REPORT OF THE REVIEW OF CLINICAL SUPERVISION FOR NURSING IN THE HPSS 2006

ON BEHALF OF THE DHSSPS

NIPEC

In May 2006, the Chief Nursing Officer for Northern Ireland, Professor Martin Bradley, asked NIPEC to review current guidance on clinical supervision in the HPSS, to evaluate current supervision systems and establish an action plan for ensuring that clinical supervision systems are in place. The CNO placed the importance of this review in the context of DHSSPS Quality Standards for Health and Social Care, published in March 2006, which set out five key quality themes for the development of standards. This Report is the product of that Review.

Review of Clinical Supervision for Nursing in the HPSS 2006

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Acknowledgements

NIPEC would like to thank a range of stakeholders who have contributed to this review. We would particularly like to thank the Review Group and Chair, Mrs Hazel Baird, for their time and dedication to this project.

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Finally, we give thanks to other colleagues who attended the Consultation workshop and contributed to further development of the guiding principles and action plan.

Executive Summary

In May 2006, the Chief Nursing Officer for Northern Ireland commissioned NIPEC to undertake a review of clinical supervision for nursing, across the Health and Personal Social Services (HPSS). A regional Review Group was formed (see Appendix 2 for membership) with a remit for reviewing current guidance and relevant literature on clinical supervision, to describe and evaluate current supervision systems, develop a set of guiding principles for future supervision, and report the review findings and a recommended action plan for improvement.

This report provides an analysis of the work of the Review Group between June and November 2006. A review of the literature on the topic indicates that despite having been prominent in health care for well over a decade, clinical supervision continues to be poorly defined, often misunderstood and is under evaluated from the perspective of both its processes and outcomes.

Methods used to undertake the fieldwork for this review included structured interviews with Directors of Nursing and Senior Nurses from each of the eighteen HPSS Trusts. Each of the interview transcripts was thematically analysed, and barriers to as well as enabling factors for establishing and sustaining supervision were generated. In addition, case-studies of valued supervision models were selected using a pre-determined set of criteria. At a workshop in

August 2006, barriers to and enablers for effective supervision within these case studies were also identified.

Feedback from both the interviews and case studies were considered by the Review Group, and a draft set of guiding principles and recommended actions for supervision across the HPSS were developed. These draft principles and actions were presented to a wide range of stakeholders in a Consultative workshop. The Review Group then produced this final report and action plan.

This Review has indicated that there is limited evidence of widespread implementation of effective systems of clinical supervision across nursing in Northern Ireland, however some examples of exemplary models and approaches have been analysed during this review and reported on. In response to this, the Review Group has offered a modernised definition for Supervision in Section 7 of this report.

Recommendations for implementing effective models of supervision are offered, underpinned by the modernised definition for supervision and emphasising the importance of linking supervision to appraisal, governance systems and performance management. Supervision should therefore be the responsibility of every nurse as integral to their practice, and for every organisation must be embedded within a culture of learning and development that focuses on delivering safe and effective care.

SECTION 1 - INTRODUCTION

1.1 In May 2006, the Chief Nursing Officer for Northern Ireland, commissioned NIPEC to undertake a review of clinical supervision across acute and community nursing in the Health and Personal Social Services (HPSS). Mrs Hazel Baird (Executive Director of Nursing, Homefirst Health and Social Services Trust (HSST) and NIPEC Council Member) was invited to Chair a Review Group whose membership was composed of colleagues from across the HPSS with related expertise in this area and who were representative geographically and from across all areas of nursing.

The terms of reference for the review group were as follows:

1. To review current guidance and relevant literature on Clinical Supervision in the HPSS

2. To describe and evaluate current Supervision systems

3. To develop a set of guiding principles for Supervision

4. To report (by November 2006) the review findings and a recommended action plan for improvement, for presentation to the Department of Health, Social Services & Public Safety (DHSSPS) for implementation.

1.2 The Review Group agreed at its first meeting, that for the purpose of this review, the term ‘clinical supervision’ would

include a wide range of activities that have ‘supervision’ impact, and thus have the intention of developing practitioner competence and the enhancement of their practice. These include formal one-to-one or group clinical supervision, action learning, reflective or work-based learning groups, critical companionship, professional and peer supervision, particularly where such activities are formally identified as having similar principles to or being undertaken for supervision purposes.

1.3 This report provides an analysis of the work of the Review Group between June and November 2006, to meet the above terms of reference through fieldwork with colleagues and teams undertaking supervision across the HPSS, and culminating with a set of guiding principles and recommended actions for future supervision practice.

SECTION 2 - BACKGROUND

2.1 From a policy perspective, clinical supervision within the nursing profession in the UK was first formally highlighted in 1993 and has continued to gather policy momentum since this time (Department of Health 1993; United Kingdom Central Council for Nursing and Midwifery (UKCC) 1996; Barrowman 2000; Nursing and Midwifery Council (NMC) 2006). In offering one of a number of definitions, the NHS Management Executive (1995) defined clinical supervision as,

> *'…a formal process of professional support and learning which enables individual professionals to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex situations.'*

2.2 In supporting the establishment of clinical supervision as an important part of clinical governance, and in the interests of maintaining and improving standards of patient/client care, the NMC issued guiding principles for underpinning any system of clinical supervision, in use nationally (NMC, March 2006). These are available in Appendix 1. According to the NMC (2006) clinical supervision allows registrants to develop their skills and knowledge, and helps them to improve patient/client care.

Clinical supervision enables registrants to:

- Identify solutions to problems
- Increase understanding of professional issues
- Improve standards of patient care
- Further develop their skills and knowledge
- Enhance their understanding of their own practice.

2.3 National and regional inquiries have increased interest in and recognition of the importance of effective clinical supervision, for example The Clothier Report – The Allitt Inquiry (1994), The Bristol and Liverpool Inquiries, Shipman and more locally and recently, The Lewis Review (2003), Murtagh Review (2005) and McCleery Report (2006).

2.4 The Regulation and Quality Improvement Authority (RQIA) in Northern Ireland also recognises the importance of ensuring staff have access to effective supervision, and these are reflected in DHSSPS published Quality Standards for Health and Social Care (DHSSPS, March 2006) under 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.

2.5 The Quality Standards recommend that an effective system for clinical supervision across the HPSS can help organisations to meet each of the above Clinical and Social Care Governance standards, and specifically by:

- Having in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning (p11);
- Promoting a culture of learning to enable staff to enhance and maintain their knowledge and skills (p15);
- Ensuring 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 (p15).

(DHSSPS, Quality Standards, 2006)

2.6 In addition to the above policy recommendations and in recognition of the challenges faced by many organisations in their establishment of supervision systems this review is clearly justified. There is also an apparent lack of robust monitoring on the number of registrants undertaking supervision as well as limited evidence of evaluation of effectiveness of preparation for supervision, the experience itself and its impact on professional development and quality of practice.

2.7 In Northern Ireland, the DHSSPS undertook a survey and analysis of clinical supervision in mental health and learning disability nursing, before issuing best practice guidance (DHSSPS September 2004; DHSSPS November 2004). The current review has in part been commissioned to evaluate the impact of this guidance and review the range of supervision systems across general and specialist hospital and community nursing. A review of the literature on clinical supervision regionally, nationally and internationally would be a natural starting point for this work.

Review of relevant literature on Clinical Supervision

2.8 Despite having been prominent in health care for well over a decade, a review of the literature indicates that clinical supervision continues to not be clearly defined, is often misunderstood and is under evaluated from the perspective of both its processes and outcomes. Described by the U.K nursing pioneers of clinical supervision as,

> *'an exchange between practising professionals to enable the development of professional skills'*
>
> (Butterworth and Faugier, 1992)

2.9 Clinical supervision aims to provide a supportive service for nurses to help them reflect on their actions or possible inactions

in the provision of patient care. Despite this, a continuing lack of understanding combined with underlying mistrust by nurses can still result in obstacles for those attempting to provide supervision for nurses (Bush, 2005).

2.10 Two further, widely used definitions provide an indication for how clinical supervision has been understood and applied in a number of areas nationally. The Department of Health's definition explains how supervision,

> *'provides a support system for practitioners to ensure the provision of high-quality treatments and services through the evaluation of practice and by encouraging practitioners to learn from their experiences'*
>
> (DoH, 1999)

The RCN (1999) states that clinical supervision,

> *'involves the meeting of one or more nurses regularly to discuss aspects of work in order to think critically about practice, check procedure and deal with emotional issues arising from work'.*

2.11 Reviewing the existing literature on clinical supervision reveals that implementation is advanced in many parts of the U.K, however much more evidence is needed on the impact of the process in supporting practitioners during their work, promoting

learning and improving patient care through enhanced competence. Likewise, a range of other learning processes, closely aligned to the principles of clinical supervision are growing in popularity, for example, action learning, reflective learning groups, peer supervision, peer support, interprofessional supervision, professional-management supervision and critical companionship. Each of these activities hold similar values to clinical supervision and are utilised across a range of practice settings in Northern Ireland, however all require a stronger evidence base to understand and provide justification for the range of investments required to effectively establish their processes.

2.12 Gilmore (1999) conducted the largest evaluative review of clinical supervision to-date, commissioned by the UKCC in order to inform their continuing programme of work on clinical supervision. The majority of evaluations were found to be on the process of clinical supervision with evidence on the focus and quality of the clinical supervision provided. A number of issues were highlighted, including availability of clinical supervision, barriers to uptake, training of supervisors, record keeping, and confusion around the amalgamation of clinical supervision with managerial supervision. A range of studies have been published since this review within the UK, which have addressed the issues of effectiveness and clinical supervision (for example, Draper et al, 1999; Green 1999;

Jenkins, Rafferty and Parke, 2000; Cheater, 2001; Kelly et al 2001; Teasdale et al 2001).

2.13 Despite the above work, there is still a lack of knowledge on what makes clinical supervision effective. During the last three years however, a range of studies has begun to emerge that are providing clearer indication of the factors that impact upon the success of clinical supervision (for example, Freshwater et al 2003, Hyrkas et al 2003; Rafferty, Jenkins and Parke, 2003; Edwards et al 2005; Hyrkas et al, 2006). These factors for success relate to ensuring there is careful focus on the appropriate use of time, the environment for supervision, relationships, interventions to facilitate learning, organisational support, recording, evaluating effectiveness and competence (accountability).

2.14 In Northern Ireland, a range of evidence sources has provided an indication that over 80% of community psychiatric nurses were receiving regular supervision (Brooker and White, 1997); a high proportion of mental health nurses viewed clinical supervision as important, valuable, and highly beneficial (Kelly, Long and McKenna, 2001) and as outlined earlier, with reference to mental health nursing, Department guidelines have outlined a framework for guiding implementation of the process regionally (DHSSPS, 2004). There is however, very little evidence supporting the effectiveness of clinical supervision across the wider range of hospital and community nursing

services. In contrast to this, other models have emerged and are increasingly being reported in the literature, for example the benefits of reflective practice group sessions (McGrath and Higgins 2005), action learning as a means towards developing a nursing strategy (O'Halloran, Martin and Connolly 2005), the role of clinical education facilitators' in promoting work-based learning (McCormack and Slater 2006); group telephone supervision (O'Driscoll and Brown et al 2006) and critical companionship as a learning and development process aimed at supporting a culture of critical inquiry (Gribben and Cochrane 2006).

2.15 During 2005 NIPEC carried out a Workforce Development Survey of the registrant nursing and midwifery population of Northern Ireland as part of the design of the various components of the Development Framework project. A questionnaire was issued to the total registrant population (approximately 21,500) in February 2005 resulting in a 35% (n = 7,500) response rate. The survey provided valuable information in relation to registrant learning and development experience including formal and informal learning, appraisal activity, career development, personal development planning, supervision and participation in learning and development activities.

2.16 In relation to the above survey, when asked if they had undertaken 'supervision' sessions to support their role, 67% of

respondents said that they had no supervision (n=4754). Of those who did undertake supervision (33% of respondents to this question n=2273), 70 percent felt the experience was beneficial or very beneficial. There was strong evidence to suggest that those employed in midwifery (including hospital and community), mental health (including specialist roles in hospital and community) or organisation wide specialist posts are more likely (over 50%) to have supervision sessions to support their roles than those employed in other areas. Those employed within emergency nursing, intensive care and theatres, including specialist roles, surgical including surgical specialisms and specialist roles, or children's including specialist roles are the least likely (only around 20%) to have supervision sessions

Conclusion

2.17 From the relevant literature and survey information it is clear that there is limited evidence of widespread implementation of effective systems of clinical supervision or similar support and learning structures across nursing in Northern Ireland, thus the present review is timely and much needed. Firmer information is required on the number of practitioners undertaking clinical supervision (and similar models), the critical indicators of what organisations are calling clinical supervision, and evidence on the quality and impact of the supervision experience itself. In addition, evaluation is required on the training being undertaken

in preparation for supervision, policies and documentary reports guiding the process and enabling factors, as well as barriers to effective supervision.

SECTION 3 - PROJECT METHODOLOGY

3.1 In aiming to gain maximum insight to the range and impact of various clinical supervision models, it was agreed by the Review Group, that there would be two main aspects to the review approach, as follows:

1. The development of a structured interview schedule to be administered by NIPEC with Trust Nurse Directors (July 2006)
2. A stakeholder workshop to explore and analyse the impact of a range of supervision case studies from across the HPSS (August 2006)

3.2 The aim of this approach was to gather information on the extent and nature of supervision practice and to inform potential areas for further recommended action. It was agreed that the fieldwork process would focus on the level of supervision activity across the HPSS, what activities are currently going well, the barriers to effective supervision, what evidence there is of appropriate training, policy guidance, and the effectiveness of different models of supervision, and evidence for how supervision improves registrants' competence and practice.

3.3 The benefits of the above approach were agreed by the Review Groups as follows:

- A partnership approach would ensure that a clear service based focus informs the review process and promotes ownership of the review recommended action plan;
- Key informants will be directly involved in contributing to the review;
- Best practice exemplars will be identified and presented to inform enhancement of current supervision arrangements;
- Use of the Review Groups as a reference group to agree and validate the findings of the review and proposed action;
- The review objectives can be achieved in the tight timescale;
- The approach can provide focus that may continue beyond the life of the project.

SECTION 4 - INTERVIEW ANALYSIS

4.1 This section will provide a thematic overview of the main findings drawn from the interviews, with a particular focus on the barriers to establishing and sustaining supervision, as well as the enabling factors for effective supervision. Directors of Nursing were consulted regarding the review methodology and project plan, as well as the communication process to be followed throughout the review (see Appendix 3). Each of the eighteen HPSS Directors of Nursing agreed to be interviewed, either on a one-to-one or group basis. The majority preferred a group interview that included their senior team.

4.2 The full questioning framework followed in each interview is provided in Appendix 4. Each interview was undertaken by Bob Brown (Senior Professional Officer), recorded and transcribed verbatim by the interviewer. Having been transferred from the tape to a Microsoft Word document, the file was then sent to the relevant Director to validate the content of the transcript. A full question by question analysis summary is provided in Appendix 5.

Findings

Different models of supervision

4.3 Interviews with senior nurses suggest that HPSS Trusts recognise a wide range of learning, support and professional development activities, each of which were said to fall under a 'supervision' umbrella term. These include, formal clinical supervision (one to one and group); informal clinical supervision which might take place at the bedside, at a team meeting, or in the staff room; professional and managerial supervision; peer and clinical support supervision; action learning; mentorship, staff induction and development programmes; problem based learning; critical companionship; and through maintaining a reflective journal/diary:

> *'We use a multi-method approach to supervision, including one to one and group, action learning, mentorship and preceptorship, away days, 'live issues' model, ward managers steering group approach and strategic planning i.e. through a reflective strategy group'.*
>
> **(Trust C)**

> *'Our methods include one to one and group clinical supervision, action learning, critical companionship, reflective diaries and problem-based learning. In our*

experience a multi-method approach that recognises diversity of interest, works best'.

(Trust A)

Defining Clinical Supervision

4.4 When asked to define clinical supervision, from their organisational perspective, around half of Trusts were working with the traditional definition of clinical supervision (similar to those offered earlier in this report). Some Trusts follow no definition and have not been successful in establishing extensive supervision, while other Trusts have moved away from the term clinical supervision, and now favour terms such as 'critical inquiry framework' to recognise the breadth of activities that come under an organisational framework for learning, support and development.

'We define clinical supervision as a range of processes aimed at supporting practitioners to deliver safe and effective care for clients within a clinical governance framework. It is aimed at improving standards of care being delivered, while identifying weaknesses in practice, as well as risks that clients or staff are exposed to'.

(Trust J)

Organisational framework and policy

4.5 When asked about the level of robustness regarding supervision as part of a wider organisational framework for learning and development across the organisation, several Trusts were clearly able to articulate and evidence this, whereas the majority are working to address this. Around one third of Trusts however, appear to be somewhat behind in terms of an apparent lack of organisational impetus around supervision activity.

4.6 It is clear from the interview analysis that there is wide disparity regarding the development of policy for supervision activities. 60 percent of Trusts either have no operational policy for clinical supervision, or introduced one ‘years ago’ and this may or may not be functional. Some Trusts are currently revising their guidance on clinical supervision, while others are focusing their attention on a framework of supervision activities, embedded within a broader strategic directive set by the Director of Nursing.

> *‘We have a trust policy from seven years ago, which now has to be updated to reflect the range of supervision activities’.*
>
> **(Trust E)**

'We are currently developing our clinical supervision policy, as part of a learning and development framework that includes a focus on clinical support'.

(Trust M)

'All of these activities are underpinned by the Nursing and Midwifery Research and Development strategy'.

(Trust Q)

4.7 Evidently there is a need for regional direction to ensure there is both a corporate and operational understanding of clinical supervision as one of a range of possible supervision models offering support, learning, contributing to practice development and linked corporately to the organisational governance infrastructure.

Leadership

4.8 Skilled leadership is often considered to be an essential prerequisite for facilitating and driving clinical supervision successfully. This study would suggest, however, that in around 25 percent of Trusts, there is no designated leader for this work. In the remainder of Trusts, supervision activities are being led either singly by the Director of Nursing, through a specialist role such as a Practice Development Facilitator/Clinical Education Facilitator, or by a specific team, such as a Nursing and Midwifery Development Team.

Numbers undertaking supervision

4.9 Regarding the number of staff said to be undertaking one or more supervision activities, the majority of organisations have no accurate or complete method for monitoring this work, whereas in a small number of Trusts there is a process in place for collecting this important information on a routine basis. The need to strengthen this process is therefore apparent, and will increasingly be so as part of governance requirements.

Enthusiasm for clinical supervision

4.10 An open-ended question regarding levels of enthusiasm for clinical supervision was asked, and opinion varied from limited or mixed interest in a few areas to statements by the majority of Trusts that there has been a renewed and growing eagerness for this form of learning, support and development. It was of interest to note that in some organisations, the term ‘clinical supervision’ is no longer used, in preference for an awareness of a wider range of activities that have supervision intent. Terms such as ‘clinical support and learning’, a ‘framework for critical inquiry’ or ‘methods of reflective practice’ are now being used in some cases. The following quote is representative of the experience in the small number of Trusts who are successfully developing this work:

'My experience is that people welcome supervision activities. A model of consultation allows protected time for managerial and practice issues to be discussed in a learning environment. The name, whether it is supervision or consultation isn't important, it is the process that counts. In the areas where it is not currently successful, a supportive framework for these activities is emerging'.

(Trust F)

4.11 There is concern in some areas that clinical supervision is being seen as of less importance due to an increased emphasis being placed on appraisal and the NHS Knowledge and Skills Framework. It may therefore be that greater recognition and awareness is required for how supervision activities can help a practitioner to demonstrate their learning and development individually as complementary to and integrated with appraisal and continuous professional development processes, thus promoting learning and development, as well as quality and safety of care.

'Roles are changing, services are modernising and staff are responding to the challenge and recognising that clinical supervision is a means of helping them to do this effectively'.

(Trust L)

Time for clinical supervision

4.12 The issue of 'protected time' is often perceived as a barrier to establishing clinical supervision effectively. In some areas (30-40 percent of Trusts), lack of time is seen as the main reason for not implementing widespread supervision, and it is suggested that a greater recognition of this requirement at a policy and commissioning level is needed to assist Trusts to move forward. It is interesting to note however, that a growing number of Trusts are 'getting on' with this type of learning activity without additional resource attainment because their focus is on enabling all staff to recognise the value of supervision as embedded in and essential to their everyday practice:

> *'Protected time isn't an issue, people want to do this and we have enabled a framework to be in place to help them to do so – it is integrated in everyday practice'.*
>
> **(Trust G)**

4.13 There are a number of models of supervision across the HPSS that do offer regular and protected time, such as in relation to staff nurse induction and development programmes, specialist roles such as in child protection, and in some areas of mental health. It would seem however, that widespread awareness is required at all levels of nursing to change the way many senior nurses manage the issue of 'time' for supervision activity. To

focus on the issue of 'protected' time is increasingly seen to be inappropriate, and instead attention is being given, at least in the areas where supervision appears more successful, to facilitate a greater awareness of this as an essential activity and to enable staff to use their time more effectively.

> *'Rather than focusing on the barrier of protected time, we are drawn towards developing new and creative ways of learning that become accepted and embedded in practice'.*
>
> **(Trust C)**

Evaluation of clinical supervision

4.14 Evaluation of clinical supervision models has been a topic of much consideration in the literature, however much of the focus has been on evaluating the process of the supervision experience, rather than on the outcomes of this in relation to improving practice. Another area receiving insufficient attention to-date has been the lack of evaluation on the connection between preparation for supervision and an effective supervision experience, as well as little attention being given to competency monitoring that would help to ensure that supervisors and supervisees maintain up-to-date skills in this area. When Directors were asked whether or not clinical supervision had been evaluated in their Trust 50 percent had no or very limited evidence of evaluation to offer. A few Trusts

have audited models of supervision and process evaluated other activities such as action learning, problem-based learning and critical companionship, however it was openly acknowledged that in most cases an evaluation strategy for supervision activities is only beginning to be established. One Trust has undertaken a lot of work in this area and created an evaluation framework to monitor the range of supervision activities they offer. This approach has been in place for several years and would provide a useful approach for other Trusts to utilise, as it is clear a lot of regional direction is required in this important area.

> *'Our action learning sets are being process evaluated, however as a result of this review we hope there will be recognition and guidance on developing a framework for evaluating the impact of action learning and other models of supervision'.*
>
> **(Trust A)**

Training for clinical supervision

4.15 Preparation for undertaking clinical supervision has tended to be through a programme delivered by the in-service education providers, with around 60 percent of Trusts utilising these short programmes to train supervisees and supervisors. There appears to be recognition, however, that these programmes alone do not adequately prepare registrants for undertaking

clinical supervision, and it has become apparent that more creative and integrated approaches to preparation for supervision are required than those currently available regionally:

> *'We use the in-service approach and as far as I understand it, training has been positive, but overall there are serious gaps about training and the promotion of clinical supervision among the services'.*
>
> **(Trust O)**

> *'The in-service training approach is somewhat narrow and hasn't moved on from many years ago. It needs to focus more on developing reflective practice, supporting and enabling people as they embark on supervision and for a period of time after this as they develop their skills'.*
>
> **(Trust D)**

4.16 Around 40 percent of Trusts are recognising the importance of providing practitioners with a range of training opportunities and in line with the growing number of supervision models on offer. Both universities offer post-graduate facilitation in learning modules, the RCN Practice Development School has been introducing the concepts relevant to practice development, including facilitation, for a number of years. Some Trusts are providing in-house supervision and facilitation training and ensuring this is part of leadership development programmes.

Analysis of the Trust interviews reflects the fact that training for supervision should not be time-limited to the preparation stage, thus opportunities for training in practice and for developing the wide-ranging skills of various supervision activities over time are recognised and should be encouraged. An increase in opportunities for accredited training, linked to individual portfolio development and which monitor competence for undertaking supervision throughout a registrants career could provide the kind of innovation required. This would offer the range of opportunities a number of senior nurses have been advocating regarding ways of ensuring supervision activities become embedded in practice, as a means of contributing reflective evidence that would then be used by a practitioner as part of their ongoing appraisal.

Recording supervision sessions

4.17 When interviewees were asked what records were kept to evidence the range of supervision taking place, e.g. proformas, and action plans etc, the majority of Trusts either had no record or were depending on the use of a record that was part of a supervision policy introduced some time ago. In around 40 percent of Trusts however, there is a record in place for one or more activities, and this may be used for evaluation or monitoring purposes. While there it limited evidence regionally to show how supervision records display an audit trail from the

supervision experience to a generated improvement in practice, this is the intended outcome for most Trusts.

> *'There is a gap between the final supervision action plan and the communication of this to managers, and lack of a mechanism to deal with ways of working in a focused way on action plans'.*
>
> **(Trust N)**

> *'We would welcome guidance on the formality and content of records for supervision activities'.*
>
> **(Trust I)**

Barriers to establishing clinical supervision

4.18 Trusts were then asked to indicate the 'barriers' they had experienced when implementing clinical supervision. Many barriers were offered and have been thematically analysed into the following areas:

1. Negativity, cynicism, lacking acceptance and lacking commitment to the concept of supervision.

2. Confusion and misunderstandings around what clinical supervision is about.

3. No one leading or championing the process.

4. No organisational framework, strategic direction or strong value base for supervision activities.

5. The sheer number of nurses across an organisation who would be required to avail of these opportunities.

6. Lack of a resource infrastructure to enable staff to engage in supervision i.e. funding to protect time for work-based learning, and the demands of service that make it difficult to find time for supervision activities.

Barriers to sustaining clinical supervision

4.19 A wide range of barriers to 'sustaining' clinical supervision were also offered in response to a separate question asking interviewees to outline the factors that prevent them from mainstreaming this activity throughout their organisation. These have been thematically analysed as follows:

1. Lack of a big enough pool of experienced and well trained supervisors/facilitators.

2. Increasingly integrated and cross-boundary working and the potential impact of organisational re-structuring may affect sustainability of these activities.

3. Increasing expectations on experienced nurses to mentor, teach, assess and supervise practitioners at a range of levels.

4. Failure to evaluate supervision activities through not creating a strong monitoring framework, and therefore not fulfilling the need to prove through evaluation that there are benefits to these activities.

5. Failing to recognise the importance of placing the wide range of learning and development activities under a single and well resourced organisational framework.

6. Lack of apparent value being placed on supervision activities at a commissioning level, and the need for appropriate funding streams if all forms of experiential learning are to work alongside formal classroom learning.

7. Lack of continual and ongoing leadership, drive and commitment.

Enabling factors for effective supervision

4.20 The final question invited Trust Directors and senior nurses to reflect on the factors that enable supervision activities to work effectively and become sustainable. This question was particularly directed to those Trusts that are experiencing success in one or more activities. A wide range of enabling

factors for effective clinical supervision was offered, and these have also been thematically analysed as follows:

1. Organisational commitment and gifted leadership.

2. Developed from the bottom up and driven from the top down.

3. Having a clear vision that becomes a strategic plan and supervision framework.

4. A strong professional value base that recognises the usefulness of these activities.

5. A critical mass of people who have the skills in this way of working and facilitation.

6. Integrated processes, flexibility of approach and working across professional groups.

7. Specific strands of project work and a range of developing tools and processes to underpin critical inquiry.

8. Modernising learning and building up the importance of experiential learning and the time for these activities.

9. Reciprocity in that all involved understand and share the benefits of supervision.

10. Robust evaluation of the processes and outcomes of supervision activities.

Conclusion

4.21 The findings of the eighteen interviews with senior nurses from each Trust have provided a comprehensive and detailed analysis of supervision experience, as it currently stands, across the HPSS. This evidence was then scrutinised by the Review Group, and combined with the workshop case-study analysis that follows, to develop a set of Guiding Principles and an Action plan, to be submitted to the DHSSPS for consideration.

SECTION 5 - CASE STUDY ANALYSIS

5.1 A workshop was held on 21st August 2006, to enable service colleagues to engage with the Review Group to share their supervision activities and reach consensus on the factors that enable effective supervision processes. The aim of the workshop was to appreciate the best of what is currently available across the HPSS on the subject of clinical supervision (and related models of reflective practice that include support, challenge and learning). The methodology guiding the workshop was one of an Appreciative Inquiry (Bushe, 1995), which is about appreciating what is good in relation to something and exploring this further.

> *"Appreciative inquiry, as a method of changing social systems, is an attempt to generate a collective image of a new and better future by exploring the best of what is and has been".*
>
> (Bushe, 1995 p. 14)

5.2 Appreciative Inquiry has its roots as a methodology in action research and organisational development and is increasingly used to understand change processes in relation to the complexity of organisational systems, through encouraging stakeholder engagement, in a way that brings people together to develop practice in a specific area of concern. It is a collaborative approach that focuses on facilitating organisational learning. The method followed at the workshop

involved understanding the strengths of each model, developing consensus regarding what is required to enable each supervision activity to be successful, and to produce ‘statements of intent’ that could be used to inform future regional work in this area.

5.3 The criteria developed by NIPEC to be used by Directors when considering offering a model of supervision for the workshop is contained in Appendix 6, as well as an overview of the workshop programme (Appendix 3). Twenty-five submissions were received from across Northern Ireland, with most Trusts offering at least one model for consideration. These were assessed against the set criteria by a group of Review Group evaluators, and twenty-one models of supervision were then invited to the workshop. At the workshop four broad models of supervision activity were represented – one-to-one clinical supervision, staff nurse induction and development programmes, health visiting and child protection models and action learning (further information is contained in Appendix 3 and examples of each of the above models are contained in Appendix 7). The format of the workshop followed three cyclical stages. In stage one each of the groups discussed the following questions and fed back the work they had completed on flip charts:

1. What works about this example of a model of clinical supervision? i.e. what is effective

2. For whom does it work? i.e. individuals, team, organisation
3. Why does it work?
4. In what circumstances? i.e. we were looking at context here, such as the enabling factors and barriers to implementation etc.

5.4 As the group fed back their discussion on the above questions, an observer from each of the five groups noted key themes from the feedback session. The group of observers met over lunch to thematically analyse their notes and reached consensus on the key themes that had emerged from the 1st analysis cycle (see Appendix 3). The five groups then reconvened to discuss the thirteen factors and produce a series of 'provocative propositions' (statements of intent). Provocative propositions (Hammond, 1998) are challenging statements of goals developed in the Appreciative Inquiry process e.g. 'Everyone in the organisation will understand everyone else's role regarding clinical supervision'.

5.5 Once each group had reached consensus on their statements, the whole group met again to share feedback by reading out their statements. Following discussion it was agreed that the group of observers would negotiate a consensus on which statements would be taken forward, as a means of informing the next stage of the review. These were agreed as follows:

- There will be a shared commitment to supervision in each organisation.
- There will be an organisational framework that identifies structures and processes for supervision.
- Every member of staff will engage in supervision activities that demonstrate learning on and in practice.
- Organisations will develop a critical mass of skilled facilitators to enable the operationalisation of supervision activities.
- Individual champions of supervision activities will be recognised, nurtured and enabled to take this forward.
- There will be appropriate organisational wide preparation for engaging in supervision.
- Organisations should focus on the development and valuing of workplace learning cultures that aim to facilitate and develop person-centred care.
- At all levels within the organisation there must be strong leadership and commitment for supervision, with clear lines of responsibility and accountability.
- Development of robust monitoring and evaluation frameworks to identify the benefits of supervision for those involved and on the quality and safety of care will be a priority.

- Organisations and individuals will recognise the value of all types of learning and development, recognising that different situations require different types of learning (i.e. a blended approach).

5.6 The above statements were then considered by the Review Group in September 2006, and after comparing these with the analysis of the interviews, a set of Guiding Principles and Recommended Actions were developed and reported on, at a consultative workshop with senior nurses in October 2006.

SECTION 6 - CONSULTATION WORKSHOP ANALYSIS

6.1 A workshop was facilitated by NIPEC on 27th October 2006 to present to service colleagues the interview and case-study analysis, and through a group work approach to discuss the draft guiding principles and recommended actions that the Review Group had produced as a result of this work. The workshop was attended by forty-eight people and the majority of Trusts were represented at Director of Nursing, senior nurse, education facilitator or practice development level.

6.2 Following a presentation of the interviews and case-study workshop analysis by Bob Brown on behalf of the Review Group, participants attending focused on the following questions in their groups:

1. Do the guiding principles and recommended actions seem reasonable?
2. Having considered the guiding principles and recommended actions, does there appear to be any missing?
3. How easy would it be to implement the recommended actions?

Feedback from Groupwork

In response to the above questions, an intensive and wide-ranging discussion was undertaken by those attending the workshop and is summarised as follows:

6.3 It was considered important to share agreement on the difference between a guiding principle and a recommended action. A ‘Guiding Principle’ is a shared belief about something that should be achieved, whereas a ‘Recommended Action’ is the act(s) that must take place to ensure the guiding principle is achieved.

6.4 There was widespread agreement that we should be using the term ‘Supervision’ rather than Clinical Supervision, to reflect the range of activities and responsibilities and thus highlight that Supervision can have professional, managerial or clinical intent and be undertaken using a wide range of approaches.

6.5 It was suggested that the Guiding Principles should be fewer in number (eight had initially been offered), and not overly prescriptive. Thus the onus is on organisations to find the ‘best fit’ for this range of activities in their locality, through interpreting the guidance and actions in a meaningful and productive way. It was agreed that the recommended actions should have clear focus by stating what is required and be targeted at specific groups.

6.6 Emphasis is clearly placed on creating an organisational infrastructure for supervision activity, as part of a growing learning and development culture in each area, and facilitated by champions of supervision who display strong leadership qualities in this area, and through doing so, help registrant nurses to value this experience much more. Clearly, individual registrants have a personal responsibility to seek out opportunity for supervision, particularly when a strong infrastructure is in place.

6.7 There was concern about the practicalities of a recommended action that suggests supervision must be mandatory and that ‘every nurse has the equivalent of 1-2 hours of supervision experience at least quarterly’. It was generally agreed that the focus should be on ensuring that a modernised approach to supervision activity is part of each organisations infrastructure, embedded in practice through strong leadership and facilitation and valued over time as essential by every registrant nurse. Employers and registrants have a shared responsibility to ensure effective supervision is available for all. Opportunities to fully integrate supervision with appraisal as an ongoing learning process and through individual career planning should help to emphasise and develop this ethos.

6.8 Monitoring of supervision activity across each organisation and implementation of a robust and systematic evaluation process

is seen as crucial, and must be linked to internal governance mechanisms and accountability review. It was agreed that emphasis must be placed on ensuring that supervision activities are evaluated in a range of ways, including the impact of training, on competence, quality of the supervision experience and the resulting impact on individual development, performance and ultimately quality and safety of care.

6.9 There was widespread agreement that to receive the attention it requires regionally, supervision needs to be accepted and embedded in the DHSSPS and HSSA/Trust performance management framework as a Priority for Action target.

SECTION 7 - RECOMMENDATIONS AND CONCLUSIONS

Context

7.1 This section provides recommendations for future supervision activity, by offering a series of Guiding Principles and an Action Plan to assist the establishment of effective models of supervision across nursing in the HPSS. As a result of the work of the Review Group, through carrying out interviews with senior nurses in every Trust, facilitating a case-study workshop of 'best-practice models' of supervision, and a consultation workshop with key stakeholders to create the action plan for approval, a modernised definition for supervision will also be offered.

7.2 As noted in the previous section, the Review Group understand a 'Guiding Principle' to be a shared belief about something that should be achieved, whereas an 'Action' is the act(s) that must take place to ensure the guiding principle is achieved.

7.3 In recent years there has been increasing recognition of the role of supervision in health settings throughout the UK. Supervision, when effective, remains a pivotal activity in delivering safe and efficient services, is central to workforce development across professional disciplines, and to the retention of skilled staff. In response to the Victoria Climbie Inquiry Report, for example, the Commission for Health Improvement included supervision and support as one of the

eleven core self-assessment areas for clinical teams. Similar requirements exist within the National Service Framework for Children, Young People and Maternity Service (Department of Health 2004), which states:

> *'High quality supervision is the cornerstone of effective safeguarding of Children and Young People and should be seen to operate effectively at all levels within the organisation'*
>
> (NSF, p. 170)

7.4 In Northern Ireland, the report of the McCleery Inquiry (EHSSB, May 2006) highlighted concerns about the operational structure of the Trust concerned, in terms of clinical governance, line management and professional accountability. The report cited clinical supervision as an area where they considered confusion or ambiguity to have been in evidence. The inquiry panel recommended that all policies and procedures should provide for a robust system of monitoring and evaluation and demonstrate how this will relate to clinical governance arrangements. This included clear identification of responsibility for putting in place a written policy to introduce and maintain clinical supervision for nursing staff.

7.5 Other contextual drivers for more effective supervision include the increasing move towards integrated service delivery which sees closer working between, for example, nursing and social

care professionals when undertaking assessments for earlier discharge, and community care assessment that impacts on continuing care policy, in relation to, for example, free nursing care. Supervision is crucial in supporting and quality assuring such assessments, and when undertaken effectively, can enable staff to manage changes, negotiate extended roles and work with confidence in integrated settings.

7.6 Other drivers for supervision include a growing spotlight across disciplines on supervision, focus on workforce development, employer liability for duty of care to staff under stress and increased expectations from newly trained staff for good supervision. It has also become clear as a result of this review that while effective resource management is important as a means of ensuring staff have an opportunity for regular and effective supervision, the most important implementation factor relates to the need to change staff mindsets around the importance of supervision as integral to their day-to-day work and complementary to their ongoing personal and professional development. Supervision should therefore be something that every nurse requests and can access through a clearly defined organisational infrastructure for learning and development that offers a range of supervision models and contributes to individual appraisal. Finally, for supervision to be effective, it must be located within an overall performance management framework, and linked to competency and clinical governance systems.

Introduction to Guiding Principles and Action Plan

7.7 As a result of the extensive fieldwork, case study analysis and consultative feedback, the Review Group has agreed a modernised definition, set of Guiding Principles and an Action Plan in order to achieve effective Supervision systems across the HPSS.

7.8 The following modernised definition for Supervision (adapted from the NHS Management Executive definition, 1995) is offered by the Review Group, and should be used to underpin the implementation of future supervision activities across the HPSS:

> *'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice, and enhance service-user protection, quality and safety of care'.*

7.9 The following Guiding Principles and Action plan are presented, as a means of influencing effective supervision systems of the kind discussed above. They highlight four areas of responsibility and accountability – at a regional level,

organisational infrastructure level, Executive Director of Nursing and individual nurse level.

SUPERVISION GUIDING PRINCIPLES

1. A Regional Standard for Supervision should reflect a modernised definition, recognise diversity of approach and include key infrastructure components outlining documentation, monitoring and evaluation requirements.

2. Organisations should implement effective arrangements to meet Supervision, based on the Regional Standard in place, as part of their governance systems.

3. The Executive Director of Nursing should provide the professional leadership for Supervision within the organisation.

4. All registered nurses should recognise their responsibility and professional accountability for undertaking Supervision, as integral to their day-to-day practice.

SUPERVISION ACTION PLAN

(i)	A Regional Standard on Supervision will be developed to include a modernised definition and refer to a range of current and innovative approaches.	**Timescale April 2007 - Responsibility DHSSPS**
(ii)	A framework based on the Regional Standard for Supervision will be developed and implemented in every organisation and embedded with governance systems	**Timescale March 2008 - Responsibility Executive Director of Nursing**
(iii)	Responsibility for Supervision will be invested in the Executive Director of Nursing, who will report to Trust Board annually on Supervision monitoring and evaluation activity.	**Timescale March 2009 - Responsibility Trust Chief Executive**
(iv)	Supervision activity should complement appraisal and performance review processes for all registrant nurses.	**Timescale March 2008 - Responsibility Executive Director of Nursing**

(v) Service and education providers will review the quality of training and ongoing development for Supervision activity, based on the Regional Standard, and will modernise this accordingly.	**Timescale March 2008 - Responsibility DHSSPS**
(vi) Organisations must address capacity building to implement the Regional Supervision Standard.	**Timescale March 2008 - Responsibility DHSSPS, Trusts and Education Providers**
(vii) Documentation for Supervision activities must be developed and implemented for recording and evaluation purposes.	**Timescale October 2007 - Responsibility DHSSPS**
(viii) Robust monitoring and evaluation strategies must be developed and agreed, to demonstrate effectiveness of the Regional Supervision Standard and its impact on quality of care.	**Timescale October 2009 - Responsibility Executive Director of Nursing**

Summary conclusions from the Review Group

7.10 This review has provided a robust and systematic evaluation of a range of supervision models across nursing in the HPSS in 2006. A wide range of barriers to and enabling factors for effective supervision has been identified, as well as a concise and targeted action plan for future development work in this area. This report builds on the work undertaken by the DHSSPS in 2004 when offering recommendations for 'clinical supervision' in mental health and learning disability nursing.

7.11 The Review Group have offered a set of Guiding Principles and an Action Plan that we believe offers clear guidance for those planning a 'Supervision framework' in the re-structured HPSS. It is crucial to see supervision as integral to and embedded within an organisational learning culture that recognises the complementary nature of supervision, alongside learning and development, performance management and through influencing a care system governed by patient safety and continually improving practice.

7.12 It is clearly recognised that the term 'Supervision' within the professional context, in differing from the supervision of work activity, includes a wide range of activities and approaches that have a 'supervision' impact, such as action learning, individual and team supervision, reflective learning groups, critical

companionship, professional, managerial and peer supervision. Rather than being restrictive to the use of specific models, those planning supervision are challenged to recognise the diversity of approach required, so that individual nurses not only have a choice, but can identify with a strong and supportive organisational infrastructure that advocates a shared responsibility for this work, and builds confidence in individual processes. This also requires organisations to establish a robust system for monitoring supervision activity and evaluating its effectiveness in terms of patient safety and continuous improvement to nursing care across a range of levels.

References

Barrowman L (2000) Clinical supervision: the future imperatives. The National Board for Nursing, Midwifery and Health Visiting for Northern Ireland (NBNI), Belfast

Brooker C and White E (1997) The Fourth Quinquennial National Community Mental Health Nursing Census of England and Wales. The Universities of Manchester and Keele

Bush T (2005) Overcoming the barriers to effective clinical supervision. Nursing Times, 101, 2, 38-41

Bushe G (1995) Advances in Appreciative Inquiry as an organisation development intervention. Organisation Development Journal, 13, 1, 14-18

Butterworth T and Faugier J (1992) Clinical supervision and mentorship in nursing. London, Chapman and Hall

Cheater F (2001) An evaluation of a local clinical supervision scheme for practice nurses. Journal of Clinical Nursing, 10, 1, 119-130

Department of Health (1993) A Vision for the Future: Report of the Chief Nursing Officer. London, HMSO

Department of Health (1994) The Clothier Report: Independent inquiry relating to the deaths on the children's ward at Grantham and Kesteven General Hospital, London, HMSO

Department of Health (1999) Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare. London, HMSO

Department of Health (2004) A National Service Framework for Children, Young People and Maternity Services in England. London, HMSO

Department of Health, Social Services and Public Safety (2004) Clinical supervision for Mental Health Nurses in Northern Ireland: Best Practice Guidelines. Belfast, DHSSPS

Department of Health, Social Services and Public Safety (2005) Clinical supervision for Learning Disability Nurses in Northern Ireland: Best Practice Guidelines. Belfast, DHSSPS

Department of Health, Social Services and Public Safety (2006) The Quality Standards for Health and Social Care. Belfast, DHSSPS

Draper B, Koukos C, Fletcher P, Whitehead A, Reynolds F, Coleman M, Rafferty M (1999) Evaluating an initiative: Clinical supervision in a community health trust. British Journal of Community Nursing, 4, 525-530

Edwards D, Cooper L, Burnard P, Hannigan B, Adams J, Fothergill A, Coyle D (2005) Factors influencing the effectiveness of clinical supervision. Journal of Psychiatric and Mental Health Nursing. 12, 405-414

Freshwater D, Storey L, Walsh L (2003) Establishing clinical supervision in prison healthcare settings. Foundation of Nursing Studies Dissemination Series 1, 1-4

Gilmore A (1999) Review of the United Kingdom Evaluative Literature on Clinical Supervision in Nursing and Health Visiting. London, UKCC

Green A (1999) A utilisation focused evaluation of a clinical supervision programme for nurses and health visitors in one national health service trust. Journal of Vocational Education and Training. 51, 493-504

Gribben B and Cochrane C (2006) Critical companionship: our learning journey. Practice Development in Health Care, 5, 1, 14-19

Hammond S (1998) The Thin Book of Appreciative Inquiry (2nd Edn.) New York, Thin Book Publishing Co.

Hyrkas K, Appelqvist-Schmidlechner K, Haataja R (2006) Efficacy of clinical supervision: influence on job satisfaction, burn out and quality of care. Journal of Advanced Nursing, 55, 4, 521-535

Hyrkas K (2003) Translating and validating the Finnish version of the Manchester Clinical Supervision Scale. Scandinavian Journal of Caring Sciences 17, 358-364

Jenkins E, Rafferty M, Parke S (2000) Clinical supervision: What's going on in West Wales? Nursing Times Research, 5, 5, 21-36

Kelly B, Long A, McKenna H (2001) A survey of community mental health nurses' perceptions of clinical supervision in Northern Ireland. Journal of Psychiatric and Mental Health Nursing. 8, 33-44

Laming H (2003) The Victoria Climbie Inquiry. Report of an Inquiry by Lord Laming, London, Norwich

Lewis RJ, Cole D, Williamson A (2003) Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

Kolb D (1984) The experiential learning cycle. New York, Addison-Wesley

McCleery Inquiry Panel (2006) Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board

McCormack B and Slater P (2006) An evaluation of the role of the clinical education facilitator. Journal of Clinical Nursing 15, 135-144

McGrath D and Higgins A (2006) Implementing and evaluating reflective practice group sessions. Nurse Education in Practice. 6, 175-181

National Health Service Executive (1995) Clinical Supervision: a resource pack, London, Department of Health

Northern Ireland Practice and Education Council for Nursing, Midwifery and Health Visiting (2005) NIPEC Corporate Strategy (2005-2008), NIPEC

Nursing and Midwifery Council (2006) Guiding Principles for Clinical Supervision, London, NMC

O'Driscoll J, Brown R, Buckley A, Morgan C, McGuire B, Murphy C, Middleton H, Uglow J, Allinson M, Silcock S (2006) Exploring the use of telephone group clinical supervision to support the work of practice development nurses in the Developing Practice Network. In Shaw T and Sanders K (Eds.) Foundation of Nursing Studies Dissemination Series, 3, 6

O'Halloran, Martin G, Connolly D (2005) A model for developing, implementing and evaluating a strategy to improve nursing and midwifery care. Practice Development in Health Care 4, 4, 180-191

Rafferty M, Jenkins E, Parke S (2003) Developing a provisional standard for clinical supervision in nursing and health visiting: the methodological trail. Qualitative Health Research. 13, 10, 1432-1452

Regional Quality Improvement Authority (2005) Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

Royal College of Nursing (1999) Realising Clinical Effectiveness and Clinical Governance through Clinical Supervision. Royal College of Nursing Institute Open Learning Pack, Abingdon, Radcliffe Medical Press

Teasdale K, Brocklehurst N, Thorn N (2001) Clinical supervision and support for nurses: an evaluation study. Journal of Advanced Nursing 33, 216-224

United Kingdom Central Council for Nursing and Midwifery (UKCC) (1996) Position statement on Clinical Supervision for Nursing and Health Visiting. United Kingdom Central Council for Nursing. Midwifery and Health Visiting, London

APPENDICES

Appendix 1: NMC Guiding Principles for Clinical Supervision (March 2006)

The NMC supports the principle of clinical supervision but believes that it is best developed at a local level in accordance with local needs. The following set of principles has been defined, which the NMC believes should underpin any system of clinical supervision that is used:

- Clinical supervision supports practice, enabling registrants to maintain and improve standards of care
- Clinical supervision is a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor
- Registrants and managers should develop the process of clinical supervision according to local circumstances. Ground rules should be agreed so that the supervisor and the registrant approach clinical supervision openly, confidently and are aware of what is involved
- Every registrant should have access to clinical supervision and each supervisor should supervise a realistic number of practitioners
- Preparation for supervisors should be flexible and sensitive to local circumstances. The principles and relevance of clinical supervision should be included in pre-registration and post-registration education programmes
- Evaluation of clinical supervision is needed to assess how it influences care and practice standards. Evaluation systems should be determined locally.

The NMC supports the establishment of clinical supervision as an important part of clinical governance and in the interests of maintaining and improving standards of patient/client care.

Appendix 2: Review Group Membership

Name	Position
Hazel Baird	Executive Director of Nursing, Homefirst HSST Project Chair
Phelim Quinn	Director of Nursing, Regional Quality Improvement Authority
Pat Patten	Council Lay Member, NIPEC
Phil Mahon	Director of Healthcare, Foyle Trust
Mary Burke	Senior Manager/Education Facilitator, Craigavon Area Hospital Group Trust
Brendan Mullen	Director of Mental Health and Learning Disability, Ulster & Community Hospitals Trust
Paula Forrest	Practice Development Facilitator, Royal Belfast Hospital for Sick Children
Maurice Devine	Nurse Consultant, Learning Disability, Down and Lisburn Trust
Kathy Fodey	Nursing Officer, DHSSPS
Sharon Barr	Community Nursing Manager, North and West Belfast Community Trust
Tracey Lupari	Child Protection Nurse Specialist, Homefirst HSST
Geraldine Connolly	Primary Care Facilitator, SHSSB
Anne Canning	Education Manager, Educare
Avril Redmond	Clinical Education Facilitator, Belfast City Hospital
Wendy Megarrell	Training & Operations Support Manager, Fourseasons Health Care
Janice Smyth	Deputy Director, RCN
Paddie Blaney	Chief Executive, NIPEC
Bob Brown	Senior Professional Officer, NIPEC
Lesley Barrowman	Senior Professional Officer, NIPEC

Appendix 3: Review methodology, project time-table and communication process

The methodology guiding the review process was informed by Appreciative Inquiry (Bushe, 1995). Three main fieldwork components were undertaken.

Stage One: The first stage involved undertaking structured one-to-one or focus group interviews with senior nurses to explore the experience of supervision across the HPSS, and through a focus on the following:

- What level of activity is in place?
- What is currently going well?
- What are the barriers to effective clinical supervision?
- What would help to ensure clinical supervision goes well every time?
- What evidence is there of training, policy guidance, and the effectiveness of different models of supervision?
- What evidence is there that clinical supervision improves nurses' competence and practice?

Stage Two: The second stage involved facilitating a case-study workshop to consider the effectiveness of a range of supervision models. The aims of the workshop were to appreciate the best of what is currently available in N.I on the subject of supervision (and related models of reflective practice that include support, challenge and learning)

The method used at the workshop involved:

1. A grounded observation of the 'best of what is'
2. Collaboratively articulating through exercises in vision and logic, 'what might be'
3. Developing consensus and obtaining consent of those in the system to 'what should be'
4. Collectively experimenting with 'what can be' (Bushe 1995, p. 15)

The following people attended the workshop and took part in group work according to the following areas of interest:

Area 1 – One to One models of Supervision

Sharon Dunn and Shirley Forsythe – Role Supervision – Royal Victoria Hospital
Bernadette Gribben – Critical companionship – Royal Group of Hospitals Trust
Mary Charlton and Mary McShane – Specialist Practice Clinical Supervision – Belfast City Hospital Trust
Damien Brannigan – Mental Health Supervision – Ulster and Community Hospitals Trust

Area 2 – Staff Nurse Induction and development programmes

Judy Houlahan and Margaret Murphy – Clinical supervision development programme – Foyle Community Trust
Suzanne O'Boyle – Staff Nurse Induction and development programme – Mater Hospitals Trust
Mary Burke – Rotational programme – Craigavon Area Hospital Group Trust
Anne-Marie Tunney and Jean Lennox – Staff Nurse Development programme – Causeway Hospitals Trust

Area 3 – Health Visiting and Child Protection models

Roisin Toner and Julie McConville – Craigavon & Banbridge Community Trust
Denise Kerr – Homefirst Trust
Angela Boyle and Frances Donovan – Down and Lisburn Trust
Caroline Goldthorpe and Debbie McCormack – Armagh and Dungannon Trust

Area 4 – Action Learning

Margaret Devlin – Cardiology Set – Royal Victoria Hospital

Carol McCorry – Ward Managers Set – Craigavon Area Hospital Group Trust
Annetta Quigley – Action learning in Coronary Care – Sperrin and Lakeland Trust
Rita Devlin – Problem-based Learning model – Ulster and Community Hospitals Trust
Vicky Toner and Teresa McCann – PD Action Learning Sets – Newry and Mourne Trust
Carolyn Kerr and Geraldine McKay – Action Learning Sets – United Hospitals Trust

The workshop was facilitated by the following people:

Bob Brown, Senior Professional Officer, NIPEC
Lesley Barrowman, Senior Professional Officer, NIPEC
Kathy Fodey, Nursing Officer, DHSSPS
Brenda Creaney, Directorate Manager - RBHSC
Wendy Megarrel, Training & Operations Support Manager, Fourseasons Healthcare

The process engaged in was as follows:

Cycle 1: Each of the groups discussed the following questions and fed back the work they had completed on flips charts

- What works about this example of a model of clinical supervision? i.e. what is effective

- For whom does it work? i.e. individuals, team, organisation

- Why does it work?

- In what circumstances? i.e. we were looking at context here, such as the enabling factors and barriers to implementation etc.

Cycle 2: As the group fed back their discussion on the above questions, an observer from each of the five groups noted key themes from the feedback session. The group of observers met over

lunch to thematically analyse their notes and reached consensus on the key themes that had emerged from the 1st analysis cycle.

Cycle 3: The five groups then reconvened to discuss the themes and produce a series of 'provocative propositions' (statements of intent).

N.B Provocative propositions (Hammond, 1998) are challenging statements of goals developed in the Appreciative Inquiry process e.g. 'Everyone in the system will understand everyone else's role regarding clinical supervision'.

Once each group had reached consensus on their statements, the whole group met again to share feedback by reading out their statements. The observers then negotiated a consensus on which statements should be taken forward and these were then analysed by the Review Group and along with the interview analysis was used to inform the first draft of Guiding Principles and Recommended Actions.

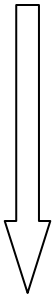
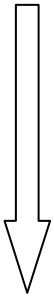
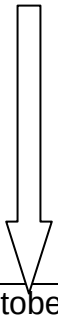
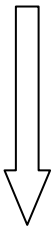
Stage Three: This final stage involved facilitating a consultative workshop with senior nurses from across the HPSS, to enable a critical discussion to take place on the draft guiding principles and recommended actions that had emerged from the analysis of Phases One and Two. The following questions were addressed:

1. Do the guiding principles and recommended actions seem reasonable?

2. Having considered the guiding principles and recommended actions, does there appear to be any missing?

3. How easy would it be to implement the recommended actions?

Clinical Supervision Review Group Work Plan

23 June 2006 	1st meeting of the Review Group Actions – Agree review methods and discuss fieldwork interview schedule/questioning content  Continue e-mail correspondence with Review Group to agree interview questions and criteria for Case Studies  Undertake fieldwork (Bob Brown)
25 July 2006 	Present fieldwork analysis to-date and discuss Plan case study workshop (Selected participants – date to be agreed – August 06) Plan format for analysis workshop (Review Group – workshop likely to take place in September/October 06)
25 August 2006 	• Present all interview analysis • Undertake case study workshop analysis • Agree all review findings • Plan consultative workshop format - all key stakeholders will meet to validate analysis and draft action plans
27 October 2006 	Consultation workshop with key stakeholders to discuss the above analysis and recommended action plan/guiding principles for future HPSS supervision activity
9 November 2006	Review Group meet to agree the recommended actions and guiding principles and discuss the structure of the review report.

Communication Framework for the Clinical Supervision Review

1. Monthly meetings of the review group will take place at NIPEC between June and November 2006.

2. The Review Chair has written to each Director of Nursing, outlining the review and asking for their support.

3. A review group email has been set up to enable regular communication between NIPEC and group members. This will include the sending of agendas and minutes from meetings and consultation on the project methodology and timeframe.

4. The progress of the review will be reported on the NIPEC web-site and E-news.

5. As the review progresses, Directors of Nursing will be invited to take part in telephone or face-to-face interviews, offer case studies of good clinical supervision practice (according to set criteria) and have representation at stakeholder workshops. Communication regarding each of the above will be via email, letter and telephone.

6. The findings of the fieldwork undertaken during July and August will be consulted on with the review group and at a stakeholder workshop in September/October. In addition to face-to-face contact, the analysis of this information and eventual agreement on findings and an action plan will include e-mail correspondence.

7. The Review group will be invited to contribute to the final report, which will be available on the NIPEC web-site and forwarded to the DHSSPS in November 2006.

Appendix 4: Interview Questioning Framework

1. How does the organisation define clinical supervision and what activities come under the remit of 'supervision'

2. Is there an organisational framework for supervision activities?

3. Who has led the implementation of clinical supervision across the Trust?

4. Is there a supervision policy in the Trust – when was it implemented, how effective is it in guiding organisational implementation of clinical supervision and has its impact been evaluated? Does the policy state that nurses 'must' undertake clinical supervision, or do they have a choice?

5. Can the Trust provide evidence of the number of people undertaking supervision and the regularity of this; length of sessions etc? How many supervisors are there and how do supervisees choose a supervisor? Are supervisees and supervisors matched?

6. What is the level of enthusiasm for undertaking supervision across the organisation? How do you believe clinical supervision is viewed across your organisation by supervisees, supervisors and others i.e. practitioners and managers?

7. Is there protected time allocated for supervision? If yes, how has time for clinical supervision been facilitated? If not, how has the process been established?

8. Has the Trust evaluated supervision methods i.e. establishing supervision, effectiveness of processes and outcomes – how and what evidence is there of this i.e. on individuals and on improving the quality of practice?

9. How are supervisors/supervisees and managers with responsibility for supervision trained – has the impact of

training been evaluated? Is there any feedback on whether the training itself was appropriate?

10. What records are kept on supervision i.e. contracts and written accounts of sessions, action plans from sessions – can the Trust provide examples of how effective this is?

11. Has the Trust faced any barriers to ‘establishing’ supervision? If so, what are these?

12. Has the Trust faced any barriers to ‘sustaining’ supervision and enabling ‘effective’ supervision? If so, what are these?

13. What (if any) is currently going well as a method of supervision in the organisation? What are the factors that are enabling this to work well? Is there a particular group of staff that it has been easier to establish clinical supervision for?

Appendix 5: Interview Analysis Overview

Analysis of principles and interviews/focus groups with Trust Directors of Nursing/Senior Nurses using the Questioning Framework (1-13 below) and undertaken during July and August 2006.

The following question format was used. For each question, an overview of the analysis follows

Q1. How does the organisation define clinical supervision and what activities come under the remit of 'supervision?'

Interview analysis indicates that Trust definitions for clinical supervision fall under three main areas:

No definition for clinical supervision is being used	25% of Trusts have not defined clinical supervision
A traditional definition for clinical supervision has been in place for some time	50% of Trusts have followed this approach
More modern approaches to supervision are reflected in definitions other than for clinical supervision e.g. action learning	25% of Trusts have moved beyond a definition for clinical supervision and focus on defining other approaches to learning and development e.g. critical inquiry, clinical support and learning

The range of activities that fall under a broad definition of clinical supervision are widespread and include:

- Formal clinical supervision (one to one and group)
- Informal clinical supervision
- Professional supervision
- Managerial supervision
- Peer supervision
- Clinical support supervision
- Professional group meetings
- Team meetings
- Action learning

- Mentorship
- Staff nurse induction and development programmes
- Problem-based learning
- Critical Companionship
- Reflective diaries

Q2. The level of robustness of organisational frameworks for supervision activities would appear to fall into one of three groups, as follows:

Organisational wide framework	Several Trusts (5%) have established a framework that ensures a range of supervision activities are in place.
Recently addressing the importance of implementing effective supervision frameworks	Around 65% of Trusts are working to develop an organisational framework for supervision activities that encompass a range of models
Appears to be somewhat behind in terms of an apparent lack of organisational impetus around supervision activity	Around 30% of Trusts would appear to fall into this category

N.B. An organisational framework for supervision activities could be defined as a 'clearly articulated and strategically focused organisation-wide approach to supervision, which is well established and has at least displayed emerging evidence of effectiveness'.

Q3. Who has led the implementation of clinical supervision across the Trust?

The level of leadership in each Trust to establish and sustain supervision activities falls into four categories, as follows:

No obvious leader for supervision activities	25% of Trusts
Being led by Director of Nursing	25% of Trusts
Being led by Senior Nurses and Practice Development/Clinical Education Facilitators	25% of Trusts
Being led by a specific team i.e. Trust Nursing and Midwifery Development Team	25% of Trusts

There is general consensus that the Director of Nursing has responsibility for leading clinical supervision, and this often involves promoting the concept of supervision at Trust Executive and Senior Management level, to gain support and feedback the impact of this work, increasingly from a governance context. While no Trust suggested that they were not interested in establishing clinical supervision, it is concerning that in approximately 25% of cases, there is no obvious leadership for this work.

Q4. Is there a supervision policy in the Trust?

The extent to which Trusts have an operational policy guiding clinical supervision fell into the following five categories:

No clinical supervision policy	Approximately 20% of Trusts
Old policy, which appears to be non-functional	10% of Trusts
Old policy that is/may be being followed in some areas of the organisation	30% of Trusts
Newly emerging clinical supervision policy directive	20% of Trusts
No clinical supervision policy	20% of Trusts

because guidance is focused on other areas e.g. nursing strategy	

It is clear from the above information that there is wide disparity regarding the development of policy for supervision activities. Evidently there is a need for a regional organisational review to ensure there is both a corporate and operational understanding of clinical supervision and related models of learning and development.

Q5. Can the Trust provide evidence of the number of people undertaking supervision and the regularity of this?

There was an immensely variable response to this question, ranging from Trusts that were unable to give any indication of the number of nursing staff availing of supervision, to the other extreme when numbers are carefully monitored. There were three categories to summarise this as follows:

No numbers available to suggest how many staff are undertaking supervision activities	Approximately 25% of Trusts
Vague or incomplete information on the number of staff undertaking supervision	50% of Trusts
Clarity on actual numbers undertaking supervision activities	25% of Trusts

The above evidence suggests there is an urgent need for a robust monitoring arrangement for supervision activity in each organisation. Similarly, only a few Trusts were able to offer clear information on how often staff undertake supervision and the length of these sessions. A vague estimate suggests that for the majority of Trusts 10-20% of staff regularly avail of one or more supervision activities. In one or two Trusts this figure may be closer to 40-50%.

Q6. What is the level of enthusiasm for undertaking supervision across the organisation?

It has become evident from the responses to the above question that while in some areas enthusiasm for clinical supervision is limited,

mixed or sporadic, the majority of Trusts suggest that there has been a renewed and growing interest in these activities in recent years. In some areas, enthusiasm is building to the extent that staff are requesting supervision, are placing a high degree of value on the importance of this and increasingly accepting that supervision is essential in any learning, development and governance culture. Two points of caution however relate to concerns around the term clinical supervision, to the extent that some Trusts are focusing their attention on developing an overarching framework for 'clinical support and development' or 'critical inquiry'. Secondly, while Trusts in general recognise the importance of clinical supervision as contributing to performance review and Knowledge & Skills Framework development, a number have indicated that staff are so focused on appraisal that supervision activities are not being given the emphasis they require. This is therefore an area requiring greater awareness and promotion in a way that helps nurses to recognise the importance of integrating the wide range of learning and development activities available to them.

Q7. Is there protected time allocated for supervision?

The issue of protected time has long been the focus of much contention among those responsible for establishing and undertaking clinical supervision. The literature highlights the fact that for some, clinical supervision is unsuccessful because it is not resourced financially and therefore isn't time protected. Others will argue that time isn't as important a factor as developing an ethos for and organisational understanding of clinical supervision that sees it as part of everyday practice and underpinned by processes of structured reflective practice.

Analysis from this question in the current review falls into the following three categories:

No protected time is given because there is no resource available for this	40% of Trusts
Protected time is offered to some groups	40% of Trusts
The focus is not on protected time, but on facilitating time, thus the focus is on valuing and enabling processes of supervision and embedding these in practice.	20% of Trusts

Q8. Has the Trust evaluated supervision methods i.e. establishing supervision, effectiveness of processes and outcomes – how and what evidence is there of this i.e. on individuals and on improving the quality of practice?

Evaluation of the impact of clinical supervision has also been the focus of a wide body of national literature in recent years. Rarely however is evaluation undertaken on whether supervision has a positive impact on the quality and safety of clinical practice, as usually the focus is on evaluating the process of supervision and on individual learning and development.

The current review analysis suggests that there are four categories that encompass the range of evaluation experience across Trusts in Northern Ireland:

No evaluation has been undertaken	30% of Trusts
Clinical supervision processes have been audited	20% of Trusts
Action learning has been process and outcome evaluated	20% of Trusts
Limited evaluation has been undertaken, lacking any robustness	20% of Trusts
Evaluation is embedded in monitoring the impact of a framework of supervision activities	10% of Trusts

While evaluation of supervision activities is generally weak across much of the HPSS, there is recognition of the importance of developing a robust evaluation framework that assesses the quality of supervision experience, impact on the individuals taking part, and on the quality of care. Several Trusts have placed careful emphasis on ensuring an evaluation component is built into their supervision work, and are actively pursuing evidence that displays impact on practice and performance. Despite this, it is doubtful whether any trust has evaluated the impact of supervision activity on improving quality and safety of care. Clear recommendations are therefore required to develop this area of interest.

Q9. How are supervisors/supervisees and managers with responsibility for supervision trained; is there any feedback on whether the training itself was appropriate?

The issue of training and preparation for clinical supervision was of great interest to senior nurses taking part in interviews, judging by the number of occasions that concerns about the quality of this was mentioned in discussions alluding to this and other questions.

It has become apparent that there are three categories representing the experience of training and preparing for supervision:

No training has been commissioned	20% of Trusts
In-service Education provision	60% of Trusts commission this
A range of training through in-house, facilitation programme, academic modules and practice development school	40% of Trusts commission this

While the majority of Trusts commission the traditional approach to training for clinical supervision through their in-service education contract, there are widely held concerns about the ability of this programme to prepare practitioners for supervisor or supervisee roles. Opinions vary from stating that surveys show staff in one Trust felt inadequately prepared despite accessing this training, to views that the training is narrow, lacking in depth and requires a creative and modernised approach to delivery.

Increasingly staff from Trusts throughout Northern Ireland are attending the RCN Practice Development school in addition to or separate from undertaking the Postgraduate Diploma in Facilitation, Learning and Development, which offers RCN Facilitator Accreditation. These opportunities are relatively new and while they are usually positively evaluated as learning experiences, it will be a few more years before the impact of these programmes on the quality of facilitating supervision activities will be recognised.

As noted earlier, evaluation of supervision activities across the HPSS must include monitoring the effectiveness of facilitation or supervisor roles and the quality/impact of training and preparations. It is also likely that a recommendation is required that calls for a review of current in-service provision in this area.

Q10. What records are kept on supervision i.e. contracts and written accounts of sessions, action plans from sessions?

The maintenance of records in line with various supervision models is possibly the weakest area across the HPSS. The following three categories indicate the level of recording apparent at Trust level:

No records are kept	30% approximately
The operational policy that has been in use for a number of years, offers guidance on records, but there is limited awareness of whether this is followed	30% approximately
Records are in place and regularly monitored for clinical supervision and other activities e.g. action learning	40% approximately

Given the lack of clarity around recording apparent during interviews and guidance sought by some Trusts on how best to record supervision activities, it is likely that a recommended action around a minimum record will be offered as a result of this review. The above figures are only approximates because often those being interviewed could not indicate how robust recording approaches are in their organisation, suggestive of a general lack of appreciation and detailed monitoring. In future is it likely that Trusts will have to maintain a clinical supervision record for every employee that sits within the governance framework of the organisation.

N.B An analysis of questions 11-13 has been presented in the main text of this report (pages 30-33).

Appendix 6: Criteria for Case-study Submissions

Criteria followed by Directors of Nursing when considering offering a case-study on 'effective' Supervision

1. Someone is 'leading' it locally, nurturing ownership of/enthusiasm for this model of supervision

2. The process can be described locally, particularly the success factors

3. The positive outcomes of this form of supervision can be offered as evidence supporting an effective model

4. The process of supervision has been documented and records are available to show this. There may be other records that show an evidence trail for how supervision impacts on personal and practice development i.e. action plans.

5. This form of supervision has been established for a reasonable enough time frame to enable others to identify the success factors, issues and challenges that have been overcome and impact of the process on individuals and practice

6. There is evidence of investment in the development of those involved i.e. supervisors/supervisees have been trained and are continuing to learn and develop in different ways

7. There should be at least some evidence to indicate that this form of supervision is working.

In selecting case studies we are aiming for exemplars of supervision that offer experience in a range of settings and using different models.

Appendix 7: Case-study examples

Role Supervision in the Royal Group of Hospitals

The development of reflective practice strategies falls under the remit of the Director of Nursing Research and Practice development and is operationalised by the Nursing and Midwifery Development team. The Developing Practice Manager has the role of monitoring and quality assuring these activities.

Sharon Dunn has led the development of role supervision in the Division of Medicine and Surgery in the Royal Victoria Hospital. Role supervision offers an opportunity for a ward manager to engage with their line manager is a process of critical inquiry into their role and development of that role.

Role supervision offers high levels of challenge and support to ward managers, encourages critical dialogue between the ward manager and the supervisor which enables the individual to develop their own learning, practice and personal development. The supervision relationship is also developmental for the supervisor. Each individual maintains their own record of the sessions which forms the basis for evidence of development which will be maintained in the individual's personal portfolio.

Role supervision has been established for 18 months within the Medicine and Surgery Division and has been seen to have a positive outcome for those involved. Ward managers feel more supported in their role and have displayed increased confidence in decision making. These individual managers have also developed their skills as facilitators through experiential learning with their line manager who is an experienced facilitator and who is also in clinical supervision examining her own practice. Some members have developed further through undertaking the in-house 'Facilitation in practice' module. Individuals evaluate the experience using the critical inquiry framework.

Supervision in the Ulster and Community Hospitals Trust Mental Health Directorate

Dawn Heather White, Assistant Director, Mental Health is leading the supervision model within mental health (Adults and Children & Adolescent Mental Health Services) and monitors implementation through meetings with the Senior Management Team and quarterly reporting from these managers.

Damien Brannigan, Senior Manager and Professional Lead for Mental Health Nursing within the Mental Health Directorate chairs the monthly Mental Health & Learning Disability Senior Nurse Managers meetings and the monthly Mental Health & Learning Disability Professional Issues Forum.

The process is directed by a local policy. All community staff have monthly supervision with their Line Manager. They also have access to peer supervision through the monthly Professional Nursing Issues forum. Supervision sessions are minuted, as are the forum meetings. The arrangements have been in place for ten years.

One of the positive outcomes of the monthly supervision is that staff no longer felt the need for separate quarterly professional supervision as their professional needs were being met through both their supervision with their Line Manager and attendance at the Professional Nursing Issues forum. However, staff can request professional supervision if they encounter a particular professional issue that they wish to discuss.

Other positive outcomes:

- Staff come prepared with an agenda
- Attendance is good
- Minutes are recorded
- Actions are agreed and implemented
- Development needs are identified and addressed both on an individual and team/group basis
- Trends re. development needs or emerging issues are identified.

All supervision sessions are minuted and both supervisor and supervisee keep a signed copy. The minutes include a summary of discussion and any agreed action, which is then followed up during subsequent supervision sessions. The Managers include a list of the dates staff have engaged in supervision in their quarterly reports to Dawn Heather White.

All community staff within Mental Health have engaged in monthly supervision with their Line Manager since the teams were restructured at the beginning of 1996. When a Trust merger took place in 1998, the policy was then implemented with staff in the Mental Health Day Hospital.

Training for supervision was commissioned by the Directorate from The Beeches for several consultation days. All G Grades and above are being facilitated in completing the Nurse Leadership Programme which has an emphasis on reflective practice and practice development.

Staff attend supervision routinely and are prepared to seek an alternative date should they be unable to attend the timetabled session. There are Supervision files for each member of community and day hospital staff. As action is agreed at each session the minutes would indicate that the actions are followed up and reviewed during subsequent sessions. The Directorate has just drafted a Supervision questionnaire to evaluate staff satisfaction with the supervision arrangements and monitor adherence to the local policy.

Group Clinical Supervision for newly qualified nurses on the Rotational Programme at Craigavon Area Hospital Group Trust

As part of the Trusts recruitment and retention strategy a rotational programme was developed for newly qualified nurses in October 2003. This programme was seen as a new and innovative way of recruiting and retaining staff and one that would support the newly qualified nurses' individual personal and professional development. This 12 month programme consisted of four 3 month placements covering general medicine, general surgery, care of the older person and a speciality of the individual's choice.

Group clinical supervision was the model adopted to support and facilitate the newly qualified nurse to develop as a safe, reflective confident and competent practitioner. Group clinical supervision can be described as a process, whereby nurses are brought together to reflect on aspects of practice/professional issues in a secure and confidential environment.

The newly qualified nurses on the rotational programme have a two-hour workshop at the beginning of their rotational programme to prepare them for group clinical supervision. They are given the option as to whether they wish to participate in group supervision and to date no-one has refused. Following agreement to participate a contract is agreed between the supervisor and supervisee. Group clinical supervision is guided by this contract which consists of ground rules, time, dates, duration of session etc and these are revisited and amended if necessary at the beginning of each supervision session. The group meets approximately every 4-6 weeks for a 3-hour period.

What happens in a set?

- Icebreaker
- Review the ground rules
- Feedback from actions undertaken from previous session
- Decide who presents
- Presentation of issues
- Clarifying, enabling and reflective questions to the presenter
- Identify actions

- Review the learning
- Evaluation of clinical supervision session

The positive outcomes of this form of supervision can be offered as evidence supporting an effective model:

- Nurses recognise the importance of reflecting on practice/professional issues
- Practitioners take actions away from group clinical supervision
- Share experience of practice issues learning from each other
- Promotes safe accountable practice
- Develops individual confidence to deal with emergencies e.g. cardiac arrest, anaphylaxis, infection control
- Develops knowledge
- Develops problem solving skills and leadership skills
- Improves communication skills
- Develops ability to question/challenge practice at ward level
- Develops ability to manage conflict
- Highlights additional training requirements
- Contributes to life long learning
- Values practice – identifying and building on what nurses do well
- Identifies and exposes what nurses do least well
- Supports personal growth and development
- Develops individual confidence and competence
- Enables nurses to meet PREP requirements
- Offers protected time for nurses to attend clinical supervision.
- Supported and approved by Director of Nursing & Quality, Assistant Director of Nursing & Quality and Directorate Managers
- Supported by a designated person to lead and facilitate group clinical supervision

Nurses keep records of ground rules, personal reflections issues they have presented and the actions they have identified and undertaken from their presentations. This is recorded in their personal professional portfolio

The supervisor/facilitator keeps brief records on the following:

- Ground Rules
- Attendance
- Ice breaker used
- Issues discussed/presented
- Actions identified
- Feed back on actions
- Additional training highlighted
- Evaluation of session
- Hopes, Fears, Expectations undertaken with nurses at the beginning of their rotational programme, these are revisited and reviewed at the end of the 12 months

Clinical Supervision commenced in October 2003 with 8 rotational nurses on the first programme. To date we have had 38 Nurses who have received group clinical supervision within the Trust through the rotational programme. Evaluations have been carried out at the end of each programme using semi-structured questionnaires. This is evidenced through the positive evaluation of the programme from the newly qualified nurses and the ward managers. The Trust has retained these staff and there is evidence to suggest that they have a wider range of knowledge and skills acquired from the range of clinical settings they experience. These nurses are demonstrating that they have been able to apply and transfer their knowledge and skills to other clinical settings and there have been requests from Clinical Service Managers/Ward Managers for placement of them in particular wards/departments, as they are deemed more competent and confident to work in speciality areas. Their individual confidence and ability to question practice issues has been noted.

Health Visiting Supervision in Craigavon and Banbridge Community Trust

The Director of Elderly and Primary Care takes a strategic lead and appropriately delegates through line managers the on-going development and review of models of supervision across its nursing disciplines.

The Trust health visiting team managers have developed this model of supervision in partnership with the health visiting policies and procedures group and in consultation with senior nurse managers. The philosophy and benefits of supervision are embedded within health visiting policies and procedures and through the induction process of new staff.

This model has further influenced the development of supervision models for other groups of staff in the Trust. The supervision process is described in detail within the relevant policies and procedures. All health visitors have a personal copy of the supervision policy and procedure and it is also available on the Trust Intranet.

The supervision procedures include specific standards on frequency and content of supervision meetings. The Trust provides supervision to health visitors using 4 methods:

- Individual clinical supervision
- Open door contact
- Peer group mentoring
- Audit of health visiting records.

Kolb's experiential learning cycle (1984) is utilised to explore complex issues during individual clinical supervision and peer group mentoring. This model is utilised to promote reflective practice, learning and to enable effective problem solving. Newly appointed health visitors must undertake supervision twice weekly for the first three months, and then monthly for three months, before continuing supervision on a 2-3 monthly basis after that. Each of the stages may be increased in length according to individual needs. Feedback from staff would indicate that they place a high value on the supervision provided.

This model of supervision effectively provides an opportunity:

- For team managers to develop rapport and support staff
- To encourage reflective practice and professional development
- To highlight good practice and give positive feedback
- To encourage staff to comply with Trust standards
- To identify training needs
- To identify emerging deficits in practice at an earlier date in order to agree a personal development plan with the staff member.

The supervision procedure contains a number of profomas, which reflect the different types of supervision offered and records of supervision activity are retained by supervisor and supervisee. The proformas are structured to include discussion and the actions/outcomes required following supervision.

Supervision for health visitors has been integral to practice for many years but the process was formalised in 2002 and updated in 2005. The health visiting team managers have an induction programme which includes training in supervision of staff.

Health visitors engage positively with this process and actively seek out opportunities for supervision. Team managers have identified faltering performance with individual practitioners and have been able to put strategies in place to address issues.

Evaluation of supervision activity includes findings from audit reports (2002, 2004) which indicate that health visitors felt that supervision was supportive, allowed work related issues to be addressed and positively impacted on their practice.

Action Learning as an example of group supervision in Causeway HSST

In May 2005, the Director of Acute Services identified that the process of support provided for newly qualified nurses within the acute sector required review and development. The Practice Development Nurse was asked to develop a preceptorship programme for newly qualified nurses coming to work in Causeway Hospital. One aspect of this programme is the provision of action learning as a form of supervision for newly qualified nurses. The Practice Development Nurse continues to lead the project locally, supported by Senior Managers within the Hospital.

Twenty-nine newly qualified nurses commenced a twelve month preceptorship programme in January 2006. As well as having a ward based preceptor, the Practice Development Nurse acts as Lead Preceptor coordinating the process and addressing identified training and development needs. This is carried out on a one to one basis between newly qualified nurses and their Lead Preceptor. In addition, bi-monthly, newly qualified nurses come together as a larger group to attend in-house training sessions facilitated by specialist nursing staff.

All newly qualified nurses were provided with a Personal Development Portfolio at the outset of the programme and an awareness session provided them with information on what to put into the portfolio and how to format this.

The main success factor in the preceptorship programme has been the establishment of action learning sets for the group. The larger group has been broken down into four smaller groups for the purpose of action learning. The Practice Development Nurse (who has completed a Postgraduate Certificate in Lifelong Learning (Facilitators Course) facilitates the action learning sets.

To date, a number of success factors and positive outcomes from action learning have been noted. These are evidenced in the following quotes from those undertaking action learning:

- *"I feel that the action learning set enables nurses to realise that everyone has similar problems to deal with in nursing. Having the ability to present these issues and attempts to resolve them is quite satisfying".*

- *"I really enjoy the action learning sets and learn a lot from each session. I find the learning sets a great way of talking through personal problems and helping other peers through their problems. Really look forward to the learning sets".*

- *"It is nice to discuss problems with other colleagues from different departments and know it was all confidential. It also helps to hear how others would cope in the same situation".*

- *"Allows us as nurses to share common problems in confidence. It makes me feel that I am not going through certain issues alone".*

- *"I was a bit nervous about presenting but the feedback was helpful. I like the idea of learning from one another and hearing/understanding other nurses experiences".*

- *"It was good to hear others also had concerns – useful to share your worries and get feedback".*

- *"An excellent opportunity to discuss/liaise with other newly qualified staff members and to share each others views and experiences of the working environment. I feel it has provided me with additional support and guidance as a newly qualified nurse".*

The Practice Development Nurse as facilitator of the sets keeps records pertaining to the action learning sets. These records contain information on who presented at each session and what they presented. These are kept confidential, as is all that is discussed within the sets. There is an individual section within the newly qualified nurses Personal Development Portfolio for written reflection

prior to them presenting their own issue and for written reflection on the experience of being a set member listening to others present.

Ward Managers have also commented on the success of the programme and a process has been established to ensure that the initiative continues for all newly qualified staff to the hospital. A formal evaluation day will take place in January 2007 (at the end of the twelve month period of preceptorship). This will be attended by Senior Managers, Ward Managers, preceptors and preceptees and will be facilitated by the Practice Development Nurse. This will give everyone the opportunity to evaluate the success of the initiative and to make recommendations for changes to current process. At the end of the twelve month period of preceptorship, clinical supervision will be provided on a one to one basis, organised at ward level.

Ward based preceptors have expressed an interest in action learning for themselves both as preceptors and for their own work environment. This demonstrates the positive impact that participation by newly qualified nurses in action learning has had on the rest of the work team.

Action learning among a group of coronary care staff nurses in Sperrin and Lakeland Trust

Action learning was adopted in Sperrin & Lakeland Trust, as a method of enabling critical reflection among a group of staff nurses in their new roles as lead coronary care nurses. Adopting an action research methodology, the seven nurses and the senior nurse for professional development became co-learners and co-researchers in agreeing the following objectives:

- To identify nurses' perceptions of the impact of action learning on their learning and development
- To establish individuals level of critical reflection
- To identify the actions that emerged from participation in action learning
- To identify any perceived barriers to individual's ability to undertake action
- To identify the level of autonomy achieved/experienced by the group

The action research methodology provided a systematic and rigorous means of evaluation that complemented the cyclical process of action learning. Moreover, reflective cycles of critical questioning, discovery and action are central to both processes. Also the nurses were already familiar with the techniques and the fundamental principles of collaboration, negotiation and critical questioning that was created through the unique researcher-participant relationship.

The process we engaged in involved 8 reflective sessions lasting 3 hours each, with the critical dialogue focusing on the impact of the components of action learning on individual experience. A range of evaluation evidence was collected, for example, through Values and Beliefs clarification, use of visual arts, set evaluations, reflective diaries and peer observation notes. In addition, the lead facilitator used audio taped narratives and field notes from open ended interviews written verbatim with co-researchers. As a result of an in-depth evaluation of this experience, the following learning outcomes became evident.

There was evidence of:

- Increased openness & honesty among individuals with the set;
- Increased support for each other and for those whom we worked with;
- Increased confidence as action learners and practitioners;
- Increased collaboration within and outside of nursing responsibilities;
- Increased levels of reflection within the workplace and individually;
- Increased skills in problem solving among the set;
- Increased focus on patient-centered care;
- Increased responsibility and accountability for decisions and actions;
- Increased critical dialogue with other colleagues and disciplines;
- Increased focus on involving patients in decision making about their care.

Whilst all participants reported that their confidence had increased significantly, this was interdependent upon how supported they felt within the group. In turn, the level of support was dependent upon disclosure from others, which only increased when others openly declared their apprehension and vulnerability. Sustaining an environment of mutual respect and collaborative working created significant trust among participants that had not been experienced before the meetings.

'Reflection' was accredited as having the most powerful impact on the nurse's learning and development. However, there were significant differences between the levels of reflection that each experienced. At its simplest, reflection caused all to think and to seek understanding and meaning. Some valued the structure of using a reflective cycle for solving problems on their own including its application in various situations in their wider lives.

Overall the findings reveal that action learning had a significant and mainly positive impact upon the participants learning and development. Challenges to the success of action learning include facilitating time for the process, encouraging commitment, and the potential for anxiety that can arise from in-depth and challenging critical dialogue, a factor that can be a feature of the emotional impact of the issues being discussed, and thus requires skilled facilitation. However the majority welcomed this self-determining and empowering form of learning, which supports the usefulness of adopting action learning in future staff development programmes and organisational initiatives.

Department of
Health, Social Services and Public Safety
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AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

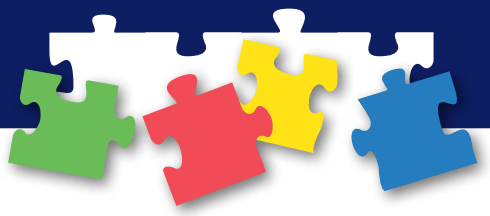
MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

A Partnership for Care

Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015

MAHI - STM - 089 - 2835

Contents



A Message from the Minister

As Minister for Health and Social Care I have had many opportunities to witness first hand the immense impact that nurses, midwives and support workers have on the delivery of care across a range of settings. Traditionally nurses and midwives are seen as the guardians of care, working closely with patients/clients and their families twenty four hours a day, leading, managing and working in teams, advocating for patients and facilitating change and reform. It is this central role that is so vital to our health and social care system.

Nurses and midwives teach, support and nurture the professionals of tomorrow and remind us of the importance of the person, the patient and community that must be central to our services.

All of us, whether as patients or staff, want to be treated courteously, with dignity, respect, sensitivity and compassion. How we work and interact can have a real impact upon the experience of those who use our services, creating an environment where we can all take pride in the services that we offer. A considerable amount of progress has been made with the launch in 2008 of the patient experience standards, but we cannot be complacent, which is why I am delighted to see the needs of patients/clients reflected throughout this strategy.

I recognise that in health and social care our staff are the most important resource. While no one can deny that the current economic climate will present difficult choices and decisions I am optimistic that through working in partnership we will face these challenges together to improve the health and well being of the population in Northern Ireland.

Michael McGimpsey, MLA
Minister for Health, Social Services and Public Safety

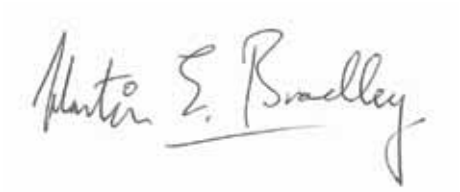
Foreword by Chief Nursing Officer

Whatever your role within the family of nursing and midwifery this strategy is for you, it sets out our priorities for the next five years as we progress with drive and enthusiasm to achieve our vision of working in partnerships to meet the health and social care needs of our population.

In my role as Chief Nursing Officer I am fortunate to be able to spend time with members of the nursing and midwifery family throughout Northern Ireland observing the excellent work they do caring for patients and clients.

As nurses, midwives and support workers what we do affects every single person in our community. We welcome life, help people to make healthy choices, support those with a disability or chronic disease, and care for those who are terminally ill. In the past few years we have seen fundamental changes to the way our health and social care services work, with the establishment of the new Trusts, the Health and Social Care Board, Public Health Agency, Business Services Organisation and Patient Client Council. These organisational changes are designed to put the patient/client at the centre of our services and secure good health for the whole population.

The next five to ten years will bring an ever greater pace of change, and difficult choices – rather than wait passively for the tough choices to emerge, we must look ahead, act now and prepare for the future.



Martin Bradley
Chief Nursing Officer

Our Strategy

This strategy is the culmination of a range of work which has been undertaken in Northern Ireland in response to the Modernising Nursing Careers agenda and supports the Midwifery 2020 initiative. It has been developed in consultation with members of the nursing and midwifery family and patient representatives through a series of engagement workshops. Its development has been overseen by a steering group chaired by the Chief Nursing Officer.

This strategy has been developed under the four strategic themes of:

- **Promoting Person Centred Cultures**
- **Delivering Safe and Effective Care**
- **Maximising Resources for Success and**
- **Supporting Learning and Development.**

Based on the information obtained during the engagement workshops three key perspectives have been identified under each of the strategic themes. These will be used as lenses through which to view the strategy and achieve the vision. Each of the key perspectives is articulated at strategic, organisational and individual level to ensure that every nurse, midwife and support worker has a place in this strategy and can clearly see what it means for them.

Strategy Development

Trust Strategies

Reflected within the strategy are the themes contained within each of the five Health and Social Care Trust nursing and midwifery strategies which have been published during 2008/09, namely

Western Trust - Nursing ...Making a Difference – 2008 – 2012

Northern Trust – Our Futures, our journey – 2008 – 2012

South Eastern Trust – Nursing and Midwifery Strategy 2008 – 2011

Southern Trust – A passion for care – compassion for people 2009 - 2014

Belfast Trust – Striking the balance – 2009 – 2012

This strategy should be seen as a high level road map to guide the family of nursing and midwifery over the next five years. It is based on the principle that the contribution of every nurse, midwife and support worker is valued and has a part to play in ensuring the delivery of high quality safe and effective care to patients/clients. The strategic themes capture both the enduring values of nursing and midwifery as well a vision for the future.

This strategy will generate local action plans from each of the HSC Trusts, the Public Health Agency and DHSSPS and will also be adopted by the independent and voluntary and community sector.

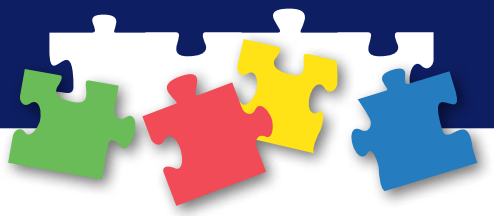
The Strategic and Policy Context

It is an exciting and challenging time to be part of the nursing and midwifery family in Northern Ireland. The restoration of devolved government and the implementation of the Review of Public Administration have reshaped organisational and management structures. Throughout this unprecedented period of change the delivery of safe, high quality, effective and compassionate care has relied upon the family of nurses and midwives working across a diverse and wide range of settings with the aim of providing person centred care 24 hours a day 365 days of the year.

In addition to improved social conditions and public health successes, new drugs and technologies have contributed to the population living longer with people increasingly living with one or more chronic condition. Many of these conditions, such as cardiovascular disease, cancer, diabetes and chronic respiratory disease are linked by common preventable risk factors. Smoking, prolonged unhealthy nutrition, physical inactivity, and excess alcohol use are major causes of ill health within the population. As members of integrated, multidisciplinary teams nurses and midwives have important roles to play in working with patients/clients and their families in the prevention, treatment and management of chronic diseases from preschool through to old age.

The establishment of the new Public Health Agency, Health and Social Care Board and the Patient Client Council in April 2009 was driven by the need to improve the health and wellbeing of the people of Northern Ireland and reduce inequalities; as such the health and social care system should be proactive in working towards, anticipating and preventing health and social care problems rather than merely reacting to them. To achieve this there will be an increased focus on anticipatory care that crosses organisational boundaries. A self care approach will be adopted which will allow people with long term conditions to have access to improved information, education and support, as well as new technology aimed at enhancing home-based care. Similarly, health and social care organisations, local government and the independent, voluntary and community sectors will work together to ensure the person is placed at the centre of decision making processes and that safe and effective care services are increasingly delivered in the individuals home.

Changes in demographic trends and the aging population mean that increasingly more of the nursing workforce is employed in the independent / voluntary and community sectors. The review of the nursing and midwifery workforce conducted in September 2008 indicated that between 2000 and 3000 qualified nurses are currently employed within these sectors. It is therefore important that we recognise the knowledge; skills and experiences attained within these settings and cultivate a highly skilled and flexible workforce for the future.



The monitoring and inspection of the availability of health and social care services, including those within the independent sector is undertaken in Northern Ireland by the Regional Quality Inspection Authority (RQIA) who examine all aspects of the care provided and work to ensure public confidence in these services. In addition with the transfer of duties from the Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009, RQIA undertakes a range of responsibilities for people with a mental illness and those with a learning disability.

In Northern Ireland a range of policy initiatives, launched since 2002, have reflected the changing context of Health and Social Care and set the direction for future service delivery, namely:

- Developing Better Services: Modernising hospitals and Reforming Structures;
- Investing for Health;
- A Healthier Future: A Twenty Year Vision for Health and Wellbeing;
- Caring for People Beyond Tomorrow;
- The Review of Public Administration;
- Changing the Culture;
- The Bamford Review;
- Patient Client Experience Standards.

A summary of these documents is attached at **Appendix 1**

These policy documents and initiatives reflect the changing face of health and social care in Northern Ireland. Nurses and midwives must embrace the future opportunities and challenges that the professions face and exercise the direction outlined in this strategy to help shape the future.

Nursing and Midwifery in Northern Ireland

Nurses and Midwives are registered with the Nursing and Midwifery Council, with nursing subdivided into the four areas of adult, mental health, learning disability and care of children.

Pre–Registration Education

The students of today are the registrants of tomorrow. Effective educational programmes and mentorship will support and develop nurses and midwives for the future.

In Northern Ireland pre registration education is delivered by Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. Further information on these courses can be found on the relevant websites outlined below.

Queens University
www.qub.ac.uk/schools/SchoolofNursingandMidwifery

University of Ulster
www.science.ulster.ac.uk/nursing

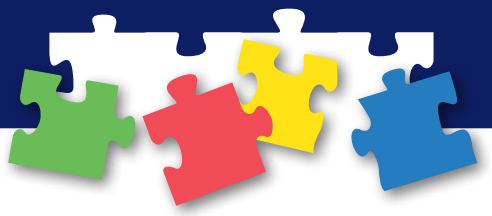
Open University
www3.open.ac.uk/study/undergraduate/health-and-social-care/nursing/index.htm

Post Registration Practice

Consolidation period Post Registration - Guidance from the NMC recommends that all new registrants be afforded protected time in their first year of practice with the support of a preceptor. For midwives this period of consolidation culminates in a review process at which the progression from AfC band 5 to AfC band 6 takes place.

Career Progression

Following the consolidation period some practitioners will choose to specialise in a particular area of practice, whereas others will maintain a wider general focus. Both routes are of equal value. As nurses and midwives progress in their careers they will amass a portfolio of knowledge, skills and attributes with an emphasis on advanced decision making, advanced clinical skills, research, leadership and management.



Healthcare Support Workers

Health Care Support Workers are an important and valued part of our workforce and they play a key role in the delivery of safe and effective care across a range of settings.

In considering the roles and responsibilites of support workers there is more work required to obtain consensus on a number of areas including a common title for support workers at AfC bands 2 and 3, establishing a common level of educational attainment for entry into posts, new roles such as the maternity support worker and learning and development opportunities consistent with and supportive of the Knowledge and Skills Framework.

This will offer opportunities within the needs of service to further careers at a pace appropriate to abilities, skills and aspirations with the potential to progress to pre registration education.

Work in this area will be undertaken as part of the Central Nursing and Midwifery Advisory Committee (CNMAC) workforce planning and development and modernisation subgroup.

Our Vision

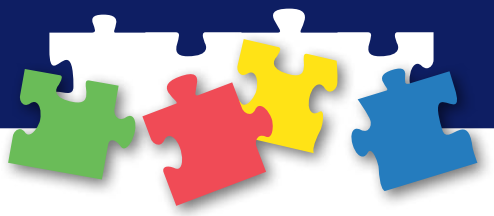
A Partnership For Care

To achieve this vision we will maximise the effectiveness of the nursing and midwifery contribution to improving health and social wellbeing and tackling inequalities for the popluation of Northern Ireland.

To support this vision nurses, midwives and support workers will:

- have the patient and families as their primary concern, reducing inequalities and working in partnership with individuals, communities and the public for improved health and social outcomes;
- work with other professional groups, agencies, patients and communities to maximise the use of everyone's talents and skills;
- be accountable, skilled and flexible, always striving to work effectively and efficiently to provide safe, accessible and equitable care acting as the patient/client advocate;
- practise in an atmosphere of continual learning and development, demonstrating their commitment to continuous quality improvement and an ability to learn from experiences and accredited sources of evidence and contributing to that evidence.

Our Values



The underpinning values of the nursing and midwifery family are the principles and beliefs that guide the choices and daily practice of individuals. These are relevant to any system, care setting or career structure. For nurses and midwives these principles are embodied within the Nursing and Midwifery Council Code: Standards of Conduct Performance and Ethics (2008). These values articulate the manner in which they work and the passion they have for care. These need to be at the core of our practice and support person centred care.

The family of nursing and midwifery will:

- treat people with **care and compassion**, with **dignity and respect** and with **impartiality**;
- work in **partnership and collaboration** with patients, clients, carers and colleagues in the interests of providing high quality care;
- be **accountable** for their actions;
- provide **leadership** to ensure safe and effective care;
- maintain **ongoing competence** throughout their working careers.

These vision and values statements are an integral part of the ways of working, regardless of the setting. Every member of the nursing and midwifery family has a personal responsibility to express these values in the way they interact with patients and clients and each other. These values should underpin every professional decision and are reflected throughout this strategy.

The Strategy for Nursing and Midwifery

A Partnership for Care

Promoting Person Centred Cultures

> Being person centred requires the formation of therapeutic relationships between professionals, patients/clients and others significant to them in their lives and that these relationships are built on mutual trust, understanding and a sharing of collective knowledge
> ***(McCormack & McCance, 2006)***

Through the development of Person Centred Cultures the nursing and midwifery family aim to ensure that the patient/client is an equal partner with the nurse/midwife. Assessing, identifying options for and delivering the most appropriate care for the individual. This involves sharing information on all aspects of the patient/client needs and available services. This requires mutual respect and courtesy.

Effective care, values the rights and needs of individuals and is accessible, responsive and promotes health and wellbeing.

To achieve this we will focus on three key perspectives:

- **ENSURING PERSONAL AND PUBLIC INVOLVEMENT**
- **IMPROVING THE PATIENT/ CLIENT EXPERIENCE**
- **WORKING TOGETHER FOR POSITIVE OUTCOMES**

ENSURING PERSONAL AND PUBLIC INVOLVEMENT (PPI)

Engagement with individuals and communities should be an integral part of service planning, commissioning and delivery. It means discussing with those who use our services and the public: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.
(HSC circular (SQSD) 29/07)

At a Strategic Level

- The Director of Nursing in the Public Health Agency (PHA) and the Directorate of Nursing and Midwifery within DHSSPS, in conjunction with the Patient and Client Council, will ensure the voice of the citizen is heard by supporting the involvement of patients and the public in shaping health policy and influencing service redesign leading to a partnership approach to better health.

- The commitment to PPI will be reflected in the leadership and accountability arrangements within HSC organisations. The nursing and midwifery elements of involvement will be coordinated and monitored by the Director of Nursing within the Public Health Agency in conjunction with the Trust Directors of Nursing, in line with regional strategy.

At an Organisational Level

- Directors of Nursing will adopt a systematic approach to PPI that links corporate decision making to local communities.

- Directors of Nursing will work with PPI leads to ensure a co-ordinated and equitable approach to involvement across the HSC and where relevant the independent, community and voluntary sectors.

At an Individual Level

- Each nurse and midwife will recognise that PPI is part of their responsibilities and demonstrate an individual contribution at their performance review.

- Nurses, midwives and support staff will use every opportunity to put patients, clients and the public in the lead for managing their care through a process of shared decision making.

"If the acquisition of PPI knowledge and skills becomes part of everyone's personal development plans, it will enhance practice, service and also inculcate a sense of ownership of the PPI agenda." (*Nurses and PPI, 2009)*

IMPROVING THE PATIENT/CLIENT EXPERIENCE

Patients and clients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained. This principle should be supported by all health and social care organisations and professional bodies, enabling staff to provide a quality service.
(Improving the Patient and Client Experience, 2008)

At a Strategic Level

- The Chief Nursing Officer (CNO) in partnership with the Director of Nursing at the PHA will oversee the regional implementation and monitoring of the "Improving the Patient and Client Experience" standards.
- A regional working group will develop appropriate measurement methodology that will generate evidence of achievement against the patient and client experience standards.

At an Organisational Level

- Directors of Nursing will ensure that organisational policies have due regard to the implementation of the patient and client experience standards.
- Directors of Nursing, ward sisters and their senior teams will act as inspirational role models providing visible leadership throughout their organisations acting on identified aspects of poor practice.

At an Individual Level

- Nurses and midwives will demonstrate through their behaviour, their role as advocates of quality care through the implementation of the patient and client experience standards and adherence to their code of conduct.
- Nurses, midwives and support staff will proactively seek and act upon a range of feedback to evaluate the impact of the patient and client experience standards.

"Good quality care is everyone's business; it requires champions in the boardroom and at the bedside." (*M Bradley, 2008)*

WORKING TOGETHER FOR POSITIVE OUTCOMES

Health and social care is a complex business; collaborative working, coordination and teamwork are necessary to achieve the positive outcomes nurses and midwives seek for patients and clients.

At a Strategic Level

- Nurses and midwives will work collaboratively within a multi-agency environment to put public health and social well being at the core of the health and social care system.
- The family of nursing and midwifery will secure an integrated and person centred approach to the development of services, within the existing and developing service frameworks.

At an Organisational Level

- Effective commissioning requires effective population needs assessment. Directors of Nursing will support nurses and midwives to work in partnership with community groups, statutory and voluntary agencies to compile and/or contribute to health and social care profiles of local populations to inform the commissioning process.
- Directors of Nursing will work collaboratively to enhance and sustain effective environments that value and support the contribution of nurses and midwives working together with a range of disciplines to achieve positive outcomes.

At an Individual Level

- Nurses and midwives will work in partnership with their patients and clients, in therapeutic relationships, supporting them to make informed choices about their care and treatment.
- Nurses, midwives and support staff will work closely with and value the contributions of the multi-disciplinary team, actively seeking positive outcomes for patients/clients.

"Understand the contribution that effective interdisciplinary team working makes to the delivery of safe and high-quality care.....work with colleagues in ways that best serve the interests of patients."
(GMC,Tomorrow's doctors, 2009)

Delivering Safe and Effective Care

> The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.
> ***(Quality Standards for Health and Social Care, 2006)***

The delivery of safe and effective care is the responsibility of all staff within the health and social care system including the independent, voluntary and community sectors. Nurses and midwives must recognise their personal responsibility and accountability for the delivery of evidenced based care. They will do this through competent decision making and the effective identification and management of risk, recognising and acting on areas of poor practice to ensure the best outcomes for patients and clients.

To achvieve this the family of nursing and midwifery will focus on three key perspectives:

- **BEING ACCOUNTABLE FOR CARE**
- **MANAGING RISK**
- **DELIVERING EVIDENCE BASED CARE**

BEING ACCOUNTABLE FOR CARE

Accountability is integral to professional practice. Nurses and midwives make decisions that effect patient/client care in a wide variety of circumstances and environments based on professional knowledge, judgement and skills. Accepting responsibility and being accountable for such decisions is an essential part of delivering safe and effective care.

At a Strategic Level

- The CNMAC will work with the CNO and senior colleagues to develop a regional accountability framework for nurses and midwives.
- The Local Supervising Authority Midwifery Officer at the PHA will act as a point of contact for supervisors of midwives and provide leadership, support and guidance on a range of matters.

At an Organisational Level

- Directors of Nursing will exercise their executive power and influence from ward to board, acting in the best interests of patients and clients.
- Directors of Nursing will monitor the implementation and maintenance of supervision processes against the regional standards through the annual report submitted to the CNO.
- Midwifery supervision is a statutory function. Supervisors of midwifery will provide a mechanism of support and guidance which will protect women and babies by actively promoting safe standards of care.

At an Individual Level

- Nurses and midwives will demonstrate through their actions understanding of their accountability to patients/clients, employers and the Nursing and Midwifery Council.
- Nurses, midwives and support staff will take ownership for quality care, holding themselves and others to account for the highest standards of care, acting to escalate concerns and address poor standards.

"As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions."
(Nursing & Midwifery Council, 2008)

MANAGING RISK

To ensure the delivery of safe and effective care nurses and midwives must be able to manage risk, embrace accountability, and meet the demands of governance. By adopting an anticipatory approach nurses and midwives can act proactively to minimise risk and provide a high quality service that meets patient/client needs and act on lessons learnt to drive improvements in the quality and safety of services ensuring that practice is informed and improved.

At a Strategic Level

- The Director of Nursing at the PHA will lead on a regional approach to learning from incidents, accidents and reviews including the establishment of a Regional Adverse Incident and Learning (RAIL) system.
- The Directorate of Nursing and Midwifery within DHSSPS will ensure that learning outcomes are fed back into all training and development activities to maximise the learning and reduce the risk of reoccurrence.

At an Organisational Level

- Directors of Nursing will exercise their executive power and influence informing, advising and assisting colleagues at board level to understand how strategic decisions may affect the quality and safety of patient care and the wider patient experience.
- Directors of Nursing will provide active leadership within a governance framework to enable risk to be assessed and managed effectively.

At an Individual Level

- Nurses, midwives and support staff will have access to and work within established risk management policies and processes.
- Nurses and midwives will be able to comprehensively assess and proactively respond to service users' individual needs and identified risks within their sphere of practice.

"…..Hospitals should do the sick no harm."
(F Nightingale, 1820 – 1910)

DELIVERING EVIDENCED BASED CARE

As professionals nurses and midwives must be able to demonstrate the effective integration of evidence, including research findings, into their clinical decision making processes to ensure the delivery of safe and effective care. Evidence based care must therefore be a core component of contemporary nursing and midwifery practice.

At a Strategic Level

- The nursing and midwifery directorate within DHSSPS will ensure professional expertise is fully integrated into decision making processes at policy level.
- The CNMAC Research and Development subgroup will provide leadership and strategic direction for nursing and midwifery research and development in order to improve patient/client experience and outcomes.

At an Organisational Level

- Directors of Nursing will ensure the dissemination of evidenced based policies, procedures, standards and guidelines for nursing and midwifery practice. These will be supported by a dynamic programme of audit to monitor practice and highlight concerns at an early stage.
- Directors of Nursing will support practitioners to develop research expertise and utilise these skills within the healthcare settings.

At an Individual Level

- Nursing and midwifery decisions will be made through a process of critical analysis, characterised by compassion, respect and dignity.
- Nurses and midwives will utilise practice development, research and benchmarking to integrate evidence based care into their practice and will contribute to the development of that evidence.

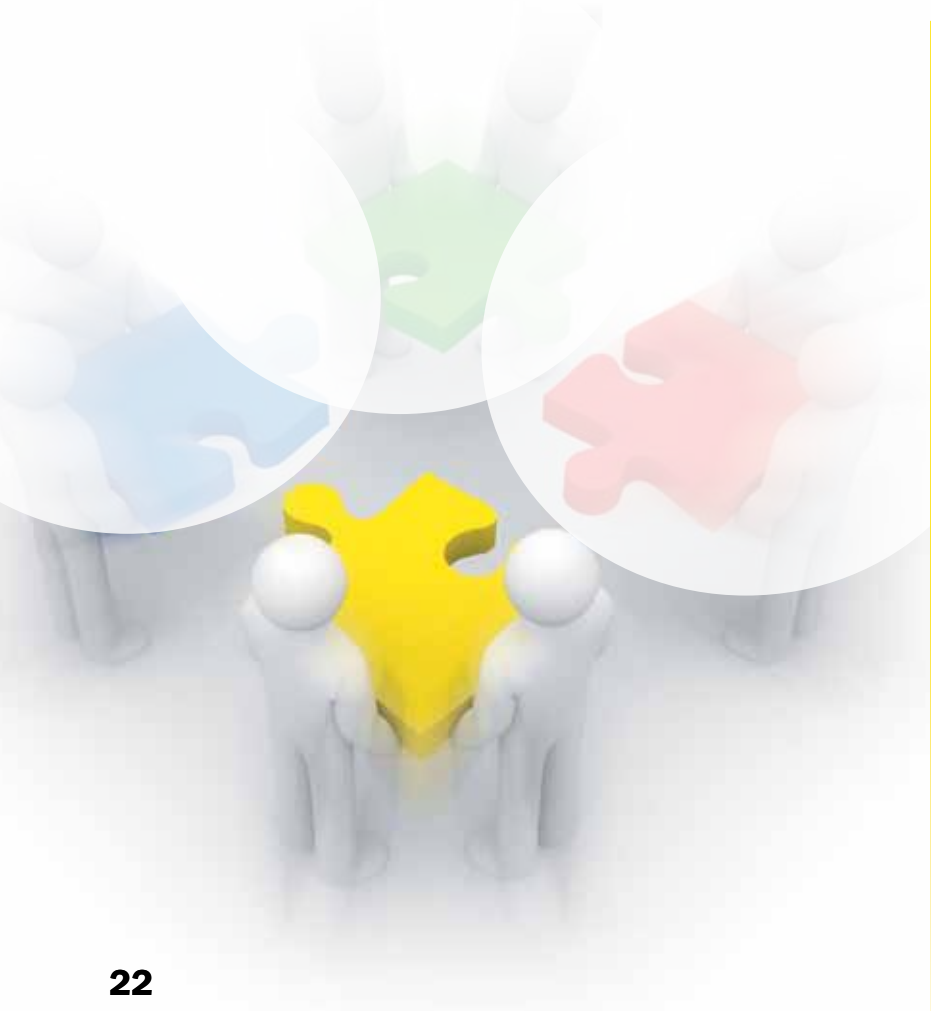
"The translation of discoveries into interventions that deliver benefits for patients and the public requires the involvement of many different disciplines." *(A Shared Vision for UK Health Research, 2010)*

Maximising Resources for Success

> Nursing innovations are key to improvement and progress in health systems worldwide.
> ***(International Council for Nurses, 2009)***

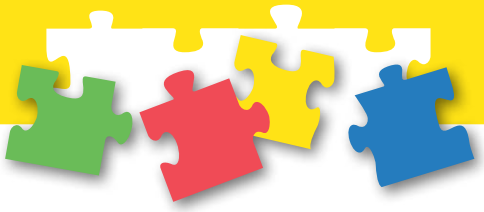
Individuals and organisations need to ensure that public resources are fully utilised and focused to meet the needs of patients and clients, providing and improving health and social care.

This strategy encourages entrepreneurship and innovation balanced with the need to maintain the safety of patients and clients. It recognises that nurses and midwives need to take appropriate actions to maximise the available resources and respond to the needs of patients and clients to ensure the best possible outcomes.



To achieve this the family of nursing and midwifery will focus on three key perspectives:

- **RESPONDING TO NEED**
- **IMPROVING OUTCOMES THROUGH INNOVATION**
- **WORKFORCE PLANNING**



RESPONDING TO NEED

Nurses and midwives are ideally placed to assist in identifying the needs of their patients and clients and to develop new and innovative ways to deliver quality care across a range of settings. New and expanding roles require additional skills and competencies building upon the solid foundations of existing practice and placing patients and clients at the centre of care.

At a Strategic Level

- The changing context of health care delivery will require the focused review of nursing and midwifery practice areas to ensure they are fit for purpose and meeting the needs of patients and clients.
- The CNO and Director of Nursing at the PHA will champion the development of new and innovative ways of delivering high quality, compassionate care.

At an Organisational Level

- Directors of Nursing will adopt the use of service improvement methodologies to design systems and processes which respond to the needs of patients/clients, avoid duplication and maximise the use of resources.
- Directors of Nursing will lead on the assessment of need and development of enhanced roles for nurses and midwives which improve the patient/client experience.

At an Individual Level

- Nurses, midwives and support staff will recognise their unique contribution to improving the health and wellbeing of the population and will work with others to meet the needs of patients/clients.
- Nurses, midwives and support staff will strive to protect and secure optimum independence and self determination for each individual patient/client and their family.

"Every system is designed to achieve exactly the results it gets....if you don't like the results, change the system."
(Don Berwick, Institute of Health care Improvement, 1996)

Maximising Resources for Success

IMPROVING OUTCOMES THROUGH INNOVATION

Those who deliver care are best placed to make improvements in that care. In Northern Ireland nurses and midwives are at the forefront of service re-design, pushing the boundaries and challenging traditional practices. The adoption of a transformational leadership approach will encourage innovation in the development of nurse, midwife and healthcare support roles which harness and develop individual talents to improve outcomes for patients and clients.

At a Strategic Level

- The Directorate of Nursing and Midwifery within DHSSPS will support initiatives such as the Florence Nightingale foundation travel scholarship to enhance nursing and midwifery practice, service delivery and improve patient/client care.
- The Directorate of Nursing and Midwifery within DHSSPS and the Research and Development Office of the PHA will promote access to research opportunities to enhance practice and ultimately improve outcomes for patients and clients.

At an Organisational Level

- Directors of Nursing will promote a "can do" culture within organisations supporting ward sisters/charge nurses/team leaders, individuals and teams to challenge traditional practices to improve patient client care.
- Directors of Nursing will encourage staff to celebrate and share validated innovations and research findings and where appropriate adopt and sustain new ways of working for the benefits of patients/clients.

At an Individual Level

- Nurses, midwives and support staff will identify opportunities for practice/ service improvements and communicate these to line managers.
- Nurses, midwives and support staff will spread and embed innovation and research findings to improve outcomes for patients and clients.

"Society and the health care system will value nurses and midwives not only as clinicians, but also as managers, teachers, researchers, activists, thinkers and policy-makers."
(Commission on the Future of Nursing and Midwifery in England, 2009)

WORKFORCE PLANNING

The management of people and finance go hand in hand. To maximise resources and ensure best possible outcomes for patients and clients the nursing and midwifery family will ensure the right people are in the right place with the right skills at the right time. Effective workforce planning leads to the recruitment and retention of a flexible, responsive and high performing workforce who can meet the needs of service delivery.

At a Strategic Level

- The CNO will task CNMAC to establish a regional workforce planning, development and modernisation subgroup which will advise DHSSPS on a Northern Ireland wide approach to the effective management of supply and demand within the nursing and midwifery professions.

- The Director of Nursing at the PHA in collaboration with Directors of Nursing will build a workforce planning toolkit to ensure the right people with the right skills in the right job. This will include assessment of population health needs, knowledge of current nursing and midwifery staff, their skill-mix, and data on other healthcare professionals.

At an Organisational Level

- Directors of Nursing will be proactive in identifying future nursing and midwifery workforce requirements. This intelligence will influence workforce commissioning to ensure the future needs of patients and clients are met.

- Directors of Nursing will focus on the values and worth of nursing and midwifery, highlighting the strengths and advocating the professions as top careers for the future.

At an Individual Level

- Nurses, midwives and support staff will recognise their skill sets both transferable and specialist to enable them to move flexibly between different environments of care.

- Nurses, midwives and support staff will work with and support one another to help achieve a balance between work and personal life.

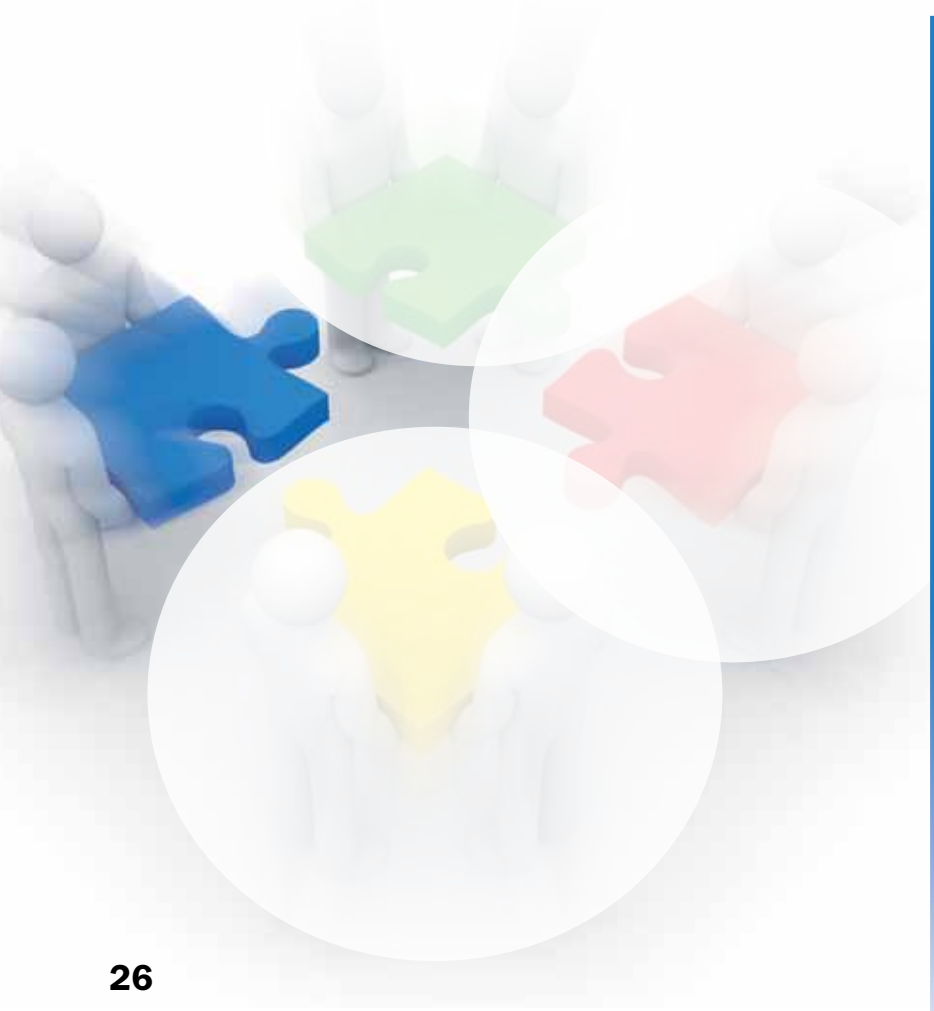
"Effective workforce planning in nursing has a profound impact on patient care – directly effecting factors such as mortality and failure to rescue."
(Professor Anne Marie Rafferty, 2009)

Supporting Learning and Development

> Lifelong learning and development for staff in the Health and Social Care is key to delivering a modern patient and client focused service. It is important that DHSSPS, working with its partners and related sectors, develops and equips staff with the skills they need to support changes and improvements in patient and client care.
> ***(DHSSPS, Workforce Learning Strategy 2009 – 11)***

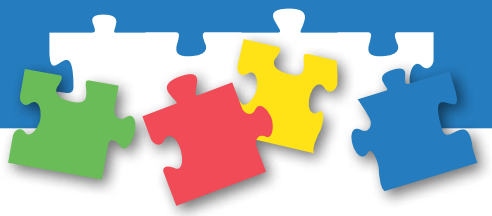
Nurses, midwives and their support staff can only deliver high quality care if they maintain and develop their knowledge and skills, working together respecting one another and communicating effectively. Given the pace of change in the delivery of health care and the rise in public expectations the principles and values of lifelong learning are increasingly important to all members of the nursing and midwifery family.

This strategy will ensure that within supportive culture, learning and development will continue to contribute to a knowledgeable and dynamic workforce, supported by strong and visible leadership at all levels.



To achieve this the family of nursing and midwifery will focus on three key perspectives:

- **PROMOTING A LEARNING CULTURE**
- **DEVELOPING THE WORKFORCE**
- **DEVELOPING LEADERSHIP**



PROMOTING A LEARNING CULTURE

A culture of learning does not necessarily develop spontaneously; it has to be nurtured, supported and developed over a period of time. Within a culture of learning the family of nursing and midwifery will create, acquire and transfer knowledge enabling staff to reflect upon practice and with new knowledge and insights improve outcomes for patients and clients.

At a Strategic Level

- Based on the learning needs analysis of nursing and midwifery the Education Commissioning Group will work in partnership with service and education providers to commission courses and development opportunities based on the needs of patient/clients. The impact of this learning will be evaluated to determine its bearing on practice.

- The CNO in association with NIPEC will adopt a regional approach to knowledge management through the practice and quality development database which will spark innovation, operational improvement and enhanced care.

At an Organisational Level

- Directors of Nursing will embrace the principles of a learning organisation ensuring that a learning and development action plan is implemented in each organisation and its impact evaluated.

- Directors of Nursing will promote fair and equitable access to learning and development. This will support the Knowledge and Skills Framework and the appraisal/personal development process to meet training needs and demonstrate learning outcomes.

At an Individual Level

- Nurses, midwives and support staff will take responsibility for their personal development and career plan maximising formal, informal and experiential learning opportunities.

- Nurses, midwives and support staff will actively participate in practice development opportunities and share the learning with others to improve outcomes for patients and clients.

"In a learning organisation people continually expand their capacity to create the results they truly desire, new and expansive patterns of thinking are nurtured, collective aspiration is set free, and people are continually learning to see the whole together." (*Peter Senge, 1990)*

DEVELOPING THE WORKFORCE

Within health and social care the workforce is the greatest resource and asset. In a context of continuing change and developments in people's health and social care needs, advancing technology and rising public expectations the pattern of practice and the organization of care delivery creates both challenges and opportunities for nurses, midwives and support staff in working towards improvements in care.

At a Strategic Level

- The CNMAC workforce planning, development and modernisation subgroup will review the outcomes of the Modernising Nursing Careers and Midwifery 2020 initiatives and advise on new ways of working including the role of nurse consultants and health care support workers.
- Building on the work already undertaken in the development of a post registration career framework we will adopt a skills escalator approach to support flexible career paths.

At an Organisational Level

- Directors of Nursing will encourage and promote confidence in staff to develop new skills and knowledge supporting the development of new roles which will improve patient/client care.
- Directors of Nursing will embed the practice education coordinator and facilitator roles, to support learners in practice.

At an Individual Level

- Nurses, midwives and support staff will engage in continuing development that will enhance practice and meet career aspirations.
- Nurses and midwives will facilitate the professional and personal development of others, demonstrating leadership, reflective practice, supervision, quality improvement and teaching skills.

"Health care provision requires that practitioners possess the knowledge and skills to respond and adapt to current and future health care priorities and needs." (*WHO, Strategic Directions for Nursing and Midwifery, 2002)*

DEVELOPING LEADERSHIP

Leadership in nursing and midwifery is crucial to the quality of patient/ client care and to the development of the professions. Leaders need to be confident, competent, well motivated, self aware, and socially skilled. They need to be team players who are able to work with others across professional and organisational boundaries. In short good leaders make positive, tangible changes to the delivery of care.

At a Strategic Level

- The CNO working with the Director of Nursing at the PHA will provide professional leadership to the family of nursing and midwifery, working closely with statutory bodies, professional and staff associations, HSC Trusts and the voluntary and independent sectors.
- Nursing and midwifery will adopt a succession planning approach to leadership development, identifying and nurturing leaders of the future in a commitment to ensure continuous, seamless leadership transition.

At an Organisational Level

- Directors of Nursing will provide strategic leadership and act as role models to ensure safe and sustainable services.
- Ward Sisters, Charge Nurses and Team Leaders will provide leadership to frontline teams ensuring the delivery of safe, effective compassionate care.

At an Individual Level

- Nurses, midwives and support staff will set an example of excellence for others.
- Each nurse and midwife will be prepared to lead and be accountable for improvements in patient care.

"The ability of midwives to be strategic leaders in service, policy and higher education requires that these roles are there to start with; and that midwives have the expertise, credibility and leadership skills to represent the profession and its contributions." (*Delivering high quality midwifery care, 2009)*

Where do we go from here

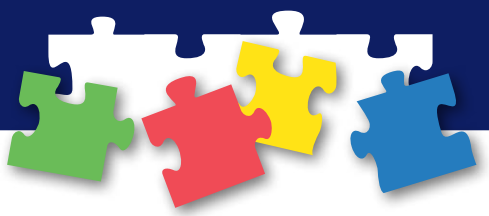
This strategy outlines a strategic vision for the family of nursing and midwifery in Northern Ireland. Each of our strategic themes of Prompting Person Centred Cultures, Delivering Safe and Effective Care, Maximising Resources for Success and Supporting Learning and Development have identified three perspectives through which together we will achieve our vision.

At an individual level each nurse, midwife and support worker has a responsibility to embrace the perspectives expressed in this strategy.

At an organisational level Executive Directors of Nursing will develop action plans that will bring forward the implementation of this strategy and its key perspectives.

At a strategic level the CNO and the Director of Nursing in the PHA will support and monitor the progress of this strategy.

Appendix 1 – Summary of Policy Documents



Developing Better Services; Modernising Hospitals and Reforming Structures - published in June 2002 this document contained a range of proposals for modernising acute hospital services, building on the recommendations from the Acute Hospitals Review Group report of 2000. The key areas addressed were the future configuration of hospital services; future organisational structures and workforce. These issues have subsequently been largely subsumed by the Review of Public Administration and the introduction of Agenda for Change.

Investing for Health – also published in 2002 this document presented a cross-departmental, multi-sectoral framework for action to improve health and wellbeing in Northern Ireland by setting out how the Northern Ireland Executive plans to achieve its aim of 'working for a healthier people'.

The strategy recognises the important contribution made by members of statutory and non-statutory groups and identifies the principles and values that should guide future action to improve health highlighting the cost of poor health to the individual, families and to the economy.

A review of the investing for health strategy is underway and is due to be concluded by mid 2010.

A Healthier Future - this regional strategy for health and wellbeing was published in December 2004.The strategy is a vision for health and wellbeing in Northern Ireland over the next twenty years and intends to give the direction of travel for health and social services.

The strategy places a strong emphasis on:

- promoting public health;
- engagement with people and communities to improve health and wellbeing;
- the development of responsive and integrated services which will aim to treat people in communities rather than in hospital;
- new, more effective and efficient ways of working through multi-disciplinary teams;
- measures to improve the quality of services; and
- flexible plans, appropriate organisational structures and effective, efficient processes to support implementation of the strategy.

Appendix 1 – Summary of Policy Documents

In April 2009, the Minister launched the new Public Health Agency. This saw a range of functions in Health and Social Care brought together to focus on improving the health and wellbeing of everyone in Northern Ireland. This restructuring is an opportunity to create a system for health and social care services and health promotion that can deliver more effectively on the vision, strategic themes and policy directions set out in A Healthier Future.

Caring for People Beyond Tomorrow published in October 2005 is a primary health and social care strategic framework for individuals, families and communities in Northern Ireland. This strategy sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

Key aspects of the Strategic Framework are:

- A service focused on providing comprehensive person centred care;
- A first point of contact that is readily accessible and responsive to meet people's needs day or night;
- A co-ordinated, integrated service employing a team approach with multi-agency linkages;
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered;
- A focus on prevention, health education and effective self-care.

The Review of Public Administration (RPA) was launched by the Northern Ireland Executive in June 2002 with the final outcome announced by the Secretary of State in November 2005. Its purpose was to review Northern Ireland's system of public administration with a view to putting in place modern, accountable and effective arrangements for public service delivery in Northern Ireland. It allowed for joined up thinking and the promotion of key cross cutting values such as efficiency, equality, accountability and co-terminosity.

Within Health and Social Care there were two major phases for implementation of the RPA. The first phase involved the establishment of the 5 new integrated HSC Trusts and the retention of the NI Ambulance Trust with effect from 1 April 2007. The second phase completed in April 2009 witnessed the establishment of a Health and Social Care Board, a new Public Health Agency and a Patient Client Council to replace the previous four boards and health and social services council structure.

Changing the Culture published in 2006, sets out a three year action plan to minimise Healthcare Acquired Infections. The key areas within the document are as follows:

- Organisation and culture;
- Education, training and practices;
- Governance, accountability and audit;
- Surveillance;
- Patient and public partnerships.

Since the publication of this document a range of activities have been undertaken, including a full review of the action plan entitled Changing the Culture 2010.

The Bamford Review published in 2007 is a series of eleven reports which outline a strategic direction for Northern Ireland to modernise and reform mental health and learning disability policy and service provision. The reports set out a clear vision on how an excellent service for those with mental health and or learning disabilities and their families can be provided, with the service user experience at the heart of any improvement.

The Bamford Action Plan (2009 – 2011) sets out the governments commitment to improving mental health and wellbeing of the population of Northern Ireland and to driving service improvement for those with a mental health need or a learning disability.

Improving the Patient, Client Experience Standards published in 2008, sets out the five standards relating to respect, attitude, behaviour, communication, privacy and dignity describing what the public should expect from staff in the health service.

References

Berwick, D.M (1996) *A primer on leading the improvement of systems*. BMJ 1996;3127031:619–622.

DHSSPS (2002) *Developing Better Services; Modernising Hospitals and Reforming Structures*.
http://www.dhsspsni.gov.uk/index/hss/developing_better_services.htm

DHSSPS (2008) *Improving the Patient and Client experience*. Produced for DHSSPS by NIPEC in partnership with the RCN.
http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

DHSSPS (2002) *Investing for Health*.
http://www.dhsspsni.gov.uk/invest1.pdf

DHSSPS (2004) *A Healthier Future*. A Twenty Year Vision for Health and Wellbeing in Northern Ireland.
http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

DHSSPS (2005) *Caring for People Beyond Tomorrow*. A strategic framework for the development.
http://www.dhsspsni.gov.uk/primarycare05.pdf

DHSSPS (2007) HSC Circular 29/07 *Guidance on strengthening personal and public involvement in health and social care*.
http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

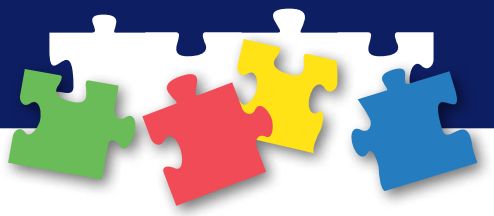
DHSSPS (2009) *Review of the Nursing and Midwifery Workforce*. ASM Horwath.

DHSSPS (2006) *Quality Standards for Health and Social Care*.
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

DHSSPS (2009) *Workforce Learning Strategy for the Northern Ireland Health and Social Care Services 2009 – 2014*.
http://www.dhsspsni.gov.uk/workforce-learning-strategy-apr-2009.pdf

DoH (2009) *Delivering high quality midwifery care: the priorities, opportunities and challenges for midwives*.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106064.pdf

DoH (2006) *Modernising Nursing Careers – Setting the Direction*. Department of Health. London.
http://www.dhsspsni.gov.uk/index/nmag/nmag-projects/nmag-modernising_nursing_careers.htm



General Medical Council (2009) *Tomorrows doctors. Outcomes and standards for undergraduate medical education*.
http://www.gmc-uk.org/static/documents/content/TomorrowsDoctors_2009.pdf

International Council of Nurses (2001) *Definition and Characteristics of the Role*. Advanced Practice Network.
http://www.icn-apnetwork.org/

International Council of Nurses Innovations Database, accessed December 2009.
http://www.icn.ch/innovations/

London Southbank University (2009) *Nurses and Patient and Public involvement:* A consultation in Four Strategic Health Authorities in England. Commissioned by the Royal College of Nursing.
http://www.rcn.org.uk/__data/assets/pdf_file/0007/269242/LSBU_Nurses_-and-_PPI_Short_Report.pdf

McCormack, B. McCance, T. (2006). *The development of a framework for Person – Centred Nursing*. Journal of Advanced Nursing

Nightingale, F. (1860) *Notes on Nursing. What it is and what it is not*. D Appleton and company. New York.
http://digital.library.upenn.edu/women/nightingale/nursing/nursing.html

Nursing and Midwifery Council (2008) *Advice sheet on accountability*. NMC London.
http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4018

Nursing and Midwifery Council (2008) *The Code. Standards of conduct, performance and ethics for nurses and midwives*. NMC: London.
http://www.nmc-uk.org/aArticle.aspx?ArticleID=3057

Nursing and Midwifery Council (2009) *Standards for pre registration midwifery education*. NMC London.
http://www.nmc-uk.org/aArticle.aspx?ArticleID=2867

Office for Strategic Coordination of Health Research (2010) *A Shared Vision for UK Health Research*.
www.centralservicesagency.com/files/rdofficedocs/file/Shared%20Vision%20for%20UK%20Health%20Research.pdf

References

Prime Ministers commission on the Future of Nursing in England (2009)
The Commission's current vision of the future of nursing and midwifery in England.
http://cnm.independent.gov.uk/second-phase/summary-vision/

Senge, P. (1996). *The Fifth Discipline: Art and Practice of the Learning Organization*. Doubleday. USA.

Rafferty AM (2009) Press Release. *Kings Fund to lead UK branch of largest ever nursing workforce study in Europe*.
http://www.rn4cast.eu/attachments/UK%20press%20release[1].pdf

RPA (2005) *Review of Public Administration in Northern Ireland. A Further Consultation*.
http://www.rpani.gov.uk/2005_consultation_doc.pdf

World Health Organisation (2002) *Nursing and Midwifery Services, Strategic Directions 2002 – 2008*.
http://www.searo.who.int/LinkFiles/Resources_Anglais.pdf

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Llywodraeth Cymru
Welsh Government

The Scottish Government

Strengthening the commitment

The report of the UK Modernising Learning Disabilities Nursing Review

Contents

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.

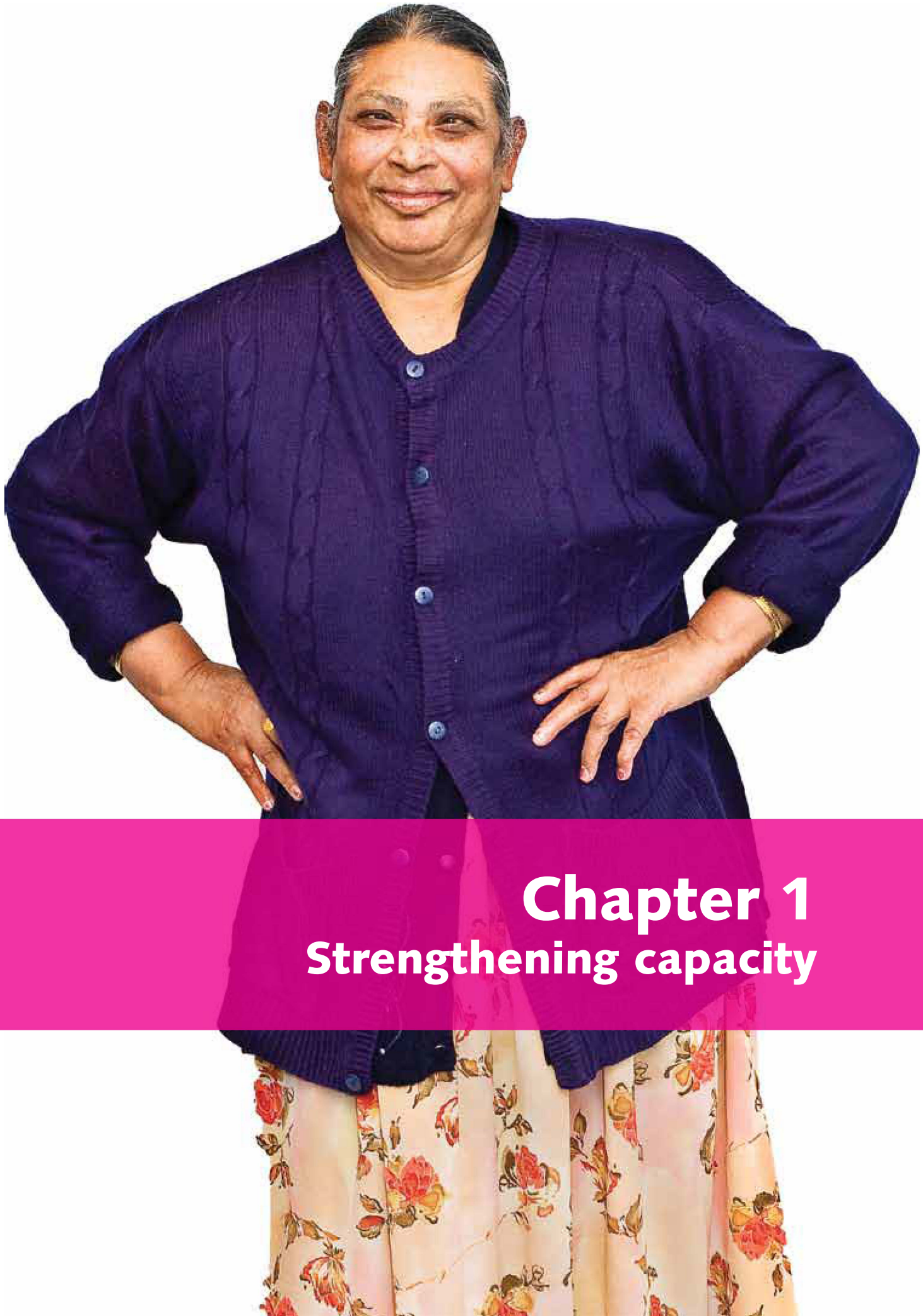
[F] NHS provision may include partly or fully integrated health and social care structures/services.

"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.

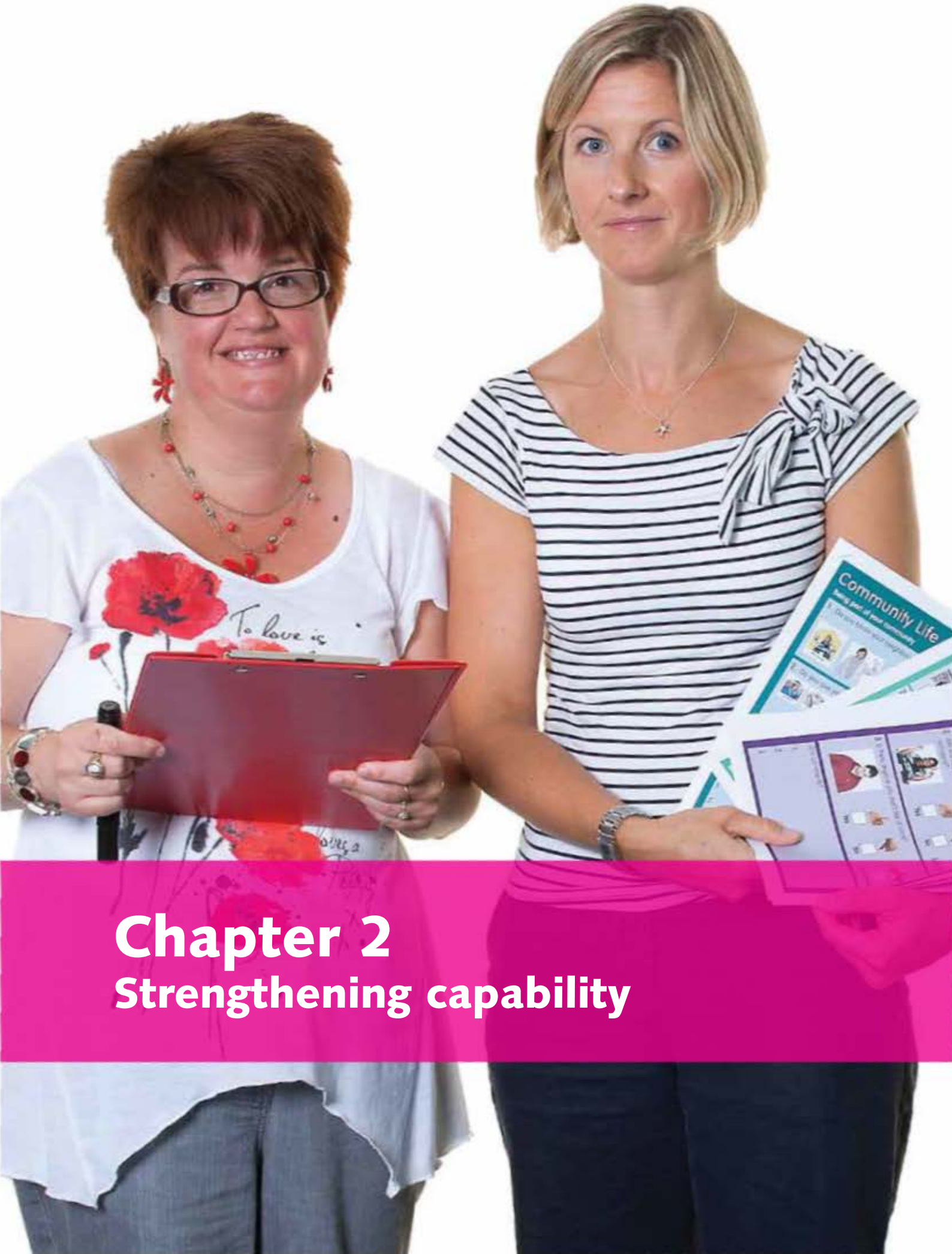
For care and treatment to be equitable, adjustments need to be made so that the health care experiences and outcomes of people with learning disabilities in hospital are improved. An example of reasonable adjustments at St George's involved Trevor, a man who had capacity to consent to have dialysis but 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] and Paul Thomas at [redacted]

Older age

Learning disabilities nurses must be prepared for the continuing rise in the number of older people with learning disabilities. These individuals are at risk of a range of physical and mental health conditions and may be frequent users of health and care services and other related agencies. In addition, some people with learning disabilities may be at risk from conditions that are similar to those experienced by older people (such as dementia), but may be too young to access generic older people's care services.

Recommendation 6

Commissioners and providers of health and social care should ensure the skills, knowledge and expertise of learning disabilities nurses are available across the lifespan. This should be enabled through effective collaborative working across health and social care structures.

2.3 Addressing health needs

Where we are now

There is strong evidence that people with learning disabilities have poorer physical and mental health and greater health needs (including needs related to behavioural difficulties) than the general population. In addition, many have difficulties accessing and using general health services. Learning disabilities nurses have expertise in facilitating and supporting access to general health care services.

The Nursing and Midwifery Council (NMC) standards for pre-registration nursing education (18) reflect the health role and function of learning disabilities nurses, stating:

> *"Learning disabilities nurses must have an enhanced knowledge of the health and developmental needs of all people with learning disabilities, and the factors that might influence them. They must aim to improve and maintain their health and independence through skilled direct and indirect nursing care. They must also be able to provide direct care to meet the essential and complex physical and mental health needs of people with learning disabilities."*

The contribution of learning disabilities nursing in addressing health needs within the social model of disability has been the source of some confusion. It is important that learning disabilities nurses and services recognise that poor health (in its widest context) limits participation in society.

Where we want to be

As the Learning Disability Consultant Nurse Network (19) states:

> *"The primary focus of learning disabilities nursing interventions within the social model of disability is upon reducing or eliminating barriers to good health and thereby increasing social inclusion."*

Learning disabilities nurses and their employers should recognise their crucial responsibility in improving health and well-being and reducing inequalities and should engage actively in commissioning, designing, monitoring and delivering services to ensure their accessibility.

A partnership approach across the lifespan involving primary care, child health, mental health, secondary care and specialist learning disabilities health services is essential.

Learning disabilities nurses are ideally placed to contribute to the preventative, early-intervention, strengths-based and public health approaches that are increasingly being applied to the general population to address health needs. While health promotion activity has been at the forefront of learning disabilities nurses' practice for many years, other more proactive preventative and public health approaches to addressing health needs have been less visible in their day-to-day work.

This broader holistic approach to addressing health needs will:

- ensure preventative action and early intervention is a core component of assessment and care planning;
- encourage people with learning disabilities, their families and carers to take a more active role in controlling their own health; and
- support strengths- or assets-based approaches to care and interventions.

There is a clear need for public health interventions to meet the needs of people with learning disabilities, their families and carers and for learning disabilities nurses to engage with colleagues within public health, primary care and other relevant health and cross-sectoral agencies, such as criminal justice and homelessness services.

A proposed model for addressing health needs in the context of learning disabilities nursing is set out in Fig. 1.

Fig. 1

Proposed model for addressing health needs in the context of learning disabilities nursing

Context		Nursing roles/interventions		Outcomes
Working with children	→	Family support. Early intervention. Skills teaching.	→	Maximised potential of the child. Improved interagency working. Reduced incidence of long-term health issues.
Inequalities in health	→	Health screening/facilitation. Health action planning/ interventions. Improving access. Education of others. Policy-influencing. Advocacy.	→	Healthier lifestyles. Reduced morbidity and mortality. Reduced risk for patients in generic services. Social inclusion.
Working with parents and families	→	Supporting parents and siblings of people with learning disabilities. Supporting parents with learning disability. Family therapy. Education/awareness.	→	Family-orientated service delivery. Reduced safeguarding issues. Improved family health and lifestyle.
People facing additional risks	→	Targeting relevant public health needs (e.g. mental health, drugs/alcohol and sexuality). Group interventions. Strengths-based approaches.	→	Enhanced self-care, peer support and independence. Reduced risk and safeguarding issues. Reduced self-harm and distress.
Commissioning	→	Caseload/population needs assessment.	→	Improved and informed commissioning of services.

Positive practice example

Health facilitation

The health facilitator role focuses on ensuring people with learning disabilities live healthier lives and enjoy better health. A significant number of adults with learning disabilities are not receiving a service from community learning disabilities teams but are known to GP practice staff.

A database is presently being constructed in the Southern Trust region of Northern Ireland to provide accurate figures. All practices have been visited by the health care facilitator who will:

- meet with the practice manager to cross-reference names of adults with learning disabilities with practice population lists;
- deliver an education session to GPs, practice nurses and reception staff on health needs and barriers to meeting need;
- encourage practice staff to establish clinics and complete a thorough health check on each individual;
- explain the requirements of the direct enhanced services (DES); and
- agree dates for clinics with GPs and advise on how to ensure good uptake of appointments.

Figures from primary care show that 932 health assessments were carried out in 2009 and 904 in 2010. GPs and practice nursing staff appreciate clinical input and support to develop understanding about people with learning disabilities, especially around behaviour management, communication difficulties, consent issues and health needs. Analysis to date suggests that practices with the health facilitator on site are more likely to meet the requirements of the DES.

A large number of health issues have been identified, including obesity, diabetes, hypertension, lack of medication review and lack of electrocardiograms for people on anti-psychotic medication. Many of these health issues have previously been undetected and unaddressed. GPs and practice staff have developed a rapport with people with learning disabilities, their families and carers, and practice staff have a better understanding of their health issues.

For further information, contact Brea Crothers at [redacted] or Marie Loughran at [redacted]

Recommendation 7

Commissioners and providers of health and social care should ensure that learning disabilities nurses are able to collaborative effectively with general health services, including mental health services, to address the barriers that exist for people with learning disabilities to improving their health. This should include proactive health improvement, prevention, whole-family and public health approaches.

2.4 Providing specialist services

Where we are now

Existing specialist services, when appropriately deployed, provide early intervention, crisis resolution and outreach that can reduce unnecessary admissions to hospital through expert assessment, care planning, interventions and evaluations for individuals and their families.

The need for specialist nursing skills in these areas is already significant and is likely to grow in the future. Learning disabilities nurses working within specialist services should possess, or be working towards developing, the appropriate specialist skills and should be able to demonstrate higher levels of judgement, discretion and decision-making in clinical care (20) relevant to their role.

Where we want to be

Evidence collected by the review suggests that assessment and treatment services could further develop and use a range of therapeutic interventions that have positive outcomes for people with learning disabilities. This would require further support and investment in education and development. The specialist role of learning disabilities nursing within assessment and treatment services must therefore be supported through the development of appropriate models of care and provision of relevant education support.

Health care providers and commissioners should review the needs of their populations and make provision to ensure delivery of specialist learning disabilities nursing skills where needed. This may involve reviewing their current workforce configuration and increasing collaboration with education providers.

To ensure that people with learning disabilities and their families receive the best holistic care, skills traditionally associated with acute and community nursing will need to become a core part of learning disabilities nurses' "toolkit".

Positive practice example

Specialist services

A low-secure unit that provides assessment and treatment for men with learning disabilities and forensic issues in Northern Ireland has developed group work and 1:1 therapeutic work for individuals who exhibit behaviours (or who are at risk of committing behaviours) that are sexually harmful to others.

The assessment and treatment programme initially implemented for this group was the Home Office accredited "Adapted Sex Offender Treatment Programme". Prior to implementation, two nursing staff were required to undertake intensive accredited training in advanced group work delivery and complete a period of secondment with probation services, delivering programmes and compiling risk assessments and management plans for offenders. Further training was then completed to deliver treatment specifically to those with learning disabilities.

The programme was based on the cognitive behavioural therapy model, giving individuals the opportunity to take responsibility for their offending behaviour and work towards skills development that would help them identify their specific areas of dynamic risk and formulate relapse-prevention strategies to lower their risk of reoffending.

The work was acknowledged in 2008 when two nurses from the hospital were granted the RCN Nurse of the Year for Northern Ireland award in recognition of setting up and facilitating a programme of treatment that at the time was unparalleled in Northern Ireland.

Nursing staff are providing consultancy on facilitation techniques, programme content and delivery. It is envisaged that nurses who are already qualified to deliver advanced group work will also become involved in training other staff to deliver the new programme. This will lead to a core group of nurses within the hospital who are able to work as therapists, delivering treatment within group work and 1:1 settings and compiling risk assessments and management plans in partnership with people with learning disabilities to facilitate return to community living in the most appropriate and safest way.

For further information, contact Rhonda Scott at [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

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Chapter 3. Strengthening quality

This chapter addresses some of the key considerations underpinning quality. Clearly, the appropriate preparation and development of learning disabilities nursing will contribute to all chapters of this report, but in this case has been linked to quality in relation to the following issues:

- **demonstrating quality outcomes**
- **quality improvement**
- **preparing and developing learning disabilities nurses**
- **maximising recruitment and retention**
- **developing workforce knowledge and skills for the future**
- **accessing supervision.**

3.1 Demonstrating quality outcomes

Where we are now

Demonstrating the quality, effectiveness and impact of learning disabilities nursing through outcome measurement presents a range of challenges, not least of which is the fact that learning disabilities nurses' work is often placed within a wider interdisciplinary and interagency team context that makes it difficult to identify their particular contribution to achieving outcomes.

Where we want to be

Positive health outcomes not only improve people's health status and quality of life, but also contribute to the achievement of organisational and policy drivers such as person-centredness, safety, effectiveness and efficiency through improving access to general health services, preventing admissions to hospital and securing early discharge.

A measurement framework of outcomes and outcome indicators would allow learning disabilities nurses to demonstrate their effectiveness in assessments, care planning and nursing interventions at individual and service levels within a multidisciplinary context. The potential for such measurement frameworks to be adapted and used across sectors to support health and social care integration should be explored.

A measurement framework should focus on effective assessment, care planning, intervention and evaluation. All interventions by nurses, individually or as part of a wider team, should be based on a competent and structured nursing assessment of the abilities and needs of the person with learning disabilities. Person-centred objectives for nursing interventions with identified timescales for evaluation should then be clearly written within nursing care plans.

An agreed set of indicators developed in collaboration with nurses and people with learning disabilities, their families and carers would allow the contribution of learning disabilities nurses to be evidenced and measured. This is particularly important given the current emphasis on efficiency, effectiveness and added value.

A range of outcomes and outcome indicators can identify effective and high-quality nursing care related to specific roles and practice settings. Examples may include:

- improvements in health status
- increasing access to general health services
- promoting independence and social functioning
- improving nutrition
- enhancing psychological and emotional well-being
- reducing seizures.

A more targeted and specific approach to outcome measurement dependent on role, function and setting may also be necessary. Role-specific indicators (for learning disabilities nurses employed, for example, as health facilitators or those working in acute liaison roles or within forensic services), condition-specific indicators (such as for epilepsy nurses), patient experience and quality-of-life outcome measures (via service user questionnaires and surveys, complaints and compliments, for example) and inclusion of learning disabilities in measurement of generic key performance indicators at service or policy level or via established rating scales (such as the Health of the Nation Outcome Scales for People with Learning Disabilities (HONOS-LD) (21)) will be required.

It is important that people with learning disabilities, their families and carers are involved in determining the outcomes.

Positive practice example

Developing behavioural family therapy

A specialist learning disabilities nurse in Lothian has worked with other clinicians in adapting and delivering behavioural family therapy (BFT) for people with learning disabilities and has trained 18 nurses to use the approach. The service now has three BFT trainers who specialise in learning disabilities and has developed close links with general mental health clinicians and trainers.

The approach is being implemented within several community learning disabilities teams. Clinicians now routinely use a series of outcome measures to monitor its effectiveness, with the client completing the Clinical Outcomes in Routine Evaluation – Learning Disability (CORE-LD) assessment and family members completing the Caregiver Strain Questionnaire (CGSQ) and the Family Functioning Questionnaire (FFQ). Care agency staff also complete an adjusted FFQ.

A successful case study demonstrating a reduction in carer stress for a family member and an increase in functioning for support staff and the family member was presented at the British Association of Behavioural and Cognitive Psychotherapy conference in 2011. A case series of five families was presented at the Seattle Club conference on research in intellectual and developmental disabilities in 2011. The results demonstrated a decrease in family stress on the CGSQ over the five cases, with family functioning improving in all members. There was a decrease in levels of distress in three of the four people with learning disabilities who completed the CORE-LD. It is noteworthy that services had been involved over a prolonged period of time for all five cases, suggesting that their problems were longstanding and that other treatment approaches had not been effective.

Learning disabilities nurses have increased knowledge and confidence following BFT training. The training has also given clinicians a clear structure to deliver the approach. Regular supervision has helped to maintain delivery while maintaining clinician confidence. Plans to further develop this work include:

- continuing to develop the evidence base evaluating the efficacy of the approach;
- expanding the BFT training to all community learning disabilities teams in NHS Lothian and continuing to expand the supervision network;
- developing better pathways for referrals and level of intensity of BFT based on the complexity of mental health issues;
- extending the BFT training to social work, allowing better joint working between health and social care; and
- establishing links with NHS Education for Scotland with a view to developing the approach for nurses on a wider scale.

For further information, contact Keith Marshall at [redacted]

Recommendation 9

Learning disabilities nurses, their managers and leaders should develop and apply outcomes-focused measurement frameworks to evidence their contribution to improving person-centred health outcomes and demonstrating value for money. This may require a specific piece of work to scope current frameworks.

3.2 Quality improvement

Where we are now
Learning disabilities nurses embrace the wider drive for evidence-based practice and improvement, but their contribution could be enhanced. Transformational work is currently being undertaken across the UK under patient safety programmes and work to drive quality, innovation, productivity and prevention. Elements of learning disabilities nursing practice may benefit from the systematic application of productivity tools like the Productive Series/Releasing Time to Care and robust improvement science.

Where we want to be
Learning disabilities nurses should increase their involvement in the range of transformational work, productivity, improvement and practice development.

Recommendation 10

Learning disabilities nurses should strengthen their involvement and links to transformational work, productivity improvement and practice development.

3.3 Preparing and developing learning disabilities nurses

Where we are now
A well-prepared, developed and supported workforce at all levels is essential to the delivery of quality health care for people with learning disabilities, and education and training throughout the career pathway is key to achieving this.

People with learning disabilities, their families and carers should be involved in all aspects of curriculum design, development and delivery.

Person-centred care (22) should be the foundation of learning disabilities nurse education. It has been defined as:

> *"... the delivery of a healthcare experience that recognises and responds flexibly to each person as a unique individual, builds trust and empathy, and engages them in decisions that affect their healthcare and wellbeing. Person-centred care is an approach which recognises that the quality of communication and human engagement with the person receiving healthcare will underpin the effectiveness of the clinical encounter, and therefore impact on the person's healthcare experience and outcomes."*

This means working alongside people to identify meaningful goals that fit with their aspirations and the outcomes they want to achieve, rather than focusing on what health and social services think people need.

Where we want to be
Pre- and post-registration education programmes should be designed to reflect issues such as person-centred care and the personalisation agenda and the more complex care needs that are now presenting within the population.

This review focuses on learning disabilities nurses, but the importance of all nursing students at undergraduate level developing core knowledge and skills to work with people with learning disabilities, their families and carers cannot be ignored. This has been emphasised with the NMC standards for pre-registration nursing education (20) and the Michael Report into access to health care for people with learning disabilities (23).

Positive practice example

Supporting the development of skills and knowledge in other fields of nursing (percutaneous endoscopic gastrostomy (PEG))

People who are reliant on their nutrition, hydration and medication being administered via PEG can experience difficulties when their devices block or are removed. This can result in attendance at accident and emergency departments. Community learning disabilities nurses in Swansea work in collaboration with the accident and emergency liaison nurse, specialist nutrition nurse and hospital nurse practitioners to develop individual pathways for direct access to intervention. The outcomes of this work include:

- clear and safe pathways to access secondary care
- reduced risk of invasive interventions such as surgery or endoscopic procedures.

The nurses also identified that people with learning disabilities who had enteral feeding needs were sometimes having to access nursing home facilities for respite care, were relying on registered nurse home visits for domiciliary care, and were unable to access day services unless registered nurses were available. The community learning disabilities nurses worked in partnership with a wide range of organisations to develop a programme of training for independent sector care providers and social services to enable individualised person-centred care plans to be devised, meaning people no longer have to access nursing environments for respite and day services or be reliant on district or continuing care nursing services to deliver support. This process entailed seamless joint working and planning to minimise the identified risks to individuals and those involved in their care, while promoting person-centred services.

For further information, contact Helen Lewis at [redacted]
or Paula Phillips at [redacted]

Recommendation 11

Those who commission, develop or deliver education should ensure that all learning disabilities nursing education programmes reflect the key values, content and approaches recommended in this report. They should also ensure that nurses in other fields of practice develop the core knowledge and skills necessary to work safely and appropriately with people with learning disabilities who are using general health services.

3.4 Maximising recruitment and retention

Where we are now

As we noted previously, the number of providers of pre-registration learning disabilities nursing education has reduced over the years. This will need to be addressed to reflect population and workforce planning needs.

Access to learning disabilities nurse preparation can be problematic for students in some parts of the UK, including remote and rural areas where no learning disabilities nursing education programmes are available locally. High attrition rates are a problem on some pre-registration programmes and the changing face of service provision for people with learning disabilities requires higher education institutions to develop a range of options for clinical placements that support the attainment of competences required by the NMC.

Throughout the review, students said that they feel more valued and better supported where there is strong mentorship in practice placements and close collaboration between practice and education settings. There are opportunities for learning disabilities nursing to trailblaze new models of delivery in education programmes that strengthen work-based support for students and enhance partnership working between education and practice settings.

Where we want to be

New approaches to identify and engage with potential recruitment pools, particularly existing nonregistered staff and students undertaking higher national certificate (HNC) programmes in further education colleges, are required. These opportunities are currently underexploited. The use of IT and social media may offer a route to accessing these groups.

The development of a wider range of accelerated routes and award models could further maximise potential to recruit from existing groups, including nurses on other parts of the register and people wishing to change their careers.

The wide range of educational technology now available provides more flexible options in relation to delivery of education programmes. Flexible and sustainable models of pre-registration curriculum development offer the most positive options for future progression in learning disabilities nursing, and the NMC standards promote these kinds of approaches. Models that support flexibility and sustainability, such as hub and spoke, blended learning approaches and disseminated models, should be considered to support effective delivery of pre-registration education across the UK. Innovative approaches to programme design and delivery that involve people with learning disabilities and families, promote rights-based and person-centred approaches and review options in interprofessional education must be more widely explored.

Recommendation 12

Updated strategic plans for pre- and post-registration learning disabilities nursing programmes are necessary for each country of the UK to support flexibility and ensure an efficient and sustainable model of delivery for the long term. This highlights the need for appropriate numbers of places on pre-registration learning disabilities nursing programmes to meet future workforce requirements.

3.5 Developing workforce knowledge and skills for the future

Where we are now

Post-registration education and continuing professional development (CPD) options are restricted by the relatively small learning disabilities nursing workforce. In addition, data on education needs and development opportunities, including those at post-registration level, are not easily available.

The skills profile of learning disabilities nursing is changing, with greater emphasis being placed on meeting complex health needs and employing specific interventions such as psychological therapies; some learning disabilities nurses are also assuming prescribing responsibilities. There are opportunities for higher education institutions and CPD providers to respond to these changes in the development and delivery of their programmes.

Nonregistered staff already play a vital role, which will change as the role of registered nurses develops. It is important that service providers build an educational infrastructure that meets the needs of this group.

Where we want to be

Creative opportunities for the development of education programmes include blended learning approaches, collaborative working across education providers and across sectors and further development of interprofessional education opportunities.

Positive practice example

Collaborative curriculum design and delivery

The learning disabilities team at Edinburgh Napier University has worked with people with learning disabilities, their families and carers, mentors and other stakeholders for a number of years to influence, design and deliver pre-registration nurse education for learning disabilities. People with learning disabilities, their families and carers and learning disabilities nurses are involved in the selection and interview of students and in developing learning materials, delivering sessions in the classroom, online and in the clinical skills labs, and assessing students in practice.

This partnership approach is central to education provision. In addition to a wide group of people who work as associate lecturers, a learning disabilities nursing development group and stakeholder group meet regularly to review and develop joint initiatives such as creating new modules, expanding the use of educational technology, supporting practice learning environments and promoting practice-based projects. The content of the learning materials has application to practice and the involvement of experts in delivery ensures students experience a strong focus on person-centred, family-centred health care that is relevant to practice.

With the move to increasing use of online technologies, a strategy is being developed to support people with learning disabilities, their families and carers and mentors to develop skills and competence in using technologies such as Elluminate Live and online discussion forums. This work has been commended by NHS Education for Scotland and the agency undertaking revalidation work for the NMC.

For further information, contact Janet Smith at [redacted]

Recommendation 13

Education providers and services must work in partnership to ensure that educational and developmental opportunities for nonregistered staff are developed and strengthened and their benefits are evidenced through appraisal systems, and that educational and development opportunities are available for registered learning disabilities nurses to support their ongoing development, reflecting the needs of people with learning disabilities.

3.6 Accessing supervision

Where we are now

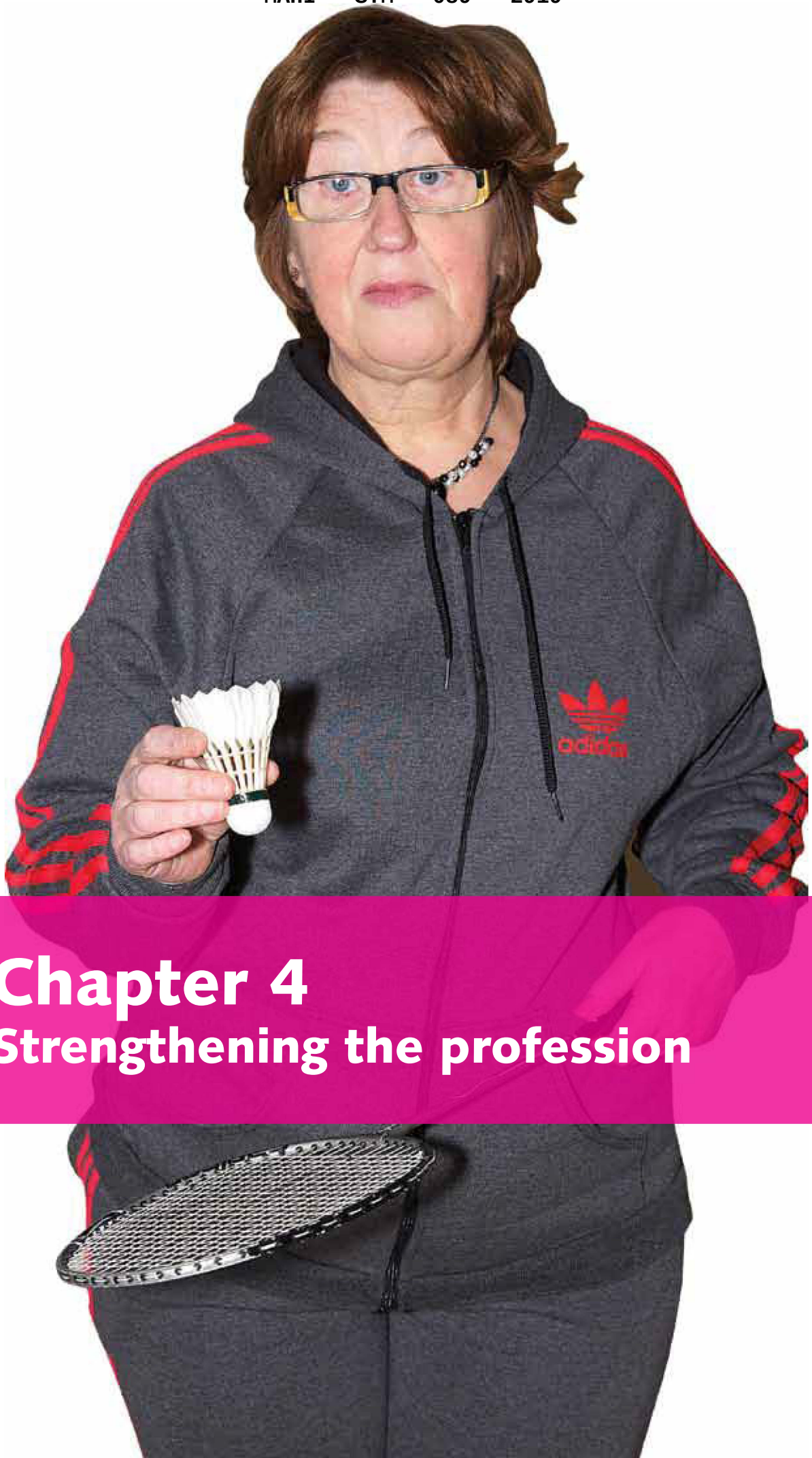
Clinical supervision is recognised as a supportive way to enable learning from experience with the aim of developing knowledge and improving care (24). It was evident through the review processes that learning disabilities nurses engage in supervision at a number of levels and with a variety of professionals during their careers. Engagement with clinical supervision nevertheless varies throughout the UK and possibly between sectors.

Where we want to be

Given the link between effective supervision, reflective learning and safe person-centred practice, supervision should be viewed as essential to contemporary learning disabilities nursing practice and must be supported by employers and nurses. They can demonstrate its value by creating and maintaining protected time and support for clinical supervision and by seeking to illustrate the outcomes of supervision in a way that demonstrates improvements in care.

Recommendation 14

Services should provide systems to ensure that learning disabilities nurses have access to regular and effective clinical supervision and that its impact is monitored and evaluated on a regular basis.



Chapter 4
Strengthening the profession

"Learning disabilities nurses listen to us and respect us as adults."

Person with learning disabilities

"My eyes have been opened to the world of adults with learning disabilities by the learning disabilities nurse. Delivering teaching sessions about young people and transition together has been an invaluable learning experience for us both."

Consultant paediatrician

Chapter 4. Strengthening the profession

This chapter addresses some of the key considerations underpinning modernising the learning disabilities nursing workforce in relation to:

- **leadership and management**
- **promoting the profession**
- **research and evidence.**

4.1 Leadership and management

Where we are now

Health and social care structures often bring together learning disabilities, mental health and/or community services, which means there may not be a senior learning disabilities nurse in a leadership role to ensure that learning disabilities nursing issues are identified and addressed. This local situation is reflected at national level: devolution in the UK has led to differences in policy and service provision across the four countries, which impacts on how leadership is defined nationally. There may not always be clear opportunities for learning disabilities nurses to demonstrate political leadership at this level.

There has been a lack of investment in some areas in leadership roles at senior level, including consultant nurse and advanced nurse practitioner roles, despite changing patterns of need giving rise to a requirement for strong leadership to drive the development of appropriate service provision.

Changing patterns of service provision and organisational structures have had an impact on the scope of management roles, affecting managerial responsibilities, accountability lines and supervision and appraisal mechanisms. Learning disabilities nurses working in multidisciplinary teams often manage, and/or are managed by, other professions.

The demographic profile of the profession indicates that many managers will be retiring from services over the next decade, resulting in a need for sophisticated workforce and succession planning.

Where we want to be

Strong leadership in learning disabilities nursing is essential, given the challenges set out in earlier chapters. Leadership is also important to drive forward the profession and to ensure a modernised workforce is in place to meet current and future needs. Learning disabilities nurses need to continue to acknowledge and develop their clinical leadership responsibilities and demonstrate and develop strong professionalism.

The leadership role should be supported through the development of clear career pathways, succession planning and leadership "champions" in all areas and through the creation of consultant nurse posts in key areas where there currently are none.

The need for a dynamic career and development framework to support learning disabilities nurses to become the leaders and managers of the future has been covered in Recommendation 4.

Positive practice example

Leading and influencing services (palliative care)

Community learning disabilities nurses in Bridgend, Wales demonstrated leadership in service development through making links with local palliative care services to increase their knowledge base and to "map out" services. Working collaboratively with these services, it became evident that individuals with learning disabilities within the locality rarely accessed palliative care services, which reflects the wider picture nationally.

The learning disabilities nurses identified resources to support people with learning disabilities, their families and carers and took measures to raise awareness of their needs for palliative and end-of-life care through an initiative called "Living Well, Dying Well." This and other measures were presented at a national palliative care conference in 2011.

The awareness-raising has led to requests to provide advice and support, creating opportunities to forge closer links with other services to meet the needs of people with learning disabilities, their families and carers. This work is continuing, with learning disabilities nurses:

- investigating systems to identify individuals with learning disabilities who have a life-limiting condition (this database will enable health professionals to strategically plan person-centred care for their future palliative and end-of-life care needs);
- continuing to work collaboratively with palliative care services to improve experiences of life and death; and
- continuing to contribute to the evaluation of the palliative care and end-of-life pathway with the aim of improving its efficiency.

For further information, contact Sharon Dixon at [redacted]
or Claire Jenkins at [redacted]

Recommendation 15

Leadership in learning disabilities nursing needs to be strengthened in practice, education and research settings with robust, visible leadership at all levels, including strategic and national levels. Services must ensure all learning disabilities nurses in clinical practice have access to a dedicated professional lead for learning disabilities nursing. In addition to existing leadership and development programmes, a UK-wide cross-sector project to nurture and develop aspiring leaders in learning disabilities nursing will be led by the four UK health departments.

4.2 Promoting the profession

Where we are now

Learning disabilities nursing has traditionally had a low profile among the general population and has received less focus than other nursing fields in policy over recent years. The demographic and policy challenges described throughout this report nevertheless mean that raising the profile of learning disabilities nursing is now more important than ever.

Learning disabilities nurses have historically embraced networking, and the strong existing networks for learning disabilities nurses across the UK provide a powerful platform from which to celebrate and promote their unique contribution.

Where we want to be

It is important that the profession is promoted to ensure all sectors are aware of the unique contribution and added value that learning disabilities nurses offer and that learning disabilities nursing is presented as a positive and rewarding career choice.

Promoting the image of the learning disabilities nursing profession therefore has an important part to play in encouraging recruitment, but it goes further than that. It is also about demonstrating to people with learning disabilities, their families and carers, the wider public, fellow professionals and policy-makers the advantages that learning disabilities nurses bring and developing their understanding of what they can deliver.

As part of that endeavour, partnership working with the RCN focusing on how the profession can be promoted to wider professional and lay audiences is being progressed, with a promotional resource under development. This work is expected to be completed in 2012.

The health and social care agenda provides further opportunities for developing networks that could strengthen partnership working across the profession in all sectors. Investment in forward-thinking, high-quality networks could support many of the initiatives outlined in this report.

Positive practice example

Managed Knowledge Network Learning Disability Portal, NHS Education for Scotland (NES)

The Managed Knowledge Network (MKN) Learning Disability Portal, supported by NES Knowledge Services, supports the health and social care workforce working with people with learning disabilities.

The MKN portal provides a sustainable, flexible and responsive means of ensuring that contemporary information on health needs and learning disabilities is available to the workforce quickly and efficiently, providing a platform for sharing best practice, promoting educational opportunities and hosting resources. The link to the Knowledge Network allows access to online journals and 500 bibliographic databases.

The portal also serves to bring together organisations and people with a common interest in finding, sharing and using knowledge to support people with learning disabilities. It includes online opportunities for accessing and sharing knowledge alongside support for development of skills and behaviours in finding and sharing knowledge effectively.

The development of the portal provides a unique opportunity for learning disabilities nursing to engage across all areas of practice and specialties and interface with other professional groups. The rapidly changing health and social care environment requires the learning disabilities nursing workforce to be responsive to change in practice, service alignment and integration.

The portal is designed for workforce use, but it also allows people with learning disabilities, their families and carers to access information and contribute to debates, helping to build confidence and influence in developing practice. The interactive model requires and encourages learning disabilities nurses to take ownership, engage and develop new initiatives and discussions, creating communities of practice.

This developing portal has the ability to network and engage across the UK, consequently linking national initiatives and helping translate them into local practice. The portal can respond, grow and adapt to changing technology, practice and policy.

For further information, contact Tommy Stevenson at [redacted]
The portal can be accessed at **www.knowledge.scot.nhs.uk/learningdisabilities**

Recommendation 16

Learning disabilities nurses need mechanisms to share best practice and develop the evidence base to continue to advance as a profession. Services must support learning disabilities nurses to participate in appropriate networks. A UK academic network for learning disabilities nursing will be created to support this drive.

4.3 Research and evidence

Where we are now

While the amount of research concerning learning disabilities nursing is increasing (25), there is still scope to further develop robust evidence. Learning disabilities nursing therefore requires support for:

- research activity
- research training
- implementation of research findings in practice.

Clinical–academic research careers have been promoted as one approach to developing partnerships between education and practice. A greater orientation towards evidence-based and evidence-informed practice can be achieved where educationalists have a clinical commitment within their portfolios and clinicians retain a strong education and research focus in their practice. Clinical–academic posts can promote greater integration between practice, education and research by supporting the enhancement of the evidence and education focus of practice and promoting a strong practice orientation in education and research. Currently, however, there are inconsistencies in the development and appointment of learning disabilities clinical–academic posts across the UK.

Where we want to be

Exciting opportunities nevertheless exist within the NHS and independent/voluntary sector to develop a broader range of clinical–academic roles that would strengthen and sustain practice, education and research provision. These roles should include researchers and educationalists maintaining links with clinical practice through clinical work, supervision of practitioners and joint working on particular practice development projects, and practitioners linking into education and research through teaching, research and initiatives that support education in practice. Clear organisational commitment is required to create models to develop sustainable roles such as these.

Research activity should be directly related to informing the practice of learning disabilities nursing and should focus on areas that add value and provide clear benefits to people with learning disabilities, their families and carers. Collaborative research studies involving higher education institutions that cover a range of geographic areas are required to facilitate larger-scale and comparative studies that can highlight differences and similarities in terms of need and developments. Existing links within the learning disabilities research community in the UK and internationally should facilitate this.

Most important, collaborative working with people with learning disabilities is essential to ensure that research is relevant to their needs and experiences. Learning disabilities nursing already has some good examples in this area and could lead on engaging, enabling and facilitating people with learning disabilities, their families and carers to participate in research.

Positive practice example

Learning disabilities nurses' involvement in research

The Confidential Inquiry into Deaths in People with Learning Disabilities is a three-year research study funded by the Department of Health and the Learning Disability Public Health Observatory in England. It is led by the Norah Fry Research Centre at the University of Bristol and is being carried out across Avon and Gloucestershire. The Inquiry is investigating all deaths among people with learning disabilities over the age of four years with the aim of adding to the current limited body of evidence, detecting any potentially avoidable and modifiable features involved in deaths and learning from positive practice.

The Mencap report *Death by Indifference* (7) highlighted the importance of involving families when evaluating care. In designing the Inquiry, the research team wanted to enable carers to be included and acknowledged that appropriately skilled staff were required to ensure that their views on the deceased were sought, understood and appropriately recorded. At the same time, it was important that their needs, as grieving carers, were also sensitively met.

As person-centred practitioners skilled in communicating with families and possessing sound understanding of the systems of care and complex health problems experienced by people with learning disabilities, a team of 11 learning disabilities nurses, supported by a lead nurse, were recruited to work part time as members of the Inquiry team. The nurses are seconded from their substantive posts to work with families of people who have died, conducting interviews, supporting them and signposting them to bereavement support agencies, if required. In addition, they advocate for the families at multi-agency local review panels held to discuss all death investigations.

For further information, contact Lesley Russ at [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

Andy Graham, Chair of the Scottish Community Learning Disability Nurses Network

Billy Pate, Scottish Community Learning Disability Nurses Network

Carol Dobson, Chief Nursing Officer, Mental Welfare Commission for Scotland

David Currie, Development Manager, Castlebeck Group Ltd

Elaine Kwiatek, Project Manager, Learning Disabilities Managed Care Network

Gillian Henderson, Mental Health and Suicide Risk Management Advisor, Scottish Prison Services

Hazel Powell, Programme Manager, NHS Lothian

Hugh Masters, Nursing Officer (Mental Health and Learning Disabilities), Scottish Government

Jonathan Gray, Nurse Consultant Learning Disabilities, NHS Highland

June Brown, Nurse Consultant Learning Disabilities/Clinical Lead for Learning Disability Services, NHS Grampian

Linda Allan, Nurse Consultant Learning Disabilities, NHS Greater Glasgow and Clyde

Margaret Serrels, Clinical Services Development Manager, NHS Lanarkshire

Mark Gillespie, Nurse Consultant Forensic Mental Health and Learning Disabilities, NHS Greater Glasgow and Clyde

Melanie Hornett (Chair), Nurse Director, NHS Lothian

Michael Brown, Nurse Consultant and Reader in Health and Social Care, NHS Lothian/ Edinburgh Napier University

Rosemary Duffy, Scottish Prison Services

Selina Clinch, Programme Manager, Healthcare Improvement Scotland

Susanne Forrest, Programme Director, NHS Education for Scotland

Tommy Stevenson, Educational Project Manager, NHS Education for Scotland

Wales

Andy Bell, LDS Programme Manager, Betsi Cadwaladr University Health Board

Cheryl Evans, Head of Nursing, Abertawe Bro Morgannwg University Health Board

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

References

1. **Emerson E, Hatton C (2009)**
Estimating Future Numbers of Adults with Profound Multiple Learning Disabilities in England.
Lancaster: Centre for Disability Research, Lancaster University.
2. **Department of Health (2001)**
Valuing People: a new strategy for learning disability for the 21st century.
London: Department of Health.
3. **Royal College of Nursing (2011)**
Learning from the Past – Setting out the Future: developing learning disability nursing in the United Kingdom.
London: RCN.
4. **Parrott R, Tilley N, Wolstenholme J (2008)**
Changes in demography and demand for services from people with complex needs and profound and multiple learning disabilities.
Tizard Learning Disability Review. 13(3):26–34.
5. **Emerson E, Baines S (2010)**
The Estimated Prevalence of Autism among Adults with Learning Disabilities in England.
London: DOH.
6. **Torr J, Davis R (2007)**
Ageing and mental health problems in people with intellectual disability.
Current Opinion in Psychiatry. 29(5):467–471.
7. **Mencap (2007)**
Death by Indifference.
London: Mencap.
8. **Mansell I, Wilson C (2010)**
'It terrifies me the thought of the future': listening to current concern of informal carers of people with a learning disability.
Journal of Intellectual Disability. 14(1):21–31.
9. **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.
10. **Seedhouse D (1986)**
Health. The foundations for achievement.
Chichester: John Wiley.
11. **Department of Health (2006)**
Modernising Nursing Careers.
London: Department of Health.
12. **Department of Health (2010)**
Positive Practice Positive Outcomes: a handbook for professionals working with offenders with a learning disability.
London: Department of Health.
13. **Department of Health (2010)**
Evaluation of Nurse and Pharmacist Independent Prescribing.
London: Department of Health.

14. **Coiffait FM, Marshall K (2011)**
How to recognise and respond to mental health needs.
Learning Disability Practice. 14(3):23–28.
15. **Brown M, Marshall K (2006)**
Cognitive behaviour therapy and people with learning disabilities: implications for developing nursing practice.
Journal of Psychiatric and Mental Health Nursing. 13:234–241.
16. **Royal College of Nursing (2003)**
Defining Nursing.
London: RCN.
17. **Department of Health, Social Services and Public Safety (2005)**
Care at its Best. Report of the regional multidisciplinary inspection of the service for disabled children in hospital.
Stormont: DHSSPS.
18. **Nursing and Midwifery Council (2011)**
Standards for Competence [online].
Available at: http://standards.nmc-uk.org/PreRegNursing/statutory/competencies/Pages/Competencies.aspx
19. **Learning Disability Consultant Nurse Network (2006)**
Shaping the Future: a vision for learning disability nursing.
London: LDCNN.
20. **Nursing and Midwifery Council (2001)**
Standards for Specialist Education and Practice [online].
Available at: www.nmc-uk.org/Educators/Standards-for-education/Standards-for-specialist-education-and-practice
21. **Roy A, Matthews H, Clifford P, Fowler V, Martin DM (2003)**
Health of the Nation outcome scales for people with learning disabilities.
The British Journal of Psychiatry. 180:61–66.
22. **NHS Education for Scotland (2011)**
Person Centeredness [online].
Available at: www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/public-health/health-improvement/current-health-improvement-work/person-centredness.aspx
23. **Michael J (2008)**
Healthcare for All: report of the independent inquiry into access to healthcare for people with learning disabilities.
London: HMSO.
24. **Nursing and Midwifery Council (2011)**
Clinical Supervision [online].
Available at: www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Clinical-supervision-for-registered-nurses
25. **Griffiths P, Bennett J, Smith E (2007)**
The Research Base for Learning Disability Nursing; a rapid scoping review.
London: King's College.

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Modernising Learning Disabilities Nursing Review Strengthening the Commitment

Northern Ireland Action Plan

March 2014

Updated April 2016

INVESTORS IN PEOPLE

INDEX

FOREWORD

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

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 25th 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 and will be revisited and monitored by a regional implementation group on an ongoing basis.

MAHI - STM - 089 - 2956

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

MAHI - STM - 089 - 2958

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

MAHI - STM - 089 - 2960

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 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 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 practises 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 NIPEC and the Royal College of Nursing, establish a Regional Professional Development Network/Forum 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.**

- **Establish formal links and work collaboratively with the UK Steering Group to support each of the four UK Implementation Groups.**

References

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* Belfast; DHSSPS.

Department of Health, Social Services and Public Safety (2011). *Quality 20/20: A 10-year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland.* Belfast; DHSSPS.

Department of Health, Social Services and Public Safety (2011). *Transforming your Care.* Belfast; DHSSPS.

Department of Health, Social Services and Public Safety (2012). *Fit and Well: Changing lives - 2012-2022: A 10 year Public Health Strategic Framework for Northern Ireland: A consultation document.* Belfast; DHSSPS.

Department of Health, Social Services and Public Safety (2012). *Learning Disability Service Framework.* Belfast; DHSSPS.

Department of Health, Social Services and Public Safety (2012). *Delivering the Bamford Vision : Action Plan 2012 - 2015.* Belfast; DHSSPS.

Guideline and Audit Information Network (2010). Guidelines on Caring For People with a Learning Disability in General Hospital Settings, Belfast; GAIN.

The Scottish Executive (2012) *The Report of the UK Modernising Learning Disabilities Nursing Review* : *Strengthening the Commitment.* Edinburgh; Scottish Government.

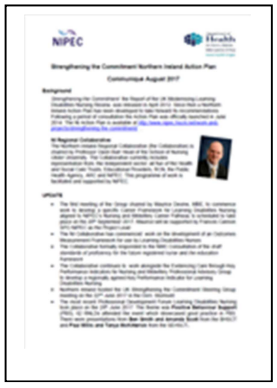
NORTHERN IRELAND ACTION PLAN FOR LEARNING DISABILITY NURSING NORTHERN IRELAND COLLABORATIVE

Progress Report

October 2017

In June 2014 the Northern Ireland Collaborative was convened to lead, drive, and support and monitor the delivery of the Action Plan. The Collaborative comprises representation from; the Independent/Voluntary sector; five Health and Social Care Trusts, nursing students at pre and post registration level, Ulster University, Queen's University, NIPEC, the PHA, RQIA, RCN and ARC. A full membership list can be viewed at Appendix 1, the Collaborative intend to refresh the current Terms of Reference which will available on the NIPEC website.

When the Collaborative was established Dr. Glynis Henry CBE, Head of HSC Clinical Education Centre chaired the meetings. In September 2016 the Collaborative bade farewell to Dr Glynis Henry who retired. We would like to acknowledge her commitment and diligence in chairing the Collaborative since it was first convened. Since then Professor Owen Barr, at the request of the Chief Nursing Officer, has chaired the Collaborative and we wish him every success as he leads the Collaborative in taking forward the NI Action Plan. Project support continues to be provided by Frances Cannon, Senior Professional Officer (SPO), NIPEC. To disseminate the work of the Collaborative a Communique is disseminated on a quarterly bases to a range of interested stakeholders.



UK StC Steering Group

Since the end of 2016 Maurice Devine, Assistant Head of the Clinical Education Centre represents Northern Ireland on the UK Strengthening the Commitment Steering Group which continues to meet on a six monthly basis. The Steering Group's current emphasis, agreed with the four UK CNO's, is to identify the central requirements and objectives for the learning disabilities nursing profession related to four high impact areas including:-

- working across the lifespan
- public health
- high quality interventions (broadening out from PBS)
- leadership

Through local arrangements each country will consider these areas within their own context. It is anticipated the Steering Group will produce a range of core documents to support the development of practice in these areas which will endeavour to reflect the key policy direction of all four countries.

Collaborative Priorities

Since our last report in March 2016 the Collaborative continues to meet on a quarterly basis with an average attendance of 14 members at each meeting. In our last report we identified the priorities of the Collaborative for 2016-2017. These are presented in Table 1 which provides a high level summary of progress to date and a RAG[1] status indicating levels of achievement. The detail relating to how these priorities have been progressed is included within the body of this report aligned to the four themes within the Action Plan. A number of other initiatives aside to the identified priorities have been progressed throughout the reporting period as opportunities arose, these will also be reported and aligned to the four themes as follows:

Themes:

- Strengthening Capacity,
- Strengthening Capability,
- Strengthening Quality
- Strengthening the Profession.

[1]RAG, Red = Significant issues. Amber = Issues which can be addressed. Green = On target.

Table 1: NI Collaborative Priorities 2016-17

NI Action Plan Priorities 2016-2017	Progress	Status
Theme: Strengthening Capacity **Learning Disabilities Career pathway**	A project group chaired by Maurice Devine support by NIPEC has been established to develop a web-based NI Career Pathway/ Framework for Registered Learning Disabilities Nursing. This will sit within the career specific pathway section of the NIPEC Nursing and Midwifery Career Pathway website	
Theme: Strengthening the Profession In collaboration with the RCN establish a Regional Professional Development Network for learning disability nursing staff in all sectors	Through the Collaborative NIPEC and the Royal College of Nursing have worked in partnership to establish a Regional Professional Development Network/Forum for Learning Disabilities Nurses. The Forum is open to RNLDs working across all settings including, HSC Trusts, the Education Sector and the Independent/voluntary sector	
Theme: Strengthening Quality **Establish processes to capture the demonstrable outcomes of Learning Disabilities nursing interventions.**	A final draft of an outcomes measurement Framework specifically applicable to Learning Disabilities Nursing has been prepared and shared with the Collaborative members. The purpose of the Outcomes Measurement Framework is to act as a resource for RNLDs to enable the demonstration of the outcomes of nursing practice.	
Strengthening the Profession **Evaluation of the RCN Leadership Programme**	During 2017 the CNO through the NI Collaborative, requested NIPEC to engage with the participants who had completed the programme *to undertake an impact measurement evaluation.* Nine participants contributed to the evaluation a full copy of the report can be accessed on the NIPEC website	
Strengthening Quality **Link with the Regional Key Performance Indicators (KPIs) project to consider the introduction for relevant KPIs within settings where RNLDs work**	Significant work has been progressed and it is anticipated the first KPI developed by the Collaborative will be released in January 2018 – find further detail on page 4 of this progress report.	

Strengthening Capacity

- The Collaborative plan to use the November 2017 RNLD Forum to provide an opportunity for Learning Disabilities nurses to contribute to the work of the Nursing and Midwifery Task Group (NMTG) Workforce subgroup. The aim of the next forum meeting is to capture the views of RNLDs and identify workforce priorities for the profession. The report prepared by the Collaborative - A Description of the Learning Disabilities Nursing Workforce in NI – is being utilised by the Nursing and Midwifery Task Group (NMTG) to inform the focus of this workshop.

Strengthening Capability

- A project group chaired by Maurice Devine support by NIPEC has been established to develop a web-based NI Career Pathway/ Framework for Registered Learning Disabilities Nursing. This will sit within the career specific pathway section of the NIPEC Nursing and Midwifery Career Pathway website. The project group includes representations from five HSC Trusts, Independent Sector, Staff Side Organisations, Public Health Agency (PHA) Department of Health (DOH), Royal College of Nursing (RCN), Queen's University Belfast, Ulster University, Regulation Quality Improvement Authority (RQIA) and the Clinical Education Centre (CEC).

- For the first time in four years places on the Specialist Practice Programme - Learning Disabilities Nursing at Ulster University has been commissioned and delivered, additionally 12 registrants have undertaken the Contemporary Issues in Learning Disabilities Nursing.

Strengthening Quality.

- A draft Learning Disabilities Nursing KPI was presented in June 2017 at the Regional KPI Steering Group. The Regional KPI Steering group gave some valuable feedback which was used to redraft the KPI which currently reads as follows-

….% of clients with Learning Disabilities on the case load of a Learning Disabilities Nurse who have a nursing intervention in their plan of care targeting health improvement….

- It is anticipated that this iteration of the KPI will be presented at the regional KPI Steering group in December 2017 and will be rolled out and implemented in practice from January 2018.

- A final draft of an Outcomes Measurement Framework specifically applicable to Learning Disabilities Nursing has been prepared and shared with the Collaborative members. The purpose of the Outcomes Measurement Framework is to act as a resource for Registered Learning Disabilities Nurses to enable the demonstration of the outcomes of nursing practice. The framework provides a short synopsis of the tool and a link to web based resources. The Collaborative members have been instrumental in developing the Outcomes Measurement Framework which identifies tools most frequently used by RNLDs.
- A new Regional Hospital Passport has been launched to help improve the experience of hospital visits for people with a learning disability across Northern Ireland and support hospital staff in making any necessary reasonable adjustments to their practice. The Public Health Agency (PHA), in partnership with the Regional General Hospital Forum: Learning Disabilities, Health and Social Care Trusts, and people with a learning disability and their careers, developed the passport which holds details about the personal contact details, person's communication abilities, medical history, their abilities and needs in relation to personal care, and staying safe and happy. The launch took place in Stormont on 9th May 2017 and is available for download at http://publichealthagency.org/publications/hsc-hospital-passport

- The Health Equalities Framework (HEF) was piloted within the one Trust during 2015/2016. Nursing staff positively evaluated the impact of using the HEF tool in practice, with comments including:

"HEF validates the decision making process"

"HEF helps demonstrate the unique contribution of the role of the learning disability nurse"

- Since the pilot a programme for implementation of the HEF across the Trust has been progressed, supported by additional specific training for staff. It is anticipated that the use of HEF across the hospital site will be operational from end of January 2018. Champions on each ward are being identified to give additional support to the Ward Teams. Following full implementation it is planned that a review will take place in May 2018 to formally evaluate the impact on practice of using the HEF as an outcomes measurement Tool.

- The HEF training has made available to all HSC Trusts – to date a small number of Learning Disabilities Nurses from other organisations have accessed the training.

- Through the work undertaken in the preparation of - ***A Description of the Learning Disabilities Nursing Workforce in Northern Ireland – A Report***, the Collaborative established that there are professional governance and accountability structures for learning disabilities nursing within all HSC Trusts and for those who work in the independent and voluntary sector.

Strengthening the Profession.

- Through the Collaborative NIPEC and the Royal College of Nursing have worked in partnership to establish a Regional Professional Development Forum. The Forum is open to RNLDs working across all settings including, HSC Trusts, the Education Sector and the Independent/voluntary sector. The forum is chaired by Donna Morgan, Professional Lead for Learning Disabilities Nursing, NHSCT supported by Rosaline Kelly Professional officer RCN. The first meeting was held on the 2nd March 2017, and it plans to meet three times a year. The average attendance is 55 RNLDs nurses from across all settings. The Forum aims to provide a platform for

Registered Nurses Learning Disabilities to exchange best practice, explore professional issues and promote networking opportunities. The Forum maintains strong links with the RCN RNLD Nursing Network.

- In 2015 in association with the NI Collaborative the Chief Nursing Officer (CNO) commissioned the Royal College of Nursing (RCN) to plan and deliver a bespoke Senior Nurse Leadership Development Programme for Registered Nurses Learning Disabilities. The programme was delivered between 5th February 2015 and the 13th March 2015 finishing with a consolidation day on 26th March 2015. A total of 19 participants attended the programme, five from the independent sector and 14 from five Health and Social Care (HSC) Trusts, with a Band mix ranging from band 5 to band 8a. During 2017, the CNO through the NI Collaborative, requested NIPEC to engage with the participants who had completed the programme *to undertake an impact measurement evaluation.* Nine participants contributed to the evaluation. The evaluation highlighted that attendance at the programme was a really valuable experience which introduced the participants to a range of leadership concepts, tools and resources, some participants suggested that the implementation and embedding of learning in practice could be enhanced by the use of learning sets and /or mentorship arrangements. A full copy of the report can be accessed on the NIPEC website. The Collaborative specifically co-opted participants who had completed the Senior Nurse Leadership Development Programme unto the Career Pathway work stream as a means of enhancing and developing their leadership potential.
- The Collaborative collectively on behalf of the RNLDs in NI co-ordinated and submitted a response to the NMC Consultation on the NMC draft pre-registration Nurse Education Standards and the Educational Framework.
- The Collaborative submitted a response to the Consultation on the Reform of Adult Care and Support.
- Northern Ireland continues to have representation at the national Learning/Intellectual Disability Nursing Academic Network (LIDNAN)[2] and contributes to relevant national initiatives. Northern Ireland hosted the last

[2] LIDNAN was developed as a response to Recommendation 16 from *Strengthening the Commitment: the report of the UK review of learning disabilities nursing* (Scottish Government 2012).

meeting in the Ulster University, Belfast Campus on the 7th July 2017. Most recently the LIDNAN group also co-ordinated and submitted a response to the NMC Consultation on the NMC draft pre-registration Nurse Education Standards.

- Wendy McGregor, Learning Disabilities and Mental Health inspector, RQIA, and a member of the NI Collaborative presented at the StC UK Annual Conference, Cardiff in November 2016. Her presentation was entitled ***learning from You learning for Me***.

Learning Disabilities nursing was extremely well represented at the 2017 RCN Nurse of the Year awards with four RNLDs making the finalist list including:

- Paul McAleer from the NHSCT who won the Inspiring Excellence in Mental Health & Learning Disability for his role in delivering the 'Second Chance for Change' psychodrama project. Second Chance for Change, delivered by the Northern Trust's Promote Team in collaboration with Educational Shakespeare Company, which gives service users living with a learning disability the opportunity to reflect on personal traumatic events, identify positive changes and realise their potential for development.

- Sara McCann, an Epilepsy Nurse specialist, also from the NHSCT won the Learning Disability Award Category. Sarah developed a Nurse Led Epilepsy Clinics to ensure the additional health care needs of people with learning disabilities were being continually met.

- Yvonne Diamond form Priory Adult care was the runner up in the Chief Nursing Officers Award. Yvonne was jointly nominated for her achievements if developing a new pathway for people with complex mental health issues as a consequence of acquired brain injury.

- Siobhan Rogan who is an Advanced Practitioner

and Manager for the Intellectual Disability CAMHS in the Southern Health and Social Care Trust received the overall **RCN Nurse of the Year 2017** award. Siobhan was recognised for her inspirational work in establishing a Child and Adolescent Mental Health Service (CAMHS) that is fully inclusive of Children and Adolescents who have an Intellectual Disability in Northern Ireland.

Overall this was an excellent achievement for the Learning Disabilities Nursing Profession at the Nurse of the year awards in Northern Ireland.

Other Events

- Belfast hosted the prestigious **Bridging the gap: from evidence to improved health for persons with intellectual and developmental disabilities** conference which attracted a range of international speakers and numbers of other international delegates from the world of Learning Disabilities Nursing.

- Margaret Donnelly from the BHSCT won the prestigious nurse of the Year Randox Award. Margaret works in Muckamore Hospital in the BHSCT. The award recognises excellence in day-to-day patient care, innovation, and after-care, and those who endeavour to improve the standards of healthcare provision, and the health of our population.

- The RCN NI Learning Disability Nursing Network hosted a very successful conference in September 2017 – "**Celebrating Excellence in Person Centred Care in Learning Disability Nursing**", attended by 80 delegates, including colleagues representing the Irish Nurses and Midwives Organisation; Registered Nurses Intellectual Disability Section. Participants included Charlotte McArdle, CNO, Janice Smyth, Director RCN NI, and Damien Hughes, Consultant Psychiatrist, as well as powerful stories delivered by relatives. The RCN NI Nurse of the Year finalists were interviewed about the work that contributed to winning their awards, by the ARCNI/TILLI Group Roving Reporters. Feedback for the event was overwhelmingly positive with

one delegate stating "*Well timed conference- nursing is difficult, lots of barriers and resource issues but this Person-Centred Care event reminded me about the important values underpinning why we are learning disability nurses*

- The 2018 Positive Choices Conference is being hosted in Dublin in early 2018.

Progress Update: Summary

Significant work has been progressed by the Collaborative in the last year not only to meet the identified priorities 2016-2017 but also to meet a number of other related aspects of the NI Action Plan. There is no doubt that the work of the Collaborative has played a part in enhancing the profile of the work of RNLDs in Northern Ireland at regional and national levels.

Priorities 2018-2019

At the next meeting, scheduled for January 2018, the Collaborative will take the opportunity to identify and agree priorities for 2018-2019 mindful of the recommendations and implications of the following:

- The priorities of STC UK Steering Group as outlined earlier
- Actions already progressed
- Long term objectives set out in the first Annual Report including:-

➢ Take steps to explore how the Positive Behaviour Support Framework developed by LIDNAN can be embedded in practice
➢ Scope preceptorship within Learning Disabilities Nursing:-seek assurance that preceptorship is in place.

Appendix 1

Membership of the Northern Ireland Regional Collaborative

Name	Title	Organisation
Professor Owen Barr (CHAIR)	Head, HSC Clinical Education Centre	CEC
Maurice Devine,	Assistant Head, HSC Clinical Education Centre	CEC
Frances Cannon	Senior Professional Officer	NIPEC
Esther Rafferty	Associate Director of Learning Disability Nursing.	BHSCT
Donna Morgan	Head of Service Learning Disability	NHSCT
Sharon McRoberts	Assistant Director of Nursing Workforce and Education	SEHSCT
Kieran McCormick	Regulated Services Manager Adult Services	SEHSCT
Siobhan Rogan	Director of Mental Health and Disability (Acting)	SHSCT
Barbara Tate	Lead Nurse, for Children's Learning Disability	SEHSCT
Eileen Dealey	Head of Service & Professional Lead Nurse	WHSCT
Lorraine Kirkpatrick	Regional Manager representing Independent Sector	FSHC
Laurence Taggart	(RCN LD nursing forum rep)	RCN LD nursing forum
Wendy McGregor	Mental Health & Learning Disability Inspector	RQIA
Peter Griffin	Nurse Lecturer & Learning Disability Nursing (Professional Lead)	Queen's University of Belfast
Briege Quinn	Nurse Consultant	PHA
Deirdre McNamee	Public Mental Health and Learning Disability Nurse	PHA
Rosaline Kelly	Senior Professional Development Officer	RCN
Emma Flynn	Pre Registration, rep students	Queen's University of Belfast
Ailish McMeel	Post Registration rep student	Ulster University
Circulation only Leslie-Anne Newton	NI Director	ARC NI

CEC – Clinical Education Centre
NIPEC – Northern Ireland Practice and Education Council for Nursing & Midwifery
BHSCT – Belfast Health & Social Care Trust
NHSCT – Northern Health & Social Care Trust
SEHSCT – South Eastern Health & Social Care Trust
SHSCT – Southern Health & Social Care Trust
WHSCT – Western Health & Social Care Trust
FSHC – Four Season Health Care
QUB – Queens University of Ulster
UU – Ulster University
RCN – Royal College of Nursing
RQIA – Regulation & Quality Improvement Authority
PHA - *Public Health Agency*

FSHC – Four Season Health Care
ARC NI – *Association for Real Change*

For further Information, please contact

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This document can be downloaded from the NIPEC website

www.nipec.hscni.net

Evolving and Transforming to Deliver Excellence in Care

A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2025)

Updated May 2016

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

NIPEC

HSC

FOREWORD BY THE DHSSPS CHIEF NURSING OFFICER

It is vital that the Nursing and Midwifery workforce in Northern Ireland offers enough flexibility and innovation for future changes in service delivery models and public need.

To this end, this Workforce Plan for Nursing and Midwifery:

- Sets out clearly the education and training commissions we intend to make between 2015 and 2025;
- Explains the context and processes on which these decisions have been made;
- Provides the aggregate number of commissions and the trend increases and decreases within and between key groups and specialties;
- Highlights key trends and emerging themes from the wider health and social care system and other workforce plans that may have implications for service delivery in future years;
- Identifies key challenges that will need to be addressed if we are to make improvements in the workforce planning processes next year and beyond so that the investments we make better reflect the future needs of patients and clients.

We appreciate that there is no exact science or agreed methodology for predicting or responding to future patient and client need. Therefore we must work closely with a wide range of stakeholders to help us make these difficult judgments, within a finite budget. This will require a culture of transparency and openness, where we can share and challenge each other's assumptions to ensure that the decisions we make result in safe, effective, person-centred and compassionate care with improved outcomes and positive patient and client experiences.

The recommendations for action contained within this Plan aim to lay the foundation for the development of a competent, confident, critical-thinking and innovative nursing and midwifery workforce in Northern Ireland for the future. To take this forward, I will ensure that the Regional Workforce Planning Group places this Plan on their agenda and work-plan to ensure robust multi-disciplinary workforce planning.

I would like to express my sincere thanks to the members of the Project Steering Committee who committed their time, energy and expertise to the development of this Workforce Plan. I would also like to thank all of the individuals across the HSC system who provided us with evidence and information and the wide range of stakeholder representatives who contributed to and participated in various meetings,

surveys, workshops, focus groups and interviews during this process. The Central Nursing Advisory Committee CNMAC have completed an indepth examination of Band 5 recruitment processes and this paper has also been drawn upon to include an updated position for 2016.

A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for project managing the development of this Plan and to Skills for Health for their permission to reproduce material from their Six Steps Methodology to Integrated Workforce Planning (2009).

Mrs Charlotte McArdle
DHSSPS Chief Nursing Officer

The starting point for any discussions on our Nursing and Midwifery workforce requirements should be patient and client needs and in particular the workforce requirements necessary to ensure the best possible outcomes.

Everything else flows from that.

CONTENTS

EXECUTIVE SUMMARY

Evolving and Transforming to Deliver Excellence in Care has been developed to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to meet the health and care needs of the population in Northern Ireland over the next ten years, and beyond. A range of methods were employed between January and November 2014 including reviewing the international literature, gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups, interviews and meetings with stakeholders across the Health and Social Care system, including the independent sector, and reviewing relevant policies and strategies to identify proposed service developments or changes over the next ten years.

Throughout the project, participants repeatedly highlighted the challenges facing nurses and midwives during a period of transition from predominantly hospital-based to community settings. These include a growing number of older people, children and other vulnerable groups with complex needs in the community; the rise in the number of people with long-term conditions and co-morbidities requiring complex nursing care; the associated drive to prevent hospital admissions and to ensure end of life care at home; the requirement for specialist and advanced level practice and non-medical prescribing; the increase in the delivery of nurse and midwife led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, stakeholders reported a range of recruitment processes that have led to the perception of a developing culture of "*any nurse will do*". Nonetheless, an interest and enthusiasm to drive improvements in service responses and delivery to ensure safe, effective and person-centred care were evident during stakeholder engagement. It was clear throughout the project that all employers are starting to feel the effects of the well documented global shortage of Nurses.

A series of recommendations have been developed which command a consensus among stakeholders. Chief among them are:

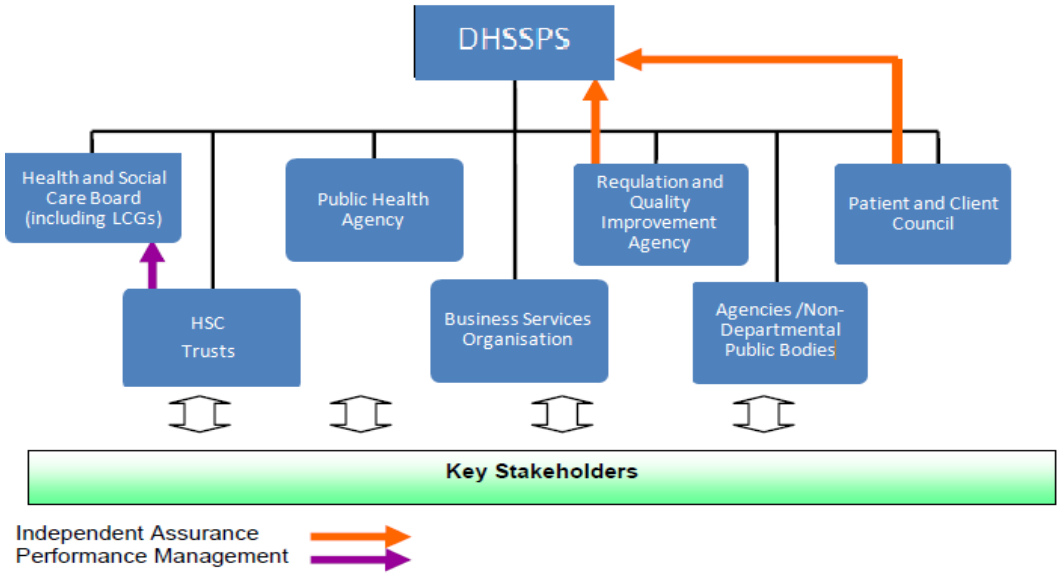
- the need for a strategic approach to the future supply and demand of Nursing and Midwifery to make Northern Ireland a destination Employer of Choice;
- a review of HSC Trusts' nursing and midwifery recruitment processes;
- a review of the nursing and midwifery workforce within the independent sector;
- implementation of pre and post registration education programme forecasts;
- the introduction of Advanced Practice Programmes across the statutory and independent sectors.

An action plan and structure for taking the work forward is proposed along with a monitoring process.

INTRODUCTION

Health and social care in Northern Ireland are provided as an integrated service with a number of organisations working together to plan, deliver and monitor health and social care (Figure 1):

Figure 1: Northern Ireland Health and Social Care Structure



Source: (DHSSPS, 2011a)

Nurses and midwives comprise the largest part of the Health and Social Care (HSC) workforce delivering services 24 hours a day, 365 days a year, designed to meet peoples' health and healthcare needs across the age spectrum and in every health sector (statutory and independent) including primary, secondary and tertiary care, and in schools, prisons and workplaces. While the role of the professions has always been highly valued, recent reports have highlighted the need to maximise and further release the potential of the nursing and midwifery workforce to provide safe, effective, person-centred and compassionate care (Francis, 2013; International Council of Nurses, 2014).

This is particularly relevant with the *Transforming Your Care* agenda (DHSSPS 2011b), driving the transition of service delivery from predominantly acute hospital based to community settings and other key policy directives (DHSSPS, 2011c; DHSSPS, 2012a; DHSSPS, 2012b; DHSSPS, 2013a; DHSSPS, 2014a). To support this, more nurses will be needed with skills in complex case management, advanced and specialist practice knowledge, and the confidence to work independently in community rather than acute hospital settings.

Workforce planning has become a key component of all health and social care planning as the impacts of demographic changes and a shrinking labour market are increasingly understood. Not only will the needs of patients and clients continue to change and demand for our services increase, but the workforce profile and characteristics of our staff will also change as our own workforce ages.

Workforce planning involves commissioning the services required to implement strategic priorities and the workforce to deliver those services. NHS England's (2014) recent publication *Five Year Forward View,* highlights that we can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.

To support this, the HSC system has a vital role to play in the commissioning of pre and post-registration nursing and midwifery education programmes. This requires partnership working between the DHSSPS, Health and Social Care Board (HSCB), HSC Trusts, Local Commissioning Groups (LCGs), Integrated Care Partnerships (ICPs) and the independent sector organisations. This is particularly pertinent to *Delivering Care* (DHSSPS, 2013b), the policy direction for agreeing nurse staffing levels in Northern Ireland. The first phase of this work is in the process of implementation and will require additional funding, during a period of significant financial constraints.

The last major *Review of the Nursing and Midwifery Workforce in Northern Ireland* was published by the DHSSPS in 2009. This included workforce projections up to and including 2013 therefore the production of this Workforce Plan is timely. During the period between 2009 and 2014, there has been a 4% (whole time equivalent) increase in the number of registered nurses and midwives, which includes student health visitors and midwives. We now have an ageing nursing and midwifery workforce with up to 46% eligible to retire over the next ten years in some practice areas, who will need to be replaced with the HSC system.

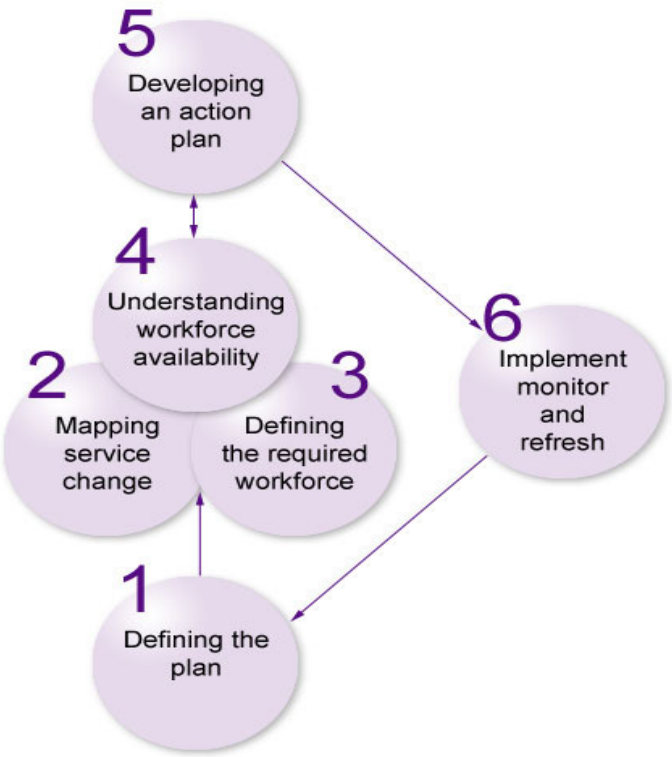
This Workforce Plan will support the needs of the nursing and midwifery workforce in an increasingly demanding working environment. It will assist the DHSSPS in the development of strategies to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to support the delivery of safe, effective and person-centred care and meet the needs of the service overall. The recommendations will also aim to lay the foundations for the development of a more systematic and standardised approach to nursing and midwifery workload and workforce planning processes to improve the current situation.

SIX STEP METHODOLOGY FOR WORKFORCE PLANNING

Effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, within the correct budget, delivering services to provide the best possible patient and client care. Workforce planning is complex and comprises of many elements.

The Skills for Health Six Steps Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this Workforce Plan (Figure 2):

Figure 2: Six Step Methodology to Integrated Workforce Planning (Skills for Health, 2009)



This high-level stepped approach has been endorsed by the health and social care workforce planning community across Northern Ireland. It has proven useful in supporting the establishment of information on the supply and demand factors relevant to the nursing and midwifery workforce.

This in turn has helped to inform decision-making on the number of nursing and midwifery education and training places to be commissioned between 2015 and 2025 and to develop an understanding of the issues impacting on recruitment, retention and career progression of those employed.

GUIDING PRINCIPLES OF THE WORKFORCE PLAN

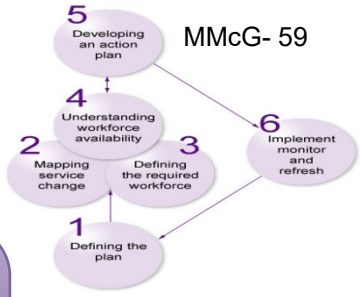
The following principles were employed to guide the development of this *Workforce Plan for Nursing and Midwifery (2015-2025)*:

Guiding Principles

- ✓ The Nursing and Midwifery Workforce Plan is set within the wider context of the international perspective on workforce, education and training, legislative, professional and practice issues, taking into account and reflecting activity at national, regional and local levels;
- ✓ The Plan will take account of the demographics and health and care needs of the patient and client population in Northern Ireland, the services for which there is expressed demand, the profile and dynamics of workforce supply and availability, and assess the extent to which a balance of demand and supply can be achieved;
- ✓ The whole of the registered nursing and midwifery workforce is taken into account, including the numbers, skills and skill mix required;
- ✓ There is a willingness and commitment from health and social care organisations to share high level data;
- ✓ A person-centred approach is central to health and care delivery, treatment, outcomes and patient and client experience;
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required;
- ✓ Human resources and finance departments must be central to supporting the service delivery and planning agenda;
- ✓ Stakeholder engagement should be employed throughout the whole process of implementation;
- ✓ The Plan will include recommendations and actions to ensure it is integrated within the overall approach to service planning within the wider health and social care system.

ABBREVIATIONS

AfC	Agenda for Change
ANP	Advanced Nurse Practitioner
BSO	Business Services Organisation
CNMAC	Central Nursing & Midwifery Advisory Committee (DHSSPS)
DHSSPS	Department of Health, Social Services & Public Safety
ECG	Education Commissioning Group
GP	General Practitioner
HC	Headcount
HSC	Health & Social Care
HSCB	Health & Social Care Board
ICP	Integrated Care Partnership
Independent sector	Includes independent, voluntary and private sectors
ICN	International Council of Nurses
LCG	Local Commissioning Group
NMC	Nursing & Midwifery Council
NIPEC	NI Practice & Education Council for Nursing and Midwifery
NISRA	Northern Ireland Statistics and Research Agency
PHA	Public Health Agency
RCN	Royal College of Nursing
RCM	Royal College of Midwifery
RQIA	Regulation and Quality Improvement Authority
RWPG	Regional Workforce Planning Group (DHSSPS)
Staff in Post	The total number of staff employed (usually of a given group)
WTE	Whole Time Equivalent
WHO	World Health Organisation



STEP 1: DEFINING THE PLAN

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

1.1 Purpose

In December 2013, the DHSSPS Chief Nursing Officer commissioned the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) to manage a project to develop a Workforce Plan for Nursing and Midwifery.

The Project Objectives:

- Identify the profile and characteristics of the current nursing and midwifery workforce;
- Review the literature and relevant policies and strategies;
- Analyse recruitment and retention issues;
- Engage and consult with relevant stakeholders;
- Utilise a recognised workforce model to predict trends and requirements;
- Produce a final report with recommendations and an action plan to address these.

The primary purpose of this Plan is to support the forecasting of the number of Nursing and Midwifery Council (NMC) approved pre-registration nursing and midwifery and post-registration specialist nursing places to be commissioned on an annual basis over a ten year period (2015–2025).

This will enable relevant organisations to have a workforce pool to draw from in order to employ sufficient nurses and midwives who will deliver person-centred practice and, in partnership with the wider care delivery team, improve outcomes for patients, clients and their families.

The Plan will ensure:

- A clear understanding of the future direction of the nursing and midwifery workforce in Northern Ireland;
- An integration with service and financial strategies;
- A base of realistic and affordable assumptions;
- Short and medium term changes to service are taken account of;
- Engagement with clinical staff and wider stakeholders;
- A link to commissioning plans;
- The provision of an evidence base.

It will build on a range of significant work streams already commissioned, some of which have been completed.

Commissioned Work Streams:

- An overview of the Nursing and Midwifery Workforce;
- A scoping of new roles required as a consequence of *Transforming Your Care* (DHSSPS, 2011b);
- *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b);
- *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- *A Career Pathway for Nursing and Midwifery* (NIPEC, 2014).

All of the above work streams will, because of their focus on the development of the nursing and midwifery workforce, supplement the Plan which will be the umbrella document addressing the many issues currently facing the workforce.

1.2 Scope

Considering the wide range of health and healthcare services provided in Northern Ireland, this Plan is by necessity, broad in its scope, acknowledging that nurses and midwives deliver care 24 hours a day, 365 days a year, across the age spectrum. It has relevance to registered nurses and midwives employed within the statutory and independent sectors, taking account of primary, secondary and tertiary care settings and the major areas of practice to include: both the nursing and midwifery professions, the three parts of the NMC register and associated fields of practice and Agenda for Change (AfC) Bands ranging from Band 5 to Executive Nurse.

As the primary purpose of this Plan is to support the prediction of pre and post registration education places to be commissioned for nurses and midwives, health care support staff have not been included in this Plan.

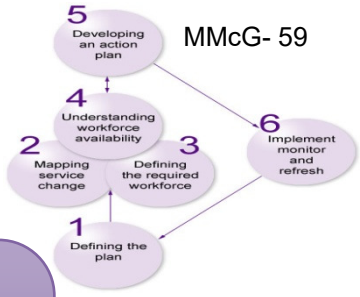
Availability of nursing and midwifery workforce statistics relating for the independent sector were limited at the time of developing this Plan therefore it has proven difficult to include accurate, up-to-date figures. However, some important information obtained during stakeholder engagement has been included, particularly the need to strengthen reported recruitment issues. Nonetheless, work currently underway relating to nursing and midwifery within this sector will be taken into consideration during the implementation of the recommendations contained within this Plan.

A range of methods were employed between January and November 2014 to meet the project aim and objectives including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups and interviews with stakeholders across the HSC system and reviewing relevant policies and strategies to identify proposed capital and service developments or changes over the next ten years. The findings have been used to inform and shape the content and recommendations included within this Plan.

1.3 Ownership

The need to ensure the support and ownership of the health and social care system and the professions was considered critical in the development of this Plan. A Regional Steering Committee was therefore established to oversee the project, chaired by the Chief Nursing Officer, with representation from the DHSSPS, the five HSC Trusts, Public Health Agency, Business Services Organisation, Independent Sector and Professional and Trade Union organisations. Membership of the Project Steering Committee is listed in Annex A. Extensive stakeholder engagement and analysis of relevant statistical data was conducted and all relevant health policy documents were reviewed and a full list may be found in Annex B.

The Plan takes account of, and requires synergy with, the full range of legislative, policy and professional requirements and developments aimed at enhancing standards, care delivery and patient and client outcomes. It must also be considered in the multi-professional and inter-agency context of the settings in which nurses and midwives work. For this reason, it is important that it is linked with other relevant Workforce Reviews and Plans, in particular, the full range of Medical Workforce Reviews. The Plan will inform the education commissioning process in partnership with the Regional Workforce Planning Group (RWPG), as outlined in the monitoring process at point 6.2.



STEP 2: MAPPING SERVICE CHANGE

This is the first of three interrelated steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

2.1 Population and Health Profile

In Northern Ireland we have the fastest growing population of any country within the UK (DHSSPS, 2013a). The Northern Ireland Statistics and Research Agency (NISRA, 2014) reported that births in Northern Ireland have remained stable over the last 5 years with 25,300 live births registered during 2012. They also projected the population to rise from 1.79 million in 2010 to nearly 2 million in 2025 (an increase of almost 8 per cent).

There are 430,763 children and young people under the age of 18 in Northern Ireland (PHA, 2014). The number of people aged 65 and over is forecast to increase by 42 per cent, from 260,000 to 370,000. Significantly, though, the number of people of working age is only projected to increase by 1.4 per cent, from 1,109,000 to 1,124,000, by 2025. Over the same period, the number of people aged 85 and over will increase by 25,000 to 55,000.

In 2012, there were 14,756 deaths registered in Northern Ireland, an increase of 552 deaths (3.9%) compared to 2011. Of the 14,756 deaths registered in 2012, just under half (49%) of deaths occurred in hospital. A further 27% died in their own home, followed by 18% in a nursing home. The remaining 6% of deaths occurred elsewhere (NISRA, 2014). The average age at death has increased over the last 30 years from 70.1 years in 1982 to 76.4 years in 2012 (NISRA, 2014).

The main cause of death was cancer accounting for 28% of deaths in Northern Ireland. According to NISRA (2014), cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in Northern Ireland has increased from 18% in 1981 to 29% of all deaths in 2011. By way of contrast, deaths in 2011 due to ischemic heart disease decreased by 60% since 1981 from 4,909 to 1,966 (PHA, 2014).

Life expectancy across the region has improved by 8 years for females and 6 years for males since 1980/82. In 2008/10 males can expect to live to the age of 77.1 years and females to the age of 81.5 years. As overall life expectancy in Northern Ireland has continued to rise over the past 30 years (O'Neill et al., 2012), so has the likelihood of developing a long-term condition or experiencing co-morbidities (more than one long-term condition). A report by the Institute of Public Health in Ireland (2010) predicted that between 2007 and 2020 the prevalence of long term conditions amongst adults in Northern Ireland, namely Hypertension, Coronary Heart Disease, Stroke and Diabetes, is expected to increase by 30%.

The prevalence of long-term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2014). Across Northern Ireland the most prevalent long-term conditions are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

During 2011/12 long-term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 of the population (aged 18+).

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2014).

The number of alcohol related deaths has been increasing over the past decade. Since 2001, there has been a total of 2,785 alcohol related deaths, 68% of which have been deaths to males. Of this total, 854 or 31% were registered to Belfast Local Commissioning Group's (LCG's) area of residence (PHA, 2014).

The Health Survey Northern Ireland (DHSSPS, 2014c) indicated that three-quarters of children aged 2-10 years old (75%) were either underweight or normal weight, while a fifth (19%) were overweight and 6% were classed as obese. Overall, a quarter of adults (25%) were measured as obese with a further two-fifths (37%) classed as overweight. Males (69%) were more likely than females (57%) to be overweight or obese.

In Northern Ireland between 2001 and 2011, 37,500 people died prematurely of conditions which were potentially preventable. An additional 8,765 people died prematurely of conditions which, if diagnosed and treated early enough, might have been avoidable (PHA, 2014).

High levels of mental health problems, self-harm, suicide and alcohol and drug abuse are reported in the homeless population and an estimated 2/3 of prisoners have mental health problems (PHA, 2014). *Transforming Your Care* (DHSSPS, 2011b) highlighted that 24% of women and 17% of men in NI have a mental health problem – over 20% higher than the rates in England or Scotland. *The Service Framework for Mental Health and Wellbeing* (DHSSPS, 2011d) highlights that 10-20% of older people (aged 65 years or over) suffer from serious mental health problems. Similarly, *Healthy Child Healthy Future* (DHSSPS, 2010c) reported that the prevalence of mental health problems amongst children and adolescents is estimated at 20% and 'Looked After Children' are amongst the most socially excluded of our child population. In addition, children and young people with complex physical needs are increasingly being supported at home, including ventilated children (DHSSPS, 2011b).

The Dementia Strategy (DHSSPS, 2011e) indicates that levels of dementia are projected to increase to 60,000 by 2051 from 19,000 in 2010. Between 17-21% of the population have a physical disability, and around 37% of households include at least one person with a disability (NISRA, 2014).

2.2 Drivers for Change

The success of the *Transforming Your Care* (DHSSPS, 2011b) strategy, particularly in respect of the delivery of new service models, is significantly dependent on the development of an appropriately trained and competent nursing and midwifery workforce. The challenges facing nurses and midwives during this period of transition include a growing number of older people, children and other vulnerable groups requiring nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; high levels of mental health problems; the associated drive to prevent hospital admissions and to ensure end of life care at home; the development of eHealth technologies, including tele-monitoring; the requirement for advanced physical assessments and non-medical prescribing; the increase in the delivery of nurse led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, public expectations of health and social care are changing and patients and carers expect high-quality services to be delivered close to their homes.

To effectively meet emerging demographic, social and disease challenges and drive the transition of service delivery from predominantly acute-based to community settings, as outlined in *Transforming Your Care* (DHSSPS, 2011b), there is an increasing need for Specialist Nursing expertise particularly with skills in complex case management, advanced specialist practice knowledge, and the confidence to work autonomously in community rather than acute hospital settings.

A number of Specialist Nursing roles have already been developed in Northern Ireland, particularly in the areas of long-term conditions management, and increasingly in the management of conditions such as urology, dermatology, cancer, diabetes, Parkinson's disease, chronic heart failure and dementia. In many cases the involvement of a Specialist Nurse can prevent patients from being re-hospitalised (RCN, 2010).

The independent sector is becoming increasingly important in the delivery of care; mainly due to demographic changes and as our population continues to age. Increasingly more of the nursing workforce is employed within these sectors and it is important that the knowledge, skills and experiences attained within these settings are recognised and cultivated to ensure a highly skilled and flexible workforce for the future.

The demands for nursing and midwifery services will become greater as the health and social care landscape in Northern Ireland continues to evolve, during the shift from acute to community based services and given the recent onus on quality and patient safety highlighted in a range of recent regional and national strategies, reviews and public inquiries including:

- Quality 2020 Strategy (DHSSPS, 2011c)
- Public Inquiry into the Outbreak of Clostridium Difficile (Hine, 2011)
- Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)
- Independent Review into Healthcare Assistants and Support Workers (Cavendish, 2013)
- Winterbourne View Report (DH, 2013)
- Review into the Quality of Care (Keogh, 2013)
- Improving the Safety of Patients (Berwick, 2013)
- Management of Unscheduled Care Report (RQIA, 2014)

The need for investment in high quality, nursing and midwifery services has never been greater.

It is therefore important that consideration is given to ensuring that 'the right number with the right skills are in the right place at the right time with the right attitude, doing the right work, at the right cost, with the right work output (WHO, 2010), to achieve the quality goals set by health and social care organisations. To enable this we need to ensure that effective education and training and continuous professional development is available and ongoing to support the way forward. Ultimately, we want to assure our patients and clients that every service is safe and effective and provided by staff who are caring and compassionate.

2.3 Financial Challenges

Although the HSC continues to face significant financial challenges it must play a full and active role in delivering the efficiencies required to reduce the expenditure set by the Northern Ireland Executive. The implications of the efficiency challenges facing the HSC workforce over the next ten years will be significant, particularly in relation to meeting existing commitments; irrespective of any modernisation, reform and improvement.

A key financial objective within the *Transforming Your Care* (DHSSPS, 2011b) reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. The *Transforming Your Care* report highlights the intention to shift approximately 5% (£83 million) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme. In order to affect this shift of care and funding out of hospital services and into the primary/community setting, the HSCB will commission services to be delivered in a different way.

2.4 Service Changes

2.4.1 Strategic Direction and Transformation

Although Northern Ireland differs from much of the rest of the UK, in having an integrated health and social care system, it faces many of the same challenges (outlined in the diagram below) and must deliver similar changes if it is to be successful and sustainable in the future.

Source: Adapted from the NHS Confederation (2014)

The demographic changes described previously demonstrate the need to preserve and sustain our health and social care services in the face of increasing demands and to meet the care needs of the population within a difficult financial climate.

2.4.2 Regional Reviews and Strategies

Successful outcomes in the provision of health care are linked to the broader public health agenda and require integrated working at local and regional levels. The HSC has begun to address the challenges it expects to face, commencing work on a number of initiatives aimed at continuously improving the quality of services. A number of reviews and strategies (Annex B) are at various stages of development and implementation. Key themes arising from which will have an impact on the Nursing and Midwifery workforce are identified below:

Healthcare Policy

- Focus on measuring effectiveness, reducing variations and improving productivity
- High profile for improving quality of care and safety
- Designing effective healthcare systems and structures
- Continuing effort to improve evidence-based decisions on provision of services
- Revision of pattern of hospital services, concentration of specialisms and more care closer to home
- Personal and public involvement (PPI)

Supply of Healthcare

- Growing role for the independent sector
- Substantial investment in information technology
- Increase in the use of telecare to support people at home

Demands for Healthcare

- Changing patterns of disease, shifting dependency ratios
- Changing modes of service delivery
- Financial constraints
- Continuing emphasis on health promotion and prevention
- Persistent health inequalities
- High priority on supporting self-care in long-term conditions
- Growing demand for patient choice
- Developments in technology
- Move to 7 day working to support Integrated Care Pathways
- Outpatient Reform
    - increased use of virtual clinics
- Enhanced Care at Home Models
    - enhancement of community nursing services
    - rapid response to patients out of hours suffering an acute episode
    - single gateway multidisciplinary approach
- Stroke Care
    - increase direct entry to stroke units from 70% to 90%
    - early supported discharge
- Older persons' assessment and liaison (OPAL) Teams
    - specialist geriatric assessment outside of care of elderly wards
    - daily in-reach to ED's for screening
    - rapid access to out-patient clinics
- Alternatives to admission -
    - Shifting of resource to the community

Step 3: Defining the Required Workforce

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

3.1 Workforce Projections

Significant workforce change and development is expected to support enhanced community and primary care services associated with the implementation of *Transforming Your Care* (DHSSPS, 2011b). This will result in substantial training, re-training and re-deployment of associated nursing and midwifery staff, creating significant pressure on the Education Commissioning Budget as community based specialist practice programmes are full-time and are among the most costly elements of the Education Commissioning budget to fund. Similarly, there are a range of *Hot Spot Areas* which will have an impact on the nursing and midwifery workforce projections over the next ten years, as presented below.

The full time nature of Specialist Practice Programmes should be reviewed and consideration given to delivering these programmes on a part time basis

3.1.1 Hot Spot Areas

Impact of a Global Shortage of Nurses and Midwives

A range of reports and studies warn that global shortages are placing the nursing and midwifery workforce under pressure and risking the quality of patient care (Kelly et al., 2011; Van den Heede & Aiken, 2013; Imison & Bohmer, 2013; ICN, 2014). In the UK, the Centre for Workforce Intelligence (2013) forecast a likely reduction of 63,800 nurses over the period 2013 to 2016. Similarly, an NHS Employers report (2014) highlighted that 83% of NHS Trusts in England are currently experiencing qualified nursing workforce supply shortages.

In addition, there has been an outward shift of many of the internationally recruited nurses who moved to Northern Ireland during the last decade, mainly among the Filipino and Indian nursing community. This is particularly pertinent to the independent sector who report significant difficulties in attracting and retaining

nurses, even from overseas, at a time when an increasing number of patients and clients are being cared for by this sector. Northern Ireland employers from all sectors are holding major Job Fairs in an attempt to recruit, retain and attract nurses and midwives to their organisation. Similarly, employers from outside Northern Ireland are offering competitive relocation packages and choice of specialty with enhanced training to attract nurses and midwives. The evidence suggests that the international shortage of nurses will continue to be an issue of particular importance for Northern Ireland during the period of this Workforce Plan. In CNMAC's paper December 2015 (Annex C) there is a recommendation that immediate steps be taken to support a regional international recruitment process from both EC and Non EU countries

Action Point: A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice.

Impact of Recruitment Processes for Nurses and Midwives

During the development of this Plan, stakeholders identified a range of recruitment issues within HSC Trusts relevant to nursing and midwifery. The current practice of recruiting to temporary posts and/or the development of long waiting lists for posts, whereby nurses in particular are offered posts which do not take into consideration areas of preference or alignment to knowledge and skills, has led to the perception of a developing culture of "*any nurse will do*". This practice is counter-productive and is not resulting in ensuring the right nurse is deployed in the right area.

Similarly, recruitment processes and methods employed to backfill maternity leave and sickness absence were reported by stakeholders as difficult and protracted, leading to staff being under extreme pressure and experiencing heavy workloads; resulting in increased levels of workplace stress and low morale impacting on patient care. The impact of regional recruitment was reported as further concern. The CNMAC paper December 2015 gives more detail on the issues surrounding recruitment of Nursing and Midwifery staff.

Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review.

Action Point: Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review to support the implementation of this Workforce Plan.

Impact from Other Professional Groups

Workforce planning is currently underway for the medical profession to determine both the required size and distribution, by specialty, across Northern Ireland. Whilst there has been some success in recruiting to medical vacancies during 2013/14, pressures still remain in the system at both Consultant and Specialty Doctor level (Emergency Departments and Medical Specialties). Filling General Practitioner (GP) Specialist training roles is also proving difficult which will impact on future GP recruitment. With proposed reductions in the number of trainees within medical specialties and difficulty recruiting to all junior medical posts, this Plan is anticipating greater medical workforce pressures especially in some key areas where there are existing recruitment issues.

During the course of developing this Plan and further to recommendations made by the College of Emergency Medicine, work is underway to consider where Advanced Nurse Practitioners (ANPs) may offer a solution to the recruitment difficulties being experienced within the medical profession and/or where their competencies can best meet service needs. Areas to date include Primary Care, Community Care, Emergency Departments and Urology and it is expected that there will be similar recommendations from the Medical Paediatric Review. The Northern Ireland *Advanced Nursing Practice Framework* (DHSSPS, 2014b) provides a mechanism for greater understanding of the definition, role and competencies required to practice at this level. The HSC Trusts must take the opportunity to link the development of new roles explicitly to the planning process and commission future training numbers based on such plans alongside developing funding streams. This may require additional funding or a re-profiling of overall staff budgets within these areas.

Action Point: Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.

Implementation of Delivering Care

Demand for nursing and midwifery in Northern Ireland is set to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). During a scoping exercise on implementation of the first phase, it was anticipated that an additional 284 (WTE) adult nurses would be required to meet the normative nurse to bed and skill mix ratio in acute and specialist medicine and surgery. This is also a policy direction in the other UK countries; England now requires all hospitals to publish staffing levels on a ward-by-ward basis and guidance from NICE (2014) is likely to strengthen the demand for nursing and midwifery in many areas. Scotland and Wales are moving in a similar direction.

It is anticipated that any recruitment exercise required to address implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

During the development of this Plan, stakeholders from the independent sector reported that they are forced to recruit from other countries due to the significant recruitment and retention issues within this sector. Therefore, in order to address any concern regarding instability of nurse staffing within the Independent sector consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within this sector.

Action Point: An infrastructure to support learning and assessment in practice and availability of a period of preceptorship must be available within the independent sector similar to that already available within the Statutory Sector to ensure adequate supervision, support and guidance to enable consolidation of nursing and midwifery training.

The second, third and fourth phases of *Delivering Care* are running concurrently at present and intend to replicate the methodology used during phase one to produce a range for staffing levels within Emergency Departments, District Nursing and Health Visiting teams.

These phases are due to report by the end of March 2015 and may have further implications for nurse staffing in those areas. The project will subsequently look at other areas such as mental health, learning disability, children's and midwifery however an agreed timeline is yet to be established for these areas.

Action Point: Ensure that as new and emerging evidence and developments become available from *Delivering Care* (DHSSPS, 2013b), these are reflected within the implementation, monitoring and refresh stage of the Workforce Plan.

Professional Issues for Nursing and Midwifery

As previously outlined at point 2.2 above, many factors will present challenges for the nursing and midwifery professions over the next ten years and beyond. Similarly, a range of professional issues will have a significant impact on the nursing and midwifery workforce, including the following:

- A Revised NMC Code for Nurses and Midwives;
- A new NMC Model of Revalidation;
- Implementation of *Delivering Care: Nurse Staffing Levels* (DHSSPS, 2013b);
- Development of Advanced and Specialist Practice roles and implementation of the *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- Implementation of *Job Planning Guidance for Clinical Nurse Specialists* (NIPEC, 2012);
- Implementation of the *Preceptorship Framework* (NIPEC, 2013);
- Mentorship and practice training in community settings;
- Implementation of *Standards for Supervision for Nursing* (DHSSPS, 2007) and *Midwives Rules and Standards* (NMC, 2012);
- Nursing and Midwifery accountability and delegation of care;
- Implementation of a *Career Pathway for Nursing and Midwifery* (NIPEC, 2015).

Technology and Technical Skill Demands

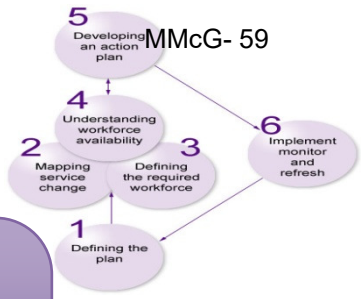
Changes in technology continue and we wish to embrace these changes in order to reap the benefits that they will bring in terms of more efficient and effective working. Already facilities such as video conferencing, Apps, digital dictation, e-learning, electronic prescribing, use of tablets and remote working are starting to become a reality for some nurses and midwives and support staff. However, accessibility to information and communication technology facilities require further enhancement in many areas, particularly within community nursing.

Many nursing and midwifery staff encounter telehealth and telecare applications in their daily work and an increasing number are taking a lead role in telehealth and telecare programmes. By expanding access to specialist services, providing real-time health advice, and remotely monitoring both care environments and health status, telehealth and telecare programmes have the potential to reduce visits by patients to care providers (and vice versa), facilitate more localised care, provide more timely diagnosis and intervention, and even reduce costs (RCN, 2014).

It is difficult to comprehend how much technology might have changed by the end of this workforce planning period. However, in order to gain maximum benefit from future technological change the HSC will require a workforce with increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

Action Point: Provision of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.

This is a commissioning responsibility which must be addressed if we are to offer patients and clients a better quality service, with easier access to the services required and to ensure effective and efficient utilisation of this particular workforce.



STEP 4: UNDERSTANDING WORKFORCE AVAILABILITY

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

4.1 Workforce Figures (based on HRPTS data at March 2014)

Workforce data and information in relation to the overall workforce within the HSC sector in Northern Ireland are held and maintained on a new system, Human Resources, Payroll, Travel and Subsistence (HRPTS). This system was introduced using a phased approach during 2013 and 2014 and is now in use across all of the HSC organisations. The HRPTS data is continually updated and managed locally by the employer organisations. The DHSSPS produces a quarterly statistical summary report for the whole of the HSC workforce.

The data relating to the nursing and midwifery workforce available on HRPTS provides a reasonable baseline demonstrating the numbers presently employed within the HSC workforce. It should, however, be noted that some areas have been difficult to analyse using the data, due to the categorising of some staff and some inconsistencies in the core data provided from HSC Trusts. At present, HRPTS grades all such staff as acute nurses, and although detailed interrogation of the system may permit the identification of staff statistics by sub-specialty, this is not easily done and is not part of the routine quarterly reporting.

Similarly, although the strategic direction, outlined in *Transforming Your Care* (DHSSPS, 2011b), is to drive the transition of service delivery from predominantly acute-based to community settings, the number of District Nurses, who are key professionals in supporting this agenda, has reduced by 13% since the previous Workforce Review (DHSSPS, 2009). This would suggest that some HSC Trusts are categorising these nurses on HRPTS under other grades, for example, 'Specialist Nurses' as during the same timeframe, Specialist Nurses at Bands 5 and 6 increased by 104%. In addition, the coding of some Band 5 and Band 6 nurses as 'Specialist Nurses' needs to be addressed as Band 5 nurses do not practice at a

Specialist level. HSC Trusts' workforce plans should address these categorisation and coding issues.

Action Point: The HRPTS categorisation and coding of the workforce needs to be reviewed and addressed by the HSC Trusts, particularly in respect of District Nurses and Specialist Nurses.

The figures included within this Plan are reported as they have been recorded on HRPTS. To allow meaningful analysis, bank staff and staff on career breaks have been excluded. Where staff have more than one post in the same organisation, or even within a different organisation, each post will have been counted in the 'Staff in Post' headcount, but the whole-time equivalent (WTE) will reflect the proportion of standard hours that are worked in each post. Staff who are temporarily absent from their position, for example due to maternity leave or sick leave, have been included in the analysis. In contrast to previous Nursing and Midwifery Workforce Reviews, Prison Nurses, who are now employed by the South Eastern HSC Trust, have been included in the 2014 workforce figures (n=55.2 WTE).

The data obtained for the purpose of this Workforce Plan includes a breakdown of the current workforce figures, inter alia, by:

- **Employing organisation;**
- **Service area (e.g. acute, midwifery, mental health, etc);**
- **Age;**
- **Gender;**
- **Headcount (HC) and Whole Time Equivalents (WTEs);**
- **Full-time or part-time status.**

4.2 HSC Workforce Profile

At the time of developing this Plan, the most recent statistical report was for the workforce as at 31st March 2014, therefore this point in time has been selected as the baseline for analysis.

4.2.1 Composition of the Registered Nursing and Midwifery Workforce

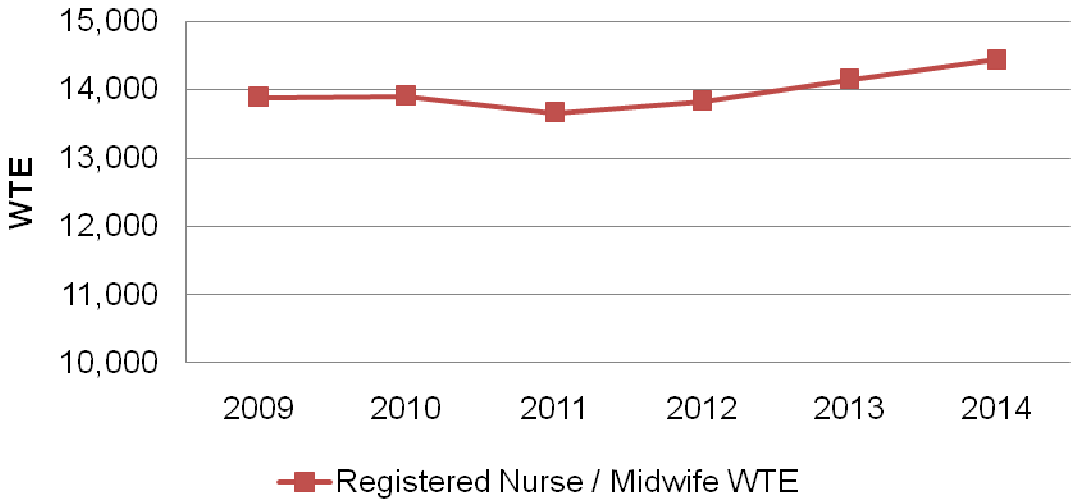
The HSC employs 16,646 or 14,328.7 Whole Time Equivalent (WTE) registered nurses and midwives (excluding bank staff and career breaks) with a comprehensive range of skills geared towards meeting the needs of patients and clients (Table 1). It is the largest staff group within the HSC, accounting for around 27% of all staff.

Table 1: HSC Registered Nurses & Midwives as at 31st March 2014

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

Since the previous Nursing and Midwifery Workforce Review (DHSSPS, 2009), levels of registered nurses and midwives (including student midwives and health visitors for comparison) remained steady between 2009 and 2010, with a slight reduction in numbers during 2011 (Figure 3).

Figure 3: HSC Registered Nurses & Midwives (WTE) 2009-2014



*includes student midwives and student health visitors for comparison with 2009 Review.

Table 2 demonstrates that overall, comparing 2014 with 2009, whole-time equivalent number of registered nurses and midwives have increased by 4%.

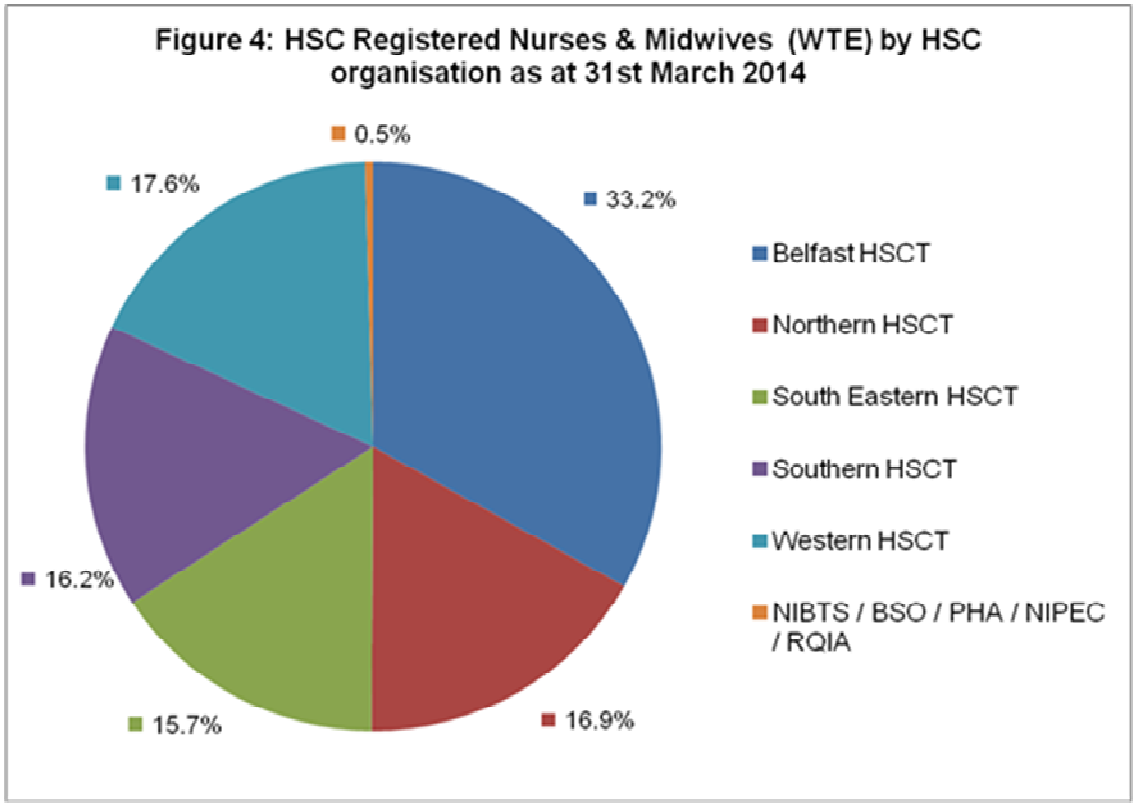
Table 2: Comparison of HSC Registered Nurses and Midwives (including post-registration students) 2009 and 2014

Combined Grades	2009		2014 *		% Change 2009-2014	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses / Midwives	16,251	13,875.9	16,646	14,328.7	3.1%	4.0%
Student Midwives / Student Health Visitors			105	99.8		
Total	16,251	13,875.9	16,751	14,428.5	3.1%	4.0%

*Figures include Student Midwives and Health Visitors for comparative purposes. The 2014 figures include Prison nursing staff (55.2 WTE).

4.2.2 Employing Organisation

Belfast HSC Trust employs the largest percentage of the registered nursing and midwifery staff (33.2%), with the other HSC Trusts employing between 15.7% and 17.6% (Figure 4). However, it is important to note that the Belfast HSC Trust provides a range of regional services.

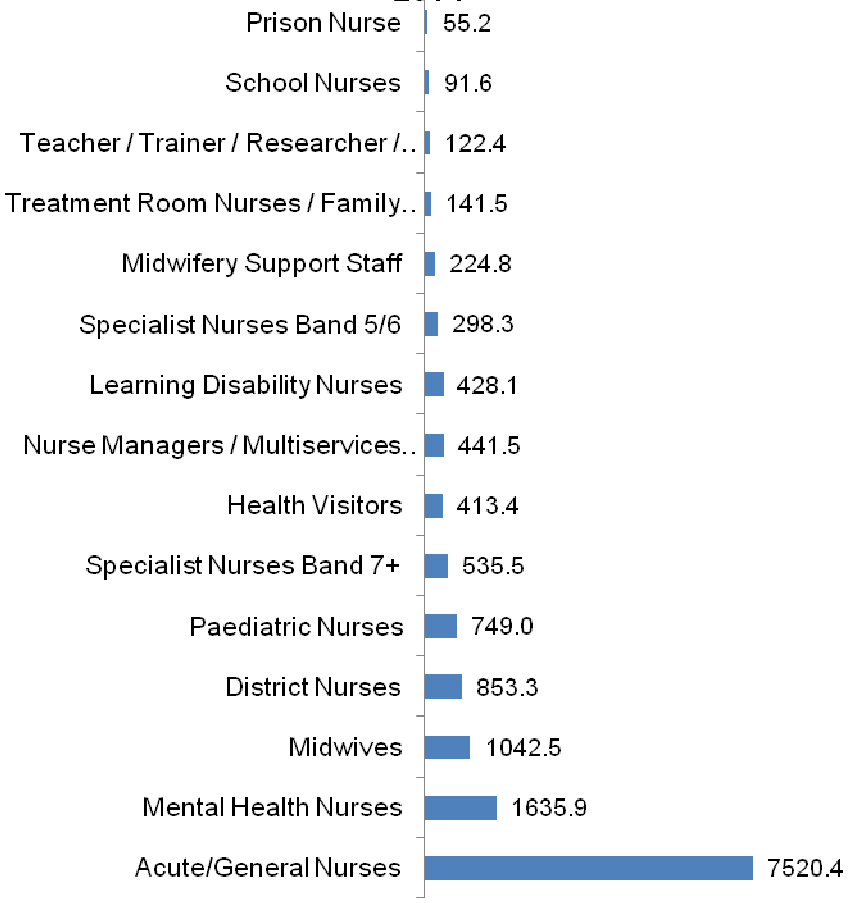


4.2.3 Registered Nurses and Midwives by Practice Area

Figure 5 below illustrates the number of registered nursing and midwifery staff by service/practice area. As previously highlighted, the data recorded on HRPTS by all HSC Trusts is not consistently coded to permit analysis of particular areas, such as, acute nurses working within specific wards, departments or sub-specialties.

Similarly, there appear to be some inconsistencies across all HSC Trusts in relation to how nursing staff are categorised on HRPTS, particularly District Nurses, who may, on some occasions have been categorised as other grades, for example, 'Specialist Nurses'. These issues present potential difficulties regarding the prediction of nursing and midwifery commissions within specific service/practice areas and will therefore be considered when discussing the predicted commissions over the next ten years within this Plan.

Figure 5: HSC Registered Nurses & Midwives (WTE) by service/practice area as at 31st March 2014



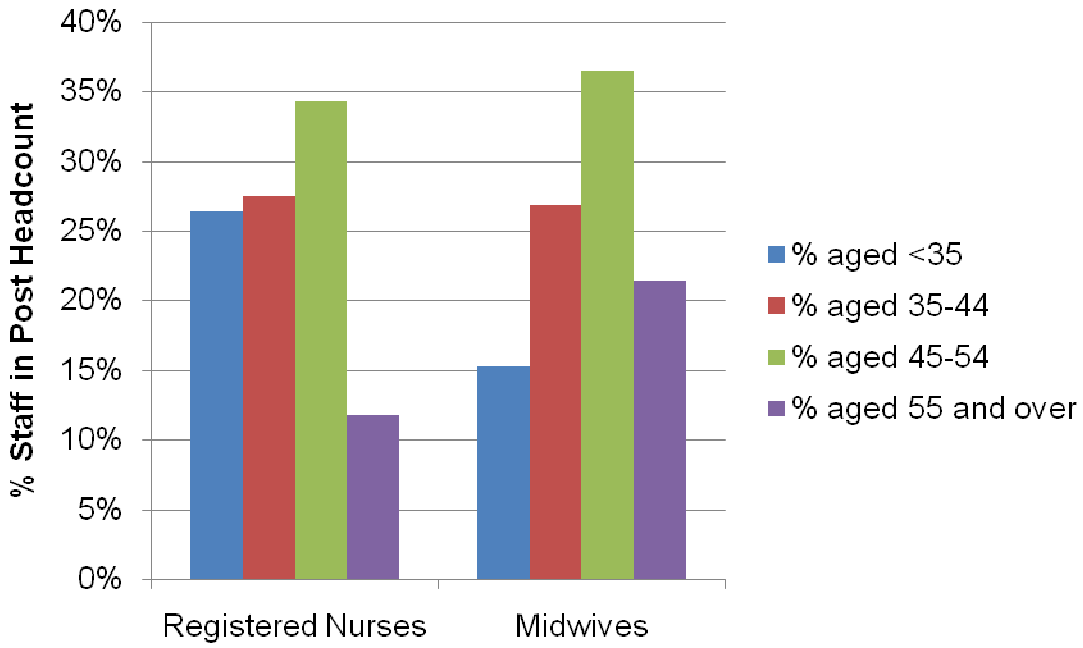
A more detailed illustration of the registered nursing and midwifery workforce by service/practice area within each HSC organisation has been included in Annex C.

4.2.4 Age of the Registered Nursing and Midwifery Workforce

Figure 6 presents (by staff category) the percentage of registered nursing and midwifery staff within each age category (using staff in post headcount). In terms of the 4 age categories presented, analysis shows that the highest proportion of staff within each category are aged 45-54. Midwives have the largest percentage of staff aged 45 and over (58%), followed by registered nurses (46%).

This compares with the 2009 Review which reported midwives had the largest percentage of staff aged 45 and over (54%), followed by registered nurses (39%).

Figure 6: HSC Registered Nurses & Midwives by Age Group at 31st March 2014



Further analysis shows that the midwives category has the largest percentage of staff aged 55 and over (21%), compared to registered nurses (12%). This compares with the 2009 Review which reported that 13% of midwives were aged 55 and over and 8% of registered nurses were aged 55 and over. A more detailed illustration of the registered nursing and midwifery workforce by service/practice area and age has been included in Annex D.

Ensuring the health needs of our ageing workforce is essential, not least in recognising that some nursing, midwifery and support roles have a substantial physical element which may become more onerous, particularly with the transition of service delivery from predominantly acute-based to community settings (DHSSPS, 2011b), and the increase in patterns of lone working which this often entails. In

addition, the Health and Safety Executive (2013) identified differences in the sickness absence patterns between younger and older workers which need to be considered. Typically younger workers tend to be absent more often, but for shorter periods of time, whereas older workers are less likely to be absent less frequently but are more likely to have a longer period of absence.

The figures included in Annex E present the current numbers of staff aged 45 – 54 years who are likely to retire within the next five to ten years (or who may otherwise be more liable to leave the service for other reasons), particularly in the front-line service areas of mental health nursing (43%), district nursing (43%), health visitors (44%), school nursing (46%), specialist nursing (55%) and nurse managers (59%). Similarly, the numbers and the health and well-being of staff aged 55 or older, particularly in the front-line service areas of midwifery (21%), school nursing (21%), teaching and training (22%) will need to be considered. Furthermore, in other service areas, particularly acute nursing, where the age profile is generally younger and the workforce is predominantly female, the continuing incidence of part-time working and maternity leave is likely to prove challenging, particularly in respect of filling shifts which are relatively unpopular, including weekends and nights.

4.2.5 Registered Nursing and Midwifery Workforce by Gender

Table 3 demonstrates that 15,597 of the registered nursing and midwifery workforce are female with 1,049 being male.

Table 3: HSC Registered Nurses & Midwives by Gender (headcount)

Combined Grades	Female	Male	Total
Registered Nurses/Midwives	15,597	1,049	16,646

Figure 7 outlines that the figures are consistent with the 2009 Review which reported that 91.9% of the overall workforce was female and 8.1% male.

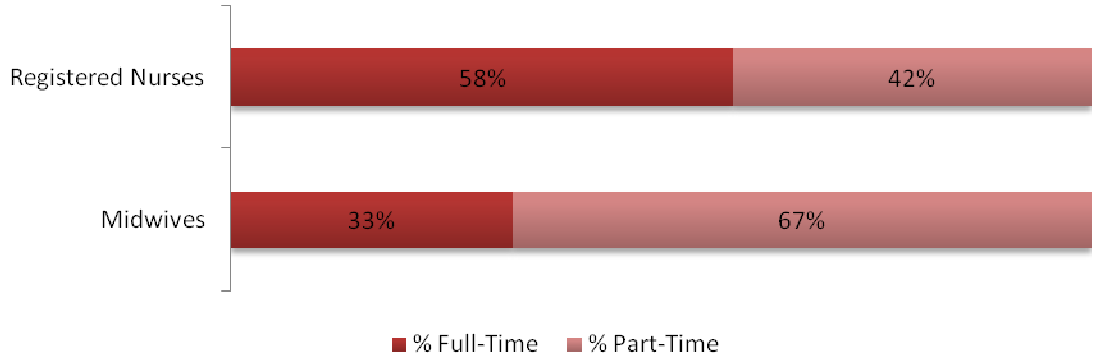
Figure 7: HSC Registered Nurses & Midwives by Gender as at 31st March 2014

A detailed illustration of the registered nursing and midwifery workforce by service/practice area and gender has been included in Annex E.

4.2.6 Registered Nursing and Midwifery Working Patterns and Conditions

In terms of contract type, analysis of registered nursing and midwifery staff whole-time equivalents (WTE) shows that the midwives category has a greater proportion of part-time staff at 67% compared to the registered nurses (42%): (Figure 8).

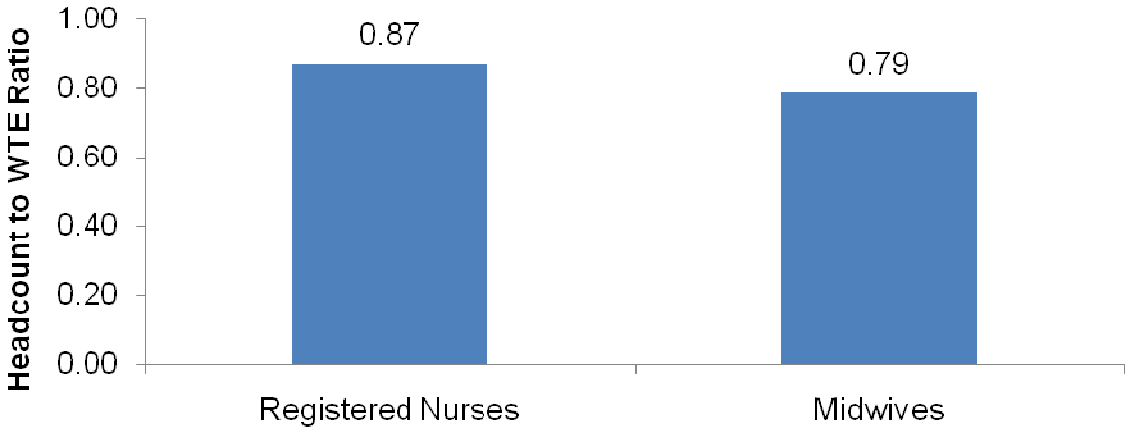
Figure 8: HSC Registered Nurses and Midwives - Proportion of Full-Time / Part-Time* staff as at 31st March 2014



* Part-time is defined as anyone working less than full-time hours (i.e. 37.5 hours per week).

As demonstrated in Figure 9 below, although the midwives category shows a greater proportion of part-time staff, analysis of the overall headcount to whole-time equivalent ratio shows that they have a marginally lower ratio (0.79) compared to the registered nurses category (0.87).

Figure 9: HSC Registered Nurses & Midwives - Ratio of Headcount to Whole-time Equivalent as at 31st March 2014



Analysis of contract type in HPRTS shows that the registered nursing and midwifery workforce consists of mostly permanent contracts (excluding bank), as presented in Figure 10.

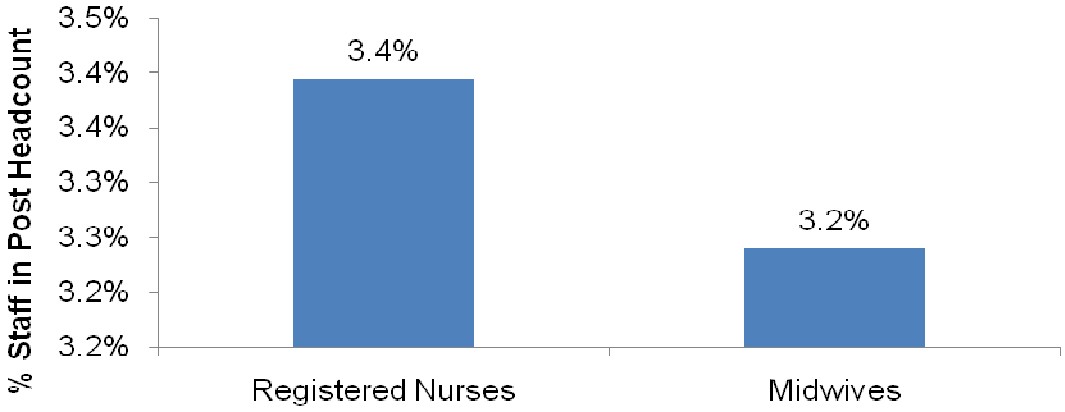
Figure 10: HSC Registered Nurses & Midwives by contract type as at 31st March 2014

The whole-time equivalent contribution of bank staff cannot currently be analysed, however, the majority of registered nursing and midwifery staff bank contracts held within HRPTS are for staff who also have a substantive post within HSC organisations (around 80%).

4.2.7 Registered Nursing and Midwifery Staff Maternity/Adoption Leave

Figure 11 below shows analysis of attendance/absence type in HRPTS and shows the percentage of staff recorded as being on maternity/adoption leave as at 31st March 2014.

Figure 11: Percentage of HSC Registered Nurses & Midwives recorded as being on maternity/adoption leave as at 31st March 2014



A breakdown of registered nursing and midwifery staff recorded as being on maternity leave as at 31st March 2014 is presented in Table 4 below.

Table 4: Percentage of HSC Registered Nurses & Midwives recorded as being on maternity/adoption leave as at 31st March 2014 (Headcount and Whole-time equivalent)

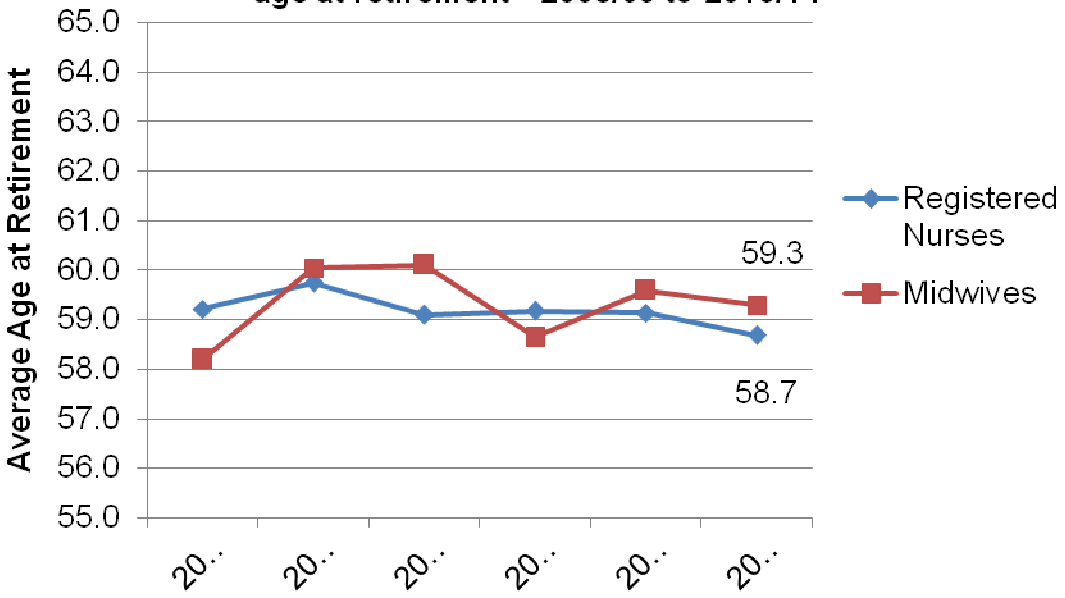
Staff Category	Recorded as being on Maternity/ Adoption Leave		Total staff		% recorded as being on Maternity / Adoption leave	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses	520	464.0	15,319	13,286.2	3.4%	3.5%
Midwives	43	36.7	1,327	1,042.5	3.2%	3.5%

Although HRPTS high level statistics demonstrate that overall maternity rates are fairly low, representing 3.4% of registered nurses and 3.2% of midwives, at team level maternity absences can have a significant impact, for example, an Orthopaedic theatres team – 2 out of 10 staff on maternity leave = 20% or a Health Visiting team – 3 out of 16 staff on maternity leave = 19%.

4.2.8 Registered Nursing and Midwifery Staff Retirement Trends

Retirements present an opportunity for change and redesign of the workforce. However, it is worth noting that there is often a wealth of skills and experience embodied in these people, gained over many years of service, which will be lost to the HSC and will therefore take time to develop and re-establish. Eligibility for retirement can differ for specific grades of nurses and midwives or due to the pension scheme in question. Average age at retirement for registered nurses decreased slightly in 2013 but has ranged from 58.8 - 59.6 over the last 5 years. For midwives, average retirement age was increasing during the period 2008-2010, with a dip in 2011/12, followed by a period of increase in 2012/13 and 2013/14 (Figure 12).

Figure 12: HSC Registered Nurses & Midwives - Average age at retirement * 2008/09 to 2013/14



*The above figures include those with 'Reason Left' recorded as Retirement, Ill Health Retirement or Voluntary Early Retirement (excluding bank staff), but only for those aged 55+.

It might be expected that retirements could be predicted with some degree of accuracy; however, this Plan is being written at a time when such predictions are more difficult due to the current economic climate and pension changes for staff. For instance, with effect from 1 April 2011 employers can no longer operate policies that include a compulsory retirement age. In addition, by 2015 the state retirement age for men and women will be 65 years. It could therefore be expected that women may reconsider the age at which they retire resulting in a gradual increase in age.

Similarly, it seems likely that public sector pension schemes will change during the period of this Plan, based on the Hutton Review of Public Sector Pensions (2011). The main changes will include linking the age at which the Occupational Pension is paid (based on a career average rather than a final salary scheme) to the age at which the State Pension is paid. The implications of these changes might be that staff will continue to work beyond the age at which they had previously planned to retire under the existing scheme, in order to match their existing pension or improve on this. Alternatively, the proposed changes may prompt staff to retire earlier than planned, prior to any definitive changes. Furthermore, *Mental Health Officer Status* is held by many staff which enables them to retire at the age of 55 years, without any reduction to their pension. This status is not available to staff who did not have it granted before 6 March 1995, so the numbers who fall into this category will be reducing during the timescale of this Plan.

The decision about when to retire will be a personal one, whether related to any or all of the above issues, the economy and how it impinges on people's lives or for other reasons. Predicting numbers that are expected to retire is not precise, but we can assume, based on historical trends, that staff will leave when they reach the current average retirement age for their group. Further work on the impact of the age profile and pension changes should be undertaken to support this Plan, particularly during annual reviews.

Action Point: The impact of the nursing and midwifery age profile and relevant pension changes should be undertaken to support the implementation of this Plan, particularly during annual reviews.

4.2.9 Registered Nursing and Midwifery Staff Health and Wellbeing

The DHSSPS collects high level sickness absence information from HSC organisations twice a year. HSC Trusts must continue to support in the best way possible, those of its staff who suffer ill health.

Figure 13 below shows the trend of sickness absence rates amongst registered nursing, midwifery and support staff, ranging between 6 and 6.6%.

Figure 13: HSC Trust Nursing & Midwifery staff (including support staff)- Sick absence rates (percentage of working days lost)

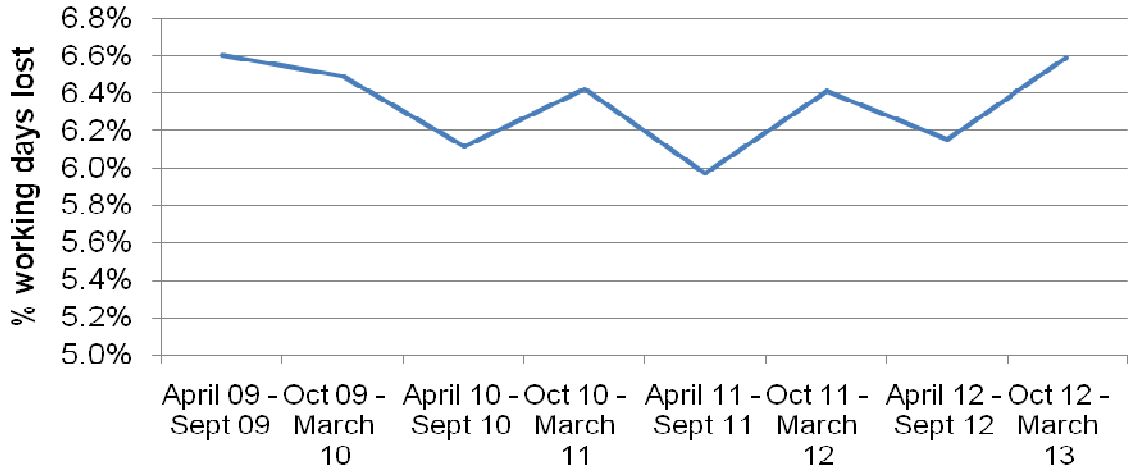
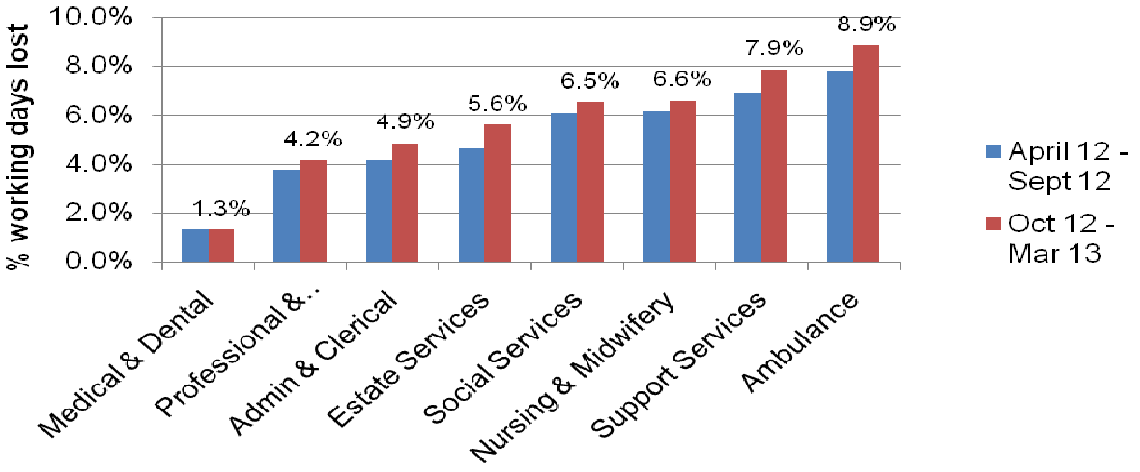


Figure 14 below shows a comparison of sickness absence rates in other occupational families for the two collection periods in 2012/13. The registered nursing, midwifery and support workforce had a similar sickness absence rate during 2012/13 to the social services workforce but not as high as support services or ambulance staff (note the percentage label in the chart relates to the period October to March).

Figure 14: HSC Trust Sick Absence Rates by Occupational Family 2012/13

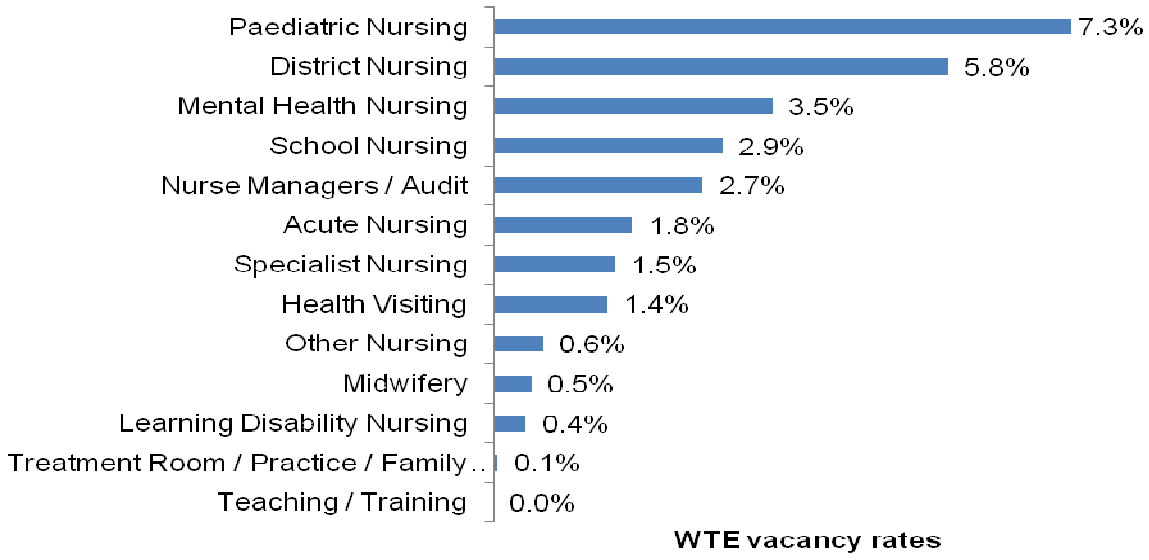


Delivering Care (2013b) includes a 5% target for Sickness Absence. The regional average for the monitoring period October 2012 – 31 March 2013 is up from 6.41% last year to 6.6% therefore a significant reduction in sickness absence will be required to meet this target. The HSC Trusts should continue to seek to reduce sickness absence rates over the period of this Plan (2015-2025).

4.2.10 Nursing and Midwifery Vacancies and Supplemental Staffing

A vacant post is defined as a post '*actively being recruited to' (DHSSPS*). The DHSSPS collects data on vacancies via a survey twice a year. Figure 18 below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.

Figure 18: HSC Nursing, Midwifery & Support WTE vacancy rates by service area as at 30th September 2013



All HSC Trusts had varying levels of vacancies, at 30th September 2013, amounting to 470 (headcount) or 419.1 (WTE) vacant posts, representing a rate of 2.3% (based on WTE) across the HSC nursing & midwifery occupational family, with the highest vacancy rates in paediatric nursing (7.3%), district nursing (5.8%), mental health nursing (3.5%) and school nursing (2.9%) at that time. Vacancy numbers, rates, Agenda for Change bands and service areas across the HSC Trusts are presented in Annex F.

HSC Trusts operate their own staff banks or overtime system and/or utilise agency staff to supplement the nursing, midwifery and support workforce. This is normally in response to vacancies, planned and unplanned/sickness absence in order to minimise service disruption and ensure service standards are maintained. HRPTS figures demonstrate that the majority of bank contracts (around 80%) are held by registered nurses and midwives who already have a substantive post within the relevant Trust.

HSC Trusts' Financial Returns submitted to the DHSSPS (Table 5) demonstrate variations in the use of bank and agency staff.

Table 5: Bank/Agency Expenditure from DHSSPS Finance Directorate 2008-2013

Agency Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
08/09	8,829,000	622,401	2,581,926	1,289,099	846,399	14,168,825
09/10	6,066,000	481,465	3,303,414	1,185,710	1,268,818	12,305,407
10/11	2,818,000	612,964	3,398,887	452,734	1,525,742	8,808,327
11/12	3,114,000	836,225	2,031,664	263,240	2,070,303	8,315,432
12/13	3,742,000	1,078,594	2,768,074	672,111	1,591,350	9,852,129
Total	**24,569,000**	**3,631,649**	**14,083,965**	**3,862,894**	**7,302,612**	**53,450,120**

Bank Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2008/09	6,957,000	7,059,211	494,641	2,732,462	3,046,598	20,289,912
2009/10	10,861,422	4,138,646	2,511,105	3,703,771	2,971,304	24,186,248
2010/11	12,833,926	4,684,905	2,847,489	4,097,985	3,891,876	28,356,181
2011/12	15,067,266	5,612,623	5,604,662	6,327,428	3,158,444	35,770,423
2012/13	16,664,000	6,242,135	6,207,717	7,825,280	4,774,951	41,714,083
Total	**62,383,614**	**27,737,520**	**17,665,614**	**24,686,926**	**17,843,173**	**150,316,847**

Source: Trust Financial Returns (TFR E&S)

It is important to note that HSC Trust data on bank and agency staff is primarily financial, and HRPTS does not record the use or deployment within specific service

areas of agency and bank staff, making it difficult to track the impact of their use. In addition, the whole-time equivalent (WTE) contribution of bank staff cannot currently be analysed by HRPTS.

This compares with the picture across Northern Ireland at the time of the previous review (DHSSPS, 2009), with 2006/07 returns for bank and agency nursing costs (Table 6) showing the following:

Table 6: Bank/Agency Expenditure from DHSSPS Finance Directorate 2006-2007

Bank and Agency Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2006/07	10,552,000	798,000	1,758,000	464,000	982,000	**14,553,000**

Source: Trust Financial Returns (Expenditure: Salaries and Wages)

The use of bank and agency staffing has more than doubled in the intervening years since the last nursing and midwifery workforce review (DHSSPS, 2009). As demonstrated in the Report into Mid-Staffordshire NHS Trust (Francis, 2013), there appears to be a clear link between temporary staff and poorer outcomes for patients and families.

The Keogh Report (2013) also noted a positive correlation between inpatient to staff ratio and a high hospital standardised mortality ratio (HSMR) score. Another key finding was that actual nurse staffing levels in the 14 Trusts were below those that had been reported in national indicators. High use of temporary staff, higher use of health care assistants, low levels of nurse staffing at nights and weekends, and relatively high levels of nurse vacancies were among key staffing issues.

One recommendation was that '*Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience*.' The Report also noted the National Quality Board's (2013) guide to nursing, midwifery and care staff capacity and capability and further guidance has recently been published by the National Institute of Clinical Excellence (2014).

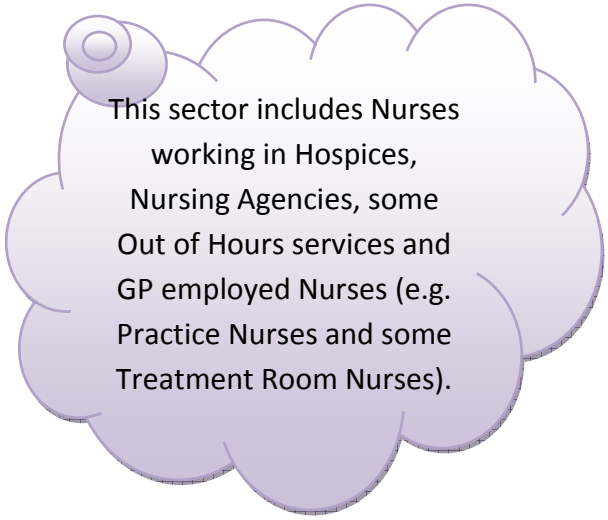
To support this, significant work is ongoing in Northern Ireland to address the use of bank and agency with mechanisms and processes in place within HSC Trusts to facilitate the use of the most cost effective supplementary staffing solution, be it bank

or overtime. In addition, the Nurse Leaders in Northern Ireland have agreed that as posts are filled via *Delivering Care*, the use of bank/agency/overtime must be reduced by 75% when the work has been completed. A Regional Initiative, led by the Chief Nursing Officer, *Evidencing Care through Key Performance Indicators for Nursing and Midwifery* will monitor compliance with the agreed 75% reduction, as a further assurance that the use of bank and agency staff will be minimised alongside a reduction in vacancies and absenteeism.

It is in the best interest of each employer, the staff and the patient to reduce to the lowest possible level the use of nursing and midwifery bank and agency staff within Northern Ireland. HSC Trusts must implement *Delivering Care: Nurse Staffing in Northern Ireland* (DHSSPS, 2013b) to reduce vacancies and the use of bank and agency staff to ensure safer patient and client care.

4.3 Workforce Figures for the Independent Sector

The independent healthcare sector refers to private, voluntary and not for profit establishments covering a wide variety of services and organisations (Skills for Health, 2011).



Historically it has proven difficult to obtain accurate, up-to-date workforce figures for nurses within the independent sector. This is mainly because no mechanism or process currently exists whereby independent sector employers are required to present their workforce data in a consistent manner and/or many employers in this sector may be concerned about commercial sensitivity and are not prepared to release workforce data.

This is consistent with attempts to gather data from this sector during the previous Workforce Review (DHSSPS, 2009) which suggested that the total number of nursing staff may be as low as 2,000 or well over 3,000. A UK wide *RCN Employment Survey* (2013a) indicated that 12.3% of Northern Ireland respondents (n=9,553) reported working within this sector. Comparing this with the NMC register at 31st March 2014, it appears that the number of nurses working within this sector ranges from 2,731 to 3,475.

Although the previous Review (DHSSPS, 2009) indicated that the Regulation and Quality Improvement Authority (RQIA), the independent HSC regulatory body for Northern Ireland, were seeking to gather workforce data from the independent sector, no data was available during our period of stakeholder engagement.

The independent sector providers are facing a growing complexity of care; some are delivering consultant lead intermediate care bed services, fracture rehabilitation services, assessment bed services, acute mental health and alcohol dependency services along with their nursing care and dementia care services. Their need for registered nurses is increasing as they respond to these demands yet they are unable to recruit sufficient numbers of nurses to meet demand and are currently recruiting extensively overseas.

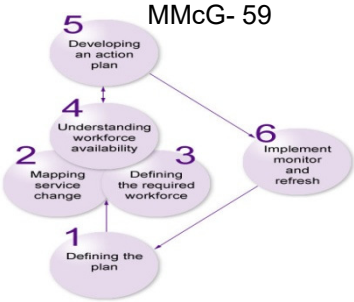
This is supported by a recent report from the Care Quality Commission (CQC; 2014), the inspectorate for health and social care in England, which highlighted a severe shortage of nurses in nursing homes, made worse by the efforts of NHS hospitals to hire more staff following the Report into Mid-Staffordshire NHS Trust (Francis, 2013).

This sector has been lobbying to increase pre-registration nursing places in Northern Ireland throughout the compilation of this Nursing and Midwifery Workforce Plan. The Four Seasons Group alone recruited 209 registered nurses via European Union (EU) routes during 2014. They now have to recruit further afield and in December 2014 they undertook recruitment trips to Cochin in India and to Manila in the Philippines as they can no longer acquire the volume of nurses required through either local recruitment or the EU route.

The EU nurses recruited by the Independent Sector often move on to HSC posts within one year of coming to Northern Ireland as they will then have no work permit restrictions.

The new NMC registration process for non EU nurses is currently not clear due to the delay in UK Visas and Immigration (UKVI) making determination on the entry visa type for these NMC applicants. The NMC have been in discussion with UKVI and a decision on the change of policy is imminent. The Department of Health in England has been lobbying for a decision by UKVI due to the magnitude of the nursing shortages they are facing.

Action Point: A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.



Step 5: Developing An Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical.

5.1 Commissioned Nursing and Midwifery Student Places

Learning and development is an intrinsic element of workforce planning; necessary for the attainment and maintenance of professional registration, the further development of nursing and midwifery roles, competence and capability and, ultimately, the delivery of safe, effective and person-centred care.

5.1.1 Pre-registration Nursing and Midwifery Commissioning

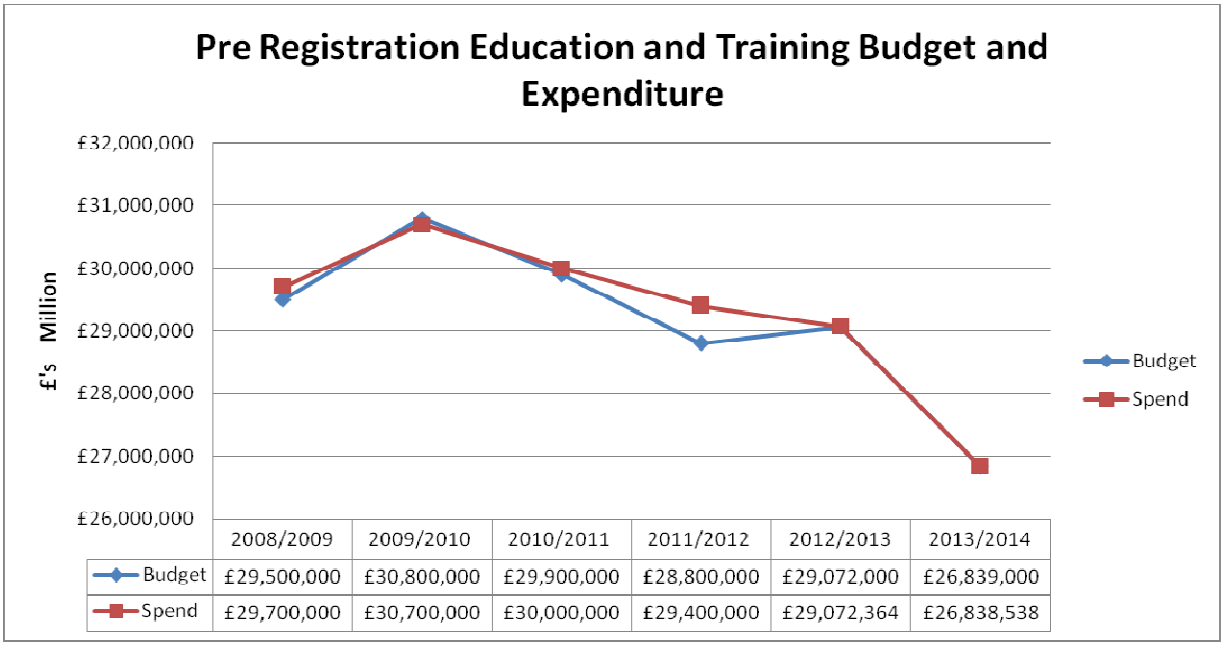
The DHSSPS commissions pre-registration nursing and midwifery education in Northern Ireland; delivered by three providers, namely Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. From 2011, Northern Ireland moved from diploma/degree to degree level only programmes, incorporating the Nursing and Midwifery Council (2010) requirements.

The commissioning profile should be continually assessed to ensure it meets the needs of service. Table 7 demonstrates that the number of pre-registration nursing and midwifery places commissioned has fallen in recent years from 792 in 2008/2009 to 685 in 2014/2015 despite reported difficulties in recruiting nurses to the Independent sector. As previously reported, this sector is continuing to recruit from overseas, however recruitment and retention difficulties exist.

Table 7: the number of pre-registration nursing and midwifery places commissioned

Branch	Pre-Registration Commissioned Places by Year						
	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Adult	525	535	471	471	444	444	444
Adult OU	0	18	0	9	9	7	9
Mental Health OU	36	18	18	9	9	18	16
Children's	55	60	60	60	55	55	55
Mental Health	99	99	99	99	96	96	96
Learning disability	15	30	30	30	30	30	30
Midwifery D/Entry	30	30	30	30	35	35	35
Midwifery, Additional Registration	32	35	35	35	25	25	0
Totals	**792**	**825**	**743**	**743**	**703**	**710**	**685**
Year of completion	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**

Figure 19 below shows that the Pre-registration Nursing and Midwifery Education Commissioning Budget has been significantly reduced from £29,500,000 in 2008/2009 to £26,839,000 in 2013/2014, representing a 9% reduction.



The RCN (2013b) in their publication '*Frontline Nurse: Nursing on Red Alert*', reported concerns about the reduction in training places as a key factor contributing

to an impending nursing shortage. As the nursing commissioning and education process takes at least three years it may be some time before we feel the full effects of this reduction in supply. It will then take several years to respond to a potential nursing shortage through the education system. England in particular is currently recruiting aggressively in Northern Ireland and offering relocation packages of up to £3,000 to new nurse graduates here. This is a trend that will continue until the education system can address the shortfall of nurses in the other three countries. England, Scotland and Wales have all increased pre-registration nurse training places in 2015/2016 due to the impact of nursing shortages. This Review recommends increasing Pre-registration numbers by at least 100 places.

5.1.2 Post-registration Nursing and Midwifery Commissioning

The DHSSPS also commissions post-registration education for nurses and midwives from a range of providers across Northern Ireland, which includes the three universities, independent providers, such as the Royal College of Nursing and the Clinical Education Centre and in some cases Universities outside Northern Ireland. Programmes are also funded for provision at local HSC Trust level.

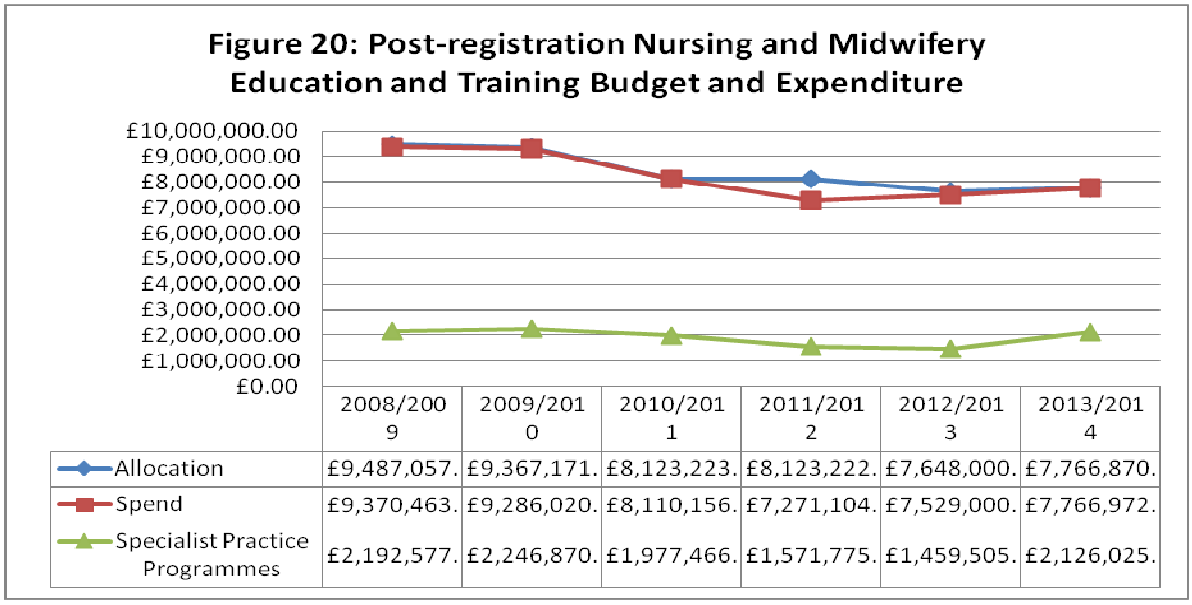
In addition, the DHSSPS commissions 32 *Return to Practice* programmes on an annual basis within the four fields of practice including Adult, Children's, Mental Health and Learning Disability Nursing. The University of Ulster reports that competition remains oversubscribed for these programmes with between 80-90 applications per year. Presently there is no pathway for NMC Part 3 registrants, including Health Visitors.

The commissioning process is currently managed through the DHSSPS Education Commissioning Group (ECG). Commissioned programmes include study days, stand alone modules and short courses leading to an NMC regulated programme such as Specialist Practice Qualifications.

Nursing and Midwifery post registration education is crucial to maintain competence and to develop new specialist skills for specialist roles, including District Nursing, Health Visiting, Infection Prevention, Neonatal Care, Respiratory Disease and Diabetes.

The nursing and midwifery post-registration education and training and expenditure budget from 2008/2009 to 2013/2014 is presented in Figure 20 below which demonstrates that the Post-registration Nursing and Midwifery Education Commissioning budget allocation has been significantly reduced since 2008/2009 by £1,720,187.00, representing a 19% reduction.

Figure 20: Nursing and Midwifery Education Commissioning Budget Allocation



	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Allocation	£9,487,057.	£9,367,171.	£8,123,223.	£8,123,222.	£7,648,000.	£7,766,870.
Spend	£9,370,463.	£9,286,020.	£8,110,156.	£7,271,104.	£7,529,000.	£7,766,972.
Specialist Practice Programmes	£2,192,577.	£2,246,870.	£1,977,466.	£1,571,775.	£1,459,505.	£2,126,025.

*Specialist Practice Programmes relate to Replacement Monies for staff back fill (based on full-time, midpoint Band 5)

5.1.3 Continuing Professional Development Commitments

NMC revalidation places a high degree of demand on nurses and midwives to demonstrate they remain fit to practice. Continuing professional development (CPD) is necessary for the maintenance of NMC registration, the delivery of high quality nursing care and the further development of nursing and midwifery roles. Lord Willis, speaking at the 2014 RCN Congress, argued that training for nursing should continue long after registration:

> *"I would like to look at continuous professional development (CPD) and preceptorship because when a nurse has finished training they are not the finished article and should continue to learn throughout their career. For that to happen we need a seismic change to CPD".*

During our discussions with stakeholders, a number of issues were identified:

- the increasing requirements for nursing and midwifery staff to undertake mandatory training restricts their ability to undertake some CPD pursuits. CPD represents a major resource commitment at service level, both in time required to be released from service delivery, and also in the provision of staff to *back fill*;

- the increasing complexity of patient and client clinical need in the independent sector requires nurses to up-skill to reduce reliance on the HSC Trusts' workforce to support the independent sector staff;

- supervision of staff/mentoring roles places a high degree of demand at service level this has been particularly emphasised by the Independent sector;

- training should be developed according to programmes of care;

- the annual appraisal system must be linked to the Education Commissioning Process to ensure that staff develop in a way that is consistent with HSC Trust Reform Plans, regional strategies and priorities;

- HSC organisations must embed succession planning and ensure strong and capable leadership at all levels within nursing and midwifery to develop practice, improve quality of care and optimise patient and client outcomes.

5.2 Risk Assessment

This Workforce Plan emphasises the importance of continuing to develop Key Performance Indicators linking workforce metrics, such as, vacancies, use of bank and agency staffing and absenteeism to quality metrics, for example, patient falls, pressure ulcers, omitted or delayed medication and patient experience data.

The HSC Trusts' Executive Directors of Nursing are responsible for the identification, mitigation and, where possible, avoidance of risks, including risks associated with the workforce. Risks should be recorded and managed through a robust corporate approach to Risk Management and monitored via accountability arrangements with the DHSSPS.

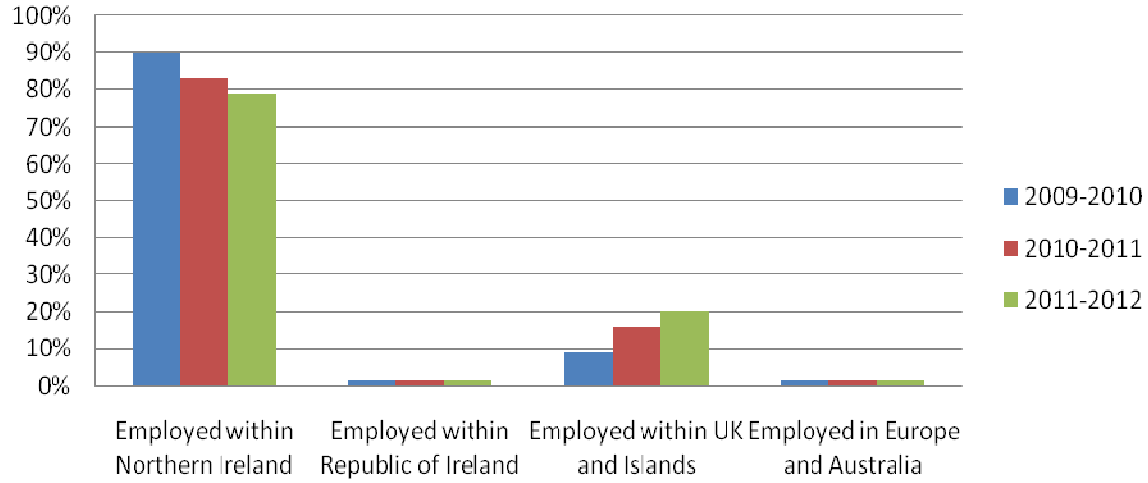
5.3 Student Nurses and Midwives

5.3.1 Destination of Student Nursing and Midwifery Leavers

Within recent years, countries such as the US, Canada and Australia have been offering generous salary and relocation packages, and fast-tracked residency status with the prospect of naturalisation, for example, the '*US Green Card*' system. Similarly, the transferability of the UK professional registration facilitates the free movement of both nurses and midwives currently working within the UK (including Northern Ireland).

Figure 21 below presents the findings from a survey conducted by Queen's University, Belfast. This demonstrates an increasing trend (currently 21%) for newly qualified nurses and midwives being employed outside Northern Ireland following completion of their programmes. It is important to note that those nurses and midwives *Employed within Northern Ireland* (Figure 21) include the independent sector who use the same *pool* as the HSC to recruit from.

Figure 21: Destination of Nursing and Midwifery Leavers (QUB, 2014)



At the time of developing this Plan, comparable destination figures were unavailable from the University of Ulster and Open University in Northern Ireland. However, the University of Ulster suggested that a lower number of student nurse graduates, representing approximately 7%, went to work elsewhere in the UK over the last four years, with no figures presented for other countries.

5.3.2 Attrition rates for Northern Ireland

The number of students leaving before completing their pre-registration training in Northern Ireland is provided below. The numbers provided are inclusive of students who have left midwifery training.

Academic Year	Total
2010/11	51
2011/12	80
2012/13	63
2013/14	46
2014/15	65

Trainee nurses and midwives are admitted to universities by academic year and therefore the information is available by academic year rather than financial year.

This loss represents almost 10% per year.

Action Point: Further work should be commissioned immediately to track destination and attrition rates for all Universities in Northern Ireland.

5.3.3 Perspective from Student Nurses and Midwives

As part of this Plan, final (3rd) year Student Nurses and Midwives (direct entry and additional registration programmes) were asked to participate in a survey to ascertain their views on taking up a post in Northern Ireland following completion of their educational programme and NMC registration.

Ninety six students commenced the survey with 87 (90.6%) completing it. The key findings are presented below.

Students were asked if they felt a sense of duty/responsibility to stay in Northern Ireland on completion of their programme. From a total of 85 respondents, 39% (n=33) reported that they did feel a sense of duty/responsibility to stay in Northern Ireland, however 61% (n=52) reported that they did not.

"Yes preferably in Trust areas where I've had placements as I've got to know patients, staff and families over the last 3 years" (Student)

"I originally would have felt so however over the course of my training I have felt disheartened with how poor the recruitment process is with waiting lists rather than specific posts" (Student)

"I would rather stay at home and be close to friends and family but with offers of much better pay and benefits I plan on moving on" (Student)

"I know the DHSSPS have paid for my training and provided a bursary but permanent jobs are scarce" (Student)

Students were asked "What would encourage you to take up a post in Northern Ireland". The main reasons reported from those who responded (n=90, 94%) include:

being close to home * good promotion opportunities * a supportive employer

good preceptorship programme * job security * choice to work in area of interest

familiar with the system * permanent post * early advertisement of posts

Students were asked "What would discourage you from taking up a post in Northern Ireland". The main reasons reported from those who responded (n=91, 95%) include:

temporary contract * lack of staff on wards * unsupportive working environment

poor preceptorship programme * waiting lists for jobs * placed in area I don't want

lack of opportunity to progress * working conditions putting registration at risk

The majority (67%, n=64) of those who responded reported that they would consider moving to another part of the UK or abroad when qualifying?

"Nurses seem to be held with a higher outlook in society in other countries and offered rotational programmes" (Student)

"Easier to obtain permanent jobs with better career opportunities and terms and conditions elsewhere" (Student)

"Higher standards of care, better staff working relationships" (Student)

"Elsewhere they give you an opportunity to work in your preferred area in nursing and opportunities for preceptorship" (Student)

Students were asked if they would consider a post in the independent sector on completion of their programme, with 58% (n=56) reporting Yes, 29% (n=28) reporting No and a further 13% (n=12) reporting they would, but only if they could not obtain a post within the HSC. From a total of 85 respondents, 60% (n=51) also agreed they would consider a rotational Graduate Scheme (across the statutory and independent sectors) at MSc level if they were unable to obtain a post following completion of their programme. The main reasons reported include:

beneficial to gain experience * great way to further education and develop skills

brilliant opportunity to transition and feel confident * gain insight into other areas

create better quality nursing care * increase suitability for different environments

5.4 Factors impacting on the Nursing and Midwifery Workforce

There are many factors impacting on the Nursing and Midwifery Workforce as discussed in the previous sections. The key factors which will have a significant impact on the demand and supply over the next ten years have been extrapolated from a variety of sources and include:
:

- impact of more nurses and midwives delivering care closer to and in the patient's/client's own home *(Transforming Your Care*; DHSSPS, 2011b);
- increasing numbers of patients being looked after in the independent sector, major recruitment issues and relying on recruiting overseas (stakeholder engagement);
- the impact of the independent sector, which include Practice Nurses and some Treatment Room Nurses, using the same *pool* as the HSC to recruit from;
- impact of rising numbers of the population over the age of 85 years and rising levels of long-term conditions (DHSSPS, 2013a);
- impact of the age profile and imminent high number of retirements, particularly in relation to the Health Visiting, District Nursing, Mental Health Nursing and School Nursing workforce (HRPTS);
- implementation of *Delivering Care* (DHSSPS, 2013b); the first phase (acute and specialist medicine and surgery) recommended an increase of 284 (WTE) registered nurses (adult) in addition to current staffing levels;
- impact of working patterns (94% female, 42% working part-time in some areas) and reported recruitment difficulties in covering maternity leave and sickness absence (HRPTS);
- impact of a global shortage of nurses with destination figures from Queen's University, Belfast demonstrating an increasing trend (21%) for employment of new nursing graduates outside Northern Ireland;
- impact of attrition rates of almost 10% in pre-registration training
- impact of regional recruitment (stakeholder engagement);
- reported recruitment issues of an attitude that *"any nurse will do*", management of long waiting lists with a lack of preference for nurses in where they choose to or are trained and experienced to work and holding of vacancies (stakeholder engagement);
- releasing staff to avail of further training and development opportunities due to difficulties in backfilling posts (stakeholder engagement);
- ensuring adequate programmes are in place to support CPD, mentorship, preceptorship and a career pathway for nurses and midwives (stakeholder engagement);
- increasing role of ICT and the impact of training and development and embedding such innovations in practice (stakeholder engagement).

5.5 Pre-registration Nursing and Midwifery Education Forecasts

5.5.1 Introduction

This section includes figures and tables relating to each of the Pre-Registration Branch programmes including Adult Nursing, Children's Nursing, Mental Health Nursing, Learning Disability Nursing and Midwifery.

Where relevant to the above Branches, Additional Registration and Community Nursing Programmes have also been included. The tables assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses and 59.5 years for midwives).

5.5.2 Pressures Points Identified for Education Commissioning

Significant pressures on the Nursing and Midwifery Education Commissioning Budget exist, particularly with regard to the community practice placements which are increasing due to policy direction of *Transforming Your Care* (DHSSPS, 2011b). HSC Trusts reported that the commissioning of Additional Registration programmes should also be considered carefully as under AfC terms and conditions, nurses with two such qualifications will attract a higher pay band; which has prevented advertisement of this type of position.

Additional Registration programmes do however have their place, particularly when shortages of nurses in specific practice areas exist, as training can be undertaken within a much shorter time frame. Similarly, some areas should support staff to undertake Additional Registration programmes, for example, Emergency Departments, Children's and Mental Health, where nurses require the knowledge and skills to treat a wider range of conditions and co-morbidities.

5.5.3 Adult Nursing

In addition to the main factors detailed previously, those impacting particularly on the Adult Nursing Workforce include:

- Impact of *Delivering Care (DHSSPS, 2013b)* on acute and specialist medical and surgical wards;
- Planned new builds (hospitals) all with single room accommodation;
- Difficulties in recruiting middle grade doctors particularly to Emergency Medicine and plans to introduce Advanced Nurse Practitioners;
- Impact of Reviews, Strategies and Service Frameworks;
- Implementation of the recommendations from the Francis Report (2013);
- Increased acuity in hospital, co-morbidities, high dependency patients within medical and surgical areas with no extra resource;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct care;
- Advances in technology and associated training and development needs;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns including high numbers of female (95.4%) and part-time staff (46%).

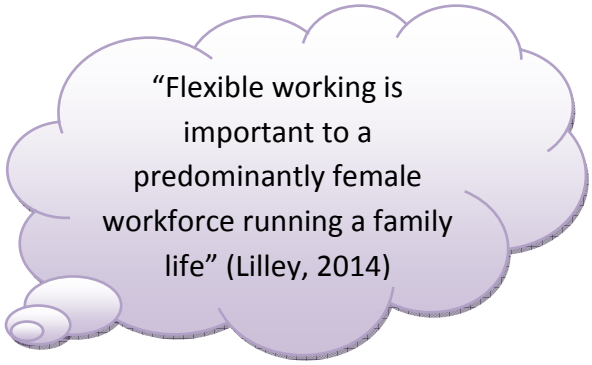


Table 8 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 – 59	60+	Total	% aged 55 and over
2015	2,933	1,214	1,375	1,358	1,441	761	337	9,419	12%
2020	***1,098***	2,933	1,214	1,375	1,358	1,441	761	9,419	23%
2025	***1,441***	***1,098***	2,933	1,214	1,375	1,358	1,441	9,419	30%
2030	***1,358***	***1,441***	***1,098***	2,933	1,214	1,375	1,358	9,419	29%

Table 9a below demonstrates the number of commissioned education places for adult nursing between 2008/09 and 2014/15.

Table 9a: Adult Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	**08 09**	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Direct Entry	559	570	489	489	462	469	469

Considering all of the above, the first reaction is to consider increasing the number of commissioned education places for adult nursing. However, we must keep in mind that Queen's University, Belfast report losing 21% of new graduates to positions outside of Northern Ireland. Focused work must take place to retain these newly qualified nurses and midwives as well as increasing Pre-registration Adult Nurse commissions by 100 places.

Taking factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%) and retirement and previous education commissions for this group into consideration, Northern Ireland must show a demonstrable improvement in employing these newly qualified nurses, however Adult Pre-registration Nurse places must be increased by at least 100 places as soon as possible. In addition, retirements over the next 10 years are expected to rise from the current 11% rate to 30%. Therefore proposed commission forecasts from 2015 - 25 are presented in Table 9b below:

Table 9b: Proposed Adult Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places *	560	560	560	560	560	560	560	560	560	560

* These figures include Return to Nursing programmes

Northern Ireland must show an immediate and demonstrable improvement in employing their new graduate nurses as due to the three year lead in period, we cannot respond quickly enough to the demand discussed at length within this Workforce Plan.

5.5.4 Children's Nursing

In addition to the main factors detailed previously, those impacting particularly on the Children's Nursing Workforce include:

- Planned new builds (hospitals) and impact of the Regional Children's Hospital on recruitment in other HSC Trust;
- Difficulties in recruiting middle grade doctors to this speciality and plans to introduce Advanced Nurse Practitioners;
- Implementation of Paediatric, Neo-natal and Medical Reviews;
- Age appropriate settings for children up to the age of 18 years - requiring a significant workforce shift;
- Increase in the number of children with complex needs in the community and transitions required to support this;
- Reduction in the trend of filling children's nursing posts with general nurses and need to consider qualified skill mix;
- Difficulties in providing mentorship and preceptorship and a limited career pathway;
- A predominantly young, female (95.4%) workforce with 50% working part-time hours.

Table 10 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	351	128	105	123	126	42	11	886	6%
2020	***53***	351	128	105	123	126	42	886	19%
2025	***126***	***53***	351	128	105	123	126	886	28%
2030	***123***	***126***	***53***	351	128	105	123	886	26%

The HSC will lose up to 53 children's nurses to retirement imminently based on current retirement trends. Table 11a below demonstrates the number of commissioned education places for children's nursing between 2008/09 and 2014/15.

Table 11a: Children's Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	55	60	60	60	55	55	55
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	4	6	6	5	2	7	7
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	4	6	6	4	5	3	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends and previous education commissions for this group, alongside new build plans and increasing numbers of children with complex needs requiring care in the community this Plan would recommend an increase in pre-registration numbers (Direct Entry and Additional Registration programmes) as presented in Table 11b below.

Table 11b: Proposed Children's Nursing Commission Forecasts 2015/16 – 2024/25

Proposed Places	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	64	70	70	70	60	55	55	55	55
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	0	10	0	10	0	10	0	10	0	10
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	10	0	10	0	10	0	10	0	10	0

5.5.5 Mental Health Nursing

In addition to the main factors detailed previously, those impacting particularly on the Mental Health Nursing Workforce include:

- Mental health nurses being recruited to learning disability posts to fill deficits;
- Reform within mental health continues with the closure of long-stay wards by 2015 – need to consider future challenges associated with this;
- Planned new builds (hospitals) all with single room accommodation;
- Development of Advanced Nurse Practitioners/Consultant Nurses in condition specific/specialist need areas, i.e. addictions, eating disorders, dementia;
- Increasing nurse prescribing role;
- Increased care of patients with co-morbidities and complex care required;
- Implementation of pending Capacity legislation, the Service Framework for Mental Health and Well-being (DHSSPS, 2011d), Dementia Strategy (DHSSPS, 2011e), Bamford Action Plan (DHSSPS, 2012b) and Recovery Orientated Practice;
- Increase in public health and mental health prevention/early intervention roles;
- Issues related to availability of male staff particularly for acute and PICU settings;
- The need to strengthen the knowledge and skills in evidence based therapeutic interventions to support the implementation of the Psychological Therapies Strategy;
- The need to strengthen senior mental health nursing leadership to ensure nursing issues and needs are identified and addressed;
- Increasing age profile of this workforce and the impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (75.8%) and part-time staff (17%).

Table 12 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	318	212	258	375	362	142	53	1,720	11%
2020	***195***	318	212	258	375	362	142	1,720	29%
2025	***362***	***195***	318	212	258	375	362	1,720	43%
2030	***375***	***362***	***195***	318	212	258	375	1,720	37%

The HSC will imminently lose up to 195 mental health nurses to retirement. Table 13a below demonstrates the number of commissioned education places for mental health nursing between 2008/09 and 2014/15.

Table 13a: Mental Health Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	99	99	99	99	96	96	96
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	16	7	1	0	0	1	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	2	4	4	0	2	0	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan would recommend an initial decrease in pre-registration numbers with a subsequent increase as presented in Table 13b below.

Table 13b: Proposed Mental Health Nursing Commission Forecasts 15/16 – 24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	90	90	95	95	100	110	120	120	120	120
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	10	0	10	0	10	0	10	0	10	0

This Plan also recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. Similarly, increasing the length of the Mental Health Programme is recommended to ensure it includes an element of evidence based psychotherapeutic intervention training to best meet the new challenges this workforce is facing regarding early interventions.

Action Point: Review and future proof the Mental Health Nursing programmes to ensure the workforce are equipped to fulfill an increasing public health role, support co-morbidities and unmet physical needs and deliver evidence based psychotherapeutic interventions.

5.5.6 Learning Disability

In addition to the main factors detailed previously, those impacting particularly on the Learning Disability Nursing Workforce include:

- Difficulties experienced in recruiting learning disability nurses;
- Planned learning disability specialist nursing home for high complex needs within the Belfast HSC Trust;
- Increasing numbers of people with a learning disability and older people;
- More complex care in the community, increasing co-morbidities, challenging behaviour and unmet physical needs;
- Need for improved therapeutic interventions, crisis response, prevention of hospital admissions and early discharge;
- Strengthening knowledge and skills to work effectively with children and developing skills in traditional nursing procedures i.e. enteral feeding, catheterisation and medicines management;
- The need to strengthen senior learning disability nursing leadership to ensure nursing issues and needs are identified and addressed;
- The need for a clear service model for learning disability nurses to determine the future roles and skills required and impact of implementation of *Strengthening the Commitment* (DHSSPS, 2012d)
- Nurses increasingly working in service areas registered as social care settings including residential, domiciliary and day care;
- Issues related to availability of male staff (14.2%);
- Impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (85.8%) and part-time staff (25%).

Table 14 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	134	69	58	65	87	32	20	465	11%
2020	***52***	134	69	58	65	87	32	465	26%
2025	***87***	***52***	134	69	58	65	87	465	33%
2030	***65***	***87***	***52***	134	69	58	65	465	26%

The HSC will lose up to 52 learning disability nurses to retirement imminently based on current retirement trends. Table 15a below demonstrates the number of commissioned education places for learning disability nursing between 2008/09 and 2014/15.

Table 15a: Learning Disability Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	15	30	30	30	30	30	30
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	0	6	1	0	1	2	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	6	7	0	0	0	10	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan recommends maintaining training numbers, as presented in Table 15b.

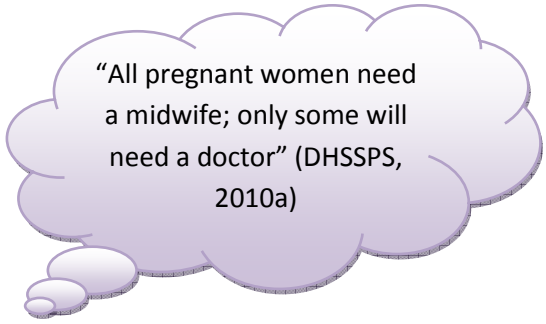
Table 15b: Proposed Learning Disability Nursing Commission Forecasts 15/16-24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	30	30	30	35	35	35	35	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	0	10	0	10	0	10	0	10	0	10

This Plan recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. A review of the Learning Disability programmes is recommended to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

Action Point: Review and future proof the Learning Disability Nursing programmes to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

5.5.7 Midwifery



In addition to the main factors detailed previously, those impacting particularly on the midwifery workforce include:

- A steadying birth rate (NISRA, 2013), with rising social and medical complexities;
- Major role in the promotion of normalising birth and as the lead professional for women with straightforward pregnancies (DHSSPS, 2012a);
- Key coordinator of care within the multidisciplinary team for complex pregnancies as highlighted in *Midwifery 20:20* (DHSSPS 2010a);
- Impact of a shift to community based care, increasing midwife led care in births and home births alongside free standing birthing centres;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns within this group including high numbers of female and part-time staff (67%);
- There are currently more midwives than there are jobs available.

Table 16 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	247	170	193	196	290	207	77	1,380	21%
2020	***284***	247	170	193	196	290	207	1,380	36%
2025	***290***	***284***	247	170	193	196	290	1,380	35%
2030	***196***	***296***	***284***	247	170	193	196	1,380	28%

The previous Review (DHSSPS, 2009) recommended that the number of commissioned places for midwifery should be increased, mainly due to the ageing profile. However, significantly lower numbers retired than expected therefore this workforce is now much older.

Furthermore, the projected retirements are expected to increase during this Review period from a current level of 21% to 35%. The HSC will lose up to 284 midwives to retirement imminently based on current retirement trends. Table 17a below demonstrates the number of commissioned education places for midwifery between 2008/09 and 2014/15.

Table 17a: Midwifery Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	30	30	30	35	35	36	35
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (18 mths)	32	35	35	30	25	25	20

Not all newly qualified midwives are being offered a post following completion of their programme. The cohorts of direct entry are obtaining posts in midwifery within a year of qualifying. There is an acknowledgment however of a loss back to nursing positions from the 18 month programme, due to a lack of available posts.

Taking this into consideration and based on the factors impacting on the workforce highlighted above, new mothers are becoming older and are increasingly presenting with co-morbidities which make the Addittional Registration Programme indispensable. Midwifery numbers commissioned should aim to meet those presented in Table 17b below.

Table 17b: Proposed Midwifery Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	35	35	35	35	30	30	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (18 mths)	20 per year up to 21/22 and then 15 from 22/23 onwards									

5.6 Post-registration Nursing Education Forecasts

5.6.1 Introduction

The areas in this section include figures and tables relating to the post-registration programmes (District Nursing, Health Visiting and School Nursing). These programmes refer to registered nurses who work in community settings. For the purpose of assessing demand and supply we have excluded some areas, for example, Mental Health, Learning Disability and Paediatric Nurses because they are predominantly supplied by pre-registration programmes, as previously highlighted.

These programmes (full-time) currently receiving Replacement Monies (based on Midpoint Band 5) include:

- District Nursing (10mths)
- Health Visiting (12mths)
- School Nursing (12mths)

The tables included in the sections below assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses).

5.6.2 District Nursing

In addition to the main factors detailed previously, those impacting particularly on the District Nursing Workforce include:

- Changing profile of district nursing including increased role in palliative care, intravenous infusions, rapid response, 24/7 working patterns;
- Implementation of Reform Plans and Integrated Care Partnerships;
- Changing demographics: increase in older people, long-term conditions, complex care in the community and acuity management;
- Implementation of various strategies and service frameworks;
- Registered nurse skill mix in district nursing teams will impact on the number required to be undertake the specialist practitioner programme which will be determined by the pending phase of *Delivering Care for District Nursing;*
- DHSSPS Guidance (2010d) on care management, assessment and care planning requirements;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct patient care;
- Impact of evolving futuristic technologies and training and development;
- Impact of the age profile and imminent high number of retirements related to the district nursing workforce;
- Impact of working patterns within this group including high numbers of female (97.5%) and part-time staff (53%);

Table 18 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	137	117	191	207	251	117	38	1,058	15%
2020	***155***	137	117	191	207	251	117	1,058	35%
2025	***251***	***155***	137	117	191	207	251	1,058	43%
2030	***207***	***251***	***155***	137	117	191	207	1,058	38%

The HSC will lose up to 155 district nurses to retirement imminently and this trend is set to more than double from 15% to 43% during the period of this Plan. Table 19a below demonstrates the number of commissioned education places for district nursing between 2008/09 and 2014/15.

Table 19a: District Nursing Education Commissions 2008/09 – 2014/15

	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Commissioned Places	18	12	9	9	17	26	23

Based on the significant factors impacting on this workforce, as highlighted previously and the Minister for Health's commitment to double the number of district nurses in training, this Plan would recommend increasing the commissioned numbers as presented in Table 19b below.

Table 19b: Proposed District Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	40	40	40	30	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for District Nursing* has been agreed.

5.6.3 Health Visiting

In addition to the main factors detailed previously, those impacting particularly on the Health Visiting Workforce include:

- Health Visiting is on the Risk Register of every HSC Trust and the Public Health Agency for risk associated with the delivery of the Universal Screening Programme and Safeguarding;
- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Increased role within Family Nurse Partnerships (Ministerial Target 2014/15);
- Increase in the black and minority ethnic population (BME) and the need for interpreters;
- Public health challenges: childhood obesity, peri-natal, infant, child and adolescent mental health, domestic abuse, child abuse, child sexual exploitation (CSE), deprivation and poverty;
- Increase in referrals from social services regarding children under 4 years old (5% between 2007 and 2012);
- *Delivering Care for Health Visiting* has not yet been published and will need to be taken account of when considering future commissioned education places;
- Impact of working patterns within this group including high numbers of female (99.7%) and part-time staff (48%);
- Impact of the age profile and imminent high number of retirements.

Table 20 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	84	62	76	117	122	62	18	541	15%
2020	***80***	84	62	76	117	122	62	541	34%
2025	***122***	***80***	84	62	76	117	122	541	44%
2030	***117***	***122***	***80***	84	62	76	117	541	36%

The HSC will lose up to 80 health visitors to retirement imminently and this trend is set to more than double during the period of this review from 15% to 44%. Table 21a below demonstrates the number of commissioned education places for health visiting between 2008/09 and 2014/15.

Table 21a: Health Visiting Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	29	26	24	18	25	37	61

Based on the factors impacting on this workforce as highlighted previously, this Plan would recommend the commissioned numbers as presented in Table 21b below.

Table 21b: Proposed Health Visiting Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	45	45	45	40	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for Health Visiting* has been agreed.

5.6.4 School Nursing

In addition to the main factors detailed previously, those impacting particularly on the School Nursing Workforce include:

- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Increase in students with chronic diseases, mental health issues and high-risk behaviours;
- Improving access to early prevention and support for children and families and help reduce the need for referral to social services;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Impact of working patterns within this group including high numbers of female (100%) and part-time staff (78%);
- Impact of the age profile and imminent high number of retirements.

Table 22 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 – 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	24	29	61	78	82	43	32	349	21%
2020	***74***	24	29	61	78	82	43	349	36%
2025	***82***	***74***	24	29	61	78	82	349	46%
2030	***78***	***82***	**74**	24	29	61	78	349	40%

The HSC will lose up to 74 school nurses to retirement imminently and this trend is set to increase incrementally throughout the period of this review from 21% to 46%. Table 23a below demonstrates the number of commissioned education places for school nurses between 2008/09 and 2014/15.

Table 23a: School Nursing Education Commissions 2008/09 – 2014/15

	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Commissioned Places	4	0	6	2	4	5	0

Based on the factors impacting on this workforce as highlighted previously, retirement trends**,** part-time working and low numbers commissioned since the previous Review (2009)**,** this Plan would recommend increasing the commissioned numbers as presented in Table 23b below.

Table 23b: Proposed School Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Proposed Places	20	20	20	15	15	15	20	20	15	15

5.6.5 Specialist Nursing

Specialist nursing has a key role to play in the delivery of *Transforming Your Care* (DHSSPS, 2011b) and education places need to be commissioned focusing particularly on Programmes of Care, for example, Frail Elderly, Respiratory, End of Life Care, Diabetes and Stroke. The current reliance on Learning Needs Analysis, as part of the Education Commissioning Process, needs to be strengthened and this Plan recommends the development of an Education Commissioning Direction Framework. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Plan well in advance of commissioning the new services.

Action Point: Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

Education Commissioning must set the direction of travel and focus both the strategic and service priorities. The current Education Commissioning Plan must be re-profiled and focus on strategic and service priorities rather than be based wholly on individual/personal development.

Specialist Nursing numbers have increased dramatically since the previous *Review of the Nursing and Midwifery Workforce* (DHSSPS, 2009) as presented in Table 24 below. It is believed that this is not an accurate picture as the numbers include AfC Band 5 nurses, however Band 5 nurses do not practice at a specialist nursing level. Conversely, the numbers of district nurses have reduced significantly. It is widely accepted by HSC Trusts that this increase is an HRPTS coding issue. The specialist nurse section of HRPTS should undergo a data cleanse exercise to better understand both specialist nursing and district nursing numbers.

Table 24: Comparison of Specialist Nurses and District Nurses (WTE) between 2009 and 2014 as recorded on HRMS and HRPTS

Categorisation/Year	2008	2009	2010	2011	2012	2013	2014
Specialist Nurses Bands 5, 6 & 7	386.4	425.8	495.7	687.7	752.7	807.6	787.6
Variance		+39.4	+69.9	+192	+65	+54.9	-20
District Nurses	972.6	932.9	902.0	823.5	833.7	860.3	850.4
Variance		-43.3	-30.9	-78.5	+10.2	+26.6	-9.9

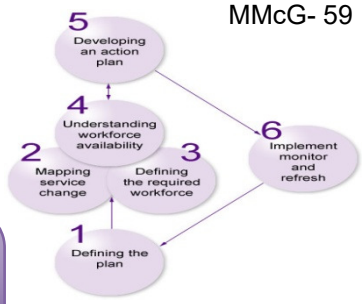
5.7 Summary of Nursing and Midwifery Education Commissions 2015 - 2025

Table 25 below presents a summary of the proposed nursing and midwifery education commissions over the next 10 years, taking into account the factors impacting on the workforce as highlighted previously.

Table 25: Summary of Proposed Education Commissions 2015 - 2025

Programme	Commissioning Projections (all programmes must be reviewed on an annual basis to reflect changes in demand, attrition rates and destination figures)									
	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Adult Nursing	560	560	560	560	560	560	560	560	560	560
Children's Direct Entry	55	64	70	70	70	60	55	55	55	55
Children's Additional	0	10	0	10	0	10	0	10	0	10
Children's Community	10	0	10	0	10	0	10	0	10	0
Mental Health Direct Entry	90	92	95	95	100	110	120	120	120	120
Mental Health Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Mental Health Community	10	0	10	0	10	0	10	0	10	0
Learning Disability Direct Entry	30	30	30	35	35	35	35	30	30	30
Learning Disability Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Learning Disability Community	0	10	0	10	0	10	0	10	0	10
Midwifery Direct Entry	39	35	35	35	35	30	30	30	30	30
Midwifery Additional	25	20	20	20	20	20	20	15	15	15
District Nursing	40	40	40	30	30	30	30	30	30	30
Health Visiting	40	45	45	45	40	30	30	30	30	30
School Nursing	20	20	20	15	15	15	20	20	15	15

Action Point: Due to the huge reform agenda, all Nursing and Midwifery educational programmes at both pre and post registration level should have a taught element on Quality Improvement methodologies and ideally be required to identify and implement a quality improvement project.



Step 6: Implement, Monitoring and Refresh

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

6.1 Next Steps / Further Work to be Undertaken

The overall ambition of this Workforce Plan is to ensure we have a healthy, productive workforce, who are appropriately trained, and will provide the highest quality healthcare services at the right time in the right place. Change requires leadership and, in many health and care systems, it also requires improved opportunities for stakeholder involvement. "Top down" change is often unsustainable: the support of nurses and midwives is required, as is the active participation of other stakeholders (commissioners, education providers, professional and union organisations and other key professionals, particularly medical staff). The recommendations outlined in this Plan can support informed decision-making and prioritisation at a local and regional level.

To take this forward, the Regional Workforce Planning Group (RWPG) will oversee the implementation of the recommendations, underpinned by a robust implementation and monitoring strategy.

The following actions, to be undertaken include:

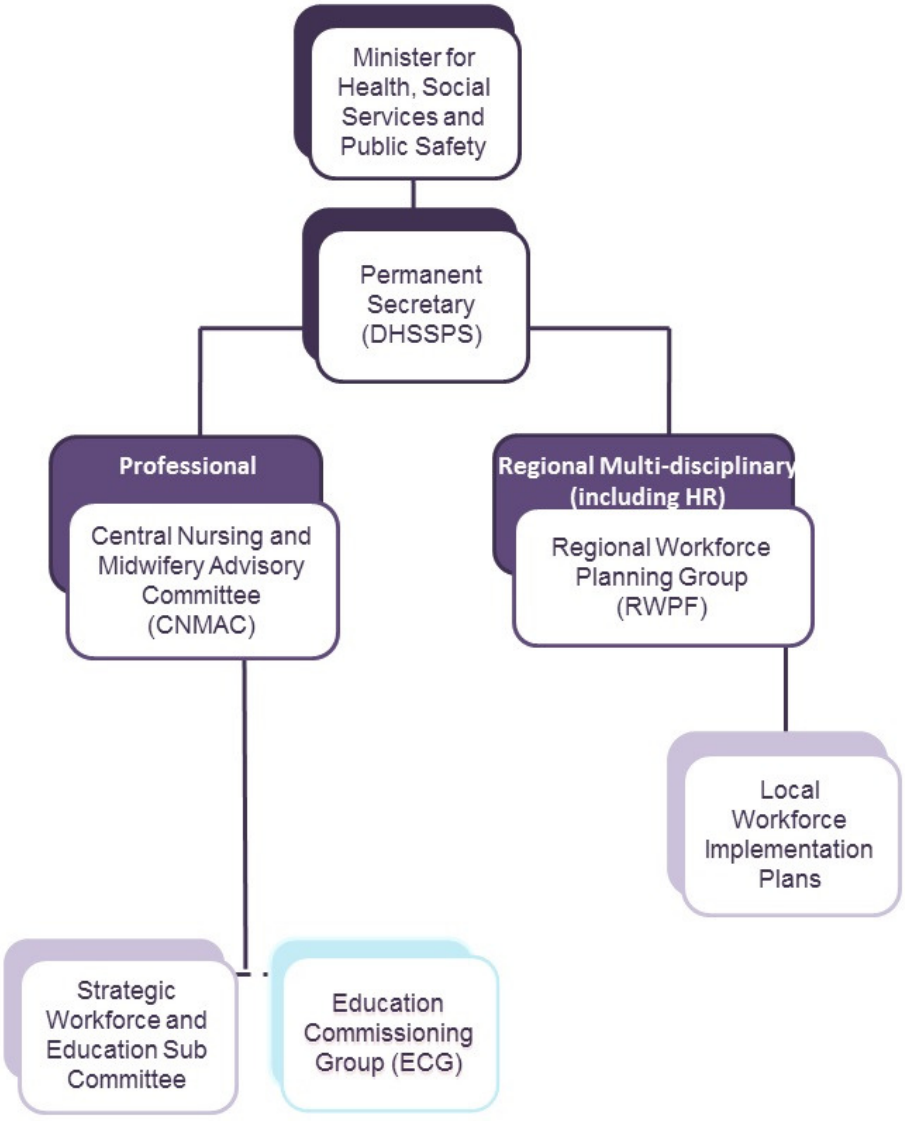
- Costing the Recommendations for consideration within this Plan
- Present the Plan and Recommendations to the DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) for professional approval
- Present the Plan and Recommendations to the Regional Workforce Planning Group for DHSSPS approval
- Once agreed, CNMAC's Workforce and Education Sub-Committee will be charged with overseeing and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews as at 5.5.6.

6.2 Monitoring Process

The monitoring of this Plan will sit in tandem with the Regional Workforce Key Performance Indicators currently being developed, particularly in relation to vacancy rates, bank and agency usage and associated improvements on recruitment processes, as presented in Figure 22.

The DHSSPS Chief Nursing Officer will include this information during mid and end of year Accountability Meetings.

Figure 22: Structure for implementation and monitoring of the Workforce Plan



CONCLUSION

Major workforce change is expected to support the many developments being undertaken in Northern Ireland over the next 5 to 10 years. There includes a shift of resource from acute hospital to community and primary care settings which will require substantial re-training and re-deployment of staff in nursing and midwifery. This will have a significant impact on the Nursing and Midwifery Education Commissioning Budget, however immediate steps should be taken to ensure this budget is delivering value for money before making projections on any additionality.

Demand for nursing and midwifery in Northern Ireland is likely to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). The second, third and fourth phases are due to report by the end of March 2015 however, no timeline has been agreed for areas such as mental health, learning disability, children's and midwifery. It is anticipated that any recruitment exercise required to address the implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

In addition, a range of reports and studies have highlighted the likelihood of a significant decline in the future supply of nurses in the UK (Centre for Workforce Intelligence, 2013; Imison & Bohmer, 2013; NHS Employers, 2014). This is already being felt in Northern Ireland and we are in the process of commencing our own international recruitment campaign during 2016 whilst we still face competition with other countries who are recruiting aggressively from within our universities. Employers in Northern Ireland must make themselves attractive to newly qualified nurses if they are to grow and maintain a steady workforce.

Whilst we have included the use of retirements to make our education commissioning forecasts, we must be aware of the needs of the independent sector as they will be using the same *pool* from which to recruit nurses in addition we are in an era of increasing demand This Plan recommends increasing training numbers at pre-registration level by at least 100 places.. The Plan also urges an immediate review of post-registration education programmes to ensure they are commissioned to meet regional strategies and priorities and to ensure best value for money.

Practitioners, managers, educationalists and commissioners will be required to interpret and apply the recommendations contained within this Plan, based on local circumstances. Similarly, organisational and corporate commitment will be required if it is to result in positive change and outcomes. The Regional Workforce Planning Group (RWPG) will oversee the implementation of this Plan to ensure a nursing and

midwifery workforce capable of meeting the health and care needs of the people of Northern Ireland over the next decade and beyond.

RECOMMENDATIONS

No	Recommendation
Theme: Future Supply and Demand of Nursing and Midwifery	
1	A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice including a radical review of the recruitment processes, methods and timescales used within HSC Trusts and categorisation and coding of nurses and midwives on HRPTS.
2	Destination and attrition rates for all Universities in Northern Ireland should be tracked on a yearly basis.
3	A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.
Theme: Supporting Nurse Training	
4	Consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within the independent sector.
Theme: Annual Review	
5	Ensure that emerging evidence from further phases of *Delivering Care* (DHSSPS, 2013b), additional registration programmes and the impact of the nursing and midwifery age profile and relevant pension changes, are reflected during annual reviews.
6	Commissioning of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.
Theme: Education Programmes and Commissioning	
7	Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.
8	Ensure that all pre and post registration Nursing and Midwifery educational programmes include a taught Quality Improvement methodologies element and ideally be required to identify and implement a quality improvement project. Review and future proof the Mental Health and Learning Disability Nursing programmes to ensure the workforce is equipped to fulfil an increasing public health role, manage and provide interventions to those with co-morbidities and/or complex physical and mental health needs.
9	Consideration needs to be given to delivering the Specilaist Practice Community Programmes on a part time basis
10	Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

REFERENCES

Berwick, D. (2013) *A promise to learn – a commitment to act. Improving the safety of patients in England*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (accessed 3 April 2014)

Care Quality Commission (2014) The state of health care and adult social care in England 2013/14. Available at: http://www.cqc.org.uk/sites/default/files/state-of-care-201314-full-report-1.1.pdf (accessed 8 November 2014)

Cavendish, C. (2013) An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf (accessed 4 May 2014)

Centre for Workforce Intelligence (2013) *Future nursing workforce projections. Starting the discussion*. London: Centre for Workforce Intelligence.

Department of Health (2013) *Winterbourne View Report*. Available at: https://www.gov.uk/government/publications/winterbourne-view-progress-report (accessed 3 May 2014)

Department of Health, Social Services and Public Safety (2007) *Standards for Supervision for Nursing. Belfast: DHSSPS.*

Department of Health, Social Services and Public Safety (2009) *Review of the Nursing and Midwifery Workforce 2008-2009*. ASM Horwarth.

Department of Health, Social Services and Public Safety (2010a) *Midwifery 2020: Delivering Expectations*.
Available at: http://www.dhsspsni.gov.uk/midwifery_2020_report.pdf (accessed 14 August 2014)

Department of Health, Social Services and Public Safety (2010b) *Healthy Futures 2010 – 2015.* The Contribution of Health Visitors and School Nurses in Northern Ireland. Available at: http://www.dhsspsni.gov.uk/healthy_futures_2010-2015.pdf (accessed 14 July 2014)

Department of Health, Social Services and Public Safety (2010c) *Healthy Child Healthy Future* (DHSSPS, 2010). Available at: http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf (accessed 13 November 2014)

Department of Health, Social Services and Public Safety (2010d) *Care Management, Provision of Services And Charging Guidance.* Available at: http://www.dhsspsni.gov.uk/hsc-eccu-1-2010.pdf (accessed 24 November 2014)

Department of Health, Social Services and Public Safety (2011a) *Framework Document.* Belfast: DHSSPS Available at: http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf (accessed 4 April 2014)

Department of Health, Social Services and Public Safety (2011b) *Transforming Your Care: Vision to Action*. Belfast: DHSSPS. Available at: http://www.tycconsultation.hscni.net/wp-content/uploads/2012/10/TYC-Vision-to-Action-Consultation-Document.pdf (accessed 4 August 2014)

Department of Health and Social Services and Public Safety (2011c) *Quality 2020*: *A 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland*. Belfast: DHSSPS.

Department of Health and Social Services and Public Safety (2011d) *Service Framework for Mental Health and Wellbeing*. Available at: http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf (accessed 10 March 2014)

Department of Health and Social Services and Public Safety (2011e) Improving Dementia Services In Northern: A Regional Strategy. Available at: http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-a-regional-strategy-november-2011.pdf (accessed 10 April 2014)

Department of Health and Social Services and Public Safety (2012a) *A Strategy for Maternity Care in Northern Ireland 2012 – 2018.* Available at: http://www.dhsspsni.gov.uk/maternitystrategy.pdf (accessed 9 March 2014)

Department of Health and Social Services and Public Safety (2012b) *Delivering the Bamford Action Plan* 2012-2015. Belfast: DHSSPS.

Department of Health and Social Services and Public Safety (2012c) *Health Survey Northern Ireland*. Belfast: DHSSPS.

DHSSPS (2012d) Strengthening the Commitment. Modernising Learning Disabilities Nursing Review. Easy Read Summary. Available at: http://www.dhsspsni.gov.uk/strengthening_the_commitment_modernising_learning_disabilities_nursing_review_easy_read_summary.pdf (accessed 23 September 2014)

Department of Health, Social Services and Public Safety (2013a) *Who cares? The future of adult social care and support in Northern Ireland. Discussion document*. Belfast: DHSSPS. Available at: www.dhsspsni.gov.uk/showconsultations?txtid=58501 (accessed on 4 August 2014)

Department of Health, Social Services and Public Safety (2013b) *Delivering Care: Nurse Staffing in Northern Ireland*. Available at: http://www.dhsspsni.gov.uk/index/dc.htm (accessed 18 August 2014)

Department of Health, Social Services and Public Safety (2014a) *Making Life Better. A Whole System Strategic Framework for Public Health.* Available at: http://www.dhsspsni.gov.uk/mlb-strategic-framework-2013-2023.pdf (accessed 9 August 2014)

Department of Health, Social Services and Public Safety (2014b) *Advanced Nursing Practice Framework. Supporting Advanced Nursing Practice in Health and Social Care Trusts.* Available at: http://www.dhsspsni.gov.uk/advanced_nursing_practice_framework.pdf (accessed 1 December 2014)

Department of Health, Social Services and Public Safety (2014c) *Health Survey Northern Ireland 2012/13 Report*. Belfast: DHSSPS.

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Available at: http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive %20summary.pdf (accessed 4 April 2014)

Health Education England (2013) *Investing in People: Developing People for Health and Healthcare. Workforce Plan for England.* Available at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/12/Workforce-plan-UPDATE-interactive.pdf (accessed 28 August 2014)

Health and Safety Executive (2013) Diversity in the Workforce. Available at: http://www.hse.gov.uk/diversity/index.htm (accessed 2 May 2014)

Hine, D. (2011) Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals Northern Ireland. Available at: http://www.cdiffinquiry.org/index/inquiry-report.htm (accessed 9 November 2014)

Hutton, J. (2011) Independent Public Service Pensions Commission. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207720/hutton_final_100311.pdf (accessed 21 November 2014)

Imison, C. & Bohmer, R. (2013) *NHS and Social Care Workforce: Meeting our Needs Now and in the Future?* London: King's Fund.

Institute of Public Health in Ireland (2010) *Making Chronic Conditions Count: Hypertension, Stroke, Coronary Heart Disease, Diabetes. A Systematic Approach to Estimating and Forecasting Population Prevalence on the Island of Ireland. Dublin:* Institute of Public Health in Ireland.

International Council of Nurses (2014) *Nurses: A Force for Change. A Vital Resource for Health.* Geneva: International Council of Nurses.
Available at http://www.sep.org.pt/files/2014/03/IND_Kit_2014.pdf (accessed 30 April 2014)

Kelly, L.A., McHugh, M.D. & Aiken, L.H. (2011) Nurse outcomes in magnet and non-magnet hospitals. *Journal of Nursing Administration*; 41: 428–433.

Keogh, B. (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Available at:*
http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf (accessed 20 March 2014)

Lilley, R. (2014) *Part of the problem: news and comment*. Available at:
http://www.nhsmanagers.net/ (accessed 29 September 2014)

NHS Employers (2014) *NHS Qualified Nurse Supply And Demand Survey – Findings. Report produced for the Health Education England Nursing Supply Steering Group*. Available at:
http://hee.nhs.uk/wp-content/uploads/sites/321/2014/05/NHS-qualified-nurse-supply-and-demand-survey-12-May1.pdf (accessed 9 August 2014)

NHS England (2014) *Five Year Forward View*. Available at:
http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 11 November 2014)

National Institute for Clinical Excellence (2014) NICE Guideline SG1. Safe staffing for nursing in adult inpatient wards in acute hospitals. Available at: https://www.nice.org.uk/Guidance/SG1 (accessed 23 September 2014)

NIPEC (2012) *Job Planning Guidance for Clinical Nurse Specialists.* Available at:
http://www.publichealth.hscni.net/sites/default/files/doc%20InterimSpecialist%20Nursing%20Tool%20Kit%20Mar%202012.pdf (accessed 24 November 2014)

NIPEC (2013) *Preceptorship Framework for Nursing, Midwifery and Specialist Community Public Health Nursing*. Belfast: Northern Ireland Practice and Education Council.

NIPEC (2014) A Career Pathway for Nursing and Midwifery in Northern Ireland. Pending Publication.

Northern Ireland Statistics and Research Agency (2013) Registrar General Northern Ireland Annual Report. Available at:
http://www.nisra.gov.uk/archive/demography/publications/annual_reports/2012/Chapter1.pdf (accessed 4 August 2014)

Nursing and Midwifery Council (2012) *Midwives Rules and Standards*. Available at:

http://www.nmc-uk.org/Documents/NMC publications/Midwives%20Rules%20and%20 Standards%202012.pdf (accessed 23 March 204)

O'Neill, C., McGregor, P. & Merkur, S. (2012) United Kingdom (Northern Ireland): Health System Review'. *Health Systems in Transition*; 14(10), 1–91.

PHA (2014) as cited in HSCB/PHA Commissioning Plan 2014/2015. Draft - 24 March 2014. Available at: http://www.hscboard.hscni.net/board/meetings/March%202014/Item%2010%20-%2002%20%20Draft%20Commissioning%20Plan%202014%2015%20%2013%20March%20Board%20PDF%204423KB.pdf (accessed 9 August 2014)

Queen's University Belfast (2014) *Destination of Leavers from Higher Education (DHLE) Survey*. Belfast: QUB.

RCN (2010) *Specialist Nurses: Changing Lives, Saving Money*. London: RCN. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0008/302489/003581.pdf (accessed 20 July 2014)

RCN (2013a) *Employment survey 2013*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0005/541292/Employment_Survey_2013_004_503_FINAL_100214.pdf (accessed 24 September 2014)

RCN (2013b) *Frontline Nurse: Nursing on Red Alert*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0003/518376/004446.pdf (accessed 28 August 2014)

RCN (2014) *Telehealth and Telecare.* Online. Available at: http://www.rcn.org.uk/development/practice/e-health/telehealth_and_telecare (accessed 23 November 2014)

RQIA (2014) An Independent Review of Arrangnements for Management and Coordination of Unscheduled Care in the Belfast HSC Trust and Related Regional Considerations. Available at: http://www.rqia.org.uk/cms_resources/UnscheduledCare_Report_Website.pdf (accessed 9 November 2014)

Skills for Health (2009) *Six Steps Methodology to Integrated Workforce Planning.* Available at: http://www.skillsforhealth.org.uk/workforce-planning/six-steps-workforce-planning-methodology/ (accessed 9 February 2014)

Skills for Health (2011) *Careers in Healthcare. A guide to working in the Independent Healthcare Sector*. Available at: file:///C:/Users/ProfOfficer/Downloads/IAG_Independent_11-09.pdf (accessed 24 November 2014)

Van den Heede, K. & Aiken, L.H. (2013) Nursing workforce a global priority area for health policy and health services research: A special issue. *International Journal of Nursing Studies*; 50(2): 141-142.

World Health Organisation (2010) *Nurses and midwives: a force for health. Survey on the situation of Nursing and Midwifery in the Member States of the European Region of the World Health Organisation.* WHO Regional Office for Europe. Available at : http://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/data-and-statistics (accessed 9 June 2014)

ANNEXES

Annex A

Membership of Project Steering Committee (Working Group member)

Charlotte McArdle (Chair), Chief Nursing Officer, DHSSPS
Catherine Daly, Under Secretary, DHSSPS
Dr Paddy Woods, Deputy Chief Medical Officer, DHSSPS
Paula Smyth, HRD, DHSSPS
Caroline Lee, Nursing Officer, DHSSPS (Working Group member)
Dr Carole McKenna, Senior Officer, NIPEC (Project Lead) (Working Group member)
Alison Dunwoody, Deputy Principal Statistician, DHSSPS (Working Group member)
Angela McLernon, Chief Executive, NIPEC (from July 2014)
Dr Glynis Henry, Chief Executive, NIPEC (to June 2014)
Richard Cardwell, Assistant Statistician, DHSSPS
Damien McAllister, Director of HR, NHSCT
Joan Peden, Co-Director of HR, BHSCT
Ann McConnell, Assistant Director of HR, WHSCT
Myra Weir, Assistant Director of HR, SEHSCT
Monica Molloy, Senior HR Manager, BHSCT
Iain Gough, Senior HR Manager, SHSCT
Hugh McPoland, Director of HR, BSO
Nicki Patterson, Executive Director of Nursing, South Eastern HSC Trust
Olive Macleod, Executive Director of Nursing, Northern HSC Trust
Alan Corry-Finn, Executive Director of Nursing, Western HSC Trust
Brenda Creaney, Executive Director of Nursing, Belfast HSC Trust
Francis Rice, Executive Director of Nursing, Southern HSC Trust
Pat Cullen, Interim Director of Nursing and AHP, PHA
Janice Smyth, Director, RCN
Breedagh Hughes, Director, RCM
Kevin McAdam, HSC Representative, Unite
Anne Speed, HSC Representative, Unison
Carol Cousins, Independent and Voluntary sector representative (from August 2014)

Annex B

Northern Ireland Health Policy and Strategy Documents

Title	Published
A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland (DHSSPS, 2004)	Dec 2004
Improving the Patient and Client Experience (DHSSPS, 2008)	Nov 2008
Service Framework For Respiratory Health And Wellbeing (DHSSPS, 2009)	Jan 2009
Adult Safeguarding in Northern Ireland. Regional and Local Partnership Arrangements (DHSSPS, 2010)	Mar 2010
Living Matters Dying Matters. A Palliative and End of Life Care Strategy for Adults in Northern Ireland (DHSSPS, 2010)	Mar 2010
Improving Dementia Services in NI: A Regional Strategy, Consultation Paper (DHSSPS, 2010)	May 2010
Healthy Child, Healthy Future. A Framework for the Universal Child Health Promotion Programme in Northern Ireland (DHSSPS, 2010)	May 2010
A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery 2010-2015 (DHSSPS, 2010)	Jun 2010
A Strategy for the Development of Psychological Therapies Services (DHSSPS, 2010)	Jun 2010
Midwifery 2020, Delivering Expectations (DHSSPS, Welsh Assembly, DH, & Scottish Government, 2010)	Sep 2010
Delivering Excellence Supporting Recovery: Professional Framework for Mental Health Nursing 2011-2016 (DHSSPS, 2010)	Oct 2010
Safeguarding Children Supervision Policy for Nurses (DHSSPS, 2011)	Feb 2011
Service Framework For Cancer Prevention, Treatment And Care (DHSSPS, 2011)	Feb 2011
Service Framework For Mental Health And Wellbeing (DHSSPS, 2011)	Oct 2011
Quality 20:20, A 10 year Strategy to Protect and Improve Health and Social Care in Northern Ireland (DHSSPS, 2011)	Nov 2011
Improving Dementia Services in Northern Ireland. A Regional Strategy (DHSSPS, 2011)	Nov 2011
Transforming Your Care: A Review of Health and Social Care in NI (DHSSPS, 2011)	Dec 2011
Learning Disability Service Framework (DHSSPS, 2011)	Dec 2011
Strengthening the Commitment, the UK Modernising Learning Disability Nursing Review (DHSSPS, Welsh Assembly, DH, & Scottish Government; 2012)	Apr 2012
Promoting Good Nutrition. A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016 (DHSSPS, 2011)	Jun 2012

A Strategy for Maternity Care in Northern Ireland 2012-2018, (DHSSPS, 2012)	Jul 2012
Fit and Well – Changing Lives (DHSSPS, 2012)	Jul 2012
Service Framework For Learning Disability (DHSSPS, 2012)	Sept 2012
Delivering the Bamford Action Plan 2012-2015 (DHSSPS, 2012)	Nov 2012
Transforming Your Care: Vision to Action, A Post Consultation Report (DHSSPS, 2013)	Mar 2013
Transforming Your Care: Strategic Implementation Plan (DHSSPS, 2013)	Oct 2013
Service Framework For Older People (DHSSPS,2013)	Sept 2013
A Review of Paediatric Healthcare Services Provided in Hospitals and in the Community, Consultation Document (DHSSPS, 2013)	Nov 2013
A Review of Children's Palliative and End of Life Care in NI, Document for Public Consultation (DHSSPS, 2014)	Jan 2014
Strengthening the Commitment, One Year On, Progress Report on the UK Modernising Learning Disability Nursing Review (DHSSPS, 2014)	Apr 2014
Making Life Better. A Whole System Strategic Framework for Public Health (DHSSPS, 2014)	Jun 2014
Modernising Learning Disabilities Nursing Review Strengthening the Commitment. Northern Ireland Action Plan (DHSSPS, 2014)	Mar 2014
Service Framework for Cardiovascular Health and Wellbeing 2014 – 2017 (DHSSPS, 2014)	May 2014

Note: this is not an exhaustive list.

Annex C

HSC Registered Nurses & Midwives by HSC organisation and Service/Practice Area as at 31st March 2014 (HRPTS)

	Belfast HSCT		Northern HSCT		South Eastern HSCT		Southern HSCT		Western HSCT		NIBTS / BSO / PHA / NIPEC / RQIA		Total	
Combined Grades	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Acute/General Nurses	3,413	2,930.7	1,276	1,088.7	1,307	1,114.0	1,350	1,125.7	1,388	1,247.3			8,751	7,520.4
Mental Health Nurses	434	414.9	326	311.2	249	233.8	310	289.9	401	386.1			1,720	1,635.9
Learning Disability Nurses	212	198.2	30	27.4	35	30.3	113	100.1	75	72.2			465	428.1
District Nurses	200	170.4	226	172.4	222	172.1	187	148.2	223	190.2			1,058	853.3
Midwives	339	264.8	228	176.3	256	201.0	281	212.8	222	186.5			1,327	1,042.5
Health Visitors	77	65.1	118	98.1	84	73.6	118	98.4	92	78.3			489	413.4
Paediatric Nurses	384	320.8	139	119.0	104	79.6	124	105.3	135	124.3			886	749.0
School Nurses	31	23.5	24	16.4	20	13.9	29	19.4	21	18.5	37	34.0	125	91.6
Treatment Room Nurses / Family Planning Nurses	29	17.5	114	67.2	25	16.4	24	16.9	32	23.4			224	141.5
Specialist Nurses Band 5/6	98	81.0	120	99.8	50	42.3	30	22.8	60	52.4			358	298.3
Specialist Nurses Band 7+	157	143.4	119	113.2	91	83.6	105	96.5	94	89.7			575	535.5
Nurse Managers / Multiservices Manager / Non Acute Ward Sister /	113	103.9	109	106.1	128	121.0	67	60.3	41	40.2			468	441.5
Prison Nurse					56	55.2							56	55.2
Teacher / Trainer / Researcher / Counsellor	22	18.1	33	29.7	7	7.0	31	22.4	18	14.6	33	30.6	144	122.4
Total	5,509	4,752.3	2,862	2,425.5	2,634	2,243.8	2,769	2,318.7	2,802	2,523.8	70	64.6	16,646	14,328.7

Annex D

HSC Registered Nurses & Midwives by Service/Practice Area and Age (based on headcount) as at 31st March 2014 (HRPTS)

Combined Grades	<25	25-29	30-34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total
Acute/General Nurses or Prison Nurses	438	1,136	1,336	1,172	1,274	1,183	1,268	685	315	8,807
Mental Health Nurses	33	111	174	212	258	375	362	142	53	1,720
Learning Disability Nurses	24	55	55	69	58	65	87	32	20	465
District Nurses	7	41	89	117	191	207	251	117	38	1,058
Midwives	6	54	143	167	189	194	290	207	77	*1,327
Health Visitors		16	44	53	66	111	119	62	18	*489
Paediatric Nurses	72	145	134	128	105	123	126	42	11	886
School Nurses /Treatment Room Nurses / Family Planning Nurses	0	10	14	29	61	78	82	43	32	349
Specialist Nurses Band 5/6	13		48	49	63	92	63	23	7	358
Specialist Nurses Band 7+		29		46	112	173	144	56	15	575
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit / Researcher / Counsellor	16			37	77	140	147	55	15	487
Teacher / Trainer			7	5	24	35	26	21	7	125
Total	581	1,584	2,085	2,084	2,478	2,776	2,965	1,485	608	16,646

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex E

HSC Registered Nurses & Midwives by Service/Practice Area and Gender as at 31st March 2014 (HRPTS)

Combined Grades	Female	Male	Total	% Female	% Male
Acute/General Nurses	8,352	399	8,751	95.4%	4.6%
Mental Health Nurses	1,304	416	1,720	75.8%	24.2%
Learning Disability Nurses	399	66	465	85.8%	14.2%
District Nurses / Treatment Room Nurses / Family Planning Nurses	1,250	32	1,282	97.5%	2.5%
Midwives / Health Visitors	1,810	6	1,816	99.7%	0.3%
Paediatric Nurses	874	12	886	98.6%	1.4%
School Nurses	125	0	125	100.0%	0.0%
Specialist Nurses Band 5/6	346	12	358	96.6%	3.4%
Specialist Nurses Band 7+	540	35	575	93.9%	6.1%
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit	425	43	468	90.8%	9.2%
Prison Nurse	42	14	56	75.0%	25.0%
Teacher / Trainer / Researcher / Counsellor	130	14	144	90.3%	9.7%
Nurse / Midwifery Support	4,023	625	4,648	86.6%	13.4%
Total	19,620	1,674	21,294	92.1%	7.9%

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex F

HSC Nursing, Midwifery and Support Staff Vacancies as at 31st March 2014

	Nurse Support		Qualified Nurses						
Pay band	1 - 4		5 - 7		8 - 9		TOTAL		Overall WTE Vacancy Rate *
Staff Group	HC	WTE	HC	WTE	HC	WTE	HC	WTE	
Acute Nursing	63	54.3	132	120.0	1	1.0	196	175.3	1.8%
Mental Health Nursing	7	7.0	74	71.9	0	0.0	81	78.9	3.5%
Learning Disability Nursing	0	0.0	3	3.0	0	0.0	3	3.0	0.4%
Midwifery	2	1.1	7	4.8	0	0.0	9	5.9	0.5%
Health Visiting	0	0.0	18	15.0	0	0.0	18	15.0	1.4%
District Nursing	7	5.6	41	33.6	0	0.0	48	39.2	5.8%
Paediatric Nursing	14	10.6	66	62.3	0	0.0	80	72.9	7.3%
School Nursing	3	2.3	1	0.7	0	0.0	4	3.0	2.9%
Treatment Room / Practice / Family Planning Nursing	0	0.0	1	0.1	0	0.0	1	0.1	0.1%
Specialist Nursing	0	0.0	16	12.7	1	1.0	17	13.7	1.5%
Nurse Managers / Audit	0	0.0	7	6.7	5	5.0	12	11.7	2.7%
Teaching / Training	0	0.0	0	0.0	0	0.0	0	0.0	0.0%
Other Nursing	0	0.0	1	0.5	0	0.0	1	0.5	0.6%
Total	96	80.8	367	331.3	7	7.0	470	419.1	2.3%
WTE Vacancy Rate		2.0%		2.3%		1.9%		2.3%	2.3%

* The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).

For further Information, please contact

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This document can be downloaded from the NIPEC website
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