Nursing And Midwifery Task Group (NMTG)

Report and Recommendations

March 2020

MAHI - STM - 089 - 3069

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FOREWORD FROM SIR RICHARD BARNETT

It has been an absolute privilege to have chaired the Nursing and Midwifery Task Group (NMTG) over the last two years. I am completely humbled by the work of nurses and midwives and the amazing contribution they make to the lives of people across the life course every day in Northern Ireland (NI).

NI like the rest of the United Kingdom faces the challenges of rising demand which far exceeds the resources available. This reality as set out in 'System not Structures'[1] is putting enormous pressure on a system not designed to meet the changing needs of the population. There is growing consensus that for health and social care services to become sustainable, it cannot keep doing what it has always done. Without significant transformation, it is conceivable that the entire NI block grant would be needed to meet the demand being placed on health and social care. This is why I believe the transformation of nursing and midwifery services is essential to the stability and sustainability of the NI health and social care system.

During the course of the review I met with hundreds of nurses and midwives and their dedication, often in difficult circumstances, must be commended. Nursing and midwifery are the backbone of the NI health and social care system, and whilst those who lead nursing and midwifery are clearly committed to enhancing the professions contribution, it is crucial that nursing and midwifery are seen as an asset by all those involved in leading health and social care delivery. During the course of my review the Department of Health commitment to addressing the challenges facing nursing and midwifery is clearly evident through the provision of significant transformation funding of over £50million. This investment contributing to safe staffing, has enabled a significant growth in the numbers of undergraduate nursing and midwifery places and has enhanced a wider range of nursing specialisms and midwifery services. Clearly this level of investment needs to be sustained and the recommendations set out in this report will require the development of a costed implementation plan.

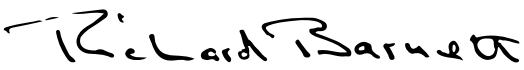
I believe an investment in nursing and midwifery is not only an investment in the lives of people who need care, but also in the NI economy. This report sets out an ambitious future agenda for nursing and midwifery which I believe will make a significant contribution to the transformation of health and social care, as set out in the *Health and Wellbeing 2026: Delivering Together* 2026 Vision. The recommendations in this report will facilitate the:-

1. Adoption of a population public health approach and put prevention and early intervention at the heart of nursing and midwifery practice.

2. Stabilisation of the nursing and midwifery workforce therefore ensuring safe and effective care.

3. Transformation of health and social care service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams (MDTs).

I want to thank all those who contributed to the formulation of the recommendations in this report. I believe if these recommendations are implemented, nurses and midwives can be confident that they will be able to deliver sound evidence based care, with the right numbers, at the right time, in the right place, by the right person with the right knowledge, and of course most importantly delivering the right experience for people, families and their communities.



Sir Richard Barnett
Chair of NMTG

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

1. NMTG Context

The previous Health Minister, Michelle O'Neill established a NMTG independently chaired by Sir Richard Barnett. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured Health and Social Care (HSC) system over the next 10-15 years. The group were asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes.

2. NMTG Review Methodology

The review team adopted an outcome based accountability and co-production approach and set up three major workstreams to provide focus and concentrate the work on how the contribution of nursing and midwifery could be maximised to improve outcomes. Almost 1,000 participants from all branches of nursing, midwifery, including representatives from independent sectors and from other professions took part in over 36 events. The findings from these events were compared with a wide range of evidenced based literature and were used in the formulation of the report's recommendations.

In line with the terms of reference of the NMTG, the recommendations set out in this report provide a 10—15 year road map which will deliver ***S.A.F.E*** care through:-

S

Stabilising the nursing and midwifery workforce, therefore ensuring safe and effective care.

A

Assuring the public, the Minister, the Department of Health (DoH) of the effectiveness and impact of person centred nursing and midwifery care.

F

Facilitating the adoption of a population health approach across nursing and midwifery practice resulting in improved outcomes for people across the lifespan.

E

Enabling the transformation of HSC service through enhancing the roles of midwives and nurses within and across a wide range of MDTs/services.

3. NMTG Overview of Work Streams

The Nursing and Midwifery Workforce

This workstream focused on four core areas: building and sustaining safe stable teams; the scale of the workforce focusing particularly on the numbers of pre and post registration nurses and midwives; exploration of evidenced based options for the further development and/or introduction of new nursing and midwifery roles in order to improve outcomes; and the depth and breadth of nursing and midwifery leadership.

Long Term Conditions (LTC)

This workstream focused on identifying the contribution of nursing and midwifery across primary, community, acute, specialist nursing and midwifery services. To do this a number of long term conditions (LTC) were chosen to explore how the contribution of nursing and midwifery could be maximised, which included frailty, diabetes and respiratory conditions. These conditions ranked in the top for admissions to acute care and their prevalence in primary care and effect on pregnancy and the baby. In addition, two further sources of information were included: the findings from a review into the role of mental health nursing commissioned by the Chief Nursing Officer (CNO); and the findings from a focus group discussion with learning disability nursing. The LTC chosen were indicative and were used to help model the recommendations for nursing and midwifery now and in the future.

Population Health Work Stream

Maximising the contribution of nursing and midwifery in terms of improving population health outcomes was a core objective of the review. This workstream analysed a range of public health data, particularly data relating to the impact of deprivation, adverse childhood experience, mental health and lifestyle choices on health and wellbeing. As a result the workstream focused on the actions needed to not only 'make every contact count' (MECC) but those required to build a strong public health agenda within and across nursing and midwifery services.

4. NMTG Key Findings

Workforce Planning

Unsurprisingly the issues surrounding workforce predominated discussions. The report emphasises that nursing and midwifery as the single largest group (representing 34% of the health care workforce) is fundamental to the delivery of a sustainable health and social care system. Therefore investment in nursing and midwifery needs to be

commensurate with its role in providing care across the lifespan. Workforce data indicates that 94% of the workforce are female and 6% male, and almost 60% of the nursing workforce hold posts at Band 5 and midwives mainly at Band 6. This is over double the amount, when compared with other professions categorised as Band 5. Indeed with the exception of Band 6, when compared with other professions at Band 7 and above, nursing and midwifery has significantly lower number of clinicians at senior grade. Alongside workforce shortage the report identifies the lack of specialist and advanced clinical posts as a major concern, particularly the impact on delivering the ambition outlined in Deliver Together (2026). The report also highlights the increasing number of nurse and midwife vacancies, which have grown to an average of 12% (2,500 posts).

In addition, agency spend has risen from £9,852,129 in 2010/2011 to £51M in 2018/2019. Bank costs have also doubled from £30M in 2010/11 to £61M 2018/19. Clearly this is very concerning, not only in cost terms, but also its impact on the stability of the workforce. Therefore the report recommends the need for a five – ten year sustainable plan to increase the number of undergraduate places. It should be noted that the increase in the number of undergraduate places made possible by transformation funding provides a foundation for growth. This however needs to be sustained in order to keep pace with both population and workforce demographics. There was also a significant call for the introduction of legislation for safe staffing in order to safeguard patient care.

Postgraduate Education

In terms of postgraduate education the report highlights that in order to both retain and develop our nurses and midwives there is a need to restore and incrementally grow postgraduate training budgets. Over the last ten years the core postgraduate education budget in nursing and midwifery has progressively decreased from £10.8 million to £7.3 million. This reduction has been further compounded over this time period by an increase in postgraduate education costs and the increased costs associated with backfill for some of the training places. It is important to note however over the last two years these reductions have been offset by non-recurrent transformation funding. In the absence of sustained recurrent transformation funding and/or a restoration of core funding commensurate with the size of nursing and midwifery workforce, this will have significant implications for nursing and midwifery practice, career pathways, and wider health and social care reform.

Morale and Collective Leadership

The report also emphasises the need to address the morale of the profession, reduce bureaucracy and the unwarranted variation in the roles, teams and the structures of nursing and midwifery, from point of care to the boardroom. One of the core recurring messages that emerged from all those who participated in the workshops was a perspective that nurses and midwives do not feel valued as equal members of the MDTs. This was strongly linked to the fact that the vast majority of nurses are Band 5. This was further compounded by the lack of a systematic approach to workforce development and therefore opportunities for career or grade progression have been limited. A review of the roles and functions of nursing and midwifery leadership also showed significant variation in managerial infrastructure. The lack of dedicated investment has highlighted the need for bespoke leadership development. Across all of the workshops the issue of pay divergence with other professions and the rest of the UK was a recurring concern.

Public Health and Population Health

In relation to population health, there was a strong message that promoting health and wellbeing for the population of NI should be every nurse and midwife's business. Nurses and midwives felt their public health contribution had been compromised largely because of competing demands in their roles. It was also determined that the lack of dedicated and recognised public health nursing roles was also a compounding factor. The epidemiological and demographical realities over the next 10 – 15 years create a strategic imperative to maximise the contribution of nursing and midwifery in improving population health and wellbeing outcomes across all ages, all settings and all communities. The development of primary care Multi-disciplinary Teams (MDTs) creates a real opportunity to enhance the public health nursing roles, particularly in health visiting, mental health nursing and district nursing.

Socio-economic Value of Nursing and Midwifery

Whilst more bespoke work is needed on the socio-economic value of nursing and midwifery, we compared our findings with a wide range of evidence based literature. The report draws on a plethora of emerging evidence that correlates improved patient experience, and outcomes (reducing morbidity and mortality) with increased graduate nurse patient ratio. In addition, there is clear evidence that public health and early years nursing (Midwifery, Health Visitor, School Nursing, Paediatric and Family Nurse Partnership) contributes significantly to enabling the best start in life and in particular reducing risks associated with poor lifestyle choices and in promoting developmental, psychological and social wellbeing. Further evidence now shows that Specialist and Advanced Nurse Practitioners (ANPs) improve clinical care outcomes and provide a cost effective solution in augmenting the role of doctors.

5. Department of Health Transformation Programme

Since the launch of *Health and Wellbeing 2026: Delivering Together* the Department of Health (DOH) has made significant investment in a wide range of nursing and midwifery services with over £50M invested in three key critical areas:-

Workforce Stabilisation

An additional investment of £7M undergraduate education has enabled the highest number (1025) of nursing and midwifery training places commissioned in NI 2019/20. This represents an increase of 45% from 2015/16 and demonstrates the Department of Healths commitment to addressing the current shortages and growing the local nursing and midwifery workforce.

In 2016 the Department embarked on a regional international nursing recruitment campaign with the aim of bringing 622 overseas nurses by November 2020 to strengthen the local HSC workforce. Transformation investment into the Clinical Education Centre (CEC) has supported overseas nurses to meet the essential registration requirements to practice as a nurse in the U.K.

The Department launched its Delivering Care Policy (safe staffing) and has commissioned to date nine discreet phases which have resulted in an investment of over £15.2M.

Workforce Development

The post registration transformation investment of over £7.7 million has delivered significant educational opportunities for the nursing and midwifery professions, benefiting 1,965 participants over the last two years. Investment has enabled a wide range of programmes to be funded to build the clinical expertise and leadership capacity within the workforce. The investment has supported the strategic direction with a focus on community specialist practice programmes such as District Nursing, Health Visiting and School Nursing. Investment in the development of ANP roles in Primary Care, Emergency Care and Children's Nursing has been a significant achievement with the first Masters level ANP programme delivered in NI.

A range of other programmes, including bespoke quality improvement and leadership initiatives have been funded across mental health, learning disability, adult, children services and midwifery. Furthermore, investment has facilitated an innovative post registration nursing Master's programme for NI, designed to develop leadership skills in new nurses and support workforce retention. Additionally, transformation investment in a regional nursing and midwifery data transformation project is assisting the professions with implementing electronic record keeping and digitalisation.

Service Developments and Reforms

The Department has also invested £18M in nursing service developments across the life span. This has resulted in additional Health Visitors (HV) enabling a new ratio of 1 HV to every 180 children. In addition, a District Nursing Framework 2018-2026 was launched that has been designed to enable the delivery of 24 hour district nursing care no matter where you live. This has also enabled a new ratio of 8-10 whole time equivalent (WTE) per 10,000 of the population. Through the establishment of MDTs there has been additional investment in Neighbourhood Nursing teams and in ANP within Primary Care Teams.

6. NMTG Ambition

The recommendations proposed reflect a new vision/ambition to maximise the contribution of nursing and midwifery. It is the ambition that nursing and midwifery deliver the right evidence based care, with the right numbers, at the right time, in right place, by the right person with the right knowledge, and of course most importantly delivering the right experience and outcomes for persons, families and communities.

7. Recommendations

Before moving onto the recommendations of the report it is worth highlighting the recommendations also take account of the new mandatory Nursing and Midwifery Council (NMC) Future Nurse Future Midwife (FNFM) proficiency standards launched in May 2018 (Nursing) and November 2019 (Midwifery). These standards are set to revolutionise and modernise nursing and midwifery practice, and they are strongly focused on evidence based care, delivering population health, and patient and women centred care which will improve outcomes for people. The review team analysed all of the data from the workshops and following a literature review themed the recommendations under three core headings. The recommendations have been framed to reflect a new vision/ambition designed to maximise the contribution of nursing and midwifery.

7.1 Theme 1: Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes: Clearly nurses and midwives have a critical and collective leadership role to play across the lifespan in promoting health and well-being. It is within this context that the report is recommending:

7.1.1 The development of a new population health management programme for nursing and midwifery.

7.1.2 The creation of dedicated population/public health advanced nurse and midwife consultant roles across all of our HSC bodies.

7.1.3 To increase the number of school nurses, health visitors and expand the family nurse partnership programme across all of NI.

7.1.4 Recognising the demographic shifts, nursing needs to have joint and collective responsibility for the development, planning and leadership of older people services, including all nursing care services provided in the independent sectors.

7.2 Theme 2: Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice: Addressing the workforce challenges is strategically essential for the stabilisation of the nursing and midwifery workforce and health and social care delivery, therefore under this theme it is recommended we:

7.2.1 Sustain a minimum of 1000 undergraduate nurse and midwife placements per year for at least the next five years until we have reached a position of oversupply.

7.2.2 Establish a ring-fenced post education budget commensurate with both the size of the workforce and the HSC transformation agenda and as a minimum re-establish the previous investment of £10M.

7.2.3 Build and resource a new career framework for nursing and midwifery to ensure that within ten years we have advanced nurse, specialist midwife and nurses roles, as well as nurse and midwife consultant roles across all branches of nursing and midwifery.

7.2.4 Increase the number of clinical academic careers roles across all branches of nursing and midwifery.

7.2.5 Put Delivering Care Policy (safe) staffing on a statutory footing.

7.2.6 Develop arrangements for accelerated pay progression Band 5 to Band 6 grades similar to other professions. This in particular recognises that many Band 5 nurses after several years of practice acquire additional specialist knowledge and skills and take on additional responsibilities commensurate with Band 6 role as a senior clinical decision maker. Midwives become Band 6 within a year post registration.

7.2.7 Develop a person-centred practice policy framework for all nursing services and continue to develop woman and family centred midwifery services.

7.3 Theme 3: Doing the right things in the most effective way and working in partnership: The recommendations under this theme recognise the need for collective leadership and the development of integrated practice models within and across MDTs. For this to be fully realised there is a need to:

7.3.1 Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse/midwife leadership framework and investment in leadership training for nurses and midwives.

7.3.2 Invest in improvement science training and increase role of nursing and midwifery leadership in quality improvement initiatives.

7.3.3 Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness.

7.3.4 Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) new digital nurse leadership role in all HSC bodies.

8. NMTG High level Implementation Plan

In order to take forward these recommendations, a new nursing and midwifery strategy will need to be developed that is in line with *Health and Wellbeing 2026: Delivering Together* priorities. Indeed the Bengoa Report (October 2016) makes clear that system transformation is dependent on the modernisation of practice. Nursing and midwifery in line with the recommendations of this report will undergo significant practice reforms and clearly with a multi-disciplinary approach which is central to the delivering of better outcomes. The recommendations in this report will inevitably require legislative and ministerial approval and the development of a dedicated action plan. Clearly the recommendations will require additional significant investment over a 10-15 year period and this will be dependent on resources being released through service reconfiguration and/or efficiencies as well as securing new investment.


Registered Nurse
Health and Social Care
Registered Nurse
Health and Social Care
Health and Social Care

1

THE TASK

SECTION 1: THE TASK

On 25 October 2016, the then Minister of Health, Michelle O'Neill launched an ambitious 10 year approach to transforming health and social care ***Health and Wellbeing 2026: Delivering Together***[2]. This vision document, based on the findings of the Expert Panel report, led by Professor Rafael Bengoa, ***'Systems, not Structures: Changing Health and Social Care***, recognised that our society is getting older and people are living longer with long term health conditions. The vision document set out the necessary 'change' to deliver the world class health and social care services the people of NI deserve, acknowledging that current health and social care services were designed to meet the needs of a 20th century population, with a requirement for a programme of transformation implemented in a safe and sustainable way that meets the challenges of a 21st century population.

It was within this context and the many challenges facing nursing and midwifery that the Health Minister established a NMTG in 2017. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured HSC over the next 10-15 years. The group was asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes.

The Task Group reflected the current strategic mandates set out in:-

Health and Wellbeing 2026: Delivering Together

Particularly ensuring that the nursing and midwifery strategic direction mirrors the quadruple aim ambition:-

- people are supported to stay well in the first place
- people have access to safe, high quality care when they need it
- staff are empowered and supported to perform their roles - recognising that they are the most valuable resource available to the HSC organisations
- services are efficient and sustainable for the future

As detailed in *Health and Wellbeing 2026: Delivering Together*, the Task Group also sought to reflect the nursing and midwifery contribution to the 'change needed' in:

1. **Building capacity in communities and prevention** particularity in reducing health and social inequalities.
2. **Providing more support in primary care** and at home.
3. **Reforming our community and hospital services** so that our population receive evidence based care in the right place.
4. **Organising health and social care** by ensuring systems are co-designed, and are delivered in the most efficient and effective way.

The group also reflected the strategic objective reflected in;-

- Systems not Structures; Changing Health and Social Care – the Expert Panel Report
- Programme for Government (PfG) Framework 2016 - 2021[3] particularly on creating the condition for the people of NI to 'enjoy healthy active lives'
- Making Life Better – A Whole System Strategic Framework for Public Health 2013 – 2023[4]

The work of the Task Group was to be underpinned by a public health approach that promoted health and wellbeing. It was also expected to identify best practice and innovations in nursing and midwifery practice, embracing and building on work already undertaken across the UK and Ireland and further afield. The Task Group membership was to examine the socioeconomic value of nursing and midwifery and identify potential opportunities for the future. The NMTG was chaired by Sir Richard Barnett, and full membership of the Group is included at **Annex A.**

The 10-15 Year Road Ahead

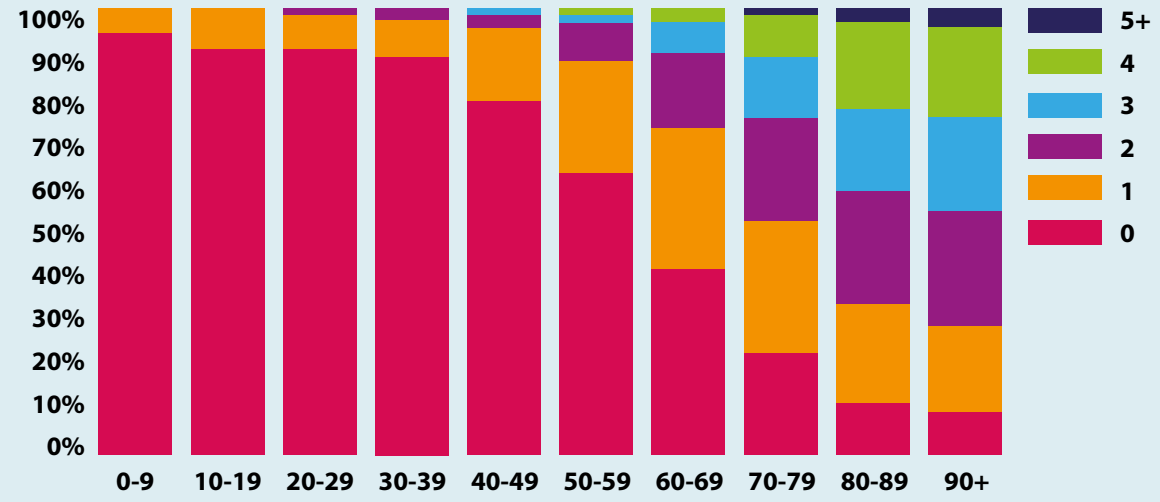
Looking forward over the next 10-15 years, NI like all the other countries of the UK and Ireland is facing a world where demographic realities and the pace of technological and social change will transform the relationship people have with health and social care.

The challenges outlined in **figure 1** will require a systemic, integrated and partnership approach across nursing and midwifery, the wider health and social care system and with the public.

Figure 1 - Reference NI NHS Conferdertion#NICON15

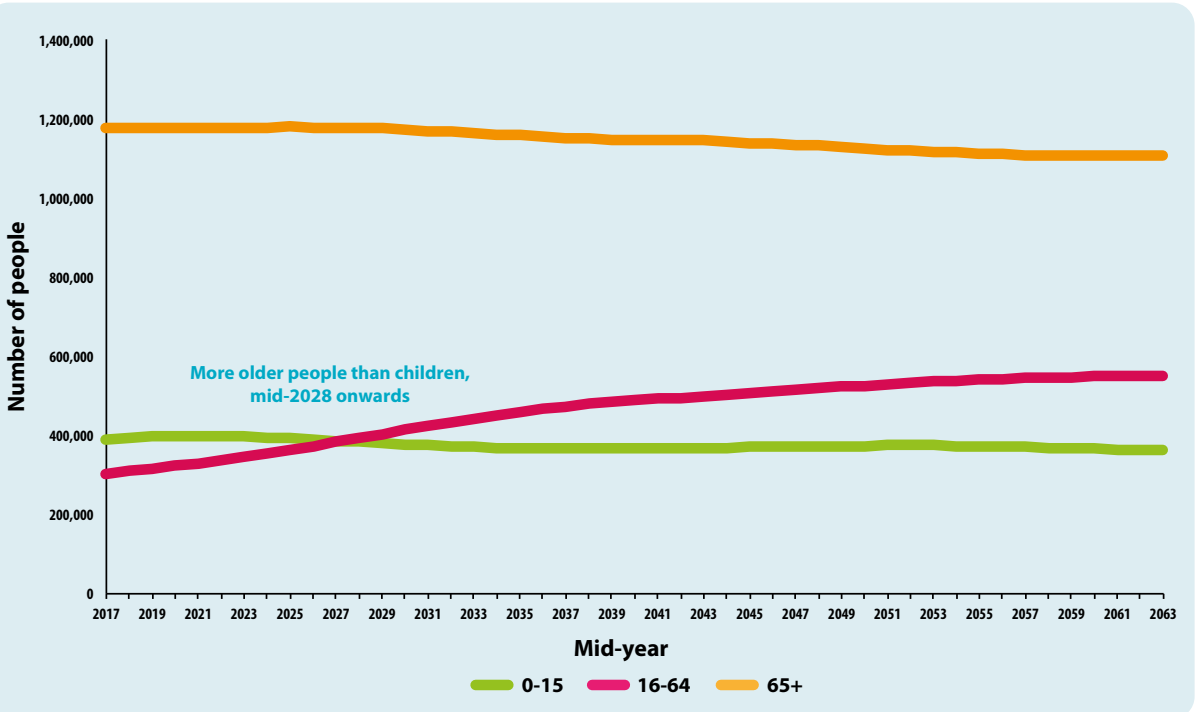
We know demand for services is arising largely as a result of an ageing population, many of who are living with complex needs and long-term conditions **(figure 2)**.

Figure 2 - Percentage of patients in each age band with the indicated number of morbidities



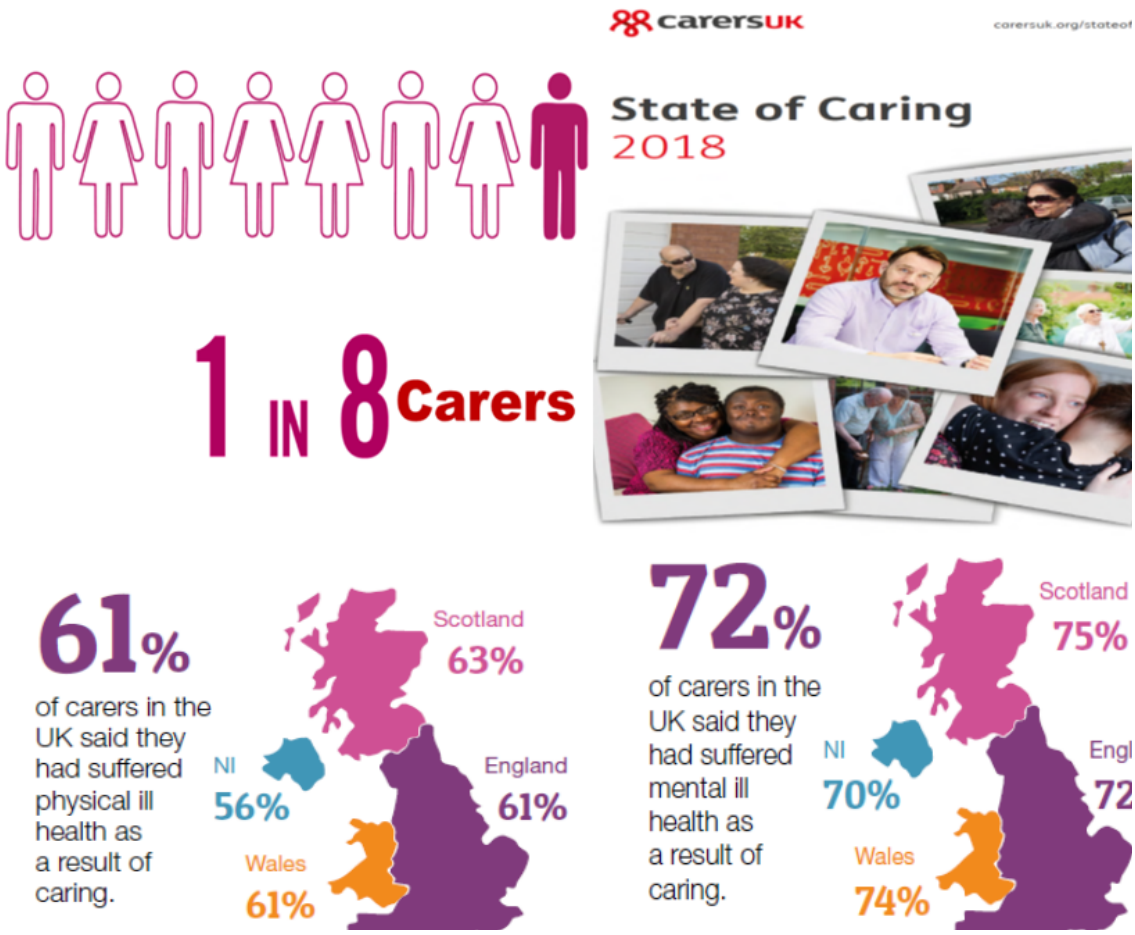
As set out in **figure 3** it is estimated by the year 2028 the population of older people in NI will be greater than the number of children. Indeed by 2023 the number of people over the age of 65 will make up 30% of the population and by 2061 it will grow to 50% of the population. The largest growth in the older person population will be those aged 85+. We also know this means there will be a commensurate rise in co-morbidities.

Figure 3 - Population by age group (mid-2017 to mid-2063)



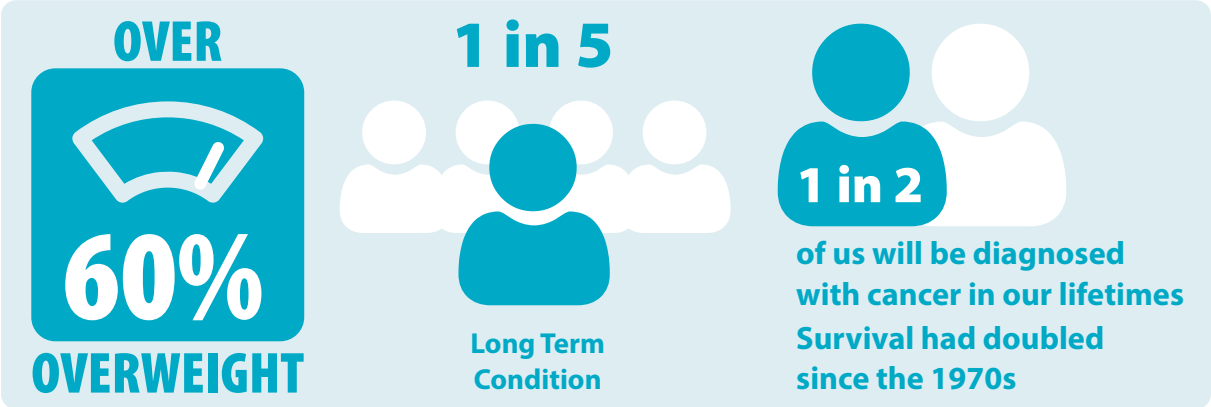
The reality behind these numbers also means that the numbers of people with dementia is estimated to increase from an average of 20,000 to 60,000 by 2051. It is also estimated that 1 in 8 adults are also carers. **(Figure 4)** It is anticipated the number of carers in NI is expected to rise from 220,000 to 400,000 by 2037, meaning that 1 in four adults in NI will be carers. Clearly we are increasingly becoming reliant on older people as informal carers, many who themselves will be vulnerable from poor health. Research by Carers UK (2018) found that in NI 61% of carers experienced poor physical health and 71% had experienced stress and depression as result of their caring role.

Figure 4 - State of Caring



We also know that 1 in 5 of our population now live with a long term condition, 1 in 2 of us will experience cancer and about 60% of us are overweight, this along with sedentary lifestyles and excessive drinking has created additional demand on the health and social care system. **(Figure 5)**

Figure 5 - Picture of Health Needs



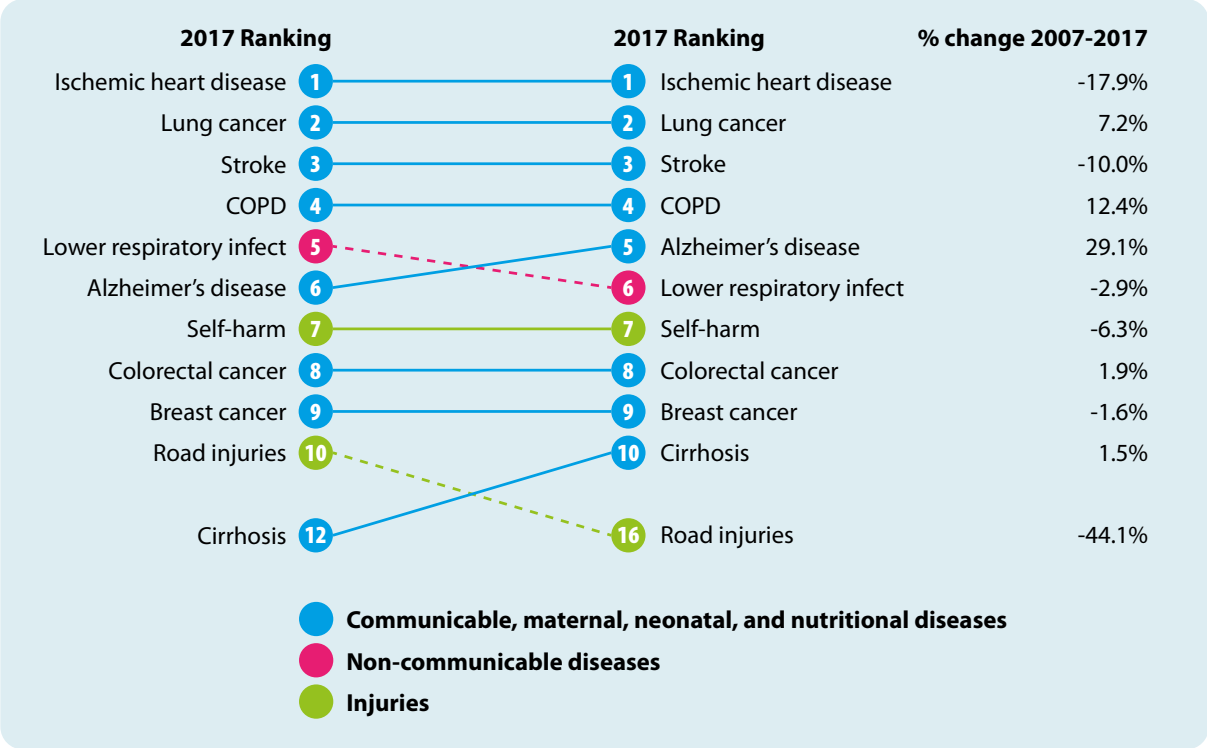
It is also regrettable as set out in **figure 6** that in NI life expectancy remains 7 years less for males and over 4 years less for females in the most deprived areas when compared with the least deprived areas of NI.

Figure 6 - Left Expectancy

Issue	Least Deprived	Most Deprived	Gap
Male Life Expectancy (2012-14)	81.1 years	74.1 years	7.0 Years
Female Life Expectancy (2012-14)	84.1 years	79.7 years	4.4 Years
Male Healthy Life Expectancy (2012-14)	63.4 years	51.2 years	12.2 Years
Female Healthy Life Expectancy (2012-14)	68.0 years	53.4 years	14.6 Years
Alcohol-related Deaths per 100,000 (2010-14)	7.9	33.0	318%
Alcohol-related Admissions per 100,000 (2012/13-2014/15)	318	1,600	403%
Smoking-related Deaths per 100,000 (2010-14)	111	255	129%
Self Harm Admissions to Hospital per 100,000 (2010/11-2014/15)	106	427	302%
Suicide Deaths per 100,000 (2010-14)	9.2	27.2	196%
Preventable Deaths per 100,000 (2010-14)	140	347	148%
Low Birth Weight (2015)	6.1%	7.8%	27%

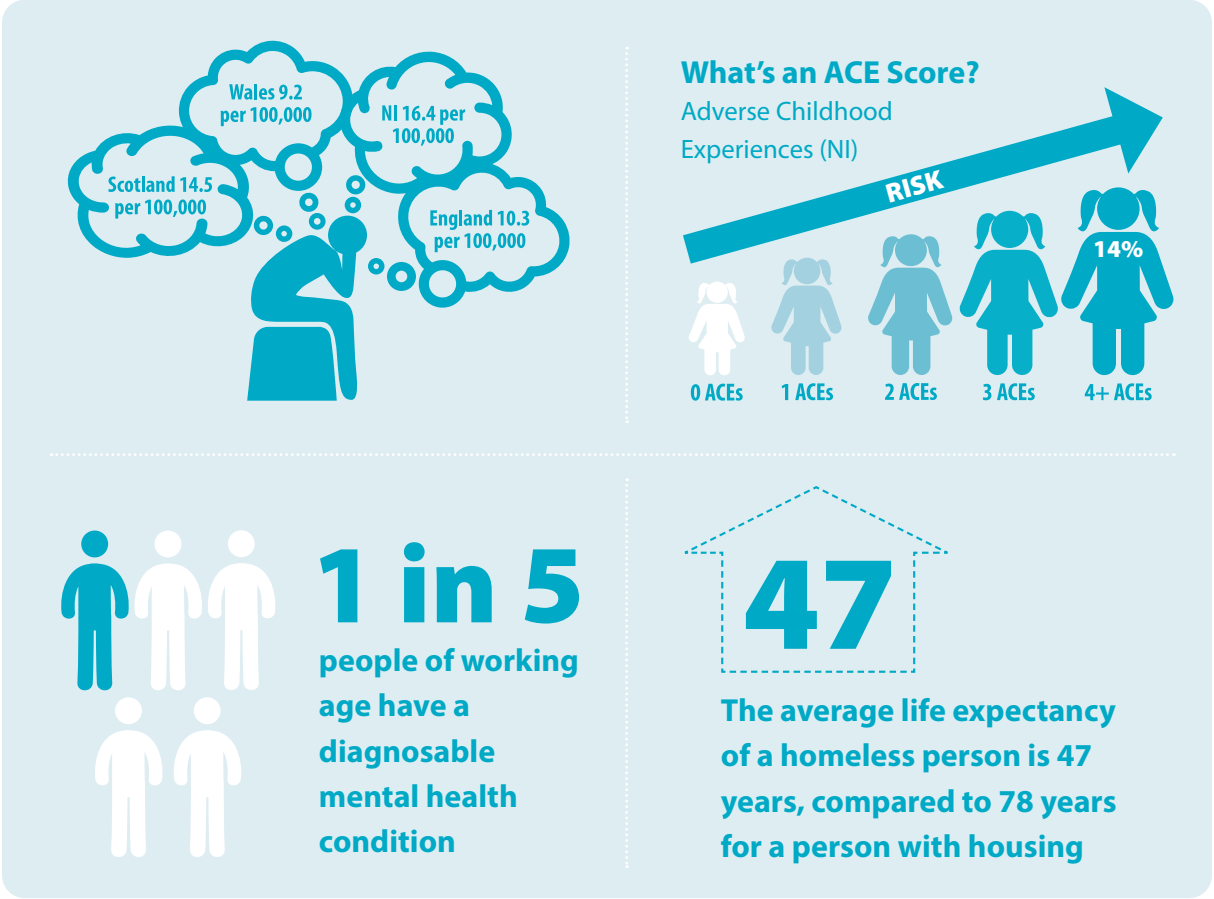
As set out in **figure 7** many of the causes of premature death are preventable through adopting healthier lifestyles.

Figure 7 - What causes the most premature death?



We also know that 1 in 5 **(figure 8)** people in NI will experience mental ill health. For people who experience serious mental ill health, research shows they live shorter lives by some 15- 20 years. Indeed research also shows if you experience homelessness your average life expectancy is 47 years. We know that around about 14% of Children and Young People (CYP) experience four or more Adverse Childhood Experience. Worryingly this means they are more likely to develop serious physical and mental health long term health conditions. This reality inevitably means the robust adoption of a population health approach and the fast tracking of innovation and implementation of evidence in order to prevent ill health, reduce the impact of health and social adversity, and enable people to live well and/or more independently with long term conditions. This means every nurse and midwife will have a critical role to play in promoting health and well-being and working in partnership with individuals, family, and their communities to address the wider social determinants of health.

Figure 8 - Profile of Mental Health Needs



Adopting a population health approach will enable nursing and midwifery to balance the intensive care needs of those in greatest need, with preventative health and social care intervention. This means health care will be driven by the utilisation of digital and data-driven technologies which will not only improve care outcomes but will enable the targeting of resources towards prevention and the early identification of risks.

Emerging and new personalised technologies (wearable devices) will change the way people will monitor and manage their health and will drive the personalisation of care and enable self-management/self-directed care. The expansion of remote care models, such as video consultations and symptom checkers, provided inside and outside the HSC system will also change the nature of the interaction with health care professionals. The advancement in genomics and precision medicine will improve the prevention, management and treatment of disease. Indeed the application of technologies, powered by health data will improve diagnostics, triage, reduce variation and increase efficiencies. Consequently new and emerging enabling technologies will radically change nursing and midwifery practice over the course of the next 10 -15 years. Such innovation unleashes the full potential of nurses and midwives to deliver more expert, personalised, and targeted health and social care in response to the changing demographic needs of the population of NI.

2

THE VALUE OF NURSING AND MIDWIFERY TO GLOBAL HEALTH

SECTION 2 – THE VALUE OF NURSING AND MIDWIFERY TO GLOBAL HEALTH

The value of nursing and midwifery is almost inestimable. Nurses and midwives make up nearly half of the global health workforce, with around 20 million nurses and 2 million midwives worldwide. Working in a wide variety of roles and in many different contexts, nurses are often the first and only health professionals people see for their health-care needs. Nursing and Midwifery is essential to meeting the challenges posed by demographic changes and rising health-care demands.[5] Also, nurses and midwives have a central role in universal health coverage (UHC). Nurse-led clinics could allow rapid and cost-effective expansion of services for non-communicable diseases, ANPs and Nurse Specialists could strengthen primary care, and nurses and midwives could be at the forefront of public health promotion and prevention campaigns and interventions.

It is within this context that nurses and midwives play a critical role in building communities that are resilient and capable of managing and responding to their own healthcare needs[6]. This is dependent upon a workforce which is both available and accessible to all. The professions of nursing and midwifery act as enablers to service delivery and many notable achievements have been made in this area. As the largest professional workforce they have the ability to transform how healthcare is both organised and delivered. It is important that nursing and midwifery is seen as a system asset and that policy makers and health and social care planners seek to optimise the potential that exists within the nursing and midwifery professions in order to improve the health of the population. This can be best achieved through evidence based policy development, effective collective leadership, strong professional governance and management.

In the United Kingdom, the nursing and midwifery workforce continues to develop practice and services, embracing new and emerging evidence to adapt to the changing environment and population needs. Change includes responding to an increasing complexity of care within differing models of service delivery, where safety, quality and service user experience are fundamental principles of professional practice[7]. As a result, significant gains have been made in increasing life expectancy and reducing many of the risk factors associated with mortality[8]. Crucially nursing and midwifery has a significant role particularly in the earlier years to address the wider social determinant of health.

In the words of Professor Marmot *"**Nurses are the most trusted group of people. Rightly so. Nurses and midwives treat individuals with compassion and care, and have great potential to improve the health of communities, through action on the social determinants of health."***

Recent inquiry has sought to define the economic value and impact of nursing and midwifery to society whilst recognising the challenges of providing such evidence, where value to the individual citizen is more often related to intangible psychological and emotional benefits that are difficult to measure quantitatively[9].

Studies globally from 2009 – 2011[10] have demonstrated that nurse staffing and missed care were significantly associated with increased mortality rates. A systematic review of these studies in 2016 asserted that the evidence points towards a higher proportion of registered nurses being associated with the most cost effective approach to provision of healthcare, when a wider consideration of societal benefits, such as averted lost productivity, could provide a substantial potential net economic benefit[11].

The World Health Organisation (WHO) Global Strategy on Human Resources for Health sets out an overwhelming case for robust workforce planning, investment in education and providing an environment conducive to the delivery of safe high quality health care. There is a clear alignment with *Health and Wellbeing 2026: Delivering Together* and the Health and Social Care (HSC) Workforce Strategy[12]. Whilst there are ongoing healthcare challenges presented by shortages of available workforces, addressing the health of a population should ensure healthcare resources are employed and deployed strategically. The report[13] argues for a "contemporary agenda with an unprecedented level of ambition. Better alignment to population needs, while improving cost-effectiveness depends on recognition that integrated and people-centred healthcare services can benefit from team-based care at the primary level". WHO asserts that a reshaped and transformative agenda through policy should provide a different type of healthcare worker with attention to expanded practice that enables appropriate utilisation of the workforce. The nursing scope of practice is highlighted as one which is flexible to populations and patient health needs, and has been particularly successful in delivering services to the most vulnerable and hard-to-reach populations[14].

Similarly, the midwifery scope of practice has the potential to provide 87% of the essential care needed for sexual, reproductive, maternal and newborn health services[15]. The 2014 Lancet series on the contribution of midwifery demonstrated the substantial health and wellbeing benefits for women, mothers and their infants when high-quality midwifery care was delivered[16]. The series recognised that the generation of further evidence of economic value was required; however that which existed established that midwifery care provided by educated and regulated practitioners was cost-effective, the return on investment similar to the cost per death averted for vaccination programmes.

Midwives make a critically important contribution to the quality and safety of maternity care providing skilled, knowledgeable, respectful and compassionate care for all women, newborn infants and their families. Their work is across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum and the early weeks of life including the woman's future reproductive health wellbeing and choices, as well as very early child development and the parent's transition to parenthood. The midwife is central to high quality maternity care, and the principle that 'all women need a midwife and some need a doctor too' is widely accepted.

Policies are in place with the aim of promoting woman centred care, continuity of care, greater choice of place and type of birth, reduction of unnecessary interventions, reduction of inequalities and improving safety. Recent policy on early years also underlines the importance of high quality maternity services.

Midwifery led settings are a cost-effective alternative to the prevailing model of obstetric led settings, increasing the agency of both women and midwives. A substantial body of evidence now exists to show that care provided by midwives in a continuity of care model, where the midwife is the lead professional in the planning, organisation and delivery of care throughout pregnancy, birth and postpartum period, contributes to high quality safe care. The recent Cochrane review (2016) has demonstrated that this model of care is associated with significant benefits for mothers and babies and has no identified adverse effects. Women experiencing this model of care are less likely to have an epidural, amniotomy or episiotomy; instrumental birth; have a premature birth; or experience fetal loss. They are more likely to have a spontaneous vaginal birth; to know the midwife who looks after them during labour and birth; express satisfaction with information, advice, explanation, preparation for childbirth and women who find services hard to access (due to social complexity), particularly value midwifery continuity of care.

A future leadership imperative is to continue to define and evidence the impact that the nursing and midwifery professions have on population health outcomes, developing and aligning service provision where the best use of registrant expertise is demonstrated.

3

THE AMBITION

SECTION 3 – THE AMBITION

Nurses and midwives already make a significant contribution across the lifespan in partnering and empowering the people of NI to:-

- Enjoy healthy active lives,
- Recover, from ill health and in promoting self-management for those with pre-existing /long term conditions.
- Make person centred choices through effective end of life care.

This provides a crucial foundation on which to maximise the future contribution of nurses and midwives over the next 15 years. **Figure 9**: **Maximising the Contribution of Nurses and Midwives** below presents a strategic map of the future direction that will maximise the positive contribution of nursing and midwifery across health and social care.

Figure 9: Maximising the Contribution of Nurses and Midwives

We Enjoy Long Healthy Active Lives

The health aspiration outlined in the Executive's Draft Programme for Government (PfG) was the outcome ***'we enjoy long, healthy, active lives'.*** *Health and Wellbeing 2026: Delivering Together* outlined an ambitious roadmap reflecting the quadruple aim. In order to maximise the contribution of nurses and midwives, a part of that ambition is to strengthen the development of the professions that leads to every nurse and midwife understanding the importance of, and contributing to, public health approaches across the life course. Across all services and levels nurses and midwives will lead and contribute to understanding the needs of the population they serve, proactively co-designing solutions that prevent avoidable illness and improve health and social well-being outcomes based on population profiling and needs stratification.

Right Number of Nurses and Midwives with Right Skills, Doing Right Thing, At Right Times, In Right Places working in partnership and across boundaries

This ambition requires the development of knowledge, skills and abilities, to equip nurses and midwives to improve population outcomes. Central to this is the reform of nursing and midwifery education at pre-registration and post-registration levels including the intent to strengthen apprenticeship approaches and development of graduate entry models. A further enabler is the establishment of core standards for staffing levels across all midwifery and nursing services to ensure the right number of nurses and midwives are doing the right thing, in the right place, at the right time. Furthermore, this ambition can only be realised through the development of significant nursing and midwifery leaders for the future.

Person centred practice that enables health and wellbeing, preventative and early intervention, recovery, self-management, and end of life care

Visible leadership which is person-centred in word and deed, is central to the ambition and requires a commitment to a core set of values reflected in the practice of nurses and midwives at all levels from frontline to boardroom positions and across a range of career pathways. This approach recognises the need for collective leadership across education, practice, research and policy careers to support the future provision of person-centred health and social care.

Enabling people to make healthy choices and live well

Through the development of the nursing and midwifery workforce, the people of NI, irrespective of their age, personal circumstances and health status, will be enabled to make healthy choices and live well:

across their life course

whilst managing chronic and long term conditions

through acute and episodic care and treatment

and at the end of life

Delivering population, person and family centred outcome focussed care in the most appropriate setting

The ambition takes account of the vision for health and social care within NI which is to deliver world class health and social care services that are a safe and sustainable way to meet the challenges of a 21st century population. It recognises the challenges of achieving person-centred outcomes in the context of shared decision making and complexity of care delivery across diverse care environments.

In summary, this ambition will enable us to deliver person centred outcomes for patients, people, families, carers and staff which are aligned to the quadruple aim: improving the health of our people, ensuring sustainability of services, improving the quality and experience of care and supporting and empowering our staff.

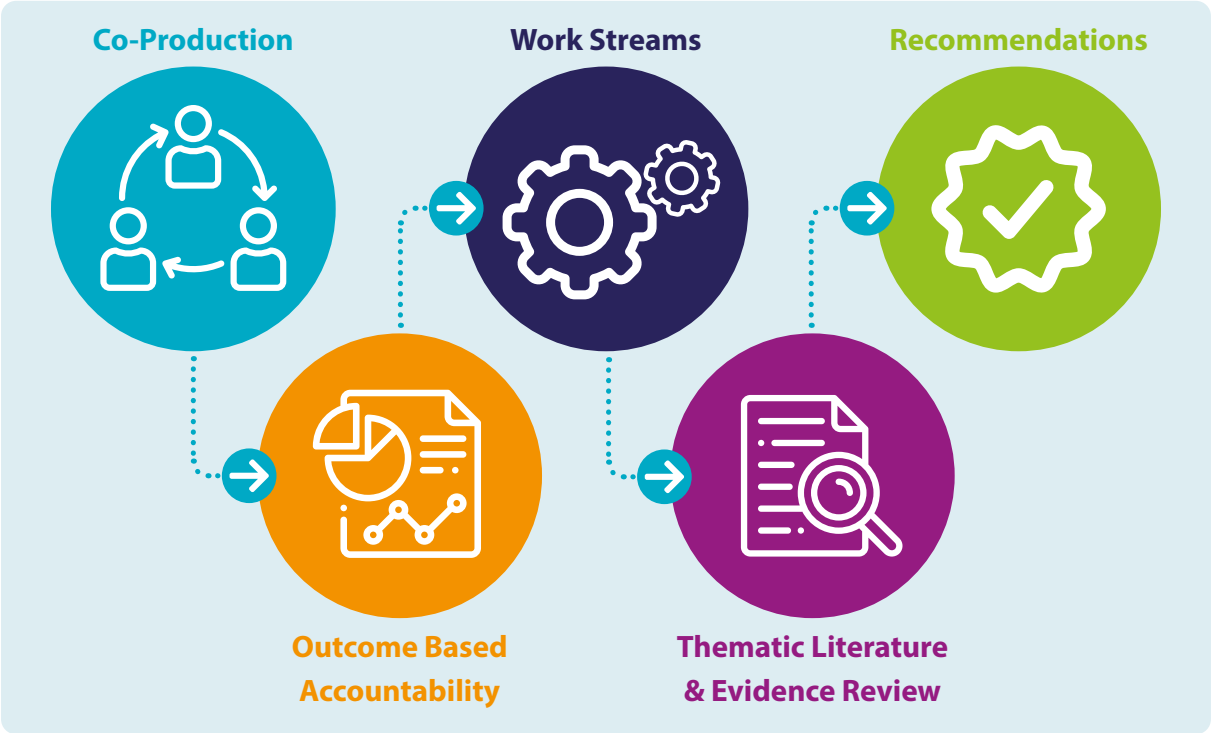
4

THE APPROACH

SECTION 4 – THE APPROACH

The core aim of the NMTG, as previously stated, was to develop a roadmap which would provide direction in achieving world class nursing and midwifery services in a reconfigured HSC over the next 10-15 years. The work of the Task Group was shaped by adopting a population health, evidenced based outcomes and life span approach. The approach has been shaped by the NMC Code of Conduct, NMC Future Nurse Proficiency Standards, NMC Education Standard's and UK CNO Enabling Professionalism. The work involved five key strands as outlined in **figure 10**, below.

Figure 10: Overview of the Approach



In order to create ownership across the midwifery and the nursing family a Co-Production model was adopted. This involved engaging midwives and nurses at all levels and across a wide range of services and settings, who through their engagement have contributed to the recommendations of this report.

In line with the Draft PfG, engagement events were modelled on the Outcomes Based Accountability (OBA) approach. This approach focuses on high level outcomes as the starting point of work rather than the end product, and works towards agreeing actions to achieve these outcomes. OBA supports a long term vision, allowing the Task Group to look ahead to the contribution of nursing and midwifery to population outcomes over the next 10-15 years.

As part of the OBA approach, three core workstreams were established to assist in the formulation of the recommendations in this report. These work streams were: nursing and midwifery workforce, long term conditions and population health presented in **figure 11**, below. This was achieved through group discussions that focused on:-

1. Lived and worked experience of staff.
2. Evidence of what works
3. What needs to change in order to deliver better outcomes?
4. How would we recognise success?

Across the three work-streams, the NMTG hosted over 36 events and had almost 1,000 participants from all branches of nursing and from midwifery, including independent sectors. Other professions also contributed to the work.

Figure 11: Overview of Nursing and Midwifery Group Attendee

	Worksteams	Number of Meetings	Ave Number of People Attending	Total
Stable Teams	3	8	25	200
Long Term Cond	3	9	25	225
Population Health	3	9	25	225
Learning Disability	1	1	25	25
Cancer Nurses Network	1	1	25	25
NIPEC Event	1	1	100	100
Practice Nurses	1	1	20	20
Mental Health Nurses	1	5	25	125
Leadership event	1	1	25	25
Total	15	36	32	970

- Estimated number of participants, calculated on basis on min 3 works streams 3 events per theme by average of 25 people attending)

Figure 12: Overview of Work Streams

Workforce

This workstream focused on four core areas: building and sustaining safe stable teams; the scale of the workforce focusing particularly on the numbers of pre and post registration nurses and midwives; exploration of evidence based options for the further development and/or introduction of new nursing and midwifery roles in order to improve outcomes; and the depth and breadth of nursing and midwifery leadership. Data in respect of workforce were drawn from the DoH Workforce Policy branch, and also from other work streams where workforce featured as part of discussion.

Long Term Conditions

This workstream focused on identifying the contribution of nursing across primary, community, acute and specialist nursing, and midwifery services. To do this a number of long term conditions were chosen to explore how the contribution of nursing and midwifery could be maximised, which included frailty, diabetes and respiratory conditions. These conditions ranked the top for admissions to acute care and their prevalence in primary care and for diabetes and respiratory conditions, their impact on pregnancy and the baby. In addition, two further sources of information were included: the findings from a review into the role of Mental Health Nursing commissioned by the CNO; and the findings from a focus group discussion with Learning Disability nursing.

Population Health

In light of the overall aim, population health was the third work stream. Having analysed data relating to key public health concerns, this workstream focused on healthy weight, mental health and emotional wellbeing and public health approaches in nursing and midwifery.

Data from the three work streams was collated and thematically analysed to draw out key areas that were further explored in the context of the existing evidence base. This resulted in nine themes which are presented in Section 7, page 81 and formed the foundation for the development of the recommendations outlined at page 85.

The final stage in the approach was the development and drafting of the report. This was an iterative process undertaken by a sub group of the NMTG and involved external expert review.

5

THE CURRENT PICTURE

SECTION 5: THE CURRENT PICTURE

Collectively the registered nurses, midwives and aligned support staff are the largest professional group in the HSC workforce, accounting for 34.4% of the total number of staff[17]. In this report we have presented evidence emphasising the value of nursing and midwifery. Within a challenging current context that often mitigates against the professions maximising their contribution. Nurses and midwives consistently demonstrate their contribution to the health and wellbeing of the population in NI, leading the way in delivering high quality, innovative person-centred care, contributing to the strategic objectives of transformation and co-production.

This section highlights some examples of nursing and midwifery practice excellence across NI, whilst contrasting some of the challenges for the current workforce.

Transformation of Nursing and Midwifery Service

Since the launch of *Health and Wellbeing 2026: Delivering Together* the Department has made significant investment in a wide range of nursing and midwifery services with over £50 million invested in three key critical areas:-

1. Workforce Stabilisation

An additional investment of £7 million undergraduate education has enabled the highest number (1025) of nursing and midwifery training places commissioned in NI 2019/20. This represents an increase of 45% from 2015/16 and demonstrated the Department's commitment to addressing the current shortages and growing our local nursing and midwifery workforce.

In 2016 the Department embarked on a regional International Nursing recruitment campaign with the aim of bringing 622 overseas nurses by November 2020 to strengthen the local HSC workforce. Transformation investment into the CEC has supported overseas nurses to meet the essential registration requirements to practice as a nurse in the U.K

The Department launched its Delivering Care Policy (safe staffing) and has commissioned to date nine discreet phases which has resulted in an investment of over £15.2M.

2. Workforce Development

The post registration transformation investment of over £7.7 Million has delivered significant educational opportunities for the nursing and midwifery professions, benefiting 1,965 participants over the last two years. Investment has enabled a wide range of programmes to be funded to build the clinical expertise and leadership capacity within the workforce. The investment has supported the strategic direction with a focus on community specialist practice programmes such as District Nursing, Health Visiting and School Nursing. Investment in the development of ANP roles in Primary Care, Emergency Care and Children's Nursing has been a significant achievement with the first Masters level ANP programme delivered in NI. A range of other programmes, including bespoke quality improvement and leadership initiatives have been funded across mental health, learning disability, adult, children services and midwifery. Furthermore, investment has facilitated an innovative post registration Nursing Masters programme for NI, designed to develop leadership skills in new nurses and support workforce retention. Additionally, transformation investment in a regional nursing and midwifery data transformation project is assisting the professions with implementing electronic record keeping and digitalisation.

3. Service Developments and Reforms

The Department has also invested £18M in nursing service developments across the life span. This has resulted in additional Health Visitors that has enabled a new ratio of 1 Health Visitor to every 180 children. In addition a District Nursing Framework 2018-2026 was launched that has been designed to enable the delivery of 24 hour district nursing care no matter where you live. This has also enabled a new ratio of 8-10 Whole Time Equivalent per 10,000 of the population. Through the establishment of Multi-Disciplinary Teams (MDTs) there has been additional investment in a Neighbourhood Nursing teams and in ANP within Primary Care Teams.

Examples of Nursing Improvement and Transformation

Across HSC Trusts nurses and midwives have been leading innovation and improvement across services. Examples include:

- A programme of work to prevent hospital admission for patients accommodated in a nursing home with a range of complex needs, including dementia, physical disability, and both chronic and terminal illness. A registered nurse worked with patients, relatives, staff, local GPs, allied health professionals, rapid response team and care managers to develop advanced care pathways. This initiative resulted in a significant reduction in decisions to admit patients from the nursing home to hospital.

- A donor transplant nurse having realised the number of kidneys transplanted from live donors was much lower in NI than the rest of the UK, embarked on a mission to streamline the process and worked with other colleagues to reduce the assessment time from two years to a one-day process. In doing so she has made it easier for people who wish to donate a kidney, improved the quality of life for patients, and ultimately saved lives.
- The first community-based fully integrated child and adolescent mental health service (CAMHS) for young people with intellectual disability established specialist teams within CAMHS, providing early intervention and holistic bio-psychosocial assessment through to high intensity intervention. This has improved referral pathways, the delivery of effective interventions, risk management, reduced the use of psychotropic medication and has demonstrated high levels of service user satisfaction.
- A telephone follow-up aftercare service for people who were being treated for head and neck cancer providing education and support for people and their families/ carers, empowered individuals to develop skills and confidence for self-surveillance and facilitated fast tracking to follow up services. This created a patient-led follow up service and reduced the requirement for a routine appointment follow up service.
- A pioneering nurse led initiative that provides treatment and care for patients who require intravenous therapies such as blood transfusions and intravenous antibiotics, now enables patients who would normally have been treated in an in-patient unit or out-patient department of major acute hospitals to be treated in their local communities.

Workforce Trends

The midwifery and nursing workforce make up approximately 34% of the health and social care workforce, making it the largest single professional group. Crucially midwifery and nursing are the backbone of health care and are therefore central to leading and delivering transformation across the entire life-course and across the health and social care system.

Currently the picture across health and social care is one of high vacancy and pressured work environments - registered nurse vacancy levels ranging from 8-10 %[18]. The shortfall of nurses and midwives in NI and across the UK, is reflective of the global position. The WHO predicts that by 2030 the global nursing deficit will be 7.6 million[19]**.** In a predominantly female profession, high levels of maternity leave is an ongoing workforce challenge, compounded by a shortage of available nurses and midwives to cover temporary posts. Consequently, heavy reliance on bank and agency support to maintain safe staffing levels has resulted in spiralling costs that could be invested more productively to benefit the workforce. High vacancy and pressured environments have consequently led to climbing sickness absence rates in the nursing and midwifery professions, **figure 13**.

Figure 13 - Health & Social Care Staff by Occupational Family (% WTE), March 2018

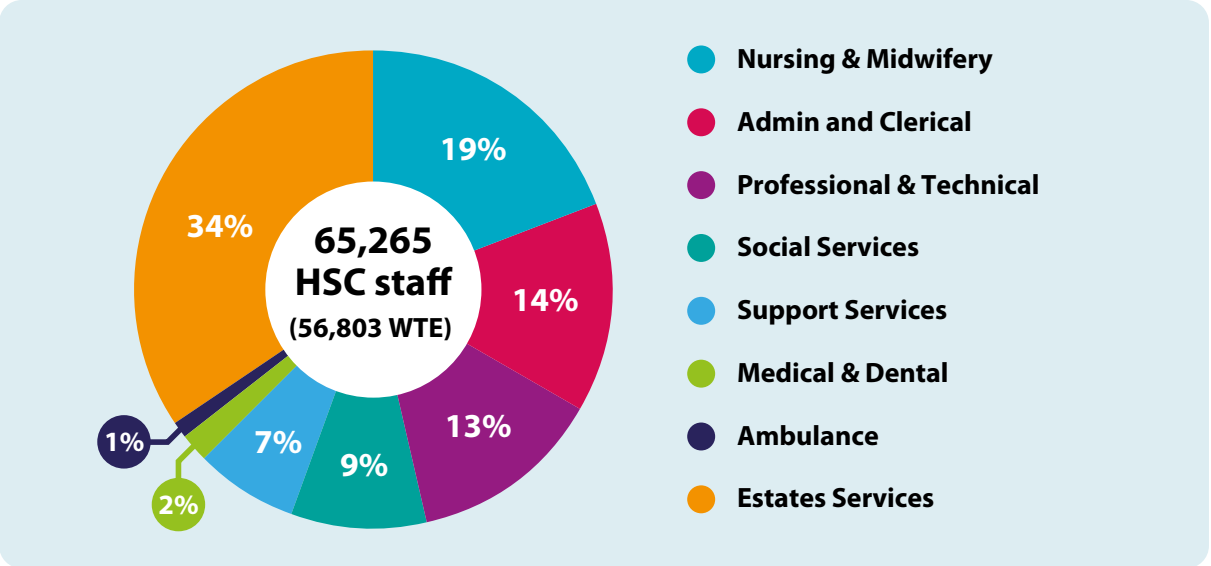
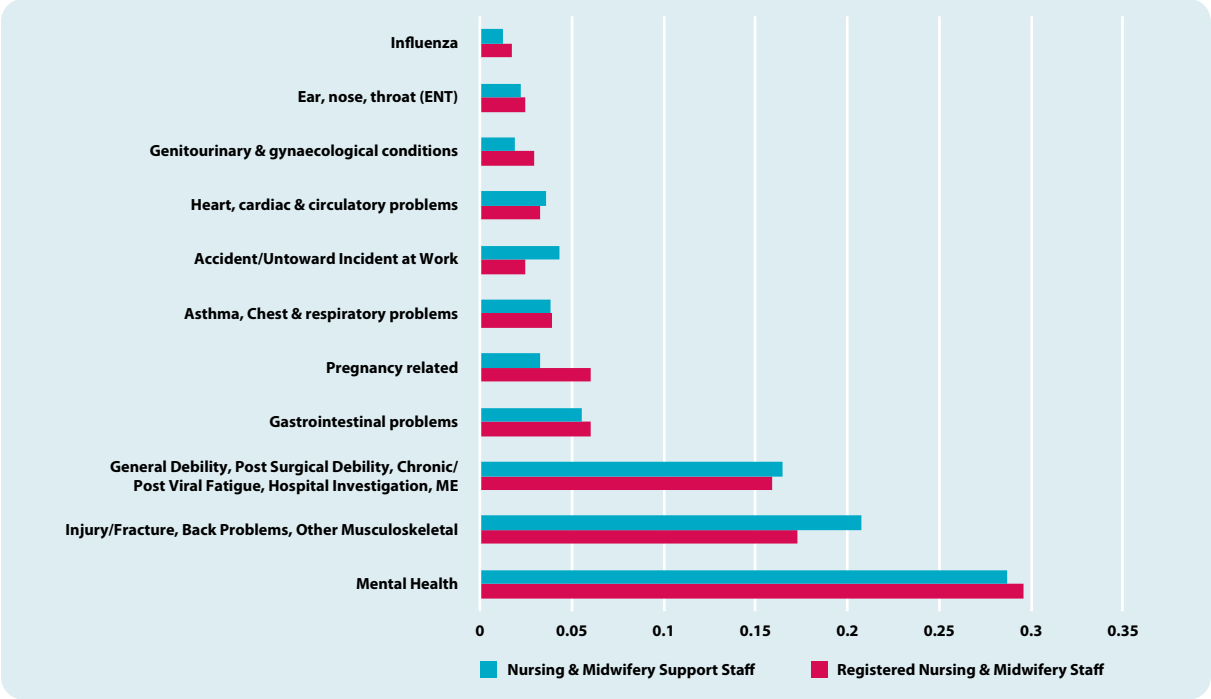


Figure 14 - Proportion of HSC Sickness Absence Hours Lost by Top 12 Absence Categories - 2018/19



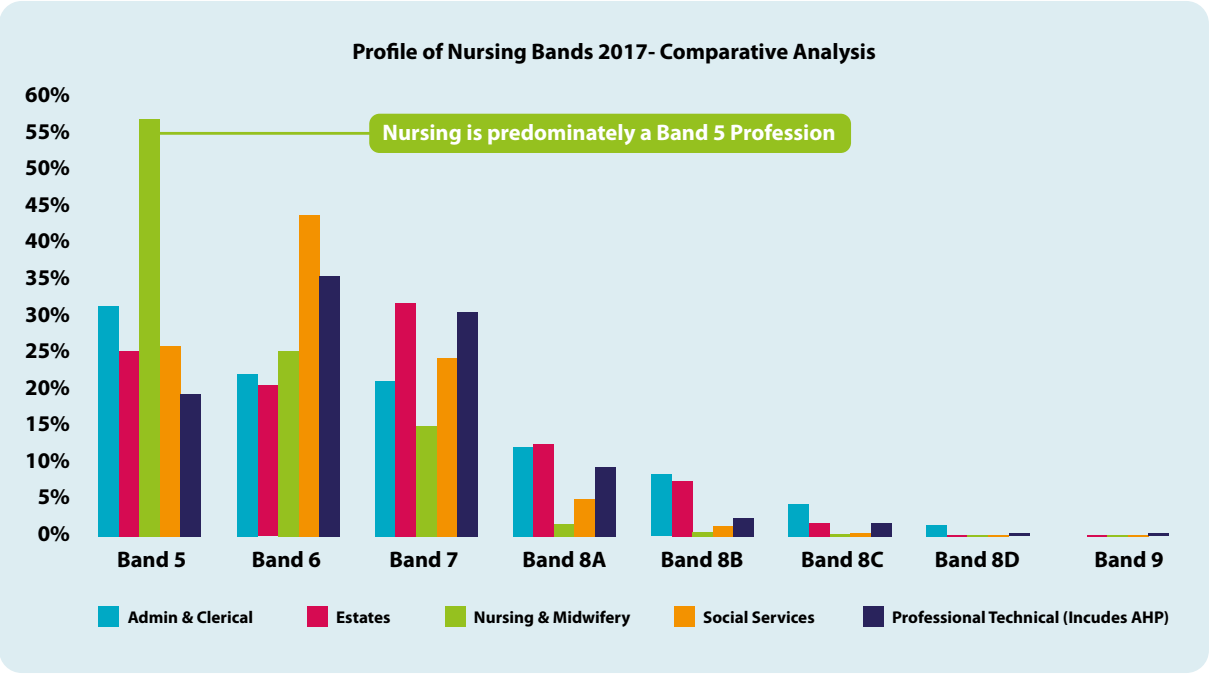
Between March 2016 and March 2017 the NMC reported a significant reduction in registrants[20]. The NMC surveyed those people who had left the register between June 2016 and May 2017. 4,544 former registrants responded citing working conditions as the top reason for leaving (44%). During the period 2008 to 2017 the nursing and midwifery workforce in NI increased by 7.8%. This has not kept pace with the increasing demand however, nor has it aligned with other professional groups.

Career Progression for Nurses and Midwives

The majority of health and social care professionals, with the exception of medicine, once graduated and registered with their regulatory body take up employment within the HSC enter the Agenda for Change (AfC) Pay Structure in Band 5 posts. Progression from the bottom of the pay band to the top of the pay band takes at least 7 years. HSC staff in NI have not received any pay uplift for 2017/2018. They are currently paid 1% less than National Health Service (NHS) staff in England and 2% less than Scotland. NHS staff in England have just accepted a pay deal that will see all staff at the top of each pay band receive a minimum of a 6.5% increase in pay over 3 years[21]. The pay structure is being simplified and the number of pay points are being reduced enabling staff to reach the top rate in each pay band sooner. NHS staff in Scotland are to receive 9% increase over three years and Wales are still in pay negotiations. The gap between NHS pay in NI and pay in the rest of UK is growing, making it difficult to recruit and retain an increasingly mobile workforce.

Furthermore, a higher percentage of roles carried out by registered nurses and midwives within the HSC are in lower pay bands than that of social services or professional technical. Over half of the qualified nursing workforce (56.8%) are in the lowest pay band (Band 5) and there are consistently lower percentages of registered nurse or midwife posts than social services or professional technical posts, across pay bands 6, 7, 8a. 8b, 8c and 8d as presented in **figure 15.** This pattern is also repeated in nursing and midwifery support posts across AfC Bands 1-4.

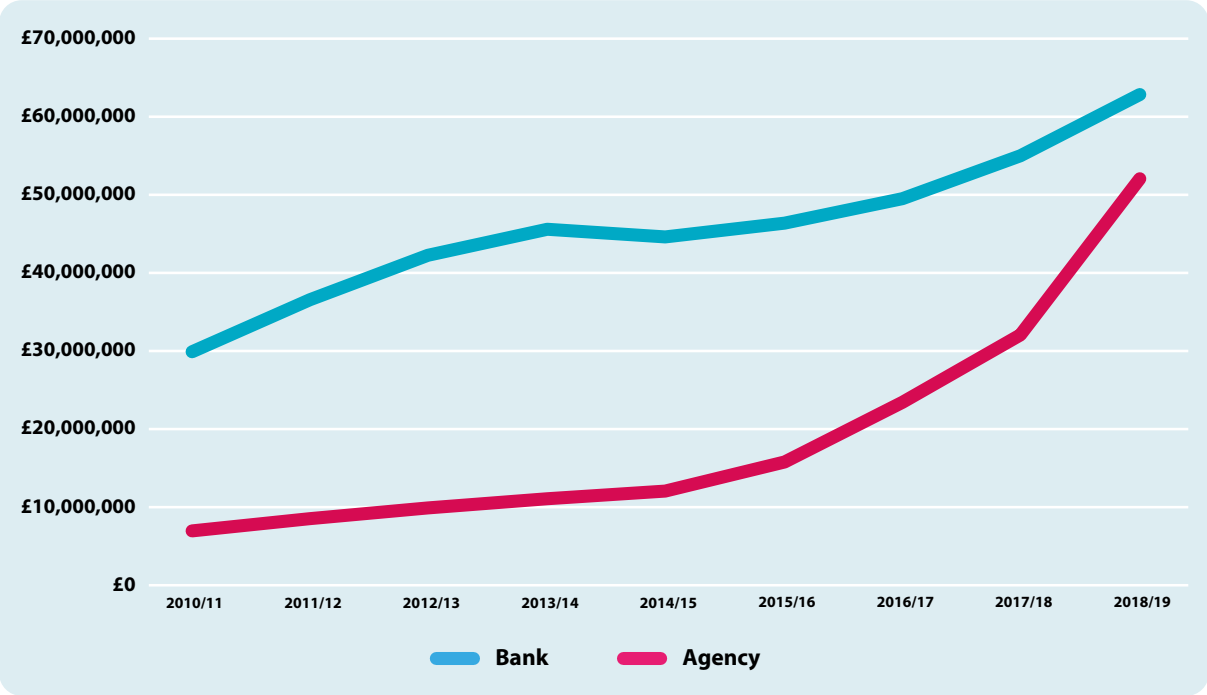
Figure 15 - Whole Time equivalent and % NI HSC Staff by Occupational Family & Pay Band 5-9 (March 17)



Impact on Nurses and Midwives

Within HSC organisations, the percentage of scheduled hours lost in the 2016/17 year due to sickness absence was around 6.6% and accounted for over £100 million[22] with mental ill health accounting for 30% of hours lost. HSC Staff surveys carried out in 2009[23], 2012[24] and 2015[25] report over 70% of nursing and midwifery staff working more than their contracted hours, with surveys consistently presenting increasing numbers of unpaid hours worked each week (59% working 1-5 hours, 13% 6-10 hours and 5% over 10 hours in 2015). The Royal College of Nursing (RCN)[26] reported that in 2017, shifts with one or more bank or agency nurse working was highest in NI cited at 50% compared with 45% in England, 40% in Wales and 38% in Scotland. A significant number of nursing staff respondents from NI (56%), also reported that they were unable to take sufficient breaks. **Figure 16** demonstrates a comparison between rising bank and agency costs across the nursing and midwifery workforce.

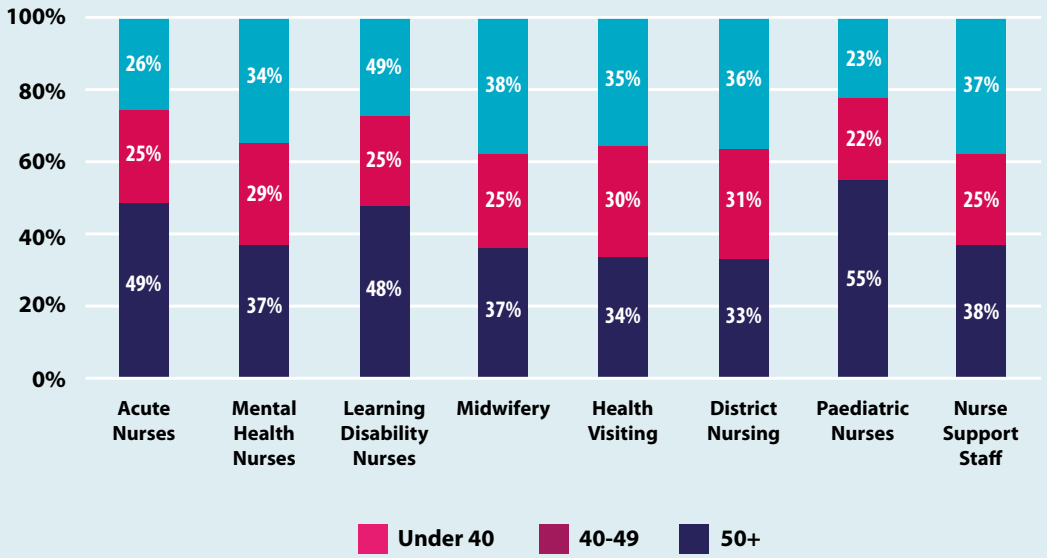
Figure 16 - Expenditure on Nursing & Midwifery bank and agency staff



In Source for **figure 16:** HRPTS. Figures exclude bank staff and staff on career breaks. 2010/2011 the HSC spent a total of £9,852,129 funding agency shifts across the service in NI. This has risen over the last 9 years to £51M in 2018/2019. Bank costs have also doubled from £30M in 2010/11 to £61M 2018/19. Clearly this is very concerning not only in cost terms but also its impact on the stability of the workforce.

The RCN reports that (across the 4 countries) that 65% of nursing staff are working on average almost one hour extra, of which 93% were not paid for. For nursing staff working outside the NHS across the UK this figure was 76%. This was highest in NI where 69% of respondents reported working additional unpaid time.

Figure 17 - Nursing and Midwifery Staff by Age Group (5 Head count) March 2018 Census



Furthermore as set out in **figure 17** over 32% of the Nursing and Midwifery workforce are over the age of 50, clearly this has significant implications for workforce planning and reinforces the need to raise the number of undergraduate places over the next five years to not only address current vacancies, but also to address potential retirements. There is therefore a need to develop a dynamic workforce model, which factors in need, demand, complexity, work-pattern flexibility, safe staffing, new ways of working, and staff leavers, in order to predict the number of nurses and midwifes in the next 5-10 years.

In summary, this paints a picture of a registered workforce under pressure and presents a compelling case for change in order to maximise the contribution of nursing and midwifery to improve the health of the population of NI.

Nursing and Midwifery in the Wider Context

Nurses and midwives are central to care and service provision for people with actual or potential health and social care problems across a range settings. As set out in **figure 17** nursing and midwifery has a long tradition of being an outward looking profession. Nurses and midwives have always proactively worked with other professionals (Doctors, Social Workers, AHPs) to deliver an integrated experience of care and improved outcomes. Within the context of *Health and Wellbeing 2026: Delivering Together* integrated working between professionals and across professional boundaries is an essential requirement for the transformation and the delivery of safe effective care.

As all professions examine, reform and transform their practice models, it is crucial as outlined in the Workforce Strategy that multi-professional and interdisciplinary practice adapts in response to our population needs. Whilst this means each profession must understand and respect the unique contribution of each other. It also creates opportunities to work together to develop new ways of working, for knowledge sharing and for the blending of skills (integrative practice models) across services and professions. Over the course of the next ten years nurses and midwives will play both core and enhanced roles in public health, primary care, acute, community and specialist care service. Therefore within the context of the HSC Collective Leadership Strategy (2017), nurses and midwives will take collective ownership for population health outcomes and in so doing will ensure that their distinct knowledge and skills complement the roles of other professions.

Promoting social justice is one of the foundational values of nursing and midwifery. Nurses and midwives are committed, therefore, at an individual, family and community level to work with others to address the health and social inequalities to improve outcomes among different population groups. This requires nurses and midwives to share responsibility for safeguarding, advocating and promoting the human rights for vulnerable people. Through strengthening community development approaches within nursing and midwifery, this will not only augment community planning approaches, but will create real opportunities for the development of assets, people and community based approaches to

health and social care reform. In so doing nurses and midwives make a positive partnership based contribution to creating the conditions for:-

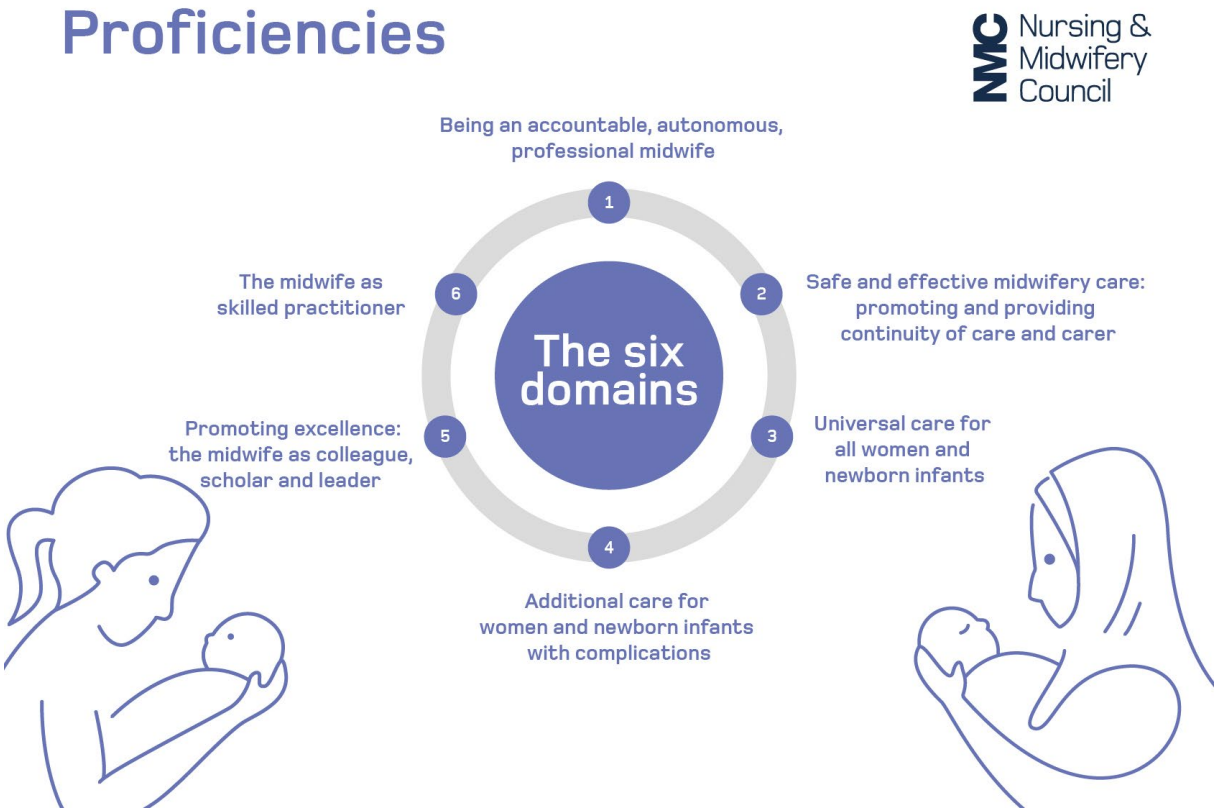
- a more equal society (PfG Outcome 3)
- people to *lead long, healthy and active lives* (PfG Outcome)
- a collaborative approach across sectors where we care for others and we help those in need (Progamme for Government Outcome 8)
- the delivery of high quality public services (PfG Outcome 11)
- Our children and young people the best start in life. (PfG Outcome 14)

Midwifery vignettes

In 2018 Lagan Valley Midwifery Led Unit (MLU) was named 'Best Maternity Unit' at the NI Positive Birth Conference. This is a Free Standing Midwife Led Unit (FMU) which promotes a positive childbirth philosophy and a calm and relaxing atmosphere. The midwives provide a fully integrated service caring for women in pregnancy, birth and beyond and the team is well established in the local community. In the previous year 92% of women who attended Lagan Valley MLU had a normal birth, 37% of these births were in water. The transfer rate to local Obstetric Units is 13%, subsequently 87% of women who start their labours in Lagan Valley MLU give birth there without the need for transfer. This reflects findings from the Birthplace UK study (2011).

The Belfast HSC Trust appointed a Specialist Midwife for Social Complexity and Perinatal Mental Health to increase the level of support and improve the coordination of care across the maternity and neonatal service. The role provides support to vulnerable mothers in pregnancy improving antenatal care services for these women, signposting and referring to appropriate agencies and services in order to enhance health, wellbeing and parenting preparation. This can reduce the associated risks including, the incidence of growth restricted babies; neonatal unit admissions due to drug/alcohol withdrawal symptoms; feeding problems; the associated increased incidence of intrauterine death and Sudden Infant Deaths amongst this group; adverse emotional behavioural and development outcomes associated with disturbed bonding processes with a vulnerable mother.

Future midwives in Northern Ireland will be educated to achieve the proficiencies illustrated below



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6

SHAPING THE FUTURE

SECTION 6: SHAPING THE FUTURE

Throughout the engagement process, a large amount of rich information was gathered from the perspective of nurses, midwives and support staff working at different levels from a wide range of sectors. Review of this information has generated nine themes that are presented in **figure 18**, below. This section will describe each theme and sub-themes within, highlighting the key messages and ideas articulated by workshop participants. The data gathered within the nine themes in a common structure are:

- ***Where We Are Now*** – providing a summary of strategic context and direction for the theme
- ***What We Heard*** – providing summary detail of the messages from staff and stakeholders who attended the workshops
- ***Where We Need to Be*** – providing a summary of the vision for the theme articulated by staff and stakeholders who attended the workshops

Each theme concludes with a summary of key messages that have informed the development of the recommendations for the Minister for Health, presented in Section 7.

Figure 18: Nine Themes from Engagement Events

Championing Person-centredness

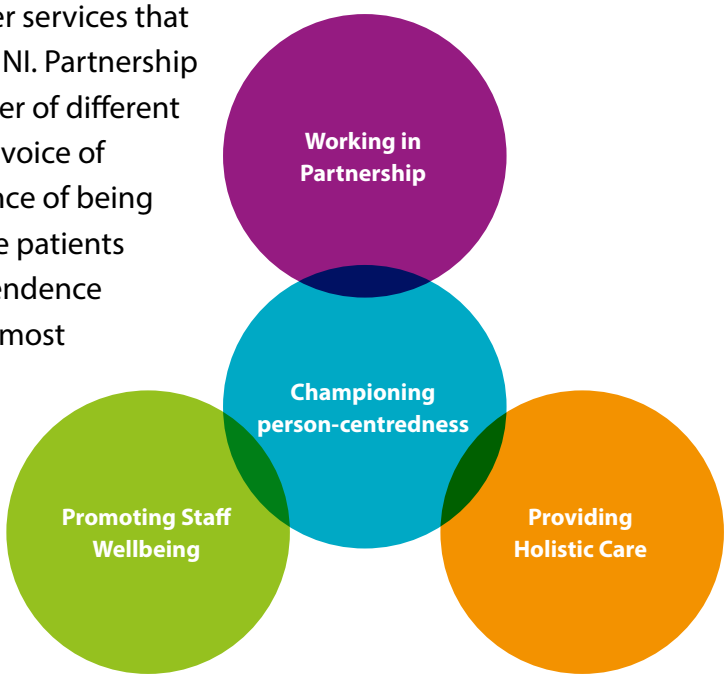
Create and promote a culture of appreciation in all directions.

Where we are now

The challenges in delivering quality care in practice, however, continue to be well recognised, and this debate has been fuelled by high profile inquiries and reviews suggesting that the experience of care is variable and often fails to meet the expected standard[27]. This has led to a commitment within the professions to reaffirm the importance of the fundamentals of care, emphasised in publications over the past 10 years[28], all of which highlight the challenges for nurses and midwives in providing sensitive and dignified care. There has, however, been consistent effort across the healthcare system within NI to develop person-centered practice in the nursing and midwifery professions, with a focus required for wider application and sustainability over time. This has been reflected in previous and current regional nursing and midwifery strategies and is now the clear policy direction as laid out in *Health and Wellbeing 2026: Delivering Together*.

What we heard

A consistent thread across many of the engagement events reflected person-centred care and its component parts. There was a strong emphasis on the desire to ***provide holistic care***, refocusing on the fundamentals of nursing and midwifery practice. This was in recognition of a perceived increasing shift towards a task orientated approach to care delivery that was being driven by workforce issues and demands to deliver services within highly pressurised environments. Closely aligned to this was a commitment to ***working in partnership*** to develop and deliver services that meet the needs of the population of NI. Partnership working was discussed from a number of different perspectives including: securing the voice of service users based on their experience of being in the system; and working alongside patients and their families to promote independence and develop pathways that ensured most appropriate place of care. Whilst effective partnerships within the multidisciplinary team to facilitate working across boundaries was referred to in the data, this was less evident in the context of delivering person-centred care.



There was also a focus on ***promoting staff well-being*** and creating workplace cultures that enabled people to flourish, which is an important aspect of person-centred practice.

Where we need to be

In NI we want nursing and midwifery to lead the way in creating the conditions that enable the development of person-centred cultures that will deliver on positive outcomes. In order to achieve this, there needs to be a shared understanding across the professions of person-centredness in its broadest sense and development of strategies that enable this to be operationalised across services and settings. The new Guide for Co-production in NI[29], will provide an impetus to move forward particularly working in partnership with the population of NI to achieve the best health and wellbeing outcomes.

Midwives have a long history of working in partnership with women, enabling their views and preferences and helping to strengthen their capabilities. Their focus on women centred care has long been central to the provision of safe, respectful, nurturing, empowering and equitable care, irrespective of social context and setting. Further development of midwife led models of care will continue to ensure that midwives are in a position to advocate for women within a complex system, coordinating care.

The benefits of championing person-centeredness for the nursing and midwifery workforce reach beyond impact to patients, clients and families. Emerging evidence indicates positive outcomes for staff well-being through proxy measures such as improved staff recruitment and retention. Furthermore, these outcomes are aligned to the quadruple aim with a particular focus on improving the quality and experience of care, supporting and empowering staff. Nurses and midwives are well placed to lead the development and implementation of approaches underpinned by co-production that will ensure a positive patient experience.

Key Messages:

- **A desire to refocus on the fundamentals of practice that enable a positive care experience for patients, families and staff**
- **The need to develop effective strategies that will deliver person-centred outcomes**
- **Co-production should be integral to working in partnership with people, families communities and within and across teams and services**

Providing Visible Leadership At All Levels

Where are we now

For some years, there has not been, a systematic or sustained approach to leadership and management training across the nursing and midwifery family in NI. The reality is that many staff stepping into their first leadership roles have not received any formal development or training.

Whilst the vast majority of HSC bodies have Executive Directors of Nursing, the scope of their strategic and operational responsibilities varies across the region. Inevitably this variation is reflected in the levels supporting the Executive Director of Nursing role, resulting in operational decisions about nursing being taken by other disciplines or professions. This includes decisions about adding or removing nursing and midwifery posts.

There are programmes currently focused on leadership development for Ward Sisters, Charge Nurses and Team Leaders and ad-hoc training in generic leadership programmes. From this positive starting position there are many opportunities to develop and grow leaders at levels through alternative approaches such as mentoring and coaching.

What we heard

Visible leadership was highlighted as essential to the delivery of safe and effective care. It is within this context that nurses and midwives stated they want to be 'well led' and 'empowered' by their leaders to influence the design and delivery of services. There was a strong sense that nurses and midwives had become increasingly 'micromanaged' and therefore nurses want existing leadership to create the conditions so that they can have more autonomy to act. Those attending the workshops were clear that they wanted this leadership to be more 'visible' and to 'take time' to appreciate and understand the realties for staff who were delivering direct care in clinical environments. The need for ***courageous leaders*** who would be ambassadors for the professions to challenge and remove the barriers to change was viewed as the enabler for nurses and midwives to do the 'job they trained to do'.

There was a sense that staff were often 'dropped' into senior roles without the necessary leadership training or support. Staff experience was often reliant on the leadership style and abilities of the person or people line managing their teams. Inevitably this led to variation in staff experience and the ability of team members to ***live out person-centred values***. As a result of decades of a general management approach to service delivery, staff perception was that nursing and midwifery leadership roles had become increasingly advisory with the consequences that a number of senior operational nursing leadership posts had been progressively disappearing. This was cited as having had a negative impact on the leadership capacity of the professions and the need to ***develop leadership skills for the future***.

Where do we need to be?

Within the context of the Collective Leadership Strategy[30] nurses and midwives are ready to be equal partners in policy, strategy, operational and professional leadership. Crucially within the collective leadership model, it will be important that the expertise of the nursing and midwifery professions is nurtured to ensure nurses and midwives are appropriately represented at all levels. Furthermore, it is imperative to ensure nurses and midwives at all levels are professionally led by senior nurse and midwife leaders, including staff working in social care and arm's length bodies. Furthermore, over the next decade the professions will be at the cutting edge of transformation, requiring nursing and midwifery to be equipped as current and future leaders from the front line to the boardroom, to maximise their contribution in improving peoples' experience of health and social care and the health and wellbeing of the population.

Key Messages:

- **Lack of a sustained approach to leadership development within nursing and midwifery**
- **Variation in HSC structures has resulted in other professions making operational decisions about nursing and midwifery care and resources.**
- **Nurses and midwives need to be equipped to lead the transformation of future services to enhance the health and well-being of the population.**

Improving Public Health

Public Health isn't just about children - our older population deserve support and help

Where we are now

Many of the previous reforms in health and social care have placed greater emphasis on development of services which impact on the present rather than investing in the future. Nurses and midwives have not yet had the capacity to influence more widely as the skills of population health assessment are not always recognised or valued by the professions and others[31]. Furthermore, the pressure and demands of work do little to promote good health and wellbeing in nurses and midwives. Improvements in this area are inextricably linked to capacity and support, along with remuneration and a stable workforce. *Health and Wellbeing 2026: Delivering Together* redresses that balance with a clear aim of investing in the future and in improving the health and wellbeing of the population.

Currently, the significant emphasis for public health nursing is on children and health visiting, with little or no recognition or investment in the role of public health nurses more widely across the life course.

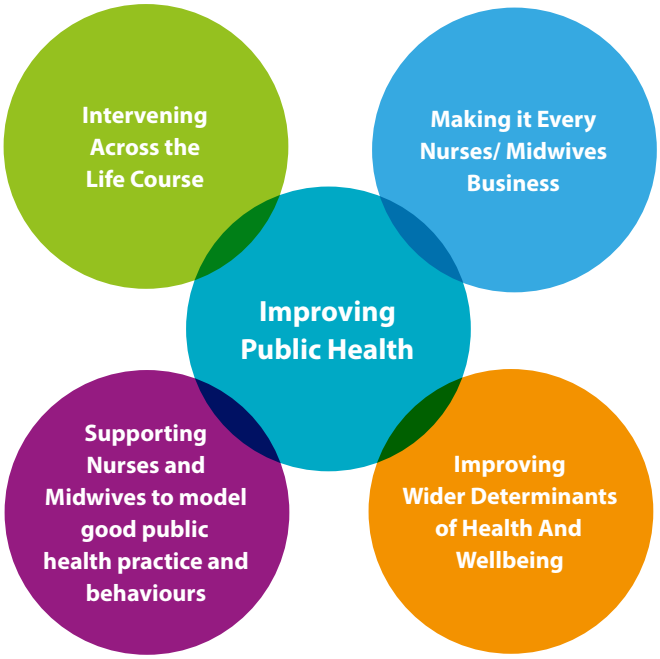
What nursing and midwifery brings to the future is a steadfast commitment to improving the health and wellbeing of individuals and communities at all ages and in all places. In response to increasing demands on nursing and midwifery services the focus on public health being everyone's business has weakened over the last decade, although the new NMC FNFM standards (2018 & 2019) emphasise public health. Whilst there are some small targeted public health nursing/midwifery initiatives in marginalised groups such as: MECC, Early Intervention Transformation Programme (EITP), and Family Nurse Partnerships and are starting to redress the balance in some small and focused areas of practice but they are not consistent across NI[32]. It is within this context that the pace of public health and population health nursing needs to be stepped up and maximised across the life course.

Recognise and promote the impact of every nurse / midwife from pre conception to older age and event moment between

We need to live the values we espouse and at times we will need help to do that

Who can make a difference to individual and population health through the social determinants of health

What we heard



Pregnancy and early years have a decisive impact on the health and well-being of mothers, children and families. The midwife has a vital part to play not only in helping to ensure the health of mother and baby, but in their future health and well-being and that of society as a whole. Pregnancy and early life lay the foundations for our individual health, well-being, cognitive development and emotional security – not just in childhood but also in adult life. What happens to children before they are born and in their early years profoundly affects their future health and well-being.

Midwives are crucial members of the public health workforce, well placed to help every child make the best start in life. Their health promotion and health protection activities improve maternity outcomes and long term health gains by addressing individual and social health determinants such as breastfeeding, smoking, drinking and their social and behavioural origins. The public health approach includes a commitment to the promotion of positive parenting and an acknowledgement of the importance of the parent's emotional well-being.

The promotion of health and wellbeing as ***every nurses' and midwives' business*** was a key message. It was recognised that the focus of public health and wellbeing practice early intervention; prevention and health promotion, promoting social inclusion and reducing inequalities in health and wellbeing. If nurses and midwives were to have the capacity and skills to maximise every contact they have with individuals and communities the impact on health and wellbeing could be significant. Furthermore, feedback reinforced that the influence of nurses and midwives to improve public health must be ***across the life course*** and in all places, including the young, those at working age and adults who are older, where we grow, where we work and where we live. Nurses and midwives recognised that they should ***model good public health practice and behaviours*** in maintaining their own health and wellbeing and promote a positive coaching approach. The data also reinforced the positioning of nurses and midwives as integral to where people work and live and as such can impact on every aspect of life. This is strengthened by the respect nurses and midwives are held in, yet they are often not afforded the time and capacity to influence beyond health and social care. There was a strongly held view that the relationship with communities has been lost in the pressure of service delivery reducing the ability of nurses and midwives to ***improve the wider determinants of health and wellbeing.***

Where do we need to be?

There is a significant role for the professions to impact on the health of the population. The main focus should be to facilitate the capability of nurses and midwives to avail of every opportunity to impact on individual and population health and wellbeing. The value and contribution of nurses and midwives to improving the health and wellbeing of the population of NI must therefore be supported and recognised. This will enable NI to rapidly move to the vision in *Health and Wellbeing 2026: Delivering Together* and nurses and midwives will be better prepared and supported to play their role in improving public health. Nurses and midwives should be facilitated to make the fullest contribution to public health across the life course and in all places working with other partners, such as local councils to improve the life changes for all.

To achieve this aim, the professions need to be appropriately prepared for their role in improving the health and wellbeing of the public at all levels within a public health career pathway. This will require roles for nurses and midwives that enable them to lead on population health approaches across the life span, including population health needs analysis, health and wellbeing improvement, health protection and providing public health practice within and across the system. One very important aspect of this vision is the need to support nurses and midwives to live the values of public health in both their professional and personal lives.

Key Messages:

- **Promoting health and wellbeing for the population of Northern Ireland should be every nurse and midwives' business**
- **Public health approaches should be normalised into nursing and midwifery practice to impact on all ages across settings and communities**
- **The need to develop population health management knowledge and skills to maximise the contribution of nursing and midwifery to health and wellbeing**

Staffing For Safe And Effective Care

Where we are now

It is timely and significant that the recent publication of the Health and Social Care Workforce Strategy by the DoH, takes a very detailed look at the workforce challenges facing health and social care in NI. The strategy sets out ambitious goals for a workforce that will match the requirements of a transformed system and which addresses the need to tackle the serious challenges with supply, recruitment and retention of staff. One of the key actions is to develop and sustainably fund an optimal workforce model for reconfigured health and social care services by 2026.

The implementation and progression of the Department's policy framework, *Delivering Care: Nurse Staffing in NI*, has served to highlight a stark disparity between actual staffing levels across a range of specialities and those staffing models identified for optimum delivery of safe and effective care.

The DoH has increased investment in pre-registration commissioning since 2016, following a five year downturn in training places between 2010-2015. In 2018/19 a further significant investment, supported by transformation funding, has financed a total of 1000 pre-registration places, which is at an all-time high.

International nurse recruitment is a current strategic short term measure to strengthen the existing workforce. A regional international campaign commenced in 2016 and is on track to deliver 622 nurses into NI by March 2020. Recruitment has yielded greater success in non-EU countries than in EU countries. The impact of the United Kingdom leaving the European Union in 2019, brings a further uncertain dimension to the current workforce challenges that could potentially exert a destabilising influence on the nursing and midwifery workforce, particularly on those workplaces in close proximity to the Republic of Ireland.

Evidence exists of enhancing contribution through role development, as nurses and midwives endeavour to embrace change and adapt their practice to meet service needs and demands. One such example is the development of ANP roles, the value of which is strategically endorsed in *Health and Wellbeing 2026: Delivering Together* and is gaining increasing recognition across primary and secondary care settings.

Within the unregistered nursing and midwifery workforce, roles have developed to provide additional support to the registered workforce, operating within the context of the delegation framework. In recognition of the valued contribution of this cohort of staff, the DoH, in 2018 mandated a suite of regional resources specifically to support nursing assistants and senior nursing assistants, including Standards and an Induction and Development Pathway.

What we heard

The urgent need to ***increase the numbers of registered nurses and midwives*** was a consistently strong and unanimous message. The presenting data painted a concerning picture of a pressurised, under resourced workforce, curtailing the capacity and capability of the nursing and midwifery professions to effectively deliver person-centred, safe and effective care. There was widespread recognition that sufficient resourcing of the workforce was a critical enabling success factor for safe staffing and improving outcomes for all. Increasing investment in pre-registration nursing and midwifery training was viewed as a key pivotal priority, for effective workforce planning in addressing the current workforce deficit.

It was clear from the evidence gathered that the ***providing support and reducing bureaucracy*** was highly valued and inextricably linked to the wellbeing and resilience of the nursing and midwifery workforce. Increased bureaucracy was cited as a significant barrier to enabling efficient functioning of the nursing and midwifery workforce, with frustrations expressed around data collection requirements, HRPTS and cumbersome electronic HR processes, which impede timely recruitment into vacant posts. Support was viewed as crucial for nurses and midwives in managerial and leadership roles, particularly with regard to recruitment processes, and managing sickness absence and also clinical support for newly registered staff.

There was a real desire and enthusiasm expressed to ***enhance nursing and midwifery contribution through the development of new roles*** within the professions. Opportunities to access, develop and resource new and innovative roles was viewed as essential for the preparedness of the future workforce, for example, the development of advanced nurse practitioner roles.

Furthermore, the value placed on the contribution of the non-registered workforce was also highlighted and viewed by registrants as a vitally important area for development, to maximise the impact of this group of staff, in supporting the delivery of safe and effective person-centred care.

Where do we need to be?

In order to achieve staffing for safe and effective care, we need to move to a desired position of having a sufficiently resourced and supported nursing and midwifery workforce in NI. This is crucial for maximising the contribution of the professions to deliver positive health and wellbeing outcomes for our population.

There is a lack of staff. We need to train more nurses and midwives to meet the demand

Reduce bureaucracy especially in recruitment to speed up the process as it is very cumbersome

We need to develop new and expanding roles in response to need and changes in nursing practice e.g. in Primary Care settings

Clinical support for newly qualified staff

A range of supportive measures is needed at all levels to enable the workforce to function effectively and focus on delivering high quality nursing and midwifery care. Supportive models should be developed for newly qualified registrants joining the workforce and also for experienced registrants in managerial and leadership roles, with HR and administrative support for recruitment processes, absence management and data collection requirements.

We need to promote, develop and sufficiently resource enhanced roles to optimise the nursing and midwifery contribution to population health, and ensure readiness of the professions to meet current and future challenges and demands.

Key Messages:

- **A fundamental and pressing priority is the need to address workforce shortages and to strengthening the capacity of the nursing and midwifery workforce to deliver safe and effective care.**
- **The workforce should be supported to function effectively by reducing unnecessary bureaucracy**
- **Enhancing the development of new roles should be nurtured and progressed to optimise the contribution made by the professions across the life course.**
- **There is a need to ensure safe staffing levels are mandatory and funded**

Educating For The Future

Where are we now

Education and lifelong learning is fundamental to supporting nurses and midwives to meet challenges now and into the future. An educated, competent and motivated nursing and midwifery workforce is crucial to support UHC as a key imperative for improvement[33].

From April 2016, revalidation is the process that all nurses and midwives in the UK follow to maintain their registration with the NMC which includes a requirement to undertake CPD. The process of revalidation is aligned to The Code[34] which outlines professional standards of practice to ensure the safeguarding and general well-being of people. As previously cited, NMC has radically overhauling pre-registration nursing and midwifery standards and implementing a new education framework for the delivery of nursing and midwifery education and training in the UK. The NMC next piece of work will be on reforming post-registration standards.

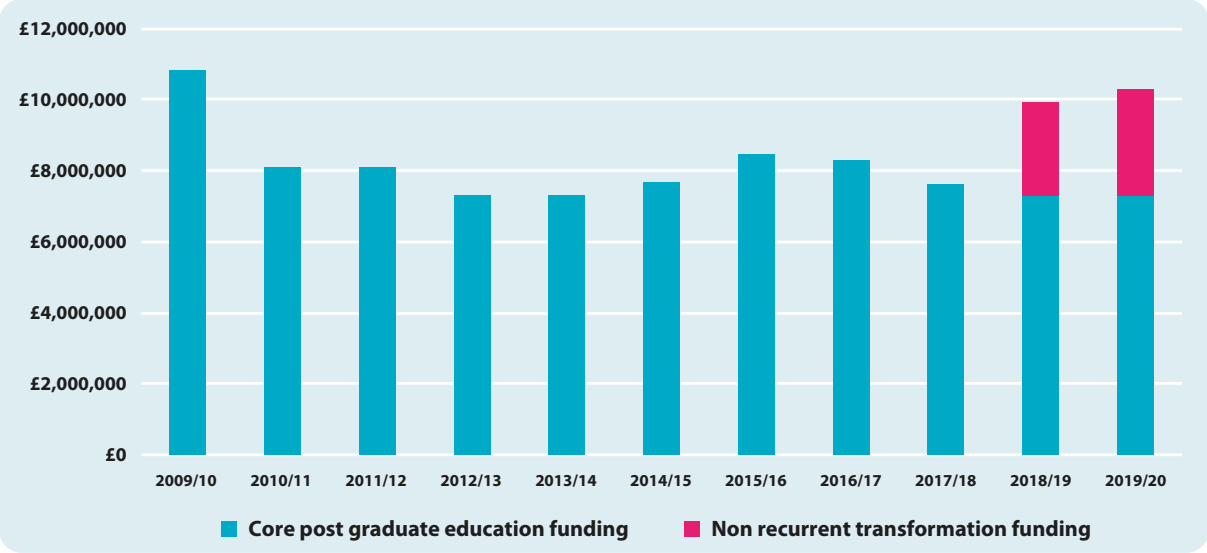
Within this context nurses continue to develop and expand their roles and responsibilities and exemplars of good practice are demonstrable across all settings in NI. Several programmes of work are already being taken forward at regional and national level to address a number of issues which have emerged regarding the current and future education of nurses and midwives. For example: development of Specialist midwife and Advance Nurse Practitioner (ANP) roles across a range of settings and consultant nurse and midwife roles. Much of this has been funded by redirecting resources from across the education budget and often resulted in deficits elsewhere. On occasions despite access to education there has also been lack of support for those wishing to pursue careers roles such as Clinical Academic Careers despite availability of PhD sponsorship.

Within the DoH, the CNO has responsibility for the post registration nursing and midwifery budget. On an annual basis a business case is developed to propose what is needed for the incoming year. This process is not sustainable as it is not possible to commission post registration programmes from universities and other education providers beyond the current annual and ad hoc basis. In terms of post-graduate education the report highlights that in order to both retain and develop our nurses and midwives there is a need to restore and incrementally grow postgraduate training budgets.

Over the last ten years **(figure 19)** the postgraduate education budget in nursing and midwifery has been progressively decreased from £10.8 million to £7.3 million. This reduction has been further compounded over this time period by an increase in post-graduate education costs and the increased costs associated with backfill for some of the training places. It is important to note however over the last two years these reductions have been

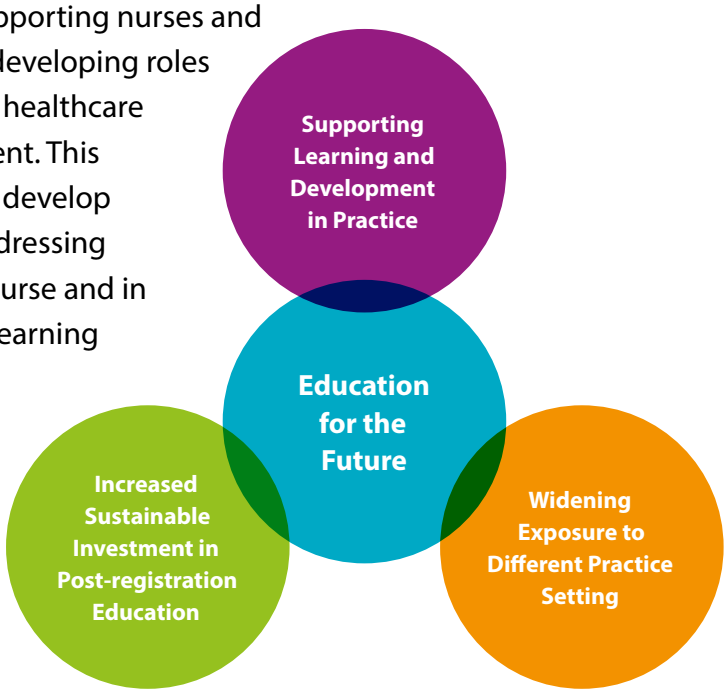
offset by non-recurrent transformation funding and an increase in both nurse and midwife student places. In the absence of sustained transformation funding and/or a restoration of recurrent funding commensurate with the size of nursing and midwifery workforce, this will have significant implications for nursing and midwifery practice career pathways and wider health and social care reform.

Figure 19 - Nursing & Midwifery Post Registration Education Investment Profile Source DOH



What we heard

Lifelong education and learning across a graduate workforce was highlighted as pivotal to maximising the potential for nurses and midwives to contribute to improving health and wellbeing of the population. Supporting nurses and midwives to take on innovative and developing roles was considered crucial for continued healthcare improvement and service development. This included the knowledge and skills to develop services outside hospital settings, addressing the needs of people across the life course and in particular those with comorbidities, learning disabilities, mental health needs and older people. Timely access to postgraduate education using blended learning approaches, where possible, delivered on a multi-professional flexible basis was identified as a fundamental driver for success.



Professional facilitation roles that support learning and development in practice such as preceptors, mentors and clinical educators, were viewed as enablers to learning and development in and outside of care environments. In particular, there was an expressed need to support new registrants in the immediate post qualifying period. Preceptors reported a feeling of being pressurised and found it difficult to spend time to focus on supporting newly qualified colleagues in the work place. Learning outside traditional boundaries through pre and post registration programmes within a multi-disciplinary context was considered a key component to ***widening exposure to difference practice settings***. Despite the current workforce challenges there was a real desire to ensure that the student nurse experiences in university and practice placements were positive and appropriate with a good level of support in a culture that encourages innovation and improvement.

A major concern was that qualified and experienced staff who were motivated to maintain and extend their skills and roles through Continuous Professional Development (CPD), were finding it difficult to access education. There was also widespread concern that postgraduate education was often inappropriate and inaccessible and that better outcomes could often be achieved through multidisciplinary training at a local level. There was a case made for ***increased and sustainable investment in post-registration education*** that would maximise the contribution of nurses and midwives into the future.

Where do we need to be?

The new proficiency standards for nursing and midwifery have been practice launched by the NMC. These standards are set to revolutionise and modernise nursing and midwifery practice, and they are strongly focused on delivering population health, and evidenced based interventions which will improve outcomes for people. The CNO has now established a Future Nurse Board to ensure NI becomes an exemplar of these standards. These standards will complement the direction of travel proposed in our report and indeed they have also been factored into the recommendations.

The recent Health and Social Care Committee, England, nursing workforce inquiry[35] has significant messages for all countries. It looked at the current and future scale of the shortfall of nursing staff and whether the Government and responsible bodies have effective plans to recruit, train and retain this vital workforce. The Committee heard a clear message that access to continuing professional development plays an important role in retention. Whilst it was noted that efforts are being made to retain staff, key recommendations included a reversal of cuts to nurses' CPD budgets; specific funding made available to support CPD for nurses working in the community; and access to continuing professional development needed to reflect skill shortages and patient needs. There is a need therefore, to ensure that the workforce is supported and developed to enable registrants and those contemplating a career in nursing or midwifery to lead service improvement and impact significantly on the delivery of person centred care.

Moving toward a future where nurses and midwives are at the forefront of service transformation requires a commitment to support the professions across their careers through progression and role expansion. There is a need to invest in post-registration education to ensure the right number nurses and midwives, with the right knowledge, skills and experience are working in the right place at the right time to improve the health and meet the needs of the population. Opportunities to undertake masters and doctoral programmes should be available, including the establishment of clinical academic careers. This should include establishing clinical academic posts for midwifery and each branch of nursing in all HSC organisations to strengthen the research and development capacity within nursing and midwifery teams. Cognisance should be taken of nurses working in lone roles, such as Practice Nurses. Furthermore there should be support for education in clinical practice available through a range of opportunities e.g. Clinical teaching, eLearning, Human Factors training, coupled with opportunities for Higher Education Institutions to plan for the development and delivery of programmes within a sustainable model which meets the emerging policy and strategy needs of the DoH.

Key Messages:

- **Continuous professional education and development is vital for safe effective practice and career development**
- **Within the current context and due to workforce constraints nurses and midwives are finding it increasingly difficult to access educational opportunities**
- **A sustainable funding and workforce model is required to support post-registration education to deliver on the transformational agenda**
- **Professional facilitation roles should be further enhanced to enable learning and development in a range of care environments.**

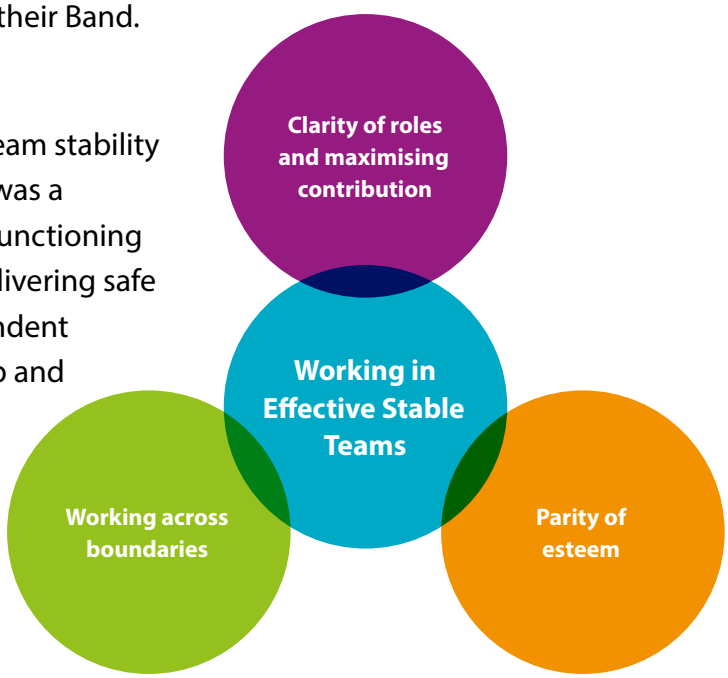
Working In Effective Stable Teams

Where we are now

Nurses and midwives are working across care settings in pressured environments which affects the stability of their teams. It is clear that working in teams that are short staffed has a negative impact on the professions, affecting their own safety and wellbeing, as well as eroding pride in their roles. Nurses and midwives serve as an around the clock surveillance system for early detection and prompt intervention when people's conditions deteriorate both in community practice and within hospitals. That surveillance system must be adequately resourced and communication systems must be excellent to ensure delivery of safe and effective care by stable teams. The context presented in section 5, reflects workforce trends including vacancy rates, recruitment and retention, and subsequent use of bank and agency staff that significantly challenge the establishment of effective teams.

NI has much fewer opportunities for nurses and midwives above pay Band 5 than the rest of the United Kingdom. This lack of opportunity frustrates the professions in NI, as they feel there is very little opportunity for career progression, with no reward for midwives and those nurses who are working at the top of their Band.

What we heard



The need to strengthen and sustain team stability across all environments and settings was a resounding message. Effective team functioning was viewed as a crucial enabler to delivering safe and effective care with stability dependent on adequate staffing, good leadership and effective communication. Issues raised around this theme included the importance of regular team meetings, supervision and support, shift patterns and recruitment and retention. The reasons provided for this challenge were: frequent use of agency staff; delayed replacement of staff exiting the organisation; and a lack of opportunity for meaningful staff meetings. Staff identified that crisis management was the norm, where moving staff to areas under even more pressure was common practice. The reality was that nursing and midwifery staff were 'acting down' to plug gaps brought on by deficiencies in administrative support.

There was a need for ***clarity of roles that maximised the contribution*** of nursing and midwifery. Evidence was provided that nurses were expected to pick up on tasks and duties previously performed by other members of the multidisciplinary team. Staff also identified the lack of opportunity to experience different roles and regularly enquired about an internal transfer system for employees already in the HSC system enabling them to ***work across boundaries*** whilst avoiding a full application and recruitment process.

Nurses and midwives used the example of the advancement across AfC pay scales for other professions as an indicator of lack of ***parity of esteem***. This often played out in the effective functioning of teams; for example, AfC Band 5 nurses provided an example of mentoring new social workers who automatically progress to Band 6 pay scale after one year, whilst an experienced nurse remains at Band 5. This was counter-intuitive to an agenda that releases the potential of nurses and midwives and maximises their contribution within the system.

Where do we need to be?

Improving teamwork competency across nursing and midwifery could have enormous financial and quality care implications across the health and social care sector as a whole. Improving teamwork competency saves lives[36] and is marked as an international priority in discussions about restructuring nursing care provision[37]. Furthermore, in hospitals where nursing teamwork is rated as strong they report less missed patient care (Kalisch, Lee & Rochman 2010), fewer patient falls (Kalisch et al. 2007) and higher quality of work life impacting staff recruitment and retention (Brunetto et al. 2013)[38]. A direct correlation between teamwork, adequate staffing levels and job satisfaction has been evidenced[39]. Familiarity with team members, stability of the team, a shared common purpose among team members, as well as the right physical working environment that is conducive to staff engagement are all thought to characterise high performance teams.

The Department has invested in developing new roles in Advanced Nurse Practitioner (ANP) and it will be vital that employers ensure jobs are developed to match the skills of these very highly trained practitioners. In addition there needs to be encouragement and incentives for nurses to work at the top of their scope of practice. Nurses are the members of the inter-professional team which is available to the patient/client 7 days a week and 24 hours per day, so it makes sense to incentivise them to up-skill and work at the very top of their scope of practice. There is also a need for nurses especially out of hospital to operate in virtual, flexible and multiple teams, working across teams and agencies is a critical leadership skill.

Key Messages:

- **Workforce trends such as vacancy rate, use of bank and agency, and sickness absence rates are impacting on the establishment of effective stable teams**
- **There is a clear link between teamwork competency and the provision of safe and effective care**
- **There is a need to maximise the contribution of nurses and midwives within teams by incentivising them to work at the top of their scope of practice through appropriate career progression**

Maximising Digital Transformation

Where we are now

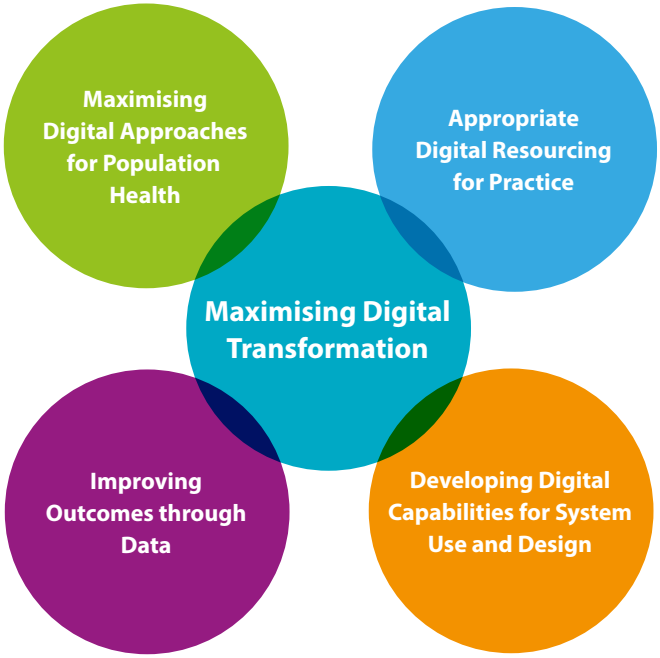
Technology systems in NI, with the notable exceptions of the Northern Ireland Electronic Care Record (NIECR) and the primary care system used by General Practitioners, are in the main unable to communicate with other technological systems between and across organisations. People in NI do not have electronic access to their health records; health records are mainly in paper format; innovation is slow to mainstream in practice and data requires more standardisation and structure. Where electronic records are operating, they tend to be in a form filing format, where there is limited ability to interrogate, report on or use the vast amount of information that nurses and midwives input to these systems every day.

> ***Encourage the role of technology to keep [those with mental health issues] connected with family and other members of the community e.g. WhatsApp***

Access to the internet and therefore infrastructure to support digital technologies can be difficult in some geographical localities of NI, particularly in rural areas. The abilities and skills to engage with, direct, develop and use digital technologies and data are not currently included in nursing and midwifery programmes across NI, neither at undergraduate or post-graduate levels.

Nurses and midwives often express the fact that they are not equipped with the necessary up-to-date hardware or software to do their jobs efficiently. They also often debate the utility of some of the systems currently deployed in NI citing that they are not intuitive to use, lack user-friendly interfaces (known as Application Programme Interfaces or APIs) and can be time consuming to complete, removing them from the opportunity to spend more time engaging with patients, women and their families.

This mirrors a recent UK-wide survey undertaken by the RCN, published in 2018[40] relating to the progress towards digital readiness for nursing to use health technologies in every day practice. This survey, whilst limited in the number that responded and therefore representative sampling, demonstrated messages about what nurses wanted in relation to technologies. Those nurses that responded sent a clear message that they wished to engage more in the development of health technologies, that current systems were not fit for purpose and that organisations needed to get the basics right in terms of provision of hardware and software to the registrant workforce, enabling them to do their job well.



What we heard

Necessary steps were identified by nurses and midwives for future digital maturity for health and social care services in NI. There was a repeated focus on ***appropriate digital resources to support practice*** through hardware and digital infrastructure for mobile and remote working across organisations. The ***development of digital capabilities for system use and design*** across all levels of the professions was also a strong theme that linked to ***understanding data*** from technological systems for the purposes of practice and ***outcome improvement***. From a future facing perspective, there was a clear message that systems design and opportunities to use technology to ***maximise digital approaches to population health*** should have nurses and midwives at the forefront, driving innovation. This included the use of digital approaches to support self-management of chronic conditions for the population of NI, both technologies currently available and those yet to be developed.

Where do we need to be?

NI has a strategy underpinning eHealth and technology[41] with a focus on developing both technologies to assist the public, health and social care service providers, and staff to use them. Real-time engagement about care and services with the public of NI through patient portals fostering the spirit of coproduction, a clear message from *Health and Wellbeing 2026: Delivering Together*; capture of data through remote monitoring systems; capture of data by the public themselves through fitness tracking equipment and health apps, could provide vital information about the health of our population and future opportunities to promote health and wellbeing. Nurses and midwives need to be appropriately equipped to track this data, understand utility for improvement and trend for bigger messages relating to population health and the impact of nursing interventions on health outcomes. In addition, a single system that communicates seamlessly across all sectors in NI is the ambition, through the Encompass programme of work currently being taken forward. Nurses and midwives understanding how to use this system and maximise the information flowing from it to improve outcomes for people should characterise the future.

Invest in technology infrastructure and training for nurses and midwives

The recent Wachter Review[42], commissioned to review and articulate the factors impacting the successful adoption of health information systems in care services in England, was tasked with providing a set of recommendations drawing on the key challenges, priorities and opportunities, messages resonating across all countries in the UK. In particular, there was a focus on the importance of developing digital leaders and clinician informaticians across organisations with appropriate resources and authority. Indeed recommendation 3 stated that efforts should be made to '*develop a workforce of trained clinician informaticians at the Trusts and give them appropriate resources and authority*'.

There is opportunity for nurses and midwives, therefore, to develop the required digital capabilities to enable quality improvement, appropriate data gathering – including decisions on that which should, and should not be gathered, data analysis, and engaging with technology driven healthcare to improve outcomes for populations[43]. Experienced nursing and midwifery roles are crucial to the implementation of interventions that are technology based[44], with significant opportunity to impact the implementation and design of digital health technologies because of their expert clinical workflow knowledge, decision making capacity and leadership role[45]. Nursing and midwifery leaders are also highly influential in the adoption of practice trends and should therefore seek to understand what digital providers offer including how these systems can assist or hinder nursing practice[46].

Key Messages:

- **Investment is needed for digital equipment and infrastructure to support its widespread use**
- **There is a need to build the skills and authority of nurses and midwives to lead the potential for future digital practice**
- **Digital systems need to be designed collaboratively with appropriately skilled registrants to ensure they are fit for nursing and midwifery practice**
- **Nurses and midwives need to be enabled to lead and engage with and influence the design of innovative digital health approaches for the population**

Recognising And Rewarding Excellence In Practice

Where we are now

In a UK-wide report, *Safe and Effective Staffing: The Real Picture*[47] four out of five Directors and Deputy Directors of Nursing indicated that their organisations ran on the good will of their staff to provide services. Nearly three in five (57%) of Directors and Deputy Directors of Nursing said that staff wellbeing declined over the past two years. In a similar report within HSC organisations in NI, 52% of nursing staff reported not having enough time to carry out all their tasks and duties and 28% reported that there were too few staff, feeling overwhelmed by workload[48].

In 2017, the Commissioner for Older People exercised his discretion to commence a statutory investigation into specific matters affecting older people, carrying out an investigation into the standards of care received by residents of Dunmurry Manor Nursing Home. His report of the findings of his investigation[49] set out 59 recommendations. These include a recommendation to ensure workforce plans are developed that take cognisance of nurse staffing requirements for the Independent Sector. He also recommended that a high level of staff turnover and use of agency should be considered a "red flag" issue for commissioners of care and the Regulation and Quality Improvement Authority (RQIA).

The DoH and the Northern Ireland Practice and Education Council (NIPEC)[50] have published a suite of documents to ensure a consistent approach across HSC Trusts regarding role, remit, function, training and education of Nursing Assistant and Senior Nursing Assistant roles undertaking delegated aspects of nursing care supervised by a registered nurse or midwife. This includes core elements of a job description for AfC Band 2 and 3 staff.

The DoH and NIPEC have also published an Interim Career Framework for Specialist Practice Roles[51], an Advanced Nursing Practice Framework[52] and Professional Guidance Supporting Consultant Nurse and Consultant Midwife Roles[53], distinguishing characteristics within components of practice between these roles. Alongside of these developments, nurses and midwives have consistently demonstrated their contribution to the health and wellbeing of the population in NI. There are cited examples, included in Section 5, of how they are leading the way in delivering high quality, innovative person-centred care, contributing to the strategic objectives of transformation and co-production.

Finally, NI has been collecting and demonstrating evidence on the contribution and impact of nursing and midwifery practice to person-centred health outcomes through the collection of Key Performance Indicators (KPIs) across a number of work programmes and

operational directorates. This initiative has been led collaboratively by the Public Health Agency and NIPEC since 2012 and is chaired by the CNO. Over the last 6 years since the work began, a wealth of data has been collected that has evidenced the positive impact of nurses and midwives on the health outcomes of people receiving health and social care services in NI. For further information on nursing and midwifery KPIS in NI please go to: http://www.nipec.hscni.net/work-and-projects/stds-of-pract-amg-nurs-mids/evidencing-care-kpi-for-nurs-mid-project/

What We Heard

Nurses and midwives across all care settings consistently reported feeling overstretched, resulting in patient care being compromised and care being left undone due to lack of time. Repeated concerns were raised about gaps in skill mix and a lack of corporate and professional infrastructure to support the professions. Participants at the workshops frequently reported that they felt the impact personally in terms of their own health and wellbeing and were concerned about work life balance, their own welfare and that of their colleagues. Morale was repeatedly described as "low", and regular statements were made relating to 'a simple thank you' from employers being appreciated by nurses and midwives. There was a clear message of the value of ***celebrating and rewarding success*** and promoting excellence in practice.

There was a consistent message about nurses and midwives being expected to take on the roles of other health and social care staff specifically administrative and domestic staff, Allied Healthcare Professionals, medical staff and social workers. The system was characterised by "too much bureaucracy", too much unnecessary paperwork and duplication of effort. This was further exacerbated by a lack of IT support and systems. There was strong consensus that these issues needed to be addressed in order to release time to ***maximising the value of nursing and midwifery*** care.

Many expressed concerns about the lower rates of pay earned by staff on AfC terms and conditions in NI. There was a generalised perception that the contribution of other health and social care professionals was being recognised in terms of AfC Banding, whilst the contribution made by nurses and midwives was not. There was a perceived lack of openness and transparency in relation to development opportunities and access to post-registration education and development programmes. Staff also cited occasions when they had been supported by their employer to complete specialist development programmes but were subsequently not employed, deployed, or in a position to utilise their specialist practice knowledge and skills in post following completion. There were also situations recounted of nurses utilising higher level skills beyond their AfC Job Band however were not remunerated at an appropriate level. This articulates a rationale for ***ensuring appropriate remuneration aligned to career progression for nurses and midwives***.

Issues relating to the ability of staff to provide appropriate levels of safety, quality and patient/ client experience were reinforced, such as: inadequate workforce planning, an increasing number of staff secured via agencies, and the stability of nursing and midwifery teams. These issues have been discussed in more detail in previous sections of this report. Shortages were more acutely felt in the Independent Sector and participants expressed dismay that workforce planning had consistently excluded the requirements of this sector.

Where do we need to be ?

Nurses and midwives need to feel valued and should be rewarded for advancing practice and being a significant contributor to the transformation agenda alongside other professions who are similarly acknowledged through career advancement and pay progression. Similarly, future services contracted out to be provided on behalf of the HSC by the Independent Sector HSC contracts must ensure that terms and conditions of employment for staff support a stable workforce.

A number of key policies and best practice documents from a professional and system perspective have painted a clear picture of the future in relation to recognition, enabling transformative leadership to achieve the overall aim within the current PfG aim of 'enjoying long, healthy and active lives'. Nurses and midwives are well placed to significantly contribute to improving the public health of the community, maximising transformation through person centred practice and improving quality and experience of care. The *Health and Social Care Workforce Strategy* identified two themes focused on actions in relation to promoting the health and wellbeing of the workforce and maintaining an effective work life balance.

Nurses and midwives should not suffer the unintended consequences of any service reform, particularly of administrative and support services that adversely impact on their ability to provide safe and effective care to patients and clients. Administrative processes that cause a duplication of effort placing an increasing burden on nurses and midwives need to be eradicated. Rather a system of streamlined information management and technology is required to support nurses and midwives to deliver person centred, safe and effective care. In shaping the future it is imperative for the professions to be able to evidence the impact of their practice which is key to maximising the contribution of nursing and midwifery to the population of NI.

Key Messages:

- **Action is required to improve the health and well-being and work-life balance of nursing and midwifery staff.**
- **In the interests of bringing stability to the nursing and midwifery workforce and reducing reliance temporary bank and agency staff, nurses and midwives pay in Northern Ireland should be commensurate with that in the other countries of the UK.**
- **The clinical infrastructure to support nursing and midwifery must be strengthened and critically involves reducing bureaucracy, streamlining information management and technology.**
- **HSC contracts for the independent and voluntary organisations must ensure that terms and conditions of employment for staff support a stable workforce in this sector.**
- **The future development of nursing and midwifery should be informed by the generation of evidence in practice and through the development of clinical academic careers.**

Leading Quality And Innovation

Where we are now

Health and Wellbeing 2026: Delivering Together sets out the road map for the development of a word class health and social care system. Any system that aspires to be world class must take a strong position on quality improvement. It is within this context that all health and social care professionals are required to fully integrate quality improvement into their work. This will mean improving our capacity to foster local innovation and to implement what works at scale. The NMC Code and Enabling Professionalism framework also articulates the requirement for nurses and midwives to continually learn and improve in practice. Through the Quality 2020 Strategy the IHI Improvement skills training suite, quality improvement capacity is being developed across nursing and midwifery services. There was also a deep recognition that QI training in nursing and midwifery is at an early stage of development and more needs to be done to build capacity across the nursing and midwifery workforce. In addition, the work of Regional Nursing Key Performance Indicator Advisory Group has increasingly introduced a culture of outcome measurement.
Again much more work is needed to ensure effective measurement of nursing and midwifery practice to become a systemic part of delivering routine care.

What we heard:

There was a recognition across all the workshops that to deliver care interventions based on evidence, nurses and midwives needed to be proactively supported to lead on quality and innovation.

Utilising and managing data to enable learning and improvement was linked to maximising the impact of nursing and midwifery practice across the life course.

This was clearly linked to the development of a supportive IT infrastructure to enable the capture and use of both experiential and clinical data and learn from and improve practice. Nurses and midwives expressed the need to ***engage in improvement and implementation science*** but there was recognition that nursing and midwifery as the largest professions still needed to build quality improvement capacity and capability, which would require sustained dedicated investment. There was an expectation that nurses and midwives should be ***leading and enabling innovation***. It was within this context that there was also a call for the system to recognise and value the opportunities for role enhancement across the professions. This was considered a critical enabler of services transformation and in improving population outcomes over the next 10 years.

Where do we need to be?

Nurses and midwives are critically positioned to provide the creative and innovative solutions for current and emerging health and social care challenges such as ageing population. We need to invest, therefore, in building improvement and implementation capability at undergraduate and postgraduate levels. Up until now, the potential for the professions to lead improvement science activities has not been fully realised. In their day-today practice nurses and midwives do not routinely receive opportunities to conduct research and contribute to improvement science (Taylor et al. 2010). The ability of the professions to seek the best research evidence, measure care outcomes and use empirical data to assess their current practice (Sherwood 2010) is dependent on the development of improvement science knowledge and skills. Crucially implementation science explores how the latest research and evidence can best be implemented to change healthcare policy and practice. This in turn assists the profession to translate evidence into practice and therefore improve care outcomes[54].

Value based approaches to quality improvement such as human factors and practice development are effective in bringing about cultural change and should also inform quality improvement and innovation. Understanding, applying and deploying such methods needs to be embedded across the HSC. Furthermore, in recognition that nurses and midwives play a key role in determining the quality of health and social care it is essential nurses and midwives are liberated through effective job planning to engage in quality improvement and in generating new ways of thinking, new ways of working and in new ways of utilising enabling technologies.

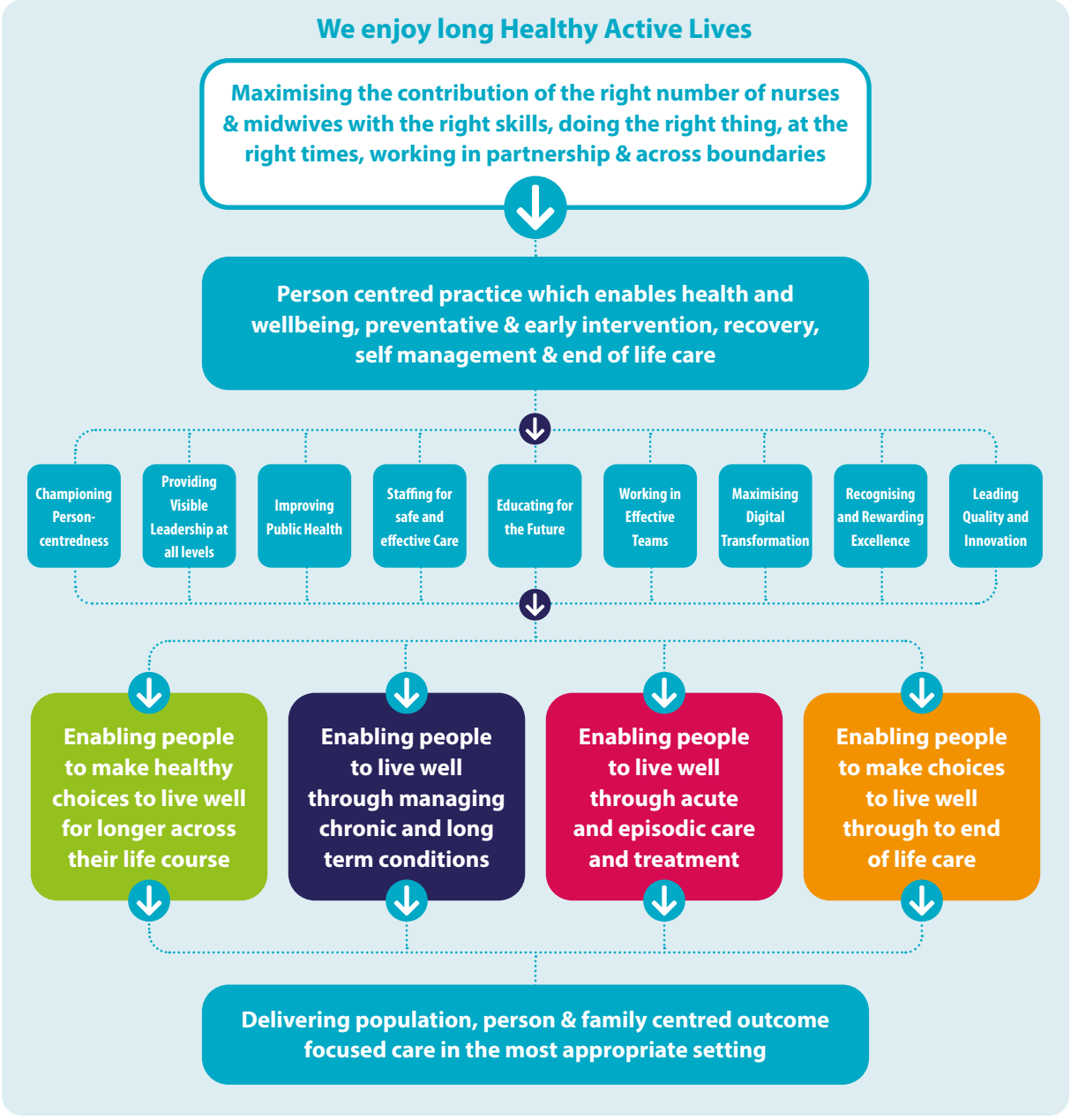
Key Messages

- **Nurses and midwives have the potential to significantly contribute to and to lead in the field of improvement science in healthcare.**
- **Opportunities need to be increased for nurses and midwives to be developed in a range of improvement and implementation science approaches.**
- **Nurses and midwives need to develop skills in gathering, collating and analysing data from across a range of professional and clinical systems for improving practice and driving innovation.**

7

THE WAY FORWARD - RECOMMENDATIONS

SECTION 7: THE WAY FORWARD – WORKING TO ACTION



Realising the Value of Nursing and Midwifery: - A Socio-Economic Perspective

In formulating the recommendations of this report it was important to consider the current and potential value of nursing and midwifery particularly in the context of enabling the population of NI to 'enjoy long healthy active lives'. It has been internationally recognised that the nurses and midwives undertake different roles in different circumstances, but they all share in the combination of knowledge, practical skills and values that has them well placed to meet the current and future needs of the population[55]. Whilst other professions share some or all of these features, the nursing and midwifery

contribution is unique because of its underpinning evidence base, the range and diversity of professional roles and the scale of the workforce. In reality the professions provide around the clock care, are often the first point of contact, and sometimes the only health professional engaging with people in the delivery of care and treatment. They are also an important part of the community, sharing its culture, strengths and vulnerabilities. Furthermore, nurses and midwives can shape and deliver effective interventions to meet the emerging needs of patients, families and local neighbourhoods. Whatever their particular role, they are guided by professional education, knowledge and their deep rooted person centred and humanitarian values.

Enabling people to make healthy choices to live well for longer across their life course.

Nursing and midwifery together spans the life course. When the family of midwives, health visitors, paediatric nurses, school nurses and Child and Adult Mental Health Services work collectively they are crucial to enabling the best start in life. The research shows that when this happens the costs associated with developmental delay, physical, social and mental health problems are significantly reduced[56]. Adverse Childhood Experience (ACE) research demonstrates that multiple ACEs is a major risk factor for many health conditions and represents risks for the next generation (e.g., violence, mental illness, substance use and long term physical health conditions)[57]. The research also shows that children and young people with four or more ACE's are more likely to develop serious long term health conditions, mental ill-health and significant levels of socio-economic disadvantage. Additionally, for early years, the contribution of midwifery has realised substantial health and wellbeing benefits for women, mothers and their infants when high-quality midwifery care is delivered and midwifery care provided by educated and regulated practitioners was found to be more than cost-effective.

Through the work of health visiting and early years nursing it is possible to reduce the cost of long term health conditions and to reduce intergenerational trauma and poor mental ill health. We know that mental ill health costs the NI Economy £3.5 billion[58]. Investing in prevention through enhanced early years and mental health nursing and midwifery roles could therefore significantly reduce the social and economic costs associated with poor mental health. An excellent example of this in practice is the family nurse partnership. A recent evaluation by demonstrated that it adds value through transforming the lives of children and their parents and breaking the intergenerational cycle of disadvantages[59].

Older people, whether in hospitals, care homes or in their own homes, who do not get enough opportunity to mobilise, are at increased risk of reduced bone mass and muscle strength, reduced mobility, increased dependence, confusion and demotivation[60].

These problems can be attributed to the phenomenon of what can be termed as 'deconditioning syndrome'. This affects well-being as well as physical function and could result in falls, constipation, incontinence, depression, swallowing problems, pneumonia and leads to demotivation, and general decline. We know that 10 days of bed rest in hospital leads to the equivalent of 10 years of ageing in the muscles of people over 80. Getting patients up and moving has been shown to reduce falls, improve patient experience and reduce length of stay by up to 1.5 days[61].

Enabling people to live well through acute and episodic care and treatment

As an evidence based profession nursing and midwifery delivers substantial socio-economic benefits[62]. Caird et al (2010), in their systematic literature review demonstrated that nurses and midwives working in a range of areas across the life span, collectively reduced costs by enabling people to be well. This included cost avoidance as result of the preventative roles undertaken by nurses and midwives. Research illustrates that prevention reduces costs, for example, falls by over £3,000[63], sepsis between £2,000 - £5,000[64], pneumonia by £2,000[65] and hospital acquired pressure ulcers between £2,000 -£3,000 per patient[66]. The estimated savings from preventing or delaying dementia for 1 year is £15,000 per person[67] on aggregate this data clearly presents an opportunity to increase productivity and reduce the cost of care failure through effective nursing and midwifery care.

In addition, research also shows preventing and effectively treating mental ill health has significant socio-economic benefit[68]. It is estimated that the cost of physical healthcare is around £2,000 extra when the patient is also mentally ill[69]. So if we treat a physically ill person for their mental illness we can expect to save up to £1000 a year on physical healthcare (due to the 50% recovery rate)[70]. It is also estimated that within two years of recovery following successful treatment, the employment rate for those with moderate/ severe mental health problems who recover is increased by 11.4 percentage points and by 4.3 percentage points for those with mild mental health problems. This means for every person who regains or retains employment an annual saving is made of £12,935 in terms of public expenditure[71].

A recent [72]systemic review of the literature on nurse skill mix, evidenced a correlation between higher numbers of registered [73]graduate nurses and lower risk of mortality: for every 10% increase in graduate nurses there was a 7% reduction in mortality rates. Research shows that [74]richer nurse skill mix (e.g., every 10-point increase in the percentage of professional nurses among all nursing personnel) was associated with lower odds of mortality (OR=0.89), lower odds of low hospital ratings from patients (OR=0.90) and lower odds of reports of poor quality (OR=0.89), poor safety grades (OR=0.85) and other poor outcomes (0.80<OR<0.93), after adjusting for patient and hospital factors.

Each 10 percentage point reduction in the proportion of professional nurses is associated with an 11% increase in the odds of death. Therefore a bedside care workforce with a greater proportion of professional nurses is associated with better outcomes for patients and nurses and thus saves money on terms of beds days and the cost associated with delayed recovery.

Enabling people to live well through managing chronic and long term conditions

Whilst more work is needed on establishing the socioeconomic value of nursing many studies show the beneficial impact of nursing and midwifery across different settings. The Institute of Education, University College London, in 2010 undertook a rapid systematic review of the socioeconomic value of nursing and midwifery.[75] They reviewed 32 international studies and concluded that interventions provided by specialist nurses or led by nurses were shown to have a beneficial impact on a range of outcomes for long-term conditions when compared with usual care.

Further individual studies show benefits from nurse-led care including reduced costs[76], higher patient satisfaction, shorter hospital admissions, better access to care, and fewer hospital-acquired infections[77]. Nurse-led interventions for chronic conditions such as diabetes have resulted in patients making more informed decisions about their care and being more likely to adhere to treatment. ANPs not only improved access to services and reduced waiting times, but also delivered the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up[78]. Similarly, an English study also showed that in a comparison of care effectiveness and cost effectiveness of general practitioners and ANPs in primary health care, outcome indicators were similar for nurses and doctors, but patients cared for by nurses were more satisfied[79].

There is evidence to suggest that person and community centred approaches that empower people to become partners in care create the conditions for self-management. Research by NESTA indicates that self-management approaches for people with particular long-term conditions could equate to net savings of around £2,000 per person reached per year, achievable within the first year of implementation[80]. This is now supported by international evidence that suggests changing the way in which patients and clinicians work (co-production) improved health outcomes across a range of long-term conditions, including diabetes, Chronic Obstructive Pulmonary Disease (COPD), hypertension, heart disease and asthma. Patients were less prone to exacerbation and demonstrated improvements in their core clinical indicators. As a result, there was a reduction in the cost of delivering healthcare of approximately seven per cent through decreasing Emergency Department (ED) attendances, reduced hospital admissions, reduced length of stay, and decreased patient attendances[81]. It was further hypothesized that implementing this approach in England could save the NHS £4.4 billion.

The Health Foundation publications on person-centred practice and self-management also suggest found that people who are supported to manage their own care more effectively are less likely to use emergency hospital services[82]. For example, people who take part in shared decision making are more likely to engage actively in their treatment plan, which results in better outcomes. The Foundation also found that self-management programmes can reduce health care utilisation. Several studies reported that self-management can reduce visits to health services by up to 80%. If implemented within NI, this would have significant impact on population health outcomes considering that one in five people live with a long-term condition. Across the life course nursing and midwifery are therefore uniquely placed to enable recovery and reduced costs associated with length of stay, acuity and adverse health care experience.

Recommendations

Enabling people to make choices to live well through end of life care

Whilst acknowledging there is a need for deeper and more rigorous socio-economic evaluation of the impact of nursing and midwifery, an attempt has been made to place recommendations in the context of the socioeconomic evidence. The recommendations are focused on four key areas presented below.

Maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

1. The development of a new population health management programme for nursing and midwifery.
2. The creation of dedicated population/public health midwife and advanced nurse and nurse and midwife consultant roles across all of our HSC bodies.
3. To increase the numbers of School Nurses, Health Visitors and expand the Family Nurse Partnership programme across all of NI.
4. Recognising the demographic skills, nursing needs to have joint and collective responsibility for the development, planning and leadership of older people services, including all nursing care services provided in the independent sectors.

Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice

5. Sustain a minimum of 1000 pre-registration nursing and midwifery places and increase in line with the needs of the population over the next five years.
6. Establish a ring-fenced post education budget commensurate with both the size of the workforce and the HSC transformation agenda and as minimum re-establish the previous investment of £10M.
7. Build and resource a new career framework for nursing and midwifery to ensure that within ten years we have advanced nurse, specialist midwife and nurse roles as well as nurse and midwife consultant roles across all branches of nursing and midwifery.
8. Increase the number of clinical academic careers roles across all midwifery and all branches of nursing.
9. Put Delivering Care Policy (safe staffing) on a statutory footing.
10. Develop arrangements for accelerated pay progression Band 5 to Band 6 grades similar to other professions. This in particular recognises that many Band 5 nurses after several years of practice acquire additional specialist knowledge and skills take on additional responsibilities commensurate with band 6 role as a senior clinical decision maker. Midwives currently move to Band 6 a year after registration.
11. Develop a person centred practice policy framework for all nursing and midwifery services.

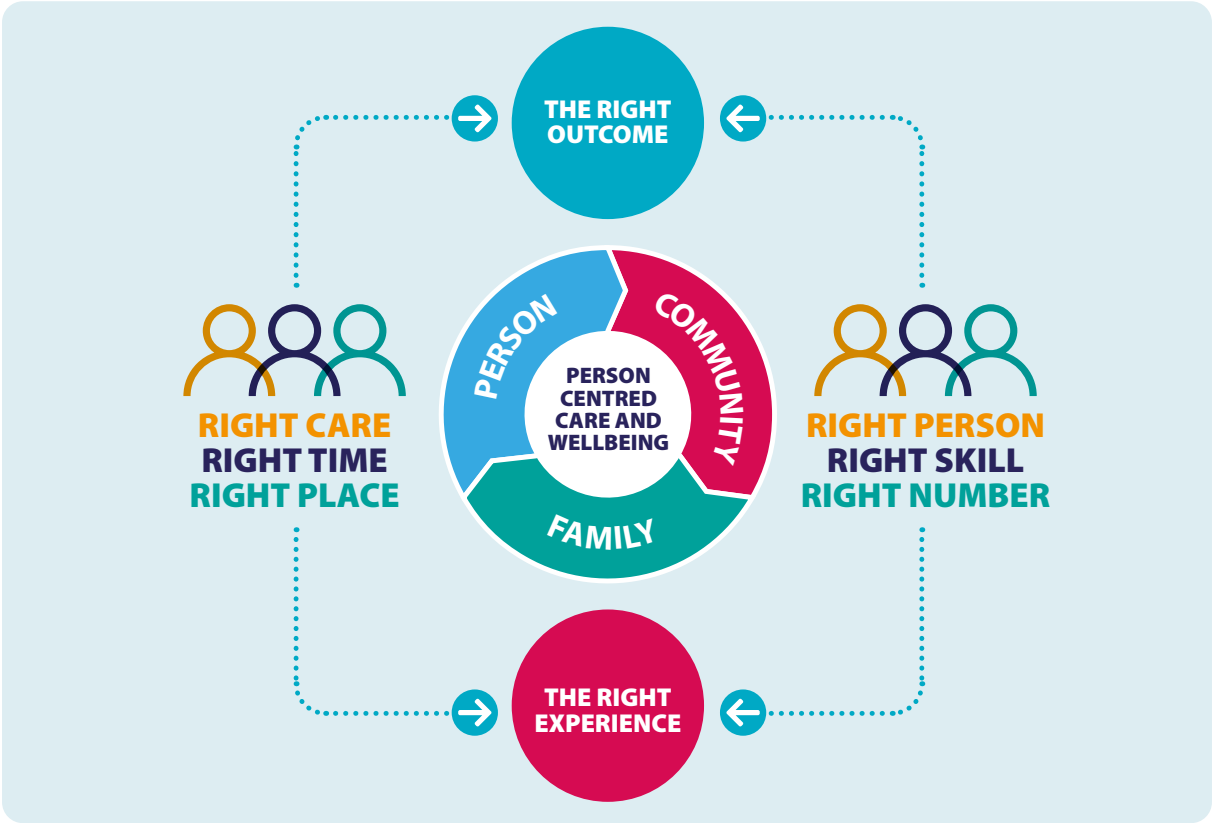
Doing the right thing in the most effective way – working in partnership

12. Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse/midwife leadership framework and investment in leadership training for nurses and midwives.
13. Invest in improvement science training and increase role of leadership in nursing and midwifery in quality improvement initiatives.
14. Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness.
15. Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) of a new digital nurse leadership roles in all HSC bodies.

Conclusion

The recommendations outlined above reflect a new vision/ambition **figure 20** to maximise the contribution of nursing and midwifery, which can be both used to guide decision making, but also to measure progress. It is our ambition that nursing and midwifery deliver the right evidence based care, with the right numbers, at the right time, in right place, by the right person with the right knowledge, and of course most importantly delivering the right experience for persons, families and communities.

Figure 20 - The Nursing and Midwifery Ambition



In order to take forward the recommendations outlined above, a new nursing and midwifery strategy will need to be developed that is in line with *Health and Wellbeing 2026: Delivering Together* priorities. Indeed the Bengoa Report (October 2016) makes clear that system transformation is dependent on the modernisation of practice. Nursing and Midwifery in line with the recommendation of this report will undergo significant practice reforms and clearly with a multi-disciplinary approach which is central to the delivering of better outcomes. The recommendations in this report will inevitably require legislative and ministerial approval and the development of a dedicated action plan. Clearly the recommendations will require additional significant investment over a 10-15 year period and this will be dependent on resources being released through service reconfiguration and/or efficiencies as well as securing new investment.

ANNEX A

Membership

The following members have been appointed to the Nursing and Midwifery Task Group:

- Chair – Sir Richard Barnett
- Expert panel – Bronagh Scott (NHS Wales)
- Education and research / person centred care – Prof Tanya McCance (UU)
- Public Health – Prof Viv Bennett (Public Health England)
- NIPEC – Angela McLernon
- RCN – Dr Janice Smyth
- Population Health Improvement – Dr Mary Hinds (PHA)
- Quality, Safety and Innovation – Dr Anne Kilgallen (DoH)
- Workforce and Education – Caroline Lee (CEC)
- eHealth – Sean Donaghy (HSCB)
- Former Director of Nursing – Alan Corry-Finn
- Deputy Chief Nursing Officer – Rodney Morton (DoH)
- Director of Nursing – Eileen McEneaney (NHSCT)
- RCM – Breedagh Hughes / Karen Murray
- Independent Sector – Carol Cousins (Four Seasons)

Additional Support

Additional support was also provided by the following:

- Angela Reed, NIPEC
- Heather Finlay, DoH
- Mary Frances McManus, DoH
- Verena Wallace, DoH
- Dr. Dale Spence, DoH
- Alison Dawson, DoH

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GLOSSARY

NMTG	Nursing Midwifery Task Group
DoH	Department of Health
LTC	Long Term Conditions
CNO	Chief Nursing Officer
HSCB	Health and Social Care Board
MECC	Making Every Contact Count
ANP	Advanced Nurse Practitioner
CEC	Clinical Education Centre
HV	Health Visitor
WTE	Whole Time Equivalent
MDT	Multi-disciplinary Team
NMC	Nursing Midwifery Council
UHC	Universal Health Coverage
CYP	Children and Young People
WHO	World Health Organisation
CAMHS	Child and Adolescent Mental Health Services
AfC	Agenda for Change
RCN	Royal College of Nursing
NHS	National Health Service
PfG	Programme for Government
MLU	Midwifery Led Unit
FMU	Free Standing Midwifery Led Unit
FNFM	Future Nurse Future Midwife
EITP	Early Intervention Transformation Programme

MAHI - STM - 089 - 3161

MAHI - STM - 089 - 3162

MAHI - STM - 089 - 3163

MAHI - STM - 089 - 3164

For Further Information Contact Nursing and
Midwifery Directorate Department of Health
nursingandmidwifery@health-ni.gov.uk

THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) 2009

THE HEALTH AND SOCIAL CARE (GENERAL PROVISIONS) (NO 2) DIRECTION (NORTHERN IRELAND) 2010

The Department of Health, Social Services and Public Safety[1] in exercise of the powers conferred on it by section 3 of the Health and Social Care (Reform) Act (Northern Ireland) 2009[2], and of all other powers enabling it in that behalf, hereby directs as follows:-

The provisions for the issue of alert letters as set out in the schedule shall be adopted with immediate effect by all HSC bodies identified in Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Diane Taylor

Senior Officer [3] of the Department of Health, Social Services and Public Safety

19th **April 2010**

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[1] *See* Art. 3(6) of S.I. 1999/283 (N.I. 1)
[2] 2009 c.1 (N.I.)
[3] *See* Art. 4(3)(b) of S.I. 1999/283 (N.I. 1)

SCHEDULE

MAINTAINING HIGH PROFESSIONAL STANDARDS

SCHEME FOR THE ISSUE OF ALERT NOTICES FOR HEALTH CARE PROFESSIONALS IN HEALTH & SOCIAL CARE IN NORTHERN IRELAND

THE ISSUE OF ALERT NOTICES FOR HEALTH CARE PROFESSIONALS

Summary

1. The DHSSPS has strengthened the current arrangements for the issue and revocation of alert notices for health care professionals in Northern Ireland.

2. The system is described in the attached scheme. This requires Health and Social Care (HSC) bodies to request alerts in line with the requirements contained within this system.

SCHEME FOR THE ISSUE OF ALERTS REGARDING HEALTHCARE PROFESSIONALS IN NORTHERN IRELAND

Introduction

1. The issue of an alert is a way by which HSC bodies and professional organisations, as listed in Appendix 1, can be made aware of a registered healthcare professional whose performance or conduct gives rise to concern that patients, staff or the public may, in future, be at risk of harm either from inadequate or unsafe clinical practice or from inappropriate personal behaviour. It is also a means of ensuring that HSC organisations are made aware of healthcare professional that may pose a threat to patients, staff, or the public because their conduct seriously compromises the effective functions of a team or delivery of service.

2. The alert system is intended to cover those situations where an HSC employer considers that a member of their healthcare staff may pose a threat to patient safety if they worked in that professional capacity. The alert system is not part of either the HSC employees' disciplinary process or statutory regulatory framework. It is an integral part of the system for pre-employment checks. It is intended as a means of alerting prospective employers to check that the applicant's employment record is complete and appropriate references are obtained and that information relevant to safe employment is known in advance of an appointment being made.

3. Employers should always undertake comprehensive checks on registration, qualifications and references and carry out Enhanced Disclosure Certificates by AccessNI, Criminal Records checks and occupational health checks in accordance with normal recruitment policies.

4. This guidance requires HSC bodies to implement and manage the alert scheme in accordance with the steps described within this scheme. These requirements are mandatory for HSC bodies.

5. In developing this system, consideration has been given to human rights issues, as they affect the employer/employee relationship. In making decisions careful adherence to the procedures contained within this scheme will ensure that the rights of those who are subject to an alert are respected. Of particular importance is the need to ensure that alerts are regularly reviewed so that they can be revoked as soon as there is evidence the alert

should no longer remain live. However, an alert will not be revoked solely on the basis of an assurance from the individual unless this is binding on their permission to practice (e.g. an undertaking to the professional regulatory body or a court).

Who is covered by the alert system?

6. The alert system covers any healthcare professional currently subject to statutory regulation by one or more of the bodies listed in Appendix 1.

Triggering an alert

7. An alert may only be issued by the Chief Professional Officer, DHSSPS and only where it is considered that an individual poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC in that capacity, and there is a pressing need to issue an alert notice. Other bodies may also request the issue of an alert (see paragraph 17-18).

8. Concerns may arise about the conduct and performance of a healthcare professional in a number of different ways, including concerns raised by other staff, findings arising from internal investigations, the disciplinary process, information from the regulatory bodies, complaints, police investigations, appropriate bodies outside the UK and information arising from the audit and inspection process. The issue of an alert is a serious step and should only be considered where a significant risk of harm to patients, staff or the public has been identified. It is important that investigations are brought to a conclusion, even when employees have left the HSC body, both to safeguard future patients and staff elsewhere and in the interests of the individual (who may otherwise be left with an unresolved alert).

9. An alert may be issued where the regulatory body has not yet decided to take action to make an interim suspension order or take other measures. Where the regulatory body has taken interim measures, the alert should remain live as it is intended to reduce the risk of inappropriate employment in any capacity. This will enable the HSC body to provide a full reference if requested by a prospective employer.

10. An alert should not be issued in circumstances where an individual's performance or conduct is being considered by their HSC employer.

Other staff and bogus professionals

11. In exceptional circumstances a situation may arise in which a member of staff not covered by paragraph seven may pose a threat to public safety and is likely to seek employment elsewhere (e.g. a staff member who falsely holds himself out to be a healthcare professional and is seeking work in the NHS/HSC in that capacity). In such circumstances, it would be a proportionate response to take action based upon the principles contained within this scheme to safeguard public protection.

Who in the DHSSPSNI should issue an alert?

12. Alerts must be issued on behalf of the DHSSPS by the Chief Professional Officer in the DHSSPS. The Chief Professional Officer is formally responsible for assessing whether or not an alert should be issued and remains in place, and for formally revoking an alert when appropriate. The Chief Professional Officer must ensure that appropriate professional advice is taken before an alert is issued.

13. The Chief Professional Officer must delegate responsibility for occasions when they are not available to issue an alert personally. Such occasions may arise during periods of annual leave, sickness absence or other planned absences. The Chief Professional Officer retains overall responsibility for overseeing the process for issuing and revoking alerts and should be notified of all alerts issued in his or her absence on returning to work.

The role of the employing/referring body

14. There will be circumstances when information comes to light that suggests that a particular individual, who may be a current or former employee, poses a significant risk of harm to patients, staff or the public and intends or may intend to seek permanent or temporary work in the NHS/HSC or elsewhere in that capacity.

15. Responsibility for requesting the issue of an alert must be made at Chief Executive or Executive Board member level. Employers may wish to seek their own legal advice in complex cases or those in which there is any doubt about the incidents or behaviour which gave rise to the concerns. The request must contain the name and last known address of the individual who is the subject of the notice. It must also contain a summary of the circumstances which gave rise to the request including a summary of all relevant information, an assessment of the relevant risks and any advice taken. The request must also explain what action the HSC body has already

taken in respect of the individual to the relevant health regulatory body and must state the gender and ethnic origin of the individual, if known.

16. An assessment of the degree of risk should be based on the circumstances of each individual case taking into account the advice of the Director of the professional group in the HSC body. Other sources of advice include the regulatory body and other professional organisations. Where relevant professional advice is not available within the HSC body, advice may be obtained from an appropriate source in another HSC body. The National Patient Safety Agency has developed an incident decision tree that may help evaluate whether incidents, which gave rise to initial concern, raise doubts about the conduct or performance of a particular individual. In all cases, the employing/referring body should consider carefully what other measures could be taken, other than issuing an alert notice, to ensure the protection of the public. In the particular case of midwives, this should include referral to the local supervising authority.

Requests for alerts from other bodies

17. Where an education provider considers that an alert should be issued in respect of a professional in training, he or she should seek advice from the Chief Professional Officer in the DHSSPS.

18. There may be instances where another body (e.g. a non - HSC employer) considers that an alert should be issued in respect of a healthcare professional that they employ or have previously employed. In such cases they should contact the Chief Professional Officer in the DHSSPS to discuss the details of the case, so that he/she can decide whether to issue an alert. The Chief Professional Officer in the DHSSPS may issue an alert notice in any circumstance considered appropriate provided that having taken appropriate advice, he/she is satisfied that a healthcare professional (or person holding himself out to be a healthcare professional) poses a significant risk of harm to patients, staff or the public and may seek work in the NHS/HSC in that professional capacity.

The role of the DHSSPS

19. When the Chief Professional Officer in the DHSSPS has considered the request from the referring body, he/she should consult with relevant senior professional colleagues.

20. If, in light of all the information presented to the DHSSPS, the Chief Professional Officer agrees that the individual concerned may pose a significant risk of harm to patients, staff or the public and may seek work in the NHS/HSC/Private Sector in that professional capacity and there is a pressing need, he/she may issue an alert. The DHSSPS must advise the referring body whether or not an alert will be issued, and the reasons behind the decision. The DHSSPS must issue an alert to the bodies listed in the footnote[4] and to the individual concerned.

Action following the decision to issue an alert notice

21. If the DHSSPS issues an alert, the referring body must refer the case to any relevant statutory regulatory body or professional body with disciplinary powers as a matter of urgency, if this has not been done already (see paras 36-37). There may be exceptional circumstances when immediate referral might not be appropriate, for example when investigations are ongoing to gather evidence to support a referral to the regulatory body. In such circumstances referral must be made at the earliest possible opportunity. If investigations conclude that a referral to a regulatory body is not warranted, the referring body should ask the DHSSPS to revoke the alert without delay. In the case of midwives, the NMC and the local supervising authority should be informed of the issue of the alert and notify the DHSSPS of any action it takes.

22. Once an alert is issued, the individual concerned must be notified by the DHSSPS within seven days (in writing to their last known home address and, where appropriate, their registered address). He/she should be given a summary of the DHSSPS reasons for this action. He/she may ask the DHSSPS to review its decision.

23. If, for whatever reason the DHSSPS is satisfied that h/she does not in fact represent a threat to patients, staff or the public, the alert must be formally revoked. This should be notified to the individual concerned and the referring body, by the DHSSPS as soon is as practicable.

Circulation of alerts

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[4] The Health and Social Care Board, HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, the Northern Ireland Guardian ad Litem Agency, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

24. The alert will be issued in the form of a letter by the Chief Professional Officer, DHSSPS to the Chief Executives of all Health and Social Care Bodies listed in footnote 2, the Chief Professional Officers for Scotland, Wales and England and the regulatory body which regulates the profession or purported profession of the individual to whom the letter relates. The notification [see Appendix 2 for a model] will ask them to contact a named officer at the referring body for a written reference, if the individual concerned contacts them with a view to obtaining employment.

25. The Chief Professional Officer in the DHSSPS may also send copies of the alert notice to other organisations which provide services to the HSC and which, in the opinion of the DHSSPS, may be approached by the subject of the alert notice with a view to seeking work. The Chief Professional Officer should carefully consider the degree of risk posed by the subject of the alert and the interest of the third party in obtaining the information.

26. Alerts are strictly confidential and should be marked 'alert system in confidence'. They should only be shared within an organisation on a strict 'need to know' basis, and should be stored securely. An alert should be part of the employment record of the referring body. The same procedure and circulation list should apply when an alert is revoked.

Action to take on receipt of an alert

27. If an employing body becomes aware that an employee or prospective employee or an applicant for inclusion on its list is the subject of a current alert, then they should contact the referring body, as set out in the written notification.

28. Where contact is made by telephone, care must be taken to ensure that information is provided in a fair and consistent matter. Details should be based on the factual information provided to the DHSSPS or other facts that have subsequently emerged.

29. The employing body should then review the information provided by the individual in their application forms in the light of the information provided by the referring body, and take any appropriate action to ensure that the safety of patients and the public is maintained.

Monitoring and revocation of an alert

30. The DHSSPS must keep the alert notice under review to ensure it is regularly reviewed so it can be revoked as soon as there is evidence the alert should no longer remain live. A review should take place no later than six months from the last review. However, an alert should not be revoked solely on the basis of any undertaking unless this is binding on the practitioner (e.g. an undertaking to the regulatory body or a court). If new circumstances come to light that give rise to further concerns about the individual, the process to issue another alert notice should begin again.

31. The subject of the notice may at any time seek a review of the decision to issue an alert where new evidence or information comes to light. This should include the outcome of any proceedings by the police, the civil courts, regulatory body, disciplinary proceedings as appropriate or any information arising from the source of the concern which initially gave rise to the request for an alert to be issued. This will ensure that where information comes to light, which shows that the individual concerned does not pose a threat to the patients or staff, the DHSSPS can consider revoking the alert at the earliest opportunity. However, the DHSSPS will still need to take account of all the circumstances that gave rise to the issue of an alert in the first place.

32. Each case must be considered on its merits and alerts should not remain in force any longer than is necessary to ensure the protection of patients, the public and staff. DHSSPS will therefore review decisions when any further information comes to light and carry out a review no later than six months from the last review. The review will be a proactive process during which the DHSSPS will contact the sources of the concern, which originally resulted in the issue of the alert notice, to establish whether there have been any changes in circumstances or any new information which should be taken into account in deciding whether the alert notice should remain in force. The individual concerned will be informed by the Chief Professional Officer when an alert has been revoked.

33. The Chief Professional Officer in the DHSSPS will maintain and keep up to date a secure list of all alerts that he/she has issued and, where applicable the date the alert was revoked. There is an obligation on the DHSSPS to hold up to date information in respect of the person who is the subject of the alert, as far as it is reasonably practicable to do so. The Chief Professional Officer in the DHSSPS will compile an annual statistical return for the Departmental Board and the Minister.

34. The Chief Professional Officer in the DHSSPS must keep details of the alert for five years after it has been revoked. The existence of a revoked alert would form an important piece of evidence should the same individual again be considered to pose a threat to patients or staff at a later date.

35. If having consulted the contact point named in the alert an employer wishes to appoint an individual who is currently subject to an alert (or include them on their list) the employer will need to consider what safeguards need to be put in place. The employer may also wish to notify the Chief Professional Officer which issued the notice so that he/she is aware that the practitioner is working in the NHS/HSC/or private sector. The Chief Professional Officer can then consider whether further action is required such as reviewing the notice or notifying the regulatory body of the subject of the alerts' continued employment in the NHS/HSC/or private sector. Where the Chief Professional Officer is made aware of such a decision he/she may wish to seek their own legal advice.

Liaison with the statutory regulatory bodies

36. Where an alert is issued the case should have been referred to the appropriate regulatory body by the referring body (or in the case of midwives, the local supervising body) as a matter of urgency, unless there are exceptional circumstances. The purpose of doing this is for the regulatory body to consider whether any further action is required by it to protect patients, staff or the public.

37. If the regulatory body concludes its consideration of the case in terms that allow the individual concerned to remain in practice, either with or without conditions, the Chief Professional Officer will review the need for the alert to remain in place. It does not automatically follow that the alert will be revoked – there may be other good reasons for it to continue.

38. Prospective employers contacting a regulatory body regarding the registration status of an individual will also be informed if an individual is being considered formally under their fitness to practise procedures, in accordance with the appropriate rules governing disclosure of information to employers. This two-pronged approach strengthens protection for patients, staff and the public.

Appendix 1

List of Regulatory Bodies:

The Nursing and Midwifery Council

The Health Professions Council

Appendix 2

Standard contents for an alert notice

1. Always mark the covering letter **"ALERT NOTICE: MANAGEMENT IN CONFIDENCE"**

2. The notice must :

   - be addressed to the Chief Executive of the body
   - contain the subject's full name, their national insurance number and/or date of birth if known and the name of the body where they work or where they formerly worked (normally the body which triggered the alert system)
   - include the registration number of the individual, if registered by one of the statutory regulatory bodies
   - explain in what capacity the subject formerly worked and in what specialty and in what other capacity they can work
   - state clearly the name, position, address and telephone number of the person to be contacted should the subject submit an application for employment

No further information about the individual or the case may be included in the alert notice.

Maria McIlgorm
Chief Nursing Officer

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

Chief Executive, Public Health Agency;
Chief Executive, HSC Board (for cascade to GP Practices);
Chief Executives, HSC Trusts;
Chief Executive, Business Service Organisation;
Chief Executive, RQIA (for cascade to independent sector employers);
Chief Executive, Patient Client Council;
Chief Executive, NI Guardian Ad Litem Agency;
Chief Executive, NI Social Care Council;
Chief Executive, NIPEC;
Chief Executive, NIMDTA;
Chief Executive, NI Blood Transfusion Service;
Chief Executive and Registrar, Nursing and Midwifery Council;
Director of Nursing and AHPs, PHA;
Directors of Nursing, HSC Trusts;
Director of Human Resources, BSO;
Directors of Human Resources, HSC Trusts;
Head of School of Nursing and Midwifery, QUB;
Head of School of Nursing, UU; and
Senior Lecturer, Faculty of Health and Social Care OU (Belfast).

C5.14
Castle Buildings
Stormont Estate
BELFAST
BT4 3SJ

Tel: [redacted]
[redacted]

Date: 7 December 2022

Dear Colleagues,

Revocation of the Scheme for the Issue of Alert Notices for HSC Professionals in NI

The Department of Health (DoH) has completed an internal review of the operation of the Scheme for the Issue of Alert Notices for Health and Social Care (HSC) Professionals in Northern Ireland (NI). The scheme only applied to those in the applicable professions in Northern Ireland and was not replicated across the rest of the United Kingdom.

Following the conclusion of this review, Minister of Health, Robin Swann, has accepted the recommendation to stand down the scheme. The Department made a Direction to that effect, ***the Health and Social Care (General Provisions) (No. 2) (Revocation) Directions (Northern Ireland) 2022***, today. A copy is attached for your records.

You will be aware that the scheme applied to three professional groups, Nurses, Midwives and Allied Health Professionals (AHPs). These professions are governed by the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC)

respectively. A key duty of both regulators is to protect the public by making sure all registrants are safe, meet the standards of training and skills and have up-to-date knowledge of their practice and expected behaviours.

Information on referring staff to each of these regulators is available through the below websites:

NMC: https://www.nmc.org.uk/concerns-nurses-midwives/make-a-referral/making-an-employer-referral-to-us/

HCPC: https://www.hcpc-uk.org/concerns/raising-concerns/employer/

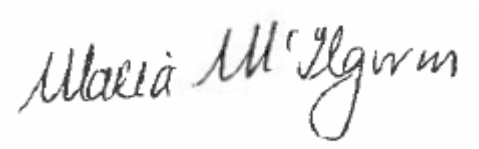
As a result of the decision to stand down the Professional Alerts process, going forward all future concerns regarding fitness to practice will not require notification under the DoH Professional Alerts process and should be referred directly to the appropriate regulatory body. Employers should ensure that they review their relevant policies and remove any reference to seeking the issue of an Alert from these with immediate effect. Please confirm with the Department that this has been completed by 30 November 2022.

What Happens Now?

My team will contact each of the organisations employing staff members who are subject to an outstanding professional Alert, to advise on how such cases will be closed. We will also write directly to all those subject to an active Alert to confirm that their Alert will be lifted with immediate effect and that their respective professional regulatory body will continue to progress the investigation into the issue(s) leading to the Alert being applied.

If you have any queries regarding the content of this letter, or the decision to stand down the scheme, please contact my team at nursingandmidwifery@health-ni.gov.uk .

Yours sincerely



MARIA MCILGORM
Chief Nursing Officer

FROM THE DIRECTOR OF REGIONAL STRATEGY AND PUBLIC SAFETY
Nigel Carson

Chief Executives of HSS Trusts
Chief Executives of HSS Boards

Room C5.5
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
Tel: [redacted]
[redacted]
Email: [redacted]

Date: 24 April 2006

Dear Colleague

GUIDANCE ON RESTRAINT AND SECLUSION IN HPSS

I am pleased to attach the document "Guidance on Restraint and Seclusion in Health and Personal Social Services", produced by the Human Rights Working Group which was formed to look at the issues from a human rights perspective.

The Working Group was established by the DHSSPS Human Rights Liaison Group in 2003 in recognition of the need to assist HPSS staff, and others, to ensure that their practice is safe and meets human rights requirements. The resulting guidance draws on the expertise of Group Members and others with a specialist knowledge of restraint and seclusion and associated legal issues. The Working Group spent considerable time researching and exploring these issues.

In developing this Guidance, the Working Group looked at the core issues associated with the use of restraint and seclusion. The Guidance is intended to provide a broad framework to inform the development of policy and procedures in the HPSS. Trusts and other HPSS bodies should review the guidance and develop specific policies, procedures and practices related to the needs of particular care setting and/or client groups.

In presenting the guidance to the Equality and Human Rights Steering Group (which has assumed the role of the Human Rights Liaison Group), the Working Group acknowledged the significant input from HPSS bodies and others who

responded to the questionnaire and targeted consultation exercise, which informed the development of the Guidance. In drafting the Guidance, the Working Group drew on examples of good practice and a wide body of knowledge from the health, social care and legal perspectives. It also observed that the wish for consistency of approach across Northern Ireland was clear and recommended that, where examples are provided in the Guidance of reporting and monitoring, Boards and Trusts work together to produce standardised regional guidance.

This Guidance is entirely the product of the Working Group established to look at the issues and does not constitute formal guidance issued by the Department. However, the Guidance is commended to you as having a useful contribution to make to the development of operational policies and procedures on the use of restraint and seclusion across the HPSS to ensure both service users safety and the protection of staff. In developing policies, care should be taken to ensure that policies are appropriate to the characteristics of the children or adults cared for within particular services. As the Guidance would also be of interest to those who provide services on behalf of the HPSS, it should be made available to other interested bodies and individuals.

As always, risk assessment is an essential element in the treatment and care of patients and should underpin this guidance. Assessment of risk, an agreed management plan (with the individual where possible) and proper induction, training and supervision of staff is essential to the prevention and management of aggression and violence.

Restraint and seclusion are areas likely to raise on-going concern and in which the standards and practices are constantly being reviewed and developed. Boards and Trusts will, therefore, need to keep their policies under review in the light of such developments.

Yours sincerely

Nigel Carson
Director of Regional Strategy
And Public Safety

cc: Chief Executive of RQIA
Chief Executive of NIMDTA
Chief Executive of CSA

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

Guidance on Restraint and Seclusion in Health and Personal Social Services

AUGUST 2005

MAHI - STM - 089 - 3182

CONTENTS

MAHI - STM - 089 - 3186

WHO SHOULD READ THIS GUIDANCE?

This guidance is intended to be used by:

- service commissioners in health and social care;
- managers of health and social care services;
- staff/professionals working with children and adults who may require to use restraint and/or seclusion;
- internal monitors of services and/or facilities;
- persons responsible for the operation of independent sector services or homes;
- Registration and Inspection staff;
- trainers and training providers.

The information in this guidance may also be helpful to:

- parents and those with parental responsibilities;
- Health and Social Services Councils;
- the Mental Health Review Tribunal;
- the Mental Health Commission;
- independent advocates;
- service users.

MAHI - STM - 089 - 3188

1. INTRODUCTION

Background to this guidance

1.1 This guidance on the use of restraint and seclusion is issued by the Department of Health and Social Services (DHSSPS) to inform practice across the Health and Personal Social Services (HPSS) bodies and their agents. It is the result of work undertaken by a HPSS Working Group, initiated by the DHSSPS Human Rights Liaison Group to assist in promoting human rights in these key areas.

1.2 The Liaison Group recognised that restraint and seclusion was an issue of common concern across HPSS and best tackled collaboratively. The Working Group which compiled the guidance was multi-professional and comprised of members from both the voluntary and statutory sectors. The outline terms of reference of the group are provided at **Annex A** and the membership at **Annex B**. Aspects of this guidance relating to the legislative context were taken forward through a sub-group and **Annex C** provides details of those involved.

Purpose of this guidance

1.3 The guidance is intended to be of an overarching nature, to be used to inform at provider level, the development of policies and procedures, training and practice across the relevant client groups in both hospital and other residential settings. The starting point for establishing good practice in the use of restraint and seclusion is the development of organisational policies, which reflect current legislation and case law as well as Departmental guidance, professional Codes of Practice and local circumstances, including the characteristics of the children or adults cared for within particular services. Every agency included within the remit of this guidance is expected to have a policy on the use of restraint and/or seclusion. The definitions of restraint and seclusion for the purpose of this guidance are examined at Section 2. The amount of detail needed will depend upon local circumstances but it should cover the areas set out in **Annex D** (example of HSS Trust Management of Aggression Policy), **Annex E** (example of HSS Trust Protocol on the Use of Physical Restraint and **Annex F** (example of HSS Trust Policy on Seclusion), as appropriate.

1.4 This guidance is issued to help ensure that staff working in various health and social care settings adopt consistent practices in the use of restrictive physical interventions and seclusion based upon common sets of principles. This will provide the most effective support for individual service users and reduce the possibility of confusion or disagreements between staff employed by different agencies.

1.5 This guidance will help staff in health and social services and elsewhere to address important outcomes for children and other service users, such as protecting and promoting their rights, providing appropriate choices, promoting independence and encouraging their social inclusion.

1.6 This guidance, by providing a clear framework to inform staff's practice in these complex areas of work, seeks to facilitate service standards which are consistent with best practice in relation to safeguarding service users and the Human Rights Act and that also reduce the risk to staff of litigation. **HSS Trusts should use the guidance to inform the production of policies and procedures on the use of restraint and/or seclusion.**

Legislative context

1.7 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to:

- respect for his/her private and family life;
- the right not to be subjected to inhumane or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.

1.8 People are also protected under domestic legislation in terms both of the protection of their rights and the potential for redress through the criminal and civil law for assaults against the person.

1.9 Underlying this guidance is the principle that actions must both comply with the letter of the law and incorporate the spirit of respect for human rights.

Legislative position

1.10 The issues of restraint and seclusion are not usually dealt with in primary legislation. Generally, these procedures are informed by guidance and regulations. There is, therefore, little uniformity of approach across both client groups and service areas. There is an increasing focus on the legitimacy of restricting the liberty of an individual, arising from increased awareness of the potential for challenge as a breach of an individual's rights. In addition, increased awareness of individual's rights to seek redress through resort to the criminal and civil courts has raised both staff's and employers' interest in ensuring these processes are used as a last resort, in a safe and therapeutic manner and in a way which protects both staff and the service user.

1.11 Section 4 (Legislative Context) and paragraph 5.2 of this guidance provide detailed consideration of some of the key legislative considerations which need to be considered when using either restraint or seclusion.

When may restraint or seclusion be appropriate?

1.12 Restraint and seclusion should be used only for controlling violent behaviour or to protect the service user or other persons. In exceptional circumstances, physical intervention may be necessary to give essential medical treatment. The decision to use either is extremely serious and restraint and seclusion should only be used as follows:

- as intervention of **last resort;**
- where other, less restrictive, strategies have been unsuccessful, although an emergency situation may now allow time to try those other strategies;
- **never** for punishment;
- in reaching the decision, consideration should also be given to the individual needs of each service user in deciding the best method of control or restraint to be employed.

1.13 Decisions to use either restraint or seclusion have serious civil liberties implications as these interventions limit or restrict the freedom of movement of an individual. Section 4 on the Legislative Context covers these issues in more detail.

Risk assessment

1.14 Risk assessment is an essential element in the care and treatment of all patients and clients and should underpin the guidance which service providers make available to staff. It could be argued that it is one of the most fundamental interventions in the recognition, prevention and therapeutic management of violence and aggression. The use of other interventions such as observation, psychosocial interventions or restraint should be part of a management plan based on an assessment of risk. While it is acknowledged that the occurrence of aggressive or violent incidents are not always predictable, assessment of risk, followed by a properly developed management plan is essential to the prevention and management of aggression and violence. Being able to predict who is more likely to engage in a violent act may enable staff to reduce the risk.

Current position - questionnaire

1.15 To examine the current available guidance across Northern Ireland, the working group issued a questionnaire to all statutory agencies and a selection of independent providers. A copy of the questionnaire and the summary findings are at **Annex G.**

Existing professional or practice guidance

1.16 Guidance on the use of restraint for adults is available in the book *Physical Interventions: A Policy Framework* (BILD 1996), which provides advice and information on the use of physical interventions in different service settings.

Equality Impact Assessment: equality screening

1.17 This paper has been screened for equality implications and the findings are given in **Annex H**.

2. DEFINITIONS AND CONCEPTS

Definition of "service user"

2.1 In this guidance, the term 'service user' is used to refer to adults and children who receive services from HPSS organisations and their agents in care establishments, hospitals or any other health settings and within their own homes.

Definition of "restraint"

2.2 **Different forms of physical intervention are summarised in the table below.** The table demonstrates the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons, this guidance is specifically concerned with the use of restrictive physical interventions. For the purpose of this guidance the terms "restraint" and "physical restraint" mean "restrictive physical interventions".

Examples of non-restrictive and restrictive physical interventions

	Bodily contact	**Mechanical**	**Environmental change**
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

2.3 Physical restraint can, therefore be summarised as:

The use of any part of one's body, or mechanical method, to prevent, restrict or subdue movement of any part of another person's body. It can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;

- to separate the person from a 'trigger', for example, removing one service user who has responded to another with physical aggression;

- to protect a service user from a dangerous situation – for example, the hazards of a busy road.

2.4 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans; and

- *emergency or unplanned* use of force which occurs in response to unforeseen events.

2.5 In common law anyone who has the duty to care for another person is expected not to interfere unduly with the personal freedom and autonomy of the person in his/her care. Nevertheless, if restraint is necessary for the safety of that person or others it may be justified as long as it is the **absolute minimum necessary for the minimum time possible**. As this raises the questions of what constitutes necessity and what is the absolute minimum of restraint in a given situation, it is useful to identify general principles. The section on Principles Involved (including Statement of Principles at paragraph 5.19) addresses this in more detail.

Definition of "proportionate"

2.6 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm likely to be caused. These judgements have to be made at the time, taking due account of all the circumstances, the unpredictable nature of the work and including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques employed should be those with which the staff involved are familiar and able to use safely and are described in the service user's support plan. Where possible, there should be careful planning of responses to individual service users who are known to be at risk of self-harm, or of harming others.

2.7 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming or potentially self-harming behaviours;

- injury to self, other service-users, or staff ;

- serious damage to property;

- an offence being committed.

2.8 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses, where possible. (See paragraph 1.14 on "Risk assessment".)

Definition of "seclusion"

2.9 Seclusion is the **supervised confinement** of a service user alone in a room, the essence being the involuntary isolation of the individual. In the Mental Health (Northern Ireland) Order 1986 Code of Practice, the Mental Health Commission define seclusion as 'the forcible denial of the company of other people by constraint within a closed environment". The service user is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit available to the service user. This situation would also arise where the door is not locked from outside but the service user is unable to open the door, due to, for example, the height of the door handles or the person's physical disability. The breadth of the definition is important because the practice of seclusion is subject to very stringent control and recording in comparison to other procedures.

2.10 The issue of seclusion is particularly complex. Seclusion is an emergency procedure, only to be resorted to when there is an immediate risk of significant physical harm. There is general agreement that it should not be considered as a form of treatment; the aim should be simply that of safe containment. Seclusion is usually unpleasant, and difficult for a service user to view other than as punishment, and not a therapeutic experience. In 1996, the Royal Colleges of Psychiatry and Nursing published a joint review into strategies for managing disturbed violent patients ("*Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units").* The reason for the review stemmed from the well-founded and widespread concern about the potential for the misuse of seclusion. Concerns had focused on its use for prolonged periods of time (Department of Health and Social Security, 1980; Department of Health and Social Security, 1985 – full references to these reports and those below in this paragraph are given at section 6 of this guidance) as well as on the indications for, and frequency of, its use. Matters came to a head with the occurrence of several deaths, notably those of Sean Walton at Moss Side Hospital in 1988 and of three patients at Broadmoor Hospital (Department of Health, 1993). In 1992 the Committee of Inquiry into complaints at Ashworth Hospital strongly recommended the abolition of seclusion within that hospital as well as a wider, statutory prohibition (Department of Health, 1992). Since the Ashworth Inquiry the Special Hospitals have made it their stated policy to limit the use of seclusion to exceptional circumstances and to promote alternative approaches for the

management of violence. **This approach is endorsed by this Working Group which recommends its adoption.**

2.11 In considering seclusion there is a need to draw a distinction between:

- *seclusion* where a service user is forced to spend time alone against his/her will;
- *time out* which involves restricting the service user's access to all positive reinforcements as part of a behavioural programme (this is explored in more detail in paragraph 2.13); and
- *withdrawal* which involves removing the person from a situation which causes anxiety or distress, to a location where he/she can be continuously observed and supported until ready to resume usual activities.

2.12 The 1996 review (see paragraph 2.10 above) noted that:

> "Any credible review of the use of seclusion must consider other, more routine and therapeutic approaches to aggression that might forestall or replace the practice."

Definition of "time out"

2.13 Time out is a procedure whereby the service user is separated temporarily from the current environment as part of a planned and recorded therapeutic programme to modify his/her behaviour. The breadth of its definition is open to misuse to encompass what is, in fact, seclusion. Although a distinction is made between it and seclusion, in practice it is less readily separable. This potential for confusion is open to abuse. The widespread use of time out, particularly with certain service user groups, such as children or those with a learning disability, makes it difficult to regulate to the same extent as seclusion. It has been recommended that the term 'time-out' be avoided in preference to a clear description of the procedure that is actually proposed. Such an approach inevitably raises the issue of consent, which should underwrite all therapeutic processes. **The term 'time out', or another comparable term, must state explicitly exactly what this entails within the practice of the unit and procedures regarding consent etc for its use. Policies should also provide for ensuring that the understanding of service users is clearly recorded and the action monitored and reported to a senior staff member as soon as possible: in the case of children, parents or those with parental responsibility should also be informed at the earliest possible opportunity.**

Nature and types of physical interventions

2.14 There are three broad categories of physical interventions as described by Harris et al (1996):

- **direct physical contact** between a member of staff and services user;
- **the use of barriers** to limit freedom of movement;
- **materials or equipment which restrict or prevent movement.**

2.15 **Physical intervention skills** are described by McDougall (1996) as a set of techniques that are designed and taught to momentarily prevent or curtail a behaviour which is deemed to be dangerous to that individual or others.

2.16 No physical intervention, whether planned or emergency, should ever intend or knowingly be allowed to cause pain.

Planned physical interventions

2.17 The planned use of physical interventions involves the use of an agreed strategy which includes the possible use of physical intervention to intervene in a sequence of behaviours with the aim of avoiding or reducing injury/injuries.

2.18 Planned physical interventions, including restraint for the purposes of medical interventions, should be part of a broader therapeutic strategy. It is envisaged that there may be rare occasions when restraint might be necessary, in someone's best interests, to facilitate urgent medical treatment. Where medication may be used to facilitate restraint in the management of disturbed or violent behaviour, reference should be made to the recent NICE guidance "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments".

2.19 Planned physical interventions are normally used as a last resort. Strategies designed to manage aggressive/violent behaviours should include:

i. ecological strategies and the environment of the service user;
ii. early intervention and de-escalation;
iii. emergency use of physical intervention.

(i) Ecological strategies and the environment of the service user (primary prevention)

2.20 Ecological Strategies involve providing environments likely to reduce the likelihood of aggressive or violent behaviours occurring. It involves changing aspects of an individual's personal environment to minimise situations arising that are known precursors to the service user displaying behaviours which have implications for the safety of him/herself or others.

2.21 It is the context in which violence occurs that is of most importance when considering measures to limit the use of restraint and/or seclusion. Violence may reflect the expectations of the staff, low levels of staffing or changing staffing. The emphasis is moving from the control of violence to its prevention

by measures such as an improved environment and staffing, both in levels and skills. Crucial to this are staff attitudes, training, good communications and supervision.

2.22 Children are particularly responsive to their surroundings. Special attention needs to be paid to creating a safe environment for disturbed and violent children. A designated safe area or safe room may be helpful, but this should reflect normal domestic living space as far as possible. Children and adults with certain disabilities, such as autism, benefit from routine, regularity and predictability in their lives which in turn makes disturbed and violent behaviour less likely to occur. People of all ages are less likely to show such behaviour if they are provided with choices or are kept active with relevant challenges.

2.23 In a designated safe area, it is necessary to minimize the risk of self injury or of serious damage to property. In achieving this aim, it is important to balance the service user's need to be cared for in an environment which reflects normal living space (in terms of decoration and furnishings, where appropriate) with the need to ensure his/her safety.

2.24 Trusts and other providers in constructing operational guidance for the use of seclusion and/or restraint need to consider how they can manage the service users' environment or care setting to limit the potential for violent and/or aggressive behaviour. Environment, in this context, includes both the physical environment and the level and qualification of staff. A comprehensive understanding of how setting, staff and service users can interact is necessary to ensure preventative as well as reactive strategies are in place to deal with service users with complex and at times challenging needs.

(ii) Early intervention and de-escalation (secondary prevention)

2.25 Plans for early intervention and de-escalation are instigated after it becomes clear that an aggressive episode of behaviour is likely to occur. They seek to prevent the escalation of such behaviours and in all cases they should be individualised to the service user concerned. These approaches focus on communication, negotiation, use of staff body language, personal space etc. with the overall aim of maintaining safety.

2.26 The use of physical interventions generally raises a number of serious issues for service users, staff and service providers alike. The following are some issues which should be considered more fully, with each organisation regularly providing clear guidelines and advice to staff.

- Consent of service users issues as covered in DHSSPS Guidance "Good Practice in Consent", particularly where there are issues relating to children and the competence of other service users to provide valid consent.

- Assessment for benefit and risks associated with the procedure.

- Legal, ethical and professional issues.
- Physical health status of the service user.
- Impact on individual of intervention.
- Least restrictive physical intervention.
- Particular vulnerability of service users taken into account.
- Staff requirements.
- Method of recording, reporting and reviewing.

(iii) Emergency use of physical interventions

2.27 Emergency physical interventions may be required in response to unexpected episodes of aggressive or violent behaviours. Physical interventions can be justified to maintain the safety of the service user or others. However, the amount of force used must be proportionate to the level of threat presented by the service user - staff should use the minimum amount of force for the least amount of time required with the aim of maximising the safety of everyone involved.

2.28 Following the use of emergency physical interventions, procedures should be followed which entail recording/reporting the incident and the updating of the service user's individual care plan to include assessment of risk, preventative strategies and a programme of planned responses to any such future behaviour. (See paragraphs 3.9-3.18 on Post-Incident Management Monitoring).

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3. QUALITY ASSURANCES, COMPLAINTS AND ADVOCACY ARRANGEMENTS AND POST INCIDENT MANAGEMENT AND MONITORING

Quality assurances

3.1 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables service users, regardless of age or need, maximum opportunity for personal growth and emotional wellbeing.

3.2 In care settings, good practice in the use of restraint and seclusion described in this guidance will be monitored as part of HSS Trusts' compliance with the Duty of Quality requirements established by the HPSS Order 2003, which commenced in April 2003. The establishment of the HPSS Regulatory and Improvement Authority (HPSSRIA), which is scheduled to become operational in 2005, will also ensure that standards of practice and levels of compliance in these areas will be regulated on an independent basis across the statutory and independent sectors. It is also expected that local policies and procedures explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restraint and/or seclusion.

3.3 Under health and safety legislation, employers are responsible for the health safety and welfare of their employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of restraint and seclusion. Employers should establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about service users with whom they are working.

- Leadbetter and Trewartha (Leadbetter, D and Trewartha, R (1995) A question of restraint, *Care Weekly*, 18 May, 10-11) noted that employers have to give equal priority to the safety of staff and service users. Under Health and Safety legislation (Health and Safety at Work Act 1974), they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This obligation has been reinforced by civil cases successfully brought by employees against their employers. Leadbetter and Trewartha cite the case of Walker v. Northumberland County Council (1994) where the judgement hinged on the council's failure in their duty of care in that they had not taken action to avoid or mitigate 'reasonably foreseeable' risks to their employee's health.

- Lindsay and Hosie (Lindsay, M and Hosie, A (2000) *The Edinburgh Inquiry - Recommendation 55. The Independent Evaluation Report.*

University of Strathclyde and the former Centre for Residential Child Care) state that in the case of litigation employers would have to demonstrate that the method of restraint they chose best suited the needs and circumstances of their clients and, on the basis of the best available advice, was likely to address the demands of day to day practice. The problem is that there is a striking absence of evidence about the respective merits of the various techniques.

3.4 Commissioning authorities will need to ensure that provider agencies' policies and procedures follow this guidance where restraint and/or seclusion is used. Registration and Inspection staff will also monitor the implementation of the resulting policies and procedures in the course of their work across the statutory and independent sectors.

Complaints and advocacy arrangements

3.5 Complaints arrangements should follow policies developed for Trusts in response to the "Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services (April 2000)" and Children Order (Article 45(3)) requirements in respect of complaints and representations made in relation to children's social services.

3.6 Trust staff should ensure that complainants are easily able to make a complaint, that this process is simple and aimed at satisfying the complainants' concerns. Where necessary staff should provide information on the Advocacy Service available. Responses to complainants should be timely and emphasise early resolution. Staff should be informed of the existence of a complaint and appropriate staff involved in the investigatory process. Staff should also be informed of the outcome of any complaints made in respect of them.

3.7 Discussions should take place on the investigatory process and feedback from complaints should inform any review of complaints at team meetings.

3.8 Training and awareness building should usually be managed within the organisation, with lessons emerging from complaint case studies used to promote the development of good practice. To this end, Trusts and other providers should annually monitor complaints received in relation to the use of restraint and seclusion. This annual review should be used to inform, where necessary, the revisions of policies and procedures and the design of staff training and support processes.

Post-Incident Management and Monitoring

General

3.9 It is recognised that Post- Incident Management and Monitoring (PIM&M) is critical where restraint or seclusion are used. Some Trusts may regularly audit the use of these processes as this is considered good practice. Auditing and

monitoring should be carried out on a multi-disciplinary basis, where appropriate.

3.10 The PIM&M procedure will have the following elements clearly itemised within it:

- feedback to those with parental responsibility/carers that does not infringe on the service user's right to confidentiality;
- debriefing the service user after the incident;
- providing information on how to make a complaint;
- service users who are injured will always be examined by a doctor following the incident;
- Trust accident/incident form will be completed as soon as possible after the incident, stating exactly what happened – **no assumptions: facts only** (examples of incident forms are given at Annex I (a) - Restraint Report Form - and Annex I (b) (Seclusion Report Form – organisations will develop their own format to cover their particular circumstances);
- details of all/incidents are recorded in service users' files. In some instances, this record is required even where a separate monitoring form is in use.
- Reports to outside agencies (Mental Health Commission, HPSSRIA etc).

3.11 If staff are injured – a statement must be completed to include as a minimum the following information:

- place where injury happened;
- number of staff on duty and their location at the time of the incident;
- number of service users in the area.

Staff

3.12 Where staff are injured the following actions are required:

- refer staff to Occupational Health Department or Accident and Emergency Department if injured. If they decline, advise them to contact their own GP and record this advice;

- accident report form to be completed according to Trust policy requirements.

3.13 It is important that staff are made aware of the potential emotional shock that may follow on from an assault or injury. Managers/peers need to be supportive, recognising that even minor incidents, such as verbal abuse/comments, can be traumatic. Staff should be given the opportunity to talk and express how they feel. A de-briefing discussion after an incident can assist those involved. Relevant areas for discussion include:

- identification of cause/trigger factors to incident;
- ascertaining what exactly occurred;
- identifying staff's role in the incident;
- ascertaining the feelings of staff involved;
- what learning experiences and/or training needs can be identified from incident.

Staff Support

3.14 Employers have responsibilities to support all staff. To this end, individual members of staff involved in an incident must be given an opportunity to discuss their feelings. This will include:

- individual/group discussion with the line manager;
- access to confidential counselling from Occupational Health Department through self-referral or line management referral;
- awareness of professional body or Trade Union role/support;
- multidisciplinary review/debriefing discussion of incident with colleagues/peers to allow staff to review, reflect and talk about their views following the occurrence;
- access to confidential staff care or support system.

Monitoring Arrangements

3.15 Effective monitoring procedures are essential and must be comprehensive and timely. Monitoring includes:

- the risk of violence being regularly assessed by appropriate senior staff which will vary according to the setting;

- assessing the effectiveness of the implementation of existing policies and procedures, identifying any gaps or need for updating;

- reassessing the effectiveness of countermeasures introduced and disseminating good practice examples;

- discussions at staff meetings, senior staff meetings etc. to raise issues arising with a view to improving safeguards for both service users and staff. This should include ensuring staff are aware of whistle blowing policy and feel confident in using it;

- recording and analysis of complaints made, ensuring that reports are regularly brought to the attention of the Trust's Chief Executive under Clinical and Social Care Governance arrangements.

Audit

3.16 Audit mechanisms should focus on a number of factors which can give managers a baseline assessment on the effective implementation of policy, such as:

- number of incidents of physical injuries sustained by service users as a result of a violent episode;

- number of incidents of physical injuries sustained by staff as a result of a violent episode;

- number of incidents of verbal/threatening behaviour to staff/service users;

- number of occasions that physical restraint, "time out" or equivalent was carried out in a setting, identifying any possible explanation for peaks and troughs in its usage over time.

3.17 It can be helpful to use audit information to compare levels of violence, restraint or seclusion across similar service areas to ascertain if there are any environmental factors (see paragraphs 2.20-2.24) which are either serving to reduce or increase levels in any setting.

Where service users are injured

3.18 If a service user is injured as a consequence of the use of restraint, the following action is required:

- ensure the service user receives appropriate and timely medical assistance;

- notify carer, parent or those with parental responsibility immediately of the injury and the steps taken to deal with the injury, securing appropriate consent for treatment where necessary;

- make a detailed record of the event and the consequences in the service user's case file;

- complete an accident report form and inform the Trusts Risk Management Unit which will make any other necessary notifications;

- complete a Physical Intervention Monitoring/Restraint Report Form (example attached at **Annex I(a) – organisations will develop their own forms to cover their particular circumstances**);

- senior managers review incident on discussion with staff and ascertain if there are any training, support or supervisory matters which require to be addressed;

- inform service user, carer, parent or those with parental responsibility of the Trust's complaints arrangements and how to access them.

4. LEGISLATIVE CONTEXT

General

4.1 Generally, primary legislation makes little explicit reference to the use of restraint and seclusion, with the issue being dealt with in most areas by Guidance and Regulation. The exception to this is the education sector where the use of restraint in schools by authorized persons is regulated by primary legislation and by detailed guidance. There is, however, no uniformity of approach across different sectors and no standard threshold indicating when restraint or seclusion can be used legally. Legislatively and in terms of best practice, restraint and seclusion in relation to the care of service users should only be used in exceptional circumstances and it must be ensured that all techniques used are approved, safe and in compliance with international rights standards. The DHSSPS has issued guidance on consent (Good Practice in Consent) with which staff should acquaint themselves.

4.2 The remainder of this section considers **the European Convention on Human Rights (ECHR)** and **the United Nations Convention on the Rights of the Child (UNCRC)** before outlining some case decisions to assist with identifying situations where the use of restraint or seclusion is potentially open to challenge under these international conventions. It concludes with comment on the legislative context for specific groups of service users who are identified as particularly vulnerable.

The European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998

4.3 Many of the following paragraphs use children's cases for illustrative purposes. This reflects the expertise of the legal issues sub-group whose remit was to specifically address the issue in respect of children. The messages emerging have, however, wider application and the working group has edited the sub-group's contribution and extended parts of the material to the wider field.

4.4 The Human Rights Act 1998, which came fully into force in October 2000, enables most of the rights enshrined in the ECHR to be pursued in the domestic courts rather than through the European Court of Human Rights (ECtHR). All public authorities are obliged to discharge their functions in accordance with the rights sets out in the ECHR and the courts must take Convention rights into account when deciding cases. These rights apply to both children and adults.

4.5 In the context of the use of restraint and seclusion the following articles of the ECHR should be taken into consideration.

Article 3 ECHR

4.6 No one shall be subjected to torture or inhuman and degrading treatment or punishment.

Article 5 ECHR

4.7 Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;

(b) the lawful arrest or detention of a person for non compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority;

(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purposes of bringing him before the competent legal authority;

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, and of drug addicts or vagrants;

(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

Article 8 ECHR

4.8 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The United Nations Convention on the Rights of the Child (UNCRC)

4.9 The UNCRC is an international treaty on children's rights, which all countries have signed with the exception of U.S.A. and Somalia. The key relevant provisions of the UNCRC are set out below.

Article 1 UNCRC

4.10 For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2 UNCRC

4.11 States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

4.12 States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members.

Article 3 UNCRC

4.13 In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

4.14 States Parties undertake to ensure the child such protection and care as is necessary for his or her well being, taking into account the rights and duties of his/her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end shall take all appropriate legislative and administrative measures.

4.15 States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff as well as competent supervision.

Article 12 UNCRC

4.16 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 19 UNCRC

4.17 States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child.

Article 25 UNCRC

4.18 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 37 UNCRC

4.19 States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which take account of the needs of a person of his/her age. In particular every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

(d) Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 UNCRC

4.20 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self respect and dignity of the child.

The United Nations Committee on the Rights of the Child

4.21 The implementation of the UNCRC is monitored by the United Nations Committee on the Rights of the Child. In the "Concluding Observations of the United Nations Committee on the Rights of the Child, United Kingdom of Great Britain & Northern Ireland", October 2002[1] the Committee expressed concern about figures indicating that children had sustained injuries as a result of the use of restraints and control in prison. In addition, the Committee expressed concern about the frequent use of physical restraint in residential institutions and in custody as well as the placement of children in solitary confinement in prisons.

4.22 The Committee recommended the review of the use of restraint and solitary confinement in relation to children and young people in custody, education, health and welfare institutions to ensure compliance with the UNCRC in particular articles 25 and 37 UNCRC (paragraphs 4.18 and 4.19 respectively of this Guidance).

4.23 The Committee also expressed concern that the principle of primary consideration for the best interests of the child is not consistently reflected in legislation and policies affecting children and recommended that the principle of the best interests of the child as a paramount consideration should be enshrined in all legislation and policy affecting children.

Restraint and seclusion: human rights issues and the key caselaw

4.24 Seclusion is described in the Department of Health (England and Wales) Code of Practice (1999) as:

[1] The Concluding Observations of the UN Committee on the Rights of the Child published on 9 October 2002 and available online at www.unhchr.ch/tbs/doc.nsf

> "*the supervised confinement of a patient in a room, which may be locked for the protection of others from significant harm."*

4.25 In practice, seclusion is a form of solitary confinement which can be used for therapeutic, containing or punitive purposes. The purpose of restraint has been described by the Department of Health as the use of physical force against a patient to minimise unacceptable behaviour. Both seclusion and restraint in relation to the care of service users raise potential human rights issues. A number of these issues have been raised in the domestic courts and further guidance can be obtained from the case law of the European Court of Human Rights (ECtHR).

4.26 The leading domestic authority on the use of restraint in the mental health context remains the House of Lords decision in *Pountney* v *Griffiths* [1976] AC 314 where it was held that hospital staff had "powers of control over mentally disordered patients, whether admitted voluntarily or compulsorily, though the nature and duration of the control varies with the category of patient to which the patient belongs." The ECtHR decision in *Herczegfalfy* v *Austria* [1992] has placed the concept of medical necessity at the core of any intervention of this type. The ECtHR stated that:

> "the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with…..The established principles of medicine are admittedly decisive in such cases; **as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading**. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist." (Highlighting added.)

4.27 The question of the burden of proof in relation to whether a medical necessity has been "convincingly shown" was examined in *R* v *Dr M and others* ex parte *N* [2003] 1 WLR 562 where the Court of Appeal held that while the requirement was not equivalent to a criminal burden of proof it still required a high standard of proof. The decision in this case is an important one in that the Court of Appeal reviewed the common law authorities on consent to treatment. Simon Brown LJ found that the "therapeutic necessity" test applied both to patients with and without capacity. This decision would appear to indicate that where treatment of questionable therapeutic benefit is administered to a patient who strongly opposes it, and which will, if administered, involve the use of physical force with possible detrimental effects to the patient's health, that this will constitute a violation of Article 3 of the Convention. This approach should, therefore, apply to the use of restraint and seclusion of all service users who have capacity and to those whose capacity may be questioned as a consequence of their age or other impairment.

4.28 In order to breach the terms of Article 3 of the Convention the treatment in question must reach a particular threshold of severity. (See *S* v *Airedale NHS*

Trust [2002] EWHC 1780). Brief periods of seclusion and proportionate instances of restraint are, therefore, unlikely to reach the requisite threshold to constitute a breach of a Convention Right.

4.29 There is the possibility that restraint and seclusion could be argued as a breach of Article 5 of the ECHR. In the context of adult mental health the developing jurisprudence has held that Article 5 protections are restricted to the determination of whether detention is lawful or not. (See *R* v *Governor of Parkhurst Prison* ex parte *Hague* [1992] 1 AC 58.) Where detention of a child or adult takes place on a non-statutory basis then the possibility of an Article 5 breach arising from the use of either seclusion or restraint is a real one.

4.30 Similarly, treatment that falls short of medical necessity may constitute a breach of Article 8 of the ECHR. However, the broad justifications available in Article 8(2) are likely to render many interventions with service users to be in accordance with the ECHR.

4.31 The decision in *Herczegfalfy* found that there was no breach of Article 8 where the individual was restrained and force fed in circumstances where he was "entirely incapable of taking decisions for himself." It remains to be determined whether differential treatment of service users deemed to lack capacity because of age or intellectual impairment will fall foul of the anti-discrimination provisions of Article 14 of the Convention. It should be noted that a mere assertion of differential treatment is not enough to ground an Article 14 point. (See Carswell LCJ's discussion in *Re Jean McBride* [2003]).

Impact of legislation for specific service users

Professional guidance relating to medical settings

4.32 The British Medical Association in a recent publication set out a number of considerations in relation to the use of restraint in respect of the care of children in medical settings:[2]

1. Restraint should only be used where it is necessary to give essential treatment or to prevent a child from significantly injuring him/herself or others.

2. Restraint is an act of care and control, not punishment.

3. Unless life prolonging or other crucial treatment is immediately necessary, the approval of a court should be sought where treatment involves restraint or detention to override the views of a competent

[2] British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People*, BMJ Books, 2001.

young person, even if the law allows doctors to proceed on the grounds of parental consent.

4. All steps should be taken to anticipate the need for restraint and to prepare children, their families and staff for its use.

5. Wherever possible, the members of the health care team involved should have an established relationship with the child and should explain what is being done and why.

6. Treatment plans should include safeguards to ensure that restraint is the minimum necessary to achieve the clinical therapeutic aim, and that both the child and parents have been informed what will happen and why the use of restraint is considered necessary.

7. Restraint should only be used in the presence of other staff, who can act as assistants and witnesses, unless there is no other means of protecting the service user or others.

8. Any use of restraint or detention should be recorded in the medical case records. These issues are appropriate subject for clinical and social care audit.

4.33 The Royal College of Nursing has issued Guidance on the use of restraining and preventing children from leaving a medical setting.[3]

Children's residential care services

4.34 The relevant provisions on children's residential care services are to be found in the Children (Northern Ireland) Order 1995, regulations made under the Order and in Volume 4 (Residential Care) of the associated series of volumes of "Guidance and Regulations". There is no reference at all in the 1995 Order to the use of restraint or isolation. The Children's Homes Regulations (Northern Ireland) 1996, made under the Children Order, make provision at regulation 8 in relation to control and discipline. Regulation 8 (2) sets out measures which should not be used on children in a children's home; and regulation 8 (3) gives measures which the regulations do not prohibit, including "the taking of any action immediately necessary to prevent injury to any person or serious damage to property".

4.35 These provisions are considered under 'Good Order and Discipline' in Chapter 4 of Volume 4 of the Guidance and Regulations. In particular, the following areas are set out and dealt with:

- Disciplinary Measures – general (Paragraph 4.14)

[3] The Royal College of Nursing. *Restraining, Holding Still and Containing Children: Guidance for Good Practice.* London: RCN, 1999.

- Permitted disciplinary measures (Paragraphs 4.15 – 4.19)

- Prohibited measures (paragraph 4.20)
  Corporal punishment
  Deprivation of food and drink
  Restriction or refusal of visits/communications
  Requiring a child to wear distinctive or inappropriate clothing
  The use or withholding of medication or medical or dental treatment
  The use of accommodation to physically restrict the liberty of any child
  Intentional deprivation of sleep
  Imposition of fines
  Intimate physical searches

- General principles governing interventions to maintain control (Paragraph 4.21)

- Methods of care and control of children which fall short of physical restraint or the restriction of liberty (Paragraph 4.42)

- Use of physical presence of staff (Paragraphs 4.43 – 4.24)

- Holding (Paragraphs 4.2.5 – 4.25)

- Touching (Paragraphs 4.27 – 4.28)

- Physical restraint (Paragraphs 4.29 – 4.34)

- Restriction of liberty (Paragraphs 4.35 – 4.39)

- Monitoring (Paragraph 4.40)

4.36 The Children Order guidance provides specific guidance on the use of restraint and the restriction of liberty. Paragraph 4.13 specifically prohibits the locking of children in their bedroom at night "whatever their age and competence". The Guidance outlines permissible forms of care and control and establishes a comprehensive list of general principles governing interventions to maintain control.

Foster care

4.37 The Foster Placement (Children) Regulations (NI) 1996 provide for the approval of Foster Parents (Regulation 3), the Review and Termination of Approval (Regulation 4), Placements (Regulation 5) and Termination of Placements (Regulations 7).

4.38 Regulations 3(6)(b) provides that an authority shall not place a child with an approved foster parent unless he enters into a written agreement with it covering the matters specified in Schedule 2 (Matters and obligations to be covered in foster care arrangements). Pursuant to Paragraph 5 of the Schedule each foster carer must specifically agree "Not to administer corporal punishment to any child placed with him".

4.39 Under the Guidance issues in respect of the Children (NI) Order 1995 (Volume 3 Family Placements and Private Fostering) at paragraph 4.31 (Assessment and approval of foster carers) there is a duty placed on the social worker to 'ascertain the applicant's views on discipline with particular regard to the issue of corporal punishment which is not regarded as an appropriate means of correcting children'. The term "corporal punishment" is then defined to cover 'any intentional application of force as a form of punishment, including slapping, pinching, squeezing, shaking, throwing objects and rough handling. It would also include punching or pushing in the heat of the moment in response to violence from young people. It does not prevent a person taking necessary physical action where any other course of action would be unlikely to avert immediate danger of physical injury to the child or to another person, or to avoid immediate danger to property. Verbal abuse, derogatory remarks and pointed jokes can cause psychological harm to a child and should be avoided'.

4.40 In relation to children who are privately fostered, the Trust does not approve or register private foster parents but must satisfy itself that the arrangements are satisfactory that the private foster parents are suitable. The responsibility for safeguarding and promoting the welfare of the privately fostered child rests with the parents. Regulation 2(2)(j) of The Children (Private Arrangements for Fostering) Regulations 1996 places a duty on the Trust to satisfy itself that the private foster parent is being given any necessary advice. Pursuant to Chapter 15 (Suitability of the foster parent) of the Guidance Volume 3 there is reference to discipline with particular regard to the issue of corporal punishment (paragraphs 15.13-15.14). The definition of corporal punishment is provided and there is requirement that a child should not be refused meals or drink as punishment nor restricted from visiting or being visited by family and friends as a means of punishment. The UK National Standards for Foster Care requires policies to be in place on corporal punishment to ensure that each child in foster care is protected from all forms of corporal punishment (smacking, slapping shaking) and all other humiliating forms of treatment or punishment.[4]

There is no legislative provision in relation to the use of restraint and isolation for the child who is in foster care – either under the Children (NI) Order 1995 itself or any regulations issued thereafter. There is similarly, no specific guidance in relation to restraint and isolation. However the Trust is under a duty to assess foster carers (and give advice to private foster carers) and in this context these issues may be addressed by the individual Trusts. Guidelines are

[4] Published by the National Foster Care Association on behalf of the UK Joint Working Party on Foster Care.

issued by the National Foster Care Association on the Care and Control of Children in Foster Homes.

Secure accommodation

4.41 Article 44 of the Children (NI) Order 1995 sets out the criteria by which a child can be placed or kept in secure accommodation. The associated regulations are the Children (Secure Accommodation) Regulations 1996. This statutory provision permits the restriction of liberty of children but also ensures that any such decisions taken by the Trust or others are scrutinised and endorsed by the Court. A child cannot be placed or kept in secure accommodation unless it appears that

(a) (i) he has a history of absconding and is likely to abscond from any other description of accommodation; and

(ii) if he absconds, he is likely to suffer significant harm; or

(b) that if he is kept in any other description of accommodation he is likely to injure himself or other persons." (Article 44)

4.42 The criteria must apply and once it no longer applies then the child must not continue to have his liberty restricted (even if there is a court order authorising the restriction currently in existence). The definition of "restriction of liberty" is a matter which is to be determined by the Court and may include any practice or measure which prevents a child from leaving a room or building of his own free will. This is a measure of last resort and will only be permitted when it is evidenced that there is no appropriate alternative. The onus is therefore on the Applicant to show that everything else has been comprehensively considered and rejected. The secure placement should only be for as long as is absolutely necessary (and not for the duration of the Court Order itself). The Trust have a duty to take reasonable steps to avoid the need for children to be placed in secure accommodation (The Children (NI) Order 1995; Schedule 2 paragraph 8(c)).

4.43 There is one unit in Northern Ireland which provides secure accommodation for children at Lakewood in Bangor.

Services provided under the mental health legislation

4.44 The use of restraint and seclusion in respect of service users is not referenced in the primary legislation, the Mental Health (NI) Order 1986. The Code of Practice, which accompanies the Mental Health (NI) Order 1986, does, however, provide limited guidance on the use of restraint and seclusion generally.[5] Section 5.33 requires every Unit of Management (i.e HSS Trust) to have a policy on the use of all forms of physical restraint (physical restraint in

[5] 1992, Belfast, HMSO

the context of this guidance includes locked ward doors, time out and seclusion). Sections 5.32 – 5.53 of the Code of Practice gives guidance on restraint, locked doors on open wards, time out and seclusion. Within this Guidance there is, however, no specific reference to children and young people.[6]

4.45 In the case of *S* v *Airedale NHS Trust* a young person who was a mental health in-patient challenged his detention in seclusion by the NHS Trust while they sought a more suitable placement to meet his needs. S was being held in a locked room at night because a bed was not yet available for him at a secure unit. He argued that the NHS Trust was obliged to follow the Mental Health Code of Practice (1999) and that there had been a breach of Article 3 ECHR in relation to the conditions he was held under and a breach of Article 8 ECHR. The High Court rejected the application stating that the conditions he was held under were not poor enough to constitute a breach of Article 3 ECHR. It was concluded that the NHS Trust had acted lawfully, but S appealed to the Court of Appeal, which considered his case alongside the case of Colonel Munjaz who was challenging the policy at Ashworth Hospital not to follow the Mental Health Code of Practice when patients were secluded for more than three days.[7]

4.46 Seclusion is defined in paragraph 19.16 of the 1999 Code of Practice as the supervised confinement of a patient in a room, which might be locked to protect others from significant harm. The Code states that seclusion should be used as a last resort and for the shortest period of time; that a decision to seclude should be taken by a doctor or nurse in charge and that the continued need for seclusion should be reviewed every two hours by a nurse and every four hours by a doctor. The question before the Court of Appeal was whether seclusion was capable of infringing Articles 3, 5 and 8 of the ECHR as incorporated by the Human Rights Act 1998. It was no longer argued that in these particular cases a breach of Article 3 had occurred.

4.47 The Court of Appeal accepted that there was an implied power for the authorities to seclude a person who was compulsorily detained under the Mental Health Act within a hospital setting as a "necessary ingredient flowing from the power of detention for treatment". In addition, seclusion could amount to medical treatment. The Court was of the view that there was no doubt that seclusion could potentially amount to inhuman and degrading treatment or punishment prohibited under Article 3 ECHR, but segregation from other detained patients did not itself constitute such treatment. Seclusion also infringed Article 8 (2) ECHR unless it could be justified under Article 8(2) ECHR. However, the further seclusion of a detained patient did not amount to a deprivation of liberty for the purposes of Article 5 ECHR which was concerned

[6] See also the Mental Health Act 1983, Revised Code of Practice (1999) which applies in England and provides more detailed guidance on restraint, seclusion, locked wards and also contains a detailed section on children and young people.

[7] The Court of Appeal gave judgment in both cases in R (*Munjaz) v Mersey Care NHS Trust and R(S)v Airedale National Health Service Trust and others* [2003] EWCA Civ 1036 (16 July 2003)

with the lawfulness not the conditions of detention, although there would be a breach of Article 5 (1) ECHR if a person was detained in a type of institution which was inappropriate to meet the purpose of his detention.

4.48 Where issues relating to a patient's human rights were engaged, the Code of Practice should be followed by all hospitals unless there was good reason to depart from it in individual cases. In the Munjaz case, the Court held that the wholesale departure from the Code of Practice in certain groups of cases based on the length of time spent in seclusion was unlawful. In the case of S, on the facts the Court found his seclusion (which was in breach of the Code of Practice and used on the basis that there was no other more suitable placement available for him) to be unjustified.

Other areas of interest

4.49 Although not directly related to the HPSS sector, the following examples of interpretation of the law in other sectors are of interest and knowledge of them may assist staff working in settings which interface with either the education or youth justice sectors.

Education sector

4.50 Article 4 of the Education (NI) Order 1998 came into force on 21 August 1998 and authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

4.51 Non teaching staff are also authorised to use reasonable force in these circumstances provided they have been authorised by the Principal to have lawful control or charge of pupils.

4.52 Detailed guidance for schools is contained in "Guidance on the Use of Reasonable Force to Restrain or Control Pupils", DE Circular 1999/9 and is included in "Pastoral Care in Schools; Child Protection". A copy of this guidance is attached at **Annex J** for reference.

Youth justice

4.53 The use of restraint and seclusion of children in a custodial youth justice setting is regulated by the Juvenile Justice Centre Rules (NI) 1999. Regulation 29 allows for the use of "forms of control" approved by the Secretary of State in

dealing with "unruly children".[9] Regulation 30 allows for the use of temporary confinement of a child for up to 24 hours. These Rules must be interpreted in light of the ECHR as incorporated by the Human Rights Act 1998.

4.54 In a recent case taken by the Howard League for Penal Reform in England[10] an 18 year old applicant (who was 17 at the time complained of) argued that his segregation on two periods for five and four days respectively in a segregation unit in a young offenders centre and the conditions under which he was detained there amounted to a breach of the Young Offender Institution Rules 2000 ("the Rules") and a breach of his rights under Article 3 and Article 8 of the European Convention On Human Rights. The judge held that there had been a breach of the Rules, but on the facts no breaches of Articles 3 and 8 of the Convention. It is of note, however, that the judge stated that, although he was not making a finding under Article 3 in this particular case, he was prepared to accept that solitary confinement of a child (in other words, someone under 18) could amount to a breach of Article 3 in circumstances where it would not in relation to an adult. In respect of Article 8 he stated:

> " *I hope I may be permitted merely to utter this warning: there are clear dangers in placing young people in segregation units in relation to their rights enshrined in Article 8".*

Conclusion

4.55 The legal issues relating to the use of restraint and seclusion are complex. The discussion above has, therefore, sought to highlight issues which staff and their employers need to take into account in using these procedures with any service user. The use of restraint and seclusion are measures of last resort. Staff in making use of either procedure should have a clear understanding of the rights of service users and when it is appropriate for them to employ either restraint or seclusion and the safeguards that should be in place to ensure they are not subject to legal challenge. Employers have a duty to provide key staff with training on human rights considerations under ECHR and other relevant international instruments, and that their policies and procedures ensure that work in these difficult areas is of a high professional standard. There is, therefore, a clear link between this section of the guidance and those relating to policy, training, complaints and management and monitoring arrangements.

[9] This is the wording of Regulation 29

[10] *The Queen on the Application of BP v The Secretary of State for the Home Department* [2003] EWHC 1963 Admin

5. PRINCIPLES INVOLVED

General

5.1 This section discusses some of the key principles relating to the use of restraint and/or seclusion and ends with a statement of principles which should underpin the use of these interventions.

5.2 Important principles regarding the protection of individuals from abuse by State organisations or the staff working within them are set out in the Human Rights Act 1998. In addition, it is a criminal offence to use physical force, or to threaten to use force, unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock a service user in a room without a court order (even if they are not aware that they locked in) or the consent of the service user, except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. For children, rules are specified in the regulation 6 of the Children (Secure Accommodation) Regulations (NI) 1996 ("the 72 hours rule"). Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

5.3 The use of restraint and seclusion should always be designed to achieve outcomes that reflect the best interests of the individual service user whose behaviour is of immediate concern and others immediately affected by the behaviour.

5.4 The decision to use restraint or seclusion must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing either restraint or seclusion as a method of intervention.

5.5 Efforts to minimise the use restraint or seclusion should be in place. This may require the adoption of primary and secondary preventative strategies.

5.6 Primary prevention is achieved by:

- ensuring that the number of staff deployed and their level of competence corresponds to the needs of service users and the likelihood that physical interventions will be needed. Staff should not be placed in vulnerable positions;

- helping service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities;

- developing care plans, which are responsive to individual needs and include current information on risk assessment;

- creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement;

- developing staff expertise in working with service users who present challenging behaviours;

- talking to service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some service users prefer withdrawal to a quiet area to an intervention which involves bodily contact.

5.7 Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing 'defusion' techniques to avert any further escalation. Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of interventions at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective, and

- the risks associated with *not* acting are greater than the risks of using restraint or seclusion; and

- other appropriate methods, which do not involve restraint or seclusion, have been tried without success.

5.8 All prevention strategies should be carefully selected and reviewed to ensure that they do not, except through necessity, either constrain opportunities or have an adverse effect on the welfare or the quality of life of service users (including those in close proximity to the incident) . In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities, which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment.

5.9 Particular regard should be had to service users' attitudes towards physical contact, physical stature, age, gender and previous life experiences when restraint is being used. Restraint and seclusion should be used as measures of a last resort and in a way that is sensitive to, and respects the cultural expectations of service users. Any physical intervention used in restraint should avoid contact that might be misinterpreted as sexual.

5.10 Where restraint is employed staff must ensure that they only employ a reasonable amount of force, that is, the minimum force needed to avert injury or serious damage to property, applied for the shortest possible period of time.

Planned physical interventions should only be used as part of a holistic strategy where the risks of employing an intervention are judged to be lower than the risks of not doing so.

Proactive use of restrictive physical interventions

5.11 In most circumstances, restraint or seclusion will be used reactively. Occasionally, it may be considered in the best interests of the service user to accept the possible use of an intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to 'shadow' the child and to adjust the level of any physical intervention needed according to the child's behaviour. Similarly, staff might be sanctioned to use restraint, if necessary, as part of an agreed strategy to help a person who is gradually learning to control his/her aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.

5.12 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate.

Emergency use of restrictive physical interventions

5.13 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence shows that injuries to staff and to service users are more likely to occur when restraint is used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions is used.

5.14 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restraint to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property.

5.15 Even in an emergency situation, any force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restraint in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences, which might have occurred without the use of a physical intervention.

5.16 There must be a written protocol, which includes:

- a description of behaviour sequences and settings which may require the use of restraint or seclusion;
- the results of any assessment which has determined any contra-indications for the use of physical interventions;
- a risk assessment which balances the risk of using physical intervention against the risk of not using a physical intervention;
- a record of the views of the service user or those with parental responsibility in the case of children, and family members in the case of adults not deemed competent to make informed choices;
- a system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages;
- a record of previous methods which have been tried without success;
- a description of the specific physical intervention techniques which are sanctioned, and the dates on which they will be reviewed;
- details of staff who are judged competent to use these methods with this person;
- the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

5.17 An up-to-date copy of this protocol must be included in the service user's individual care plan.

5.18 The use of a restraint or seclusion should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. See paragraphs on Post-Incident Management and Monitoring (paragraphs 3.9-3.18).

STATEMENT OF PRINCIPLES

5.19 **The following principles should underpin the use of restraint and seclusion with service users across the range of client groups**.

- **The philosophy of care is the least restrictive and controlling possible for the individual service user.**
- **Prevention strategies are in place to minimise the need to use either of these interventions.**
- **Institutions or settings employing either restraint and/or seclusion have clearly defined policies for the management of violent service users.**
- **Restraint and seclusion are interventions of last resort, used for the minimum time necessary to protect life, to safeguard from harm or to prevent serious damage to property.**
- **The management of disturbed and violent behaviour requires a multidisciplinary approach to planning for the care and treatment of the service user.**
- **The principles for the management of disturbed and violent behaviour which poses a risk to the individual or other service users are the same whatever the institution or setting.**
- **Planned use of these interventions is based on a risk assessment and is part of the care plan for the individual service user, of which they are informed.**
- **The risk assessment specifies if there are reasons why a specific intervention should not be employed with an individual service user.**
- **The age, gender, personal characteristics of the service user and setting specific factors are all drawn together to inform the use of any approach designed to manage or control behaviours.**
- **The use of these interventions is recorded in a standardised manner as soon as possible after the incident.**
- **Post incident monitoring is carried out at a senior level within the service to:**
  - **ensure compliance with human rights requirements;**
  - **ensure compliance with the *last resort* principle;**

- **ensure that the minimum amount of force was used for the shortest possible period of time;**

- **compliance with the policies and procedures;**

- **that staff involved were appropriately trained; and**

- **determine what lessons can be extracted to inform future practice, training or staff support.**

- **Staff employing these interventions are appropriately trained to ensure they use the procedures to promote the well being and best interests of service users and in a manner consistent with the Human Rights Act and the European Convention on Human Rights.**

- **Staff working with children ensure that their practice is consistent with the United Nations Convention on the Rights of the Child and that complaint procedures are available in a child friendly format.**

- **Staff and service users have opportunities for de-briefing after the use of these interventions.**

- **Management strategies for disturbed and violent behaviour should be regularly monitored and audited.**

- **Service users and their families are aware of how to complain if they are dissatisfied about the way they were managed prior to, during and after the incident.**

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ANNEX A

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

OUTLINE TERMS OF REFERENCE

Restraint and seclusion can be used in a variety of health and social care settings eg. residential/nursing homes, children's homes, hospitals and facilities accommodating people with a learning disability and mental health problems. There are possible implications for Articles 3, 5 and 8 of the ECHR. The purpose of this piece of work is to develop guidelines for staff to ensure that any restraint or seclusion is reasonable, proportionate and justifiable in the circumstances and that appropriate documentation is completed.

Methodology

- Examine current policies and procedures.
- Examine current practices, including local audits, work in progress, research reports - is there evidence of best practice anywhere?
- Examine current documentation and recording mechanisms.
- Examine complaints in this area to identify weaknesses and areas for action.
- Examine existing case law to identify issues and guiding principles.

Product

User-friendly, practical guidelines which:

(a) are human rights compliant and which have been validated by the appropriate professions, legal advisors, the NIHRC, the Equality Commission;

(b) have been quality assured; and

(c) are capable of incorporation into training for new and existing staff, where relevant.

Accountability

Boards, Trusts etc. will be asked to report on progress on implementation of the guidelines within the framework of Priorities for Action and the Health and Well-being Investment Plans. It is not envisage that this piece of work will be issued as a Departmental circular as the objective is to support and encourage staff to develop a human rights culture within their organisations and their own policies and procedures to implement the guidance. This approach recognises that different organisations will be at different stages of applying practice and have varying needs depending on their client group and whether they are residential or community based services.

ANNEX B

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

MEMBERSHIP

Mrs Marion Reynolds (Chair)	Social Services Inspectorate, DHSSPS
Ms Tara Caul	Children's Law Centre
Mr Arthur Dick	Down Lisburn HSS Trust
Ms Heather Ellis	Human Rights Liaison Group
Mrs Roisin Gallanagh	School of Nursing, University of Ulster
Mr Gene Gillease	Western Equality & Human Rights Forum
Dr Joan McGuinness	Armagh & Dungannon HSS Trust
Mr Clinton Stewart	North & West Belfast HSS Trust
Ms Alison Wilson	Secure Units, Lakewood
Ms Linda Wilson	Barnados
Mr Cecil Worthington	Ulster Community and Hospitals HSS Trust
Mr Niall Young	Homefirst HSS Trust
Mr Stewart Love	Human Rights Unit, DHSSPS

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ANNEX C

MEMBERSHIP OF SUB-GROUP ON LEGISLATIVE CONTEXT

Tara Caul

Prof Tony McGleenan

Henry Tower QC

Carol Sholdis BL

Denise Hunt BL

Marion O'Neill, Solicitor

Hilary Wells, CSA

ANNEX D

EXAMPLE OF HSS TRUST

MANAGEMENT OF

AGGRESSION POLICY

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1.0 POLICY STATEMENT AND TRUST'S PRINCIPLES

It is the policy of this Trust to promote an organisational culture and develop associated structures that prevent aggression in the workplace. The Trust seeks to equip all staff with the appropriate attitudes, knowledge and skills to work with service users in those situations which critically challenge how they are supported. This will enable management of aggression to be achieved in a caring manner by the implementation of training and policy initiatives that promote best practice.

This approach must fit with the wider quality issues of clinical and social care governance and controls assurance. Each service should develop, where appropriate, local procedures reflecting the ethos of this policy.

The existing law requires that individuals do not interfere with the rights of others, eg the use of physical intervention techniques. Such action can, however, be defended if it is intended to prevent harm to the service user or others. Members of Trust staff must be able to demonstrate clearly that they act at all times in the best interests of the individual.

The following are the Trust's principles underpinning the policy.

- Service users and carers should be treated with respect at all times and their dignity maintained.

- Person centred approaches, sensitive to the needs of the individual and promoting effective communication between service users and staff, should be practised to help reduce the likelihood of aggressive incidents.

- Prevention of aggression is preferable to intervention at a later stage.

- The use of physical intervention techniques, may on occasions be necessary to fulfil a duty of care. However, these should be kept to an absolute minimum and carried out within local service guidelines. Physical intervention techniques when used will take full account of the service user's need for respect, privacy and dignity as well as social and cultural considerations.

- The personal safety of staff, service users, carers, students on placement and other persons carrying out authorised tasks on behalf of the Trust is of paramount importance to this Trust. Personal safety takes priority over damage to property.

- The Trust recognises its legal and moral responsibility to reduce risk to staff, service users, carers, students on placement and others to the lowest level practicable.

- Trust staff have individual and collective responsibility for ensuring that aggressive incidents are kept to a minimum and effective risk management procedures are in place to secure this aim. The safety of service users is everyone's responsibility.

- The training and support provided to Trust staff will recognise these principles and will provide staff with a tool-kit of skills that will enable them to manage difficult situations in a person-centred manner.

2.0 DEFINITION OF AGGRESSION

The Trust defines aggression as behaviour resulting in damaging or harmful effects (physical or psychological) on another person or persons. This includes:

- verbal abuse
- non verbal abuse (eg stalking)
- threats of physical abuse
- physical abuse
- threats of sexual abuse
- sexual abuse
- damage to property

The above definition includes behaviour directed at staff, service users, carers, students on placement and other persons carrying out authorised work on behalf of the Trust.

3.0 RESPONSIBILITIES

[Describe the relevant responsibilities within the Trust]

The Trust Board has the responsibility for overseeing the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. The Chief Executive in conjunction with his colleagues on the operational Management Team is charged with meeting these responsibilities. The Operational Management Team, which includes the Heads of Service in the Trust, directs all Trust initiatives to reduce the risks of aggression whilst providing person-centred services to service users. The Operational Management Team is accountable through the Chief Executive to the Trust Board.

3.1 Staff Responsibilities

All staff have a responsibility to ensure that their behaviour towards service users and their carers reflect a person-centred approach. Staff should be aware of the impact of their own behaviour and how this could precipitate or increase the severity of an incident of aggression. All staff who work directly with service users should endeavour to be aware of the risk factors for aggressive

behaviour. Trust training will reinforce the value of appropriate communication skills. Staff are obliged to adhere to this policy and associated training at all times.

While it is the legal responsibility of the Trust to provide safe systems of work, individuals have a personal responsibility to follow safe working practices.

3.2 Management Responsibilities

Chief Executive

The Chief Executive carries overall responsibility for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. He is responsible to:

- ensure that appropriate arrangements are in place within the Trust to manage aggression;
- ensure that those systems that are in place are in line with clinical and social care governance;
- ensure that effective monitoring systems are in place to quality assure these arrangements

Heads of Service

- Ensure that their staff are aware of the policy and that its relevance to their work is recognised
- Ensure any additional local procedures in a particular service area fits with the Trust-wide approach.
- Allocate resources (time, people and financial outlay) according to areas of highest risk.
- Ensure staff are adequately trained.
- Provide High level monitoring of the level and effectiveness of training.
- High level monitoring of incident patterns.
- Develop systems which will support staff and service users following an aggressive incident.
- Communicate, where appropriate information, information about significant known risks to ensure remedial action is taken to address these.

Service Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Implement Trust recruitment and selection procedures to ensure that applicants are fully aware of the roles and inherent risks associated with

the job. This should facilitate the selection of an appropriate person for the post.

- Ensure staff are adequately trained.
- If necessary draw up service specific local procedures to support and underpin the Trust-wide policy and approach.
- Ensure that appropriate risk assessments of aggressive behaviour associated with use of Trust's services have been carried out in conjunction with staff, service users and carers and using a multi-disciplinary approach. This should occur within the annual service-planning cycle.
- Fully implement the Trust's incident reporting policy
- Ensure that any risks identified are managed appropriately through an action-plan approach. These risks should be reviewed within an agreed timescale
- Ensure arrangements to support and supervise staff are implemented and monitor their effectiveness.
- Ensure that managers have a system for investigating any aggressive incidents in their area.
- Monitor and implement lessons learned from incidents and provide feedback and information to staff and the Risk Management Unit.
- Inform their Service Head of areas of significant risk to ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

First Line Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Provide Induction Training for new staff.
- Implement Trust recruitment and selection procedures to ensure that persons applying are fully aware of the roles and inherent risks associated with the job. This should facilitate the selection of an appropriate person for the post
- Ensure appropriate management of aggression and the provision of learning and skills development. This should include, as appropriate, training in a multi-disciplinary and at times multi-agency fashion.
- Ensure all training given to their staff is formally recorded and staff's training is kept up to date.
- Ensure that appropriate risk assessments are carried out and remain up to date.
- Involve other disciplines, as appropriate, in the management and assessment of risk of aggressive incidents.

- Ensure all incidents are reported promptly to the Trust's Incident Reporting Centre.
- Carry out investigation of any incidents occurring, supported by their Service Manager and the Risk Management Unit for significant incidents.
- Arrange for appropriate and comprehensive support for employees following an incident.
- Promote team-working.
- Monitor practice (formally and informally) and ensure the best standard by ongoing supervision.
- Use manpower planning skills to release staff for training.
- Keep Service Manager informed of any significant risks or implementation problems and ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

Supervisory Management

- Promote best practice by example and on the job training for staff.
- Assist in implementing risk assessment procedures.
- Ensure that all incidents are reported promptly.
- Inform first-line manager of significant risks or problems and the arrangements required to reduce risk.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

3.3 Special Responsibilities

Consultants and Lead Clinicians/Social Care Professionals

- Responsible to ensure adequate and appropriate assessment of the service user presenting a risk because of aggressive behaviour. Although this process may initially start with one discipline it will in many cases involve a multi-disciplinary approach and may also require involvement from other Trusts and agencies as appropriate.
- Following assessment, development of management/care/treatment plans.
- Monitor, review and adjust these plans following re-assessment of the service user.
- Ensure that known risks are communicated where appropriate to staff and others to ensure other decisions are properly informed.
- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.

- Ensure that their staff receive appropriate induction and updated training, and support and supervision.
- Implement the Trust's Incident Reporting Policy.
- Ensure that their staff are aware of arrangements for post-incident staff support and that these are readily available when required.
- Lessons learned from incidents should be effective in changing practice in the workplace. Any information from this process should be passed on to the relevant staff and the Risk Management Unit.
- Promote team-working.

Head of Operational Support

- Chairs the Health and Safety Committee
- Provides quarterly reports to the Operational Management Team about aggressive incidents including learning points.
- Senior manager responsible for risk management advice, as member of the strategic Operational Support Team.
- Manages the Service Manager responsible for the Risk Management Unit.
- Responsible for alerting other senior managers to significant risk issues to ensure timely, appropriate responses.

Risk Manager

- Service manager responsible for managing the Risk Management Unit.
- Provides professional advice on Trust-wide management of risk.
- Devises, develops and reviews policies and procedures to reduce risk.
- Devises and manages risk assessment processes.
- Manages the process of reporting and monitoring incidents ensuring that managers are kept informed about incidents reported in their area and any significant implications for work practices.
- Responsible for analysing trends and providing managers with quarterly information about lessons to be learnt.
- Manages the training function for the reduction of risk.
- Advises managers at every level on targeting high risk areas.
- Provides assistance to managers to find risk solutions, leading to action plans.
- Ensures that the Trust minimises the risk of civil and criminal liability and that there is appropriate legal defence where cases are filed against the Trust.

Head of Human Resources

- Senior manager responsible for Occupational Health Services, learning and development and all other human resource issues.

- Sets high-level recruitment and selection procedures.
- Responsibility for redeployment and disciplinary issues.
- Provides high-level specialist advice to the Trust in the above areas.
- Establishes processes and protocols and makes arrangements for post-incident staff support and monitors its effectiveness.

Occupational Health Sister

- Manages the process of pre-employment health assessments.
- Provides a service for pre-employment risk assessment.
- Provides specialist advice to managers on employee's health.
- Advises managers and employees on return to work following an incident.
- Provides approved courses for Trust is First-Aiders.
- Organises appropriate health surveillance.
- Provides a work-place assessment service for managers

Human Resources Managers

- Provide advice on managing the processes of recruitment and selection.
- Advise managers on performance management issues.
- Assist and advice managers in implementing disciplinary procedures etc..

Trade Union Health and Safety Representatives

- May investigate hazards and dangerous occurrences in the workplace.
- May investigate complaints relating to health, safety and welfare at work by the staff they represent.
- May make appropriate representations to Trust Management in respect of the above issues.
- May carry out inspections in respect of the above issues.
- May represent appropriate staff in consultations with Trust Management, or inspectors of any enforcing agency.
- May attend meetings of safety committees, as appropriate, in connection with the above functions.

4.0 ARRANGEMENTS FOR MANAGING AGGRESSION

4.1 Organisational Risk Assessment

Information from the individual assessments of service users and risk factors regarding the working environment must feed into a process. This will help inform the broader assessment of risk of a ward, Trust facility/department or caseload. It is important that a collective view of risk is formed, as this is the way risk can best be managed and high-risk areas can be appropriately targeted.

The process is as follows:

- first-line managers of the ward/department/Trust facility have responsibility to initiate the process;
- risk issues from individual risk assessments are drawn together and patterns of risk are identified;
- consideration of any factors which may increase or decrease risk in any place where staff are at work;
- assessments should result in the production of action plans to prioritise and manage high risk and significant risk issues;
- information from this assessment should be used to inform their line manager so that a picture of risk emerges. This will enable the Service Manager to make plans to manage risk through the annual service-planning cycle and also on a day-to-day basis;
- finally, this process should inform the Heads of Service and the Operational Management Team about significant Trust-wide risks.

The organisational assessment of the risk of aggression will include:

- the actual number of incidents;
- the service user groups involved;
- the perceived risks associated with the work situation and procedures;
- staff perceptions of risk;
- the use of preventative strategies;
- the appropriateness of support and supervision arrangements provided by the Trust;

4.2 Individual Risk Assessment

Appropriate professionals should routinely carry out suitable and sufficient risk assessments in conjunction with staff, service users and carers. These assessments must be completed and reviewed at appropriate regular intervals and should include consideration of the risk of aggressive behaviour associated with the use and provision of Trust services.

The individual service user's risk assessment must address the following areas:

- harm to self or others;
- past history of aggression, its pattern, frequency and seriousness;
- likelihood of any possible incident;
- individuals who may potentially be at risk;
- precautions that already exist;
- any further actions that need to be taken to reduce risk.

Following risk assessment a reasoned judgement must be reached and recorded regarding the assessed degree of risk. Appropriate action and communication must then be taken on the basis of that judgement. The initial risk assessment will be reviewed and may change to reflect the ongoing management of the service user's care. Where there is disagreement between professionals regarding the proposed strategy of managing risk, decisions should be taken to a more senior level.

4.3 Communication of Risk Information

Managers and staff must consider their responsibility to provide information about significant risks which may affect other departments/services within the Trust. This should include sharing information about measures in place to address the risks. Information should be exchanged with all people who may be at risk in a timely and easily understood manner. Care must be taken to preserve the confidentiality of service user's information. Serious and imminent danger to others will however on rare occasions form a reasoned basis for the sharing of confidential information.

In addition, all managers have a legal responsibility (under Health and Safety legislation) to inform other persons not employed by the Trust who may be at risk due to the actions, or failure to act, of the Trust.

4.4 Recruitment and Selection

Recruitment and selection documentation should be explicit about the nature of the work, and any foreseeable risks in handling challenging behaviours. Profiles of facilities should be used and reviewed regularly. Recruitment panels, where appropriate, may assess staff's ability, (or potential ability) to deal with situations where aggressive behaviours may occur. At recruitment the pre-employment risk assessment process developed by Occupational Health should be followed.

4.5 Staff Learning and Development

4.5.1 Induction

Managers must ensure that all new staff attend the organisational induction programme. They must agree a personal development plan for the next twelve months for all new staff. New staff will be required to read and understand their responsibilities within the Management of Aggression policy. Line managers should discuss any questions and clarify issues so that new staff have a clear idea of what to expect and how best to manage the different situations.

Training courses should be available, if possible before service commences, or as soon as possible thereafter.

4.5.2 Monitoring and Supervision

People responsible for staff must assist staff with their professional development. They are also responsible for assisting with the development of a competent staff team by identifying training needs.

Ongoing monitoring of compliance with the requirements of the Management of Aggression policy and staff performance will be included in the supervision process.

4.5.3 Training and Development

All staff will have the opportunity to develop their knowledge and skills in a person-centred approach to managing aggression. Appropriate learning and development initiatives currently within the Trust will facilitate this process. The need for staff development will be identified as part of the process of risk assessment. Learning and development will be targeted to address assessment of actual risks and will include the use of information from previous incidents or potential incidents.

The experience and knowledge of service users and carers will be incorporated when staff development resources are being produced and implemented.

Overseeing learning and skills development will be the responsibility of the first line manager and should, where appropriate, include training in a multi-disciplinary and at times multi-agency fashion.

Management of Aggression learning and development objectives will be evaluated in terms of how effectively the knowledge and skills learned have been applied to the workplace by staff. This training should be service specific.

4.5.4 Performance Management and Redeployment

Managers have a responsibility to constantly monitor the performance of staff in managing aggression. If managers or staff are aware of any performance issues this should be addressed using some or all of the following options:

- counselling;
- further training;
- job advice;
- redeployment options;
- disciplinary action.

Where staff have experienced a particularly traumatic incident/s the manager has special responsibility to consider how best to support staff in the working environment.

4.6 Managing an Incident

4.6.1 Reporting, Investigating and Monitoring

Information is essential to assist in the reduction and prevention of incidents, the need for staff development and evaluation of the efficacy of training or other interventions.

The Trust's Incident Reporting Procedure must be implemented throughout Divisions as follows:

- all incidents of aggression must be reported as soon as possible to the person in charge of the relevant area/department by the person(s) directly involved;
- all staff must use the Trust's Incident Report Form to report all significant incidents of aggression (as defined in this policy) and forward immediately to the Incident Reporting Centre at Trust Headquarters;
- major incidents must be reported to the Incident Reporting Centre within 24 hours or as soon as possible. This is a legal requirement under the Reporting of Injuries Diseases and Dangerous Occurrences, (Northern Ireland), Regulations 1997. The responsibility for reporting under these regulations lies with the Risk Management Unit. Managers and staff discharge their responsibility once they have reported to the Incident Reporting Centre.

Line managers must investigate every incident that occurs within their business areas. However, serious or highly significant incidents must involve the Risk Management Unit.

These reporting and investigatory arrangements do not detract from the legal responsibilities placed upon the Trust to formally investigate and report on individual incidents where injury has occurred.

The significance of aggressive incidents will vary within the differing service areas in the Trust. It is the responsibility of the Service Manager to define which incidents are significant for their particular area.

The importance of reporting incidents should be promoted more positively by demonstrating how effective information collection and analysis can contribute to the implementation of appropriate change measures eg training initiatives, resource strategies etc..

Managers should monitor the frequency and severity of incidents in their business areas. The Risk Management Unit will produce reports at agreed intervals for managers to assist them in this task. Areas most at risk need to be clearly identified and remedial measures put in place.

4.6.2 Post Incident Support

The Trust wishes to promote a culture of support that permeates the total organisation. Each service should demonstrate a commitment to providing support to staff, service users and carers involved in an incident.

Service managers are responsible for ensuring that the individual receives the appropriate form of support.

The form of support should be responsive to individual need and the following options should be offered:

- support immediately after the incident within the department/unit (Group or individual);
- opportunity to go off duty;
- contact relative, friend or Trade Union representative;
- taxi Home/Transport arrangements;
- assistance and accompaniment to hospital;
- ongoing managerial contact with individual in a considerate/supportive manner;
- long-term support eg staff care, occupational health.

Managers should be aware of the potential long-term effects of an incident and the incremental effects of a series of incidents on their staff's well-being and performance.

If a member of staff feels it is necessary to pursue legal action against an aggressor in the context of their work the Trust will, where appropriate, offer emotional support to staff through the resulting legal process.

4.6.3 Post Incident Review

Each service should have an Incident Review Procedure. Service managers must demonstrate that their service reviews individual incidents within a prescribed time period from the incident occurrence, (ideally 4-7 days post incident).
It is the manager's responsibility to investigate all incidents of significance within their area of responsibility.

The process of incident review should involve consultation with those involved; ie staff, service user, carer or any other person involved in the incident. Each incident should be examined in terms of:

- antecedents – actions, stressors, behaviour etc that may have contributed to the incident;
- nature of incident;
- how it was handled – identify positive and negative staff interactions and strategies adopted that influenced the effectiveness with which the incident was handled.

4.6.4 Learning from Incidents

Incident Review should be regarded as an opportunity:

- to learn from experience;
- to obtain information to prevent/reduce the risk of further incidents;
- to improve services/resources where necessary;
- to promote a learning culture.

It is important that lessons are learned and conclusions drawn from each and every experience. Managers should promote learning from experience and team working throughout their business areas. Opportunities to share learning across the Trust should be maximised to prevent the reoccurrence of similar incidents in other Trust facilities/departments. These may include: management of aggression training sessions, team meetings, and manager's meeting.

4.6.5 Arrangements to Assist Staff Returning to Work Following an Incident

Every effort will be made to provide support to staff in returning to work following an incident. This will include:

- advice from Occupational Health;

- advice from Personnel Services;
- supportive return to work interview with the line manager;
- implementation as soon as possible, of any organisational learning from the incident;
- provision of any required training in management of aggression.

It is primarily the line-manager's responsibility to provide all possible positive support in re-integrating the member of staff back into the workplace.

4.6.6 Contact with External Organisations

Health and Safety Executive (Northern Ireland)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997, require that certain incidents of aggression must be reported to the Health and Safety Executive. In certain circumstances these reports must be made within 24 hours of the incident occurring. This is a legal requirement and failure to meet this requirement constitutes a criminal offence. The Risk Management Unit is responsible for making these reports and it is the responsibility of persons reporting incidents to report them promptly to the Incident Reporting Centre, Trust Headquarters. In cases of death or serious injury these reports should be made by telephone with the form sent on by post, as soon as possible.

Mental Health Commission

It is the responsibility of the Trust to immediately notify the Commission of the following:

- the death of any service user not resulting from natural causes in both the hospital and community settings;
- suspected suicides in both settings;
- sexual assaults in both settings;
- actual or alleged physical assaults by members of staff in both settings.

Where any of the above incidents have occurred within the community, the Commission would not normally require a report on service users who have not received care or treatment for a mental disorder for more than two years.

Written reports of incidents must be submitted to the Mental Health Commission within six weeks of the incident occurring and must include the following information:

- a brief account of the circumstances of the incident;
- information on the mental state of the service user, particularly at the time of the incident;
- information regarding any other person involved in the incident indicating whether staff, other service user or member of the public;
- a copy of the minutes of the multi-disciplinary review meeting.

Where there was no multi-disciplinary involvement with the service user the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action taken as a result of the investigation.

The Commission expects that the Trust will record, monitor and review all incidents and will inspect records and review management's policies and procedures regarding all untoward events.

Registration and Inspection Unit (R&I Unit)

The same reporting requirements for the Mental Health Commission apply for this external agency. The R&I Unit only requires reports with regard to Trust's residential facilities.

Office of Care and Protection

Where any person suffering from a mental disorder has been referred to the Office of Care and Protection, and has been the victim of mishaps or accidents and suffered injury/loss/damage to property which might entitle him/her to compensation, then the Office of Care and Protection needs to be notified. This is to ensure the rights of such persons are protected.

Police Involvement

The Trust recognises the legal right of employees and others to be protected by the police. The Trust may in exceptional cases instigate legal proceedings for those situations in the interests of Trust staff and the community. This may be against the wishes of individuals who have suffered the consequences of aggression but it may be necessary for the protection of others.

The Trust's training programme and service specific procedures should include guidance for staff on the recognition of those situations when it would be appropriate to call for the assistance of the police.

APPENDIX 1 Committees and Groups with Management of Aggression Responsibilities

APPENDIX 2 OTHER RELEVANT TRUST DOCUMENTS

For example:

Health and Safety Policy

Untoward Incident Reporting Policy

Managing Diversity Policy

Confidentiality Policy

Managing Attendance Policy

Special Observation Policy

APPENDIX 3 RELEVANT LEGISLATION

Mental Health (Northern Ireland) Order 1986, *ISBN 0-11-066595*

Children (Northern Ireland) Order 1995, *ISBN 0-337-92257-8*

The Northern Ireland Health and Personal Social Services Order 1991

Health and Safety at Work Order (Northern Ireland) 1978 *ISBN 0-11-084039-9*

Management of Health and Safety (Northern Ireland) Regulations (1992) *ISBN 0-337-90359-X*

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1997) *ISBN 0-337-93043-0*

APPENDIX 4 SOURCES OF FURTHER INFORMATION

B.I.L.D, Physical Interventions, a policy framework, 1996, *ISBN 1-873791-86-0*

Dealing with Violence against Nursing Staff, an RCN Guide for Nurses and Managers, 1998, order code 000837

Violence at Work, UNISON

The Management of Aggression and Violence in Places of Care. An RCN position statement, 1997, order code 000 713

Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*

Violence and Aggression to Staff in the Health Services. Guidance on Assessment and Management. Health and Safety Commission, Health Services Advisory Committee, 1997, *ISBN 0-7176-1466-2*

Management of Imminent Violence, clinical practice guidelines to support mental health services. Occasional paper, 1998, Royal College of Psychiatrists Research Unit.

Trainers in the Management of Actual or Potential Aggression. Code of Professional Conduct and Minimum Training Standards RCN Institute 1997

Practitioner-Client relationships and the Prevention of Abuse, UKCC, 1999

Code of Professional Conduct, UKCC, June 1992

Protecting the Public, UKCC, July 1997

Guidelines for Mental Health and Learning Disabilities Nursing, UKCC, April 1998

Guidelines for Records and Record-keeping, UKCC, October 1998.

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ANNEX E

EXAMPLE OF HSS TRUST

Protocol on the Use of Physical Restraint

Mental Health Hospital Services and Adolescent Psychiatric Inpatient Services

TABLE OF CONTENTS

1.0 Introduction

This policy underpins the Trust's *"Management of Aggression Policy"* and should be read in conjunction with it. It is specifically written for Mental health Hospital Services and Adolescent Psychiatric Inpatient Services, it is not applicable to any other business area of the Trust.

The law requires that individuals do not unnecessarily/arbitrarily interfere with the rights of others, e.g. the use of physical intervention techniques. However, such action may be defended *if it is intended to prevent harm to the service user or others.* Trust staff must be able to demonstrate that they have acted at all times with regards to the best interest of the individual. All physical restraint must be carried out in accordance with the principles and ethos taught in the Management of Aggression training provided by the Trust.

Since staff have a responsibility for the health and safety of themselves and others, they must give assistance in managing aggression where and when necessary. This does not mean that all staff will become involved directly with the physical restraint of a service user, but that they may be able to provide other supporting assistance in meeting the needs of the situation.

In compliance with Section 75 of the Northern Ireland Act 1998, this policy/protocol has been drawn up, with the underlying principle, that this course of action should not adversely impact any of the 9 equality groups set out in Section 75 of the above Act.

2.0 When should physical restraint be used?

Physical restraint is designed to take control of a dangerous situation, limiting the person's freedom for no longer than necessary to end or reduce the potential harm to self or others.

Staff should attempt to remain calm and use de-escalation techniques before, and during, the use of physical restraint. Physical restraint should only be used when all other approaches at de-escalation have failed and/or physical aggression is actual or imminent.

The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All physical restraint should be applied in a manner that attempts to defuse, rather than provoke, further aggression.

Physical restraint should only be employed as a proportionate response to aggression likely to harm the service user or others. Damage to property does not usually warrant the use of restraint, unless the act in itself is going to cause danger to others or the service users themselves.

The number of staff required to safely employ physical restraint will depend on the situation. If alone and faced with real or potential violence staff should attempt to escape from the situation, then summon assistance by the most appropriate means e.g. use of alarm systems, shout for help etc..

3.0 Training

[Provide information on any training available to staff.]

4.0 Best Practice in the use of Physical Restraint

There are basic principles that should be borne in mind when using physical restraint. These principles and practical guidance for their implementation are contained within the Trust's Management of Aggression training courses. Staff attending these courses will be provided with this knowledge and skill.

- Service users should be treated with respect at all times and their dignity maintained.

- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users' co-operation and a return to voluntary control as soon as is safely possible.

- Well-briefed, trained and a co-ordinated staff response will be the most effective means of dealing with restraint situations.

- The aim is to restrain the service user safely in a low stimulus environment. This may mean moving the service user or asking others to leave.

- Preferably staff taking the lead in restraint situations should be those who have received training within the Trust as they will be able to provide advice and guidance to others.

5.0 Weapons

For the purpose of this document a weapon is defined as:

"Any object that is made, adapted or intended to be used to cause physical injury to a person"

A concise dictionary of Law (1192) pp 282
Oxford University Press, Oxford

Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgements must be made using professional knowledge and

experience, risk assessment and management of aggression training. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police.

6.0 Involvement of Police Service of Northern Ireland

There may be times when the level of threat posed or the nature of the attack means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the nurse in charge of the unit to action appropriate assistance. The use of the police for assistance will trigger the completion of an untoward incident review.

7.0 Management of physical restraint

1. One person should take the lead in the restraint and nominate others to assist him/her.

2. In a team restraint situation the person taking care of the head should co-ordinate the restraint. The rest of the team should take their instruction from the co-ordinator.

3. The service users' co-operation should be sought and encouraged at all times.

4. Communication with the service user is imperative throughout and he/she should be kept informed of what is happening to encourage his/her co-operation.

5. All persons not involved in the restraint should be asked to leave however, other staff should be available to provide additional assistance if required.

6. The doctor should be called to see the service user as soon as possible after commencement of restraint in the adult wards. Young People's Centre staff should refer to the procedure for restraint of an individual in their unit.

7. A full account of the incident must be documented clearly and concisely in the service user's notes and on the incident form and a physical intervention monitoring form must be completed (see Appendix 1).

8. If physical restraint is employed for more than half an hour a review must be carried out by the nurse manager/duty nurse manager at that time, and every half-hour thereafter to ensure that only intermittent restraint is used. This review must be fully documented in the service user's notes.

9. Following restraint the nursing team must review their interventions. The multi-disciplinary team must review the interventions as soon as possible.

Appendix 1
Physical Intervention Monitoring Form - Sample

Trust
PHYSICAL INTERVENTION MONITORING FORM

Service User's Name	Service User's Number	Unit/Ward	Date of Incident

Exact time commenced and exact location am/pm	Exact time discontinued and exact location am/pm

Staff action(s) immediately PRIOR to using physical intervention (please tick

1. None-insufficient time	☐	4. Administration of PRN medication	☐
2. Told the service user to stop	☐	5. Counselling	☐
3. Attempts to de-escalate the situation (specific in comments section)	☐	6. Other (specify in comments section)	☐

Why did you first intervene? ***(tick one box only)***
Aggressive behaviour in progress

1. Towards others	☐
2. To self	☐
3. Other (specify)	☐

Details of all people involved

Name	Job title	Role/Responsibility	Method used*

*Key
1. Looking after the head
2. Immobilisation of the legs
3. Immobilisation of an outstretched arm
4. Immobilisation of a bent arm
5. Immobilisation of the hand
6. Taking over from a colleague

Breakaway (please indicate point of contact eg wristgrab, method used to breakaway and subsequent actions.)

Service User's position during the restraint

Column 1 – Please indicate all positions that the service user was held in during the restraint process. Number from 1 accordingly.

1st position – 1,
2nd position – 2 etc

Column 2 – Please indicate the SINGLE position that was maintained the most throughout the restraint process

1. Sitting on a chair/sofa		
2. Sitting on a bed		
3. Sitting on the floor		
4. Kneeling on the floor		
5. Lying on a bed – face up		
6. Lying on a bed – face down		
7. Lying on the floor – face up		
8. Lying on the floor – facedown		
9. Walking to another area		
10. Standing		

Use of protective clothing or other equipment by staff

Not used		Plastic apron	
Latex gloves		Cut-resistant gloves	
Ligature cutters		Eye wear	

Injuries occurring during the intervention process

Service User	*Injury*	*Staff*
	No visible injury	
	Reddening/bruising	
	Swelling	
	Lacerations/Cuts	
	Scratches	
	Friction burns	
	Thermal burns/Scalds	
	Other – Please specify In the 'comments' box	

Subsequent Action
'As required' medication given

No Further Action Required ☐ **Orally** ☐ **Injection** ☐ **Time administered** ☐

Comments: Further details of actual behaviour preceding restraint, and attempts made to prevent the situation escalating any injuries sustained, use of protective clothing or equipment and any other relevant points.		
Date of Completion	Name of person leading	Signature
For administration use only Incident form no……	Copies to: Incident Report Centre	

TO BE COMPLETED BY THE PERSON IN CHARGE AT THE TIME OF THE PHYSICAL INTERVENTION TAKING PLACE

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ANNEX F

EXAMPLE OF HSS TRUST

POLICY ON SECLUSION

Definition for Seclusion

The forcible denial of the company of other people by constraint within an enclosed environment.

(Code of practice Mental Health NI Order 1986)

The objective of seclusion is the short term safe containment of patients who are displaying severely disturbed behaviours which are likely to cause harm to themselves or others. It is an emergency management procedure, used only when all other reasonable steps/measures have been exhausted.

Seclusion facilities

Seclusion should be in a safe, secure and clearly identified room which offers maximum opportunity for observation. The room should have adequate heating, lighting and ventilation. Patients should be asked regularly if they require to use the toilet and be escorted to and from the toilet. Staff must make a careful judgement as to what the patient is permitted to take into the room. The patient must always be clothed when placed in seclusion but all belts, ties and shoe laces that could cause harm must be removed. Safety must always be a priority.

The decision to authorise any visit to a patient in seclusion rests with the patients consultant or a medical officer acting on the consultants behalf.

Courtyards should not be sued for seclusion. Where patients wish to access a Courtyard the door must remain unlocked, permitting the patient to re-enter the unit.

Procedure for the use of seclusion

The initial decision to place a patient in seclusion can be taken by:

The Medical Officer
The Nurse-In-Charge of the unit
The Nurse Duty Officer

Where the decision is taken by someone other than a doctor the medical officer should be contacted immediately. The patient should be constantly observed by a designated nurse until the authorisation is obtained from the medical officer.

If not involved in the decision to seclude a patient the nurse duty officer should be informed as soon as possible.

Where seclusion is required frequently or for extended periods, the patient must be referred to the multi-disciplinary team for consideration of their legal status, if not subject to detention.

A nurse should be present and observe the patient from outside the seclusion room door when:

A. the patient has been sedated prior to being secluded.

B. The patient is on constant supervision.

The purpose of seclusion should be explained to the patient, where possible.

Observation

The objective of observation is to assess the condition of the patient, ensure his/her well-being and to determine whether seclusion can be terminated.

The patient should be directly observed at least every 15 minutes and more frequently if individual circumstances demand. A documented report must be made every 15 minutes. This should include information on the patients mood, behaviour, appearance and any request made by the patient. In the case of continued seclusion a review should take place every two hours by the nurse in charge and every four hours by a doctor.

If seclusion continues for more than eight hours consecutively or 12 hours in total over a period of 48 hours, the responsible consultant should be informed by the nurse in charge, to ascertain if a review is necessary.

Record keeping

Detailed records should be maintained in the patients care plan of any use of seclusion, this will include:-

The reasons for its use
Time commenced
Medical staff involved and time of notification
Nurse Duty Officer and time of notification
Nurse in charge of unit
Staff to patient ratio
Staff allocated for observation
Reports on observation and reviews
Time terminated

In addition to recording in the patient care plan, the information will also be forwarded via the day/night report to Nursing Administration for central recording/audit purposes.

Patient requested "Seclusion"

Seclusion is not regarded as a treatment technique. However there may be times when a quiet period in a room may help to reduce agitation or alleviate distress. Individual patients may request time separated from the presence of others. This is not regarded as seclusion unless the door is locked.

Occasionally the patient may request/insist that the door be locked. Where the patient can open the door from inside the room this is not defined as seclusion, however where a patient request time alone in a locked room and cannot open the door from inside this should in all circumstances be regarded as seclusion. The patient should be observed every 15 minutes as per policy and asked if they wish to leave the seclusion room. Seclusion must be terminated immediately on request by the patient.

Use of unlocked seclusion room

There may be occasions where the seclusion room is accessed by a patient with the door unlocked, this does not meet the definition of seclusion. In all cases it should be authorised by the Nurse-In-Charge, discussed with the multi-disciplinary team and recorded in the patients care plan and day/night report.

ANNEX G

QUESTIONNAIRE AND SUMMARY OF FINDINGS

1. To assist in establishing the current position, a questionnaire was issued in June 2003 to all HSS Trusts and to a range of other service providers.

2. The questionnaire issued to providers is attached as an Appendix to this annex.

3. A total of 81 responses were received, greater than the number of organisations approached as in some cases corporate responses were received from units within organisations while others gave a single response. 54 responses were received from HSS Trusts, including Hospital HSS Trusts and Community HSS Trusts, and 27 from voluntary or private organisations and both adult and children's services were covered.

4. The questionnaires asked about restraint and seclusion policies and practices under four main headings:

   Policies and Procedures
   Monitoring Arrangements
   Training
   Complaints Procedure

Policies and Procedures

5. Most of the organisations responding indicated that some policies and procedures on restraint and seclusion were in place: for restraint of adults – 46; restraint of children – 13; seclusion of adults – 6; and seclusion of children – 5. There were 17 organisations which said they did not have or did not need these policies or procedures – however, some of these were in the process of developing a policy. Of those with policies and practices, a number were high level policies, and others were by reference to standards and guidance of professional organisations, eg Royal College of Nursing. Some were detailed documents for the particular organisation and others were relatively brief guidelines. In some instances, although lacking a policy on restraint or seclusion, training was provided on management of violence and aggression.

6. A few organisations (9 in total) said they had facilities for seclusion.

Monitoring Arrangements

7. 15 organisations indicated they had conducted a local audit of practice in relation to restraint and 5 in relation to seclusion.

8. Proformas were available in 32 organisations for recording restraint and in 9 organisations for seclusion.

9. Arrangements were in place to review each client group in the use of restraint in 42 organisations and on the use of seclusion in 8 organisations.

Training

10. For restraint, 53 organisations provided information to their staff of policies and procedures and 39 provided training to staff. For seclusion, 9 organisations indicated that they provided information and 5 training.

11. On the inclusion of human rights implications in training, 33 organisations indicated that it was included for restraint and 7 for seclusion.

Complaints

12. The response to the questionnaire indicated that 45 organisations had mechanisms in place to scrutinise complaints on restraint and 7 had mechanisms in place for seclusion.

Outcome

13. The responses to the questionnaires and the accompanying papers provides very useful background to the working group in establishing the current positions and considering the extent and content of the guidance required.

Annex G, Appendix

HSS TRUST/OTHER SERVICE PROVIDER

QUESTIONNAIRE ON RESTRAINT & SECLUSION

(Please return completed Questionnaires by 27 June 2003)

Name of Trust/Other service provider: ……

Name of Member of staff
responsible for completing
this questionnaire: ……..……

Position in Organisation: ……

Business area/programme of care ……

Contact telephone number:…..……...

E-mail address: ……

Policies & Procedures

1. Do you have policies and procedures, which inform, across all client groups, the use of:

- restraint of adults Yes ☐ No ☐
- restraint of children Yes ☐ No ☐
- seclusion of adults Yes ☐ No ☐ N/A ☐
- seclusion of children Yes ☐ No ☐ N/A ☐

If you have answered **Yes** to any of the above please forward copies of the policies and procedures when returning the completed questionnaire.

If you have answered **No** please outline below what arrangements are in place to regulate the use of **both** restraint and seclusion.

2. Do you have a definition of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of these with the completed questionnaire.

3. Do you have facilities for seclusion: Yes ☐ No ☐

If **Yes** please provide details on the facility and any other information which you feel would be helpful to us in understanding your provision.

Monitoring Arrangements

4. Has your organisation conducted a local audit of practice in relation to:

- the use of restraint with any client group Yes ☐ No ☐
- the use of seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of the audit report with the completed questionnaire.

5. Do you have pro forma for each client group to record use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of the pro forma with the completed questionnaire.

6. Do you have arrangements in place to review each client group the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please provide copies of any pro formas used **or** outline below these arrangements.

Training

7. Do you have arrangements in place to inform staff across all professional groups and programmes of care of your policies and procedures regarding the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please outline the arrangements below

MAHI - STM - 089 - 3280

8. Do you provide training to staff on the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please attach a sheet detailing the **range** of training provided, the **frequency** at which it is provided and the **number** of staff trained each year. If you have a written training programme on restraint and/or seclusion, please enclose it with the completed questionnaire.

9. Please name the type of training provided, indicating, where appropriate, the accrediting body.

10. Does your training include consideration of the human rights implications of using:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please outline the issues covered.

Complaints Procedures

11. Do you have mechanisms in place to scrutinize complaints to identify weaknesses and areas for action in respect of the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please provide details below, including how you have specifically addressed restraint and seclusion issues in this process.

12. If you have any other comments, which you feel would assist us in this area please outline these.

Completed Questionnaires should be returned **by 27 June 2003 to:**

Mrs Heather Humphries
Room C4.22
Castle Buildings, Stormont
BELFAST BT4 3SQ
Email [redacted]

Many thanks for your assistance

ANNEX H

DRAFT GUIDANCE ON RESTRAINT AND SECLUSION IN HEALTH AND PERSONAL SOCIAL SERVICES

EQUALITY IMPACT ASSESSMENT: EQUALITY SCREENING

1. BACKGROUND

1.1 Section 75 of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- **between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;**
- **between men and women generally;**
- **between persons with a disability and persons without; and**
- **between persons with dependants and persons without.**

1.2 In addition, without prejudice to the above obligation, public authorities must also, in carrying out their functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

1.3 Schedule 9 of the Act requires public authorities to prepare Equality Schemes, which should state, among other things, the authorities' arrangements for assessing the likely impact of policies adopted, or proposed to be adopted, by the authority on the promotion of equality of opportunity. Schedule 9 also requires a public authority, in publishing the results of an assessment, to give details of any consideration given to measures which might mitigate any adverse impact of the policy on the promotion of equality of opportunity and alternative policies which might better achieve the promotion of equality of opportunity.

1.4 Equality Schemes are in place for the Department of Health, Social Services and Public Safety and all Health and Social Services Boards and Trusts. The Department and its associated bodies are committed to promoting equality of opportunity.

2. PROPOSALS

2.1 The proposed guidance on Restraint and Seclusion in Health and Personal Social Services (HPSS) is intended to assist HPSS bodies in developing and implementing policies on restraint and seclusion. The purpose is to protect and promote the human rights of anyone in their care who may be subject to such procedures. It is designed to help ensure compliance with, and respect for, the provisions of the Human Rights Act, which gives effect to the European Convention on Human Rights, and other human rights conventions.

2.2 Restraint and seclusion issues, as defined in the guidance, may arise in a range of care settings, such as residential homes for the elderly, children or disabled people, in hospitals, in day-care centres, health centres and where people are being cared for in their own homes.

3. EQUALITY IMPACT ASSESSMENT SCREENING

3.1 Specific areas of concern in relation to the issues of restraint and seclusion may arise for young people, older people and persons with a disability who are in a position of being cared for, whether in a residential setting or otherwise. It is therefore possible that these proposals could differentially impact on **persons of different age** and **persons with or without a disability**. However, no quantifiable evidence is available on the groups subject to restraint and seclusion procedures in HPSS.

3.2 There is no indication of any differential impact in terms of the other seven Section 75 distinctions:

- **between men and women generally;**
- **persons of different marital status;**
- **persons of different religious belief;**
- **persons with/without dependants;**
- **persons of different political opinion;**
- **persons of different racial group;**
- **persons of different sexual orientation.**

3.2 These proposals are intended to inform the development of policies by Health and Social Services Trusts, Boards and other agencies. All public authorities designated as such for the purposes of Section 75 will in any event have to screen these policies as they are developed, to determine whether a full Equality Impact Assessment is desirable. This fact affords a double safeguard regarding equality of opportunity.

4. CONCLUSION

4.1 The proposals are intended to be entirely beneficial in protecting and preserving the human rights of the people affected. There is no adverse impact on other people. Accordingly, it is considered that the proposals do not have an adverse impact in terms of any of the Section 75 distinctions.

4.2 It is also considered that these proposals will have no effect on good relations between persons of different religious belief, political opinion or racial group.

ANNEX I(a)

HSS TRUST

RESTRAINT REPORT FORM

This form should be completed if physical restraint is used in the management of any incident or accident.

Physical restraint refers to any method of responding to aggressive or violent behaviour which involves some degree of direct physical force to limit or restrict movement or mobility, ie the actions of one person which restricts the movements of another person. Physical restraint implies the restriction of a person's movement which is maintained against resistance. It is therefore qualitatively different form other forms of physical contact such as manual prompting, physical support or guidance.

Physical Restraint may involve:

1. **Direct physical contact between a member of staff and a client** eg holding a client's hand to prevent him hitting etc.
2. **The use of barriers, such as locked doors, to limit freedom of movement,** eg placing someone in a chair with a table in front so that he/she can cannot easily stand up or move away, locking doors, etc.
3. **Materials or equipment which restrict or prevent movement,** eg strapping someone into a wheelchair, having a person wear a helmet to reduce the effects of head banging, placing splints on a person's arms to restrict movement, etc.

(A) Form Reference Number ☐

(B) Type of Restraint used: Physical Contact ☐ Barriers ☐ Equipment ☐

(C) Outline the reasons why restraint was used

MAHI - STM - 089 - 3288

(D) Outline details of the method of restraint used (who was involved in the restraint procedure; what procedure was used; who carried out different elements of the procedure; what areas of eth body were in contact etc).

(E) Time restraint started: (24 hr clock) ☐ Time restraint stopped: (24 hr clock) ☐

(F) Outline the individual's response to the restraint procedure being applied.

(G) Was a body check of the individual completed following the restraint procedure?

Check completed	Check refused	Delayed as may have caused Further aggression
☐	☐	☐

Outline details of any injury noted

(H) Outline the tasks completed in recording and reporting this incident (eg IRI form completed; reported incident to carer, manager etc)

(I) Outline any issues arising from this incident which may influence future contact with this individual.

Name of person Completing form _____ Signature _____

Date _____

Please return to _____ by _____

ANNEX I(b)

HSS TRUST

SECLUSION REPORT FORM

Ward No. Date:

Patient's Name _____ Status and Reg No. _____

Description of Incident _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Alternative Measures Tried Prior to Seclusion _____

_____

_____

_____

_____

_____

_____

Patient checked for harmful objects/clothing | Yes/No |

Nurses present _____

Authorisation for seclusion given by _____

Ward Doctor/Duty Doctor informed _____ At _____

Visited by Doctor _____ At (time) _____

Senior Nurse Manager _____ Notified at (time) _____

Duration of Seclusion: From _____ To _____

Monitor Chart Completed | Yes/No

2 Hourly Review by Nurses _____

_____

_____

_____

_____

4 Hourly Review by Doctor _____

_____

_____

_____

Signed: _____

(Nurse in Charge)

CLINICAL SERVICES MANAGER'S REPORT

_____

_____

_____

_____

_____

_____

Signed: _____

ANNEX J

DENI CIRCULAR NUMBER 1999/9 –

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Subject:

Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils

Circular Number:
1999/9

Date of Issue:
8 March 1999

Audience:

- Principals and Boards of Governors of all grant-aided schools;
- Education and Library Boards;
- Council for Catholic Maintained Schools;
- Association of Governing Bodies of Voluntary Grammar Schools;
- Northern Ireland Council for Integrated Education; and
- Teachers' Unions.

Summary of Contents:

This Circular provides clarification and guidance on the use of reasonable force, by teachers and other authorised staff, to restrain or control pupils in certain circumstances. It gives guidance about who can use reasonable force, when it is appropriate to use it, and the procedures for recording incidents where reasonable force was used. It also advises that schools should have a written policy about the use of reasonable force which should be made known to parents.

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Mr Jackie Simpson (Tel: 01247-279247)
Pupil Support Branch
Department of Education
Rathgael House
Balloo Road
BANGOR
BT19 7PR

Status of Contents:
Advice
Information for schools

Related Documents:
Circular 1999/10
(Pastoral Care in Schools: Child Protection)

Superseded Documents:
None

Expiry Date:
Not applicable

DENI Website:
This Circular is also available on http://www.deni.gov.uk

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

1. All schools have a pastoral responsibility towards the pupils in their charge and should therefore take all reasonable steps to ensure that the welfare of pupils is safeguarded and that their safety is preserved. The Board of Governors and the Principal of each school also have a duty to promote and secure good behaviour and discipline on the part of pupils at the school.

2. Article 4 of the Education (Northern Ireland) Order 1998, which came into force on 21 August 1998, clarifies powers which already exist under common law. It enables a member of staff of a grant-aided school to use, in relation to any pupil at the school, such force as is reasonable in the circumstances to prevent a pupil from:

a. committing an offence;

b. causing personal injury to, or damage to the property of, any person (including the pupil himself); or

c. engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils, whether during a teaching session or otherwise.

3. The right of a member of staff to use such force as is reasonable to restrain or control a pupil applies:

- where the member of staff is on the premises of the school; or
- elsewhere at a time when he/she has lawful control or charge of the pupil concerned;
- to teachers at the school, **and** to any other member of staff who with the authority of the principal has lawful control or charge of pupils.

4. **The need to use reasonable force to restrain or control a pupil should be rare.** This Circular and the attached Appendix provide clarification and guidance on a number of issues relating to the use of "reasonable force" by teachers and others to restrain or control pupils. **However, it is emphasised that corporal punishment remains unlawful, and that neither Article 4 nor this Circular, in any way, authorise teachers or others to use any degree of physical contact which is deliberately intended to cause pain or injury or humiliation.** The application of reasonable force to restrain or control a pupil is to be used as a last resort, only when other behaviour management strategies have failed, and when the pupil, other pupils, members of staff, or property are at risk, or the pupil is seriously compromising good order and discipline.

Article 4 does not however prevent any person from exercising his/her right under common law to defend themselves against an attack provided he/she does not use a disproportionate degree of force to do so. The purpose of Article 4 is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Need for Schools to Have a Written Policy

5. The use of reasonable force is only one of the strategies available to schools and teachers to secure pupils' safety and well being and also to maintain good order and discipline. All those who may have to use reasonable force with pupils must clearly understand the options and strategies open to them, and they must know what is regarded as acceptable action on their part and what is not. It is important, therefore, that schools have a clear written policy about the use of reasonable force to restrain or control pupils. This should be understood by teachers, authorised staff, pupils and parents and should form part of the school's policy on discipline and child protection within its overall pastoral care policy.

6. In drawing up a written statement of the school's disciplinary policy, as required in Article 3 of the 1998 Order, it is recommended that the Board of Governors, in consultation with the Principal, should:

- include a statement setting out the school's policy and its guidelines on the use of reasonable force to restrain or control pupils;
- discuss these with staff who may have to apply them; and
- issue or make them known to parents and pupils.

Boards of Governors should also have regard to any advice issued by Education and Library Boards and, where appropriate, the Council for Catholic Maintained Schools.

7. The Department has asked a Working Group, comprising representatives from the Education and Library Boards, CCMS and schools, who are already drafting best practice guidelines for schools on a wide range of disciplinary matters, to draft a model policy for schools on the use of reasonable force based on the guidance in this Circular. This will be available later this year. Schools may wish to draw up their own policies in the meantime in order to provide guidance to staff and others on the use of reasonable force and its place in the school's strategies for maintaining good behaviour and discipline.

8. A statement of the school's policy on the use of reasonable force to restrain or control pupils should be included with the information the school gives parents about its overall policy on discipline and standards of behaviour.

9. The Department considers that it would also be useful if schools designated an experienced senior member of staff (the Principal or a senior teacher, or perhaps the designated teacher for child protection) as having special responsibility for providing guidance to other staff on the use of reasonable force. This teacher should also assume responsibility for notifying parents about incidents where reasonable force has had to be used and for dealing with any complaints which may emerge. This will help to ensure a consistent approach within the school to the use of reasonable force and the reporting arrangements.

C JENDOUBI (MRS)
School Effectiveness Division

Appendix

GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Who may use reasonable force?

Teachers

1. Article 4 of the 1998 Order authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

Non-teaching staff

2. Other members of staff at the school are also authorised to use reasonable force in the circumstances described at 1. above, provided they have been authorised by the Principal to have lawful control or charge of pupils. This might, for example, include classroom assistants, midday supervisors, and escorts. In addition the authorisation could extend to education welfare officers and educational psychologists.

3. In determining which non-teaching staff to authorise, Principals will wish to have regard to the roles and responsibilities of the staff concerned. In particular they should consider whether the staff have a responsibility to supervise pupils as part of their normal duties or whether, from time to time, they may have to take on that responsibility when a teacher is not present.

Volunteers

4. Suitably vetted volunteers normally work only under the direction and supervision of a teacher or other member of staff and should not be expected to assume sole responsibility for the safety and well-being of pupils. Where a situation arises, therefore, where the use of reasonable force may need to be exercised, the volunteer should alert the member of staff in charge and defer to his/her judgement as to the appropriate means of handling the situation.

There may, however, be circumstances in which the Principal may need to authorise a volunteer to use reasonable force in exceptional circumstances. These might include school visits, holidays and residential activities where some degree of delegated responsibility may have to be given to the volunteers in the organisation of activities; where a member of school staff may not be readily available to deal with an incident; and where it is possible that significant harm will occur if action

is not taken immediately. Where volunteers are so authorised, it is essential that they receive appropriate training and guidance.

5. **The key issue is that all non-teaching staff and volunteers must be identified and specifically authorised by the Principal to be in control of or in charge of pupils.** The Principal should clearly inform all persons concerned and ensure that they are aware of and understand what the authorisation entails. Principals may find it helpful to arrange for training or guidance to be provided by a senior member of the teaching staff who has been designated as having special responsibility for this matter and who has already received suitable training on the use of reasonable force. Principals should also keep an up to date list of authorised non-teaching staff and others who are so authorised and ensure that teachers know who they are, for example, by placing a list on the staff room notice board.

Where can reasonable force be used?

6. The right of a teacher or other person to use reasonable force applies where the pupil concerned is on the school premises **and** when he/she has been authorised to have lawful control or charge of the pupil concerned elsewhere e.g. supervision of pupils in bus queues, on a field trip, or other authorised out of school activity such as a sporting event or educational visit.

What is meant by reasonable force?

7. There is no precise legal definition of "reasonable force" so it is not possible to state, in fully comprehensive terms, when it is appropriate to use physical force to restrain or control pupils or the degree of force that may reasonably be used. It will always depend on the circumstances of each case. However, there are three relevant considerations to be borne in mind:

- the **use of force** can be regarded as reasonable **only** if the circumstances of the particular incident warrant it. The use of any degree of force is unlawful if the particular circumstances do not warrant the use of physical force. Therefore physical force could not be justified to prevent a pupil from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force;

- the **degree of force** employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. Any force used should always be the minimum needed to achieve the desired result;

- whether it is reasonable to use force, and the degree of force that could reasonably be employed, might also depend on the age, level of understanding and sex of the pupil, and any physical disability he/she may have.

Is it appropriate to use reasonable force in every situation?

8. **Reasonable force should not be used automatically in every situation nor should it be used as a form of discipline. In a non-urgent situation, reasonable force should only be used when other behaviour management strategies have failed.** That consideration is particularly appropriate in situations where the aim is to maintain good order and discipline, and there is no

direct risk to people or property. Any action which could exacerbate the situation needs to be avoided, and the possible consequences of intervening physically, including the risk of increasing the disruption or actually provoking an attack, need to be carefully evaluated. The age and level of understanding of the pupil is also very relevant in those circumstances - physical intervention to enforce compliance with staff instructions is likely to be increasingly inappropriate with older pupils and **should never be used as a substitute for good behaviour management.**

9. Staff may not always have the time to weigh up the possible courses of action and it would be prudent therefore for them to have considered in advance the circumstances when they should and should not use reasonable force. Staff should, whilst taking due account of their duty of care to pupils, always try to deal with a situation through other strategies before using reasonable force. All teachers need to be aware of strategies and techniques for dealing with difficult pupils and situations which they can use to defuse and calm a situation. Best practice guidelines on successful discipline policies are currently being drawn up by a Working Group comprising representatives from schools, the Education and Library Boards and CCMS. These will be circulated to all schools shortly.

When might it be appropriate to use reasonable force?

10. In a situation where other behaviour management strategies have failed to resolve the problem, or are inappropriate (eg in an emergency), there are a wide variety of circumstances in which reasonable force might be appropriate, or necessary, to restrain or control a pupil. They will fall into three broad categories:

a. where action is necessary in self-defence or because there is an imminent risk of injury;

b. where there is a developing risk of injury, or significant damage to property;

c. where a pupil is behaving in a way that is compromising good order and discipline.

11. Examples of situations that fall into one of the first two categories are

- a pupil attacks a member of staff, or another pupil;
- pupils are fighting;
- a pupil is causing, or at risk of causing, injury or damage by accident, by rough play, or by misuse of dangerous materials, substances or objects;
- a pupil is running in a corridor or on a stairway in a way in which he/she might have or cause an accident likely to injure him- or herself or others;
- a pupil absconds from a class or tries to leave school (**NB this will only apply if a pupil could be at risk if not kept in the classroom or at school**).

12. Examples of situations that fall into the third category are:

- a pupil persistently refuses to obey an order to leave a classroom;
- a pupil is behaving in a way that is seriously disrupting a lesson.

13. However, some practical considerations also need to be taken into account:

- Before intervening physically a member of staff should seek to deploy other behaviour strategies. Where these have failed, the member of staff should, wherever practicable, tell the pupil who is misbehaving to stop, and what will happen if he/she does not. The member of staff should continue attempting to communicate with the pupil throughout the incident, and should make it clear that physical contact or restraint will stop as soon as it ceases to be necessary. A calm and measured approach to a situation is needed and staff should never give the impression that they have lost their temper, or are acting out of anger or frustration, or to punish the pupil.

- Sometimes a member of staff should not intervene in an incident without help (unless it is an emergency), for example, when dealing with an older pupil, or a physically large pupil, or more than one pupil, or if the teacher believes he/she may be at risk of injury. In those circumstances the member of staff should remove other pupils who might be at risk, and summon assistance from a colleague or colleagues, or where necessary telephone the Police. The member of staff should inform the pupil(s) that he/she has sent for help. Until assistance arrives the member of staff should continue to attempt to defuse the situation orally, and try to prevent the incident from escalating.

- Situations where a pupil refuses to obey an order to leave a classroom need to be handled carefully as they can be a prelude to a major confrontation, especially if reasonable force is used to eject older pupils. Where a pupil persistently refuses to leave a classroom and the teacher believes that the use of reasonable force will endanger the teacher or other pupils, the school should have an emergency response procedure whereby assistance can be summoned quickly, for example a trusted pupil is sent for help.

- If a school is aware that a pupil is likely to behave in a disruptive way that may require the use of reasonable force, it will be sensible to plan how to respond if the situation arises. Such planning needs to address:

  - managing the pupil (eg reactive strategies to de-escalate a conflict, holds to be used if necessary);
  - involving the parents to ensure that they are clear about the specific action the school might need to take;
  - briefing staff to ensure they know exactly what action they should be taking (this may identify a need for training or guidance);

- ensuring that additional support can be summoned if appropriate.

What might be regarded as constituting reasonable force?

14. Physical intervention can take a number of forms. It might involve staff:

- physically interposing between pupils;
- blocking a pupil's path;
- holding;
- pushing;
- pulling;
- leading a pupil by the arm;
- shepherding a pupil away by placing a hand in the centre of the back; or
- (in extreme circumstances) using more restrictive holds.

15. In exceptional circumstances, where there is an immediate risk of injury, a member of staff may need to take any necessary action that is consistent with the concept of "reasonable force", for example, to prevent a young pupil running off a pavement onto a busy road, or to prevent a pupil hitting someone, or throwing something. **However, staff should never act in a way that might reasonably be expected to cause injury, for example by:**

- holding a pupil round the neck, or by the collar, or in any other way that might restrict the pupil's ability to breathe;
- slapping, punching, kicking or using any implement on a pupil;
- throwing any object at a pupil;
- twisting or forcing limbs against a joint;
- tripping up a pupil;
- holding or pulling a pupil by the hair or ear;
- holding a pupil face down on the ground.

16. Staff should also avoid touching or holding a pupil in any way that might be considered indecent.

What action can be taken in self-defence or in an emergency situation?

17. Neither Article 4 nor the guidance contained in this Circular can cover every possible situation in which it might be reasonable for someone to use a degree of force. For example, everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of force to do so. Similarly, in an emergency, for example if a pupil is at immediate risk of injury or on the point of inflicting injury on someone else, any member of staff would be entitled to intervene whether or not specifically authorised by the Principal to do so. The purpose of Article 4 and this Circular is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Is physical contact with pupils appropriate in other circumstances?

18. The Code of Conduct for staff which has been issued to all schools makes it clear that, although physical contact with pupils should generally be avoided, there can be occasions when physical contact with a pupil may be proper or necessary other than those situations covered by Article 4. For example, some physical contact may be necessary to demonstrate exercises or techniques during PE lessons, sports coaching, music or technology and design, or if a member of staff has to give first aid. Young children and children with special educational needs may also need staff to provide physical prompts or help. Touching may also be appropriate where a pupil is in distress and needs comforting. Teachers should use their own professional judgement when they feel a pupil needs this kind of support. Guidance on these issues can be found in the Code of Conduct, and also in paragraphs 73 and 74 of the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

19. There may be some children for whom touching is particularly unwelcome, because, for example, they have been abused. Physical contact with pupils becomes increasingly open to question as pupils reach and go through adolescence, and staff should also bear in mind that even innocent and well-intentioned actions can sometimes be misconstrued.

Should incidents where reasonable force is used be recorded?

20. It is extremely important that there is a detailed, contemporaneous, written report of any occasion (except minor or trivial incidents) where reasonable force is used. This may help prevent any misunderstanding or misrepresentation of the incident, and it will be helpful should there be a complaint. Schools should keep an up-to-date record of all such incidents, in an incident book. Immediately following any such incident the member of staff concerned should tell the Principal or a senior member of staff and provide a short written factual report as soon as possible afterwards. That report should include:

- the name(s) of the pupil(s) involved, and when and where the incident took place;
- the names of any other staff or pupils who witnessed the incident;
- the reason that force was necessary (eg to prevent injury to the pupil, another pupil or a member of staff);

- briefly, how the incident began and progressed, including details of the pupil's behaviour, what was said by each of the parties, the steps taken to defuse or calm the situation, the degree of force used, how that was applied, and for how long;
- the pupil's response, and the outcome of the incident;
- details of any obvious or apparent injury suffered by the pupil, or any other person, and of any damage to property.

At least annually, the Chairman of the Board of Governors and the Principal should review the entries in the incident book. Records of incidents should be kept for 5 years after the date they occurred.

21. Staff may find it helpful to seek advice from a senior colleague (eg the Principal or senior member of staff who has been designated to provide training and guidance on the use of reasonable force), or a representative of their professional association when compiling a report. They should also keep a copy of the report.

22. Incidents involving the use of force can cause the parents of the pupil involved great concern. It is always advisable to inform parents of an incident involving their child (other than a trivial incident), and give them an opportunity to discuss it. The Principal, or a member of staff to whom the incident is reported, will need to consider whether that should be done straight away or at the end of the school day, and whether parents should be told orally or in writing.

Are complaints about the use of reasonable force likely to occur?

23. Involving parents when an incident occurs with their child, and having a clear policy about the use of reasonable force that staff adhere to, should help to avoid complaints from parents. It will not, however, prevent all complaints, and any complaint from a parent about the use of reasonable force on his/her child should be dealt with in accordance with the procedures set out in the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

24. The possibility that a complaint might result in a disciplinary hearing, or a criminal prosecution, or in a civil action brought by a pupil or parent, cannot be ruled out. In these circumstances it would be for the disciplinary panel or the court to decide whether the use and degree of force was reasonable in all the circumstances. In doing so, the disciplinary panel or court would have regard to the provisions of Article 4. It would also be likely to take account of the school's policy on the use of reasonable force, whether that had been followed, and the need to prevent injury, damage, or disruption, in considering all the circumstances of the case.

Will suitable training and supporting advice on the use of reasonable force be provided for teachers and other authorised staff?

25. Education and Library Boards are being asked to arrange suitable training courses for a senior teacher in each school who will then be responsible for providing "cascade" training and advice to other staff in the school. Boards are being asked to place an emphasis on and cover behaviour management strategies which seek to avoid the need to use reasonable force to restrain or control pupils. Such training will be in the context of schools' behaviour and child protection

policies. Arrangements are also being made for suitable training to be included as part of INSET and initial teacher training courses.

26. The Education and Library Boards are also establishing multi-disciplinary Behaviour Support Teams, to offer professional advice and practical support to schools on a range of behavioural and disciplinary matters, including the use of reasonable force.

Dr Maura Briscoe
Director Mental Health & Disability Policy

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

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

To:
Chief Executive of HSC Trusts
Chief Executive of HSC Board (for cascade to GPs and other relevant practitioners)
Chief Executive of PHA
Chief Executive of RQIA (for cascade to private hospitals, clinics and other relevant establishments and agencies)
Chief Executive of PCC
British Medical Association (NI)
Royal College of Nursing (NI)
Royal College of Psychiatry (NI)
British Association of Social Workers (NI)
College of Occupational Therapists (NI)

Castle Buildings
Belfast BT4 3SQ
[redacted]
Email: maura.[redacted]

Your Ref:

Our Ref: HSC/MHDP – MHU 1 /10 - **revised**

Date: 14 October 2010

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance

Purpose

1. The purpose of this circular is to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty. The guidance is issued pursuant to the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case (see Annexe 1) and is therefore an important element in the protection of Human Rights of patients as required under the European Convention of Human Rights. The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 (the Order) and best practice, pending the introduction of new mental capacity legislation in Northern Ireland.

2. The guidance is intended for use by staff working in hospital and/or community care settings across all HSC organisations and relevant independent sector organisations where an individual may be subject to deprivation of their liberty.

A copy of this circular has been placed on the Department's website (www.dhsspsni.gov.uk).

3. This guidance revokes and replaces Circular Letter HSC/MHDP – MHU 1/10: DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance, issued by the Department on 1 March 2010.

The Case

4. Attached (annexe 1) is a summary of the Bournewood judgement which involved HL, a man who had autism and learning disabilities who was admitted to Bournewood Hospital for treatment. HL eventually took proceedings to the ECHR against the UK government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirement of Article 5(4) of the ECHR. The summary conclusions of the ECHR are important and are attached.

Deprivation of Liberty

5. The European Court found that HL had been deprived of his liberty within the meaning of Article 5(1) of the Convention. It is important to note that the judgement does not concern the treatment of incapacitated patients generally. It was only concerned with the question of deprivation of liberty of an incapacitated person.

6. The European Court's judgement does not, therefore, mean that incapacitated patients admitted to hospital or to care homes are automatically deprived of their liberty, even if staff would prevent them leaving unescorted for their own safety.

7. There must be particular factors which provide the "degree" and "intensity" to render the situation one of deprivation of liberty. The factors might relate for example, to the type of care being provided, its duration, its effects and the ways in which admission came about.

8. In this case, the European Court said that:

> "the key factor in this present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements".

and, noting that HL had been resident with his carers for over three years the Court went on to say that

> " the clear intention of Dr M and the other relevant health care professionals [was] to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from hospital to the care of Mr and Mrs E as and when professionals considered it appropriate (paragraph 91).

9. Accordingly the Court found that "the concrete situation was that the applicant was under continuous supervision and control and was not free to leave" (paragraph 91).

10. The Court attached particular importance to the fact that HL had a settled home with his paid carers to which he was prevented from returning and that his contact with those carers was (to some extent) restricted by the staff of the hospital. The court did not consider the issue of whether the ward was "locked" or "lockable" to be determinative.

Lack of Procedural Safeguards

11. The European Court did not find that HL's rights had been breached simply because he was admitted to hospital on the basis of common law doctrine of necessity (i.e. in his "best interests"), rather than under specific statutory provisions (e.g. the Mental Health Order).

12. However, the Court did find that the absence of procedural safeguards surrounding his admission failed to protect him against "arbitrary deprivation of liberty on grounds of necessity and, consequently, (failed) to comply with the essential purpose of article 5(1) of the Conventions".

13. In this latter respect, the European Court was clearly influenced by the "lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" when contrasted with "the extensive network of safeguards applicable to psychiatric committals covered by the (Mental Health Act 1983). Paragraph 120 is of relevance.

14. The European Court also said:

> "the nomination of a representative of a patient who could make certain objections and applications on his/her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities" (paragraph 120)
>
> By which it presumably had in mind the role of the nearest relative under current mental health legislation.

15. Above all, although it did not question their good faith, the Court seems to have been concerned that the hospital's health care professionals were able to assume "full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit" (paragraph 21).

16. The Court did not say that HL should have been formally detained under the Mental Health Act. Nor, in the Department's view, does the judgement mean that procedural safeguards for people in HL's position must be identical to those patients detained under the current mental health legislation. However, it is accepted that to avoid further violations of Article 5(1), new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in the best interests under common law doctrine.

Breach of Article 5(4)

17. The European Court also found a violation of his rights under Article 5(4) of the convention.

Next Steps

The following paragraphs outline the next steps to be taken by DHSSPS, HSC organisations and relevant independent sector organisations.

Proposals for new procedural safeguards

18. The Department will bring forward new safeguards in law via the proposed Mental Capacity (Health, Welfare and Finance) Bill.

Interim steps that might be taken by HSC bodies and relevant independent sector organisations.

19. Until these safeguards are established in law, the effect of the Bournewood Judgement is that it would be unlawful for an HSC body (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of Article 5 of the Convention unless the patient were detained under the Mental Health (NI) Order 1986.

20. Nonetheless, the HSC will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period, both for their good, and, it follows, the care and protection of other patients.

21. Pending the development of new safeguards described above, HSC bodies will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of successful legal challenges.

22. The Department suggests that HSC bodies and relevant independent sector organisations will want to ensure they have systems in place so that when making arrangements to provide care to an incapacitated person which involves a restriction on the liberty of that person, consideration is given as to whether what they are proposing amounts in practice to a deprivation of that person's liberty within the meaning of Article 5 of the Convention, taking into account the range of factors identified by the Court set as described above and also contained within (a) to (f) in the Bournewood Judgement attached. The same question will need to be asked when reviewing the circumstances of those people who they have already placed who may, in practice, be deprived of their liberty.

23. If patients are considered to be deprived of their liberty (or at risk of it), consideration should always be given to alternatives to ensure that they get adequate care but which falls short of deprivation of liberty. In particular, HSC bodies and independent sector organisations will want wherever possible, to avoid situations in which professionals may be said to take "full and effective control" over patients care and liberty.

24. Elements of good practice which are likely to assist in this, and in avoiding the risk of legal challenge, may include:

- ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. There should, for example, be a proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed, and that decisions should be taken on the basis of proper medical advice by a person properly qualified to make the judgement.

- effective, documented care planning and record keeping for such patients, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare and safety.

- ensuring that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case.

- ensuring appropriate information is given to patients themselves and to family, friends and carers. This would include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews and the way in which they can challenge decisions (e.g. through the relevant complaints procedure). The involvement of local advocacy services, where these are available, should be encouraged to support patients and their families, friends and carers.

- taking proper steps to help patients retain contact with family, friends and carers, with proper consideration given to the views of these people. If, exceptionally, there are good clinical reasons why that is not in the patient's best interests, those reasons should be properly documented and explained to the people they affect.

- ensuring both the assessment of capacity and the care plan are kept under review. It may be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the HSC Body/independent organisation, or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the organisation's decisions. But, even where there is no dispute, an organisation must ensure its decision making stands up to scrutiny.

25. If it is concluded that there is no way of providing appropriate care which does not amount to deprivation of liberty, then consideration will have to be given to using the formal powers of detention in the Mental Health (NI) Order 1986. However it is important to remember that:

- nothing in the judgement changes the requirements in the Mental Health Order which must be met before patients can be detained. It should not therefore be assumed that all patients who are to be subject to restrictions

which may amount to deprivation of liberty can be detained under the Order. (For example, it would be unlawful to detain patients under the Order if their mental disorder does not warrant detention in hospital, although reception into guardianship under the Order might be appropriate in some cases).

- there are dangers in using the Order simply to be "on the safe side". Although it provides procedural safeguards, the use of the Mental Health Order will not necessarily be welcomed by their family, friends or carers, given the stigma that is often (wrongly) perceived to attach to it. Moreover, a significant increase in the use of the Mental Health Order will inevitably put considerable further pressure on approved social workers, the availability of second opinion appointed doctors (SOADs) and on the operation of the Mental Health Review Tribunal (MHRT).

Action Required

26. I should be grateful if Trust Chief Executives would bring this guidance to the attention of all relevant personnel; ensure the principles it contains are embedded into Trust's procedures; and, confirm to me by **10 December 2010** that this has been done.

Yours sincerely

[SIGNED]

DR MAURA BRISCOE
Director of Mental Health and Disability Policy

Annex 1

The Bournewood Judgement

The Bournewood judgement refers to the European Court of Human Rights' decision in the case of "H.L. v the UK" (published on 5th October 2004).

The case involved H.L, a man who suffered from autism and learning disabilities, who was admitted to Bournewood hospital for treatment under the common law doctrine of necessity. H.L lacked the capacity to consent or object to being admitted and detained for treatment. Although H.L. did meet the criteria for detention under the Mental Health Act 1983 (the 1983 Act) he was not formally detained because he was compliant and did not resist admission and was, therefore, admitted as an "informal patient".

This approach was taken in compliance with the Code of Practice drawn up under the 1983 Act. Chapter 2 of that Code specifically provided that, "if at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal. The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common law doctrine of necessity".

H.L. applied, by his carers, to the High Court for leave to apply for judicial review of the hospital/Health Trust's decision to admit him, for a writ of habeas corpus and for damages for false imprisonment and assault. The Court held that, although the 1983 Act provided a comprehensive statutory regime for those formally admitted to psychiatric care, section 131(1) of that Act preserved the common law jurisdiction in respect of informal patients. It concluded that H.L. had not been "detained" but had been informally admitted and that the requirements of the common law principle of necessity had been satisfied. The application was therefore refused.

H.L appealed and the Court of Appeal held that he had been detained by the hospital/Trust and that the right to detain a patient for treatment for mental disorder was to be found only in the 1983 Act, which excluded the application of the common law doctrine of necessity. It considered that section 131(1), which preserved the right to admit a patient informally, applied only to a patient who had the capacity to and did consent to his/her admission. The Court of Appeal therefore held that, since H.L. had been admitted for treatment without his consent and without the other formalities required by the 1983 Act, his detention was unlawful.

The hospital/Trust then appealed to the House of Lords, which unanimously allowed the appeal.

H.L. then took proceedings to the ECtHR against the UK Government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that the procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirements of Article 5(4) of the ECHR.

The relevant parts of Article 5 are set out below.

Article 5 - Right to liberty and security

Article 5(1):
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty *save* in the following cases and in accordance with a procedure prescribed by law.

Article 5(1)(e):
The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants.

(The case of *Winterwerp v Netherlands* (1979) set out the criteria which must be satisfied in order to lawfully deprive a person of his/her liberty on the basis of unsoundness of mind, namely: the person concerned must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.)

Article 5(4):
Everyone who is deprived of his/her liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his/her detention shall be decided speedily by a court and his/her release ordered, if the detention is not lawful.

European Court of Human Rights considerations

The ECtHR had to consider whether H.L. had in fact been detained: and, if so, whether that detention was lawful (i.e. whether detaining H.L in his own best interests under the common law doctrine of "necessity" complied with Article 5(1)); and also whether sufficient safeguards existed to comply with Article 5(4).

The ECtHR concluded that:

- H.L. had in fact been detained and, therefore, the right to liberty in Article 5(1) had been engaged.

  The Court considered that the question as to whether there has been a deprivation of liberty or a restriction upon a person's liberty depends on the particular circumstances of the individual case and "account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question". It stated that "the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance". It considered the facts of HL's case and concluded that he had been detained because he was constantly under supervision, was not free to leave and because "the health care professionals treating and managing him exercised complete and effective control over his care and movements".

- HL's detention under the common law doctrine of necessity in his own best interests was unlawful under the ECHR, as it did not comply with Article 5(1): i.e. it lacked procedural safeguards which are required to protect against the risk of arbitrary deprivation of liberty.

The ECtHR considered the common law under which H.L was detained. It noted particularly "the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" in contrast with the extensive safeguards available to persons who are compulsorily detained under the Mental Health Act 1983. It also noted the lack of the following attributes which would be necessary to ensure compliance with Article 5(1):

a) Formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions;

b) A requirement to fix the exact purpose of admission (e.g. for assessment or for treatment);

c) Limits in terms of time, treatment or care which should attach to the person's admission;

d) Specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention;

e) A requirement to nominate or appoint a representative of a patient who could make certain objections and applications on his/her behalf; and

f) Arrangements to enable the person (or his/her representative) to have access to a court/body with judicial character to have the lawfulness of the detention and/or any decision relating to deprivation of liberty reviewed and dealt with within a reasonable period of time.

The Court concluded that "this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1)".

- HL's detention was also contrary to Article 5(4) because he was unable to take proceedings by which the lawfulness of his detention could have been challenged and decided quickly by a court.

  The ECtHR considered that HL's application for leave to apply for judicial review of the decision to admit and detain, including a writ of habeas corpus, did not provide H.L. with an adequate means to challenge his deprivation of liberty. Therefore, Article 5(4) of the ECHR was breached.

The ECtHR formally held that Articles 5(1) and 5(4) of the ECHR were violated by the UK Government.

Department of Health
Mental Health Action Plan

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

MAHI - STM - 089 - 3313

Ministerial foreword

As a population we are only too aware that mental health, and mental ill health, is a huge challenge for our society. Too many people are struggling to access appropriate mental health services when they need them and suicide is robbing our communities of too many young lives.

When I became Health Minister I set out very clearly that mental health would be one of my top priorities. I am therefore very pleased to publish this Mental Health Action Plan, which will deliver key improvements to services in the short term, while preparing the ground for future strategic change. Three actions stand out. Firstly, in this Action Plan I am confirming the commitment to co-produce a Mental Health Strategy. Secondly, I am confirming my announcement of 27 April to create a Mental Health Champion to champion and enhance mental health in all aspects of public life. Thirdly, I am including an action to develop perinatal mental health services. By providing a bespoke, specialist service to those with perinatal mental health needs, this vulnerable group can get the specialist services they need.

During these particularly difficult times, I am committed to ensuring that those who's psychological wellbeing and mental health sufferers as a result of the COVID-19 pandemic will receive the support they need. I am therefore including a COVID-19 Mental Health Response Plan as an annex to the Mental Health Action Plan. The Response Plan outlines key areas of intervention during the pandemic to help and support the population as a whole.

Much work has been done in recent years to improve mental health services, and I am grateful for the focus and energy of staff who work in this important field and who recognise the need for change. This Action Plan provides the impetus to drive this work forward as a matter of urgency.

Yet the publication of this Action Plan is only the first in a series of steps I will take to ensure those suffering from mental ill health will be able to access the services they need, when they need them. It will put the foundations in place for the longer term, strategic improvements which will be set out in the new Mental Health Strategy. However, it is worth remembering the difficult context in which we operate and that any investment in mental health services will have to be balanced against other service priorities and in the context of the Department's financial settlement.

I would like to thank all those stakeholders who played a part in developing this Action Plan. Your voice, your experiences and your expertise were invaluable in creating an Action Plan that will kick-start real improvement in mental health services, and I look forward to working together with you as we move forward.

Robin Swann MLA
Minister of Health

Introduction

Since the early 2000s, mental health services in Northern Ireland have seen great improvements. An ever increasing strategic focus has been placed on improving the quality of life for service users by adopting a person centred recovery approach to care and effecting cultural change in the mental health system through the promotion of parity of esteem. Stories captured from people with lived experience evidence improving services and better experiences.

At the centre of this shift was the Bamford Review, and the impact of the publication of its reports[1] between 2005 and 2007 should not be underestimated. They have been the foundation upon which the Department of Health has built its strategic direction in the last decade and have produced significant improvements in mental health and learning disability services in Northern Ireland. Services are now largely mainstreamed into the wider service provision and the evidence suggests that many patients have had significantly better outcomes and experiences than they would have prior to the Review.

It is only right to recognise the excellent work from people across health and social care in making Bamford a success, whether employed by statutory Health and Social Care organisations, independent contractors or the voluntary and community sector. However, the time has also come to build upon their efforts with a new strategic direction.

It is clear that a new way forward is required for mental health, a view endorsed by the Northern Ireland Affairs Committee in its report on health funding published in November 2019.[2] The Department of Health is therefore putting the pieces in place to develop a new mental health strategy. In the interim this co-produced action plan is designed to create a common direction and focus for mental health services in Northern Ireland, in

[1] https://www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability

[2] https://publications.parliament.uk/pa/cm201920/cmselect/cmniaf/300/30008.htm

preparation for the new mental health strategy, while also delivering key and essential improvements to service delivery in the short and medium term. It has been shaped by recurring themes from a number of post Bamford reports and studies which have highlighted how the services should be developed.

The first of these is the draft Bamford Evaluation report which is a review of the second Bamford action plan (2012-2015) carried out by the Department in 2016. Focused primarily on outcomes that matter to service users and their families, the evaluation also considered the effectiveness of the current Bamford structures and whether or not Bamford's aims have been mainstreamed within the ordinary course of business. The general conclusion was that the Bamford Review and subsequent Action Plans have been a catalyst for the development of improved mental health and learning disability services in Northern Ireland but that there are still needs and gaps within both services.

"Building on Progress: Achieving Parity for Mental Health in Northern Ireland", commonly known as The Lord Crisp Report, was produced by the Commission on Acute Adult Psychiatric Care and published on 17 June 2016. Its recommendations concentrated on parity of esteem for mental health, service structure, improved functioning of the system, support for patients and carers, investment, reform of commissioning and the need for improved data.

''Health and Wellbeing 2026 - Delivering Together''[3] was approved by Health Minister Michelle O'Neill in October 2016 and sets out the 10 year vision for the Department of Health. It promotes person-centred care, and is focussed on prevention, early intervention, supporting independence and wellbeing. Specifically it states there should be better specialist mental health services in Northern Ireland, expansion of services in the community, services to deal with the trauma of the past and a commitment to parity of esteem between mental health and physical health.

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

The Department, as part of Confidence and Supply Transformation Funding, commissioned an independent review of the acute inpatient pathway which was produced in 2019 and made 12 recommendations all of which are reflected in this Action Plan. Other documents of influence include the NICS Outcomes Delivery Plan[4] (specifically outcomes 4 and 8) and Protect Life 2.[5]

The evidence provided by these reports has been presented to a wide range of stakeholders for collaborative policy development and a number of key themes have emerged which this document addresses. Patient experience, access to services, workforce issues and governance structures are areas that have been identified for improvement and many of the actions included involve completing work that has already started, or that has been agreed but not yet initiated. Specific objectives have been set for each theme and progress towards achieving targets will be monitored by a lead organisation, which will usually be the Department, the Health and Social Care Board or the Public Health Agency.

All actions, even those that are not directly relating to improvements for persons with mental ill health, are aimed to improve the person centred care approach, with an underpinning trauma focussed methodology. The outspoken aim within the Action Plan is to improve the person's experience of mental health services and to help the health and social care system work better to be able to improve the person's experience.

The actions in this Mental Health Action Plan fall into three broad categories; immediate service developments, longer term strategic objectives and preparatory work for future strategic decisions. The first category aims to provide fixes to immediate problems and immediate service developments where there has been an identified immediate need. This includes, for example, consideration of alternative methods of

[4] https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/outcomes-delivery-plan-2018-19.pdf

[5] https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF

working for the mental health workforce to respond to the immediate, and significant, workforce pressures. The longer term strategic objectives aim to fulfil future strategic needs and includes, for example, a workforce review to consider how the mental health workforce should be structured. The third category relates to preparatory work for future strategic directions. This includes, for example, development of an action plan for the use of technology and creating better governance structures.

It should be noted that the Mental Health Action Plan includes specific actions which are in addition to normal service development. Not every development work or ongoing issue is noted in the plan and normal business planning for mental health services continue alongside the plan. This includes, for example, the work to ensure discharge from hospital is not delayed through working with Supporting People colleagues in other Departments, and work relating to Protect Life 2. The absence of such actions from the Action Plan is not due to lack of importance, rather an indication that the work is already ongoing through normal business channels. Similarly actions as a direct consequence to the COVID-19 pandemic are not included in the main Action Plan. Instead a separate COVID-19 Mental Health Response Plan has been developed and included as an annex to the main Action Plan. However, going forward much learning must be taken from the actions to respond to the psychological wellbeing and mental health COVID-19 challenges. This will allow continuation of new practices such as use of technology, where found effective and appropriate.

Strategic Linkages

COVID-19 Mental Health Response Plan

The COVID-19 pandemic has created very specific challenges to the psychological wellbeing and mental health of the whole population. Measures, such as complete societal lock down, social isolation and financial hardship, normally not seen outside a war zone has become the norm. This will undoubtedly lead to new challenges to mental health and require appropriate responses. In addition normal services have not been able to function in the same way as they normally do, with meeting being held remotely and using new technology.

These challenges will create problems, but also offer opportunities. Linkages must be had with new initiatives and with the work underway to help and support those who are suffering as a result of the pandemic. A dedicated COVID-19 Mental Health Response Action Plan has been created to outline the actions to respond to the challenges. Going forward, the implementation of the Mental Health Action Plan must be with the pandemic response in mind.

Mental Health Strategy

The development of a new 10 year strategy has been accepted by all key stakeholders as a key priority. It will be co-produced with multi-disciplinary and multi-sectoral participation in its development, be evidence based, take a whole life approach, focus on population need, be trauma informed and place the need and experiences of the persons using the system at its centre. This will be a significant undertaking given the wide variety of stakeholders, the complexity of the issues to address, and the need to develop a funding plan. Due to this it is anticipated that it will take a number of months to complete. *New Decade, New Approach* set a target date for the publication of the Strategy to the end of 2020. Due to the pandemic co-production has not been possible as expected, meaning that there will be delays in publication of the new Mental Health Strategy. Nevertheless, the delays will be kept to a minimum; whilst quick publication of the Strategy is important, getting it right is more important.

The Strategy will be broad in its scope, and will consider the mental health needs of the population at all stages in life, from childhood to old age. Prevention and early intervention will be a key consideration, and the Strategy will seek to bring together work being taken forward across government.

The Strategy will also consider the future configuration of specialist mental health services, including psychological therapies, personality disorder services, support for people with eating disorders, and perinatal mental health support. The new Strategy will seek to provide a strategic basis for the further development of the Regional Mental Trauma Network, as featured in the Stormont House Agreement. The Strategy will also provide a clear mapping of funding and structures.

Interdepartmental Action Plan in response to Still Waiting

An Interdepartmental cross-sectoral action plan has been developed in response to the NICCY "Still Waiting" report, a rights based review of mental health services and support for children and young people in Northern Ireland. The Interdepartmental Action Plan was published in draft in October 2019 and sets out a range of actions to address the agreed recommendations of the 'Still Waiting' report and improve child and adolescent mental health services (CAMHS), such as full implementation of the CAMHS care pathway, development of regional guidelines on transitions between CAMHS and Adult Mental Health Services and more mental health support in schools.

While the Interdepartmental Action Plan in response to 'Still Waiting' maintains focus on mental health services and support for children and young people, many of its actions overlap with those in the Mental Health Action Plan, such as implementation of a Managed Care Network for CAMHS, fund mapping and improved transition planning from CAMHS to adult services.

The two Action Plans remain separate, but closely linked. Implementation of one will complement and drive progress on the other; and both work together towards the overall goal of improving mental health across the lifespan.

Protect Life 2

Protect Life 2 2019-24 is a long-term strategy for reducing suicides and the incidence of self-harm with action delivered

across a range of Government departments, agencies, and sectors. It recognises that no single organisation or service is able to influence all the complex interacting factors that lead someone to harming themselves or, ultimately, to taking their own life.

There are a number of close linkages between Protect Life 2 and the Mental Health Action Plan with several actions which are complementary. In particular the focus on crisis intervention and crisis services requires close work between officials and services going forward. Protect Life 2 highlights the importance of the Early Liaison Service, and design of crisis de-escalation services. The evaluation of the Multi Agency Triage Team initiative and Belfast Crisis De-escalation Service pilot in BHSCT will inform future service delivery. Protect Life 2 also contains a number of actions in relation to the new Mental Health Liaison Service.

Protect Life 2 also has a focus on upstream intervention to improve emotional health and wellbeing and several initiatives are commissioned and planned to support this.

Improving Health Within Criminal Justice Strategy

The Improving Health Within Criminal Justice Strategy, and associated Action Plan, was published in June 2019. It was developed jointly between Departments of Health and Justice and outlines a substantial work programme to ensure that children, young people and adults in contact with the criminal justice system have the highest attainable standard of health and well-being.

The strategy recognises that many members of the community who come into contact with the Criminal Justice System have unmet health needs, with mental ill health often prominently featuring within these needs.

The strategy outlines a commitment to better align resources, to enhance access to relevant health services, and to improve the continuity of care delivered to the criminal justice population. It aims to improve the health and well-being of our criminal justice population and in doing so also contribute to safer detention and a reduced risk of reoffending.

Implementation of the strategy ongoing, with 11 of the 45 action measures in the action plan explicitly referencing mental health.

Regional Trauma Network

Implementation of the Regional Trauma Network (RTN) is included in the draft PfG Outcome 4 and Outcome 8. As part of the Stormont House Agreement in 2014, the Northern Ireland Executive made a commitment to establish a comprehensive Mental Health Trauma Service (the RTN). Once implemented, this network will deliver a comprehensive regional trauma service drawing and building on existing resources and expertise in the statutory and community and voluntary sector with particular focus on trauma and PTSD.

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Work to develop and implement the RTN is ongoing. The HSCB recently undertook a public consultation: 'Regional Trauma Network: Service Delivery Model and Equality Impact Assessment' which closed in October 2019 and the responses are currently being considered and will inform service development considerations prior to the launch of the new service.

We will also work to support the commitments to veterans in *New Decade, New Approach*

The Action Plan

The Action Plan contains a number of commitments to review and develop services, and to put measures in places to ready the system for the long term strategic change that will be brought about by the development and implementation of the 10 year Mental Health Strategy. A major strategic driver is the commitment announced on 27 April 2020 to create a Mental Health Champion.

Service developments

The Action Plan contains a number of service developments. The primary development is the determination and creation of a specialist community perinatal mental health service. It is likely that creating this service will take some time, to ensure that the right people are in post to deliver the service.

Other service developments include the creation of dedicated managed care networks for CAMHS and forensic mental health and the consideration if the forensic services should be regionalised into one regional service. There is also a proposal for an innovation fund which would provide earmarked funding for local initiatives. This could be to help in-patients or community services.

Reviews

There are a number of reviews in the Action Plan. These will pave the way for more efficient services in the future and underpin the mental health strategy work. There is a review to consider the response to homicide and suicide, the use of restraint and seclusion, transitions between CAMHS and adult service and adult services and old age psychiatry, outcomes data collection and future inclusion of community and voluntary sector's role in core mental health services.

Co-production

Whilst co-production is underpinned in all actions across the whole Action Plan, and has been one of the key principles in the development of the Plan, a number of actions specifically address the importance of co-production. This includes greater inclusion of persons with lived experience and staff in local decision making.

Governance

A number of actions seek to improve the governance structures of mental health services. With more streamlined and efficient governance, better decisions can be made, and more quickly. By improving the governance structure in preparation for a new mental health strategy, the organisations will be ready for future action plans stemming from the strategy.

Workforce

The mental health workforce are facing significant challenges. The Action Plan recognises this by including actions for new ways of working for staff and an increase in the mental health workforce.

A work plan for the actions can be found in **Annex A**.

Much work has been done in recent years to improve mental health services. This Action Plan provides the impetus to drive this work forward as a matter of urgency. Most of the actions in the Mental Health Action Plan are either resource neutral or are implementing decisions already taken regarding services which are currently already funded. It does not provide resources for the actions that require additional funding, but will prepare the way for informed decisions regarding future funding requirements. There are some specific costs in the Action Plan for year 1 after publication which can be categorised as below:

- Mental Health Strategy – up to £100k.
- Work associated with a Mental Health Strategy – up to £295k.
- Mental Health Champion – up to £75k.
- Service improvements, including a new perinatal mental health service – up to £1,521k.
- Reviews, including homicide and suicide, restraint and seclusion, transitions and specialists services – up to £420k.
- Governance, including new structures – up to £35k.
- Innovation fund – up to £500k.

The total cost of the Mental Health Action Plan in in the first year is up to £2.8m. The recurrent cost in future years is higher with the cost for perinatal mental health is expected to be up to £3.6m per year and the Mental Health Champion up to £500k per year.

Until the new 10 year mental health strategy is published, this Action Plan will ensure that momentum is not lost in terms of mental health service improvement. It will provide the drive to continue to improve and develop services to better support our population. The Action Plan has been drafted in line with the Department's commitment to co-production and has had input from those with lived experience, carers, community and voluntary organisations, academics, health professionals and their representative bodies, Health and Social Care organisations, politicians and governmental Departments. It has been scrutinised and approved by a Project Board consisting of representatives from these stakeholder groups, and a number of engagement methods have been employed to encourage stakeholder interaction. This included a series of workshops to identify key priorities, analyse them, and refine drafts of the document, some of which were managed in partnership with Inspire, Action Mental Health and the Patient Client Council.

Mental Health Action Plan

Mental Health Strategy							
Objective	**No**	**Action**	**Measures**	**Outcome**	**Lead**	**Resource implications**	**Time frame for completion**
Mental Health Strategy	1	Coproduce a sustainable mental health strategy based on the identified needs of people, created through cross Departmental, cross sectoral and multidisciplinary co-production.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	1.1	Create a 10 year mental health strategy.	Approval by July 2020. Project Board established September 2020. Consultation in March to June 2020. Mental health strategy published by July 2021.	A clear mental health strategy for the next 10 years.	DoH	Requires funding of up to £100k.	July 2021.
	1.2	Prepare for a Mental Health Strategy	Publish final Bamford Evaluation Report by September 2020. Evaluate and close the psychological therapies strategy by February 2021. Evaluate and close the personality disorder strategy by February 2021	Closure of Bamford as the policy direction for mental health. Closure of the psychological therapies strategy. Closure of the personality disorder strategy.	DoH	None for publication of the final Bamford Evaluation Report. Up to £35k for psychological therapies strategy.	February 2021.

						Up to £35k for personality disorder strategy.	
	1.3	Implement the inter-departmental Action Plan in response to NICCY's Still Waiting report	Implement the inter-departmental action plan by June 2021.	Better outcomes for children and young people.	DoH	Funding requirements as per the inter-departmental action plan.	June 2021.
10 year funding plan	2	Evaluate funding patterns and create a clear funding plan					
	2.1	Create a 10 year funding plan for mental health	Published with strategy by July 2021. Fund map mental health services, adults and CAMHS by September 2021.	A clear funding plan which will help improve decision making and commissioning.	DoH	Up to £100k for fund mapping.	September 2021.
Mental Health Champion	3	Create a Mental Health Champion					
	3.1	Create a Mental Health Champion	Executive approval by May 2020. Start appointment process by June 2020. Appoint a Champion in September 2020 to be in post by February 2021.	An independent voice who will support work on mental health and champion mental health across all sectors of life.	DoH	Up to £75k in 2020/21. Up to £500k per year after 2020/21.	February 2021.
People / Experience							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Better understanding of the system	4	Create a service map of the system to help and guide					

		understanding of what services are available	[redacted]				
	4.1	Create a map of the services available throughout the system.	Scope the extent of service mapping available by connecting to Directorate of Services work. Services map based on the stepped care pathways completed.	Better understanding of the system by both users and professionals.	DoH	Requires funding of up to £25k	July 2021.
Enhanced user involvement	5	Enhance the involvement of people with lived experience, including service users and carers in service delivery and service planning.	[redacted]				
	5.1	Embed co-production in all service improvement processes.	Regional agreed policy directions in the Trusts for service improvement processes by March 2021. Regional agreed policy direction in the Trusts for inclusion of carers in co-production. New for a for patient / staff involvement including peer support workers by March 2021.	Increased involvement of service user and people with lived experience (including carers) and therefore better user experience.	Trusts	None	March 2021.
	5.2	Create a regional service user and carer structure and ensure that processes are in place to support this by restructuring the Bamford Monitoring Group.	Consider the role of Patient Client Council and the Bamford Monitoring Group. A new terms of reference, membership criteria and name for Bamford Monitoring Group.	Better system for supporting service user consultants and a regional approach to service user involvement.	DoH HSCB Trusts PCC	Up to £30k	December 2020.

			New regional structures to support service user involvement.				
Enhanced pathways and structures	6	Improve mental health service pathways and structures.	[redacted]				
	6.1	Repeal the Mental Health Order for over 16's and commence Mental Capacity Act	Mental Capacity Act fully commenced for over 16's.	Reduced stigma for mental health patients.	DoH	None	Timings to be confirmed after Ministerial approval.
	6.2	Create managed care networks	Fund and implement the CAMHS managed care network by April 2021. Fund and implement the forensic mental health managed care network and consider a regional forensic service by April 2021.	Better outcomes for CAMHS patients. Regional consistency of approach and standardisation where appropriate. Greater local evidence based developed to inform commissioning of forensic mental health services.	DoH HSCB	Up to £200k for CAMHS MCN Up to £350k for forensic MCN	April 2021.
	6.3	Full implementation of mental health care pathways. Fully implement the "You in Mind" mental health care pathway.	Fully implemented You in Mind mental health pathway. Fully implemented CAMHS pathway. Ensure compliance with NICE guidelines. Implement the You in Mind forensic service model pathway	Under development.	HSCB PHA Trusts	None	April 2021.
	6.4	Review the process for dealing with suicide and homicide and deaths by mental health patients or a	Robust review to ensure that all is done to avoid, gather learning and engage appropriately with those affected by suicide, homicide and death of persons	Better response to suicide and homicide. Safer practice and implementation of	DoH HSCB PHA	Up to £60k	Review completed by July 2021.

		person known (within the last 12 months) to mental health services subject to funding .	known to mental health services. The review should benchmark outcomes against other jurisdictions. Implementation of good practice to reduce likelihood of suicide and homicide, drawing on the recommendations from the National Confidential Inquiry into Suicide and Homicide, Towards Zero Suicide and quality improvement initiatives.	learning from suicide and homicide SAI reviews.			Implementation dependent on outcome of review.
	6.5	Review restraint and seclusion.	Review of restraint and seclusion. Final report to contain regional policy on restrictive practices and seclusion and regional operating procedures for seclusion. Review to be completed by December 2020. Outcomes to be implemented by April 2021.	Better patient care and safe practice.	DoH	Up to £30k	Review completed by December 2020. Implementation by April 2021.
Improved transitions	7	Improve transitions between different aspects of mental health services.	[redacted]				
	7.1	Improve transitions in mental health services	Consider a new model for CAMHS to smooth transitions when a child turns 18 subject to funding. Multi-disciplinary project team set up to review and consider options to reduce difficult transitions by September 2020. Review completed by March 2021.	Less complex and traumatic transitions.	DoH HSCB PHA	Up to £100k in year 1 and up to £50k in year 2. New model may require funding.	Reviews completed by March 2021. Review of transitions into old age services completed by March 2022.

			Review and consider transitions between adult and old age mental health services and create transition pathways subject to funding by March 2022. Review and consider interfaces between services, including between different mental health specialisms, physical health, dual diagnosis, learning disability, autism, looked after children and criminal justice system by March 2021				
	7.2	Introduce availability of Mental Health Passports for all service users to assist with transition between services subject to funding.	All patients who wish to have a mental health passport should have one. Consider inclusion in the patient portal work.	Service users have a smoother transition between services	HSCB PHA Trusts	Costs to be scoped Initial allocation of up to £30k	March 2021
Improved care and treatment in an emergency	8	Consider and enhance the experience when a person is experiencing a mental health crisis, in particular in relation to emergency care.	[redacted]				
	8.1	Consider the outcome of the RQIA Review of Emergency Mental Health Service Provisions across Northern Ireland.	Consider the review and provide responses by December 2020. Support the work of review of emergency and urgent care.	RQIA recommendations taken into consideration	DoH	None	December 2020
	8.2	Reconfigure mental health crisis services	Evaluate alternative to ED for people in mental health crisis.	Reduction in people attending ED in a MH crisis.	DoH	£50k	December 2020

			Evaluation and rollout of Multi Agency Triage Team. Consider interactions between different crisis responses such as MATT, Home Crisis Teams, ED, 999, police, primary care MDT and similar. Further development of liaison mental health services across all trusts.	Better MH crisis response.			
Access to services							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Improved specialists services	9	Review and develop specialist services across the mental health system.	[redacted]				
	9.1	Decide on perinatal mental health services.	Consideration of business case for perinatal mental health services – April 2020. Agreement on new service model for specialist perinatal mental health services by September 2020.	Better services for those suffering from perinatal mental health needs which will also improve the child's health and development.	DoH	Up to £3.6m recurrent £900k in 2020/21	September 2020
	9.2	Review specialist mental health services.	Consideration of options paper for eating disorder services by March 2021. Review eating disorder services to provide a new service model for specialist eating disorder mental health services by July 2021.	Better services for those people diagnosed with eating disorders.	DoH	Up to £100k	July 2021.

			Review of current personality disorder services to evaluate effectiveness, identify gaps and make recommendations for future service developments by July 2021.				
	9.3	Consider model for both low secure and rehabilitation services and develop concrete proposals subject to funding.	Proposals for way forward by December 2020, subject to any revised NICE guidelines.	Better care for those with specialist needs.	DoH HSCB	Costs to be scoped	December 2020 (subject to any revised NICE guidelines).
	9.4	Implement the first phase of the Regional Trauma Network.	Implement the first phase of the Regional Trauma Network by April 2021.	Better care for those who have suffered trauma.	DoH HSCB	Existing funds	April 2021
Better mental health care and treatment in primary care	10	Enhance mental health in primary care					
	10.1	Create opportunities for training of GPs on general and specialist mental health and CAMHS, including dual diagnosis and those patients with a learning disability or autism that also have a mental illness subject to funding.	New / improved training programme for GPs for adult mental health. New / improved training programme for GPs for CAMHS.	Improved knowledge of mental health conditions, mental health brief interventions and mental health services among GPs.	DoH HSCB PHA	Costs to be scoped	July 2021.
	10.2	Roll out of mental health workers in primary care MDTs.	Support agreed further roll out of mental health workers in primary care MDTs – ongoing.	Improved access to mental health intervention services in primary care.	DoH	Funding provided through transformation and primary care programme of care.	ongoing
	10.3	Consolidate and expand the availability	Increase uptake on counselling provisions in primary care.	Improved access to services in primary	DoH HSCB	Costs to be scoped.	Significantly advanced by

		of talking therapies and other community based support through mental health hubs, and expand the geographical coverage of mental health hubs. Subject to funding	Increase availability of evidence based and professionally accredited counselling. Significantly advance integration of primary care hubs / talking therapy hubs into primary care within 24 months of approval. Improve regional consistency in delivery of hubs within 24 months of approval. Clear strategy for inclusion of community and voluntary sector in regional consistency.	care for those who do not need specialist secondary care services.	C&V		December 2021.
	10.4	Create an integrated model for primary care hubs / talking therapy hubs where primary care is responsible for service delivery. Consider the transfer of mental health hubs to GPs and GP Federations, linked to the Primary Care MDT model	Scope model for primary care / talking therapy hubs. Create model where the hubs are driven through primary care.	Improved access to services in primary care for those who do not need specialist secondary care services.	DoH HSCB C&V	Costs to be scoped.	Work commenced by September 2021.
Staff / workforce							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Help all staff to work more effectively	11	Create systems and procedures that reduces bureaucracy and helps staff deliver effective services.					

	11.1	Review documentation that is currently used and consider how it is used subject to funding.	Review of use of non-essential documentation with clear recommendations by July 2021. Consider outcome of review of documentation and take appropriate action	More effective use of staff time.	HSCB PHA	Up to £30k	July 2021
Encourage local initiatives and improve staff morale	12	Create a system that encourages local initiatives and improves staff morale and helps them feel more resilient, supported and respected	[redacted]				
	12.1	Create clear systems where all front-line staff are included in co-production and a leadership environment that encourages staff involvement	Consider current systems and ensure there is sufficient front-line staff included in decision making on a system wide level by December 2020.	Improved morale among staff and improved local services.	Trusts	None	December 2020.
	12.2	Create regional and local fora that encourages staff innovation and local initiatives subject to funding.	Each trust to create a local fora to consider local initiatives by October 2020. The HSCB and PHA to create a regional fora to support local forums by October 2020. Create a fund earmarked for local initiatives for the fora to distribute.		Trusts HSCB PHA	Up to £500k (circa) Funding may require Ministerial approval.	Immediate
Stronger mental health workforce	13	Create a stronger and more resilient mental health workforce	[redacted]				
	13.1	Initiate a workforce review of the mental	Review to be initiated by DoH Workforce Directorate.	A better understanding of the current mental health workforce and	DoH	Costs to be scoped	Timeline for review to be scoped.

		health workforce subject to funding.		the pressures and the requirements for the future.			
	13.2	Review and create a regional protocol for peer support workers including clear governance structure and role subject to funding.	New protocol for peer support workers including clear definition of the role and the governance structures.	Better understanding among peer support workers and others of the role of peer support workers.	Trusts	Up to £30k	December 2020.
	13.3	Consider the mental health workforce. Consider new ways to use the mental health workforce subject to funding.	Consideration of alternative methods of working and alternative workforce. Implement new methods as soon as possible thereafter. Increase the mental health workforce subject to funding.	More resilient workforce. Better services	DoH HSCB Trusts C&V	Costs to be scoped	Immediate
Structures, evidence and commissioning							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Enhance governance structures	14	Enhance the governance structures in the mental health system					
	14.1	Carry out a review of governance structures for policy making and policy accountability of the mental health system to create clear lines of accountability.	Review completed by September 2020. Implement review by December 2020. Create a process map of structures by December 2020.	Greater accountability in mental health governance structures to ensure that decisions are taken at the right level by the right people.	DoH	£5k	December 2020.
Better evidence and better use of evidence	15	Increased use of evidence and using the right evidence.					
	15.1	Create an outcomes framework for mental	Create a multi-disciplinary task and finish group established by	Greater understanding of what works and	DoH HSCB	Up to £50k (circa)	September 2021.

		health services to measure outcomes data subject to funding and ensure consistence in data collection.	October 2020 to consider an outcomes framework and how to develop based on mental health service framework and integration with Encompass. Final product developed by March 2021. Implemented by September 2021. Ensure all Trusts are enrolled in NHS benchmarking by September 2020	evidence to help in bidding for funding and commissioning. Implement practice based outcomes for capturing effective therapeutic interventions in all mental health services.			
	15.2	Conduct a prevalence study for adult mental health subject to be scoped	Prevalence study for Adult mental health complete	Better understanding of the prevalence of mental health which may indicate unmet need and may redirect investment and will help investment based on evidence.	HSCB PHA	Costs to be scoped	24 months after approval
Improved commissioning	16	Ensure regional commissioning					
	16.1	Create structures for more regional consistency in commissioning within the commissioning framework.	Introduce a regional structure for commissioning based on other working practices within existing commissioning framework.	Better commissioning with more regionally consistent services which will ultimately have a better outcome for the person who is suffering from mental illness.	HSCB	None	December 2020.
	16.2	Create a regional approach to bed management to ensure consistency in admission and discharge	Regional consistency in bed stay (with explained local variations).	Better commissioning with more regionally consistent services which will ultimately have a better outcome for the person who is suffering from mental illness.	DoH HSCB PHA	None	December 2020.

New ways of working and technology	17	Consider new innovative ways of working					
	17.1	Understand where the pressures on the system are and how the community and voluntary sector can help relieve such pressures	Create task and finish group to consider community and voluntary involvement in mental health services by October 2020. Report on improvements by March 2021.	Better and increased use of the community and voluntary sector where it is relevant to do so.	DoH HSCB PHA	None for task and finish group work.	March 2021.
	17.2	Enhance the use of technology subject to funding.	Monitor trial of body worn cameras in Southern Trust and consider feasibility for regional roll out. Consideration in line with timelines for trial. Monitor trial of advanced cameras in seclusion rooms in Southern Trust and on completion of trial consider regional roll out and how it should be implemented. Monitor C&V sector trial of chat bots and consider how it can be developed across HSC systems and how Trusts can link with C&V sector. Create an action plan to develop the use of technology in mental health services subject to funding by March 2021. Support the introduction of Encompass in mental health services.	Enhanced services for patients. Better safety for patients and staff. Better use of staff resources.	DoH HSCB PHA Trusts C&V	Costs to be scoped	Ongoing.

It is important to note the timescales and costs outlined in this plan are indicative and will require further prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required is in addition to existing expenditure in mental health services and is dependent on the release of resources either through service efficiencies and reconfiguration or new year on year investment. Any investment in mental health services will have to be balanced against other service priorities and in the context of the Department's financial settlements and this will determine the pace of change.

Annex A – Workplan for actions

Mental Health Action Plan - workplan

Action	2020 July	Aug	Sep	Oct	Nov	Dec	2021 Jan	Feb	Mar	April	May	June	July	Aug	Sep
1.1 Mental Health Strategy															
1.2 Prepare for Strategy															
1.3 Implement NICCY action plan															
2.1 10 year funding plan															
3.1 Mental Health Champion															
4.1 Service map															
5.1 Embed co-production															
5.2 Regional SU structures															
6.1 Mental Capacity Act															
6.2 Create Managed Care Networks															
6.3 Implement pathways															
6.4 Review of suicide, homicide and deaths															
6.5 Review of restraint and seclusion															
7.1 Improve transitions															
7.2 Introduce mental health passports															
8.1 Urgent and emergency care															
8.2 Review crisis services															
9.1 Perinatal mental health															
9.2 Review specialist services															
9.3 Review low secure and rehab facilities															
9.4 Implement Regional Trauma Network															
10.1 Training in primary care															
10.2 Support primary care MDT															
10.3 Expand availability of hubs															
10.4 Integrate hubs and primary care															
11.1 Review documentation															
12.1 Integrate co-production															
12.2 Innovation fund															
13.1 Workforce review															
13.2 Peer support review															
13.3 New ways of working for the workforce															
14.1 Review governance structures															
15.1 Outcomes framework															
15.2 Prevelance study															
16.1 Structures for regional commissioning															
16.2 Structures for bed management															
17.1 Review involement of C&V sector															
17.2 Improved use of technology															

Strategic work
Co-production
Reviews
Service developments
Governance
Workforce

Annex B
Department of Health
COVID-19 Mental Health Response Plan

May 2020

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

Introduction

This document is the Department of Health COVID-19 Mental Health Response Plan.

This is a living document and will be updated regularly in response to the rapidly changing environment.

This response plan focusses on seven strategic themes that have been identified to respond to the impact of the pandemic on the population in Northern Ireland. The overarching outcome of the plan is to increase the psychological wellbeing and good mental health for the population as a whole.

The COVID-19 Mental Health Response Plan outlines the high level actions of the Department, and how support is provided to the Health and Social Care system, independent sector and others.

The response plan is in addition to the existing work, in particular the inter-Departmental Resilience and Mental Health Working Group in response to COVID-19, implementation of a Mental Health Action Plan and Strategy and regular mental health service improvements and strategic work by the Department of Health. The COVID-19 Mental Health Response Plan does not replace existing strategic directions, such as Protect Life 2, but builds on existing work.

Strategic linkages with existing and future work are vital to ensure improvements post-COVID-19. Key linkages are provided at the end of the plan.

The document has been developed by the Department of Health.

Background

Mental health services in Northern Ireland are provided in line with the stepped care model used in mental health services across the region.[6] This approach remains during COVID-19. Mental health services have not stopped, and all who need care and treatment will be provided with services that are clinically appropriate.

The responses in this response plan are to ensure that the stepped care model is still deliverable during the pandemic and provide COVID-19 specific actions to mitigate the psychological and mental health impact.

[6] The picture represents the adult stepped care mode set out in the You in Mind Regional Mental Health Care Pathway.

Background

There are a number of COVID-19 specific factors which will likely have an impact upon the mental wellbeing of our population during this pandemic. These include:

social distancing and isolation

bereavement

unemployment

financial hardship

inability to access services

stress

There is significant evidence of the impact of these on psychological wellbeing and mental health.[7]

[7] Rapid review - Mental Health Impact of the Covid-19 Pandemic in Northern Ireland; Greenberg et al Managing mental health challenges faced by healthcare workers during COVID-19 pandemic, 2020; Rhodes et al, The impact of hurricane Katrina on the mental and physical health of low-income parents in New Orleans, 2010; Department of Health; World Health Organisation; Mental Health Foundation; Centre for Mental Health; articles in the British Medical Journal and the Lancet

Prior to the pandemic Northern Ireland is estimated to have higher levels of mental ill health than any other region in the UK with 1 in 5 adults (185,000 people) having a mental health problem at any one time.

The impact of large scale trauma could mean an increase in higher levels of mental health diagnosis (including depression, acute stress disorder, adjustment disorder, post-traumatic stress disorder, prolonged grief disorder, psychotic illness and other anxiety disorders) and substance use.

Health and social care staff are at specific risk of negative outcomes, with challenges such as moral dilemmas relating to inadequate resources, fears about lack of knowledge or experience and the traumatic experiences faced.

Social isolation is associated with suicidal ideation, where those who frequently experienced loneliness were at 21% increased risk of having suicidal thoughts (as against 2.5% of those who were not as frequently lonely) and had a 8.4% chance of attempting suicide as against 0.7% for those who were less frequently lonely.

Infection with the virus will directly impact on the mental well-being of some people, through the experience of being in an intensive care environment which is known to cause PTSD for some.

It is known that unemployment is a factor of mental ill health and it is estimated that the likelihood of developing a mental health disorder is doubled if unemployed. That means for every 1% increase in unemployment an estimated 9,000 people are twice as likely to develop mental health disorders.

Financial loss may lead to anger or anxiety with those on a lower income more likely to be affected. Stigma, due to a perception of risk of infection, may be a factor particularly for healthcare workers perpetuating the trauma and distress already experienced.

Strategic Themes

Considering the evidence of the psychological and mental health impact of the pandemic we have identified a number of problems and have structured a response across seven broad themes. The themes broadly covers the work to respond to, and mitigate, the effects of the pandemic on psychological distress and mental ill health.

Mental health and resilience response to COVID-19	Public health messaging	Provision of advice, information and support	Evidence based support and interventions	CAMHS specific issues	Existing mental health services contingency	Service realignment
• To ensure a coherent and joint up response to the pandemic we are committed to creating structures to respond to the psychological and mental health needs.	• To help and support the whole population to have clear, accurate and up to date information we will provide coordinated public health messaging to promote psychological wellbeing and good mental health.	• As help and support desperately needed during difficult times are not available using normal channels, we will provide advice, information and support using both digital and traditional methods.	• Many people will need help and support to cope during the pandemic, and some will require specialist help and support. It is vital to be able to provide quick and accurate information without pathologising people. We are therefore committed to provide evidence based support and interventions.	• Children and young people are faced with particular challenges during the pandemic. Normal activities have stopped and the peer support normally enjoyed is not as easily accessible. We will ensure that children and young people are considered in the strategic response to COVID-19 and that any children and young people specific issues are resolved.	• Mental health services in Northern Ireland faced significant challenges prior to COVID-19. This, in combination with COVID-19 specific pressures, means there are challenges in providing the care and treatment required. We are committed to supporting services, and to provide a framework to ensure those who need mental health services can avail of them.	• It is expected that the pressures on mental health services post-COVID-19 will continue to increase, potentially significantly. This will mean that service recovery and realignment will be key going forward. We are committed to working closely with delivery partners to create clear recovery plans.

1. COORDINATED MENTAL HEALTH AND RESILIENCE RESPONSE TO COVID-19

Action 1.1

Create a mental health and resilience work stream to ensure a coherent, cross-departmental and cross-sectoral strategic approach

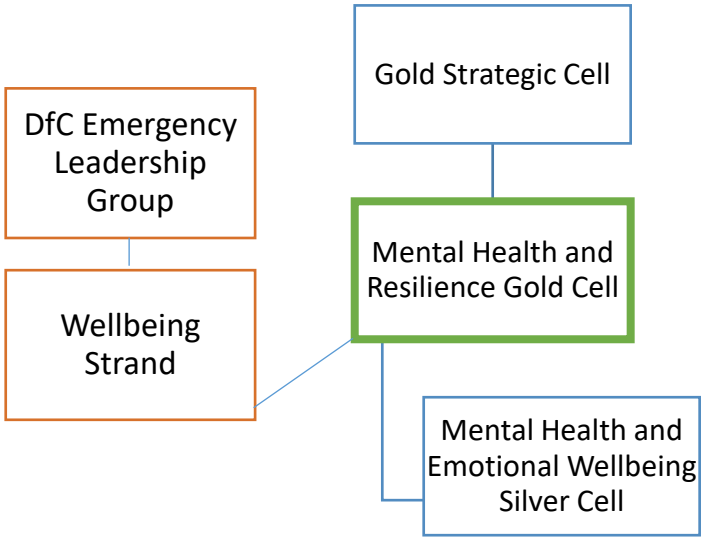
Theme 1 – Coordinated mental health and resilience response to the pandemic

COVID-19 affects all areas of life and all aspects of mental health and wellbeing. It is expected that the pandemic will have significant impact on the wellbeing of the population across Northern Ireland.

Health and social care services are provided by a broad range of bodies including statutory sector, community and voluntary sector and the independent sector providers. When delivering actions it is vital that all parts of the system must be considered and must be supported to enable us to deliver the response that is required at this time.

The strategic response must be coordinated and have clear outcomes. This will help in ensuring consistency in messaging and linking in to the Executive COVID-19 Strategy.

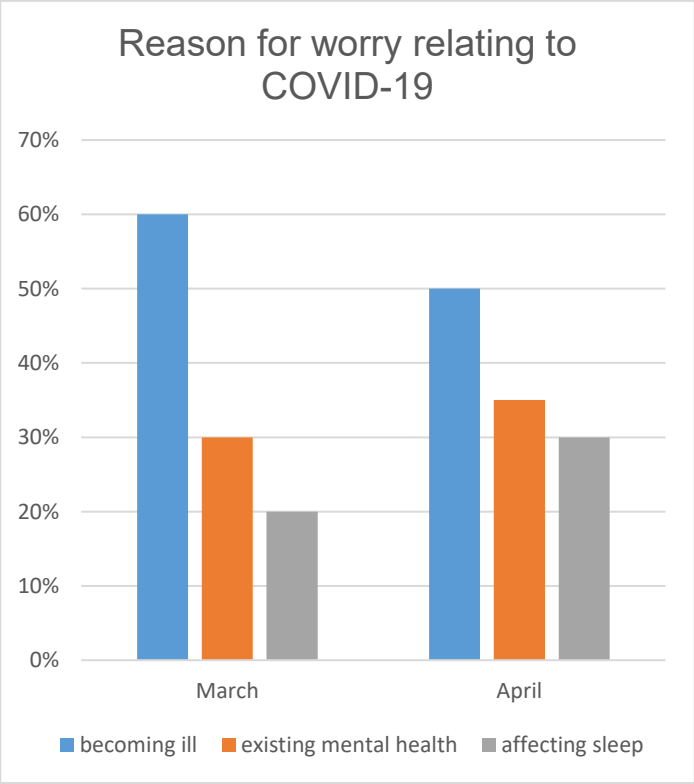
To ensure that this is captured in the response to the pandemic a mental health and resilience work stream has been created to ensure coherent, cross-departmental and cross-sectoral strategic approach to psychological wellbeing and good mental health during COVID-19.



2.
PUBLIC HEALTH MESSAGING

Theme 2 - Public health messaging to promote mental wellbeing

There are clear early indications that people are worried about the pandemic and that anxiety levels are increasing.



Preventative steps are essential to mitigate this and will include a clear and widely proliferated message setting out how to address mental wellbeing and support good mental health.

It is therefore important to provide clear and consistent messages and advice across media outlets, to avoid over-crowding, conflicting messages and subsequent lack of understanding and confusion.

We will work in partnership with the Health and Social Care system and across government to ensure consistency in public messaging specifically relating to maintaining mental wellbeing while at home and improving good mental health

2.
PUBLIC HEALTH MESSAGING

Action 2.1
Create public health messaging to promote mental wellbeing

Action 2.1 – Create public health messaging to promote mental wellbeing

The Department of Health, the Public Health Agency, the Health and Social Care Board, the Health and Social Care Trusts, community and voluntary and independent sector have a responsibility to give clear, coherent evidence based information and consistent advice and information to the population.

The Public Health Agency's Take 5 Steps to Wellbeing is a useful framework to support both the physical and mental health of our population during the pandemic and provides accessible and familiar messaging for the wider population.

The Department is committed to ensure consistent public health messaging supporting the Take 5 Steps to Wellbeing and ensuring that this is the main message made public.

The Department will also support and promote Minding Your Head (www.mindingyourhead.info) as a useful platform for information for help and support for mental health. A wide range of information will continue to be made available through the Family Support NI website (www.familysupportni.gov.uk).

2.
PUBLIC HEALTH MESSAGING

Action 2.2
Support the development on a regional HSC owned communications plan

Action 2.2 – Support the development on a regional HSC owned communications plan

The primary driver for public health messaging rests with the Public Health Agency.

During the pandemic it is important that the messaging provided is consistent and continuous. The Department is supporting the development of a regional HSC owned communications plan, outlining key areas of communication and methods to reach everyone who needs information.

The objectives of the communication plan are to:

- acknowledge the natural emotional distress as result of the pandemic;
- acknowledge and provide support to those who are grieving the loss of loved ones and colleagues in these very difficult times and circumstances;
- provide clear facts and dispel myths about mental health and wellbeing; and
- acknowledge and provide support to those who are grieving the loss of loved ones, colleagues and those in their care.

The communications plan includes specific actions during Mental Health Awareness Week, 18 to 24 May, to help and promote psychological wellbeing and good mental health both as a result of the pandemic and relating to mental health in general.

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Theme 3 – Provision of advice, information and support

During periods of social distancing and isolation, alternative means of providing information, advice and support are needed as the ability to meet in person is limited. In particular, online and digital tools can provide an excellent way for people to stay in touch, to access therapy or other support services and to get up to date, factual information.

It is also important to consider the needs of those for whom the internet or other digital tools are not available or inaccessible. We will work with partners across government to ensure such groups are identified, their needs assessed, and support is put in place.

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.1
Provide online classes for stress control

Action 3.1 – Provide online classes for stress control

It is widely accepted that people feel stressed as a result of the pandemic. In a recent UK wide survey the Mental Health Foundation found that:

57% of all asked are worried about COVID-19	**17%** of all asked are panicked about COVID-19	**26%** of unemployed asked felt hopeless

When normal methods cannot be used to help people control stress, we must work to deliver alternative channels. Stress Control are available free of charge online through a collaboration across the UK nations and Ireland. The classes are made by Dr Jim White, Consultant Clinical Psychologist.

The class is six sessions long over three weeks and are viewable on YouTube with supporting material on Stress Control's website. The first class started on 13 April and the second class started on 11 May. Further information on classes and supporting material can be found at www.stresscontrol.org.

The classes have been successful to date:

- The 1st session had 10,548 views and further sessions had an average of 6,207.
- Most people who watched more than the first session finished the course.
- 75% of users were women.
- 87% of users were between the ages of 25 and 65.

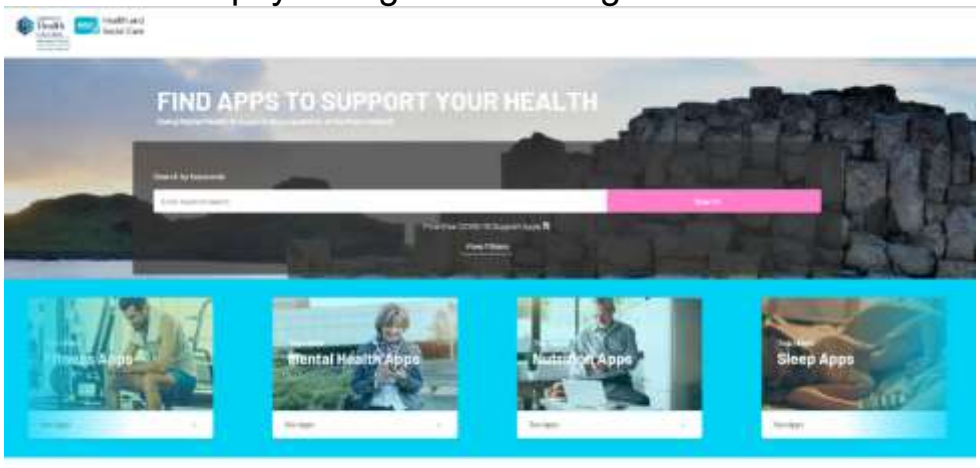
3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.2
Create an apps library for HSC safe apps for mental resilience and wellbeing

Action 3.2 – Create an apps library for HSC safe apps for mental resilience and wellbeing

Due to social isolation and the reduction in personal contacts, alternative methods to provide help and support are needed, without pathologising the population. One method to do this is to provide safe and approved online resources. The HSC has therefore partnered with ORCHA (The Organisation for the Review of Care and Health Apps), to create a library of health and wellbeing apps that have been reviewed and rated as helpful, safe and secure.

The library is being launched in phases and will support the population through the pandemic and beyond. The first phase launched on 5 May by the PHA using existing ORCHA libraries relevant to psychological wellbeing.



The apps library can be accessed at: https://apps4healthcareni.hscni.net

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.3
Provide support for health and social care workers

Action 3.3 – Provide support for health and social care workers

Those working in health and social care, both in the HSC workforce, independent sector and volunteers, are particularly at risk of negative impact on their mental health because of the extreme pressures during the pandemic.[8] Centre for Mental Health notes in their 15 May COVID-19 Briefing:

Health and care workers and other frontline workers are at greater risk of developing mental health problems as a result of Covid-19.

50% increase in significant stress for those who have worked with SARS-CoV patients	Psychological impact on staff from SARS-CoV between **29-93%**	**40%** of staff showed significant mental health symptoms 3 years after SARS-CoV	**44%** of doctors in UK are self reporting mental health problem due to COVID-19

Three specific support mechanisms have been created:

- A framework for supporting staff developed by clinical psychology with input from others such as Trade Unions, occupational health services and HSC organisations was published on 16 April.
- Seven days a week phone line to help and support all health and social care workers. Phone numbers can be found on PHA's website.
- Handbook for new staff who have qualified earlier than expected.

[8] Centre for Mental Health Covid Mental Health Forecasting 15 May 2020; Douglas et al, Preparing for Pandemic Influenza and its Aftermath, 2009; Wu et al, The Psychological Impact of the SARS Epidemic on Hospital Employees in China, 2009; BMA, Stress and burnout warning over COVID-19, 2020

4.
EVIDENCE BASED SUPPORT AND INTERVENTIONS

Theme 4 – Evidence based support and interventions

It is essential that appropriate evidence based support is available throughout this time for those who need it.

In many instances this may be provided digitally using online tools and apps, and we will work to provide access to appropriate, safe and clinically recommended digital solutions. However, it is also important to ensure individuals have access to more traditional support options if required.

This is particularly important for staff working on the front line across the statutory, independent and community and voluntary sectors, where psychological first aid is one of the globally recommended responses.

4.
EVIDENCE BASED SUPPORT AND INTERVENTIONS

Action 4.1
Review / research into impact

Action 4.2
Enable access to psychological first aid

Action 4.3
Enable prescription of specific apps within the apps library

Action 4.1

To fully understand the impact of the pandemic on people, services and strategy evidence is required.

We will continue to work with research partners inside and outside the HSC, including Universities, external research agencies and those with appropriate expertise who are willing to provide guidance and evidence.

We will draw on the experiences from past pandemics, and evidence from COVID-19 specific research and incorporate the findings in decision making going forward.

Action 4.2

The World Health Organisation, War Trauma Foundation and World Vision International have developed psychological first aid, which involves humane, supportive and practical help, to help others who are suffering a serious crisis event.

We will support the HSC to develop and make psychological first aid available across Northern Ireland.

The HSC has in collaboration with the Red Cross and NHS Education Scotland made available interim guidelines and a short E-Learning module on Psychological First Aid.

Action 4.3

As noted above, an apps library has been developed in cooperation with ORCHA to provide advice, information and support.

Further phases of the apps library will allow clinicians and wider professionals to “prescribe” and allocate apps to clients as appropriate.

We are working with the HSC to create licences and to support Trust implementation.

This also involves research and evaluation to quality improve and assess the impact of the website and apps library.

5. CAMHS SPECIFIC ISSUES

Theme 5 – Child and Adolescent Mental Health Services specific issues

The pandemic has brought with it a myriad of unprecedented challenges for children and young people. Closure of schools, academic uncertainty, restricted contact with support networks and increased exposure to social media and 24/7 news outlets are all likely to have an adverse effect on the mental health of children and young people both now and in the future.[9]

The expectation from Child and Adolescent Mental Health Services (CAMHS) professionals is that a surge in referrals will be seen, due to the negative impacts of the pandemic on children and young people. It is important that children and young people know how, where and when to get help and that CAMHS continues to operate efficiently and effectively to provide care and treatment for those children and young people that need it.[10]

Children and young people are considered in all aspects of mental health services and feature in all strategic areas. However, particular actions have been developed for this group.

[9] Education Policy Institute Social media and children's mental health: a review of evidence, 2017; Volkin, S. The Impact of the COVID-19 Pandemic on Adolescents, John Hopkins University, 2020; The Children's Sociaty Young people's mental health and well-being during COVID-19, https://www.childrenssociety.org.uk/news-and-blogs/our-blog/young-peoples-mental-health-and-well-being-during-covid-19 accessed 14 May 2020.

[10] UN Policy Brief: The Impact of COVID-19 on Children 15 April 2020; Waite et al, Report 02: COVID19 worries, parent/carer stress and support needs, by child special educational needs and parent / carer work status 3 May 2020.

5.
CAMHS SPECIFIC ISSUES

Action 5.1
Create a sub cell with focus on CAMHS

Action 5.2
Suspend transitions from CAMHS to AMHS

Action 5.3
Promote the use of electronic platforms

Action 5.4
Promote and signpost

Action 5.1	Action 5.2	Action 5.3	Action 5.4
Creation of a sub cell to the Mental Health and Emotional Wellbeing Silver Cell in the command and control structures to focus on the mental health needs of children and young people during and after the pandemic, to support recovery and to quickly raise any issues with the Department for resolution. This will ensure that children and young people specific issues are not forgotten and are dealt with quickly.	Transitions from CAMHS to adult mental health services for 18 year olds have been temporarily suspended. This will help to facilitate continuity of care for patients and families, to enable risks to be safely managed and ease pressures on mental health beds. The suspension is reviewed every 4 weeks.	Promote the use of electronic platforms in appointments and communications with young people. This will ensure that services are provided in line with social distancing guidelines.	Promote and signpost to: Helplines: – Lifeline – Childline – Samaritans – NSPCC Online resources: – Annafreud.org – PHA website – Family Support NI website Continued use of Family Support Hubs. This will ensure awareness of the support and services available to them.

6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

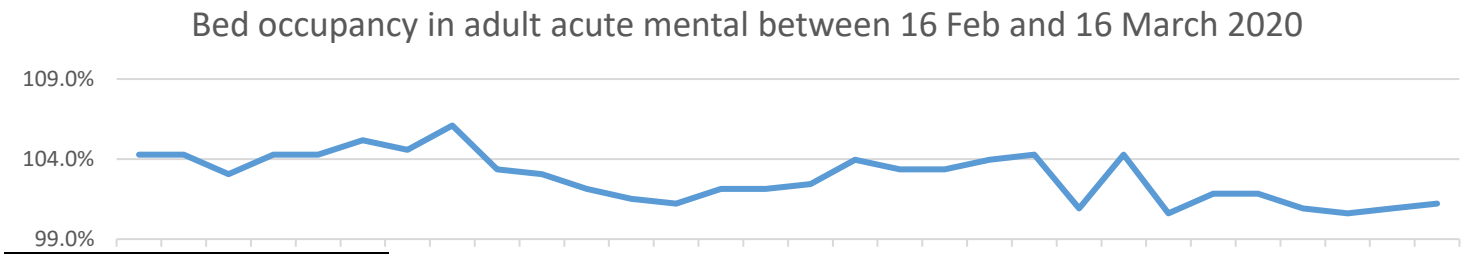
Theme 6 – Existing mental health services contingencies

In our planning for the impacts of COVID-19 a significant number of staff were expected to be unavailable for work, either through illness, isolation or shielding.

These pressures on mental health services come at a time when services across all five HSC Trusts have been experiencing significant pressures. Vacancy levels pre-COVID-19 among mental health nurses were up to 25%, bed occupancy levels in mental health in-patients were regularly over 100% and growing breaches of CAMHS waiting list targets.

Combining existing pressures with new pressures on mental health services, both during and after COVID-19 will provide significant challenges. Northern Ireland experiences higher levels of mental ill health than in other parts of the UK and Ireland. UK wide predictions estimates a significant level of increase of general mental ill health and increases in serious mental ill health.

At least half a million more people in UK may experience mental ill health as a result of Covid-19, says first forecast from Centre for Mental Health.[11]



[11] Centre for Mental Health https://www.centreformentalhealth.org.uk/news/least-half-million-more-people-uk-may-experience-mental-ill-health-result-covid-19-says-first-forecast-centre-mental-health

6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

Action 6.1
Establish coordination between HSC Trusts, Board and the Department

Action 6.2
Surge plans for mental health services

Action 6.3
Emergency statutory provisions and guidance

At all times mental health services have to be provided to ensure that those who need services can access services that meet the need they have. Any restriction in access to services, or alteration to normal provisions is a balance between safely caring for people, and ensuring that there is a functioning mental health service even with a reduced staffing complement or an outbreak of COVID-19 in mental health services.

A crisis situation requires clarity between providers of care, commissioners and the Department on key decisions. A clear governance, reporting and communication structure, with monitoring was therefore set up through a series of actions. Included in this were surge plans which included pre-planned actions for specific pressures.

Further it was identified that the safe care and treatment of mental health patients would not be possible without legislative change.

Action 6.1	Action 6.2	Action 6.3
Twice weekly conference calls between the Department/Board/Trusts/ PHA have been established to ensure quick communication channels and to deal with emerging issues.	The HSC Trusts have developed surge plans for mental health services, and the surge plans have been provided to the Department to help and support the practical work to ensure continued availability of mental health services.	The Coronavirus Act 2020 makes amendments to the Mental Health (NI) Order 1986 to ensure continued ability of HSC Trusts to provide safe and effective mental heath services even during extreme workforce pressures due to COVID-19.

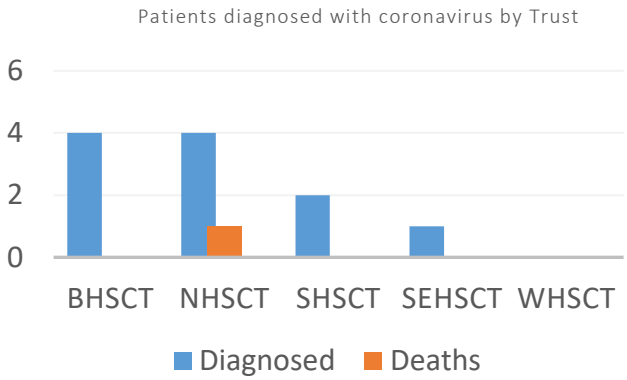
6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

Action 6.4
Monitor infection rates and bed occupancy to quickly identify mitigating actions

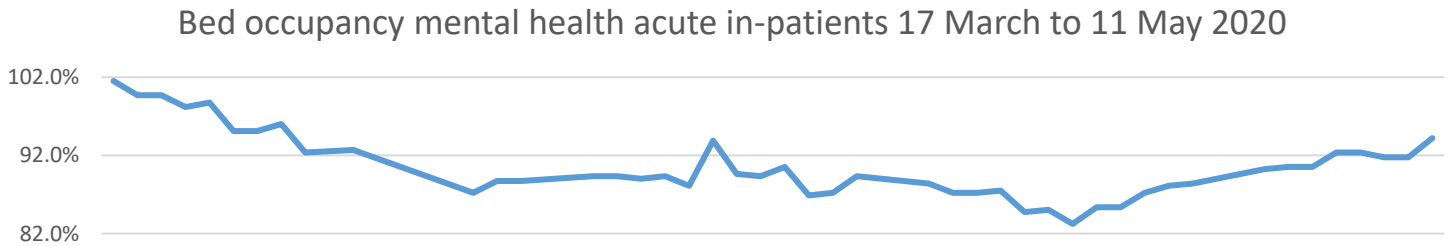
Action 6.5
Respond to pressures and approve temporary practices

Action 6.4

Daily statistics on inpatient bed pressures are captured to monitor change in need and all admissions to inpatient facilities are swabbed. At 11th May 11 patients had been diagnosed with Coronavirus with one death recorded.



Bed occupancy levels dropped from over 100% to below 85% at the end of April. Since then the levels have been steadily rising.



Action 6.5

We are committed to using both statistics and evidence from professionals to identify where temporary practices are necessary.

Temporary modification have been made:

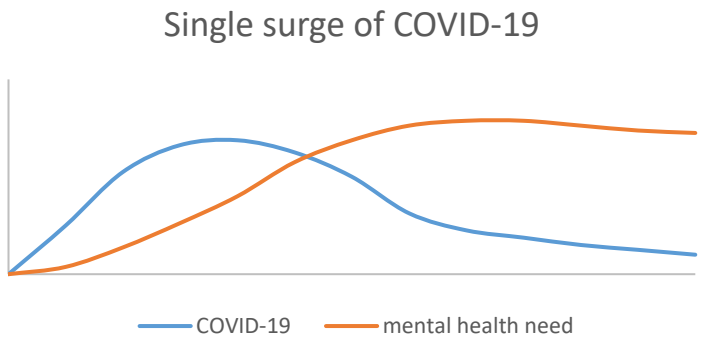
- The regional bed management protocol;
- The process for medical examinations for detention for assessment;
- The Promoting Quality Care protocol; and
- Approved Social Worker procedures.

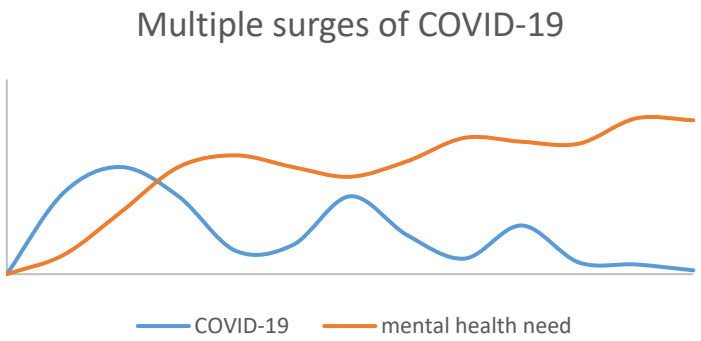
7. SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Theme 7 – Service realignment and business post-pandemic

The number of people who will need mental health services support post-COVID-19 is expected to be significant, together with the built up need among those who normally use mental health services, but who may have felt unable to do so during COVID-19.

The expected impact on mental health is linked to the impact of COVID-19. A single surge of COVID-19 will create pressures that will ease out, with the peak coming after the COVID-19 peak. If there are multiple surges of COVID-19, it is expected that the mental health pressures will be cumulative, with little resetting between surges, as outlined below.





Mental health services therefore need to consider, as part of their business continuity planning, existing and emerging evidence to plan for service realignment, which will include consideration of future needs and service delivery models. We will work with the HSC Board and HSC Trusts to do this as part of their normal business planning approaches. This work will also be taken forward in liaison with the Silver Cell on Mental Health and Emotional Wellbeing.

7.
SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Action 7.1
Develop recovery plans

Action 7.1 – Develop recovery plans

We will work with the HSC Board and HSC Trusts to develop sustainable recovery plans. The plans will be based on a clear decision making framework, with key indicators and will account for pressures in the mental health system. This will allow robust action plans with regional consistency on key areas, such as service levels, staff redeployment, isolation, visiting and physical health of patients.

	Status	Green	Amber	Red	Black
	Pressure	Low			High
	C-19 +ve Patients / Residents in 24 hour care settings with C	Up to **4** patients / resident	Up to **10** patients / resident	**10>** patients / resident	**50%** of ward/Unit
	C-19 +ve Staff in 24 hour care settings	Up to 10% Staff	10-25% Staff	25-50% Staff	>50%
	PPE & Equipment required for management of COVID-19	Adequate PPE & equipment for one month	Adequate PPE & equipment for one week	Not adequate PPE or equipment currently to meet service needs	
	Surge in referrals to Statutory Mental Health	**5%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**Up to 10%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**Up to 20%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**20%+** increase in referrals received Baseline Community = Baseline Inpatient =
	Maintenance & prioritisation of Mental Health & Emotional Well Being	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders

7.
SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Action 7.2
Incorporate new ways of working

Action 7.2 – Incorporate new ways of working

The pandemic and social isolation has required new working practices, such as remote access, use of technology and new innovative practices. Post-pandemic work is required to analyse what has happened, the effectiveness and how to incorporate new ways of working in normal mental health services. We are committed to using the difficult experiences during the pandemic to our advantage post-COVID-19.

In **CAMHS** the use of technology should be evaluated to consider if new ways of using technology had a positive impact and what effect it had on efficiency. The continued use of technology post-pandemic may help in reducing pre-pandemic waiting lists and provide quicker access to quality services for children and young people.

For **adult services**, the use of remote delivery has enabled ongoing contact and treatment of people with mental ill health. On line resources for prevention, early intervention, and treatment of mild to moderate mental illness has been particularly developed and increased. The outcomes of remote delivery will be evaluated and adopted longer term if found to be efficient and effective.

For **adult in-patient services**, an initial reduction in bed occupancy of over 15% and reduction in admissions of over 20% was noted, taking the bed occupancy levels to its lowest in a number of years. This may be because of differences in risk management, but it may be as result of working with patients in different ways. If the alternative use of in-patient services is as effective, this may help post-pandemic pressures on in-patient services.

POST COVID-19 PRIORITY WORK STREAMS

Post COVID-19 priority work streams

Mental health development work does not stop with the pandemic, and must incorporate the response to the pandemic. The good work on psychological wellbeing and improving mental health during COVID-19 feeds into a number of existing mental health priority policy work streams.

Work stream 1	Work stream 2	Work stream 3	Work stream 4
Creation of a **Mental Health Champion.** The purpose of the Mental Health Champion is to further the mental health agenda to promote emotional health and wellbeing, access to evidence based support and services and promote recovery.	Incorporation of COVID-19 specific work in **existing service developments**, including the action plan in response to the NICCY 'Still Waiting' report and work on immediate mental health pressures, in particular pressures on adult in-patient services.	Implement the **Mental Health Action Plan** and develop a **Mental Health Strategy**. This will also link with the development of a new strategy to address substance misuse.	Continued consideration of **legislative changes**, including the Coronavirus Act, the Mental Health Order and the Mental Capacity Act.

COVID-19 Mental Health Response Plan strategic themes and post-COVID-19 work streams

Work stream 1
Mental Health Champion

The Mental Health Champion is a joint initiative across the NI Executive, and is fully supported by all Executive Ministers.

The development of a Champion was announced on 27 April 2020.

What will the Champion do?
The purpose of the Mental Health Champion is to further the mental health agenda across all platforms and fora to promote emotional health and wellbeing, access to evidence based support and services and promote recovery.

The Champion will be a public advocate, consensus builder, network hub and challenger of decisions.

Co-production
The Mental Health Champion will have to work closely with people with lived experience. It is important that the Mental Health Champion will work to promote wellbeing and share a positive message, both in terms of public messaging and in the policy work the Champion is involved in.

The Champion must also focus on recovery, as a key element in the journey of those suffering from mental ill health.

Work stream 2
Existing service developments

Mental health services pre-pandemic was experiencing significant pressures and were undergoing change.

This will link to the cross-Departmental action plan in response to NICCY's Still Waiting. It will also link to mental health service in general, and in-patient services in particular. The pandemic has changed the approach to in-patient care, and the use of community and voluntary sector. This learning must be incorporated in the ongoing work on these service pressures.

COVID-19 Mental Health Response Plan strategic themes and post-COVID-19 work streams

Work stream 3
Mental Health Strategy

The pandemic, and the effect of COVID-19, is likely to have a long term impact on people's mental health and on mental health services.

As part of the New Decade, New Approach a commitment was made to create a new long term Mental Health Strategy. The Strategy will be person centred, with a whole life approach and a whole system focus and the aim is to ensure long term good outcomes for people's mental health.

The Strategy will have to consider the pandemic, and the effect on peoples mental health and mental health services.

This response plan will feed directly into this work and the strategic work will also drive the work on legislative challenges and address existing service developments.

The Mental Health Champion will have an integral part in ensuring that the Strategy will provide the best outcomes possible for the whole population.

This will also link with the development of a new strategy to address substance misuse.

Work stream 4
Legislative challenges

The Coronavirus Act 2020 made amendments to the Mental Health Order and the Mental Capacity Act. These must be reviewed, and considerations must be had on long term changes as a result, including the options of remote working and using technology in statutory functions.

The pandemic has also highlighted the importance of ethical decision making and person centred approach. Both are key components of the Mental Capacity Act and learning from the pandemic must shape the implementation planning going forward

MAHI - STM - 089 - 3371

Mental Health Strategy 2021-2031

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