the DHSSPS. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder and other developmental disorders. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care;

- a detailed assessment of the needs of mentally disordered prisoners and their carers should be commissioned by the joint DHSSPS/NIPS project to transfer responsibility for prison healthcare to the NHS;

- an assessment should also be commissioned to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements;

- NIPS should commission research on the feasibility of reducing the number of people in prison by providing a broader range of facilities in the community , including lower security placements for mentally disordered women;

- research should also be commissioned to evaluate the methodology of assessing people in police stations and prisons with a view to ensuring the accurate identification of specified forms of mental disorder and need;

- epidemiological research should also be conducted into the needs of the population for forensic services;

- Research should also be incorporated into the developing services for of fender therapy and personality disorder; and

- There are a number of clinical conditions that are poorly recognised or understood that require research priority such as AS/HFA and Attention Deficit Hyperactivity Disorder (ADHD) in adulthood.

THE PROCESSES OF CHANGE

12.18 The following outline sequence for the implementation of its recommendations proposes:

YEAR 1

12.19 The Regional Forensic Network should be established and its structures, resources, principles and purposes should be agreed. The Network should develop strategies for workforce planning, information systems and research.

12.20 An ongoing Workforce planning process should be developed for Forensic Services.

12.21 In Year 1 a detailed needs assessment should be commissioned to examine current and projected needs for high, medium and low security inpatient services and community facilities for people suf fering from mental illness, learning disability and personality disorder and other developmental disorders. The results of this needs assessment should inform decisions on the needs for future services such as a high security service, additional medium secure places (particularly for longer stay), the numbers of new low secure places and the number and range of community facilities.

12.22 In addition the DHSSPS should examine the current obstacles to high secure care that are experienced by unsentenced prisoners and certain others and it should decide its strategy to resolve this highly unsatisfactory situation.

12.23 In Year 1 it is expected that responsibility for the healthcare of prisoners will transfer to the NHS. This will require agreement of the organisational structures and the range of services to be provided, and consideration of the assessed needs of prisoners including women and prisoners in healthcare centres.

12.24 A prison mental health promotion group should be established and also a consortium to provide therapies for offenders.

12.25 The Community Forensic Services should be developed further and a regional forensic learning disability service should be initiated.

12.26 Work should commence on developing an interagency framework for the assessment and management of risk.

YEAR 2

12.27 Further needs assessment should be commissioned to establish the needs of the population for Forensic Services. The assessments should also include specific examination of the needs of mentally disordered people in police stations, on bail, at court and on probation and the needs of their carers.

12.28 A strategy should be agreed on the future profile and development of high, medium and low secure provision and related community facilities.

12.29 Proposals should be published on an interagency risk framework.

12.30 Work should begin to develop regional guidance on fitness for interview , fitness to attend court, and to review the appropriate adult scheme.

12.31 The Regional Forensic Network should agree quality standards for mental health and learning disability services to people in the Criminal Justice System and for forensic inpatient and community services.

12.32 Health promotion opportunities should be identified in the Criminal Justice System and for forensic inpatient and community services.

YEAR 3

12.33 Commissioners should use the results of the needs assessments to commission a full range of mental health and learning disability services to people in police stations and also local Community Forensic Learning Disability Teams.

12.34 Five CFT's should be resourced and fully operational.

12.35 A regional strategy should be agreed on the future assessment, treatment and care of people with personality disorder.

12.36 Psychotherapy services should be fully integrated within inpatient and community forensic services.

12.37 The regional body with responsibility for quality assurance should agree quality standards for mental health and learning disability services to people in the Criminal Justice System and for forensic inpatient and community services.

12.38 A health promotion strategy should be agreed and implemented for the Criminal Justice System and for forensic inpatient and community services.

YEAR 5

12.39 Further assessment should be undertaken of the needs of the population for Forensic Services, including examination of the needs of people in the Criminal Justice System and forensic inpatient and community services.

12.40 A comprehensive offender therapy consortium should be in place.

12.41 Regional guidance should be completed.

YEAR 7

12.42 Low secure services should be in place to meet the assessed needs.

YEAR 10

12.43 Further assessment should be undertaken of the needs of the population, including people in the Criminal Justice System and forensic inpatient and community services.

12.44 Additional high secure and medium secure places should be provided to meet the needs.

PERFORMANCE INDICATORS

12.45 The following tables provide further details of the performance indicators, tar gets, milestones, responsibilities and the sources of information that will confirm implementation:

1. Regional Planning and Co-Ordination to Include Service Users and Car ers

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Regional Forensic Network to be established and to include user & carer representatives	Network established User & carer representatives appointed	Year 1 Year 1	DHSSPS	Network structures, values, principles and plans
DHSSPS & NIPS to agree organisational structures in prisons, to include user & carer representatives	Structures agreed User & carer representatives appointed	Year 1 Year 1	Transfer project	DHSSPS & NIPS

2. Assessment and Monitoring of the Needs of Service Users and Car ers

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Assessment of the needs of prisoners, including the needs of carers, women and prisoners in healthcare centres	Information for service planning and funding Information on need and service impact, to aid service planning	Year 1 Repeat at years 5 & 10	NIPS/DHSSPS transfer project	Transfer Project Local Service Providers
Assessment of the needs of people in police stations, on bail, at court and on probation	Information for service planning Information on need and service impact, to aid service planning	Year 2 Repeat at years 5 & 10	DHSSPS	DHSSPS
Assessment of needs for high, medium & low security & community placements for short, medium and long stay for people with mental illness & learning disability	Information for service planning Information on need and service impact, to aid service planning	Year 1 Repeat at years 5 & 10	DHSSPS	DHSSPS
Assessment of needs for secure & community placement for people with personality disorder & other developmental disorders	Information for service planning Information on need and service impact, to aid service planning	Year 2 Repeat at years 5 & 10	DHSSPS	DHSSPS
Service information from Community Forensic Services & Regional Secure Unit	Information for service planning	Annual	Local Service Providers	Local Service Providers

3. Effective Mental Health and Learning Disability Services for People Subject to the Criminal Justice System

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Full range of mental health and learning disability services arranged for prisoners	All services in place before transfer of responsibility in April 2007	Year 1	Transfer project	Information published by Transfer project
Commissioners to commission a full range of mental health & learning disability services to people in police stations, on bail, at court and on probation	Completed following needs assessment	Year 3	DHSSPS	DHSSPS
Service providers to provide a full range of mental health & learning disability services to people in police stations, on bail, at court and on probation	Protocols and services in place to provide access to full range of services	Year 5	Local Service Providers	Local Service Providers
Development of an offender therapy consortium	Basic structure established Resource needs agreed Comprehensive services in place	Year 1 Year 2 Year 5	DHSSPS	DHSSPS
Regional guidance on fitness for interview, fitness to attend court, review of appropriate adult scheme etc	Group(s) formed All work completed	Year 2 Year 5	DHSSPS	Regional guidance issued and appropriate training & resources provided

4. Effective Inpatient and Community Forensic Mental Health and Learning Disability Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Review of options and formulation of strategy for high security provision	High secure services must be available to all people in N Ireland who require them. Follows needs assessment in Year 1	Year 2	DHSSPS	DHSSPS
Strategy for high, medium & low security & community placements for short, medium and long stay for people with mental illness & learning disability	Full range of places must be available to meet needs Strategy follows needs assessment in Year 1 Provision of low secure and community facilities Provision of high security and long stay medium security	Year 2 Year 7 Year 10	DHSSPS	DHSSPS
Development of community forensic teams Initial development Further development	5 fully operational teams Further developments following service information and needs assessment	Year 3 Year 7	DHSSPS	DHSSPS
Development of a regional forensic learning disability service	Regional inpatient and community service	Year 1	DHSSPS	DHSSPS

4. Effective Inpatient and Community Forensic Mental Health and Learning Disability Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Development of local forensic learning disability teams	5 local teams	Year 3	DHSSPS	DHSSPS
Services for people with personality disorder	Needs assessment	Regional strategy	Year 2	Year 3
Psychotherapy services	A full range of psychotherapy services fully integrated within all inpatient & community forensic services	Year 3		

5. Assessing and, Where Possible, Minimising the Risks of Harm that are Associated with Mental Disorder

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
DHSSPS & NIO to develop a risk assessment and management framework	Group constituted Proposals published Framework implemented	Year 1 Year 2 Year 3	DHSSPS	DHSSPS
Inpatient and community forensic services to develop risk assessment and management policies, procedures and protocols	Policies, procedures and protocols in place. Regular updates	Year 1	Regional Forensic Network	Regional Forensic Network

6. Continuing Quality Improvement

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
DHSSPS & NIPS to agree clinical governance and internal quality assurance mechanisms for prisons	Clinical governance and internal quality assurance mechanisms agreed and implemented before transfer	Year 1	Transfer Project	Transfer Project
Clinical governance and internal quality assurance mechanisms to be agreed for inpatient & community forensic services	Clinical governance and internal quality assurance mechanisms agreed	Year 1	Local Service Providers	Local Service Providers
Development of regional standards for mental health and learning disability services to the criminal justice system and for forensic inpatient & community services	Standards agreed Year 2	Regional Forensic Network	Regional Forensic Network	
Regional quality assurance body to develop quality standards for mental health and learning disability services to the criminal justice system and for forensic inpatient & community services	Quality standards agreed	Year 3	RQIA Regulation and Quality Improvement Authority	RQIA Regulation and Quality Improvement Authority

7. Promoting Mental Health

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Establish a regional prison mental health promotion group	Agree and implement strategy before transfer of responsibility	Year 1	Transfer project	Transfer project
Identify opportunities for mental health promotion for people in police stations, on bail, in court and on probation	Assess opportunities Agree and implement strategy	Year 2 Year 3	DHSSPS	DHSSPS
Identify opportunities for mental health promotion for people in inpatient & community forensic services	Assess opportunities Agree and implement strategy	Year 2 Year 3	Regional Forensic Network	Regional Forensic Network

8. Meeting the Information Needs of Service Users, Car ers and Service Providers

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Healthcare information systems to be established in prisons to meet the needs of mentally disordered prisoners	Completed before transfer of responsibility	Year 1	Transfer project	Transfer project
HPSS information systems should extend to people in police stations and courts	Appropriate HPSS information accessible to healthcare staff working in the Criminal Justice System	Year 3	DHSSPS	DHSSPS
Promoting communication with all relevant parties	Forensic inpatient & community services to develop information strategies	Year 2	Regional Forensic Network	Regional Forensic Network
Promoting research	Forensic inpatient & community services to develop research strategies	Year 2	Regional Forensic Network	Regional Forensic Network

9. Delivering an Effective, Competent and Confident Workforce

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
A comprehensive workforce strategy for forensic services	Agreed strategy	Year 1	DHSSPS	DHSSPS
A strategy for workforce recruitment	Strategy implementation targets to be agreed	To be agreed	DHSSPS	DHSSPS
A strategy for training needs analysis and workforce training	Agreed strategy	To be agreed	DHSSPS	DHSSPS
A strategy for training in psychotherapies	Agreed strategy for training in psychotherapies	Year 1	DHSSPS	DHSSPS

Recommendations

1. A Regional Forensic Network should co-ordinate and lead the strategic planning of forensic services in Northern Ireland.

2. Strategic planning must be guided by evidence and by values and principles. The Regional Forensic Network must establish systems of gathering the necessary information and evidence to inform the further development of services.

3. The Regional Forensic Network should establish explicit values and principles to guide the planning and development of forensic services. The values and principles adopted by this Review (see 2.3-2.5) are recommended. In addition the following principles are recommended for forensic services:

   i. there should be joint co-operative planning between the Criminal Justice Agencies and the Health and Personal Social Services and joint delivery of services in order to best meet the needs of service users and carers;

   Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

   ii. as far as possible in the community, rather than in inpatient settings;

   iii. under conditions of security and restriction no greater than as is justified by the degree of danger they present to themselves or others; and

   iv. open, accountable and subject to external review.

4. The planning and development of forensic services should take full account of the 10 Standards identified in this Report.

5. Service commissioners must commission a full range of statutory mental health and learning disability services to meet the needs of mentally disordered people detained in police stations.

6. Providers of statutory , voluntary and community mental health and learning disability services must ensure they provide equity of access and provision of services for people detained in police stations.

7. Mental health and learning disability services to people detained in police stations should be provided locally and co-ordinated regionally . The Department of Health, Social Services and Public Safety (DHSSPS) should lead this co-ordination in liaison with the Regional Forensic Network.

8. Research should be commissioned to assess the needs of mentally disordered people and their carers in police stations throughout Northern Ireland. This research should include recommendations leading to the establishment of systems to monitor ongoing need and the impact of services on need.

9. Advocacy services associated with community mental health and learning disability services should be extended to include police stations.

10. Clear or ganisational structures, accountability and governance arrangements must be agreed for mental health and learning disability services to police stations.

11. Service providers should develop information systems that enable FM0s and staff working in mental health and learning disability services to gain appropriate access to the health records of people detained in police stations.

12. Research should be commissioned to evaluate the methodology of assessing suspects in police stations with a view to ensuring the accurate identification of specified forms of mental disorder and need.

13. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to produce guidance on assessment of fitness for interview and related matters.

14. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising representatives of all the relevant stakeholders to review the appropriate adult scheme. The group should consider the effectiveness, efficiency and practical working of the scheme, including the criteria invoking the use of appropriate adults.

15. Commissioners should commission services for the safe assessment, treatment and care of mentally disordered offenders in police stations.

16. Service providers and other stakeholders should agree joint protocols for the assessment and management of mentally disordered people in police stations, including those whose behaviour is disturbed.

17. Commissioners should commission services that provide police with ready access to advice from suitably qualified health professionals.

18. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in police stations.

19. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services must ensure that quality standards are developed for mental health and learning disability services in police stations and that services are audited and subject to external independent inspection.

20. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion within police stations and ensure that appropriate services are provided and their impact evaluated.

21. The DHSSPS should ensure that research programmes are commissioned to examine the efficacy of different models of services to mentally disordered offenders in police stations with a view to informing further service planning.

22. The DHSSPS should ensure that development of Information Systems within the HPSS takes account of the need to provide health and social services to people in police stations.

23. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including police, FMO's, lawyers and health and social services staff.

24. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

25. The development and maintenance of services for mentally disordered people in police stations across the province requires appropriate funding from the relevant sources. Funding should be delivered in accordance with a long term plan that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

26. The Northern Ireland Prison Service (NIPS) should commission research on the feasibility of reducing the number of mentally disordered people in prison by providing a broader range of facilities in the community . The research should address the mental health and social needs of male and female remand prisoners as well as the requirements of the Criminal Justice System. It should consider the potential utility of facilities with joint input by criminal justice staff and health and social services staff to offer different levels of supervision and therapy for a wide range of mental disorders including mental illness, learning disability, personality disorders and alcohol and substance misuse.

27. Service commissioners should commission a full range of statutory , voluntary and community mental health and learning disability services to meet the needs of mentally disordered people attending courts.

28. Providers of community mental health and learning disability services should ensure they provide equality of access and provision of services for people attending courts.

29. In Year 5, when forensic mental health and learning disability services in Northern Ireland have increased in size and capacity , a detailed option appraisal should be undertaken to consider the provision of assessments and other services for the courts by alternative means, including by service level agreements.

30. The DHSSPS in partnership with Criminal Justice Agencies should establish a group of relevant stakeholders to produce guidance on the assessment of fitness to attend court.

31. Service providers must ensure that healthcare staf f assessing and treating prisoners attending court have ready and appropriate access to existing healthcare information

32. The DHSSPS should establish a group with the Court Service and other relevant stakeholders to review and develop procedures and protocols in relation to mentally disordered offenders to ensure efficient and effective operation.

33. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services should ensure that quality standards are developed for mental health and learning disability services in courts and that services are audited and subject to external independent inspection.

34. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion at courts and ensure that appropriate services are provided and their impact evaluated.

35. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including court staff, lawyers, judiciary and health and social services staf f.

36. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

37. The proposed review of options for mental health and learning disability services to the courts should include consideration of funding mechanisms.

38. Improvement of the mental health of prisoners requires a partnership between the DHSSPS and the NIPS to ensure:

- development of a prison environment that actively promotes mental health and well-being; and
- provision of a comprehensive range of mental health and learning disability services which address the needs of prisoners and are integrated with other community and prison services to ensure ef fective through care.

39. The Review welcomes the decision to transfer responsibility for the healthcare of prisoners to DHSSPS and emphasises that it must be supported by robust quality assurance mechanisms and by sufficient resources to meet the needs.

40. The Review recommends that planning the future of mental health and learning disability services for prisoners is integrated with the planning of mental health and learning disability services throughout Northern Ireland including the joint strategic approach co-ordinated by the Regional Forensic Network.

41. The joint DHSSPS/NIPS project to transfer responsibility must ensure that a detailed assessment of the needs of mentally disordered prisoners and their carers is completed by the end of 2006. The assessment of need must encompass all those suffering from mental disorder including mental illness, learning disability, personality disorder and alcohol and substance misuse. It must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff.

42. The needs assessment must lead to the provision for service commissioners of systems to monitor and evaluate in an ongoing manner the needs of service users and carers and the impact of services on need.

43. The DHSSPS and NIPS in partnership should develop explicit values and principles for mental health and learning disability services and Criminal Justice Services for prisoners that guide the development of a prison environment that actively promotes mental health and well-being and that provides a comprehensive range of mental health and learning disability services.

44. The DHSSPS and NIPS in partnership should agree arrangements to develop strong and cooperative working relationships between prison staff, health and social services staff, and Criminal Justice Agencies at operational and managerial levels. These should include the supporting organisational structures, training and the development of joint policies, protocols and procedures.

45. Commissioners of mental health and learning disability services in prisons must ensure that service users and carers are involved in the development, delivery and monitoring of services.

46. Commissioners of mental health and learning disability services in prisons must ensure that advocacy services and complaints procedures are developed for service users in prisons, building on those already in place.

47. The project overseeing the transfer of lead responsibility must ensure that joint working arrangements with all relevant mental health and learning disability service providers are agreed and published before April 2007. It must be demonstrated that service providers have sufficient resources and capacity to meet the identified needs, including the needs of prisoners and discharged prisoners who are suffering from mental illness, learning disability, personality disorder and alcohol and substance misuse. The arrangements must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff in relation to prisoners and discharged prisoners.

48. The Review supports the recommendations made by Professor McClelland and colleagues (2005) in relation to the assessment, treatment and care of prisoners on committal to prison. The transfer project should ensure that work continues as quickly as possible to address these recommendations and that arrangements are made to complete any outstanding work following transfer of responsibility.

49. Commissioners of mental health and learning disability services for prisoners must ensure that services provide assessment, treatment and care for all people suf fering from mental disorder including those suffering from personality disorder.

50. DHSSPS should take the lead in developing, in partnership with the Criminal Justice Agencies, an inclusive model of assessment, treatment and care of people suf fering from personality disorder.

51. A specific mental health needs assessment should be commissioned as part of the programme of the transfer of lead responsibility to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements. This should be completed by the end of 2006.

52. Services should be commissioned for women prisoners that are gender sensitive and that have the capacity to respond appropriately to the range of their mental health and learning disability needs, including substance misuse and personality disorder.

53. NIPS should commission a research project into alternatives to prison for mentally disordered women, including placements at lower levels of security.

54. A full range of mental health and learning disability services including adolescent, psychotherapy and personality disorder , alcohol and substance misuse should be commissioned. Community service providers must ensure that a full range of co-ordinated services is developed and provided to those who are under the age of 18, and DHSSPS must play its part in ensuring adequate provision of the necessary expertise.

55. Service providers must develop protocols and procedures so that management plans are jointly agreed in the case of each adolescent suf fering from mental disorder when transferring to adult prison services or healthcare services in the community.

56. The transfer project team should define requirements and, together with service commissioners and providers, put such arrangements in place before April 2007.

57. People who require admission to hospital for assessment or treatment under the provisions of the mental health legislation must have equal access and priority whether they originate in prison or in the community . The application of this standard in practice should be subject to external audit by the appropriate health care inspection body.

58. The transfer project should ensure that specific joint working arrangements between service providers, the Prison Service and the DHSSPS are agreed and published before April 2007.

59. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in prisons. The framework must not discriminate unjustifiably against people suffering from mental disorder.

60. Mental health and learning disability services and Criminal Justice Agencies should develop joint co-ordinated interagency standards that encompass both the creation of a prison environment that promotes mental health and the provision of a full range of mental health and learning disability services. These standards should be supported by clinical governance arrangements, internal quality assurance mechanisms, external independent inspection and systems of learning from adverse events. NIPS and DHSSPS should jointly set up an effective operational group in 2006.

61. The DHSSPS, involving the body with regional responsibility for mental health promotion, in partnership with NIPS, service providers and representatives of users and carers should establish a Regional Prison Mental Health Promotion group to address mental health promotion and suicide prevention. The group should build upon the existing policy and formulate a strategy that sets explicit standards. It should seek to establish a culture and ethos in the prisons that promotes mental health and well-being for prisoners and staff and that further reduces the risks of suicide. The goal should be for the initial strategy to be implemented by 2007. Work should continue in conjunction with the regional body with responsibility for mental health promotion and should include evaluation of its ef fects.

62. The transfer project should ensure that information systems are established before April 2007 to meet the needs of mentally disordered prisoners. Information systems for prisoners should integrate and evolve with the HPSS systems and should be developed, where appropriate, to integrate with criminal justice systems in support of joint working.

63. The DHSSPS should commission and promote ethically approved research in relation to the needs and services for mentally disordered prisoners, for example research should be undertaken into the needs for healthcare centre places, the transfer of prisoners to Health Service, bail and community step-down facilities, the ef ficacy of of fender management programmes and the efficacy of mental health promotion strategies.

64. The DHSSPS must ensure that development and maintenance of services for mentally disordered prisoners are supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

65. Service providers must ensure that learning and development strategies for all staf f are closely linked to service development and to governance arrangements.

66. A multi-agency consortium should be formed in 2006 to promote psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. The lead should be taken by DHSSPS with input from criminal justice agencies and the relevant health sector bodies.

67. The strategic development of mental health and learning disability services for prisoners requires sustainable additional funding. Funding arrangements must support the joint co-ordinated multi-agency planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended tar gets.

68. Strategies should be developed to ensure effective joint working between PBNI and the full range of mental health and learning disability services in relation to the assessment, treatment and care of mentally disordered people who are under going assessment by Probation or are subject to a Probation Order.

69. The Regional Forensic Network should co-ordinate the development of services at the interfaces between PBNI and:

- community forensic mental health and learning disability services;
- prison forensic services; and
- inpatient secure services.

70. The DHSSPS should, in partnership with PBNI, co-ordinate the development of services at the interfaces between PBNI and other mental health services.

71. PBNI, the Regional Forensic Network and the DHSSPS should agree joint arrangements to assess and monitor the needs of mentally disordered individuals, their carers, their representatives, service providers and the wider community . The results of ongoing assessment should inform service planning.

72. PBNI, the Regional Forensic Network and the DHSSPS should agree joint purposes, clear organisational structures and lines of accountability and should develop policies, protocols and procedures for joint working and information sharing.

73. PBNI, the Regional Forensic Network and the DHSSPS should develop comprehensive and accessible joint services to assess and provide treatment and care for mentally disordered people in contact with probation. There are particular needs to develop joint psychotherapeutic approaches.

74. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people undergoing assessment by Probation or subject to a Probation Order.

75. PBNI, the Regional Forensic Network and the DHSSPS should agree standards for joint working. Services should be subject to internal and external evaluation of performance and quality.

76. PBNI and mental health and learning disability services should identify opportunities for mental health promotion and agree appropriate services.

77. Inter-agency learning and development arrangements should be established to support joint working between PBNI and forensic and other mental health and learning disability services.

78. The development of forensic and other mental health and learning disability services to support the work of PBNI requires sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

79. The Regional Forensic Network should promote co-ordination of forensic service provision for the people of Northern Ireland, including with high security services at the State Hospital, Carstairs, Scotland.

80. The current arrangements for high secure services for people in Northern Ireland have unacceptable gaps in service provision. All people in Northern Ireland must have access to high secure services when they require them. The DHSSPS must take the lead in urgently finding solutions to the current obstacles to treatment and care in conditions of high security.

81. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high and medium security . The assessment should include people suf fering from mental illness, severe mental impairment and from personality disorder . It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

82. This assessment of high and medium secure needs should be combined with an assessment of the needs for low secure and step-down community services (Chapter 9) and the needs for forensic learning disability services (Chapter 10).

83. The Review recommends the provision of an additional secure facility in Northern Ireland to meet the identified high and medium secure needs of service users. The regional high and medium secure facilities should be complemented by local low secure facilities and community step-down facilities to form a range of short, medium and longer stay facilities that meet the needs of forensic service users.

84. New secure services should be developed in accordance with the standards proposed by this Review.

85. The Regional Forensic Network should explore the range of opportunities to co-ordinate training for staff in Forensic Mental Health and Learning Disability Services in Northern Ireland with the training available in adjacent jurisdictions.

86. The Regional Forensic Network should promote the development and delivery of regional medium secure services and their co-ordination with interconnecting services.

87. The DHSSPS must take account of the assessment of need for secure services and it must plan and develop long stay medium secure services and step-down low secure and community services

88. In order to inform service planning and development Shannon Clinic staf f should analyse the needs of each service user and the constraints on his or her progress.

89. The Regional Forensic Network should establish systems to monitor ongoing need for high, medium and low secure services and step-down community services for forensic service users with short, medium and longer stay needs. This information should contribute to the planning and delivery of forensic services.

90. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer to hospital of mentally disordered people who require treatment in conditions of medium security .

91. Service providers should develop regional expertise at Shannon Clinic in the assessment and management of risk in relation to service users who require assessment, treatment and care in conditions of medium security.

92. Shannon Clinic should develop explicit quality standards and quality assurance mechanisms, including audit and independent external inspection by the relevant regional body.

93. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure inpatient services to mental health promotion and public education.

94. The Regional Forensic Network should develop information and research strategies and promote the involvement of secure inpatient services.

95. The Regional Forensic Network should promote the integration of InformationTechnology systems between medium secure services and interconnecting services to help ensure the effective transfer of information.

96. The model used by Shannon Clinic of closely integrating training with clinical practice should extended to other forensic services.

97. The DHSSPS must ensure that development and maintenance of secure inpatient services is supported by robust workforce planning and provision of opportunities for staf f to avail of learning, development and support.

98. The development and maintenance of medium secure services requires appropriate funding in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

99. The DHSSPS should ensure the development and delivery of low secure forensic services including step-down rehabilitation and long-stay services.

100. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of low security The assessment should include people suf fering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

101. The needs assessment should consider the optimal configuration of low secure services, including the needs of specific groups such as women.

102. The needs assessment should lead to the development of low secure services that are fit for purpose. This is likely to require substantial new provision.

103. It is recommended that future low secure services, including low secure forensic services are developed in accordance with the standards advocated in Chapter 2.

104. The Regional Forensic Network should lead and co-ordinate the planning and development of community forensic services. It should both support and build upon the capabilities of current services as well as developing and integrating new specialist services.

105. The 5 CFT's that are currently partly staffed and funded require the necessary funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity by 2010. Thereafter teams should be developed in response to need to ensure that they have capacity to fulfill the range of services required by service commissioners and service users.

106. Commissioners must commission a full range of community forensic services with the following purposes:

- assessing local referrals to secure inpatient services;
- supporting the dischar ge of service users from inpatient secure services to the community, facilitating self management, opportunities for employment and engagement in social activities;
- working jointly with other mental health and learning disability services to provide consultation, assessment, and support and, in some cases, shared or sole treatment and care;
- liaison with police stations and courts;
- in-reach to prisons and support of dischar ged prisoners with mental disorder;
- assessments at the request of probation;
- input to offender therapy programmes; and
- supporting the work of the MASRAM or its successor .

107. The CFT' s should produce information on their workload and performance which, combined with needs assessments should help guide the future planning of CFTs including suitable accommodation in the community.

108. Community Forensic Services should develop specific service models and structures and agreed methods of working with interconnecting services.

109. A CFT should comprise a range of staff with the necessary skills to meet the needs of users and carers. The following is considered representative of the skills and funding levels required:

1 Consultant Forensic Psychiatrist
1 Consultant Chartered Forensic Psychologist
1 Forensic Psychologist
1 Psychotherapist
2 Social Workers
1 Occupational Therapist
5 Nurses
2 Administrative Staff
User and carer advocacy services

The composition of CFTs should be adjusted in response to information on need and service performance.

110. The Regional Forensic Network should co-ordinate the development and delivery of community forensic services, including the development of policies, procedures and protocols.

111. The Regional Forensic Network should co-ordinate the development of risk assessment and management policies, procedures and protocols by community forensic services.

112. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

113. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic services contribute to mental health promotion and public education.

114. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

115. The DHSSPS must ensure that development and maintenance of community forensic services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

116. The development of community forensic services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

117. The Regional Forensic Network should lead the development of forensic learning disability services in Northern Ireland, in co-ordination with the Learning Disability Implementation Group. Forensic Learning Disability Services should link with forensic services outside the province, including the State Hospital Carstairs and the Scottish Forensic Mental Health Services Managed Care Network. Co-ordinated services must be planned and developed to meet the short, medium and longer term needs of service users at high, medium and low levels of security.

118. The needs assessment and service mapping exercise advocated at 8.28 and 9.17 should include a detailed assessment of the needs for forensic learning disability services. This should lead to the development of a comprehensive plan and the development of a full range of inpatient and community forensic learning disability facilities and services. The Review advocates the provision of additional high and medium security services for people with learning disability in the proposed new unit (Recommendation 83). There is also a need for local low security services and community forensic learning disability services.

119. The forensic learning disability services in Northern Ireland are currently so patently inadequate that their initial development does not need to await the completion of a needs assessment exercise. A regional forensic learning disability service should be developed immediately which supports the further development of 5 localised and regionally co-ordinated teams.

120. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer of people who require assessment, treatment and care in forensic learning disability inpatient services.

121. The DHSSPS must address the current obstacles to service users with learning disability receiving inpatient care, including uncertainty over the definition of the term "severe mental handicap" and the lack of step-down services at low security and in the community.

122. The Regional Forensic Network should promote the development of joint working policies, procedures and protocols between forensic learning disability services and interconnecting mental health and learning disability services and services in the Criminal Justice System.

123. The Regional Forensic Network should promote the development by forensic learning disability inpatient services of risk assessment and management polices, procedures and protocols that co-ordinate with mental health services and with the Criminal Justice System (see Chapter 11).

124. The Regional Forensic Network should co-ordinate the development of robust systems to assess performance and assure quality and clinical governance for forensic learning disability inpatient services.

125. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure forensic learning disability inpatient services to mental health promotion and public education.

126. The Regional Forensic Network should co-ordinate the development of information systems and research in forensic learning disability services.

127. The Regional Forensic Network should promote the integration of InformationTechnology systems between forensic learning disability services and interconnecting services to help ensure the effective transfer of information.

128. The DHSSPS must ensure that development and maintenance of forensic learning disability inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

129. The development and maintenance of forensic learning disability services requires appropriate funding from the relevant sources. Funding should be delivered in accordance with long-term plans that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

130. The Regional Forensic Network should liaise with the Learning Disability Implementation Team and take the lead role in promoting the planning and development of community forensic learning disability services.

131. The proposed needs assessment and service mapping exercise (Chapter 8) should include the gathering of information to guide the further development of community forensic learning disability services, following the initial development of a regional service.

132. Immediate measures should be taken to create a regional community forensic learning disability service linked to an inpatient assessment and treatment service. This regional service should support the development of 5 locally based and regionally co-ordinated community forensic learning disability teams. These teams must have suf ficient capacity to fulfill the same purposes as those identified for other community forensic services (Chapter 9).

133. Community Forensic Learning Disability Teams must be developed with the necessary staffing levels and range of skills to meet the needs of users and carers. The proposed regional team is likely to require similar staf fing levels and resources to the Community Forensic Teams proposed at Chapter 9, with the addition of access to speech and language therapy services.

134. The Regional Forensic Network should ensure that community forensic learning disability services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the arrangements of interconnecting services.

135. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic learning disability services and

ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

136. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic learning disability services contribute to mental health promotion and public education.

137. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic learning disability services. It should promote the use of information technology to support and enhance multi-disciplinary and inter - agency communication and information-sharing, in accordance with agreed protocols.

138. The DHSSPS must ensure that development and maintenance of community forensic learning disability services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

139. The development of community forensic learning disability services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended tar gets.

140. The DHSSPS and the Northern Ireland Of fice and relevant Criminal Justice Agencies should produce a comprehensive interagency and community response to help of fenders reduce their risks of offending and to provide protection to the public from high risk sexual and violent offenders, irrespective of whether or not they suffer from mental disorder. This Risk Assessment and Management Framework should include:

- the legislative framework, including options to provide courts with risk assessments such as a risk assessment order and sentencing options such as an order for lifelong restriction;
- processes, methods and standards of risk assessment, risk management and offender therapy programmes;
- interagency strategies and working arrangements, including information sharing and other joint protocols and procedures;
- development of best practice, guidance and quality assurance mechanisms;
- training in risk assessment, risk management and offender therapy methods;
- accreditation of practitioners;
- the services required for the assessment and management of risk and the provision of offender therapies, including specialist facilities in conditions of security and in the community;
- the development of research strategies and methods of research and evaluation; and
- assessment of the workforce requirements and the provision of appropriate workforce planning and funding to meet the identified needs.

141. The Regional Forensic Network should ensure that all inpatient and community forensic services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the Risk Assessment and Management Framework.

142. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for risk assessment and management by forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external review.

143. The DHSSPS should revise current Discharge Guidance to ensure that it is compatible with the principles recommended by this Review and is supported by training and other appropriate resources.

144. The DHSSPS and NIPS must ensure that services are developed for people with personality disorder , including of fenders. The services require co-ordinated joint approaches by both the Criminal Justice System and the Health and Social Services. Service users, carers and their advocates must be involved in service planning and delivery

145. The DHSSPS should ensure that assessment and treatment services are made available to offenders suffering from personality disorder along with support for their carers. Services should be provided in prisons and in the community . Services in the community should comprise outpatient, day patient and therapeutic community services. In the prisons outpatient and day patient services should be provided. A residential secure service should also be developed.

146. The DHSSPS should commission a detailed assessment of needs to inform the planning of services for offenders with personality disorder.

147. Service providers must ensure that services for the assessment and management of personality disorder are supported by the development of policies, procedures and protocols that recognise the respective responsibilities of all key stakeholders and that coordinate with the proposed Risk Assessment and Management Framework.

148. The commissioners and providers of services for of fenders with personality disorder must ensure that services have strong quality assurance and governance arrangements including internal audit and independent external inspection and review.

149. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that forensic services for people with personality disorder contribute to mental health promotion and public education, including contributing to understanding of the development of personality disorders and the most effective ways of preventing them.

150. The Regional Forensic Network should promote the development of information and research strategies for forensic services for people with personality disorder . Research should be conducted into the needs of of fenders with personality disorder and into the efficacy of therapeutic interventions.

151. The Regional Forensic Network should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

152. The DHSSPS must ensure that robust workforce planning systems are developed to ensure the recruitment, training support and retention of suitable staff to support the development of services for offenders with personality disorder.

153. The development and maintenance of forensic services for the assessment and treatment of high risk of fenders and individuals suf fering from severe personality disorder requires appropriate funding from the relevant agencies. This should be delivered in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

154. The Regional Forensic Network should co-ordinate a programme of training for staff in the identification, assessment, treatment and care of people suf fering from Asperger's Syndrome or High Functioning Autism (AS/HFA) in Forensic Mental Health and Learning Disability Services and the Criminal Justice System.

155. The DHSSPS in partnership with Criminal Justice Agencies should commission a regional needs assessment to ascertain the prevalence of AS/HFA within the Criminal Justice and Forensic Services in Northern Ireland and to assess the needs of users and carers.

156. The DHSSPS should promote research into AS/HFA, including its relationship with offending behaviour , the ef fectiveness of specific psychological and environmental interventions, the development of models of service models and the definition of acceptable outcomes.

157. Service commissioners and providers must ensure that services are gender sensitive. Planning and development of forensic services must take account of the needs and wishes of service users, their advocates and carers.

158. The Regional Forensic Network should co-ordinate the development of gender sensitive policies in all forensic services.

159. The proposed assessment of needs for secure provision (Chapter 8) should consider options to meet the needs of service users in a manner that is gender sensitive. This should include consideration of whether a separate low secure facility is more appropriate to the needs of women service users than the current provision in Shannon Clinic.

160. Community services should be provided individually to male and female users on the basis of individual needs and must be gender sensitive.

161. Service providers must ensure that staff in all Forensic Services receive training to ensure that services are gender sensitive.

162. The DHSSPS, the Regional Forensic Network, service commissioners and providers must ensure that planning and development of all inpatient and community mental health and learning disability forensic services incorporate and integrate a range of multi-disciplinary psychotherapeutic approaches.

163. All clinical staf f working in forensic services must be provided with the appropriate opportunities and support to develop high levels of psychotherapeutic knowledge and skill.

164. The planning and delivery of forensic services must also include the provision of services by specialist Psychotherapists and Forensic Psychotherapists.

165. The DHSSPS must ensure that development and maintenance of forensic mental health and learning disability inpatient and community services is supported by robust workforce planning that takes account of the need to recruit and retain specialist Psychotherapists and Forensic Psychotherapists and to provide supervision, support and training to staf**f** working in forensic services.

168. The Review recommends the establishment of a Regional Forensic Network to co-ordinate the planning and delivery of Forensic Services at regional and local levels.

169. Forensic Services should be commissioned on a regional basis.

APPENDIX

The Bamford Review of Mental Health and Learning Disability Services (Northern Ireland)

In October 2002, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent review with the following terms of reference:

(i) To carry out an independent review of the ef fectiveness of current policy and service provision relating to mental health and learning disability , and of the Mental Health (Northern Ireland) Order 1986.

(ii) 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 high risk of offending; and
- issues relating to incapacity.

(iii) To make recommendations regarding future policy , strategy , service priorities and legislation to reflect the needs of users and carers.

The Review was structure into a Steering Committee and 10 Expert Working Committees:

- Social Justice and Citizenship;
- Legal Issues;
- Learning Disability;
- Adult Mental Health;
- Mental Health Promotion;
- Child and Adolescent Mental Health;
- Dementia and Mental Health Issues of Older People;
- Alcohol and Substance Misuse;
- Forensic Services; and
- Needs and Resources.

Remit of the Forensic Services Committee

The Forensic Services Committee adopted the following remit:

'To examine the needs and make recommendations for services for mentally disordered adult offenders and those with similar needs including mentally disordered people:

- *In police stations*
- *Attending court*
- *On bail*
- *In prisons and young offenders' centres*
- *In contact with probation services*
- *Requiring specialised forensic services:*
  - *high, medium & low security inpatient settings*
  - *community forensic services, including both statutory and independent services'*

The Methods Adopted by the Forensic Services Committee

The membership of the Forensic Services Committee (the Committee) includes broad representation from service users and carers, the wider community, Criminal Justice Agencies and health and social services in both the statutory and independent sectors.

The members of the Committee met regularly and also consulted with other key stakeholders. The Committee arranged a series of one – day meetings to which there was an open invitation. These meetings examined key issues with the assistance of presentations and discussion from national and international experts. In addition it commissioned a review of the published scientific literature to ensure that its recommendations were evidence-based and it commissioned a survey of stakeholder views. That review of the scientific literature and of stakeholder views has been published separately[1] and its key findings have been incorporated within this report.

The Committee considered and made recommendations on the values and principles that should guide the development and delivery of forensic services. From these it developed standards which it then applied to the current components of forensic services in Northern Ireland. This process helped highlight service needs. The Committee then collated the identified needs and formulated recommendations to remedy them, considering the components of forensic services individually and collectively, as an interconnecting system. The Committee prioritised its recommendations, identifying the key elements for change and the sequences in which such changes should be made. This draft report has been compiled and submitted for public consultation before the Committee report was finalised.

FORENSIC SERVICES WORKING COMMITTEE

Membership:

Convenor: Dr Fred Browne - Consultant Forensic Psychiatrist

- Prof David Bamford - Chair of MH & LD Review & UU
- DS Andrew Bailey - PSNI
- Dr John Farnan - Forensic Medical Officer
- Dr Bill Lockhart – Youth Justice Service
- Dr Colin Milliken - Consultant Psychiatrist
- Brendan Fulton - Probation Board NI
- Cathy McPhillips - SHSSB
- Raymond Kitson – Public Prosecution Service
- Dr Jackie McCall – EHSSB
- George Keatley - Court Service
- Dr Philip McClements – NI Prison Service
- Anne Rafferty - Criminal Justice Policy Division, NIO
- Winston McCartney - Advocate
- Deborah Devaney - Carer
- Dr Ian Bownes - Consultant Forensic Psychiatrist
- Dr Harry Kennedy - Consultant Forensic Psychiatrist
- Dr Geraldine Henry - Consultant Psychiatrist
- Geraldine O'Hare - Probation Board NI
- Rev Trevor Williams
- Maureen Warner - Occupational Therapist
- Emmet Murray – Forensic Psychologist
- Brian Simpson - WHSSB
- DS Andrew Thompson - PSNI
- Dr Ian McMaster - DHSSPS
- David McCrum – Service User
- DI Gary Mullan – PSNI
- Sally Newton – NI Prison Service
- Prof Jackie Bates-Gaston – NI Prison Service
- Noel McKenna – Independent Monitoring Board

GLOSSARY

‘Forensic’, ‘Services’ and ‘Forensic Service Users’

The word ‘*forensic’* is derived from the Latin word ‘*forum*’, meaning ‘the court’ and thus the word ‘*forensic’* means ‘relating to the courts’ or, more widely, ‘relating to the Criminal Justice System’. This report examines the needs of mentally disordered offenders and those with similar needs, such as those who suffer from mental illness or personality disorder and who engage in dangerous, persistently challenging or aggressive behaviour. Forensic Services comprise a range of components, such as services to people in prison, community forensic services and secure inpatient services. In keeping with the other reports from this Review the term ‘service user’ is used in preference to other terms such as ‘patient’ or ‘client’. Within the context of this report ‘service user’ has been used to refer to certain individuals who suffer from mental disorder and who require forensic services to meet their needs. It should be noted that forensic health and social services are not yet well developed in Northern Ireland and that the use of the term ‘service user’ does not necessarily indicate that a forensic service currently exists to adequately meet their needs.

Psychiatric Hospital

The term ‘Psychiatric Hospital’ is used to include hospitals that provide inpatient treatment and care for those suffering from mental illness and from learning disability.

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Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England

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Contents

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Summary

Background

The work in this report was conducted by the Centre for Disability Research at Lancaster University on behalf of Mencap. The aim of the project was to estimate changes in the needs of adults with learning disabilities in England for social care services from 2009 to 2026. Previous estimates have suggested that the extent and pattern of need for social care services for adults with learning disabilities in England is likely to change over the next decade, changes driven by three main factors:

- Decreasing mortality among people with learning disabilities, especially in older age ranges and among children with severe and complex needs;
- The impact of changes in fertility over the past two decades in the general population;
- The ageing of the 'baby boomers', among whom there appears to be an increased incidence of learning disabilities.

It is predicted that these demographic changes will result in a significant increase in the numbers of older people with learning disabilities and young people with complex needs and learning disabilities requiring support. These increases are likely to be associated with even greater changes in demand for support due to a range of factors that will act to reduce the capacity of informal support networks to provide care, networks that have primarily relied on the unpaid labour of women. These include:

- Increases in lone parent families
- Increasing rates of maternal employment
- Increases in the percentage of older people with learning disabilities (whose parents are likely to have died or be very frail)
- Changing expectations among families regarding the person's right to an independent life.

However, the factors that are leading to increased need and demand are operating at a time of decreasing birth rates in the general population. For example, the number of children in England aged below one dropped by 15% from 660,000 in 1991 to 558,000 in 2001. Since 2001 birth rates have begun to increase, with the number of children in England aged below one rising to 620,000 in 2006. While the impact of changes in birth rates will, to an extent, be modified by reductions in child mortality, the number of children currently reaching adulthood is expected to decrease from 2008 to 2018, after which it will begin to rise.

In this report we build on methods we have developed for estimating changes in need for local areas, based on information about current users of adult social care services for people with learning disabilities and possible new entrants into adult social care services transitioning from children's services.

These methods take account of factors influencing the prevalence of learning disabilities in the context of changes in the overall population of young people in England.

The Process

The process of estimating future need involved the following six stages.

1. The number of children with Special Educational Needs (SEN) associated with learning disability in England was ascertained from the Department of Children, School and Families' (DCSF) spring 2008 School Census.
2. These data, adjusted for the effects of mortality, were used to estimate the number of children with Special Educational Needs (SEN) associated with learning disability in England who would reach 18 years of age between 2009 and 2026.
3. We derived upper, middle and lower estimates of the percentage of these children that were likely to become eligible for adult social care services under current Fair Access to Care Services (FACS) eligibility criteria.
4. We used information from the Information Centre for Health and Social Care and information extracted from the Sheffield, Merton, Sutton and Lambeth learning disability case registers to estimate the number and age profile of adults with learning disabilities who were using social care services in 2008.
5. We adjusted the population of current adult service users for the expected effects of mortality over the period 2009-2026.
6. These data were combined with estimated inflows from child services to estimate net changes in need over the period 2009-2026. For each of the three estimates of eligibility (upper, middle, lower) we investigated three approaches to the rationing of adult social care:
    a. Adult social care services would only be available to people with critical or substantial need;
    b. Adult social care services would only be available to people with critical or substantial need and 50% of people with moderate need;
    c. Adult social care services would only be available to people with critical, substantial or moderate need.

Findings: Estimated Change in Overall Need 2009-2026

All scenarios suggest sustained growth in the need for social care services for adults with learning disabilities over the period 2009-2026. Average estimated *annual* increases varied from 1.04% (lower estimate of eligibility, services only provided to new entrants with critical or substantial needs) to 7.94% (upper estimate, services are provided to new entrants with critical, substantial or moderate needs). It is notable that in our previous work, commissioned by the Department of Health, we had estimated an average annual increase of 1.10% between 2001-2011.

However, we believe that rationing access to social care to those with just critical or substantial needs is incompatible with current policy objectives for adult social care services. If these estimates are excluded the average estimated annual increases vary from 3.20% (lower estimate, services provided to 50% of new entrants with moderate needs) to 7.94%. These estimates would involve providing support to between an additional 47,000 (34%) adults (lower estimate) to 113,000 (82%) adults with learning disabilities over the next ten years.

For all estimates the annual rate of growth in need slows from 2009 to 2018/19 at which point it stabilises. However, in our estimates based on providing services to 50% of new entrants with moderate needs the annual rate of growth in need never falls below 1.9% in any given year.

The characteristics of new entrants to adult social care will depend on the assumptions used in the estimates. To give an idea of the potential range, we estimated the severity of learning disability and ethnicity of predicted new entrants to adult social care between 2009 and 2026 for the two most extreme scenarios (lower level estimate with services only provided to people with critical or substantial needs, upper level estimate with services provided to people with critical, substantial or moderate needs).

There was little difference between these two most extreme estimates with regard to the ethnic composition of predicted new entrants into social care. In both estimates over 20% of new entrants to adult social care are expected to belong to British minority ethnic communities.

There was, however, a marked difference between the two most extreme estimates with regard to the severity of intellectual disability. Increasing the estimate of the proportion of people who are likely to be eligible for adult social care services, or reducing rationing has the same effect. Both have the effect that higher level estimates (or estimates with less stringent rationing) include a significantly greater proportion of people with less severe learning disabilities. It is this group of people (people with mild or moderate learning disabilities) who are currently at greatest risk of ‘falling through the net’.

Comments

All scenarios included in our estimation procedures suggested sustained growth in the need for social care services for adults with learning disabilities over the time period 2009-2026. Our estimates that are compatible with current policy objectives for adult social care services suggests that the average estimated annual growth in need will vary from 3.20% (lower estimate, services provided to 50% of new entrants with moderate needs) to 7.94%. These estimates would involve providing support to between an additional 47,000 (34%) adults (lower estimate) to 113,000 (82%) adults with learning disabilities over the next ten years.

These estimates are based on a number of assumptions, some we believe to be highly robust, some less so. The most critical source of uncertainty in the predictions lies in estimating the likely eligibility for social care services for new entrants with mild or moderate learning disabilities. For example, people with mild learning disabilities constitute 85% of the population of young people with learning disabilities. An increase in their estimated eligibility for social care of 1% is associated with a 0.15% increase in annual average growth rates over the period 2009-2026. Most young adults with mild learning disabilities, unless they are parents, are unlikely to have 'critical' or 'substantial' needs due to their learning disability per se. However, people with mild learning disabilities do have much higher rates of mental health problems, have poorer health and are much more likely to live in poverty than their non-disabled peers. It is this combination of mild learning disabilities and additional adversity and/or health problems that is likely to determine eligibility for social care.

It is our opinion that the estimates of eligibility used in these analyses are conservative. Indeed, it is notable that the one consultation response we had that questioned our estimates did so explicitly on our (alleged) under-estimate of the eligibility for social care among young people with mild and moderate learning disabilities. However, there is a pressing need to empirically test the validity of these eligibility estimates in practice.

Background

The work in this report was conducted by the Centre for Disability Research at Lancaster University on behalf of Mencap. The aim of the project was to estimate changes in the needs of adults with learning disabilities in England for social care services from 2009 to 2026.

In 2004 we attempted to derive national estimates of future need for services for adults with learning disabilities by applying age-specific prevalence estimates to general population projections.[1 2] These estimates suggested that the extent and pattern of need for social care services for adults with learning disabilities in England is likely to change over the next decade. These changes will be driven by three main factors:[3]

- Decreasing mortality among people with learning disabilities, especially in older age ranges and among children with severe and complex needs;
- The impact of changes in fertility over the past two decades in the general population;[4]
- The ageing of the 'baby boomers', among whom there appears to be an increased incidence of learning disabilities.

These demographic changes will result in a significant increase in the numbers of older people with learning disabilities and young people with complex needs and learning disabilities requiring support. These increases are likely to be associated with even greater changes in demand for support due to a range of factors that will act to reduce the capacity of informal support networks to provide care, networks that have primarily relied on the unpaid labour of women. These factors include:

- Increases in lone parent families[5]
- Increasing rates of maternal employment[5]
- Increases in the percentage of older people with learning disabilities (whose parents are likely to have died or be very frail)[6 7]
- Changing expectations among families regarding the person's right to an independent life.

However, the factors that are leading to increased need and demand are operating at a time of decreasing birth rates in the general population. For example, the number of children in England aged below one dropped by 15% from 660,000 in 1991 to 558,000 in 2001.[8] Since 2001 birth rates have begun to increase, with the number of children in England aged below one rising to 620,000 in 2006. While the impact of changes in birth rates will, to an extent, be modified by reductions in child mortality,[8] the number of children currently reaching adulthood is expected to decrease from 2008 to 2018, after which it will begin to rise.

In this report we build on methods we have developed for estimating changes in need for local areas, based on information about current users of adult social care services for people with learning disabilities and possible new entrants into adult social care services transitioning from children's services.[9 10]

These methods take account of factors influencing the prevalence of learning disabilities in the context of changes in the overall population of young people in England.

The Process

The process of estimating future need involved the following six stages.

1 The number of children with Special Educational Needs (SEN) associated with learning disability in England was ascertained from the Department of Children, School and Families' (DCSF) spring 2008 School Census.
2 These data, adjusted for the effects of mortality, were used to estimate the number of children with Special Educational Needs (SEN) associated with learning disability in England who would reach 18 years of age between 2009 and 2026.
3 We derived estimates of the percentage of these children that were likely to become eligible for adult social care services under current Fair Access to Care Services (FACS) eligibility criteria.
4 We used information from the Information Centre for Health and Social Care and information extracted from the Sheffield, Merton, Sutton and Lambeth learning disability case registers to estimate the number and age profile of adults with learning disabilities who were using social care services in 2008.
5 We adjusted the population of current adult service users for the expected effects of mortality over the period 2009-2026.
6 These data were combined with estimated inflows from child services to estimate net changes in need over the period 2009-2026.

Further details of the process are given below.

Stage 1: Identifying Children with SEN Associated with Learning Disability

Each school term the DCSF conducts a School Census, collecting data on all children attending school in England.[a] The pupil-level component of the School Census collects information on, among many other things, whether a pupil is recorded as being at the School Action Plus stage of assessment of SEN or has a Statement of SEN. If the pupil meets either of these criteria, information is collected on the primary and (for some children) secondary type of SEN. The SEN categories include four categories that are associated with learning disabilities:

- MLD – Moderate learning difficulties
- SLD – Severe learning difficulties
- PMLD – Profound and multiple learning difficulties
- ASD – Autistic spectrum disorder

The categories MLD, SLD and PMLD refer to *general* learning difficulties (i.e., what would be termed learning disabilities in non-educational settings). They do not include children with *specific* learning difficulties (e.g., dyslexia) who are identified separately in the School Census.

[a] http://www.teachernet.gov.uk/management/ims/datacollections/sc2008/

From the spring 2008 School Census we calculated the number and percentage of children with MLD, SLD, PMLD and ASD across the 6.8 million pupils who were 4-15 years old at the commencement of the school year. We determined these *administrative prevalence rates*[b] separately for each year age group for boys and girls. We excluded children younger than 4 years of age and children older than 15 years of age as presence of SEN associated with learning disabilities is likely to be associated with early school entry and, especially for children with MLD, leaving school at age 16.

As would be expected, administrative prevalence rates of all categories of SEN (but especially MLD) rise with age across the primary school years, primarily due to delays in the identification of SEN and time-lapse between identification and the involvement of external professional staff (a criterion of being placed at School Action Plus). They then drop slightly across secondary school years. It is not possible within these data to distinguish between cohort effects (changes in the prevalence of learning disabilities across children born at different points in time) and time-related effects (changes in prevalence rates among children born in a particular year over time).

In the modelling contained in this report we made the assumption that prevalence rates of SEN associated with learning disability are *constant across different age cohorts of children*. We estimated prevalence rates from the average prevalence rate among children aged 7-15 in the spring 2008 School Census.

The estimates we used were (per 1,000 children):

- 35.8 for MLD
- 4.63 for SLD
- 1.14 for PMLD
- 8.20 for ASD

These estimates are broadly consistent with the findings of epidemiological studies of the prevalence of learning disabilities and ASD among children.[11-16] We were interested in information on the number of children with ASD as, while it is known that approximately 50% of children with ASD also have learning disabilities,[13 14] the combination of ASD and MLD/SLD/PLMD was relatively rarely recorded in the data.

To test the validity of the identification of SEN associated with learning disabilities in these data, we examined the extent to which prevalence varied by gender and social deprivation. All categories of SEN associated with learning disabilities were significantly more common among boys, with girl:boy ratios of 1:1.85 for MLD, 1:1.83 for SLD, 1:1.28 for PMLD and 1:5.73 for ASD. These associations are broadly consistent with the results of previous epidemiological studies. Social deprivation was measured by the Income Deprivation Affecting Children Index (IDACI) from the English Indices of Deprivation 2007.[17] There were significant associations between the prevalence of MLD and to a much lesser extent SLD and the area-based IDACI. There was no significant association between the prevalence of PMLD or ASD and IDACI. Again, these associations are broadly consistent with the results of previous epidemiological studies.

[b] *Administrative* prevalence refers to the percentage of children identified through administrative records (in this case the School Census) with a particular characteristic. Administrative prevalence is influenced by the true or underlying prevalence of a particular condition and the efficiency and reliability of administrative systems in correctly identifying children with that particular characteristic.

In our estimates of the numbers of children with learning disabilities, we included children with recorded SEN of MLD, SLD or PMLD and 50% of children with recorded SEN of ASD (after taking into account the small number of children who had been identified in the data as having ASD and MLD/SLD/PLMD).

We derived estimates of the numbers of children with learning disabilities in each year age band from 0-17 by applying our prevalence estimates to current population projections of children in England.[c] This resulted in the identification of 466,000 children with learning disabilities in England aged under 18 in 2008. A breakdown of the numbers of children by category of SEN is given below in Table 1.

Table 1: Estimated Number of Children (Age Under 18) with Learning Disabilities in England 2008

SEN Category	Total Number	Average per One-Year Age Band
Moderate Learning Difficulties	394,078	21,893
Severe Learning Difficulties	50,896	2,828
Profound Multiple Learning Difficulties	12,567	698

[c] http://www.gad.gov.uk/Demography_Data/Population/2006/england/weng06singyear.xls We used these estimates as they include all children in England including those not covered by the DCSF School Census (e.g., children being educated at home).

Stage 2: Adjusting for Child Mortality

The second stage of the process involved estimating the number of children with learning disabilities in England who would reach 18 years of age between 2011 and 2026. In order to estimate these numbers we adjusted the current cohort of children to take account of cohort attrition as a result of child mortality between the child's current age and age 18.

It has been suggested that mortality rates among people with mild learning disabilities may be similar to those of the general population.[18 19] However, given that children with mild or moderate learning disabilities (equivalent to the SEN category of MLD) are much more likely than other children to live in poverty[20] and that exposure to poverty is associated with increased child mortality,[21] we made a conservative estimate that mortality rates among children with MLD would be 50 per cent higher than those observed among children in the general population of a similar age and gender.[19] Population child mortality rates were taken from the latest data available from the Office for National Statistics.[8]

For children with SLD and children with ASD and learning disabilities we estimated mortality rates on the basis of information extracted from the Sheffield Learning Disability Case Register on child mortality over the last decade.[d] For children with PMLD we estimated annual mortality rates to be 50% higher than the rates estimated for children with SLD.[18]

The estimates we used were (per year per 1,000 children):

- MLD age 5-9 (0.17), age 10-14 (0.20), age 15-18 (0.56)
- SLD and ASD (7.40)
- PMLD (11.10)

Application of these mortality estimates predicted an average of 680-690 deaths per year among the cohort of children with learning disabilities.

[d] http://www.signpostsheffield.org.uk/health/case-register

Stage 3: Estimating the Numbers of Young People Who Are Likely to Become Users of Adult Social Care Services

Not all young people with learning disabilities will become users of social care services for adults. Two factors are particularly important when attempting to estimate the number of likely new entrants into social care services for adults.

- The percentage of potential users with learning disabilities who are likely to meet differing levels of eligibility for adult social care under the current Fair Access to Care Services (FACS) guidance.[22]
- The rationing of access to adult social care services by FACS eligibility criteria.

At present no data are available regarding the percentage of young people with varying degrees of learning disabilities who meet differing levels of eligibility for adult social care under current FACS guidance. As a result, we adopted a consultative approach to deriving estimates.

First, we asked expert organisations (e.g., member organisations of the Learning Disability Coalition, Local Government Association, Association of Directors of Adult Social Services, Information Centre for Health and Social Care, Department of Health, Office for Disability Issues, National Development Team) to provide their best estimate of the percentage of young people with MLD, SLD, PMLD, ASD and learning disabilities who, in their opinion, would meet the criteria for critical, substantial, moderate and low need.

From this response we constructed upper, middle and lower estimates of probable FACS eligibility for the four categories of SEN associated with learning disabilities. We adopted a conservative approach to this task by taking the estimate provided by this exercise as the *upper* estimate. To create the *middle* and *lower* estimates we progressively reduced the proportions of people with MLD, SLD and ASD+LD we estimated would be assessed at higher levels of eligibility to derive middle and lower estimates. We did not reduce the proportion of people with PMLD we estimated would be assessed at higher levels of eligibility as there exists a strong consensus that all people with PMLD have 'critical' needs. The main effect of these adjustments is to reduce the proportion of people with less severe learning disabilities in the predicted population of likely service users.

Finally, we circulated these estimates to the same set of organisations for comment. The comments received suggested that either our estimates appeared reasonable or were too conservative, especially with regard to estimating eligibility among people with less severe learning disabilities.

The estimates used in the subsequent analyses are presented below in Table 2.

Table 2: Estimates of Assessed Level of Eligible Need by SEN Associated with Learning Disabilities					
Upper Estimate					
	Critical	Substantial	Moderate	Low	None
MLD	5%	10%	30%	45%	10%
SLD	30%	70%	0%	0%	0%
PMLD	100%	0%	0%	0%	0%
ASD+LD	30%	40%	20%	10%	0%
Middle Estimate					
	Critical	Substantial	Moderate	Low	None
MLD	3%	5%	25%	57%	10%
SLD	20%	70%	10%	0%	0%
PMLD	100%	0%	0%	0%	0%
ASD+LD	20%	40%	30%	10%	0%
Lower Estimate					
	Critical	Substantial	Moderate	Low	None
MLD	2%	3%	25%	45%	25%
SLD	20%	60%	10%	10%	0%
PMLD	100%	0%	0%	0%	0%
ASD+LD	15%	30%	45%	10%	0%

For each of these three estimates we investigated three approaches to the rationing of adult social care:

1. Adult social care services would only be available to people with critical or substantial need. In 2007-08, 72% of councils were operating this level of rationing.[23] However, significant concerns have been expressed regarding the conflict between this level of rationing and the importance, a policy objective strongly emphasised in *Putting People First*[24], of adopting a more *preventative* approach to social care.[23 25] We believe that such a stringent approach to rationing is incompatible with current policy objectives and, as a result, also include two alternative scenarios.
2. Adult social care services would only be available to people with critical or substantial need and 50% of people with moderate need.
3. Adult social care services would only be available to people with critical, substantial or moderate need.

Stage 4: Estimating Attrition among Current Users of Adult Social Care Services

The most recent information available suggests that, in 2006-7, 137,000 adults with learning disabilities used adult social care services in England. [26] This estimate is lower than the estimate of 187,000 adults with learning disabilities known to health and social care services[27] as not all people known to health and social care services will be actual users of social care services in any given year. The available data does not, however, provide a detailed breakdown of the age profile of the population of current users. To do this we applied an age-profile estimated from data provided to us from the Sheffield, Merton, Sutton and Lambeth learning disabilities case registers,[e] the City of Manchester and the Metropolitan Borough of Stockport.

For this cohort of current users of adult social care services we applied year on year age-specific adjustments for predicted mortality for the period 2009-2026. The mortality estimates used were derived from actual death rates recorded by the Sheffield Case Register (1998-2007), the Sutton and Merton Case Registers (2003-2007) and the Leicestershire Case Register (1993-2005). Data from Sheffield, Merton and Sutton was provided for us by the register managers. Data from Leicestershire were extracted from a published report.[28] These mortality estimates (presented in Table 3) were derived from information covering over 60,000 person-years. For purposes of comparison, death rates (per 1,000) in the general population for 2006 were below 1 in the 20-34 year age range, below 10 in all age groups below 65, rising to 23.2 in the 65-74 age group and 64.7 in the 75-84 age group.[8] The markedly greater death rates among people with learning difficulties apparent in these figures is consistent with that reported in previous research studies.[28]

Table 3: Age-Specific Mortality Estimates

Age Group	20-29	30-39	40-49	50-59	60-69	70-79	80+
Annual mortality rate (per 1,000)	5.07	6.62	8.61	21.38	34.96	70.04	118.59

Stage 5: Estimating Net Changes in Adult User Population

In order to estimate net changes in the population of people with learning disabilities who use adult social care services we combined our estimates of inflows from children's services with our estimates of attrition in the cohort of current service users. Nine estimates were generated by combining the three estimates of likely eligibility (upper, medium, lower) with each of the three scenarios of rationing.

[e] http://www.i-count.org/index.html http://www.signpostsheffield.org.uk/health/case-register

Findings: Estimated Change in Overall Need 2009-2026

Our projection for future need for social care services for adults with learning disabilities in England are presented below in Tables 4-6. Each table presents upper, middle and lower estimates of the number of eligible users under a distinct scenario of service rationing. In each table we present for each year the estimated numbers of eligible adult users of social care services and the annual percentage change from the previous year. Figures 2-4 present the data contained in Tables 4-6 in graphical form.

All scenarios suggest sustained growth in the need for social care services for adults with learning disabilities over the full time period. However, average estimated annual increases vary from 1.04% (lower estimate, services are only provided to new entrants with critical or substantial needs) to 7.94% (upper estimate, services are provided to new entrants with critical, substantial or moderate needs).

As we have stated above, we believe that rationing access to social care to those with just critical or substantial needs is incompatible with current policy objectives. If these estimates are excluded the average estimated annual increases vary from 3.20% (lower estimate, services provided to 50% of new entrants with moderate needs) to 7.94%. These estimates would involve providing support to between an additional 47,000 (34%) adults (lower estimate) to 113,000 (82%) adults with learning disabilities over the next ten years.

Table 4: Services Provided to New Entrants with Critical or Substantial Needs Only

	Estimated Eligible Users: Upper	Estimated Eligible Users: Middle	Estimated Eligible Users: Lower	% Annual Change: Upper	% Annual Change: Middle	% Annual Change: Lower
2009	142,507	140,452	139,339	4.0%	2.5%	1.7%
2010	147,757	143,707	141,514	3.7%	2.3%	1.6%
2011	152,684	146,711	143,479	3.3%	2.1%	1.4%
2012	157,443	149,578	145,325	3.1%	2.0%	1.3%
2013	161,981	152,268	147,018	2.9%	1.8%	1.2%
2014	166,367	154,817	148,579	2.7%	1.7%	1.1%
2015	170,734	157,340	150,109	2.6%	1.6%	1.0%
2016	174,851	159,660	151,464	2.4%	1.5%	0.9%
2017	178,782	161,830	152,689	2.2%	1.4%	0.8%
2018	182,484	163,821	153,763	2.1%	1.2%	0.7%
2019	185,985	165,652	154,701	1.9%	1.1%	0.6%
2020	189,472	167,464	155,617	1.9%	1.1%	0.6%
2021	193,111	169,379	156,612	1.9%	1.1%	0.6%
2022	196,936	171,421	157,702	2.0%	1.2%	0.7%
2023	200,815	173,495	158,814	2.0%	1.2%	0.7%
2024	204,810	175,642	159,979	2.0%	1.2%	0.7%
2025	209,102	178,000	161,309	2.1%	1.3%	0.8%
2026	213,371	180,333	162,614	2.0%	1.3%	0.8%
			Average	3.1%	1.8%	1.0%

Table 5: Services Provided to New Entrants with Critical or Substantial Needs and 50% of New Entrants with Moderate Needs						
	Estimated Eligible Users: Upper	Estimated Eligible Users: Middle	Estimated Eligible Users: Lower	% Annual Change: Upper	% Annual Change: Middle	% Annual Change: Lower
2009	146,187	143,708	142,634	6.7%	4.9%	4.1%
2010	155,014	150,127	148,010	6.0%	4.5%	3.8%
2011	163,390	156,181	153,061	5.4%	4.0%	3.4%
2012	171,549	162,053	157,946	5.0%	3.8%	3.2%
2013	179,412	167,679	162,610	4.6%	3.5%	3.0%
2014	187,105	173,149	167,125	4.3%	3.3%	2.8%
2015	194,798	178,607	171,624	4.1%	3.2%	2.7%
2016	202,158	183,789	175,873	3.8%	2.9%	2.5%
2017	209,269	188,765	179,936	3.5%	2.7%	2.3%
2018	216,067	193,485	183,770	3.2%	2.5%	2.1%
2019	222,591	197,980	187,401	3.0%	2.3%	2.0%
2020	229,114	202,468	191,022	2.9%	2.3%	1.9%
2021	235,883	207,138	194,803	3.0%	2.3%	2.0%
2022	242,948	212,032	198,777	3.0%	2.4%	2.0%
2023	250,112	216,996	202,810	2.9%	2.3%	2.0%
2024	257,469	222,102	206,965	2.9%	2.4%	2.0%
2025	265,288	227,561	211,429	3.0%	2.5%	2.2%
2026	273,089	232,998	215,872	2.9%	2.4%	2.1%
			Average	5.5%	3.9%	3.2%

Table 6: Services Provided to New Entrants with Critical, Substantial or Moderate						
	Estimated Eligible Users: Upper	Estimated Eligible Users: Middle	Estimated Eligible Users: Lower	% Annual Change: Upper	% Annual Change: Middle	% Annual Change: Lower
2009	149,867	146,965	145,929	9.4%	7.3%	6.5%
2010	162,271	156,546	154,506	8.3%	6.5%	5.9%
2011	174,097	165,651	162,643	7.3%	5.8%	5.3%
2012	185,656	174,527	170,567	6.6%	5.4%	4.9%
2013	196,842	183,090	178,202	6.0%	4.9%	4.5%
2014	207,843	191,481	185,671	5.6%	4.6%	4.2%
2015	218,862	199,875	193,140	5.3%	4.4%	4.0%
2016	229,464	207,918	200,282	4.8%	4.0%	3.7%
2017	239,757	215,699	207,182	4.5%	3.7%	3.4%
2018	249,650	223,149	213,776	4.1%	3.5%	3.2%
2019	259,197	230,309	220,101	3.8%	3.2%	3.0%
2020	268,757	237,471	226,427	3.7%	3.1%	2.9%
2021	278,655	244,898	232,994	3.7%	3.1%	2.9%
2022	288,961	252,644	239,851	3.7%	3.2%	2.9%
2023	299,408	260,498	246,806	3.6%	3.1%	2.9%
2024	310,128	268,562	253,951	3.6%	3.1%	2.9%
2025	321,473	277,121	261,548	3.7%	3.2%	3.0%
2026	332,807	285,664	269,129	3.5%	3.1%	2.9%
			Average	7.9%	6.0%	5.4%

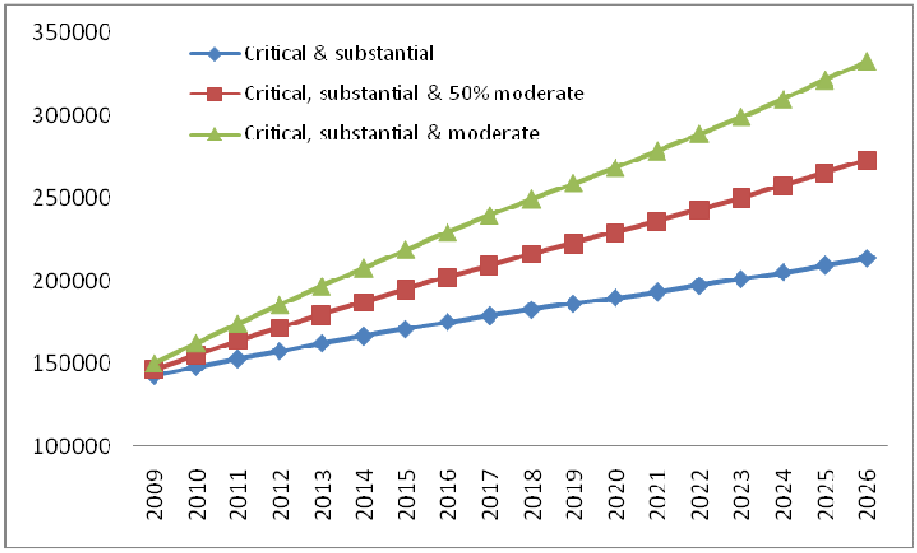

Figure 1: Predicted Need (Upper Estimate) by Level of Rationing

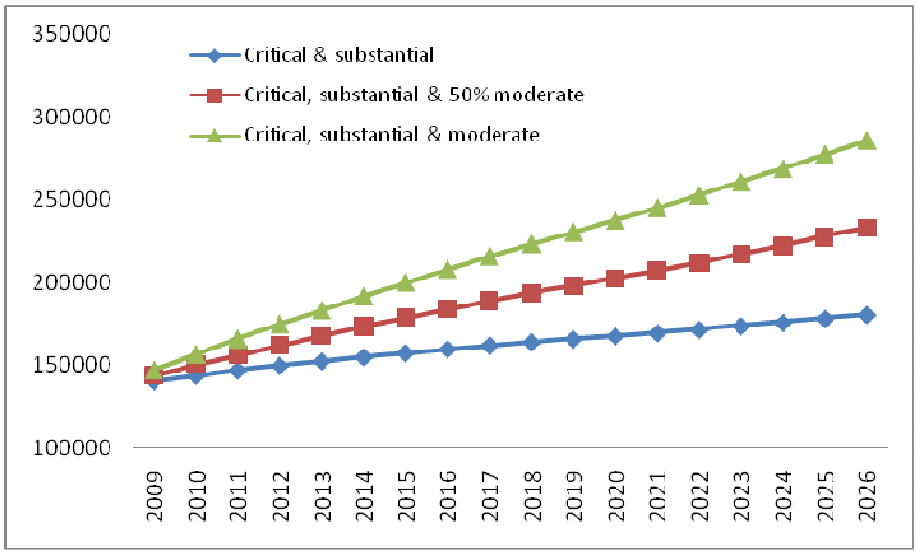

Figure 2: Predicted Need (Middle Estimate) by Level of Rationing

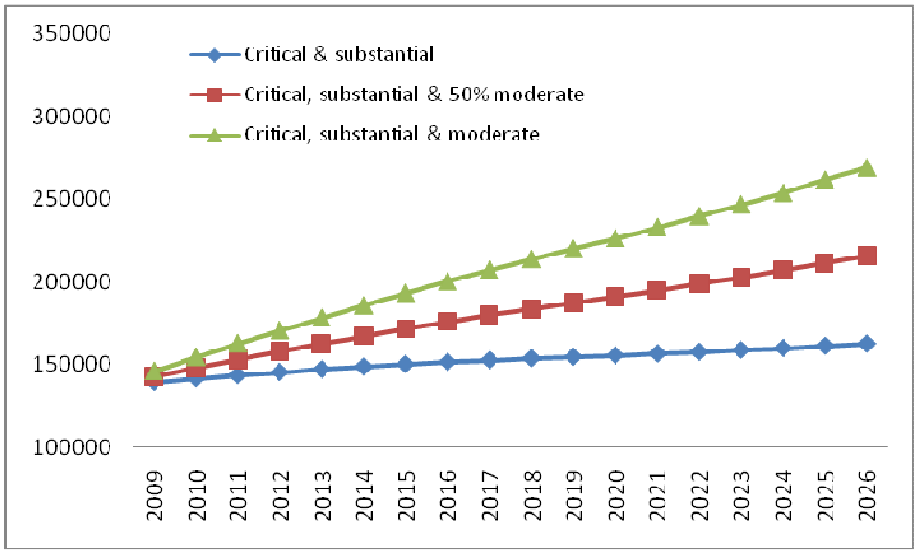

Figure 3: Predicted Need (Lower Estimate) by Level of Rationing

For all estimates the annual percentage growth rate slows from 2009 to 2018/19 at which point it stabilises. This pattern reflects changes in birth rates over the last two decades. The number of live birth in England has declined year on year from 1991 to 2001, since which time it has gradually increased. As a result, the latest population projections for England estimate that the number of children in each one year age band drops systematically from 675,000 children aged 17 years to 557,000 children aged 7 years.[f] This will mean that the total number of children reaching adulthood (and the total number of children with learning disabilities reaching adulthood) will gradually drop over the next decade, after which it will gradually begin to rise.

[f] http://www.gad.gov.uk/Demography_Data/Population/2006/england/weng06singyear.xls

Selected Characteristics of Young People with Learning Disabilities Entering Adult Social Care Services: 2009-2026

The characteristics of new entrants to adult social care will depend on the assumptions used in the estimates. To give an idea of the potential range, a breakdown of the severity of learning disability and ethnicity (as recorded in the School Census) of predicted new entrants to adult social care between 2009 and 2026 is presented in Table 7 for the two most extreme scenarios (lower level estimate with services only provided to people with critical or substantial needs, upper level estimate with services provided to people with critical, substantial or moderate needs).

Table 7: Severity Of Learning Disability And Ethnicity Of Predicted New Entrants To Adult Social Care Between 2009 And 2026

	Lower estimate, services only provided to people with critical or substantial needs	Upper estimate, services provided to people with critical, substantial or moderate needs
Severity of Learning Disability		
Mild/Moderate	27.0%	73.6%
Severe	55.8%	21.1%
Profound Multiple	17.2%	5.2%
Ethnic Group		
African	3.2%	2.8%
Caribbean	1.7%	1.9%
Other Black Background	0.7%	0.6%
Total Black Background	*5.6%*	*5.3%*
Chinese	0.3%	0.2%
Bangladeshi	1.6%	1.4%
Indian	1.9%	1.7%
Pakistani	5.1%	4.7%
Other Asian Background	1.1%	0.8%
Total Asian Background	*10.0%*	*8.8%*
Gypsy/Romany	0.3%	0.5%
Irish	0.3%	0.3%
Traveller of Irish Heritage	0.2%	0.3%
White British	76.4%	78.0%
Other White Background	2.7%	2.5%
Total White Background	*79.9%*	*81.6%*
White and Asian	0.6%	0.6%
White and Black African	0.4%	0.4%
White and Black Caribbean	1.2%	1.3%
Other Mixed Background	1.3%	1.1%
Total 'Mixed' Background	*3.5%*	*3.4%*

There is little difference between these two estimates with regard to the ethnic composition of predicted new entrants into social care with nationally over 20% coming from minority ethnic communities.

There is, however, a marked difference between the two estimates with regard to the severity of intellectual disability. Increasing the estimates and reducing rationing both have the effect of increasing the proportion of predicted new entrants with less severe learning disabilities. While the proportions of people with different levels of severity of learning disabilities varies between estimates, the predicted number of people with profound multiple learning disabilities does not as all estimates assume that all people with profound multiple learning disabilities will be eligible for services. The estimated number of new entrants to adult social care services with profound multiple learning disabilities ranges between 559 and 763 per year, with an average of 630. Year by year projections are presented in Figure 5.

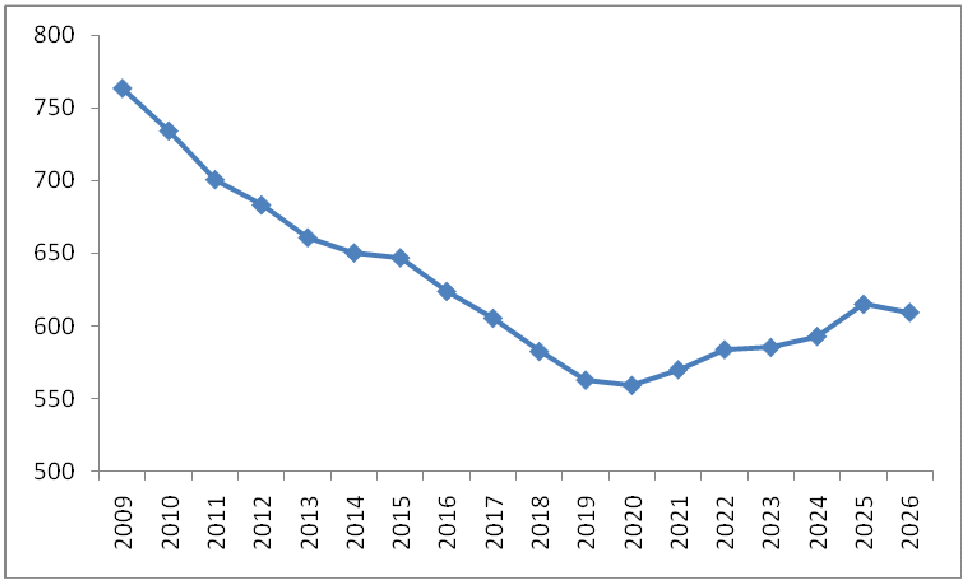

Figure 4: Predicted Number of New Entrants to Adult Social Care Services with Profound Multiple Learning Disabilities

The decrease in the number of predicted new entrants with profound multiple learning disabilities between 2009 and 2019 is the result of the reductions in the numbers of children reaching adulthood in the general population.

Summary & Comments

All scenarios included in our estimation procedures suggested sustained growth in the need for social care services for adults with learning disabilities over the time period 2009-2026. As we have stated above, we believe that rationing access to social care to those with just critical or substantial needs is in. Our estimates that are compatible with current policy objectives indicate that annual increases in need will range from 3.20% (lower estimate, services provided to 50% of new entrants with moderate needs) to 7.94%. These estimates would involve providing support to between an additional 47,000 and 113,000 adults with learning disabilities over the next ten years. In our previous work, commissioned by the Department of Health, we had estimated an average annual increase of 1.10% between 2001-2011.[27]

These estimates are based on a number of assumptions, some we believe to be highly robust, some less so. In Table 8 we list the key assumptions and data sources used and indicate the degree of confidence (from fair to very high) we feel can be placed in these assumptions/data. We also estimate the sensitivity of the predictions to any reasonably expected error in these assumptions (rated from very low to moderate).

Table 8: Assumptions and Data Included in the Projections

Assumption/Data	Confidence	Sensitivity
Age-specific general population predictions published by the Office for National Statistics	Very high	Moderate
Prevalence of learning disabilities estimated for 2008 spring School Census data	High	Low
General population age-specific child mortality estimates published by the Office for National Statistics	Very high	Very low
Adjustment of age-specific general population child mortality estimates for children with mild/moderate learning disabilities	High	Low
Child mortality estimates for children with more severe learning disabilities	Moderate	Low
Age-specific mortality estimates for adult users of learning disability services	Moderate	Low
Estimates of eligibility for new entrants with mild/moderate learning disabilities	Fair	Moderate
Estimates of eligibility for new entrants with severe learning disabilities or ASD and learning disabilities	Moderate	Low
Estimates of eligibility for new entrants with profound multiple learning disabilities	High	Very low

The most critical source of uncertainty in the predictions lies in estimating the likely eligibility for social care services for new entrants with mild or moderate learning disabilities. For example, people with mild learning disabilities constitute 85% of the population of young people with learning disabilities. An increase in their estimated eligibility for social care of 1% is associated with a 0.15% increase in annual average growth rates over the period 2009-2026. Most young adults with mild learning disabilities, unless they are parents, are unlikely to have 'critical' or 'substantial' needs due to their learning disability per se. However, people with mild learning disabilities do have much higher rates of mental health problems and are much more likely to live in poverty than their non-disabled peers.[20 29] It is this combination of mild learning disabilities and additional adversity or mental health problems that is likely to determine eligibility for social care. It is our opinion that the estimates of eligibility used in these analyses are conservative. Indeed, it is notable that the one consultation response we had that questioned our estimates did so explicitly on our (alleged) under-estimate of the eligibility for social care among young people with mild or moderate learning disabilities. Clearly, there would be considerable value in empirically testing these eligibility estimates.

There are a number of factors that would have an impact on future need that we did not take into account. These included:

- Effects due to international migration. We believe that *at a national level* any net effects are likely to be minimal. Effects may be of local importance, however, in areas with high concentrations of refugee children.
- Changes in the incidence of learning disabilities over time. We do not feel that there are sufficient grounds for building in estimates of changes in the incidence of learning disabilities. Factors that are likely to lead to an increase in the incidence of learning disabilities include increases in maternal age (associated with higher risk factors for some conditions associated with learning disabilities, such as Down's syndrome), improved survival of 'at risk' infants (e.g., very low birth weight or very pre-term infants), increasing levels of HIV and AIDS in children. Factors that are likely to lead to a decrease in incidence include the increasing availability of prenatal screening for Down's syndrome, improving health care and support resulting in fewer 'at risk' infants developing learning disabilities, reductions in child poverty rates and improvements in early years services. The net effect of these competing pressures on the incidence of learning disabilities is not known. We consider it unlikely, however, that any changes that do occur will be of a magnitude to have a significant impact on these predictions.
- Changes in mortality rates among people with learning disabilities over time. Current trends suggest that mortality rates among people with learning disabilities should continue to fall (as they are expected to do in the general population). It is not possible, however, top predict these changes with any degree of precision. Given that the model used is relatively insensitive to changes in mortality rates (i.e., such changes have little impact on the final estimate), we decided to make a conservative assumption that mortality rates would remain constant. Any error here would lead us to marginally underestimating future need.

Finally, it must be stressed that our predictions are based on estimates of 'need' rather than 'demand'. Changes in demand are likely to outstrip changes in need due to a variety of factors combining to reduce the capacity of informal support networks to provide care, networks that have primarily relied on the unpaid labour of women. As noted above, these factors include:

- Increases in lone parent families[5]
- Increasing rates of maternal employment[5]
- Increases in the percentage of older people with learning disabilities (whose parents are likely to have died or be very frail)[6 7]
- Changing expectations among families regarding the person's right to an independent life.

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October 2009

Ministerial Foreword

I am pleased to publish this Action Plan in support of the Executive's response to the Bamford Review Recommendations. This Bamford Action Plan (2009-2011) will drive change over the coming years. This change will however only be fully realised through the commitment not just of health and social care staff, education professionals and an inter-governmental and agency approach, but also through the drive of service users, carers and the voluntary sector. In fact the issues addressed in this document are the business of local communities and the entire population of Northern Ireland. This is because improving population mental health and wellbeing, and promoting social inclusion and removing stigma is everyone's business.

One in six of our population has a mental health need at any one time, and there are an estimated 27,000 people with a learning disability. In addition, there are many others who have or will develop dementia in the future. Therefore, over the coming years, the contents of this Action Plan are likely to touch the lives of all in our society.

The promotion of dignity, social inclusion and assurance of human rights for those with a mental health need or a learning disability requires a culture shift in our thinking, which will be aided by a new legislative framework encompassing mental capacity and mental health legislation, and a continued emphasis on public service improvement.

We can be proud of what we have already achieved in service improvements, but more needs to be done. Actions speak louder than words – that is why this document sets out a range of key actions with associated timeframes for delivery. All Government Departments have endorsed these actions which are to be delivered by end 2011. Thereafter, there will be a review of progress and further action plans endorsed by the Executive.

The overall vision for mental health and wellbeing, and for learning disability, will take 10-15 years to achieve. I want to reiterate the commitment of my Department and the Executive to the promotion of population mental wellbeing and emotional resilience, and to the further development of public services for those who need them.

The implementation of this Action Plan will be monitored through an Interdepartmental Group on Mental Health and Learning Disability. New arrangements will also be put in place, through the Patient and Client Council, to ensure that the voice of those with a mental health need or a learning disability is heard and to ensure that we can learn from those who are experts by experience.

MICHAEL McGIMPSEY, MLA

Minister for Health, Social Services and Public Safety

CONTENTS

Executive Summary

This Action Plan (2009-2011) sets out the Government's 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.

The document emphasises the requirement for integrated working, not just across Government departments, but also with families and communities and with the statutory, voluntary and private sectors.

Many factors adversely impact on the mental health of the population; for example, unemployment, social deprivation, low self esteem and educational attainment, poor physical health and environment, alcohol and drug misuse, and domestic and sexual violence. As a society, working together, we can improve outcomes for communities and for individuals. Population approaches to health and wellbeing are important, but so too are specific interventions which identify early and support individuals and vulnerable groups who are at risk. The new Public Health Agency will have a key role in promoting health and wellbeing and in reducing health inequalities. The Agency will promote cross-sectoral working and will be one of the HSC organisations pivotal to the success of this Action Plan.

Individuals with a learning disability, their families and carers are included in this focus on health and social wellbeing. For change to happen, a societal commitment to culture change is required that promotes social inclusion and recognises the specific needs of certain groups, their families and carers.

Linked to this, is the need for a continued emphasis on modernisation and reform of services and of development of a new legislative framework for mental capacity and mental health. At the heart of this framework will be the assumption that individuals have a right to make their own decisions about their treatment, care, welfare and assets. Where decision making is impaired, then additional powers and protections need to be put in place.

Regardless of the underlying condition, future services for mental health and learning disability need to support people to live as full a life as is possible through:

- early intervention and support;
- integrated care planning with the involvement of individuals, their families and carers;
- the promotion of independence, personal fulfilment and, where possible, recovery;
- effective interagency working and partnership with community, voluntary and private sectors, appropriate to the needs of individuals;
- the recognition of the needs of families and carers throughout the lifecycle of the individual and the importance of effective transition and succession planning, information and advice;
- development of services, including specialist services, which will be underpinned by standards outlined in mental health and learning disability service frameworks; and
- a focus on performance improvement to ensure that the patient/client experience and the quality of care delivered to individuals, families and carers is of the highest possible standard.

It is recognised that some of the issues in the Action Plan also impact on people with autism, people with acquired brain injury and people with physical and sensory disabilities.

The detailed Action Plan is divided into three sections.

Section 1 - sets out a summary of the Bamford recommendations, the Executive's vision for the future, the challenges ahead, resources, and the integrated "Bamford" structures needed to drive change. This section also includes a chapter on the importance of positive mental health, emotional resilience and suicide prevention. Legislative reform is also a key element of change; therefore, there is a separate chapter on this topic. Cross departmental working is fundamental to success of the action plan, but it is also recognised that health and social care services play a pivotal part in delivering services to meet individual need. Therefore, there are summary chapters on delivery of change within health and social care settings and how Bamford recommendations have been integrated into current DHSSPS policy and HSC commissioning and delivery.

Section 2 - This section starts by outlining how the detailed Actions should be read. The Action Plan is divided into two main sections- one for mental health and the other for learning disability. All actions are grouped under five themes. These are

Promoting positive health, wellbeing and early intervention;
Supporting people to lead independent lives;
Supporting carers and families;
Providing better services to meet the needs of individuals;
Developing structures and a legislative framework.

The mental health (and learning disability) sections of the action plan can be read as stand- alone documents. All actions are grouped under the above themes, and specify the ownership of the action, the outcome required, timetable for completion and benefits to people. Of necessity, some actions are repeated in both sections of the action plan. This is because the action will impact on many people in society, not just those who have a mental health need or a learning disability.

Section 3 - This section contains actions which relate to leaning disability. As with mental health, the actions are grouped under the five themes identified above. The focus within this section is an emphasis on an integrated, lifelong approach which recognises that a learning disability is a lifelong condition for the individual, their family and carers. In such circumstances people require more sustained support, and not just individual episodes of care, treatment and support. The goal is to help individuals with a learning disability to use their individual strengths to reach their full potential. In doing so, provision of services for people extend far beyond traditional health and social care services and require cross departmental and interagency action. Action contained in the plan outline outcomes, benefits, timetable for delivery and who is responsible for the action.

Infrastructure to deliver

The specific actions committed to, either by individual Departments or jointly in this Action Plan, will be monitored through the inter-Departmental Groups. The HSC Mental Health and Learning Disability Task Force will be responsible to DHSSPS for delivery of those actions attributed to the health and social care sector. With leadership from the Patient and Client Council, there will be a new Bamford Monitoring Group which will

harness the views of service users, carers and relevant organisations to ensure that change is happening in front line services, recognising the contribution of all Departments.

Progress on this Action Plan (2009-11) will be reviewed by the Ministerial Group during 2011 and an updated rolling Action Plan will be published, subject to endorsement of the Executive.

SECTION 1

Setting the scene

The Vision for the Future

The Challenges Ahead

The Need for leadership and Integrated working

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Legislative Reform

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CHAPTER 1 – SETTING THE SCENE

1.1 Introduction

This cross-departmental Action Plan sets out the key actions that will be taken forward over the period 2009-2011 in response to the Bamford Review recommendations. It takes into account the responses received from the consultation during 2008 on *Delivering the Bamford Vision*, the Executive's response to the Bamford Review. The Action Plan re-affirms the Executive's commitment to protect and preserve the mental health of the population as a whole, where possible to promote better mental health for everyone and to improve the lives of those with a learning disability or a mental health need. The Action Plan includes actions with target dates for completion; these will be reviewed and rolled forward in 2011 in the light of progress, emerging issues and funding available.

1.2 Background

In 2002 DHSSPS initiated an independent review of mental health and learning disability law, policy and service provision, now referred to as the Bamford Review. The review produced a series of 10 reports between June 2005 and August 2007, which together represent a far-reaching vision for radical reform and modernisation of mental health and learning disability law, policy and services and an opportunity to deliver truly world class mental health and learning disability services. The scope of the review was such that everyone in Northern Ireland is affected to some extent by the recommendations made.

The NI Executive accepted the thrust of the recommendations made by the Review and set out its proposals for taking forward its response to the Bamford review in *Delivering the Bamford Vision*, a consultation document issued in June 2008.

1.3 Summary of responses

A summary of responses to the consultation is available on the DHSSPS website. Key messages from the consultation were:

- the NI Executive is perceived as not moving fast enough on implementing Bamford recommendations;
- the document did not contain enough hard targets;
- there was not sufficient evidence of joined-up working across Departments;
- learning disability was thought not to be adequately addressed in the document;
- concerns that the resettlement programme for people in long stay learning disability hospitals would adversely affect a significant number of people who had been in hospital for so long that betterment would be unlikely to be achieved through a placement in the community; and
- dissatisfaction with the proposals for the sequential development of new legislation.

The consultation however elicited support for much of the general direction of service reform and the actions proposed.

This Action Plan has been drawn up in the light of the responses to the consultation. It sets out specific commitments made by Departments and their agencies, mainly for the next two years, after which the Plan will be reviewed and rolled forward.

CHAPTER 2 – THE VISION FOR THE FUTURE

2.1 The Bamford Review Recommendations

The Bamford review called for:

- the mental health of the whole community to be promoted and protected through preventative action;
- people with a mental health need or a learning disability to be valued and given rights to full citizenship, equality of opportunity and self-determination; and
- reform and modernisation of services that will make a real and meaningful difference to the lives of people with a mental health need or a learning disability, to their carers and families.

The review envisaged a 10-15 year timescale for reforming and modernising services in line with its recommendations, the timescale being dependent to a large extent on the availability of additional resources, particularly within the HSC. To support its recommendations, the Bamford review called for a doubling of health and social care (HSC) resources currently dedicated to mental health and learning disability services.

2.2 The Executive's Response – the vision for the future

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.

This is the vision for the future which will drive change over the next 10-15 years. It will be supported by all Government Departments and re-emphasised in future policies and strategies.

CHAPTER 3 – THE CHALLENGES AHEAD

3.1 Introduction

There are a number of challenges for the future which have a major influence on implementation of this action plan and future plans. These include a continued focus on population mental health and wellbeing, tackling the determinants of ill health including social deprivation and social exclusion. A focus on early intervention is essential as is the need to integrate treatment, care and support to meet the needs of individuals regardless of age or geographical location. As recommended by Bamford, investment in mental health and learning disability needs to continue for the next 10-15 years.

3.2 Population estimates

Protecting and improving mental wellbeing is relevant to each of us. In addition, it is estimated that in Northern Ireland:

- 250,000 adults and 45,000 children and young people have a mental health need at any one time;
- 26,500 people have a learning disability, of whom about half are aged 0-10; and
- 16,000 people have dementia.

Most families in Northern Ireland are therefore likely to be touched at some stage by issues covered by the Bamford Review.

3.3 Demographic change

Demographic changes, particularly our longer lifespans, and the increasing complexity of needs are likely to bring additional demand for services over coming years, in particular for a range of treatments to deal with depression and other common mental health needs, to support people with dementia and their carers and to support people in the community who have a learning disability. This will increase the need for effective collaboration between Departments and

their agencies. It must also be recognised that people with a mental health need or a learning disability often have other health problems, which require treatment and care. There is, therefore, a need for joined-up working with other parts of the health and social care sector beyond mental health and learning disability services. This care, delivered by other parts of the health and social care community, must take account of the particular vulnerabilities of some of these people.

3.4 Investment in services

People with a mental health need or a learning disability benefit from services funded by a range of Departments, but DHSSPS, DE and DSD are key contributors. DHSSPS and DE have specific funding streams devoted to services for these groups of people.

Within DHSSPS's area of responsibility just over £200m was spent in 2007/08 on mental health services and just under £200m on learning disability services. It is estimated that around £200m was spent on services for older people with dementia – together accounting for approximately £600m, almost one quarter of Health and Social Care Trusts' expenditure. However too high a proportion of mental health and learning disability funding is spent on hospital services; the aim is to provide more care in community settings.

As a result of the 2008-2011 Comprehensive Spending Review, in which the Executive agreed the allocations to Departments for 2008 to 2011, DHSSPS allocated from within its resources an additional £44m to be allocated to mental health and learning disability services (£27m for mental health services and £17m for learning disability services) and an additional £3m for mental health promotion over the three years.

In addition to the revenue budget described above, the Department's capital programme includes provision for mental health and learning disability facilities. The planned capital budget over the years 2009-10 to 2010-11 is some £476m of which it is planned that £48m will be spent on facilities for those with mental

health needs or learning disabilities. When completed, these projects will represent an investment of £78m.

The Department of Education also provides significant funding in support of all children with special educational needs including those with a learning disability or other mental health needs. In order to address continuing increased needs, in addition to existing funding baselines, £82m has been provided from 1996 to date for the implementation of the Code of Practice on the Identification and Assessment of SEN. A further £53m was made available over the 2005/06 to 2007/08 period, through Spending Review 2004 and Budget and Priorities 2006-2008, to support children with special educational needs. This increased funding has resulted in approximately £185m being expended in 2007/08 for provision for children with special educational needs. This includes £100m for special schools and £55m to meet the additional costs of statemented pupils in mainstream schools and units. Also included is some £23m under the Targeting Social Need factor of the Local Management in Schools Formulae, which inter-alia, assesses the likely proportion of pupils who require additional support for learning.

DE has also allocated a further £2m in 2008/09 to sustain the Independent counselling support service for pupils in post primary schools and a regional anti-bullying helpline operated by Childline.

DSD also makes a substantial contribution, both in terms of capital funding for buildings and associated revenue, through the supported housing programme, but it is not possible to specify the amounts relevant to mental health and learning disability alone.

CHAPTER 4 – THE NEED FOR LEADERSHIP AND INTEGRATED WORKING

4.1 Introduction

Bringing about the strategic changes envisaged by the Bamford Review requires leadership and action across Departments, their organisations and agencies. Much of the action to deliver the Bamford vision is the responsibility of DHSSPS and its health and social care agencies, but many other Departments and their agencies, either individually or jointly, make significant contributions in areas such as education, training, employment, housing, transport and leisure. There are already good examples of strong cross-sectoral working to promote positive mental wellbeing and to identify and address the needs of individuals with disabilities and to support their families and carers; but more needs to be done.

4.2 The contribution of Government Departments

Table 1 outlines the broad contribution that other Government Departments plan.

TABLE 1 - KEY ISSUES AFFECTING PEOPLE WITH A MENTAL HEALTH NEED OR A LEARNING DISABILITY

Issue	Lead Department	Cross-Departmental involvement
Promoting human rights, equality of opportunity and social inclusion	All have responsibility (lead OFMDFM)	All Departments
Promoting positive mental health	All have responsibility (lead DHSSPS)	All Departments
Infant and early years health and wellbeing, supporting parents	DHSSPS and DE (early years services)	OFMDFM has lead responsibility on children and young people's strategy
Education Teacher training	DE	DHSSPS responsible for provision of some therapeutic services in schools
Further and Higher education, training and employment	DEL	DEL, DHSSPS and DE on transitions from school to training and employment DEL and DHSSPS on Pathways to Work and Condition Management

Housing	DSD	DHSSPS involved through Supporting People
Personal finance including benefits	DSD	DSD and DHSSPS on improving access to Psychological therapies as part of Welfare to Work programme
Health and social care	DHSSPS	
Transport	DRD	
Leisure, sport	DCAL	
Law and Order	NIO NI Courts Service	NIO and DHSSPS on healthcare in prisons

4.3 Structures to support integrated working and leadership

The table above illustrates the need for a strong co-ordination and leadership role to ensure that Departments and their agencies are working together in the best interests of the people who need public services. The breadth of the Bamford agenda requires an integrated approach to drive forward:

a) *mental health promotion and suicide prevention* - through promoting positive mental health and improving mental resilience

b) *legislative reform* - recognising that, where possible, people have the right to make decisions about their own treatment, care, welfare and finances

c) *modernisation of public services* - to respond effectively to the needs of individuals and families

b) *partnership working* - between Departments and between their local agencies, local government and the voluntary and community sectors.

Leadership must begin within the NI Executive, but reform must extend to local level within and between public sector agencies, local government and the voluntary and community sectors.

An inter-Departmental Ministerial Group on Mental Health and Learning Disability will oversee and drive forward changes across Departments and their agencies in a co-ordinated way. An inter-Departmental Implementation Group of senior officials will support the Ministerial Group. The Ministerial Group will be kept informed on issues relating to mental health promotion and suicide prevention through two other Ministerial groups which oversee these aspects. Issues relating to children and young people with a mental health need or a learning disability will also be considered by the Ministerial Sub-Committee on Children and Young People.

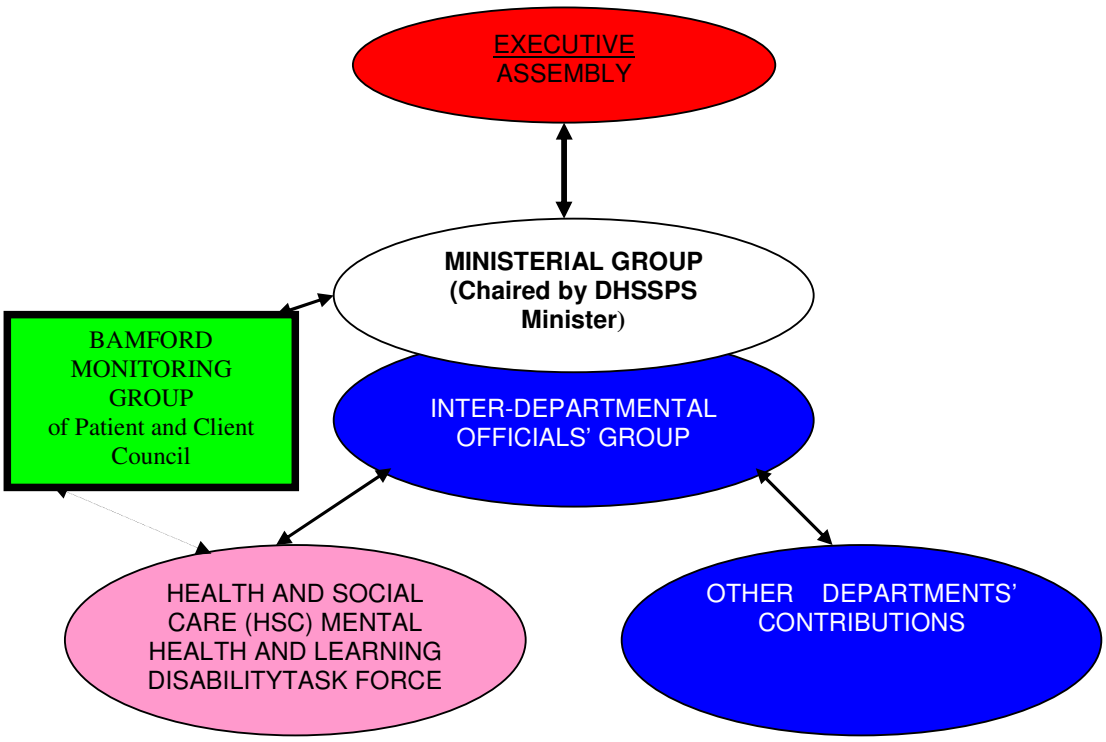
To operationalise the Bamford Action Plan in the context of implementing HSC actions, including those which require local cross-sectoral working, a Health and Social Care (HSC) Mental Health and Learning Disability Task Force will be established. The Task Force will drive forward action within the HSC and promote collaboration with other sectors across the while agenda, from promoting good health and wellbeing and early intervention through to high quality responsive services. This will be jointly led by the Health and Social Care Board and the Public Health Agency, with representation from other stakeholders, including the voluntary and community sector and service users and carers, and will report to the Minister for Health, Social Services and Public Safety on progress. Within the remit set by this Action Plan, the Public Health Agency and Health and Social Care Board will develop the detail of how they intend to ensure that appropriate actions are identified and implemented, progress is monitored and assurance provided along the reporting lines outlined above.

The Task Force structure and its reporting arrangements are designed to give a particular focus on mental health and learning disability issues and are complementary to the wider roles and responsibilities of the HSC Board and the Public Health Agency and their lines of reporting and accountability to DHSSPS.

Other Departments will put in place suitable arrangements to address issues relevant to them.

Service users and carers will be the ultimate judges of whether real change is happening. A Bamford Monitoring Group, with substantial representation from service users and their carers, will be established and supported by the Patient and Client Council to provide an independent challenge function on the extent to which the changes being put in place align with the Bamford vision. This group will report at least annually to the Minister for Health, Social Services and Public Safety.

Fig 1. BAMFORD MANAGEMENT STRUCTURES



4.4 Review in 2011

Progress on this Action Plan will be reviewed in full by the inter-Departmental Ministerial Group on Mental Health and Learning Disability during 2011 and an updated Action Plan will be published, taking account of progress to date and resource availability.

CHAPTER 5 – PROMOTING MENTAL HEALTH AND WELLBEING AND SUICIDE PREVENTION

5.1 Introduction

The need to promote and protect the mental wellbeing of the whole community through preventative action was a fundamental element underpinning all of the work of the Bamford Review. The burden of disease attributable to mental ill-health and the economic cost to our society are significant. Positive mental health and wellbeing is fundamental to a healthy society and a key requisite for a competitive and productive society.

5.2 Promoting mental health

Many factors affect mental and emotional health and these can be addressed at a number of levels, from individual action to population-wide initiatives. Work to promote mental health is not just a matter for health and social care services; it is cross-sectoral and multi-agency and there must be co-ordination of activities across sectors to maximise effectiveness. Lead responsibility for the work on mental health promotion will remain within the health and social care sector, as it is inextricably linked with other health improvement and health inequalities strategies and programmes. The Public Health Agency will play a lead role in taking forward the mental health promotion agenda, not just in terms of health and social care actions but also through its role in facilitating better cross-sectoral working to tackle health inequalities.

To ensure early intervention, work with children and young people must be a priority, with the health visiting service, parental support services and schools as key contributors. The mental health needs of other population groups, including older people, people from ethnic minority communities, people who are hearing impaired, or with other communication difficulties, prisoners, and people with a learning disability, also need particular attention.

In people of working age, mental health problems are an important cause of absence from work and of worklessness due to ill health. Evidence also suggests that they are one of the main causes of lower productivity due to the impact of illness on work. The stigma and discrimination attaching to mental ill health contribute to under-recognition and to delayed interventions.

The *Promoting Mental Health Strategy and Action Plan* (2003) set out a cross-sectoral agenda aimed at improving mental health and wellbeing. This was followed by more detailed work on suicide prevention. *Protect Life – A Shared Vision* was published in 2006 to address the rising trend in suicide. It includes a set of actions both at population level and targeted at people and communities most at risk. In 2008 the Health, Social Services and Public Safety Assembly Committee issued its Report on the Inquiry into the Prevention of Suicide and Self Harm, making a series of recommendations for further action. A cross-departmental response to the Committee's report and a timeframe for implementation were endorsed by the Executive in March 2009.

The *Promoting Mental Health Strategy and Action Plan* (2003) is currently being reviewed and a new Promoting Mental Health and Wellbeing Strategy will be published in autumn 2009. Work to inform the development of the new strategy, led by the Northern Ireland Association for Mental Health, was submitted to DHSSPS in July 2009. The Association has gathered evidence locally and considered international evidence on the most effective interventions for promoting mental health and wellbeing. The review is assessing implementation of the actions in the 2003 strategy including the various awareness raising campaigns, partnership working with the Department of Education, and development of training such as Mental Health First Aid.

The development of the new *Promoting Mental Health and Wellbeing Strategy* is also taking account of progress on *Protect Life* and the recommendations of the Bamford review. Under *Protect Life* a number of initiatives have been developed including "Lifeline" the regional 24/7 crisis response telephone line and support services, community-led prevention services, deliberate self harm pilot projects, guidelines for media reporting and research projects.

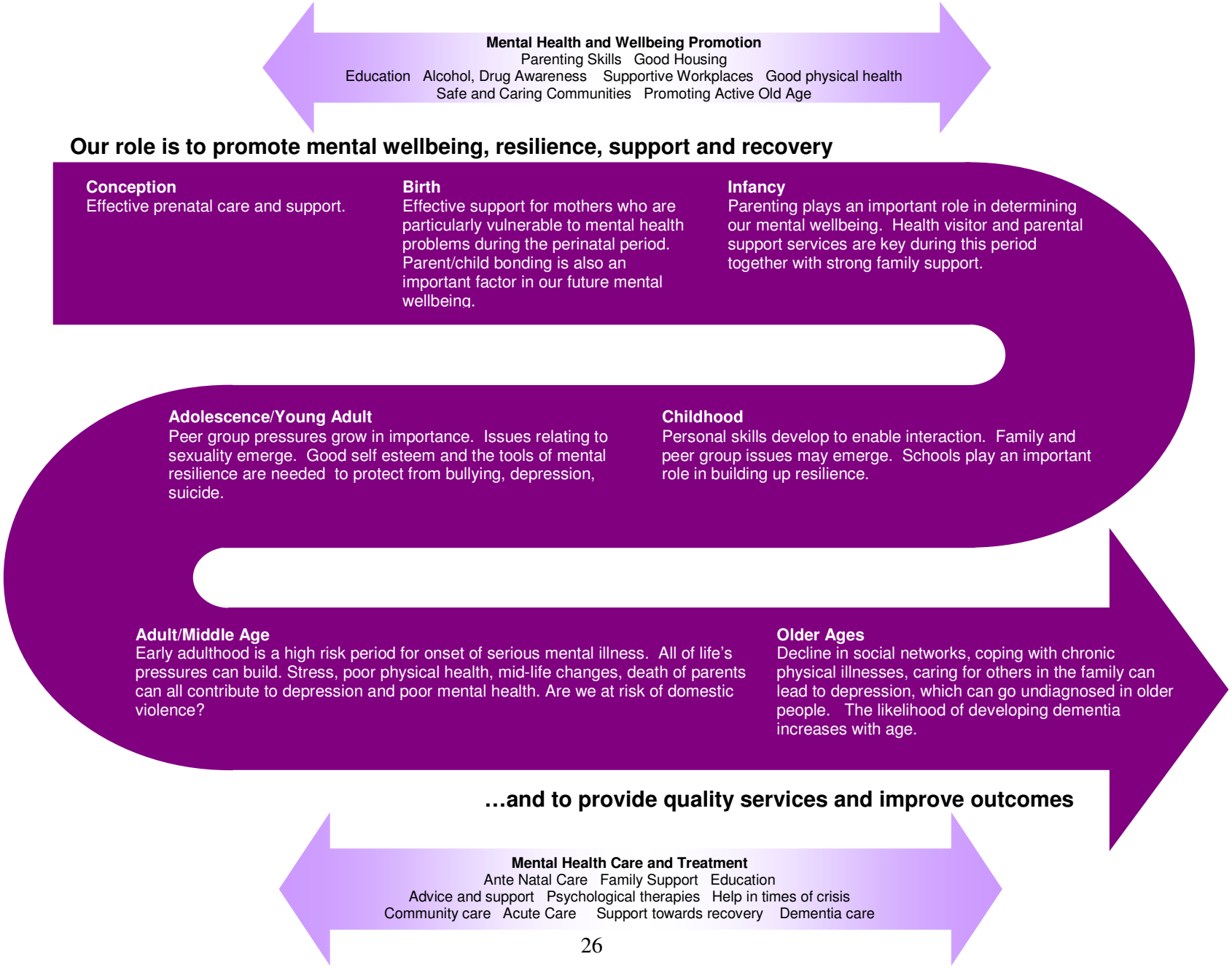
The new strategy will include a population based approach and targeted approaches to key groups such as children, and families facing difficulties. It will also identify key settings for the promotion of mental health and wellbeing such as pre-school groups, schools, workplaces and community settings.

Alcohol and drug misuse and domestic and sexual violence as contributors to mental ill-health, are also being addressed through cross-Departmental strategies and associated action plans.

Through the New Strategic Direction for Alcohol and Drugs (NSD) action is being taken forward to prevent and reduce the harm related to substance misuse in Northern Ireland. Within the NSD there is a specific focus on young people's drinking, binge and problem drinking, and the misuse of legal and illegal drugs, including the issue of harm reduction in injecting drug misuse. In this context, the recently developed Hidden Harm Action Plan should play a crucial role as parental problem substance use can have a significant impact on the mental and emotional well being of children and young people.

Figure 2 – *A Journey Through a Lifetime* – highlights the importance of mental health, social wellbeing, resilience and support throughout life. This begins before the birth of the baby with effective prenatal support and is continued throughout childhood and into adolescence and adulthood. Creating the environment which supports positive mental health and wellbeing is important throughout the life of the individual. Mental health treatment and care services extend beyond traditional HSC boundaries and such services can play a major role in promoting the recovery of an individual who has a mental health need. The overall aim is to facilitate the individual to become a fully integrated member of society, living with or without a mental health condition.

Fig 2. A Journey Through a Lifetime



CHAPTER 6 – LEGISLATIVE REFORM

6.1 Introduction

The need to update the current mental health legislation was a primary driver for establishing the Bamford review. The review's recommendations for changes to mental health legislation and for the introduction of new mental capacity legislation based on a common set of principles have been accepted by the NI Executive. The aim is to promote the dignity and human rights of those who lack capacity to make decisions for themselves, and to ensure that the law is fit for purpose so that people with a mental health need receive effective assessment, treatment and care in accordance with modern clinical and social care practice.

6.2 Principles based legislation for mental capacity and mental health

A major element of reform is to build on the Bamford recommendations and to embed a common set of principles in the face of the legislation. The main principle is autonomy - that is the assumption of capacity - respecting a person's right to decide and act on his or her decisions regarding treatment, care, welfare, finances and/or assets. Where decision making is impaired, the legislation will provide for substitute decision making and for additional powers and protections to be put in place which will act in the best interest of the individual.

6.3 Consultation on the Legislative Framework for mental capacity and mental health

The consultation document *Delivering the Bamford Vision* and the Department's subsequent consultation on its legislative proposals, proposed the parallel enactment of separate mental capacity and mental health legislation with a common set of principles. However arising from the later consultation there was a strong body of opinion, voiced by professional, carer and service user organisations, that there should a single Act encompassing mental capacity and mental health. These responses contended that a single Act was the best way of reducing the stigmatisation of those with mental disorder and improving protection of their human rights. After further consideration and consultation with Executive Ministers, the DHSSPS will lead on the preparation of a single Act.

This will be a very large and complex piece of legislation which has not been attempted in any other jurisdiction. It will be the largest ever Bill to be brought before the NI Assembly. Given the innovative approach of the single Bill approach, it will require detailed consideration; hence it will be the next Assembly (beyond 2011) before it can be enacted.

6.4 Interim Arrangements

In two areas the Department plans however to put in place interim arrangements to guard against challenge under the European Convention on Human Rights (ECHR).

(a) Nearest Relative Provisions in the Mental Health (NI) Order 1986

Currently under the 1986 Order patients do not have the right to apply to court to have their nearest relative replaced. Cases brought by patients at the European Court have established that this contravenes Articles 5 and 8 of the ECHR and this has been rectified in other UK legislation. The Department has decided this issue is sufficiently important that it cannot await the enactment of a new single Bill. Consequently the Department proposes to take forward within this Assembly a small amendment to the 1986 Order.

(b) Safeguards in respect of those Deprived of their Liberty for their Protection

Case law at the ECHR has again highlighted that those deprived of their liberty under the common law doctrine of Necessity for their care and protection contravenes Article 5 of the Convention in that they have no recourse to challenge the deprivation of liberty in a court. Statutory safeguards will be included in the proposed single Bill and in the interim the Department will provide guidelines for HSC Trusts on the need for managers of care homes and hospitals to be aware of the judgement and to comply with it within current practice.

6.5 Advocacy

People with a mental health need or a learning disability may require support in making their own wishes heard and advocacy services can help. Advocacy services in mental health and learning disability services have been developed

locally using a variety of models, including peer advocacy, and these are being supported and enhanced with additional funding. The issue of a statutory right to advocacy for mental health and learning disability service users will be considered as part of the mental health and mental capacity legislative changes being proposed.

6.6 Wider Legislative Protections

Wider legislation and policies to protect people's human rights, promote equality of opportunity and promote social inclusion will also be used to support people with a mental health need or a learning disability in living as full a life as possible. A strategy to promote the social inclusion of people with a disability is being developed by the Office of the First and Deputy First Minister. The needs of people with a mental health problem or a learning disability will be included in this strategy. Should the need for further work emerge on mental health and learning disability, during the course of development of this strategy, due consideration will be given by the inter-Departmental Ministerial Group on Mental Health and Learning Disability on how this should be taken forward.

CHAPTER 7 – DELIVERING THE VISION IN THE HEALTH AND SOCIAL CARE SECTOR

7.1 Delivering HSC services to support people to live full lives

Cross-Departmental action is essential to the success of the Bamford Vision, but statutory, community and voluntary sector providers across primary, community and secondary health and social care services have a pivotal role in delivering services to meet individual needs. Within the health and social care sector, service provision to support people in living a full life in the community requires:

- integrated care planning with the involvement of individuals, their families and carers;
- early intervention and support;
- effective interagency working and partnership with community, voluntary and private sectors, appropriate to the needs of individuals;
- integration of people with a mental health need or a learning disability and their families into the community;
- the promotion of healthy lifestyle choices and effective chronic disease management;
- the recognition of the needs of families and carers throughout the lifecycle of the individual and the importance of effective transition and succession planning, information and advice;
- the promotion of independence, personal fulfilment and, where possible, recovery;
- development of services, including specialist services, which will be underpinned by standards outlined in mental health and learning disability service frameworks; and
- a focus on performance improvement, not just in waiting times and hospital discharge targets, but also to ensure that the patient/client experience and the quality of care delivered to individuals, families and carers is of the highest possible standard.

7.2 Partnership with Users and Carers in Planning and Delivering Care

Each person with a mental health need or a learning disability is different and has needs which are unique to that person and which will change over time. Services must be designed and delivered in a flexible way to allow people who need them to make informed choices about the care and support they wish to receive. There must be a partnership approach, where people with a mental health need or a learning disability are not passive recipients of services but active participants, along with their family and carers. A "whole life" approach must be part of the care planning process, where individuals, carers and families are actively involved in the development and proactive review of such plans.

In planning at a population level, the Health and Social Care Board and its Local Commissioning Groups should ensure that service users and their families and carers are involved in a meaningful way in decisions about the mental health and learning disability services to be commissioned and in their subsequent monitoring and evaluation. This is in line with guidance on strengthening personal and public involvement (PPI) in all health and social care services.

7.3 Self-directed support

There are other ways of helping service users and carers to design the services that they want for themselves. Self-directed support is about personalisation, choice and control and reflects how the system for providing social care for adults is being transformed. It should become part of the mainstream of social care delivery, empowering people to maximise independent living and to be active citizens in their communities.

Self-directed support builds on the platform provided by Direct Payments legislation and can be used instead of, or in addition to, services that are provided through the statutory sector. A person can buy self-directed support from a service provider, or by employing their own personal assistance. This support may be in the person's home, or to provide support to take part in a range of activities beyond the home setting, for instance attending college or enjoying leisure pursuits, or to facilitate a short break. Self-directed support is an

opportunity to meet the assessed needs of the whole person in a creative and flexible way.

7.4 The valuable contribution of carers

The valuable contribution of informal carers requires recognition and support. Caring is often rewarding but can also be very demanding, and carers have their own needs, including mental health needs. Carers are entitled to have their own needs assessed, to have access to information, advice, training and emotional & practical support. This support is underpinned by the *Caring for Carers Strategy* (DHSSPS 2006).

In May 2008, Michael McGimpsey, Minister for Health Social Services and Public Safety and Margaret Ritchie, Minister for Social Development announced a joint review of Support Services for Carers. The purpose of the review is to examine the support for carers in a holistic way following on from the Review of the National Carers' Strategy. The Review is due to be completed in 2009.

7.5 New Health and Social Care Structures – a real opportunity for change

The health and social care sector is a complex structure and has recently undergone considerable re-organisation as a result of the Review of Public Administration. The Health and Social Care Reform Act established a number of new health and social care organisations including the Health and Social Care (HSC) Board, the Public Health Agency (PHA) and the Patient and Client Council. The Act also introduced a requirement on the HSC Board and PHA to develop a joint commissioning plan describing how the allocated health and social care budget would be invested to meet Ministerial priorities and improve health and social wellbeing and outcomes. The new structures therefore provide an opportunity to integrate fully, the twin aims of promoting mental wellbeing and ensuring high quality responsive services.

The HSC Mental Health and Learning Disability Taskforce mentioned in Chapter 4 will be jointly led by the PHA and HSC Board and will be supported by staff at local and regional level in the PHA, HSC Board and partner organisations.

Details of the working arrangements and programme structure will be developed by the Taskforce and will integrate the functions of each organisation – health and social wellbeing improvement, commissioning, performance, finance, safety and quality, patient and client experience, research and evaluation, and advice from health and social care professionals.

Recommendations agreed by the PHA and HSCB for reform and development of mental health and learning disability services will be reflected in the plans of Local Commissioning Groups and in the overall joint commissioning plan.

There will be nominated leads at senior level for mental health and learning disability for both adults and children in DHSSPS, the PHA, the HSC Board, and each Health and Social Care Trust.

7.6 Expanding the skilled workforce

A skilled and adequate workforce is essential to delivery of a modern and responsive mental health and learning disability service. The scale of service developments envisaged by the Bamford review will require increases in staffing numbers, particularly to develop more specialist services, along with a move of some existing hospital-based staff to community-based services.

There are current workforce shortages in mental health and learning disability services, traditionally seen as challenging work areas, which must be addressed. Many experienced staff are now approaching retirement age and for a variety of reasons, there has not been an adequate supply of new staff with the right skills for the future. New opportunities are afforded by new service models and increased emphasis on multi-disciplinary team working and in involving service users themselves in providing support for other service users. DHSSPS has commissioned a workforce planning study to support implementation of the Bamford Review recommendations, due to complete shortly. This will inform wider action to address workforce issues to complement reform and modernisation of the services.

7.7 The importance of linkage to the Independent Sector

The voluntary, community and private sectors make a valuable contribution to the range of mental health and learning disability services provided and some specialist mental health and learning disability services are also purchased from the private sector. The Health and Social Care Board will ensure that health and social care is commissioned from providers who can offer both quality and value for money, irrespective of sector.

7.8 Improving Quality of Services

New Service Frameworks for mental health and learning disability are currently being prepared as part of the development of a wider programme of Service Frameworks. These aim to set specific standards of care and improve health and social care outcomes through effective commissioning and delivery of care. These standards will underpin service delivery and will represent the quality benchmark that will be used to inspect services into the future. In doing so, this should lead to more uniform, regionally agreed models of care. The focus of these service frameworks is to promote health and wellbeing and drive performance improvement. The Mental Health Service Framework will be consulted upon shortly with the Learning Disability Framework following later.

Increased service user and carer involvement in design, delivery and monitoring of services will also help to drive up quality and ensure that they are responsive to people's needs. It is also planned that by April 2010 there will be a lead officer in each Trust with responsibility for service improvement in mental health and learning disability.

7.9 Physical Infrastructure – capital investment

The shifts envisaged in service provision, from hospital to the community, will have major implications for the current stock of buildings used to deliver services, many of which are in poor physical condition and are not designed for a modern service. Upgrading of facilities is being taken forward as part of the ongoing

programme of capital improvement and modernisation for the health and social care infrastructure across Northern Ireland.

In the next 2 years (up to 2011) there will be investment in Muckamore Abbey Hospital, the Regional Adolescent and Family Unit at Forster Green Hospital, Iveagh and Lisburn Assessment and Resource Centre. Over the following 7 years of the current Investment Strategy for Northern Ireland (up to 2018), there are plans for investment of £96m in facilities such as new mental health inpatient units in Belfast and Omagh and Oakridge SEC.

7.10 Information and Monitoring

DHSSPS, working closely with the Board and Trusts, will continue to examine how existing information systems need to be enhanced or replaced to support planning and monitoring. Work is in hand with the Board's Performance Management and Service Improvement Directorate to improve access to anonymised information about those using inpatient facilities to support planning and monitoring functions. Further work will be carried out in 2009/10 to improve information regarding those using community services and also about the range of mental health services available across NI. An exercise is also underway to improve the information available at regional level on respite care, again to support planning and better targeting of these services.

7.11 Performance Improvement

The Health and Social Care Board will have a key responsibility for performance management for mental health and learning disability services, as for all health and social care services. DHSSPS in collaboration with the Task Force will set performance indicators and targets which will be used to monitor the performance of the HSC to identify areas where services need to improve and to support the implementation of necessary changes. For mental health and learning disability services, there are a number of current priorities; improving access to services by reducing waiting times, ensuring timely discharge from hospital for those who have needed an admission for assessment or treatment, resettling people from hospital to the community with the necessary shift in

resources to enable them recover as much of their lives as possible, supporting services that use evidence based and modern approaches to delivering care and ensuring that the full capacity of our services is used to maximum effect. It is recognised that as implementation of the Action Plan progresses, performance targets will change and will need to take account of the Task Force's implementation plan and any new evidence base.

People who use the services and their families and carers will provide another important dimension to the drive to improve services, through the Bamford Monitoring Group, described in Chapter 4.

7.12 Regulation, inspection and review of services

Monitoring, inspecting and encouraging improvements in the availability and quality of health and social care services in Northern Ireland are the responsibility of the Regulation and Quality Improvement Authority (RQIA). As part of the changes arising from the Review of Public Administration, the functions of the Mental Health Commission as prescribed in the *Mental Health (Northern Ireland) Order 1986* transferred to RQIA with effect from 1 April 2009.

RQIA has worked in partnership with the Mental Health Commission to ensure a seamless transition. RQIA has established a dedicated team responsible for inspecting and reviewing mental health and learning disability services across Northern Ireland.

RQIA will also work in partnership with Criminal Justice Inspectorate Northern Ireland and Her Majesty's Inspectorate of Prisons to monitor health and social care services for people detained in prison.

7.13 The importance of research and development

The Bamford review highlighted the need for research relating to some specific aspects of mental health and learning disability services. A prioritised plan for health and social care research relating to mental health and learning disability

will be drawn up and taken forward within the overall programme of HSC research.

7.14 Conclusion

This chapter highlighted the importance of delivering the Bamford Vision in health and social care services. It summarised what needs to happen to facilitate people to lead fuller lives. In addition to mental health and learning disability services and infrastructure, there are a number of interconnected conditions which have the potential to impact on mental health and on learning disability; some of these are highlighted in the next chapter.

CHAPTER 8 – INTER CONNECTED ISSUES

8.1 Introduction

There are a number of interconnected issues which have the potential to impact on mental health or a learning disability. In such circumstances it is recognised that co-morbidities can often occur. Of particular note are:

- Autism Spectrum Disorder (ASD);
- Acquired brain injury;
- Physical and Sensory Disabilities; and
- Domestic or sexual violence.

These issues require significant cross-sectoral working, not just within the HSC but across education, housing, employment, transport and criminal justice.

8.2 Autism Spectrum Disorder (ASD)

It has been estimated that over 16,000 people in Northern Ireland are affected by autism. Approximately 200 people are diagnosed with autism each year and the number diagnosed is increasing. The Bamford review recognised that the needs of children and adults with Autism Spectrum Disorder (ASD) and their carers were wide ranging and complex.

In response to the emerging ideas from the Bamford Review and in acknowledgement of the increase in the numbers of young people in schools affected by Autism, the Department of Education supported the education and library boards to establish an Inter-board ASD group in 2003 to provide a support programme to children on the autistic spectrum within each education and library board (ELB) area.

The Minister for Health, Social Services and Public Safety convened an Independent Review Group in September 2007 to identify the gaps in current service provision to children and adults and to make recommendations on how to address these. The Terms of Reference for the Independent Review of Autism

Services in Northern Ireland included consideration of the needs of adults, and those making the transition from child to adult services.

Following on from this, the Autism Spectrum Disorder Strategic Action Plan was published in August 2008 for public consultation, and concluded on 12 December 2008. There was overwhelming support for the themes within the plan in the responses received and the final *ASD Strategic Action Plan 2008/09 - 2010/11* was subsequently published on the Departmental Website together with a summary of responses. A key focus within the plan is on improving access to diagnostic, treatment and care services for children, adolescents and adults so that they and their families receive support as quickly as possible and that, when a diagnosis can be made, person-centred care plans are developed and implemented as quickly as possible. In addition the ASD Action Plan recognises the importance of transitional support and improvements in adult ASD services.

Within the education service, the Inter-board ASD group has developed an ELB strategic action plan which is taken forward through ASD advisory teams established within each Board. The Education and Training Inspectorate (ETI) has recently evaluated the work of the 'Inter-Board Autistic Spectrum Disorder Advisory Service' and found evidence of some excellent work.

To progress the Bamford Vision further, the Department of Education proposes to develop a strategic policy for the education service. This would present an opportunity to draw attention to the many examples of good, innovative practice, particularly in relation to multi-disciplinary working, that have been developed in recent years. The ETI evaluation identified some evidence of useful collaborative action between health and education that needs to be directed at a strategic level. An autism policy would give strategic direction to the replication of local good practice on a regional basis, leading to more efficient utilisation of resources and more seamless and effective provision for families and children with ASD. The development of a strategic policy for education at this time would present an opportunity for plans across the education and health sectors to dovetail. A DE-hosted ASD conference is planned for November 2009, which is likely to have a practical focus, showcasing good practice in providing support to parents and professionals in the field of communication.

In 2007 a company was established, with funding from the Department of Education (DE) and the Department of Education and Science (DES) to oversee development of the Middletown Centre for Autism. The four key services to be provided by the centre are a learning support service, an educational assessment service, a training and advisory service, and an autism research and information service. The centre is to be multi-disciplinary in nature and will operate in support of local services, but will not offer a primary referral service. It will be dedicated to improving and enriching the educational opportunities of all children and young people with autism.

The services proposed for the Centre are being phased in order to coincide with the completion of the building refurbishment programme. The Centre has begun by offering the training and advisory service and the autism research and information service in the first instance whilst the delivery of the educational assessment service will be modelled during 2009. The learning support service will be the fourth service to be offered, as it requires completion of the new building. This is expected to be in late 2010.

The Bamford Action Plan must be considered together with the DHSSPS ASD Strategic Action Plan and the Department of Education's Strategic Policy, as service improvements and developments detailed in this Plan will also apply to individuals with ASD where their needs require it.

8.3 Acquired Brain Injury

There is growing recognition of the mental health needs of adults with neurological conditions, including acquired brain injury. Such conditions can lead to a range of impairments in physical and cognitive functioning, which in turn can result in reduced independence. People with acquired brain injury are at greater risk of mental ill-health, and this can often go undiagnosed, impacting negatively on morbidity and mortality.

Close collaborative working between mental health and physical disability services is essential in ensuring those affected by this condition have the services they require.

8.4 Physical and Sensory Disabilities

Disabled people encounter the same range of mental health needs as the general population, but coping with a disability – including discomfort or pain, the likelihood of increased social isolation, particularly whether there are communication difficulties through deafness, for example - can pose additional threats to emotional wellbeing.

It has become apparent that while Physical and Sensory Disability encompasses a wide and diverse range of disabilities, a general but over-arching strategy is required to cover all areas. For this reason, the Minister for Health Social Services and Public Safety has committed to producing a Physical and Sensory Disability Strategy, which will be issued for public consultation in early 2010.

In recognition that the expediency with which learning materials can be accessed by children and young people with a visual impairment is an area where further enhancements to service delivery could be made, the ELB Regional Strategy Group for Special Educational Needs (RSG) established a working group which is dedicated to the specialist area of visual impairment. The aim of the group is to promote a consistent approach across the five ELBs in relation to service delivery. The working group has consulted with the voluntary sector, statutory sector, parents and children.

The Group has recently reported its findings to RSG and the key recommendation of the report was that the consultation process produced a consensus view that, in the context of an overall strategy of achieving full educational inclusion and of improving levels of educational attainment amongst children and young people with a visual impairment, a resource base for the north of Ireland should be established. Under the direction of the RSG the Working Group is currently considering the strategic proposals and options.

8.5 Domestic and Sexual Violence

Research has shown that those people (mostly women) who suffer from domestic violence and abuse are more likely to suffer from depression, misuse alcohol and suffer from conditions related to post-traumatic stress, such as anxiety disorders and sleeping disorders.

Mental health impacts of sexual violence can include symptoms of post-traumatic stress disorder (PSTD), depression, anxiety and panic attacks, social phobia, alcohol and drug misuse, eating disorders and suicidal tendencies. Adult survivors of childhood sexual abuse may suffer the same impairments to their lives, with research indicating that 50% of female psychiatric inpatients in Northern Ireland report a history of childhood sexual abuse.

DHSSPS, in partnership with a range of other Departments, agencies and the community and voluntary sectors, is implementing the *Tackling Domestic Violence at Home* strategy through a series of annual action plans. A Government-wide strategy on Tackling Sexual Violence and Abuse is also being taken forward through annual action plans.

The Department of Education recognises that domestic violence is one of the key stressors on children and a barrier to achieving their educational outcomes. The Department is currently exploring a number of options for the Women's Aid Foundation to raise awareness within the education sector of the issues of domestic and sexual violence.

8.6 Conclusion

The importance of an integrated and multi-agency approach to treatment, care and support across a range of conditions has been highlighted in this chapter. The next chapter (chapter 9) illustrates the policy progress that has been made to date to implement the Bamford Vision.

CHAPTER 9 – PROGRESS TO DATE ON SERVICE IMPROVEMENT

9.1 Introduction

Over the course of the Bamford review, Government Departments have been aware of emerging themes around person-centred services and improved collaborative working and have already been working to address some of these issues. While much still remains to be done, government departments and agencies have been successful in taking forward a number of the recommendations contained in the Bamford Review, and are making continued progress on others, as was reflected in *Delivering the Bamford Vision*. Work has continued to progress since the publication of that document in 2008 and includes improvements in both mental health and learning disability services.

9.2 Mental Health Service Improvement

The following is a summary of a specific service improvement in mental health. In addition, other service improvement areas impact on both mental health and learning disability services. These include, for example, developments in children's services, nursing care particularly for those with complex needs, early intervention through changes outlined in the Review of Health Visiting and School Nursing, and additional services to support individuals and families who suffer from domestic or sexual violence.

Changes which have a direct impact on services for those with a mental health need include:

- A Directed Enhanced Service (DES) introduced in 2008/09 to encourage the provision within primary care of non-drug therapies in the treatment of mild to moderate depression, in line with NICE guidelines.
- Community mental health services have undergone a process of reorganisation across Northern Ireland.
- Access to services is improving rapidly through these new organisational arrangements and through better performance management arrangements.

- Home treatment as an alternative to in-patient treatment will soon be available in every part of Northern Ireland.
- A regional bed management protocol agreed across all Trusts to ensure that acute psychiatric beds are available for those who needed them.
- Arrangements have been put in place to ensure Computerised Cognitive Behavioural Therapy is available to all GP practices from April 2009.
- Work is well advanced to develop the service framework, which will support mental health service improvement.
- A review of priorities for capital developments was completed in September 2008.
- Over 80 long stay patients have been discharged from mental health hospitals since April 2008.
- A strategy to improve access to psychological therapies was issued for consultation in December 2008 and service improvement work is now under way.
- A strategy for personality disorder services was issued for consultation in December 2008.
- Guidance on the choice of the Selective Serotonin Re-uptake Inhibitors (SSRIs) antidepressants for the management of depression and anxiety in adults in both primary and secondary care settings was issued in October 2008.
- A multi-agency training needs analysis for practitioners and other relevant staff working in forensic services has been completed in 2008.
- Responsibility for healthcare in prisons, where there is a high prevalence of mental health needs, has transferred to the health and social care sector.
- DE, the SEELB and the Education and Training Inspectorate has produced a flexible educational model, to replace the provision in the former Lindsay School, for CAMHS patients with significant medical, social, emotional and behavioural needs. This model, which commenced in the 2007/08 school year, will be easily transferred to the new purpose built Regional Child and Adolescent Psychiatric Centre, which will include a Learning Resource Centre, when it opens in 2010. The aim is to ensure that the children and young people under the care of Child and

Adolescent Mental Health Service (CAMHS) receive the most appropriate support from both health and education services.

9.3 Learning Disability Service Improvement

A number of specific service improvements have taken place. These include:

- The learning disability resettlement target of 40 long-stay patients to be resettled by March 2008 was successfully achieved and the 08/09 target has also been achieved.
- The target to resettle all children has been achieved.
- 150 purposeful placements for young people on transition from special schools into the community have been created and funding is in place to maintain these placements.
- DHSSPS is working with the Equality Commission Northern Ireland to ensure all those with a learning disability have equal access to services and the appropriate information.
- Direct Payments have been promoted and developed, and use is increasing.
- Work is currently underway to improve services for people with Autistic Spectrum Disorder, including the establishment of a Regional ASD Network, through the development of terms of reference and appointment of relevant staff.
- A review of priorities for capital developments was completed in September 2008
- Work is well advanced to develop the service framework, which will support learning disability service improvement.
- There is an embryonic community forensic service in two of the Health and Social Services Board areas, however these community services need further strengthening. A learning disability forensic service also needs to be developed to cover all Health and Social Service Board areas. The Regional Group on Forensic Mental Health is currently assessing these needs and will recommend improvements to the new Health and Social Care Board.
- Education transition co-ordinators have been appointed to strengthen the transition planning of pupils from school to post school placements.

- Following the implementation of SENDO, the ELBs have established a Dispute Avoidance and Resolution Service and an Advice and information Service.

9.4 Other related service improvements

- A DHSSPS Autism Spectrum Disorder Action Plan (2008/9 – 2010/11) was published in June 2009.
- An Acquired Brain Injury Services Action Plan was issued for consultation in March 2009.
- A Physical & Sensory Disability Strategy will be issued for consultation in early 2010.
- A Speech and Language Therapy Action Plan is in development and will be published shortly.
- A cross Governmental Strategy of Sexual Violence and Abuse was published in June 2008. Annual Action Plans to implement the Strategy are being put in place.
- A cross Departmental Domestic Violence Strategy was published in 2005. Annual Action Plans are being put in place to implement change.
- The damaging consequences of underachievement for the child, their family, their community and for society as a whole are well documented. In these challenging economic times, raising educational standards and eliminating underachievement is now more important than ever. Through a number of reforms and programmes the Department of Education (DE) has prioritised tackling underachievement and inequality and promotes the raising of standards in all schools. DE wants to ensure that every child can succeed regardless of background, gender, sexual orientation, religion, race, whether or not they have a disability, come from the Travelling Community, or are newcomer pupils and will provide support for those who need it.
- The DE Review of SEN and Inclusion has highlighted the vital importance of an effective working partnership with the health sector. To this end, DE is working closely with health colleagues to strengthen

and develop links, from a strategic level through to delivery, to gain a shared commitment and ensure that planning, assessment and delivery of special education provision, interventions and therapies are timely and realistic. Due to the cross cutting nature of the draft policy proposals, the SEN and Inclusion Review's Policy Proposals are to be considered by the Executive, seeking agreement to issue for public consultation. It is hoped that this will happen before the end of the current academic year (2009/10).

9.5 Conclusion

Whilst much progress has been made over the last few years to enhance Health and Social Care services, more work still needs to be done. The following action plan sets out actions which need to be completed by respective Departments and organisations within the 2009-11 timeframe. Chapter 10 outlines how delivery, monitoring and review of the Action Plan will be achieved.

SECTION 2

THE MENTAL HEALTH ACTION PLAN (2009-11)

HOW TO READ THE ACTION PLAN

Four broad work areas emerged from the Bamford review:

- promoting and preserving mental wellbeing and building emotional resilience within the population as a whole;
- having legislation which promotes self-determination but supports those unable to make decisions for themselves;
- improving services for people of all ages with a learning disability and their families and ensuring better joining-up across agencies; and
- improving services for people of all ages with mental health needs and their families and ensuring better joining-up across agencies.

In this section of the Action Plan there is an introductory section on mental health services. This is to set the scene for the detailed Action Plan on mental health.

Because public service resources are agreed for three-year time cycles, this Action Plan concentrates on actions which can be achieved within the resources available up to March 2011, but also signals actions which will in the longer term contribute to the Bamford vision. It is anticipated that further additional resources will be needed in future spending cycles and the Action Plan will be reviewed in 2011 to reflect progress and the funding position. All actions are grouped under five themes:

Promoting positive health, wellbeing and early intervention;
Supporting people to lead independent lives;
Supporting carers and families;
Providing better services to meet the needs of individuals;
Developing structures and a legislative framework.

Each action has a timetable for completion, who is responsible for it, the outcome required and the benefits for individuals and for society.

MENTAL HEALTH SERVICES

Introduction

The focus of mental health services in the future will be on the provision of a comprehensive range of safe and effective services that support people with a mental health need to achieve and maintain their maximum level of functioning. This will be achieved through a focus on the recovery model, by providing an early and appropriate service response, as far as possible within the primary and community care sector.

People's mental health needs may change with age. There are separate mental health services for children and young people up to their 18th birthday and some services for older people with mental health needs or dementia are provided alongside other services for older people rather than with mental health services for adults.

The following sections provide some background to mental health service development including:

- adult mental health services;
- children and young people's mental health services;
- services for older people with mental health needs and dementia; and
- forensic mental health services.

In addition, this section recognises that other conditions and circumstances impact on mental health, including alcohol and substance misuse.

The Recovery Model

A central thrust of the Bamford Review was the promotion of a system of care based on the recovery model, particularly for those people with more complex needs. The recovery model is an approach to mental ill-health or substance dependence that emphasises and supports each individual's potential for recovery. Recovery is seen as a personal journey, that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning (often gained through occupation or employment). The use of the concept in mental health emerged as deinstitutionalization resulted in more individuals living in the

community. It has gained impetus due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that more people can recover than had previously been thought possible. Recovery-based services will support people with a mental health need to plan and build a satisfying life, engaging in work or other meaningful activities and contributing to and participating in society. Partnership between the service user and those providing services is fundamental to a recovery-based approach. Tools such as the Scottish Recovery Indicator have been developed to support use of the recovery model.

Involving Service Users

Involving those who have been mental health services users as "experts by experience" in providing support and advice to other service users gives strong backing to the recovery model and will be encouraged and supported. The contribution that can be made by former service users and their training needs will be taken into account as new mental health service models are developed.

Stepped Care

The Stepped Care model of service provision will provide the framework for future commissioning and delivery of mental health service provision in Northern Ireland. The Stepped Care model is advocated by NICE for common mental health conditions, with the number and precise nature of steps varying to address particular needs. As a general rule, however, the steps progress from awareness, recognition and assessment/ diagnosis, provided within primary care, at Step 1 through to the highest steps of inpatient or intensive treatment programmes, depending on level of need. By way of illustration, the stepped care model for depression, as advocated by NICE, is shown at Figure 3. This however is based solely on a healthcare model and does not take account of Northern Ireland's integrated health and social care service.

The aim of the Stepped Care model is to provide services which are more timely and responsive and less stigmatising and enable a greater proportion of care to be delivered at an early stage within the usual primary care setting. The model aims to provide a graduated range of care options, including self help and the provision of support and treatment within the primary care setting (or non statutory / voluntary sector) before a referral to more specialist services would be considered.

Fig 3. STEPPED CARE MODEL FOR DEPRESSION (NICE)

		Who is responsible for care?	What is the focus?	What do they do?
Step 5	Inpatient treatment for depression	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4	Treatment of depression by mental health specialists	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3	Treatment of moderate to severe depression in primary care	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2	Treatment of mild depression in primary care	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1	Recognition in primary care and general hospital settings	GP, practice nurse	Recognition	Assessment

Source: From NICE guidance on depression

Innovating for Excellence

Ten High Impact Changes shown to make a difference to mental health services are:

- providing home based care and support as the norm for the delivery of mental health services;
- improving access to screening and assessment;
- managing variation in service user discharge processes;
- managing variation in access to all mental health services;
- avoiding unnecessary contact and provide necessary contact in the right care setting
- increasing the reliability of interventions by designing care based on what is known to work and that service users inform and influence
- applying a systematic approach to enable the recovery of people with long term conditions
- improving service user flow by removing queues
- optimising service users and carers flow through the service using an integrated care pathway approach
- redesigning and extending roles in line with efficient service user and carer pathways to attract and retain a effective workforce.

These will be progressed within mental health services in Northern Ireland through an Innovating for Excellence programme, led by the Health and Social Care Board working with the Trusts. The Service Improvement lead to be appointed in each Trust will play a key role in this work.

Primary Care Services

The vast majority of people with mental health needs are cared for entirely within the primary care setting. DHSSPS will seek to enhance such provision, as primary care services are universal, accessible and less stigmatizing. Because of their generalist nature, both mental and physical health needs can be dealt with as part of a holistic approach; many people presenting to primary care with physical health problems have a mental health component to their problem and people with mental health needs may also require support in maintaining their physical health.

Primary care professionals must have available to them a range of options for dealing with the mental health needs of people presenting to them, in line with the stepped care model outlined earlier. These options would include self-help,

signposting to relevant groups and organisations which can provide support, medication and/or psychological therapies or, where necessary, referral to mental health services.

The voluntary and community sector has an important role in support of primary care services; many such organisations are run by or have input from people who have been mental health services users themselves and can therefore provide informed and sensitive support and advice. This partnership with statutory services requires both sectors to work together in a more concerted way.

Primary care staff will be supported to promote better recognition of mental health needs and ensure clear working arrangements to provide access to specialist mental health advice where necessary through the stepped care model.

The Quality and Outcomes Framework (QOF), part of the UK-wide General Medical Services contract with GPs, provides financial incentives to GP practices which maintain registers of their patients with some specific mental health conditions, review these patients at regular intervals and provide ongoing management of their care. The mental health conditions covered within QOF are depression, dementia and schizophrenia, bipolar affective disorder and other psychoses. Although QOF is voluntary, the majority of practices are achieving the required targets.

The prevalence of depression in those presenting to primary care services and the increasing numbers of people, particularly young men, at serious risk of suicide have been driving factors in the recent programme to raise awareness of depression among primary care staff. A Directed Enhanced Service (DES) has also been introduced in 2008/09 to encourage the provision within primary care of non-drug therapies in the treatment of mild to moderate depression, in line with NICE guidelines.

Beating the Blues is a self help computer based CBT programme, approved by NICE for use in the treatment of mild depression. Work is well advanced to roll a CCBT programme out to all GP practices in NI, with the aim to have regional access to the programme by March 2010.

Psychological Therapies

The evidence base for use of psychological therapies has strengthened in recent years. DHSSPS is developing a strategy for improving access to psychological therapies, which should be finalised during 2009 and will help to determine priorities for the use of additional resources secured for the period 2008/09 to 2010/11 to improve access to psychological therapies.

Mental Health Teams in the Community

Multi-disciplinary Mental Health Teams in the community are key in supporting service users and families in community settings. There has been a process of ongoing development of Community Mental Health teams for some years, including the reorganisation of teams, the development of Crisis Response, Home Treatment and Assertive Outreach Services and the development of specialist services for those with specific needs, such as eating disorders. The consistency and responsiveness of the variety of service models in place will need to be reviewed so that everyone in Northern Ireland can expect common standards of care no matter where they live. At the same time, service improvement efforts will focus attention on maximising the impact of investments to date and ensuring that future investment is targeted on those services that demonstrate effectiveness.

Other Community Mental Health Services

A range of services will be provided to complement the work of the community mental health teams, including day services, vocational training, respite and other support services for carers, supported accommodation and psychological therapies. Day support and vocational services need to become more recovery focused and integrated with the local communities that they serve. Respite care will need further development so that carers are supported in their roles. A range of supported living services are already in place but more will need to be done, particularly with regard the development of so-called 'floating support schemes'. Much of this can and should be provided by the voluntary and community sector.

In-patient Facilities

There will still be a need for some people to be admitted to hospital for assessment and treatment. The continued development of community mental health services, however,

should result in a 10% reduction in admissions to mental health hospitals by 2011. Over time there will be a shift from large psychiatric institutions to smaller psychiatric units and a network of step-up and step-down facilities closer to the community, with a smaller number of beds overall.

There will be a growing focus on the quality of care that is provided within hospitals so that it modernises and improves at the same pace as other services. Inpatient services must be of a high quality, with all the necessary resources and therapeutic interventions required to ensure swift access to treatment and care and timely discharge to the least restrictive setting.

Resettlement from long-stay psychiatric hospital inpatient units will continue to be a priority. It was estimated that additional funding secured for the period 2008/09 to 2010/11 for resettlement would result in 90 long stay patients being discharged over the 3 year period. That target has been virtually achieved within the first year alone, and resettlement from long stay mental health hospitals will continue to achieve the overall target of no person remaining unnecessarily in hospital by 2013. Partnership working with the independent sector and with other public agencies is vital in providing the support required to achieve this.

People with Special Mental Health Needs

The Bamford review identified a number of groups of people with particular needs for specialist mental health services. Actions relating to improving services for people with eating disorders, people with personality disorder and women with perinatal mental health needs are included in the later section of this Action Plan. In addition work relating to people with autism and with acquired brain injury is referred to later in this document. Other specialist needs will be addressed as resources permit.

Children and Young People's Mental Health

The Bamford Review highlighted the need for joint working between health and social care, education and youth justice sectors. The Ministerial Sub-Committee on Children and Young People will bring an increased focus at Departmental level on issues relating to children and young people with a mental health need.

Support for Parents

The NI Executive will continue to promote a range of strategies and programmes aimed at supporting parents in raising their children, as far as possible in partnership with the voluntary and community sectors. The mental health needs of looked after children, for whom DHSSPS has lead policy responsibility, will also be taken into account.

Schools

Work is being done in schools through the curriculum; Personal Development and Mutual Understanding at primary level and Learning for Life and Work at post-primary level provides opportunities to promote positive mental and emotional wellbeing among young people. A Pupils' Emotional Health and Wellbeing Programme is being developed initially for the post-primary sector, addressing how a pupil's emotional health and wellbeing is promoted by the school, what support systems are available to a pupil under stress and what support is available to a school in event of a crisis. An independent counselling service has been available to post-primary pupils since September 2007. Work is underway to determine the support that should be made available to primary and special schools. DE funds a regional anti-bullying helpline operated by Childline and is working with the local Anti-bullying Forum to promote good practice in tackling bullying in schools, including guidance on cyber bullying and a website providing advice and information. A DE/ DHSSPS group at senior level will continue to work on issues of mutual interest, including the emotional wellbeing of children and young people.

Special Education

The purpose of special educational provision is to remove or diminish the barriers to achievement, which children and young people with special educational needs may face. These may include the classroom approach to learning or the physical nature of the learning environment. The Department of Education and the Education and Library Board Regional Strategy Group for Special Educational Needs continue to be proactive in moving forward with a wide range of service improvements within the existing SEN framework.

Health and Social Care Services

Child and Adolescent Mental Health Services are provided for children and young people up to their 18th birthday and are being developed in line with the 4-Tier model

advocated in the Bamford Review. The Performance Management and Service Improvement Directorate, as part of the new Health and Social Care Board, is leading a process of reform and modernisation aimed at ensuring that CAMH services respond in a more accessible way and maximise the significant investment that has occurred and is planned in coming years.

A comprehensive pattern of child and adolescent mental health services requires the development of primary care services and the build up of community mental health services in parallel with enhanced specialist services, including inpatient care. By 2010, 33 mental health inpatient beds will be provided for children and young people up to the age of 18 in Northern Ireland.

Older People's Mental Health and Dementia

Dementia is a major health concern for older people in society, but older people may also have a range of other mental health needs. Detection of mental health needs in older people tends to be poorer than for the rest of the population. The demographic changes anticipated in Northern Ireland could see the number of dementia sufferers rise by 30% by 2017 and are also likely to result in an increase in the number of older people with functional mental illness

Mental Health Promotion and Early Detection

The mental health needs of older people will be taken into account in the development of the proposed updated *Promoting Mental Health* strategy and action plan. Work to improve recognition of mental health needs by primary care staff will benefit older people as well as the rest of the population. Staff providing the wide range of health and social care available for older people need to be aware of and alert to dementia and mental health issues.

Assessment

Work has been completed to develop a Northern Ireland Single Assessment Tool (NISAT), which aims to capture a complete picture of the older person and his/her care needs, and will trigger more specialist assessment, including mental health assessment, where appropriate. An implementation plan is in place to roll out use of the tool by June 2010.

Mental Health and Dementia Services in the Community

Work to enhance mental health teams in the community and to agree common care pathways will include consideration of the needs of older people with mental health needs. The strategy for improving access to psychological therapies will include provision for older people, and DHSSPS, with service commissioners and providers, will examine ways to improve older people's access to other therapies which are proven to be beneficial.

Commissioners of services will take into account the needs of older people with dementia or mental health needs for the full range of community based services. The development of intermediate care and new approaches to delivering in-patient assessment functions will help to deliver the Bamford vision for older people with mental health needs or dementia. DHSSPS and health and social care bodies will work with DSD and housing bodies to encourage the development of a range of models which will meet the needs of older people with dementia or mental health needs and their families and carers and will exploit as fully as possible the benefits of assistive technology.

Decisions on the need for care home provision will be on the basis of an individual, multi-disciplinary, assessment of need, covering the physical, mental and social functioning of the person, taking account of the needs of their family and any other carers and, as far as possible, will be carried out in the person's own home environment.

Hospital Care

The requirement for inpatient provision for older people with mental health needs or dementia has been taken into account in the review of mental health inpatient provision. It is likely that further changes will occur as Trusts develop more modern approaches to in-patient care based on commissioner assessments of need and develop services specifically tailored to the needs of older people.

Dementia Services

DHSSPS has commenced work to develop a strategy for dementia services, covering all aspects from assessment and diagnosis through to highly specialised forms of care. This will be taken forward in partnership with all relevant agencies and interest groups.

Alcohol and Substance Misuse

The relationship between alcohol and drug misuse and mental health is complex, and can be problematic, particularly co-morbidity, or dual diagnosis – the occurrence of substance misuse with mental health needs – which is a major challenge facing mental health services. Through the New Strategic Direction for Alcohol and Drugs (NSD) action is being taken forward to prevent and reduce the harm related to substance misuse in Northern Ireland. Within the NSD there is a specific focus on young people's drinking, binge and problem drinking, and the misuse of legal and illegal drugs, including the issue of harm reduction in injecting drug misuse. There is also a specific acknowledgement of the impact that parental problem substance use can have on the mental and emotional well being of children and young people. This is being taken forward through the Hidden Harm Action Plan which encourages communication and cooperation between adult addiction services and children services.

Through the NSD, the DHSSPS will continue promote a unified approach across Northern Ireland on assessments and outcome measures. The 4-Tier model of service delivery described in the National Treatment Agency for Substance Misuse *Model of Care* document will be adopted and will incorporate rehabilitation services. There will also be a renewed focus on developing a regional commissioning framework for addiction services across Northern Ireland. Joint working between addiction services and mental health services will be supported.

Forensic Mental Health Services

The NI Executive is committed to improving safe, secure and supportive service provision for people who have a mental disorder and come into contact with the Criminal Justice System (CJS).

A Northern Ireland Forensic Network involving users of services and carers and the relevant agencies at senior level will be established to support development of forensic services in a strategic and co-ordinated manner.

To assist collaborative working and facilitate meaningful communication, a training needs analysis has been completed on a multi-agency basis for practitioners and other relevant staff working in forensic services and collaborative training initiated.

New purpose-built, in-patient facilities have been provided for people with a mental illness and for people with learning disability and community forensic teams have been established. By March 2010 a plan will be developed to review current provision of low secure and community forensic placements and assess the need for further investment.

People with a personality disorder are significantly over-represented in the CJS. In December 2008 a strategy for services for people with a personality disorder was issued for stakeholder consultation. Investment in this area has already been identified in each of the next two years,

Work will be undertaken to agree appropriate standards and protocols for dealing with people detained in police stations. The involvement of the Health and Social Care Trusts in leading prison healthcare should ensure the development of the service in keeping with that in the community and facilitate seamless transfer of care across the interface between prison and the community.

The following section of the Mental Health Action Plan outlines specific actions under 5 themes:

- Promoting positive health and early intervention
- Supporting people to lead independent lives
- Supporting carers and families
- Providing better services to meet people's needs
- Providing structures and legislative base to deliver the Bamford Vision

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Publish a revised cross-sectoral Promoting Mental Health and Wellbeing Strategy	All Departments, led by DHSSPS Investing for Health Group	A renewed emphasis on building the emotional resilience of our population and on mental health and wellbeing promotion across all sectors, taking account of lessons learned from previous work	By December 2009	Better mental wellbeing in the population
Implementation of the Protect Life action plan	Relevant Departments, led by DHSSPS Investing for Health Group Public Health Agency (PHA/Board to lead on HSC actions	Reduce overall suicide rate by 15% by 2011 (baseline: 2004-06)	Ongoing	Decrease risk of people taking their own lives
Implementation of Health Committee recommendations on the prevention of suicide and self harm	DHSSPS Investing for Health Group, DE, DCAL Public Health Agency (PHA/Board to lead on HSC actions	Reduce overall suicide rate by 15% by 2011 (baseline: 2004-06) Reduce levels of deliberate self harming	May 2009 to March 2010	Decrease risk of people taking their own lives
Develop, consult and implement a 10 year Early Years Strategy	DE led Ministerial sub-committee for Early Years.	Consultation on Strategy Implementation Plan	Autumn 2009 Spring 2010	Prevention and lessening of emotional and behavioural problems in young children by ensuring access to - physical nurturing - nourishing food - exercise and play (particularly outdoor play - adequate sleep - emotional and social support

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Introduce a revised curriculum which provides opportunities through Personal Development and other areas for young people to develop the skills they need to cope with challenging personal situations such as violence against women and children; self-harm etc.	DE – Curriculum & Assessment Team	All schools to have implemented the revised curriculum	By September 2009	Pupils benefit from the opportunity to develop the skills they need to cope with a range of challenging personal situations; teachers receive guidance and support, including training, to implement the revised curriculum.
Produce guidance and support material for post primary schools on proactively promoting positive emotional health and well being among staff and pupils Produce guidance for schools on the management of critical incidents and ensure consistent support to schools across all board areas	DE – Pupil Support Unit	All schools understand their role in promoting positive outcomes for pupils There is consistent minimum provision across all post primary schools within the curriculum and pastoral care supports	Commencing Autumn 2009 Ongoing	All pupils and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Sustain the Independent counselling support service for pupils in post primary schools	DE – Pupil Support Unit	Continued access for all schools that wish it to a minimum of half day counselling support per week	Ongoing	Support, independent of the school, accessible for pupils experiencing stress
Develop proposals for developing resilience among primary aged pupils and those in special schools for consultation; to implement agreed new services	DE – Pupil Support Unit	Age and ability specific programmes which promote positive outcomes operating in primary and special schools	Commencing Autumn 2009.	All primary age pupils, those in special schools and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies
Support schools in their work to create an anti-bullying culture with guidance and materials which tackle all forms of bullying, including homophobic bullying, are up to date and reflect the dynamic nature of the problem	DE – Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils are confident that their concerns about bullying will be dealt with in an appropriate and timely manner
Progress ongoing work of the DE Safeguarding Co-ordination Group	DE- led by Supporting and Safeguarding Children Division	The DE Safeguarding Coordination Group will raise awareness of the range of safeguarding issues, including domestic violence, across DE business areas	Ongoing	Vulnerable children will be supported and signposted to appropriate interventions

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Promote Teacher Health and Wellbeing through: • Revision of *Promoting a Dignified Workplace* (a policy statement and code of practice on measures to combat bullying and harassment of teaching staff in school)	Teacher Negotiating Committee (TNC) (an amalgam of the Department of Education, employing authorities and teachers' unions responsible for negotiating all aspects of teachers' pay and conditions of service) Employing authorities	Reduction in incidence of bullying and harassment	Draft presented to employing authorities in December 2008. Once approved will go forward to the teachers' unions for comment and possible negotiation prior to ratification by TNC	Potential benefits to all teachers
• Centralisation of counselling services for teachers	TNC	Improved level of support available to teachers	Ongoing from 1 April 2009	Benefits to teachers who have been bullied or have other mental health issues
• Revision of guidance on violence and other abuse of teachers by pupils or third parties		Greater clarity for schools in dealing with and preventing this problem	A workshop to consider revised guidance was held in November 2008 and feedback is currently being collated. Guidance document will issue to schools in Autumn 2009	Will benefit schools whose staff have been abused

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Commission a scoping study of Pastoral Care arrangements in FE	DEL	To ensure that the FE sector is fully aware of and responsive to the needs of its students including having in place comprehensive pastoral care arrangements across all campuses to identify and address any problems experienced by students	Scoping study commissioned by Public Procurement commenced July 2009 Findings of scoping study by December 2009 Implementation plan for any identified actions by March 2010	More effective, comprehensive and consistent pastoral care services for students across all 6 regional colleges
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	From September 2009	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation
Publish guidance for employers in general on "Creating a working environment that encourages Mental Wellbeing"	HSENI	All employers will be better equipped to address workplace mental wellbeing issues.	December 2009	Fewer employees will suffer from work related stress. More working environments will encourage mental well being. More employers will feel confident about employing someone who has mental health needs

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Set up a Stress and Mental Wellbeing Unit comprising health and safety inspectors and business advisors to focus on high stress risk work sectors	HSENI	The Unit will through the provision of advice and where necessary enforcement ensure that organisations in sectors, in which employees are at a high risk of suffering from stress related ill health caused by or made worse by their work, have adopted systems to manage such a risk	December 2009	In high stress risk work sectors see, as a result of reduced stress related ill health and associated absenteeism, increased productivity
Ongoing implementation and development of the New Strategic Direction for Alcohol and Drugs, and its underpinning Hidden Harm and Young People's Drinking Action Plan	DHSSPS (with other relevant Departments) PHA to lead on HSC actions	5% reduction in the proportion of adults who binge drink (baseline 2005) 10% reduction in the proportion of young people who report getting drunk (baseline 2003) 5% reduction in the proportion of young adults taking illegal drugs (baseline 2002/3) 10% reduction in the number of children at risk from parental alcohol and/or drug dependency (baseline under development)	By 2011	Reduce levels of harm related to alcohol and drug misuse
Progress the Tackling Sexual Violence and Abuse Strategy 2008-2013	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of sexual violence and abuse
Implement the domestic violence strategy *Tackling Violence at Home*	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of domestic violence and abuse

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Implement the recommendations and associated actions arising from the Review of School Nursing and Health Visiting, once agreed post-consultation	**HSC**	Service delivery will be targeted on parenting support and mental health early interventions	As set in the Action Plan from the Review of School Nursing and Health Visiting	Children and young people's emotional health is promoted, all children are supported to lead happy healthy lives and problems are prevented from escalating to more serious mental health needs

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Publish a report on the 'Promoting Social Inclusion' work	OFMDFM, Equality / Rights & Social Need Division with input from Departments and the sector as appropriate	The work of the PSI Group for people with disabilities covers a range of topics and cuts across Departmental boundaries – The report will provide a composite set of recommendations for Executive consideration which will improve the quality of life for people with disabilities.	Autumn 2009	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; • Legislation, Citizenship, Language and Attitudes, and • Lifelong Learning, Arts, Sports and Culture
Publish an action plan for the implementation of recommendations arising from the PSI report (above)	OFMDFM Equality / Rights & Social Need Division (with input & agreement from other Departments as necessary)	As above. The action plan for this PSI work will be taken forward in the context of the wider 'anti-poverty and social inclusion' strategy - Lifetime Opportunities	Agreed action plan by March 2010	As above
Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment	OFMDFM, Commission for Victims and Survivors	Better information on the extent of the impact of the Troubles on the mental health needs of victims and survivors	September 2009	Better planning of services for victims and survivors

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Bring forward primary legislation to establish the Office of Commissioner for Older People	OFMDFM Equality, Rights and Social Need Division with input and agreement from other Departments as necessary	Legislation to establish a Commissioner for Older People, with a range of functions, powers and duties	Introduce legislation in May 2010	Will provide a strong independent voice for older people, including those experiencing mental ill health
"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 people affected by mental ill health, their families and carers have availed of enhanced opportunities for social interaction through reading and learning activities enabling them to play a fuller role in community life and to access further training or employment if they so wish; and 15,000 people in the wider community have enhanced levels of understanding of mental ill health and awareness of positive mental health, thus promoting tolerance and inclusion and enabling them to take action to prevent mental ill health	5 years from October 2009	People affected by mental ill health and their families have improved access to information and support

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Complete an analysis of DEL provision across the further education and training sector for those with a disability, including those with special educational needs or with mental health needs. This work to build on detailed reviews of Students with Learning Difficulties and/or Disabilities provision in FE, barriers to Training for Success and also recent inspection reports of provision	DEL Education and Training Inspectorate	Identification of areas for future DEL action where appropriate; also, an indication as to whether individuals have access to the services they require consistently across further education and training	Report finalised by June 2009	More effective services for individuals accessing DEL programmes and services
Consider the findings of the overarching review (above) and any strategic implications for DEL and develop an action plan	DEL	Strategic action plan to address cross-departmental issues identified that impact on individuals with mental ill health and /or learning disability	Action plan in place for 2010/11 Key milestones - consider resource implications, both staff and financial - identify delivery mechanisms - seek approvals to proceed	More effective services for individuals accessing DEL programmes and services

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Undertake scoping study of provision for those not in education, training or employment (NEET), including those with mental ill-health or learning disability	DEL in liaison with other organisations, including PHA	Determination of available provision	Scoping study completed by Autumn 2009	Improved information to enable consideration of need for cross-Departmental strategic approach/ further actions
Continue to deliver DEL provision to address the employment needs of Incapacity Benefit and Employment and Support Allowance (ESA) recipients including those with mental ill-health	DEL	Individuals with mental ill health issues are assisted via DEL programmes , including the Condition Management Programme offered in conjunction with DHSSPS to re-enter the labour market	Ongoing	Individuals with mental ill health issues can access the necessary training and support to enable them to re-enter the labour market
DEL to consider, following recommendations from the Disability Liaison Group, improved information and communications about provision, including the possibility of an “easy to read” directory of DEL provision aimed at individuals with mental ill health and/or learning disability and their families	DEL (in conjunction with the sector)	A range of clear and accessible information resources	Summer 2010	Better informed decision making in terms of future education, employment and training options available

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Examine the benefits for NI of adopting similar partnership arrangements to those put in place by the Scottish Executive that detail the roles and responsibilities of agencies involved in meeting the educational, health and social needs of people with additional needs accessing DEL provision	DEL jointly with DHSSPS/ HSC and other relevant Departments	Clear understanding of the respective roles and responsibilities including information sharing between DHSSPS and its agencies, DEL and its delivery partners and other agencies in addressing the needs of these learners (in particular assistance with assessment, personal care, transport etc), and that the findings are disseminated locally to DEL delivery partners and HSC	Stage 1: Scope benefits by end 2009 -Identify resource to undertake project - establish steering group for the project Stage 2 : Bring forward proposals to develop partnership working guidance in 2010. Report progress to Inter – Ministerial Group	Better awareness of the challenges of delivering provision to learners with profound and complex needs and clear signposting for individuals, families and providers Better informed healthcare and other professionals in relation to the education and training programmes and services relevant to and accessible by adults with mental ill health and/or learning disability
Carry out a policy evaluation of the Supporting People programme	DSD	Examination of the governance arrangements, commissioning process and funding arrangements, to ensure compliance with the policy intention that Supporting People is to fund advice and guidance for relevant individuals/organisations	March 2010	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Collaborative work between DSD, NIHE, DHSSPS and HSC	Supporting People Commissioning Body, chaired by the Northern Ireland Housing Executive	Ensure that the accommodation needs of vulnerable adults are included in the delivery of the Social Housing Development Programme in as far as resources are available at that time.	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
Publish action plan of how NICS will promote diversity	CHR to lead with all other NICS departments	Equal opportunities monitoring of the NICS workforce. Review the 2008 – 2011 NICS Employment, Equality and Diversity Plan.	December 2009	A working environment where everyone has a right to equality of opportunity and individual differences are valued and respected The NICS workforce will be more representative of the community by attracting a more diverse applicant pool for advertised posts including applications from those with a disability
Develop mandatory equal opportunities and diversity awareness training to all staff at all levels within the NICS	CHR to lead with all other NICS departments	Ensure that all employees are aware of their duties and responsibilities to ensure equality in the workplace and to fully include employees with disabilities, including mental conditions in the working environment.	Mandatory Training to commence in October 2009. To be complete by June 2010	To raise awareness of issues facing staff and customers with disabilities including those with a mental condition by ensuring all NICS employees are trained in equal opportunities and diversity awareness
Additional information and advice services for mental health service users and their carers	HSC	Improved information and advice services, at least some of which delivered by voluntary sector.	Ongoing	Better support for service users and carers in understanding the services available and in making their views heard

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Increase uptake of Direct Payments	HSC	Double the number of recipients of Direct Payments in mental health programme of care (baseline June 2007)	By March 2011	Give service users and their carers greater choice in the support they receive
Resettlement of long stay patients from mental health hospitals	HSC in collaboration with voluntary and community sector	10% reduction in the number of long-stay patients in mental health hospitals care (baseline 2007/08) No-one will remain unnecessarily in a mental health hospital	By 2011 By 2013 (Programme for Government target)	More people with a mental health need able to live in community settings with appropriate support.
Implementation of harm reduction strategies, including needle and syringe exchange and substitute prescribing	DHSSPS (with other relevant departments) PHA to lead on HSC action	Delivery of key harm reduction projects	Ongoing	Support for drug users to live less chaotic lives, and to reduce the harm they face in relation to their drug misuse

MENTAL HEALTH ACTION PLAN

THEME: Supporting carers and families

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Complete a joint Review of Support Provision for Carers	DHSSPS/DSD	Improved support services for carers who look after people of all ages who have a learning disability or mental health issues	Autumn 2009	People with a learning disability or mental health issues are supported to live independent lives in their own home for as long as possible and carers are supported in their caring role so that they can continue to care for as long as they wish and are able to do so
Improve regional information on provision of respite care	DHSSPS/ HSC	Pilot data collection and refine as necessary Monitor respite care provision in NI on a quarterly basis	By December 2009 Ongoing	Respite provision can be better planned and monitored
Improve respite care for people with dementia	HSC in collaboration with voluntary and community sector	Additional 2000 places per year (baseline 2007/08)	By March 2011	Improve access to respite care
Additional information and advice services for mental health service users and their carers	HSC Trusts, HSC Board, PHA in collaboration with voluntary and community sector	Improved information and advice services, at least some of which delivered by voluntary sector	Ongoing	Better support for service users and carers in understanding the services available and in making their views heard
Increase uptake of Direct Payments	HSC	Double the number of recipients of Direct Payments in mental health programme of care (baseline June 2007)	By March 2011	Give service users and their carers greater choice in the support they receive

MENTAL HEALTH ACTION PLAN

THEME: Supporting carers and families

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Implementation of Hidden Harm Action Plan – supporting the needs of children and young people born to or living with substance misusing parents or carers	DHSSPS (with other relevant departments) PHA to lead on HSC action	10% reduction in the number of children at risk from parental alcohol and/or drug dependency (baseline under development)	By 2011	Increased support (at local and regional level) for children and young people with substance misusing parents or carers

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Provide a service wide, supportive, quality driven environment to promote Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Submit consultation schemes under section 19 of the Health and Social Care (Reform) Act (Northern Ireland) All organisations to embed PPI consistently as part of organisational activity. Establish leadership and accountability arrangements for PPI. Monitor and Evaluate progress; agree priorities and targets for subsequent year; report annually	Jan 2010 Apr 2010 Apr 2010 From Apr 2010	• Improvements in service design. • Improvements in user and carer experience of services. • Promotion of social inclusion • Improved safety and quality of treatment. • Reduction in complaints • Improved management of demand • Understanding of how and when care goes wrong • Reduction of risk

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Re-direction of 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.	By 2011/12	Greater access to community mental health services and fewer people need to be admitted to hospital
Develop a Service Framework for mental health services and commence implementation	DHSSPS/ HSC	Strengthen the integration of health and social care, enhance health and wellbeing, promote evidence – informed practice, focus on safe and effective care and enhance multidisciplinary and inter-sectoral working	By January 2010	Set out the standards of care that people who use services, their family and carers can expect to receive
Review range of facilities used to provide both inpatient and community based mental health and learning disability services and agree future pattern of provision	DHSSPS/HSC	An agreed plan for facilities required to deliver mental health and learning disability services	The Capital Priorities Review was completed in September 2008. A Policy Infrastructure Forum has been established to address new requirements and ongoing prioritisation.	Services will be delivered in appropriate, accessible, fit for purpose buildings
Complete a workforce planning study for mental health and learning disability health and social care services	DHSSPS (HR Directorate) in collaboration with HSC	Agree a prioritised action plan to take forward recommendations from the commissioned workforce study	December 2009	Adequate numbers of appropriately trained staff to deliver services needed
Develop and take forward a prioritised plan for research on mental health and learning disability issues	DHSSPS/ PHA/ R&D Office/ HSC	Plan agreed with a timetable	June 2010	Service provision informed by local research on needs and on evidence of what works

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Improve information systems on provision and use of mental health and learning disability services	HSC Board in collaboration with HSC	Anonymised database on inpatients in mental health facilities available at regional level for use by DHSSPS and HSC bodies Extend the database to include users of community based services	October 2009 April 2011	Services can be better planned to meet needs and monitored to ensure service improvement, based on up to date local information.
Complete and maintain a map of mental health services across Northern Ireland	PHA/ HSC Board in collaboration with HSC and voluntary and community sector	Compile mapping information on all mental health services provided	Mapping to be completed by March 2011 and maintained on ongoing basis	New services can be better targeted and gaps in existing services can be filled
Develop a stepped care model for mental health services	HSC Board/ PHA in collaboration with HSC and voluntary and community sector	A regionally agreed model across all HSC services	By March 2010	People should be able to access mental health services appropriate to their needs
Increase levels of community mental health services	HSC Board in collaboration with PHA and HSC Trusts	240 additional staff in community mental health services (baseline 2007/08) 10% reduction in admissions to mental health hospitals (baseline 2007/08)	March 2011 March 2011	Greater access to community mental health services and fewer people need to be admitted to hospital
Develop a strategy for improving access to psychological therapies	DHSSPS	Strategy to be agreed	By October 2009	Improved access to psychological therapies

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Introduce a computerised Cognitive Behavioural Therapy programme	HSC Board in collaboration with HSC	Introduce programme and monitor uptake and patient outcomes	Ongoing	Improved support for those with mild to moderate depression
Develop regional guidance on assessment and management of risk in mental health and learning disability services	DHSSPS and HSC HSC	Agreed guidance to cover full range of mental health and learning disability services with regionally agreed tools to support guidance. Implement guidance and supporting tools	By September 2009 From September 2009	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.
Develop regional prescribing guidance on anti-psychotic medicines for primary and secondary care sectors	DHSSPS, HSC Board, PHA and primary care leads	Provide regional guidance to those prescribing anti-psychotic medicines	March 2010	Ensure that anti-psychotic medicines are prescribed and managed appropriately
Develop pilot of community pharmacy medicines management initiative for people with mental health needs	DHSSPS, HSC Board, PHA, in partnership with HSC Trusts and primary care leads	Commence pilot and put in place evaluation	From September 2009	Provide better and more accessible advice and support to people with mental health needs who are taking medication

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Establish specialist medicines management clinics for people who have been prescribed benzodiazepines	DHSSPS/ HSC	Complete an initial assessment of effectiveness of such clinics Undertake formal evaluation of clinics	March 2011 During 2011/12	Provide better advice and support to people who have been prescribed benzodiazepines and, where appropriate, support reduction in use
Develop a strategy for services for people with a personality disorder	DHSSPS	Agreed strategy with implementation plan to provide a range of services to address the varying needs of people with personality disorders	By October 2009	Better access to services for people with a personality disorder and support for their carers
Establish procedures to ensure people leaving hospital who need continuing mental health care receive it	DHSSPS/ HSC	From April 2009, all mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within 7 days of discharge	Ongoing	Better community support for those discharged from hospital
Establish procedures to ensure people presenting at A&E departments who need continuing mental health care receive it	DHSSPS/ HSC	From April 2009, all mental health patients seen at A&E departments and assessed as requiring further mental health care should have an appointment made with mental health services before they leave the A&E department	Ongoing	Better follow up and support for those in need of mental health services
Improve and harmonise model for crisis intervention services	DHSSPS/ HSC	DHSSPS to issue regional principles for provision of crisis mental health services Trusts to ensure regional principles are complied with and that services are harmonised across Northern Ireland	October 2009 Action Plan drawn up by December 2009 and action taken to agree timescales thereafter	People in crisis will be able to receive appropriate care and support to a consistent standard

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Appoint a Service Improvement lead for mental health and learning disability in each HSC Trust	HSC Trusts in collaboration with HSC Board	Ensure that service improvement in mental health and learning disability services is given sufficient focus	April 2010	People using mental health and learning disability services have access to high quality, efficient and effective care and treatment
Introduce inpatient services for eating disorders	HSC Board and PHA in collaboration with HSC Trusts	Develop regional approach to inpatient services with appropriate in-reach	By March 2011	Continuity of care from community services for those who need to be admitted to hospital. Less people will require admission to a facility outside Northern Ireland
Improve perinatal mental health services	DHSSPS in collaboration with HSC	Take forward action plan to implement relevant NICE guidance across all Trusts and primary care	Consult on proposed action plan by October 2009 Agree action plan and timescales for implementation by January 2010	Better detection and treatment of mental illness during pregnancy and the post natal period
Improve interface between adult mental health services and child care services.	HSC	To explore and agree how best to ensure appropriate liaison between adult mental health services and child care services. Develop guidance for staff working across these services	Ongoing	Better service for all family where the parent has a mental health problem.

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Provide a mental health information resource for young people and their families	PHA to lead with HSC Board	Web-based resource including directory of mental health services for young people	By April 2010	Young people encouraged to look after their mental wellbeing and provided with information on sources of support
New facilities with 33 mental health inpatient beds provided for children and young people up to the age of 18	HSC Trusts in collaboration with HSC Board with DE/ ELB input on education provision	New linked units for children and young people who require inpatient mental health treatment	By 2010	Increased inpatient provision in new purpose-built facilities
Develop a strategy for dementia services, including the needs of younger adults.	DHSSPS with HSC and relevant agencies	Agree draft strategy and associated action plan and issue for consultation	By December 2009	Improved services for people with dementia and their families and carers
Support the Northern Ireland Dementia Services Development Centre	DHSSPS and HSC	Centre to deliver a range of training, educational, consultative and research services to HSC and to service users and carers	Ongoing to March 2012	Improved services for people with dementia and their families and carers
Establish a Northern Ireland Forensic Mental Health and Learning Disability Steering Group involving users of services and carers and the relevant agencies at senior level.	HSC with other relevant agencies	A co-ordinated approach across HSC and criminal justice agencies to improve forensic services	September 2009	Better joined up services for people who need forensic services

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Conduct a review and produce a strategy to increase the provision of low secure and community forensic placements	HSC Board in collaboration with the Northern Ireland Forensic Mental Health and Learning Disability Steering Group	Current inpatient provision quantified and need for low secure and community forensic placements determined. A strategy developed for future provision based on assessed need.	March 2010 March 2011	Appropriate levels of support provided in the least restrictive conditions for those who need forensic services

MENTAL HEALTH ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford Vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Establish Health and Social Care Mental Health and Learning Disability Task Force	HSC Board and PHA to lead	A co-ordinated approach across HSC to improving mental health and reforming mental health and learning disability services in line with Bamford.	By October 2009	Mental health and learning disability services will be reformed and modernised in line with Bamford vision
Establish Bamford Monitoring Group	Patient Client Council	Provide a challenge function on the extent to which the reform of services is working.	By October 2009	Service users and carers will have an opportunity to feed back their views to Minister on how services are meeting their needs
Inter-Departmental Ministerial and Implementation groups to continue	DHSSPS (with other Departments)	A co-ordinated approach across Ni Executive improving mental health and reforming mental health and learning disability services in line with Bamford.	Ongoing	Better joining up of services across agencies
Introduce new mental capacity and mental health legislation	DHSSPS (with other Departments)	Commence new mental capacity and mental health legislation	Post 2011, exact timing depending on legislative programme	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 reason
Introduce a small amendment to the Mental Health (NI) Order to enable patients to apply to the court to replace their nearest relative.	DHSSPS	An amendment to the 1986 Order enabling patients to apply to court to replace their nearest relative	By March 2011	Patients will be able to challenge the appointment of a nearest relative. This will be important in situations where the relationship with the nearest relative has broken down or where there is a history of abuse by the nearest relative

MENTAL HEALTH ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford Vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Issue guidelines to health trusts advising of a European Court of Human Rights judgement requiring safeguards for those deprived of their liberty for their protection	DHSSPS	Guidelines issues to health trusts.	By December 2009	Those deprived of their liberty for their protection in nursing homes and hospitals and their relatives and carers will be consulted on the nature and extent of the deprivation

SECTION 3

THE LEARNING DISABILITY ACTION PLAN (2009-11)

HOW TO READ THE ACTION PLAN

Four broad work areas emerged from the Bamford review:

- promoting and preserving mental wellbeing and building emotional resilience within the population as a whole;
- having legislation which promotes self-determination but supports those unable to make decisions for themselves;
- improving services for people of all ages with a learning disability and their families and ensuring better joining-up across agencies;
- improving services for people of all ages with mental health needs and their families and ensuring better joining-up across agencies.

In this section of the Action Plan there is an introductory section on learning disability services. This is to set the scene for the detailed Action Plan.

Because public service resources are agreed for three-year time cycles, this Action Plan concentrates on actions which can be achieved within the resources available up to March 2011, but also signals actions which will in the longer term contribute to the Bamford vision. It is anticipated that further additional resources will be needed in future spending cycles and the Action Plan will be reviewed in 2011 to reflect progress and the funding position. All actions are grouped under five themes:

Promoting positive health, wellbeing and early intervention;
Supporting people to lead independent lives;
Supporting carers and families;
Providing better services to meet the needs of individuals; and
Developing structures and a legislative framework.

Each action has a timetable for completion, who is responsible for it, the outcome required and the benefits for individuals and for society. In addition, the learning disability action plan has been informed by the values contained in the Bamford Equal Lives Report.

Equal Lives Values

1	Citizenship	People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.
2	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.
3	Empowerment	People with a learning disability must be enabled to actively participate in decisions affecting their lives.
4	Working Together	Conditions must be created where people with a learning disability, families and organisations work together in order to meet the needs and aspirations of people with a learning disability.
5	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.

All actions detailed in the following Learning Disability Action Plan will state which of the values they comply with, numbered 1 to 5.

The following text provides a summary of service development within learning disability services. This is designed to inform the reader and to set the context for the actions contained in the learning disability action plan.

LEARNING DISABILITY SERVICES – AN INTEGRATED LIFELONG APPROACH

Introduction

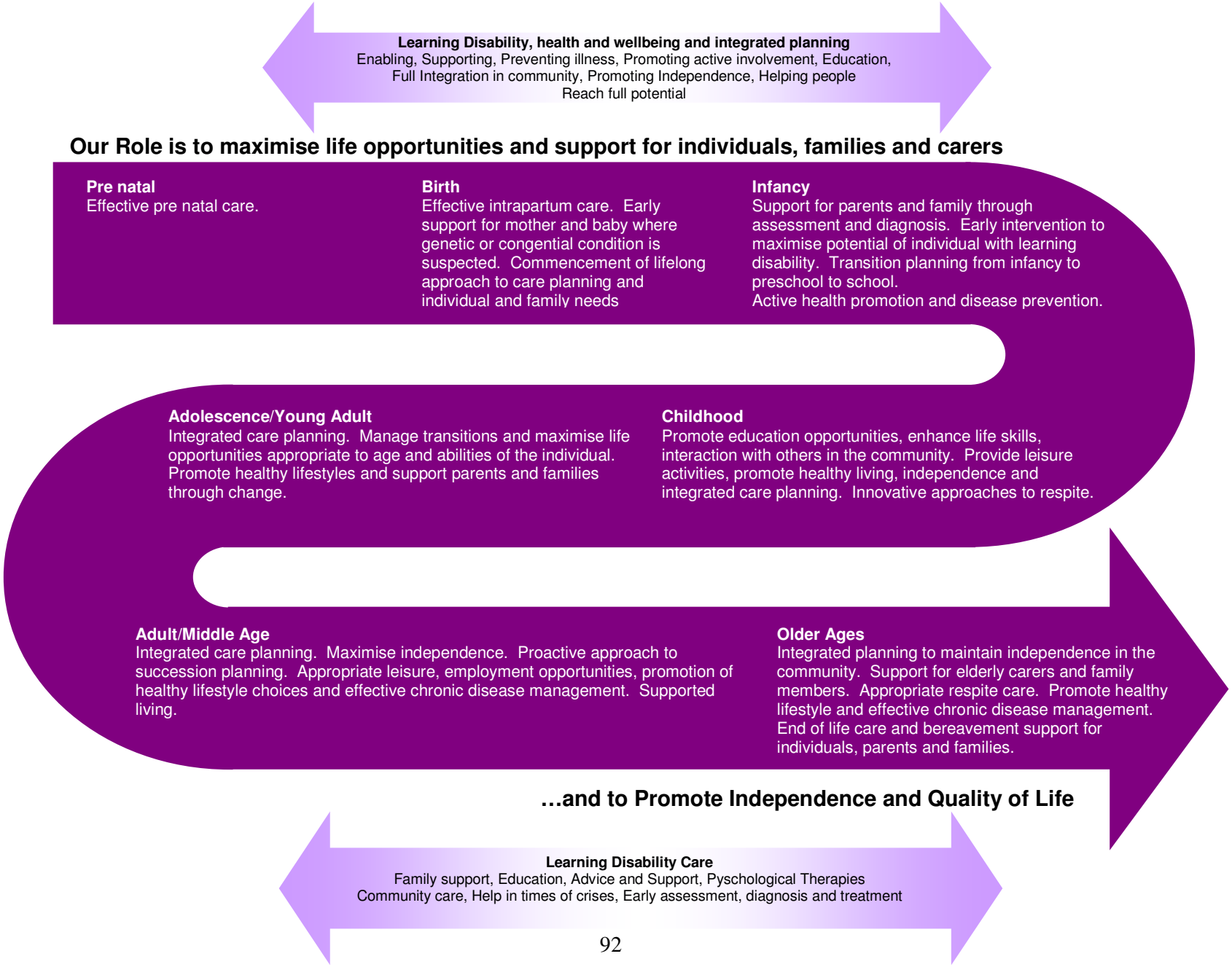
People with a learning disability must be treated as equal citizens, fully included in mainstream services and in the life of the community, empowered to participate actively in decisions affecting their lives, enabled to work together with their families and representatives and helped to use their individual strengths to reach their full potential. When developing services for people with a learning disability, we must not forget that a learning disability is a lifelong condition; as such, clients require more sustained services, not just individual episodes of care and treatment. It is also important to acknowledge that the provision of services for people with a learning disability is not solely a Health issue; it requires a multi-agency and integrated approach.

This life long approach encompasses:

- early intervention and support for individuals, families and carers;
- appropriate interagency care planning with involvement of individuals and carers;
- education, training and life opportunities, appropriate to individual needs;
- promoting and maintaining physical and mental health and wellbeing and the management of chronic conditions;
- effective management of transitions – from infancy to school, childhood to adolescence, adolescence to adulthood and adulthood to old age;
- effective succession planning and supported living to meet the needs of older relatives and the individual with learning disability; and
- end of life care and bereavement counselling.

Figure 4 represents a life cycle approach to promoting health, wellbeing and independence for individuals with a learning disability, and support for family and carers.

Figure 4. A Journey Through a Lifetime



Support for Families of Children with a Learning Disability

Children and young people grow and develop best in their natural families. Sometimes stress and/or financial issues can lead to families feeling under pressure or unable to cope, and requiring support and assistance from Health and Social Care services. The Equal Lives Review recommended that family support be remodelled to be more family directed and suited to the families' needs and wishes. To this end, respite services will be developed by moving away from inflexible residential provision towards a range of short break services, including home based support, community based activity, family placements and residential options.

Children with a Learning Disability

Enabling children with a learning disability to participate as fully as possible in education is a key element in maximising their potential in later life. The statutory responsibility for securing special education provision for pupils with special education needs (SEN) rests with the Education and Library Boards. There are approximately 13,271 (DE Census 2008) children with SEN statements, with increases in recent years both in the number of SEN children and in the complexity of their needs. Special education provision is matched to the individual needs of the child and can be delivered in a range of settings. The Department of Education provides a range of guidance material to schools, ELBs and relevant voluntary sector organisations to support their work in providing services to SEN pupils.

The Special Education Needs and Disability (NI) Order 2005 (SENDO) strengthened the rights of SEN children to be educated in mainstream schools. A Dispute Avoidance and Resolution Service (DARS) and an Advice and Information Service were introduced in 2005 to improve support for SEN children and their parents in dealing with schools and ELBs.

The Review of Special Educational Needs and Inclusion, due to be published in 2009, is expected to result in recommendations for improved interdisciplinary working between education and health professionals. A review of speech and language therapy provision has been undertaken and the recommendations will be considered jointly between DHSSPS and the Department of Education in relation to the way forward for speech and language therapy provision. An action plan is currently being developed, which will see

a focus on pre-school interventions, and speech and language services for those children who attend mainstream schooling.

We want to see an emphasis given to adequate service provision as early as possible, or "right from the start" whereby health, social, developmental and education needs are identified and a coordinated plan of action put in place to address these needs. The joint DE/ DHSSPS group on issues of mutual interest will work to strengthen and develop links to ensure that planning, assessment and delivery of services is co-ordinated to meet children's needs.

Much of the work through schools to maintain and improve the mental wellbeing of children and young people, which is outlined in the Mental Health section of this Action Plan, also impacts on children with a learning disability.

Transition to Adulthood

A DE/ DEL/ DHSSPS inter-Departmental group to consider the transition arrangements to adult life for young people with SEN reported in early 2006 and recent monitoring indicates that all but one of the actions have been met in full. DE made available funding of over £2.4m from 2005/06 to 2009/10 to meet the DE-related recommendations, to strengthen the transition planning process in schools, by appointing 10 Education Transition Co-ordinators. Further funding, from the Children and Young People's Funding Package, of £200k over the period 2006/07 - 2007/08 was used to enhance life skills training and improve self-help and independent living for over 370 pupils in special schools through a range of school-based programmes.

A recent ETI survey, published in February 2009, has found that " the transition arrangements and provision for school leavers in almost all the school are of good and sometimes excellent standard. The work of the Transitions Co-ordinators, though at an early stage of development, is progressing well, a positive work ethic and approach is evident and good links have been established with the key stakeholders." As a result of this positive evaluation DE will mainstream the funding of the 5 Education and Library Board Transition Service.

DHSSPS also secured from the Children and Young People's Funding Package an additional £0.9m recurrent, for the improvement of day care for young people when they

become 18 and are moving from children's services into adult services. 150 purposeful placements for young people on transition from special schools into the community have since been created. Funding has now been mainstreamed in order to maintain these placements.

DE, DEL and DHSSPS continue to work closely in developing joined-up services for children and young people with a learning disability, and especially for those young learning disabled people who are making the transition into adulthood. A sub-group of The Ministerial Sub Committee on Children and Young People is currently developing an Action Plan which is focussing on transition of young people from school to adulthood. The plan will contain actions to further strengthen policy delivery and post school provision. The timescales for the delivery of a range of actions are being considered at present.

Day Opportunities

A cultural shift away from a reliance on day centres will be encouraged, towards alternative options, including further education and supported employment, where appropriate. This will enable individuals with a learning disability to participate in society through education, and work based activities that will improve their skills and allow them the opportunity to integrate with others.

Succession Planning

Demographic changes mean that individuals with a learning disability are living longer, often being cared for by elderly parents and relatives. This can increase the burden on services for such individuals and their carers. Services need to be developed in line with these changes to the learning disability population, to ensure that all clients have access to the services they need.

Each individual should have an appropriate care plan to ensure they have access to all the services required to accommodate their needs and the needs of their carer/s. HSC Trusts must work together with the community and voluntary sector to achieve this.

Advocacy

The Equal Lives Review concluded that a new service model needed to be developed, drawing a line under the notion that people with a learning disability should be grouped

together and segregated from services enjoyed by the rest of the population. This new model must be based on social integration and encourage people with a learning disability to fully participate in community life. This includes ensuring that people have greater choice and more control over their own lives. To do this, we must develop person-centred approaches in all services and ensure all users have access to Advocacy and Direct Payments, where appropriate to their need.
Many people with a learning disability find it hard to make their voices heard. Advocacy gives people the opportunity to get involved in decisions about their own care plan, and make their opinions heard.

Access to Health Care

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. People with a learning disability will be living in local communities rather than having their homes in specialist hospitals.

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 includes for example, improved and supported access to primary care services (GP, dentistry, optometry and the full range of health screening), secondary care services (particularly in-patient acute services), mental health services, sexual health services, and end of life services, if necessary.

Good health however begins with emphasis being given to promoting good physical and mental health, and ensuring that people with a learning disability, throughout their lives are involved in strategies and schemes to build resilience, and prevent the onset of ill health.

A Directed Enhanced Services for adults with a severe learning disability has been introduced. It is designed to improve primary healthcare through the introduction of annual health checks, and could enable the introduction of health facilitators and / or other options to liaise with individuals and their families and other relevant agencies to ensure healthcare needs are met.

Individual health actions plans will also be developed on a person-centred basis, and will involve people with a learning disability and their carers in effective multi-agency and multi-disciplinary care planning, prepared with and for the individual concerned and will identify the responsible professional or agency for addressing the health needs identified.

Optometry

There are already some examples of good practice in relation to people with learning disabilities accessing mainstream services. An example is vision screening for people with learning disabilities in the Belfast Trust. Staff from the low vision clinic in the Royal Hospital, supported by community learning disability nurses and sensory support workers have addressed a number of the barriers that prevent people from accessing opticians in their local community. People are provided with information before the assessment and prepared for the equipment and tests that will take place. The service is provided in a location that is familiar to the individual. An evaluation has demonstrated that this has been effective in identifying a number of people with vision difficulties who otherwise might not have been spotted.

Dental Services

The findings from a review of the literature related to the oral health of people with disability, confirm that people with a learning disability have similar oral diseases but poorer oral health and poorer health outcomes from care than the general population (Fiske et al 1999; BDA, 2003).

The care of patients with moderate to severe learning disabilities falls to the Community Dental Service (CDS), which is a small specialist Trust based service. While significant improvements have been made over the last number of years to dental services for people with a learning disability, more needs to be done. The Review of the Community Dental Service (2003) recommended that patients with special needs should be the focus for clinical activity for the CDS. For this shift in focus to be successful, there is a pressing need for training, both in terms of continuing professional development and in recognised training pathways, to provide specialist clinicians.

The DHSSPS undertook a Survey of Dental Services to People with Learning Disabilities in Northern Ireland in December 2005. While progress has been made on many fronts in relation to the recommendations contained in the survey, lack of

resources and the absence of key staff has prevented others being taken forward. We must endeavour to ensure that these recommendations are implemented, so that individuals with a learning disability have the same level of access to community dental services, and can enjoy the same standards of oral health as the rest of the community.

Access to Health Information

The Equality Commission has produced a report on the ease of access to health information for people with a learning disability. The Department is working together with the Equality Commission to ensure that all those who have a learning disability have access to the health information they need in an appropriate format that best suits their needs.

Respite

Respite care is an important component of the wide range of health and social care services provided in response to assessed care needs. Funding has been secured in the Comprehensive Spending Review 2008 -2011 to invest in additional respite packages for people with a Learning Disability. This funding will be used to provide an additional 200 new or enhanced Learning Disability respite packages over the CSR period to benefit at least 800 people by 2011. This includes children, young people and adults.

The Department of Health, Social Services and Public Safety is piloting a new statistical data collection during the first quarter of 2009 to begin the process of monitoring respite care. This will inform the next Comprehensive Spending Review period.

Re-settlement in the Community

The resettlement of patients from Learning Disability hospitals has been a Departmental policy for many years, but the Bamford Review brought it to the fore as one of its key recommendations. An Action Plan was announced in January 2007 to ensure that by March 2009 no child would be permanently resident in a learning disability hospital. The plan also provides for an increase in the number of patients resettled each year. The Programme for Government (January 2008) set a goal to ensure that, by 2013, anyone with a mental health need or a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital.

The resettlement programme must be supported by improved community care services. The process of resettling patients is a complex one, involving both community and hospital multi-disciplinary teams along with the patient and family and DSD and the NI Housing Executive, as lead Department and lead provider of the Supporting People programme for supported living.

A patient is identified for resettlement only when it is clinically appropriate and it is clear that the patient's needs can be met and quality of life can be improved by the placement – the concept of "betterment". The Executive appreciates that there is apprehension among families of some people who have been in hospital for considerable periods of time and accepts that there will be particular challenges in ensuring betterment for some of these people.

The Executive remains committed to the goal of having no-one unnecessarily remaining in hospital. A target has been set for a reduction in long-stay inpatients by 2011, in line with resource availability up to 2010/11, and good progress is already being made to achieve this target. It is acknowledged that additional resources will be required in the following two years to achieve the overall 2013 goal.

Capital Planning

The principle of "betterment" must apply to individuals, who are part of the resettlement process. Targets set for the resettlement of patients from learning disability hospitals will present considerable challenges, and discussions are ongoing between the HSC, the DHSSPS and the DSD on the associated planning, financial and operational issues. For example, the HSC and the NI Housing Executive will need to agree proposals for the future development of new residential schemes to facilitate the resettlement of people into the community.

The relocation of children's services from Muckamore Abbey Hospital will also require additional residential schemes to be developed, which will offer long-term, shared care and respite provision for children. Further proposals for respite services must also be agreed to ensure the target of 200 extra packages will be available by March 2011.

Community Services and Support

The Resettlement programme goes hand in hand with investing in community infrastructure and appropriate support mechanisms. Multi-disciplinary Learning Disability teams provide a key service by supporting service users, their carers and families within the community, and will continue to do so as progress is made towards resettling all clients from learning disability hospitals into the community. However, with the shift towards community based service provision, reduction in utilisation of hospital based care, and the subsequent management of those with complex needs, there needs to be a clear understanding of what is required within community based services to address demographic change and new patterns of care delivery.

Voluntary and community groups also have an important role to play by providing various services to complement the work of the Learning Disability teams, such as day services, vocational training, supported employment and housing, respite, etcetera.

Complexity of Needs

There remains the potential for a new long stay population within learning disability hospitals to develop, especially those people who are experiencing frequent admissions and are involved in "revolving door" experiences. Many of these people present with very complex needs, associated with very challenging behaviours. It is essential, therefore, that community services are developed to meet such needs, and in particular the skills mix of community learning disability teams. Only when these challenging behaviours are addressed within the full range of community settings, will there be a reduction in potential new long stay population of our hospitals.

Assistive Technology for people with a Learning Disability

When considering the needs of people with more profound and multiple disabilities the potential for technological advancements to maximise opportunities for independence needs to be more fully considered. The Bamford Review recommended that housing planners and service providers 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. A consultation exercise is due to be taken forward shortly by the European Centre for Connected Health.

Forensic Issues

The Bamford Review recognised that 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.

The Review recommended 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.

In order to start developing these services, the HSC will be asked to produce a plan for the future implementation of forensic services. A new PfA target will be set for 2010/11 to achieve this.

A Service Framework for Learning Disability – Promoting Quality and Performance Improvement.

The Learning Disability Service Framework being developed will identify a range of service standards to ensure that people with a learning disability and their families are clear about the support they can expect from these services. While the basic premise of the Learning Disability Service Framework 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, the volume and range of separate services will decrease as learning disability expertise is developed within mainstream HSC services.

DELIVERING THE BAMFORD VISION – LEARNING DISABILITY ACTION PLAN

Equal Lives Values

1	Citizenship	People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.
2	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.
3	Empowerment	People with a learning disability must be enabled to actively participate in decisions affecting their lives.
4	Working Together	Conditions must be created where people with a learning disability, families and organisations work together in order to meet the needs and aspirations of people with a learning disability.
5	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.

These five values that underpinned the service development recommendations in the Equal Lives Review have been carefully considered during the drafting of this Action Plan. All actions detailed in the following **Learning Disability Action Plan** will state which of the values they comply with, numbered 1 to 5.

Themes:

1. Promoting positive health, well-being and early intervention
2. Supporting children, adults and older people to be independent and reach their full potential
3. Supporting carers & families (to include information and advice, respite)
4. Providing better services to meet people's needs
5. Providing structures and legislative base to deliver the Bamford Vision

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Ensure that persons with a learning disability have equal access to the full range of primary health care services to improve the physical and mental health inequalities experienced by them A directed enhanced service (DES) to work in partnership with multi-disciplinary learning disability team and primary care staff will be developed across the region Develop individual health actions plans on a person centred basis involving people with a learning disability and their carers	HSC Primary Care, Acute Hospitals, Multi-Disciplinary Learning Disability Teams, Other Providers	A directed enhanced service (DES) will be rolled out regionally for adults with learning disabilities and will be provided in 90% of GP practices which will: • Develop and maintain a register of clients with a learning disability • Develop individual health action plans for children and adults with a learning disability. • Provide a recall system • Provide annual health checks integrated into the personal health record • Involve carers and support workers • Provide a review mechanism to include outcomes and actions from assessments	2011	• Better health promotion 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 • Health problems detected and treated earlier to minimise risk to the person's health and well-being • Enhanced usage of generic health services • Promote a team based approach to care with improved liaison with carers, health and social care professionals • Seamless care provided • Provide accessible health & social care information to people with a learning disability and their carers	1, 2, 3,4 and 5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
		• Develop specific health facilitation posts where appropriate • Allow full access to the full range of health screening services that are available to the general population • Develop screening and early identification mechanisms regarding mental health			
Publish a revised cross-sectoral Promoting Mental Health Strategy	All Departments, led by DHSSPS Investing for Health Group	A renewed emphasis on mental health promotion across all sectors, taking account of lessons learned from previous work	By December 2009	Better mental wellbeing in the population	5

LEARNING DISABILITY ACTION PLAN

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Increase oral health promotion programmes aimed at clients with a Learning Disability and their families	HSC Board in collaboration with wider HSC	Development of regional and local programmes that will empower LD clients, their carers and families to improve oral health	Ongoing	Increased awareness of oral health as a personal priority for people with a Learning Disability Increased knowledge of personal measures that can be taken to improve or maintain oral health Improved attendance at primary Dental Care services Reduced referrals to Specialist/Secondary Care	3, 4, 5
Develop, consult and implement a 10 year Early Years Strategy.	DE led Ministerial sub-committee for Early Years.	Consultation on Strategy Implementation Plan	Autumn 2009 Spring 2010	Prevention and lessening of emotional and behavioural problems in young children by ensuring access to - physical nurturing - nourishing food - exercise and play (particularly outdoor play) - adequate sleep - emotional and social support	5

LEARNING DISABILITY ACTION PLAN

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Introduce a revised curriculum which provides opportunities through Personal Development and other areas for young people to develop the skills they need to cope with challenging personal situations such as violence against women and children; self-harm etc.	DE – Curriculum & Assessment Team	All schools to have implemented the revised curriculum	By September 2009	Pupils benefit from the opportunity to develop the skills they need to cope with a range of challenging personal situations; teachers receive guidance and support, including training, to implement the revised curriculum	1, 2, 4, 5
Produce guidance and support material for post primary schools on proactively promoting positive emotional health and well being among staff and pupils Produce guidance for schools on the management of critical incidents and ensure consistent support to schools across all board areas	DE – Pupil Support Unit	All schools understand their role in promoting positive outcomes for pupils There is consistent minimum provision across all post primary schools within the curriculum and pastoral care supports	Commencing Autumn 2009 Ongoing	All pupils and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies	2, 4, 5

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KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Develop proposals for developing resilience among primary aged pupils and those in special schools for consultation; to implement agreed new services	DE – Pupil Support Unit		Commencing Autumn 2009.	All primary age pupils, those in special schools and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies	1, 2, 4, 5
Support schools in their work to create an anti-bullying culture with guidance and materials which tackle all forms of bullying, including homophobic bullying, are up to date and reflect the dynamic nature of the problem	DE – Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils are confident that their concerns about bullying will be dealt with in an appropriate and timely manner	1, 2, 4
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	From September 2009	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation	1, 2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Progress the Tackling Sexual Violence and Abuse Strategy 2008-2013	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of sexual violence and abuse	2, 3, 5
Implement the domestic violence strategy *Tackling Violence at Home*	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of domestic violence and abuse through funding a range of support/education programmes.	2, 3, 5
Commission a scoping study of Pastoral Care arrangements in FE	DEL	To ensure that the FE sector is fully aware of and responsive to the needs of its students including having in place comprehensive pastoral care arrangements across all campuses to identify and address any problems experienced by students.	Scoping study commissioned by Public Procurement. Commenced July 2009 Findings of scoping study by December 2009 Implementation plan for any identified actions by March 2010	More effective, comprehensive and consistent pastoral care services for students across all 6 regional colleges	1, 2, 4, 5

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THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Review of the NI Child Health Promotion Programme (Health for all Children -Hall 4) to ensure early identification and intervention from the ante-natal period through pre-school and school age years	DHSSPS; PHA; Regional Health for All Children Group; and HSC Trusts	Redesign of Child Health Promotion Programme to ensure best practice is being delivered	Implementation from 1 January 2010	Early identification of disability to secure early intervention and support	1, 2, 5
Increase access to dental hygienists for education and regular appointments	School of Hygiene HSC	To train increased numbers of Hygienists Develop Oral Hygiene Services Utilise skill mix in workforce to deliver increased oral hygiene programmes to the Learning Disability population	To progress by 2011 and review progress against longer term targets.	Improved oral hygiene for people with a Learning Disability Reduce levels of dental decay Reduced usage of dental general anaesthetic & intravenous services	2, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Publish a report on the 'Promoting Social Inclusion' work led by OFMDFM with input from Departments and the sector as appropriate	OFMDFM, Equality / Rights & Social Need Division	The work of the PSI Group for people with disabilities covers a range of topics and cuts across Departmental boundaries – the report will provide a composite set of recommendations for Executive consideration which will improve the quality of life for people with disabilities.	Autumn 2009	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; • Legislation, Citizenship, Language and Attitudes, and • Lifelong Learning, Arts, Sports and Culture	1, 2, 3, 4, 5
Publish an action plan for the implementation of recommendations arising from the PSI report (above)	OFMDFM Equality / Rights & Social Need Division (with input & agreement from other Departments as necessary)	As above. The action plan for this PSI work will be taken forward in the context of the wider 'anti-poverty and social inclusion' strategy - Lifetime Opportunities	Agreed action plan by March 2010	As above	1, 2, 3. 4, 5

LEARNING DISABILITY ACTION PLAN

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Mainstream the funding of 5 Education and Library Board Transition Service Pilot Project, subject to positive outcome of ETI Inspection Report	DE - Special Education Branch	To strengthen the transition planning process in school and provide a co-ordinated approach to transition planning with other statutory agencies and advice givers	Consider and evaluate outcomes of ETI Inspection Report which has been published in February 2009 and, if positive, mainstream funding from 2009/10 financial year	This action will benefit all pupils with a statement of special educational needs (including those pupils with a mental health problem or a learning disability) by ensuring that Education and Library Boards/the Education Skills Authority provide a cohesive approach to transition planning and that pupils are supported and informed about post school options and placements	2,3,5
Consider and develop, under the auspices of the Transitions Sub-Group of the Ministerial Sub Committee on Children and Young People, an Inter-departmental Action Plan to further strengthen policy delivery and the provision for young people with special educational needs as they make the transition from school to adulthood	DE – Special Education Branch, as Chair and Secretary to the Sub-group. Action Plan to be implemented by all participating Departments, i.e.; DE, DEL, DHSSPS, DSD, NIO, JJS, OFMDFM	To implement, through inter-departmental working and collaboration, an action plan to consider and remove barriers to the successful transition of young people with special educational needs from school to adulthood and the provision of continuing education, work opportunities and appropriate health and social care interventions	May 2009	Benefits young people with special educational needs (including those pupils with a mental health need or a learning disability) as they make the transition from school to adulthood	2, 3, 5

LEARNING DISABILITY ACTION PLAN

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Issue Review of SEN and Inclusion Policy Proposals for public consultation. Develop agreed guidance and quality indicators which will cover issues such as:- - early identification and intervention; - the effectiveness of strategies and services employed; the effectiveness of funding and delivery of resources	DE Review of SEN and Inclusion team	A shared commitment between DE and DHSSPS to the planning and timely provision of locally commissioned services which are child centred, easily accessible, effectively and consistently delivered to those children and young people who need them	During 2009 (subject to agreement of Executive to move to consultation phase).	Every child and young person, facing barriers to learning and social inclusion (in particular, those with disability or health needs and social and emotional factors) is given a fair and equal chance and provided with the necessary support as early as possible to help them achieve their potential	1, 2, 5
Commission research to ascertain the impact on people with learning difficulties of the policies and actions contained in the Accessible Transport Strategy	DRD	The research would provide an assessment of how accessible services supported by DRD are to people with a learning disability. It would also consider areas such as the provision of travel information, training provision and personal safety and confidence issues	Report commissioned April 2009 Date for delivery of draft report by end of October 2009	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability	1, 2, 5

LEARNING DISABILITY ACTION PLAN

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Complete an analysis of DEL provision across the further education and training sector for those with a disability, including those with special educational needs or with mental ill health. This work to build on detailed reviews of Students with Learning Difficulties and/or Disabilities provision in FE, barriers to Training for Success and also recent inspection reports of provision	DEL Education and Training Inspectorate	Identification of areas for future DEL action where appropriate; also, an indication as to whether individuals have access to the services they require consistently across further education and training	Report finalised by June 2009	More effective services for individuals accessing DEL programmes and services	1, 2, 4, 5
Consider the findings of the overarching review and any strategic implications for DEL and develop an action plan	DEL	Strategic action plan to address cross-departmental issues identified that impact on individuals with mental ill health and /or learning disability	Action plan in place for 2010/11 Key milestones - consider resource implications, both staff and financial - identify delivery mechanisms - seek approvals to proceed	More effective services for individuals accessing DEL programmes and services	1, 2, 4, 5

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Undertake scoping study of provision for those not in education, training or employment (NEET), including those with mental ill-health and/or learning disability	DEL in liaison with other organisations, including PHA	Determination of available provision	Scoping study completed by Autumn 2009	Improved information to enable consideration of need for cross-Departmental strategic approach/ further actions	1, 2, 4, 5

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Examine the benefits for NI of adopting similar partnership arrangements to those put in place by the Scottish Executive that detail the roles and responsibilities of agencies involved in meeting the educational, health and social needs of people with additional needs accessing DEL provision	DEL jointly with DHSSPS/ HSC and other relevant Departments	Clear understanding of the respective roles and responsibilities including information sharing between DHSSPS and its agencies, DEL and its delivery partners and other agencies in addressing the needs of these learners (in particular assistance with assessment, personal care, transport etc), and that the findings are disseminated locally to DEL delivery partners and HSC	Stage 1: Scope benefits by End 2009 -Identify resource to undertake project - establish steering group for the project Stage 2 : Bring forward proposals to develop partnership working guidance in 2010. Report progress to Inter – Ministerial Group	Better awareness of the challenges of delivering provision to learners with profound and complex needs and clear signposting for individuals, families and providers Better informed healthcare and other professionals in relation to the education and training programmes and services relevant to and accessible by adults with mental ill health and/or learning disability	2, 4, 5

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Develop new exhibitions / exhibits to include provision for those with learning difficulties	W5	Include exhibits/Exhibitions with sensory experiences, graphics and limited text to be inclusive to those with learning difficulties.	Ongoing	Inclusion and enjoyment in exhibition	1, 2, 4, 5
Carry out a policy evaluation of the Supporting People programme	DSD	Examination of the governance arrangements, commissioning process and funding arrangements, to ensure compliance with the policy intention that Supporting People is to fund advice and guidance for relevant individuals/organisations	March 2010	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it	1, 5
Collaborative work between DSD, NIHE, DHSSPS and HSC	Supporting People Commissioning Body, chaired by the Northern Ireland Housing Executive	Ensure that the accommodation needs of vulnerable adults are included in the delivery of the Social Housing Development Programme in as far as resources are available at that time	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it	2, 5

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Publish action plan of how NICS will promote diversity	CHR to lead with all other NICS departments	Equal opportunities monitoring of the NICS workforce. Review the 2008 – 2011 NICS Employment, Equality and Diversity Plan	December 2009	A working environment where everyone has a right to equality of opportunity and individual differences are valued and respected The NICS workforce will be more representative of the community by attracting a more diverse applicant pool for advertised posts including applications from those with a disability	1, 2, 5
To develop mandatory equal opportunities and diversity awareness training to all staff at all levels within the NICS	CHR to lead with all other NICS departments	Ensure that all employees are aware of their duties and responsibilities to ensure equality in the workplace and to fully include employees with disabilities, including learning disabilities, in the working environment	Mandatory Training to commence in October 2009. To be complete by June 2010	To raise awareness of issues facing staff and customers with disabilities including those with a learning disability by ensuring all NICS employees are trained in equal opportunities and diversity awareness	1, 2, 5

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Improve communication methods and access to information for people with a learning disability	PHA to lead in partnership with HSC Board and Trusts, working with DEL and DSD	Increase in information and advice services, at least some of which will be delivered by voluntary sector Provision of information in easily accessible formats to cater to users' needs – this will involve training for staff in contact with those with a learning disability Reasonable adjustments should be made to provide information to make services more accessible	Ongoing	Better support for service users and carers in understanding the services and making their views heard	1, 3, 4, 5
Education and Library Boards to continue to develop their information and advice service	DE	Improvement of statutory information and advice service	Ongoing	Better support and advice for parents, pupils and schools in understanding the services available	1,3,4,5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

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Resettlement of long stay patients from learning disability hospitals	DHSSPS HSC DSD NIHE	25% reduction in the number of long-stay patients in learning disability hospitals (baseline 2007/08) Anyone who has a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital	By 2011 By 2013 (Programme for Government Target)	More people with a learning disability able to live independent lives safely in the community	2, 4, 5
Development of a plan by Local Commissioning Groups demonstrating what advocacy services are currently in place and the vision for the future	HSC	To enable individuals and carers to actively engage in care planning and quality assurance	By March 2011	People with a learning disability and their carers will be better informed to make their own decisions and will have a greater opportunity to have their voices heard and influence their care which will improve their independence	2, 3

LEARNING DISABILITY ACTION PLAN

THEME: Supporting carers

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Complete a joint Review of Support Provision for Carers	DHSSPS/DSD	Improved support services for carers who look after people of all ages who have a learning disability or mental health issues	Autumn 2009	People with a learning disability or mental health issues are supported to live independent lives in their own home for as long as possible and carers are supported in their caring role so that they can continue to care for as long as they wish and are able to do so	2, 4, 5
Improve regional information on provision of respite care	DHSSPS/ HSC	Pilot data collection and refine as necessary Monitor respite care provision in NI on a quarterly basis	By December 2009 Ongoing	Respite provision can be better planned and monitored	1, 2, 5
Support to families with a child with a learning disability	HSC	Family Support Plans which will identify unmet need and changing needs as children grow The appointment of a key worker to support families and carers at time of diagnosis and beyond and to co-ordinate and link in with other services required	March 2011	Families will be provided **with more co-ordinated support** at an earlier stage	3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Supporting carers

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Support for individuals with a learning disability and their carers and families by the provision of short breaks and respite opportunities	HSC in collaboration with voluntary and community sector	The provision of 200 additional respite packages benefitting 800 people (baseline 2007/08) There should be a move away from traditional respite to the delivery of a more flexible and responsive service, taking full advantage of Direct Payments, self-directed support and other innovative forms of respite	March 2011	People will be afforded more flexible respite options which will help maintain their care settings by supporting their carers.	3, 4, 5
Increase uptake of Direct Payments	HSC	Double the number of recipients of Direct Payments in learning disability programme of care (baseline June 2007)	By March 2011	Give service users and their carers greater choice in the support they receive	2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS	VALUES MET (numbered 1 to 5 – see above for definitions)
Provide a service wide, supportive, quality driven environment to promote Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Submit consultation schemes under section 19 of the Health and Social Care (Reform) Act (Northern Ireland) All organisations to embed PPI consistently as part of organisational activity Establish leadership and accountability arrangements for PPI Monitor and Evaluate progress; agree priorities and targets for subsequent year; report annually	Jan 2010 Apr 2010 Apr 2010 From Apr 2010	• Improvements in service design. • Improvements in user and carer experience of services. • Promotion of social inclusion • Improved safety and quality of treatment • Reduction in complaints • Improved management of demand • Understanding of how and when care goes wrong • Reduction of risk	1, 2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
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	4, 5
Develop a Service Framework for learning disability services	DHSSPS	Strengthen the integration of health and social care, enhance health and wellbeing, promote evidence – informed practice, focus on safe and effective care and enhance multidisciplinary and inter-sectoral working	By December 2010	Set out the standards of care that people who use services, their family and carers can expect to receive	2, 4, 5

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Increase levels of community learning disability services	HSC Board in collaboration with PHA and HSC Trusts	Increase the LD community based workforce commensurate with the improvement in community infrastructure to meet the needs of the learning disabled population.	2011	Greater access to community learning disability services	2, 4, 5
Improve information systems on provision and use of mental health and learning disability services	HSC Board in collaboration with HSC	Anonymised database on inpatients in learning disability facilities available at regional level for use by DHSSPS and HSC bodies Extend the database to include users of community based services	October 2009 April 2011	Services can be better planned to meet needs and monitored to ensure service improvement, based on up to date local information	4,5
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	April 2010 and ongoing	New services can be better targeted and gaps in existing services can be filled	1,2,3,4,5

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Review range of facilities used to provide both inpatient and community based mental health and learning disability services and agree future pattern of provision	DHSSPS/HSC	Plan for facilities required to deliver mental health and learning disability services	The Capital Priorities Review was completed in September 2008. A Policy Infrastructure Forum has been established to address new requirements and ongoing prioritisation	Services will be delivered in appropriate, accessible, fit for purpose buildings	4, 5
Complete a workforce planning study for mental health and learning disability health and social care services	DHSSPS (HR Directorate) in collaboration with HSC	Agree a prioritised action plan to take forward recommendations from the commissioned workforce study	December 2009	Adequate numbers of appropriately trained staff to deliver services needed	4, 5

LEARNING DISABILITY ACTION PLAN

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Improve services for people with challenging behaviours and their carers	DHSSPS DE HSC	Production of agreed regional guidelines in partnership with service providers and the voluntary sector on the management of challenging behaviours within services	March 2011	Assist carers in managing challenging behaviours e.g. by directing to appropriate "behaviour services"	4, 5
Improve collaboration between education and health sectors in meeting the educational needs of children and young people with significant challenging behaviours	DHSSPS DE	Production of agreed agreed protocols	March 2010	Smooth transition between health and education services to appropriate placements	1,2,3,4,5
Training of primary dental care professionals to improve quality of care provided to patients with a Learning Disability	Consultant in Specialist Care Dentistry (SCD) Specialist network in SCD NI Medical, Dental Training Agency (NIMDTA)	Provide training in disability awareness and communication skills Undergraduate and postgraduate training in provision of dental care to people with a Learning Disability	2011 initially and progress towards longer term target	Increased local availability of dental care to Learning Disability population Increased local levels of dental care Reduced levels of secondary referrals to SCD specialist teams Increased access to mainstream primary dental care services	2, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Establish consultants in Specialist Care Dentistry (SCD)	DHSSPS School of Dentistry HSC	Appoint consultant in SCD Fund additional SCD consultant position	March 2011	Improved quality of services for patients with severe / complex Learning Disability needs Strengthen SCD network; provide absence cover; reduce waiting lists	1,5
Establish training pathways in Specialist Care Dentistry (SCD)	DHSSPS School of Dentistry HSC	Specialist registrar positions in SCD Training for community based specialists in SCD Training for Dentists with Special Interests in SCD Training for Primary Dental Care Practitioners	2011 initially and progress towards longer term target	Increased local availability of dental care to Learning Disability population Increased local levels of dental care Reduced levels of secondary referrals to SCD specialist teams Increased access to mainstream primary dental care services	1, 2, 5
To provide assessment and treatment for children with a learning disability Provide suitable respite facilities to ensure children do not have to remain in hospital	HSC Board and PHA in collaboration with wider HSC	Provide an 8 bedded assessment and treatment unit at Iveagh Provide 8 respite places. The location / locations of these respite places have to be determined and will provide residential and respite care for children who challenge services	January 2010 In line with agreed DHSSPS Capital Priorities	To ensure those children affected are looked after in the safest, most suitable location	4, 5

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THEME: Providing better services to meet people's needs

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Establish a Northern Ireland Forensic Mental Health and Learning Disability Steering Group involving users of services and carers and the relevant agencies at senior level	HSC with other relevant agencies	A co-ordinated approach across HSC and criminal justice agencies to improve forensic mental health and learning disability services	September 2009	Better joined up services for people who need forensic mental health & learning disability services	4, 5
Develop a plan for a community LD Forensic Service	HSC with other relevant agencies	A plan for the future implementation of services, providing specialist low secure community accommodation and community based forensic services	By March 2011	Improved forensic learning disability services delivered by appropriately trained staff	4, 5
Inclusion of learning disability in all service frameworks.	DHSSPS	The standard and quality of care for people with a learning disability will be improved. All services should be accessible to people with a learning disability and all service frameworks should explicitly reference the needs of people with a learning disability	Ongoing	The framework will improve the health & well being of people with a learning disability through promoting social inclusion, reduce inequalities in health & wellbeing, and improve quality of care. They will be better supported to live in the community which will reduce the need for them to be cared for in learning disability hospitals.	2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Completion of a needs assessment to inform the future need for and provision of learning disability services.	DHSSPS DSD DEL HSC Board and PHA DE, who already have a statutory assessment process in place within the SEN framework	To develop a joint policy to progress inclusive and co-ordinated planning processes for services to inform comprehensive spending reviews.	2010/11	This will improve the services provided to those with a LD as services will be co-ordinated.	4, 5
Improve the experience of those with a Learning Disability accessing the HSC in all care settings	DHSSPS HSC	Training of staff to make them more aware of the needs of people with a learning disability.	Ongoing	Staff will be better equipped to recognise the needs of people with a learning disability and to deal with them appropriately with respect to their disability The experiences for people with a learning disability in all HSC settings will be improved. This will help them achieve the best outcomes from interventions and improve their health	2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Improve the information provided to people with a learning disability to ensure appropriate health and social care is given where needed.	DHSSPS HSC	Implementation of best practice identified in the Equality Commission Report into the accessibility of health information in Northern Ireland for people with a learning disability. Passporting for both children and adults should be developed and rolled out (for example, the Sixth Sense project in SHSCT)	Ongoing	Enhanced exchange of information between individuals, their families and carers and HSC Services.	2,4,5
Develop a Regional Bed Management Protocol for those with a learning disability.	HSC Board to lead in collaboration with HSC Trusts	A bed management protocol which will cover the 5 Trusts and 3 hospitals	December 2009	Safer and more effective access to care for those with a learning disability	5
Increase the provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community	DHSSPS DEL (Disablement Advisory Service) DSD (benefits)	Provide better day support opportunities, including employment opportunities, recognising the impact of demographic changes	March 2011	Opportunities tailored to the needs of people with a learning disability promoting their inclusion in society	1, 2, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Improve transitions planning for all children with statements of special educational needs	DE, Education and Library Boards, DHSSPS and HSC	A shared Transitions Plan between education and health and social care sectors. Multi agency planning to facilitate improved planning and delivery at local level	Ongoing	Person-centred planning to meet the needs of the individual	1, 2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Establish Health and Social Care Mental Health and Learning Disability Task Force	HSC Board and PHA to lead	A co-ordinated approach across HSC to improving mental health and reforming mental health and learning disability services in line with Bamford	By October 2009	Task Force will be charged with ensuring that services are reformed and modernised in line with Bamford vision	4, 5
Establish Bamford Monitoring Group	Patient Client Council	Provide a challenge function on the extent to which the reform of services is working	By October 2009	Service users and carers will have an opportunity to feed back their views to Minister on how services are meeting their needs	1, 2, 3
Inter-Departmental Ministerial and Implementation groups to continue	DHSSPS (with other Departments)	A co-ordinated approach across NI Executive improving mental health and reforming mental health and learning disability services in line with Bamford	Ongoing	Better joining up of services across agencies	1, 2, 5
Introduce new mental capacity and mental health legislation	DHSSPS (with other Departments)	Commence new mental capacity and mental health legislation	Post 2011, exact timing depending on legislative programme	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 reason	5

LEARNING DISABILITY ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Introduce a small amendment to the Mental Health (NI) Order to enable patients to apply to the court to replace their nearest relative	DHSSPS	An amendment to the 1986 Order enabling patients to apply to court to replace their nearest relative	By March 2011	Patients will be able to challenge the appointment of a nearest relative. This will be important in situations where the relationship with the nearest relative has broken down or where there is a history of abuse by the nearest relative	5
Issue guidelines to health trusts advising of a European Court of Human Rights judgement requiring safeguards for those deprived of their liberty for their protection	DHSSPS	Guidelines issues to health trusts	By December 2009	Those deprived of their liberty for their protection in nursing homes and hospitals and their relatives and carers will be consulted on the nature and extent of the deprivation	5

Appendix 1

HUMAN RIGHTS AND EQUALITY IMPLICATIONS

Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 requires Departments in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between person with a disability and persons without; and
- between persons with dependants and persons without.

In addition, without prejudice to the above obligation, Departments should, in carrying out their functions relating to Northern Ireland, have due regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Departments also have a statutory duty to ensure that their decisions and actions are compatible with the European Convention on Human Rights and to act in accordance with these rights.

The Bamford Review

A Human Rights and Equality Sub-Group was established as part of the Bamford Review to consider the relevant legislation and other requirements particularly relating to human rights, discrimination and equality in relation to people with a mental health need and/or learning disability. The Sub-Group considered a number of situations where actual or potential human rights and/or equality issues arise for people with a mental health need and/or learning disability and made a number of recommendations that will be addressed as part of the ongoing reform of mental health and learning disability services. The Sub-Group also developed a set of overarching human rights and equality guidelines against which each of the Review's Working Committees could test their discussions and recommendations. The Sub-Group's report on Human Rights and Equality of Opportunity can be accessed at:

http://www.rmhldni.gov.uk/human_rights_and_equality_report.pdf

Background

Overall it is estimated that in Northern Ireland about 250,000 adults and 45,000 children under 18 have a mental health need. About 26,500 people have a learning disability, of whom about half are aged 0-10. About 16,000 people have dementia, the vast majority of whom are older people.

Policy Aims

The overall aims of the Bamford Review and of NI Executive policy as articulated in *Delivering the Bamford Vision* and in this Action Plan are to:

- promote mental wellbeing for the whole population;
- protect the rights of people with a mental health need or a learning disability;
- promote equality of opportunity for them; and
- improve the public services offered to them and their families and carers.

Delivering the Bamford Vision set out a broad statement of policy for services for all people with a mental health need or a learning disability. This Action Plan sets out specific action to be taken over the next two to three years. As this work is taken forward and more detailed policies and strategies are developed in response to specific elements of the Bamford vision, the equality implications of these policies and strategies will be taken into consideration. The human rights and equality implications of the proposed legislation referred to in this Action Plan will also be considered separately as the legislation is progressed.

Groups Affected by the Policy

The policy includes mental health promotion, which affects the population generally. Work is under way on revising the Government's strategy and actions in relation to promoting health, emotional wellbeing and the equality implications of this strategy will be considered as this work is progressed.

In relation to people with mental health needs or a learning disability, information from the sources listed below has been considered and will be taken into account as services are designed or re-designed.

Gender

Using a GHQ12 score of 4 or more as an indicator of possible mental health problem, the Health and Wellbeing Survey 2005/06 showed that such scores were higher for women (21%) than for men (16%).

Since women generally live longer than men, they are more likely to suffer from dementia.

DHSSPS Equality and Human Rights Literature Review *Access to Health and Social Services* (April 2005) found that men tend to be more vulnerable to mental health problems and suicide for a number of reasons including:

- many men are reluctant to talk about their problems or feelings or to admit that they may be depressed.
- the reluctance of many men to consult with their GP for mental and emotional health problems.
- unemployment and the adverse impact of the continued decline of certain industries (such as the manufacturing industry).

The Bamford Review also highlighted specific mental health service needs for some women in the perinatal period.

There is no evidence of a gender difference in relation to prevalence of learning disability.

Age

The Health and Wellbeing Survey 2005/06 found that GHQ12 scores increased with age group, from 16% for 16-24 year olds to 23% for 55-64 year olds and then decreased again to 16% for those aged 75+. There is some evidence that mental health problems such as depression are less likely to be detected and treated in older people.

Delivering the Bamford Vision and this Action Plan recognise the differing mental health needs of children and young people, adults of working age and older people and the need for good interfaces to facilitate transition between the services when people reach the upper age limits for particular services.

Dementia affects mainly older people, although some younger people can develop it.

Learning disability is a life-long condition, affecting all ages, so services for people with a learning disability have to provide a life long continuum. The need for specialist services for children and young people with a learning disability is recognised. Transition to adult life is a stressful time when decisions about further education, employment or other meaningful daytime activities are being made.

Religion

More Catholics (21%) and those of other religions (20%) had a high GHQ12 score than Protestants (17%) (Health and Wellbeing Survey 2005/06).

There are no data to suggest a difference in prevalence of learning disability.

Marital Status

Fewer currently married people had a high GHQ12 score (16%) than single people (18%) with widowed (24%), divorced (28%) and separated people (35%) having greater risk (Health and Wellbeing Survey 2005/06).

Few people with a learning disability are married.

People with Dependants

The 2001 Health and Wellbeing Survey found that people with dependent children were more likely to have experienced stress in the previous year – 16% of those with dependent children reported a great deal of stress compared with 10% of those without dependent children.

Few people with a learning disability have dependents.

People with a Disability

This policy relates to people with a disability – either a mental health need or a learning disability. There is also evidence to suggest that people with physical and sensory disabilities are more likely to have a mental health need. The 2005/06 Health and Wellbeing Survey found that those who reported their general health as not good were more likely to have high GHQ12 scores – 51% compared to 10% who reported their

health as good. The particular mental health needs of deaf people was highlighted by the Bamford review.

People with a learning disability who develop mental health needs may also require specialised services.

Ethnicity

There are well-documented cultural differences in the way psychological distress presents, is perceived and interpreted. Different cultures also develop different responses for coping with psychological stress. As a consequence, mental health interventions that emphasise individualism may not be appropriate for all cultures and belief systems.

Sexual Orientation

National Institute for Mental Health in England found that Lesbian, Gay and Bisexual people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self harm than heterosexual people (*Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people – a systematic review (2008)*.

Conclusion

This Action Plan covers a broad range of policy and service developments for services for people with a mental health need or a learning disability. While the overall policy aim is to improve the lives of people with mental health needs or a learning disability, some of the actions relate to groups of such people who have been identified as having particular needs for targeted services and there is the potential for some service developments to impact negatively on particular groups. The NI Executive recognises that as more detailed policies and strategies are developed in response to specific elements of the Bamford vision, the human rights and equality implications of these will be considered separately and their impact monitored as they are implemented.

Abbreviations

ASD	Autistic Spectrum Disorder
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
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
NIO	Northern Ireland Office
OFMDFM	Office of the First Minister and deputy First Minister
PHA	Public Health Agency
PCC	Patient and Client Council
RPA	Review of Public Administration
SEN	Special Education Needs
SENDO	Special Education Needs and Disability Order

Department of
Health, Social Services and Public Safety
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SERVICE FRAMEWORK FOR LEARNING DISABILITY

Working for a Healthier People

INVESTOR IN 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. 2. All HSC organisations and organisations providing services on behalf of the HSC have **Safeguarding Plans** in place. 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. Establish baseline March 2014. Performance level to be determined once baseline established March 2015. 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)		Report percentage increase of patient and client satisfaction March 2016.
	3. Percentage of staff who have gained PPI training (details to be agreed for 2015/2016)	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. 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.	Develop and implement SAAT March 2015. Performance levels to be determined based on outcomes of SAAT March 2016. 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. 2. Each person with a learning disability can access a named person who can signpost them to relevant services.	Development and implementation of SAAT March 2015. Performance levels to be determined once baseline established March 2016. 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. 2. Percentage of GPs who have a system for identifying people with a learning disability on their register. 3. Each GP practice has a designated link professional within local learning disability services. 4. Evidence of reasonable adjustments by health service providers.	All HSC Trusts establish baseline March 2015. Performance levels to be determined once baseline established March 2016. Baseline as per learning disability DES 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	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.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	5. Percentage of females with a learning disability who access cervical and breast screening services.	Establish baseline March 2015. Performance levels to be determined once baseline established March 2016.
	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.
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.	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 where indicated in their treatment plan.	Establish baseline March 2016. Performance levels to be determined once baseline established March 2017.
	3. Percentage of Health Action Plans and health checks which include mental health assessment and mental health promotion.	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.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes 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.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.
	3. Percentage of people in receipt of public funding living in households of 5 people or less with a learning disability.	Develop and implement SAAT March 2015. Performance levels to be determined based on SAAT outcomes March 2016.
	4. Percentage of people leaving learning disability hospital within one week after treatment has been completed.	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

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
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.
Responsibility for delivery/implementation
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.
Quality Dimensions
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

Performance Indicator	**Data Source**	**Anticipated Performance Level**	**Date to be achieved by**
This information will be monitored to show if the standard is being delivered.	This identifies where the information will be derived from.	This describes how well the service must perform against this indicator.	This specifies when the anticipated performance level should be reached.

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

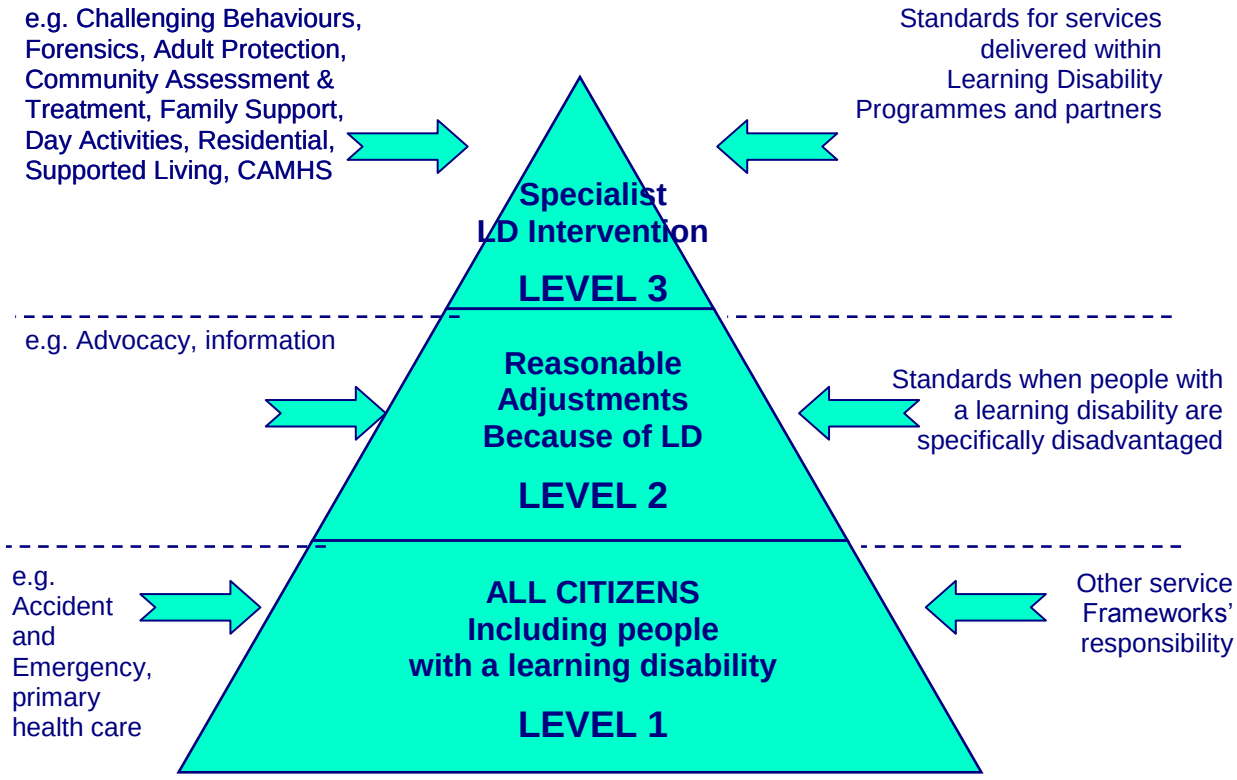

Figure 2

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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DH Department of Health

DHSSPS
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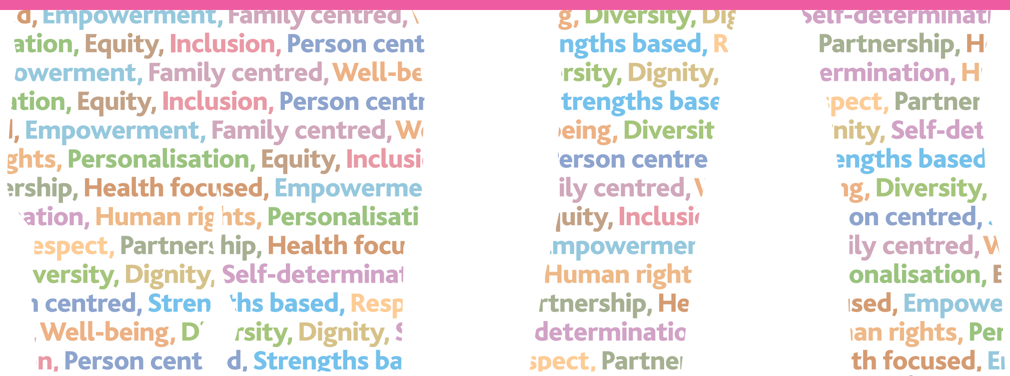
Llywodraeth Cymru
Welsh Government

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

[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.

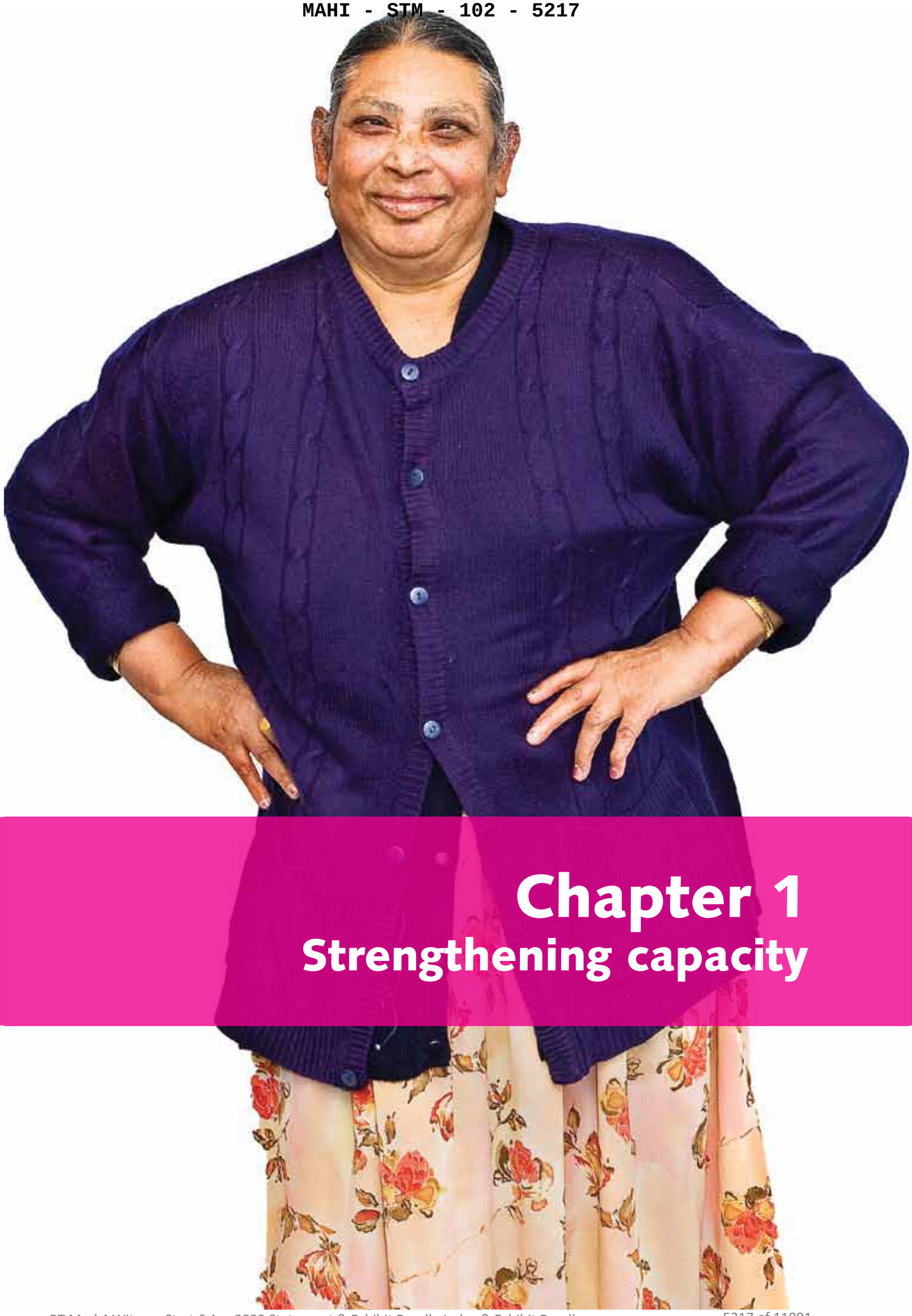
[F] NHS provision may include partly or fully integrated health and social care structures/services.

"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 at [redacted]

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 [redacted]

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.

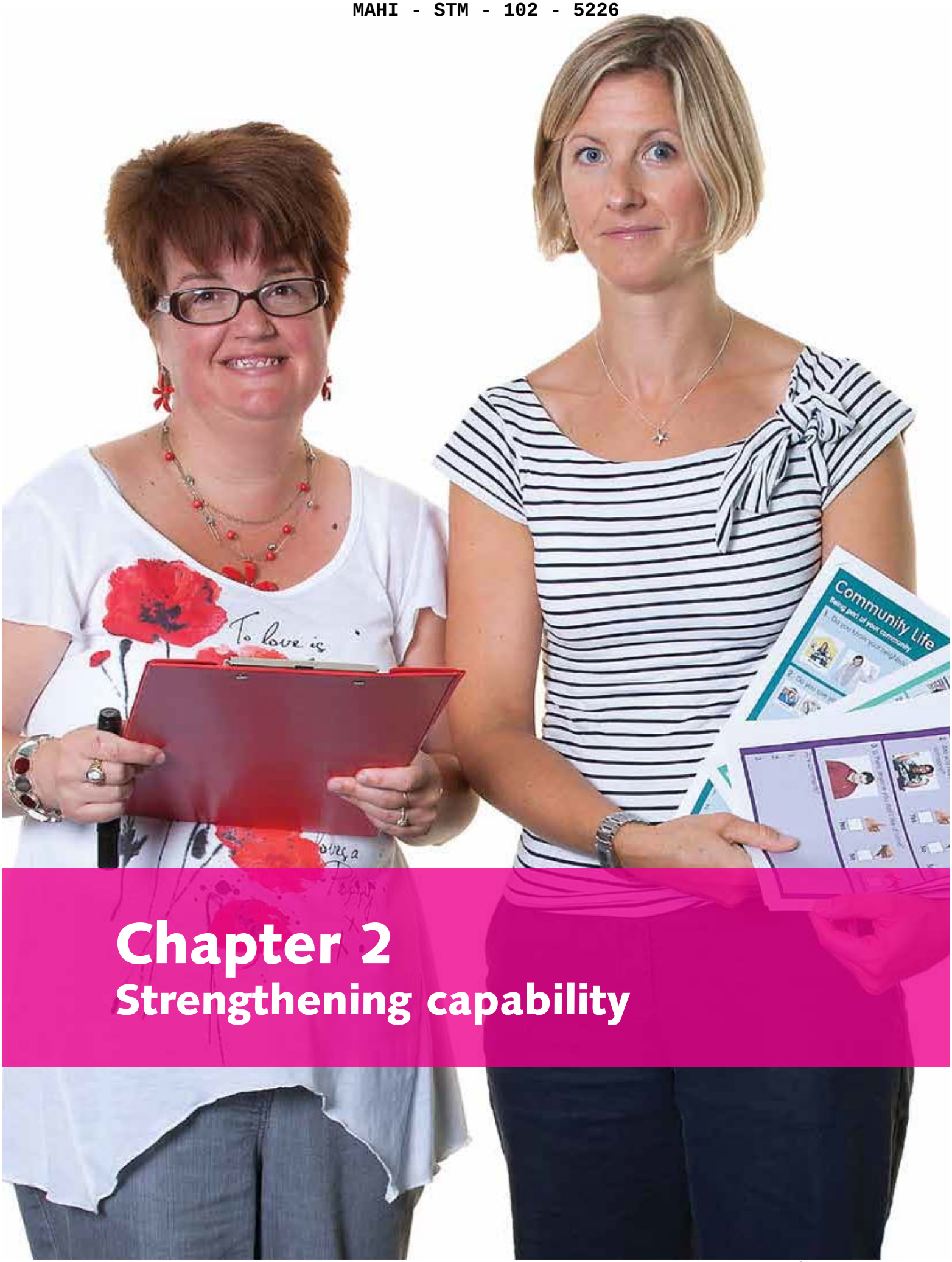
For care and treatment to be equitable, adjustments need to be made so that the health care experiences and outcomes of people with learning disabilities in hospital are improved. An example of reasonable adjustments at St George's involved Trevor, a man who had capacity to consent to have dialysis but 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: **www.sabp.nhs.uk/services/ld**).

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]k 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.

[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 [redacted]

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
W 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 a [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 [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

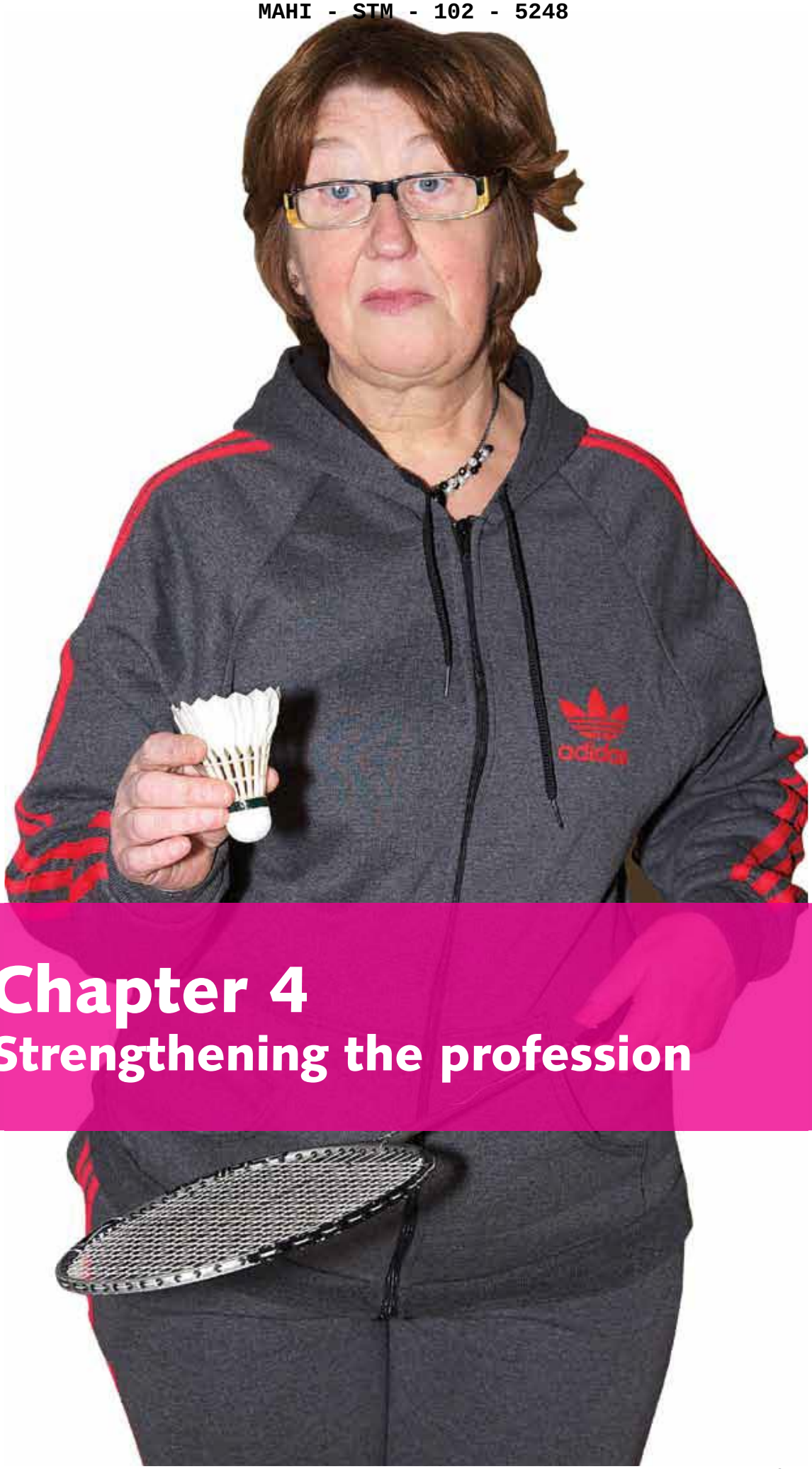
Clinical supervision is recognised as a supportive way to enable learning from experience with the aim of developing knowledge and improving care (24). It was evident through the review processes that learning disabilities nurses engage in supervision at a number of levels and with a variety of professionals 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 [redacted]

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.
London: Department of Health.

Department of Health (2007)
Good Practice in Learning Disability Nursing.
London: Department of Health.

Department of Health (2008)
Healthcare for All: report of the independent inquiry into access to healthcare for people with learning disabilities.
London: Department of Health.

Department of Health (2009)
Valuing People Now: a new three-year strategy for people with learning disabilities.
London: Department of Health.

Department of Health (2009)
World Class Commissioning for the Health and Wellbeing of People with Learning Disabilities.
London: Department of Health.

Department of Health (2009)
The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.
London: Department of Health.

Department of Health/Department for Children, Schools and Families (2009)
Healthy Lives, Brighter Futures. The strategy for children and young people's health.
London: Department of Health.

Department of Health (2010)
Raising Our Sights: services for adults with profound intellectual and multiple disabilities. A report by Professor Jim Mansell.
London: Department of Health.

Gates B (2011)
Learning Disability Nursing: task and finish group: report for the Professional and Advisory Board for Nursing and Midwifery.
London: Department of Health.

Emerson E, Baines S, Allerton L, Welch V (2011)
Health Inequalities & People with Learning Disabilities in the UK: 2011.
Improving Health and Lives: Learning Disabilities Observatory.

Northern Ireland

Department of Health, Social Services and Public Safety (2005)
Equal Lives: review of policy and services for people with a learning disability in Northern Ireland: the N. I. Bamford Review.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2005)
A Healthier Future: a twenty year vision for health and well being in Northern Ireland 2005–2025.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2006)
The Bamford Review of Mental Health and Learning Disability (NI): forensic services.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2007)
Complex Needs – the nursing response to children & young people with complex physical healthcare needs.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (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).
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.

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.

Department of Health, Social Services and Public Safety (2011)
Improving Dementia Services in Northern Ireland: a regional strategy.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2010)
A Partnership for Care: Northern Ireland strategy for nursing and midwifery 2010–2015.
Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2011)
Learning Disability Service Framework. Consultation document.
Belfast: DHSSPS.

Guidelines and Audit Implementation Network (2010)
Guidelines: caring for people with a learning disability in general hospital settings.
Belfast: DHSSPS.

Scotland

NHS Health Scotland (2004)
Health Needs Assessment Report: people with learning disabilities in Scotland.
Edinburgh: NHS Health Scotland.

NHS Quality Improvement Scotland (2006)
Best Practice Statement: promoting access to healthcare for people with learning disabilities.
Edinburgh: NHS Quality Improvement Scotland.

NHS Quality Improvement Scotland (2009)
Tackling Indifference: healthcare services for people with learning disabilities national overview.
Edinburgh: NHS Quality Improvement Scotland.

Scottish Executive (2000)
The Same as You? A review of services for people with learning disabilities.
Edinburgh: Scottish Executive.

Scottish Executive (2002)
Promoting Health, Supporting Inclusion: the national review of the contribution of nurses and midwives to the care and support of people with learning disabilities.
Edinburgh: Scottish Executive.

Scottish Government (2007)
Equally Well. The report of the Ministerial Task Force on Health Inequalities.
Edinburgh: Scottish Government.

Scottish Government (2008)
Better Health, Better Care: action plan. What it means for you.
Edinburgh: Scottish Government.

Scottish Government (2008)
Achieving our Potential: a framework to tackle poverty and income inequality in Scotland.
Edinburgh: Scottish Government.

Scottish Government (2010)
Getting it Right for Every Child.
Edinburgh: Scottish Government.

Scottish Government (2010)
The Healthcare Quality Strategy for NHSScotland.
Edinburgh: Scottish Government.

Scottish Government (2010)
Towards an Autism Strategy for Scotland.
Edinburgh: Scottish Government.

Wales

Learning Disability Implementation Advisory Group and Welsh Assembly Government (2011)
Practice Guidance on Developing a Commissioning Strategy for People with Learning Disabilities.
Cardiff: Welsh Assembly Government.

National Assembly for Wales (2002)
Inclusion, Partnership and Innovation.
Cardiff: National Assembly for Wales.

Public Health Wales and Welsh Government (2011)
Good Practice Framework for People with Learning Disabilities Requiring Planned Secondary Care.
Cardiff: Public Health Wales and Welsh Government.

Welsh Assembly Government (2004)
Learning Disability Strategy. Section 7: guidance on service principles and service responses.
Cardiff: Welsh Assembly Government.

Welsh Assembly Government (2007)
Statement on Policy and Practice for Adults with Learning Disabilities.
Cardiff: Welsh Assembly Government.

Welsh Assembly Government (2009)
A Community Nursing Strategy for Wales.
Cardiff: Welsh Assembly Government.

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

Co-production Steering Group (supported by Scottish Consortium for Learning Disability)
Ann Burke, Bainsford

Keith Findlay, Glasgow

Angela Halpin, West Dunbartonshire

Lorraine MacKenzie, West Dunbartonshire

Rona Membury, Highland

Ian Stones, Aberdeen

Alexander Thomson, Fraserburgh

England

Allyson Kent, Deputy Head of Nursing, Humber Mental Health Teaching NHS Trust

Alison Giraud Saunders, Independent Consultant, Policy into Practice

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

Ann Norman, Professional Nurse Adviser: Learning Disabilities/Prison Nursing, Royal College of Nursing

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)

Jacky Vincent, Lead Nurse, Learning Disability & Forensic Services, Hertfordshire

Janet Cobb (Chair), Independent Consultant, Jan-Net Ltd

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

Stephan Brusch, Health Access Manager and Head of Learning Disability Development Team, NHS London

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

Tricia Handley, Nursing Manager Adult Social Care, Camden

Vicky Stobbart, Service Manager - Learning Disability, Southwark

Northern Ireland

Anne Campbell, Operations Manager, Belfast Health & Social Care Trust

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

Francis Rice (Chair), Director of Nursing, Southern Health & Social Care Trust

Garvin McKnight, Staff Nurse, Muckamore Abbey Hospital, Belfast Health & Social Care Trust

Gillian McMullen, Project Manager Bamford Monitoring Group, Patient Client Council (PCC)

Glynis Henry, Chief Executive, Northern Ireland Practice & Education Council (NIPEC)

John Mc Eleney, Assistant Director, Praxis Care NI

Maurice Devine, Nursing Officer (Mental Health, Learning Disability and Older People), Department of Health, Social Services and Public Safety

Maureen Piggot, Director, Mencap Northern Ireland

Molly Kane, Regional Nurse Consultant Mental Health & Learning Disability, Public Health Agency

Neil Kelly, Operations Manager, Belfast Health & Social Care Trust

Professor Owen Barr, Head of School of Nursing, University of Ulster

Paula McLorinan, Consultant Child & Adolescent & Learning Disability Psychiatrist, Belfast Health & Social Care Trust

Peter Griffen, Discipline Lead, Learning Disability Nursing, Queen's University Belfast

Rosaleen Harkin, Assistant Director of Adult Services, Western Health & Social Care Trust

Thomasina Duff, Staff Nurse, Belfast Health & Social Care Trust

Scotland

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Billy Pate, Scottish Community Learning Disability Nurses Network

Carol Dobson, Chief Nursing Officer, Mental Welfare Commission for Scotland

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Gillian Henderson, Mental Health and Suicide Risk Management Advisor, Scottish Prison Services

Hazel Powell, Programme Manager, NHS Lothian

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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

Wales

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Christopher Griffiths, Consultant Nurse/Lecturer, Abertawe Bro Morgannwg University Health Board

Dave Hawkins, Lead Nurse Learning Disabilities, Hywel Dda Health Board

Hayley Tarrant, Head of Learning Disability Services, Powys Teaching Health Board

Jenifer Clarke, Nursing Officer/Public Health and Health Professions Department, Welsh Government

Julie Kendall (Chair), Lead Nurse for Learning Disability Services, Aneurin Bevan Health Board

Ian Mansell, Senior Lecturer, University of Glamorgan

Pete Jones, Clinical Governance Co-ordinator, Betsi Cadwaladr University Health Board

Dr Robert Jenkins, Divisional Head of Learning Disability, University of Glamorgan

Ruth Northway, Professor of Learning Disabilities, University of Glamorgan

Ruth Wyn Williams, Lecturer in Learning Disability Nursing/Lecturer (Welsh medium) in Nursing, Bangor University

Sharon Williams, Assistant Head of Specialist Services, Learning Disabilities Directorate, Aneurin Bevan Health Board

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   Valuing People: a new strategy for learning disability for the 21st century.
   London: Department of Health.
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Modernising Learning Disabilities Nursing Review
Strengthening the Commitment

Northern Ireland Action Plan

March 2014

INVESTORS IN PEOPLE

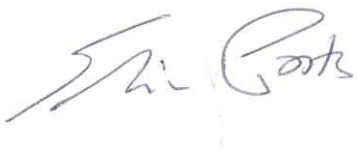
INDEX

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

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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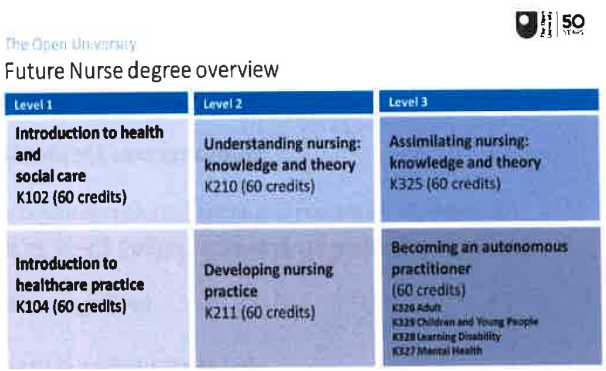
Introduction

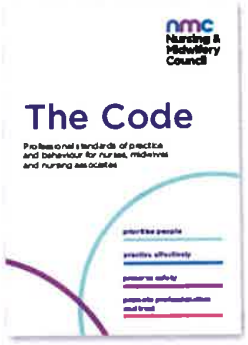
BHSCT support Open University (OU) pre-registration nursing students who are also our trust employees. The students undertake a 4 year part-time degree programme in one of the four fields of practice - Adult, Children's & Young People, Learning Disability or Mental Health.



There are 3 parts to the programme and each part includes both theory and practice placement learning components. Students have an electronic Northern Ireland Practice Assessment Document (ENIPAD) for each part.

Part	Duration	Number of placements during the part
Part 1	16 months	3
Part 2	16 months	3
Part 3	16 months	3
Eligible to apply for NMC registration		

OU students have a practice tutor/academic assessor who acts as a link between the university and the trust about the practice aspects of your programme and are available for ongoing support relevant to the programme. Module tutors support with tutorials, assignments and examinations. Tutorial attendance is mandatory.



The NMC Code of Conduct (2018) states that registrants must: **Practise effectively**

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence.

The Open University
STUDENT NURSE

If you require any further information please contact your local Practice Education Facilitator.

Belfast Health and Social Care Trust
caring supporting improving together

The Open University

Information for BHSCT staff

Open University / NMC Entry Criteria

Applicants must:

Have good health and good character (to be maintained throughout the programme)

Be prepared to travel to placements

Have their manager's support

Have experience of care delivery

Meet the literacy and numeracy requirements prior to application as below

Literacy requirements

Key Skills Level 2 in Literacy

GCSE English Grade A-C

A-Level English (Level 3)

Level 4 English

GCSE (A-C) English equivalents acquired overseas (accompanied by ENIC statement confirming equivalency)

Numeracy requirements

Key Skills Level 2 in Numeracy

GCSE Maths Grade A-C

OU module Y182 (Y162) 'Starting with Maths'

BTEC or other equivalents that include Maths

GCSE (A-C) Maths equivalents acquired overseas (accompanied by ENIC statement confirming equivalency)

Level 3 Certificate in Adult Numeracy subject

BHSCT entry requirements

Applicants must:

Hold a permanent contract of at least 26 hours per week or have negotiated this with their line manager.

Have secondment approval agreed by their service manager on application form – the decision is at the discretion of the service manager.

Recruitment and Selection

Annual cycle - Begins in December/January

OU webinars held virtually

Interviews held in April/May by Trust staff and OU staff

English and Maths qualifications must be achieved and certificates available at the time of application

Places are commissioned by DHSSPS

Programme commences September

Supporting staff on the programme

Students have a timetable for each part of the programme. The timetable incorporates substantive post weeks (blue), placement weeks (red) and study weeks (yellow). Annual leave is organised with the student and their base manager. Annual leave must only be taken during the substantive post weeks.

Open University Sample Timetable

26-Feb-23	Base Area			
06-Mar-23	Base Area			
13-Mar-23	Base Area			
20-Mar-23			37.5	
26-Mar-23	Base Area			K102 TMA05
03-Apr-23	Base Area			
10-Apr-23	Base Area			
17-Apr-23	Base Area			
24-Apr-23	Base Area			
01-May-23	Base Area			
08-May-23			37.5	
15-May-23			37.5	
22-May-23		37.5		EMA K102
29-May-23		37.5		
05-Jun-23		37.5		
12-Jun-23		37.5		
19-Jun-23		37.5		

During placements OU students can cla m travel expenses via HRPTS from their base area to the placement area. If claiming for mileage the student must have business classification included on their car insurance. All travel claims are taken from the base area's budget.

OU students can claim unsocial hours during their placements. The student sends an email to their base manager and copies in the placement manager stating the unsocial hours being claimed. The base manager completes the Monthly ETM02 Timesheet and emails this to Monthly_timesheet.ssc@hscni.net

OU students are provided with 5 uniform tunics at the start of the programme which are ordered via the Practice Education Team.

Belfast Health and Social Care Trust

Open University Pre-registration Nursing Manager Information Checklist

1. **General Information**
   - The Open University offer four pre-registration nursing programmes
   - process is managed by the Practice Education Team in partnership with the OU.
   - The numbers supported are agreed annually by the Practice Education Team and this is dependent upon practice placement capacity.
2. **Open University / NMC Entry Criteria:**
3. **Specific Trust Criteria** In order to apply applicants must already hold a contract of at least 26 hours per week, or have negotiated this with their line manager and have secondment approval agreed by their service manager. The secondment decision is at the discretion of the directorate based on the exigencies of the service.
4. **Timetable information**
5. **Replacement money**
6. **Trust responsibility** During the programme the trust will:
   - Pay the staff member's current salary inclusive of special duty payments where these apply
   - Provide the staff member with OU nursing student tunics
   - Facilitate clinical placements
   - Provide practice mentors within the base area and within clinical placements

7, **Student responsibility** The Student will:

   - Be available to undertake the course on the date of the programme commencement.
   - Ensure they can travel to meet practice placement requirements of the programme

- Take annual leave integral to the programme at times suitable to the OU
- Complete all necessary documentation, e.g. hard copy of special duty payments and travel expenses form in a timely manner.
- Understand that study in your own time will be required

Process for student commencing commissioned course that require a current NI Access.

Current NI Access is defined as a certificate that has been issued within a 3 year time period at registration for the programme and will remain so for the duration of the programme.

Commissioned programmes that require a current NI Access include:

Open University Pre-Registration Nursing Programme

You must register with access NI Using hyper link below

https://accessni.nidirect.gov.uk/Customer/Account/LogIn?ReturnUrl=%2fCitizenEnhancedApplication

Use Pin Number **xxxxxxx** (This number is confidential and should not be shared with anyone else)

You are required to provide 3 items of identification for verification (driving licence, passport, and 1 other such as birth or marriage certificate) .

Many Thanks

Carol Chambers
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NURSING & MIDWIFERY COUNCIL

NURSING & MIDWIFERY COUNCIL

The NMC code of professional conduct: standards for conduct, performance and ethics

standards ·07·04

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Protecting the public through professional standards

Protecting the public through professional standards

NURSING & MIDWIFERY COUNCIL

The NMC code of professional conduct: standards for conduct, performance and ethics

The *Code of professional conduct* was published by the Nursing and Midwifery Council in April 2002 and came into effect on 1 June 2002. In August 2004 an addendum was published and the *Code of professional conduct* had its name changed to *The NMC code of professional conduct: standards for conduct, performance and ethics*. All references to "nurses, midwives and health visitors" were replaced by "nurses, midwives and specialist community public health nurses" and a new section on Indemnity Insurance was included. This updated version of the code was published in November 2004.

The NMC code of professional conduct: standards for conduct, performance and ethics

As a registered nurse, midwife or specialist community public health nurse, you are personally accountable for your practice. In caring for patients and clients, you must:

- respect the patient or client as an individual
- obtain consent before you give any treatment or care
- protect confidential information
- co-operate with others in the team
- maintain your professional knowledge and competence
- be trustworthy
- act to identify and minimise risk to patients and clients.

These are the shared values of all the United Kingdom health care regulatory bodies.

1 Introduction

1.1 The purpose of The NMC code of professional conduct: standards for conduct, performance and ethics is to:

- inform the professions of the standard of professional conduct required of them in the exercise of their professional accountability and practice
- inform the public, other professions and employers of the standard of professional conduct that they can expect of a registered practitioner.

1.2 As a registered nurse, midwife or specialist community public health nurse, you must:

- protect and support the health of individual patients and clients
- protect and support the health of the wider community
- act in such a way that justifies the trust and confidence the public have in you
- uphold and enhance the good reputation of the professions.

1.3 You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.

1.4 You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.

1.5 You must adhere to the laws of the country in which you are practising.

2 As a registered nurse, midwife or specialist community public health nurse, you must respect the patient or client as an individual

2.1 You must recognise and respect the role of patients and clients as partners in their care and the contribution they can make to it. This involves identifying their preferences regarding care and respecting these within the limits of professional practice, existing legislation, resources and the goals of the therapeutic relationship.

2.2 You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.

2.3 You must, at all times, maintain appropriate professional boundaries in the relationships you have with patients and clients. You must ensure that all aspects of the relationship focus exclusively upon the needs of the patient or client.

2.4 You must promote the interests of patients and clients. This includes helping individuals and groups gain access to health and social care, information and support relevant to their needs.

2.5 You must report to a relevant person or authority, at the earliest possible time, any conscientious objection that may be relevant to your professional practice. You must continue to provide care to the best of your ability until alternative arrangements are implemented.

3 As a registered nurse, midwife or specialist community public health nurse, you must obtain consent before you give any treatment or care

3.1 All patients and clients have a right to receive information about their condition. You must be sensitive to their needs and respect the wishes of those who refuse or are unable to receive information about their condition. Information should be accurate, truthful and presented in such a way as to make it easily understood. You may need to seek legal or professional advice or guidance from your employer, in relation to the giving or withholding of consent.

3.2 You must respect patients' and clients' autonomy – their right to decide whether or not to undergo any health care intervention – even where a refusal may result in harm or death to themselves or a fetus,

unless a court of law orders to the contrary. This right is protected in law, although in circumstances where the health of the fetus would be severely compromised by any refusal to give consent, it would be appropriate to discuss this matter fully within the team and with a supervisor of midwives, and possibly to seek external advice and guidance (see clause 4).

3.3 When obtaining valid consent, you must be sure that it is:

- given by a legally competent person
- given voluntarily
- informed.

3.4 You should presume that every patient and client is legally competent unless otherwise assessed by a suitably qualified practitioner. A patient or client who is legally competent can understand and retain treatment information and can use it to make an informed choice.

3.5 Those who are legally competent may give consent in writing, orally or by co-operation. They may also refuse consent. You must ensure that all your discussions and associated decisions relating to obtaining consent are documented in the patient's or client's health care records.

3.6 When patients or clients are no longer legally competent and have lost the capacity to consent to or refuse treatment and care, you should try to find out whether they have previously indicated preferences in an advance statement. You must respect any refusal of treatment or care given when they were legally competent, provided that the decision is clearly applicable to the present circumstances and that there is no reason to believe that they have changed their minds. When such a statement is not available, the patients' or clients' wishes, if known, should be taken into account. If these wishes are not known, the criteria for treatment must be that it is in their best interests.

3.7 The principles of obtaining consent apply equally to those people who have a mental illness. Whilst you should be involved in their assessment, it will also be necessary to involve relevant people close to them; this may include a psychiatrist. When patients and clients are detained under statutory powers (mental health acts), you must ensure that you know the circumstances and safeguards needed for providing treatment and care without consent.

3.8 In emergencies where treatment is necessary to preserve life, you may provide care without consent, if a patient or client is unable to give it, provided you can demonstrate that you are acting in their best interests.

3.9 No-one has the right to give consent on behalf of another competent adult. In relation to obtaining consent for a child, the involvement of those with parental responsibility in the consent procedure is usually necessary, but will depend on the age and understanding of the child. If the child is under the age of 16 in England and Wales,12 in Scotland and 17 in Northern Ireland, you must be aware of legislation and local protocols relating to consent.

3.10 Usually the individual performing a procedure should be the person to obtain the patient's or client's consent. In certain circumstances, you may seek consent on behalf of colleagues if you have been specially trained for that specific area of practice.

3.11 You must ensure that the use of complementary or alternative therapies is safe and in the interests of patients and clients. This must be discussed with the team as part of the therapeutic process and the patient or client must consent to their use.

4 As a registered nurse, midwife or specialist community public health nurse, you must co-operate with others in the team

4.1 The team includes the patient or client, the patient's or client's family, informal carers and health and social care professionals in the National Health Service, independent and voluntary sectors.

4.2 You are expected to work co-operatively within teams and to respect the skills, expertise and contributions of your colleagues. You must treat them fairly and without discrimination.

4.3 You must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients.

4.4 Health care records are a tool of communication within the team. You must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. It should be consecutive, written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

4.5 When working as a member of a team, you remain accountable for your professional conduct, any care you provide and any omission on your part.

4.6 You may be expected to delegate care delivery to others who are not registered nurses or midwives. Such delegation must not compromise existing care but must be directed to meeting the needs and serving the interests of patients and clients. You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision or support is provided.

4.7 You have a duty to co-operate with internal and external investigations.

5 As a registered nurse, midwife or specialist community public health nurse, you must protect confidential information

5.1 You must treat information about patients and clients as confidential and use it only for the purposes for which it was given. As it is impractical to obtain consent every time you need to share information with others, you should ensure that patients and clients understand that some information may be made available to other members of the team involved in the delivery of care. You must guard against breaches of confidentiality by protecting information from improper disclosure at all times.

5.2 You should seek patients' and clients' wishes regarding the sharing of information with their family and others. When a patient or client is considered incapable of giving permission, you should consult relevant colleagues.

5.3 If you are required to disclose information outside the team that will have personal consequences for patients or clients, you must obtain their consent. If the patient or client withholds consent, or if consent cannot be obtained for whatever reason, disclosures may be made only where:

- they can be justified in the public interest (usually where disclosure is essential to protect the patient or client or someone else from the risk of significant harm)
- they are required by law or by order of a court.

5.4 Where there is an issue of child protection, you must act at all times in accordance with national and local policies.

6 As a registered nurse, midwife or specialist community public health nurse, you must maintain your professional knowledge and competence

6.1 You must keep your knowledge and skills up-to-date throughout your working life. In particular, you should take part regularly in learning activities that develop your competence and performance.

6.2 To practise competently, you must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent.

6.3 If an aspect of practice is beyond your level of competence or outside your area of registration, you must obtain help and supervision from a competent practitioner until you and your employer consider that you have acquired the requisite knowledge and skill.

6.4 You have a duty to facilitate students of nursing, midwifery and specialist community public health nursing and others to develop their competence.

6.5 You have a responsibility to deliver care based on current evidence, best practice and, where applicable, validated research when it is available.

7 As a registered nurse, midwife or specialist community public health nurse, you must be trustworthy

7.1 You must behave in a way that upholds the reputation of the professions. Behaviour that compromises this reputation may call your registration into question even if is not directly connected to your professional practice.

7.2 You must ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations.

7.3 When providing advice regarding any product or service relating to your professional role or area of practice, you must be aware of the risk that, on account of your professional title or qualification, you could be perceived by the patient or client as endorsing the product. You should fully explain the advantages and disadvantages of alternative products so that the patient or client can make an informed choice. Where you recommend a specific product, you must ensure that your advice is based on evidence and is not for your own commercial gain.

7.4 You must refuse any gift, favour or hospitality that might be interpreted, now or in the future, as an attempt to obtain preferential consideration.

7.5 You must neither ask for nor accept loans from patients, clients or their relatives and friends.

8 As a registered nurse, midwife or specialist community public health nurse, you must act to identify and minimise the risk to patients and clients

8.1 You must work with other members of the team to promote health care environments that are conducive to safe, therapeutic and ethical practice.

8.2 You must act quickly to protect patients and clients from risk if you have good reason to believe that you or a colleague, from your own or another profession, may not be fit to practise for reasons of conduct, health or competence. You should be aware of the terms of legislation that offer protection for people who raise concerns about health and safety issues.

8.3 Where you cannot remedy circumstances in the environment of care that could jeopardise standards of practice, you must report them to a senior person with sufficient authority to manage them and also, in the case of midwifery, to the supervisor of midwives. This must be supported by a written record.

8.4 When working as a manager, you have a duty toward patients and clients, colleagues, the wider community and the organisation in which you and your colleagues work. When facing professional dilemmas, your first consideration in all activities must be the interests and safety of patients and clients.

8.5 In an emergency, in or outside the work setting, you have a professional duty to provide care. The care provided would be judged against what could reasonably be expected from someone with your knowledge, skills and abilities when placed in those particular circumstances.

9 Indemnity insurance

9.1 The NMC recommends that a registered nurse, midwife or specialist community public health nurse, in advising, treating and caring for

patients/clients, has professional indemnity insurance. This is in the interests of clients, patients and registrants in the event of claims of professional negligence.

9.2 Some employers accept vicarious liability for the negligent acts and/or omissions of their employees. Such cover does not normally extend to activities undertaken outside the registrant's employment. Independent practice would not normally be covered by vicarious liability, while agency work may not. It is the individual registrant's responsibility to establish their insurance status and take appropriate action.

9.3 In situations where employers do not accept vicarious liability, the NMC recommends that registrants obtain adequate professional indemnity insurance. If unable to secure professional indemnity insurance, a registrant will need to demonstrate that all their clients/patients are fully informed of this fact and the implications this might have in the event of a claim for professional negligence.

Glossary

Accountable	Responsible for something or to someone.
Care	To provide help or comfort.
Competent	Possessing the skills and abilities required for lawful, safe and effective professional practice without direct supervision.
Patient and client	Any individual or group using a health service.
Reasonable	The case of Bolam v Friern Hospital Management Committee (1957) produced the following definition of what is reasonable. "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent… it is sufficient if he exercises the skill of an ordinary man exercising that particular art." This definition is supported and clarified by the case of Bolitho v City and Hackney Health Authority (1993).

Summary

As a registered nurse, midwife or specialist community public health nurse, you must:

- respect the patient or client as an individual
- obtain consent before you give any treatment or care
- co-operate with others in the team
- protect confidential information
- maintain your professional knowledge and competence
- be trustworthy
- act to identify and minimise the risk to patients and clients

Further information

The *NMC code of professional conduct: standards for conduct, performance and ethics* is available on the Nursing and Midwifery Council's website at www.nmc-uk.org. Printed copies can be obtained by writing to the Publications Department, Nursing and Midwifery Council, 23 Portland Place, London W1B 1PZ, by fax on 020 7436 2924 or by e-mail at publications@nmc-uk.org.

A wide range of NMC standards and guidance publications expand upon and develop many of the professional issues and themes identified in *The NMC code of professional conduct: standards for conduct, performance and ethics*. All are available on the NMC's website. A list of current NMC publications is available either on the website or on request from the Publications Department as above.

Enquiries about the issues addressed in *The NMC code of professional conduct: standards for conduct, performance and ethics* should be directed in the first instance to the NMC's professional advice service at the address above, by e-mail at advice@nmc-uk.org, by telephone on 020 73336541/6550/6553 or by fax on 020 73336538.

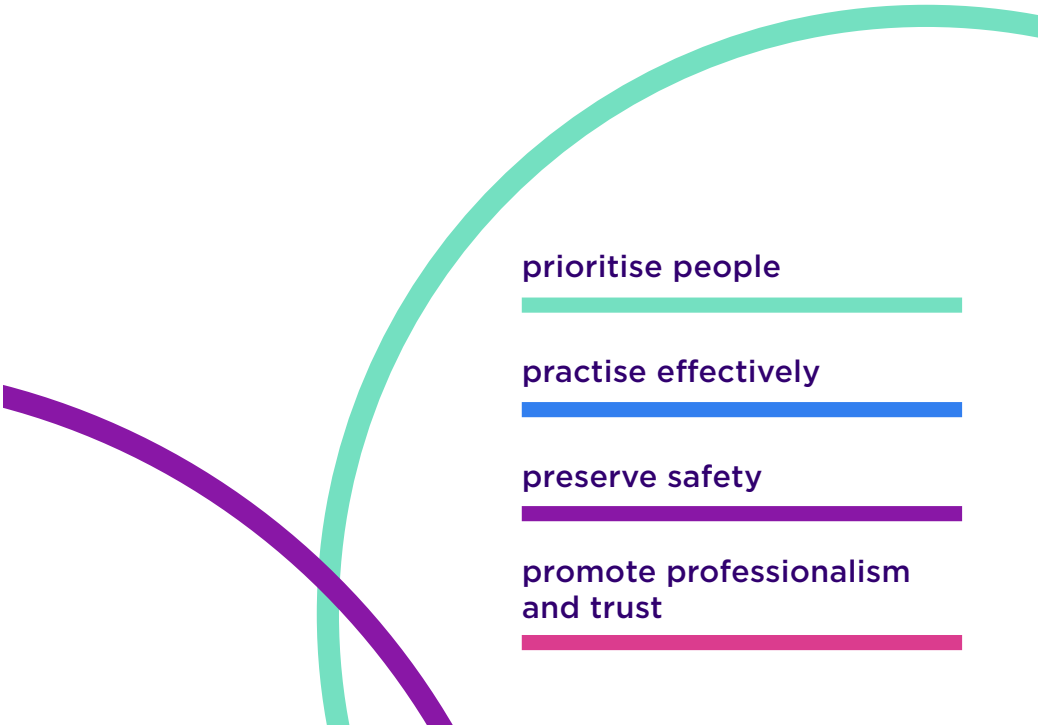
The Nursing and Midwifery Council will keep *The NMC code of professional conduct: standards for conduct, performance and ethics* under review and any comments, suggestions or requests for further clarification are welcome, both from practitioners and members of the public. These should be addressed to the Director of Registration and Standards, NMC, 23 Portland Place, London W1B 1PZ.

November 2004

Nursing & Midwifery Council

The Code

Professional standards of practice and behaviour for nurses, midwives and nursing associates



About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015 **Effective from:** 31 March 2015
Updated to reflect the regulation of nursing associates: 10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:
www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates[1] must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing[2] and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

1 Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.

2 We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at **www.nmc.org.uk/standards**

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5 take all steps to make sure that records are kept securely

10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at **www.nmc.org.uk/indemnity**

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care

13.5 complete the necessary training before carrying out a new role

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The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at **www.nmc.org.uk/raisingconcerns.**

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at **www.nmc.org.uk/standards.**

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at **www.hse.gov.uk**

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 maintain the level of health you need to carry out your professional role

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at **www.nmc.org.uk/standards**

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment

21.2 never ask for or accept loans from anyone in your care or anyone close to them

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

21.5 never use your status as a registered professional to promote causes that are not related to health

21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

22.1 keep to any reasonable requests so we can oversee the registration process

22.2 keep to our prescribed hours of practice and carry out continuing professional development activities

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at **www.nmc.org.uk/standards.**

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment

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When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at **www.nmc.org.uk.**

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.1 never allow someone's complaint to affect the care that is provided to them

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

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Standards to support learning and assessment in practice

NMC standards for mentors, practice teachers and teachers

Front cover, from left to right: Julie Dalphinis, Clinical Learning Environment Lead (West) at the East of England Multi Professional Deanery; Edward Phillips, Practice Development Nurse for Nursing and Patient Services at Bedford Hospital; Dr Anna Brown, Director of Studies for Midwifery Degree Programmes at the University of Surrey.

Photographer: Sam Shiell

Foreword

Welcome to the second edition of Standards to support learning and assessment in practice (the standards). A series of NMC Circulars has been produced following an assessment of the impact of the 2006 edition, and as a result of a high volume of enquiries received by the NMC. Whilst there is no fundamental change to the standards themselves, the additional information is intended to support easier application in practice. The decision has been taken to incorporate the information into this version of the standards. The opportunity has also been taken to provide an update on wider policy developments which have impacted on the standards. An overview of the revisions is provided on pages 9–10.

The standards have outcomes for mentors, practice teachers and teachers, and take the form of a single developmental framework, outlined in Annexe 1. The framework defines and describes the knowledge and skills nurses and midwives need to apply in practice when they support and assess students undertaking NMC approved programmes that lead to registration or a recordable qualification on the register. The NMC has agreed mandatory requirements for each part of the register, summarised below. The outcomes for each role are identified as different stages within the framework. It is possible to enter or exit the framework at any stage, and each stage is not dependent on having met the outcomes of a previous stage.

A range of information including an electronic version of the standards themselves, the Circulars which support implementation and responses to frequently asked questions is also provided on the NMC's website at **www.nmc.org.uk**

The NMC has agreed mandatory requirements for each part of the register. These are:

Nursing

- Students on NMC approved pre-registration nursing education programmes, leading to registration on the nurses' part of the register, must be supported and assessed by mentors.

- From September 2007 a sign-off mentor, who has met additional criteria (paragraph 2.1.3), must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved (paragraph 3.2.6).

- From September 2007 students on NMC approved specialist practice programmes leading to a recordable qualification on the nurses' part of the register must be supported and assessed by sign-off mentors who have met additional criteria (paragraph 2.1.3), or practice teachers where this is a requirement by commissioners. The sign-off mentor must make the final assessment of practice and confirm that the required proficiencies for recording a specialist practice qualification have been achieved (paragraph 3.2.6).

Midwifery

- Students on NMC approved pre-registration midwifery education programmes, leading to registration on the midwives' part of the register, can only be supported and assessed by mentors who have met the additional sign-off criteria (paragraph 2.1.3). Sign-off mentors must also make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved (paragraph 3.2.6).

Specialist community public health nursing (SCPHN)

- Students on NMC approved specialist community public health nursing programmes, leading to registration on the specialist community public health nurses' part of the register, must be supported and assessed by practice teachers. Where education providers are unable to meet this standard they have been able to make an application to the NMC for a temporary deferment up to 2010. From September 2007 the practice teacher must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved (paragraph 3.3.6). All practice teachers are required to meet the additional sign-off criteria (paragraph 2.1.3).

NMC requirements for implementing the standards

The standards update the previously published Standards to support learning and assessment in practice (NMC 2006) which replaced the previously published Standards for the preparation of teachers of nurses, midwives and specialist community public health nurses (NMC 2004).

Nurses and midwives who started teacher preparation programmes prior to 1 September 2007 may complete them – meeting the outcomes of the 2004 standard.

All new entrants to mentor, practice teacher or teacher preparation programmes from 1 September 2007 must meet the requirements of the standards.

The standards will be further reviewed once the UK-wide outcomes of Modernising Nursing Careers: Setting the Direction (DH 2006) and the Government White Paper Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (DH 2007) are known and at least every five years thereafter.

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Introduction

Background

The Nursing and Midwifery Council (NMC) is the regulator for two professions: nursing and midwifery. The primary purpose of the NMC is to protect the public. It does this by maintaining a register of all nurses, midwives and specialist community public health nurses (SCPHN) eligible to practise within the UK, and nursing associates eligible to practise in England. It also sets standards for their education, training, conduct, performance and ethics. When setting standards, or issuing any guidance, the NMC consults those on the register, the public, employers, those involved in education and training, and nursing and midwifery students. Once standards have been set they are reviewed on a regular basis – at least once in every five years.

The Council published standards for the preparation of teachers of nursing, midwifery and specialist community public health nursing in 2004. The standards were originally set by the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) in 1999, adopted and republished by the NMC in April 2002, and had a minor review to bring them in line with the new register in August 2004. A complete review of the standards began in 2003, with a consultation on the proposed new standards closing in October 2004.

The NMC also considered fitness for practice at the point of registration as a separate project (2005). There were overlapping issues between both consultations in relation to the quality and nature of support for learning and assessment in practice.

In August 2006 the NMC published standards to support learning and assessment in practice, reflecting the responses to both consultations, and the final standards approved by Council in March 2006. The standards replaced those previously published for the preparation of teachers of nurses, midwives and specialist community public health nurses (NMC 2004) and included new standards for mentors and practice teachers. NMC Circular 17/2007 made explicit the requirement for programme and placement providers to implement the standards, which have been mandatory since 1 September 2007. This included the requirement for mentor, practice teacher, and teacher programmes to have gained NMC approval prior to accepting students on to such programmes from 1 September 2007.

Revisions within this edition

1. Equality and diversity

The standards have been reviewed to ensure they meet the requirements of the NMC equality and diversity schemes implemented in 2007/8.

These are concerned with promoting equality of opportunity on the grounds of race, gender, and disability, and treating individuals with fairness, respect and understanding. They include principles that enhance equal opportunities and recognition of diversity, such as emphasising the need to tailor learning and assessment in an appropriate way, recognising that students have many different learning needs and preferences. Further details can be found on the NMC website, and on page 19.

2. Post qualifying nursing programmes

2.1 Review of specialist practice qualifications

In the previous edition, a number of references were made to a proposed NMC review of Specialist Practice Qualifications (SPQ) and the implications for the introduction of the practice teacher standard. This work will now be informed in the longer term once the future framework for post-registration qualifications is established by the four UK Government health departments as outlined in Modernising Nursing Careers (DH 2006). The NMC will then determine whether regulation will need to be applied and standards will be set accordingly. The framework for supporting learning and assessment of any post-registration programmes for which the NMC set standards will subsequently need to be determined. Until such a time as new arrangements are in place, all reference to requiring practice teachers to supervise and assess students on SPQ programmes has been removed from the standards. However, where commissioners of SPQ programmes require the involvement of practice teachers this should continue e.g. for district nursing.

2.2 Review of the implementation of the standard for advanced nursing practice

In the previous edition, a number of references were made to the proposed review of the implementation of the 'Standard for advanced nursing practice'. An application was made to the Privy Council in December 2005 to open a subpart of the register. It was stated within the Government White Paper Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (DH 2007) that the Department of Health would discuss the next steps with the NMC.

The White Paper Implementation Plan is awaited and has identified that there will be cross-over work on revalidation. Until the NMC has received further detail regarding this work all references to advanced nursing practice have been removed from the standards.

3. Revised arrangements for the practice teacher standard

Revised arrangements for the introduction of the practice teacher standard were introduced in April 2007 (NMC Circular 08/2007), which changed the time allowed to complete a practice teacher qualification from six months to it being normally completed within six months as detailed in paragraph 3.3.1.

The Circular confirmed that practice teachers were required to be in place to supervise and assess SCPHN students from September 2007. Where education providers were unable to meet this standard they have been able to make an application to the NMC for a temporary deferment up to 2010.

Also, the requirements for practice teachers for SPQs and ANP were deferred, as explained above.

The practice teacher standard in its entirety will be reviewed in the future in light of the outcomes of points 2.1 and 2.2 above, and further guidance will be issued at that time.

Currently, practice teacher preparation programmes including arrangements for the preceptorship period can be implemented flexibly to meet local circumstances such as the structure of SCPHN programmes, and placement arrangements.

4. Applying due regard to learning and assessment in practice (see glossary for definition of due regard)

Since the previous edition of these standards, NMC Circulars 26/2007 (for nursing and SCPHN) and 02/2008 (for midwifery) (Annexe 3) were issued setting out the ways in which the principle of due regard may be applied more flexibly (see paragraphs 1.2 and 2.1.3).

5. Sign-off mentors and/or practice teachers

5.1 Confirmation of proficiency

The role of the sign-off mentor and/or practice teacher is to make judgments about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register. The previous version of the standards implied that the sign-off mentor and/or practice teacher should provide confirmation of achievement of practice proficiency directly to the NMC. The sign-off process is integral to the overall programme assessment requirements which the NMC endorse as part of programme approval. The programme leader, or lead midwife for education, confirms to the approved education institution assessment board that both the theoretical and practice elements have been achieved on completion of the programme. Sign-off mentors and/or practice teachers are therefore not required to directly inform the NMC of the practice assessment outcomes. References to the role of sign-off mentor and/or practice teacher have been modified accordingly (see pages 5, 17 and 18).

5.2 Implementation of the sign-off mentor and /or practice teacher role across the three parts of the NMC register

Sign-off mentors and/or practice teachers have been a requirement for all students commencing NMC approved programmes from September 2007.

All sign-off mentors are nurses or midwives who having met the additional criteria (see paragraph 2.1.3) can make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register. However, the role is applied slightly differently across the three parts of the NMC register. The process for achieving sign-off status for new mentors/practice teachers is also slightly different. These differences have been set out in this version of the standards and are summarised below.

5.2.1 Sign-off mentors in nursing

a. Sign-off mentors for pre-registration nursing students
Sign-off mentors are required only for students on final placements.[1] This means that only mentors who support pre-registration nursing students on final placements are required to meet the sign-off criteria (see paragraph 2.1.3).

[1] Sign-off will normally take place in the full placement or period of practice learning. Occasionally this may occur slightly earlier, especially if the final experience is an elective.

From September 2007 those mentors who are subsequently required to become sign-off mentors must demonstrate that they have met the sign-off mentor criteria in full (see paragraph 2.1.3), including having been supervised on at least three occasions for signing off proficiency (at the end of a final placement) by an existing sign-off mentor before being annotated as such on the local mentor register.

b. Sign-off mentors for students on specialist practice programmes
The requirement for the introduction of Practice Teachers for specialist practice programmes was revised in NMC Circular 08/2007. As a result sign-off mentors are required for all students on specialist practice programmes leading to a recordable qualification on the nurses' part of the register.

From September 2007 students on NMC approved specialist practice programmes leading to a recordable qualification on the nurses' part of the register must be supported and assessed by sign-off mentors who have met additional criteria (paragraph 2.1.3) or by practice teachers where this is required by commissioners. For sign-off mentors this includes having been supervised on at least three occasions for signing off proficiency at the end of a final placement by an existing sign-off mentor before being annotated as such on the local register. (This can occur with a student on any NMC approved programme).

5.2.2 Sign-off mentors in midwifery

Sign-off mentors for pre-registration midwifery students
Sign-off mentors are required for all students on pre-registration midwifery programmes.

From September 2007 all midwives who undertake mentor preparation programmes are required to have met the additional sign-off criteria (paragraph 2.1.3) including having been supervised on at least three occasions for signing off proficiency by an existing sign-off midwifery mentor during the programme.

Since the previous edition of the standards, the NMC has outlined in NMC Circular 13/2007 how sign-off at progression points within a pre-registration midwifery programme can be used for making summative judgments about safe and effective practice. This is clarified in NMC Circular 02/2008 and outlined at 3.2.6.

5.2.3 Practice teachers for students on SCPHN programmes

Practice teachers are required for all students on SCPHN programmes unless a deferment application has been approved by the NMC as stated in NMC Circular 08/2007.

From September 2007 all nurses who undertake practice teacher preparation programmes are required to have met the additional sign-off criteria (paragraph 2.1.3). The process by which nurses and midwives undertaking practice teacher preparation programmes should consolidate their training and achieve sign-off status was clarified in NMC Circular 27/2007 and is outlined at paragraph 2.2.

6. Guidance for small scale service providers in applying the NMC's Standards to support learning and assessment in practice

The standards (NMC 2006) introduced local registers of mentors and practice teachers and processes for review and maintenance of mentor/practice teachers qualifications including annual updating and triennial review (see pages 15 and 16).

Placement providers were identified as being responsible for developing and maintaining the local registers and undertaking triennial review.

Since the introduction of the standards, however, it has become clear that some smaller scale placement providers, particularly in the independent sector (e.g. nursing homes), may not be best placed to undertake this responsibility. NMC Circular 28/2007 enabled education providers to take responsibility for developing and maintaining local registers of mentors/practice teachers, providing annual updates, and undertaking triennial reviews, as appropriate, through negotiation with small scale providers with whom they work in partnership.

7. The ongoing achievement record and sharing of personal information

The standards have been updated in respect of principles for sharing personal information necessary to maintain continuity of assessment and to ensure safe and effective practice through the ongoing achievement record, as outlined in NMC Circular 33/2007 (Annexe 3). The term 'student passport' is no longer being applied to the ongoing achievement record.

8. Previous discrepancies in Annexe 1

A number of inconsistencies have been corrected relating to Annexe 1 regarding the outcomes for mentors and practice teachers.

In the table on page 62 (Mentor – stage 2, domain Creating an environment for learning) the words ‘development of others’ were inadvertently omitted from the last bullet point and have been added.

At 2.1.2 in the text (Mentor – stage 2, domain Establishing effective working relationships) the outcome ‘develop effective working relationships based on mutual trust and respect’ has been removed from the text. In the table on page 62 this outcome appears in its correct place under stage 1 of the framework (registered nurses and midwives).

At 2.1.2 in the text (Mentor – stage 2, domain Evaluation of learning) the wording of outcome ‘contribute to evaluation of student learning and assessment experiences – proposing aspects for change resulting from such evaluation’ has been amended slightly to ensure consistency with this outcome in the table on page 66.

At 2.2.2 in the text (Practice teacher – stage 3, domain Establishing effective working relationships) outcome ‘have effective professional and interprofessional working relationships to support learning for entry to the register and education at a level beyond initial registration’ appeared in the text at practice teacher – stage 3, and in the table at mentor – stage 2. This outcome applies to practice teacher – stage 3 and has been inserted into the table on page 62. For mentor – stage 2, the outcome should read ‘have effective professional and interprofessional working relationships to support learning for entry to the register’ and has been inserted into the text at 2.1.2, and amended in the table on page 62.

At 2.2.2 in the text (Practice teacher – stage 3, domain Facilitation of learning) outcome ‘foster professional growth and personal development by use of effective communication and facilitation skills’ has replaced the previous wording to ensure consistency with that in the table on page 63.

At 2.2.2 in the text (Practice teacher – stage 3, domain Leadership) outcome ‘lead and contribute to evaluation of the effectiveness of learning and assessment in practice’ has been inserted into the table on page 70 as this had been inadvertently omitted in the previous version.

The framework to support learning and assessment in practice

There is a single developmental framework to support learning and assessment in practice. It defines and describes the knowledge and skills nurses and midwives need to apply in practice when they support and assess students undertaking NMC approved programmes that lead to registration or a recordable qualification. The NMC has identified outcomes for mentors, practice teachers and teachers so that there is clear accountability for making decisions that lead to entry to the register.

There are eight domains in the framework, each with identified outcomes at the four developmental stages. The domains are:

1 Establishing effective working relationships

2 Facilitation of learning

3 Assessment and accountability

4 Evaluation of learning

5 Creating an environment for learning

6 Context of practice

7 Evidence-based practice

8 Leadership

The framework has been designed for application within the context of inter-professional learning and working in modern healthcare.

The way the framework has been designed makes Accreditation of Prior (Experiential) Learning (AP(E)L) possible. Approved educational institutions (AEIs) can use their own AP(E)L processes to map prior learning from other qualifications or work experience. These processes are confirmed at programme approval. AP(E)L provides the facility for stepping on or stepping off the framework at various points of development, as well as recognition of existing qualifications.

The developmental framework takes account of the NHS Knowledge and Skills Framework and standards set by other health and social care regulators for supporting learning and assessment in practice. It also recognises the HE Academy requirements for teachers working in higher education settings, ensuring that there is a fit between the NMC requirements for teacher preparation and those defined by the HE Academy.

The developmental framework gives service and education providers opportunities to develop other roles that meet local requirements for supporting learning and assessment in practice – such as practice education facilitator or lecturer practitioner.

Programme level and length

The NMC has determined minimum lengths and academic levels for programmes to prepare mentors, practice teachers and teachers. It is expected that all preparation programmes include work-based learning to enable new knowledge, skills and competencies to be applied in practice. These requirements are set out in section 3 in relation to each outcome in the framework.

Recognition of prior learning

The NMC does not expect mentors, practice teachers and teachers who have undertaken a preparation programme previously approved by one of the National Boards, or since April 2002 undertaken preparation approved by programme providers to have to repeat such preparation. The NMC advises that:

- Nurses and midwives already holding a mentor or practice teacher qualification recognised by programme providers, should map their current qualification and experience against the new NMC standard and meet any outstanding outcomes through continuing professional development (CPD).

- Nurses and midwives who have existing teaching qualifications recorded on the NMC register and who are actively engaged in teaching students on NMC approved programmes should, by virtue of their qualifications and experience, already meet the new standard. However they are advised to use the outcomes for teachers in the framework to guide their CPD.

- Nurses and midwives who hold qualifications that may be considered comparable to mentors or practice teachers, and which were not previously approved by one of the previous National Boards or by a programme provider, e.g. NVQ assessor, must use the AP(E)L processes available as specified previously and undertake any further education as required by the programme providers to ensure that they meet the standard. The nature of such education may be academic, work-based or a combination of both.

Local registers of mentors and practice teachers

Placement providers are responsible for ensuring that:

- An up-to-date local register of current mentors and practice teachers is held and maintained.

- They have currency by regularly reviewing the local register and adding or removing names of nurses and midwives as necessary.

Education providers should use the (local) register to confirm that there are sufficient mentors and practice teachers who meet the NMC standards to support learning and assessment in practice, to adequately support the number of students undertaking the range of NMC approved programmes currently being offered.

Mentors who are designated as being able to sign-off proficiency at the end of a programme (to be known as ‘sign-off mentors’) must be annotated as such on the local register. While all mentors may assess individual competencies, only those who have met additional NMC criteria to be a sign-off mentor (paragraph 2.1.3) are entitled to sign-off practice.

All midwifery mentors will have met the sign-off criteria as part of their preparation programme.

Practice teachers will have this authority assigned following a period of preceptorship after having successfully completed the practice teacher programme (NMC Circular 27/2007).

Teachers who work in both practice and academic settings, e.g. lecturer practitioners, must have met the additional sign-off criteria and have a current practice-based role in order to be annotated on the local register. These teachers will be subject to triennial review (see Triennial review of mentor and practice teacher below) in the same way as mentors and practice teachers.

Review and maintenance of mentor or practice teacher qualifications

Mentors or practice teachers must demonstrate their knowledge, skills and competence on an ongoing basis. Placement providers must ensure that:

- Each mentor or practice teacher is reviewed every three years (triennial review) to ensure that only those who continue to meet the mentor/practice teacher requirements remain on the local register.

- Mentors who meet the criteria for signing-off proficiency in practice at the end of a programme are annotated on the local register.

- Arrangements are in place for appraising mentor/practice teacher performance, addressing concern where appropriate, and for adding and removing individuals from the local register – including mentors identified as having met the criteria to be able to sign-off proficiency.

Triennial review of mentors and practice teachers

The nature of the triennial review of mentors and practice teachers is for the placement providers to determine but may form part of an employer-led personal development appraisal.

To be maintained on the local register the individual must have evidence of having:

- Mentored at least two students (practice teachers to have supervised at least one student)[2] with due regard (extenuating circumstances permitting) within the three year period.

- Participated in annual updating – to include an opportunity to meet and explore assessment and supervision issues with other mentors/practice teachers.

- Explored as a group activity the validity and reliability of judgements made when assessing practice in challenging circumstances.

- Mapped ongoing development in their role against the current NMC mentor/practice teacher standards.

- Been deemed to have met all requirements needed to be maintained on the local register as a mentor, sign-off mentor or practice teacher.

[2] This must be a student intending to enter the SCPHN part of the register.

Roles to support learning and assessment in practice

As a result of consultation the NMC has set standards for mentors, practice teachers and teachers that must be achieved to support and assess students undertaking NMC approved pre-registration nursing and midwifery, and SCPHN programmes. The NMC has determined mandatory requirements for each part of the register.

These are:

Nursing

- Students on NMC approved pre-registration nursing education programmes, leading to registration on the nurses' part of the register, must be supported and assessed by mentors.

- From September 2007 a sign-off mentor, who has met additional criteria (paragraph 2.1.3), must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved (paragraph 3.2.6).

- From September 2007 students on NMC approved specialist practice programmes leading to a recordable qualification on the nurses' part of the register must be supported and assessed by sign-off mentors who have met additional criteria (paragraph 2.1.3) or practice teachers where this is a requirement by commisisioners. The sign-off mentor must make the final assessment of practice and confirm that the required proficiencies for recording a specialist practice qualification have been achieved (paragraph 3.2.6).

Midwifery

- Students on NMC approved pre-registration midwifery education programmes, leading to registration on the midwives' part of the register, can only be supported and assessed by mentors who have met the additional criteria for sign off (paragraph 2.1.3). Sign-off mentors must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved (paragraph 3.2.6).

Specialist community public health nursing

Students on NMC approved specialist community public health nursing programmes, leading to registration on the specialist community public health nurses' part of the register, must be supported and assessed by practice teachers. All practice teachers will be required to meet the additional sign-off criteria (paragraph 2.1.3) on successful completion of the practice teacher programme, and following a period of preceptorship (NMC Circular 27/2007).

Where education providers are unable to meet this standard they have been able to make an application to the NMC for a temporary deferment up to 2010. From September 2007 the practice teacher must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved (paragraph 3.3.6). Where deferment has been given, sign off may be undertaken by sign-off mentor.

Preceptors

The original standard for teachers included an advisory standard for preceptors. The NMC supports and strongly recommends that preceptorship be made available to nurses and midwives following initial registration. The original standard has been strengthened and guidelines published in NMC Circular (NMC 21/2006).

Fitness for practice

The purpose of the standards to support learning and assessment in practice is to assure the Council that those who make judgements of students have been appropriately prepared to assess performance in practice against the relevant NMC standards. Overall achievement of relevant standards of proficiency leads to registration or a qualification that is recorded on the register.

Throughout an NMC approved programme, mentors/practice teachers (who are on the local register) will assess competence in practice and confirm that students are capable of safe and effective practice. Specific competencies for entry to the register or recording a qualification are clearly identified within each of the Standards of proficiency for nursing, midwifery or specialist community public health nursing (NMC 2004) and Standards for specialist education and practice (UKCC 1994).

The NMC requires confirmation at the end of such programmes that both practice and theory parts of the programme have been successfully achieved. In practice settings a sign-off mentor or practice teacher will consider the practice evidence to make a judgement that all competencies have been met and that the student is considered proficient. They will then sign off the practice part of the programme.

Sign-off mentors and practice teachers who sign off students as being proficient in practice are confirming to the programme provider that the student has met the defined NMC standards of proficiency and is capable of safe and effective practice. In addition, teachers of nurses, midwives and specialist community public health nurses who sign off successful completion of the approved programme for registration, or for recording a qualification, are confirming that all of the NMC programme requirements have been met.

Mentors, practice teachers and teachers who sign off all, or part of the practice component of a programme leading to registration are accountable to the Council for their decisions. Confirmation by the mentor or practice teacher that the student is capable of safe and effective practice will be considered by the assessment board along with other assessed outcomes to determine whether the student has met all requirements for successful programme completion.

Equality and diversity

All public bodies including the NMC, health providers and education establishments have a duty to promote equality of opportunity on the grounds of race, gender and disability, whilst within the private sector it has long been recognised that best practice in promoting equality and diversity has many benefits. Mentors, practice teachers, and teachers through their role-modelling of best practice play a vital role in promoting equality of opportunity by treating students with fairness, respect and understanding.

Mentors, practice teachers, and teachers will also bring their own experiences and perspectives and these standards will help ensure that discrimination however unintentional is less likely to occur.

The NMC recognises the importance of supporting all students to achieve their full potential in both practice and academic learning environments. NMC approved programmes are open to all applicants providing that they are able to meet the defined selection criteria. This includes the NMC entry requirements for literacy, numeracy, good health and good character as specified in the standards of proficiency for the relevant programme, and any educational requirements set by programme providers.

Supporting students who have a disability

Programme providers will have made decisions related to any declared disabilities or health conditions when undertaking selection processes. They are bound by the general duties of the Disability Discrimination Acts (1995 and 2005)[3] and will have determined the nature of any reasonable adjustments to support achievement of programme requirements.

The NMC advises that all mentors, practice teachers and teachers should receive disability equality training. Programme providers should work in partnership to prepare placement areas for supporting students with disabilities and prepare students for the demands the placements will make of them. In particular, the learning environments in practice and academic settings should enable students to be confident that disclosure of their specific needs will not lead to discrimination. Consideration should be given to allocating time for mentors, practice teachers and teachers to meet the special needs of students with disabilities.

[3]The Disability Discrimination Act has been repealed and replaced by the Equality Act 2010.

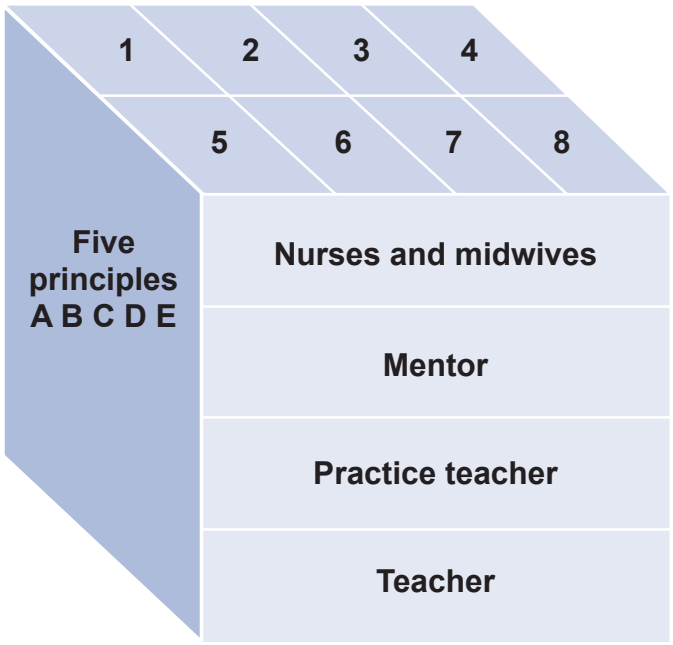
Section 1: The developmental framework and its underpinning principles

1.1 The developmental framework

The framework has been designed to facilitate personal and professional development. The domains and outcomes enable nurses and midwives to plan and measure their achievement and progress. The framework enables nurses and midwives and approved educational institutions to map other learning, such as previous preparation programmes e.g. NVQ Assessor or Verifier, in order to determine credit for prior learning. The NMC expects nurses and midwives to include CPD for their teaching roles in their personal development plans. Nurses and midwives may wish to develop a portfolio of evidence mapped against the outcomes of particular stages of the framework to demonstrate how they are developing the knowledge, skills and competence related to supporting learning and assessment in practice. Not all of the stages in the framework apply to all parts of the NMC register; this is clarified in Section 3 related to applying the standards.

The framework (see Annexe 1) is underpinned by five principles (paragraph 1.2). It has eight domains, each with an overall descriptor. There are four stages setting out the supervision, teaching and ongoing requirements of mentors, practice teachers or teachers each with more specific outcomes relevant to one of the eight domain descriptors. The NMC would expect that the majority of nurses and midwives would at least meet the outcomes of a mentor.

It is possible to enter and exit the framework at any stage; this means that no one stage is a pre-requisite for a subsequent stage. If a decision is taken to use the framework developmentally, credit should be awarded for prior knowledge, skills and experience achieved in a previous stage.



Stage 1 reflects the requirements of *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*[4]. All nurses and midwives must meet the defined requirements, in particular:

Stage 2 identifies the standard for mentors. Nurses and midwives can become a mentor when they have successfully achieved all of the outcomes of this stage. This qualification is recorded on the local register of mentors

Stage 3 identifies the standard for a practice teacher for nursing[5] or specialist community public health nursing. Nurses and midwives can become a practice teacher when they have successfully achieved all of the outcomes of this stage. This qualification is recorded on the local register of practice teachers

Stage 4 identifies the standard for a teacher of nurses, midwives or specialist community public health nurses. Nurses and midwives can become a teacher when they have successfully achieved all of the outcomes of this stage. This qualification may be recorded on the NMC register on application to the NMC and payment of the relevant fee.

The NMC will approve preparation programmes for these standards and monitor their implementation (section 4: Approval and monitoring of mentor, practice teacher and teacher preparation programmes).

1.2 The underpinning principles

The underpinning principles for supporting learning and assessment in practice for any student undertaking an NMC approved programme leading to registration or a qualification that is recordable on the register are that nurses and midwives who make judgments about whether a student has achieved the required standards of proficiency for safe and effective practice must:

A be on the same part or sub-part of the register as that which the student is intending to enter. NMC Circulars 26/2007 (for nursing and SCPHN) and 02/2008 (for midwifery) (Annexe 3) set out the ways in which the principle of due regard may be applied more flexibly without reducing the degree of rigour applied to assessing student competence. (See glossary for definition of due regard);

B have developed their own knowledge, skills and competency beyond that of registration through CPD – either formal or experiential learning – as appropriate to their support role;

C hold professional qualifications at an appropriate level to support and assess the students they mentor/teach, i.e. professional qualifications equal to, or at a higher level than, the students they are supporting and assessing and;

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[4] Any subsequent changes to this document must be considered in the context of the most up to date version.

[5] For nursing this would apply to SPQ programmes where commissioners require practice teachers to be used.

D have been prepared for their role to support and assess learning and met NMC defined outcomes. Also, that such outcomes have been achieved in practice and, where relevant, in academic settings, including abilities to support interprofessional learning. In addition:

E Nurses and midwives who have completed an NMC approved teacher preparation programme may record their qualification on the NMC register. Other teaching qualifications may be assessed against the NMC teacher outcomes through the NMC accreditation route.

1.3 Guidance for applying the underpinning principles

Principle A

Nurses and midwives who make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice must be on the same part or sub-part of the register as that which the student is intending to enter.

The NMC recognises that, as part of interprofessional learning and working, others will contribute to learning and assessment in practice. These may be nurses and midwives from other professions. However to ensure public protection, only those who are NMC sign-off mentors or practice teachers may confirm overall achievement of proficiency that demonstrates a students' fitness for practice. They determine that the student has met the relevant competencies or standards of proficiency for entry to the register or for a qualification that is recordable on the register (see circular 26/2007 in Annexe 3 for further information on interprofessional placements).

Other mentors, practice teachers or teachers may be involved in developmental (formative) assessment where the student is gaining a breadth of experience but where their learning is not intended to demonstrate competence as a nurse, midwife or specialist community public health nurse. For example, midwifery students may have a placement in a nursing environment, nursing students may have a social work placement, specialist community public health nurses may spend time with other professionals involved in child protection or public health. These placements are to gain a breadth of experience and normally do not involve assessment of competence related to the professions they intend to enter. In such placements the right person to assess outcomes (developed as part of the whole programme) would be the professional who has the knowledge, competence and experience in that area of practice.

In relation to nursing students the standards of proficiency have to be achieved within the context of the branch programme they are studying – adult, mental health, learning disability and children's nursing. The NMC recognises that within every field of practice, and between professional groups, there will be areas of shared competence.

The mentors or practice teachers who sign off proficiency for nursing students must have a mark on the register that corresponds with the branch programme the student is studying.

Principle B

They must have developed their own knowledge, skills and competency beyond that of registration through CPD – either formal or experiential learning – as appropriate to their support role.

The NMC supports and advocates lifelong learning for all nurses and midwives and requires evidence of CPD for mandatory renewal of registration. Mentors and practice teachers, acting as role models, will be able to demonstrate clinical decision-making abilities, enabling students to gain a holistic view of professional roles. The increased evidence-base that mentors and practice teachers have developed and shared with their students will help students to learn how to justify decision-making in their own practice and to begin to take responsibility for these decisions.

Principle C

Their professional qualifications will be at an appropriate level to support and assess the students they mentor/teach, i.e. they must hold professional qualifications equal to, or at a higher level than, the students they are supporting and assessing.

Mentors, practice teachers and teachers must hold professional qualifications that are at least equal[6] to the students for whom they support learning and are assessing. Equal in this context means registration level, i.e. initial registration or SCPHN. Students benefit from being exposed to mentors, practice teachers and teachers who have developed themselves to a standard beyond that at which they are learning, in both academic and practice qualifications.

Principle D

They have been prepared for their role to support and assess learning and met NMC defined outcomes. Also, that such outcomes have been achieved in practice and, where relevant, in academic settings, including abilities to support interprofessional learning.

The NMC has agreed that it will approve mentor and practice teacher preparation programmes so that that they can be assured of the consistency of preparation for supporting learning and assessment in practice. Preparation programmes for teachers are already approved by the NMC and will continue to be so. Principle D is achieved within the context of interprofessional learning and working – therefore the guidance given for Principle A applies. However the NMC would expect that the majority of mentors, practice teachers and teachers would be nurses and midwives and would have been prepared to meet the NMC outcomes defined in this framework, and that this would be a requirement where proficiency is being assessed.

[6] With regard to initial registration the NMC no longer offers second level preparation and accepts that those registrants on the second level sub-part of the nurses' part of the register will, through meeting NMC renewal of registration requirements for CPD, have developed their knowledge, skills and competence beyond their initial registration. Programme/placement providers must satisfy themselves that second level nurses who will be involved in supporting and assessing students have the knowledge, skills and competence to do so.

Principle E

Nurses and midwives who have completed an NMC approved teacher preparation programme may record their qualification on the NMC register. Other teaching qualifications may be assessed against the NMC teacher outcomes through the NMC accreditation route.

The NMC will record a teaching qualification for those who have undertaken an NMC approved teacher preparation programme and successfully achieved the outcomes of stage 4 of the framework. Recognition of prior learning will be in accordance with the process detailed in paragraph 4.4.

Section 2 – NMC standards for mentors, practice teachers and teachers

2.1 NMC mentor standard

An NMC mentor is a registrant who, following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an AEI as meeting the NMC mentor requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes.

A mentor is a mandatory requirement for pre-registration nursing and midwifery students.

Mentors who are assessing competence must have met the NMC outcomes defined in stage 2 of this standard, or be supervised by a mentor who has met these outcomes. Those who sign off proficiency must have met the additional criteria to be a sign-off mentor (see section 2.1.3). All midwife mentors must have met the additional criteria to be a sign-off mentor.

Once mentors have been entered on the local register (normally held by placement providers) they are subject to triennial review (see Roles to support learning and assessment in practice in the introduction).

Mentors are responsible and accountable for:

- Organising and co-ordinating student learning activities in practice.
- Supervising students in learning situations and providing them with constructive feedback on their achievements.
- Setting and monitoring achievement of realistic learning objectives.
- Assessing total performance – including skills, attitudes and behaviours.
- Providing evidence as required by programme providers of student achievement or lack of achievement.

- Liaising with others (e.g. mentors, sign-off mentors, practice facilitators, practice teachers, personal tutors, programme leaders) to provide feedback, identify any concerns about the student's performance and agree action as appropriate.

- Providing evidence for, or acting as, sign-off mentors with regard to making decisions about achievement of proficiency at the end of a programme.

2.1.1 Criteria for supporting learning and assessing in practice – mentors

Nurses and midwives who intend to take on the role of mentor must fulfil the following criteria:

- Be registered in the same part or sub-part of the register as the student they are to assess and for the nurses' part of the register be in the same field of practice (adult, mental health, learning disability or children's). See Circular 26/2007 for further information (Annexe 3).

- Have developed their own knowledge, skills and competence beyond registration i.e. been registered for at least one year.

- Have successfully completed an NMC approved mentor preparation programme (or a comparable programme which has been accredited by an AEI as meeting the NMC mentor requirements).

- Have the ability to select, support and assess a range of learning opportunities in their area of practice for students undertaking NMC approved programmes.

- Be able to support learning in an interprofessional environment – selecting and supporting a range of learning opportunities for students from other professions.

- Have the ability to contribute to the assessment of other professionals under the supervision of an experienced assessor from that profession.

- Be able to make judgements about competence/proficiency of NMC students on the same part of the register, and in the same field of practice, and be accountable for such decisions.

- Be able to support other nurses and midwives in meeting CPD needs in accordance with *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*.

2.1.2 Competence and outcomes for a mentor

Mentor competencies are achieved by successful completion of an NMC approved mentor preparation programme that achieves all of the outcomes of stage 2. These outcomes are as follows:

Establishing effective working relationships

- Demonstrate an understanding of factors that influence how students integrate into practice settings.
- Provide ongoing and constructive support to facilitate transition from one learning environment to another.
- Have effective professional and interprofessional working relationships to support learning for entry to the register.

Facilitation of learning

- Use knowledge of the student's stage of learning to select appropriate learning opportunities to meet individual needs.
- Facilitate the selection of appropriate learning strategies to integrate learning from practice and academic experiences.
- Support students in critically reflecting upon their learning experiences in order to enhance future learning.

Assessment and accountability

- Foster professional growth, personal development and accountability through support of students in practice.
- Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team.
- Provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future.
- Be accountable for confirming that students have met, or not met, the NMC competencies in practice. As a sign-off mentor confirm that students have met, or not met, the NMC standards of proficiency in practice and are capable of safe and effective practice.

Evaluation of learning

- Contribute to evaluation of student learning and assessment experiences – proposing aspects for change resulting from such evaluation.
- Participate in self and peer evaluation to facilitate personal development, and contribute to the development of others.

Creating an environment for learning

- Support students to identify both learning needs and experiences that are appropriate to their level of learning.
- Use a range of learning experiences, involving patients, clients, carers and the professional team, to meet defined learning needs.
- Identify aspects of the learning environment which could be enhanced – negotiating with others to make appropriate changes.
- Act as a resource to facilitate personal and professional development of others.

Context of practice

- Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated.
- Set and maintain professional boundaries that are sufficiently flexible for providing interprofessional care.
- Initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained.

Evidence-based practice

- Identify and apply research and evidence-based practice to their area of practice.
- Contribute to strategies to increase or review the evidence-base used to support practice.
- Support students in applying an evidence base to their own practice.

Leadership

- Plan a series of learning experiences that will meet students defined learning needs.
- Be an advocate for students to support them accessing learning opportunities that meet their individual needs – involving a range of other professionals, patients, clients and carers.
- Prioritise work to accommodate support of students within their practice roles.
- Provide feedback about the effectiveness of learning and assessment in practice.

2.1.3 Criteria for a sign-off mentor

Underpinned by principle A which states that:

Nurses and midwives who make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice must be on the same part or sub-part of the register as that which the student is intending to enter.

Only sign-off mentors[7] and practice teachers that are on the same part of the register and in the same field of practice may confirm that students have met the relevant standards of proficiency for the particular programme leading to registration or a qualification that is recordable on the NMC register.

Placement providers must ensure that a nurse or midwife designated to sign-off proficiency for a particular student at the end of a programme is:

- Identified on the local register as a sign-off mentor or a practice teacher.
- Registered on the same part of the register.
- Working in the same field of practice as that in which the student intends to qualify.

And additionally to be a sign-off mentor they must have:

- Clinical currency and capability in the field in which the student is being assessed.
- A working knowledge of current programme requirements, practice assessment strategies and relevant changes in education and practice for the student they are assessing.
- An understanding of the NMC registration requirements and the contribution they make to the achievement of these requirements.
- An in-depth understanding of their accountability to the NMC for the decision they must make to pass or fail a student when assessing proficiency requirements at the end of a programme.
- Been supervised on at least three occasions for signing off proficiency by an existing sign-off mentor (see paragraph 5.2 in introduction).
- A working knowledge of current programme requirements, practice assessment strategies and relevant changes in education and practice for the student they are assessing.
- The achievement of these requirements.

[7] Placement providers will decide in the first instance who may be considered as a sign-off mentor and annotate these mentors accordingly. The NMC would expect that such mentors would meet all criteria except that of being supervised by an existing sign-off mentor. All midwife mentors will be sign-off mentors.

- An understanding of the NMC registration requirements and the contribution they make to meeting these requirements.

- An in-depth understanding of their accountability to the NMC for the decision they make to pass or fail a student when assessing proficiency requirements at the end of a programme.

2.2 NMC practice teacher standard

An NMC practice teacher is a registrant who normally will have previously fulfilled the NMC requirements to become a mentor, and who has received further preparation to achieve the knowledge, skills and competence required to meet the NMC defined outcomes for a practice teacher.

The NMC requires all students undertaking a programme leading to registration as a specialist community public health nurse (SCPHN) to have a named practice teacher. Practice teachers must have met NMC requirements defined in this standard, or be supervised by a practice teacher who has met them. Once practice teachers have been entered on the local register (which will be held by placement providers) they are subject to triennial review (see Triennial review of mentor and practice teacher in the introduction).

In September 2007 the process by which nurses undertaking practice teacher preparation programmes should achieve sign-off status was clarified (NMC Circular 27/2007). Trainee practice teachers must be supervised by an existing sign off practice teacher on at least one occasion for signing off proficiency of a SCPHN student at the end of their final placement.

Following successful completion of the programme the trainee practice teacher can be entered on the local register as a practice teacher. They should then undertake a period of preceptorship supported by an existing sign-off practice teacher. The nature of the period of preceptorship should be determined by the local placement provider, but would normally be for a year during which time further supervised sign-offs of SCPHN students should be undertaken.

Once the period of preceptorship is completed and the preceptor is satisfied that the preceptee is competent in signing off proficiency, the preceptee can be annotated as a sign-off practice teacher. The period of preceptorship can then be extended if necessary, but this should not continue beyond the date of their first triennial review.

The practice teacher should continue to receive support from other experienced practice teachers when making final placement assessment decisions, until they have received the first triennial review and been identified as continuing to meet the criteria to be able to sign off proficiency.

NMC practice teachers are responsible and accountable for:

- Organising and co-ordinating learning activities, primarily in practice learning environments for pre-registration students, and those intending to register as a specialist community public health nurse (SCPHN) and specialist practice qualifications where this is a local requirement.

- Supervising students and providing them with constructive feedback on their achievements.

- Setting and monitoring achievement of realistic learning objectives in practice.

- Assessing total performance – including skills, attitudes and behaviours.

- Providing evidence as required by programme providers of the student's achievement or lack of achievement.

- Liaising with others (e.g. mentors, sign-off mentors, supervisors, personal tutors, the programme leader, other professionals) to provide feedback and identify any concerns about the student's performance and agree action as appropriate.

- Signing off achievement of proficiency at the end of the final period of practice learning or a period of supervised practice.

The practice teaching role will be supported by appropriate professional and academic qualifications, and practice development activity, to provide an evidence-base for teaching. Practice teachers will have met the additional criteria for a sign-off mentor (section 2.1 .3) as part of their preparation. The practice teacher role may vary according to the nature of the student they are supporting. Specific additional criteria, where appropriate, are identified in the relevant standards of proficiency for nurses, midwives and specialist community public health nurses.

2.2.1 Criteria for supporting learning and assessing in practice – practice teacher

Nurses who intend to take on the role of practice teacher, and who will be assessing the student's fitness for practice, must fulfil the following criteria:

- Be registered in the same part of the register, i.e. SCPHN, and from the same field of practice e.g. school nursing, health visiting, occupational health nursing (or relevant SPQ where this is a local requirement) as the student they are to assess (see NMC Circular 26/2007 Annexe 3).

- Have developed their own knowledge, skills and competence beyond registration i.e. registered and worked for at least two years, and gained additional qualifications that will support students in SCPHN, or SPQ where this is a local requirement.

- Have successfully completed an NMC approved practice teacher preparation programme or a comparable programme that has been accredited by an AEI as meeting the NMC practice teacher requirements. And, normally, having previously met the outcomes for acting as a mentor and gained experience in this role.

- Have the abilities to design, deliver and assess programmes of learning in practice settings – supporting a range of students in their area of practice, i.e. pre-registration, SCPHN, CPD of peers, other professionals.

- Be able to support learning in an interprofessional environment – selecting and supporting a range of learning opportunities for students from all professions – relevant to their level of practice and specialist expertise.

- Be able to use agreed criteria for cross-professional assessment and supervise NMC mentors and other professionals using such criteria.

- Be able to make judgements about the competence/proficiency of NMC students, for registration on the same part of the register and be accountable to the NMC for such decisions.

- Be able to provide leadership to all those involved in supporting learning and assessing in practice for NMC students – enabling effective learning environments to be developed.

2.2.2 Competence and outcomes for a practice teacher

The competencies of a practice teacher are achieved by successful completion of an NMC approved practice teacher preparation programme achieving all of the outcomes of stage 3. These outcomes are as follows:

Establishing effective working relationships

- Have effective professional and interprofessional working relationships to support learning for entry to the register, and education at a level beyond initial registration

- Be able to support students moving into specific areas of practice – or a level of practice beyond initial registration, identifying their individual needs in moving to a different level of practice.

- Support mentors and other professionals in their roles to support learning across practice and academic learning environments.

Facilitation of learning

- Enable students to relate theory to practice whilst developing critically reflective skills.

- Foster professional growth and personal development by use of effective communication and facilitation skills.

- Facilitate and develop the ethos of interprofessional learning and working.

Assessment and accountability

- Set effective professional boundaries whilst creating a dynamic, constructive teacher-student relationship.

- In partnership with other members of the teaching team, use knowledge and experience to design and implement assessment frameworks.

- Be able to assess practice for registration, and also at a level beyond that of initial registration.

- Provide constructive feedback to students and assist in identifying future learning needs and actions, managing failing students so that they may either enhance their performance and capabilities for safe and effective practice, or are able to understand their failure and the implications of this for their future.

- Be accountable for confirming that students have met, or not met, the NMC standards of proficiency in practice for registration, at a level beyond initial registration, and are capable of safe and effective practice.

Evaluation of learning

- Design evaluation strategies to determine the effectiveness of practice and academic experience, accessed by students, at both registration level and those in education at a level beyond initial registration.

- Collaborate with other members of the teaching team to judge and develop learning, assessment and to support appropriate practice and levels of education.

- Collect evidence on the quality of education in practice, and determine how well NMC requirements for standards of proficiency are being achieved.

Creating an environment for learning

- Enable students to access opportunities to learn and work within interprofessional teams.

- Initiate the creation of optimum learning environments for students at registration level and for those in education at a level beyond initial registration.

- Work closely with others involved in education – in practice and academic settings – to adapt to change and inform curriculum development.

Context of practice

- Recognise the unique needs of practice and contribute to development of an environment that supports achievement of NMC standards of proficiency.

- Set and maintain professional boundaries, whilst at the same time recognising the contribution of the wider interprofessional team and the context of care delivery.

- Support students in exploring new ways of working, and the impact this may have on established professional roles.

Evidence based practice

- Identify areas for research and practice development based on interpretation of existing evidence.

- Use local and national health frameworks to review and identify developmental needs.

- Advance their own knowledge and practice in order to develop new practitioners, at both registration level and education at a level beyond initial registration, to be able to meet changes in practice roles and care delivery.

- Disseminate findings from research and practice development to enhance practice and the quality of learning experiences.

Leadership

- Provide practice leadership and expertise in application of knowledge and skills based on evidence.

- Demonstrate the ability to lead education in practice, working across practice and academic settings.

- Manage competing demands of practice and education related to supporting different practice levels of students.

- Lead and contribute to evaluation of the effectiveness of learning and assessment in practice

2.3 NMC teacher standard

An NMC teacher is an NMC registrant who, following successful completion of an NMC approved teacher preparation programme, has achieved the knowledge, skills and competence required to meet the NMC defined outcomes of stage 4 of the developmental framework.

The NMC teacher standard is mandatory for those nurses and midwives based in higher education who support learning and assessment in practice settings for students on NMC approved programmes. The NMC recognises that some academic teachers will not be nurses or midwives, but will instead have specialist knowledge and expertise that contributes to professional education. The NMC will, through its quality assurance processes, verify that the majority of teachers who make a major contribution to NMC approved programmes hold, or are working towards, a teaching qualification that meets the outcomes of stage 4 of the developmental framework.

NMC teachers are responsible for:

- Organising and co-ordinating learning activities in both academic and practice environments.

- Supervising students in learning situations and providing them with constructive feedback on their achievements.

- Setting and monitoring achievement of realistic learning objectives in theory and practice.

- Assessing performance and providing evidence as required of student achievement.

Their teaching role will be supported by appropriate professional and academic qualifications and ongoing research, education and/or practice development activity to provide an evidence base for their teaching. Only teachers who work in both practice and academic settings e.g. lecturer practitioners may assess practice.

2.3.1 Criteria for supporting learning and assessing in practice – teachers

Nurses and midwives who intend to take on the role of teacher must fulfil the following criteria:

- Be registered in the same part or sub-part of the register as the students they support.
- Have completed at least three years post-registration experience, gained additional professional knowledge and skills, and have experience in an area where students are gaining practice experience relevant to their registration.
- Have extended their professional knowledge, relevant to their field of practice, to at least first degree level, prior to undertaking an NMC approved post-graduate teacher preparation programme.
- Have the abilities to lead programme development and co-ordinate the work of others in delivering and assessing programmes of learning in practice and academic settings – supporting a wide range of students.
- Able to support interprofessional learning and working, selecting and supporting a range of learning opportunities for students from all professions, and supporting practice development.
- Have the ability to generate and use cross-professional assessment criteria, supervising mentors, practice teachers and teachers from other professions in the implementation of such criteria.
- Able to teach and assess in both practice and academic settings, contributing to decisions about fitness for practice of NMC students for both registration and qualifications at a level beyond initial registration – and be accountable to the NMC for such decisions.
- Able to provide leadership in education in both practice and academic settings, e.g. nurse/midwife consultant roles, clinical academic roles, programme leader, etc.

2.3.2 Competence and outcomes for a teacher

The competencies of a teacher are achieved by successful completion of an NMC approved teacher preparation programme achieving all of the outcomes of stage 4 of the developmental framework. This preparation programme must have included, as part of the overall programme, a period of assessed teaching activity to include experience in both academic and practice settings, at least equivalent to a minimum of 12 weeks (or 360 hours), with students studying an NMC approved programme.

The competencies of a teacher are:

- Demonstrate effective relationship building skills sufficient to support learning, as part of a wider interprofessional team, for a range of students in both practice and academic learning environments and supporting mentors and practice teachers.

- Facilitate learning for a range of students, within a particular area of practice and where appropriate, encourage self-management of learning opportunities and provide support to maximise individual potential.

- Assess learning, in order to make judgements related to the NMC standards of proficiency for entry to the register or, for recording a qualification at a level beyond initial registration, being the final point of accountability for 'fitness for practice' decisions.

- Determine strategies for evaluating learning in practice and academic settings to ensure that the NMC standards of proficiency for recording a qualification at a level beyond initial registration have been met.

- Create an environment for learning, where practice is valued and developed, that provides appropriate professional and interprofessional learning opportunities and support for learning to maximise achievement for individuals.

- Support learning within a context of practice that reflects healthcare and educational policies, managing change to ensure that particular professional needs are met within a learning environment that also supports practice development.

- Apply a knowledge and practice evidence-base to their own work and contribute to the further development of such an evidence-base for practice.

- Demonstrate leadership skills for education within practice and academic settings,

- The outcomes for a teacher to meet the competencies are as follows:

Establishing effective working relationships

- Demonstrate effective relationships with other members of the teaching teams, in practice and academic settings, based on mutual trust and respect.

- Maintain appropriate supportive relationships with a range of students, mentors, practice teachers and other professionals.

- Foster peer support and learning in practice and academic settings for all students.

- Support students to integrate into new environments and working teams to enhance access to learning.

Facilitation of learning

- Promote development of enquiring, reflective, critical and innovative approaches to learning.
- Implement a range of learning and teaching strategies across a wide range of settings.
- Provide support and advice, with ongoing and constructive feedback to students, to maximise individual potential.
- Co-ordinate learning within an interprofessional learning and working environment.
- Facilitate integration of learning from practice and academic settings.
- Act as a practice expert to support development of knowledge and skills for practice.

Assessment and accountability

- Set and maintain professional boundaries that are sufficiently flexible for interprofessional learning.
- Develop, with others, effective assessment strategies to ensure that standards of proficiency for registration, or recordable qualifications at a level beyond initial registration, are met.
- Support others involved in the assessment process – students, mentors and peers.
- Provide constructive feedback to students and assist them in identifying future learning needs and actions, managing failing students so that they may either enhance their performance and capabilities for safe and effective practice, or be able to understand their failure and the implications of this for their future.
- Be accountable for their decisions related to fitness for practice for registration or recordable qualifications – underpinning such decisions with an evidence-base derived from appropriate and effective monitoring of performance.[8]

Evaluation of learning

- Determine and use criteria for evaluating the effectiveness of learning environments – acting on findings, with others, to enhance quality.
- Foster and participate in self and peer evaluation to enable students to manage their own learning in practice and academic settings and to enhance personal professional development.
- Evaluate the effectiveness of assessment strategies in providing evidence to make judgements on fitness for practice.
- Report on the quality of practice and academic learning environments to demonstrate that NMC requirements have been met, particularly in relation to support of students and achievement of standards of proficiency.

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[8] Only those teachers with a practice role and who have met the additional criteria for a sign-off mentor may assess students in practice settings.

Creating an environment for learning

- Develop, in partnership with others, opportunities for students to identify and access learning experiences that meet their individual needs.
- Ensure such opportunities maintain the integrity of the student's professional role whilst responding to the interprofessional context of practice.
- Determine, with others, audit criteria against which learning environments may be judged for their effectiveness in meeting NMC requirements.
- Support and develop others involved to ensure that learning needs are effectively met in a safe environment.
- Explore and implement strategies for continuous quality improvement of the learning environment.

Context of practice

- Support students in identifying ways in which policy impacts on practice.
- Contribute effectively to processes of change and innovation – implementing new ways of working that maintain the integrity of professional roles.
- Negotiate ways of providing support to students so that they can achieve their learning needs within the context of professional and interprofessional practice.
- Act as a role model to enable students to learn professional responsibilities and how to be accountable for their own practice.
- Adapt to change, demonstrating to students how flexibility may be incorporated whilst maintaining safe and effective practice.

Evidence-based practice

- Advance their own knowledge and practice abilities through access to, and involvement in – where appropriate – research and practice development.
- Consider how evidence-based practice, involving patients, clients, carers and other members of the health and social care team, enhances care delivery and learning opportunities.
- Empower individuals, groups and organisations to develop the evidence-base for practice.
- Disseminate findings from research and practice development to enhance the quality of learning, care delivery and academic environments.

Leadership

- Demonstrate effective communication skills to facilitate delivery of educational programmes that lead to registration or a recordable qualification.

- Initiate and lead programme development and review processes to enhance quality and effectiveness.

- Develop effective relationships with practice and academic staff, who are involved in programme delivery, to ensure clarity of contribution and strategies to respond to evaluation of learning experiences.

- Demonstrate strategic vision for practice and academic development relevant to meeting NMC requirements.

- Manage competing demands to ensure effectiveness of learning experiences for students.

- Lead, contribute to, analyse and act on the findings of evaluation of learning and assessment to develop programmes.

- Provide feedback about the effectiveness of learning and assessment in practice.

Section 3 –Applying the standards to support learning and assessment in practice

3.1 Applying the standards to nursing, midwifery and specialist community public health nursing education programmes

The NMC has acknowledged that nurses, midwives and specialist community public health nurses have different needs when applying the standards to support learning and assessment in practice.

These are clarified as:

- Nursing education – requires mentors, practice teachers and teachers to provide the full range of support and assessment required to meet the needs of pre-registration, and specialist practice education

- Midwifery education – requires only mentors and teachers.

- Specialist community public health nursing education – requires practice teachers and teachers.

3.2 Applying the NMC mentor standard in practice

From 1 September 2007 the NMC mentor standard is mandatory for supporting the learning and assessment of pre-registration nursing and midwifery students. NMC requirements will be updated in the future in the light of the review of specialist practice qualification and advanced nursing practice, as explained in the introduction to this document.

The standard for mentors needs to be read in conjunction with the relevant Standards for pre-registration nursing education (NMC 2010), Standards for pre registration midwifery education (2009), Standards for specialist education and practice (UKCC 1994) and also with respect to the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules Order of Council 2004 (SI 2004 No 1767) hereafter referred to as the Education Rules; and the Nursing and Midwifery Council (Midwives) Rules Order of Council 2004 (SI 2004 No 1764) hereafter known as the Midwives Rules.

The following requirements are set by the NMC for implementing the mentor standard. Guidance is provided to help interpret the requirements.

3.2.1 Mentor preparation programmes

Mentor preparation programmes must be:

- At a minimum academic level of HE Intermediate level (previously known as level 2) or SCQF Level 8.
- A minimum of 10 days, of which at least five days are protected learning time.
- Include learning in both academic and practice settings.
- Include relevant work-based learning, e.g. experience in mentoring a student under the supervision of a qualified mentor, and have the opportunity to critically reflect on such an experience.
- Normally, be completed within three months.[9]
- Should provide a foundation for undertaking an NMC approved practice teacher programme.
- Allow AP(E)L to be applied to up to 100% of the programme, and recognise previous preparation of an equivalent nature and standard. It is for placement providers to determine if an individual meets the NMC additional criteria to sign-off a student's proficiency (section 3.2.6), and therefore they may be placed immediately on the local register with an annotation to identify this.

[9] All midwifery mentors are required to meet the additional criteria to be a sign-off mentor (see section 3.2.6) as part of their preparation programme; the length of this programme should be adjusted to take account of this requirement to allow time for midwifery mentors to be supervised as a sign-off mentor on at least three occasions.

3.2.2 Continuing professional development for mentors

The NMC requires all qualified mentors to maintain and develop their knowledge, skills and competence as a mentor through regular updating. The NMC requires placement providers to maintain a record of current mentors and, where appropriate, (and in partnership with local education providers) to make provisions for annual updating of these nurses and midwives.

The purpose of annual updating is to ensure that mentors:

- Have current knowledge of NMC approved programmes.
- Are able to discuss the implications of changes to NMC requirements.
- Have an opportunity to discuss issues related to mentoring, assessment of competence and fitness for safe and effective practice.

Mentors should be prepared to demonstrate to their employers, and NMC quality assurance agents as appropriate,[10] how they have maintained and developed their knowledge, skills and competence as a mentor. Placement providers will consider evidence of updating as part of triennial review.

3.2.3 Allocated learning time for mentor activity

The NMC recognises that nurses and midwives who are mentors are primarily employed to provide care for patients and clients. Pre-registration students have supernumerary status and can expect to be able to work with mentors. All students must be supervised at all times, either directly or indirectly. Being a mentor requires a commitment. The NMC requires that as a minimum:

Whilst giving direct care in the practice setting at least 40% of a student's time must be spent being supervised (directly or indirectly) by a mentor/practice teacher.

The nature of supervision will vary from direct to indirect depending upon the:

- Nature of the activity the student is engaged in.
- Evidence of their current competence.
- Need to assess achievement of NMC outcomes or competencies for progression on the programme.

Mentors will use their professional judgment and local/national policy to determine where activities may be safely delegated to students and the level of supervision required. They are accountable for such decisions and for ensuring public protection.

They will need time, when undertaking work with a student, to be able to explain, question, assess performance and provide feedback to the student in a meaningful way.

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[10] All NMC approved programmes are monitored regularly. This may involve NMC quality assurance agents in practice and education visits to examine evidence that NMC requirements are being met.

3.2.4 Supporting learning in practice

The NMC requires mentors to support learning in practice for several reasons (section 2.1):

- Provide support and guidance to the student when learning new skills or applying new knowledge.
- Act as a resource to the student to facilitate learning and professional growth.
- Directly manage the student's learning in practice to ensure public protection.
- Directly observe the student's practice, or use indirect observation where appropriate, in order to ensure that NMC defined outcomes and competencies are met.

The following requirements enable effective mentorship to be realised:

NMC Requirements	Guidance
Every student has a named mentor for each period of practice learning.	Mentors should be allocated prior to commencement of a placement. This should be sufficiently in advance of the placement to enable both the student and their mentor to prepare adequately for the placement. The NMC would recommend that, at a minimum, this should be one week prior to commencement of the placement.
Mentors should not normally support more than three students, from any discipline, at any point in time.	Mentors need to be able to commit themselves to supporting learning and assessment in practice. Their workload need to reflect the demands of being a mentor.
Whilst giving direct care in the practice setting at least 40% of the student's time must be spent being supervised (directly or indirectly) by a mentor/ practice teacher.[11] When in a final placement this 40% of the student's time is in addition to the protected time (one hour per week) to be spent with a sign-off mentor (paragraph 3.2.6)	At all times students must be directly or indirectly supervised in the practice setting. The mentor's responsibility is to plan and co-ordinate the student's whole learning experience, determining the amount of direct supervision required by the mentor, and what experience may be through indirect supervision (student working independently). Some experience may be supervised by others (other professionals, mentors or practice teachers). The named mentor is accountable for their decisions to let the student work independently or with others.

[11] In some NMC approved programmes there is a specified requirement for the amount of practice that is supervised to exceed 40%.

NMC Requirements	Guidance
An ongoing achievement record including comments from mentors must be passed from one placement to the next to enable judgements to be made on the student's progress. (Further detail: see circular 33/2007 in annexe 3)	Students are expected to keep a record of their learning experiences, identifying evidence to support achievement of NMC outcomes and competencies and where further support and supervision is required. This record should be made available to the named mentor at the beginning of a new experience to enable discussion of strengths and areas for improvement. Students must be kept fully informed regarding the ways in which information is intended to be shared, used and stored, including the length of time it is to be retained and when it will be destroyed. (Data Protection Act 1998)[12]
The mentor should have access to a network of support and supervision to enable them to fulfil their mentoring responsibilities, assist them in making complex judgements regarding competence such as failing a student and to support their professional development.	Support and supervision may be provided by, for example, other mentors, practice facilitators, practice teachers or link tutors, with due regard to the part of the register and field of practice. Where necessary, inexperienced mentors should seek support from a sign-off mentor who has met the NMC additional criteria for assessing proficiency.
Placement providers are responsible for ensuring that an up-to-date local register of mentors is maintained, with annotations of those who have met the NMC additional criteria for assessing proficiency (sign-off mentors).	The register will provide evidence for quality assurance purposes that there are a sufficient number of mentors, who met the NMC standards, to support learning and assessment in practice related to NMC approved programmes.
Placement providers are responsible for triennial review of mentors to ensure that only those who continue to meet the NMC's mentor requirements remain on the local register.	The NMC sets general requirements for remaining on the local register (see introduction – triennial review). It would be a matter for placement providers to determine locally any additional criteria needed for mentors to remain on the register.

[12] The Data Protection Act 1998 has been superseded by the Data Protection Act 2018.

3.2.5 Assessing learning in practice

Mentors will have been prepared to assess student performance in practice and will be accountable for their decisions to pass, refer or fail a student. The NMC recognises that failing students may be difficult and that all assessment decisions must be evidence-based. Sign-off mentors who assess proficiency in the final placement or at the end of a period of supervised practice will have met additional criteria set by the NMC (section 3.2.6).

NMC Requirements	Guidance
Most assessment of competence should be undertaken through direct observation in practice.	Students must normally demonstrate their competence in the practice setting. However, where experience is limited, e.g. basic life support skills, simulated experience or OSCEs may be used. The majority of assessment should be through direct observation.
Mentors should be involved wherever possible, when competence is assessed through simulation.	Summative assessment using simulation may occur where opportunities to demonstrate competence in practice are limited. Mentors should be involved in designing, using and evaluating such assessment strategies.
Mentors should consider how evidence from various sources might contribute to making a judgement on performance and competence.	The NMC recognises that the total assessment strategy would include assessment through various means i.e. direct care, simulation, OSCEs and other strategies.
Mentors should seek advice and guidance from a sign-off mentor or a practice teacher when dealing with failing students.	Inexperienced mentors may require support from a sign-off mentor or practice teacher when faced with a failing student to help them to communicate concerns, identify action and evaluate progress.

3.2.6 Signing off practice proficiency

In order to ensure public protection the NMC needs to be assured that students have been assessed and signed off as capable of safe and effective practice at the end of a programme. Additional criteria have been defined for the mentor to be able to sign-off proficiency in practice at the end of a programme (paragraph 2.1.3).

Placement providers will determine when a mentor has met the additional criteria and will be annotated as a sign-off mentor on the local register. The NMC statutory midwifery committee has decided that all midwife mentors must have met the additional criteria to be sign-off mentors.

Due regard
In accordance with underpinning principle A (paragraph 1.2):

- Only a registered nurse may sign off a nursing student (the nurse must have a mark on the nurses' part of the register that coincides with the branch programme the student has undertaken).

- Only a registrant with the same SPQ may sign off a SPQ student

- Only a registered midwife may sign off a midwifery student.

Confirmation of proficiency
The sign-off mentor, who has met the NMC additional criteria for assessing proficiency, is responsible and accountable for making the final sign-off in practice – confirming that a student has successfully completed all practice requirements. This confirmation will contribute to the portfolio of evidence considered by the AEI's examination and assessment board. The NMC requires mentors who have not yet met the additional criteria to be supported by a sign-off mentor or a practice teacher if it is the student's final placement, or when failing a student.

NMC Requirements	Guidance
The NMC has identified progression points within each approved programme where confirmation is required that students have met specified outcomes and competencies. For pre–registration midwifery programmes a sign-off mentor is required to confirm the outcomes at each progression point – NMC Circulars 24/2007 and 13/2007. For progression points for nursing and SCPHN see the relevant standards of proficiency for nursing and SCPHN (NMC2004). For these programmes a sign-off mentor/practice teacher is required to confirm the outcomes only at the end of the programme.[13]	Confirmation is required at points where a student may not progress without a formal decision that they have met the outcomes or competencies of a previous part of the programme.

[13] For pre-registration nursing, mentors rather than sign-off mentors are required to sign-off outcomes for entry to the branch.

NMC Requirements	Guidance
All mentors may assess specific competencies throughout the programme.	NMC competencies may be achieved throughout the programme, unless otherwise indicated in programme standards. A mentor may confirm achievement of competencies, including those to be achieved at, or by, a progression point. Only a sign-off mentor, who has met the additional criteria, may sign-off proficiency at the end of a final period of practice learning.
Mentors must keep sufficient records to support and justify their decisions on whether a student is, or is not, competent/ proficient.	The NMC considers it important that mentors have an audit trail to support their decisions. Throughout a placement where a critical decision on progress is to be made the mentor should ensure that regular feedback is given to the student and that records are kept of guidance given.
In the final placement of a pre-registration programme, mentors are required to be either a sign-off mentor, or supported by a sign-off mentor or a practice teacher, in order to make final decisions on proficiency.	Mentors are responsible and accountable for making decisions on the student's achievement of outcomes and competencies. They may assess competencies throughout the programme but only a sign-off mentor or a practice teacher may make final assessment of proficiency.
Sign-off mentors must have time allocated to reflect, give feedback and keep records of student achievements in their final period of practice learning. This will be the equivalent of an hour per student per week. This time is in addition to the 40% of the student's time to be supervised by a mentor (paragraph 3.2.4).	Sign-off mentors will require allocated time to ensure that students have effective feedback on their performance so that the ultimate decision on their proficiency is not unexpected. The time allocated may need to be greater earlier in the placement and reduced as they become more confident and competent.
Only sign-off mentors, who have met the additional criteria, must sign off achievement of proficiency at the end of the programme, unless the mentor is being supervised by a sign-off mentor or practice teacher who should countersign that the proficiency has been achieved by the student.	The final assessment of proficiency draws on evidence of assessment over a sustained period of time. The sign-off mentor may use the student passport and other evidence to see if competence has been achieved and maintained previously, as well as demonstrated in the current placement.

NMC Requirements	Guidance
The programme leader/lead midwife for education must confirm to the AEI Examination/Assessment Board that all NMC requirements have been met (to the best of their knowledge) for individual students presenting evidence of sign-off practice from a sign-off mentor or practice teacher.	AEI Examination or Assessment Boards should ensure that confirmation is received, based on recorded evidence, that all NMC requirements have been met. The AEI examination board must consider the record of achievement of practice proficiency, signed at the end of the final period of practice learning by a mentor who has met the NMC additional criteria.
The student must self-declare their good health and good character for entry to the register.	Good health and good character will have been assessed for admission to, and continued participation in, the programme. Students should be encouraged to advise their personal tutors of any issues that may affect this. They are responsible and accountable for their self-declaration to the NMC when applying for registration.
The programme leader/lead midwife for education must provide a supporting declaration of good health and good character of the student for registration.	A registrant who is the programme leader/lead midwife for education, or their designated deputy, whose name has been previously notified to the NMC, must complete a declaration in support of the student's self-declaration. There should be an audit trail of evidence (normally in the student's record).

3.3 Applying the NMC practice teacher standard in practice

The NMC practice teacher standard is mandatory for supporting learning and assessing nurses and midwives studying for registration as a specialist community public health nurse (SCPHN), and also for specialist practice qualifications where this is a local requirement.

The NMC standard for practice teachers needs to be read in conjunction with Standards of proficiency for specialist community public health nursing (NMC 2004) and Standards for specialist education and practice (UKCC 1994), and also with respect to the Education Rules (SI 2004 No 1767). The following requirements are set by the NMC for implementing the practice teacher standard. Guidance is provided to assist interpretation of the requirements.

3.3.1 Practice teacher preparation programmes

Practice teacher preparation programmes must:

- Be a minimum academic level of HE Honours (previously known as level 3) or SCQF Level 9.[14]
- Include at least 30 days protected learning time – to include learning in both academic and practice settings.
- Include relevant work-based learning with the opportunity to critically reflect on such an experience, e.g. acting as a practice teacher to a student in specialist practice under the supervision of a qualified practice teacher.
- Meet the additional criteria for a sign-off mentor.
- Normally be completed within six months.
- Should provide a foundation for undertaking an NMC approved teacher preparation programme.
- Allow AP(E)L to be applied to up to 100% of the programme. Previous preparation of an equivalent nature and standard should be recognised. It is for the education provider to determine if this allows the individual to be placed immediately on the practice teacher register without the need for further preparation.
- The content of a previous mentor programme, where appropriate, may be accredited, enabling the practice teacher programme to be completed in less time.

3.3.2 Continuing professional development for practice teachers

The NMC requires all practice teachers to maintain and develop their knowledge, skills and competence through annual updating. Additionally they would need to maintain and develop their extended knowledge and skills gained for practice in a specialist area. The NMC requires placement providers to maintain a record of current practice teachers and, where appropriate – in partnership with local education providers, to make provisions for annual updating of these nurses (see section 2 and Triennial review of mentor and practice teacher in the introduction).

The purpose of annual updating is to ensure that practice teachers:

- Have current knowledge of NMC approved programmes.
- Are able to discuss the implications of changes to NMC requirements.
- Have an opportunity to discuss issues relating to supervision, assessment of competence and fitness for safe and effective practice.

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[14] This may vary according to the needs of specific professions and any additional requirement will be identified within the Standards of proficiency for each part of the NMC register.

Practice teachers should be prepared to demonstrate to their employers, and NMC quality assurance agents, as appropriate,[15] how they have maintained and developed their knowledge, skills and competence as a practice teacher. Placement providers will consider evidence of updating as part of triennial review.

3.3.3 Allocated learning time for practice teacher activity

The NMC recognises that nurses and midwives who are practice teachers are primarily employed to provide care for patients and clients. Students gaining registration as a specialist community public health nurse, are required to undertake a period of practice during which they would normally work on a one-to-one basis with their practice teachers.

The nature of supervision will vary from direct to indirect depending upon the:

- Nature of the activity the student is engaged in.
- Evidence of their current competence.
- Need to assess achievement of NMC outcomes or competencies for progression on the programme.

Practice teachers will use their professional judgment and local/national policy to determine where activities may be safely delegated to students and the level of supervision required. They are accountable for such decisions.

Practice teachers will need time, when undertaking work with a student, to be able to explain, question, assess performance, and provide feedback to the student in a meaningful way. A practice teacher should be allocated to a SCPHN student throughout the programme (or sign-off mentor where this has been agreed through the deferral process – see NMC circular 08/2007).

3.3.4 Supporting learning in practice

The NMC requires practice teachers to support learning for several reasons (section 2.2):

- Provide support and guidance to the student when learning new skills, applying new knowledge and transferring existing knowledge and competence to a new context of practice.
- Act as a resource to the student to facilitate learning and professional growth.
- Manage the student's learning in practice in order to ensure public protection.
- Directly observe the student's practice, or use indirect observation where appropriate, to ensure that NMC defined outcomes and competencies are met.

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[15] All NMC approved programmes are monitored regularly. This may involve NMC quality assurance agents in practice and education visits to examine evidence that NMC requirements are being met.

The following requirements enable effective practice teaching to be realised:

NMC Requirements	Guidance
Every SCPHN student (and SPQ student where this is a local requirement) has a named practice teacher.	Practice teachers should be allocated prior to commencement of supervised practice. This should be sufficiently in advance of the placement to enable both the student and their practice teacher to prepare adequately for the placement.
Practice teachers should support only one SCPHN student (or SPQ student) at any point in time.	Practice teachers need to be able to commit themselves to supporting learning and assessment in practice. Their workload needs to reflect the demands of being a practice teacher.
An ongoing achievement record must be maintained and reviewed regularly throughout the student's supervised practice experience to enable judgements to be made on the students. For further details see Circular 33/2007 in annexe 3.	Students are expected to keep a record of their learning experiences, identifying evidence to support achievement of NMC outcomes and competencies and where further support and supervision is required. This record should be reviewed at intervals by their named practice teacher during their supervised practice experience to enable discussion of strengths and areas for improvement.
Placement providers are responsible for ensuring that an up-to-date local register of practice teachers is maintained.	The register will provide evidence for quality assurance purposes that there are a sufficient number of practice teachers, who meet the NMC standards, to support NMC approved programmes leading to a recordable specialist practice qualification or SCPHN registration. Students must be kept fully informed regarding the ways in which information is intended to be shared, used and stored, including the length of time to be retained and when it will be destroyed. (Data Protection Act 1998)[16]
Placement providers are responsible for triennial review of practice teachers to ensure that only those who continue to meet the NMC practice teacher requirements remain on the local register.	The NMC sets general requirements for remaining on the local register (see introduction – triennial review). It would be a matter for programme providers to determine any additional criteria for practice teachers to remain on the local register.

Students must be kept fully informed regarding the ways in which information is intended to be shared, used and stored, including the length of time it is to be retained and when it will be destroyed. (Data Protection Act 1998)[16]

[16]The Data Protection Act 1998 has been superseded by the Data Protection Act 2018.

3.3.5 Assessing learning in practice

Practice teachers will have been prepared to assess student performance in practice in programmes leading to registration as a SCPHN. They will be accountable for their decisions to pass, refer or fail a student. The NMC recognises that failing students may be difficult and that all assessment decisions must be evidence-based. All practice teachers will be deemed to have met the NMC additional criteria for signing off proficiency (section 3.3.6) at the end of a programme by virtue of, where relevant, their previous mentor experience and the preparation they have undertaken for their practice teacher role.

NMC Requirements	Guidance
Assessment of competence should be undertaken through both direct observation in practice and evidence gained from indirect observation.	Students must demonstrate their competence in the practice setting. The nature of their programme may require that they are able to work autonomously with a defined caseload by the end of the programme. Practice teachers will seek evidence of their performance from patient/user satisfaction reports, self-reports from students, observation by other colleagues and their own direct observation.
Practice teachers should be directly involved in assessing competence through simulation.	Summative assessment using simulation may occur where opportunities to demonstrate competence in practice is limited, e.g. a simulated case conference for child protection.
Practice teachers should consider how evidence from various sources might contribute towards making a judgement on performance and competence.	The NMC recognises that the total assessment strategy would include evidence from direct observation, witness statements from other professionals, contributions from patients/clients and other strategies.
Inexperienced practice teachers should seek guidance from experienced practice teachers/teachers when making complex judgements, such as failing a student.	Inexperienced practice teachers may require particular support from experienced practice teachers/teachers when faced with a failing student to help them to communicate concerns, identify action and evaluate progress.

3.3.6 Signing off practice proficiency

In order to ensure public protection the NMC needs to be assured that students have been assessed and signed off as being capable of safe and effective practice at the end of a programme. Practice teachers must have met the additional criteria to be able to sign-off proficiency in practice at the end of a programme (section 2.1.3).

Due regard
In accordance with underpinning principle A (section 1.2):

- Only a registered SCPHN may sign-off a SCPHN student. The SCPHN must also be from the same field of practice that coincides with the field that the student has undertaken (see NMC Circular 26/2007, Annexe 3).

Confirmation of proficiency
The practice teacher is responsible and accountable for making the final sign-off in practice confirming that a student has successfully completed all practice requirements for a SCPHN qualification. This confirmation will contribute to the portfolio of evidence considered by the approved educational institution's examination/assessment board, who will confirm to the NMC that the proficiencies in relation to both theory and practice and programme requirements have been successfully achieved.

NMC Requirements	Guidance
Practice teachers must keep sufficient records to support and justify their decisions on whether a student is or is not competent/proficient.	The NMC considers it is important that practice teachers have an audit trail to support their decisions.
Practice teachers must have time allocated to reflect, give feedback and keep records of student achievement in the final period of practice learning. This will be the equivalent of an hour per student per week.	Throughout supervised practice experience the practice teacher will require time to ensure that the student has effective feedback on their performance so that the ultimate decision on their proficiency is not unexpected.
The practice teacher must sign-off achievement of practice outcomes, competencies and final proficiency.	The practice teacher is responsible and accountable to the NMC for confirming that outcomes, competencies and NMC standards of proficiency have been met, which take account of outstanding issues e.g. a repeat placement.
The programme leader must confirm to the AEI Examination Board that all NMC requirements have been met (to the best of their knowledge) for individual students presenting evidence of sign-off of practice from the student's named practice teacher.	AEI Examination and Assessment Boards should ensure that confirmation is received, based on recorded evidence of both theory and practice assessment, that all NMC requirements have been met and proficiency achieved.

NMC Requirements	Guidance
The student must self-declare their good health and good character for entry to a new part of the register.	Good health and good character will have been assessed for admission to and maintenance on the register at initial registration, and again for entry to and continued participation in the current programme. Students should advise their Personal Tutors of any issues that may affect this. They are responsible and accountable for their self-declaration to the NMC when applying for registration in a new part of the register.
The programme leader/official correspondent must provide a supporting declaration of good health and good character of the student for registration.	A declaration of the student's self-declaration must be completed by a registrant who is the programme leader/official correspondent (or her deputy), whose name has been previously notified to the NMC, There should be an audit trail of evidence (normally in the student's record).

3.4 Applying the NMC teacher standard in practice settings

The NMC teacher standard is mandatory for those nurses and midwives who are teachers employed in higher education and who support students on NMC approved programmes in practice settings. The NMC recognises that AEIs will have other teachers, who are not nurses and midwives, who will contribute to teaching on NMC approved programmes in their area of specialist expertise. The NMC will, through its quality assurance processes verify that the majority of HE teachers who support NMC students in practice settings have attained, or are working towards, a teaching qualification that meets the NMC outcomes from stage 4.

Approved educational institutions that employ teachers holding an NMC approved qualification will determine the requirements for applying the standard in academic settings. The NMC is concerned that those nurses and midwives who meet the outcomes of stage 4 of the framework are able to apply their knowledge, skills and competence in practice and academic settings. The NMC requires that 50% of learning for its approved pre-registration and specialist practice programmes takes place in practice.

NMC nurse, midwife and specialist community public health nurse teachers must have contemporary experience to be able to support learning and assessment in practice settings. Such experience may take a variety of forms, such as: acting as a link tutor, supporting mentor development and updating, having an active clinical role for a part of their time, supporting clinical staff in their professional development in practice, being involved in practice development to support the evidence-base from which students draw, and contributing to practice-based research.

3.4.1 Teacher preparation programmes NMC approved teacher programmes must:

- Be at a minimum academic level of postgraduate study, i.e. postgraduate certificate, diploma or degree (M level), according to the requirements of programme providers.
- Be at least one academic year in duration.
- Include a minimum of 12 weeks (360 hours) teaching practice.
- Demonstrate achievement of all of the outcomes of stage 4.

Programme providers should take account of the UK Professional Standards Framework for teaching and supporting learning in higher education (HE Academy, February 2006 – see Annexe 2). This framework was developed by the Higher Education Academy on behalf of the Higher Education sector and commissioned by Universities UK, the Standing Conference of Principals (SCOP) and the UK HE funding councils. The model provides a descriptor-based approach for HE institutions to determine their own criteria in the application of the standards framework. It is based upon applying areas of activity, core knowledge and professional values.

The UK Professional Standards Framework (above) complements the NMC Standards to support learning and assessment in practice. The framework is designed to be sector owned and applied to various staff groups from teaching assistants to those who have a substantive teaching role. This would allow programme providers to seek accreditation of their NMC approved teacher preparation programmes and, potentially, to have outcomes for mentors and practice teachers recognised by the HE Academy.

3.4.2 Continuing professional development for teachers

The NMC requires all NMC teachers to maintain and develop their knowledge, skills and competence as a teacher through regular updating. Those teachers employed in approved educational institutions will need to meet the requirements of their employers for scholarly activity. The NMC also requires that teachers focus on the practice aspects of their roles and ensure their knowledge of practice is contemporaneous and that, where appropriate, their skills are fit for safe and effective practice.

Teachers should be prepared to demonstrate to their employers, and NMC quality assurance agents, as appropriate,[17] how they have maintained and developed their knowledge, skills and competence as teachers.

3.4.3 Signing off proficiency

Teachers are responsible for signing off the academic component of the programme. Many teachers will be involved in supporting learning and assessing assignments throughout the programme. The Programme Leader for Nursing or the Lead Midwife for Education, whose name has previously been notified to the Council, will make the final sign-off for the programme. They must ensure that they have seen evidence that the practice component of the programme has been signed off by a sign-off mentor or a practice teacher.

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[17] NMC approved programmes and providers are subject to monitoring as part of the NMC's UK wide QA framework.

Only teachers who have a practice-based role, and who have met the additional criteria for a sign-off mentor (section 2.1.3) may undertake sign-off of practice. This may apply where teachers have a role requiring them to take a practice caseload, as well as work in academic settings.

3.4.4 Allocated time for practice teaching activity

Approved educational institutions will employ nurses and midwives who have successfully met the outcomes of stage 4 and recorded their qualification on the register, and other teachers who are not nurses and midwives. The NMC expects teachers who are nurses and midwives to be able to support learning and assessment in both academic and practice learning environments. Teachers are therefore expected to spend a proportion of their time supporting student learning in practice (Recommendation 26 from Fitness for Practice, UKCC 1999). The NMC advises that this should be approximately 20% of their normal teaching hours.

Teachers in HE might specialise in teaching, research or practice and these specialities may at times be in conflict. The NMC requirement for teachers to support practice-based learning may be achieved through a variety of strategies such as:

- Acting as a clinical teacher or a link tutor.
- Preparing, supporting and updating mentors and practice teachers.
- Taking part in practice-based action learning groups.
- Contributing to practice development.
- Undertaking practice-based research activity.
- Any other strategies that would enable teachers to maintain practice knowledge and awareness, and where appropriate, practice skills, i.e. midwifery teachers would require effective registration as a midwife, specialist community public health nurses teachers would normally have a limited caseload, nurse teachers working in specialist areas may similarly wish to maintain a limited caseload.

It is for programme providers to ensure that students have access to a sufficient number of teachers with expertise in practice, teaching, research and development to support their learning in both practice and academic learning environments.

Section 4 – Approval and monitoring of mentor, practice teacher and teacher standards

4.1 NMC approval of mentor/practice teacher preparation programmes

The NMC has agreed two routes for the approval of mentor/practice teacher preparation programmes. Programme providers may choose the option best suited to their purposes. The routes are:

Route 1

Route 1 would be suited to NMC programme providers seeking approval for NMC programmes leading to registration: Nursing, Midwifery and SCPHN. A combined event could consider the pre-registration programme and a mentor/practice teacher programme. Separate documentation would be necessary for the mentor/practice teacher preparation programme.

Route 2

Framework approval events allowing one event to approve all standards set by the NMC as teaching roles. Route 2 would be best suited to those programme providers who already offer an NMC approved teacher preparation programme and who would be interested in developing these further to provide outcomes for mentors and practice teachers. Such programmes should provide stepping on and stepping off points and processes for AP(E)L to recognise achievement of previous stages (or equivalent) in the developmental framework. This route would also be suitable to those who do not offer an NMC approved pre-registration programme but who would wish to have approved mentors – such as those programme providers offering return to practice programmes or the overseas nurses programme.

4.2 NMC approval of teacher preparation programmes

The NMC already approves teacher preparation programmes leading to a recordable qualification on the register as part of its quality assurance processes. This arrangement will continue unchanged.

4.3 NMC monitoring arrangements

Reports of quality assurance activities, annual monitoring, and list of approved programmes are published on the NMC website at www.nmc.org.uk

4.4 NMC recognition of other teaching qualifications

The NMC recognises that some nurses and midwives may undertake teacher preparation programmes for their own interest and career development before making the decision to become a nurse, midwife or specialist community public health teacher. The NMC has previously offered a route for recording such a teaching qualification where it is deemed comparable to the NMC standard for the preparation of teachers. The NMC has agreed that this route should continue.

In such cases, the NMC requires sufficient evidence to demonstrate that the entry criteria for teacher preparation have been met, that the programme undertaken is comparable to that of an NMC approved programme in nature and content and that the registrant can provide evidence of mapping their learning and experience to demonstrate the current NMC requirements have been met. This includes evidence of assessed teaching activity, comparable with students studying an NMC approved programme for a period equivalent to a minimum of 12 weeks (or 360 hours). Such evidence must be verified by a nurse, midwife or specialist community public health nurse teacher, who has a recorded teaching qualification on the NMC register.

Nurses and midwives intending to use the NMC recognition route to record a teaching qualification must be able to provide evidence that they:

- Meet NMC criteria for entry to a teacher preparation programme.
- Have undertaken continuing professional development, at least to first degree level, relevant to their area of practice.
- Have undertaken a post-graduate programme of teacher preparation.
- Have mapped their learning and experience to demonstrate that the outcomes of stage 4 have been met. This must be verified by a registrant who already has a teaching qualification recorded on the register and is currently employed to teach students in education leading to registration or a recorded qualification with the NMC.
- Are able to supply a reference from practice to support that they have the ability to teach students in practice.
- Confirm that they have undertaken at least 12 weeks (or 360 hours) of assessed teaching activity with students on an NMC approved programme leading to registration or a recordable qualification. An NMC registrant who has a recorded teaching qualification on the register must have assessed such teaching activity.
- Such nurses and midwives would need to prepare a portfolio of evidence for local assessment by an NMC registrant who has a teaching qualification recorded on the register and who is employed at an NMC approved educational institution. This registrant will confirm to the NMC that evidence has been provided that all stage 4 outcomes have been met.

Section 5 – Glossary, references and annexes

Glossary

Glossary of terms	
Accreditation of Prior (Experiential) Learning (AP(E)L)	Process of awarding credit for formal or experiential learning by mapping it against defined learning outcomes of the programme offered (see NMC QA Factsheet I/2004).
Approved Educational Institutions (AEI)	An institution recognised by the NMC to provide NMC approved programmes. Normally these are in higher education, however the Nursing and Midwifery Order 2001 allows the NMC to approve other institutions to deliver programmes that meet NMC standards.
Approval	A process whereby the partners (see below) present their programme for external scrutiny (or validation) which, if successful, leads to joint approval by the NMC and the approved educational institution.
Competency	A competency describes the skills and abilities to practise safely and effectively without the need for direct supervision. Competencies are achieved incrementally throughout periods of practice experience during a programme. At the end of the final period of practice experience or supervised practice it is the evidence of achievement of all competencies that enables sign-off mentors or practice teachers to decide whether proficiency has been achieved.
Due regard	Differentiates between the nurses', midwives' and specialist community public health nurses' parts of the NMC register as well as specific fields of practice within nursing, e.g. adult, children, mental health and learning disability. Mentors and practice teachers normally assess others only with due regard to the parts on which they, themselves, are registered.
Fitness for practice	Requires the student to demonstrate that they are practising safely and effectively, have met the standards of proficiency and all other requirements to become registered.
Lead Midwife for Education	Named person within an approved educational institution responsible for leading midwifery education and involved in all processes relating to the approval and monitoring of NMC approved midwifery programmes.
Local register of mentors/practice teachers	Placement providers hold a register of all current mentors, including sign-off mentors and practice teachers, that have met the NMC outcomes for these roles and have additionally met the NMC requirements for maintenance on the register.
Mentor	A registrant who has met the outcomes of stage 2 and who facilitates learning, and supervises and assesses students in a practice setting.

Glossary of terms	
Nurses and midwives	This term refers to a nurses and midwives whose names are held on the NMC register. There are three parts of the register: nursing, midwifery and specialist community public health nursing. In addition, the term midwife has a legal definition: “A midwife is a person who having been regularly admitted to a midwifery education programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.” (ICM 2005).
Outcomes	Outcomes identify the skills required at each stage of the framework to meet the defined final competencies.
Parts of the register	The NMC register, which opened on 1 August 2004, has three parts: nurse, midwife and specialist community public health nurse. A mark on the register identifies the field of practice, i.e. adult, children, mental health and learning disability nurses.
Postgraduate	A postgraduate preparation programme is normally undertaken following graduation from a first degree (or equivalent) and, normally, at Master’s level. Academic outcomes may be of postgraduate certificate, diploma, degree or a specified number of M level credits.
Practice proficiency	A student is deemed proficient when they have successfully met all of the NMC standards of proficiency for nursing, midwifery or specialist community public health nursing, at the end of an NMC approved programme. Practice proficiency may only be signed off by a practice teacher or a mentor who has met the NMC additional criteria.
Practice teacher	A registrant who has gained knowledge, skills and competence in both their specialist area of practice and in their teaching role, meeting the outcomes of stage 3, and who facilitates learning, supervises and assesses students in a practice setting.
Preceptorship	The process through which existing nurses and midwives provide support to newly qualified nurses and midwives.
Proficiencies	These are contained within the standards of proficiency for each of the three parts of the register. Fitness for practice is demonstrated by meeting all NMC proficiencies and other requirements by the end of the programme.
Programme providers	Programme providers are partnerships formed between AEIs and service partners providers who provide placement opportunities for students on NMC approved programmes. Normally these programmes are 50% theory and 50% practice. All partners are responsible for ensuring that learning opportunities and support for learning and assessment is available in both theory and practice learning environments.
Quality Assurance (QA)	The initial approval to allow a programme to be delivered and ongoing monitoring during the lifespan of NMC approved programmes.

Glossary of terms	
Recordable qualification	A qualification, approved by the NMC that may be recorded on the NMC register.
Registrable qualification	A qualification approved by the NMC that enables admission to a part of the NMC professional register.
Registrants	Previously used by the NMC to describe nurses and midwives whose names are held on the NMC register.
Rules	Rules are established through legislation and they provide the legal strategic framework from which the NMC develops standards, e.g. Education, Registration and Registration Appeals Rules 2004 (SI 2004/1 767).
Sign-off mentor	Mentors are required to meet specified criteria in order to be able to sign-off a student's practice proficiency at the end of an NMC approved programme. All midwife mentors and practice teachers will have met the requirements through their preparation programme.
Specialist Community Public Health Nurse	The NMC register has a part for registered specialist community public health nurses (SCPHN). The Council has agreed standards of proficiency for entry to this part of the register. Existing groups of nurses have migrated to this part of the register; these include health visitors, school nurses (who hold a specialist practice qualification) and occupational health nurses (who hold a specialist practice qualification). Nurses and midwives who work in public health roles, and can demonstrate that they have met the academic and practice standards of proficiency for this part of the register, may be able to apply to be registered as SCPHN.
Standards	The NMC is required by the Nursing and Midwifery Order 2001 to establish standards of proficiency to be met by applicants to different parts of the register. The standards are considered to be necessary for safe and effective practice [Article 5(2)(a)]. These are set out within the standards of proficiency for each of the three parts of the register. The standards support the rules, are mandatory and gain their authority from the legislation.
Teacher	A registrant who has undertaken an NMC approved teacher preparation programme, or equivalent and successfully achieved the outcomes defined in stage 4 of the developmental framework.

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- Nursing and Midwifery Council (2008) The Prep handbook, London, NMC

- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) Standards for specialist education and practice, London, UKCC

- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) Fitness for Practice, London, UKCC

NMC Circulars

- 20/2006 Introduction of the Standards to support learning and assessment in practice
- 21/2006 Preceptorship Guidelines
- 08/2007 Revised arrangements for the introduction of the practice teacher standard in relation to specialist community public health nursing programmes
- 13/2007 Preparing midwife mentors to meet the NMC's Standards to support learning and assessment in practice
- 17/2007 Approval process and timetable to implement the Standards to support learning and assessment in practice for NMC Approved Programme Providers
- 26/2007 Applying due regard to learning and assessment in practice
- 27/2007 Sign-off status and preceptorship for Practice Teacher students
- 28/2007 Guidance for small scale service providers in applying the NMC's Standards to support learning and assessment in practice
- 33/2007 Ensuring continuity of practice assessment through the ongoing achievement record
- 02/2008 Applying due regard to learning and assessment in practice for student midwives

Annex 1

The developmental framework to support learning and assessment in practice

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Demonstrate effective relationship building skills sufficient to support learning, as part of a wider interprofessional team, for a range of students in both practice and academic learning environments				
Establishing effective working relationships	• work as a member of a multi-professional team, contributing effectively to team working • support those who are new to the team in integrating into the practice learning environment • act as a role model for safe and effective practice • develop effective working relationships based on mutual trust and respect	• demonstrate an understanding of factors that influence how students integrate into practice settings • providing ongoing and constructive support to facilitate transition from one learning environment to another • have effective professional and interprofessional working relationships to support learning for entry to the register	• have effective professional and inter-professional working relationships to support learning for entry to the register and education at a level beyond initial registration • be able to support students moving into specific areas of practice or a level of practice beyond initial registration, identifying their individual needs in moving to a different level of practice • support mentors and other professionals in their roles to support learning across practice and academic learning environments	• demonstrate effective relationships with other members of the teaching teams in practice and academic settings based on mutual trust and respect • maintain appropriate supportive relationships with a range of students, mentors, practice teachers and other professionals • foster peer support and peer learning in practice and academic settings for all students • support students to integrate into new environments and working teams to enhance access to learning

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Facilitate learning for a range of students, within a particular area of practice where appropriate, encouraging self-management of learning opportunities and providing support to maximise individual potential				
Facilitation of learning	• co-operate with those who have defined support roles contributing towards the provision of effective learning experiences • share their own knowledge and skills to enable others to learn in practice settings	• use knowledge of the student's stage of learning to select appropriate learning opportunities to meet individual needs • facilitate the selection of appropriate learning strategies to integrate learning from practice and academic experience • support students in critically reflecting upon their learning experiences in order to enhance future learning	• enable students to relate theory to practice whilst developing critically reflective skills • foster professional growth and personal development by use of effective communication and facilitation skills • facilitate and develop the ethos of interprofessional learning and working	• promote development of enquiring, reflective, critical and innovative approaches to learning • implement a range of learning and teaching strategies across a wide range of settings • provide support and advice, with ongoing and constructive feedback to students, to maximise individual potential • co-ordinate learning within an interprofessional learning and working environment • facilitate integration of learning from practice and academic settings • act as a practice expert to support development of knowledge and skills for practice

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Assess learning in order to make judgements related to the NMC standards of proficiency for entry to the register or for recording a qualification at a level above initial registration				
Assessment and accountability	• work to the NMC Code in maintaining own knowledge and proficiency for safe and effective practice • provide feedback to others in learning situations and to those who are supporting them so that learning is effectively assessed	• foster professional growth, personal development and accountability through support of students in practice • demonstrate a breadth of understanding of assessment strategies and ability to contribute to the total assessment process as part of the teaching team • provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future	• set effective professional boundaries whilst creating a dynamic, constructive teacher-student relationship • in partnership with other members of the teaching team use knowledge and experience to design and implement assessment frameworks • be able to assess practice for registration and also at a level beyond that of initial registration	• set and maintain professional boundaries that are sufficiently flexible for interprofessional learning • develop, with others, effective assessment strategies to ensure that standards of proficiency for registration or recordable qualifications at a level beyond initial registration are met • support others involved in the assessment process, students, mentors and peers

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Assess learning in order to make judgements related to the NMC standards of proficiency for entry to the register or for recording a qualification at a level above initial registration				
Assessment and accountability		• be accountable for confirming that students have met or not met the NMC competencies in practice and as a sign-off mentor confirm that students have met or not met the NMC standards of proficiency and are capable of safe and effective practice	• provide constructive feedback to students and assist them inidentifying future learning needs and actions, manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future • be accountable for confirming that students have met or not met the NMC standards of proficiency in practice for registration at a level beyond initial registration and are capable of safe and effective practice	• provide constructive feedback to students and assist them in identifying future learning needs and actions, manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future • be accountable for their decisions related to fitness for practice for registration or recordable qualifications, underpinning such decisions with an evidence base derived from appropriate and effective monitoring of performance

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Determine strategies for evaluating learning in practice and academic settings to ensure that the NMC standards of proficiency for registration or recording a qualification at a level above initial registration have been met				
Evaluation of learning	• contribute information related to those learning in practice, and about the nature of learning experiences, to enable those supporting students to make judgements on the quality of the learning environment	• contribute to evaluation of student learning and assessment experiences, proposing aspects for change resulting from such evaluation • participate in self and peer evaluation to facilitate personal development and contribute to the development of others	• design evaluation strategies to determine the effectiveness of practice and academic experience accessed by students at both registration level and those in education at a level beyond initial registration • collaborate with other members of the teaching team to judge and develop learning, assessment and support appropriate to practice and levels of education • collect evidence on the quality of education in practice, and determine how well NMC requirements for standards of proficiency are being achieved	• determine and use criteria for evaluating the effectiveness of learning environments, acting on findings, with others, to enhance quality • foster and participate in self and peer evaluation to enable students to manage their own learning in practice and academic settings and to enhance personal professional development • evaluate the effectiveness of assessment strategies in providing evidence to make judgements on fitness for practice • report on the quality of practice and academic learning environments to demonstrate that NMC requirements have been met, particularly in relation to support of students and achievement of standards of proficiency

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Create an environment for learning, where practice is valued and developed, that provides appropriate professional and interprofessional learning opportunities and support for learning to maximise achievement for individuals				
Create an environment for learning	• demonstrate a commitment to continuing professional development to enhance own knowledge and proficiency • provide peer support to others to facilitate their learning	• support students to identify both learning needs and experiences that are appropriate to their level of learning • use a range of learning experiences, involving patients, clients, carers and the professional team, to meet defined learning needs • identify aspects of the learning environment which could be enhanced negotiating with others to make appropriate changes • act as a resource to facilitate personal and professional development of others	• enable students to access opportunities to learn and work within interprofessional teams • initiate the creation of optimum learning environments for students at registration level and for those in education at a level beyond initial registration • work closely with others involved in education, in practice and academic settings, to adapt to change and inform curriculum development	• in partnership with others, opportunities for students to identify and access learning experiences that meet their individual needs • ensure such opportunities maintain the integrity of the student's professional role whilst responding to the interprofessional context of practice • determine with others, audit criteria against which learning environments may be judged for their effectiveness in meeting NMC requirements • support and develop others involved to ensure that learning needs are effectively met in a safe environment • explore and implement strategies for continuous quality improvement of the learning environment

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Support learning within a context of practice that reflects health care and educational policies, managing change to ensure that particular professional needs are met within a learning environment that also supports practice development				
Context of practice	• whilst enhancing their own practice and proficiency, a registered nurse or midwife, act as a role model to others to enable them to learn their unique professional role	• contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated • set and maintain professional boundaries that are sufficiently flexible for providing interprofessional care • initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained	• recognise the unique needs of practice and contribute to development of an environment that supports achievement of NMC standards of proficiency • set and maintain professional boundaries, whilst at the same time recognising the contribution of the wider interprofessional team and the context of care delivery • support students in exploring new ways of working and the impact this may have on established professional roles	• support students in identifying ways in which policy impacts on practice • contribute effectively to processes of change and innovation, implementing new ways of working that maintain the integrity of professional roles • negotiate ways of providing support to students so that they can achieve their learning needs within the context of professional and interprofessional practice • act as a role model to enable students to learn professional responsibilities and how to be accountable for their own practice • adapt to change, demonstrating to students how flexibility may be incorporated whilst maintaining safe and effective practice

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Apply evidence-based practice to their own work and contribute to the further development of such a knowledge and practice evidence base				
Evidence-based practice	• further develop their evidence base for practice to support their own personal and professional development and to contribute to the development of others	• identify and apply research and evidence based practice to their area of practice • contribute to strategies to increase or review the evidence base used to support practice • support students in applying an evidence base to their own practice	• identify areas of research and practice development based on interpretation of existing evidence • use local and national health frameworks to review and identify developmental needs • advance their own knowledge and practice in order to develop new practitioners, at both registration levels and education at a level beyond initial registration, to be able to meet changes in practice roles and care delivery • disseminate findings from research and practice development to enhance practice and the quality of learning experiences	• advance their own knowledge and practice abilities through access to and involvement in, where appropriate, research and practice development • consider how evidence-based practice, involving patients, clients, carers and other members of the health and social care team, enhances care delivery and learning opportunities • empower individuals, groups and organisations to develop the evidence-base for practice • disseminate findings from the research and practice development to enhance the quality of learning and care delivery and academic environments

Domain	Stage 1 Nurses and midwives	Stage 2 Mentor	Stage 3 Practice teacher	Stage 4 Teacher
Demonstrate leadership skills for education within practice and academic settings				
Leadership	• use communication skills effectively to ensure that those in learning experiences understand their contribution and limitations to care delivery	• plan a series of learning experiences that will meet students' defined learning needs • be an advocate for students to support them accessing learning opportunities that meet their individual needs, involving a range of other professionals, patients, clients and carers • prioritise work to accommodate support of students within their practice roles • provide feedback about the effectiveness of learning and assessment in practice	• provide practice leadership and expertise in application of knowledge and skills based on evidence • demonstrate the ability to lead education on practice, working across practice and academic settings • manage competing demands of practice and education related to supporting different practice levels of students • lead and contribute to the evaluation of effectiveness of learning and assessment in practice	• demonstrate effective communication skills to facilitate delivery of educational programmes leading to registration or a recordable qualification • initiate and lead programme development and review processes to enhance quality and effectiveness • develop effective relationships with practice and academic staff involved in programme delivery to ensure clarity of contribution and strategies to respond to evaluation of learning experiences • demonstrate strategic vision for practice and academic development relevant to meeting NMC requirements • manage competing demands to ensure effectiveness of learning experiences for students • lead, contribute to, analyse and act on the findings of evaluation of learning and assessment to develop programmes • provide feedback about the effectiveness of learning and assessment in practice

Annexe 2

The UK Professional Standards Framework for teaching and supporting learning in higher education

HE sector-owned standards

The HE Academy has developed a National Professional Standards Framework for Teaching and Supporting Learning in Higher Education. The framework was developed by the Higher Education Academy on behalf of the Higher Education sector and commissioned by Universities UK, SCOP and the UK HE funding councils. The model provides a descriptor-based approach for HE institutions to determine their own criteria in the application of the standards framework. It is based upon applying areas of activity, core knowledge and professional values. These areas are applied to learning outcomes and assessment activities within professional development programmes in order to demonstrate application of the standards.

Areas of activity, core knowledge and professional values within the framework

Areas of activity

1 Design and planning of learning activities and/or programmes of study

2 Teaching and/or supporting student learning

3 Assessment and giving feedback to learners

4 Developing effective environments and student support and guidance

5 Integration of scholarship, research and professional activities with teaching and supporting learning

6 Evaluation of practice and continuing professional development

Core knowledge

Knowledge and understanding of:

1 The subject material

2 Appropriate methods for teaching and learning in the subject area and at the level of the academic programme

3 How students learn, both generally and in the subject

4 The use of appropriate learning technologies

5 Methods for evaluating the effectiveness of teaching

6 The implications of quality assurance and enhancement for professional practice

Professional values

1 Respect for individual learners

2 Commitment to incorporating the process and outcomes of relevant research scholarship, and/or professional practice

3 Commitment to development of learning communities

4 Commitment to encouraging participation in higher education, acknowledging diversity and promoting equality of opportunity

5 Commitment to continuing professional development and evaluation of practice

Please see **www.heacademy.ac.uk** for further details.

Annexe 3: Circulars

Circular: Applying due regard to learning and assessment in practice.

Nursing and Midwifery Council Circular
Index Number: NMC Circular 26/2007
Issue Date: 21 Sept 2007
Review Date: 21 Sept 2008
Replaces: New circular
Category: Nursing General/Specialist Community Public Health Nurses
Status: Action

Summary

This circular:

- responds to challenges currently experienced in the application of due regard in meeting the Standards to support learning and assessment in practice (NMC August 2006) hereafter referred to as 'the Standards'.

(The definition of due regard is given in bold text in the background section page 73).

- sets out ways in which the principle of due regard may be applied more flexibly without reducing the degree of rigour applied to assessing student competence.

- may be applied with immediate effect in relation to nursing and specialist community public health programmes as indicated below.

- does not apply to pre-registration midwifery programmes. Further information related to the assessment of pre-registration midwifery students will follow.

This circular should be read in conjunction with:

- The Standards to support learning and assessment in practice (NMC August 2006)
- NMC Circular 20/2006

Background

The NMC has addressed some challenges in the application of due regard in the assessment of practice of approved nursing and specialist community public health nursing programmes. This includes issues relating to available resource and the need to make use of inter-professional shared learning opportunities.

Principle A (para 1.2) of the Standards states that NMC registrants:

> **'who make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice must be on the same part or sub-part of the register as that which the student is intending to enter'**

It has been reported that in some circumstances the current application of due regard for learning and assessment has become either impractical or impossible due to workforce issues and employment practices. Equally, it is important that students can be placed with a professional from a different part of the register or a different profession in order to meet programme outcomes.

As a consequence, the ways in which due regard can be applied have been reviewed and requirements may now be met by applying the principles set out in Methods 1 to 2c pages 74–77.

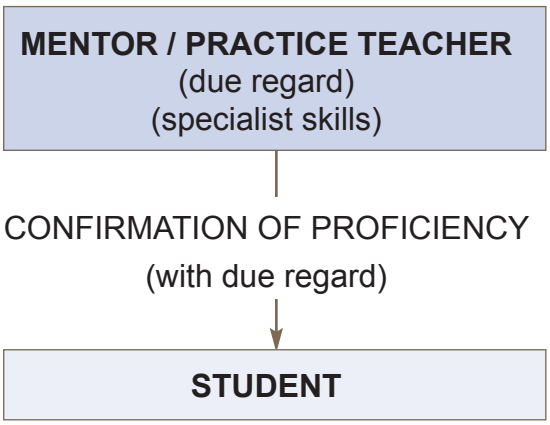
Education providers may apply these principles as described below with immediate effect without need for programme modification.

Principles to be applied

Method 1: Existing application
This method is the way in which due regard is currently applied and will likely remain the most frequently used method. It is also the only method which will apply in pre-registration midwifery programmes.

The student's mentor or practice teacher:

- has the specialist skills required to support the placement learning outcomes
- is from the same part of the register and field of practice as the student.
- supervises and monitors progress throughout this period
- assesses component skills related to the programme outcomes.



Judgements are informed by feedback from colleagues and evidence from other sources leading to an assessment determining whether the student has achieved the required standard for safe and effective practice in relation to the particular field of practice. Fields of practice are usually indicated by marks on the register as representing the nursing branches but they can also be applied more broadly, e.g. in relation to a specialist area of practice.

Method 2: Modified application
Three variations of method 2 are set out below and address the complexity of the types of placements within the different parts of the register and fields of practice.

Method 2a is intended to support the increasing need for nursing and specialist community public health nursing students to appreciate the interprofessional context in which they will be working as registrants and the need for placements to be undertaken in this way may increase. However, methods 2b and 2c are intended as interim measures to allow programme providers, placement providers and commissioners time to work together to ensure that adequate numbers of mentors and practice teachers from all parts of the register and fields of practice are prepared for these roles.

Method 2a: Where learning and assessment particularly requires specialist field input

This method enables due regard to be applied where students need to gain experience with somebody from a specialist field of practice who is not a mentor/practice teacher from the same part of the register and same field of practice as that which they intend to enter.

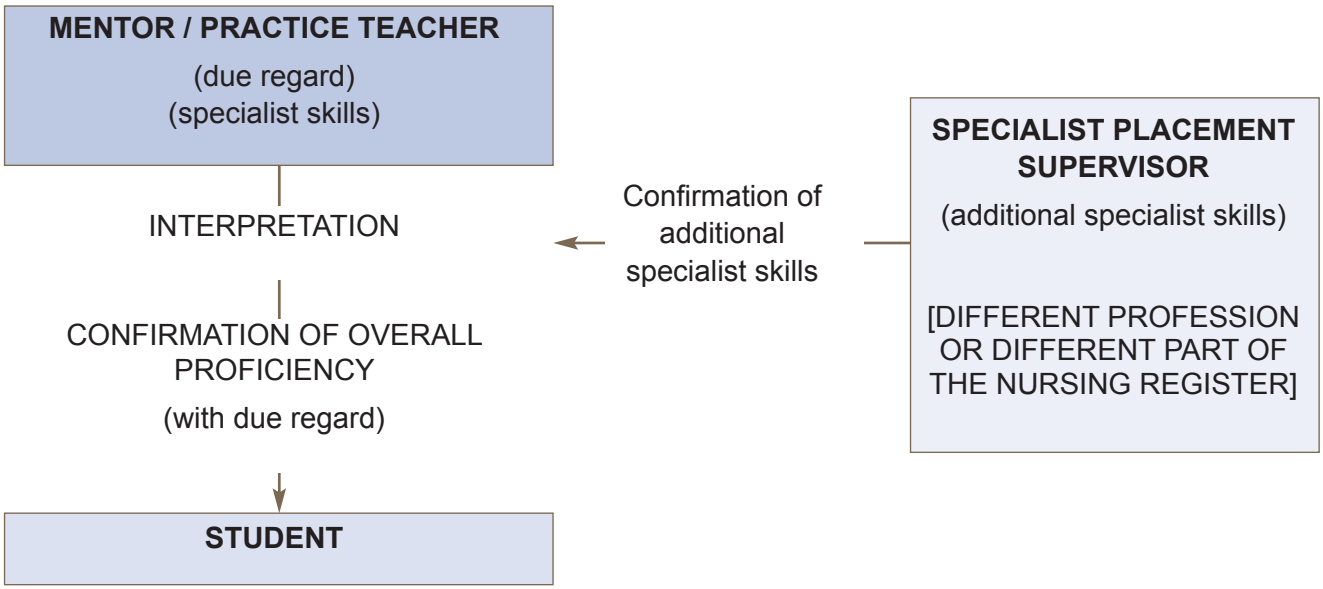
Examples could include:

- a specialist community public health nursing student who undertakes a placement within a social work environment,
- a mental health nursing student placed within a criminal justice environment
- a learning disability nursing student placed within an adult nursing environment
- a child branch nursing student placed with a specialist community public health nurse

In these circumstances the student is placed with a specialist placement supervisor who is a designated practitioner with the skills that the student needs to acquire or be exposed to. The specialist placement supervisor is normally a professional who has received preparation in supervising and assessing students in practice settings.

The specialist placement supervisor from a different part of the register or profession:

- directly supervises the student in the required activities that address the specified learning outcomes related to the specialist experience.
- assesses component skills directly related to the professional's own area of competence and scope of practice.



The placement must be overseen by a NMC registrant mentor or practice teacher with due regard who meets with the student and placement supervisor at agreed predetermined points to monitor the student's achievement in the context of the part of the register that the student intends to enter. The mentor/ practice teacher is accountable for assessment with due regard and confirming overall proficiency (or not) at the end of the placement.

NB. Practice assessment in independent/supplementary prescribing programmes is the legal responsibility of a designated medical practitioner who supports, teaches and supervises the student with, where possible, an experienced nurse prescriber who should ensure that learning is applied to specific areas of nursing practice.

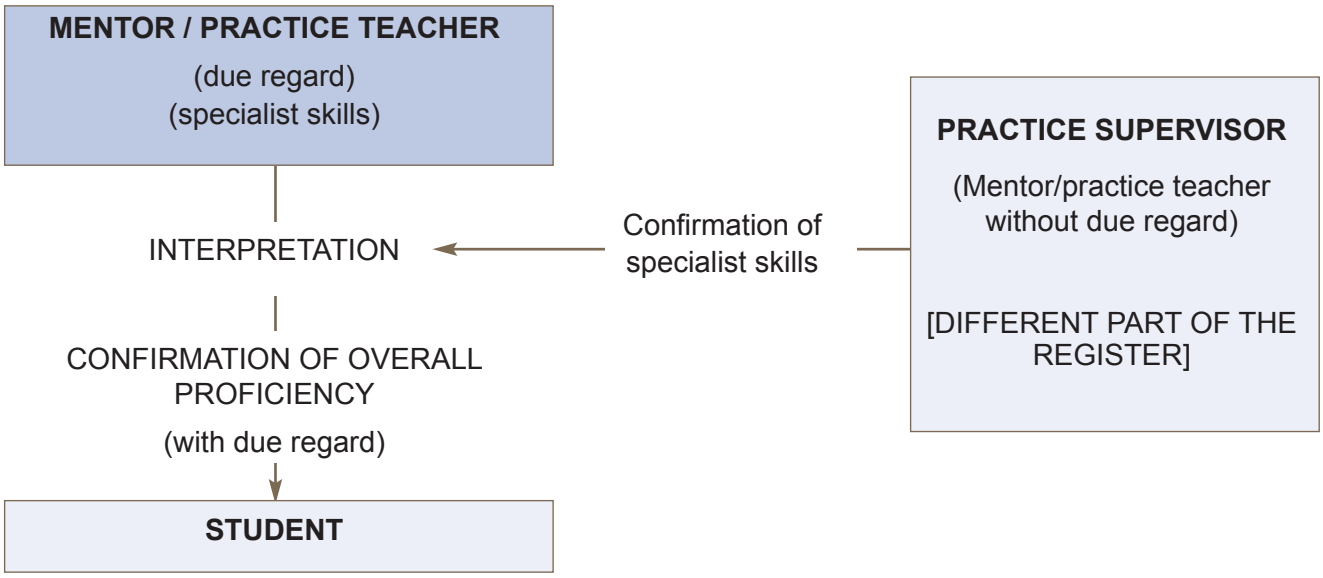
Method 2b: Where mentors and practice teachers with due regard are scarce. This method enables due regard to be applied where students need to gain experience within a required field of practice or part of the register where there are limited numbers of mentors/practice teachers available from their part of the register and/or field of practice. Direct supervision and assessment in the specialist area is provided by other NMC mentors/ practice teachers without due regard.

Examples could include a:

- mental health branch student supervised by an adult nurse in a general accident and emergency unit
- general practice nurse student supervised by an adult nurse in a minor injuries unit
- child branch student supervised by a learning disability nurse in a unit for challenging behaviour
- learning disability nurse supervised by a health visitor in a baby clinic.

A practice supervisor (mentor/practice teacher without due regard)

- directly supervises the student in the required activities that address the specified learning outcomes related to the specialist experience
- assesses component skills directly related to the professional's own area of competence and scope of practice.

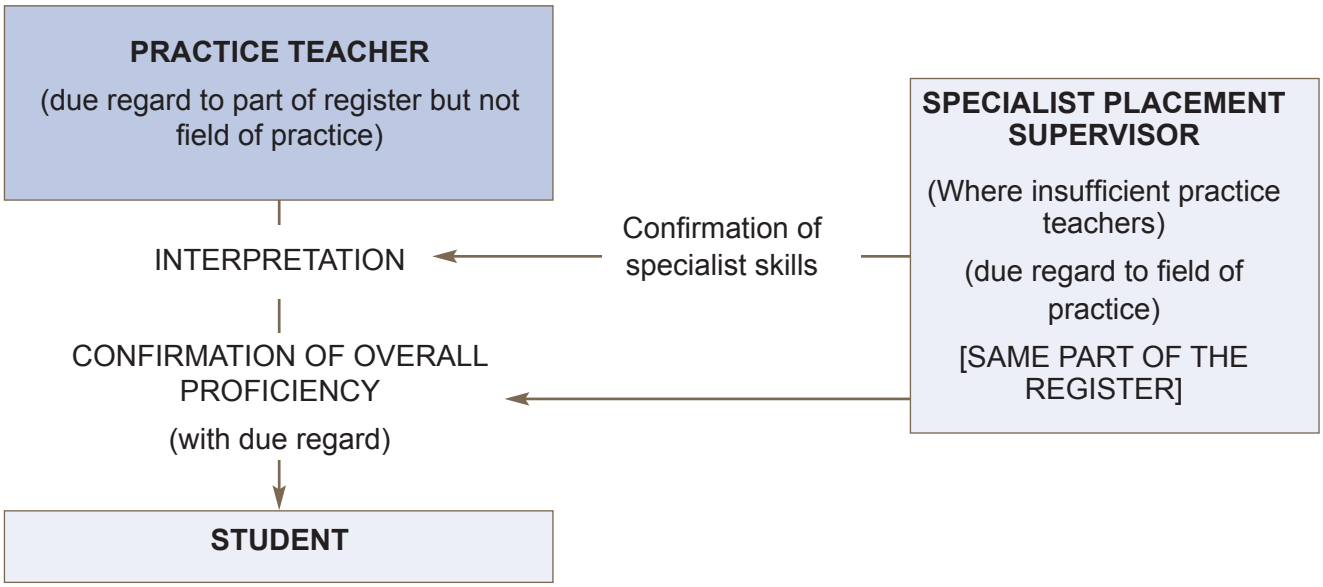


The placement must be overseen by an NMC registrant mentor or practice teacher with due regard who meets with the practice supervisor providing direct supervision at agreed predetermined points to monitor the student's achievement in the context of the part of the register that the student intends to enter. The overseeing mentor/ practice teacher is accountable for assessment with due regard and confirming overall proficiency (or not) at the end of the placement.

Method 2c: In specialist community public health nursing programmes where practice teachers are available from the part of the register but not the specific field of practice.
This enables due regard to be applied where specialist community public health nursing students are placed within a required field of practice, where there are no practice teachers from that part of the register to provide direct supervision. Specialist community public health nurse (SCPHN) registrants from the field of practice provide direct supervision and assessment in the specialist area.

An example is where there are several health visitor practice teachers but no practice teachers within the occupational health nursing field of practice. Under these circumstances:

- an occupational health student is directly supervised by a SCPHN registrant from the occupational health field of practice
- the placement is overseen by a health visitor practice teacher who meets with the student and placement supervisor at agreed predetermined points to monitor the student's achievement
- the health visitor practice teacher (from the SCPHN part of the register together with the SCPHN specialist supervisor from the specialist occupational health field of practice) jointly assess overall proficiency within context of the SCPHN part of the register and specific field of practice.



The placement supervisor and the overseeing practice teacher must both take accountability for the confirmation of proficiency at the end of the placement or programme.

N.B. The placement supervisor would normally be a registrant on the SCPHN part of the register who would also be entered on the local mentor register.

Circumstances where due regard need not apply

There are two circumstances where due regard need not apply:

- in the common foundation programme within pre-registration nursing programmes where the placement is not branch (field) specific. In these circumstances a mentor from any part of the nursing register may confirm that outcomes have been achieved.

- in formative placements where proficiencies/learning outcomes are not being assessed.

Required action

Providers of nursing and specialist community public health nursing programmes may now apply the principles in this circular in the application of due regard for the respective parts of the register and fields of practice. In applying the principles, the most important consideration is safety, public protection and confirmation of overall proficiency. This requires the specialist placement provider, mentor/practice teacher and student to work together in determining the overall practice assessment outcome.

All placement arrangements will continue to be monitored through existing practice placement audit and quality assurance mechanisms.

This circular has been issued by:

Sarah Thewlis
Chief Executive and Registrar
Nursing and Midwifery Council

Circular: Applying due regard to learning and assessment in practice for student midwives

Nursing and Midwifery Council Circular
Index Number: NMC Circular 02/2008
Issue Date: 25 January 2008
Review Date: 1 January 2010
Replaces: New Circular
Category: Midwifery
Status: Action

Summary

This circular:

- responds to challenges currently experienced in the application of due regard in meeting the Standards to support learning and assessment in practice (NMC August 2006) hereafter referred to as 'the Standards'.

- sets out ways in which the principle of due regard may be applied more flexibly without reducing the degree of rigour applied to assessing student competence.

Applying due regard to learning and assessment in practice for student midwives

This circular clarifies the principle of applying due regard in a safe and effective way across a range of different placements where student midwives may achieve competence. It should be read in conjunction with the Standards to support learning and assessment in practice. The content of the circular should be applied with immediate effect.

Due regard

The principle of due regard underpins the NMC Standards to support learning and assessment in practice. Principle A (paragraph 1.2 of the Standards) states that NMC registrants:

'who make judgments about whether a student has achieved the required standards of proficiency for safe and effective practice must be on the same part or sub-part of the register as that which the student is intending to enter'

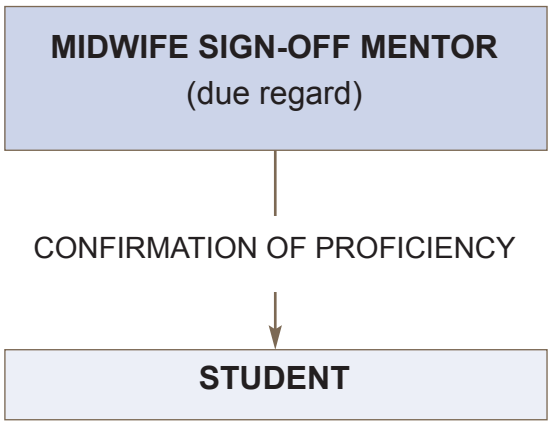
Existing application of applying due regard

Applying due regard is illustrated in the diagram below. In this model the student midwife is placed with a midwife sign-off mentor (who must have achieved the NMC requirements for sign-off). This person undertakes a number of functions. These include:

- managing the placement
- planning the student's learning experiences
- working with them on a day-to-day basis.

In so doing, the midwife sign-off mentor develops an opinion on the student's performance and learning progression throughout a practice placement which may be informed by the assessment of specific tasks and skills. Their opinion is also normally informed by feedback from colleagues and evidence from other sources. This process leads to a judgment being made as to whether the student has achieved competence by reaching the requirements for safe and effective practice set out in the NMC Standards of proficiency for pre-registration midwifery education.

The existing application of due regard

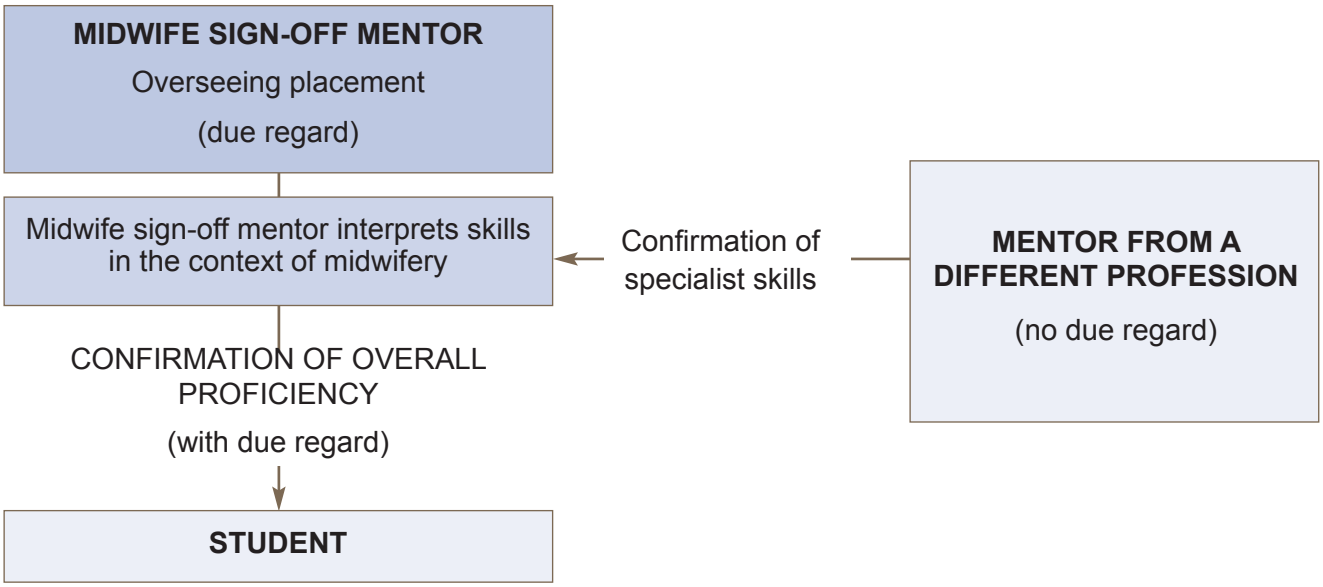


Applying due regard where mentors are available but do not meet NMC requirements for due regard

There are circumstances where it is appropriate for a student midwife to gain experience by being placed with someone form a different profession who would feedback to the student and sign-off mentor.

The final judgement as to whether the student midwife has achieved the required standard for safe and effective practice in relation to a particular aspect of the standards of proficiency, is made by a midwife sign-off mentor with due regard 'overseeing' the placement.

Applying due regard where mentors are available who do not meet NMC requirements for due regard.



In applying the above framework, the most important consideration is safety, public protection and confirmation of competence . This will be achieved by the mentor (no due regard), midwife sign-off mentor overseeing the placement (with due regard) and student working together in detailing the practice assessment outcome.

Action Required

- may be applied with immediate effect in relation to midwifery

This circular may be reproduced by all to whom it is addressed

This circular has been issued by:

Sarah Thewlis
Chief Executive and Registrar
Nursing and Midwifery Council

Circular: Ensuring continuity of practice assessment through the ongoing achievement record.

Nursing and Midwifery Council Circular
Index number: NMC Circular 33/2007
Issue Date: October 2007
Review Date: October 2010
Supports: Standards to support learning and assessment in practice (NMC 2006)
Category: Standards
Status: Action

Summary

The circular sets out the principles for sharing of personal information necessary to maintain continuity of assessment and to ensure safe and effective practice through the ‘ongoing achievement record’. This forms part of the assessment of practice arrangements for all approved programmes.

The Standards to support learning and assessment in practice (NMC 2006, page 30) requires that:

> ‘An ongoing achievement record (student passport) including comments from mentors, must be passed from one placement to the next to enable judgments to be made on the student’s progress’.

The term ‘student passport’ is no longer being applied to this process due to differing interpretations and meaning and will in future be referred to as the ‘ongoing achievement record’.

Education providers must ensure that:

- student’s consent to the processing of confidential data about him or her to be shared between successive mentors and with the relevant education providers in the process of assessing fitness for practice.
- robust processes are in place to ensure that where there are issues or concerns about a student’s progress that these are promptly and appropriately dealt with
- where there are serious concerns about a student’s health or character this should be reported promptly using established University procedures
- students are actively supported in addressing issues and concerns through a well defined and time limited development plan, either within a placement or across successive placements.
- disabled students needs are assessed and student’s are appropriately supported in addressing the requirements of any development plan.

Requirements

The vehicle for sharing information regarding student progress in practice settings will normally be through the ‘ongoing achievement record’ that forms part of the assessment of practice document.

Consent

Legal advice relating to the Data Protection Act 1998[18] has confirmed that the NMC 'is perfectly competent to require the nurse to consent to the processing of confidential data about him or her in the process of assessing her fitness to be a nurse'. This data might include both 'personal data' and 'sensitive personal data' as described within Sections 1 and 2 of the Data Protection Act 1998[18]. (In this context 'nurse' relates to student nurse and also applies to student 'midwife').

Should the student not consent to the sharing of confidential data, then this would be incompatible with ensuring fitness for practice and therefore the student would be unable to meet programme requirements.

Students must be kept fully informed regarding the ways in which information is intended to be shared, used and stored, including the length of time it is to be retained and when it will be destroyed.

'Ongoing achievement record'

Education providers must ensure that:

- student's consent has been obtained allowing the processing of confidential data about him or her to be shared between successive mentors and with the relevant education providers in the process of assessing fitness for practice.

- an 'ongoing achievement record', including comments from mentors is passed from one placement to the next to enable judgements to be made on the student's progress.

- student concerns are addressed and where relevant shared with others, including academic staff.

- sign-off mentors can access records of achievement to inform signing off proficiency, confirming that ongoing competence and any concerns have been addressed since the last progression point.

The 'ongoing achievement record' forms part of the assessment of practice document and needs to be of sufficient detail to enable the sign off mentor to confirm proficiency at the designated point of the programme. All actions must be taken with the full knowledge of the student. Mentors should not keep their own separate student progress records, everything should be contained within the assessment of practice document.

The following applies to all assessed placements but may be interpreted more flexibly for placements of less than four weeks, or for observational experience:

- the student and mentor meet together at the end of a placement to document strengths, development needs, and any concerns. The document to be shared with the education provider.

- the student to be responsible for carrying the documentation from placement to placement with copies retained by the education provider

[18]The Data Protection Act 1998 has been superseded by the Data Protection Act 2018.

- within 5 days of commencing a placement the documentation to be used by the student and mentor to develop a development plan and set goals that take account of strengths, issues and concerns raised in previous placements.

- regular meetings are scheduled to evaluate progress by student and mentor throughout a placement, (involving academic staff when appropriate) at least at the mid point and at the end of a placement where strengths and any issues for development are addressed.

- a specific development plan to address needs and/or concerns can be established at any point and must set out clear timescales for addressing the needs/concerns

- where a specific development plan has been put in place and concerns remain then an evaluation session with the mentor must be urgently scheduled and others involved as appropriate e.g. academic staff.

- where there are causes for concern a student representative might also be present.

Action Required

The above requirements apply to all NMC approved programmes and are effective from the date of this Circular. They support the requirements set out within the Standards to support learning and assessment in practice (NMC 2006)

This circular may be reproduced by all to whom it is addressed

This circular has been issued by:

Sarah Thewlis
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Standards to support learning and assessment in practice was first published in August 2006. This second edition was published in July 2008.

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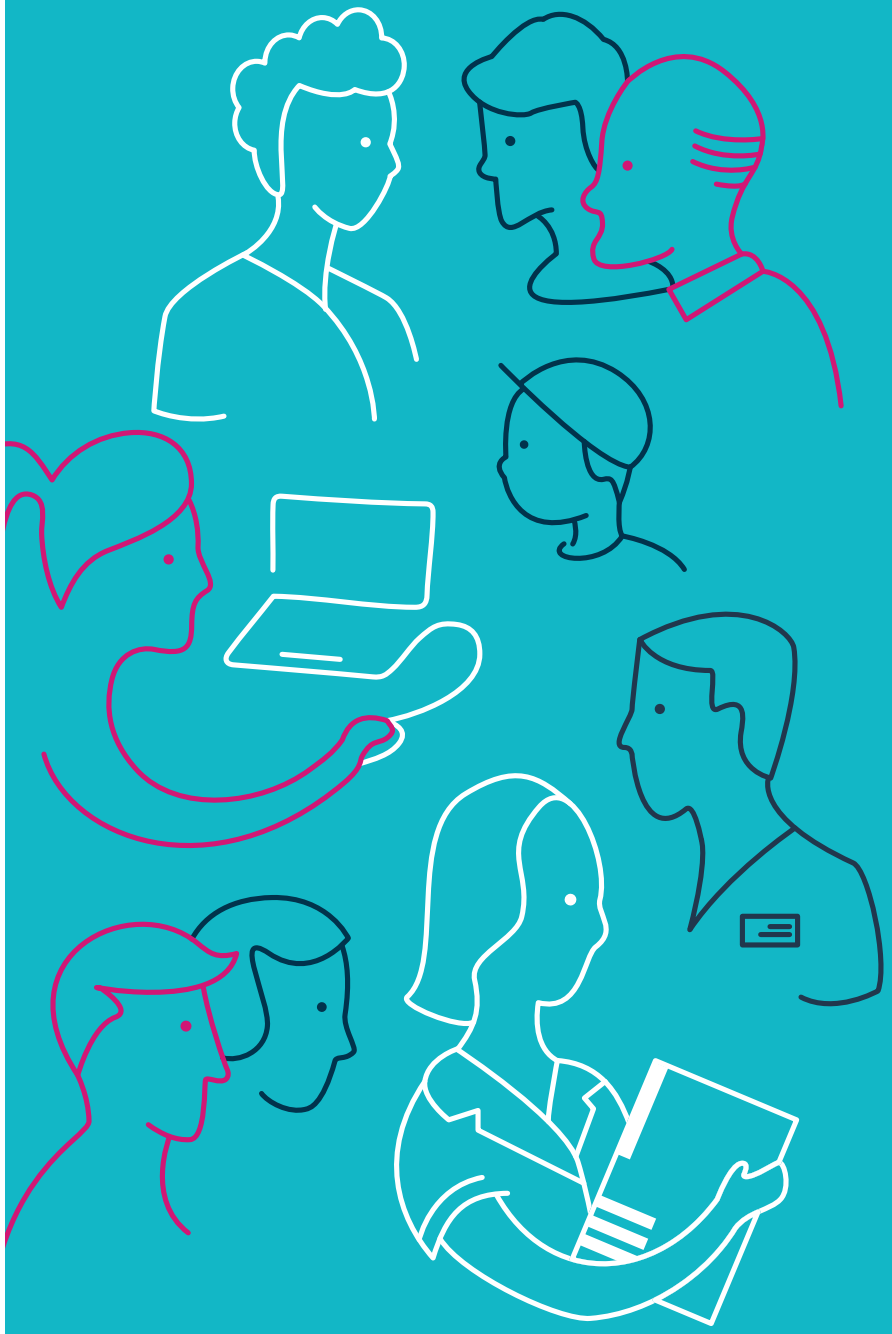


Nursing & Midwifery Council

Future nurse: Standards of proficiency for registered nurses

Published 17 May 2018

Contents

Future nurse: Standards of proficiency for registered nurses

Introduction

The Nursing and Midwifery Council has a duty to review the standards of proficiency it sets for the professions it registers on a regular basis to ensure that standards remain contemporary and fit for purpose in order to protect the public. In reviewing the standards, we have taken into account the changes that are taking place in society and health care, and the implications these have for registered nurses of the future in terms of their role, knowledge and skill requirements.

The proficiencies in this document therefore specify the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings. They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. They also provide a benchmark for nurses from the European Economic Area (EEA), European Union (EU) and overseas wishing to join the UK register, as well as for those who plan to return to practice after a period of absence.

The role of the nurse in the 21st century

Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and person-centred. They are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In order to respond to the impact and demands of professional nursing practice, they must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support.

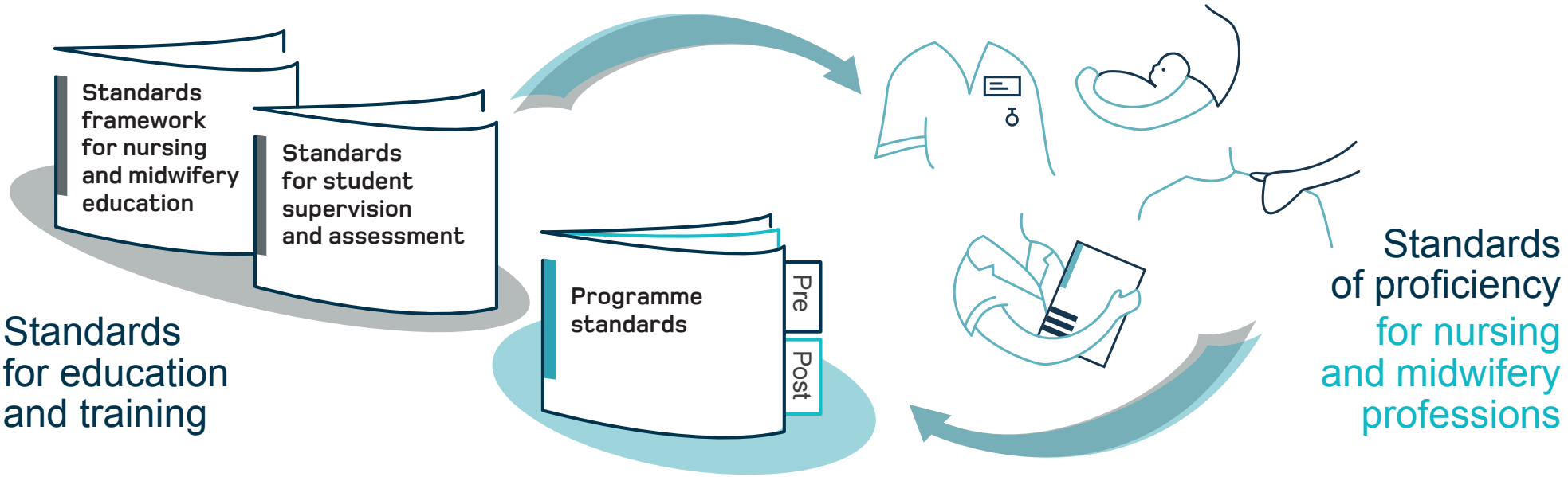
Registered nurses make an important contribution to the promotion of health, health protection and the prevention of ill health. They do this by empowering people, communities and populations to exercise choice, take control of their own health decisions and behaviours, and by supporting people to manage their own care where possible.

Registered nurses provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and beliefs. They provide nursing care for people who have complex mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly, and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation, and rapidly evolving technologies. Increasing integration of health and social care services will require registered nurses to negotiate boundaries and play a proactive role in interdisciplinary teams. The confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care therefore lies at the centre of all registered nursing practice.

About these standards

These standards of proficiency apply to all NMC registered nurses. They should be read with *Realising professionalism: Standards for education and training* which set out our expectations regarding delivery of all pre-registration and post-registration NMC approved nursing and midwifery education programmes. These standards apply to all approved education providers and are set out in three parts: Part 1: *Standards framework for nursing and midwifery education*; Part 2: *Standards for student supervision and assessment*; and Part 3: *Programme standards*, which are the standards specific for each pre-registration or post-registration programme. Education institutions must comply with our standards to be approved to run any NMC approved programmes.

Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with the flexibility to develop innovative approaches to education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards.



Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for nursing and midwifery education providers are established under the provision of Article 15(1) of the Order.

Article 5(2) of the Nursing and Midwifery Order 2001 requires the NMC to establish standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. The standards of proficiency have been established under this provision.

Future nurse: Standards of proficiency for registered nurses

How the proficiencies have been structured

The proficiencies are grouped under seven platforms, followed by two annexes. Together, these reflect what we expect a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career.

Key components of the roles, responsibilities and accountabilities of registered nurses are described under each of the seven platforms. We believe that this approach provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate.

These proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills. For example, after they register with us registered nurses will already be equipped to progress to the completion of a prescribing qualification.

The platforms are:

1. Being an accountable professional
2. Promoting health and preventing ill health
3. Assessing needs and planning care
4. Providing and evaluating care
5. Leading and managing nursing care and working in teams
6. Improving safety and quality of care
7. Coordinating care

The outcome statements for each platform have been designed to apply across all four fields of nursing practice (adult, children, learning disabilities, mental health) and all care settings. This is because registered nurses must be able to meet the person-centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges. They must also be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen fields of nursing practice.

The annexes to these standards of proficiency are presented in two sections. The annexes provide a description of what registered nurses should be able to demonstrate they can do at the point of registration in order to provide safe nursing care. Annexe A specifies the communication and relationship management skills required, and Annexe B specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely. As with the knowledge proficiencies, the annexes also identify where more advanced skills are required by registered nurses, working in a particular field of nursing practice.

Platform 1
Being an accountable professional

Registered nurses act in the best interests of people, putting them first and providing nursing care that is person-centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence-based decisions about care. They communicate effectively, are role models for others, and are accountable for their actions. Registered nurses continually reflect on their practice and keep abreast of new and emerging developments in nursing, health and care.

1. Outcomes:

The outcomes set out below reflect the proficiencies for accountable professional practice that must be applied across the standards of proficiency for registered nurses, as described in platforms 2-7, in all care settings and areas of practice.

At the point of registration, the registered nurse will be able to:

1.1 understand and act in accordance with the Code: *Professional standards of practice and behaviour for nurses, midwives and nursing associates*, and fulfil all registration requirements

1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom

1.3 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes

1.4 demonstrate an understanding of, and the ability to challenge, discriminatory behaviour

1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health

1.6 understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care

1.7 demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice

1.8 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations

1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions

1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations

1.11 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges

1.12 demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable

1.13 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues

1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments

1.15 demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice

1.16 demonstrate the ability to keep complete, clear, accurate and timely records

1.17 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills

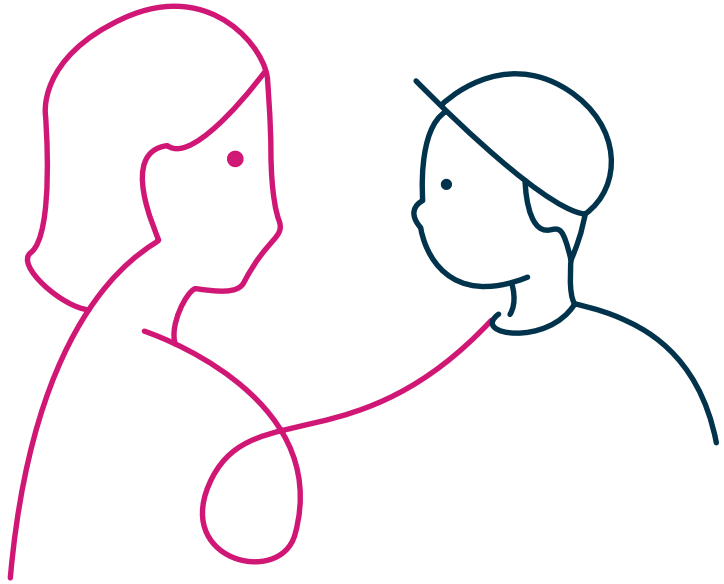
1.18 demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team

1.19 act as an ambassador, upholding the reputation of their profession and promoting public confidence in nursing, health and care services, and

1.20 safely demonstrate evidence-based practice in all skills and procedures stated in Annexes A and B.

Platform 2
Promoting health and preventing ill health

Registered nurses play a key role in improving and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to maximise their quality of life and improve health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas, and in the reduction of health inequalities.



2. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

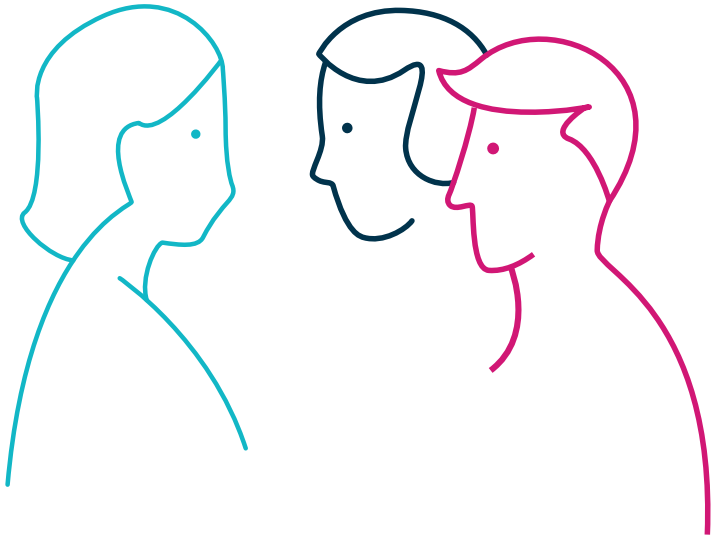
At the point of registration, the registered nurse will be able to:

2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people

2.2 demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes

2.3 understand the factors that may lead to inequalities in health outcomes

2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances



2.5 promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes

2.6 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing

2.7 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes

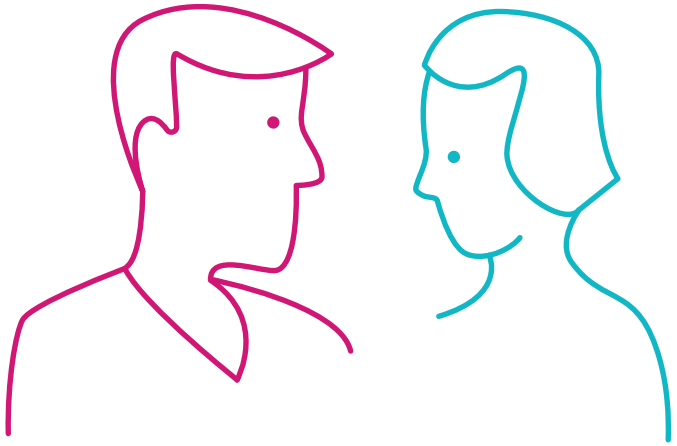
2.8 explain and demonstrate the use of up to date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments

2.9 use appropriate communication skills and strength based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability

2.10 provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care

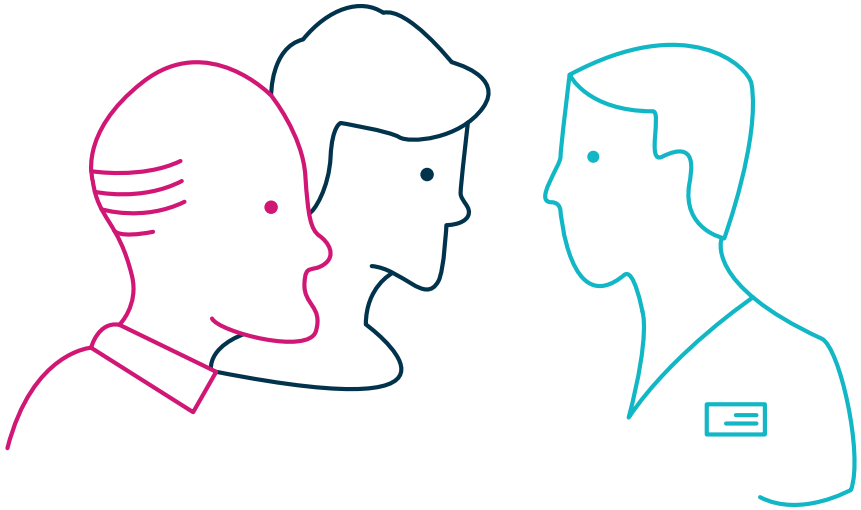
2.11 promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity, and

2.12 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.



Platform 3
Assessing needs and planning care

Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences.



3. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in assessing and initiating person-centred plans of care.

At the point of registration, the registered nurse will be able to:

3.1 demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.2 demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology and social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.3 demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person-centred care plans

3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages

3.5 demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals

3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent

3.7 understand and apply the principles and processes for making reasonable adjustments

3.8 understand and apply the relevant laws about mental capacity for the country in which you are practising when making decisions in relation to people who do not have capacity

3.9 recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable

3.10 demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation

3.11 undertake routine investigations, interpreting and sharing findings as appropriate

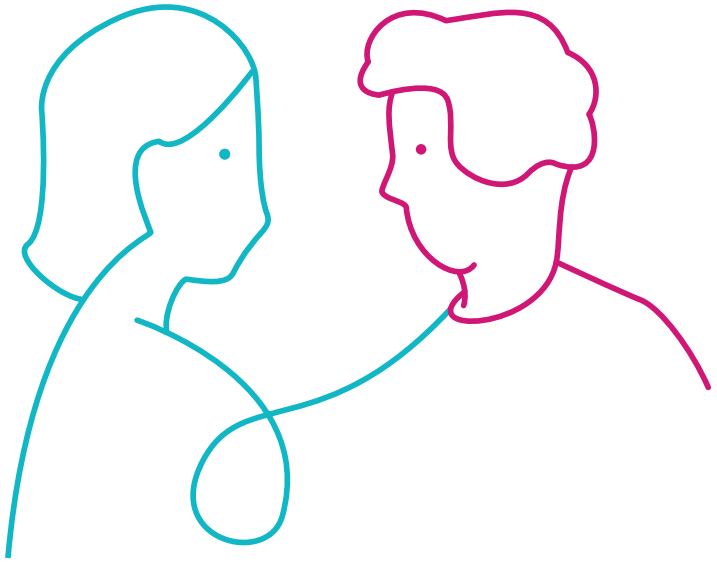
3.12 interpret results from routine investigations, taking prompt action when required by implementing appropriate interventions, requesting additional investigations or escalating to others

3.13 demonstrate an understanding of co-morbidities and the demands of meeting people's complex nursing and social care needs when prioritising care plans

3.14 identify and assess the needs of people and families for care at the end of life, including requirements for palliative care and decision making related to their treatment and care preferences

3.15 demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made, and

3.16 demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.



Platform 4 Providing and evaluating care

Registered nurses take the lead in providing evidence-based, compassionate and safe nursing interventions. They ensure that care they provide and delegate is person-centred and of a consistently high standard. They support people of all ages in a range of care settings. They work in partnership with people, families and carers to evaluate whether care is effective and the goals of care have been met in line with their wishes, preferences and desired outcomes.

4. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in providing and evaluating person-centred care.

At the point of registration, the registered nurse will be able to:

4.1 demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care

4.2 work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate

4.3 demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions

4.4 demonstrate the knowledge and skills required to support people with commonly encountered mental health, behavioural, cognitive and learning challenges, and act as a role model for others in providing high quality nursing interventions to meet people's needs

4.5 demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs

4.6 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based nursing care to meet people's needs related to nutrition, hydration and bladder and bowel health

4.7 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based, person-centred nursing care to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity

4.8 demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain

4.9 demonstrate the knowledge and skills required to prioritise what is important to people and their families when providing evidence-based person-centred nursing care at end of life including the care of people who are dying, families, the deceased and the bereaved

4.10 demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions

4.11 demonstrate the knowledge and skills required to initiate and evaluate appropriate interventions to support people who show signs of self-harm and/or suicidal ideation

4.12 demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence-based, person-centred care

4.13 demonstrate the knowledge, skills and confidence to provide first aid procedures and basic life support

4.14 understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines

4.15 demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage

4.16 demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing

4.17 apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration, and

4.18 demonstrate the ability to co-ordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings.

Platform 5
Leading and managing nursing care and working in teams

Registered nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. They are responsible for managing nursing care and are accountable for the appropriate delegation and supervision of care provided by others in the team including lay carers. They play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues.

5. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in leading and managing nursing care and working effectively as part of an interdisciplinary team.

At the point of registration, the registered nurse will be able to:

5.1 understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making

5.2 understand and apply the principles of human factors, environmental factors and strength-based approaches when working in teams

5.3 understand the principles and application of processes for performance management and how these apply to the nursing team

5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care

5.5 safely and effectively lead and manage the nursing care of a group of people, demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care

5.6 exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team

5.7 demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers

5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance

5.9 demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs

5.10 contribute to supervision and team reflection activities to promote improvements in practice and services

5.11 effectively and responsibly use a range of digital technologies to access, input, share and apply information and data within teams and between agencies, and

5.12 understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills.

Platform 6 Improving safety and quality of care

Registered nurses make a key contribution to the continuous monitoring and quality improvement of care and treatment in order to enhance health outcomes and people's experience of nursing and related care. They assess risks to safety or experience and take appropriate action to manage those, putting the best interests, needs and preferences of people first.

6. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care improvement agendas.

At the point of registration the registered nurse will be able to:

6.1 understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments

6.2 understand the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately

6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken

6.4 demonstrate an understanding of the principles of improvement methodologies, participate in all stages of audit activity and identify appropriate quality improvement strategies

6.5 demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools

6.6 identify the need to make improvements and proactively respond to potential hazards that may affect the safety of people

6.7 understand how the quality and effectiveness of nursing care can be evaluated in practice, and demonstrate how to use service delivery evaluation and audit findings to bring about continuous improvement

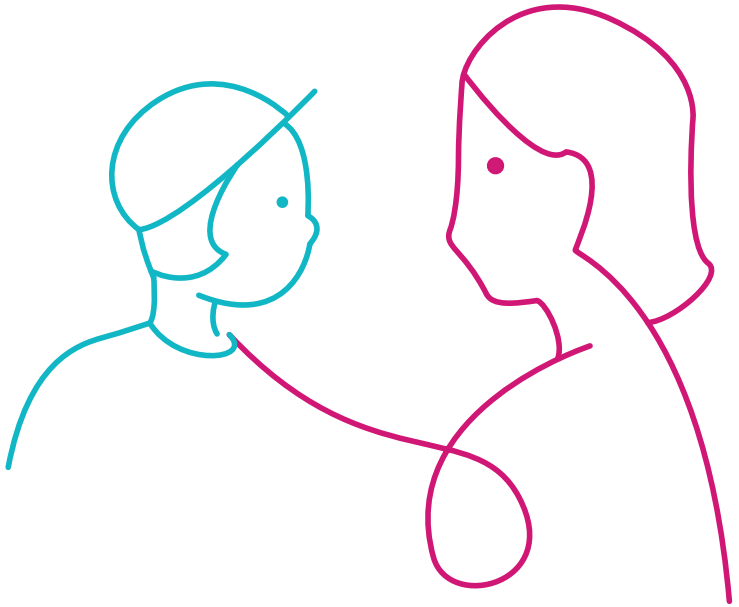
6.8 demonstrate an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice

6.9 work with people, their families, carers and colleagues to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences

6.10 apply an understanding of the differences between risk aversion and risk management and how to avoid compromising quality of care and health outcomes

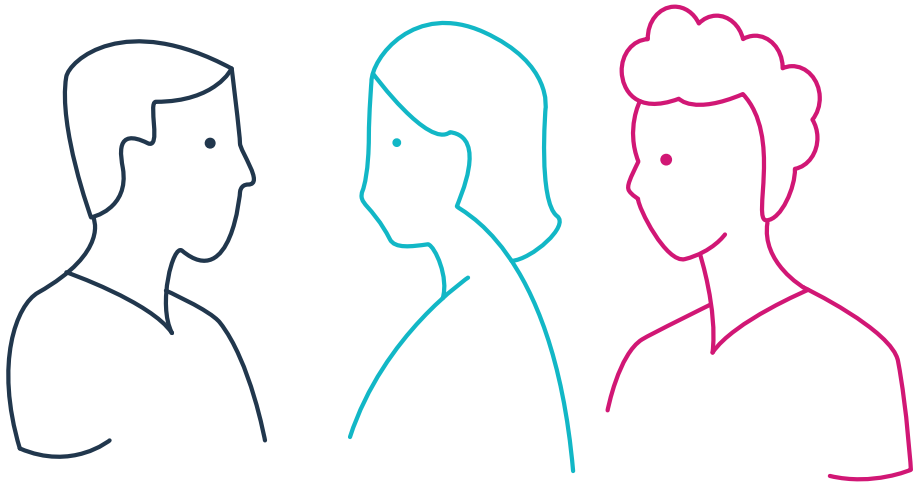
6.11 acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others, and

6.12 understand the role of registered nurses and other health and care professionals at different levels of experience and seniority when managing and prioritising actions and care in the event of a major incident.



Platform 7
Coordinating care

Registered nurses play a leadership role in coordinating and managing the complex nursing and integrated care needs of people at any stage of their lives, across a range of organisations and settings. They contribute to processes of organisational change through an awareness of local and national policies.



7. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in coordinating and leading and managing the complex needs of people across organisations and settings.

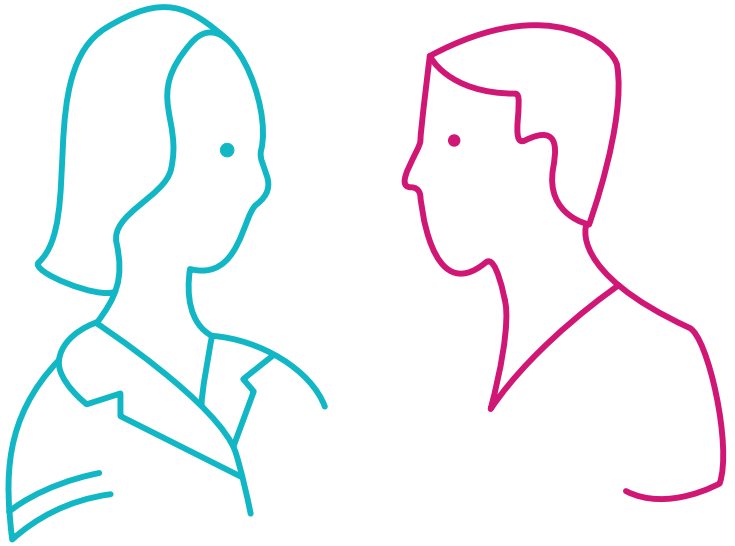
At the point of registration, the registered nurse will be able to:

7.1 understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors

7.2 understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom

7.3 understand the principles of health economics and their relevance to resource allocation in health and social care organisations and other agencies

7.4 identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care



7.5 understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs

7.6 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings

7.7 understand how to monitor and evaluate the quality of people's experience of complex care

7.8 understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives

7.9 facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care

7.10 understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services

7.11 demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed

7.12 demonstrate an understanding of the processes involved in developing a basic business case for additional care funding by applying knowledge of finance, resources and safe staffing levels, and

7.13 demonstrate an understanding of the importance of exercising political awareness throughout their career, to maximise the influence and effect of registered nursing on quality of care, patient safety and cost effectiveness.

Annexe A: Communication and relationship management skills

Introduction

The communication and relationship management skills that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes outlined in the main body of this document are set out in this annexe.

Effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive and behavioural health challenges.

This is because a diverse range of communication and relationship management skills is required to ensure that individuals, their families and carers are actively involved in and understand care decisions. These skills are vital when making accurate, culturally aware assessments of care needs and ensuring that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Where people have special communication needs or a disability, it is essential that reasonable adjustments are made in order to communicate, provide and share information in a manner that promotes optimum understanding and engagement and facilitates equal access to high quality care.

The communication and relationship management skills within this annexe are set out in four sections. For the reasons above, these requirements are relevant to all fields of nursing practice and apply to all care settings. It is expected that these skills would be assessed in a student's chosen field of practice.

Those skills outlined in **Annexe A, Section 3: Evidence-based, best practice communication skills and approaches for providing therapeutic interventions** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field of practice. Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following skills:

1. **Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care**

   1.1 actively listen, recognise and respond to verbal and non-verbal cues

   1.2 use prompts and positive verbal and non-verbal reinforcement

   1.3 use appropriate non-verbal communication including touch, eye contact and personal space

   1.4 make appropriate use of open and closed questioning

   1.5 use caring conversation techniques

   1.6 check understanding and use clarification techniques

   1.7 be aware of own unconscious bias in communication encounters

   1.8 write accurate, clear, legible records and documentation

   1.9 confidently and clearly present and share verbal and written reports with individuals and groups

   1.10 analyse and clearly record and share digital information and data

   1.11 provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care

   1.12 recognise the need for, and facilitate access to, translator services and material.

2. **Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care**

   2.1 share information and check understanding about the causes, implications and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis

   2.2 use clear language and appropriate, written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment

   2.3 recognise and accommodate sensory impairments during all communications

   2.4 support and manage the use of personal communication aids

2.5 identify the need for and manage a range of alternative communication techniques

2.6 use repetition and positive reinforcement strategies

2.7 assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use

2.8 provide information and explanation to people, families and carers and respond to questions about their treatment and care and possible ways of preventing ill health to enhance understanding

2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.

3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions

3.1 motivational interview techniques

3.2 solution focused therapies

3.3 reminiscence therapies

3.4 talking therapies

3.5 de-escalation strategies and techniques

3.6 cognitive behavioural therapy techniques

3.7 play therapy

3.8 distraction and diversion strategies

3.9 positive behaviour support approaches

4. Evidence-based, best practice communication skills and approaches for working with people in professional teams

4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of:

4.1.1 clear instructions and explanations when supervising, teaching or appraising others

4.1.2 clear instructions and check understanding when delegating care responsibilities to others

4.1.3 unambiguous, constructive feedback about strengths and weaknesses and potential for improvement

4.1.4 encouragement to colleagues that helps them to reflect on their practice

4.1.5 unambiguous records of performance

4.2 Demonstrate effective person and team management through the use of:

4.2.1 strengths based approaches to developing teams and managing change

4.2.2 active listening when dealing with team members' concerns and anxieties

4.2.3 a calm presence when dealing with conflict

4.2.4 appropriate and effective confrontation strategies

4.2.5 de-escalation strategies and techniques when dealing with conflict

4.2.6 effective co-ordination and navigation skills through:

4.2.6.1 appropriate negotiation strategies

4.2.6.2 appropriate escalation procedures

4.2.6.3 appropriate approaches to advocacy.

Annexe B: Nursing procedures

Introduction

The nursing procedures that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes, outlined in the main body of this document, are set out in this annexe.

The registered nurse must be able to undertake these procedures effectively in order to provide compassionate, evidence-based person-centred nursing care. A holistic approach to the care of people is essential and all nursing procedures should be carried out in a way which reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Registered nurses in all fields of practice must demonstrate the ability to provide nursing intervention and support for people of all ages who require nursing procedures during the processes of assessment, diagnosis, care and treatment for mental, physical, cognitive and behavioural health challenges. Where people are disabled or have specific cognitive needs it is essential that reasonable adjustments are made to ensure that all procedures are undertaken safely.

The nursing procedures within this annexe are set out in two sections. These requirements are relevant to all fields of nursing practice although it is recognised that different care settings may require different approaches to the provision of care. It is expected that these procedures would be assessed in a student's chosen field of practice where practicable.

Those procedures outlined in **Annexe B, Part I: Procedures for assessing needs for person-centred care, sections 1 and 2** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following procedures:

Part 1: Procedures for assessing people's needs for person-centred care

1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages:

1.1 mental health and wellbeing status

1.1.1 signs of mental and emotional distress or vulnerability

1.1.2 cognitive health status and wellbeing

1.1.3 signs of cognitive distress and impairment

1.1.4 behavioural distress based needs

1.1.5 signs of mental and emotional distress including agitation, aggression and challenging behaviour

1.1.6 signs of self-harm and/or suicidal ideation

1.2 physical health and wellbeing

1.2.1 symptoms and signs of physical ill health

1.2.2 symptoms and signs of physical distress

1.2.3 symptoms and signs of deterioration and sepsis.

2. Use evidence-based, best practice approaches to undertake the following procedures:

2.1 take, record and interpret vital signs manually and via technological devices

2.2 undertake venepuncture and cannulation and blood sampling, interpreting normal and common abnormal blood profiles and venous blood gases

2.3 set up and manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces

2.4 manage and monitor blood component transfusions

2.5 manage and interpret cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices

2.6 accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings

2.7 undertake a whole body systems assessment including respiratory, circulatory, neurological, musculoskeletal, cardiovascular and skin status

2.8 undertake chest auscultation and interpret findings

2.9 collect and observe sputum, urine, stool and vomit specimens, undertaking routine analysis and interpreting findings

2.10 measure and interpret blood glucose levels

2.11 recognise and respond to signs of all forms of abuse

2.12 undertake, respond to and interpret neurological observations and assessments

2.13 identify and respond to signs of deterioration and sepsis

2.14 administer basic mental health first aid

2.15 administer basic physical first aid

2.16 recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support

2.17 recognise and respond to challenging behaviour, providing appropriate safe holding and restraint.

Part 2: Procedures for the planning, provision and management of person-centred nursing care

3. Use evidence-based, best practice approaches for meeting needs for care and support with rest, sleep, comfort and the maintenance of dignity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

3.1 observe and assess comfort and pain levels and rest and sleep patterns

3.2 use appropriate bed-making techniques including those required for people who are unconscious or who have limited mobility

3.3 use appropriate positioning and pressure-relieving techniques

3.4 take appropriate action to ensure privacy and dignity at all times

3.5 take appropriate action to reduce or minimise pain or discomfort

3.6 take appropriate action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene.

4. Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

4.1 observe, assess and optimise skin and hygiene status and determine the need for support and intervention

4.2 use contemporary approaches to the assessment of skin integrity and use appropriate products to prevent or manage skin breakdown

4.3 assess needs for and provide appropriate assistance with washing, bathing, shaving and dressing

4.4 identify and manage skin irritations and rashes

4.5 assess needs for and provide appropriate oral, dental, eye and nail care and decide when an onward referral is needed

4.6 use aseptic techniques when undertaking wound care including dressings, pressure bandaging, suture removal, and vacuum closures

4.7 use aseptic techniques when managing wound and drainage processes

4.8 assess, respond and effectively manage pyrexia and hypothermia.

5. Use evidence-based, best practice approaches for meeting needs for care and support with nutrition and hydration, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

5.1 observe, assess and optimise nutrition and hydration status and determine the need for intervention and support

5.2 use contemporary nutritional assessment tools

5.3 assist with feeding and drinking and use appropriate feeding and drinking aids

5.4 record fluid intake and output and identify, respond to and manage dehydration or fluid retention

5.5 identify, respond to and manage nausea and vomiting

5.6 insert, manage and remove oral/nasal/gastric tubes

5.7 manage artificial nutrition and hydration using oral, enteral and parenteral routes

5.8 manage the administration of IV fluids

5.9 manage fluid and nutritional infusion pumps and devices.

6. Use evidence-based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

6.1 observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy and managing the use of appropriate aids

6.2 select and use appropriate continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required

6.3 manage bladder drainage

6.4 assess bladder and bowel patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention

6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate

6.6 undertake stoma care identifying and using appropriate products and approaches.

7. Use evidence-based, best practice approaches for meeting needs for care and support with mobility and safety, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

7.1 observe and use evidence-based risk assessment tools to determine need for support and intervention to optimise mobility and safety, and to identify and manage risk of falls using best practice risk assessment approaches

7.2 use a range of contemporary moving and handling techniques and mobility aids

7.3 use appropriate moving and handling equipment to support people with impaired mobility

7.4 use appropriate safety techniques and devices.

8. Use evidence-based, best practice approaches for meeting needs for respiratory care and support, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions

8.2 manage the administration of oxygen using a range of routes and best practice approaches

8.3 take and interpret peak flow and oximetry measurements

8.4 use appropriate nasal and oral suctioning techniques

8.5 manage inhalation, humidifier and nebuliser devices

8.6 manage airway and respiratory processes and equipment.

9. Use evidence-based, best practice approaches for meeting needs for care and support with the prevention and management of infection, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

9.1 observe, assess and respond rapidly to potential infection risks using best practice guidelines

9.2 use standard precautions protocols

9.3 use effective aseptic, non-touch techniques

9.4 use appropriate personal protection equipment

9.5 implement isolation procedures

9.6 use evidence-based hand hygiene techniques

9.7 safely decontaminate equipment and environment

9.8 safely use and dispose of waste, laundry and sharps

9.9 safely assess and manage invasive medical devices and lines.

10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression

10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps and other devices

10.3 assess and review preferences and care priorities of the dying person and their family and carers

10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health

10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death

10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols.

11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation

11.1 carry out initial and continued assessments of people receiving care and their ability to self-administer their own medications

11.2 recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them

11.3 use the principles of safe remote prescribing and directions to administer medicines

11.4 undertake accurate drug calculations for a range of medications

11.5 undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product

11.6 exercise professional accountability in ensuring the safe administration of medicines to those receiving care

11.7 administer injections using intramuscular, subcutaneous, intradermal and intravenous routes and manage injection equipment

11.8 administer medications using a range of routes

11.9 administer and monitor medications using vascular access devices and enteral equipment

11.10 recognise and respond to adverse or abnormal reactions to medications

11.11 undertake safe storage, transportation and disposal of medicinal products.

Glossary

Abuse: is something that may harm another person, or endanger their life, or violate their rights. The person responsible for the abuse may be doing this on purpose or may not realise the harm that they are doing. The type of abuse may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

Cognitive: The mental processes of perception, memory, judgment, and reasoning.

Co-morbidities: the presence of one or more additional diseases or disorders that occur with a primary disease or disorder.

Demography: the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Evidence-based person-centred care/nursing care: making sure that any care and treatment is given to people, by looking at what research has shown to be most effective. The judgment and experience of the nurse and the views of the person should also be taken into account when choosing which treatment is most likely to be successful for an individual.

Genomics: branch of molecular biology concerned with the structure, function, evolution, and mapping of genomes.

Health economics: a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and healthcare.

Health literacy: the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Human factors: environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

Interventions: any investigations, procedures, or treatments given to a person.

People: individuals or groups who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and other within and outside the learning environment.

Person-centred: an approach where the person is at the centre of the decision making processes and the design of their care needs, their nursing care and treatment plan.

Self-Reflection/Reflection: to carefully consider actions or decisions and learn from them.

Strength-based approaches: strength-based practice is a collaborative process between the person supported by services and those supporting them, working together to reach an outcome that draws on the person's strengths and assets.

Vulnerable people: those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

The role of the Nursing and Midwifery Council

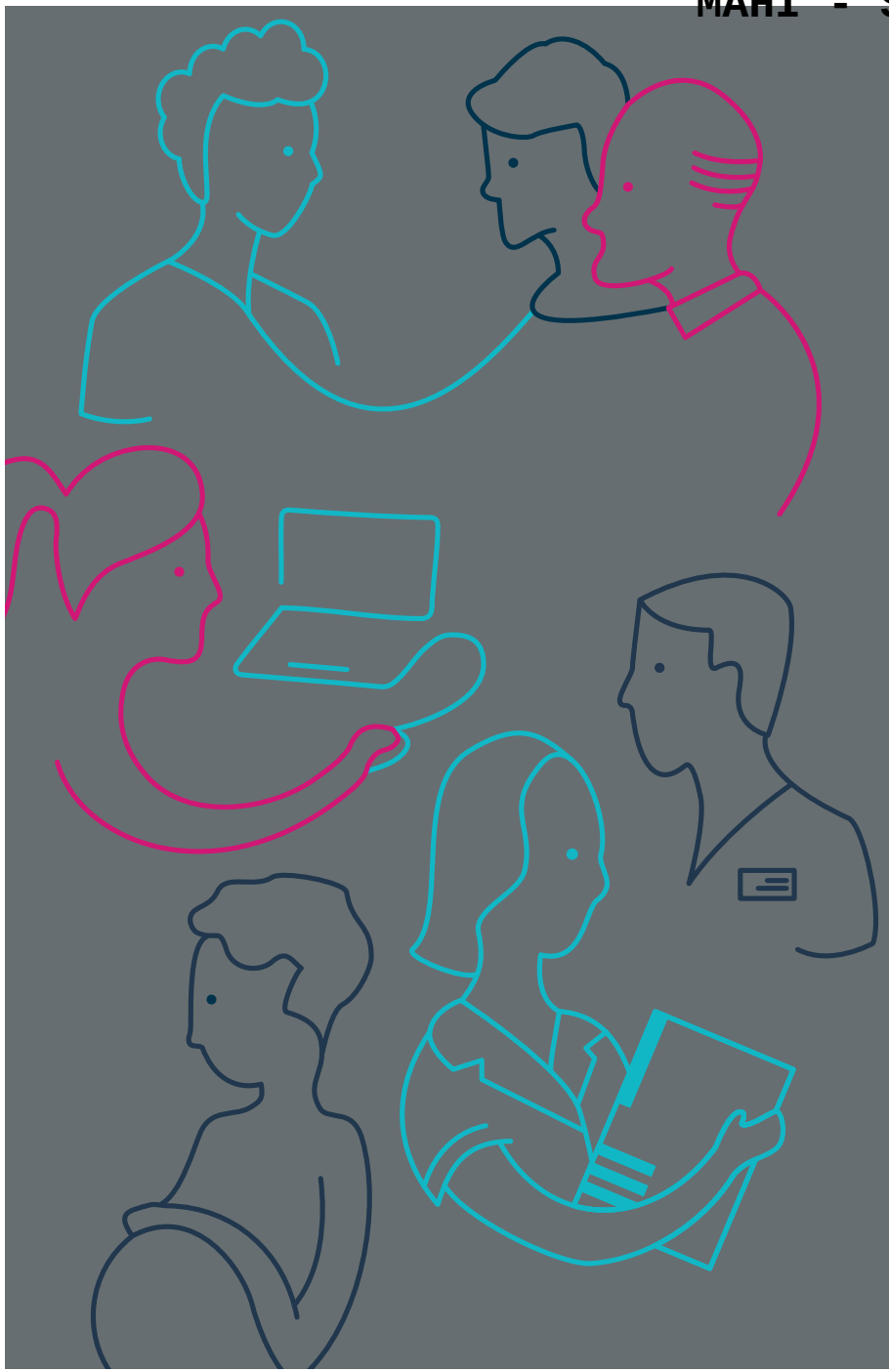
What we do

We regulate nurses and midwives in the UK, and nursing associates in England. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate professionals who fall short of our standards.

We maintain a register of nurses and midwives allowed to practise in the UK, and nursing associates allowed to practise in England.

These standards were approved by Council at their meeting on 28 March 2018.



Nursing & Midwifery Council

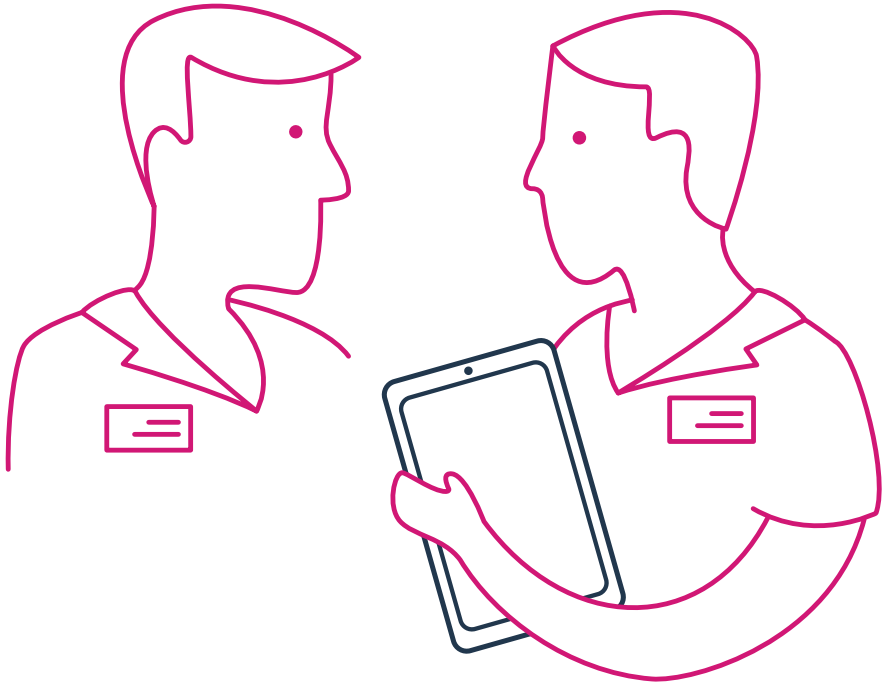
Realising professionalism:
Standards for education and training

Part 1: Standards framework for nursing and midwifery education

Published 17 May 2018

About these standards

Realising professionalism: *Standards for education and training* includes the *Standards framework for nursing*[1] *and midwifery education*, *Standards for student supervision and assessment*, and programme standards specific to each approved programme.



Our *Standards for education and training* are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards

- Standards for pre-registration nursing education
- Standards for pre-registration nursing associate education
- Standards for prescribing programmes

These standards help nursing and midwifery students achieve proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of The Code, the professional standards of practice and behaviour that nurses, midwives and nursing associates are expected to uphold.

[1] We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

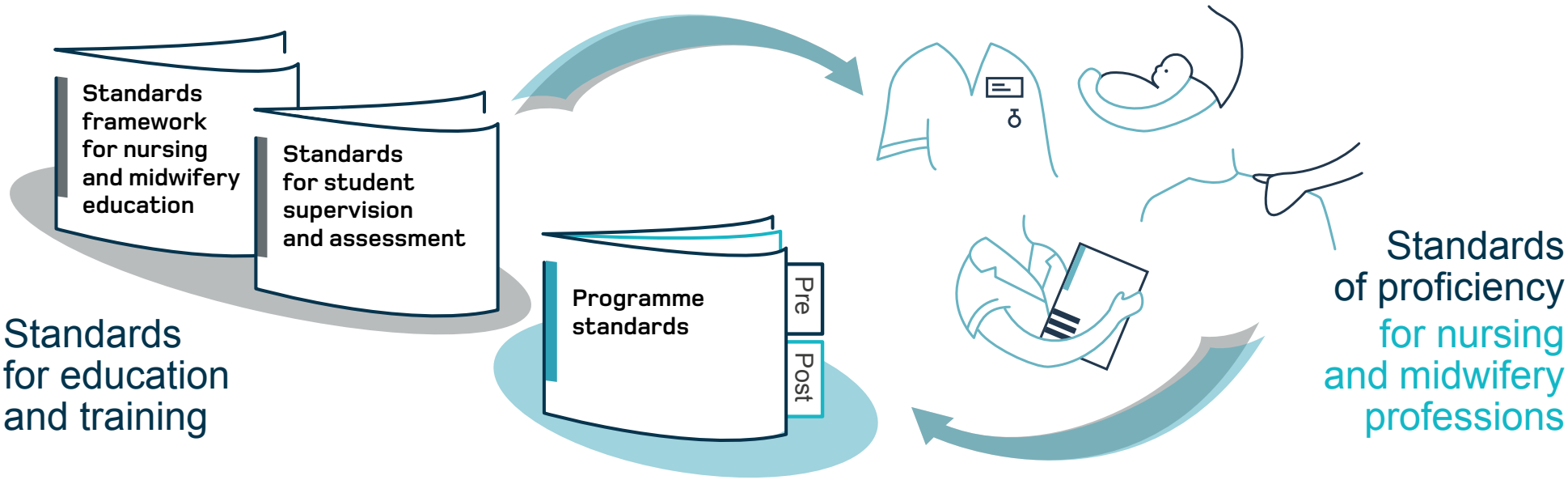
Introduction

Our *Standards framework for nursing and midwifery education* applies to all approved education institutions (AEIs) and their practice learning partners that are running NMC approved programmes.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The *Standards framework for nursing and midwifery education* is established under the provision of Article 15(1) of the Order.

These standards aim to provide AEIs and practice learning partners with the flexibility to develop innovative approaches to all education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards. Pre-registration nursing and midwifery programmes and post-registration programmes may offer various academic and flexible routes to registration and annotation when seeking approval in line with our standards.

These standards should be read with *Part 2: Standards for student supervision and assessment and Part 3: Programme standards* which are standards specific for each pre-registration and post-registration educational programme. Together these are the NMC *Standards for education and training* ('*Realising professionalism*') for the nursing and midwifery professions. Education institutions must be approved against these standards to run any NMC approved programmes.



AEIs are responsible for working with practice learning partners to manage the quality of their educational programmes. Overall responsibility for the day-to-day management of the quality of any educational programme lies with an AEI in partnership with practice learning partners who provide opportunities for practice experience to nursing and midwifery students.

Before a programme can be run, an approval process takes place through which we check that the proposed programme meets our standards.

Public safety is central to our standards. Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

Through our quality assurance (QA) processes we check that education programmes meet our standards and that education institutions and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

Approved education providers are monitored and we have processes for collecting, analysing and responding to any risk intelligence we receive regarding educational programmes, including concerns raised with us directly by students. Approved education providers are also required to self-report any risks or concerns that could affect the quality of programme delivery and, therefore, public protection.

We strongly encourage people to take part in QA events, where they will be asked to share experiences of nurse and midwifery education and suggest improvements.

AEIs must seek permission for approval for programme endorsement for programmes approved in the UK, to be delivered in a specified location outside the UK. This must be done in line with the NMC *Quality assurance framework*.

Our *Standards framework for nursing and midwifery education* is set out under the following five headings:

1. Learning culture

We will only approve programmes where the learning culture is ethical, open and honest, is conducive to safe and effective learning that respects the principles of equality and diversity, and where innovation, inter-professional learning and team working are embedded

2. Educational governance and quality

We expect education providers to comply with all legal and regulatory requirements

3. Student empowerment

We want students to be empowered and provided with the learning opportunities they need to achieve the desired proficiencies and programme outcomes

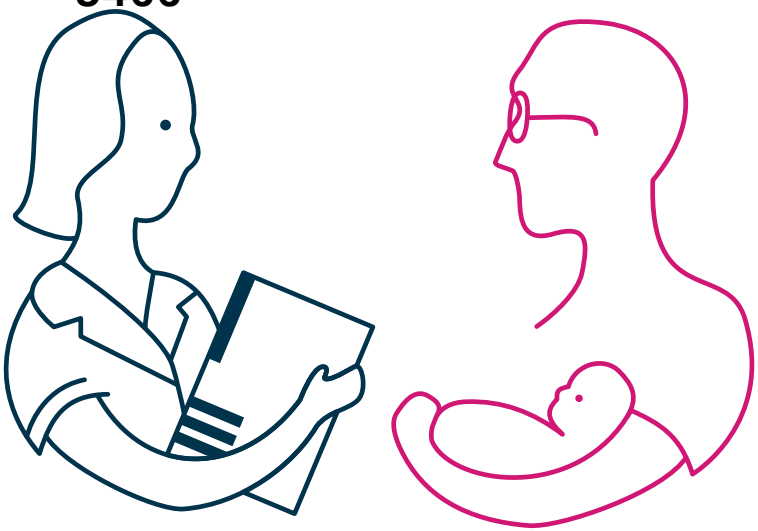
4. Educators and assessors

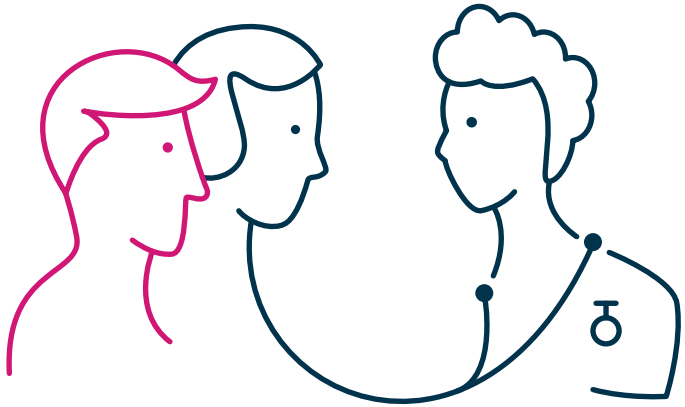
We will seek assurance that those who support, supervise and assess students are suitably qualified, prepared and skilled, and receive the necessary support for their role

5. Curricula and assessment

We set standards for curricula and assessment that enable students to achieve the outcomes required to practise safely and effectively in their chosen area

We use these standards to assess the safety and effectiveness of all learning environments.





1 Learning culture

Standards

1.1 The learning culture prioritises the safety of people, including carers, students and educators, and enables the values of *The Code* to be upheld.

1.2 Education and training is valued in all learning environments.

Requirements

Approved education institutions, together with practice learning partners, must:

1.1 demonstrate that the safety of people is a primary consideration in all learning environments

1.2 prioritise the wellbeing of people promoting critical self-reflection and safe practice in accordance with *The Code*

1.3 ensure people have the opportunity to give and if required, withdraw, their informed consent to students being involved in their care

1.4 ensure educators and others involved in supervision, learning and assessment understand their role in preserving public safety

1.5 ensure students and educators understand how to raise concerns or complaints and are encouraged and supported to do so in line with local and national policies without fear of adverse consequences

1.6 ensure any concerns or complaints are investigated and dealt with effectively

1.7 ensure concerns or complaints affecting the wellbeing of people are addressed immediately and effectively

1.8 ensure mistakes and incidents are fully investigated and learning reflections and actions are recorded and disseminated

1.9 ensure students are supported and supervised in being open and honest with people in accordance with the professional duty of candour

1.10 ensure the learning culture is fair, impartial, transparent, fosters good relations between individuals and diverse groups, and is compliant with equalities and human rights legislation

1.11 promote programme improvement and advance equality of opportunity through effective use of information and data

1.12 ensure programmes are designed, developed, delivered, evaluated and co-produced with service users and other stakeholders

1.13 work with service providers to demonstrate and promote inter-professional learning and working, and

1.14 support opportunities for research collaboration and evidence-based improvement in education and service provision.

2 Educational governance and quality

Standards

2.1 There are effective governance systems that ensure compliance with all legal[2], regulatory, professional and educational requirements, differentiating where appropriate between the devolved legislatures of the United Kingdom, with clear lines of responsibility and accountability for meeting those requirements and responding when standards are not met, in all learning environments.

2.2 All learning environments optimise safety and quality, taking account of the diverse needs of, and working in partnership with, service users, students and all other stakeholders.

Requirements

Approved education institutions, together with practice learning partners, must:

2.1 comply with all relevant legal, regulatory, professional and educational requirements

2.2 ensure programmes are designed to meet proficiencies and outcomes relevant to the programme

2.3 comply with NMC *Programme standards* specific to the programme being delivered

2.4 comply with NMC *Standards for student supervision and assessment*

2.5 adopt a partnership approach with shared responsibility for theory and practice supervision, learning and assessment, including clear lines of communication and accountability for the development, delivery, quality assurance and evaluation of their programmes

2.6 ensure that recruitment and selection of students is open, fair and transparent and includes measures to understand and address underrepresentation

2.7 ensure that service users and representatives from relevant stakeholder groups are engaged in partnership in student recruitment and selection

2.8 demonstrate a robust process for recognition of prior learning (RPL) and how it has been mapped to the programme learning outcomes and proficiencies

2.9 provide students with the information and support they require in all learning environments to enable them to understand and comply with relevant local and national governance processes and policies

2.10 have robust, effective, fair, impartial and lawful fitness to practise procedures to swiftly address concerns about the conduct of students that might compromise public safety and protection

[2] Includes, but not limited to, relevant European Union legislation and legislation passed by devolved administrations of the United Kingdom.

2.11 confirm that students meet the required proficiencies and programme outcomes in full, demonstrating their fitness for practice and eligibility for academic and professional award

2.12 provide all information and evidence required by regulators

2.13 regularly review all learning environments and provide assurance that they are safe and effective

2.14 have the capacity, facilities and resources in place to deliver safe and effective learning opportunities and practical experiences for students as required by their programme learning outcomes

2.15 be compliant with the NMC *Standards for education and training*[3] for all periods of learning undertaken outside the UK

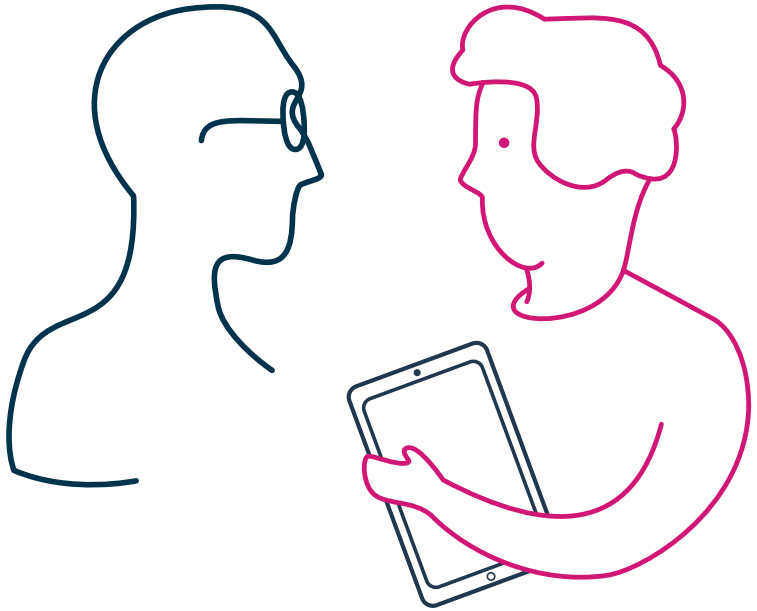
2.16 improve quality, manage risk and disseminate effective practice through the proactive seeking and appropriate sharing of information and data

2.17 proactively identify and act on any areas for improvement, regularly measuring programme performance and outcomes against the NMC standards and requirements, and other recognised quality frameworks in education

2.18 appoint appropriately qualified and experienced people for programme delivery

2.19 identify programme leaders to confirm that all proficiencies have been met by each student by the end of their programme, and

2.20 ensure appropriately qualified and experienced external examiners consider and report on the quality of theory and practice learning.



[3] NMC *Standards for education and training*, standards established by NMC Council as necessary to achieve the standards of proficiency for admission to the register. Includes Parts 1, 2 and relevant standards in Part 3 and proficiencies.

3 Student empowerment

Standards

3.1 Students are provided with a variety of learning opportunities and appropriate resources which enable them to achieve proficiencies and programme outcomes and be capable of demonstrating the professional behaviours in *The Code*.

3.2 Students are empowered and supported to become resilient, caring, reflective and lifelong learners who are capable of working in inter-professional and inter-agency teams.

Requirements

Approved education institutions, together with practice learning partners, must ensure that all students:

3.1 have access to the resources they need to achieve the proficiencies and programme outcomes required for their professional role

3.2 are provided with timely and accurate information about curriculum, approaches to teaching, supervision, assessment, practice placements and other information relevant to their programme

3.3 have opportunities throughout their programme to work with and learn from a range of people in a variety of practice placements, preparing them to provide care to people with diverse needs

3.4 are enabled to learn and are assessed using a range of methods, including technology enhanced and simulation-based learning appropriate for their programme as necessary for safe and effective practice

3.5 are supervised and supported in practice learning in accordance with the NMC *Standards for student supervision and assessment*

3.6 are supervised according to their individual learning needs, proficiency and confidence

3.7 are allocated and can make use of supported learning time when in practice

3.8 are assigned and have access to a nominated practice assessor for a practice placement or a series of practice placements in addition to a nominated academic assessor for each part of the education programme, in accordance with the NMC *Standards for student supervision and assessment*

3.9 have the necessary support and information to manage any interruptions to the study of programmes for any reason

3.10 are provided with timely and accurate information regarding entry to NMC registration or annotation of their award

3.11 have their diverse needs respected and taken into account across all learning environments, with support and adjustments provided in accordance with equalities and human rights legislation and good practice

3.12 are protected from discrimination, harassment and other behaviour that undermines their performance or confidence

3.13 are provided with information and support which encourages them to take responsibility for their own mental and physical health and wellbeing

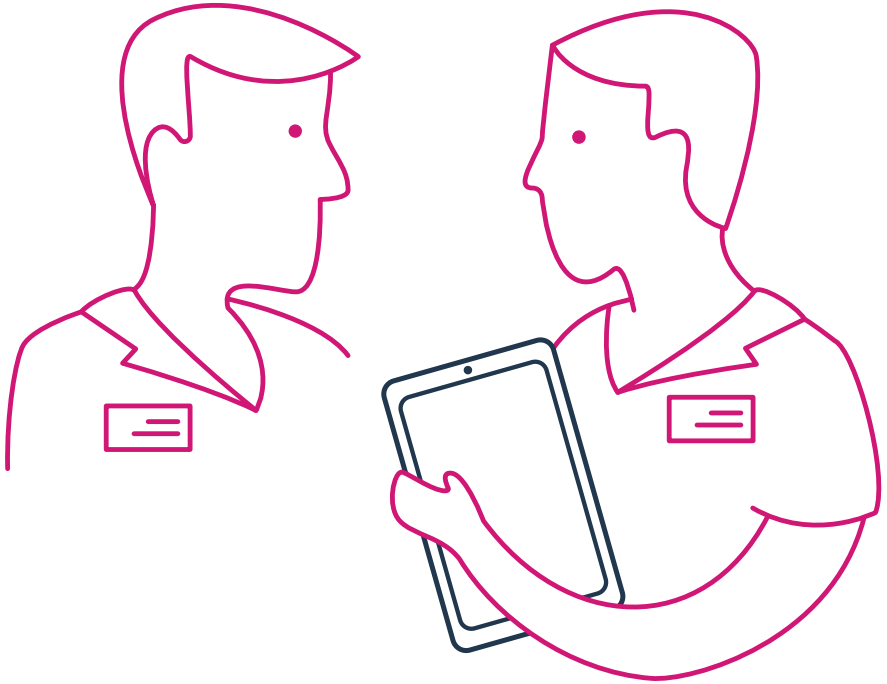
3.14 are provided with the learning and pastoral support necessary to empower them to prepare for independent, reflective professional practice

3.15 are well prepared for learning in theory and practice having received relevant inductions

3.16 have opportunities throughout their programme to collaborate and learn with and from other professionals, to learn with and from peers, and to develop supervision and leadership skills

3.17 receive constructive feedback throughout the programme from stakeholders with experience of the programme to promote and encourage reflective learning, and

3.18 have opportunities throughout their programme to give feedback on the quality of all aspects of their support and supervision in both theory and practice.



4 Educators and assessors

Standard

4.1 Theory and practice learning and assessment are facilitated effectively and objectively by appropriately qualified and experienced professionals with necessary expertise for their educational and assessor roles.

Requirements

Approved education institutions, together with practice learning partners, must ensure that all educators and assessors:

4.1 comply with all standards and requirements in the NMC *Standards for education and training*

4.2 act as professional role models at all times

4.3 receive relevant induction, ongoing support and access to education and training which includes training in equality and diversity

4.4 have supported time and resources to enable them to fulfil their roles in addition to their other professional responsibilities

4.5 respond effectively to the learning needs of individuals

4.6 are supportive and objective in their approach to student supervision and assessment

4.7 liaise and collaborate with colleagues and partner organisations in their approach to supervision and assessment

4.8 are expected to respond effectively to concerns and complaints about public protection and student performance in learning environments and are supported in doing so

4.9 receive and act upon constructive feedback from students and the people they engage with to enhance the effectiveness of their teaching, supervision and assessment

4.10 share effective practice and learn from others, and

4.11 appropriately share and use evidence to make decisions on student assessment and progression.

5 Curricula and assessment

Standard

5.1 Curricula and assessments are designed, developed, delivered and evaluated to ensure that students achieve the proficiencies and outcomes for their approved programme.

Requirements

Approved education institutions, together with practice learning partners, must ensure:

5.1 curricula fulfil NMC Programme standards, providing learning opportunities that equip students to meet the proficiencies and programme outcomes[4]

5.2 curricula remain relevant in respect of the contemporary health and social care agenda

5.3 curricula weigh theory and practice learning appropriately to the programme

5.4 curricula are developed and evaluated by suitably experienced and qualified educators and practitioners who are accountable for ensuring that the curriculum incorporates relevant programme outcomes

5.5 curricula are co-produced with stakeholders who have experience relevant to the programme

5.6 curricula provide appropriate structure and sequencing that integrates theory and practice at increasing levels of complexity

5.7 curricula are structured and sequenced to enable students to manage their theory and practice learning experience effectively

5.8 assessment is fair, reliable and valid to enable students to demonstrate they have achieved the proficiencies for their programme

5.9 adjustments are provided in accordance with relevant equalities and human rights legislation for assessments in theory and practice

5.10 students are assessed across practice settings and learning environments as required by their programme

5.11 assessment is mapped to the curriculum and occurs throughout the programme to determine student progression

5.12 practice assessment is facilitated and evidenced by observations and other appropriate methods

5.13 students' self-reflections contribute to, and are evidenced in, assessments

5.14 a range of people including service users contribute to student assessment

5.15 assessment of practice and theory is weighted appropriately to the programme, and

5.16 there is no compensation in assessments across theory and practice learning.

[4] Applies equally to all programmes whether delivered as full time or less than full time.

Glossary

Adjustments: where a student requires reasonable adjustments related to a disability or adjustments relating to any protected characteristics as set out in equalities and human rights legislation.

Approved education institutions (AEIs): the status awarded to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Co-produced: when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered, acknowledging that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better. Co-production is one of the principles of the Care Act 2014.

Educators: in the context of the NMC *Standards for education and training* are those who deliver, support, supervise and assess theory, practice or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections

Learning environments: includes any environment in terms of physical location where learning takes place as well as the system of shared values, beliefs and behaviours within these places.

People: individuals or groups who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and others within and outside the learning environment.

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs continue to meet our requirements and their approved education programmes comply with our standards.

Recognition of prior learning: a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

Service users: people accessing health or social care services, and anyone supporting the needs and circumstances of these people.

Simulation: an artificial representation of a real world practice scenario that supports student development and assessment through experiential learning with the opportunity for repetition, feedback, evaluation and reflection. Effective simulation facilitates safety by enhancing knowledge, behaviours and skills.

Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the NMC *Standards for education and training* this includes students, educators, partner organisations, service users, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC-approved programme at pre-registration or post-registration level, whether full time or less than full time.

Supported learning time: time to facilitate learning. This may include supernumerary status[5] that enables students to be supported in safely and effectively achieving proficiency.

[5] Supernumerary: see *Standards for student supervision and assessment* and specific programme standards.

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We maintain a register of nurses, midwives and nursing associates allowed to practise in the UK.

These standards were approved by Council at their meeting on 28 March 2018 and have been updated to include the regulation of pre-registration nursing associate programmes on 8 October 2018.