REPORT OF

THE FORENSIC NURSING

WORKFORCE PROJECT

GROUP

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REMIT OF THE GROUP

The creation of a full and comprehensive spectrum of forensic psychiatric services for patients in Scotland, from community support through to high security care and treatment, is now underway. The implications for the nursing profession as part of this long awaited development are significant, arguably more so than other clinical professions given the pivotal role forensic mental health nurses fulfil within current service provision both within and outwith Hospital settings, and the increase in levels of staff that will be required.

Paul Martin, Chief Nursing Officer, supported Andreana Adamson, Chief Executive of the Forensic Mental Health Services Managed Care Network, in inviting the group to, within the context of these new and developing services, identify what workplace planning initiatives need to be in place to pursue the development and sustainability of these services. This included the need to:

(i) Provide clarity on the agreed vision for this spectrum of services, including the legislative and policy context from which it has developed, and set out the implications for the nursing profession as part of this service development.

(ii) More specifically, describe what needs to be done to ensure the right number of properly skilled and competent nursing staff are in the right place, at the right time. This will include, recommendations for actions for a number of agencies including Health Boards, NHS Education, Regional Groups, Nurse Directors, Forensic Mental Health Services Managed Care Network Advisory Board and the Scottish Executive Health Department.

(iii) Describe what the real and tangible benefits to service users, their families and providers of Forensic Mental Health Services in Scotland will be, including some clinical quality indicators that will allow us to measure its success.

It was recognised at the outset of the Project that Regional Workforce Planning Directors had already established Workforce Planning Groups to develop plans to address the workforce requirements of these new and developing services.

It was vital therefore that this group did not in any way attempt to duplicate the valuable work of these groups, nor attempt to create a workforce tool in itself. Instead the groups role was to produce a Report that would both inform and support the work already underway at local, regional and national levels, while simultaneously describing a collective picture across regions, and across the spectrum of services, that would give a national understanding of the issues and challenges.

SUMMARY OF THE WORK OF THE GROUP

The entire group first met at St Andrew's House on 25 May 2005 where it agreed the scope of the work required (see appendix 1). The work was split into three particular sections which sub groups worked on to form sections of the final report. The working party members met again on 2 August 2005 and finally on 30 August 2005 to review draft sections of the report.

The final draft of the report was circulated to the entire group as well as local workforce planning groups, SEHD personnel, The State Hospital's Workforce Planner and Chief Executive of The Forensic Network for consultation before being presented to The Chief Nursing Officer in November 2005.

The Forensic Mental Health Services Managed Care Network Advisory Board invited Stephen Milloy and Carol Watson to present the report as part of a workshop entitled Workforce, Planning and Education at their National Conference, "Beyond Walls" on Tuesday 4 October 2005 at Edinburgh International Conference Centre.

ACKNOWLEDGEMENTS

The group would like to thank colleagues across the service that have been instrumental in establishing accurate figures and ratios for this report, particularly given the short timescales.

The group would also like to thank colleagues who contributed through the consultation process and would like to assure them that their comments were taken into consideration for this final version.

1. INTRODUCTION

1.1 Policy Background

NHS MEL (1999)5 Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland (Scottish Executive, 1999) set out the proposals for a co-ordinated range of services and accommodation for mentally disordered offenders designed to meet the needs of the individual and public safety. The guidance proposed that mentally disordered offenders be cared for under conditions of security appropriate to the risk they present and also emphasised the importance of rehabilitation in the care regimes that apply. The guidance further suggested that care be organised, as far as possible, in the community rather than institutional settings.

More specifically MEL (1999)5 set a clear policy statement and framework for the provision of services for mentally disordered offenders. This established the following guiding principles under which these patients should be cared for:

- With regard to quality of care and proper attention to the needs of individuals;
- As far as possible in the community rather than in institutional settings;
- Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;
- In such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- As near as possible to their own homes of families if they have them.

The MDO Policy was complementary to the Framework for Mental Health Services in Scotland (Scottish Executive 1997). The Mental Health Reference Group had been established in 1996 to assist the Scottish Office in the first drafting of the framework, which tasked Health Boards and Local Authorities to jointly organise comprehensive integrated local mental health services, based on sound interagency agreements and protocols. Priority in the provision of care and support was to be given to those with severe and/or enduring mental health problems. Core provision included a range of inpatient facilities; from the general mental health to more specifically forensic, short and longer term, inpatient care and a range of community options.

A central principle of the framework was that no patient should be discharged from hospital unless services and accommodation were in place and available. The framework anticipated the concept of the "managed clinical network" as described by the Acute Services Review Report (Scottish Executive, 1998). This highlighted the need for a formal relationship between components of a service based on standards of service, quality assurance and seamless provision of care.

It is clear that no single agency can or is expected to meet all the needs and safety dimensions involved in the care and accommodation of mentally disordered offenders. The diversity and complexity of need requires a collaborative agency approach as described in HDL (2001) 9 MDO care pathway document. Joint working and planning is the preferred route to delivering better quality services and outcomes in this and other areas of care and allows for planned activity and timetables to be agreed that reflect the different starting points for each of the Agencies involved, these include Health, Criminal Justice, Social Services, Housing and Education.

Within this policy context and in response to the consultation paper on the review of the governance at The State Hospital, "The Right Place, The Right Time" (Scottish Executive, May 2001) a Managed Care Network for Forensic Services was established with a Network Advisory Board to provide oversight.

In coming to this conclusion, the Scottish Executive Health Department (SEHD) letter drew particular attention to the challenges that exist for patients continuing to receive care in settings that no longer match their clinical needs. The establishment of a Network was considered to be the first step in the requirement in the improvement of the patient's journey. The Mental Health Care and Treatment (Scotland) Act 2003 provides patients with a right of appeal against detention to a tribunal from October 2005 and in terms of detention in levels of excessive security for their needs from May 2006 (an implementation date set in statute).

1.2 A Spectrum of Services

To improve the patient's journey, there needs to be a spectrum of services from community infrastructure, through low and medium secure care facilities to the maximum security environment of The State Hospital (see figure 1).

The SEHD have confirmed that, as policy, The State Hospital will continue to act as the national centre providing high security services for patients with mental disorders who are likely seriously to threaten others on account of their dangerous, violent or criminal propensities, and whose condition is characterised by actions outside the normal range of aggressive and irresponsible behaviour which can cause actual damage, injury or real distress to themselves and others. The most recent needs assessment for this group indicates that a smaller number of beds are required within high secure services; this will mean a gradual reduction of beds at the State Hospital over the next five years from 240 to 140. In addition, the Department made a commitment to lead in ensuring proposals for local/regional medium secure forensic psychiatric units and services be developed by the NHS Boards and their partners.

MEL (1999)5 details that within an agreed framework, NHS Boards should work towards a number of specific objectives:

- At local level a specialist service which works in tandem with the general mental health service and works closely with the criminal justice system; and management of the system so that the needs of patients and the requirement to protect the public are given equal consideration;

- Suitable medium and low secure local and regional forensic mental health accommodation for patients who have severe and enduring forms of mental illness associated with difficult and dangerous behaviour and for offender patients who require specialist services;

- Specialist forensic community services for those who require such services and onward referral to other agencies for those who do not;

- The earliest return of appropriate patients from The State Hospital to local services and the transfer of mentally disordered offenders in prison to hospital facilities where this is required;

- Regular evaluation and review of service delivery in the context of changing needs and developments

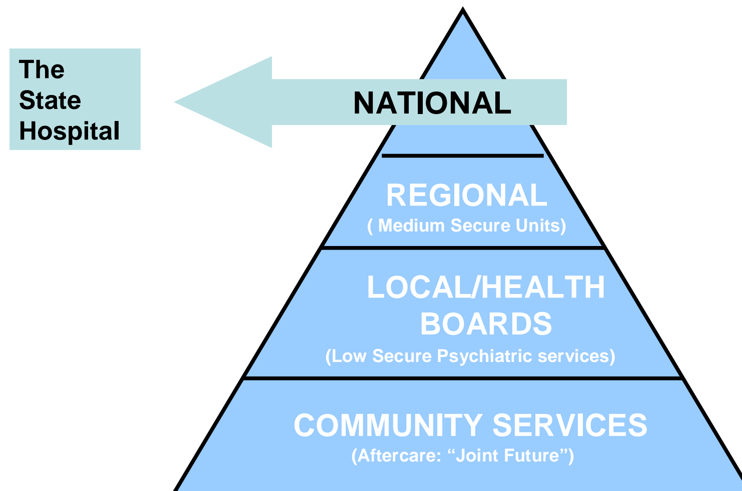


FIGURE 1

1.3 The Forensic Network

Work has already begun through the Forensic Network Advisory Board on translating these objectives into a workable regional model, current and proposed facilities and spectrum of care, in consultation with Health Boards; these are diagrammatically reflected in figures 2 to 4. It should be noted that on average 2 – 4 beds in IPCUs are used in place of low secure beds at present and are often used to nurse acutely unwell patients and that there are a further 24 low secure beds within the Covenant Churchill Clinic, an independent unit in Ayr.

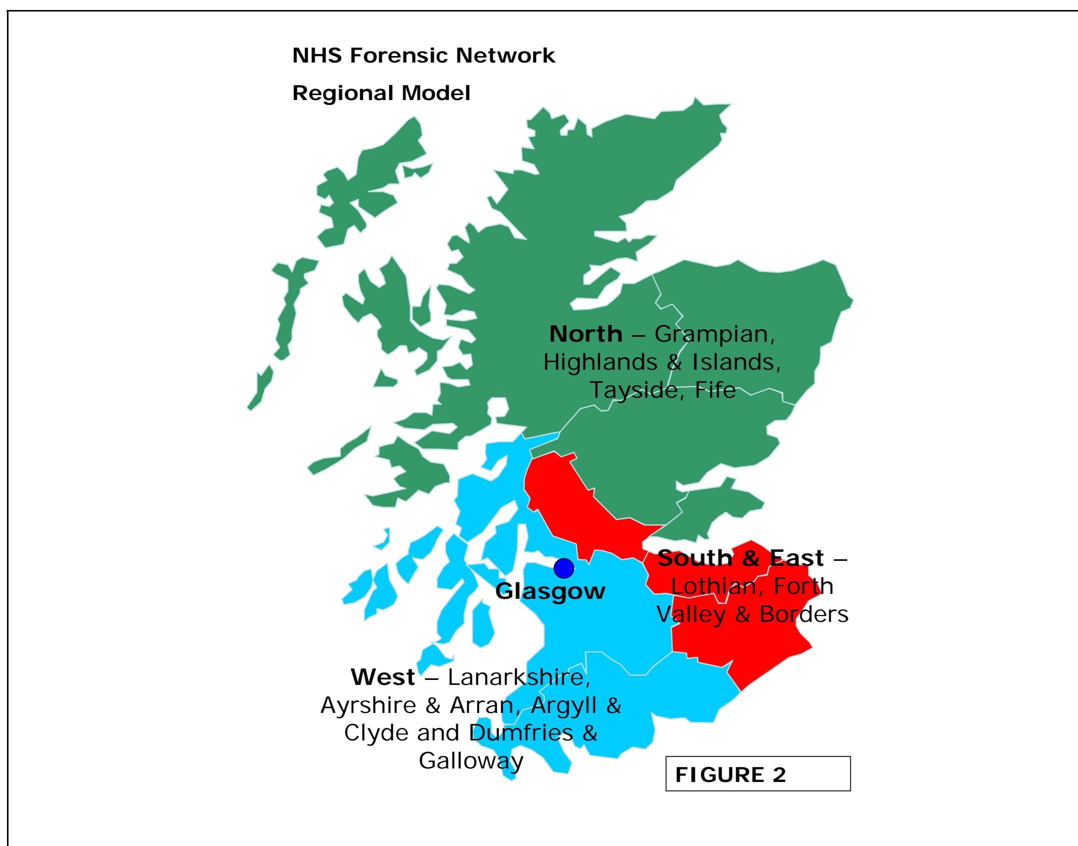


FIGURE 2

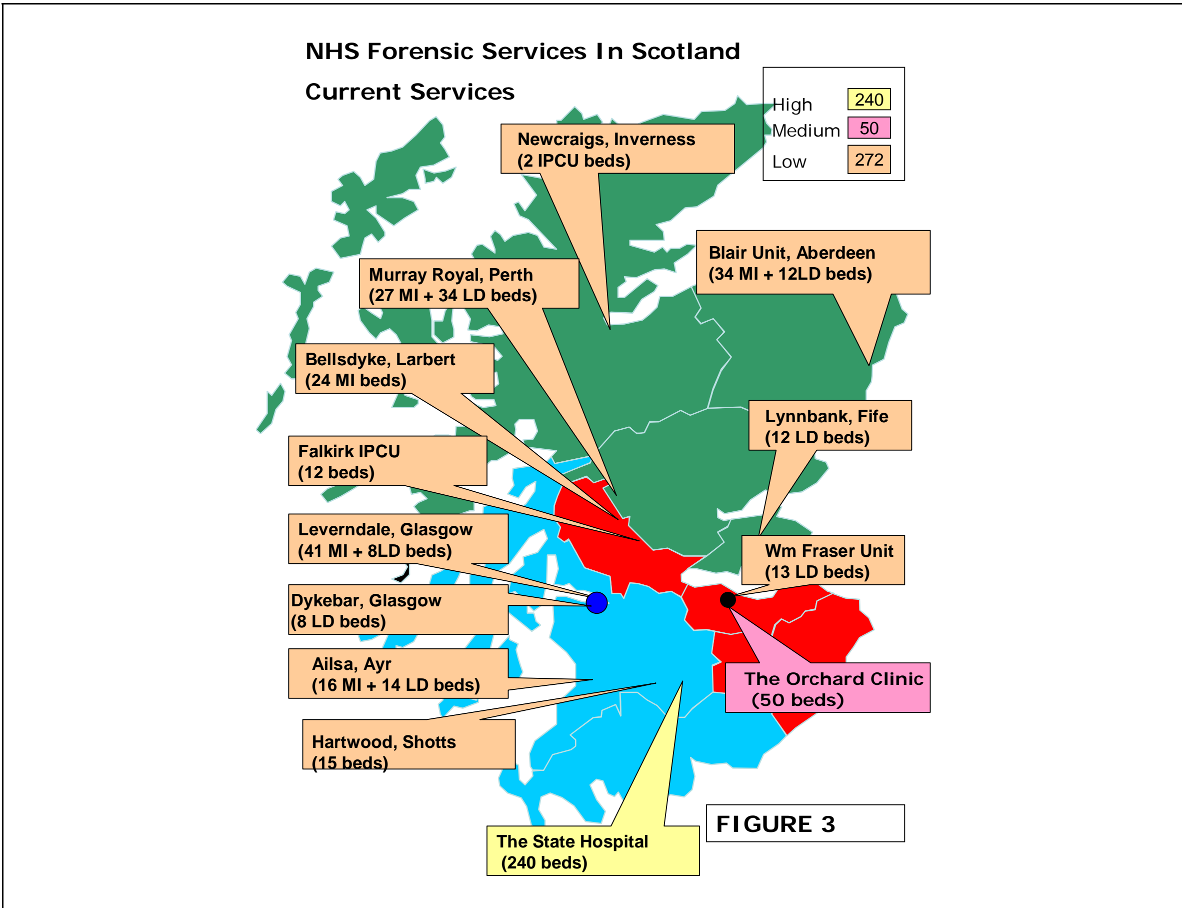


FIGURE 3

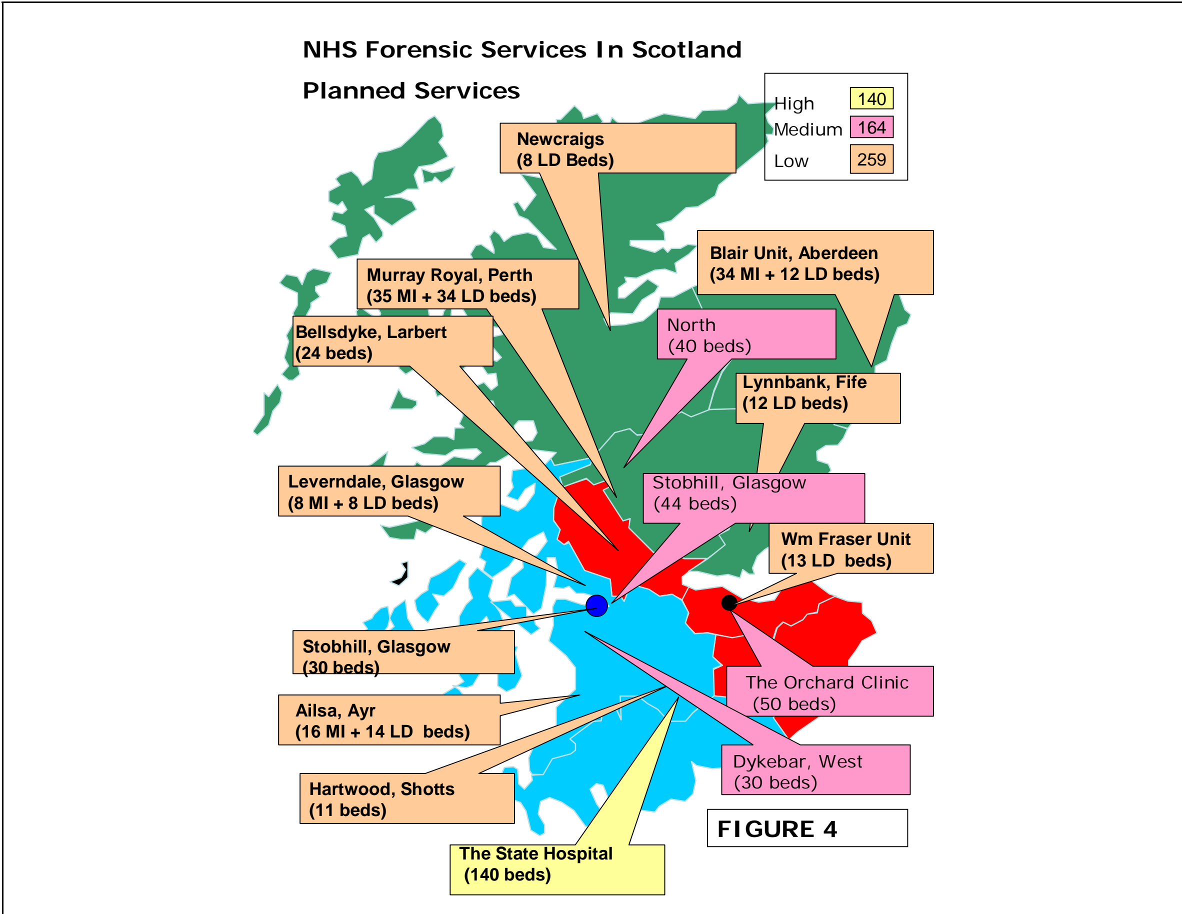


FIGURE 4

1.4 **Indicators of Success**

The achievement of these objectives by NHS Boards will bring real and tangible benefits to service users, their families and providers of forensic services in Scotland. They include:

- **Planning and Needs Assessment** – The co-ordination and the production of a comprehensive ongoing needs assessment of Forensic Mental Health Services across Scotland. NHS Boards have more recently begun to come together in Regional Planning Groupings to support the planning and development of services across NHS Board boundaries. The collation of local plans would be managed through the Regional Planning Groups which would inform a national blueprint for future forensic service provision.

- **Service Development** – The Forensic Network Advisory Board will support the Regional Groups in implementing the plan. The Board will work with the Regional Groups to ensure that correct advice is sought in the design and planning processes, to facilitate expert input, whether through training, buildings design or development of therapeutic care management packages for patients. It will also work with the Regional Groupings on ensuring adherence to the principles of the Care Programme Approach Framework.

- **Managed Clinical Networks** – One of the main indicators of success will be to create and sustain a robust managed clinical network across Scotland. Building on the existing clinical linkages, such a network could develop agreed definitions of high, medium and low secure care and decide/agree what clinical presentation should go where, offering a more transparent way of supporting clinical judgement and patient movement. The patient's journey will be supported by integrated care pathways with the way marked by clearly agreed protocols for the key stages of the patient journey including admission, assessment, transfer and discharge. It has been suggested that realisation of a fully functional clinical network might also be supported by contractual arrangements for staff to the service network (perhaps through the Regional Groupings) rather than the individual service provider.

- **Information Sharing** – The development of a comprehensive database of patients in the forensic system to provide "real time" tracking of patients and analysis of trends and potential bottlenecks in the system which may, unmanaged, lead to delays in transfers. Robust information systems will be required to secure data which can inform future planning in investment programmes and confirm that the resources are being invested in the approved development, this will include clinical data. This work would be taken forward in cooperation with local services where similar such initiatives are being progressed. The Information and Statistics Division of the NHS National Services Scotland would also be involved.

- **Research** – There is currently a solid foundation of forensic research which would be further developed. The Forensic Network Advisory Board would be encouraged to develop a broad based network of researchers / academics.

- **Education and Training** – The Forensic Network Advisory Board will have a key facilitating role in expanding the multi and uni-professional education and training in forensic mental health care and treatment. This could include bursaries, secondments, staff exchanges, academic education programmes, through to multi-professional multi-agency project working. This would minimise the risks of professional isolation. The concept of the Forensic School could be further developed.

- **Clinical Governance** – While the clinical effectiveness of local services would most appropriately be the host body's responsibility, the Forensic Network Advisory Board would however, facilitate training and the development of protocols and ensure audit processes etc. are in place. This would be achieved through providing access to a wide range of forensic services, personnel and other supports to ensure that services are fit for purpose.

- **Conflict Resolution** – Many blockages to the smooth transfer of patients across services and accommodation are due to conflicts and differing opinions between clinicians or agencies. The creation of a mechanism whereby arbitration between agencies exists, obtaining objective and independent advice/reports and making a determination of appropriate placement, will ensure a smoother seamless journey of care for patients.

- **Specialist Services** – Currently the need of smaller and discreet patient groups are not well met within our current service arrangements e.g. people with learning disabilities, personality disorders and women. The development of a broader spectrum of service will allow us to develop appropriately tailored specialists services and specialists clinicians to their benefit.

- **Appeals** – As mentioned earlier, appeals against detention and against excessive levels of security are prominent within the new Mental Health Act. The creation of a comprehensive spectrum of forensic services and facilities for patients in Scotland would unquestionably reduce the risk of high numbers of successful appeals by service users, avoiding the damaging and resource intensive fall out of such appeals for services users and their carers, service provider, NHS Boards, Tribunals and Scottish Executive Health Department.

- **Measurable Clinical Indicators** – Should all of the systems and processes outlined above be realised, then the development of clinical indicators to demonstrate patient benefit could be facilitated. Measures would include:

  - delayed discharge figures/transfer of care
  - length of stay
  - waiting lists for treatment or services
  - number of successful appeals
  - treatment efficacy
  - recidivism rates
  - patient satisfaction
  - re-admission rates

- **Workforce Indicators –** similarly, the development of workforce indicators for the full spectrum of forensic services would be enabled. Measures would include:

  - recruitment and retention
  - absenteeism
  - access to training
  - staff survey
  - compliance with staff governance standards

2. WORKFORCE REQUIREMENTS

This chapter describes the current forensic mental health in-patient services and associated nursing workforce against the projected forensic mental health in–patient service developments over the next 18 months to 5 years, as described in chapter 1 of this report.

While this is a good starting point, a comprehensive and effective spectrum of services for this patient group must have the necessary community component in place to ensure best opportunities for full rehabilitation. While community forensic services have been developing (appendix 2) much more needs done in partnerships between health & social services, and forensic and general mental health services to create a robust community infrastructure.

2.1 Scoping Current and Projected Need

In relation specifically to forensic services, very little currently exists either in the form of developed workforce models or suggested staffing levels. The Sainsbury Centre for Mental Health produced two documents, "A Mental Health Workforce for the Future" (2003) and "Finding and Keeping – A Review of Recruitment and Retention in the Mental Health Workforce" (2000). Both reports recognised the significant agenda facing mental health services in general and in particular, the challenge of achieving a workforce of sufficient numbers and quality that can respond to the amount of development associated with the requirements of national policy.

This is perhaps more so within forensic services given the requirement to provide local medium and low secure services.

The table on page 15 (figure 5) demonstrates a significant increase in the number of forensic nursing staff required over the next three years – current estimates for in-patient services alone suggest upwards of 300 extra nurses across Scotland. Although not all of the 300 posts will be registered nurses, current workforce plans suggest an average of about 160 being required.

The table shows the projected increases within each Health Board area, the proposed number of beds associated, and the resulting nurse/patient ratio. In coming to proposed staffing requirements, no recognised/standardised approach was used. A further review of literature highlighted a report "Nursing Workload Measurement in Acute Mental Health Inpatient Units" (Health Research Council of New Zealand, 2002). Although carried out in New Zealand the report concludes that an international literature review found that:

- "Historically, the usual method of workload measurement has been professional judgement and intuition and that this method remains today."

And

- "Most of the systems reviewed have been developed in general hospitals and few studies have been carried out in mental health settings."

More locally, and more recently a national Nursing and Midwifery Workload and Workforce Planning Expert Advisory Group has been established supported by a Mental Health sub–group. Reporting ultimately to the Facing the Future Group, the remit of the Mental Health sub-group will be to "Develop, pilot and assist in the implementation of nationally agreed tools for nursing workload and workforce planning including patient dependency and quality of care measures for mental health nursing". The projected timescale for this work will be 6 months and the scope of the work will include forensic mental health services.

It is anticipated that the work of this group will inform and assist local services in developing future services and will also provide a national perspective on approaches to workforce planning.

2.2 Sourcing Future Need

Historically some forensic mental health services have been staffed with nurses from the wider mental health system and from staff moving from high security services such as the State Hospital. Over the past ten years or so, general mental health services have seen major moves of staff from in-patient services to developing community services, creating and/or adding to ongoing recruitment and retention challenges.

Whilst some of the areas developing local forensic services will rely on this movement assisted by further retraction of some general mental health in-patient services, there is no doubt that this level of development would present major challenges in ensuring that safe and therapeutic levels of patient care are maintained within general mental services and developing forensic services.

Some areas have looked at the possibility of developing new roles such as "activity co-ordinator" posts, we would encourage that more of this creative approach to service and workforce planning which will be required if projected recruitment requirements are to be achieved, is developed.

Other 'new roles' may include the development of Consultant Nurses or Advanced Nurse Practitioners. There is currently only one Consultant Nurse in Forensic Services in Scotland, this could easily be developed for dedicated 'specialist areas or regional or joint' appointments enhancing both the service and the profession. These posts could provide more in the way of clinical leadership both at strategic and operational levels across developing forensic services, and in doing so maximise and champion the contribution that nurses can make within a multi-agency context.

Looking to the longer term, positive action is required to both recruit and retain more of the pool of initial recruits into nurse training, specifically mental health nursing, and to increase the recruitment pool into mental health nursing itself, to offset the potential shortfall caused by increased recruitment to specialist services.

In relation to initial pre-registration programmes support and encouragement should be given to forensic services to ensure they provide sufficient placements for undergraduate students. If student nurses are not exposed to forensic mental health placements they will be less likely to consider posts in this area once registered. Education providers too must be encouraged to review/increase forensic input into their programmes, in relation to both theory and practice and also to continue to examine and reduce attrition rates.

In relation to post-registration provision, both education and service providers should review the opportunities that are on offer and how they are marketed. Traditionally the forensic nursing population has been relatively static, with little in the way of cross-fertilisation between forensic and acute mental health services. Whilst it is vital that the development of new forensic services should not promote a significant migration of nurses from acute to forensics, it is clear that in the interests of the Continuous Professional Development (CPD) and career development of nurses there should be greater opportunities and flexibility between both services. This could be delivered with the introduction of rotation programmes, secondments and staff exchange programmes.

Increased access for health care/nursing assistants to further education through HNC in Healthcare and registration into year two of pre-registration programmes will be required. Depending on levels of uptake, further dialogue around funding/backfill arrangements will also be required. This has already proved a fruitful initiative in some areas of mental health nursing but requires consistency and sharing of good practice.

Given that the SEHD has commissioned NES to develop the one year development programme (Flying Start NHS) for all newly qualified practitioners taking up new NHS posts, it would be appropriate to use this as a vehicle to ensure that there are specific forensic mental health materials/resources and guidance for newly qualified staff in forensic services.

Given the national focus of this agenda there is an opportunity to consider a more co-ordinated and aggressive approach to marketing and advertising of future services and required workforce. For example, use of the media has proved successful in the past when targeting specific areas for development.

At a more local level, services may benefit from developing joint recruitment/workforce strategies. Over the past three months, Glasgow, West of Scotland and State Hospital staff have been meeting with this in mind and it is anticipated that approaches such as this will further support and complement the wider strategic agenda.

We are also aware that within the now published National Workforce Planning Framework, Regions are expected to publish their regional workforce plans by January 2006. At that stage a fuller picture of the demands, supply, gaps and potential for resource transfer for all professions in all mental health services, regionally and nationally, will be available. However even at this stage the indications from the Regions is that the 'gaps' identified in this report are 'additional' posts and are unlikely to be filled by resource transfer.

Figure 5

Forensic Workforce Plan: Scotland

Level of Security	Location	Current Beds		Proposed Beds		Current Staff	Proposed Staff	Difference	Skill Mix	Staff /Pt Ratio	Time scale	Comments
		MI	LD	MI	LD							
High	The State Hospital	240	0	140		279	248.4	30.6	50% / 50%	1.77		
Sub Total		240		140		279	248.4	30.6	50%/50%	1.77		
Medium	Orchard Clinic Edinburgh	50		50		94.6	94.6	No change	50% / 50%	1.90	complete	
Medium	LFPU Glasgow	0		44		0	117.5	117.5	65%/35%	2.67	Spring07/ Nov 08	
Medium	West of Scotland Dykebar	0		30		0	74.8	74.8	70% / 30%	2.50	Spring 07	
Medium	North of Scotland	0		40		0	119.12	119.12	60% / 40%	2.98	April 09	
Sub total		50		164		94.6	406.02	311.42		2.47 (average)		
Low	Leverndale Glasgow	41	8	38	8	93.3	96.7	**3.4**	65% / 35%	2.10		CURRENT: LD 8; ward 5 18; ward 6 15; boulevard 8 (LD/MI) PLANNED: Ward 5 & 6 will close. 30 beds in Stobhill plus hopefully boulevard 8 MI/LD Beds
Low	Lanarkshire Iona Ward	15	*	11		32	32	No change	65% / 35%	2.90		* 2 LD beds at Dykebar Hospital
Low	Ayrshire &Arran Ailsa Hospital	16	14	16	14	43.9	43.9	No change	65% / 35%	2.09		MI – Ballantrae 14 + 20% of IPCU LD – 14 beds from houses 5 & 6
Low	Forth Valley Bellsdyke & Falkirk	36	0	24	0	42	42	No change	40% / 60%	1.2		Bellsdyke –24 Falkirk IPCU –12
Low	West of Scotland Dykebar	0	8	To be discussed, with Glasgow possible 10 -12 beds							No timescales	Possible 32 staff available due to retraction in other services
Low	Tayside Kinnoul & Blair	27	34	35	34	60.9	83.72	**22.82**	65% / 35%	2.4		MI beds Kinnoul and Blair LD Beds Bridgefoot and Craigowl
Low	Lothian	0	13	0	13							LD Beds – Wm Fraser Unit
Low	Grampian Blair Unit Cornhill	34	12	34	12	51	51	No change	65% / 35%	1.6		MI – Acute (8) Rehab (16) IPCU (2) Hostel (8) LD – Bracken (12)
Low	Highland Newcraigs	2	0	0	8		Services currently provided within existing Mental Health IPCU beds Proposed service to be included within low secure service being developed within Tayside. (decommissioning of 32 long stay beds and developing 8 assessment and treatment LD beds – LD Report)					
Low	Fife / Lynnbank	0	12	0	12	28	No Change	No Change	55% / 45%	2.33		
Low	Dumfries & Galloway	Services currently provided within existing Mental Health IPCU beds					Proposed service to be included within low secure service being developed within West of Scotland Service					
Sub Total		171	101	158	101	323.1	349.32	26.22		2.10 (average)		
Grand Total		461	101	462	101	696.7	1003.74	307.04				

NB. At this stage the figures reflected in Figure 5 (both proposed beds and staffing) represent the projections and requirements submitted in Outline/Full Business Cases for each Region.
Taking the average skill mix figure would suggest approximately **160** of the numbers required would be **Registered Nurses**.

2.3 Skill Mix and Nurse Patient Ratios

In the absence of any recognised workforce planning model local services have relied on clinical and managerial judgement and experience to propose workforce levels. Specifically issues such as safety have been central to the process but also the need to accompany safety within a therapeutic milieu has shaped the thinking to date. The table (at figure 6) provides a comparison of nurse to patient ratios and skill mixes, in services outwith Scotland.

Workforce Plan: English Comparison

Level of Security	Location	Beds	WTE	Skill Mix	Staff / Patient Ratio
High	Broadmoor Hospital	452	794.7	52%/48%	1.76
High	Rampton	502	939	51%/49%	1.87
High	Ashworth	456	676	52% / 48%	1.48
Average					1.70
Medium	Scott Clinic Merseyside	50	120	25% / 75%	2.40
Medium	Eric Shepherd Unit Herts.	30	90	50% / 50%	3.00
Medium	Humber Centre Hull	32	67	65% / 35%	2.10
Medium	Raeside Clinic Birmingham	92	200	50% / 50%	2.20
Medium	Stockton Hall	40	95	50% / 50%	2.40
Average					2.42

FIGURE 6

Too many variables exist within each local area to comment or advise on suggested staffing levels, particularly at the upper end of the figures. The layout and location of the service, whether it is attached to existing mental health services, the number of wards, the amount of therapeutic space, the shift patterns and the existence of other key staff such as Occupational Therapy will vary across the developments and as such, proposals need to accommodate these dynamics.

However, not withstanding this, more work requires to be done on establishing ‘core’ staffing figures on the basis of safety. As such it may be more realistic to state that despite the variables one would expect to see, it would be generally expected to have no less than ‘x’ amount of nurses on duty per shift and of this number no less than ‘y’ should be registered. This would be established for low, medium and high secure services, and would be significantly informed by the contributions that are made by the wider clinical team in service provision..

3. EDUCATION AND TRAINING

In order to support workforce development in relation to nursing across the spectrum of forensic services, the subgroup carried out an initial scoping of the elements or building blocks which were already developed as well as how/if they were being currently used. As result of this exercise the following were identified. (This list is indicative and not exhaustive).

- Forensic Competency Framework- Nursing but with scope for other professions, (NBS now NES 1999)
- National Occupational Standards for Mental Health – Multi professional (Skills for Health 2001)
- Specialist Practitioner (Forensic Nursing) Programmes at Ordinary Degree and Masters Level(University of Paisley, GCU, Bell College)
- Degree level modules in forensic nursing practice (University of Paisley)
- SQA accredited units for unqualified staff –nursing (The State Hospital)

Appraisal of these resources indicated that most had a great deal of relevance, and that a short piece of work could be commissioned to update and integrate their various elements into a more cohesive forensic development framework which would support individual staff PDP's, career planning and the commission of education/training at local and national level. In addition, these could be mapped against the Knowledge Skills Framework (KSF) and the Scottish Credit and Qualification Framework (SCQF). The output of this work would then reflect current policy, legislation, service and practice development.

In addition, forensic services could be asked to review their practice education support systems, and to identify what additional (if any) resources they might require or changes they might wish to make to their structures/functions to support the increased CPD/induction/development activity over the next 3-5 years. This might also enable them to outline their CPD strategy/priorities for that timescale. It would also be helpful to identify those staff with a practice education role, (practice educator, practice education facilitator) with a view to exploring how a learning network may be established to enable them to work/plan jointly across the regions and also nationally. This would enable a consistent and value for money approach to the provision of education/training.

In order to meet the needs of the range of staff who might come to forensic services from a number of different services including other mental health/learning disability services, (ICPU, acute care, older people services) other forensic services (SPS, high secure/low secure) and to assist staff to plan their career progression within the full range of forensic provision, all development activity should be recorded in a portfolio of evidence which articulates with the individual's PDP. A clear link to the NHSS personal development planning is essential for Boards and the Network to be able to collect data on the development needs as expressed by staff, and to inform their overall CPD strategy at both local and Network level. It would be important to ensure that considerations of skill mix were refined beyond simply qualified and unqualified staff, but should capture the shape of the workforce in terms of the range of therapeutic (treatment specific) skills/competencies required to deliver contemporary quality services to patients. This will also involve consideration of new roles, some of which will be support roles to free up nurses (and AHPs) to further develop as therapeutic practitioners. Education and training will also be required for these roles.

In addition consideration needs to be given to the roles/infrastructure needed to support workforce development, and at what level?

- Workforce development manager/coordinator
- Practice Educator, a joint appointment with an education provider should be considered
- Practice Education Facilitators - at local service level
- Practice Education Co-ordinator – at Network level
- A practice Development Unit/Forensic Network School or other education /training resource?

Summary

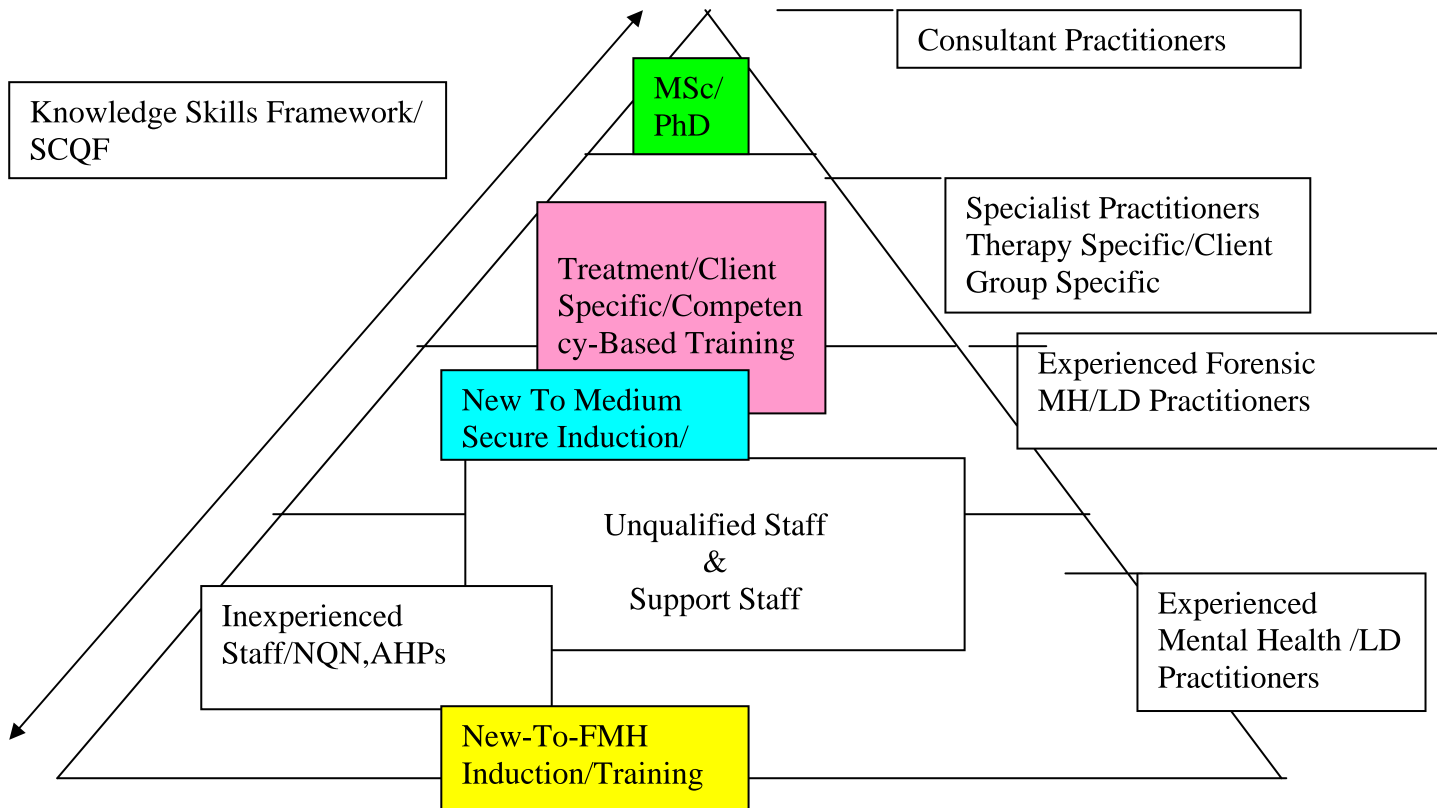
1. SEHD, through NES, commission a project officer to update the competency framework into a cohesive forensic development framework which identifies the core skills and competencies needed by forensic practitioners from induction (new to FMH) through to consultant practitioner level (see figure 7). Relevant across the whole patient journey this framework would be mapped to both KSF and SCQF and would articulate with the Newly Qualified Nurses/Midwives and AHPs development programme, the consultant nurse development programme and the current and future range of treatment specific or specialist practitioner programmes.

2. Health Boards/forensic services should review their practice education infrastructure and identify current postholders who have practice education within their remit

3. NES provides support/assistance to forensic services to develop a coherent CPD strategy, and to ensure that the development framework is integrated with staff PDP's via a portfolio of evidence.

4. Workforce modelling predictions/skill mix is clarified so that consideration can be given to the education/training needs for different roles

FIGURE 7
Draft Workforce Development/Education Training Model
August 2006



Education/training may be Health Board/Regionally/MCN/Nationally commissioned, designed delivered, or a mixture of these, with some specialist/treatment specific training delivered wholly or in partnership with HE/FE sector.

Consideration needs to be given to what new roles may need to be designed, based on an effective patient journey across all sectors of health and social care, from Primary Care, through community services to specialist forensic services-

- Liaison roles?
- Outreach workers?
- Admin support?
- Housekeepers?

The aim of this work would be that:

All forensic practitioners had access to education/training and research and development to support their current roles and enable them to progress their career within forensic mental health services, in order to meet the needs of their patients at all stages of the patient journey.

The following outcomes would be expected:

1. A clearly articulated forensic mental health development framework
2. Portfolios of evidence to support individual PDPs , which in turn will inform future development needs
3. A CPD strategy which enables the planning, commissioning and delivery of education and training at national/regional and/or local level as appropriate.

Additional Learning Outcomes in the following areas are also required:

1. PFPI and the diversity agenda
2. New legislation - Human Rights Act/Mental Health (Care and Treatment) Act and AWI/Vulnerable Adults
3. Specific risk assessment and risk management tools and strategies currently under development by the Forensic MH MCN e.g. relational, procedural environmental security
4. Care Commission Standards for Secure Care
5. Risk Management Authority
6. CPA
7. Health Economics
8. Research in Practice

4. RECOMMENDATIONS

Recommendations:

For The Scottish Executive Health Department (SEHD):

1. It is clear there will be a requirement for an increased capacity of registered nurses to ensure the development and sustainability of the full spectrum of forensic mental health services planned for Scotland. The SEHD should continue to link with NHS Employers to ensure that developing services such as forensic mental health nursing are appropriately considered for workforce planning purposes. This will have implications for commissioning the appropriate number of mental health nurse training places with the Higher Education Institutes (HEI's). This should continue to be facilitated through the Student Nurse Intake Process (SNIP). SEHD should also ensure that work is underway to address attrition rates within training programmes.

2. There has been little in the way of national marketing or recruitment strategies for mental health nurses over the years. In light of capacity requirements outlined for future services, allied to the current challenges of mental health services in recruiting nursing staff, the SEHD should ensure a significant profile within the national advertising and recruitment campaign in March 2006 for these staff. As this campaign is national, making use of multi-media opportunities, television and both regional and local media and recruitment strategies should all be taken advantage of.

3. SEHD, through NHS Education for Scotland (NES), should commission a project officer to update the current competency framework into a cohesive forensic development framework which identifies the core skills and competencies needed by forensic practitioners from induction through to consultant practitioner level. Relevant across the whole patient journey, this framework would be mapped to both KSF and SCQF and would articulate with the newly qualified nurses/midwives and allied health professional's development programme, the skills for Health Programme, the consultant nurse development programme, and the current and future range of treatment specific or specialist practitioner programmes. SEHD should also request that NES ensure that the learning resources related to forensic mental health are included within the 'Flying Start NHS' programme.

4. There is currently only one Consultant Nurse post within forensic mental health services in Scotland. The creation of more consultant nurses, particularly around specialist areas such as Women's Services, Personality Disorder, and Learning Disability, with regional focus would significantly enhance services and professional workforce development in this area. Regional Workforce Groups, Health Boards, NES, The Forensic Network, The Scottish Prison Service and SEHD should therefore enable the provision of resources to allow the network to develop several of these types of posts.

For the Forensic Mental Health Services Managed Care Network Advisory Board (Forensic Network):

5. During this initial scoping exercise we have been encouraged by the fact that Regional Workforce Planning Groups have begun to map out their projected requirements for nursing staff in their developing forensic services. However, in the absence of a recognised and validated workforce and workload assessment tool for this specialist area, not surprisingly, there is variation across the regions in relation to core staffing numbers, skill mix, staff: patient ratios, and new roles required. It is vital that consistency is brought to this while retaining some flexibility, therefore we recommend the Forensic Network should commission an inclusive working group for Workforce Development whose remit should include:

   • As a priority the development of a validated workload and workforce assessment tool for forensic mental health nursing, sensitive to local service provision circumstances, and in line with the national work in this area.

• Work with the Regions and Boards in exploring and developing new roles that add value to the service, are consistent and therefore transferable, and fit within the forensic development framework (see recommendation number 3) and are developed in line with the current national role development work.

• Explore with the SEHD, HEI's and Boards, ways to expand and develop the current Higher National Certificate (HNC) entry in the Registration Programme for Nursing Assistants/Auxiliaries to allow the service to 'grow its own' RMN's

• Act as a catalyst for sharing good practice in nursing workforce development nationally, regionally, and locally (a vehicle for this already exists in the shape of the Forensic Network's website), whilst ensuring the necessary linkages are being made with relevant groups and individuals in relation to workforce planning.

6. In line with all other clinical services, the national spectrum of forensic mental health services will need to be able to demonstrate improvements in the experience of the patients who use their service and the staff who provide it. The Forensic Network should therefore take a lead role in developing the appropriate clinical outcome measures and quality indicators as well as workforce key performance indicators.

7. We are aware the Forensic Network has already commissioned work around the concept of a Forensic School. We would encourage the Forensic Network to ensure that the conclusions from this piece of work include a clear vision of how much the school would support the development of the nursing workforce in forensic services and how it would articulate with existing education providers.

For Regionally Planning Groups:

8. We have expressed earlier in the Report that it was our intention with this exercise to provide further information and support for the work of Regional Planning Groups. We recommend therefore that the contents of this Report and its recommendations are taken into consideration by Regional Workforce Directors when developing workforce plans for Forensic Services.

9. It is likely that there will be opportunities for joint workforce initiatives and for Regional Planning Groups to work in partnership with each other and with The State Hospital. We suggest that these opportunities are developed around:

   - Advertising and recruitment of staff
   - Access to training and education
   - Joint appointments
   - Use of specialist practitioners/consultant nurses
   - Clinical management

10. Whilst the focus for this work has been nursing workforce requirements for forensic services, to achieve a full overview required consideration of local and regional plans for developing forensic services. Regional planning groups have focused efforts on medium secure care projections, plans for low secure and particularly the necessary community services are not well established in some areas, making the associated workforce requirement predictions very difficult. Regional Groups should therefore take into consideration redesign plans for the full spectrum of forensic services and in particular the need for transitional arrangements that will facilitate capacity and competence development of all clinical practitioners in a graduated fashion in advance of opening new services.

For NHS Boards:

11. During this scoping exercise we have heard of areas where the practice and commitment to the continuous professional development (CPD) of forensic nurses is of a very high standard, however this is not consistent across Scotland. We therefore recommend that all Boards should, with the support of NES, review and identify improvements to their CPD strategy and practice development infrastructures for forensic nurses. Themes should include:

    - Use of nationally agreed competencies
    - Numbers and use of Practice Education Facilitators (PEF's) and for other practice-based educator supports
    - Use of practice development structures
    - Personal development planning and learning portfolios
    - Wider access to training and development opportunities
    - Career development and the knowledge and skills framework (KSF)
    - Promoting the HNC route into nurse training within the Forensic Network

12. Health Boards should, in liaison with the appropriate HEI's, ensure there are the appropriate numbers of approved clinical areas across the full spectrum of services, that afford students high quality learning environments that are fit for purpose that in themselves contribute to the learners desire to return to work in this specialist area.

Other recommendations:

13. Ensuring the delivery of this set of recommendations is vital to the future success of the current and planned forensic mental health service in Scotland. It may therefore be prudent, given the number of stakeholders involved in the recommendations, to ask a group to oversee their implementation, monitoring progress and dealing supportively with any obstacles to progress. We recommend that the Forensic Network Workforce Development Group referred to in recommendation number 5 is asked to take on this role.

14. Throughout this exercise, several clinical professionals and workforce planners have commented positively on the value of taking a wider, co-ordinated and inclusive approach to these significant challenges. Understandably some have asked if it is planned that similar exercises be carried out for other forensic professionals. It is absolutely essential that a 'full service' approach is taken to address the gaps identified in this Report, particularly given the inter-dependant nature of effective multi-disciplinary working and the variations in practice across services. We recommend that Regional Workforce Directors and The Forensic Network develop workforce plans with this as a guiding principle.

15. Given the significance of a structured and nationally recognised framework for education and competency development within the service, NES should explore the need for a national post of Practice Education Coordinator to ensure a consistent and integrated approach is taken across regions.

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Scottish Executive (2005) *The National Workforce Planning Framework*

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Appendix 1

PROJECT SCOPE

OBJECTIVES	ACTIONS / TASKS REQUIRED	TARGET DATE	LEAD RESPONSIBILITY
1. Describe the vision for the National Forensic Managed Network.	Reference Documents: - MEL (1999) 5 - 'Right Place, Right Time' - HDL (2001) 9 MDO Care Pathway Document - Andreana Adamson Interim Network Report - Offender Mental Health Care Pathway (NICE) Jan 2005 Presentations made to Forensic Network Preface with 'purpose of the report' Explicit link to Nursing	**02.08.05**	**S Milloy** **R Samuel**
2. Identify what success will look like, including some clinical quality indicators.	Reference Documents: - As Above - New Mental Health Act - Forensic Care Standards (John Crichton) - QIS Schizophrenia Standards Need to include: - Service Indicators - Educational Indicators (Carol) - Workforce Indicators (Martin / Ron / Barbara) Orchard Clinics Experience - Successes - Quality indicators	**02.08.05**	**S Milloy** **R Samuel**

3. Identify what skills competences ratios and numbers will be required to deliver the vision.	Split Objective into (i) Numbers and Ratios and (ii) Skills and Competencies (i) Numbers and Ratios: - Need workforce model for numbers and ratios - Need for consistency across network with special cases described - Full spectrum of services included i.e community, low, medium, high - Trained : Untrained ratios included - Need for new roles (e.g activity worker) included - Must link and compliment Forensic Network Boards considerations and Regional Workforce Groups - Implications for Senior Nurses and CNS's - Examine English database for Specials, MSU's, Private (ii) Skills and Competencies - Development for staff currently in service - Induction of newly qualified RMN's into Forensic Services. - Re-examine current Forensic Competencies - 'Skills for Health' Standards - Use of, and numbers of PEF's - Use of, and numbers of HNC Students - Role of the Forensic School - Agreed model of delivery for (pre and post) Education - Use of Consultant Nurses - Skills and competencies of unregistered nurses included Orchard Clinic Experience: - Numbers and Ratios, what works, what doesn't - Skills and Competencies Reference to National Workforce Planning Report (Pauline	**02.08.05**	**M Montgomery** **R MacLeod** **B Wilson** **C Watson** **Supported by:** **Ron, Martin, John, Barbara**

	Milne) due for publication June 2005		
4. Who therefore, needs to be doing what and when (in the form of recommendations) that will include actions for; - Scottish Executive (CNO) - NHS Education - Local Boards and Services - Regional Groups - Forensic Network Board - HEI's - Others -	This 'objective' informed by other 'objectives' Immediacy of MSU development taken into consideration on timescales Themes within recommendations may include; - Commissioning of Educational Places - Commissioning of New Roles - Recruitment and retention strategies (board, regional, national) - Prison Service implications - Geographical challenges and issues for North East - Joint working between Glasgow and West of Scotland - Advertising campaigns - Links with Education and the Service - Competency (re)development - Outcomes and Clinical indicators - Service Development Plans - Funding and resourcing - Joint arrangements between Health and others Recommendations should link with and support other wider workforce plans and arrangements	02.08.05	**FULL GROUP**
5. Deliver report to CNO by 30th September 2005.			

Appendix 2

Nursing Community Forensic Services:

Health Board	Location	Max Caseload	Additional Activity	WTE	Skill Mix	Shift Pattern
Glasgow	Charing Cross	12	Court	10	100%	Monday - Friday
Argyll & Clyde	Blysthwood House Renfrew	12	Court & Prison	6	100%	Monday - Friday
Lothian	Orchard Clinic	12				Monday - Friday
Lanarkshire	Hartwood Hospital	15	Court/Prison	5	90%	Monday - Friday
Forth Valley	Gateway Business Park Grangemouth	15	Court on an on-call basis Prison	5	100%	Monday - Friday
State Hospital	Carstairs	No Community Service				
Ayrshire & Arran	MacAdam House Ayr					Monday - Friday
Dumfries & Galloway	West of Scotland	No Community Service				
Fife	Lynnbank	17	Also has generic caseload	1	100%	Monday - Friday
Tayside	Murray Royal	10	Court, prison, police cells	2	100%	Monday - Friday
Grampian	Royal Cornhill					Monday - Friday
Highlands	Newcraigs Inverness	No minimum	Court Prison Police cells Procurator Fiscal	1	100%	Monday - Friday