Evaluation Of the 2009-2011 Bamford Action Plan

As at December 2011

Integrated Projects Unit

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Department of
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CONTENTS

1 BACKGROUND

1.1 Background

Bamford Review of Mental Health and Learning Disability

1.1.1 The Bamford Review of Mental Health and Learning Disability, an independent and comprehensive review of legislation, policy and service provision, concluded in August 2007. Key messages arising from the Review called for:

- continued emphasis on promotion of positive mental health
- reform of mental health legislation
- a continued shift from hospital to community-based services
- development of specialist services, for children and young people, older people, those with addiction problems and those in the criminal justice system
- an adequate trained workforce to deliver these services.

1.1.2 The Review envisaged a 10-15 year timescale for full implementation of its recommendations.

1.2 Bamford Action Plan

1.2.1 The Northern Ireland Executive's response to the findings of the Bamford Review, Delivering the Bamford Vision, was consulted on in 2008. This led to the publication in October 2009 of the Bamford Action Plan (2009 – 2011).

1.2.2 This Plan set out the Executive's commitment across Departments to improving the mental health and well-being of the population of Northern Ireland and to driving service improvement for those with a mental health need or a learning disability. It contains agreed actions and timescales for Northern Ireland Government Departments and Health and Social Care sectors.

1.2.3 In committing to the delivery of the first stage of the Bamford reforms via the 2009-2011 Action Plan the Executive was very aware of the challenges for the future that would have a major influence on the implementation of that plan and future plans. These challenges are set out in Section 2.

1.2.4 The Plan further enhanced the key Bamford messages, Para 1.1.1, by grouping of all actions, 80 mental health and 67 learning disability, under five themes.

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers and families

- Providing better services to meet individual needs
- Developing structures and a legislative framework

1.2.5 Progressing these themes, securing adequate resourcing (Section 3) and establishing delivery structures (Section 4) of the Action Plan addressed the identified challenges and established a firm foundation for delivery for change over the first two years of the ongoing Bamford Vision.

1.2.6 The Action Plan instituted a requirement for positive cross-sectoral working within Government and recognised the need to engage with service users, their families and carers to ensure services were fit for purpose. The Plan also compelled those who provide services to engage with each other to improve interfaces and ensure a coherent approach to delivery. The Action Plan initiated steps to drive cultural change across society, Government and health and social care provision.

1.2.7 An inter-Ministerial group, chaired by the Minister for Health, Social Services and Public Safety (DHSSPS) was established to oversee the work.

1.3 Aims of Evaluation

1.3.1 The Bamford Action Plan 2009-2011 reaches its expiry date in 2011. The Plan contains a commitment to review and roll it forward in 2011. Recognising this requirement the inter-Ministerial Group in late 2010 agreed that the DHSSPS should lead on an evaluation of the implementation of the current Plan.

1.3.2 Evaluation is a continuous process of setting objectives, collecting information, judging outcomes, reviewing progress and making decisions about what else needs to happen.

1.3.3 It was envisaged that this evaluation would

- give assurance on what has been achieved
- identify any key learning from the experience of implementing this Plan; and
- inform the development of the next Plan from 2011 onwards.

1.3.4 Given the current Action Plan spans only a short period of time in a longer-term programme of modernisation and reform, the evaluation at this stage focuses on achievement of the actions in the Plan.

1.3.5 This evaluation is therefore concerned with assessing how far the Action Plan is achieving its purpose and ensuring that the investment in specific mental health and learning disability services is appropriately targeted and is making a difference for the population of Northern Ireland.

1.3.6 The evaluation is informed by:

- the routine system used to monitor the extent to which the actions in the

2009-2011 Plan have been achieved;
- relevant supporting data where quantified targets were set in the Action Plan;
- any evaluation carried out or supporting measurement of targets in relation to specific actions within the Plan; and
- reports from the Bamford Monitoring Group.

1.3.7 The following sections of this document consider:

Section 2 – Challenges
Section 3 - The resources that were dedicated to delivery of the Action Plan
Section 4 - The structures put in place to drive the Plan forward and to monitor its progress
Section 5 – The outputs achieved
Section 6 – The outcomes achieved and
Section 7 – The lessons to be learned.

Editors Note

1.3.8 Whilst every effort has been made to ensure the accuracy of information within this Evaluation the delivery and enhancement of mental health and learning disability services is continually progressing. Some of the service improvements, delivery timescales and quantitative delivery data outlined within this Evaluation, though correct at the time of writing, may have been superseded.

2 Key Challenges faced in 2009

2.1 Background

2.1.1 At the time of the formulation of the Action Plan Bamford stakeholders identified a number of challenges which would have a major influence on implementation of this Action Plan and future plans. These included:

- population mental health and wellbeing;
- demographic change, particularly our longer lifespans with increasing complexity of needs;
- the need for a shift to early intervention; and
- the need to integrate treatment, care and support to meet the needs of individuals regardless of age or geographical location.

2.1.2 It was also recognised as crucial to the success of the Bamford Vision that Government Departments and other Bamford stakeholders collaborate on bidding, cross-support and implementation. It was recognised that the voluntary and community sectors have an important role. Many such organisations are run by or have input from people who have direct experience of the services themselves and can therefore provide informed and sensitive support and advice.

2.2 Mental Health

2.2.1 The focus of mental health services was seen as the provision of a comprehensive range of safe and effective recovery-based services for all age groups that support people with a mental health need to achieve and maintain their maximum level of functioning.

2.2.2 The key challenges in the delivery of the Action Plan were seen as :

- establishing a stepped care approach to service provision;
- enhancing the range of options available to primary care professionals to deal with the mental health needs presenting to them;
- improving access to psychological therapies;
- streamlining access to all mental health services;
- providing home based care and support as the norm for the delivery of mental health services;
- applying a systematic approach to enable the recovery of people with long term conditions;
- building up the range of specialist mental health services required to meet need; and
- redesigning and extending roles and retention of an effective workforce.

2.3 Learning Disability

2.3.1 The Action Plan recognised that people with a learning disability must be treated as equal citizens, fully included in mainstream services and in the life of the community, empowered to participate actively in decisions affecting their lives, enabled to work together with their families and representatives and helped to use their individual strengths to reach their full potential. Learning disability is a lifelong condition and service users therefore require sustained services, not just individual episodes of care and treatment.

2.3.2 The Action Plan embraced a life long approach encompassing:

- early intervention and support for individuals, families and carers;
- appropriate interagency care planning with involvement of individuals and carers;
- education, training and life opportunities, appropriate to individual needs;
- promoting and maintaining physical and mental health and wellbeing and the management of chronic conditions;
- effective management of transitions – from infancy to school, childhood to adolescence, adolescence to adulthood and adulthood to old age
- effective succession planning and supported living to meet the needs of older relatives and the individual with learning disability; and
- end of life care and bereavement counselling.

2.3.4 The actions in the Action Plan aimed to address these challenges. In order to clearly identify key output areas all actions were grouped together under 5 themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers and families
- Providing better services to meet people's needs
- Providing structures and legislative base to deliver the Bamford Vision

2.3.5 Progress in each of these themes will be considered in a later section of this report.

3 INPUTS

3.1 Financial resources

3.1.1 People with a mental health need or a learning disability benefit from services funded by a range of Departments, but the DHSSPS, the Department of Education (DE) and the Department for Social Development (DSD) are key contributors. DHSSPS and DE have specific funding streams devoted to services for these groups of people.

Health and Social Care Funding

Baseline

3.1.2 In 2007/08 within the DHSSPS's area of responsibility just under £200m was spent on mental health services and just over £200m on learning disability services. Considering also the funding for services for older people with dementia, this made up almost one quarter of Health and Social Care Trusts' expenditure. However at that time it was noted that too high a proportion of mental health and learning disability funding was spent on hospital services rather than community settings.

3.1.3 At that time DHSSPS also allocated £6.8m to the implementation of the New Strategic Direction for Alcohol and Drugs and a further £4m for mental health promotion.

3.1.4 Recognising the fundamental role of voluntary and community bodies in providing support to people and in promoting partnerships in health improvement, DHSSPS supports a number of voluntary and community sector organisations who deliver services in the fields of mental health and learning disability. Annual DHSSPS expenditure on these amounts to approximately £2m.

2008-2011 Comprehensive Spending Review

3.1.5 As a result of the 2008-2011 Comprehensive Spending Review (CSR) DHSSPS planned to allocate from within its resources an additional £44m to mental health and learning disability services as set out below.

DHSSPS mental health and learning disability proposed allocation breakdown

3.1.6

		08/09 £m	09/10 £m	10/11 £m	Total £m
Learning Disability	Cumulative	7.00	9.00	17.00	
	In-year additions	7.00	2.00	8.00	17.00
Mental Health	Cumulative	12.75	14.60	27.00	
	In-year additions	12.75*	1.85**	12.40	27.00
TOTAL					44.00

* including £400k allocated direct from DHSSPS ** including £300k allocated direct

from DHSSPS

3.1.7 A further £3m was also made available to support mental health promotion and suicide prevention over the three year period.

Efficiencies

3.1.8 The Northern Ireland Assembly agreed annual service wide efficiency savings of 3% for the three years 2008 – 2011. These efficiencies impacted on all Departments and required delivery of savings totalling £700 million across the public sector over the three years of the CSR.

3.1.9 Pressures on public spending across all Departments in 2010/11 resulted in a reduction in the allocations for Bamford from what had originally been planned. This substantial reduction – from an additional £20.4m anticipated to an actual addition of £6m – impacted on the delivery of some actions within the Action Plan, which will be considered in later Sections.

		08/09 £m	09/10 £m	10/11 £m	Total £m
Learning Disability	Cumulative	7.00	9.00	12.40	
	In-year additions	7.00	2.00	3.20	12.40
Mental Health	Cumulative	12.40	14.30	17.10	
	In-year additions	12.40	1.90	2.8	17.10
TOTAL					29.50

Overall Health and Social Care Service Expenditure

3.1.10 Despite the need to meet efficiency targets in 2009/10 and 2010/11, recent data indicates that actual expenditure on mental health and learning disability services in these years compared with a baseline of 2007/08 increased by more than the amounts allocated from DHSSPS.

3.1.11 By the end of 2010/11, expenditure on mental health services had risen by £32.31 from the baseline of £195.69m in 07/08, while the additional CSR allocation for this period was £17.10m.

3.1.12 Mental Health Expenditure (£m)

	07/08	08/09	09/10	10/11
Hospital	95.81	109.49	107.04	103.46
Community and Social Services	99.88	111.96	117.26	124.54
Total actual spend	195.69	221.45	224.30	228.00
Increase over 2007/08 baseline		25.76	28.61	32.31
Bamford CSR inputs		12.40	14.30	17.10
Additional funds from HSC allocations		13.36	14.31	15.21

3.1.13 Learning disability service data demonstrates corresponding increased resourcing over and above the Bamford CSR uplift. By the end of 2010/11, expenditure on learning disability services had risen by £39.88m from the baseline of £200.2m in 07/08, while the additional CSR allocation for this period was £12.40m.

3.1.14 Learning Disability Expenditure (£m)

	07/08	08/09	09/10	10/11
Hospital	40.14	42.67	42.23	42.98
Community and Social Services	160.06	172.64	186.03	197.09
Total actual spend	200.20	215.31	228.26	240.08
Increase over 2007/08 baseline		15.11	28.06	39.88
Bamford CSR inputs		7.00	9.00	12.40
Additional funds from HSC allocations		8.11	19.06	27.48

3.1.15 A wide range of Departments and agencies fund programmes and services which benefit people with mental ill-health or a learning disability. Most of these benefit a

wider range of people; it is not therefore possible to identify how much of this funding directly impacts Bamford services.

Section 5 in this evaluation will set out the major quantifiable outputs this resourcing has supported.

3.2 Staffing

Workforce Review

3.2.1 It was recognised that the successful implementation of the reform of mental health and learning disability services would rely on the development of an appropriately sized workforce with the necessary competencies to deliver the range of services required.

3.2.2 One of the actions within the Action Plan was to complete a workforce planning study for mental health and learning disability health and social care services. Deloitte MCS Limited was commissioned by the DHSSPS to undertake a workforce planning review to support the implementation of the Bamford Vision. This work established the baseline workforce at the beginning of the Action Plan period as follows:

Mental health workforce

3.2.3 In March 2008 3,461 people were working in mental health services in the statutory sector, equating to 3,256.22 Whole Time Equivalents (WTEs). Nursing staff made up the largest proportion of the workforce accounting for just less than three quarters of the mental health staff identified.

Learning disability workforce

3.2.4 At the same date 2,139 people were working in learning disability statutory sector services or 1,881.71 WTEs. Nursing and social work were the two largest staffing groups.

Non-statutory support

3.2.5 The workforce review also recognised the invaluable role of the community and voluntary sectors and attempted to quantify the numbers of staff involved in these sectors through a Northern Ireland Council for Voluntary Action (NICVA) survey.

3.2.6 In total, 80 organisations responding to the NICVA survey stated their primary or secondary beneficiaries to be people with mental health needs those organisations employing a total headcount of 1,685 staff.

3.2.7 Within the learning disability sector the NICVA survey identified 64 organisations stated their primary or secondary beneficiaries to be people with a learning disability; employing a total headcount of 2,685 staff.

3.2.8 The total number of staff in the community and voluntary sector providing services to individuals with mental health (MH) and learning disability (LD) needs at that time was therefore estimated at 4,370.

Workforce Review recommendations

3.2.9 The Review noted major trends within the workforce with regard to age, gender and working patterns. Overall, the collated data with regard to workforce turnover indicated a relatively stable workforce, with some areas of growth.

3.2.10 The Review foresaw that implementation of the Bamford recommendations would result in a number of new roles and teams being introduced into the mental health and learning disability workforce. However the Review concluded that given the economic climate and the restraints and challenges of budgets, a considerable proportion of the change within the mental health and learning disability workforce would be through reform and modernisation of the existing workforce.

4 STRUCTURES

4.1 Bamford Vision

4.1.1 Delivering the Bamford Vision is a cross-Departmental challenge which has required the establishment of a range of structures to oversee the development of the Action Plan, drive forward its delivery and monitor progress. Lead responsibility for individual actions in the Action Plan is spread across a number of Departments and statutory agencies.

4.2 Ministerial Level

4.2.1 The Bamford Ministerial Implementation Group, chaired by the Minister for Health, Social Services and Public Safety, oversees and drives forward the broad strategic changes required across Government and ensures that the issues requiring inter-Departmental co-operation are taken forward in a co-ordinated and coherent manner. This Ministerial Group was constituted prior to the inception of the 2009-2011 Action Plan and assisted in the formulation of the Executive response to the Bamford Review.

4.2.2 The Group has representation from 10 Departments:

- Health and Social Services and Public Safety (DHSSPS) - chairing Role
- Social Development (DSD)
- Regional Development (DRD)
- Enterprise, Trade and Investment (DETI)
- Culture, Arts and Leisure (DCAL)
- Education (DE)
- Employment and Learning (DEL)
- Finance and Personnel (DFP)
- Office of the First Minister and Deputy First Minister (OFMDFM)
- Justice (DOJ)

Departmental breakdown

4.2.3 Mental Health

	Actions	Percentage
DHSSPS	32	40
HSC	18	23
PHA	2	3
PCC	1	1

DEL	9	11
DE	6	8
OFMDFM	4	5
DCAL	2	3
DETI	2	3
DFP	2	3
DSD	2	3
	80	100

4.2.4 Learning Disability

	Actions	Percentage
DHSSPS	24	36
HSC	16	24
PHA	2	3
PCC	1	1
DE	10	15
DEL	5	7
OFMDFM	2	3
DCAL	2	3
DFP	2	3
DSD	2	3
DRD	1	1
	67	100

4.3 Bamford Inter-Departmental Officials Group

4.3.1 An Officials group mirrors the composition of the Ministerial Group and is chaired by a senior official within DHSSPS. In addition to the Departments represented at Ministerial level it has representation from:

- the Health and Social Care (HSC) Taskforce and
- the Bamford Monitoring Group - user and carer representation

4.3.2 This ensures a co-ordinated response to the Bamford review and the group reports to the Ministerial Group on progress.

4.3.3 The cross-sectoral working established by this Group has been very productive in developing a network of civil servants and HSC professionals to drive forward the Bamford Vision. In addition to the twice-yearly programmed meeting members of this Group have, coordinated workshops, developed joint CSR bids, facilitated bi-lateral meetings to resolve specific issues and shared learning and wider contacts.

4.4 Health and Social Care Sector

HSC Taskforce on Mental Health and Learning disability

4.4.1 More than a quarter of the actions in the Action Plan fell to either the Health and Social Care Board (HSCB) or the Public Health Agency (PHA) to lead on and many of these required cooperation between these two bodies and other organisations. The HSC Taskforce jointly chaired by the HSCB and the PHA was formed to co-ordinate and lead on these actions.

4.4.2 Main duties of the HSC Taskforce are to:

- Promote positive mental health and wellbeing of the population of Northern Ireland, recognising that mental health is inextricably linked to a range of other health conditions, social care and lifestyle behaviours.
- Recognise the importance of good general health, wellbeing and early intervention for those with a mental health need or learning disability; and that individuals, their families and carers have a right to live as independently as possible, regardless of the cause(s) of the underlying condition.
- Continue to promote societal change which aims to destigmatise mental health and learning disabilities, recognising that a partnership approach and inter-sectoral working, which includes the voluntary and community sectors, will be necessary to effect change and improve the quality of life.
- Secure reform and modernisation of HSC mental health and learning disability services in line with Delivering the Bamford Vision.
- Co-ordinate work to take forward specific actions assigned to the HSC in the Bamford Action Plan(s) supporting Delivering the Bamford Vision and to deliver those actions to the agreed timeframe.
- Provide an annual work plan to the Minister for Health, Social Services and Public

Safety and to report annually to the Minister on that work plan.
- Provide the Bamford Monitoring Group of the Patient and Client Council (PCC) the annual work plan and annual report and any interim progress reports as agreed between the HSC Taskforce and Bamford Monitoring Group; and
- Contribute to the review of the Bamford Action Plan in 2011 and beyond, as requested by the Department.

4.4.3 In order to make progress on all of the priority areas within the timescales on the Action Plan a project structure was put in place comprising:

- HSC Taskforce Project Board comprising senior stakeholders representatives.
- Regional Commissioning team.
- Taskforce sub-groups - aligned with the key output service areas from the Bamford Vision:
    - Adult mental health
    - Learning disability
    - Autistic Spectrum disorder
    - Specialist Support Services
    - Eating disorders
    - Child and Adolescent Mental Health Services (CAMHS)
    - Protect life and mental health promotion and
    - Drugs and Alcohol

4.4.4 Sub group members include service users, carers, voluntary organisations, HSC Trusts as service providers, other statutory bodies and HSCB and PHA staff.

HSC Taskforce Work Plan

4.4.5 The Taskforce is required to make a formal annual report to the Minister. The first annual report was made in September 2010, a year after the issue of the Action Plan, setting out progress on each of the actions for which the HSC Taskforce has responsibility. The Taskforce also submitted a Work Plan setting out objectives and priorities for 2010-11 for each of the subgroups, linking these to the Bamford Action Plan 2009-2011 objectives and commissioning priorities. The Work Plan also stresses that implementation of the objectives is dependent on available funding.

4.5 Bamford Monitoring Group

4.5.1 The involvement of service users and carers in planning, delivery and monitoring of services was a strong underpinning theme of the Bamford Review itself and this is being maintained within the work to deliver the Bamford Vision. The aim of the Bamford Monitoring Group is to capture the views and experiences of those with mental health needs or learning disabilities and their families and carers on the changes resulting from the Bamford Review. The Bamford Monitoring Group is supported by the Patient and

Client Council. The group has representation from service users, carers and Patient and Client Council members and meets on a monthly basis.

4.5.2 The main duties of the Bamford Monitoring Group are to:

- Involve the public in assessing progress on implementation across Government of 'Delivering the Bamford Vision';
- Engage with the HSC Taskforce and other relevant groups;
- Support the public, people with mental health needs, learning disabilities, their families and carers in making recommendations as to how implementation can be improved;
- Advise the Minister on any specific aspects of mental health and learning disability service commissioning, delivery or outcomes as appropriate to the Bamford Review;
- Report annually to Minister and to provide a work plan.

Patient and Client Council Membership scheme

4.5.3 The wider PCC membership scheme creates opportunities for people with a general interest in health and social care service delivery to have their say in how these services are developed and implemented. Subsections of this scheme focus in on mental health and learning disability issues. The views and concerns of this wider network are channelled directly into the Bamford Monitoring Group and serve to keep the Group informed on grass-roots issues and as a sounding board for performance, implementation and policy queries. Membership is open to anyone living in Northern Ireland and includes individuals and organisations. The scheme is free to join, and there are no age restrictions.

4.5.4 It is now almost two years since the HSC Taskforce and Bamford Monitoring Group were established and the inter-Departmental groups have been operating since 2008. Their effectiveness is considered later in this document at Section 5.

5 OUTPUTS

5.1 Summary of Progress on Actions

5.1.1 This first Bamford Action Plan establishes a solid foundation for service enhancements. Many of the actions within it delivered policies and strategies that may not have delivered observable outcomes over the lifetime of this Plan, but those outcomes will be more visible through the implementation of programmes and services in future years.

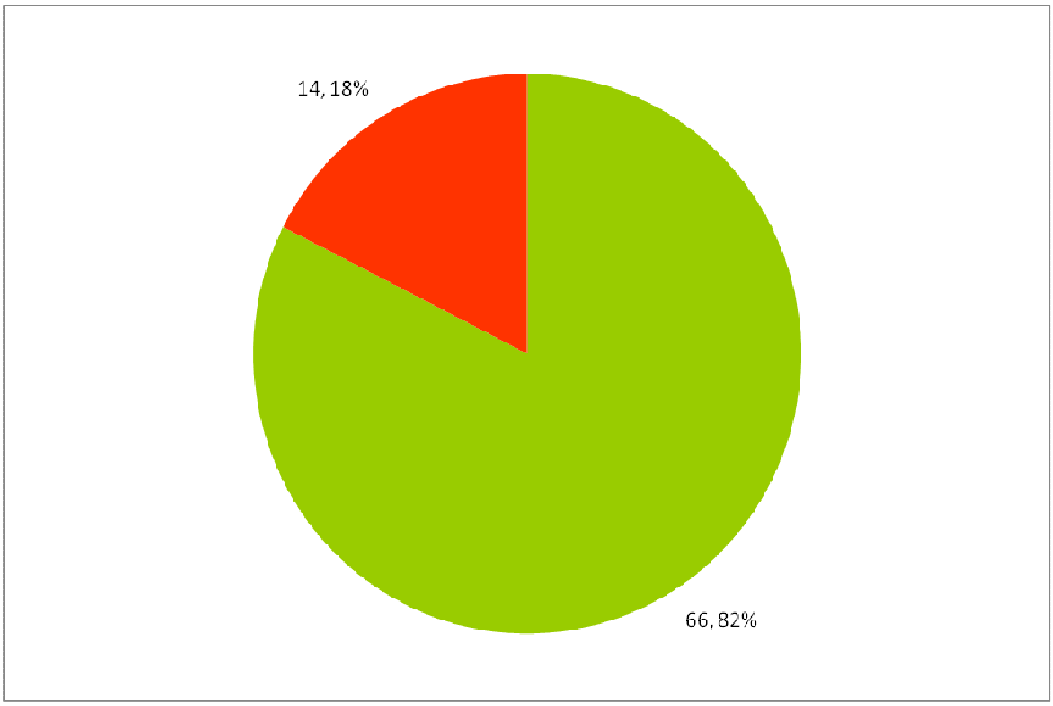
5.1.2 Each action in the Action Plan identified the Department(s) or agency(ies) responsible for delivery, the output required and the timetable for delivery. In order to report to the inter-Ministerial group on progress, monitoring arrangements have tracked the implementation of actions every six months using a traffic light indication system (Green, Amber and Red) to enable identification of those targets on track for achievement and those at either some or serious risk of failure.

5.1.3 The monitoring returns at June 2011 were used as a final indicator of the number of actions achieved or not achieved (either Green or Red) and the charts below illustrate overall progress.

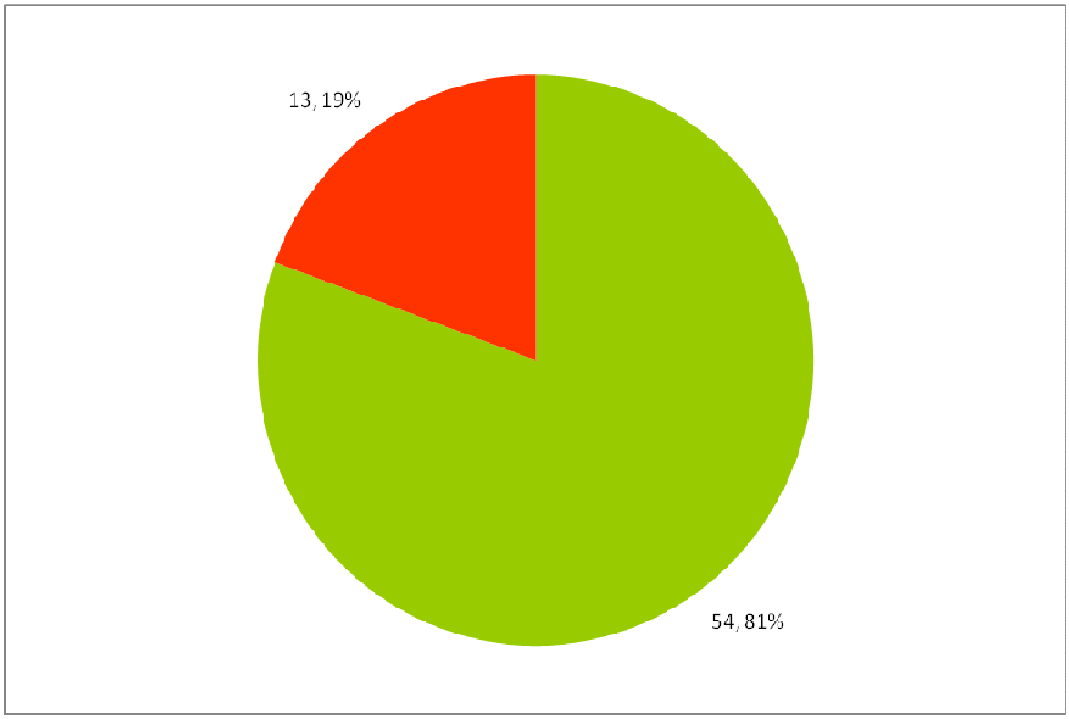
	GREEN	RED
Mental Health	82%	18%
Learning Disability	81%	19%

5.1.4

Mental health



Learning disability



5.1.5 The remainder of this section of the evaluation will reflect on the achievements and failures highlighted in these monitoring returns.

5.1.6 In considering the 14 mental health actions and 13 learning disability indicating RED; while it is entirely correct to say that the full objectives set in 2009 were not achieved, some progress has been made on many of the actions.

5.1.7 Some actions had multiple objectives within the action; a GREEN indicator was awarded only if all of these sub-objectives were achieved.

5.1.8 The reduction in funding particularly in 2010 did restrict some service delivery. In some cases lack of staffing resources delayed the implementation, e.g. service mapping. For others ongoing work, post the June monitoring, has now resulted in actions indicating RED here now being achieved, e.g. the Regional Dementia Strategy.

5.1.9 There were those actions such as the implementation of the Protect Life strategy and its associated target of a 15% reduction in the overall suicide rate that were impacted by external conditions, however even in these instances it is possible to see progress.

5.1.10 These RED indicators therefore reflect the inflexible nature of our self-imposed - achieved or not yet achieved - monitoring regime and the outcome of monitoring at June 2011. Where appropriate, these actions will continue to be progressed via the follow-on Action Plan. Annex B sets out all Bamford actions as monitored in June 2011, the numerical tags added in 2010 have also been included and referenced throughout this section.

5.2 Quantifiable Targets

5.2.1 Some of the actions set quantified targets for delivery over the life of the Action Plan. These actions are set out in Annex A. It was difficult in a small number of cases to establish baseline data immediately aligned with targets in the Action Plan because of existing database limitations, overlapping timelines or service descriptors. The tables below summarise data from Annex A

5.2.2 Learning Disability

Number of Actions	achieved	Not yet achieved	Percentage achieved
4	4	0	100%

5.2.3 Mental Health

Number of Actions	achieved	Not yet achieved	Percentage achieved
9	6	3	66%

5.2.4 Further deliberation on the failure to deliver regarding the 4 mental health actions highlighted in Annex A is presented later in this section.

Consideration of five Themes of Action Plan

5.2.5 The actions in the Action Plan were grouped in five key themes, which are considered in turn in the sections that follow.

5.3 Promoting positive health and wellbeing

5.3.1 The actions within this theme reflect the Bamford ethos of a holistic approach to promoting positive community heath, well being and early intervention. Many factors affect mental and emotional health and these can be addressed at a number of levels by a variety of organisations as well as individuals themselves. Several actions being taken forward by Department of Education recognise the importance of promoting good emotional health from an early age. The Action Plan also recognised the importance for people with a learning disability of maintaining good physical health and having access to the same health services as everyone else in order to look after their health.

Mental Health and Well-being Strategy

5.3.2 The Department committed to develop a new Mental Health & Wellbeing Promotion Strategy, M1, to replace the original Promoting Mental Health Strategy. Progress has been delayed due to need to gain cross Departmental/sectoral commitment. It is expected that a new 5 year Mental Health and Wellbeing Promotion Strategy will be published during 2012.

5.3.3 The new strategy will define the aim, objectives and priority actions for the promotion of mental wellbeing in Northern Ireland during 2011 to 2016. It will focus on building the mental and emotional resilience of the whole population and of specific "raised risk" groups. The strategy will acknowledge that all aspects of life impact on mental wellbeing and that action to promote better mental health and wellbeing requires effective collaboration across Departments and sectors. For example, it will be necessary to support action across complimentary agendas such as Anti-Poverty, Community Safety, Fuel Poverty, Housing, Domestic Abuse, Neighbourhood Renewal, Early Years, and the Children's Strategy.

Protect Life

5.3.5 The implementation arrangements for the Protect Life strategy on suicide prevention , M2/M3, are well established. The suicide strategy implementation body advises and can challenge the Department on the implementation of the strategy. Membership of that group is drawn from a wide range of areas, including the statutory sector, the voluntary and community sector and families bereaved by suicide. In addition, the Public Health Agency and HSC Trusts work with local multi agency implementation groups to develop community action plans, which are funded under Protect Life. The Public Health Agency leads on the commissioning of regional training, specific pilot projects and awareness raising. Coordination of local, regional and cross border initiatives is taken forward by the HSC Taskforce sub group. Action is also progressing to implement the All Island Action Plan for Suicide Prevention in partnership with the National Office for Suicide Prevention.

5.3.6 The Protect Life strategy set a target to reduce the overall suicide rate by 15% by 2011. This however has not been achieved. 2010 witnessed the highest ever

recorded suicide rate in Northern Ireland (20% increase on 2009), and there is concern that the ongoing economic downturn could further negatively impact on our ability to deliver on the future reduction of local suicide rates. Tackling suicide is a complex matter which is influenced by a wide range of societal issues, and enhanced cross-Departmental and cross-sectoral efforts will therefore be required to address the social, cultural, and economic determinants of health and wellbeing. Progress against the cross-Departmental actions in the refreshed Protect Life strategy will be monitored by the Ministerial Co-ordination Group on Suicide Prevention, and DHSSPS will continue to ensure identification and implementation of the latest international evidence-based interventions on suicide prevention.

5.3.7 The Bamford Monitoring Group's report, Is Bamford Making a Difference?, Section 6, noted issues during times of crisis, gaining help when needed, assessment and in relation to accessing appropriate services.

Early Years

5.3.8 Early intervention has to be a key element in the approach to improving our young people's mental and emotional health. Children and young people need to be equipped with the necessary coping skills to deal with life's problems as they come their way.

5.3.9 In June 2010 DE launched the consultation process of the draft Early Years (0-6) Strategy, L4/M4. A new strategy will be published early in 2012. The purpose of the new 5 year Strategy is to set out a vision and plan for ensuring better outcomes for children by improving the provision and quality of services to the youngest children, their parents and families. It reflects the drive for cohesion in the policies and services affecting early years so that children and parents get the best outcomes possible.

5.3.10 The Northern Ireland Child Health Promotion Programme has been redesigned and the document Healthy Child, Healthy Future: A Framework for the Universal Child Health Promotion Programme in Northern Ireland was issued in May 2010. The framework sets out a core programme of child health contacts that every family can expect, wherever they live in Northern Ireland. It recognises that individual families are different and that there is a need to be flexible and innovative to ensure that all families are able to access and benefit from the advice, support and services that are available to them.

Schools and Colleges

5.3.11 The revised school curriculum provides a means of helping children and young people to understand the stressors that can impact on their lives and about coping mechanisms and sources of help. All pupils in post primary schools have access to counselling support which is independent of the school if they wish to use it.

5.3.12 The Action Plan recognised the DE's proactive measures to support pupils throughout their educational lives through a revised curriculum, M5, a new

programme of pastoral care and counselling, M6, M7 and M8, guidance and support materials to tackle bullying, M9, and identification of those at risk, M10. Five work streams are currently taking forward different aspects of the development of the Pupils Emotional Health and Wellbeing Programme. Each Work Stream includes representatives from DE, DHSSPS, Education and Library Boards and the Voluntary and Community Sectors.

5.3.13 A Pupils Emotion Health and Well-being, PEHAW, work stream developed homework diary inserts for use for post -primary pupils in the 2010/11 school year. The design and content were updated and revised for the 2011/12 school year. Evaluative feedback and constructive suggestions on format and appropriateness of the topics covered from stakeholders will inform development of future insert issues.

5.3.14 The work of all the dedicated PEHAW workgroups is complemented by opportunities for pupils to experience the mental well-being benefits of participation in sport and physical recreation.

5.3.15 These new programmes are ensuring the needs of young people are met and resilient foundations are built for positive mental health development during adulthood.

5.3.16 The Bamford Monitoring Group has observed that more evaluative work is needed to ensure qualitative outcomes are delivered to service users.

Workplace

5.3.17 Bamford stakeholders also recognised the importance of ensuring ongoing support in the working environment M11, M14 and M15. The Health and Safety Executive NI (HSENI) supported this by funding amounting to £237K over the period of the Action Plan.

5.3.18 HSENI established the Stress and Mental Wellbeing Unit comprising of health and safety inspectors and Workplace Health Advisors in April 2009. The unit is primarily focused on the promotion of mental wellbeing in the workplace, through the prevention of work-related stress and implementation of the HSE Management Standards.

5.3.19 HSENI have ensured that all Northern Ireland Civil Servants have been issued with the HSE management standards questionnaire and have supported a number of Departments/business units in further completing the management standards process (currently 630 staff). HSENI have actively supported 13 Councils and approximately 4290 Council staff, 230 staff in the Health Sector, 250 staff in the Education sector, 800 staff in the Police Service for Northern Ireland and are actively supporting the Northern Ireland Prison Service (approximately 2350 staff).

5.3.20 In March 2010 HSENI, in partnership with a range of interested organisations, produced Mental Wellbeing – A general guide for employers. This guide purposed to create a working environment that encourages mental wellbeing to enable

employers to be better equipped to address workplace mental wellbeing issues.

Sport and Physical Recreation Strategy

5.3.21 It has been recognised that access to stress relievers such as hobbies and recreational activities is extremely important for good mental health. DCAL's Sport and Physical Recreation Strategy, L9/M13, is a 10 year strategy that sets out to improve opportunities for people to gain the mental well being benefits of participation in sport and physical recreation.

Special Olympics

5.3.22 In NI the Special Olympics programme, operating through Special Olympics Ulster (SOU) one of the regional arms of Special Olympics Ireland, has over 2,000 active registered athletes participating in 15 different sports. These athletes are supported by 3,792 volunteers in 64 different clubs throughout NI.

5.3.23 In June 2010 Sport NI produced a final business case to support funding of SOU over a 4-year period 2011/12 to 2014/15 amounting to £2,295k. Ministers from DCAL, OFMDFM, DE, DSD and DHSSPS have agreed to support funding of SOU over this period.

5.3.24 Funding for SOU does not solely cover the delivery of sporting benefits, it covers delivery of services provided through SOU which further core aims of each of the relevant Departments:

- DCAL - increased participation in sport;
- DHSSPS - health benefits for disabled people;
- DSD - volunteering and active citizenship;
- DE - provision of opportunities to actively participate in public life; and
- OFMDFM - provision of equal opportunities to those with disabilities

5.3.25 SOU anticipate that as a result of funding from the Executive it will be able to expand the number of clubs and reach out to a large number of people who are not yet engaged.

Drugs and Alcohol

5.3.26 Through the implementation of the New Strategic Direction for Alcohol and Drugs and its underpinning Hidden Harm and Young People's Drinking Action Plans, high level targets were set to reduce alcohol and drug abuse and its impact on those who abuse substances and their families, M16. This work requires action across Departments, voluntary groups and community associations.

5.3.27 A 15% reduction in the proportion of adults who binge drink, 38% 2005 to 32% in 2008, has been delivered against a target of 5%. A 10% reduction in the proportion of young people who report getting drunk from the baseline in 2003 has been

achieved and the 5% reduction in the proportion of young adults taking illegal drugs is on target for delivery.

5.3.28 The Bamford Monitoring Group has suggested that the New Strategic Direction for Alcohol and Drugs should be linked within the wider mental health strategy as many people are affected by both alcohol/drugs and mental health.

Domestic and sexual violence

5.3.29 Domestic and sexual violence can have profound effects on the emotional wellbeing of victims and their families. Cross-sectoral work, M17 and M18 has continued to take forward the Action Plans which support the strategies tackling these two issues. Work in the period since 2009 has included:

- provision of a Government-funded 24 Hour Domestic Violence Helpline to provide information, advice and support to all victims of domestic violence;
- routine checks have been introduced for pregnant women engaging HSC services and it is planned to extend to GPs and A&E Departments;
- domestic violence guidance documents for employers, agencies, faith communities and political representatives;
- appointment of a specialised Domestic Violence Officer in each PSNI command;
- specialised domestic violence training for Court and Prosecution Service staff;
- a public information media campaign on sexual violence and abuse;
- a review of sexual abuse counselling services to increase capacity and improve timescales for adult victims accessing services;
- a Regional Directory of Services which details all existing services across the voluntary and statutory sectors available for child and adult victims of sexual violence and abuse;
- work to establish, by 2012, a new Regional Sexual Assault Referral Centre SARC to provide 24 hour crisis response to adults and children who are the victims of sexual violence or abuse.

Equal Access to Health Services

5.3.30 The Action Plan required that persons with a learning disability should have equal access to the full range of primary health care services, L1. A Directed Enhanced Service (DES) for adults with a learning disability has been put in place in each Health and Social Care Trust area. The DES is being delivered in each Trust by a partnership approach between Primary Care staff and Trust Health Facilitators have now been appointed in each Trust. The Heath Facilitators ensure continuing contact between people with a learning disability and primary care. To date 3654 health checks have been carried out. The percentage of adults initially seen, and people recalled and reviewed with a learning disability will be recorded and reported as part of the DES specification.

5.3.31 The Plan also had a number of actions in relation to improving access to dental services for people with a learning disability, L49, 50 and 51. The pivotal action

related to the appointment of a consultant in Specialist Care Dentistry. While attempts were made to fill the consultant post, this was successful only for a limited period. It has not been possible therefore to progress the related actions to training pathways and to training primary care dental care professionals. The need to further enhance oral health services for people with an learning disability will be actioned in the follow-on plan.

5.3.31 People with a learning difficulty have reported difficulties in assessing and communicating with their GP. Although the DES for adults with a learning disability has been put in place in each HSC Trust, more evaluative work is necessary to assess the experiences of service users.

5.3.32 The Bamford Monitoring Group has also noted issues for people with a learning difficulty using general hospitals despite the development of recent GAIN guidelines.

5.3.33 People with a learning difficulty who are also deaf or hard of hearing have reported difficulty in accessing help through health services.

5.4 Supporting carers

5.4.1 In line with the Bamford Vision, carers are acknowledged as a vital part of the Government's vision of providing support for people to live more independent lives and helping people remain in their own homes and live independently for longer. Carers must be recognised and valued as equal partners in the provision of care at every level of public sector planning and service delivery, and be properly supported to maintain their life outside of their caring role.

Carer Support Review

5.4.2 Both the DHSSPS Valuing Carers strategy and a joint DHSSPS/DSD Review of Support Provision for Carers (2009) emphasised the importance of the provision of relevant information and signposting for carers.

5.4.3 The 2009 Review was completed and contained 15 recommendations, to be taken forward by DHSSPS and DSD.

http://www.dhsspsni.gov.uk/review-of-support.pdf

5.4.4 Progress has been made in relation to many of the recommendations contained in the Review, such as:

- The HSCB has agreed to take over chairmanship of the Carers' Strategy Implementation Group CSIG. The reconstituted CSIG will take on a role of monitoring implementation of the other recommendations of the Review;