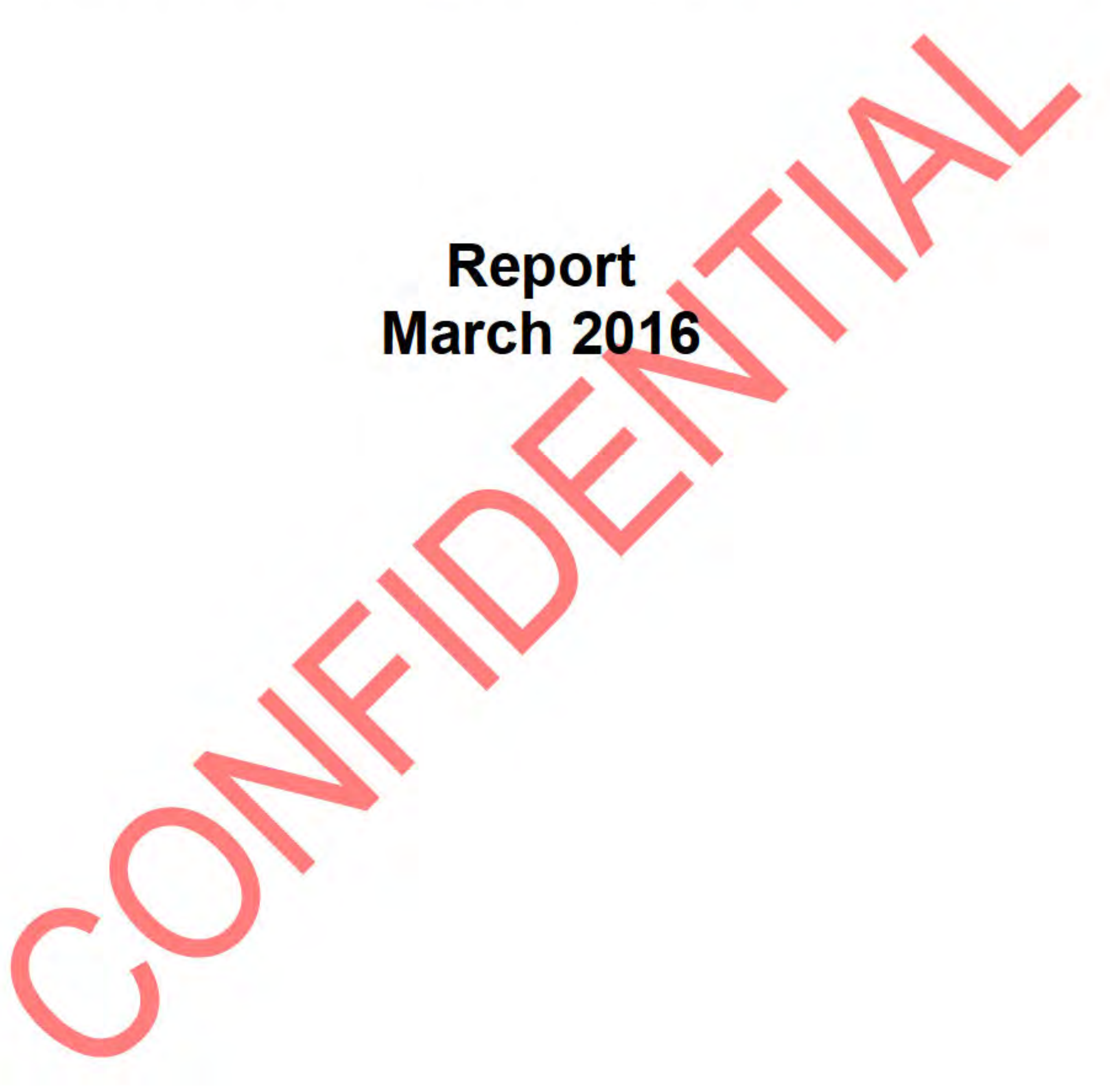
CNMAC Task & Finish Group: Recruitment of Band 5 Registered Nurses



Report
March 2016

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1. Introduction

This report presents the work undertaken by the Central Nursing and Midwifery Advisory Group (CNMAC) Task and Finish Group Recruitment of Band 5 Registered Nurses within HSC Trusts during the period July 2015 to November 2015. A number of recommendations are included and offered to CNMAC for consideration.

2. Background

Over the recent past significant and serious concerns about the shortage of registered nurses at international, and national levels have been expressed by the many including for example RCN (2015)[1], Christie and Co (2015)[2], Buchan and Calman (2005)[3] and through correspondence to the Home Secretary from the NHS Employers (10th September 2015)[4]. The recent statement by Candace Imison, Director of Healthcare Systems, Nuffield Trust offers a stark reality check:

The rising numbers of nurse vacancies in trusts speaks for itself.
There are not enough nurses to meet the NHS's needs.
(10 September 2015)[5]

The Home Secretary's agreement to include nursing on the shortage occupation list as an interim measure at midnight on 15th October 2015 provides a clear indication of extent of the recruitment difficulties faced by employers when seeking to secure sufficient registered nurses to provide compassionate, safe, effective person centred care in a context of a health and social care system characterised by increasing demands and complexity.

Northern Ireland has not been immune to the challenges of securing and retaining sufficient numbers of registered nurses to meet service needs. This has been particularly evident in regards to Band 5 Staff Nurses with the Executive Directors of Nursing for all five HSC Trusts highlighting challenges to the recruitment of registered nurses at several levels but in particular at Band 5. In light of the interdependent relationship between sectors in the NI health and social care system the Executive Directors of Nursing also acknowledge that independent and voluntary nursing home providers experience similar workforce challenges, however it is understood that a separate stream of work has been initiated to review the position within this sector.

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[1] Royal College of Nursing. International Recruitment 2015 London: Royal College of Nursing; 2015.
[2] Christie & Co. The UK Nursing Workforce Crisis or Opportunity? London: Christie & Co; 2015.
[3] Buchan J & Calman L. Summary The global shortages of registered nurses. Geneva: International Council of Nurses; 2005
[4] NHS Employers. Letter to the Home Secretary. Employment of overseas health professionals in the NHS. 10 September 2015
[5] http://www.nuffieldtrust.org.uk/media-centre/press-releases/nuffield-trust-responds-nurse-shortage-warning accessed 22nd October 2015

3. The Task

Having raised these challenges via the Central Nursing and Midwifery Advisory Group meeting of 20 May 2015, it was agreed that a Task and Finish Group would be established and commissioned to scope and describe the current challenges in relation to recruitment and retention of nurses across the five HSC Trusts and to make recommendations to CNMAC to address these challenges.

The Task and Finish Group was chaired by Mr Francis Rice, Director of Mental Health & Disability Services/Executive Director of Nursing & AHPs and the membership included representation from the five HSC Trusts, the RCN and education providers at a senior level from both nursing and human resources. Appendix 1 includes the Terms of Reference for the group.

4. Approach

A project management type approach was adopted. The Task and Finish Group met on a total of four occasions across a five month period from July to November 2015. At the outset a number lines of enquiry were agreed and initiated. These centred on:

- The collection of relevant workforce data via a specific exercise
- Information on the potential workforce pool including summary information on the intended destination of students

5. Workforce Data Collection

5.1 Purpose

The purpose of the workforce collection was to establish a baseline, at a moment in time, which allowed a high level review of the number of vacancies currently in the system and likely to be in the system.

5.2 Template

An agreed scoping template to capture relevant data was developed by the Co/Assistant Directors of Nursing and a representative of the Regional Resourcing Managers Network. A copy of the template is included as appendix 2. The template was issued through the office of Mr Francis Rice and the Trusts were asked to return completed templates by 9th October 2015. It was anticipated that the each Trust would draw its' data locally from the HRPTS on the proviso that this system would contain accurate retrievable data. The Task and Finish Group anticipated that each Trust would quality assure its data prior to submission.

5.3 Findings

The data submitted by the Trusts was reviewed and a number of key findings were identified, these are listed below:

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a) The data submitted by BHSCT, SEHSCT, NHSCT and SHSCT illustrated a gap of 412.43wte between funded establishment and staff in post as at 30th June 2015(Appendix 3).

b) The five HSC Trusts provided information in relation to 'leavers' during the period 2014-15 which indicated that a total of 546.87wte Band 5 staff nurses left their posts.

c) In respect of maternity leave each HSC Trust stipulated the wte lost for the full 2014-15 year. The range in this regard was 57.31wte to 124.13wte. The table below provides the detail in this regard:

Table 1 Maternity Leave per HSC Trust - wte lost for the year 2014-15

BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
124.13wte	116.10wte	57.31wte	73.45wte	71.3wte	442.29wte

The five HSC trusts reported 531 (480.45wte) vacancies as at 1st October 2015 in the Recruitment system. By far the greatest numbers of vacancies were reported in the adult field of practice. It is notable that three of the Trusts reported a total of ten vacancies in the Learning Disabilities field of practice.

d) The five Trusts responding reported significant levels of unplanned absence due to sickness. Each HSC Trust stipulated the wte for the full 2014-15 period as follows: BHSCT 215.23wte, SEHSCT 90.31wte, WHSCT 123.97wte, SHSCT 85.81wte and NHSCT 69.51wte.

e) In the main the Trusts reported that they did not expect to be able to fill current vacancies from current Waiting lists. It is relevant to note that the Trusts reported that their waiting lists often included many of the same candidates. The Task and Finish Group was not able to identify the extent of this, because some HSC Trusts have not migrated to the regional recruitment system and as a result there is no simple way of extrapolating this type of data.

f) Recruitment drives were cited as having been undertaken by all Trusts responding. Various Trusts also noted that they had encountered difficulties at a local level in recruiting to a number of specialties. These specialities included for example: mental health services, care of older people, non-acute hospital care, theatres, critical care, general medicine, community, learning disability and prison health. It is, however relevant to note that the 'difficult to recruit to specialities' varied from Trust to Trust.

g) The numbers of vacancies, leavers, maternity leave and sickness absence taken together have a compounding effect and which in turn, heightens the need for an available labour pool and effective and productive recruitment strategies. In response the HSC Trusts have instigated recruitment initiatives. Table 2 below provides an overview by HSC Trust of the Total absence in wte (this comprises

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maternity leave, sickness leave, term time and career break) for the full year 2014-15.

Table 2 Total Absence per HSC Trust - wte for the year 2014-15

BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
394.51wte	200.10wte	151.59wte	169.92wte	205.33wte	1121.45wte

The detailed data submitted by the Trusts is included in Appendices 4-8.

6. Available Workforce Pool

Whilst it is not possible to be absolutely definitive in the quantification of the available workforce pool, the Task and Finish Group considered that it was possible to offer a reasonable and acceptable description by defining it as comprising of five streams listed below.

6.1 Available Workforce Pool Streams

- **Stream 1**

Those exiting from pre-registration programmes delivered by local AEIs and who enter the NMC Register for the first time.

- **Stream 2**

Those re-entering the workforce following successful completion of a Return to Practice Programme. Appendix 9 illustrates the detail in this regard for the academic years 2011-12 to 2015-16.

- **Stream 3**

Those who come to or return to HSC Trusts to work as Band 5 Staff Nurses for example those returning from overseas, other parts of the UK and within NI those moving from the independent and voluntary sector to statutory services.

- **Stream 4**

Existing Staff Nurses Band 5 who move between or within HSC Trusts to take up an alternate Band 5 Staff Nurse post. It is pertinent to note that this stream does not generate new or additional capacity to workforce supply.

- **Stream 5**

Those staff undertaking the Open University pre-registration nursing programme, which is delivered on a part-time basis. These cohorts normally comprise 20-30 per year and candidates generally hold posts within HSC Trusts as nursing assistants when commencing this particular programme. When candidates successfully complete this programme only the NHSCT and SHSCT allocate these staff to existing vacancies at Staff Nurse Band 5.

It is not possible to provide a robust or well informed estimate of the numbers who fall into either Streams 3 or 4. The Task and Finish Group concluded that by far the greatest

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Exhibit 1

proportion of the potential or available workforce pool is provided by Stream 1, followed by Stream 5 and then Stream 2.

6.2 Available Workforce pool – analysis of data

The key findings emerging from the information provided by the DHSSPS and the AEIs is summarised below:

(a) During the period September 2014 – 31 August 2015, a total of 650[6] student nurse places were commissioned within Northern Ireland, which breakdown as follows across the four fields of practice:

- Adult 453
- Mental Health 112
- Children's 55
- Learning Disabilities 30.

During the year 2008-09 a total of 730[7] places were commissioned. This represents a reduction of 70 places (9.6% approximately) when compared with the number of places commissioned for the period September 2014 – 31 August 2015.

(b) There are approximately 618 students successfully completing their pre-registration nurse education programmes across Spring and Autumn/Winter 2015. These include 446 Adult, 88 Mental health, 53 Children's and 31 Learning disability fields of nursing practice. Within Northern Ireland the overall attrition rate within pre-registration nursing is consistently below 10% and compares very well with other jurisdictions in the United Kingdom.

(c) In each academic year 2011-12, 2012-13, 2013-14 and 2014-15 a total of 32 places are offered on the Return to Practice Programme (Ulster University). This figure reflects the total uptake to two cohorts (16 places per cohort) per year. Appendix 9 includes the relevant detail.

(d) Successful completions of the Return to Practice Programme range between 14 to 16 per cohort. Appendix 9 includes the relevant detail.

(e) The number of applicants to the Return to Practice Programme is reported as being significantly higher than the number of commissioned places. A total of 32 places are commissioned each year whilst the number of applicants ranges between 50 and 89 for each year between 2011-12 and 2015-16.

6.3 Destination of students – insights

Having identified the potential recruitment workforce pool and accepting that the most significant stream within that is Stream 1 (those who are entering this pool for the first time following completion of a pre-registration programme via one of the local AEIs) the

[6] Data supplied by DHSSPS Nursing, Midwifery and AHP Directorate 1 December 2015
[7] Data supplied by DHSSPS Nursing, Midwifery and AHP Directorate 2 December 2015

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Task and Finish Group concluded that it would be helpful to secure an insight into the intended destination of students and factors which influence their (students') decision making. Both Ulster University and Queen's University Belfast kindly provided summaries of destination and related information and the information below reflects the essence of that provided to the Task and Finish Group.

(a) Ulster University

Overview of plans for first post as RN – graduating in September 2015

The figures below provide an overview of the cohort of students completing their BSc Hons Nursing (Adult) and BSc Hons Nursing (Mental Health) at Ulster University. Data reported here was collected via a questionnaire distributed to the students in their last week of the course in September 2015. Responses received from 173 students (147 Adult Nursing; 26 Mental Health Nursing), which is an overall response rate of 77%.

Progress towards obtaining a first RN post

By the last week of the course 173 students had undertaken 207 interviews, of which 62% were within HSC Trusts, 18% within the Independent Sector, 11% reported as Other and 9% outside of Northern Ireland.

Of those 173 people interviewed a total of 155 posts had been offered at that time i.e. last week of their course in September 2015. HSC Trust recruitment drives were continuing at this time. The offers in place were 41% in the HSC Trusts, 27% in the Independent Sector in Northern Ireland and 14% outside of Northern Ireland and 7% in 'Other'. It is notable that the 155 job offers included some individuals holding more than one offer.

Reasons for seeking a RN Post outside of Northern Ireland

Students were planning to take up a post outside of Northern Ireland were asked what motivated them to do so. The main reasons provided for this in descending order fitted into the broad areas of:

- Perception of more opportunities to gain experience a wider range of experience
- Perception that there would be more opportunities for promotion
- Feeling that Preceptorship programmes were better developed
- Perceived lack of permanent posts in Northern Ireland HSC
- Wanted the opportunity to travel/gain more independence
- Feeling that nurses were more respected outside of Northern Ireland
- Previously from outside of Northern Ireland.

What would entice you to remain in Northern Ireland

Moving on from the above question students were asked what would entice them to stay in Northern Ireland and the broad areas highlighted the points raised above. Whilst many students reported that they intended to stay in Northern Ireland and provided personal and family reasons for doing so, there was 123 suggestions for what would make them more likely to stay in Northern Ireland. These felt under the following broad headings:

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- More permanent posts (as opposed to interviews for waiting lists)
- More posts within HSC Services
- More opportunity to choose the area of work/new post
- More flexibility with hours worked
- A well-structured Preceptorship programme
- Greater visible support for new Registrants
- Opportunities for further study
- Funding for further study
- More opportunities for development and promotion
- Better staffing levels on wards
- Opportunities to experience rotation across a variety of different work settings
- Interviews before course ends
- More positive practice learning experience as a student – more encouragement to stay in nursing
- More up to date equipment and development opportunities
- Salary similar to posts outside of Northern Ireland.

Key messages

The majority of students eligible to take up posts as RN's applied for and accepted posts within Northern Ireland. Whilst the majority of the posts were full time permanent posts a sizeable group of students (32%) were not offered full time permanent posts and many of these students were working with agencies. It is noted that some students had clear plans to work outside of Northern Ireland, often related to the desire to travel and gain wider experience, some students reported taking posts outside Northern Ireland due to the perceived greater development opportunities and support as a new Registrant. Several key areas were highlighted as possible areas for development to entice new Registrants to take up their first post in Northern Ireland.

(b) Queen's University Belfast

Destination of QUB nursing graduates 2013-14

Overall 83% of graduates gain employment in Northern Ireland. 12.5% of students gain employment in GB, RoI, Australia, Brunei. A further 4% are employed in non-graduate jobs and the remaining 0.5% is engaged in further full time study.

Employment areas of graduates who choose to remain within NI

Those nursing graduates that remain in NI are employed in the following areas:

- BHSCT 41%
- Independent sector 17%
- SHSCT 13%
- SEHSCT 12%
- NHSCT 10%
- WHSCT 5%
- Charitable sector 2%.

Reasons for taking up employment in NI

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Reasons for taking up employment in the aforementioned areas are considered to be related to:

- Geographical/family commitments
- Areas where the student felt valued (good mentorship)
- Permanent position offered at jobs fair
- Further career progression recognisable
- Opportunity for further study
- A first year structured Preceptorship programme.

Key messages

The greater majority of students responding reported that they had been offered posts in NI. BHSCT recruited just over 40% of those securing employment in NI, all other Trusts recruited between 10% and 13%. It is also notable that only 5% of student respondents indicated that they had secured a post in the WHSCT. It is relevant to note that 'zoning' is applied in the allocation of students to practice placements within the adult field of practice. 'Zoning' results in students (adult field of practice) in Queen's University Belfast being allocated to practice placements in BHSCT, SEHSCT, and SHSCT and other independent and voluntary organisations within that geography and it is postulated that they are drawn to areas they are familiar with. Discussion with the Heads of School from the two HEIs reiterated this supposition.

7. Recruitment Challenges

A number of recruitment challenges were described by the members of the Task and Finish Group. These challenges have been summarised below:

7.1 Change in needs

HSC Trusts indicated that the impact of modernisation and reform and in particular change in skills mix, changing profile of services and affordability has until recently had a significant bearing on decision making in regards to recruitment of Band 5 staff nurses. They noted that at a point in time there had been a fear of 'over recruiting'. The impetus for change in the recruitment activities of Trusts was cited as being attributable to a variety of reasons including the recent Ministerial launch of 'Delivering Care: Nurse Staffing in Northern Ireland Phase 1' on 27th January 2014[8].

7.2 Recruitment Processes

Following the establishment of the five HSC Trusts in 2007 significant efforts were made to 'standardise' recruitment processes by adopting directorate wide or organisational wide recruitment drives. Across the membership of the Task and Finish Group views on the benefits of this change in practice in recruitment drives varied. Some suggested that organisational wide approaches may have led to a loss of a sense of local ownership on the part of ward sisters/charge nurses and team leaders as hither to they would have

[8] http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-january-2014/news-dhssps-270114-health-minister-updates.htm accessed 30th November 2015

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played a significant role in the recruitment of staff to their teams. Whilst others suggested that organisational wide recruitment processes represent a more efficient way of doing things and helps to ease the recruitment associated demands on frontline ward sisters/charge nurses and team leaders.

A second practice which was suggested as creating a reluctance to accept a post or indeed having an effect in the longer term on retention was the limit which organisations applied in respect of the number of offers which might be made to an individual on a waiting list. It is relevant to note that the information relating to 'preferred choices' provided by a candidate is an important determinant in the process of offering posts.

7.3 Multiple applications

HSC Trusts noted that, having experienced numerous recruitment drives, it was apparent that students who are due to complete their programme or those new to the NMC Register tend to apply to posts advertised by a number of Trusts. Trusts described this phenomena as 'multiple applications'. The effect of multiple applications on Trusts was described as *"each Trust holds its own waiting lists but on a number of occasions the lists of individual Trusts include many of the same successful candidates"*. Whilst a successful application process is heartening for a candidate and provides him/her with opportunities to exercise choice it also leads to frustration on the part of affected HSC Trust when trying to recruit from its waiting list. The summary information provided by the Ulster University seems to reflect the phenomena of 'multiple applications'.

One of the reasons suggested by the Task and Finish Group as driving an applicant to submit multiple applications is that on entering the workforce pool for the first time an applicant may possess little or no information on the availability of posts across a range of employers and so in the hope of securing a post somewhere submits multiple applications

7.4 Scheduling of Recruitment exercises

Cohorts of students who exit programmes delivered by local AEIs tend to do so each year in September (All fields of practice Queen's University Belfast and Adult and Mental Health fields of practice Ulster University) and April/May (Adult field of practice Queen's University Belfast). HSC Trusts tend to align their recruitment drives to these schedules. This effectively means that if a HSC Trust does not secure sufficient recruits for all vacancies in for example September the Trust will have limited opportunity to fill remaining vacancies until May some six months later. In some instances this leads to the Trust being in a position of 'always playing catch up' to fill vacancies.

7.5 Competitive Recruitment Market

In addition to local HSC Trusts actively recruiting from the 'same' recruitment pool at the same/similar time they also face competition from employers external to NI. Colleagues from local AEIs reported that during recruitment fairs employers from outside of NI have established a pattern of offering interviews to students attending these events. Increasingly it has been suggested that this 'on the day recruitment process' has

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included incentivised packages. From the information provided by AEIs on destination of students, it seems that this competitive approach has rendered positive results.

8. Recommendations

On the basis of the information contained within this report the membership of the Task and Finish Group concluded that there are a number of immediate (one to three months), medium (three to six months) and longer term (six to 12 months) recommendations which if taken would go some way to address certain of the recruitment challenges presented in this report. It is also relevant to note that the HSC Trusts report that they have already initiated and are undertaking certain actions which are in keeping with the intention of the recommendations and where this is the case this is highlighted. The recommendations are listed below for consideration by CNMAC.

Recommendation 1 – Immediate
'Immediate steps should be initiated by the DHSSPS to support a region–wide recruitment process of nurses from EU and Non-EU countries. It is acknowledged that there is an imbalance between supply of and demands for registered nurses globally and that other initiatives will need to be undertaken by the DHSSPS to support the process for admission to the NMC Register. A particular concern relates to the initiation by the NMC of a pilot process of OSCEs for nurses from Non-EU countries. It is understood that this pilot process is limited to one AEI in England. Clearly, if NI is to proceed with a regional recruitment initiative of such nurses there will be an urgent need for appropriate arrangements to be established within NI.'

Recommendation 2 - Immediate
DHSSPS consider the data contained in this report including for example current vacancies, impact of planned and unplanned leave and the increasing demand for services across the province within statutory and independent and voluntary sectors, the age profile of the nursing and midwifery workforce and the implementation of current and future phases of Delivering Care: Nurse Staffing in Northern Ireland (DHSSPS 2014)[9] in order to estimate and commission the required increase to pre-registration nursing places across all fields of practice. In making this recommendation it is recognised that any increase in commissioned places will not generate an increase in the new registrant workforce pool for at least three years. Furthermore an increase in commissioned pre-registration nursing places will require to be matched by a sufficient number of available practice placements. Accordingly, therefore, it is suggested that a Task and Finish Group be established to review the availability of practice placements under the oversight of CNMAC's Strategic Workforce and Education Subgroup.

Recommendation 3 – Immediate
Whilst the employment destination of those who successfully complete a 'Return to Practice Programme' is not known the membership of the Task and Finish Group was struck by the comparison between the number of applicants to the 'Return to Practice Programme' and commissioned places. In light of this difference it is recommended that the DHSSPS takes steps to significantly increase the number of commissioned places

[9] DHSSPS (2014) Delivering Care: Nurse Staffing in Northern Ireland Phase 1. DHSSPS: Belfast

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immediately. In planning this increase it will be critical that the Trusts and others are actively involved.

Recommendation 4 – Medium
Variation on how the HSC Trusts allocate those who have successfully completed the Open University pre-registration nursing programmes to Band 5 Staff Nurse posts is evident. Members of the Task and Finish Group concluded that a continuation of this position is untenable. It is therefore recommended that all HSC Trusts adopt a standardised process with the aim of ensuring that all those who complete the programme successfully and enter the NMC Register are immediately offered an appropriate Band 5 Staff Nurse post. In addition, the membership of the Task and Finish Group are aware that some time ago the Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) completed and submitted to the DHSSPS work to support a standardised approach to the recruitment and induction of Nursing Assistant staff. In light of the workforce information contained within this report and being cognisant of the contribution under supervision of Nursing Assistants to patient/client care the Task and Finish Group recommend that the DHSSPS expedite the approval and release of the aforementioned work.

Recommendation 5 – Immediate
The HSC Trusts should review their recruitment processes with a view to facilitating choice through a more flexible approach. This should include processes to enable final year nursing students, to be given guaranteed employment subject to successful completion of their pre-registration nursing programmes and satisfactory pre-employment checks.

Recommendation 6- Immediate
Recruitment Fairs/Days offer opportunities to Trusts of a captive audience of students who are actively seeking jobs and it seems reasonable to recommend that local Trusts continue to capitalise on these opportunities by facilitating 'on the day interviews' with a view to making job offers at that time to acceptable candidates.

Recommendation 7 - Immediate
It is recommended that work is initiated to expedite the utilisation of a regional recruitment model for Band 5 Staff Nurse posts. It will be critical that such a model effectively addresses a number of concerns including for example; timeliness, assessment processes and outputs, equality in respect of the choices of candidates and due regard from the perspective of the profession including field of practice. Learning from recent regional recruitment initiatives for AHPs should be taken account of, in the design of the model.

Recommendation 8 – in place to some extent but further work on standardisation should be progressed immediately
It is recommended that each HSC Trusts standardise their approach to ensure that they are perceived as an 'employer of choice' by providing concise, clear and timely information tailored to the needs of students in the final stages of training on the:

- Availability of posts.
- Location of posts.
- Specialities within which vacant posts are available.

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- Access to induction.
- Access to Preceptorship.
- Availability and access to continuous professional development including promotional opportunities to address the perceptions of students referenced earlier in this report.
- Career development opportunities.
- Rotation programmes.

Recommendation 9 – Immediate
The DHSSPS should commission local education providers to deliver specific professional development programmes in an effort to encourage recruitment and support retention in perceived 'hard to recruit to specialities/areas'.

Recommendation 10 – Medium to Longer Term
The data illustrates the gap between funded establishments and staff in post and that this gap is widened as a result of significant levels of planned and unplanned leave (sickness in particular). To lessen the impact of these compounding factors the Trusts should at local level determine an acceptable margin of 'predictive recruiting' against funded establishments. This is likely to prove challenging to achieve in the immediate future given the imbalance between demands for and supply of registered nurses nationally and globally and the length of time to secure an output from a pre-registration nursing programme. Nonetheless, at a point in time when a rebalancing between supply and demand is achieved 'predictive recruiting' should go some way to preventing reoccurrences of some of the challenges currently being faced by the HSC Trusts.

Recommendation 11 – Medium to Longer Term
It is anticipated that the implementation of the recommendations contained within this Report will have an impact on independent and voluntary sector care providers. Mindful of the dependence of statutory services on such providers it is recommended that the DHSSPS carefully monitor and respond appropriately and in a timely way to any impact.

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Appendix 1

Exhibit 1

Appendix 1

CNMAC Task & Finish Group: Recruitment of Band 5 Registered Nurses
Terms of Reference

1.0 Authority

This Task & Finish Group is authorised by the Central Nursing and Midwifery Advisory Committee to progress or investigate any activity within its terms of reference.

2.0 Purpose

The purpose of the Task & Finish Group is to scope and describe the current challenges in relation to recruitment and retention of nurses across the five HSC Trusts and to make recommendations to CNMAC to address the immediate challenges.

3.0 Membership

This group shall be Chaired by Mr Francis Rice, Executive Director of Nursing & AHPs/Director of Mental Health & Disability Services, SHSCT. Membership of the group will include:

- Alan Corry-Finn, Executive Director of Nursing, WHSCT
- Glynis Henry, Head of Clinical Education Centre
- Lynn Fee, Assistant Director of Nursing, Workforce Development & Training, SHSCT
- Moira Mannion, Co-Director Nursing, BHSCT
- Allison Hume, Assistant Director of Nursing, NHSCT
- Sharon McRoberts, Assistant Director Nursing (Workforce and Education), SEHSCT
- Brendan McGrath, Assistant Director of Nursing, WHSCT
- Karyn Patterson, Head of Resourcing, SHSCT (representing the regional Resource Managers Network)
- Donna Gallagher, OU
- Sam Porter / Marian Traynor / Karen McCutcheon, QUB
- Owen Barr, UU
- Garrett Martin, RCN
- Unison rep tbc

Where a member is not able to attend a meeting he/she must nominate a deputy who has been briefed regarding the status of this work to attend in their place. The deputy should have the authority to take decisions on behalf of the member.

In Attendance

Other key staff may be co-opted to contribute to specific items of work.

4.0 Frequency of meetings

Meetings will be held every 6 weeks.

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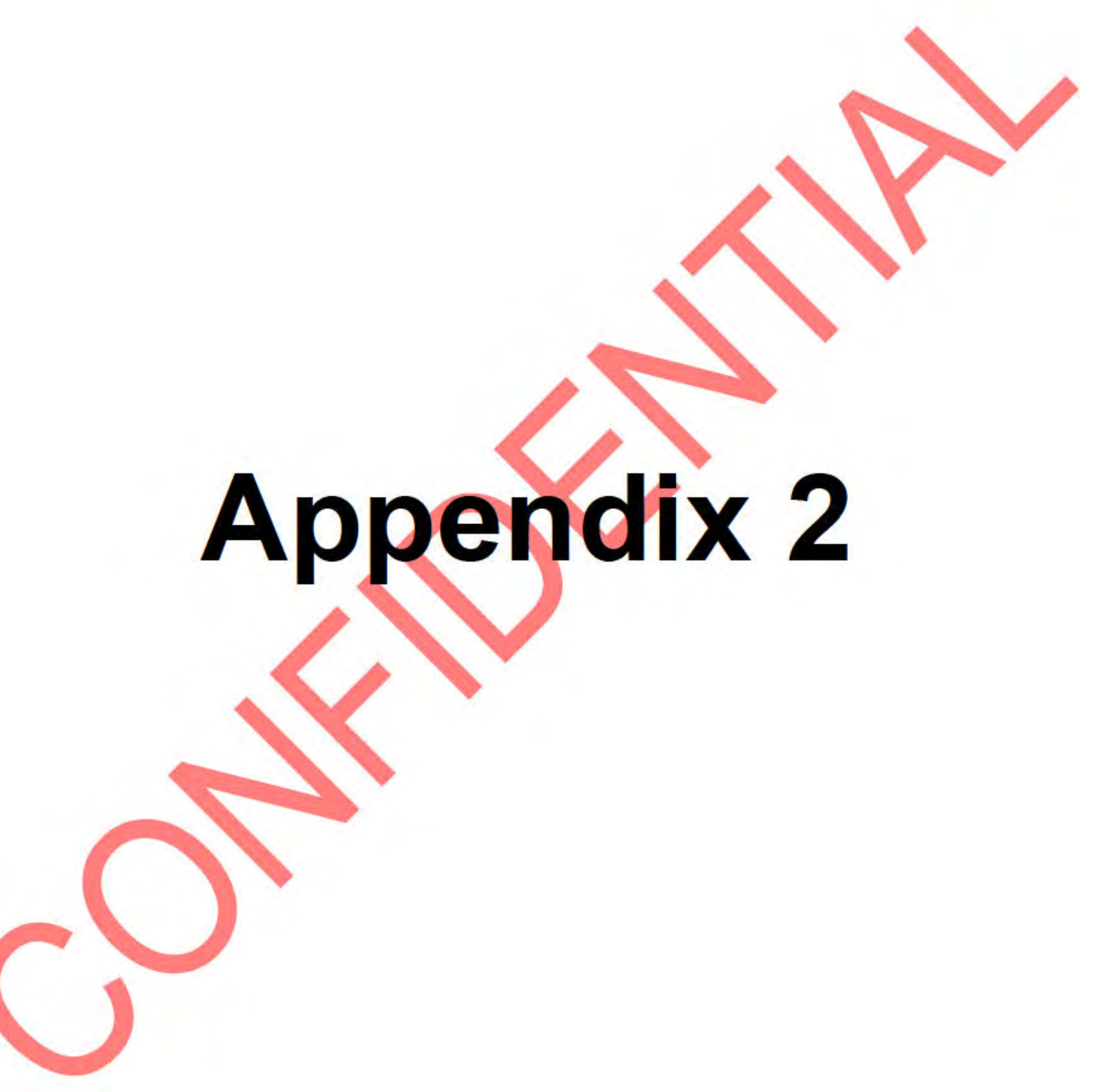
5.0 Reporting arrangements

A summary of actions and outcomes will be reported to the Chief Nursing Officer through the Central Nursing and Midwifery Advisory Committee by the Chair.



Appendix 2

Appendix 2

<table>
<tr><td colspan="2">To be completed and returned to Tracy.Griffin@southerntrust.hscni.net no later than Friday 9th October 2015</td></tr>
<tr><td>Trust</td><td></td></tr>
<tr><td>Name of Person completing form</td><td></td></tr>
<tr><td>Position of Person completing form</td><td></td></tr>
<tr><td>Date of completing Form</td><td></td></tr>
<tr><td>Purpose of Data Collection Exercise</td><td>This is for <u>BAND 5 Nurses Only</u>

The purpose of this Data Collection exercise is to establish a baseline which will allow a high level review of the number of vacancies currently in the system and likely to be in the system. This will then be compared to the number of nurses likely to be available and whether there is likely to be sufficient nurses to fulfill the HSC needs.

This is intended to be a high level review and therefore whilst more detailed analysis may be required in the future this would be intended to provide an indicative position</td></tr>
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Workforce Data - BAND 5 Only

Branch of Nursing	Funded Staffing Levels at 30 June 2015 WTE	Staff In Post at 30 June 2015 WTE	Leavers 2014 / 15 WTE	Maternity Leave 2014 / 15 WTE	Career Break 2014/15 WTE	Term Time 2014/15 WTE	Sick Leave 2014 / 15 WTE	Total Absence 2014 /15 WTE	Flexible Spend - Bank / Agency / Overtime April to June 2015 WTE
Adult								0.00	
Childrens								0.00	
Mental Health								0.00	
Learning Disability								0.00	

NOTES

Branch of Nursing - this should be achieved using jobs (grades). It is recognised this will not be 100% like for like due to possible differences of how codes are applied by different Trusts. This is also dependent upon managers having actioned necessary changes on HRPTS
Funded Staffing Levels taken at this date to include Normative Staffing levels
Maternity Leave; Career Break; Term Time and Sick Leave - there may be variances in how this is reported in each Trust therefore each Trust should put any necessary explanatory notes with this information
This data is not intended to capture internal staff movement and therefore this will be a limitation of the information provided

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Exhibit 1

Recruitment Data - BAND 5 Only

Branch of Nursing	Vacancies at 31st March 2015 Vacancy Survey		Vacancies at 31st March 2014 Vacancy Survey		Vacancies at 1st October 2015 in the Recruitment System		How Likely is it that the current vacancies can be filled from existing waiting lists?	Any other Comments
	Posts	WTE	Posts	WTE	Posts	WTE	State likely / Not likely	
Adult								
Childrens								
Mental Health								
Learning Disability								

<u>NOTES</u>

Vacancies should be taken as posts approved for recruitment and are in the active process of such.

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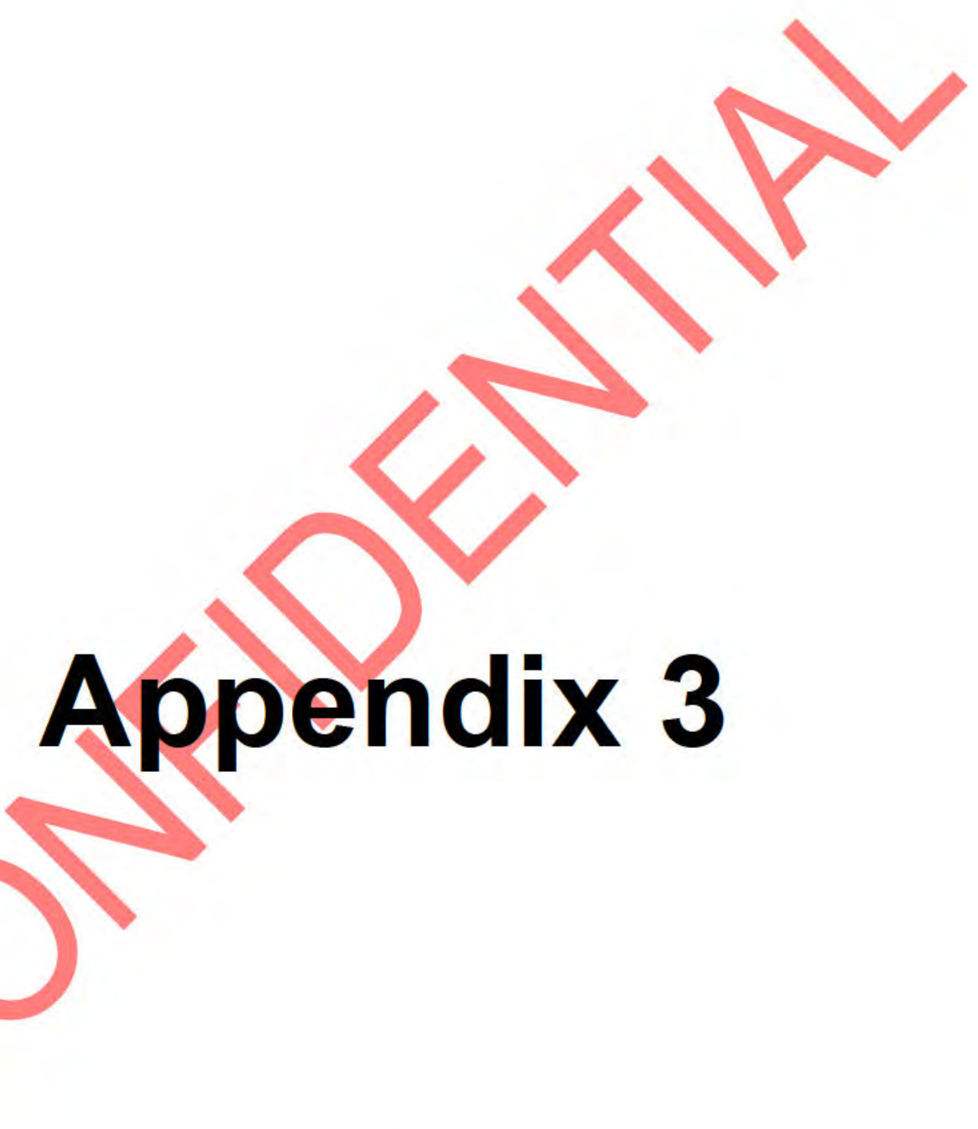

Appendix 3

Appendix 3

Gap between overall Funded Establishment (wte) and Staff in Post (wte)

HSC Trust	Overall Funded establishment 30th June 2015	Staff in post 30th June 2015	Gap 1 30th June 2015
BHSCT	3186	2962.86	223.14
NHSCT	1476.19	1405.74	70.45
SHSCT	1473.95	1390.61	83.34
WHSCT	1353.57	1477.25	Nil
SEHSCT	1300.54	1265.04	35.50

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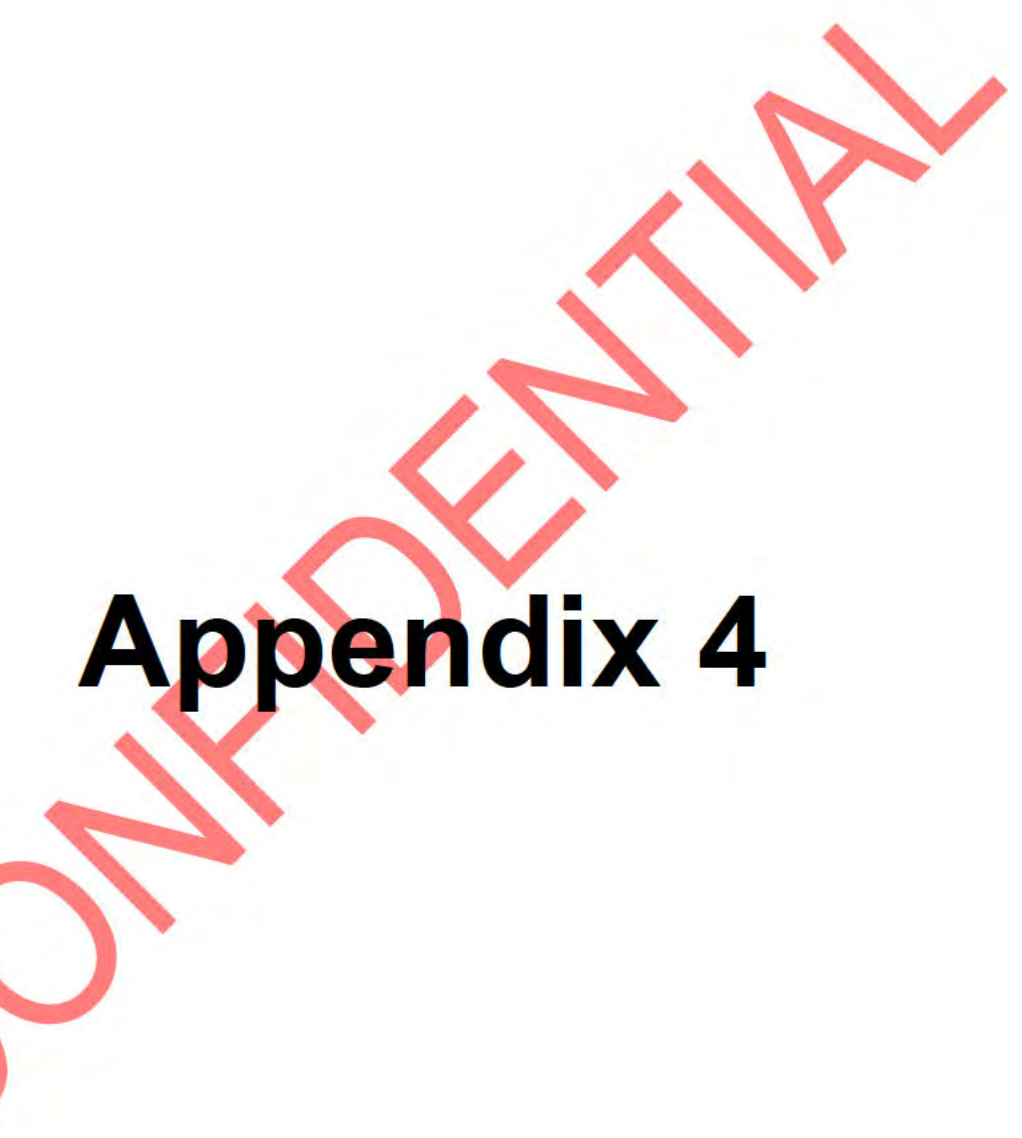

Appendix 4

Belfast HSC Trust – Workforce Data (Band 5 only) **Appendix 4**

Branch of Nursing	Funded Staffing Levels at 30 June 2015 WTE	Staff In Post at 30 June 2015 WTE	Leavers 2014/15 WTE
Adult	2552.00	2376.15	122.14
Childrens	269.00	254.56	11.22
Mental Health	227.00	129.15	16.21
Learning Disability	138.00	202.99	13.69
Total	**3186.00**	**2962.86**	**163.26**

Branch of Nursing	Maternity Leave 2014/15 WTE	Career Break 2014/15 WTE	Term Time 2014/15 WTE	Sick Leave 2014/15 WTE	Total Absence 2014/15 WTE	Flexible Spend - Bank / Agency / Overtime April to June 2015 WTE
Adult	101.86	41.93	4.00	167.45	315.24	254.00
Childrens	12.07	5.71	0.00	16.65	34.44	18.00
Mental Health	6.50	3.50	0.00	18.5	28.50	33.00
Learning Disability	3.70	0.00	0.00	12.63	16.33	19.00
Total	**124.13**	**51.15**	**4.00**	**215.23**	**394.51**	**323.00**

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Belfast HSC Trust – Recruitment Data (Band 5 only)

Branch of Nursing	Vacancies at 31st March 2015 Vacancy Survey		Vacancies at 31st March 2014 Vacancy Survey		Vacancies at 1st October 2015 in the Recruitment System		How Likely is it that the current vacancies can be filled from existing waiting lists?	Any other Comments
	Posts	WTE	Posts	WTE	Posts	WTE	State likely/Not likely	
Adult	202	194.17	136	129.42	154	144.34	Not Likely at this time	Going out to Ad for Band 5's Oct 2015
Childrens	5	4.43	4	4.00	30	27.35	Likely	
Mental Health	25	25.00	13	12.88	21	14.98	Likely	
Learning Disability	27	27.00	6	6.00	6	3.30	Not likely	Going out to Ad for L D Band 5's Oct 2015
Total	**259**	**250.60**	**159**	**152.30**	**211**	**189.97**		

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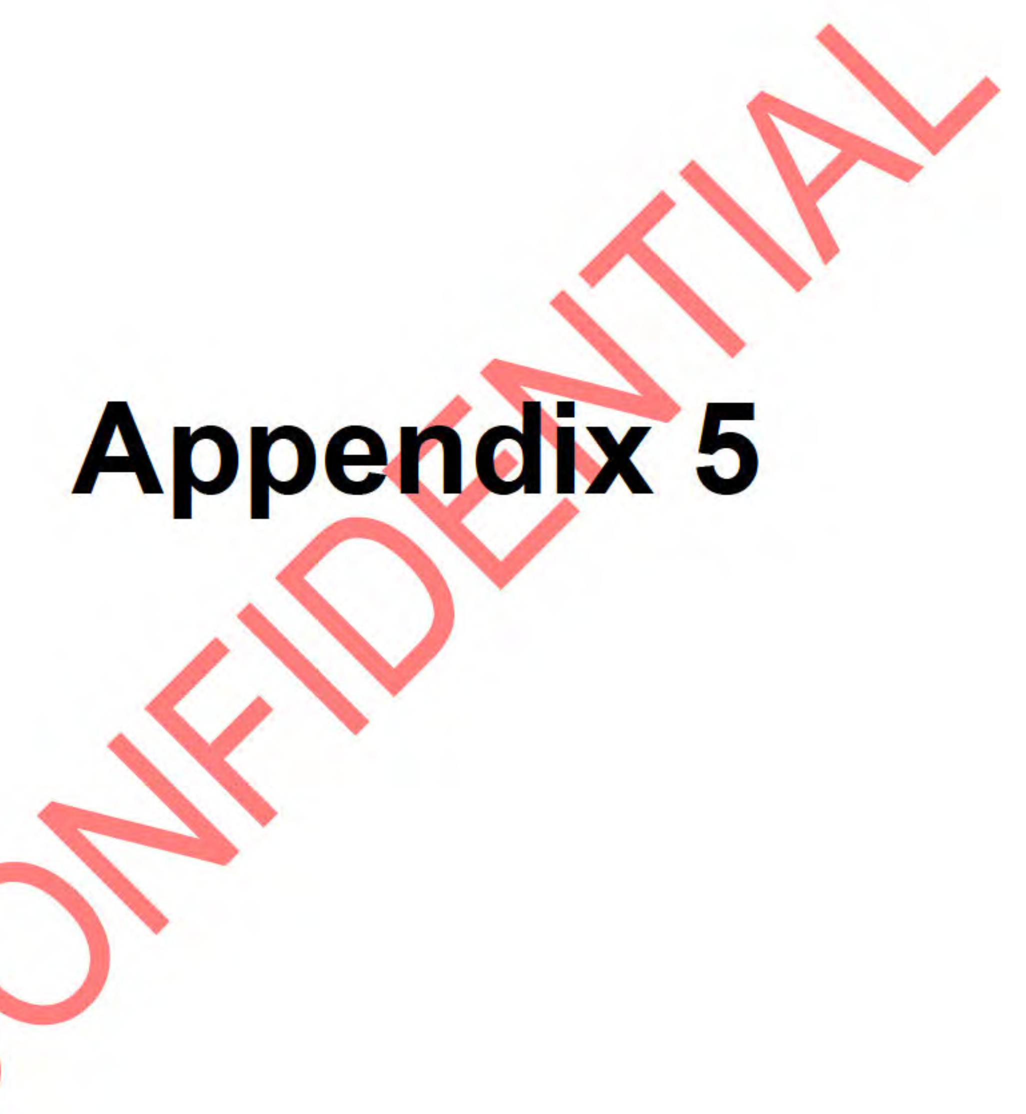

Appendix 5

Exhibit 1

Appendix 5

South Eastern HSC Trust – Workforce Data (Band 5 only)

Branch of Nursing	Funded Staffing Levels at 30 June 2015 WTE	Staff In Post at 30 June 2015 WTE	Leavers 2014/15 WTE
Adult	1125.39	1046.45	72.36
Childrens	77.10	102.52	8.84
Mental Health	93.32	102.56	5.53
Learning Disability	4.73	13.51	1.00
Total	**1300.54**	**1265.04**	**87.73**

Branch of Nursing	Maternity Leave 2014/15 WTE	Career Break 2014/15 WTE	Term Time 2014/15 WTE	Sick Leave 2014/15 WTE	Total Absence 2014/15 WTE	Flexible Spend - Bank / Agency / Overtime April to June 2015 WTE
Adult	55.62	3.83	0.00	75.25	134.70	123.55
Childrens	0.89	0.13	0.00	4.73	5.75	3.05
Mental Health	0.27	0.01	0.00	9.40	9.68	0.00
Learning Disability	0.53	0.00	0.00	0.93	1.46	22.12
Total	**57.31**	**3.97**	**0.00**	**90.31**	**151.59**	**148.72**

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South Eastern HSC Trust – Recruitment Data (Band 5 only)

Branch of Nursing	Vacancies at 31st March 2015 Vacancy Survey		Vacancies at 31st March 2014 Vacancy Survey		Vacancies at 1st October 2015 in the Recruitment System		How Likely is it that the current vacancies can be filled from existing waiting lists?	Any other Comments
	Posts	**WTE**	**Posts**	**WTE**	**Posts**	**WTE**	**State likely/ Not likely**	
Adult	59	47.00	84	84.12	85	75.5	Unlikely	The Trust has recruited for Band 5 nurses numerous times in each calendar year and still does not have enough nurses to fill the vacancies required. There are constantly more posts than available nursing staff. In addition, the Trust has responsibility for Prison Healthcare which is very challenging to recruit Nurses for.
Childrens	14	12.00	22	21.92	5	4.49	Unlikely	Can be challenging as limited recruitment pool.
Mental Health	6	5.00	10	9.00	7	7.00	Likely	
Learning Disability	0	0.00	0	0.00	1	1.00	Likely	These posts do not come up very often and are fine to fill
Total	**79**	**64.00**	**116**	**115.04**	**98**	**87.99**		

Please note that it was difficult to pull number of historic vacancies as each waiting list will fill a number of vacancies over the duration of the waiting list and it was not possible to pull on the system the actual vacancies at the one specific time, therefore this is not an accurate reflection of historic vacancies. Current vacancies for 1 Oct 2015 is more accurate.

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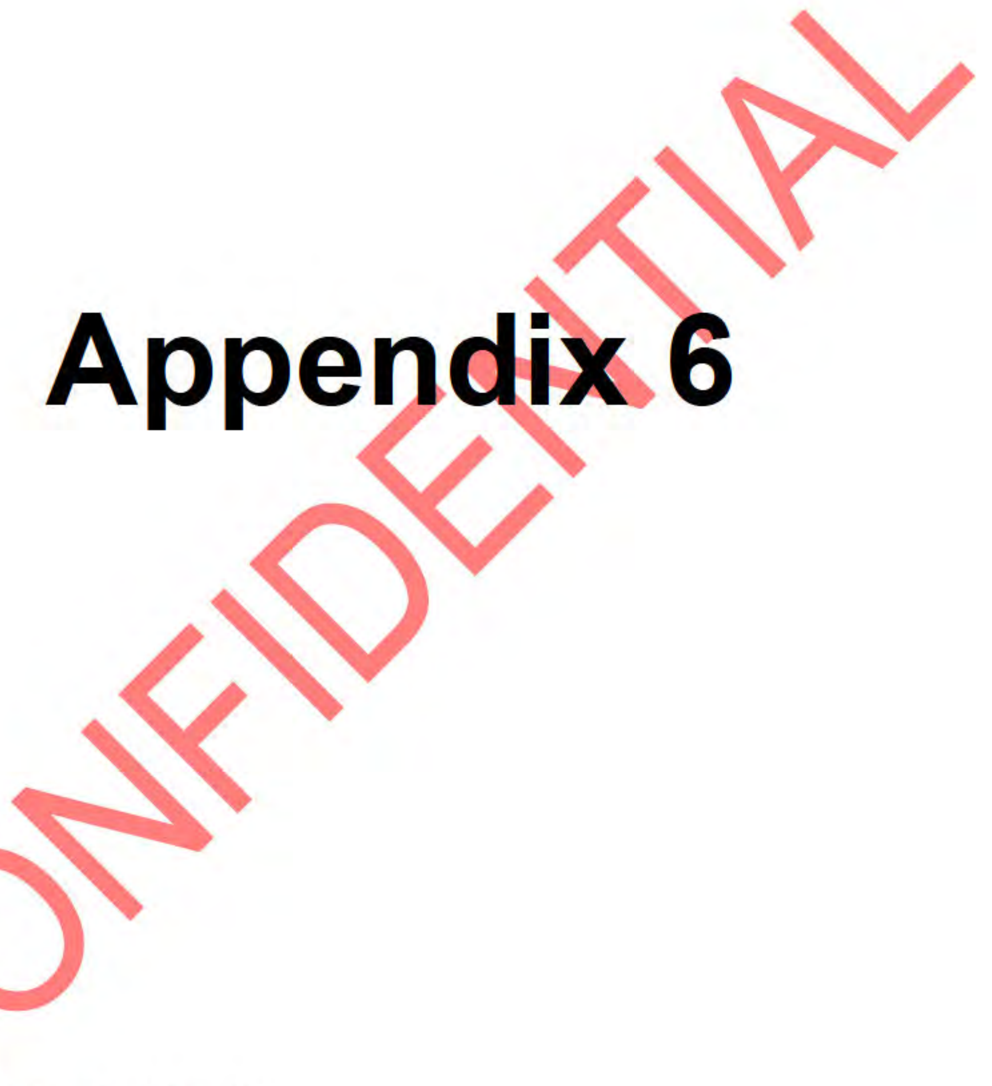

Appendix 6

Northern HSC Trust – Workforce Data (Band 5 only)

Appendix 6

Branch of Nursing	Funded Staffing Levels at 30 June 2015 WTE	Staff In Post at 30 June 2015 WTE	Leavers 2014/15 WTE
Adult	1177.23	1106.46	76.3
Childrens	131.96	150.61	10.56
Mental Health	162.34	147.67	10.62
Learning Disability	4.66	1.00	0.00
Total	**1476.19**	**1405.74**	**97.48**

Branch of Nursing	Maternity Leave 2014/15 WTE	Career Break 2014/15 WTE	Term Time 2014/15 WTE	Sick Leave 2014/15 WTE	Total Absence 2014/15 WTE	Total Flexible Spend - Bank / Agency / Overtime April to June 2015 WTE
Adult	95.01	11.05	2.21	54.00	162.27	208.31
Childrens	9.53	1.23	0.00	5.87	16.63	7.47
Mental Health	11.56	0.00	0.00	9.64	21.20	26.03
Learning Disability	0.00	0.00	0.00			3.81
Total	**116.10**	**12.28**	**2.21**	**69.51**	**200.10**	**245.62**

Notes from Trust:

1. *Branch of nursing has been extended to include all areas in the Trust where Band 5 Nurses exist*
2. *Funded staffing levels at June 2015 WTE relate only to recurrent WTEs. This includes for recently agreed normative nursing levels in a range of acute departments*
3. *Total flexible spend - bank/agency/overtime April to June expressed as a WTE has been presented by taking the spend for the 3 month period and equating to a WTE figure by using a £30k annual salary [ie £7,500 used for the 3 month period]. The Trust does not capture the level of WTE for these areas of spend on its financial systems, hence the comparator indication of the £30k salary post is used*

Northern HSC Trust – Recruitment Data (Band 5 only)

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Branch of Nursing	Vacancies at 31st March 2015 Vacancy Survey		Vacancies at 31st March 2014 Vacancy Survey		Vacancies at 1st October 2015 in the Recruitment System		How Likely is it that the current vacancies can be filled from existing waiting lists?	Any other Comments
	Posts	**WTE**	**Posts**	**WTE**	**Posts**	**WTE**	**State likely/ Not likely**	
Adult	88 (19)	77.38 (15.15)	42 (8)	37.88 (5.9)	78 (15)	70.95 (11.7)	Not Likely*	* These predictions should be quality assured with BSO SS Recruitment as they provide the recruitment function
Childrens	9	7	7	6.4	14	13.06	Not Likely*	
Mental Health	1	1			1	1	Likely*	
Learning Disability								
Total	**98**	**85.38**	**49**	**44.28**	**93**	**85.01**		

Please note the second figure () is the portion of posts (of fig 1) which sit within Community

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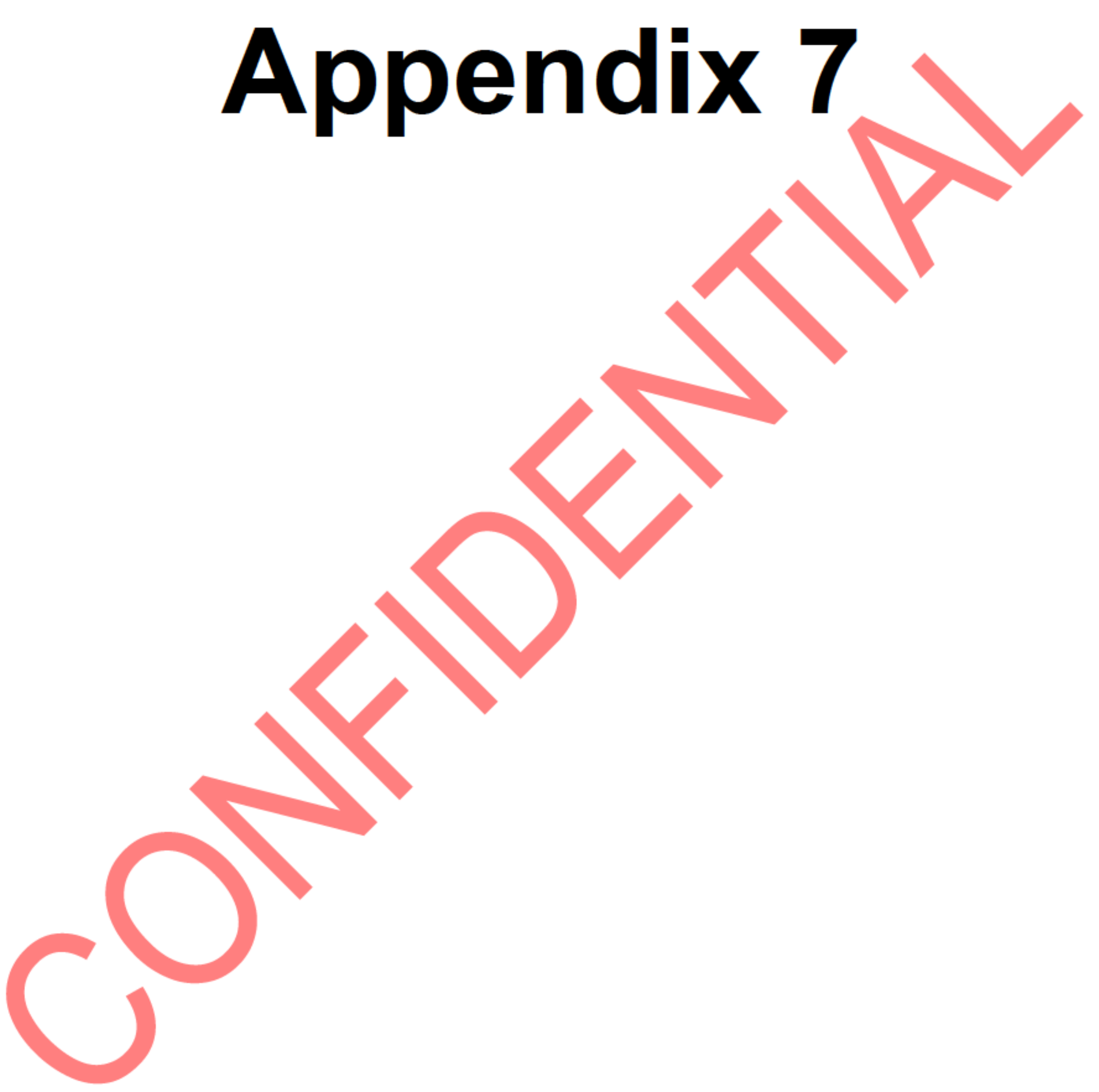
Appendix 7



Southern HSC Trust – Workforce Data (Band 5 only) **Appendix 7**

Branch of Nursing	Funded Staffing Levels at 30 June 2015 WTE	Staff In Post at 30 June 2015 WTE	Leavers 2014/15 WTE
Adult	1,160.14	1067.63	78.89
Childrens	131.67	142.89	9.63
Mental Health	155.80	139.81	16.76
Learning Disability	26.34	40.28	2.31
Total	**1,473.95**	**1390.61**	**107.59**

Branch of Nursing	Maternity Leave 2014/15 WTE	Career Break 2014/15 WTE	Term Time 2014/15 WTE	Sick Leave 2014/15 WTE	Total Absence 2014/15 WTE	Flexible Spend - Bank / Agency / Overtime April to June 2015 WTE
Adult	59.27	5.19	0.19	63.97	128.62	115.29
Childrens	5.85	2.36	1.28	7.51	17.00	14.10
Mental Health	5.80	1.65	0.00	9.33	16.78	33.25
Learning Disability	2.54	0.00	0.00	4.99	7.53	5.87
Total	**73.45**	**9.20**	**1.47**	**85.81**	**169.92**	**168.51**

NOTES - Finance advised when providing the return that they were only able to split into Branch of Nursing using Directorate. HR have reviewed this approach and in the instance of SHSCT has a very minor impact. Therefore, to ensure consistency of approach and relativities, all figures in the return have been calculated in this way. Finance have noted that the FSL includes normative staffing levels for the areas that have been completed to date. Flexible WTE is as at June 2015 and covers Bank, Agency, Overtime & Additional Hours."

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Southern HSC Trust – Recruitment Data (Band 5 only)

Branch of Nursing	**Vacancies at 31st March 2015 Vacancy Survey**		**Vacancies at 31st March 2014 Vacancy Survey**		**Vacancies at 1st October 2015 in the Recruitment System**		**How Likely is it that the current vacancies can be filled from existing waiting lists?**	**Any other Comments**
	Posts	**WTE**	**Posts**	**WTE**	**Posts**	**WTE**	**State likely / Not likely**	
Adult	58	54.17	36	32.32	52	49.82	Not Likely	The SHSCT has just completed a major recruitment even for Adult Nursing on Friday 2nd October 2015. Whilst we had an excellent day and a good number of our posts filled, we have a particular difficulty in filling the posts for Non Acute Hospitals. The Trust has had 3 major recruitment exercises since May 2015 and despite this will continue to have some difficulty meeting demands. The most recent exercise included welcoming applications from students in Year 2 or Year 3 so although a great response almost half of the applicants will not be availale for work for at least another 12 months.
Childrens	8	7.23	6.00	4.87	7	7.00	6 likely / 1 not likely	The Regional Waiting list remains limited for filling of posts in SHSCT. Whilst the current batc, bar 1, may be filled it is unlikely that we will have much fill beyond the current vacancies

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Branch of Nursing	**Vacancies at 31st March 2015 Vacancy Survey**		**Vacancies at 31st March 2014 Vacancy Survey**		**Vacancies at 1st October 2015 in the Recruitment System**		**How Likely is it that the current vacancies can be filled from existing waiting lists?**	**Any other Comments**
	Posts	**WTE**	**Posts**	**WTE**	**Posts**	**WTE**	**State likely / Not likely**	
Mental Health	8	8	5	5	11	11	likely	A further recruitment drive is required for the area of Mental Health. Some areas are more difficult to fill than others and although the number on the waiting list makes it look as though we can fill the current vacancies the possibility is that we will not fill all the vacancies currently and most definately will not fill further vacancies without a further recruitment drive despite the most recent recruitment activity only being completed in August 2015.
Learning Disability	0	0	0	0	0	0		
Total	**74**	**69.4**	**47**	**42.19**	**70**	**67.82**		

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Appendix 8

CONFIDENTIAL

Western HSC Trust – Workforce Data (Band 5 only) **Appendix 8**

Exhibit 1

Branch of Nursing	Funded Staffing Levels at 30 June 2015 WTE	Staff In Post at 30 June 2015 WTE	Leavers 2014 / 15 WTE
Adult	1026.41	1133.01	60.37
Childrens	101.7	106.84	5.1
Mental Health	192.85	201.99	17
Learning Disability	32.61	35.41	8.34
Total	1353.57	1477.25	90.81

Branch of Nursing	Maternity Leave 2014 / 15 WTE	Career Break 2014/15 WTE	Term Time 2014/15 WTE	Sick Leave 2014 /15 WTE	Total Absence 2014 /15 WTE	Flexible Spend - Bank / Agency / Overtime April to June 2015 WTE
Adult	56.82	0.00	2.36	88.58	147.76	
Childrens	7.74	0.00	1.7	8.31	17.75	
Mental Health	5.45	0.00	5	21.46	31.91	
Learning Disability	1.29	0.00	1	5.62	7.91	
Total	**71.3**	**0.00**	**10.06**	**123.97**	**205.33**	

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Exhibit 1

Western HSC Trust - Recruitment Data (Band 5 only)

Branch of Nursing	Vacancies at 31st March 2015 Vacancy Survey		Vacancies at 31st March 2014 Vacancy Survey		Vacancies at 1st October 2015 in the Recruitment System		How Likely is it that the current vacancies can be filled from existing waiting lists?	Any other Comments
	Posts	WTE	Posts	WTE	Posts	WTE	State likely / Not likely	
Adult	21	17.82	20	17.36	35	30.31	Likely	Currently being filled at Band 3 until NMC registration comes through for students
Childrens	1	0.89	0	0	16	11.99	Not likely	Regional list exhausted. WHSCT advertising own list
Mental Health	0	0	4	3.57	5	4.36	Likely	Mental Health confirming interview dates for new waiting list. Already advertised and closed
Learning Disability	3	3	0	0	3	3	Likely	
Total	**25**	**21.71**	**24**	**20.93**	**59**	**49.66**		

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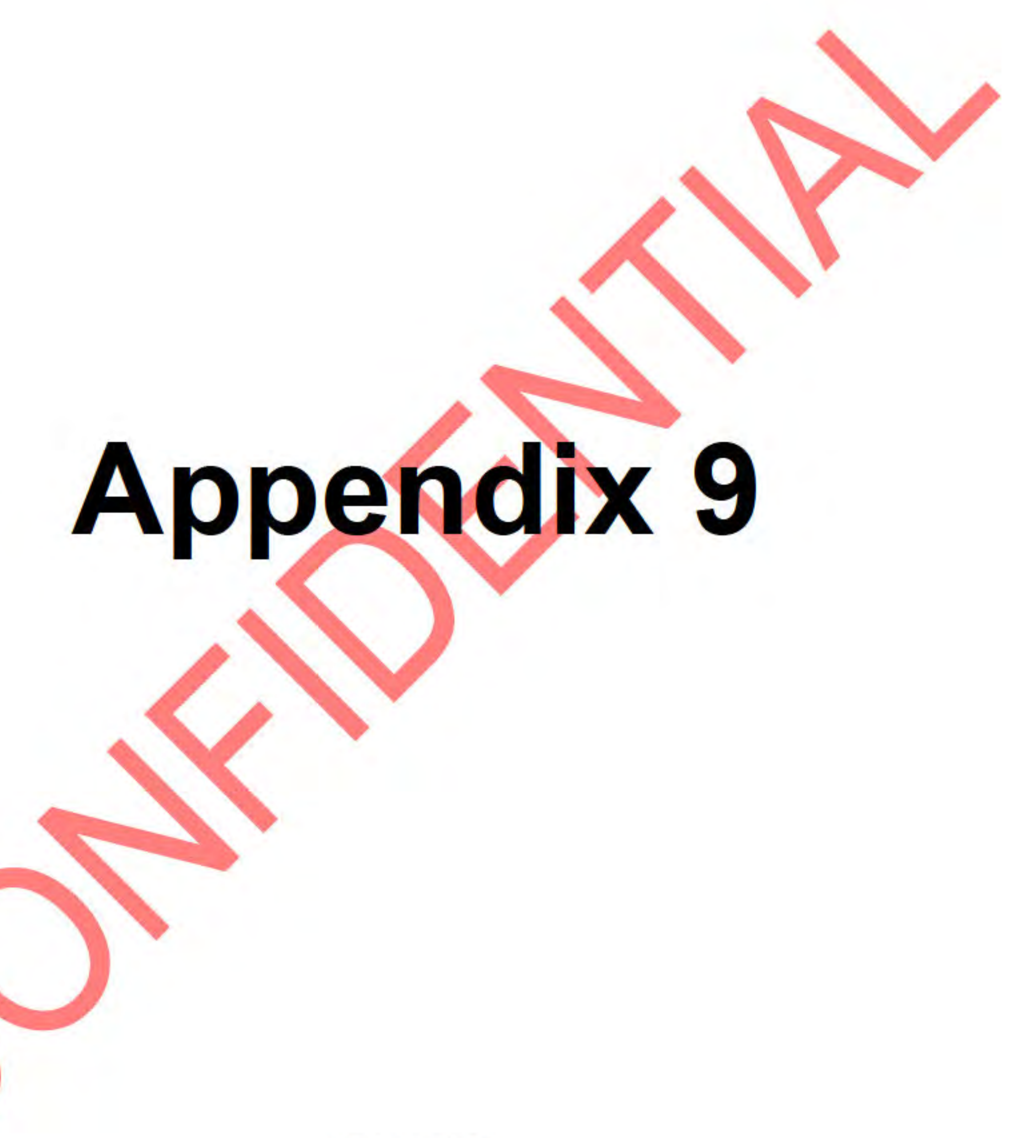

Appendix 9

Summary of entrants by year and exits from Return to Practice Programmes NI

No. of Students Applying	Intake	Intake Size	Successful Completions
11/12 Academic Year 68 Applicants	September 2011	16	16
	January 2012	16	14
12/13 Academic Year 89 Applicants	September 2012	16	15
	January 2013	16	16
13/14 Academic Year 80 Applicants	September 2013	16	15
	January 2014	16	16
14/15 Academic Year 57 Applicants	September 2014	16	15
	January 2015	16	14
15/16 Academic Year 50 Applicants	September 2015	16	Not yet available
	January 2016	16	Not yet available

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Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 10 June 2016 at 10.00 AM

Room D2 Lecture Theatre, Castle Buildings

Attendees:

Charlotte McArdle	DHSSPS	(Chairperson)
Caroline Lee	DHSSPS	
Angela McVeigh	SHSCT	
Olive Macleod	NHSCT	
Heather Finlay	DHSSPS	
Patricia McStay	PHA	
Brenda Creaney	BHSCT	
Janice Smyth	RCN	
Glynis Henry	CEC	
Carol Cousins	FSHC	
Donna Gallagher	OU	
Verena Wallace	DHSSPS	
Maura Devlin	NMC	
Kathy Fodey	RQIA	
Mary Hinds	PHA	
Angela McLernon	NIPEC	
Alan Corry Finn	WHSCT	
Gavin Fergie	UNITE	

In Attendance:

Malcolm Artt	DHSSPS	(Secretariat)
Brenda Divine	NIPEC	
Angela Reed	NIPEC	

Apologies:

Eoin Stewart	UNISON
Sam Porter	QUB
Nicki Patterson	SEHSCT
Carol Curran	UU
Mary Frances McManus	DHSSPS
Breedagh Hughes	RCM
Heather Monteverde	Macmillan
Owen Barr	UU
Sonja McIlfatrick	UU
Tanya McCance	UU
Maura Devlin	NMC

1. Welcome

1.1 Charlotte McArdle welcomed members to the meeting of the Central Nursing and Midwifery Advisory Committee (CNMAC).

1.2 Apologies recorded as above.

2. Chairman's Business

2.1 Minutes from Previous Meeting Held on 10 March 2016.

The minutes were agreed with one amendment.

2.2 Membership

Charlotte announced that there would be a few changes to the membership of the CNMAC group. Francis Rice has now taken up the position of interim Chief Executive of the SHSCT. Angela McVeigh is now the interim EDON and will be attending CNMAC. Olive Macleod is taking up the role of Chief Executive of the RQIA, Sam Porter is leaving QUB and the new head of school will replace him at CNMAC. Once the changes have taken place a submission will be sent to the Minister.

3. Supervision Framework

Charlotte stated that this piece of work has come about due to the changes in midwifery regulation. Olive has chaired a group that is developing common standards across nursing and midwifery. Charlotte has asked NIPEC to take work forward that will bring together the 3 work streams, safeguarding supervision, midwifery supervision and nursing supervision. Angela advised that subject to discussion she would set up a programme board which would have 3 subgroups to look at the 3 different areas of supervision. Brenda stated that there has already been quite a bit of work done in the midwifery

task and finish group. Olive said that she was aware of the level of support that midwifery has and would nursing to be brought up to the same standard. Angela stated that she believes that the work can be done quite quickly but the implementation could take longer.

4. Strengthening the Commitment (Learning Disability Nursing)

Charlotte advised that there were 2 papers for discussion. The first is the 'Northern Ireland Action Plan for Learning Disability Nursing Northern Ireland Collaborative Progress Report Sept 2014 - March 2016'. The second is the workforce paper. The description of the LD nursing workforce was undertaken by the Regional Collaborative for LD nursing. Both papers were issued to the group prior to the CNMAC meeting. Glynis stated that following the work completed by the 4 countries on Strengthening the Commitment a NI action plan was launched in June 2014 by the CNO. From this a regional collaborative was formed which was chaired by Glynis. Glynis then highlighted the main points of the paper. Charlotte noted her thanks to Glynis for her work and asked for her thanks to be passed on to Frances and the members of the Regional Collaborative.

Glynis then gave an update on the Workforce Review. One of the key items to take forward was the profile of the LD nursing workforce. Information was requested from the NMC to determine the number of registrants in Learning Disability nursing in NI. A scoping exercise was carried out in Trusts, the independent sector and other organisations. Glynis stated that at this time NI was the only one of the 4 countries to have been able to collate this data. Findings indicated around 625 LD nurses in NI with 326 of these holding a dual qualification. A large number of these nurses were due to retire within the next 5 years. There are 229 Health care Assistants within the LD workforce. Recruitment difficulties are an issue in the independent sector and some of the Trusts especially recruiting LD nurses in children's nursing and community. There is also a concern that the skill of non medical prescribing is not being used. LD nurses often work within a social care model.

Janice stated that the RCN had received copies of letters which had been issued by NISCC indicating to LD nurses. The contents of the letters suggested that LD nurses working in social care settings should be registered with NISCC. Janice has written to the NMC about this issue but has not received a response at this time. Charlotte suggested that she write to the NMC on behalf of CNMAC to raise this issue with them again. Charlotte stated that she did not think nurses should not be required to be regulated by two different organisations.

Charlotte asked the group for suggestions in taking the work forward. Janice suggested that they need to develop the career pathway to provide leadership in Learning Disability nursing. Mary also stated that they need to value the importance of LD nurses and the registration issue should be resolves as

soon as possible. Donna highlighted that investing in HCA's to support LD nurses was necessary and suggested the Certificate in Healthcare Practice could be an effective way to achieve this.

It was agreed to taking forward the LD work under 4 themes

1. Career Pathway which will be taken forward by the NI Regional Collaborative for LD Nursing.
2. Regulation
3. Access to training

4 Reform of adult social care.

AP1 – Charlotte to write to the NMC to seek clarification regarding regulation.

5. CPD Independent Sector

Janice Smyth raised a concern that there is a lack of support for nurses working in the independent sector. Nurses working in Nursing Homes do not have enough access to clinical skill development and therefore are unable to skill up other staff. Glynis advised that the CEC does have clinical skills labs and they do support the independent sector but they do charge a fee. Olive advised Janice that in the NHSCT 32 nursing homes are receiving upskilling and support from one band 7 nurse. Charlotte stated that some of the other Trusts are running similar programmes. Janice suggested that they should capture this information to make staff aware that these programmes are taking place. Charlotte also advised that there is a bid to June monitoring for a post to support training in LTCs for the independent sector. Donna also advised that they have 2 bids in with the Department for Education for 25 healthcare assistants and 5 nurses for Bsc honours courses. Janice also stated that there are concerns at the turnover of staff in the care homes. Alan also said that he is aware of the issue but even though their pay may be near the same, the homes can't offer the same T&Cs as the Trusts. Charlotte asked if an education piece to support the independent sector through the winter was needed.

AP2 - Mary to pull together information relating to Trust support in the independent sector.

6. Support for Mentorship in the Independent Sector

Janice again stated that his was an issue that was affected by the turnover of staff and there are no resources for practice placements for the role of post reg nursing students. Charlotte advised that an SWE group is looking at practice placements and it is one of the recommendations coming out of the primary care framework. Donna also advised that they are currently running 2 pilots and the students spend time with mentors in their own organisations.

There are also 5 or 6 places given over to the independent sector in each Trust.

7. Service Model and Nurses Roles in Supported Housing Facilities.

Heather gave a brief update. Following the discussion at the last meeting Heather checked if nursing was represented at the Adult Care and Support group. Heather was able to confirm that nursing was represented by the CNO on the project board.

8. Revalidation

Angela advised that 93% of Registrants have now registered online and the NMC are preparing for an expected 'bottleneck' in September. Angela also advised the group that Miles Wallace has moved to the media team at the NMC. Sarah Clarke will be the new Revalidation contact.

9. Band 5 Recruitment

Heather Finlay reported on the recent recruitment campaign to the Philippines. 239 Conditional offers were made and accepted subject to the full range of pre-employment checks including NMC requirements.

It is currently expected that the first appointees will arrive to NI in November 2016. All will initially be employed at Band 3 until they undertake their OSCE's prior to NMC registration. Overall this was a very successful campaign where the standard of applicants was very high. The campaign to Romania was not successful. The HSC process and documentation agreed prior to the campaign was not adhered to by the European recruitment agency. The environment for the candidates undertaking the two written assessment was also not suitable, nor was the accommodation for HSC Team. Further trips to Romania have been cancelled. Brendan McGrath, Lynn Fee and Karen Patterson are going to Italy for the recruitment campaign. The timelines for recruitment of EU nurses is 39 weeks and non EU nurses is 48 weeks. All groups involved in the recruitment are meeting regularly. Work is also ongoing with the recruitment of nurses locally as well as the overseas nursing.

Alan advised that the SWE subgroup asked him to raise a concern about the scale and the cost of the overseas recruitment campaign and questioned if more work could be done to recruit locally rather than overseas. An 18 month post grad nursing programme is available in England. An action from the recent SWE meeting is to explore this as a potential option Donna is aware of the course and will be meeting the other universities to discuss it. Donna also advised that through work with the SHSCT, they have been able to increase the number of students on the OU course from 50 to 69. Charlotte noted the concerns of the subgroup but felt there was no choice as they need to maintain safe numbers. Charlotte has discussed the issue with the Minister

and with good evidence; it may be possible to increase student numbers locally.

10. Update from the Nursing and Midwifery Task Group

There is a submission with the Minister and Charlotte has also had discussions in relation to the Task Group. Charlotte hopes to have the response from the Minister soon as to whether the Task Group will go ahead.

11. Update from CNMAC subgroups

11.1 CNMAC Safety, Quality and Experience Subgroup

Caroline advised that she had met with Tanya and Angela and discussed the overlaps between the PD group in NIPEC and the SQE subgroup. Tanya has asked if CNMAC would agree to the merger of the 2 groups. The group agreed to merge and the PD group would be stood down.

11.2 CNMAC Strategic Workforce and Education Subgroup.

Heather Finlay gave an update from the SWE subgroup. Heather advised that there is an ongoing task and finish group focusing on practice placements. The group has met twice and have a further meeting planned. Initial findings are that placement capacity is not a major issue and challenges arise with the flow of the students. There is still work to be done around educational audits and primary care. Heather also advised that MAPA is still being discussed. It was also noted that there is also some membership gaps on the group so some further nominations requests may be sent out.

11.3 CNMAC Research and Development Subgroup.

No update was able to be provided.

11.4 CNMAC Ehealth and Infomatics Subgroup.

Kathy has confirmed that the group is to be called Ehealth and Infomatics subgroup. Kathy advised that the membership has been refreshed. The Ehealth and Care Strategy has now been launched and an implementation plan is being drafted. All organisations have to send back their responses regarding the 6 aims of the strategy. Kathy and Heather plan to ask each of the other subgroups where the Ehealth and Infomatics agenda would have an impact on their work area. Heather and Kathy will take forward
Charlotte suggested it would be useful to have a CNMAC workshop to review the work of the 4 subgroups and give direction for future work. ..

AP3 – Change the subgroup name on the agenda.
AP4 - Dates to be obtained for the other CNMAC subgroup meetings

AP5 - CNMAC Workshop to review work of the subgroups

12. AOB

12.1 Glynis advised that work is ongoing in the Quality 2020 task group which focuses on Simulated Based Education and Human Factors training. Further discussions will be taking place with the universities to discuss what is happening from the nursing perspective.

12.2 Geraldine Walters has been appointed by the NMC as Director of Education, Standards and Policy at the NMC.

13.1 The next meeting will take place on Thursday 08 September 2016 at 10.00am, Room D2 Lecture Theatre, Castle Buildings.

No	Date	Action	Responsibility	Progress	Status
AP1	10/03/16	Charlotte to write to the NMC to seek clarification regarding regulation.	Charlotte McArdle		Open
AP2	10/03/16	Mary to pull together information relating to Trust support in the independent sector.	Mary Hinds		Open
AP3	10/03/16	Change the subgroup name on the agenda.	Admin	Completed	Closed
AP4	10/03/16	Dates to be obtained for the other CNMAC subgroup meetings.	Kathy/Heather		Open
AP5	10/03/16	CNMAC Workshop to review work of the subgroups	Charlotte/Admin	Completed	Closed

Central Nursing and Midwifery Advisory Committee (CNMAC)

Notes from Meeting on 18th September 2020 @ 10.00 am

Via Teleconference (Zoom)

Present:

Prof Charlotte McArdle	DoH (Chair)
Heather Finlay	DoH
Mary Frances McManus	DoH
Dr Dale Spence	DoH
Rodney Morton	PHA
Prof Carol Curran	UU
Angela McLernon	NIPEC
Karen Murray	RCM
Nicki Patterson	SEHSCT
Heather Trouton	SHSCT
Caroline Lee	CEC
Prof Sonja McIlfatrick	UU
Dr Bob Brown	WHSCT
Prof Donna Fitzsimons	QUB
Heather Monteverde	Macmillan
Suzanne Pullins	NHSCT
Anne Trotter	NMC
Laura Glover	DoH Secretariat

Apologies:

Maura Devlin	NMC
Brenda Creaney	BHSCT
Carol Cousins	FSHC
Marion Ritchie	UNITE
Prof Tanya McCance	UU
Donna Gallagher	OU
Ethel Rodrigues	Unite
Pat Cullen	RCN

1. WELCOME AND APOLOGIES

Charlotte opened the meeting and welcomed all those in attendance and the apologies were noted.

2. CHAIR'S OPENING REMARKS

The chair noted the following changes to CNMAC membership.

- Maura Devlin is standing down as the NI NMC representative from CNMAC. In her absence Charlotte acknowledged Maura's valued contribution to CNMAC. She will be replaced in October by Eileen McEneaney as the NMC representative.
- Heather Monteverde standing down as the Independent and Voluntary sector representative. Charlotte thanked Heather for her valued contribution to CNMAC and advised that she will be working with the Department of Health on the Cancer Strategy.
- Suzanne Pullins was welcomed as a new member of CNMAC, Suzanne replaces Eileen McEneaney as the interim Executive Director of Nursing in the Northern Trust.

3. NOTES / ACTION POINTS FROM LAST MEETING: 26th June 2020

The minutes of the last meeting were agreed and an update on actions followed.

AP1 - Gary Loughran to return to CNMAC in 6 months. This action was deferred to next meeting. **Ongoing.**
AP1 – Laura to share the details of the NMC webinars with CNMAC members. Completed. **Closed.**
AP2 - Laura to share the Nursing and Midwifery Task Group Report Implementation slides with CNMAC members. Completed. **Closed.**
AP3 - CNO to advise members in writing once co-chairs are confirmed for the NMTG strategic themes. This item will covered later in agenda. Completed. **Closed.**

4. NMC REVIEW OF POST REGISTRATION STANDARDS

A welcome was extended to Anne Trotter, Assistant Director of Education in NMC. Anne was invited to present on the NMC review of post registration standards. A copy of the NMC paper: *Modernising post-registration regulated specialist practice community qualifications*, was circulated to members prior to the meeting.

Anne introduced the paper advising that the review of post registration standards began in 2019. This included the SCPHN third part of the register and the Specialist Practice qualifications.

A UK post registration standards steering group was established with representation from CNO offices, education providers, professional organisations and unions. There had been two meetings prior to lockdown. Recommendations were agreed by NMC Council in January 2020

1) To replace the current generic Specialist Community Public Health Nursing standards with a core set of standards, and in addition, three bespoke sets of standards for each of the following groups; Occupational Health Nurses, Health Visitors and School Nurses

2) To scope the content of the proposed new qualification in community nursing, which would replace the current specialist practice qualifications (SPQs) in District Nursing, Community Children's Nursing, Community Mental Health Nursing, Community Learning Disabilities Nursing and General Practice Nursing. The new qualification would encompass a core set of standards and any bespoke standards for each of the individual specialties as required.

Due to the impact of COVID, a series of engagement webinars were very successful with high numbers participating. An independent research company has been undertaking a thematic analysis of stakeholder feedback data.

Feedback indicates there is general consensus on SCPHN with core standards being drafted. Mary Frances is the NI representative on the SCPHN group.

The position with SPQ is more contentious with differing dimensions and variant views across the four UK countries. Advanced practice regulation in the context of

SPQ has been raised, however the NMC has taken no decisions on regulation of advanced practice as yet.

Anne advised the timeline for the post registration standards review was that Council would approve in December, with consultation to commence in January 2021

Some discussion took place. Charlotte raised a concern that NI participation in the NMC engagement webinars was solely within an individual capacity and did not necessarily represent or align with the NI strategic direction.

All agreed this was a complex area that may not meet our needs in NI with potential implications particularly on community nursing practice. Careful consideration was needed, especially given the important strategic drivers such as Delivering Care, DN framework and NMTG Report, embedding nursing roles with a strong public and population health approach.

Charlotte noted that the NMC have agreed that in NI we will be able to make decisions aligned to our own strategic direction in taking the profession forward.

ACTION POINT 2 & 3 (Mary Frances)

a) Set up a Strategic Leaders Forum to facilitate discussion and inform the strategic response.
b) Share the draft standards SCPHN with CNMAC members.

Charlotte thanked Anne for the update. Anne left the meeting.

5. NURSING AND MIDWIFERY TASK GROUP REPORT

Charlotte provided an update on the Nursing and Midwifery Task Group Report. Following discussion at June CNMAC, the implementation model and co-chairs for the Strategic Themes have been agreed, subject to Ministerial approval, which is yet to be obtained.

1) **Population Health** – Rodney Morton (PHA) and Dr Jenny McNeill (QUB)

2) **Workforce Stabilisation –** Preeta Miller (WPD) and Rita Devlin (RCN)

3) **Enhancing Roles of Nurses & Midwives** – Prof Tanya McCance (UU) and Carol Cousins (IS)

Charlotte advised some uncertainties regarding the pandemic however; she was content the groups could be established with deferral of theme three work stream until Tanya McCance returns. She advised the supporting infrastructure needed further work and that there would be key roles for Linda Kelly, Heather Finlay and Dale Spence

Bob Brown commented he would be keen to see work progress on the nursing and midwifery strategy which hopefully will align with the strategy being developed by Western Trust to be completed in 2021. Charlotte acknowledged the need to develop the regional strategy and that any local strategy development meantime should reflect the clear direction in the Task Group Report

Nikki Patterson added that she felt it was important to maintain the enthusiasm generated by the launch of the report. Rodney endorsed a recent SET event that focused on the Task Group Report, providing an opportunity to connect with staff and make the recommendations meaningful.

7. FUTURE NURSE, FUTURE MIDWIFE UPDATE

Angela McLernon provided an update on Future Nurse, Future Midwife. The Future Nurse programme has gone live. Future Midwife will commence in September 2021.

Angela thanked everyone involved in the Programme Board. She advised that:

- A transitioning group had been established called the NI Practice Learning Collaborative. Chaired by Sharon McRoberts and Karen McCutcheon, the group met in mid-August and plans to meet monthly.
- The Midwifery Expert Reference Group (MERG) continue to meet monthly, and an NMC approval visit has been planned for QUB in November.
- The Midwifery On-Going Record of Achievement (MORA) work is ongoing with a good response to the survey in June 2020.
- Future Nurse electronic Northern Ireland Practice Assessment Document (eNIPAD) work is well underway, thanks to the Universities and should be implemented in September.
- Practice Placements

Angela highlighted there were concerns about practice placement availability for students and the challenges around COVID and the re-build agenda. She noted significant work was ongoing with continued partnership working between the universities and practice education teams.

Charlotte inquired if there were issues with practice placements in midwifery? Dale Spence confirmed there were some challenges with intrapartum placements however this was being managed at present.

Donna Fitzsimons advised that QUB are currently 400 student placements short and highlighted this as a critical issue as the placements are needed from late October. Sonja McIlfatrick also expressed concerns regarding UU students – highlighting in particular the lack of community placements which urgently needed addressed.

Heather Finlay advised that placement shortages were raised at the recent FNFM working Group. Covid related causes due to reconfiguration or closure of wards/units had been cited as contributing factors, reducing placement availability. The tireless efforts of practice education teams to secure placements was acknowledged and leadership of Sharon McRoberts who contributed to the FNFM working group discussion as co-chair of the NI Practice Learning Collaborative (NIPLC) was appreciated. Heather advised that it is imperative that placements are facilitated and that the CNO has asked for a monthly monitoring report from the NIPLC.

Charlotte reinforced these comments highlighting students should be working shifts over the 24/7 period and additional places must be found. Acknowledging the difficulty presented by COVID, she reminded the committee of the assurances received from Directors of Nursing that students would be accommodated when the additional places were being agreed.

Nikki Patterson agreed there needs to be a determined push to accommodate student placements and noted the importance of speedy escalation of any issues to the Directors of Nursing. Charlotte agreed this action should be instigated without delay

Action Point 4 - Directors of Nursing to ensure urgent escalation mechanisms are in place within their respective organisations to address any shortfall in the availability of student placements

There were various suggestions put forward as to where student placements could be obtained including the NI Hospice.

Charlotte highlighted workforce challenges within theatre nursing. Students should be accommodated to introduce them to the speciality pf theatres as undergraduates.

It was highlighted that Occupational Health services have no nursing students at present – again another valuable learning experience.

Rodney suggested that students could be utilised to work in contact tracing as part of a public health placement, it was agreed that he would link with the universities and put together a package for this.

Action Point 4 - Rodney to link with the universities and develop a package for students in Public Health Agency

8. WORKFORCE AND EDUCATION UPDATE

Heather Finlay provided an update on Workforce and Education

Vacancy update

The vacancy rate is published quarterly on the Department of Health website; the latest figures are from 30th June 2020 and have encouragingly shown a downward trend over the past few quarters, however workforce shortages still remain a challenge.

	Vacancies 30th June 2020	Vacancy Rate	March 20
Nurses	1,716	9.5%	11.1%
Midwives	70	5.0%	6.6%
Total	1,786	9.1%	10.7%

	Vacancies at 30th June 2020	Vacancy Rate	March 20
Nursing & Midwifery Support	253	4.0%	6.4%

Action Point 5 – Heather to prepare a comparison table of the vacancy rate over the past year to be sent out with the minutes.

Heather highlighted that there are particular workforce concerns in Mental Health and Learning Disability nursing, and thanked QUB who are working on providing destination statistics for their graduate nurses in these areas.

Belfast Trust is currently doing some work with ROI and hope to recruit mental health nurses in line with NMC guidelines.

International Recruitment

The project aimed to recruit 622 nurses to the HSC by March 2020. On 23rd March 2020, the Minister agreed to the immediate suspension of all international nurse recruitment in order that HSC resources could be directed towards managing COVID-19. As at the project suspension on 23rd March, there were 504 international nurse arrivals, of which 458 remain in post-suspension now lifted with 320 nurses expected to be recruited during the remainder of 2020.

Safe Staffing Delivery Framework

Safe Staffing Framework Delivery Group (SSFDG), consists of Departmental, HSC employer and trade union representatives and will report to the Minister through Workforce Policy Directorate. It will complement the work other groups, including the Workforce Strategy Programme Board. The Terms of Reference have been finalised and await Ministerial approval. A regional Agency Reduction Implementation Group set up as a sub group of the SSFDG.

9. EDUCATION UPDATE

Pre-Registration Commissioning

The first 300 of the additional 900 places over the next 3 years have been commissioned for 2020/21 making a total of 1325 places. Some additional places were granted to QUB due to the additional A Level intake this year.

Post-Registration Commissioning

The nursing and midwifery post registration education budget for 2020/21 was uplifted to £10m in line with commitment given by the Minister in the Framework

agreement. There has also been additional funding secured this year for Primary Care nursing and nursing in the care home sector.

Caroline Lee advised all Covid related programmes from CEC are free and stated that if given direction from the Department she would consider opening up non-Covid programmes to the independent sector and primary care free of charge. Charlotte thanked Caroline for this and believed it would be welcomed by these sectors.

Students and Paid Placements

Heather noted the positive feedback on the contribution of students joining the workforce in a paid capacity under the NMC emergency arrangements to the pandemic. Charlotte discussed the possibility of providing paid placements for final year students in their last few months. Charlotte will check with NMC and before any Departmental discussions regarding.

10. FLU VACCINATION PROGRAMME

Mary Frances McManus provided an update on the flu vaccination programme. The 2020/21 Flu campaign is particularly important this winter. There has been an additional investment of £750,000 across the region, the previous uptake was 70 - 75% this year's target is set for 95% There are three main programmes:

1. **Children's Vaccination Programme** - Anti-vaccination issues are a challenge. This group will cover all school age children up to and including those in year 8.

2. **General Practice and Primary Care Programme** - This group will cover all children age 2 – 4, those over 65 years old, pregnant women and those under 65 years in a clinical risk group. A decision has yet to be made on whether those between 50 and 65 years old will be included.

3. **Health and Social Care Programme** – A lot of work has gone into focusing on this group. The Target set for uptake by Health Care Workers is 75%, last year the uptake by HSC staff was only 41.2%. The HSC workforce can be vaccinated at one of 386 community pharmacy vaccination clinics or by peer vaccinators. Independent sector workforce can receive vaccines via their employer or also at community pharmacy clinics. The Department have

developed a letter to encourage everyone to take the vaccine. Caroline asked that as BSO have front line workers they need to be included in any circulars being sent out. Mary Frances will ask Jane to add them the circulation list. Caroline said that several trusts have been looking for training for immunisers.

Sonja McIlfatrick asked for clarification on students getting the flu vaccine, normally they are sent to their own GP to have this, Charlotte confirmed that students can be vaccinated at the community pharmacy clinic or peer vaccinator clinic, she floated the idea of student peer vaccinators.

Details of the clinics will be published on the Public Health Agency website.

11. UPDATE STRATEGIC WORKFORCE AND EDUCATION CNMAC SUBGROUP

Carol Curran provided an update from the last SWE CNMAC subgroup meeting, which was held on Friday 4th September 2020.

Carol began by acknowledging the contribution of all education providers in response to COVID and the commitment shown by the CNO in leading the workforce in such difficult times.

The second issue escalated from SWE was the difficulty in obtaining practice placements for students which has been discussed during the meeting.

Finally, she raised the issue of the new Nightingale Hospitals and need for a regional approach to staffing. Charlotte confirmed that this will be the case.

12. ACCESS TO EDUCATION (BAME)

An update on BAME from the last CNMAC meeting was given. Issues were raised regarding access to post registration education. New guidance from NIRAC advised that they are accepting degrees awarded in the Philippines for level three study. As yet, Indian and African nurses are unable to directly access modules. QUB will further explore this.

A Task and Finish group, chaired by Sonja McIlfatrick, will take forward education access issues

Caroline Lee is including BAME in the planned Valuing Diversity in Nursing Workshop. She is due to meet with Paula Smith at BSO to get the numbers of staff involved and the grade mix to be sure that it is parallel with the overall workforce. Caroline will liaise with Sonja on this.

13. AOB

Leadership opportunities for part time Band 6 and 7 in the CNO's team were advertised. There has been encouraging interest in these posts and shortlisting is soon to commence. The posts are:

Learning Disability Review – 1 part time post

Restraint and Seclusion - 1 part time post

Clinical Care Framework – 2 posts

Healthly Child, Healthy Future – 1 post

Nursing & Midwifery Strategy – 2 posts.

6. ENHANCING CLINICAL CARE IN CARE HOMES FRAMEWORK AND RAPID LEARNING INITIATIVE.

Linda Kelly joined the meeting and delivered a presentation, a copy of the slides were sent to CNMAC members.

14. DATE OF NEXT MEETING: 4th December 2020 @ 10am

Exhibit 3

Action Point Register

No	Date	Action	Responsibility	Progress	Status
1	27/06/19	Gary Loughran to return to CNMAC in 6 months for demonstrations and further update.	**Emma Murray**	**In Progress**	**Open**
2	23/09/20	Mary Frances McManus send Laura the draft standards SCPHN to share with CNMAC members.	**Laura Glover**	**Complete**	**Closed**
3		Mary Frances McManus to set up a Strategic Leaders Forum to facilitate discussion and inform the strategic response.	**Mary Frances**		**Open**
4		Directors of Nursing to ensure urgent escalation mechanisms are in place within their respective organisations to address any shortfall in the availability of student placements	**Directors of Nursing**		**Open**
5	23/09/20	Heather to prepare a comparison table of the vacancy rate over the past year to be sent out with the minutes.	**Heather Finlay**	**Sent out with these minutes.**	**Open**

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Exhibit 4

FOREWORD

The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". That is the health outcome I want to deliver for all our people.

But without new approaches and in the face of ever growing demand - often driven by successful interventions and improving life expectancy - we will increasingly struggle.

Change is quite simply essential to deliver the world class service - free at the point of delivery and based on need - that is our collective commitment.

We must move beyond simply managing illness and instead ensure that our health service supports people to stay well; physically, mentally and emotionally.

In other words, we need to rethink how we deliver our health and social care service.

My predecessor, Simon Hamilton, asked a panel led by the internationally recognised expert, Professor Rafael Bengoa, to help us identify how to tackle the challenges in our Health and Social Care system.

Their report tells us clearly that we need to re-organise how we do things - and that we need to do this in partnership with the people who use the service and those who work in it. Critically, we must prioritise prevention and early intervention to ensure that people stay well. This approach will produce better health and wellbeing outcomes and it will reduce demand on our over stretched acute services. It will also help us tackle what the Expert Panel Report calls "striking health inequalities" in our society.

This document, Health and Wellbeing 2026: Delivering Together, is the outworking of the Expert Panel's recommendations. It sets out a commitment to tackle the issues we face in our Health and Social Care system through decisive political leadership. We are determined to move beyond short-term approaches and crisis management.

This Executive is united as never before in its commitment to take the right, perhaps difficult, decisions. But we know this is the only way to deliver better outcomes for our people.

We are facing into a time of change for our health system but it is change that must happen. This document sets out a direction of travel that I hope all of our society can embrace and support in the challenging but exciting time ahead.

Michelle O'Neill, MLA
Minister of Health

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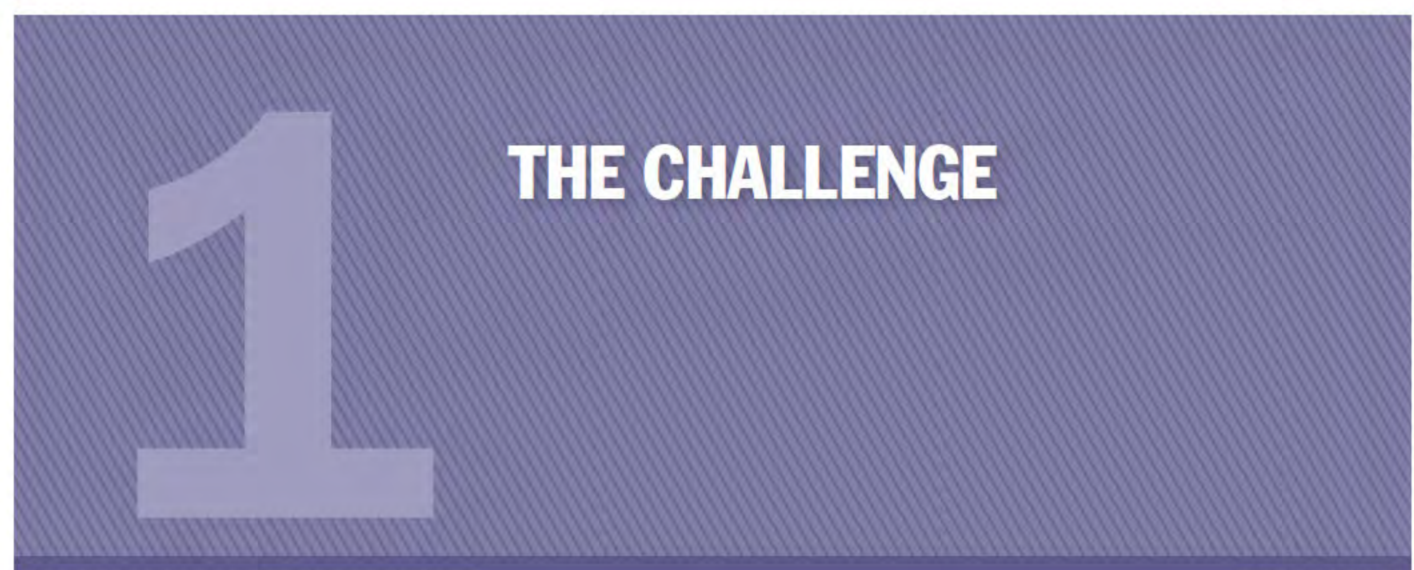
Exhibit 4



1 THE CHALLENGE

My desire for world class health and social care is based on firm foundations - we have a health and social care system staffed with many talented and dedicated people working extremely hard to deliver high quality services to those in need. But increasingly those efforts are frustrated by a system which is clearly under mounting pressure. This is impacting on both those within the system and those it serves. Without radical change there is no doubt the situation will further deteriorate. That is why I am convinced that change is needed now.

Before I set out the case for change, it is important to acknowledge and celebrate where Health and Social Care, in collaboration with wider government, is making a real difference to our health and wellbeing.

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Exhibit 4

Standardised
CIRCULATORY DEATH RATE
in under 75s
decreased by a fifth over the last 5 years

ENGAGEMENT WITH EDUCATION TRAINING OR EMPLOYMENT FOR THOSE AGED 16-21 WHO ARE IN CARE OR HAVE LEFT CARE HAS RISEN 5.7% IN THE PAST YEAR

SMOKING PREVALANCE FELL
from 26% in 2004/05
to 22% in 2014/15

7677 CARERS RECEIVED SUPPORT FROM TRUSTS IN 2015 COMPARED TO 1414 IN 2011

Over **1 in 3** adults (36%) reported that they ate the recommended **5 PORTIONS** of fruit & veg a day (2014/15)
increased by a third over the last 10 years

FAMILY SUPPORT HUBS

In 2015/16, **4522 families with children** were referred to Family Support Hubs, a **72% increase** on the previous year. Of the 5346 children referred to Hubs in 2015/16, **around 18% were children with a disability**

BOWEL CANCER DECREASE
Since **bowel cancer screening** was introduced, the percentage of people diagnosed with early stage disease has increased from **14% to 22%** thereby **improving their life chances**

LOOKED AFTER CHILDREN
achieving Key Stage 1: Level 2 or above

in English
7.5% INCREASE

in Maths
7% INCREASE

INCREASE IN ADOPTIONS
Between 2014/15 and 2015/16, there has been a **24% INCREASE** in the adoptions of Looked After Children

LIFE EXPECTANCY
over the last 5 years life expectancy has increased

1.3 YEARS
for males
(78 years)

1 YEAR
for females
(82.3 years)

Standardised
RESPIRATORY DISEASE DEATH RATE
in under 75s
decreased by a fifth
over the last 5 years

MMR VACCINE
over 95% of children received the MMR Vaccine which means we have not seen the outbreaks of measles that have occurred elsewhere

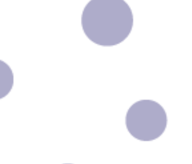

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Exhibit 4

At the heart of the many successes of the Health and Social Care (HSC) system is the hard work and dedication of all staff, in every grade and role, who are delivering care at higher levels than ever before.

However, while there is much to celebrate, we must recognise the challenges in the current system. The reality is that we increasingly cannot properly meet people's needs with our current structures. In the past, and for a range of reasons, it has not been possible to achieve the whole system transformation at the scale and with the pace we need to meet the evolving health needs of our people. More and more the impact of this is felt on a daily basis and takes its toll on both those who use services and those working in the sector.

Our Health and Social Care System faces a number of significant challenges:

Organisational

In many past reviews, professionals and staff have expressed their frustration at the limitations of our current arrangements and their desire for change, most recently in the Expert Panel report. The 20th century configuration of our services is simply not optimised to meet the needs of 21st century care.

The point has now been reached where maintaining the current delivery models is having increasingly negative impacts on the quality and experience of care for many service users, while constraining the ability of the system itself to transform to meet today's health needs.

While staff work increasingly hard to mitigate these structural issues, the overall impact is experienced by service users and their families every day, in every part of the system. Regrettably, delays in accessing services and unacceptable waiting times for treatment are commonplace. The quality of our service, and the experience of those providing and receiving it, is not as good as it should be.

Modern research shows that outcomes for patients requiring complex or specialist treatment improves where high levels of specialist expertise is available and these teams are able to keep pace with innovation. The current spread of such HSC resources, too often committed to buildings rather than outcomes for patients, is a central challenge we must address.

If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable.

In addition, the way we are organised means that opportunities are being missed to create sustainable employment, drive economic investment, and maximise the contribution of the HSC to the economic goals of the Executive. For example, the life and health sciences sector provides 10% of all of the North's exports. Closer working between the HSC, our world class universities and life and health science organisations and maximising the potential for growth in this high value sector, is fundamentally dependent on centres of clinical excellence with the right level of expertise and the necessary capacity.

Workforce

A further challenge relates to the workforce itself. People who work in health and social care are its greatest strength, working ever harder to provide the care needed by patients and service users. Year on year, investment has been directed to front line services in an effort to meet the ever growing need for treatment and care.

However, if we accept, as a whole range of reviews have, that our services are not best configured for our needs, then it follows that recruiting additional staff alone to prop up outdated service models, is not the answer. We must be able to provide safe and high quality care which keeps up with the fast pace of innovation and health and social care developments. I recognise that staff need the opportunity to develop their skills and expertise in an environment which allows for a greater degree of specialisation, whilst maintaining personalised compassionate care.

MAHI - STM - 294 - 152
Exhibit 4

It has also become clear that even when resources are made available to recruit additional staff, it has simply not been possible to fill all vacant posts. This in turn puts additional pressure on already hardworking staff and has seen our service become increasingly reliant on short term solutions such as locums and agency staff. This creates additional expense with negative implications for the quality of care. It has become a vicious circle which we must stop.

We must invest in our staff and provide the environment to allow them to do what they do best - provide excellent high quality care. This means providing opportunities to develop their skills and find suitable career paths at all levels. Where necessary, we will increase the numbers we train and consider ways of delivering care more effectively through the development of new roles and skills.

I am determined that we will make the health and social care system an employer of choice in the north of Ireland.

The Needs of a Rapidly Changing and Ageing Population

Our society is getting older: people are living longer, often with long-term health conditions, and we are having fewer children. Estimates indicate that by 2026, for the first time, there will be more over 65s than under 16s.

By 2039, the population aged 65 and over will have increased by 74% compared to the position in 2014. This will mean that one in four people will be aged 65 and over.

Similarly, the population aged 85 and over will increase by 157% over the same period, which will see their share of the population increase from 1.9 % to 4.4%.

By any analysis, this is a massive success to which our health and social care service has made a significant contribution. That said, it does present a huge and growing challenge in terms of the demands and pressures on health and social care services.

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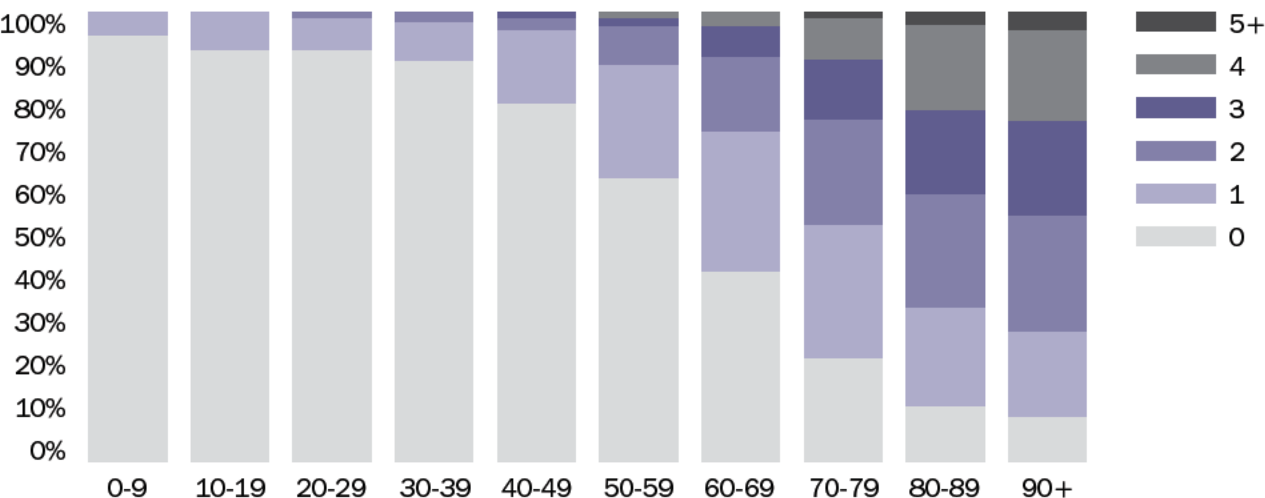

Developments in how conditions can be treated and managed mean that as we get older we are much more likely to develop and live with one or more long term conditions. The table above demonstrates that as we get older, the likelihood of having more than one condition at the same time increases dramatically, and with that the care and treatment that we require becomes much more complex.

Furthermore, people's health and social care needs have changed, and their expectations are rightly higher than at any other time before. In the past, for many conditions, where there was an effective treatment available, it often required hospital attendance or an in-patient stay. Increasingly, such treatments are available in the community, or can be provided on a day care basis; which in many instances is more appropriate to the needs of people with longer-term chronic conditions.

People today want to lead full and productive lives, staying independent for longer. In line with wider societal changes, we all expect improved access, choices and control when it comes to public services.

Health Inequalities

Despite people living longer, health inequalities continue to divide our society. The differences in health and wellbeing outcomes between the most and least deprived areas are still very stark, and completely unacceptable.

For example, men in the least deprived areas live 7.5 years longer than men in the most deprived areas. For women, the difference is over four years. In the most deprived areas, 30% of people report a mental health problem - double the rate in least deprived areas. Rates of suicide are also higher, and leave a devastating impact on people, families and those communities.

Birth weight is an important indicator of foetal and neonatal health, and a low birth weight has a strong association with poor health outcomes in infancy, childhood and throughout someone's life. Between 2010 and 2014, the proportion of babies born at a low birth weight was 44% higher in the most deprived areas than in the least deprived areas.

In 2013/14, the rate of obesity among children in Primary 1 was 71% higher in the most deprived areas than those in the least deprived areas. 42% of Looked After Children (LAC) come from the most deprived areas in the North. Being looked after is associated with poorer socio-economic outcomes in adulthood.

It is clear that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes. There is also growing evidence that children who experience adversity in childhood are far more likely to experience health issues in adult life. Specifically, these children are more likely

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Exhibit 4

to adopt health harming behaviours during adolescence which can lead to mental health illness and diseases such as cancer, heart disease and diabetes later in life. Adversity in childhood also means that children are more likely to perform poorly in school, more likely to be involved in crime and more likely to experience poverty and disadvantage in adult life.

Our future health and social care system needs to not only treat people who become sick or need support now, but also needs to do much more to ensure that the next generation is more healthy with more equitable life opportunities for all.

Our Opportunity

The problem and the compelling case for change is not in itself new, and has been made repeatedly by experts, staff and patients over many years. The Expert Panel's Report "Systems, not Structures: Changing Health and Social Care" once again reaffirms this. But despite the overwhelming evidence, the opportunity has thus far not been grasped. However, both as Minister and as an Executive we believe there is now no alternative but to transform how we design and deliver health and social care services.

The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it, and I look forward to all parties engaging with and supporting the HSC to make the difficult decisions required to improve our population's health, and build a sustainable health and social care system. This is the time for political leadership.

The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional silos and boundaries to deliver the best outcomes for the people of the North. Now is the time for us to work collectively to deliver a world class health service.

Across this island, the health and social care fabric of both jurisdictions face the same challenges. We have the opportunity to work more collaboratively with colleagues to address those challenges, and deliver services in a way that improves care for our population as a whole. There are many good examples of where this is already working well, such as cancer and cardiac services in the north west or the partnership with Dublin for children's heart surgery. There are many more such opportunities, including the transplantation of organs and rare diseases, and we have developed a programme of work with the Department of Health in the South to identify areas of mutual benefit.

Staff, clinicians and professionals from right across our health and social care system are telling us loud and clear that change is now necessary. If we do not grasp this opportunity change will happen anyway but in a reactive and unplanned way, with more potential for detrimental impacts on those who use and deliver our services.

In addition, the HSC itself is a huge contributor to the economy in many ways, through skills development, spending power and employment practices.

As the single biggest employer in the North, we have a real opportunity and responsibility to make a tangible and positive contribution to the health and wellbeing of our staff, and society as a whole. We will be an employer of choice, leading by example and investing in the wellbeing of our staff. Despite the demand, resource and service pressures being experienced, I am committed to ensuring the wellness dimensions of being an employer of this scale will be better achieved across the HSC.

In the way we operate, we have the opportunity to promote a new way of working with the community and voluntary sectors through the innovative use of social procurement clauses, and commissioning services based on social value rather than simply on the basis of lowest cost.

Working with our world class universities, skilled graduates and world leading companies, we can grow our life and health sciences sector, creating new jobs. This will mean access to cutting edge technology and therapies, and the dual benefit of improving care and economic growth. To do so requires further collaboration between HSC, academia and industry. The HSC can only play its part if it can provide the centres of expertise and excellence that will continue to attract partners, and support the recruitment and retention of experts in their fields.

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THE AMBITION

Health is a human right. I am deeply committed to the principle of universal health care, free at the point of delivery to those in need.

Aligned with the aspirations the Executive set out in the draft Programme for Government, my overarching ambition is for every one of us to **lead long, healthy and active lives**.

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Exhibit 4

Therefore, we want to see a future in which:

- people are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and wellbeing;
- when they need care, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- our services are efficient and sustainable for the future.

All of these aims are of great importance and must be addressed if we are to meet the future needs for our population.

They will underpin a new model of **person-centred care** focussed on prevention, early intervention, supporting independence and wellbeing. This will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

We will create the circumstances for people to stay healthy, well, safe and independent in the first place. We will anticipate the needs of individuals for support and care and this new model of person-centre care will intervene early to avoid deterioration.

This model will be designed for and with people and communities rather than by organisations and services. Instead of thinking about buildings and hospitals as the only place to deliver services, we will deliver care and support in the most appropriate setting, ideally in people's homes and communities. In most instances people should only have to go to hospital when they need treatment that can't be provided in their community.

The way we design and deliver services will be focussed on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

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Exhibit 4

3 THE CHANGE NEEDED

If we are to support everyone to lead long, healthy, and active lives, we need to change the focus of our services, and how and where those services are delivered. The Expert Panel has clearly said that 'something very different has to happen at the delivery of care level'.

We must:

- **Build capacity in communities and in prevention** to reduce inequalities and ensure the next generation is healthy and well;
- **Provide more support in primary care** to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems;
- **Reform our community and hospital services** so that they are organised to provide care when and where it is needed;
- **Organise ourselves to deliver** by ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients.

Build capacity in communities and in prevention

We will work with communities to support them to develop their strengths and use their assets to tackle the determinants of health and social wellbeing.

We will support the development of thriving and inclusive communities, through the work of the HSC working closely with Executive colleagues and other providers such as councils, schools, police, housing and transport.

In particular, the HSC will become better at tapping into the innovative ideas and energies in communities themselves, and in the community and voluntary sectors. In all communities, every child and young person should have the best start in life, people should have a decent standard of living, and all citizens should be supported to make healthier and better informed life choices.

We will invest in HSC community development resources to work alongside all communities to enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

It will take time to realign and grow the community development resource, and as a first step we will review existing capacity and then invest to meet any gaps, including a programme of training.

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Alongside this, we will link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities. We will strengthen the social work profession by fully implementing my Department's Improving and Safeguarding Social Wellbeing Strategy.

To give every child and young person the best start in life, we will further increase the support we provide to children, young people and families from before birth to adulthood. The universal Health Visiting and School Nursing service will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing; this will include the full delivery of the Healthy Child, Healthy Future programme. This will support the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

I will work with other Ministers to build on the success of the Early Intervention Transformation Programme and enhance early intervention services and the Family Support Hub network by exploring ways to build on the capacity of the hub model. This would include both better coordination of existing early intervention services and increasing the assessment capacity of the Hubs. This will enable us to respond quickly and flexibly to meet the needs of families early on before the problems they face become more intractable and severe. By increasing our early support to families we will reduce the need for later intervention, such as the need for children to come into care.

For children who are in the care system we will work to improve their life chances. Looked After Children experience much worse health, social, educational, and employment outcomes than other children. We will honour our corporate parenting responsibilities to the fullest extent and will be as ambitious for children in care as we are for our own children.

The range of placement options available to Looked After Children will be expanded. Through service redesign and, if necessary, new legislation we will better meet the individual needs of each child and put in place more effective supports for their caregivers, including kinship carers and families who adopt children from care. By working with the courts we will secure permanence for them more quickly helping their mental and emotional wellbeing, educational attainment and health in particular. Support will also be extended so that they are better prepared for independent living in adult life.

FAMILY SUPPORT HUBS

Family Support Hubs provide an accessible, flexible and responsive point of contact for families in need of support.

As of June 2016, 29 family support hubs were operational, providing full regional coverage across the North.

The engagement of local communities in the planning and commissioning of local services has been a key component to the successful delivery of Family Support Hubs.

In 2015/16 there were 4522 families referred through family support hubs, an increase of 1887 compared with 2014/15.

In 2015/16 a total of 5346 children were referred, 953 of which were children with a disability.

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PRACTICE BASED PHARMACISTS

This initiative will see pharmacists working as an integral part of the GP surgery practice team. This means we can use their skills and experience to improve patient outcomes through reviewing their medication and reducing errors.

Practice Based Pharmacists (PBP) can help to alleviate some of the pressures faced by general practice through triaging patients to appropriate services and in some instances undertaking the diagnosis and initiation of treatment and follow-up appointments in patients with long term conditions.This will enable GPs to spend more time with patients with complex needs.

By December 2016, it is anticipated that 54 PBPs will have been placed in GP practices across the North with further PBPs appointed and in place over the period January-May 2017.

Enhancing support in primary care

Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life. General Practitioners (GPs) and multidisciplinary primary care teams have a key role to play in improving population health and wellbeing, as well as developing care pathways and services to meet the population needs.

Our primary care service is still largely based on GPs working independently with some input from other disciplines. In future, the focus of our system will be increasingly on keeping people healthy and well in the first place. The World Health Organisation defines good health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. In the future we need a model that provides fully integrated multidisciplinary care, not just medical or nursing care.

Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life.

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates. There will be capacity and skills to proactively support individuals to address the lifestyle choices that impact upon their health and wellbeing. They will have the right tools and skills to diagnose, treat and coordinate the majority of care for their practice. They know the people they serve, and understand their needs better than anyone.

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Exhibit 4

These teams will work in a more integrated way with all other community services and development work in their area, including Community Pharmacy. Community Pharmacy is an important part of primary care and can help to reduce pressure on other parts of the HSC. We must use them better, especially to support improved public health and engaging in with the public to ensure medicines are being used appropriately.

This model is radically different from what we have at present. It will require significant change in the way staff across the HSC are organised and deployed, and in the way GPs and other members of the new teams work together. This new model will therefore be rolled out incrementally over the next 5 years, learning and addressing gaps in staffing as we proceed. The roll-out of Practice Based Pharmacists will be completed by March 2021. GP surgeries will have named health visitors and named district nurses to work with by the end of March 2017. In addition, the way that core district nursing is delivered will be transformed, and a District Nursing Framework will be published by the end of this year.

We will maximise the potential for developing social prescribing models in the multidisciplinary primary care teams, through the embedding of social workers and building linkages to the range of early support services available to service users, such as Mental Health Hubs and other early help initiatives.

Additional funding for primary care will be focussed on developing these teams, with more funding for mental health interventions in primary care and funding to test the impact that specialist allied health professionals, such as physiotherapists, can have when working alongside the primary care team. Training for the first Advanced Nurse Practitioners for primary care and a new Physician Associate post-graduate degree programme have been developed and will start in early 2017. We will work closely with GPs and other professionals on the roll-out and evaluation of this model.

Together, the enhanced community capacity, the focus on prevention based approaches and the multidisciplinary teams in primary care will provide much greater capability to keep individuals and communities well.

Reforming our community and hospital services

Sometimes, the primary care or community care teams cannot fully meet a patient's needs but it isn't appropriate for them to be admitted to a hospital.

With developments in treatments and technology, we are able to do so much more without the need to admit people to hospital. Therefore in future we want to build on new services and models which are already emerging, and ensure that these are implemented across our health and social care system, working in partnership with those who deliver and use these services.

Acute Care at Home is an example of this type of service. Patients, often frail and elderly, are treated in their own homes by doctors, nurses and other staff. Conditions such as chest infections, urinary tract infections and dehydration can all be safely treated without the need to go to hospital, which can be a worrying and anxious experience for many. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients and receive consultant led assessment and treatment.

We will make Acute Care at Home available to the whole population. We will better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. This new model of care will be rolled out to all areas within the next three years.

We are committed to the further development of **Ambulatory Assessment and Treatment Centres**, to provide a more joined up, 1-stop service. Evidence from here and elsewhere shows there are significant benefits to be gained from this approach. Our current model is based on the traditional outpatient model of care where a GP refers a patient to the specialty the GP believes most closely relates to the possible cause of the person's symptoms. But as people live longer and develop more problems, diagnosis and treatment becomes more complex. So the traditional model is no longer fit for purpose.

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Over the next 12 months, we will start to design these centres in partnership with clinicians and patients. They will provide simpler and easier access to the healthcare professionals and diagnostic equipment (such as X-Rays, CT scanners) needed to assess and diagnose conditions. Importantly, if a treatment or procedure is needed this will be possible on site with the aim of getting patients safely home the same day.

This avoids multiple outpatient visits and enables earlier diagnosis and appropriate treatment, and is therefore much better for those who use our services, and makes better use of our resources. Staff will have all the facilities they need to make the right diagnosis there and then, and to provide high quality care.

Elective Care Centres will be established to provide a dedicated resource for less complex planned surgery and other procedures. Evidence from elsewhere shows that such centres can reduce waiting times for planned care, and provide a better experience for both patients and staff. The current approach of delivering both planned and unplanned care using the same facilities and the same resources, means that waiting times can be adversely affected when the demand for urgent and emergency care is very high.

By making better use of our existing resources, and organising these in a different way, we will be able to provide larger volumes of activity, to a higher quality and in a more timely manner. The centres will be a resource for the region and the way they operate will be designed around the needs of patients. The number and location of these centres will be developed in partnership with clinicians and patients, and I expect proposals to be brought forward in the next 12 months.

Acute inpatient care will change. By changing the way preventive care, primary, community and less complex elective care is provided, and by looking after people in settings that are more appropriate to their needs, the nature of acute inpatient care will change.

Acute inpatient care will therefore focus on complex planned surgery and emergency care of patients who need an acute inpatient setting, for example, patients who have had a stroke, heart attack, or trauma, and those needing obstetric, neonatal or paediatric services or those with a significant worsening of a long term health condition. Multidisciplinary working will be a key feature of good quality inpatient care.

Across many different services there is very strong evidence that concentrating specialist procedures and services in a smaller number of sites produces significantly better outcomes for patients, as well as a much better and more supportive environment for staff

The role of our hospitals will therefore fundamentally change as they will focus on delivering the highest quality of specialist and acute care. However, not every service will be available in every hospital.

In the past few years we have seen the successful development of region-wide and cross-border **networks for highly specialist services** such as cancer, neonatology or cardiology as well as the development of the first truly all-island service in children's congenital cardiology. These are delivering innovative, world class services and we will seek to maximise opportunities to expand this approach and deliver more services on an all-island basis, where clinically appropriate to do so.

This is about changing the way that services are delivered, improving safety and quality, and making the best use of the resources we have. The Expert Panel, working with clinicians, has developed criteria which will help us to assess the sustainability and future of how services are provided, and this provides us with a route-map to work in partnership with those who use and deliver our services.

Mental Health

The North has a particular challenge with mental health, having the highest rates of mental illness in these islands. There are many talented and hardworking professionals in the system and the voluntary and community sector, who do excellent work in the services they provide. It is clear that our services need to continue to evolve and improve, building on the Bamford reforms from the last decade.

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Mental health is one of my priorities as Minister of Health, and it is an issue that I will champion at every opportunity. I want better specialist mental health services. This would include further support for perinatal mental health and inpatient services for mothers, with potential to address the need that exists across the island. We will expand services in the community and services to deal with the trauma of the past. Underpinning all of this, I am committed to achieving a parity of esteem between mental and physical health to ensure that we are tackling the true impact of mental health on our communities.

Carers

Families and friends take on most of the caring responsibilities for their loved ones and this makes an enormous contribution both to the HSC and to society as a whole. I fully recognise that carers are an equal partner in providing care, and they need our support to be carers. They also need support to enable them to do the things that those without caring responsibilities take for granted such as working, going out socially, having a break or going on holidays. In the case of young carers, they need help and support just to do the things that young people do. I am committed, along with other government departments and their agencies, to providing that support.

We know that the needs of carers are changing, this means the type of support we need to give them is also changing. We need to encourage greater take up of carer's assessments and expand the options for short breaks, as well as enabling the greater use of personalisation and personal budgets where appropriate. We need to ensure carers can access up to date information and crucially consider how we can support carers to live their own lives. The role of carers and how we can better support them will be central to the Review of Adult Care and Support and I encourage everyone to make their views known when we bring proposals forward for consultation in spring 2017.

DELIVERING ACUTE CARE AT HOME

This service enables this vulnerable patient group to retain their independence and dignity and prevents unnecessary and stressful hospital admissions.

It was designed and implemented by East Belfast Integrated Care Partnership (ICP) and subsequently rolled out across Belfast. Similar services are available in some other Trust areas.

In the Belfast area, the average length of stay for Acute Care at Home patients is 6 days compared to 11 days in hospital. Over 1084 referrals have been received for the extended service in the Southern area.

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Organising ourselves to deliver

To deliver care in a different way, it is clear that the way we plan and manage health and social care will also need to change. Therefore, in line with the recommendations of the Expert Panel's Report, we need to empower local providers and communities to work in partnership, including health and social care trusts, independent practitioners such as GPs and voluntary providers.

Embracing new models of care has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector.

Working together, they will be expected to plan integrated and continuous local care for the populations they serve. I will set the outcomes we expect them to deliver, and the frameworks within which they need to operate, and hold them to account accordingly. For the first time, they will have the autonomy to make rapid and sustainable changes to improve services and address health inequalities in their area.

Where services are highly specialised, they will be planned and delivered on a region-wide basis. Building on the programme of work currently underway with Department of Health counterparts in Dublin, we will continue to explore opportunities to plan and deliver services on an all-island basis.

The recent consultation on HSC structures supported the need to reduce bureaucracy and put in place a more effective streamlined mechanism for how we plan health and social care services.

Starting now, we will work with the wider HSC system to design the new partnership approaches to the planning and management of HSC services, which moves away from competition towards collaboration, integration and improvement.

PRIMARY PERCUTANEOUS CORONARY INTERVENTION (pPCI)

This service, based in Belfast and in Derry, means that patients having a particular type of heart attack are taken from anywhere across the North straight to a specialised centre which can undertake this life saving procedure on a 24/7 basis.

On average a total of 66 pPCI procedures are being carried out per month and from May 2016, Donegal patients have access to the Derry based service.

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Exhibit 4

THE APPROACH

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

Only by taking the right approach will these changes be the best ones for our population as a whole, and be sustainable in the long run.

Partnership Working

With people who use and deliver services

Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system.

Building on the good practice which already exists in the HSC, such as the Mental Health Recovery Colleges, we will work collaboratively in the spirit of openness and trust to deliver agreed outcomes.

When we embark on a change to our system or services, all relevant individuals or groups will be brought together, including those who use and those who deliver our services. A clear terms of reference will be developed collaboratively, ensuring all parties are clear about the task at hand, and how we will work together.

We will adopt creative and innovative ways to maximise involvement. All views and opinions will be received with equal merit. In the past the system has been criticised for delays in bringing forward change, we will support teams to work at pace.

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Co-production will empower patients, service users and staff to:

- **design the system** as whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;
- work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;
- be partners in **the care they receive** with a focus on increased self-management and choice, especially for those with long-term conditions.

A move to this model will not happen overnight. However, I am fully committed to this approach and will support this new way of working across the HSC. In order to start this process in November I will embark on a period of engagement about my proposals for the model of health and care for the future.

I am making a commitment that the design of new and reconfigured services will be taken forward on the basis of co-production and co-design.

We will strengthen the capacity of both those who use our services and those who deliver them to bring about positive change for and by themselves. This includes continued investment in initiatives such as Expert-by-Experience programmes, which provides training and development for users who work with the HSC to improve our services. We will also train staff to support the continued roll-out of the Quality 2020 Attributes Framework.

In addition, I intend to maximise the patient voice across our system, and align it much more closely to the quality improvement, and inspection and regulation. I also want to hear the voice of staff particularly those on the ground closest to those who use our services. In early 2017, I will consult and design a new feedback platform open to all those who both use and deliver our services. This will enable users and staff to tell us what matters to them in terms of their health and social care and to raise issues in as timely a manner as possible, so that they can be addressed early before they escalate to a complaint.

Co-production - a new approach to the design and development of mental health services

An example of how co-production can make a big impact on our services is the design and delivery of Mental Health Recovery Colleges. This is an innovative model that assists individuals in their personal and collective journey of recovery. This recovery focussed approach creates opportunities for those with lived experience to contribute as volunteers and in paid roles. These peer educators assist those with mental health problems to discover personal talents and develop life skills which can help them enter the labour market.

A number of people with lived experience have and continue to be developed to become peer educators and are now making a contribution to care delivery. Over 236 sessions of peer education have been delivered.

Exhibit 4
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With other providers

Partnership with other providers of care and other service providers is key to improving and safeguarding social, emotional and physical wellbeing. Health and social care has a strong tradition of working with other professions and sectors including the voluntary, community, criminal justice, education, housing and private sectors. These partnerships will be maintained and strengthened to maximise the impact we can make on improving people's health, social wellbeing and quality of life, as well as making the best use of resources.

Improving Quality and Safety

In the design and delivery of health and social care, quality and safety will always be a fundamental priority. The Expert Panel said "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

It is clear to me that, in order to achieve our ambition for health and social care, we need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. There needs to be a greater alignment between quality improvement, partnership with those who use our services, and how we regulate those services.

Like many healthcare systems, there has been a gradual increase in improvement capability across our health and social care service. One example is the Regional Mortality and Morbidity Review System, which supports the review of all hospital deaths by multidisciplinary 'frontline' teams to identify learning to improve the quality and safety of care. The system is well embedded in two Trusts at present and will be fully embedded across all Trusts by April 2017. Another example is the Medicines Optimisation Quality Framework which is supporting improvement by scaling up good practices for the appropriate, safe and effective use of medicines across health and social care.

We now need to fully integrate quality improvement into the work of every HSC organisation and provide real support for local and regional improvement work. That will mean improving our capacity to foster local innovation and to implement what works at scale. It also requires us to be able to proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs. Developing the science of improvement can be done at the same time as making improvements.

To deliver a sustainable and world class service into the future will require of all of us to work together very differently. We need an infrastructure that makes this possible.

For that reason, I intend to establish an Improvement Institute that will better align existing resources to enable improvement in our system of care. These include resources currently devoted to patient safety, regulation, evidence gathering, data analytics, information and, critically, those with experience of using our services. My aim is to establish a strong and integrated infrastructure to support improvement wherever it needs to happen across our system of care. This aim will only be achieved with the support and engagement of all leaders across the HSC system.

I have asked my Department to convene a group of local clinicians, professionals and service users with experience in improvement to advise on the design of that infrastructure. This will not be a new HSC organisation but will align existing resources and functions. The design work will be complete by February 2017 and I expect the Institute to begin to test how it will operate by May 2017.

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Exhibit 4

Investing in our Workforce

The Expert Panel has re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation. I believe the far-reaching transformation journey we are about to embark on needs the commitment and engagement of workers across the HSC at every grade if it is to succeed. I am confident that working together we can succeed.

The increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. These factors have led to an escalation in the costs of maintaining safe service provision through the use of expensive agency and locum staff, as well as longer hospital stays than necessary.

Clearly, this is unsustainable and workforce planning cannot continue to be used simply as an exercise to ensure that existing rotas are filled. It has to be a vehicle for supporting the implementation of a new and sustainable model of care. It has to take account of increasing demand as a result of demographic trends, be informed by robust and accurate workforce information and analysis, and map to the new configuration of services in secondary care and the increased focus on primary care. It also has to address the factors that enhance the attractiveness of key jobs, such as domiciliary care.

However, effective workforce planning is only one aspect of what is needed. We want to ensure that we are harnessing the skills and experience of the 72,000 individuals working in the wider HSC family.

As stated earlier, I want the HSC to be an employer of choice, leading by example and investing in the health and wellbeing of its staff. We will explore ways to build on and consolidate the health and wellbeing services we provide for our staff.

I recognise the fears and anxieties about job security, role and job location that any change process will create. Based on their lived experience, HSC staff at all grades are all too well aware of the unintended day to day impact on their own teams of previous change initiatives. Too many of these experiences to date have not been positive.

I am determined that the unique store of knowledge, commitment and public service ethos that the HSC workforce represents will be listened to, engaged and nurtured at all levels. It is the single most important resource we have to achieve lasting change.

In collaboration with stakeholders, we are committed to ensuring a Workforce Strategy is developed by spring 2017 which will cover all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles and of reskilling and upskilling initiatives. This will require investment but we are convinced that investment in every area of our workforce is critical in delivering this new model of sustainable care.

But it is clear that some action needs to be taken now to address current workforce challenges. Therefore, we will continue to invest in training by expanding GP and nurse training places. I have asked for a number of areas to be looked at in detail, including the appointment of a Nursing and Midwifery Task group which will report within 12 months with recommendations for how we can maximise the contribution nursing and midwifery can make to improved outcomes for the population.

The forthcoming Reform of Adult Social Care and Support will consider the nature, size and skills of the social care workforce needed to deliver social care in the future. I will consider carefully the findings of the Domiciliary Care Workforce Review, which is due to be completed by the end of 2016. I am committed to taking steps to improve the recruitment and retention of this critically important group of staff.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, this must be underpinned by a new approach to collective and system leadership. We are fortunate to have some of the most capable, committed and enthusiastic people making up our health and social care workforce. Many leading edge research and reports provide evidence that having continuous learning cultures and team working in health and social care organisations is crucial to ensuring safe high quality care.

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Exhibit 4

Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model. I will flatten and remove unnecessary hierarchy, eliminating those policies which inhibit innovation and improvement. If we are to move towards a model of care powered by multidisciplinary teams, we need to empower all teams to deliver care, not micro-manage them. Working in partnership with our staff, I believe this is achievable.

This will require a major programme of cultural change and it will not happen overnight. But we need to start now.

As part of this we need to enhance our clinical leadership. The Expert Panel said that change *"will be more successful if… implemented in a setting which encourages clinical and professional engagement"*. I want to see our structures have more professionals directly engaged in the management and leadership of our services, effecting the change supported by skilled and able managers.

I have recently re-established the Strategic Health Partnership Forum and see this as an important contribution to the development of a new culture of partnership, involvement and listening.

Over the next 6 months, an HSC-wide Leadership Strategy will be developed to support this aim. Resources will be directed over the next 3 years and beyond to develop the right staff and leaders, with the skills, behaviours and values that will be so crucial in developing the compassionate, collaborative and high performing culture we seek.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and on getting beyond organisational and professional silos. I am determined to realise the potential and opportunities presented by modern information technology to improve outcomes for service users and free up time for front line staff. To do so, co-production must underpin our approach, and we must learn the lessons and build on the experience of current and past HSC IT initiatives.

We will expand the range of information and interaction available to citizens, service users and those providing services both online and through apps. This will include building a new patient portal which will allow secure online access to their own health and care information where service users want this. This new patient portal will be in place for dementia patients next year and rolled out across the North by 2021.

To ensure our staff can focus on supporting individuals, the right information must be available to the right professionals, at the time they need it. Our award-winning approach to sharing information across different IT systems (the Electronic Care Record) has significantly changed the way care is delivered and improved safety. However, we still have too many different systems across the HSC making it difficult to join up data and focus on the service user.

We are currently assessing the best way to achieve a much more consolidated and common patient and user record, with fewer separate IT systems. This will be a major undertaking. We will aim to liberate time for care by equipping our community based workforce with new technology that will increase the time that doctors, nurses, therapists and social workers have to spend with patients. If we can realise a 15-minute increase in care time by reducing bureaucracy this equates to over 1,000 additional care professionals working with service users. These initiatives will also allow more staff in the HSC to work remotely, saving travel to and from hospitals, care centres and offices.

Moving to a more consolidated health record across the North will allow us to make better use of information about our population - designing new ways to intervene early and support people in managing their conditions. A programme of work to improve our use of health analytics, focussed on dementia patients, will start in 2017.

MAHI - STM - 294 - 169
Exhibit 4

THE ACTIONS

In this document I have set out my commitment to change but I recognise that much work is needed to develop, design and deliver the building blocks that will enable sustained improvement. I am committed to achieving the change required using a process of co-production.

The task is challenging and will take sustained and incremental effort over the next ten years to achieve real transformation.

But we start now. In the next section I have set out my actions for the next 12 months. These will be taken forward to make a positive and ambitious start towards stabilisation, reconfiguration and transformation.

As I have said, to deliver real and meaningful change will require an extension of the political goodwill and cooperation given to the Expert Panel. Moreover significant investment will be required. I believe this shared investment will not only improve people's health and wellbeing but have a positive impact on every aspect of their lives.

I fully believe that it is only by working together we can deliver a world class health and social care system.

Exhibit 4
MAHI - STM - 294 - 170

Stabilisation

1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work of the Health and Social Care Board, as well as the recommendations from the Expert Panel.	*January 2017*
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: - increased GP training places; - continued investment in Practice Based Pharmacists; - ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; - supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and - further roll-out of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	*March 2017*
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	*October 2017*
4	Following the completion and evaluation of a pilot project, roll-out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists.**	*October 2017*
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	*November 2016*

Reconfiguration and service change

6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	*November 2016*
7	As part of this process, my immediate priorities are:	
	• following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future;	*November 2016*
	• move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups;	*November 2016*
	• launch and commence implementation of the **Paediatric Strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families; and	*November 2016*
	• launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients.	*February 2017*
	• following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice;	*February 2017*
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres.**	*October 2017*
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	*March 2017*
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	*April 2017*

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Exhibit 4

Transformation

11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	*November 2016*
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	*November 2016*
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the long-term sustainability of the adult social care system.	*April 2017*
14	Consult on proposals for, and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	*October 2017*
15	Complete the initial design work for the **Improvement Institute.**	*February 2017*
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	*May 2017*
17	Develop a **HSC-wide Leadership Strategy** to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	*May 2017*
18	Expand the range of information and interaction available to citizens online and development of a **patient portal** for dementia patients.	*October 2017*

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Exhibit 5

Nursing And Midwifery Task Group (NMTG)

Report and Recommendations

March 2020

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Exhibit 5

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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.

Richard Barnett

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:-

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

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

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

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.

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

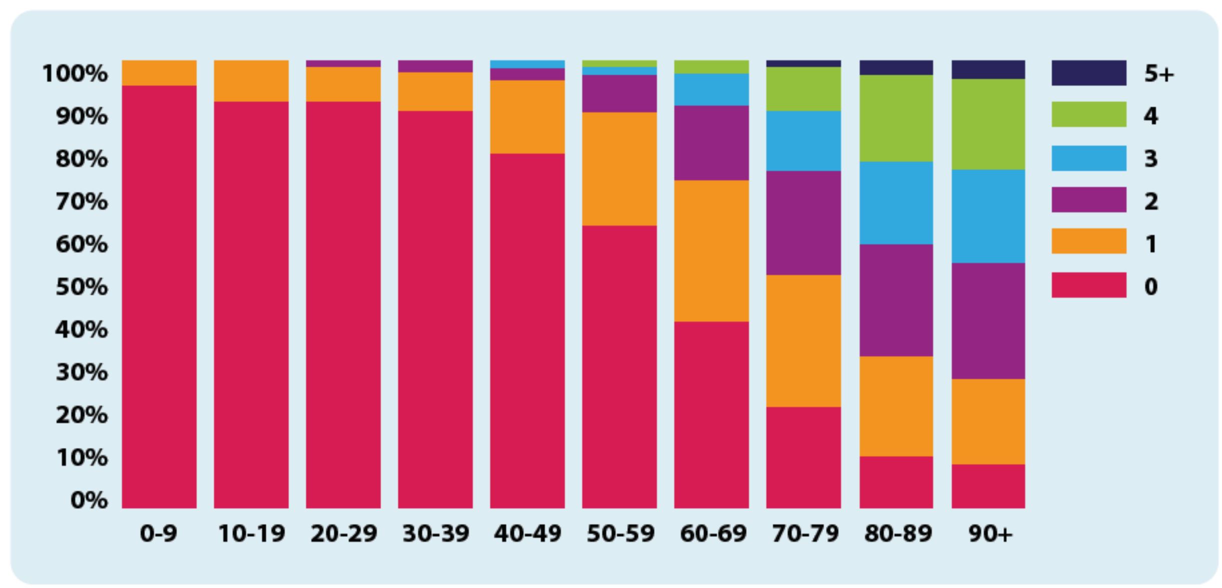
Looking forward over the next 10-15 years, NI like all the other countries of the UK and Ireland is facing a world where demographic realities and the pace of technological and social change will transform the relationship people have with health and social care.

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

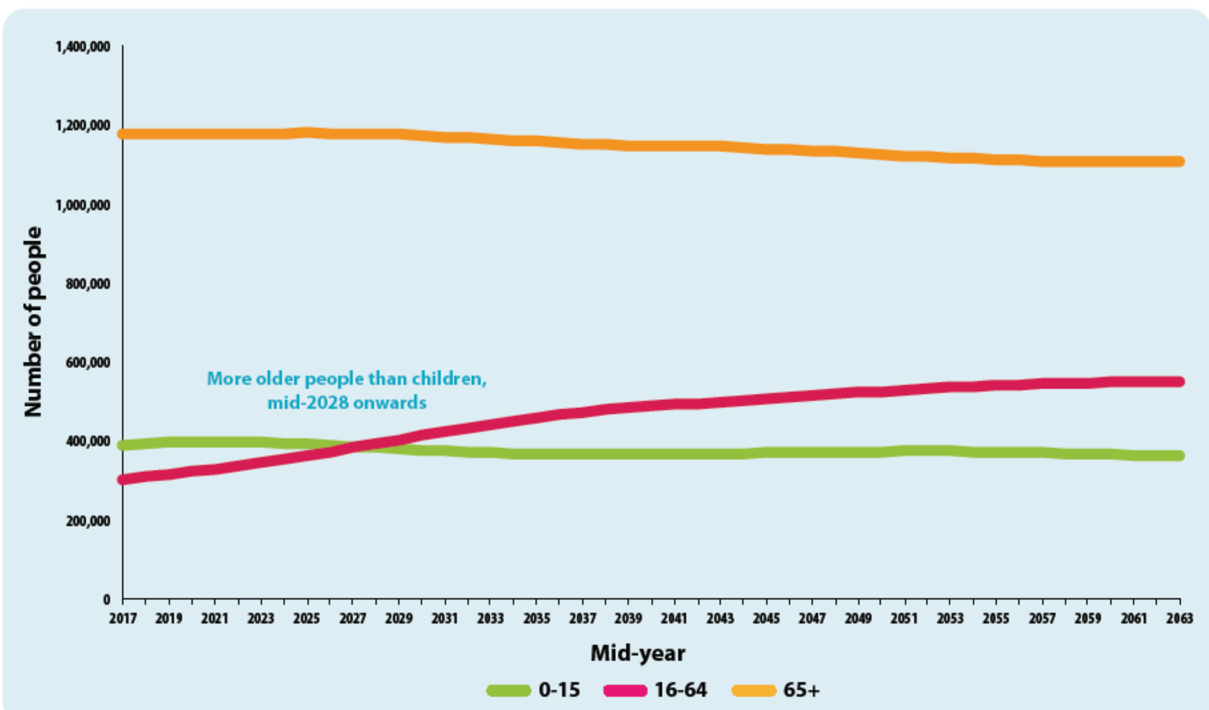
We know demand for services is arising largely as a result of an ageing population, many of who are living with complex needs and long-term conditions **(figure 2).**

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



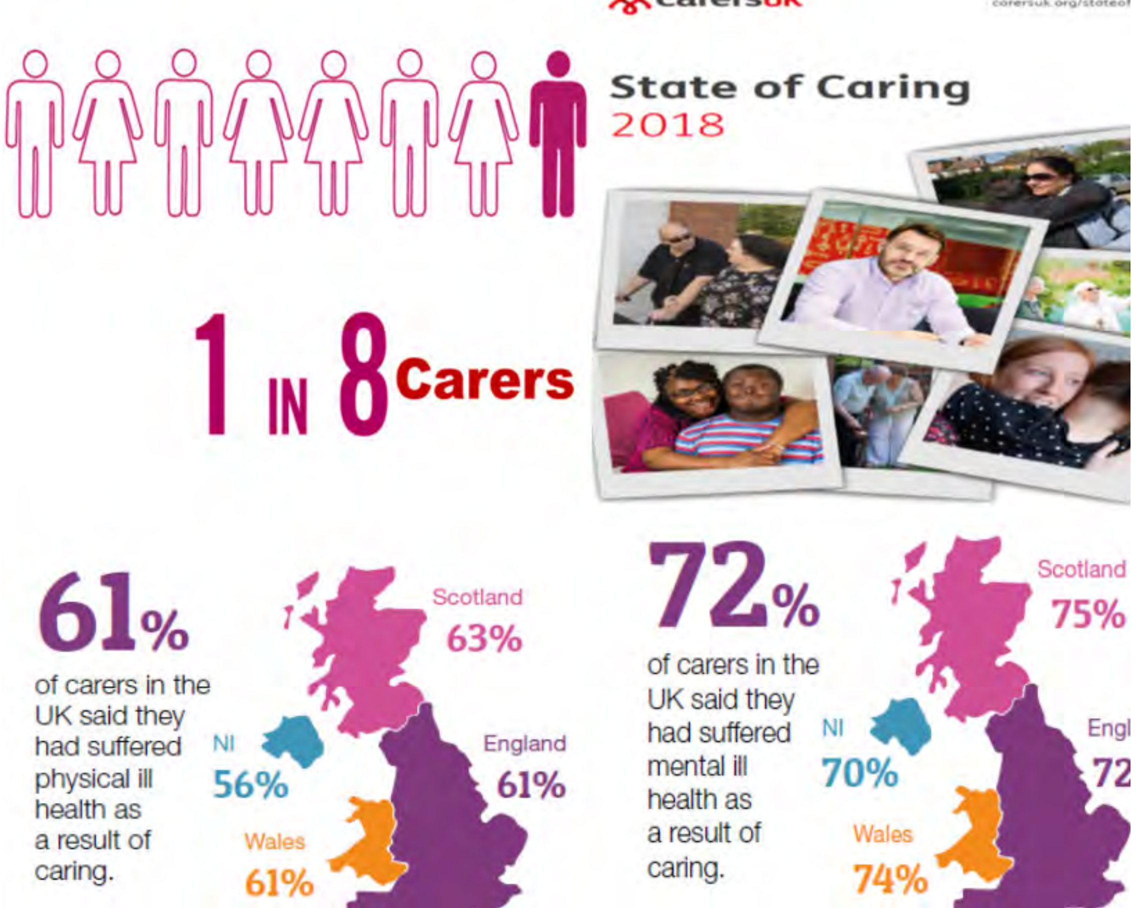
As set out in **figure 3** it is estimated by the year 2028 the population of older people in NI will be greater than the number of children. Indeed by 2023 the number of people over the age of 65 will make up 30% of the population and by 2061 it will grow to 50% of the population. The largest growth 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)



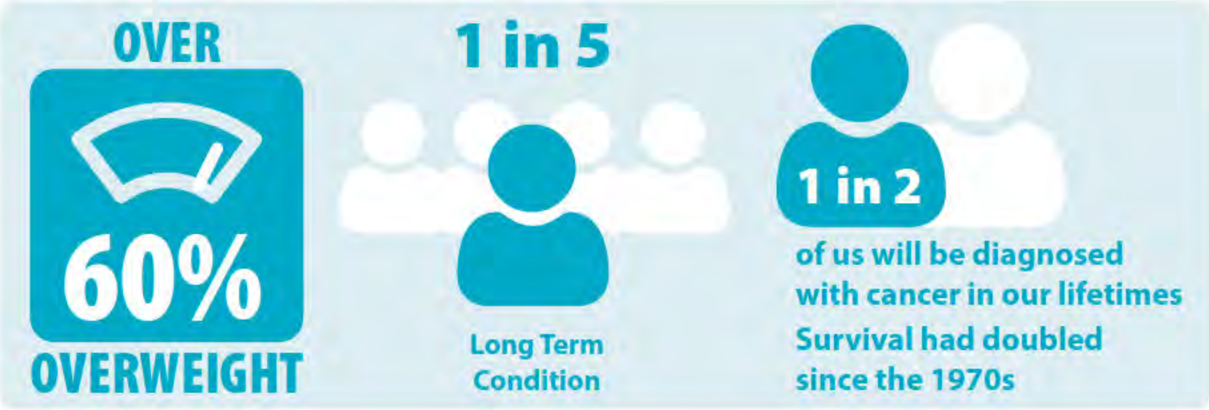
The reality behind these numbers also means that the numbers of people with dementia is estimated to increase from an average of 20,000 to 60,000 by 2051. It is also estimated that 1 in 8 adults are also carers. **(Figure 4)** It is anticipated the number of carers in NI is expected to rise from 220,000 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.

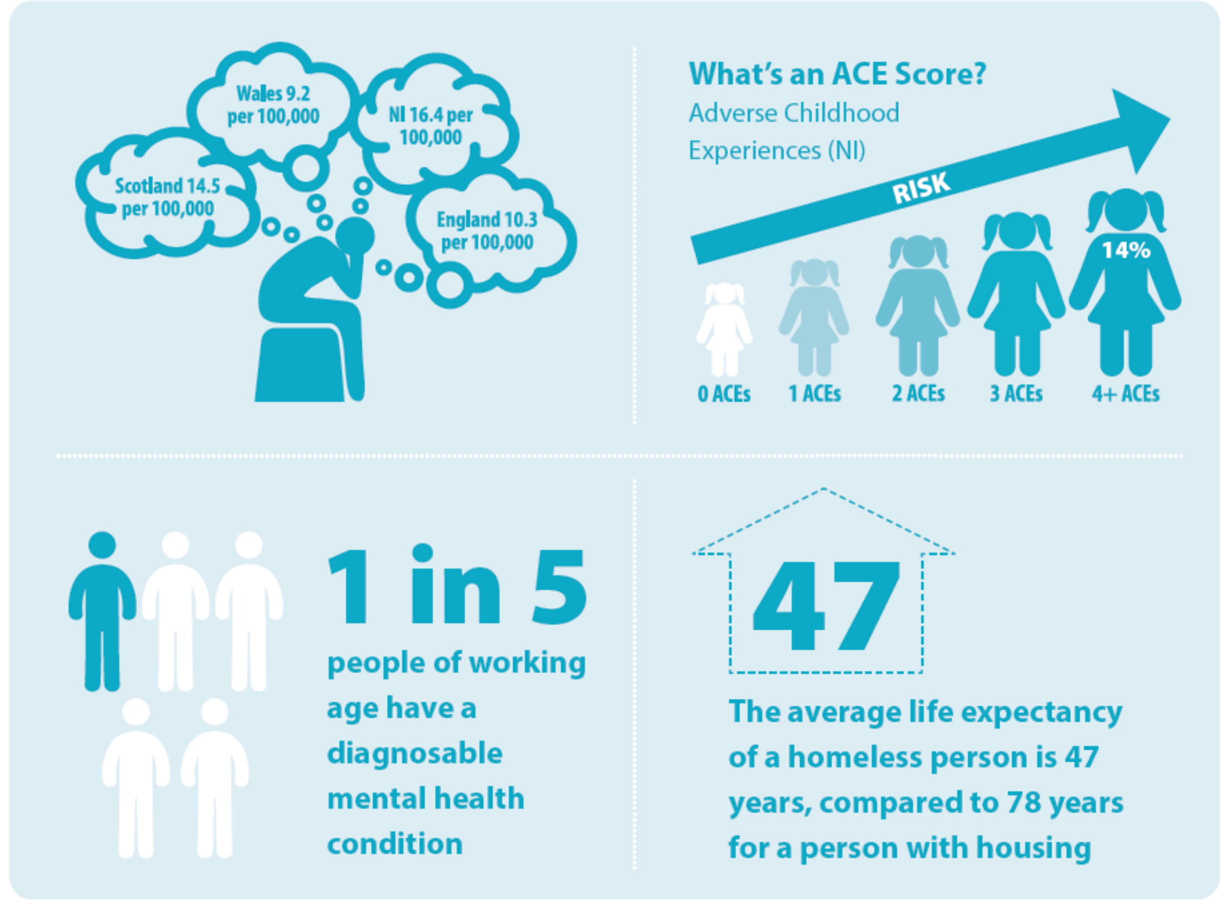
Figure 7 - What causes the most premature death?

2017 Ranking		2017 Ranking		% change 2007-2017
Ischemic heart disease	1	1	Ischemic heart disease	-17.9%
Lung cancer	2	2	Lung cancer	7.2%
Stroke	3	3	Stroke	-10.0%
COPD	4	4	COPD	12.4%
Lower respiratory infect	5	5	Alzheimer's disease	29.1%
Alzheimer's disease	6	6	Lower respiratory infect	-2.9%
Self-harm	7	7	Self-harm	-6.3%
Colorectal cancer	8	8	Colorectal cancer	1.9%
Breast cancer	9	9	Breast cancer	-1.6%
Road injuries	10	10	Cirrhosis	1.5%
Cirrhosis	12	16	Road injuries	-44.1%

Communicable, maternal, neonatal, and nutritional diseases
Non-communicable diseases
Injuries

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.

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.

THE AMBITION

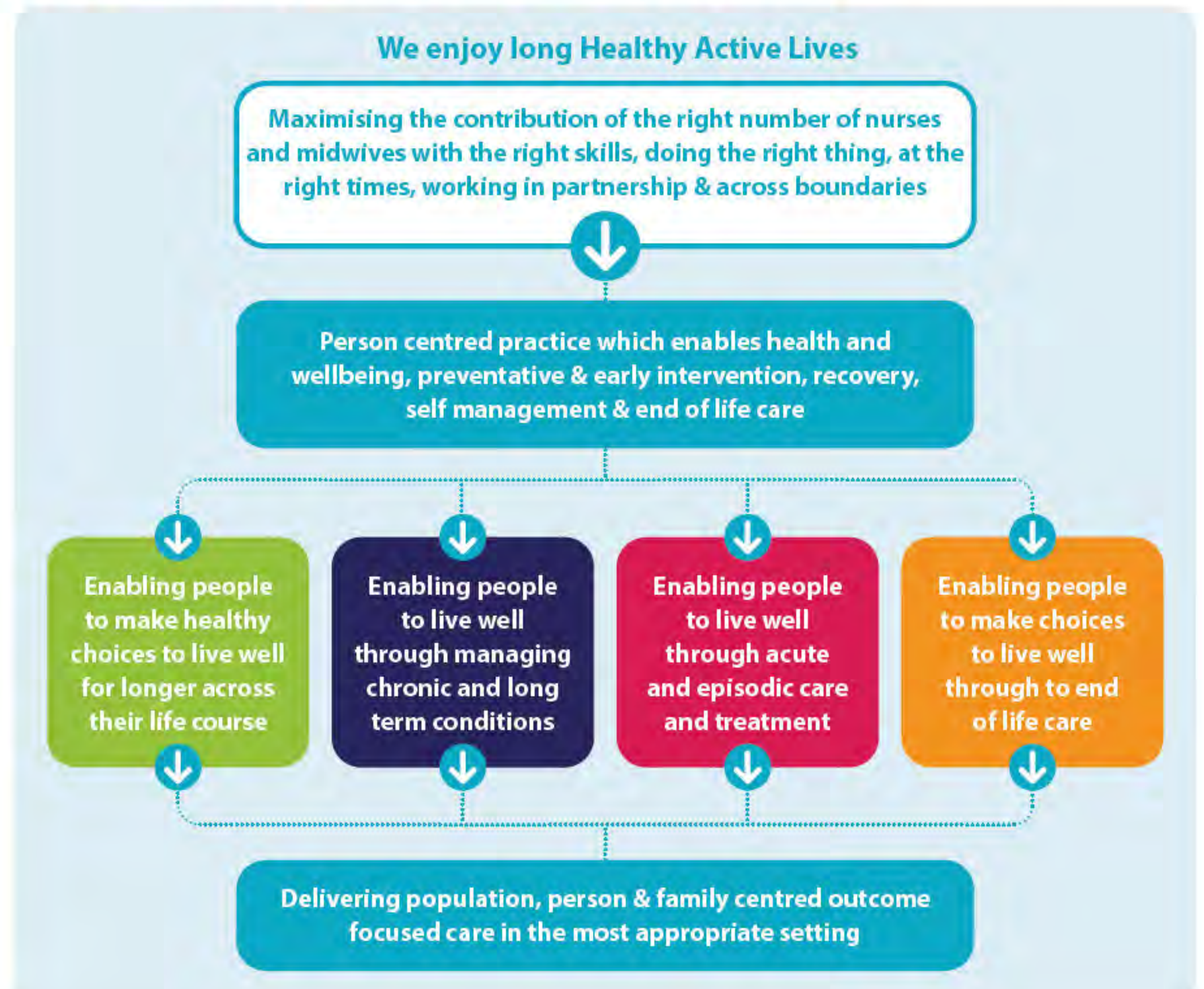
SECTION 3 – THE AMBITION

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.

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

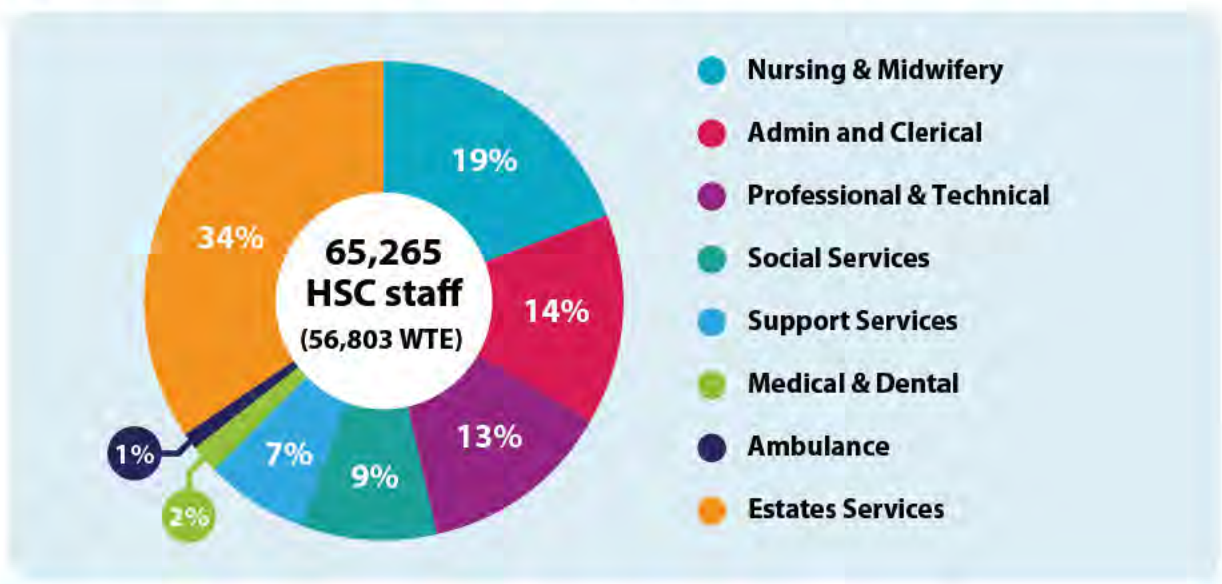
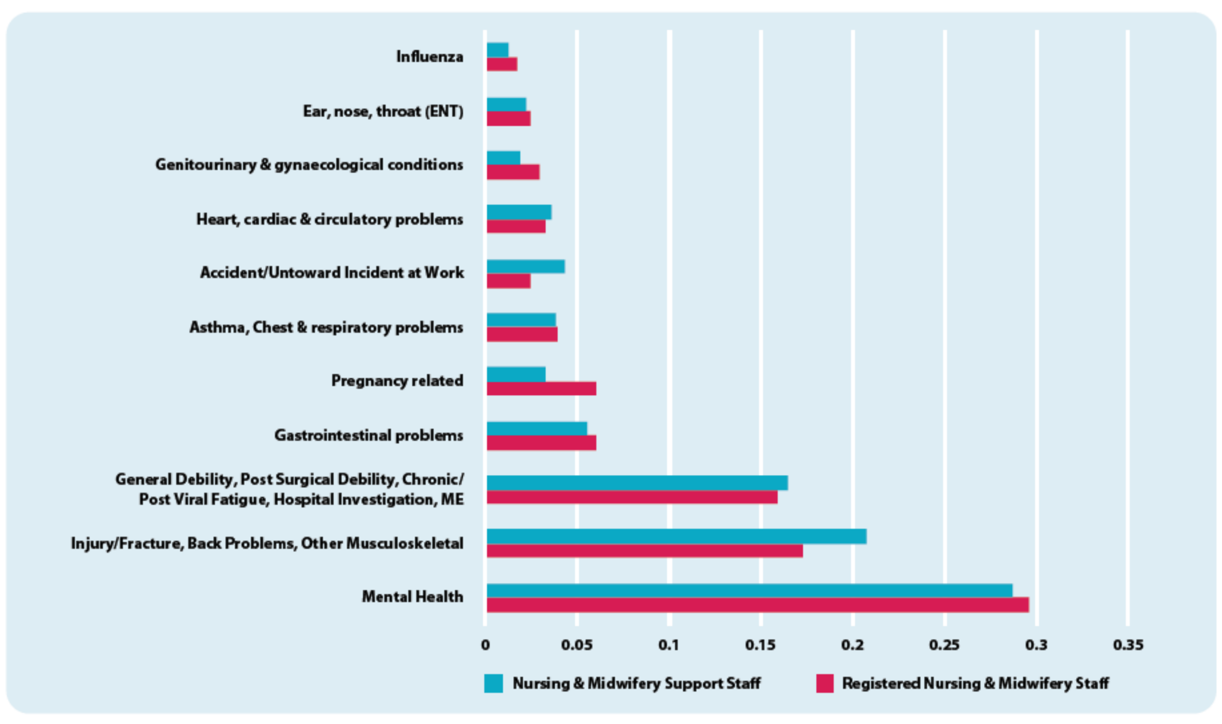


Figure 14 - Proportion of HSC Sickness Absence Hours Lost by Top 12 Absence Categories - 2018/19



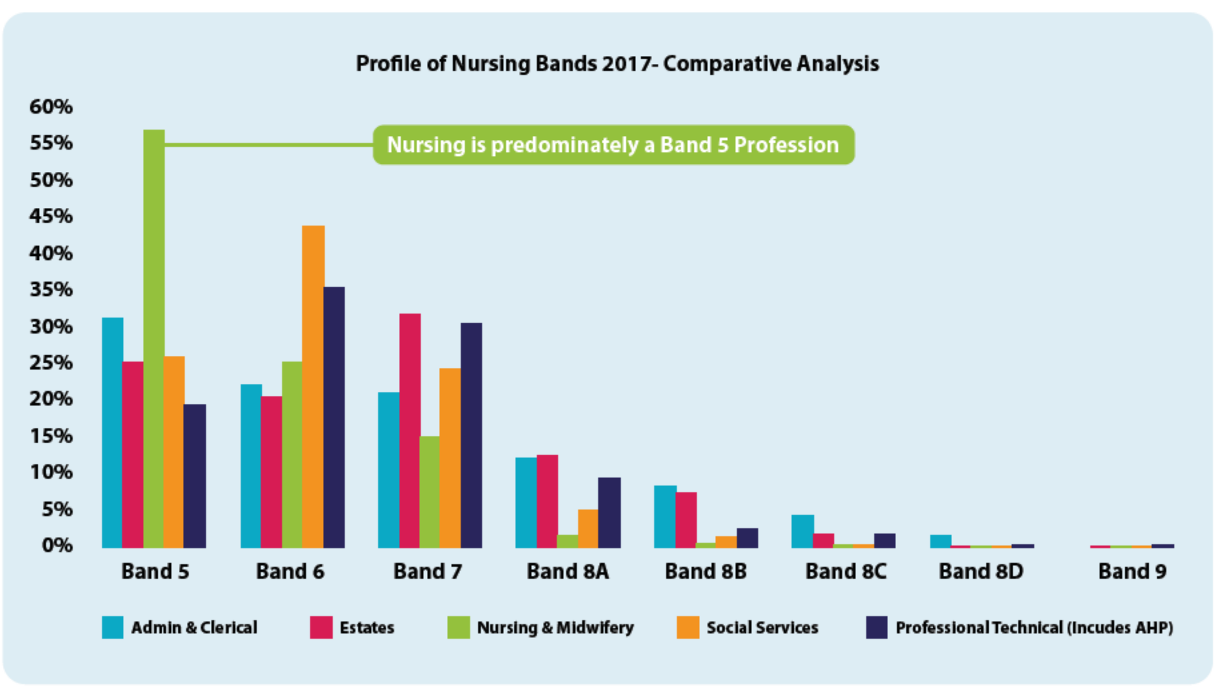
Between March 2016 and March 2017 the NMC reported a significant reduction in registrants[20]. The NMC surveyed those people who had left the register between June 2016 and May 2017. 4,544 former registrants responded citing working conditions as the top reason for leaving (44%). During the period 2008 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.

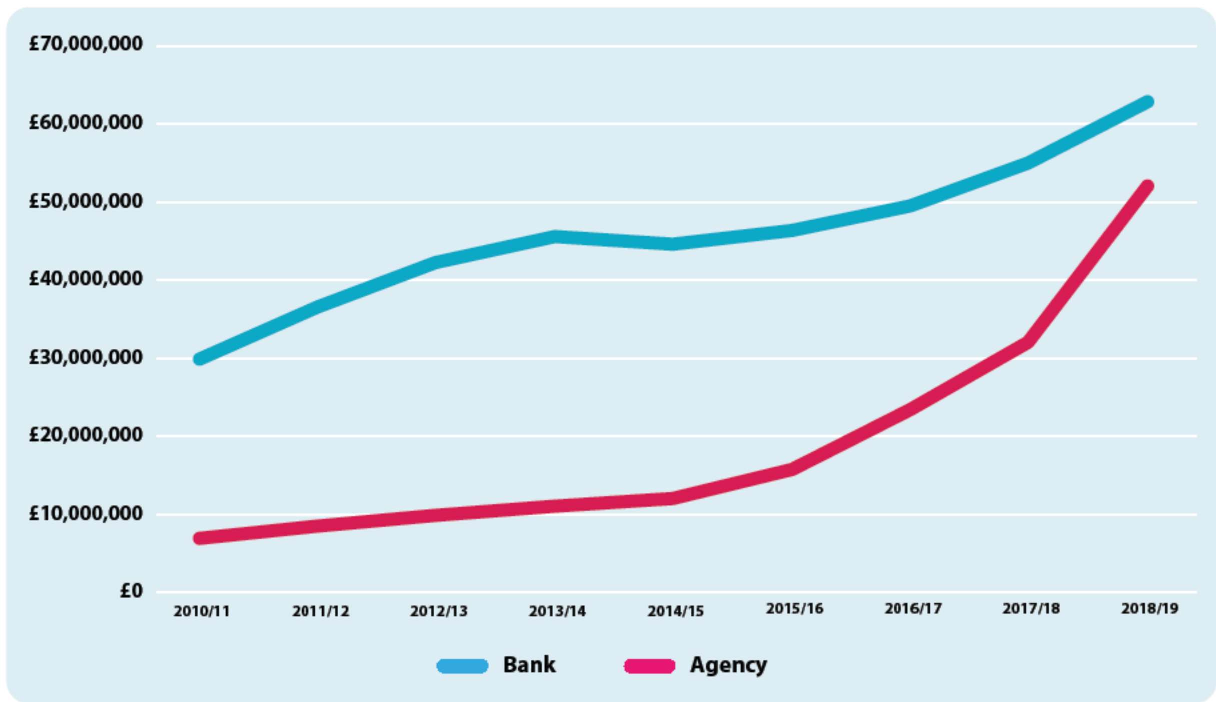
Figure 15 - Whole Time equivalent and % NI HSC Staff by Occupational Family & Pay Band 5-9 (March 17)



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.

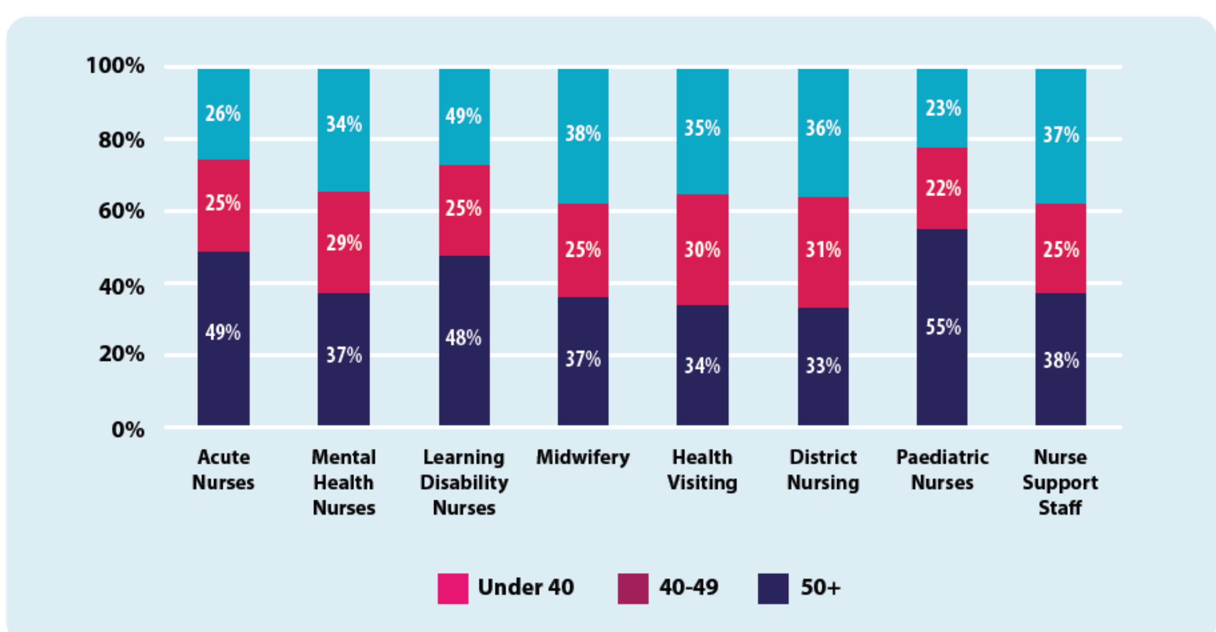
Figure 16 - Expenditure on Nursing & Midwifery bank and agency staff



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

Proficiencies

Nursing & Midwifery Council

The six domains

1 Being an accountable, autonomous, professional midwife

2 Safe and effective midwifery care: promoting and providing continuity of care and carer

3 Universal care for all women and newborn infants

4 Additional care for women and newborn infants with complications

5 Promoting excellence: the midwife as colleague, scholar and leader

6 The midwife as skilled practitioner

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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.

> ***Remove the blinkers, don't just focus on the immediate condition you are there to treat – look at the person as a whole.***

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

£12,000,000
£10,000,000
£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0

2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20

Core post graduate education funding
Non recurrent transformation funding

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.

Supporting Learning and Development in Practice

Education for the Future

Increased Sustainable Investment in Post-registration Education

Widening Exposure to Different Practice Setting

We are not being supported to develop or train- neither financially, nor given time to undertake CPD

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.

We need Collaborative education partnership with all disciplines… undergraduate and post graduate…

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.

Band 7's require some personal secretary support

Rob Peter to pay Paul mentality and I sometimes am the only regular nurse - the others are either band or agency

Lack of training opportunities

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.

Maximising the Value of Nursing and Midwifery

Recognition and Reward for Excellence in Practice

Ensuring Appropriate Remuneration Aligned to Career Progression

Celebrating and Rewarding Success

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.

Commitment to improvement quality of our patients lives

Willingness to lead change and improvment

Make Every Contact count

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.

Utilising and Managing Data

Leading Quality and Innovation

Leading and Enabling Innovation

Engaging in Improvement and Implementation Science

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.

Understanding and using Data to improve our practice

Being Innovative designing, learning reflecting researching

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.

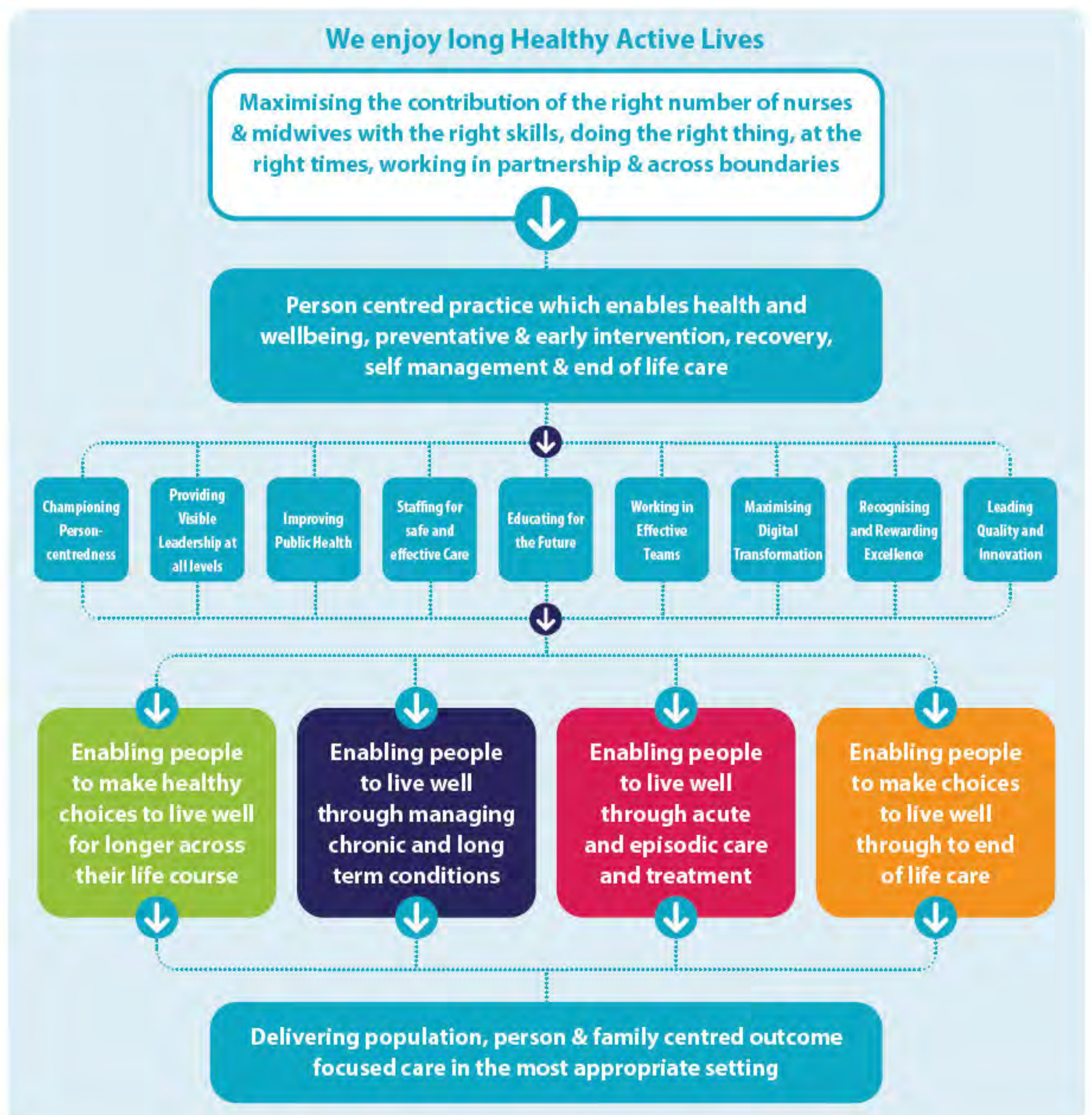
Key Messages

- **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.

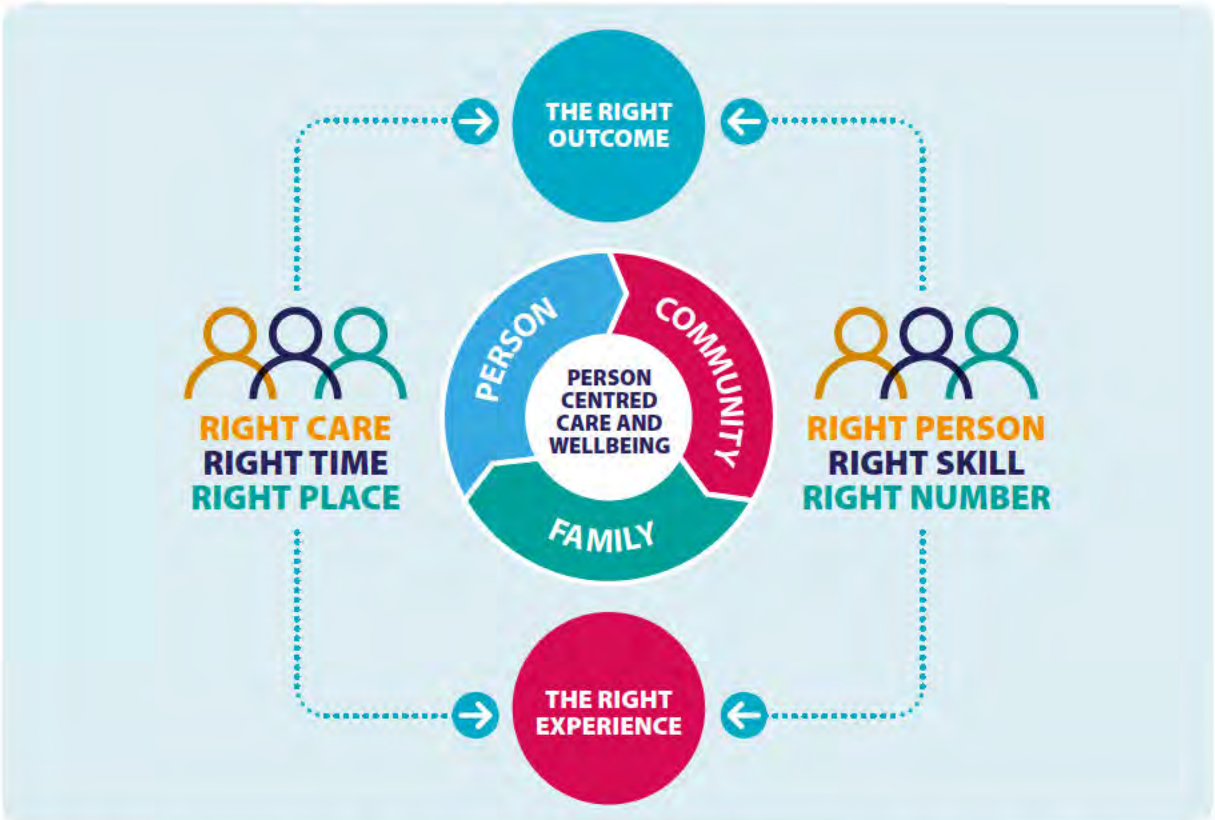
Doing the right thing in the most effective way – working in partnership

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

Exhibit 5

MAHI - STM - 294 - 268

MAHI - STM - 294 - 270

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

Nursing and Midwifery Task Group

Next Steps Framework – A Three Phased Approach

2020 - 2026

1.0 IMPLEMENTATION CONTEXT:

This plan sets out the key actions required to deliver the recommendations of the NMTG and reflect a new vision / ambition to maximise the contribution of nursing and midwifery, which can be used to guide decision making and measure progress. The recommendations of the task group aim to create the conditions for nursing and midwifery services, to develop and be co-designed to deliver the right 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 outcome and experience for people, families and their communities.

The actions in this plan have been prioritised and modelled on the NMTG '***SAFE***' principle;-

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 nurses and midwives within and across a wide range of MDTs/services.

Whilst the primary aim of the NMTG was to develop a ten to fifteen year road map, this plan adopts a three phased approach aligned with strategic themes outlined in the NMTG report.

STRATEGIC THEME 1:

The adoption of a population health approach, through putting public health, prevention and early intervention at the heart of nursing and midwifery practice.

STRATEGIC THEME 2:

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

STRATEGIC THEME 3:

Transformation of Health and Social Care Service through enhancing the roles that nurses and midwives will play within and across multi-disciplinary teams.

In line with the Minister's commitment, the plan has also been fully costed and a number of the recommendations have been identified for funding as set out in the 'New Decade, New Approach' Framework and Executive Commitment. These commitments will form part of phase one of the implementation of this plan. It is important to note the pace of implementation will be determined by the budget outcome for DoH, and all subsequent phases will require further strategic prioritisation and resource planning, this will also include the release of resources through efficiencies and transformation.

It is proposed that in 2026 this plan will be refreshed with a new five year strategic action plan, which at that stage, reflects population health needs, new political and policy mandates as well as new ways of working. The NMTG implementation plan and the development of a new Nursing and Midwifery Strategy will be overseen by the Chief Nursing Officer (CNO) in partnership with Central Nursing and Midwifery Advisory Committee (CNMAC) and in partnership with trade unions. Please note the actions outlined are indicative and may be subject to revision. In addition costs quoted in the following tables should be noted as indicative and accumulative.

2.0 STRATEGIC THEME 1

Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.
*(*Recommendations identified for funding under 'New Decade,New Approach' and Executive Commitment)*

NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	WHAT IT WILL COST AND BY WHEN: Phase 1 20/21	Phase 1 21/22	Phase 2 22/23	Phase 2 23/24	Phase 3 24/25	Phase 3 25/26
1. Put in place a new population health management programme for nursing and midwifery.	Develop a new public / population nursing & midwifery framework & develop a population health practice development programme.	Annually 1,000 nurses / midwives trained in Public Health Care.		£60K	£61K	£63K	£64K	£65K
2. The creation of dedicated Population/Public Health Advanced Nurse and Consultants roles for nurses and midwives across all of our HSC bodies.	*** Recruit a Regional Public/ Population Health Nurse /Midwife Consultant lead.**	16 WTE Public Health Practitioners resulting in improved public health outcomes.	**£70K**	**£102K**	**£104K**	**£106k**	**£108K**	**£110K**
	Strengthen Public Health Clinical Leadership Infrastructure in HSC Trust.			£426K	£434K	£443K	£452K	£461K
	Develop Public Health ANP/Midwife Programme / post.				£55K	£110K	£749K	£761K
3. Increase the number of school nurses, health visitors and expand the Family Nurse Partnership programme across all of NI.	Recruit additional Schools Nurses.	157 WTE Early Years nursing resulting in better outcomes for children young people & families.	£289K	£799K	£1.2M	£1.6M	£2.0M	£2.5M
	*** Implement Delivering Care Phase 4 Health Visiting.**			**£520K**	**£1.0M**	**£1.6M**	**£2.1M**	**£2.6M**
	Roll out Family Nurse Partnership.		£295K	£784K	£1.1M	£1.4M	£1.8M	£2.2M
4. Recognising the demographic trends, nursing should co - lead the development, planning and management of older people services including nursing care commissioned in the independent sectors.	Recruit Older Persons Nurse Consultant Leads in each HSC Trust.	30 WTE Older people nurses – resulting in improved health care across older people services.		£360K	£367K	£374K	£382K	£389K
	Enhance Community District & Specialist Nursing Home In-reach Services.		£248K	£505K	£773K	£1.1M	£1.3M	£1.4M
Total – Strategic Theme 1			**£902K**	**£3.6M**	**£5.1M**	**£6.8M**	**£9M**	**£10.5M**

3.0 STRATEGIC THEME 2

Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred care.
*(*Recommendation identified for funding under 'New Decade,New Approach' and Executive Commitment)*

NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	Phase 1 20/21	Phase 1 21/22	Phase 2 22/23	Phase 2 23/24	Phase 3 24/25	Phase 3 25/26
1. Develop a person centred policy framework for all nursing & midwifery	Commission the development of Person Centred Digitalised Pathway.	6 WTE leads & new digitised person centred app.		£260K	£319K	£326K	£332K	£338K
2. Sustaining a minimum of 1000 under-graduate nurse & midwife placements for next five years until a position of oversupply is reached.	*** Maintain the undergraduate nursing and midwifery places at 1,000 per year and increase by 300 training places each year for next three years (additional 900 students between 2020 and 2023)**	1,300 student training places per year over the next three years cumulatively increasing to 3,900 students in training by 2023.	*£6.0M	*£11.4M	*£15.8M	£18.1M Review	£18.1M Review	£18.1M Review
3. Invest recurrently in nursing & midwifery post graduate education at a level commensurate with both the size of the workforce and the transformation agenda.	*** Increase post graduate nursing and midwifery education and training.**	Enable growth in specialist nurse training in line with HSC Transformation rising from £7.3M to £11.3M	**£2.7M**	**£4.0M**	**£4.1M**	**£4.2M**	**£4.3M**	**£4.3M**
4. Build & resource a new career framework so that within ten years there are Consultant Midwives & Advanced Nurses across all branches & across nursing specialities. **5. Increase the number of clinical academic roles in midwifery & all branches of nursing.**	Develop strategic plan which will systemically increase the number of Advance Nurse Practitioners, Consultant Nurses & Midwifes and Clinical Academic nurse/midwife roles.	120 WTE ANP in primary & community / secondary care 25 WTE Nurse/Midwifery Consultants. 25 WTE Clinical Academic posts.		£1.9M	£4.6M	£7.2M	£10M	£12.9M
6. Put Delivering Care Policy (normative (safe staffing) on a statutory footing. **(Please note Delivering Care Phase 4 costs covered by recommendation 3 above)**	***Implement Delivering Care Phases 2, 3, 5, & 7 and commission systems dynamic workforce modelling for the entire nursing and midwifery workforce.** Prepare submission for Minister Re:- Delivering Care Legalisation.	Additional 908 WTE nurses (phase, 2, 3, 5, & 7).	**£9.93M** **£100K**	**£19.4M** **£100K**	**£33.9M**	**£48.3M**	**£57.8M**	**£58.9M** **Review**
7. Develop arrangements for band 5-6 pay progression similar to other professions.	**Conduct a review to establish evidence of the cost and benefits of full implementation.**	To be agreed.						
Strategic Theme 2 Totals			**£18.8M**	**£37M**	**£58.7M**	**£78.1M**	**£91M**	**£94.7M**

4.0 STRATEGIC THEME 3

Doing the right things in the most effective way – working in partnership. Transformation of Health and Social Care Service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams.

*(*Recommendations identified for funding under 'New Decade, New Approach' and Executive Commitment)*

			WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	20/21	21/22	22/23	23/24	24/25	25/26
1. Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse leadership framework and investment in leadership training for nurses and midwives	Standardise Nursing & Midwifery Leadership Infrastructure. Strengthen senior clinical nurse & midwife leadership posts. Invest in an Aspiring Nurse and Midwife Leadership Training Programme.	36 WTE clinical leadership posts in midwifery & all branches of nursing. 48 Trainees.	£418K	£852K £160K	£1.3M	£1.8M £160K	£2.3M	£2.8M £160K
2. Invest in improvement science training and increase role of nursing and midwifery leadership in quality improvement initiatives.	Invest in Nurse and Midwife QI and Implementation Science Leads.	5 WTE Qi Leads.	**£353K**	**£360K**	**£367K**	**£374K**	**£382K**	**£389K**
3. Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness	Put in place a new nursing and midwifery quality assurance framework, and prepare a submission for minister on statutory requirements to underpin the framework.	Provides assurance and evidence of the impact of nursing and midwifery at policy and board levels	**Develop framework by 2022**					
4. Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) of a new digital nurse and midwife leadership role in all HSC bodies.	Establish a digital/innovation nurse/midwife network and appoint a regional digital and innovation nurse/midwife Lead and HSC digital nurse/midwife HSC Trust Leads.	6 WTE nurse / midwifery leads.	£438K	£447K	£456K	£465K	£474K	£484K
Strategic Theme 3 Totals			**£1.2M**	**£1.8M**	**£2.1M**	**£2.8M**	**£3.2M**	**£3.8M**

5.0 SUMMARY OF STRATEGIC THEME COSTS

	WHAT IT WILL COST AND BY WHEN					
	Phase 1		Phase 2		Phase 3	
	20/21	21/22	22/23	23/24	24/25	25/26
Strategic Theme 1 Totals	£902K	£3.6M	£5.1M	£6.8M	£9M	£10.5M
Strategic Theme 2 Totals	£18.8M	£37M	£58.7M	£78.1M	£91M	£94.7M
Strategic Theme 3 Totals	£1.2M	£1.8M	£2.1M	£2.8M	£3.2M	£3.8M
Grand Total	£20.9M	£42.2M	£65.9M	£87.7M	£103.2M	£109M

RECOMMENDATIONS IDENTIFIED FOR FUNDING NEW DECADE NEW APPROACH AGREEMENT AND EXECUTIVE COMMITMENT

	20/21	21/22	22/23	23/24	24/25	25/26
Delivering Care Phase 4 Health Visiting & Public Health Nursing	£70K	£622K	£1.1M	£1.7M	£2.2M	£2.7M
Increasing undergraduate places	£6.0M	£11.4M	£15.8M	£18.1M	£18.1M	£18.1M
Post Graduate Education	£2.7M	£4.0M	£4.1M	£4.2M	£4.3M	£4.3M
Implementing Delivering Care 2, 3, 5, & 7.	£9.93M	£20.1M	£33.9M	£48.3M	£57.8M	£58.9M

	20/21	21/22	22/23	23/24	24/25	25/26
Recommendations Identified For Funding New Decade New Approach and Executive Commitment	£18.7M	£36.1M	£54.9M	£72.3M	£82.4M	£84M
Funding Gap	£2.2M	£6.0M	£11M	£15M	£20.8M	£25M

HOW GAP MIGHT BE FUNDED:

Between 2020 and 2026, in addition to those recommendation identified for funding under the 'New Decade New Approach' Agreement it is estimated that approximately an additional £25Millon would be required to fund the remaining NMTG recommendations over the next five years. The current nursing and midwifery agency spend is £51M (18/19), and assuming this could be incrementally converted into savings, then a proportion of this funding could be reinvested to cover the costs of the remaining recommendations.

MOVING AHEAD:

Our Ambition, Our Commitment:

Nursing and midwifery services dedicated to delivering person centred, evidenced based health and wellbeing care outcomes.

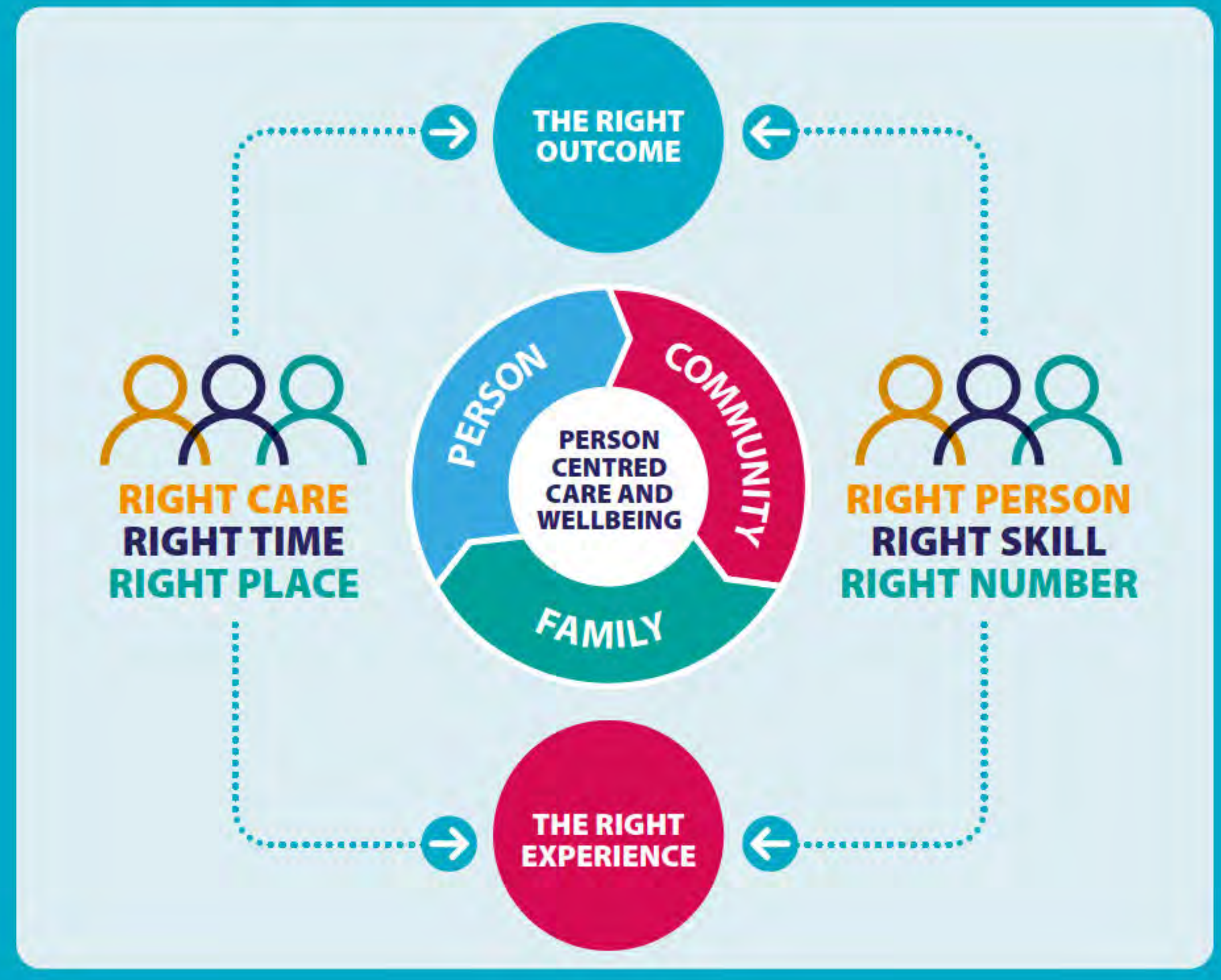

Exhibit 7

Modernising Learning Disabilities Nursing Review Strengthening the Commitment

Northern Ireland Action Plan

March 2014

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A MESSAGE FROM THE MINISTER

Ensuring that we deliver the best possible care to people with a learning disability is a key priority for the Department of Health, Social Services and Public Safety (DHSSPS). There is no doubt that we have made many significant improvements in how we deliver services to people with a learning disability, but more needs to be done in achieving our progressive and sustainable vision for learning disability.

To achieve the high quality, modernised and community based services, competent and skilled registered nurses – learning disability are a core ingredient for success. This action plan provides a road map to guide the delivery of learning disability nursing throughout Northern Ireland, ensuring that this small, specialist and very precious resource is used to the best effect within our health and social care system. We know that the learning disabled population in Northern Ireland are increasing year on year and that more children, born with a learning disability, are surviving into adulthood and old age. That in itself is a good thing, but as a consequence, it brings a range of physical and psychological health complexities, highlighting the need for highly skilled nursing across the lifespan.

I commend this Action Plan to all who have responsibility for the delivery of learning disability nursing in Northern Ireland.

Edwin Poots MLA
Minister of Health, Social Services and Public Safety

FOREWORD FROM THE CHIEF NURSING OFFICER

We are all acutely aware of the pace of change in today's HSC system. Within Northern Ireland we are currently working hard to implement the principles and requirements of Transforming your Care (DHSSPS 2011) which demands a wide ranging shift in the delivery of care, the commissioning of services, the regulation process and the culture of all organisations and agencies involved in the delivery of Health and Social Care to our local population.

As a consequence, health and social care services, professional groups and individual practitioners across Northern Ireland will be required to review current ways of working and adapt, modify and adjust accordingly.

When I consider the above, alongside the very significant current and emerging demographic changes within the population of people with learning disability, the high prevalence of physical and mental health needs and the high number of recent UK inquiries and reviews that have identified significant service and system failures, I believe it is very timely that we are taking forward an action plan to ensure that learning disabilities nursing in Northern Ireland is the best that it can be.

The following action plan reminds us all of the crucial and key role that registered nurses - learning disabilities have to play, now and in the future, in ensuring that people with learning disabilities receive safe and high quality care across all sectors involved in care delivery. The ultimate aim is to set a clear direction of travel for registered nurses - learning disabilities in Northern Ireland, one that is sustainable and one that has quality, safety and inclusion at its heart.

I therefore urge all relevant stakeholders across all agencies to actively contribute during the implementation of this action plan and by doing so; achieve even higher levels of excellence in the delivery of learning disabilities nursing in Northern Ireland.

This action plan has been influenced by many and I would like to express my thanks to all. However, a particular thank you to NIPEC for the leadership and coordination they have provided in developing this document.

Charlotte McArdle

Charlotte McArdle
Chief Nursing Office

INTRODUCTION AND BACKGROUND

In February 2011 the four Chief Nursing Officers from the United Kingdom commissioned a UK wide project that aimed to reflect upon, review and shape the future of the learning disabilities nursing profession. The project, which follows directly from recommendations of the existing four country policy 'Modernising Nursing Careers' (2006), was led by Ros Moore, CNO Scotland, and aims to maximise the contribution of the learning disabilities nursing profession across the UK to improve the experience of people with a learning disability and to improve outcomes for people with a learning disability and their families and carer's. This work fully acknowledges and recognises the multi-professional and multi-agency context within which registered nurses - learning disability work.

The UK Modernising Learning Disabilities Nursing Review, titled "Strengthening the Commitment" aims to ensure that people with learning disabilities of all ages, today and tomorrow, will have access to the expert learning disabilities nursing they need, want and deserve. That requires a renewed focus on learning disabilities nursing as a service and strategic consideration in building and developing the workforce. The review has set the direction of travel for registered nurses-learning disabilities across the United Kingdom, to ensure they can meet current and future demand and that the workforce is ready and able to maximise its role throughout the entire health and social care system.

Following the launch of the review in Edinburgh on 25 April 2012, a UK Steering Group was established (June 2012), in which each of the four countries is represented. Through the Group it was agreed that each of the four countries should produce its own Action Plan to take forward the recommendations of the Report *Strengthening the Commitment,* for local implementation.

This action plan has been developed by Northern Ireland Practice and Education Council (NIPEC), on behalf of and in partnership with the Department of Health Social Services and Public Safety (DHSSPS). This action plan reflects the expert opinion of key stakeholders within Northern Ireland who either work or have an interest in learning disabilities nursing policy, practice and education and has been further refined and enhanced following a 3 month period of consultation. It has been produced in response to and should be read in conjunction with *Strengthening the Commitment, the UK Modernising Learning Disabilities Nursing Review,* which can be accessed at http://www.scotland.gov.uk/Resource/0039/00391946.pdf

Currently, Health and Social Care in Northern Ireland is in a process of transforming the commissioning and delivery of services in order to better meet the needs of the population it serves. Therefore this action plan has taken into account the recommendations of a number of strategic direction policy documents namely:

- Equal Lives DHSSPS (2005); Guidelines on Caring For People with a Learning Disability in General Hospital Settings, GAIN (2010)
- Quality 20/20 (DHSSPS 2011)
- Transforming Your Care, DHSSPS (2011)
- The Learning Disability Service Framework, DHSSPS (2012)
- Fit and Well: Changing Lives: A Public Health Strategy for N. Ireland: Consultation document (DHSSPS 2012)
- The Bamford Action Plan 2012 - 2015 (DHSSPS 2013)

Registered nurses-learning disabilities play a key role in supporting people with a learning disability to achieve and maintain optimum health and well being. They deliver care within a context of numerous professional, economic, practice; social and policy drivers which are reflected within the following action plan.

This action plan aims to support and develop learning disabilities nursing in the context of an evolving learning disability service agenda. The action plan will be implemented and monitored by a regional implementation group who will report to the office of the Chief Nursing Officer on an annual basis.

STRENGTHENING CAPACITY

This section of the action plan addresses some of the key considerations underpinning efforts to strengthen capacity through developing the learning disabilities nursing workforce in relation to location and employment; strategic workforce planning; new ways of working; new roles and career choices.

Recommendations from National Report: Strengthening the Commitment

1. *The four UK health departments and the independent/voluntary sector should establish a national collaborative to enable better understanding of, and planning for, a high-quality and sustainable registered learning disabilities nursing workforce across all sectors.*

2. *Systems to collect workforce data are required in each country, with links across the UK, for workforce planning for future provision of learning disabilities nursing. These should be able to capture information on service provision, educational and research requirements and should cover the independent/voluntary sector.*

3. *The development of new, specialist and advanced role opportunities should be considered in light of workforce planning, service development and education provision. In particular, this should focus on the roles of non-medical prescribing, psychological therapies and tele-health and in specific settings such as the criminal justice system, mental health services (particularly dementia) and autism services.*

4. *Each of the four countries should consider aligning their existing post-registration career frameworks for learning disabilities nursing to clearly articulate the knowledge and skills required by learning disabilities nurses at all levels and across all settings. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework.*

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- Produce a workforce review/plan for registered nurses - learning disabilities in Northern Ireland that will consider all sectors and locations where these nurses work and will include nursing support staff.

  As part of this work, a data set, identifying the location of employment of registered nurses - learning disabilities in N. Ireland will be developed and will help inform decision making in a number of different contexts and levels such as:

  - succession planning
  - appropriate staffing levels/skill mix
  - pre-registration nursing programme recruitment

- Identify the need for and support the development of extended specialist and advanced roles for registered nurses - learning disabilities, to ensure an expert skills base is available and responsive to the current and emerging needs of people with learning disabilities.

  As a consequence of the Transforming Your Care agenda, it will be a priority to examine the community nursing infrastructure to assess the level and type of nursing support available to people with a learning disability in a range of community settings.

  Other priority areas in this regard include: acute liaison, challenging behaviour, mental health, epilepsy, forensic care, crisis support, psychological and physical health needs/interventions.

• Contribute to and provide a learning disabilities nursing perspective to the regional Career Pathway Project, being facilitated by NIPEC and in doing so, assist health and social care service providers and learning disabilities nurses to identify/consider/pursue the range of career progression pathways that are available to them. • Examine the potential for and the impact of, the transferability of the skills and competencies of registered nurses - learning disabilities throughout the health and social care system. This has particular relevance for acute liaison, mental health, CAMHS, prison settings and in dementia services. This work will include a separate examination of the roles undertaken by Registered nurses - learning disabilities in social care settings such as supported living environments.
Lead: N.I. Learning Disabilities Nursing Regional Collaborative
Time Scale: Prioritisation of actions and timeframes to be agreed by the NI Collaborative

STRENGTHENING CAPABILITY

This section outlines key considerations underpinning efforts to ensure a competent and flexible registered nurse-learning disabilities workforce for the future by maximising their contribution: working with people of all ages; addressing health needs and providing specialist services.

Recommendations from National Report: Strengthening the Commitment

5. *Commissioners and service planners should have a clear vision for how they ensure the knowledge and skills of learning disabilities nurses are provided to the right people, in the right places, and at the right time in a way that reflects the values - and rights - based focus of learning disabilities nurses' work.*

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

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

8. *Commissioners and service providers should ensure that specialist learning disabilities services for complex and intensive needs (including assessment and treatment services across all sectors) employ sufficient numbers of appropriately prepared and supported registered learning disabilities nurses. This highlights the need to support and develop the availability of specialist and advanced clinical skills and knowledge of learning disabilities nurses in all settings.*

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- As roles and locations of employment expand, develop a specific and targeted suite of competencies that clearly articulate the knowledge, values and skills required by registered nurses - learning disabilities in specific aspects of care.

- Ensure that the specific nursing skills and competencies of registered nurses - learning disabilities workforce are utilised appropriately and to best effect across the range of settings within which they work. It is particularly important that the nursing expertise of these Registrants is fully maximised and that an increasing emphasis is given to preventative and proactive health improvement approaches as core day to day nursing practice. This is relevant across the lifespan but is particularly necessary during early years and adolescence.

- Ensure that registered nurses - learning disabilities who work in in-patient and/or assessment and treatment services, with those with the most intensive and complex needs, are equipped with the appropriate staffing levels, skills and competence to ensure the highest possible standard of patient safety and experience in these "high risk". The NI Collaborative will give particular focus to:

  - Introducing patient-centred service improvement practices and cultures that ensure that positive therapeutic relationships and effective communication with people with learning disabilities and carers are at the heart of nursing practice.

- A targeted drive to ensure that registered nurses - learning disabilities are adequately prepared, equipped and supported in a) the management of violence and aggression, b) current risk assessment and management processes and c) effective responses to safeguarding incidents (children and adult).

- Contributing to the achievement of a workplace culture that supports the reporting of incidents and concerns, learning from things that go wrong and contributing to the implementation of action plans arising from incidents.

- The development of beacon wards/centres of nursing excellence in such settings.

Lead: N.I. Learning Disabilities Nursing Regional Collaborative

Prioritisation of actions and timeframes to be agreed by the NI Collaborative

STRENGTHENING QUALITY

This section addresses some of the key considerations underpinning quality in relation to demonstrating quality outcomes; quality improvement; preparing and developing registered nurses-learning Disability; maximising recruitment and retention; developing the workforce and accessing supervision.

Recommendations from National Report: Strengthening the Commitment

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

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

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

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

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

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

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- Develop and agree a process of measuring and demonstrating the outcomes of nursing practice.
- Link with the Regional Key Performance Indicators (KPIs) project to consider the introduction of relevant KPIs within settings where registered nurses - learning disabilities work.
- Ensure that key themes and issues identified via patient experience measures (locally and regionally) inform, improve and develop the practice of registered nurses - learning disabilities.
- Collaborate and link with HSC Trusts, other employers of registered nurses - learning disabilities and education providers, to ensure that registered nurses - learning disabilities are enabled to access post- registration education and training that is reflective of current

and emerging strategic policy, demographic changes and professional developments. • Collaborate and link with HSC Trusts, other employers of registered nurses - learning disabilities and education providers, to ensure that pre-registration students of learning disabilities nursing have access to effective and appropriate practice learning and mentorship. • Collaborate and link with HSC Trusts, other employers of registered nurses - learning disabilities and education providers, to ensure that newly qualified registered nurses - learning disabilities have access to effective preceptorship. • Support and advice upon the provision of robust professional governance and accountability structures for learning disabilities nursing within all HSC Trusts and those who work in the independent and voluntary sector. • Ensure that all registered nurses - learning disabilities actively participate in and have access to, professional advice and professional nursing supervision from a suitable registered nurse - learning disabilities who practise in the field of learning disabilities nursing. • Encourage, support and enhance the educational and developmental opportunities which should be available for non-registered nursing support staff.
Lead: N.I. Learning Disabilities Nursing Regional Collaborative
Prioritisation of actions and timeframes to be agreed by the NI Collaborative

STRENGTHENING THE PROFESSION

This section addresses some of the key considerations underpinning modernising the Registered Nurse-Learning Disabilities workforce in relation to; leadership and management; promoting the profession and research and evidence.

Recommendations from National Report: Strengthening the Commitment

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

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

17. Learning disabilities nursing research should be extended to ensure practice now and in the future is evidence based and the impact of interventions can be demonstrated. Services and education providers must ensure that all existing and future schemes for clinical−academic careers have appropriate representation of learning disabilities nursing.

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- Enhance professional leadership capacity and potential within registered nurses - learning disabilities in Northern Ireland.
- Explore and commission, models and approaches to leadership and practice development, to support the development of current and aspiring clinical leaders of learning disability nursing in Northern Ireland across all sectors.
- Ensure that Northern Ireland is represented on the national initiative to enhance leadership potential in final year learning disabilities nursing students and to take steps to build on this locally.
- Take steps to ensure that Northern Ireland is represented at the national UK academic network and that there is local involvement on and contribution to relevant national initiatives.
- In collaboration with the Royal College of Nursing, establish a Regional Professional Development Network for learning disabilities nurses to include HSC Trusts, the education sector and the independent/voluntary sector.
- Encourage and support registered Nurses - learning disabilities to access and take up nursing research activity including awards, scholarships and publications. Such activity should be encouraged in the aspects of clinical practice, policy and strategic direction and regional level concerns.

Lead: N.I. Learning Disabilities Nursing Regional Collaborative

Prioritisation of actions and timeframes to be agreed by the NI Collaborative

CONCLUSION AND NEXT STEPS

The development of this Northern Ireland Action Plan to take forward the recommendations within the National UK Strengthening the Commitment Review, has involved wide engagement with a range of key stakeholders in the local Northern Ireland context.

This engagement has informed the range of key actions that will have the greatest positive impact for people with learning disabilities, their families and carer's who receive services from learning disabilities nurses.

Registered nurses - learning disabilities now have the opportunity to ensure that the services and nursing care they deliver is the best that it can possibly be.

It is important to stress that while the actions are central to the modernisation of learning disabilities nursing in Northern Ireland, readers should engage with the full UK report, which outlines in more detail the rationale behind the actions that have been prioritised for Northern Ireland. The full UK report also has many key messages that can and should be considered in addition to the actions in this document.

To lead, drive, support, monitor and deliver this action plan the DHSSPS will:

- **Establish a N.I. Learning Disabilities Nursing Regional Collaborative by May 2014 to support delivery of the actions. The group should have representation from service user groups; the independent sector; all five of the health and social care organisations; educational providers, NIPEC; the Health and Social Care Board, Public Health Agency and take into account other stakeholders as necessary.**

- **Require that the Regional Collaborative reports on progress to the Office of the Chief Nursing Officer on an annual basis.**

- **At the end of a 3 year period, DHSSPS will formally review progress on the recommendations and consider the need for further developments.**

REFERENCES

Department of Health, Social Services and Public Safety (2005). *Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland.* Belfast; DHSSPS.

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NORTHERN IRELAND ACTION PLAN FOR LEARNING DISABILITY NURSING NORTHERN IRELAND COLLABORATIVE

Progress Report

October 2017

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

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

UK StC Steering Group

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

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

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

Collaborative Priorities

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

Themes:

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

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

Table 1: NI Collaborative Priorities 2016-17

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

Strengthening Capacity

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

Strengthening Capability

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

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

Strengthening Quality.

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

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

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

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

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

“HEF validates the decision making process”

“HEF helps demonstrate the unique contribution of the role of the learning disability nurse”

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

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

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

Strengthening the Profession.

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

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

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

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

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

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

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

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

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

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

- Siobhan Rogan who is an Advanced Practitioner

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

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

Other Events

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

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

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

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

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

Progress Update: Summary

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

Priorities 2018-2019

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

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

➢ Take steps to explore how the Positive Behaviour Support Framework developed by LIDNAN can be embedded in practice

➢ Scope preceptorship within Learning Disabilities Nursing:-seek assurance that preceptorship is in place.

Appendix 1

Membership of the Northern Ireland Regional Collaborative

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

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

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

For further Information, please contact

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Tel: 0300 300 0066

This document can be downloaded from the NIPEC website

www.nipec.hscni.net

Northern Ireland Practice and Education Council for Nursing and Midwifery

Modernising Learning Disabilities Nursing Review
Strengthening the Commitment

Northern Ireland Action Plan

October 2012

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Introduction

This draft action plan has been developed by Northern Ireland Practice and Education Council (NIPEC) on behalf of and in partnership with the Department of Health Social Services and Public Safety (DHSSPS) through an engagement workshop with key stakeholders. It has been produced in response to and should be read in conjunction with *Strengthening the Commitment, the UK Modernising Learning Disability Nursing Review,* published in 2012.

Those with a learning disability; their family members and carers, have a right to equal access to person centred care, which is safe, and effective everyday. Health and Social Care in Northern Ireland is currently in a process of transforming how its services will be commissioned and delivered to the population it serves. Therefore this draft action plan has taken into account the recommendations of those strategic direction policy documents namely *Transforming Your Care (2011)* and *The Learning Disability Service Framework (2012)* GAIN (2010).

This draft action plan reflects the expert opinion of key stakeholders within Northern Ireland who either work or have an interest in learning disability nursing policy, practice and education. It is the intention that this draft action plan will be widely consulted on within Northern Ireland.

Learning Disability nurses play a key role in supporting people with a learning disability to achieve and maintain optimum health and well being. Learning Disabilities nurses deliver care against a backdrop of numerous professional, economic, practice; social and policy drivers which are reflected within the following draft action plan.

This draft action plan will aim to support and develop learning disabilities nurses in the context of an evolving learning disability service agenda and will be revisited, monitored and developed at least annually.

To lead, drive, support, monitor and deliver this draft action plan the DHSSPS should consider:

- The establishment a NI Collaborative (March 2013) to support delivery of the actions.

- The NI Collaborative will have representation from service user groups the independent sector, all five of the health and social care organisations, educational providers including NIPEC and the Public Health Agency and take into account other stakeholders as necessary.

- The DHSSPS will work with the UK Steering Group to support each of the four UK Implementation Groups.

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STRENGTHENING CAPACITY

This section of the action plan addresses some of the key considerations underpinning efforts to strengthen capacity through developing the learning disability workforce in relation to location and employment; strategic workforce planning; new ways of working; new roles and career choices

Recommendations	Actions
1. *The four UK health departments and the independent/voluntary sector should establish a national collaborative to enable better understanding of, and planning for, a high-quality and sustainable registered learning disabilities nursing workforce across all sectors* 2. *Systems to collect workforce data are required in each country, with links across the UK, for workforce planning for future provision of learning disabilities nursing. These should be able to capture information on service provision, educational and research requirements and should cover the independent/voluntary sector.* 3. *The development of new, specialist and advanced role opportunities should be considered in light of workforce planning, service development and education provision. In particular, this should focus on the roles of non-medical prescribing, psychological therapies and tele-health and in specific settings such as the criminal justice system, mental health services (particularly dementia) and autism services.* 4. *Each of the four countries should consider aligning their existing post-registration career frameworks for learning disabilities nursing to clearly articulate the knowledge and skills required by learning disabilities nurses at all levels and across all settings. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework*	***The NI Collaborative should:*** • Scope the placements/employment status of Learning Disabilities nurses throughout Northern Ireland • Develop a data set in respect of registered and non registered (support) nursing staff • Determine how learning disability nursing can best contribute to the needs of clients with learning disabilities • Assess post registration requirements of learning disabilities nursing and consider the development of new and specialist roles • Explore the development of specialists / advanced roles and enhance the skills base within the broader family of learning disabilities nursing • Develop a career progression pathway for learning disabilities nursing which facilitates the knowledge and skills of Learning Disabilities nurses through the various roles and responsibilities required for career progression.
Lead: MHLD Nursing Officer	**Time Scale: 2013-2015**

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STRENGTHENING CAPACITY

This section outlines key considerations underpinning efforts to ensure a competent and flexible learning disabilities workforce for the future by maximising their contribution: working with people of all ages; addressing health needs and providing specialist services.

Recommendations	Actions
5. *Commissioners and service planners should have a clear vision for how they ensure the knowledge and skills of learning disabilities nurses are provided to the right people, in the right places, and at the right time in a way that reflects the values- and rights-based focus of learning disabilities nurses' work.* 6. *Commissioners and providers of health and social care should ensure the skills, knowledge and expertise of learning disabilities nurses are available across the lifespan. This should be enabled through effective collaborative working across health and social care structures.* 7. *Commissioners and providers of health and social care should ensure that learning disabilities nurses are able to collaborate effectively with general health services, including mental health services, to address the barriers that exist for people with learning disabilities to improving their health. This should include proactive health improvement, prevention, whole-family and public health approaches* 8. *Commissioners and service providers should ensure that specialist learning disabilities services for complex and intensive needs (including assessment and treatment services across all sectors) employ sufficient numbers of appropriately prepared and supported registered learning disabilities nurses. This highlights the need to support and develop the availability of specialist and advanced clinical skills and knowledge of learning disabilities nurses in all settings*	***The NI Collaborative should:*** • Consider the development a blueprint (framework) for learning disabilities nursing that will inform the knowledge and skills required to support value based responsive care across the life span with particular reference to transition points in line with policy direction • Consider ways that Learning Disabilities nurses promote the health and wellbeing of clients with Learning Disabilities across the life span in line with policy direction. • Ensure Nurse Managers have mechanisms in place for assessing the education and learning needs of registered Learning Disabilities nurses to meet the needs of the service • Review post registration education to ensure that learning disabilities nursing can contribute to the needs of learning disability clients now and into the future. • Review the current staffing to establish a normative staffing range for learning disabilities services • Ensure Nurse Managers provide access to supervision and this should involve a monitoring and reporting process.
Lead: MHLD Nursing Officer	**Time Scale: 2013-2015**

STRENGTHENING QUALITY

This section addresses some of the key considerations underpinning quality in relation to demonstrating quality outcomes; quality improvement; preparing and developing learning Disability Nurses; maximising recruitment and retention; developing the workforce and accessing supervision

Recommendations	Actions
9. *Learning disability nurses, their managers and leaders should develop and apply outcomes-focused measurement frameworks to evidence their contribution to improving person-centred health outcomes and demonstrating value for money. This may require a specific piece of work to scope current frameworks* 10. *Learning disabilities nurses should strengthen their involvement and links to transformational work, productivity improvement and practice development.* 11. *Those who commission, develop or deliver education should ensure that all learning disabilities nursing education programmes reflect the key values, content and approaches recommended in this report. They should also ensure that nurses in other fields of practice develop the core knowledge and skills necessary to work safely and appropriately with people with learning disabilities who are using general health services.* 12. *Updated, strategic plans for pre- and post registration learning disabilities nursing programmes are necessary for each country of the UK to support flexibility and ensure an efficient and sustainable model of delivery for the long term. This highlights the need for appropriate numbers of places on preregistration learning disabilities nursing programmes to meet future workforce requirements.* 13. *Education providers and services must work in partnership to ensure that educational and developmental opportunities for nonregistered staff are developed and strengthened and their benefits are evidenced through appraisal systems, and that educational and development opportunities are available for registered learning disabilities nurses to support their ongoing development, reflecting the needs of people with learning disabilities* 14. *Services should provide systems to ensure that learning disabilities nurses have access to regular and effective clinical supervision and that this impact is monitored and evaluated on a regular basis.*	***The NI Collaborative should:*** • Collaborate with the UK nurse consultants explore the use of the Health Qualities Framework Tool across Northern Ireland • Involved Learning Disabilities nurses in the transformational change of care/services in line with NI Policies • Approach the Education Strategy Group to undertake scoping exercise of the learning disabilities nursing programmes to ensure post registration programmes reflect key values as outlined in this report • Utilise workforce data (blueprint/framework) to inform the number of places on preregistration learning disabilities nursing programmes • Articulate the expected standard of conduct and performance of non registrant staff supporting learning disabilities nurses • Promote the uptake of supervision in line with local policy to all Learning Disabilities nurses
Lead: MHLD Nursing Officer	**Time Scale: 2013-2015**

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STRENGTHENING THE PROFESSION

This section addresses some of the key considerations underpinning modernising the Learning Disabilities workforce in relation to; leadership and management ; promoting the profession and research and evidence

Recommendations	Actions
15. *Leadership in learning disabilities nursing needs to be strengthened in practice, education and research settings with robust, visible leadership at all levels, including strategic and national levels. Services must ensure all learning disabilities nurses in clinical practice have access to a dedicated professional lead for learning disabilities nursing. In addition to existing leadership and development programmes, a UK-wide cross-sector project to nurture and develop aspiring leaders in learning disabilities nursing will be led by the four UK health departments.* 16. *Learning disabilities nurses need mechanisms to share best practice and develop the evidence base to continue to advance as a profession. Services must support learning disabilities nurses to participate in appropriate networks. A UK academic network for learning disabilities nursing will be created to support this drive.* 17. *Learning disabilities nursing research should be extended to ensure practice now and in the future is evidence based and the impact of interventions can be demonstrated. Services and education providers must ensure that all existing and future schemes for clinical–academic careers have appropriate representation of learning disabilities nursing.*	***The NI Collaborative should:*** • Take steps to scope the current position of the leadership / management visibility including professional corporate arrangements • Through Nurse Managers ensure that each Learning Disabilities nurse has Personal Development Plans/Appraisal/Supervision in place which maps out the practitioner's professional development • Through Nurse Directors should ensure they have a strategy for succession planning in place for their learning disabilities nursing workforce particularly around leadership research and education workforce development succession planning • Re-establish the Regional Professional Forum for Learning Disabilities nurses to include Practice Development (PD) across all sectors • Approach education providers who deliver programmes for learning disabilities nursing to ensure the content reflects evidence based practice.
Lead: MHLD Nursing Officer	**Time Scale: 2013-2015**

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References

Bamford Review of Mental Health and Learning Disability (2006) DHSSPS

GAIN (2010) Guideline and Audit Information Network: Caring for people with a Learning Disability in General Hospital Settings

Learning Disability Service Framework (2012)

Strengthening the Commitment (2012) The Report of the UK Modernising Learning Disabilities Nursing Review

Transforming your Care (2011) DHSSPS

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Insert date (month and year) of report

Launch of the Northern Ireland Action Plan for Learning Disability Nurses

20th June at The Old Courthouse, Antrim

Programme

10.00am: Welcome address: Maurice Devine

10.10am: A Director of Nursing perspective: Francis Rice

10.15am: A message from NIPEC: Dr. Glynis Henry, CBE

10.20am: The education of registered nurses-learning disability:

Professor Owen Barr

10.30am: Leaders of the Future: Jenny Mills

10.35am: What learning disability nurses mean to me: Peter and Virginia Maxwell

10.50am: Formal launch of the Action Plan and closing address: Charlotte McArdle

Tea/Coffee and scones will be served between 11am and 11.15am

Brief biographies:

Maurice Devine: Nursing Officer, DHSSPS and Assistant Head of CEC

Francis Rice: Executive Director of Nursing, SHSCT

Dr. Glynis Henry (CBE): Chief Executive NIPEC and Head of CEC

Professor Owen Barr: Head of School, UU

Jenny Mills: Student Nurse (QUB) and Student Nurse of the Year Winner

Peter Maxwell: A young man who has received support from learning disability nurses

Virginia Maxwell: Peter's mother who has received support from learning disability nurses

Charlotte McArdle: Chief Nursing Officer for Northern Ireland

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Exhibit 10

NI Action Plan: Strengthening the Commitment | NIPEC (hscni.net)

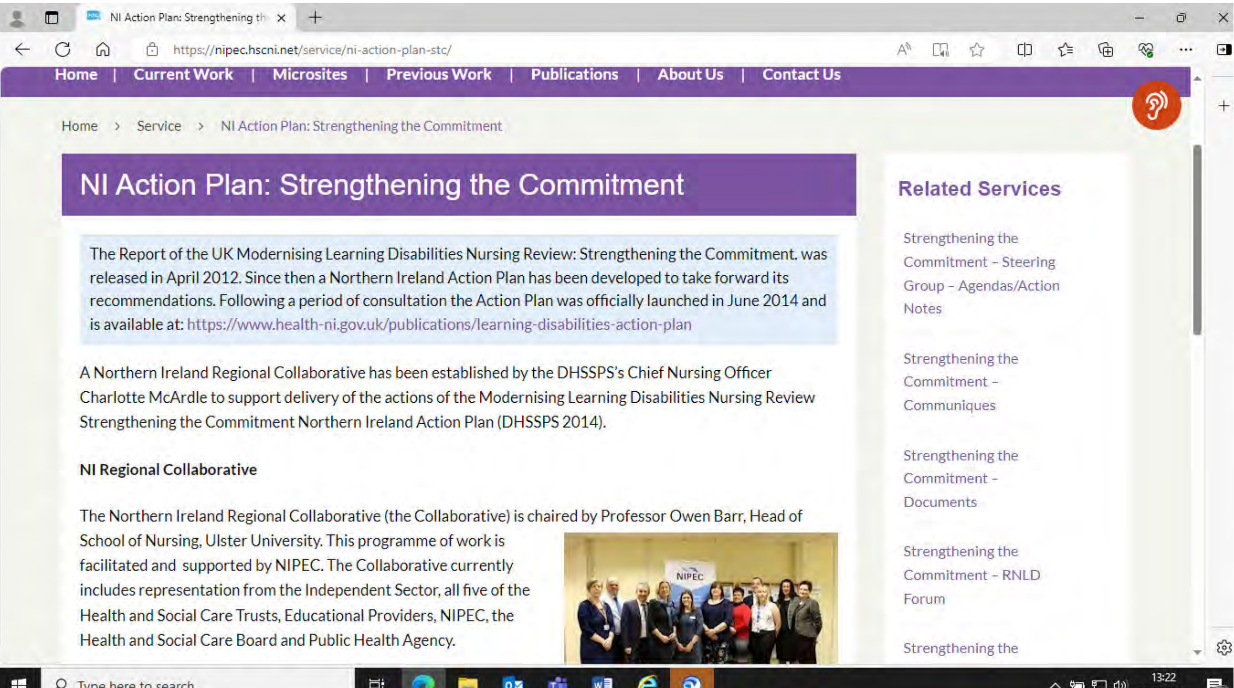
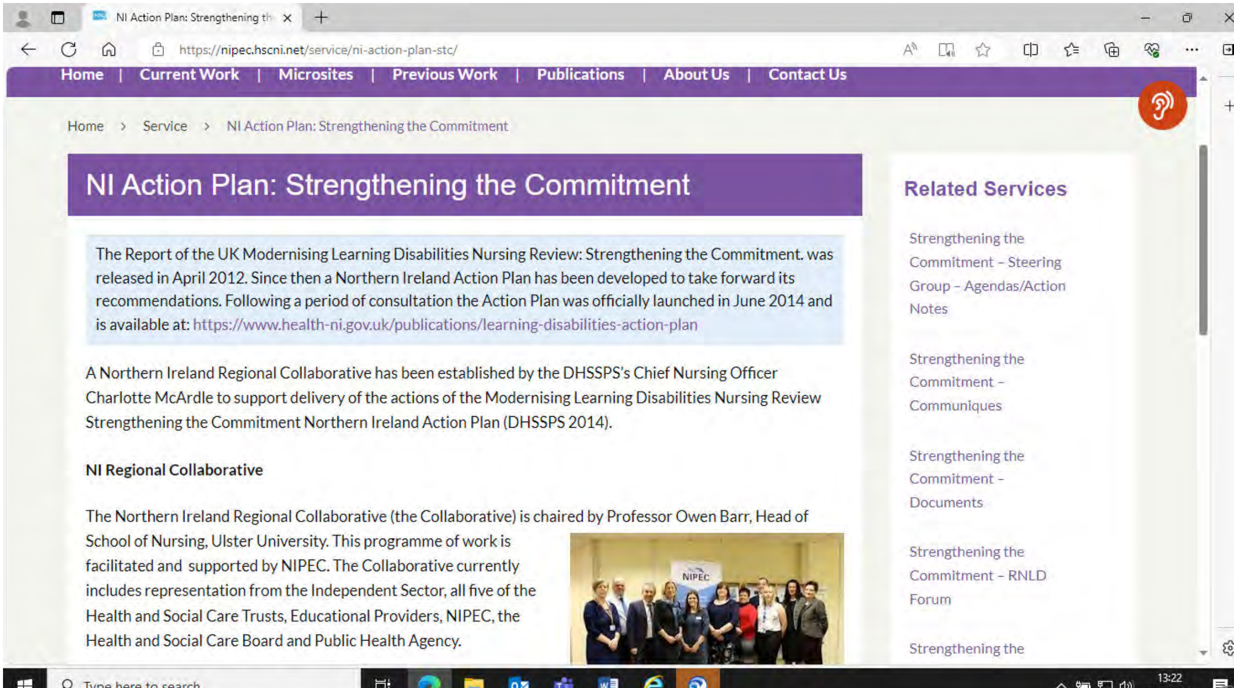


Exhibit 10

NI Action Plan: Strengthening the Commitment | NIPEC (hscni.net)



Strengthening the Commitment Northern Ireland Action Plan Communiqué August 2015

Background

Strengthening the Commitment: the Report of the UK Modernising Learning Disabilities Nursing Review was released in April 2012. This was followed by work to develop a Northern Ireland Action Plan which was launched date June 2014 by Mrs Charlotte McArdle the Chief Nursing Officer DHSSPS. The NI Action Plan is available
http://www.nipec.hscni.net/RegionalCollaborativeforNIActionPlan_NOTES.aspx

NI Regional Collaborative

A Northern Ireland Regional Collaborative has been established to take forward the NI Action Plan. Chaired by Dr Glynis Henry, CBE, Head of Clinical Education Centre and supported by NIPEC the Collaborative comprises representation from; the independent sector; all five of the Health and Social Care Trusts, Educational Providers, NIPEC; the Health and Social Care Board, Public Health Agency and ARC.

UPDATE

This communique focuses on the NI contribution to the Sharing Success StC UK Conference held on the 18th June in Derby and the StC three year on Strengthening the Commitment: Living the Commitment (2015) report. The conference and the three year on report has provided a platform for the four countries to showcase local initiatives linked to the four StC themes *Strengthening capacity, Strengthening capability, Strengthening quality and Strengthening the profession* and share best practice. The conference was oversubscribed and fully supported the Chief Nursing Officers from the four UK countries and the Chief Nurse from the Republic of Ireland. Northern Ireland submitted six abstracts for consideration by the conference organisers. Each country was awarded a winner and a highly commended place; Charlotte McArdle NI CNO presented the Northern Ireland prizes. The StC three year on report was launched at the conference. The report can be viewed at:
http://www.nursingtimes.net/Journals/2015/06/19/s/m/d/JRA-Strengthening-report.pdf

NI CNO Charlotte McArdle speaking at the Conference

Northern Ireland Winner: Olivia Boyda, WHSCT

Title: Development of Specialist Community Learning Disability Nursing Team within a Learning Disability Child & Adolescent Mental Health Service (LDCAMHS) Model

The Northern Ireland abstract winner was Olivia Boyd from the WHSCT; under the theme of ***Strengthening the Profession.*** Olivia's project described the development of a specialist community learning disability nursing team that can meet the needs of children and young people with a diagnosis of learning disability with additional emotional behavioural, psychological and mental health needs within an LDCAMHS model. Unfortunately Olivia could not be at the conference on the day; this photograph shows Maurice Devine talking to Olivia's abstract.

For further information contact: Olivia Boyda, Lead Nurse, Children's Western Health & Social Care Trust olivia.boyda@westerntrust.hscni.net

Highly Commended: Rhona Brennan, BHSCT

Title: Least Restrictive Most Effective

The Northern Ireland highly commended place was awarded to Rhona Brennan from the BHSCT; under the theme of **Strengthening Quality and Strengthening Capability.** Rhona's abstract Least Restrictive Most Effective described how patients who present with behaviours that challenge are being cared for in an inpatient setting using least restrictive, most effective evidence based care approaches and practices while ensuring that the Human Rights of each individual are upheld and promoted.

For further information contact:
Rhona Brennan, Ward Sister, Belfast Health & Social Care Trust rhona.brennan@belfasttrust.hscni.net

Other abstracts from Northern Ireland

Title: **Outcomes Measurement using HEF**

Theme: Strengthening Quality.

This abstract described how the BHSCT aim to assure the quality of health outcomes delivered by an inpatient ward in Muckamore Abbey Hospital using the Health Equalities Framework (HEF).

For further information contact
Rhona Brennan, Ward Sister, Belfast health & Social Care Trust rhona.brennan@belfasttrust.hscni.net

Title: Adapting Dialectical Behaviour Therapy (DBT)

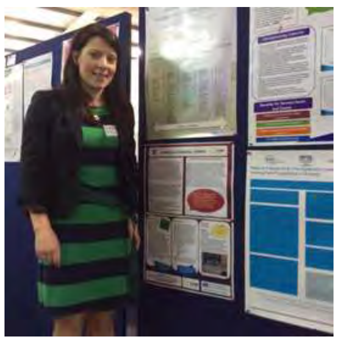
Theme: Strengthening Capability

Within the BHSCT Adapted Dialectical Behaviour Therapy (DBT) is being used as a treatment for inpatients with a learning disability who have difficulties in areas such as emotional dysregulation, interpersonal dysregulation, behavioural dysregulation self dysregulation and cognitive dysregulation.

For further information contact:
Colette Caldwell *Behaviour Nurse Specialist,* Belfast Health and Social Care Trust collette.caldwell@belfasttrust.hscni.net

Title: Learning Disability Crisis Response Service
Theme: Strengthening Capability
The SHSCT have developed a Learning Disabilities Crisis Response Service to effectively support Learning Disabilities clients with complex needs to remain in the community. The service provides short term assessment, support and treatment for individuals with learning disabilities and their families in an effort to effectively support clients to remain in their own home and avoid unnecessary admission to hospital where possible.

For further information contact: Gavin Crilly, Crisis Response and Home Treatment Practitioner Southern Health and Social Care Trust. Gavin.Crilly@southerntrust.hscni.net;



Title: Intellectual Disability CAMHS
Theme: Strengthening Capability
This project aims to ensure that every child and young person, including those with an intellectual disability living in the Southern Health and Social Care Trust , has access to CAMH services, equal to that of their non-disabled peers – nothing more, nothing less

For further information Contact:
Siobhan Rogan Intellectual Disability CAMHS Manager & Senior Practitioner Intellectual Disability CAMHS, Siobhan.Rogan@southerntrust.hscni.net

Title: Student Nurses Experience
Theme: Strengthening the Profession
Since winning student nurse of year 2014 award Jenny has aimed has to highlight the need for learning disabilities nursing within Northern Ireland as a specific field of nursing practice. Jenny's abstract focused on her elective placement to Romania with eight other nursing students and how since becoming a registrant she actively promotes learning disability nursing to students and professionals, highlighting the need for this specific field of nursing.

Jenny has been shortlisted for a "Rising Star" Nursing Time Award 2015. We wish her every success!!!

For further information contact:
Jenny Mills, Community Nurse Learning Disability Northern Health & Social Care Trust, jenny.mills@northerntrust.hscni.net;

Title: Learning Disability Leadership Programme
Theme: Strengthening Profession
This Learning Disabilities Leadership programme delivered by the Royal College of Nursing (Northern Ireland) in early 2015 seeks to build leadership capacity and capability to ensure visible and authentic leadership for the profession within NI now and into the future.
For further information:
Rita Devlin, Head of Professional Development Department, RCN Rita.Devlin@rcn.org.uk

Strengthening the Commitment: Living the Commitment (2015) report also includes a fact file of other examples of good practice from the four countries. For ease of reference the Fact file for NI is included at the end of this communique.

Other updates from the Collaborative:

- The Regional Collaborative are holding a Learning Event which is being hosted by the HSC Clinical Education Centre
  - TOPIC: Learning Disabilities Nursing: Outcomes Measurement
  - Date: 23rd October 2015 from 9.30am to 4pm
  - Nominations will be agreed locally by your organisations Collaborative representative
- The returns of the Learning Disabilities Workforce Scoping tools has been less than anticipated across the Independent and Voluntary sector. NIPEC have re-issued the

scoping tools specifically targeting organisation where it is though learning disabilities nurses work.

- The RCN NI regional Learning Disabilities nursing network had its inaugural meeting in June 2015.
- A summary report of the findings from the local information seminars regarding the NI Action Plan are now available on the NIPEC website.

For further information contact:

Frances Cannon NIPEC Senior Professional Officer frances.cannon@nipec.hscni.net. To view membership of the Northern Ireland Regional Collaborative click here http://www.nipec.hscni.net/RegionalCollaborativeforNIActionPlan_NOTES.aspx

Northern Ireland

Name/contact details	Case study title
Gordon Moore gordonw.moore@setrust.hscni.net	**Implementation of GAIN Guidelines** The GAIN guidelines identify 12 specific areas as the most pressing areas of need for people with a learning disability who use general hospital settings.
Molly Kane Molly.kane@hscni.net	**Health facilitation for people with learning disability in Northern Ireland** The development of health facilitation as a commissioned and accepted model of improving the health of people with a learning disability in Northern Ireland has relevance across the four themes of *Strengthening the Commitment.*
Sarah Boyd Sboyd30@qub.ac.uk	**Learning disabilities pre-registration programme** Student perspective on how the programme strengthens the quality of individual practice and raises the profile of the learning disability profession.
Lisa Hanna-Trainor lm.hanna-trainor@ulster.ac.uk	**Looking at retirement options for adults with intellectual disabilities** A focus on the service user supports that need to be in place to ensure an effective transition form adult services to those geared to meet the needs and preferences of older people with learning disabilities.
Maria Truesdale mn.truesdale@ulster.ac.uk	**Adults with learning disabilities and diabetes** Developing a structured diabetes education programme for people with learning disabilities and their carers and assessing potential gains from such a programme.
Edna O'Neill edna.oneill@setrust.hscni.net	**A joint epilepsy clinic** The clinic enables individuals to receive specialist care locally, in a person centred way with additional time for each clinic appointment. The epilepsy nurse can follow people up in the community in partnership with the learning disability psychiatrist and GP.

Strengthening the Commitment
Northern Ireland Action Plan
Communiqué January 2020

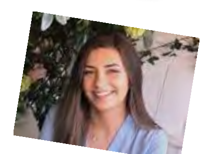
Welcome to the 12th edition of the
Strengthening the Commitment Northern Ireland Action Plan Communique

Background

Strengthening the Commitment: The Report of the UK Modernising Learning Disabilities Nursing Review, was released in April 2012. Since then a Northern Ireland Action Plan has been developed to take forward its recommendations. The NI Action Plan is available at
https://www.health-ni.gov.uk/publications/learning-disabilities-action-plan

NI Regional Collaborative

The Northern Ireland Regional Collaborative (The Collaborative) is Co-Chaired by Professor Owen Barr, Professor of Nursing and Intellectual Disabilities, Ulster University and Ms. Eileen McEneaney, Executive Director of Nursing (EDoN) in the NHSCT.



The NI Collaborative has welcomed Sarah Rooney a student nurse learning disabilities from Queen's University who will represent pre-registration nursing students on the NI Collaborative.
Membership of the NI Collaborative can be viewed on the NIPEC web page
https://nipec.hscni.net/service/ni-action-plan-stc/

Marking 100 years of nursing for people with learning disabilities: the unique contribution

Members of the NI Collaborative marking 100 years of nursing for people with learning disabilities

To celebrate 100 years of nursing for people with learning disabilities a cake was presented to the NI Collaborative at the October meeting. Members shared their thoughts and reflections on nursing people with learning disabilities in a 100 year birthday card. *Many congratulations*.

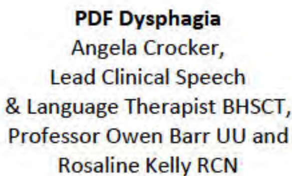
The RNLD Professional Development Forum (PDF)

The 3rd July PDF was held in the Ulster University, Jordanstown Campus with 45 attendees. The Forum was opened by Rosaline Kelly, RCN Co-Chair of the Forum, who provided an update on the NI Mental Capacity Act which was part implemented in December 2019. Mental Capacity Act | Department of Health

Angela Crocker, Lead Clinical Speech and Language Therapist BHSCT presented an excellent awareness session on Dysphagia. Following the presentation Angela invited participants to take part in a table mat exercise to review a number of case studies which focused on people with learning disabilities who had swallowing difficulties.

Following Angela's session, Deirdre McNamee, PHA presented the main findings from the Thematic Review Report on the Regional Choking Review Analysis (2018). Deirdre encouraged participants to review the PHA's web page on Dysphagia and in particular learn more about The Swallow Aware Project which is led by the PHA "working closely with statutory, independent, regulatory and community and voluntary sectors with the aim of developing systems, processes and services for people living with dysphagia in Northern Ireland".

Angela's and Deirdre's presentations can be viewed here;
https://nipec.hscni.net/service/ni-action-plan-stc/stc-rnld-forum/



PDF Dysphagia
Angela Crocker,
Lead Clinical Speech
& Language Therapist BHSCT,
Professor Owen Barr UU and
Rosaline Kelly RCN

PDF Dysphagia
Student Nurses and RNLDs
taking part in table mat
exercise on Dysphagia

On the 13th November the PDF held their final programme of the year in the Old School Canteen Tyrone and Fermanagh Hospital with 35 attendees. The session was opened by RNLD colleagues Lorraine Clark and Glenda Frazer, WHSCT. The focus of the PDF was a presentation from the RCN NI Learning Disability Nurse of the Year Winners, Siobhan Brady & Aoife Mills, SEHSCT and an overview of the NI Future Nurse Future Midwife (FNFM) Implementation Project. Presentations from all the contributors can be viewed here; https://nipec.hscni.net/service/ni-action-plan-stc/stc-rnld-forum/

Presenters and Facilitators
at the PDF in Omagh

RCN NI Nurse of the Year Learning Disability Winners 2019

The Forum was delighted to introduce the winners of the 2019 RCN NI Nurse of the Year Learning Disabilities Nursing Award, Siobhan Brady, Health Facilitator Nurse & Aoife Mills, Community Learning Disability Nurse, SEHSCT. Siobhan and Aoife presented their winning submission in relation to a project promoting health and fitness for people with learning disabilities titled "Choose to Lose". The findings from the project evidenced that patient and client health improved and that through positive engagement and client satisfaction weight loss and wellbeing was achievable. Following their thought provoking presentation Siobhan and Aoife challenged participants to consider how they might take forward a similar project within their own service area.

Siobhan Brady, Health Facilitator Nurse &
Aoife Mills, Community Learning Disability
Nurse, SEHSCT
presenting their RCN NI Nurse of the Year Learning
Disability project.

Future Nurse Future Midwife (FNFM)

Carol McGinn, WHSCT and FNFM Professional Officer, NIPEC presented an overview of the NI FNFM Implementation Project. Participants heard about the new roles of practice supervisor, practice assessor, academic assessor and nominated person. Carol informed participants how the Standards for Student Supervision and Assessment (SSSA) will change the way in which all registrants and non-registrants (when appropriate) will support student nurses in practice and how the roles relating to supervision and assessment of students will be separate.

To hear more about FNFM book a place on a FNFM roadshow. To download the FNFM roadshow presentation and FNFM information leaflets click here; Future Nurse Future Midwife – NIPEC

Carol McGinn, WHSCT and FNFM Professional Officer, NIPEC presenting an overview of the NI FNFM project

NI Practice Assessment Document (NIPAD) Learning Disabilities Nursing

Joanne Blair, Lecturer in Nursing (Learning Disabilities), QUB provided an overview of the *draft* NIPAD Learning Disabilities Nursing. Participants were able to review the NIPAD and hear how the universities and their practice partners will work together to support student learning and assessment in practice.

Joanne Blair, Lecturer in Nursing: Learning Disabilities, QUB providing an overview of the *draft* NIPAD Learning Disabilities Nursing.

CPD for RNLD's supporting FNFM

Finally Moira Mallon a RNLD and Nurse Education Consultant from the Clinical Education Centre (CEC) lead discussions on how CEC programmes could help support RNLD's gain the necessary skills within their scope of practice to support the FN student in practice.

Moira Mallon, CEC
Outlining CPD opportunities to support and upskill the present RNLD workforce in supporting the FN Learning Disabilities.

RNLD Forum

Topic:

Epilepsy

Date:

17th February 2020 @ 10.00am

Venue:

The Lecture Theatre, Clinical Education Centre, Craigavon Area Hospital, 68 Lurgan Road, Portadown BT63 5QQ

To book a place please contact lorraine.andrews@nipec.hscni.net

RCN Learning Disability Nurses Network-Update

RCN NI Learning Disability Network organised a celebration event on 25 September 2019 to celebrate 100 years of learning disability nursing. The event was attended by around 75 people. This included people with learning disability, relatives and carers, RNLD, other nursing registrants and students, university lectures, social workers, Consultant Psychiatrists, Directors of Nursing and our Deputy Chief Nursing Officer.

The morning was hosted on behalf of the Network by the Lilliput Theatre Company, Northern Ireland's premier Learning Disability Theatre Company. Lilliput performed three short sketches of which one was an educational piece used to launch the Health and Social Care Trusts Hospital Passport, this sketch in now an online resource for university students.

Other contributions included presentations from a 2019 RCN NI Learning Disability Nurse of the Year finalist, a newly qualified RNLD who both described their motivation and passion for working and caring for people with learning disability and a very interesting piece detailing the history of learning disabilities nurses from their job as mental deficiency nurses right through to their role as RNLD.

The mother of a young girl with learning disability described the invaluable contribution of the RNLD in supporting the entire family – *not a dry eye in the house*. The morning finished with a highly enjoyable performance by the choir from Glenveagh Special School who sang three songs and had the audience of their feet, singing and clapping along.

The long anticipated Mental Capacity Act (Northern Ireland) 2016 was partially implemented on 2 December 2019 with the commencement of a statutory framework for deprivation of liberty. This legislation is relevant in any place where a person lacks capacity to consent to care arrangements and therefore makes the legislation much wider than hospital settings or guardianship arrangements where the Mental Health (Northern Ireland) Order 1986 applies. It is important that everyone working in learning disability services understands both what deprivation of liberty is and how to practice lawfully.

The Department of Health commissioned a programme of training from the Clinical Education Centre to be delivered over a three month period from September – December 2019. The purpose of the training programme was to facilitate a sufficient number of staff from across health and social care services and settings with appropriate knowledge and skills to allow the legislation to become operational.

From January 2020 the delivery of the training will be the responsibility of HSC Trusts and other organisations.

For further information please contact

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or
eilish.boyle@nipec.hscni.net

Exhibit 12

A Description of the

Learning Disabilities Nursing Workforce

in Northern Ireland – A Report

Northern Ireland Practice and Education Council

for Nursing and Midwifery

September 2015

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Abbreviations

Agenda for Change (AfC)

Assistant Director of Nursing (ADoN)

Autism Diagnostic Observation Schedule (ADOS)

Chief Nursing Officer (CNO)

Child and Adolescent Mental Health Service (CAMHS)

Clinical Education Centre (CEC)

Community Children's Nurse (CCN)

Department of Health, Social Services and Public Safety (DHSSPS)

Dialectical Behaviour Therapy (DBT)

Executive Director of Nursing (EDoN)

Head Count (HC)

Health and Social Care Board (HSCB)

Health Social Care Northern Ireland (HSCNI)

Health Social Care Trusts (HSCT)

Higher Education Institutions (HEIs)

Human Resources, Payroll, Travel and Subsistence (HRPTS)

Jejunostomy (JEJ)

Learning Disabilities/Children and Adolescent Mental Health Service (LDCAMHS)

Management of Actual and Potential Aggression (MAPA)

Multidisciplinary Team (MDT)

Naso Gastric (NG)

National Institute for Clinical Excellence (NICE)

Northern Ireland (NI)

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)

Nursing and Midwifery Council (NMC)

Percuntaneous Endoscopic Gastrostomy (PEG)

Positive Behaviour Support (PBS)

Public Health Agency (PHA)

Registered General Nurse (RGN)

Registered Mental Nurse (RMN)

Registered Nurse (RN)

Registered Nurse Learning Disabilities (RNLD)

Registered Sick Children's Nurse (RSCN)

Regulation Quality Improvement Authority (RQIA)

Royal College of Nursing (RCN)

Senior Professional Officer (SPO)

Strengthening the Commitment (StC)

Transforming Your Care (TYC)

United Kingdom (UK)

1.0 Background

The number of people with learning disabilities is expected to grow by 14% between 2001 and 2021[1] as advances in science and care mean people with learning disabilities are living longer and more fulfilled lives. Strengthening the Commitment, the Report of the UK Modernising Learning Disabilities Nursing Review, (2012)[2] sets out a renewed focus for the four UK governments to ensure there is an appropriately-skilled Registered Learning Disabilities Nursing workforce to meet the needs of service users and their families. The report seeks to ensure the skills of these registered nurses are used to greatest effect across the Health and Social Care Northern Ireland (HSCNI) system and to enhance the profile of this workforce as a whole.

Strengthening the Commitment (2012) sets out a blueprint for how Learning Disabilities (LD) Nurses can develop their skills and capacity to deliver the person-centred care that people with Learning Disabilities, their families and carers need, want and deserve. LD Nurses have a long and proud history of providing care and support to people with learning disabilities and their families. Skills and knowledge are developing and must reflect the changing needs of people with learning disabilities, now and in the future.

Learning Disabilities (LD) nursing has an essential part to play in our Health and Social Care (HSC) systems. These Nurses have sometimes lacked the attention and recognition that other nursing fields of practice have attracted. Too often in the UK wide review of LD nursing - Strengthening the Commitment- examples were cited of how this skilled resource is being under-utilised. Mindful that the overall pool of LD Nurses available across the UK is comparatively small and the needs of this population now and into the future, it is essential that the expertise of this workforce is used to best effect.

1.1 Introduction

Since the release in April 2012 of the Strengthening the Commitment, a Northern Ireland Action Plan has been developed to take forward its recommendations. Following a period of consultation the Action Plan was officially launched in June 2014. The NI Action Plan is available http://www.nipec.hscni.net/RegionalCollaborativeforNIActionPlan_NOTES.aspx

The Northern Ireland Regional Collaborative (the Collaborative) was convened at the request of the Chief Nursing Officer (CNO) to take forward the actions from the NI Action plan. The Collaborative is chaired by the Head of the Clinical Education

[1] Emerson E, Hatton C (2008) Estimating Future need for Adult Social Care Services for People with Learning Disabilities in England Centre for Disability Research: Lancaster

[2] The Scottish Executive (2012) The report of the UK Modernising Learning Disabilities Nursing Review: Strengthening the Commitment. Edinburgh; Scottish Government.

Centre (CEC) and includes representation from; the Independent sector; all five of the Health and Social Care (HSC) Trusts, Education Providers, Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), Regulation and Quality Improvement Authority (RQIA), Association for Real Change (ARC) and the Public Health Agency (PHA).

One of the key actions within the NI Action Plan Strengthening Capacity particularly recommended the Collaborative to:

- *Produce a workforce review for Learning Disabilities Nurses in Northern Ireland that will consider all sectors and locations where these Nurses work and will include Nursing support staff. (*To view the detail of the action as set out in the NI Action plan see Appendix 1).

The purpose of this report is to present the findings of a Northern Ireland wide LD nursing[3] workforce review undertaken by the Collaborative during the period 2015. It includes information obtained from HSC Trusts, the Independent and Voluntary Sector and a number of Other organisations within which LD Nurses work.

1.2 Preliminary Work

In the lead up to this workforce review a Freedom of Information request was sent by the NI Collaborative to the Nursing and Midwifery Council (NMC) requesting the following information:

1. The number of LD Nurses registered in Northern Ireland
2. The number who hold a dual qualification i.e. RNLD and RMN/RGN/RSCN/RN1
3. The number of LD Nurses with a recorded post registration NMC recordable qualification
4. Where LD Nurses in Northern Ireland are practising
5. The age profile of Northern Ireland Registered LD Nurses which is conveyed in the following age ranges: 20-30, 31-45, 46+.

Table 1 presents the response provided by the NMC.

[3] Learning Disabilities Nursing includes nursing support staff/nursing assistants

Table 1: Summary of the NMC response

Question	NMC Response
1. The number of RNLDs registered in Northern Ireland	788 *To note:-this is a count of registrants whose registered addresses are in NI and who have a current registration on one of the following RN5/ RN6 /RNLD*
2. The number who hold a dual qualification i.e. RGN or RMN (i.e. RN1 /RNMH)	326
3. The number of RNLDs with a post registration NMC recorded qualifications (such as SPCLD or SPLD or V100, V150, V200 V300).	62
4. Where the Northern Ireland RNLD are practising	The NMC does not hold this information.
5. The age profile of Northern Ireland RNLD expressed in the following age ranges: 20- 30, 31-45, 46+	Age range 20-30 = 155 Age range 31-45 = 285 Age range 46+ = 348

Source Nursing and Midwifery Council (NMC) Feb 2015

This data indicates that 348 (44%) of LD Nurses registered with the NMC are over the age of 46 years.

2.0 Review Methodology

It is relevant to note that the Department of Health, Social Services and Public Safety (DHSSPS) have recently completed a Regional Workforce Plan for Nursing and Midwifery[4] in NI which took account of the LD nursing workforce. The contents of this report; *A Description of the Learning Disabilities Nursing workforce in NI,* builds on and expands the information gathered through the completion of the Regional Workforce Plan.

Thus, in order to capture as much information about the LD nursing workforce it was agreed that this review should include all known employers of this registrant workforce across all settings including:

- HSC Trusts,
- Independent/Voluntary Sector

  Other organisations to include: CEC, PHA/HSCB, RQIA, NIPEC and the three HEIs.

Scoping tools were developed to reflect the various settings and these are attached in Appendices 2, 3 and 4. The scoping tools aimed to gather a range of information including, for example:

[4] Department of Health and Social Services and Public Safety (2015-2025) Evolving and Transforming to Deliver Excellence in Care A workforce Plan for Nuring and Midwifery in NI

- The LD Nurse staffing establishment within each organisation
- Arrangements for line management
- Arrangements for Professional Supervision
- Proposed service developments and related development needs.

2.1 Scoping Tool – HSC Trusts

The scoping tool targeted at HSC Trusts which is included at Appendix 2 comprised two sections as follows:

- **Section 1**: aimed to gather data relating to Adult Learning Disabilities nursing services in the following settings: Hospital, Community Nurses as part of a HSC Trust, Residential settings, Supported Living settings and Day Care settings.

- **Section 2:** aimed to gather data relating to Children's Learning Disabilities nursing services in the following settings: Hospital, Community Nurses as part of HSC Trust, Respite settings and Schools for Children with Special Needs.

2.2 HSC Trusts

The HSC scoping tool was issued to the following Trusts:

- Belfast HSC Trust
- Northern HSC Trust
- Southern HSC Trust
- Western HSC Trust
- South Eastern HSCNI Trust

Each Trust submitted a completed scoping tool proforma. For the purposes of this report the findings are presented anonymously.

2.3 Configuration of current service provision

The Learning Disabilities model of service provision varies across the five HSC Trusts. Three of the five Trusts provide Adult Hospital based in-patient Learning Disabilities services. All five Trusts provide Adult Community based services. Two Trusts provide Children's Hospital based services whilst four of the five Trusts provide Community based Children's services as presented in Table 2 below. One Trust share services between the Community and Hospital. There is no specific Learning Disabilities Children's nursing service in one Trust; rather Adult Community LD Nurses have a number of children with Learning Disabilities on their case loads.

Table 2: Learning Disabilities service provision across the five HSC Trusts

HSC Trust	Adult Hospital based Services	Adult Community based Services	Children's Hospital based Services	Children's Community based Services
TRUST A	Yes	Yes	Yes	Yes
TRUST B	No	Yes	No	No
TRUST C	Yes	Yes	No	Yes
TRUST D	Yes	Yes	Yes	Shared team with hospital ward
TRUST E	No	Yes	NO	Yes

Table 3 below details the head count (HC) and whole time equivalent (WTE) of LD Nurses employed in each of the HSC Trusts by Agenda for Change (AfC) Band in Adult and Children Learning Disabilities services. This includes, Hospital based services where relevant, Community services including HSC Trust teams, for example, Integrated Care Teams, Statutory Residential settings and Supported Living Day Care settings.

Table 3 Total Head Count and WTE in each HSC Trust by Band

	BAND 8b		BAND 8a		BAND 7		BAND 6		BAND 5		Total	
	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE
TRUST A	1	1	6	6.5	24	24	33	24.09	144	136	209	191.5
TRUST B	1	1	0	0	12	12	18	17.1	11	11.4	42	41.5
TRUST E	0	0	4	4	6	5.6	7	6.4	15	13	33	29
TRUST D	1	1	3	3	5	5	21	22.1	35	28.5	65	59.6
TRUST C	0	0	1	1	11	13.6	19	21.6	64	60	95	107.2
Total	3	3	14	14.5	59	61.2	98	90.49	269	249.45	444	428.3

From the information submitted it was apparent that 444 (HC) LD Nurses work in the HSC Trusts, across a range of Bands which represents 429 WTE. Of the total number of LD Nurses identified, 67 (15%) work in Children's Learning Disabilities services whilst the remaining 386 (85%) work in Adult Learning Disabilities services. Trust A employs the largest proportion of the LD nursing workforce. Trust C reported that the difference in HC to WTE is due to a number of vacant posts within the organisation at the time of completion of the scoping tool.

It is of note that over the past ten years whilst there has been significant investment in the modernisation of the Learning Disabilities service provision, including the resettlement agenda, the head count of LD Nurses has remained largely unchanged. In 2006 the Registered LD Nurses headcount totalled 440 and in 2016 it is 444 (as presented in Table 3). It is relevant to note NI doubled its intake of LD pre-

registration student nursing commissioned places in 2009 – 2010 and that increased intake has been maintained since.

Three HSC Trusts reported that they each employ 1 WTE Band 8b Lead Nurse for LD nursing. One Trust has allocated 30% of 1 WTE Band 8c at Associate Director of Nursing level. Where a Band 8b post does not exist, it was reported that a Band 8a LD Nurse provides professional leadership.

Four of the five HSC Trusts reported that positions/posts currently held by LD Nurses ranging across these bands do not require the post holder to hold a LD Nursing qualification. Repeatedly, respondents noted that if these posts become vacant other professionals/members of the multi-professional team could be appointed to the position/post.

One Trust reported that within the figures provided that it employs 27 LD Nurses as Senior Social Care Workers within Supported Living settings to meet the needs of clients using this type of service. Whilst these post holders each hold current registration with the NMC as Nurses in the field of LD practice it was reported by the Trust that if these posts became vacant there would be no requirement for new recruits to be registered Nurses.

Conclusion

- On the basis of the information submitted it seems reasonable to conclude that the skills of LD Nurses are required and valued in a range of settings.
- It is interesting to note that a number of senior positions/posts currently held by LD Nurses do not require the post holder to hold a nursing qualification.
- It is also apparent there are less opportunities and limited career pathways for LD Nurses who aspire to middle and senior professional posts related to their specific field of practice

2.4 Age Ranges

The quality of the information submitted in relation to age range was variable so alternative sources were considered. Workforce data and information in relation to the overall workforce within the HSC sector in Northern Ireland are held and maintained on a new system, Human Resources, Payroll, Travel and Subsistence (HRPTS). The DHSSPS produces a quarterly statistical summary report for the whole of the HSC workforce, it was decided HRPTS would act as a suitable

alternative source to obtain the relevant data. Table 4 identifies the age ranges of LD Nurses employed by the HSC Trusts and projections for retirements from 2015 – 2030 based on a retirement age of 55 years[5].

Table 4: Age ranges of Learning Disabilities Nurses employed by the HSC and projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	134	69	58	65	87	32	20	465	11%
2020	***52***	134	69	58	65	87	32	465	26%
2025	***87***	***52***	134	69	58	65	87	465	33%
2030	***65***	***87***	***52***	134	69	58	65	465	26%

Source HRPTS 2015

Conclusion
Based on this data and a retirement age of 55 years it seems that the HSC Trusts are likely to 'loose' as many as 52 of these Nurses to retirement imminently and 119 (approx. 25% of the total workforce) within the next 5 years. This suggests a need for immediate and robust action in regards to workforce planning including succession planning within the HSCNI.

3.0 Findings HSC Trusts

Summary findings from the HSC Trusts are set out under the specific headings as detailed in the scoping tool as follows:

- Section 4.0 relates to Adult Learning Disabilities services.
- Section 5.0 relates to Children's Learning Disabilities services
- Section 6.0 presents the information submitted in respect of nursing assistants/healthcare support workers.

3.1 HSC Adult Hospital setting

3.1.1 Line management arrangements in the Adult Hospital setting.

Those HSC Trusts which provide Adult Hospital based services reported that there are clear line management structures for LD Nurses. It was reported that the Band 5 Nurses report to and receive line management from a Band 7

[5] Projected retirement age 55 years based on the HSC Pension Scheme (1995); with or without Mental Health Officer Status.

Ward Sister/Charge Nurse. Many of the Band 7 post holders are supported by Band 6 post holders. One Trust reported that all hospital based staff receive annual appraisals.

Conclusion
Clear line management arrangements were reported for LD Nurses working in Adult Hospital based settings.

3.1.2 Professional supervision arrangements in the Adult Hospital setting

All HSC Trusts which provide hospital based services reported that all LD Nurses receive and have access to professional supervision from a NMC registrant in the same field of practice. Two Trusts reported that these Nurses receive a minimum of two formal professional supervision sessions annually in line with the NI Standards for Supervision for Nursing[6] and local policy. Another Trust reported that all Nurses receive six monthly professional supervision, alongside quarterly management supervision. Various examples were provided by respondents as a means of demonstrating professional supervision arrangements at a local level. These examples included: staff engaging in group supervision and participating in action learning sets. One Trust reported that they audited the uptake of supervision monthly as it was one of its Nursing Quality Indicators.

Conclusion
Clear arrangements for professional supervision were reported across all HSC Hospital based settings for LD nurses including governance arrangements by the EXDoN.

3.1.3 Proposed developments and anticipated future Learning Disabilities workforce needs for hospital based services

One Trust (Trust A) reported that within the context of strategic drivers including the Equal Lives (2005)[7], Bamford Review (2007)[8] and Transforming Your Care (2012)[9], the Trust is modernising its Learning Disabilities service

[6] Chief Nursing Officer for Northern Ireland (2007) Standards for Supervision for Nursing, DHSSPS.
[7] Department of Health, Social Services and Public Safety Equal Lives (2005): Review of Mental Health and Learning Disability-y (Northern Ireland). Belfast; DHSSPS
[8] Department of Health and Social Services and Public Safety (2012b) *Delivering the Bamford Action Plan* 2012-2015. Belfast: DHSSPS
[9] Department of Health, Social Services and Public Safety (2011b) *Transforming Your Care: Vision to Action*. Belfast: DHSSPS. Available at:

which will impact on the associated nursing service. It was reported this will include a process of retraction of hospital based care for those patients residing in continuing care wards. Trust A reported that it aims to strengthen capacity and capability within its LD nursing workforce through the development of expertise to enable LD Nurses to provide specialised assessment and treatment inpatient services. The Trust as part of the modernisation of the service is introducing a Positive Behaviour Support (PBS) model within both adults' and children's' inpatient services with extensive training being implemented locally.

To support this, the Trust respondent reported it is reviewing this element of its nursing workforce with a view to increasing the ratio of registered to unregistered nursing support staff. Historically the ratio of the registrant workforce to non-registrants was in the region of 40% to 60% respectively. In the redesign of services it is anticipated the ratio required will be 70% registrant to 30% non-registrant within acute inpatient services. Over the past 3 years the patient acuity levels have increased. This has impacted on skill mix requiring more registrants to support the complexity of the patient profile. It has also resulted in higher levels of observations required. It is recognised this will require significant recruitment initiatives and investment to secure sufficient LD Nurses. In addition the Trust advised of the need for additional roles including Forensic Practitioners for the regional specialist low secure ward, Behavioural Nurses, Nurse Prescribers, Dialectical Behaviour Therapy (DBT) Nurse Therapists, Liaison Nurses and Intensive Support and Home Treatment Nurses. Trust A plans to commission six Specialist Practice Nursing programmes from the Ulster University to develop Specialist Nurses particularly in the following areas: Challenging Behaviour Forensics, Mental Health and Addictions. It is anticipated this investment will help meet the increasing needs of those clients presenting with complex and acute care needs. Trust A noted a need for a regional review of the provision of low and medium secure treatment services in order that the needs of patients with forensic as well as those with non-forensic needs could be safely and effectively met.

Trust A also reported that a significant number of LD Nurses are able to retire currently and within the next five years which will significantly impact on service delivery. Due to its inability to recruit the required number of LD Nurses into positions available at both temporary and permanent level, the Trust has recently extended its recruitment nationally and to Registered Mental Health (RMH) Nurses.

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http://www.tycconsultation.hscni.net/wp-content/uploads/2012/10/TYC-Vision-to-Action-Consultation-Document.pdf

Trust C noted that its inpatient hospital services have seen significant change in the recent past with the closure of its Hospital based service and the creation of dedicated assessment and treatment unit. Trust C respondent highlighted that within the next few years a number of the nursing registrant workforce within its Learning Disabilities services are due to retire and these posts will need to be replaced to meet patient/client healthcare needs and the needs of the service. In attempts to proactively address workforce potential shortfall the respondent advised that work is being progressed within the Trust to ensure there are adequate nurse staffing levels across the organisation to support the delivery of the LD nursing service going forward.

Trust C respondent also reported that the needs of the patient population being admitted to hospital has become more complex and the LD nursing workforce will require additional skills and competencies to meet these needs; including enhanced skills in the management of challenging behaviours and related evidence based therapeutic interventions. The respondent suggested LD nursing would benefit from a career pathway specific to this field of nursing practice to support career development and enhance learning and development opportunities to equip nurses to meet the needs of service users.

Finally, Trust D reported that it is in the process of redesigning its hospital based service particularly to meet the needs of clients with acute complex needs. The respondent reported that all patients will soon have been resettled into community based settings which will result in the hospital based service reducing from the current two wards to one. As a result it was reported that the Trust is seeking investment in LD nursing services. To meet this need Trust D have requested one place on the new Specialist Practitioner Community Learning Disability Programme as part of the Trust's commissioned programmes for September 2015 and other standalone modules i.e. forensic care. It is noteworthy that although the new Specialist Practitioner LD Community programme being commissioned and appearing in the DHSSPS education commissioning plans; a decision was taken strategically to defer delivery until at least 2016.

Conclusions

- The HSC will need to monitor carefully the age profile of this workforce and plan to address gaps accordingly.
- The HSC is experiencing difficulties recruiting LD Nurses due to limited availability and in certain instances are taking steps to recruit from other fields of practice
- The acuity and complexity of needs of patients admitted to hospital are increasing. In order to respond effectively, LD Nurses will need to be supported by their employers to access a range of learning and development opportunities, to acquire additional skills to meet the needs of people with learning disabilities and where appropriate extend or develop new nursing roles

3.1.4 Adult Community based Services including, Integrated Care Teams, Residential, Supported Living and Day Care settings

Arrangements for the delivery of Adult Community based Services vary across the five HSC Trusts. Table 5 below presents the numbers of LD Nurses by Band, employed in the HSC Trust Community based Services including Community, Residential, Supported Living and Day Care settings.

Table 5: Numbers of Learning Disability Nurses by Band employed in the HSC Trust Adult Community based Services

Adult Setting	TRUST A	TRUST B	TRUST E	TRUST C	TRUST D
Community	Band 8B X1 RNLD not a requirement Band 8A x1 RNLD not a requirement Band 7 X 4 Band 6 X 8	Band 8B x 1 RNLD not a requirement Band 7x 8 Band 6 x18 Band 5 X 5	Band 8A x4 Band 7x 6 Band 6x1 Band 5 x 8	Band 7x 5 (3 Specialist practitioners) Band 6 x13	Band 8B x .2 Band 8A x 1 Band 7 x 1 Band 6 X 9.5 Band 5 X 1
Residential Setting	Band 8A RNLD registration not a requirement Band 7 RNLD not a requirement	Band 5 x1 Plus 2 vacant posts	Band 7x1	N/A	Band 6 X 2 Band 5 X 2 RNLD registration not a requirement
Supported Living	Band 8B X1 RNLD not a requirement 8a Post holder above covers Supported Living and Residential Care RNLD not a requirement	Band 6 x3 Band 5x1	N/A	Band 7x 2 Band 6 x 2 Band 5 x27 (SSW/RLDN)	Band 8b .4 Band 7 X 2 Band 5 x 2
Day Care	Band 7x 1 RNLD not a requirement Band 6 x19 RNLD not a requirement	Band 8Ax1 RNLD not a requirement Band 5 x5	Band 5 x3	Band 6x1 Band 5 x 2	Band 7 X 1 Band 5 x 7

The findings from the scoping exercise demonstrates that a significant number of senior posts/positions Band 7 and above within Community based services do not require or specify the post holder to have a LD nursing qualification.

Whilst some of these posts/positions are currently occupied by LD Nurses, if these were to become vacant other professionals could apply. In other incidences senior posts are held by Social Workers.

A number of respondents raised concerns that this could impact now and more so into the future on the visible nurse leadership contribution by registered LD Nurses at

a senior level. This is of particular relevance as professional leadership is one of the key areas identified within the NI Action Plan.

One Trust (Trust B) reported that LD Nurses are employed within its Supported Living settings but tend to hold management positions such as that of Deputy Manager and above. Trust B respondent reported that it is a requirement that all Nurses remain on the NMC register and meet the requirements of revalidation in order to continue working in such posts.

Another Trust reported that 27 Registered LD Nurses are working in its Adult Supported Living settings as Senior Social Care Workers. It is relevant to note that the respondent commented that these Nurses feel that the registration and regulation of Supported Living significantly restricts their ability to practice the full range of their nursing skills. It was also reported these Nurses are anxious about their continued ability to maintain their registration as Registered Nurses in the context of the changing requirements of the NMC in relation to revalidation. Additionally, it was reported that Nurses working in these settings believe that by not allowing them to practice to the full capacity of their professional knowledge, skills and education, causes avoidable cost to the wider health and social care system, by requiring District Nurses or Community LD Nurses to provide care that they are capable of delivering.

Conclusion

- A number of senior positions do not require the post holder to hold registration with the NMC. It is suggested; this has and will continue to have an impact on the visible nurse leadership contribution by LD Nurses at a senior level.
- The situation as described above in relation to LD Nurses working in social care settings (in particular, supported living) would not appear to represent value for money. This, along with the unnecessary duplication described above, limits continuity of care and arguably may not represent the most effective way of providing holistic person centred care.
- Nurses working in supported living settings are concerned regarding their ability to utilise their skills and competencies as a LD Nurses and retain the title “Nurse”.
- Not all posts requiring the skills and expertise of an LD Nurse reflect this in the job title, therefore, the unique contribution of the Nurse may not be clear.
- To note CNO commissioned a review of NMC registrants working within Social Care setting. The output from that review should be utilised to maximise to the contribution of LD Nurses working in such settings.

3.1.5 Line management arrangements for Learning Disabilities Nurses working in Adult Community based services

Analysis of the information provided verified that clear line management structures are in place for LD Nurses working in Community based services. It was reported that Lead Nurses/Clinical Nurse Managers provide line management for Community LD Nursing Teams. Within the other community settings such as Residential settings, Supported Living and Day Care settings, a number of Trusts reported that the Line Manager is, in some cases, not an NMC registrant. A number of HSC Trusts reported that operational line management for some community services was provided by non-NMC registrants for example; Social Workers, who provided operational/line management for the LD Nurses working within that setting.

Conclusion

Clear line management structures, were reported for LD Nurses working in Community based services however, a number of Line Managers particularly within Residential settings, Supported Living and Day Care settings are non-NMC registrants.

3.1.6 Professional supervision arrangements for Learning Disabilities Nurses working in Adult Community based services

All respondents reported that arrangements for professional supervision for LD Nurses working in Community based services were in place. Professional supervision is mainly provided by the Line Manager where they are a Registered Nurse in a relevant field. It was reported that where the Line Manager is not a Registered Nurse, appropriate arrangements for professional supervision are put in place. Reported examples of arrangements for professional supervision included:

- LD Nurses in Specialist roles facilitate Professional supervision for Nurses working in day care settings
- Bi-monthly Professional meetings
- Arrangements for group supervision
- Arrangements for Professional supervision by a Nurse registrant from another setting within the Trust

Conclusion
Clear arrangements for professional supervision were reported for all LD Nurses working in Community based services including governance arrangements by the EXDoN.

3.1.7 Proposed and anticipated future Learning Disabilities Nursing workforce needs within Community based services.

Trust D reported it is currently restructuring its Learning Disabilities community teams to facilitate multi-professional working through uni-professional line management arrangements. It is intended that the new team structures will facilitate LD Community Nurses to have capacity to focus primarily on health promotion, management and improvement activities whilst working collegiately with Multidisciplinary Team (MDT) colleagues across teams. Trust D plan to have the restructured team operational from March 2016.

Trust E anticipates the possible development of Intensive Support Services which will incorporate a residential/respite assessment and treatment service within its Residential services. It is anticipated this would include the need for additional LD Nursing posts. Within Trust E, Day Care services proposed, service development includes the appointment of three additional part time LD Nurses to work in the area of complex physical health care service provision within the Adult Resource Centres. Of note, the respondent reported that 11 of their senior LD Nurses working in specialist posts will be in a position to retire within the next five years.

Trust C recognises that the needs of clients using day care are changing. It was reported that client's health care needs are becoming more complex. The Trust acknowledges it will need to ensure adequate numbers of LD Nurses are employed, particularly in Day Care settings to lead in assessing, planning and implementing person centred care plans for individuals with complex needs and ensuring there is appropriate timely nursing input to meet those needs. Additionally, Trust C identified that seven out of ten LD Nurses providing Specialist roles and two Nurses with Mental Health Officer status will potentially retire in the next five years.

Trust A reported that it has supported the development of its community infrastructure through the commissioning of Specialist Nursing Practice Courses for Nurses working with people with a Learning Disability in community settings. Trust A is also seeking to appoint two Behavioural Nurses to meet the needs of individuals who present with challenging behaviours. The Trust anticipates commissioning education programmes in the area of forensics and epilepsy management. The Trust also recognises the changing needs of those attending day services and of the increasing need to employ LD Nurses to support clients in day centres to meet the assessed needs of those with co-morbidities and complex health presentations.

Trust B respondent reported a Trust wide project has been initiated to provide a seamless journey for service users and their carers/family from the moment

they are assessed as requiring learning disabilities services. One particular work stream of the aforementioned project seeks to examine the role and function of each professional group including the LD Nurse, with the aim of defining the unique contribution of this workforce and how the profession can work most effectively to deliver services to service users within a multidisciplinary team approach, agree operational and professional management arrangements. A primary focus of this model is to facilitate an integrated care approach to effectively meet clients' needs whilst promoting a shared understanding and a mutual recognition and respect of uni-professional roles and functions.

Trust B respondent reported it is currently reviewing the LD nursing workforce to provide a current, up to date analysis of the core nursing team within the Trust. Included within this, will be recommendations for succession planning, staffing levels and recruitment/retention of staff. The respondent reported that the Trust anticipates it will need to commission learning and development opportunities for LD nursing teams to meet the needs of service users with more complex physical health care needs.

Conclusions

- The needs of people with learning disabilities are becoming more complex and in line with strategic direction, these needs are being addressed via a community based model rather than hospital based services.
- This has an impact on the skills required of the LD Nurse who as a result of service modernisation, will need access to a range of learning and development opportunities to acquire new, expanded and additional skills to effectively meet the needs of service users.
- Trusts have indicated their intention to expand the community LD Nurse infrastructure and it would be important this intention is translated into action.
- The imminent retirement of a significant number of senior LD Nurses working in specialist posts will require robust succession planning.

3.1.8 Number of nursing staff who are employed within the Adult Learning Disabilities with a nursing registration/qualification from another field of practice

The findings from the scoping tool identified nine Nurses with a nursing registration, in another field of practice, are employed across the five HSC Trusts to meet the needs of adult patients/clients with Learning Disabilities. Mental Health is the most common field of practice cited in this regard, followed by Adult nursing. Three of these posts are Band 7 and above. Two Trust respondents did not indicate at which Band the Nurse is employed.

Conclusion:
In those exceptional instances, where an employer fills a LD nursing post with a Nurse from another field of practice, employers have in place effective professional support and governance arrangements.

3.1.9 Designated Learning Disabilities Nursing Roles within Adult Learning Disabilities Services

Whilst LD Nurses in the main work within learning disabilities services, the evidence suggests[10] they also have a clear role in supporting clients with learning disabilities across a range of services including general hospital settings. Hannon (2010)[11] suggests LD Nurses are pivotal in ensuring and contributing to person centred care plans to enhance the care of people with learning disabilities.
As part of this scoping respondents also noted a number of designated[12] roles which LD Nurses undertake as detailed below.

[10] McClimens. A, Brewster. J, & Lewis. R (2013) Treatment of clients in the NHS: A case study. *Learning Disability Practice* **16**:6, 14-20..
[11] Hannon. L (2010) General Hospital Care for people with Learning Disabilities, Wiley Blackwell
[12] Designated Roles: Learning Disability Nurse with additional responsibilities for aspects of practice

Table 6: Designated roles within Adult Learning Disabilities services

Designated Role	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
Behaviour Nurse	2 Band 7	7 Band 7	1 Band 6 1 Band 7 RNLD registration not a requirement	1 Band 8A	3 Band 8A 1 Band 7 1 Band 6
Forensic Nurse	1 Band 6	1 Band 7	1 Band 7 RNLD registration not a requirement	NO	NO
Health Facilitator	NO	3 Band 6	2 Band 6	3	1 Band 7
Epilepsy Nurse	NO	1 Band 7	1 Band 7	NO	1 Band 7
Resource Nurse	1 Band 6	NO	NO	NO	NO
Practice Educator Facilitator	NO	1 Band 7	NO	NO	NO
Community Access Officer	NO	NO	1 Band 6	NO	NO
Nurse Development Lead	1 Band 7	NO	NO	NO	NO

All HSC Trusts have access to Practice Education Teams including, Practice Education Co-ordinators and Practice Education Facilitators, who along with mentors support pre-registration nursing students. The Practice Education Teams have arrangements in place to support current field of practice "due regard" NMC requirements. It was reported that the majority of the LD Nurses who undertake designated/additional roles have additional qualifications relevant to their scope of practice including, Specialist Practitioner Community Learning Disabilities, Behaviour Management, Epilepsy Prescribing/Supplementary Prescribing. A number of the reported Designated LD Nursing roles within Adult Learning Disabilities services do not reflect or include the title of Nurse.

Two new titles/roles which were noted in the course of this review were:
(1) Resource Nurse and (2) Community Access Nurse.

1. Trust A respondent reported that the Resource Nurse is not dedicated to Learning Disabilities services and although this position of Resource Nurse is currently held by an LD Nurse should it become vacant it would be available to other professionals. The post holder is responsible for undertaking audits, managing the risk register, training and compiling reports relating to trend analysis.

2. Trust D respondent reported that the Community Access Nurse provides intensive in-reach to service users own homes to prevent hospital admission.

Conclusion

- LD Nurses have a clear role in supporting clients across a number of areas. E evidence would suggest the contribution of the LD nurse is pivotal in ensuring the needs of clients are addressed through person centred care plans in a range of settings.
- In certain of the designated roles the title of nurse is not included however the requirements of the post necessitate the post holder to be a nurse. It could be argued that the particular nursing skill set required of the post is not apparent by the job title and therefore the unique contribution of the nurse may not be clear.

3.1.10 Practice Development and/or Training Role Adult Learning Disabilities Services

LD Nurses engage in practice development and training to support their colleagues within the Trust in which they work. The list below presents the information reported by the Trusts in this regard.

- The Epilepsy Nurse provides epilepsy awareness and emergency management across the Trust (Trust E) (Trust B)
- Behavioural Nurses provide Trust wide training on management of challenging behaviour (Trust E) (Trust B)
- LD Nurses deliver Management of Actual and Potential Aggression (MAPA) (Trust A) (Trust C) (Trust D)
- LD Nurses deliver “In-hospital” life support. (Trust A)
- Health Facilitator provides Learning Disabilities awareness in Primary Care setting (Trust B)
- LD Nurses in Day Care oversees medication including competence assessment (Trust C)

3.1.11. Learning Disabilities Nurse Prescriber:

Table 7 below presents the number and status of registered Nurse Prescribers within Adult LD nursing services across the HSC Trusts. Currently one Trust employs an LD Nurse who is on the Trust Prescribing Register and is actively prescribing. Another Trust employs an LD Nurse who is awaiting entry to the local Prescribing Register.

Table 7: Learning Disabilities Nurse Prescriber: HSC Trust

TRUST	On Trust Non-medical Prescribing Register	Actively prescribing
TRUST A	1	Registration in place and pilot underway
TRUST B	1	1 Supplementary Prescribing
TRUST C	0	0
TRUST D	commencing training in September 2015	
TRUST E	1	1

Conclusion

The potential of non-medical prescribing to contribute to effective and timely person centred care and in turn support the redesign and modernisation of services is highlighted within the Strengthening the Commitment Report[1], however the data submitted above would seem to suggest that the potential could be further exploited within learning disabilities services.

4.0 HSC Children' Learning Disabilities services

4.1.1 Learning Disabilities Children Hospital based services

Table 8 presents the configuration of Trusts, with Learning Disabilities Hospitals providing ward based services for Children with learning disabilities, staffing establishment and Bands of Nursing staff working in each Trust. Two of the five HSC Trusts provide Hospital based services. Trust D reported that the Children's Hospital based LD nursing team is shared with the community based service.

Table 8: Children' Learning Disabilities Hospital based services

	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
Learning Disabilities Children's Hospital based service	Band 8A x 1 Band 7 x 1 Band 6 x 1 Band 5 x 15	NO	NO	Hospital Ward & Community *Shared team* comprising Band 8a x1 Band 6 x 3 Band 5 x 5	NO

4.1.2 Learning Disabilities Children's Community Nursing Service:

Table 9 presents the staffing establishment and Band of Nursing staff working in children's community based LD nursing services across the HSC Trusts. One Trust has a shared team between the Hospital based service and the Community service.

Table 9: Learning Disabilities Children's Community Nursing Service per HSC Trust

Learning Disabilities Nursing Children's	TRUST A	TRUST B	TRUST C	TRUST D	TRUST E
Community	Band 8A x1 Band 7 X 1 Band 6 X 4	No dedicated children's learning disability nursing service but on current Adult caseloads	Band 8A x1 Band 7 x 2 Band 6 x 3	Shared team with hospital ward Band 8A x 1 Band 6 X 3 Band 5 X 5	Band 7 x 1 Band 6 x 4 Band 5 x 1
Statutory Residential setting	Band 6 x 1	No dedicated service		Band 6 X 2 Band 5 X 2 RNLD LD Nurse registration not a requirement	Band 5 x 3
Respite	Band 7 x 2 RNLD registration not a requirement Band 6 x 1 RNLD registration not a requirement Band 5 x 8	Band 7 x1 RNLD registration not requirement of post	Band 7 x 2 Band 5 X 8	Band 5 x 4	Band 6 x 2 Band 5 x 1
Special School		No dedicated service		Band 5 x 1	Band 5 x 2

4.1.3 Line management arrangements for Learning Disabilities Nurses working in the Children's: Hospital based settings

All of the HSC Trusts who provide ward based Hospital services for Children with Learning Disabilities reported there were clear line management structures for the LD Nurse working in these settings. The data obtained, indicated that Band 5 Nurses report to and receive line management support from a Band 7 Ward Sisters/Charge Nurse and that in many instances Band 7 Ward Sisters/ Charge Nurses is supported by a Band 6 Deputy Ward

Sister/Charge Nurse or Senior Staff Nurse. One Trust reported that all hospital based staff receive annual appraisals.

Conclusion
Clear line management were reported for Nurses working in Children's Hospital based Learning Disabilities settings

4.1.4 Professional supervision arrangements for Learning Disabilities Nurses working in the Children's: Hospital based settings

Of the HSC Trusts who provide Hospital based services respondents reported that all LD nursing staff receive and have access to Professional supervision from a Registered Nurse in the same field of practice. One respondent noted supervision arrangements are in line with the NI Standards for Supervision for Nursing[13]. Another reported that those Nurses working in Children's hospital based settings receive monthly supervision which includes professional supervision.

Conclusion
Clear arrangements for professional supervision were reported across all Children's Hospital based settings including governance arrangements by the ExDoN.

4.1.5 Proposed service developments and anticipated future Learning Disabilities Nursing workforce needs

One Trust (Trust D) reported that the Hospital team has been developed into a specialist home treatment team within the Learning Disability Child & Adolescent Mental Health Service (LDCAMHS) model of care. The team only admit children into hospital when all efforts at working intensively within the community have been exhausted and/or the child is at danger to themselves or others and cannot be safely managed in the community. A process has commenced to re-profile the funded establishment to create a Band 6 Deputy Nurse Manager for the team. It is anticipated that the team will require specialist training in areas such as: cognitive behaviour therapy, family therapy and sensory integration to support delivery of the service.

Trust D respondent also noted that there is a need for future investment in the LD nursing workforce of approximately two Registered Nurses and one

[13] Chief Nursing Officer for Northern Ireland (2007) Standards for Supervision for Nursing, DHSSPS.

Nursing Assistant to provide a locally based service in the Southern sector of the Trusts geography.

Trust A reported that Learning Disabilities Children's Hospital services have been jointly reviewed by the Health and Social Care Board (HSCB) which indicated that there continues to be a need for inpatient service to meet the needs of those requiring acute inpatient assessment and treatment. The hospital ward is working with the Child and Adolescent Mental Health Service (CAMHS) team to ensure consistent treatment options for those in Children's inpatient care. It was reported this will require investment to develop intensive support and home treatment options as well as community infrastructure to deliver person centred care and provide the least restrictive care options and home treatment. It is anticipated this could mean reducing hospital bed numbers from currently eight to six in the longer term and delivering outreach support to community teams.

Conclusion

- In line with strategic direction, the needs of children with learning disabilities are being addressed via a community based model rather than hospital based services.
- Strengthening the Commitment (2012) suggests that LD Nurses can make a significant impact on health and development, particularly if they are involved in an early stage in the life span.
- LD Nurses possess specific knowledge and competencies that can bring added value, particularly to children with the most complex needs, and as such then should be a central component of services delivering care to this population. The skills of LD Nurses add value in a range of areas including for example: skills development, mental health and emotional well-being, behavioural management, complex physical health needs and family-focused intervention and support.

4.1.6 Line Management Arrangements for Learning Disabilities Nurses working in Children's Learning Disabilities Community Teams

The information provided, confirmed that clear line management structures are in place for LD Nurses working in Children's Community based services. It was reported that Lead Nurses/Clinical Nurse Managers provide line management for Community Learning Disabilities nursing teams. Within other community settings such as Statutory Residential settings, Supported Living and Day Care settings, a number of respondents reported that the Line

Manager is in some cases not a Registered Nurse. A number of HSC Trusts reported that operational line management for some community services was provided by non-NMC registrants, for example: social workers, who provide operational line management for the LD Nurses working within that setting.

Conclusion
Clear line management structures were reported for LD Nurses working in Community based services. A number of non-NMC registrants/other professional's line manage Learning Disabilities Nurses particularly within Residential settings, Supported Living and Day Care settings.

4.1.7 Professional Supervision Arrangements for Learning Disabilities Nurses working in Children's Learning Disabilities Community Settings

It was reported that all LD Nurses working in Community based settings receive and have access to Professional supervision from a Registered Nurse in the field of disabilities. One respondent noted that Professional supervision is provided by a Band 7 Nurse from within the Directorate as the Line Manager is not a Nurse. Trust E reported that Community based LD Nurses attend quarterly Professional Learning Disabilities Nursing meetings which are attended by Nurses working in adult and children's services.

Conclusion
Clear arrangements for professional supervision were reported across all Children's Learning Disabilities community based settings including governance arrangements by the EXDoN.

4.1.8 Service Development: Children Community based settings

Trust D reported that the Community team has made significant progress within a LDCAMHS model of care. Work is underway to ensure that necessary professional development opportunities are taken to facilitate non-medical independent prescribing to meet the needs of children with specific disorders in line with relevant National Institute for Clinical Excellence (NICE) guidelines. The Trust also reported that plans are being progressed for one Nurse within the team to complete a family therapy course. Trust D has

identified the need for a Band 7 Manager in this team and a business case to support the appointment of the post has been approved.

Trust D also reported that a review team has been established to look at short break provision for children with Learning Disabilities. Whilst it is difficult to predict the outcome of this work at this time the Trust indicated that given the remit of this review team in respect of children with complex health care needs, it is possible that a need for an expansion of the LD nursing workforce may emerge.

Trust E reported the development of an Intensive Support Service that may include LD nursing posts including that of a team leader. The Trust at this time is considering LD Nurses having the opportunity to apply for this post.

Trust A reported that there is currently a comprehensive review underway in relation to services for Children with Learning Disabilities. This will determine and inform future service delivery and workforce needs.

Trust B reported that they do not have a dedicated LD nursing resource for children with learning disabilities however; the Adult LD Nursing team do have children on their caseloads. In addition, it was reported LD Nurses deliver a significant level of training to special schools and provide support to the Children's nursing services.

Findings from the responses submitted indicated that in total, 16 nursing staff are employed in Children's LD nursing service with a nursing registration from other fields of practice including Children's, Mental Health and level two Nurses (Enrolled Nurses) to support delivery of the nursing service and meet the needs of Learning Disabilities Clients across a range of settings.

Conclusion

- Significant anticipated service development within Community Children's Learning Disabilities service was reported. As with Adult services this has an impact on the skills required of those Learning Disabilities nurses practicing within Children's services.
- In order that nurses are enabled to continue to make positive person centred nursing contribution by acquiring new skills, they will need timely access to a range of appropriate learning and development opportunities including; behaviour therapy PBS family therapy sensory integration, therapeutic interventions to support intensive support and home treatment and independent non-medical prescribing.
- Employers, education commissioners and providers of nursing education should be well positioned to make this happen

4.1.9 Schools for Children with Special Needs

Two LD Nurses were reported as working in Special Schools across the HSC Trusts. In such cases arrangements for line management and Professional supervision were reported

4.1.10 Service Development

One respondent reported that a regional group are currently reviewing the role of the Nurse in special schools.

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4.1.11 Children's Learning Disabilities: Designated roles

A range of very specific programmes has been undertaken by a small number of LD Nurses. These programmes include: Sleep Counselling and Autism Diagnostic Observation Schedule (ADOS). It was reported that these Nurses use these skills/competencies qualifications in their day to day practice.

4.1.12 Children's Learning Disabilities: Nurse Prescribing

One LD Nurse within Children's learning disabilities services is on the prescribing register and actively prescribing. It was reported a second is undertaking the Nurse prescribing programme.

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Conclusion
As in Adult Learning Disabilities services the potential of non-medical prescribing to support and contribute to the redesign and modernisation of services is highlighted within the Strengthening the Commitment Report, however, the data in the table above would suggest this potential has not been fully exploited within Children's Learning Disabilities services.

5.0. HSC Trusts: Nursing Assistant/Healthcare Support Worker Band 3

The Table below presents the number of Band 3; Nursing Assistants/Healthcare Support Workers employed in the HSC Trusts, most are Hospital based with only 5 reported as working in Community based services.

Table 10: Band 3 Nursing Assistant/Healthcare Support Worker per HSC Trust and setting.

HSC Trust	Adult Hospital based Services	Adult Community based Services	Children's Hospital based Services	Children's Community based Services
TRUST A	181	0	18	5
TRUST B	0	0	0	0
TRUST C	7	0	0	0
TRUST D	15	0	3	0
TRUST E	0	0	0	0

Conclusion

On the basis of service need the HSC Trusts should explore the potential for skill mix via a designated Nursing Assistant/Nursing support role within the delivery of the Community LD nursing teams and/or Integrated Community Teams. NIPEC has undertaken work in respect of this role. The outputs from this work should be utilised to maximise the skill mix potential within LD Community services.

6.0 Independent /Voluntary Sector

Information was sought from Independent/Voluntary Sector organisations using a specific scoping tool at (Appendix 3).

The scoping tool was issued via the Regulation and Quality Improvement Authority (RQIA) to 1025 organisations which they register and regulate. The response and returns of completed scoping tools was less than anticipated with only 68 organisations responding, representing a response rate of 7%. A total of 53 responding organisations indicated that they did not employ LD Nurses and as such they assumed the tool did not apply to them. Through the membership of the Collaborative, relevant local intelligence was sought in regards to Independent /Voluntary Sector organisations within each HSC Trust's catchment area where it was thought LD Nurses were employed. A revised targeted circulation list was prepared by RQIA and the NIPEC Senior Professional Officer. The scoping tool was subsequently reissued to the revised targeted circulation list in July 2015. This resulted in the receipt of a further 7 (new) submissions. Anecdotal evidence suggested that a number of Independent/Voluntary Sector organisations who

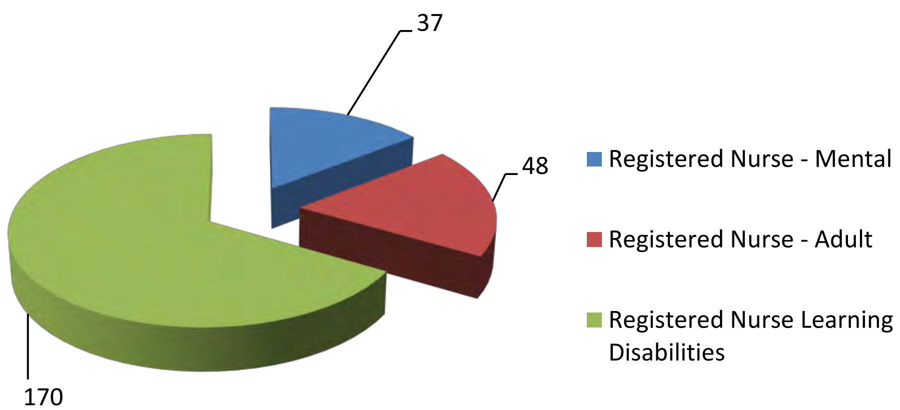
employed LD Nurses had still not responded, therefore NIPEC made contact with a further 9 organisations.

6.1.1: Findings from the Independent /Voluntary Sector

From all of the information received, 170 LD Nurses were identified as being employed in the Independent/Voluntary sector across a range of settings including private Nursing Homes, Residential settings and Supported Living

A further 37 Registered Mental Health Nurses and 48 Registered Adult Nurses were employed within these settings to meet the needs of client's with learning disabilities as presented in Table 11 One respondent from a private nursing home noted "…..we would prefer that 80% of our nursing staff were LD Nurses, currently however only 33% of our workforce are registered LD Nurses. We need an additional four LD Nurses…"

Table 11: Independent/Voluntary Sector: Learning Disabilites Nurses and Registrants from other fields of practice

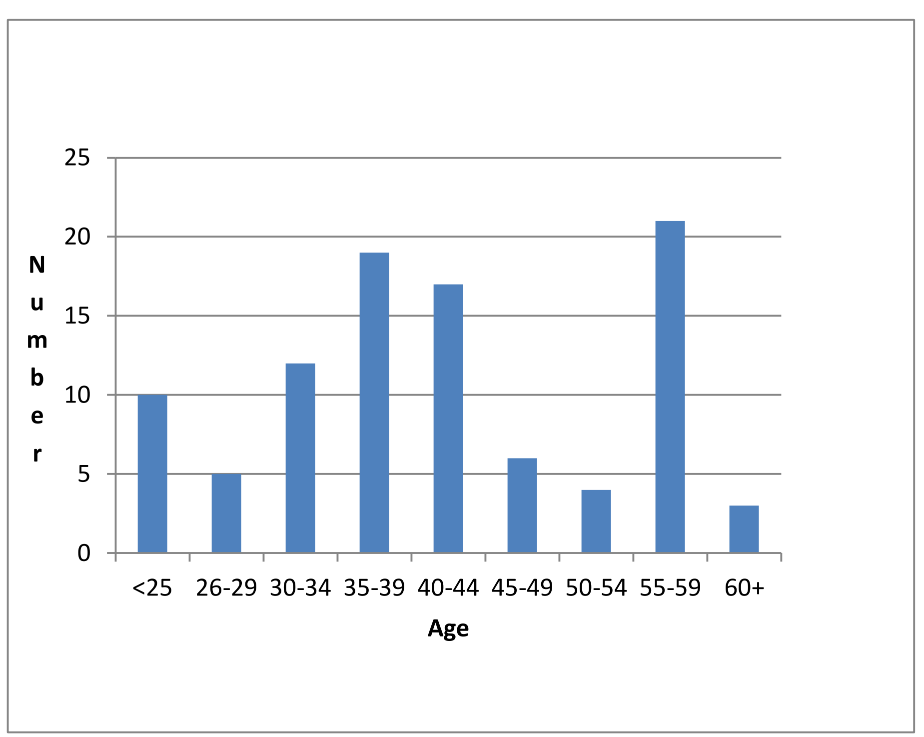


Job titles of LD Nurses employed in the Independent/Voluntary sector included Home Manager, Deputy Managers Sister/Charge Nurse and Staff Nurse. The job title most frequently reported was that of 'Staff Nurse'. A number of the respondents reported that the role of the Home Manager was supernumerary.

Information reported in relation to age range was variable with relevant data being returned in respect of the 107 Nurses. The detail in respect of age ranges is included in Table 11 which presents the spread of ages. From the information submitted it can be established that 30% of the Registered LD nursing workforce

employed in the Independent Sector are over the age of 50 years. A number of respondents reported great difficulty in recruiting LD Nurses and the delivery of the service relies on LD Nurses who have either already retired from the HSC or hold two posts working between the HSC and Bank/Agency. Additionally a number of respondents reported that in the absences of LD Nurses they employed Registered Nurses from the Adult or Mental Health field of practice.

Table 12: Age ranges of Registered LD Nurses in Independent/Voluntary Sector



Conclusion

- Independent Sector organisations rely heavily on LD Nurses who have either already retired from the HSC or hold two posts working between the HSC and Bank/Agency to meet the needs of the service.
- The age range of the LD Nurses working in the Independent/ Voluntary sector is concerning in relation to their imminent exit from the service and how these posts will be filled in the future.

6.1.2: Line Management Arrangements: Independent Voluntary Sector

The information submitted illustrated that line management arrangements depend on the setting in which the LD Nurse works. Within a Nursing Home setting it was reported that the LD Nurse reports to the Line Manager who is a Registered Nurse. In the Independent Sector, Supported Living settings, it was reported that each month the Home Manager meets with a Line Manager to complete a template which incorporates all the key service areas that the organisation provides to the clients residing on the scheme.

Conclusion
Line management arrangements were reported for those LD Nurses working in the Independent/Voluntary Sector which vary depending on the service setting.

6.1.3 Professional Supervision Arrangements: Independent Voluntary Sector

The information submitted indicated that professional supervision as with line management arrangements is dependent upon the setting in which the LD Nurse practices. Within a Nursing Home setting it was reported that LD Nurses access professional supervision from another Registered Nurse although not necessarily from the same field of practice. Respondents cited professional supervision arrangements as follows:

- three monthly supervision by Nurse Managers
- clinical supervision sessions are scheduled quarterly and Nurses also receive informal supervision on an 'as and when required' basis
- supervision is on-going throughout the year

Arrangements in respect of professional supervision were less clear in Supported Living settings. One respondent reported that each month the Home Manager meets with a Line Manager who completes a template which incorporates key areas regarding the individuals residing on the scheme.

Another respondent noted that the one LD Nurse employed within the organisation receives professional supervision from a Manager who is a Social Worker which arguably is more akin to line management.

In another Supported Living setting it was reported that the Scheme Manager is the only LD Nurse within the scheme and did not indicate where he/she received professional supervision.

Conclusions:

From the information submitted it is apparent that professional supervision as with line management arrangements is related to the setting in which the LD Nurse practices. Those working in Nursing Home settings appear to have access to Professional supervision with another NMC registrant although not necessarily a LD Nurse whereas in Independent Supported/Residential living type settings professional supervision appears to be more aligned and akin to management

6.1.4 Service development: Independent Voluntary Sector

Limited service development was reported by respondents from the Independent/Voluntary sector. The responses in this area are presented separately a) Nursing Homes and b) Residential/Supported Living settings.

a) Nursing Homes

One respondent noted that the Nursing Home does not currently employ Registered LD Nurses but are actively seeking to do so to meet the needs of clients being cared for within the home.

One of the larger Nursing Home providers reported they are actively involved in external committees as well as their own internal Learning Disabilities forum. Each Home has its local community network to ensure the lives of the residents are enhanced to their full potential.

Additional comments included

"…although there are no proposed developments within the nursing home at present the home offers residence to 24 Adults with Learning Disabilities and complex health care needs and reported it would be advantageous if Learning Disabilities pre-registration nurse education incorporated increased clinical skills and competencies.." in relation to the following:

- PEG feeding
- JEJ feeding
- NG feeding
- management of wounds,
- male and female urinary catheterisation,
- phlebotomy,
- tracheostomy
- dealing with behaviour which is challenging

The respondent noted that. "…*these skills are necessary to equip Learning Disabilities Nurses to manage complex health care needs".*

b) Residential/Supported Living settings

One provider of residential care reported that over the past two years has changed its model of service provision The respondent noted that "….*we are in the process of moving from a Residential Home to Domiciliary Care/Supported Living care setting. We will not have any* LD *Nurse in our workforce* …"

Additional Comments

"…more training is required for the independent sector relating to learning disabilities:-dementia/palliative/end of life care.."

"…there is a need for more LD student nurse placements within the Independent sector…"

"…we continue in our efforts to recruit suitably qualified LD Nurses however this has become increasingly difficult due to limited availability of Nurses with this expertise…"

In respect of the pre-registration nursing programme – Adult field, one respondent noted that -"…more emphasis should be placed on learning disabilities awareness…"

6.1.5 Designated Roles

Within the independent sector it was reported that LD Nurses in some cases carry responsibility for aspects of nursing care including, epilepsy, behaviour management and infection control.

Conclusions

- LD Nurses employed in the Independent Sector require the necessary skills and competencies to meet the increasingly more complex needs of the patients living within these settings including: end of life and palliative care.
- There is a willingness to support practice placements to facilitate pre-registration nurse training. Efforts should be taken by the relevant parties to capitalise on this willingness.

6.1.6: Practice Development and/or Training Role

One respondent indicated that the LD Nurse employed within the organisation is a Management of Actual and Potential Aggression (MAPA) trainer.

A second somewhat larger Nursing Home provider reported there are accredited MAPA trainers and 6 staff who have completed MAPA training within the organisation. A programme is currently being developed to ensure MAPA training is rolled out in all Learning Disabilities settings within the organisation.

Another provider reported that one Registered LD Nurse contributed to the delivery of epilepsy awareness training for all staff.

Additional Comments

a) Nursing Homes

- all staff are required to attend mandatory training annually and other training relevant to the needs of the residents in their care/future residents and for their own professional development portfolio
- all Nurses regardless of field of practice have dedicated time to contribute to training and practice development
- if a development need arises due to the needs of patients, Nurses would be facilitated to attend training.

b) Supported Living/residential

- one respondent reported that the Association has a designated training and development department. The Training Manager ensures that all staff employed have all the mandatory training required.

6.1.7 Nurse Prescribing:

There were no reported LD Nurses on the non-medical prescribing register within the Independent/Voluntary sector.

7.0 Other Organisations

The scoping tool attached at Appendix 4 requested a range of information from Other organisations who employ LD Nurses. The following organisations submitted a completed scoping tool:

- Clinical Education Centre
- Public Health Agency /Health and Social Care Board

- Queens University Belfast
- Ulster University
- RQIA
- NIPEC

7.1 Findings

7.1.1 Funded establishment

Collectively the Other organisations employ 11 LD Nurses. Analysis of the information received suggests that the majority of posts within the Other organisations do not require the post holder to hold a Learning Disabilities qualification and are not specifically funded as such. Respondents, however reported they endeavour to reflect a workforce that is drawn from all fields of practice to meet the needs of the service. The respondent from the Other organisation who delivers the NMC pre-registration LD nursing p programmes reported that the programme lead/post holder is required to have Learning Disabilities nursing qualification thus ensuring appropriate "due regard".

7.1.2 Line management arrangements

A range of arrangements for line management of LD nurses in the Other organisations were reported.

Conclusion
Line management arrangements were reported for LD Nurses working in Other organisations

7.1.2 Professional supervision arrangements: Other organisation

Arrangements for professional supervision of LD Nurses working in Other settings were identified. In the main professional supervision is provided by another NMC registrant, only in limited cases is professional supervision provided by another professional who is not an NMC registrant.

Conclusion:
Arrangements for Professional supervision are in place, these are dependent on the setting where the Registered LD Nurse works.

7.1.3 Do the posts carry a requirement for an NMC Approved Specialist Qualification?

The responses indicate that in the majority of cases the identified posts within Other organisations do require additional professional qualifications related to the role.

7.1.4 Service development to recruit Registered LD Nurses in the future.

No immediate service development or plans to recruit registered LD Nurses was identified by the respondents. It was reported however that if there was an identified gap Other organisations would review their workforce plan accordingly.

Conclusion
It should be recognised these Other organisations play a key role in leading and supporting the LD Nursing profession throughout their careers. Posts within Other organisations were appropriately reported as being occupied by LD Nurses and only in exceptional circumstance should non-Learning Disabilities Nurses be appointed to such posts

8.0 Limitations

Every effort has been made to engage with organisations that employ LD Nurses across all sectors during the process of this review. This report provides a high level description of the LD nursing workforce in Northern Ireland. The findings are based on the information submitted and reflect a point/period in time when the scoping tools were completed i.e. April to September 2015. It is acknowledged that since then information regarding the LD nursing workforce data may have changed. Nevertheless a range of extremely helpful information regarding the demography of the LD nursing workforce has been collated. The review provides a snap shot of the designated roles this workforce are providing; it also provides insights into anticipated Learning Disabilities service developments in light of strategic/policy drivers. This information should help inform succession planning, commissioning of learning and development activities for the LD nursing workforce to meet the needs of patients/clients mindful of the range of new and emerging service models.

9.0 Conclusions

In total 625 LD Nurses were identified through this review. This contrasts with the information provided by the NMC (Number =788) There may be a range of reasons for this including:

- 788 LD Nurses are registered with the NMC with an address in Northern Ireland hold a dual qualification i.e. RGN or RMN (i.e. RN1 /RNMH). It would be reasonable to suggest that some of those Nurses are working in other fields of practice relevant to their dual qualification
- it may be that a number of LD Nurses registered with the NMC reside in Northern Ireland but work in the Republic of Ireland.
- there may be a number of retired LD Nurses who maintain their registration with the NMC but are not actively working/employed in any setting.

- There is a reported imminent retirement of LD Nurses from the HSC within the next 5 years. This requires immediate and robust action in regards to workforce planning including succession planning within the HSC.
- The reported imminent retirement of a significant number of senior LD Nurses working in specialist posts will also require robust succession planning.
- There may be scope to examine the potential for Nurses working in Social Care settings to be part of succession planning.
- A number of HSC Trusts are actively undertaking local work force reviews to inform succession planning. Others are undertaking work streams which aim to define the unique contribution of the LD Nurses and how the profession can work most effectively to deliver services to service users within a multidisciplinary team approach and agree operational and professional management arrangements.
- This scoping exercise has identified the 229 Band 3 Healthcare Support workers/Nursing assistants are - at the time of the review - included in the funded LD nursing establishment across 3 of the 5 HSC Trusts. Only 5 of these posts are in community services.
- The age range of the LD Nurses working in the Independent/Voluntary sector is concerning, in relation to their imminent exit from the service and how these posts will be filled in the future.

- There are difficulties in the Independent/Voluntary Sector in recruiting and retaining LD nursing

- A number of Independent Sector organisations who deliver services to clients with Learning Disabilities rely on LD Nurses who have either already retired from the HSC or hold two posts working between the HSC and Bank/Agency.

- On the basis of the findings of this scoping of the LD nursing workforce, it is apparent that the needs of people with learning disabilities are becoming more complex and in line with strategic direction, these needs are being addressed via a community based model rather than hospital based services. Trusts have indicated their intention to expand the Community LD nursing infrastructure and it would be important this intention is translated into action. The skills required of the LD Nurse who as a result of service modernisation will need access to a range of learning and development opportunities to acquire new, expanded and additional skills to effectively meet the needs of service users. Details of anticipated service development and future workforce learning and development needs are summarised at Appendix 5 and should inform education planning and commissioning.

Conclusions HSC Trusts

- Clear line management structures were reported for LD Nurses working across all HSC settings however, a number of Line Managers particularly within Community Care settings in both Adult and Children's services are not necessarily LD Nurses.

- Arrangements for professional supervision for LD Nurses employed in HSC Trusts are in place.

- A number of senior posts/positions Band 7 and above within HSC Trust Community Based services do not require post holders to have a Learning Disabilities Nurses registration. A certain number of these posts are currently held by LD Nurses, if these were to become vacant other professionals would be able to apply, this could impact on the visible Registered LD Nurse leadership contribution at a senior level.

- Given the information submitted through the review it is challenging to see a clear career pathway for those LD Nurses who aspire to middle to senior professional posts.

- There is support to move towards the development of a Post Registration Learning Career Framework/Pathway which clearly articulates the knowledge and skills required by Registered LD Nurses at all levels across all settings.

- The HSC is experiencing difficulties recruiting LD Nurses due to limited availability and in certain instances are taking steps to recruit from other fields of practice.

- There are significant anticipated service developments within Community Children's Learning Disabilities service. As with Adult services this has an impact on the skills required of those LD Nurses practicing within Children's services.

- Employers, education commissioners and providers of nursing education should be well positioned to make this happen for LD Nurses working in both Adult and Children services.

- A number of LD Nurses are working in service areas registered as social care settings. Concern was raised by some individuals that registration and regulation of these settings restricts a LD Nurses ability to practice the full range of nursing skills and this is an anxiety particularly in the context of revalidation.

- There is a concern that by not allowing LD Nurses to practice to the full capacity within social care settings causes avoidable cost to the wider health and social care system and arguable may not represent the most effective way of providing person centred care.

- The CNO has commissioned work in respect of LD Nurses working in Social Care settings. The outputs from this work should be utilised to maximise their nursing contribution within Social Care settings.

- Every effort should be made to ensure that LD Nurses working in supported living settings are enabled to utilise their skills and competencies as an LD Nurse and retain the title "Nurse".

- Not all posts requiring the skills and expertise of a LD Nurse reflect this in the job title therefore the unique contribution of the Nurse may not be clear.

- LD Nurses play a pivotal role in providing specialist advice and support to registrants working in other fields of practice in a range of care settings to enhance and ensure person centred care for people with learning disabilities.

- The potential of non-medical prescribing could be further exploited within both in Adult and Children's Learning Disabilities services.

- On the basis of service needed the HSC Trusts should explore the potential for skill mix via a designated Nursing Assistant/Nursing Support role within the delivery of the Community Learning Disabilities Nursing Teams and/or Integrated Community Teams. NIPEC has undertaken work in respect of this

role. The outputs from this work should be utilised to maximise the skill mix potential within Learning Disabilities Community services.

Conclusions: Independent /Voluntary Sector

- Line management arrangements were reported of LD Nurses working in the Independent /Voluntary Sector.
- Arrangements for professional supervision are clear within Nursing Home settings. Within Supported Living /Residential settings arrangements are less clear and appeared more akin to line management arrangement.
- The Independent Sector are heavily reliant on Registered LD Nurses who have either already retired from the HSCNI or hold two posts working between the HSC and Bank/Agency.
- Registered LD Nurses employed in the Independent Sector require the necessary skills and competencies to meet the increasingly more complex needs of the patients living within these settings including palliative care.
- Practice placement opportunities for pre-registration Learning Disabilities student nurses within the Independent sector are not exploited to their full potential.

Conclusions Other Organisations

- Line management arrangements were reported for LD Nurses working in Other organisations.
- Arrangements for Professional supervision are in place and are dependent of the setting where the LD Nurse works.
- A LD Nursing qualification is not always a requirement of a number of posts within the Other organisations however, in the main identified posts within Other organisations do require an additional professional qualification related to the role.
- Other organisations play a key role in leading and supporting the LD nursing profession throughout their careers. Posts within Other organisations were appropriately reported as being occupied by LD Nurses and only in exceptional circumstances should non-Learning Disabilities Nurses be appointed to such posts

Appendix 1

Northern Ireland: ACTION PLAN

STRENGTHENING CAPACITY This section of the action plan addresses some of the key considerations underpinning efforts to strengthen capacity through developing the learning disabilities nursing workforce in relation to location and employment; strategic workforce planning; new ways of working; new roles and career choices.

Recommendations from National Report: Strengthening the Commitment

. The four UK health departments and the independent/voluntary sector should establish a national collaborative to enable better understanding of, and planning for, a high-quality and sustainable registered learning disabilities nursing workforce across all sectors.

2. Systems to collect workforce data are required in each country, with links across the UK, for workforce planning for future provision of learning disabilities nursing. These should be able to capture information on service provision, educational and research requirements and should cover the independent/voluntary sector.

3. The development of new, specialist and advanced role opportunities should be considered in light of workforce planning, service development and education provision. In particular, this should focus on the roles of non-medical prescribing, psychological therapies and tele-health and in specific settings such as the criminal justice system, mental health services (particularly dementia) and autism services.
4. Each of the four countries should consider aligning their existing post-registration career frameworks for learning disabilities nursing to clearly articulate the knowledge and skills required by learning disabilities nurses at all levels and across all settings. These developments could be utilised across sectors (with appropriate adaptation) to give a coherent career framework.

The following actions will be taken in Northern Ireland to support these national recommendations

A Northern Ireland Learning Disabilities Nursing Collaborative will be established which will:

- Produce a workforce review/plan for registered nurses - learning disabilities in Northern Ireland that will consider all sectors and locations where these nurses work and will include nursing support staff.
- As part of this work, a data set, identifying the location of employment of registered nurses - learning disabilities in N. Ireland will be developed and will help inform decision making in a number of different contexts and levels such as:
  - succession planning
  - appropriate staffing levels/skill mix
  - pre-registration nursing programme recruitment
- Identify the need for and support the development of extended specialist and advanced roles for registered nurses - learning disabilities, to ensure an expert skills base is available and responsive to the current and emerging needs of people with learning disabilities.
- As a consequence of the Transforming Your Care agenda, it will be a priority to examine the community nursing infrastructure to assess the level and type of nursing support available to people with a learning disability in a range of community settings.
- Other priority areas in this regard include: acute liaison, challenging behaviour, mental health, epilepsy, forensic care, crisis support, psychological and physical health needs/interventions.

Taken from: Department of Health, Social Services and Public Safety (2014) Modernising Learning Disabilities Nursing Review Strengthening the Commitment Northern Ireland Action Plan

Appendix 2

HSC TRUST
Learning Disabilities Nursing
Workforce Scoping Tool

Please indicate which HSC Trust you are from:

Date of completion

Compiled by:

Name: *Position Held:*

Learning Disabilities Nursing

Please provide information of the total funded Learning Disabilities Nurse staffing establishment within your Trust.

There are 2 sections in this Scoping Tool. Section 1 : aims to gather data relating to Adult Learning Disabilities Nursing services Section 2: aims to gather data relating to Children's Learning Disabilities Nursing services

If you have nursing staff who are employed in your Trust to meet the needs of adult patients/clients with a Learning Disability that are not registered Learning Disabilities nurses, but have a registration from another field of practice (e.g. Adult, Mental Health or Children) please respond in question 6

Section 1: Adult Services

1 Adult: Hospital Staffing Establishment

Job Title	Band	Funded establish ment	Headcount	WTE	Comments
Lead Nurse/clinical manager	8b				
Lead Nurse/clinical manager	8a				
Ward Sister /Charge Nurse	7				
Deputy WS/CN	6				
Staff Nurse	5				
other					
HCSW /Nursing support worker /Band	3				
HCSW /Nursing support worker /Band	2				
Comments					

1a. Line Management Arrangements

Please describe line management arrangements for learning Disabilities Nurses working in the Hospital setting.

1 b. Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses within the Hospital setting

1c. Service Development

Please detail proposed developments within Learning Disabilities services and anticipated future Learning Disabilities Nursing workforce needs

2. Adult: Community Nurse part of Statutory Trust Team for example integrated care team for adult Learning Disabilities Services

Job Title	Band	Funded establishment	Head Count	WTE	Additional Community Learning Disabilities Qualification yes/no
Lead Nurse/clinical manager * please specify	8b				
Lead Nurse/clinical manager* please specify	8a				
Community Learning Disabilities Team Leader	7				
Community learning Disabilities Sister/Charge Nurse	6				
Community learning Disabilities Nurse Staff Nurse	5				
Community learning Disabilities HCSW /Nursing support worker /Band	3				
Community learning Disabilities HCSW /Nursing support worker /Band	2				
Comments					

2a. Line Management Arrangements

Please describe line management arrangements for learning Disabilities Nurses working as a Community Nurse as part of Statutory Trust Team.

2 b Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working as a Community Nurse as part of Statutory Trust Team.

2 c Service Development

Please detail proposed developments within Community Learning Disabilities services and anticipated future LD Nursing workforce needs

3. Adult: Residential Settings

Job Title Please specify below	Band	Funded establishment	Head Count	WTE	Comments
HCSW /Nursing support worker /Band	**3**				
HCSW /Nursing support worker /Band	**2**				

3 a. Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Adult Residential Supported Living settings.

3 b. Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in Adult Residential Supported Living settings.

3c.Service Development

Please detail proposed developments within Learning Disabilities services and anticipated future Learning Disabilities Nursing workforce needs

4. Adult: Supported Living Settings

Job Title Please specify below	Band	Funded establishment	Head Count	WTE	Comments
HCSW /Nursing support worker /Band excluding Social care assistants	3				
HCSW /Nursing support worker /Band excluding Social care assistants	2				
Additional Comments:					

4 a. Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Supported Living settings.

4 b Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in Adult Supported living settings.

4 c .Service Development

Please detail proposed developments within Learning Disabilities services and anticipated future Learning Disabilities Nursing workforce needs within adult Supported living settings

5 Adult: Day Care

Job Title Please specify below	Band	Funded establishment	Head count	WTE	Comments
HCSW /Nursing support worker /Band excluding Social care assistants	3				
HCSW /Nursing support worker /Band excluding Social care assistants	2				
Additional Comments					

5 a Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in a Day Care setting.

5 b Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in a Day Care setting.

5 c Service Development

Please detail proposed developments within Day Care Learning Disabilities services and anticipated future Learning Disabilities Nursing workforce needs

Adult: Total number of Learning Disabilities nurses within the identified age ranges

Age Ranges								
<25	26-29	30-34	35-39	40-44	45-49	50-54	55-59	60+

6. Total number of nursing staff who are employed in your learning Disabilities Trust service with a nursing registration/qualification from another field of practice to meet the needs of Adult Learning Disabilities patients/clients.

Field of Practice	Number	Title *please specify & include all posts between Band 5 - Band 8B*
Registered Nurse- Mental		
Registered Nurse -Adult		
Registered Nurse- Children's		

7. *Designated* Learning Disabilities Nursing Roles
Please provide information regarding Designated Learning Disabilities Roles within your Adult Learning Disabilities Services

Role	Band	Funded establishment	Head count	Service area/Setting	Qualification
Behaviour Nurse *Specialist*					
Health Facilitator					
Epilepsy Nurse *Specialist*					
Forensic Nurse					
other					
Additional Comments					

8. Practice Development and or Training Role

Do any of the Learning Disabilities nurses have dedicated time to contribute to training/practice, for example MAPA.

9. Nurse Prescribing

How many Learning Disabilities Nurses are on your organisation's Prescribing Register?	
Additional Comments	

10. Nurse Prescribing

How many adult learning Disabilities Nurses in your organisation are actively Prescribing?	

11. Other funded nursing roles not captured already

If there are any areas not captured in their questionnaire can you please provide relevant information in the box below:
Comments

Date of completion..............................
Compiled by ....
Signed .... Professional Lead

Section 2 Children's Learning Disabilities Nursing Services:

If you have nursing staff who are employed in your Trust to meet the needs of children with a Learning Disability that are not registered Learning Disabilities nurses, but have a registration from another field of practice (e.g. Adult, Mental Health or Children) please respond in question 6

Children's Services

1 Children's: Hospital Funded staffing establishment

Job Title	Band	Funded establishment	Head count	WTE	Comment
	8b				
	8a				
Ward Sister /Charge Nurse	7				
Deputy WS/CN	6				
Staff Nurse	5				
HCSW /Nursing support worker	3				
HCSW /Nursing support worker	2				
Additional Comments					

1 a Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Hospital Children's Services

1 b Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in Hospital Children's Services

1 c Service Development

Please detail proposed developments within Hospital Children's Services LD services and anticipated future Learning Disabilities Nursing workforce needs

2. Children's: Community Nurse as part of Statutory Trust Team, for example, integrated care team for LD services

Job Title	Band	Funded Establishment	Head Count	WTE	Additional Community Learning Disabilities Qualification yes/no
please specify	8b				
please specify	8a				
Community Learning Disabilities Team Leader	7				
Community learning Disabilities Sister/Charge Nurse	6				
Community learning Disabilities Nurse Staff Nurse	5				
other please specify					
Community learning Disabilities HCSW /Nursing support worker /Band	3				
Community learning Disabilities HCSW /Nursing support worker /Band	2				
Additional Comments					

2a Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Children's Community Nurse services as part of Statutory Trust Team

2b Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in Children's Community Nurse services as part of Statutory Trust Team

2c Service Development

Please detail proposed developments within Children's Community Nurse services and anticipated future Learning Disabilities Nursing workforce needs

3 Children's: Residential Living

Job Title *Please specify*	**Band**	**Funded establishment**	**WTE**	**Head count**	**Comments**
Additional Comments					

3a. Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Children's Residential Living settings.

3b.Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in Children's Residential living settings.

3c. Service Development

Please detail proposed developments within Children's Residential living settings and anticipated future Learning Disabilities Nursing workforce needs.

4. Children's: Supported Living

Job Title *Please specify*	**Band**	**Funded establishment**	**WTE**	**Head count**	**Comments**
Additional Comments					

4a. Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Children's supported living settings.

4b.Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses working in Children's supported living settings.

4c. Service Development

Please detail proposed developments within Children's supported living settings and anticipated future Learning Disabilities Nursing workforce needs.

5. Children's: Special School

Job Title	Band	Funded establishment	WTE	Head count	Comments
Please specify					
Additional Comments					

5a Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses working in Children's Special Schools

5b Professional Supervision Arrangements

Please outline line professional supervision arrangements for Learning Disabilities Nurses working in Children's Special Schools

5c Service Development

Please detail proposed developments within LD Children's Special Schools services and anticipated future Learning Disabilities Nursing workforce needs

Total number of Children's Learning Disabilities Nurses within the identified age ranges

Age Ranges								
<25	26-29	30-34	35-39	40-44	45-49	50-54	55-59	60+

6. Total number of nursing staff who are employed in your Children's Learning Disabilities nursing service with a nursing registration/qualification from another field of practice to meet the needs of Children with Learning Disabilities.

Field of Practice	**Number & Band**	**Title** ***please specify & include all posts between Band 5- Band 8B***
Registered Mental Nurse		
Registered Adult Nurse		
Registered Children's Nurse		

7. Designated Learning Disabilities Nursing Roles

Detail the number of Children Learning Disabilities Nursing roles within your Trust or Learning Disabilities Nurses who work in designated roles

Role	**Band**	**Funded establishment**	**Head count**	**Service area/Setting**
Behaviour Nurse *Specialist*				
Health Facilitator				
Epilepsy Nurse *Specialist*				
Forensic Nurse				
other				
Additional Comments				

8. Practice Development and or Training Role

Do any of the Children's Learning Disabilities nurses have dedicated time to contribute to training/practice development for example MAPA

9. Nurse Prescribing

How many children's Learning Disabilities Nurses are on your organisation's Prescribing Register?	Number
How many children's learning Disabilities Nurses in your organisation are actively Prescribing?	

10 Other funded nursing roles not captured already

If there are any areas not captured in their questionnaire can you please provide relevant information in the box below:
Comments

Date of completion..............................
Compiled by ....
Signed .... Professional Lead

Appendix 3

Independent Voluntary Sector
Learning Disabilities Nursing
Workforce Scoping Tool

Please indicate which organisation you are from:

Date of completion

Compiled by:

Name: ***Position Held:***

Learning Disabilities Workforce Nursing Scoping Tool

Please provide information of the total funded Learning Disabilities nurse staffing establishment within your organisation.

If you have nursing staff who are employed to meet the needs of Learning Disabilities clients in your organisation are not registered Learning Disabilities nurses, but have a registration from another field of practice (e.g. Adult, Mental Health or Children) please detail in Question 6.

1. Staffing Establishment

Job Title	**Funded establishment**	**Head count**
Home Manager/s		
Deputy Manager/s		
Sister/Charge Nurse/s		
Clinical Lead Nurse/s		
Staff Nurse >2years		
Staff Nurse <2years		
HCSW /Nursing support worker		

2. Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses. **We are particularly keen to understand line management arrangements for Learning Disabilities Nurses who are not operationally managed by a Nurse.**

3. Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses within your organisation.

4. Service Development

Please detail proposed developments within Learning Disabilities services within your organisation and anticipated future Learning Disabilities Nursing workforce needs

5. Total number of Learning Disabilities Nurses within the identified age ranges

Age Ranges								
≥25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+

6. Total number of nursing staff who are employed in your organisation with a nursing registration/qualification from another field of practice to meet the needs of clients with a Learning Disability.

Field of Practice	Number	Title *please specify & include all posts between Band 5- Band 8B*
Registered Nurse- Mental		
Registered Nurse -Adult		
Registered Nurse- Children's		

7. *"Specialist"* Learning Disabilities Nursing Roles
Detail the *"specialist"* Learning Disabilities Nursing roles within your organisation or Learning Disabilities Nurses who work in specialist areas: we have suggested some examples but there may be others

Role	Number	Service area/Setting
Behaviour Nurse *Specialist*		
Health Facilitator		
Epilepsy Nurse *Specialist*		
Forensic Nurse		
other		

8. Practice Development

Do any of the Learning Disabilities nurses have dedicated time to contribute to training/practice development for example MAPA

9. Nurse Prescribing

How many Learning Disabilities Nurses are on your organisation's Prescribing Register?	

How many learning Disabilities Nurses in your organisation are actively Prescribing?	

Signed…………………………………….

Appendix 4

Independent Voluntary Sector
Learning Disabilities Nursing
Workforce Scoping Tool

Please indicate which organisation you are from:

Date of completion

Compiled by:

Name:
Position Held:

Learning Disabilities Workforce Nursing Scoping Tool

Please provide information of the total funded Learning Disabilities nurse staffing establishment within your organisation.

If you have nursing staff who are employed to meet the needs of Learning Disabilities clients in your organisation are not registered Learning Disabilities nurses, but have a registration from another field of practice (e.g. Adult, Mental Health or Children) please detail in Question 6.

1. Staffing Establishment

Job Title	**Funded establishment**	**Head count**
Home Manager/s		
Deputy Manager/s		
Sister/Charge Nurse/s		
Clinical Lead Nurse/s		
Staff Nurse >2years		
Staff Nurse <2years		
HCSW /Nursing support worker		

2. Line Management Arrangements

Please describe line management arrangements for Learning Disabilities Nurses. **We are particularly keen to understand line management arrangements for Learning Disabilities Nurses who are not operationally managed by a Nurse.**

3. Professional Supervision Arrangements

Please outline professional supervision arrangements of Learning Disabilities Nurses within your organisation.

4. Service Development

Please detail proposed developments within Learning Disabilities services within your organisation and anticipated future Learning Disabilities Nursing workforce needs

5. Total number of Learning Disabilities Nurses within the identified age ranges

Age Ranges								
≥25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+

6. Total number of nursing staff who are employed in your organisation with a nursing registration/qualification from another field of practice to meet the needs of clients with a Learning Disability.

Field of Practice	Number	Title *please specify & include all posts between Band 5- Band 8B*
Registered Nurse- Mental		
Registered Nurse -Adult		
Registered Nurse- Children's		

***7. "Specialist"* Learning Disabilities Nursing Roles**
Detail the *"specialist"* Learning Disabilities Nursing roles within your organisation or Learning Disabilities Nurses who work in specialist areas: we have suggested some examples but there may be others

Role	Number	Service area/Setting
Behaviour Nurse *Specialist*		
Health Facilitator		
Epilepsy Nurse *Specialist*		
Forensic Nurse		
other		

8. Practice Development

Do any of the Learning Disabilities nurses have dedicated time to contribute to training/practice development for example MAPA

9. Nurse Prescribing

How many Learning Disabilities Nurses are on your organisation's Prescribing Register?	

How many learning Disabilities Nurses in your organisation are actively Prescribing?	

Signed…………………………………….

APPENDIX 5

Summary Anticipated Service Development and future LD Nursing workforce needs

As a result of service modernisation Learning Disabilities Nurses will need access to a range of learning and development opportunities to acquire new and additional skills to effectively meet the needs of service users within a range of new and emerging service models. A range of learning and development needs were identified during the course of this review which will require commissioning of educational programmes including Specialist Practice programmes, short course and standalone modules and individual study days including:

- knowledge, skills and competencies to effectively work across the lifespan including traditional nursing procedures such as enteral feeding, catheterisation and medicines management

- development of skills to meet the needs of service users with more complex physical and mental health care needs, both in hospital based services and across a range of community based settings including: forensic health care, mental health, addictions and palliative care

- skills and expertise to provide improved therapeutic interventions such as intensive home treatment/crisis response, facilitation of early discharge.

- development of additional specialist nursing roles including epilepsy and behaviour management PBS, DBT

- skills and knowledge to meet the health improvement/promotion needs of learning disabilities clients
- management of challenging behaviours and related evidence based therapeutic interventions

- Additional specific to Children's Learning Disabilities Services:

    - behaviour therapy,
    - family therapy sensory integration
    - intensive support and home treatment,
    - independent prescribing

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