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CARE AT ITS BEST

Everyone wants what's best for children in Hospital

Regional Multidisciplinary Inspection
of the Service for Disabled Children in Hospital

CARE AT ITS BEST

OVERVIEW REPORT OF THE MULTIDISCIPLINARY REGIONAL INSPECTION OF THE SERVICE FOR DISABLED CHILDREN IN HOSPITAL

October 2005

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CARE AT ITS BEST

Regional Multidisciplinary Inspection of the Service for Disabled Children in Hospital

1. Introduction

1.1 Everyone wants what's best for children in hospital. For most children and young people, hospital stays can be a daunting experience, but they are usually short and relatively rare events in a child's life. For a significant number of disabled children, however, hospital admissions can be frequent and prolonged. Their needs bring many additional challenges to the children, their families and the hospital team, as well as to those responsible for their continuing care in the community. It is crucial that all involved in the care of such children should work together in the best possible ways to secure the best possible outcomes for them. 'Care at its Best' provides a framework to enable this to happen.

1.2 The members of the Inspection Team wish to record their thanks to staff in Health and Social Services Boards and Trusts for their willing assistance throughout the inspection and in particular to the inspection coordinators for their help in easing what was at times a complex and resource intensive process. The Team is also most grateful to the members of the reference group who worked hard to develop the standards and provide useful information, tips and suggestions, clearly born out of invaluable personal and professional experience. Very special thanks is due, however, to the children, young people, parents and carers who not only gave their time but shared their deepest personal experiences in the most open and uncritical manner, with a view to making the service better for children in the future.

1.3 We hope this report will do justice to the input of everyone who assisted the inspection. We believe that the findings and recommendations have much wider application than to the particular children under consideration. It is - after all - widely accepted that what's good for disabled children is more than likely to be good for all children.

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2. The Inspection

Background

2.1 The Children (NI) Order (1995) (The Children Order) sets out the powers and responsibilities of Health and Social Services Boards and Trusts (Boards and Trusts) to provide services to children in need and their families. A central principle of the Order is that whilst disabled children are children in need, they are children first and they should have access to the full range of general children's services as well as specialist provision. Amongst the additional life challenges that disabled children may face, is the fact they are likely to be more dependent on health and social care services than other children. Inevitably they will also spend more time in and out of hospital. The Children Order recognises the vulnerabilities of children in hospital, particularly those who experience a long term hospital admission of 3 months or more. It contains special provisions aimed at safeguarding their welfare - these are set out in full in Part 5.26 of this report.

2.2 This report presents the main findings of a multidisciplinary regional inspection, led by the Social Services Inspectorate (SSI), of the service for disabled children in hospital. The inspection came about as a result of concerns expressed to SSI and brought to the attention of the Children Matter Task Force[1] about the number of disabled children who spend long periods in hospital due to the absence of appropriate community based provision. It was therefore included in the SSI 2002 – 2005 inspection programme and approved by the then Minister for Health, Social Services and Public Safety.

2.3 In terms of the wider implications of the inspection, the Department of Health, Social Services and Public Safety (the Department) is currently developing a Health and Social Services Strategic Framework for Children, Young People and Families to keep pace with local, regional, national and international changes in service provision and policy for children. The Framework will set high level outcomes, indicators, targets and action plans covering all activities across health and social services. With regard to providing services for disabled children, the Framework will be significantly informed by the findings of this inspection.

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[1] An inter-agency group established by the Department to take forward the recommendations of the 'Children Matter' (DHSS, 1998) report into residential care provision for children in Northern Ireland.

Aim and scope of the inspection

2.4 The aim of the inspection was to assess the extent to which the service for disabled children in hospital met the requirements of the Children Order and reflected standards of best practice in the key areas of:

- commissioning arrangements, structure, organisation and management of children's hospital services;
- assessment and care planning for disabled children;
- the range and quality of service provision;
- educational provision for children in hospital;
- workforce planning, staff training and support;
- communication and information; and
- equality and human rights.

2.5 In determining how to achieve as full a picture as possible of disabled children and their needs, the Inspection Team decided to concentrate on a sample of children and young people who had a long term hospital admission of 3 months or more and who therefore fell within the statutory provisions of the Children Order. It was felt that their care was likely to demonstrate in a comprehensive way, the range of issues affecting all disabled children in hospital.

2.6 The Team considered medical, nursing, social work, psychology, allied health professional (AHP) and education services as well as multidisciplinary and partnership working in the service provided to children and their families. Although the inspection did not specifically review pharmacy services, the findings identified a number of issues within the pharmaceutical domain which are reflected in the recommendations. These have been discussed with the Department's Chief Pharmaceutical Officer for Northern Ireland.

2.7 The inspection fieldwork was conducted in 2003 across 8 hospital sites and final reports were issued to each hospital in 2004. Appendix A contains the terms of reference for the inspection and the methodology for the process. The members of the multidisciplinary team and the reference group are detailed in Appendix B. To assess the quality of the service provided, the Inspection Team developed a framework of draft standards and criteria for each of the areas to be considered. These are set out in full in Appendix C. This report considers key issues that emerged under each of the standards and contains recommendations about how the service should be improved.

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The children and young people

2.8 Each Hospital and Health and Social Services Trust in Northern Ireland was asked to submit to the Department, anonymized information on all children who had been admitted to hospital (or were already inpatients) for a period of not less than 3 months between 1 April 2000 and 31 March 2002. The inspection included some additional children who met the 3 months criterion and who were patients in the selected hospitals during the fieldwork process, which commenced in January 2003.

2.9 The Tables in Appendix D provide a detailed breakdown of the children's information. Reference is made to the information contained in relevant Tables throughout the report. The following is, however, a 'headline' overview of the key characteristics of this population of children:

- At least [1]173 children and young people had been in hospital for 3 months or more during the period under consideration (Table 1);
- Slightly more boys (92) than girls (81) had long term hospital stays (Table 2);
- Of the 173 children, there were more babies under 12 months (28%) and children aged 11-15 years (35%) than children of any other age group (Table 2);
- Of those children whose religion was recorded, there were significantly more Catholic (75) than Protestant (50) children. In 18% of cases, religion was recorded as 'unknown' (Table 3);
- The vast majority of the children (84%) were of white ethnic origin – the ethnicity of 14% of children was unknown/unrecorded (Table 4);
- The largest numbers of children came from Homefirst Trust (32 children), North and West Belfast Trust (28 children) and South and East Belfast Trust (26 children) (Table 5). The numbers of children from North and West and South and East Belfast Trusts were larger than expected, particularly for those admitted to the Young People's Centre and Muckamore Abbey Hospital. (Census figures show that Foyle and Down Lisburn Trusts have larger child populations than either South and East or North and West Belfast Trusts and that Homefirst Trust has approximately twice as many children and young people than either of the latter);

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[1] This allows for some margin of error in the data i.e. returns not made by some Trusts on children who fell within the criteria.

- The most recent hospital admission for children who were discharged during the period under consideration lasted between 3 and 5 months for 81 (59%) children and between 6 and 11 months for 28 (20%) children. The remaining 24 (18%) children who were discharged and whose length of stay was known had been in hospital for I year or longer (Table 6);

- At least[1] 43 (25%) children in the sample had been in hospital on at least one previous occasion and a further 29 (17%) had been in hospital continuously or almost continuously since birth (Table 7);

- Of those children who had been in hospital since birth, all but 2 were discharged or died before they were 6 months old. One child was discharged at 13 months and another child died just after her second birthday (Table 8);

- Four hospitals that provided Northern Ireland wide regional services in learning disability; mental health (children and adolescents); and neonatal, medical and surgical services including most regional specialities accounted for 71% of long term admissions (Table 9);

- Many children had multiple disabilities. The main disabilities reported were developmental delay (41%); learning disability (39%); challenging behaviour (39%); behavioural disorder (35%); emotional disturbance (31%); severe or chronic illness (28%) and physical disability (27%) (Table 10); and

- The most important reasons cited for children's admissions were challenging behaviour (22%), in hospital since birth (16%) and risk to self (14%) (Table 11).

2.10 The Inspection Team undertook an in depth analysis of the case records of 39 children and young people admitted to the hospitals whose children's services had been selected for inspection. Interviews were carried out with key staff responsible for the children's care as well as with children themselves (where possible) and with parents, carers and families.

The hospitals

2.11 The Inspection Team selected 8 hospitals (Figure 1) that together represented the main features necessary for an effective and province-wide overview of the hospital service for children. The hospitals chosen

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[1] There was most likely some under-recording of this since some children's previous admissions were picked up from the other hospitals' returns.

included those that were part of a dedicated hospital services Trust and those that formed part of a Trust responsible for both hospital and community services. They each fell within the remit of one of Northern Ireland's 4 Health and Social Services Boards. The choice took into account the profile of regional (i.e. Northern Ireland wide), specialist and acute services as well as types of disability, the age range of children and the location of children's inpatient care in dedicated children's or adult facilities. The hospitals in the sample accounted for some 145 children i.e. 84% of 173 children who experienced a long-term hospital admission during the period under consideration (Table 12).

2.12 As with most inspections of services, the recommendations of the report tend to focus on what needs to change to improve the quality of service provision. There were, however, several examples of good practice and some examples of excellent practice in the hospitals inspected. Of the many that might have been included, the Team have chosen one particular example of good practice in each of the hospitals inspected. These are by no means the most important clinical or care matters commended in each hospital, but they offer an opportunity for shared learning in innovation that might easily be transferred to other settings. The hospitals are described briefly in Figure 1, which includes paragraph references to the examples of good practice cited in the report.

2.13 Each of the hospitals had a significant interface with community Trusts through the provision of social work, AHP services, Child and Adolescent Mental Health Services (CAMHS) or other specialist services. In some cases, there were joint hospital and community based appointments of medical staff. There were also liaison relationships with community Trusts in the admission and discharge of children from hospital. These are referenced at appropriate stages throughout the report.

2.14 Final inspection reports were issued to Trusts responsible for each of the above hospitals, their respective Boards and relevant community Trusts in 2004. These are public documents, copies of which may be obtained by contacting SSI. A separate executive summary of this report is also available.

Figure 1: Profile of the hospitals inspected and good practice examples

Hospital	Description	Good practice example	Paragraph reference
Altnagelvin Hospital (Londonderry)	An acute hospital with one children's and one neonatal ward serving the Londonderry, Limavady and Strabane District Council areas of the Western Board.	The support of technology dependent children from hospital to the community.	3.19
St Luke's Hospital (Armagh)	A mental health hospital for adults incorporating Cloughmore Ward which provides two mental health inpatient beds for adolescent patients from across the Southern Board's area.	Links with the community based Child and Adolescent Mental Health Team.	5.8
The Longstone Hospital (Armagh)	A Southern Board area hospital within the adult learning disability programme of care, which occasionally admits young people under the age of 18 years.	Links with the community based Social Services Trust's Children with Disabilities and the Child Care teams.	5.34
Muckamore Abbey Hospital (Antrim)	A regional care and treatment hospital for adults with learning disability and for children with severe, moderate and profound learning disabilities who need specialist care.	Behaviour Nurse Therapy Team.	4.37
Antrim Area Hospital	An acute hospital with one children's and one neonatal unit to serve the communities of Antrim and surrounding districts within the Northern Board's area.	Multidisciplinary arrangements and the use of multidisciplinary recording.	5.44
The Royal Belfast Hospital for Sick Children	An acute hospital which also provides most regional specialities. The hospital is part of the Royal Belfast Hospitals Trust in the Eastern Board's area,	Play specialists in the children's wards.	10.10
The Young People's Centre (Belfast)	A centre that during the period of the inspection provided regional mental health inpatient services on 2 separate sites to young people aged between 13 and 18 years.	Engagement with and involvement of young people in their care planning.	5.18

Hospital	Description	Good practice example	Paragraph reference
Forster Green Hospital (Belfast)	Part of the Green Park Hospitals Trust in the Eastern Board's area. Two services were inspected on the Forster Green site.		
Neuro-rehabilition services	A regional unit for people with acquired brain injury which admits some young people from the age of 14 years.	Multidisciplinary assessment and care planning.	5.13
The Child and Family Centre	A regional centre which is the only mental health inpatient facility for children under the age of 14 years in Northern Ireland.	Baseline audit against child specific service standards.	4.55

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3. Themes to inform Strategic Planning for Disabled Children

3.1 A number of overarching themes emerged during the course of the inspection. These mainly concerned hospital-community interfaces that need to be addressed at a regional level within children's services planning frameworks. Of relevance to the themes outlined below will be the findings of the Review of Mental Health and Learning Disability, Northern Ireland, established by the Department in 2002 and led by Professor David Bamford. The Review, which will inform Departmental planning, is due to produce its final reports on children's mental health and learning disability services by early 2006. These may well draw similar matters to attention. They are well worth repeating.

Children and young people in specialist[1] hospitals

3.2 The Regional Strategy for Health and Wellbeing 1997–2002 contained the objective that by 2002, children should not be admitted to specialist hospitals, other than in exceptional circumstances (DHSS, 1997).

Children in mental health hospitals

3.3 During the 28 month period under consideration by the Inspection Team, 51 children and young people had spent periods of 3 consecutive months or longer in mental health hospitals (Table 13). Of these, 5 children had been admitted to adult psychiatric units, 28 children had been admitted to the Child and Family Centre at Forster Green Hospital and 18 young people to the Young People's Centre, then based in the centre of Belfast. The latter 2 facilities are the only inpatient mental health units in Northern Ireland dedicated exclusively to the care of children and young people. The Inspection Team supported the need for inpatient mental health provision for children and young people and strongly endorsed the continuing need for regional or area wide children's inpatient services. It was disappointing to note, however, that whilst both of these facilities, which should have been leading centres of excellence in short term assessment, treatment and care, were operating without the full multidisciplinary staffing necessary to achieve the best outcomes for children and young people in the shortest possible time. Both had significant waiting lists and a number of children had been admitted

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[1] Hospitals providing either dedicated mental health services or services to patients who have learning disabilities.

to, or remained in, each facility longer than was clinically necessary due to lack of community support or alternative specialist services, such as day units, appropriate to their needs (see 3.15-16). Neither service was operating in buildings that were suited to their purpose. The Department has, however, recently approved a business case for the replacement of the current regional inpatient mental health facility for young people with an 18 bedded purpose built adolescent unit on the Forster Green site. This will address some, but not the full developmental needs, of the child and adolescent mental health service.

3.4 ***Boards should give priority to establishing Tier 4[1] child and adolescent mental health services. The services should provide for full and intensive multidisciplinary assessment, treatment and care of children in facilities that are specifically designed for specialist interventions.***

3.5 Mental health inpatient provision for children and young people is currently under consideration by an interagency group established by the Department to advise on the regional development of child and adolescent mental health services. It is important that the findings of this inspection should inform the work of the regional group.

3.6 ***The Departmental Regional CAMHS Development Group should take account of the findings of this inspection to inform strategic planning of services and the development of new provision for children and young people with mental health needs.***

Children in hospitals for people with learning disabilities

3.7 During the 28 month period under consideration by the Inspection Team, 44 children and young people had been admitted for periods of 3 consecutive months or longer to hospitals for the learning disabled (Table 13). One children's ward in the regional facility (Muckamore Abbey Hospital) accounted for 17 children in the sample. Of the remaining 27 children and young people, 20 were accommodated in the adult wards of Muckamore and 7 in other learning disability hospitals. Conditions in the hospitals inspected, where some children had been accommodated for a number of years, were generally outdated and institutional both in the characteristics of the physical surroundings and in some of the care routines. These were found to be wholly unacceptable environments for the care of children or young people. The Department has endorsed a business plan to replace all

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[1] Definition of Tier 4 services:
"essential tertiary services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units.

existing provision presently offered on the site of Muckamore Abbey Hospital. As part of this new development, current provision for younger learning disabled children will be replaced with a small community based short-term clinical assessment and treatment facility. This is commended. Of concern to the Inspection Team, however, was the lack of a similar plan to address the future inpatient clinical assessment and treatment needs of learning disabled young people who are, in the main, accommodated in the adult wards of the regional centre.

3.8 ***In the context of the planned reprovision of regional inpatient services for adults and children with learning disabilities, commissioning Boards should formally recognise the needs of young people as being distinct from those of children or adults and should address these as a matter of urgency.***

Children and young people admitted to adult wards

3.9 In addition to the issues surrounding the continuing care of children within specialist hospitals, of further concern was the fact that during the period under consideration by the inspection, 31 children and young people had been accommodated in the adult wards of a range of hospitals (Table 14). The majority of these children (23) had learning disabilities. Of these, 18 young people were aged 16 – 17 years and 12 children were aged 11 – 15 years. The Inspection Team was also made aware that younger disabled children were, from time to time, admitted to wards accommodating a range of age groups which included adult patients. One child in the sample who was under 5 years old had spent a period of more than 3 months in a ward of this type. There were, however, special circumstances attached to this situation (Table 15).

3.10 Although it does not formally extend to Northern Ireland, the 'Standard for Hospital Services' (DOH, 2003), publication which is part of the Department of Health's National Service Framework for England states:

> 'Children should not be cared for on adult wards . …. Actual age is less important than the needs and preferences of the individual child or young person. In particular the needs of adolescents require careful consideration. In general adolescents prefer to be located alongside people of their own age who are more likely to meet their need for social interaction…'

3.11 The Department's policy document 'Child and Adolescent Mental Health services' (DHSS, 1998) stated that adult based provision for adolescents should cease as soon as possible.

3.12 Apart from the unsuitability of the social setting, some young people were being cared for alongside older patients who displayed sexually inappropriate or – on occasions - violent behaviour. There were clear child protection issues to be considered and increased pressures on staff in terms of the management of such high risk situations. Part 6.9-10 of this report contains a recommendation aimed at minimising risk if, in exceptional circumstances, children or young people are admitted to adult wards. In terms of the overall profile of such admissions, however, it is imperative that commissioners and service providers are fully aware of the use of each adult placement and address the need in a collaborative way.

3.13 ***Boards and Trusts should monitor the numbers of children and young people admitted to adult wards and the length of their stay with a view to determining whether there are sufficient children's specialist inpatient places and community based provision to meet their needs. Where there are deficits these should be addressed in a cross Board coordinated manner.***

3.14 The inspection focused on children and young people who had spent prolonged periods of time in hospital and drew particular attention to those in adult wards. It was evident in discussion with parents and professionals, however, that there was general concern about the ambiguity surrounding the age at which young people were referred to adult hospital and community services and a lack of consistency in approaches to this. In some cases children aged 14 years were referred to adult medical services and in other situations, 16 years was the upper age limit for paediatric services. The multidisciplinary clinical expertise required by young people may not be available to a very young teenager within adult medical services or to an older young person within paediatric services. Issues of age can also have an impact on the transitional arrangements for children who require services into adulthood. This is considered further in Part 5.35-37.

3.15 ***Boards should develop a regionally agreed protocol for referrals of young people aged 14 years and over to hospital and other clinical and community services. This should promote consistent approaches that take account of the young person's age and stage of development and enable appropriate expertise to be available to meet each young person's needs.***

The interface with community provision

3.16 The pre-inspection data did not cover disabled children and young people who were admitted to hospital for periods of less than 3 months. The true usage, therefore, of specialist hospitals and adult wards for children and young people is greater than the figures presented in this report. This issue cannot be considered in isolation from the current profile of community services provision. Many of the children had spent prolonged time in specialist hospitals because of the lack of appropriate community facilities for them. A number of young people had been admitted to adult wards because there were no inpatient places in the specialist centres or because there were no residential or other community facilities suited to their needs. Of further concern was the fact that the planned inpatient developments (3.3; 3.7) are unlikely to fully meet the requirements of learning disabled children and young people and those with mental health needs. There was an absence of coordinated regional plans which ensured the development of adequate community provision to support the reconfiguration of inpatient services.

3.17 ***The 'Children Matter' Task Force[1] should in its Phase 2 implementation consider the impact of impending reductions in children's specialist hospital places on current and planned community residential and other community provision with a view to informing strategic planning for future services to disabled children.***

Technology dependent children and those with complex needs

3.18 Many children have complex needs. Some are dependent on technological equipment whilst in hospital. It was evident during the inspection that some children required initial admission to specialist regional centres and there could be significant delay in transfer to local hospitals. The care of the children and their ultimate discharge home depended on the availability of trained care staff and Trusts' financial capacity to support intensive packages of community care. Neither was always readily available. The Inspection Team commended the efforts of hospitals meeting such needs, their commitment to working towards the development of new skills in staff and community carers and their expertise in helping children and their families towards discharge.

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[1] An interagency group, led by the Department and established to implement the recommendations of the Children Matter report (DHSS, 1998).

3.19 **Good practice example:**

Altnagelvin Hospital provided an example of an excellent training programme for nurses, parents and carers which resulted in the successful discharge home of a number of children who required long-term ventilation. The Inspection Team commended the hospital for its commitment to developing staff skills in this area, the standard of the training programme for staff, parents and carers, the multidisciplinary formal discharge planning associated with the programme and the effective support arrangements the hospital had established for parents and families.

3.20 More children are surviving premature birth and neo-natal complications and those with acquired serious injuries or degenerative conditions are living longer. No child should remain in hospital longer than is clinically necessary. The number of technology dependent children is likely to rise in the future and, in comparison with other community care needs, their support at home will be resource intensive. This is a relatively new and emerging matter which needs to be addressed within a policy context that takes account of the projected future demand as well as the training needs and resources required to provide effective services to children and their families.

3.21 ***The Department should agree a regional policy to address the emerging needs of technology dependent children for community care services, including the skills base required in staff, parents and carers, to ensure minimum delay in progressing care plans for these children.***

Respite care of disabled children

3.22 A few of the hospitals in the sample retained hospital beds for respite purposes. Whilst the reasons for this were generally to do with the familiarity of the hospital setting for some children who required frequent admissions, no child should be admitted to hospital for reasons other than clinical needs. An unanticipated outcome of the inspection, however, was the identification of two residential respite care units for disabled children that were associated with the hospitals in the sample, but that were operating outside the regulatory framework of the Children Order and Departmental guidance. Although they were designated as respite care units, children who needed emergency care placements had been accommodated in these facilities. During the period under consideration by the inspection, 11 children had remained in these units for periods of at least 3 months. Some children had remained a number of years. Other children had been admitted more frequently and for longer periods than would have been normally warranted within a respite arrangement. This is an unacceptable situation.

3.23 These issues raised questions and concerns about the profile of respite care provision for disabled children and young people throughout Northern Ireland. 'Children Matter', published by the Department in 1998, proposed the need for a regional review of such provision.

3.24 ***A regional review of respite provision for disabled children should be progressed by the Department without delay as part of the implementation of the Children Matter Phase 2 initiative.***

4. The commissioning arrangements, structure, organisation and management of the hospital service

Standard

The commissioning arrangements, structure, organisation and management of hospital services promote optimum quality in the planning and provision of services for disabled children.

Development of services for disabled children

4.1 The principle that disabled children are children first should govern organisational, management and planning structures as well as the services that children receive. Historically in Northern Ireland, however, services for disabled children have developed around the disability rather than the child. The Department is responsible for making legislation and establishing policies to direct and guide the provision of health and social services. Within the Department, however, policy issues for disabled children can fall within the Primary, Secondary and Community Care Directorates as well as within the Child Care Policy Directorate. Whilst the Strategic Framework for Children (2.3) will address disabled children's issues, there is currently no integrated Departmental policy on disabled children.

4.2 The Inspection Team found similar fragmentation in Boards and community Trusts. In addition to acute and specialist hospital services programmes, the commissioning, planning and delivery of services for disabled children and their families tended, with only a few exceptions, to span as many as 7 health and social care programmes.

4.3 There was a general view amongst senior managers in Boards and Trusts who were interviewed, that the lack of a unified Departmental approach to disabled children was a significant factor in sustaining artificial boundaries between services at area Board and local levels. There is a need for a strong policy focus both within the Department and regionally that will:

- recognise and value disabled children as children first and children in need within the context of the Children Order;

- tackle the range of needs common to children and their families without defining these by categories of illness or disability;

- ensure accountability for the full range of statutory obligations on Boards and Trusts in respect of disabled children;

- address the strong interface between social care services, community health (including AHP services) and hospital services;

- set out, when children have specialist community care support needs, how these will be met within children's services; and

- reliably inform and establish priorities and objectives for other overarching Departmental and inter-Departmental policies and strategies.

4.4 A Children's Services Committee has recently been established within the Department to ensure coordination across all Departmental Directorates and professional groups in relation to children's services. The above needs should inform the work of this Committee.

4.5 ***The Department's Children's Services Committee should address the need for an integrated policy on services for disabled children and establish arrangements across relevant Departmental interests to enable a coordinated approach to the matters outlined in 4.3.***

Commissioning arrangements

4.6 There were similar issues in the commissioning arrangements of Boards. None of the Boards' senior managers held overall responsibility for disabled children's services or was the 'champion' of their cause. One Board had, however, established a 'Children with Disabilities Commissioning Sub Group' and this was commended. Others were intending to review their arrangements to promote a more co-ordinated approach between the various disciplines involved in providing services to disabled children. Commissioning arrangements and management structures should assist rather than hinder the development of innovative provision so that services are not confined within programme of care boundaries and can serve the needs of a wider range of children.

4.7 ***Boards should establish commissioning and management structures that are capable of addressing the needs of disabled children and enable services to be developed in a comprehensive, child centred and fully integrated way.***

Needs assessment

4.8 There were examples of helpful needs assessments and strategy documents containing recommendations for the development of services for disabled children in each Board's area. Whilst implementation plans existed for some of these, a number lacked an implementation strategy and most had not established arrangements for monitoring and reviewing progress against the recommendations. Boards reported a problem with the lack of consistent baseline information on disabled children in their area to assist needs assessment. This included incomplete information about the number of children in each Board's area, the nature of their disabilities and their support needs. Paragraph 3 of Schedule 2 to the Children Order requires Trusts to establish 'a register of children with a disability' to inform service planning. A regional 2 year project to develop a model for the register was completed in June 2003, but Boards and Trusts reported that due to resourcing difficulties this had not been taken forward. This legislative requirement, which should have been implemented in 1996, is therefore still outstanding. Trusts are accountable through their commissioning Boards for the discharge of statutory functions under the Order.

4.9 ***In fulfilment of the requirement of the Children Order and the need to inform service planning with reliable and comprehensive information, Boards should ensure that Trusts establish a register of disabled children as a matter of urgency.***

Children's Services Planning

4.10 Despite the higher-level divisions in programme of care structures, there were a number of good planning initiatives by Boards and Trusts. Some of these had been facilitated by the Children's Services Planning (CSP) process. All Boards had undertaken general or specialist reviews of services for disabled children and young people. Some initiatives had been clearly prompted by pressing needs, such as each Board's Review of Child and Adolescent Mental Health Services. Yet others had been carried out in response to new or emerging issues such as the needs of children with a life limiting or terminal Illness and assessments to inform the development of new projects. These were commended. In general, however, hospitals and Hospital Trusts were not represented within CSP groupings.

4.11 **In view of the importance of the links between hospital and community services for children who require periods of hospital care, the CSP process should include representatives from hospitals providing children's services.**

Involvement of children, families and front line staff in service planning and development

4.12 Each Board's CSP for disabled children included parents, voluntary sector and user representative groups. There were also examples of good initiatives to promote the involvement of disabled children and young people in service planning. These were commended. In a number of situations, however, where hospitals had planned new children's inpatient developments, consultation with parents and children had either not happened at all or had not happened at a sufficiently early stage in the process. Parents and children can provide valuable contributions to inform the structure and design of buildings and services. In some situations, practitioner staff also felt that they did not have sufficient opportunity to influence the planning of new services or buildings.

4.13 ***From the outset of new service developments or new build projects for children's services, Trusts should establish planning reference groups that include children, parents and front line staff.***

The organisation of hospital services - management issues

4.14 Hospital structures and the way services are organised should enable all aspects of children's needs to be addressed and ensure that their welfare is safeguarded whilst they are in hospital. Disabled children and young people who spend frequent or prolonged periods in hospital are particularly vulnerable to any gaps or weaknesses in the system. An overarching theme, which emerged from the individual inspections was the need for a dedicated focus on children's inpatient issues at senior management level within hospital Trusts and community Trusts responsible for hospital services. Where a Children's

Services Directorate or equivalent existed within hospital services, there tended to be better planning and delivery of children services.

4.15 ***A designated senior manager with lead responsibility for children's services should be established within these hospitals providing chidren's inpatient services to:***

- ***promote an integrated approach to clinical and social care matters and the planning of children's services;***
- ***support the development of the full range of policies governing the treatment and care of children in hospital, including the 'child' proofing of general hospital policies as well as providing a focus for child protection policies and related issues;***
- ***ensure that child focused management of risk and clinical and social care governance concerns are reflected in appropriate planning and other groupings within the Trust.***

Child protection

4.16 Hospital staff may on occasions be the first to identify potential child abuse or to observe family interactions that might raise concerns about a child's well-being. It is essential, therefore, that staff are familiar with children protection issues and are aware of current issues and developments in this area. The Department's guidance, 'Co-operating to Safeguard Children' (2003) states that 'A Child Protection Panel in a hospital Trust can be helpful particularly where their work brings them into front-line contact with children and involves the assessment and treatment of children, some of whom may be at risk of significant harm'.

4.17 Of the 3 hospital Trusts considered during the inspection, 2 were represented on the Child Protection Panels of their local community Trusts. There were examples of good practice in the sharing of information from the Panels within appropriate management meetings and this was commended. The two community Trust hospitals that provided significant children's and young people's services, however, were not represented on their respective Trusts' Child Protection Panels.

4.18 ***To ensure that hospital and community links are properly managed and that general hospital-related child protection issues are addressed, hospital Trusts providing acute or specialist children's services should consider establishing a Child Protection Panel. As a minimum alternative, a senior hospital representative should have membership of an appropriate community Trust's Child Protection Panel. Community Trust hospitals providing children's services should be represented on their Trust's Child Protection Panel.***

4.19 The hospitals inspected were not members of the Boards' Area Child Protection Committees (ACPCs), whose role is to develop a strategic approach to child protection within the overall children's services planning process. There is a significant interface between hospital and community services which should be reflected in the membership of ACPCs.

4.20 ***Boards and Trusts should determine whether child protection issues for children in hospital are adequately represented at ACPC level and in light of this consider whether hospitals providing children's services should have membership of ACPCs in their own right.***

4.21 Of all professionals based in the hospital, nurses have the most face-to-face contact with children, their families and other visitors during the child's hospital admission. Each nurse has a professional responsibility to recognise and respond to child protection issues. As recommended in the Co-operating to Safeguard Children Guidance, most Trusts had a named nurse for child protection. However, in general, nurses' knowledge and understanding of child protection issues varied considerably and only one hospital Trust had established formal links with a community based child protection nurse specialist.

4.22 ***Hospitals should establish formal arrangements with local community child protection teams to ensure that hospital based nursing staff are appropriately supported by, and have timely access to, a child protection nurse specialist.***

The organisation of hospital services - professional services

4.23 Several aspects of the professional services examined were unique to the particular hospitals considered in the inspection. Key issues that had wider implications for all hospitals providing children's services are summarised below.

Social Work services

4.24 Where hospitals had established social work services, social work teams were located in the hospital and staff were employed and managed by local community Trusts. There were examples of hospital based social workers being well integrated into children's multidisciplinary teams and offering a much valued service to children and families. The Inspection Team commended the quality of social work support in a number of hospitals, where it was evident that staff had developed specialist knowledge in a range of disability related areas such as learning disability, mental health, brain damage, rehabilitation, technology dependency and bereavement counselling. Where they were based in a hospital setting, social workers generally had clearly defined roles and responsibilities within the multidisciplinary team.

4.25 In some situations however, social work teams were not adequately resourced to provide an appropriate level of service. This was evident in situations where more input was required to support families and siblings in coming to terms with or coping with the child's disability or in situations where children had died and families had a need for continuity of contact and support in their bereavement experience. Of more concern were situations in which there was no dedicated hospital based social work support to children's or young people's inpatient services. This was the case in one general hospital, in some adult hospital facilities and in the specialist mental health facility for young people. In another hospital setting, the social work role appeared to be indistinguishable from that of other professionals. In these situations, disabled children who spent long periods in hospital, their families, carers and the hospital team missed out on a range of services that should have been integral to the care of the child and the support of the family. The Inspection Team also noted that some patients' surveys that had been conducted with children did not take account of their social care needs.

4.26 All children in hospital and their families have particular needs that may become more pressing as the hospital stay is prolonged, especially when families experience additional pressures of extensive travelling and balancing other responsibilities at home. Unlike other members of the clinical team, social workers often have the flexibility to, where necessary, interview families outside the normal hospital routines and the immediate hospital setting. Social workers can have a clearly defined role in providing:

- a social work contribution to the multidisciplinary comprehensive assessment and planning for all children admitted to hospital;
- social history information on the child and family;
- an assessment of the impact of diagnosis, illness, disability and bereavement on children and their families and counselling support to assist children and their families deal with the trauma of changed lives;
- group work support to provide the opportunity for children, parents and the wider family to share experiences with, learn from and gain encouragement from others;
- access to social care and practical support arrangements for families and children for the duration of the hospital stay and beyond;
- awareness, identification and assessment of child protection risks, including the handling, notification and follow up of child protection concerns in accordance with 'Co-operating to Safeguard Children', DHSSPS, (2003);
- coordination of the care plan and review of looked after children and children who require long term hospital care;
- advice on the notification requirements and other provisions of the Children Order and ensuring that relevant actions agreed in the care plan are followed through by community services while the child is in hospital; and
- a contribution to effective discharge planning for children and the establishment of links with community support services, including, where appropriate, voluntary agency support to promote continuity of care.

4.27 ***Dedicated and specialist children's social work services should be available to children and families in hospitals providing acute or specialist services for children and young people. Where social workers are part of a hospital based multidisciplinary team, they should have a clearly defined role, which ensures that the support needs of children and families are addressed in a comprehensive way.***

4.28 ***Patient surveys should take account of the social care support needs of patients and their families.***

4.29 It is preferable for social workers dealing with inpatient services to be based in the hospital. Some social workers reported, that at times they were not included in events or informed about new community initiatives relevant to children's services. They were not always made aware of new policies that had implications for practice, particularly in the area of child protection. It is vital that hospital based social workers should be kept abreast of developments in services and policies that affect their work.

4.30 ***Trusts should establish formal arrangements which ensure that hospital based social workers are aware of new initiatives and are inducted, together with community based workers, into new policies that have implications for their practice.***

Medical services

4.31 The Inspection Team was impressed by the skill, training and commitment of staff, evidenced within hospital services for disabled children. The Team in particular commended innovation in services, and the establishment of consultant posts to take forward advances in treatment to the most vulnerable children and young people. A model of consultant working in paediatrics between hospital and the community in some of the hospitals inspected was also commended as an effective model of service provision which supported continuity of care to disabled children and their carers.

4.32 ***Trusts should consider establishing joint paediatric and community based medical consultant posts to promote continuity of care for children and their carers.***

4.33 The inspection highlighted gaps, however, in the medical services available in Trusts, particularly in rehabilitation and neurorehabilitation, learning disability services and services for children and young people with mental health needs. These had an impact on the timeliness of the care children and young people received whilst in hospital. A recommendation to address these deficiencies is made in Part 8.8-9 of this report, which deals with medical workforce planning issues.

Nursing services

4.34 The hospitals inspected had comprehensive commissioning arrangements in place with their respective Boards. The continuous evolution and diversification of nursing skills required to care for disabled children with complex needs was reflected in imaginative developments in nursing services and associated business cases for new development. These were commended. Inspectors found that the structure of nursing services was generally appropriate to meet the needs of children in hospital. All acute hospitals employed Registered Children's Nurses on children's wards as recommended in the Allitt[1] inquiry. Nevertheless, children with learning or mental health disability were mostly cared for by nursing staff trained in the equivalent adult field. Most Trusts facilitated post-registration training in children's nursing. In view, however, of continuing and significant recruitment and retention issues experienced in some mental health and learning disability facilities, it was not always possible to release staff to undertake this training. Where this is the case, arrangements should be in place to enable adult trained nursing staff to access the appropriate support and advice of a registered children's nurse.

4.35 ***Trusts should ensure that all adult trained nurses caring for children with a mental health or learning disability have access to advice and support from a qualified children's nurse.***

4.36 Some hospitals had employed a variety of specially trained nurses whose skills enhanced the care and management of children in hospital. These were commended.

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[1] Independent Inquiry Relating to Deaths and Injuries on the Children's Ward at Grantham and Kesteven General Hospital. London: HMSO, 1994.

4.37 Good practice example:

The Behaviour Nurse Therapy Team (BNT) based in the children's ward of Muckamore Abbey Hospital advised nursing staff on the management of children with challenging behaviours. For children who were referred, the team established individual behaviour management plans which were reviewed as appropriate. The Team also worked closely with teaching staff, AHPs and social workers. This initiative was clearly valued by staff and parents and was commended by the Inspection Team.

Allied Health Professional services

4.38 The Inspection Team considered the general provision of physiotherapy, occupational, speech and language therapy, nutrition, dietetics, and podiatry services in the sample of hospitals inspected. There were a variety of arrangements for the delivery of AHP services to children in hospital which included:

- hospital based services, where staff were directly employed by the hospital – physiotherapists were the most likely staff to be hospital based;
- service level agreements with community Trusts who provided, for example, occupational therapy services; and
- ad hoc arrangements with community Trusts' staff who attended the hospital 'as and when' required or, on occasions, on a good will basis.

4.39 Some hospital based AHP staff had developed a range of highly specialised skills, for example, in the areas of brain injury and rehabilitation and learning disability. This was commended. Nevertheless, the above variations in the way children's AHP services were delivered tended to limit the development of skills in children's services. This meant that few staff were afforded the opportunity to develop knowledge and receive training in paediatrics despite the fact that staff themselves regarded this as a highly specialised area.

4.40 In a number of cases the lack of hospital based staff resulted in long waiting times for AHP services, which on occasions delayed the child's discharge and meant that children did not receive therapy at the most appropriate time in their treatment plan. For children in intensive AHP programmes, such as brain injured children, the lack of AHP staff at weekends had the potential to impact adversely on their progress. There was a clear need for protocols to be developed to ensure timely response to referrals and appropriate deployment of AHP staff.

4.41 The Inspection Team also noted that there was little contribution of AHP staff to children in mental health hospitals or within the CAHMS community teams linked to the hospitals inspected. The guidance, however, on 'Staffing of Child and Adolescent Inpatient Psychiatry Units' (1997) produced by the Royal College of Psychiatrists identified the need for AHPs to form part of the multidisciplinary team.

4.42 ***Boards should assess the current provision of AHP services for children in hospital with a view to identifying unmet needs and addressing the need for future services. Formal arrangements should be established which ensure that children receive timely access to the full range of AHP services they need and staff are enabled to develop expertise in paediatric care.***

Psychology services

4.43 In view of the complex nature of disability and the adjustments required by children and their families at the time of diagnosis and afterwards, all disabled children should have access to a specialist clinical psychology assessment and treatment service. Psychology services were available to children and young people in all but one of the hospitals inspected and made a valued contribution to children's care. As with AHP services, however, there were a variety of arrangements for the provision of this support. Some hospitals had specialist staff in post. Others had been allocated an agreed number of psychology sessions per week but this was generally not regarded to be sufficient. In some situations the community Trust provided services on a good will basis and services were therefore not always available when they were most needed. Deficits in psychology services are considered further in Part 8.17-18 which deals with workforce planning. There is, however, an immediate need to address these concerns in respect of disabled children currently in hospital.

4.44 ***Boards and Trusts should establish arrangements to prioritise the timely provision of psychology support services to disabled children and young people in hospital.***

Pharmacy services

4.45 The inspection did not specifically review pharmacy issues. It was evident, however, during the fieldwork observation of ward rounds and the functioning of multidisciplinary teams that appropriate pharmaceutical input is vital to the care of children in hospital. Children cannot be treated as 'small adults' in the use of medicines, many of which have been developed for adult patients. Furthermore, disabled children are more likely to have multiple health conditions that require a holistic approach to the choice of medicines to which the contribution of clinical pharmacy is essential. The prescribing, dispensing and administration of medicines to children is therefore a critical governance and risk management issue for all hospitals providing children's services. The National Service Framework Standard for Children's Hospital Services in England (DoH, 2003), states that 'ideally, sufficient trained pharmacy staff should be available to cater for the special needs of children, to ensure that medicines are managed safely and effectively and to play an active role in the multidisciplinary team caring for children'. The Framework also stresses the need for pharmacists to advise other professionals and parents on the use of medication. Only two of the larger hospitals had pharmacist staff with a specific paediatric commitment. Where this was the case, parents and staff found their expertise an invaluable resource.

4.46 ***Hospitals providing children's services should establish dedicated expertise in paediatric pharmacy services and ensure that there is a sufficient pharmacy resource to contribute to each child's care as part of the multidisciplinary team.***

Clinical and social care governance

4.47 There were many positive aspects to clinical and social care governance arrangements within the selected Trusts responsible for children's hospital services. These included clear structures for the delivery of clinical and social care governance and in the case of some Trusts, strategies and action plans with monitoring and review arrangements. Two Trusts were using the European Foundation for Quality Management model with associated assessments and action plans. These initiatives were commended. Most hospitals had delivered training in clinical and social care governance issues. Where comprehensive governance arrangements were in place, staff were clear about their contribution to the quality agenda and had had an opportunity to attend relevant training and skills updates.

4.48 There were, however, two key areas identified for improvement. The first centred on the need to recognise in the implementation of clinical and social care governance, the particular vulnerabilities of children and young people and particularly those of disabled children in hospital. There was a need to establish discrete structures, procedures and reporting arrangements for clinical and social care governance issues in relation to children. The second area which needed to be developed was the promotion of comprehensive multidisciplinary and user representation approaches to clinical and social care governance matters. In a number of hospital settings not all professions were represented in key groupings and in some cases, children, young people and their families or carers did not have an input into the establishment of appropriate clinical and social care governance arrangements.

4.49 ***Hospitals should address children's services as a discrete area within clinical and social care governance and include a report specifically on children's issues in annual governance reporting arrangements.***

4.50 ***Trusts should ensure that the membership of clinical and social care governance (including risk management) groupings within hospitals represents as far as possible the range of professional disciplines working with child inpatients and families and includes the participation of child and parent/carer representatives.***

Risk management

4.51 All Trusts had developed risk management strategies. In some cases these included computerised databases, which retained information on all complaints, accidents, near misses and other critical incidents and provided information on trends. This was commended. All but one Trust had completed policies on promoting a learning culture, honesty, openness and minimum blame in the reporting of incidents. The remaining Trust was in the process of addressing this during the period of the inspection.

Audit arrangements

4.52 A number of helpful unidisciplinary audits had been carried out in children's services. There was just one example, however, of a full multidisciplinary audit in paediatric services. This approach needed to be developed in all hospitals providing services for children.

4.53 ***Trusts should develop full multidisciplinary audit and monitoring of services for children in hospital.***

Standards

4.54 The Inspection Team was provided with examples of unidisciplinary standards. In some situations, multidisciplinary standards had been developed to inform aspects of children's care, for example, the management of long term ventilated children and discharge planning for children in hospital. One Trust had established multidisciplinary standards for the care of children in hospital. This was commended.

4.55 Good practice example:

An example of the use of child specific standards was found in the Child and Family Centre at Forster Green Hospital. The Centre had carried out a baseline audit against a national set of comprehensive, specific and measurable standards produced in 2001 by the Quality Network for Inpatient Child and Adolescent Mental Health Services. These were used as a benchmarking exercise to identify strengths as well as practice issues and other areas to be developed in striving to promote high standards of practice. This initiative was commended.

4.56 Where standards were in place, these were commended. There was a need, however, to develop regional multidisciplinary standards to inform the care of disabled children in hospital. The draft standards developed for the purpose of this inspection should assist the development of comprehensive regional standards (Appendix B).

4.57 ***The Department's Standards and Guidelines Unit should take forward the development of multidisciplinary standards to inform the care of disabled children in hospital.***

5. Assessment and Care Planning

Standard

The well being of disabled children is promoted through multidisciplinary assessment and care planning arrangements, which enable children's needs to be identified and met in a coordinated manner.

Policies to inform the admission, care and discharge of children

5.1 From admission to discharge, disabled children, young people and their families should receive care and support that is well planned and consistent with best practice. Hospitals need to consider what this means for children at each stage of the process within their particular hospital setting. Consistency can only be assured when there are written policies governing key areas of work and all professional staff involved in the child's care are familiar with the procedures and work to best practice expectations.

5.2 The Inspection Team examined a range of policy documentation. Most of the hospitals inspected had written policies covering the admission and discharge of children. With a few exceptions, there were a number of key areas where written policies either did not exist or were deficient.

5.3 ***Boards and Trusts should ensure that hospitals providing children's inpatient services have established, as a minimum, written policies and procedures on the following:***

- ***pre-admission, admission and discharge of disabled children and young people, including emergency admissions and procedures covering children who require frequent admissions to hospital;***

- ***philosophy of care of disabled children in hospital, including the role of parents, families and carers;***

- ***multidisciplinary assessment and care planning, including contact with community care services;***

- ***child protection, to include easily accessible copies of 'Co-operating to Safeguard Children' (DHSSPS, 2003) and the Area Child Protection Committee's Child Protection Policies and Procedures;***

- ***the impact of domestic violence on children;***

- ***consent to examination, treatment or care;***

- ***intimate/invasive care of children and young people;***

- ***anti bullying;***

- ***notification to Social Services of children who have been or are likely to be in hospital for 3 months or more (this should include neo natal children); and***

- ***discharge arrangements.***

Assessment

5.4 The treatment and care of each child admitted to hospital should be based on a comprehensive assessment of the child's needs. The assessment should enable a care plan to be established that is reviewed at agreed intervals and covers the period from pre-admission through to discharge.

Pre-admission assessment information and fast tracking

5.5 It was noted in 2.9 that at least 43 children in the sample had experienced at least one previous admission to hospital in the 2 year period under consideration. Two of the acute hospitals that were inspected had fast tracking arrangements for children who needed frequent admissions. Parents particularly valued these arrangements as they prevented children from spending long periods in accident and emergency departments. This was commended.

5.6 ***Acute hospitals providing children's services should establish fast tracking arrangements for children needing frequent admissions to hospital.***

5.7 The Inspection Team commended the practice in some hospitals of completing pre-admission assessments on children who were already known to other services, including children who were being transferred to another hospital from a specialist regional centre. These focused on key aspects of the child's care and enabled staff to make prior contact with parents and plan ahead for the child.

5.8 Good practice example:

St Luke's Hospital provided an example of good partnership arrangements with community CAMHS teams in the pre-admission assessment of young people who had a planned admission and in the initial assessment of those who required an emergency admission to hospital. The Consultant Psychiatrist from the CAMHS team remained responsible for the young person's treatment while in hospital and the multidisciplinary CAMHS team's assessment was shared with hospital staff. Community staff were involved in subsequent revisions to the assessment and care planning during the young person's hospital stay. These arrangements provided continuity of care for young people and were commended by the Inspection Team.

Multidisciplinary assessment

5.9 Most medical, nursing, AHP and where appropriate, social work staff and psychologists had completed unidisciplinary care assessments on children. These generally represented a good standard within each of the respective disciplines. The principle of multidisciplinary working was implicit in the practice of each hospital but the Inspection Team observed two settings: neurorehabilitation services at Forster Green Hospital (5.13) and children's services in Antrim Hospital (5.44), that demonstrated truly integrated and coordinated working by multiprofessional teams. Parents commented on the excellent standard of communication they experienced in these situations. In each of the hospitals inspected, staff without exception had themselves recognised the value of multidisciplinary working and were aware of shortcomings in current practice, which in most cases required both a cultural shift and a realignment of resources to enable effective multidisciplinary working.

5.10 Due to the fact that assessments in general tended to be unidisciplinary, there were few examples that enabled the whole needs of the child (and not simply clinical needs) to be addressed in a structured and multidisciplinary way. 'Whole child' assessment is particularly important for disabled children and children who spend long periods in hospital where, in the context of a clinical care or treatment process, there is the potential for the full range of the child's needs to be overlooked.

5.11 With a few exceptions, assessments did not evidence that they had been informed by the views of children and families. Parents reported to the Inspection Team that the range of professionals they encounter can be a daunting experience. It is easier for everyone if assessment and care planning are coordinated in a way that makes sense of the child's treatment and enables ease and clarity of communication between professionals and with parents.

5.12 ***To assist care planning and ease of communication, assessments completed by all professionals involved in the child's care should be integrated into one multidisciplinary assessment. In addition to the child's physical and clinical care needs, the assessment should address in consultation with parents, 'whole child' needs such as social, cultural, spiritual, family support, education and children's rights issues.***

5.13 **Good practice example:**

The assessment and care planning arrangements in neurorehabilitation services at Forster Green Hospital provided an example of integrated assessment and care planning for young people who had an acquired brain injury. The assessment methods, introduced by the Consultant, were both comprehensive and succinct in assessing the patient's needs and in setting clear objectives with timescales for the multidisciplinary team in meeting these. The objectives formed the care plan which was reviewed at weekly team meetings. Team members recorded progress directly onto the assessment framework and thus the extent of each professional's input was immediately accessible to all members of the team. Parents and young people reported that they were fully involved in the assessment process and were aware of the progress made and future plans. This was commended.

Risk assessment

5.14 The evaluation of risk is central to any assessment, whether the risk is due to health, behaviour and social or environmental factors. Some hospitals were commended for their risk management strategies and the Inspection Team saw examples of unidisciplinary risk assessments that had been undertaken in respect of children and young people. Where risk assessments had been completed, it was however noted that:

- there was no process for sharing the risk assessments or undertaking a multidisciplinary risk assessment which brought together clinical, environmental, child protection and social issues for children and young people; and
- risks linked to social factors and unmet needs e.g. prolonged stay in hospital due to lack of community facilities; lack of schooling for children and young people were not generally formally assessed or documented.

5.15 ***As part of the assessment process, hospitals should include a multidisciplinary assessment of risk on each child and young person which addresses the above issues.***

Care planning

5.16 A care plan for each child should flow from the assessment. The Inspection Team recognised that it can be difficult to maintain an up to date written multidisciplinary care plan in the acute phases of a child’s illness. In the children’s cases examined, where children had been in hospital for long periods, the Team found some excellent multidisciplinary ‘person centred’ care planning which identified targets in each clinical area of work, including social work, and focused clearly on the child.

5.17 In general, however, where plans existed many were unidisciplinary. Children and parents were not always involved in the planning and the plan was often not shared with them. In some cases the plan was contained in the medical file and was not easily accessible by other professionals.

5.18 Good practice example:

An example of care planning partnership approaches with children was found in the Young People's Centre. Each young person attended weekly meetings which focused on his or her care plan and provided an opportunity for the young person to contribute to the ongoing assessment, reflect on the plan and assist in reviewing progress. This was commended.

5.19 ***Each disabled child should have a 'child centred', focused care plan based on the multidisciplinary assessment which:***

- ***covers the period from admission through to discharge;***
- ***takes account of the needs of the 'whole' child - including cultural, social and spiritual needs - in accordance with the period of time the child is likely to stay in hospital;***
- ***identifies key tasks to be undertaken by each professional, with timescales and arrangements for review; and***
- ***is easily accessible by staff, parents and children.***

Parents and children should be given the opportunity to document their agreement with the plan and if they wish, receive a copy.

Discharge planning

5.20 All children should remain in hospital for as short a time as possible. Planning for discharge should therefore commence from the point of the child's admission. For disabled children in particular, such planning forms a vital bridge between hospital and community services and serves to:

- reassure children and families about continuity of care and support;
- clarify the roles of all relevant professionals in the child's ongoing treatment and care;

- enable potential gaps or difficult issues in the provision of services to be identified at an early stage and enable these to be addressed before the child's discharge; and

- secure the involvement of community services (including education and voluntary sector support services) in planning prior to the child's discharge.

5.21 The Inspection Team commended situations in the children's cases examined where multidisciplinary discharge planning meetings had been established with parents and early links made with community services. In one hospital a Discharge Liaison Coordinator was about to be appointed for a trial period and in others, social work or nursing staff assumed the lead in this process. There were examples of excellent multidisciplinary planning in the discharge of technology dependent children and children with complex needs. In some situations, however, there was no lead professional in discharge planning and not all children had a formal discharge planning process. In these children's cases, appropriate links had not been established with key professionals or support agencies in the community. In the view of the Inspection Team, children and families were missing out on some important sources of support and unneccessary delays had occurred in securing community servises.

5.22 ***As part of each child's care plan, a structured discharge process should be established which:***

- ***identifies a professional to take the lead in planning and coordinating discharge arrangements;***

- ***takes account of the ongoing support needs of children and families (see 6.1-2);***

- ***ensures that appropriate community services (including voluntary sector and education services) are notified in a timely manner and where possible contribute to the discharge arrangements; and***

- ***provides for clear and consistent communication with families about the discharge process and follow up arrangements.***

5.23 ***Trusts should consider whether it would be helpful to take forward the assessment and care planning recommendations on a regional basis with a view to developing jointly agreed protocols and proformas.***

5.24 Some staff in the regional centres reported to the Inspection Team that the quality of post discharge support for children and families and subsequent outcomes in children's progress varied considerably between Trusts.

5.25 ***Where hospital staff are aware of inequities or gaps in the community service provision of Trusts, the hospital should ensure that Boards are formally notified of these.***

Notification arrangements

5.26 When a child has been in hospital for a consecutive period of 3 months, or when it becomes evident that the child will need to be in hospital for at least three months, the hospital has a duty under Article 174 of the Children Order to notify the community Trust in whose area the child resides. The hospital must also notify the Trust when it is proposed to end the child's hospital stay. The 'Guidance and Regulations to the Children Order Volume 5 - Children with a Disability' (DHSS, 1996), states that the Trust must 'take all reasonably practical steps to decide whether the child's welfare is adequately safeguarded and to decide whether it is necessary to exercise any of its functions under the Order'. Notification arrangements are to ensure that children are not forgotten, that Trusts assess the quality of care offered and that there is coherent planning for children.

5.27 Of 173 children who were in hospital during the period under consideration, 54 (32%) children were formally notified to community Trusts (Table 16). In 35 (20%) cases, Trusts were not notified because the child was already known to the Trust. 36 (21%) children were not notified and in 37 (21%) cases it was not known whether the children had been notified or not. In a significant number of cases, therefore, community Trusts were not fulfilling their responsibilities under the Order. Some hospital staff reported to the Inspection Team that neonatal children who spend long periods in hospital are not normally notified. Of 29 children who had been in hospital since birth and most of whom were in the neonatal wards (Table 7) only 10 children had been notified to the community Trust (Table 17). Article 174 of the Children Order also applies to these children.

5.28 ***Hospitals should ensure that they are fulfilling the notification requirements of the Children Order. This should apply to all children, including neonatal children and those who are already known to the Trust. Notifications should serve to alert Trusts' senior management of children and families who may require a service or additional services. Community Trusts should establish procedures for responding to notifications by hospitals.***

5.29 The Inspection Team was informed that some parents were concerned about Social Services knowing about their child's stay in hospital as they did not wish to have a social worker involved with their family.

5.30 ***As children and parents may not be aware of the legal requirements regarding notification and the reasons for these, hospitals should liase with community Trusts to ensure that there is appropriate written information available for parents and children which explains the role of community services and the rights of children and parents within this process.***

Looked after children[1]

5.31 Looked after children and those who become looked after while in hospital are more likely to be adversely affected than other children if proper assessment and care planning arrangements are not in place. When the looked after child is a disabled child, there are further compounding factors which make it imperative that there should be a structured and focussed approach to the child's treatment, care and discharge. Of the 173 children in the sample population, 46 (27%) were looked after at the time of their admission (Table 18).

5.32 The Inspection Team found that a significant number of disabled children had remained in hospital longer than was clinically necessary. Thirty six children were in hospital at the end of the period under consideration by the Inspection. The discharge of at least 21 children[2] had been delayed due to the lack of appropriate community care services, equipment or an alternative community care placement (Table 19). This was mainly due to the lengthy planning process required to secure appropriate community based services for children on discharge. If a child remains in hospital in such circumstances he/she is effectively 'accommodated' by the Trust from the point at which the child is declared clinically fit for discharge. All the provisions of the Children

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[1] within the meaning of Article 25 of the Children Order.

[2] In 4 cases no reason was given for the child remaining in hospital.

Order in respect of 'looked after' children therefore apply. Such children should always be notified by the hospital or community Trust to the commissioning Board. The community Trust has regulatory responsibilities under the Order to assess, plan and review the child. Staff in some hospitals had not been aware of this until the commencement of the inspection. Hospitals should ensure that respective community Trusts are aware of and are fulfilling their duties under the Children Order towards such children. Good working relationships and communication between hospital and community services are vital in these circumstances.

5.33 ***Children who cannot be discharged from hospital due to the lack of community provision should be notified to the relevant commissioning Board. Hospitals and community Trusts should ensure that the relevant Trust is fulfilling its responsibilities under the Children Order to assess and review children in these circumstances and plan to meet their needs.***

5.34 **Good practice example:**

An example of effective working relationships in respect of looked after children was noted in the Longstone Hospital. Good links had been established between the hospital, the community team that provided support for disabled children and the community child care team responsible for looked after children. There was evidence of working together with education services to provide a range of suitable services as well as effective coordination and communication in child protection matters. This was commended.

Transfer arrangements

5.35 The transfer of children to adult services can be a source of anxiety to children, parents and families because of the loss of a familiar consultant or nursing staff and fear of the child going unnoticed in the adult world. In general, clear transitional arrangements did not exist within hospitals. Ambiguity about the age at which children should access adult services at times created stress for children and parents, and highlighted further the lack of focus on the needs of young people within clinical services (see 3.14).

5.36 The Inspection Team also considered the transfer of information between children's hospital services and community services. With the exception of nursing staff (because of the nature of the records and work routines) most disciplines were able to facilitate the sharing of information and this is commended.

5.37 ***Boards and Trusts should establish a regionally agreed protocol to inform the transfer of children and young people to adult hospital or community services which:***

- ***takes account of chronological age and developmental issues;***
- ***provides for a flexible transition period; and***
- ***promotes a coordinated strategy across all disciplines that includes, with the consent of children and parents, the sharing of professional information.***

Child protection issues

5.38 The review of children's cases demonstrated that a small number of children during their time in hospital were the subject of incidents that fell within a child protection framework. In general, the issues in the initial stages were handled appropriately by staff. As they unfolded, however, it was noted that:

- some incidents involving injury to children or young people had not been fully reported to parents and relevant professionals;
- hospital files did not always contain evidence that agreements made in case conferences had been fully implemented;
- written allegations made in respect of one child's treatment were not responded to in writing;
- information which had implications for the care of specific children was not always shared with the full hospital team; and
- on occasions, communication between hospital and community services staff was by telephone when it would have been more appropriate to have convened a formal meeting.

5.39 Within the hospital team there was not always a person such as a named nurse or key worker who was responsible for checking that all aspects of the child's care (including those relating to child protection) were attended to, agreed actions were followed through and delay or lack of action in any areas were reported to an appropriate line manager. This is particularly important for children who spend long periods in hospital when decisions may be taken in relation to social care and other issues, which are not always acted upon.

5.40 ***Hospitals should review their child protection policies and procedures with a view to ensuring that procedures for dealing with the issues reported in 5.38 are included and that all staff working with children are familiar with the policy and procedural guidance in this area.***

5.41 ***For children who are in hospital for extended periods, a member of the team should be appointed as a key worker to check that all aspects of the child's care are attended to, agreed actions (including those relating to child protection) are followed through and any delays or lack of action are reported to the ward manager or an appropriate line manager.***

Hospital records, recording practices and storage arrangements

5.42 There were a number of examples of well constructed files. In general nurses, AHP staff and social workers maintained unidisciplinary files, although some professionals also made notes in discrete sections of the medical file. One hospital had introduced computerised recording in children's records. The hospital recognised that this had the potential, however, to adversely impact on multidisciplinary working, as the records were accessible only to nursing staff and records that were archived could not easily be retrieved.

5.43 Well organised and contemporaneous records are a valuable asset in ensuring that those involved in assessing and planning for children have ready access to information which presents as full a picture as possible of the child's treatment, care and family circumstances. It is the view of the Inspection Team that the best method of ensuring this is through the establishment of a single continuous record to which all disciplines contribute. The record should contain the full multidisciplinary assessment of the child's treatment and care needs, the multidisciplinary care plan for the child and relevant documentation and correspondence. Unidisciplinary records should back this up where professionals such as AHP and social work staff are employed by a community Trust.

5.44 Good practice example:

Antrim Hospital had established structures that ensured effective communication between all professionals involved in each child's assessment and care planning. These included the use of comprehensive multidisciplinary admission, assessment and care planning pro formas. A multidisciplinary method of recording in children's case records was also evident. Records were found to be well organised and clearly written, with relevant professionals recording in a consecutive manner in the multiprofessional progress notes. The hospital was commended for having achieved a consistently high standard of multidisciplinary working and recording.

5.45 ***To assist multidisciplinary working in children's services, it is recommended the hospitals should consider establishing a single continuous record to which all disciplines contribute and which contains the child's multidisciplinary assessment and care plan.***

5.46 In a number of cases it was noted that only a few health care staff in the hospital were aware of the Parent Child Health Record (PCHR), although it was evident that others made effective use of the record and this was commended. The object of the PCHR is to ensure that a parent has a comprehensive record of the child's health and treatment.

5.47 ***Hospitals should establish a policy, in consultation with parents, on the use of the PCHR when children are admitted to hospital.***

5.48 The storage arrangements for closed and current files were in general satisfactory. In some settings, however, closed and current files were not stored in a secure manner and this could have led to inappropriate access to the confidential information of patients and their families.

5.49 ***Hospitals should ensure that when files are not in immediate use they are at all times securely stored in accordance with agreed procedures to prevent breach of patient confidentiality.***

6. The Range and Quality of Service Provision

Standard

The hospital provides responsive services that are child friendly and offer choice and flexibility to disabled children and their families.

Responsiveness to children and families

6.1 Children and families were in general very positive about the care and support they had received during their hospital stay. Many parents who had long awaited a place for their child conveyed to the Inspection Team their tremendous sense of relief when a bed became available. Children and their families often experienced the most difficult of personal circumstances which were compounded, for example, by frequent or prolonged admission to hospital. Families could experience difficulty in integrating the child back into family life. Other families spoke of the sense of isolation they experienced in caring for an ill or disabled child. When help was available through the support of the hospital or community services social worker, this was appreciated. Such support, which was not always available (4.25), has an important contribution to make in helping parents to care for and more effectively support their child.

6.2 ***The needs of parents and families of disabled children for individual support should be separately assessed and addressed as part of the plan for the child's care whilst in hospital. Appropriate links with community services should also be established to ensure that parents and families continue to receive support in their own right when caring for their child at home.***

6.3 In addition to speaking to parents, children and other family members, the Inspection Team observed daily routines on the wards and made evening pre-bedtime visits to selected wards. Of the many matters raised in each of the individual hospitals, the following is a summary of common themes and issues:

- in general there was good interaction between children and staff;
- most dedicated children's wards had established good bedtime routines that were sensitive to the age of the children and took account of their holistic health needs;

- medication was generally administered in a sensitive way;
- most parents felt welcome in the hospital and were not unduly restricted in visiting their child;
- most parents felt that the hospital's initial communication with them was good;
- most parents and families felt that their views were listened to;
- staff placed value on children's contact with siblings and other family members;
- children and young people in general liked the staff and enjoyed engaging in activities with them.

6.4 The Inspection Team commended in particular, examples of child focused initiatives which included play specialists (see 10.10) in 2 of the acute hospitals and the introduction of art and music therapy in one other setting. These proved to be of enormous benefit to children and young people.

6.5 ***Hospitals providing children's services should establish age appropriate special provision such as play, music and art therapy services aimed at offering children an opportunity for reflective individual expression. This is particularly appropriate for children and young people who spend extended periods in hospital.***

6.6 Some of the areas where there was room for positive change included:

- communication - parents sometimes felt that good communication tailed off as their child's stay was prolonged;
- child protection - parents were not always fully informed about significant or potential child protection issues in their child's care;
- transport – this was often difficult for parents and they did not always receive the help they needed in claiming reimbursement;
- leisure and social activities for young people – these were generally insufficient in the hospital setting;
- equipment - when children were home for short periods as part of their rehabilitation programme, it was difficult to get appropriate equipment, such as an electric wheelchair, to assist the child's stay at home.

6.7 ***Hospitals providing children's services should establish arrangements that promote best practice in each of the above areas and ensure that the needs of children and their families are addressed in a sensitive manner.***

6.8 There were a number of matters, however, that were of particular concern to the Inspection Team. These are outlined below and must be addressed to maintain responsive approaches to the needs of children and families.

Care of children and young people in adult wards

6.9 This issue has already been considered in Part 3.9-14 of this report. It is important to record however, the concerns and in some cases, fears of parents that their children continued to remain on the adult wards of learning disability and mental health hospitals where they were exposed to inappropriate adult behaviour or the undue influence of adult patients and had little opportunity for social interaction with their peers. This matter will be considered regionally, as recommended in 3.13 and the use of adult wards will be monitored by Boards and Trusts. It is important however in the meantime that the care of each individual child and young person is safeguarded by appropriate assessment and management of risk.

6.10 ***If, in exceptional circumstances, a child or young person is admitted to an adult ward, the Board and Trust should ensure that:***

- ***a full multidisciplinary assessment of risk is undertaken with actions identified to safeguard the child during the hospital stay;***
- ***the child and staff have access to professionals who have appropriate expertise in children's services;***
- ***there are plans to address the child's needs for leisure, social interaction with peers and an appropriate physical environment;***
- ***there is a discharge plan to move the child quickly to a suitable alternative placement.***

Home visits

6.11 It is vital that children who spend long periods of time in hospital, should be able to have visits home or spend time away from the hospital setting with their families, when it is safe and appropriate for them to do so. This right should be upheld in the hospital's principles and practice. Opportunities to meet with families outside the hospital should be considered as part of each child's care plan. There were good examples of such initiatives which formed part of children's rehabilitation programmes or ensured that a child was able to maintain family ties, even when there was not likelihood of a return home. These were commended. One situation was noted however, when matters such as hospital staff resources and other issues, not related to the child, prevented planned visits home. Staff may not always be fully alert to the importance of ensuring that the child's pre-arranged contact with family is maintained and promoted, particularly at times when staff are working with limited resources.

6.12 ***When the child's care plan includes visits to family, staff should ensure that visits take place as planned. If matters unrelated to the child or family circumstances prevent this happening, staff should inform senior management immediately and seek advice to ensure that children and families are not disadvantaged by events outside their control.***

Restriction of liberty

6.13 During the period under consideration by the Inspection Team, 17 children, representing 10% of the sample had been placed in a secure (locked) ward (Table 20) and of these, 7 were under the age of 16 years (Table 21). A total of 30 children had been detained under the Mental Health (NI) Order 1986 (Table 22) and of these, 17 were under 16 years (Table 23). A small number of hospitals had 'time out' rooms which were designated for use as part of behavioural management therapies. Where 'time out' had occurred, this was not always recorded in the child's file. There was also a lack of clarity among staff about the purpose of the provision. This raised general concerns about the restriction of children's liberty while in hospital and the need for clear policies, procedures and training to inform practice in this area.

6.14 ***Where a hospital has a designated facility or makes use of behaviour management techniques that restrict the liberty of children:***

- ***the hospital should establish an appropriate policy which conforms to the Department's guidance on 'The Use of Restraint and Seclusion in Residential and other Settings' (DHSSPS 2005);***

- ***there should be clear procedures for staff covering the use of techniques to restrict the liberty of children, including an agreed level of staff training and supervision, as well as the recording of use and the circumstances surrounding this in children's case files;***

- ***where there are designated time out areas in the hospital, the Trust should seek guidance on the physical aspects to ensure that this conforms with best practice guidance;***

- ***senior management in the Trust should review policy and procedures to ensure that these do not breach the child's human rights; and***

- ***parents should be given information about restriction of liberty; they should consent to the methods used and be fully informed of any incidents involving their child.***

Group support for children, parents and siblings

6.15 The inspection identified group work as a potential area for development in the support of children in hospital and their families. Examples were found of group work initiatives for children and young people in hospital and these were commended. As has already been noted in 6.1, however, families can feel a sense of isolation when they have a disabled or very ill child who requires an extended period in hospital. A number of parents reported that they felt they were the only ones in this situation and would have valued the opportunity to talk to and share matters of mutual concern with others who had a similar experience. One such approach to support the parents of neonatal children was commended.

6.16 Other members of the family also have support needs that may go unrecognised when the disabled child is centre stage. Parents and hospital staff reported that the needs of siblings, particularly young siblings often take second place in the midst of daily visits to hospital, frequent meetings and the other issues that arise in the care of the disabled child. When a disabled child is newly born into the family or has acquired a serious injury, the child's brothers and sisters need time and attention to help them make sense of the dramatic change in their lives. It was encouraging to note that some hospitals were in the process of setting up sibling support groups led by social workers and nursing staff.

6.17 Voluntary organisations offer a range of support initiatives and information about these should be provided to children and their families. The opportunity for parents or other family members to meet with others involved with the same hospital, however, can be a valuable additional source of help. Such an approach needs to be supported by staff who are familiar with the children, the hospital and its routines. Hospital based social workers are well placed to take on this role (4.26) both in their own right and as co-workers with members of the multidisciplinary team.

6.18 ***Hospitals caring for disabled children should explore whether children, parents and siblings would benefit from group support approaches and, if they wish, ensure that they are linked into hospital based initiatives or the group support approaches of other agencies.***

Bereaved families

6.19 Sadly, there is a high death rate in the most severely disabled children. Of the children considered in the total sample, at least 16 (9%) children had died (Table 24). The death of a child is one of the most devastating events in the lives of families. The Inspection Team commended one Hospital Trust for having established an annual memorial service for families. Some hospitals also demonstrated great sensitivity to cultural issues in the way they handled the death of the child and subsequent arrangements for the family. These initiatives were commended. Whilst most families who had been bereaved valued the sensitivity of hospital staff and had received information about various support groups, some parents reported that they would have benefited from a further period of counselling by social work staff who had knowledge of and contact with the family during their bereavement. Social workers also identified the need for additional time and resources to offer this vital service (see 4.25)

6.20 ***When families have suffered the bereavement of a child, professional social work support should be made available for as long as is necessary to meet the needs of the family for support during this difficult time.***

The physical environment

6.21 The Inspection Team visited a large number of wards and hospital based facilities. Many of the findings relating to the physical environment were specific to the hospitals inspected. The following main themes emerged overall:

- children's wards in acute hospitals were generally bright and welcoming. The décor was (or was in the process of becoming) child friendly and in general, there was respect for the dignity and privacy of each child;
- in some cases, single bedrooms were available for young people who were admitted to an all child or mainly adult environment;
- where young people were placed in a 'house' rather than a hospital environment, they preferred this rather than the traditional setting of a hospital;

6.22 Some matters of concern, however, were:

- physical conditions in the mixed age group provision for people with learning disabilities and mental health needs were unacceptable;
- a number of hospitals did not have private rooms where parents could discuss or be given information about their child or where professionals such as social workers could elicit information or provide support to parents in a manner that respected their need for confidentiality and privacy in emotionally charged or distressing situations;
- a significant number or facilities in wards were not easily accessible by children or families with mobility problems;
- there were not always suitable facilities or equipment for families travelling long distances or needing to stay overnight with their child;
- lack of outdoor leisure space for some young mental health patients;
- lack of social space for young people to meet with peers, particularly in the acute sector.

6.23 Appropriate recommendations in respect of these have been made to each of the hospitals concerned.

6.24 ***Trusts should ascertain whether any of the above matters apply to their hospitals and seek with parents, children and disability representative groups to identify areas of the physical environment that should be improved.***

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7. Education Provision

Standard

Children in hospital are able to access educational support which is matched to their needs and is appropriate to the circumstances of the hospital setting.

7.1 The Inspection identified well established arrangements and practices to meet the educational needs of children and young people across almost all of the hospitals. Some areas for improvement were identified in individual hospitals to ensure that the educational support needs of children and young people would be effectively met. The more general issues are outlined below.

7.2 For children who remained in long stay hospital provision, in general, educational support was accessible as required. Where appropriate, arrangements included daily travel to local schools or access to visiting teachers. In these situations, clear arrangements were followed and support was appropriate and fit for purpose. Of 82 children who received education while in hospital, 53 (65%) received on-site provision (Table 25).

7.3 In the main, the evidence indicated that there was access to good quality provision in almost all of the settings, with some having developed a more integrated and interdisciplinary approach to planning educational and health care provision. It was noted, however, that 13 children aged 4 years and over had received no educational provision and in the case of a further 18 children, it was not known whether they had received any education during their hospital stay (Table 26).

7.4 ***All children who experience a long stay in hospital – or frequent hospital admissions – should be able to access an appropriate level of education. Where this is not the case, the care plan should contain an explanation and the appropriate Education and Library Board should be notified with a view to establishing, where this is possible and appropriate, an educational programme for the child.***

7.5 In the best examples observed, children and young people were helped to maintain their school progress, regular contact was maintained by teaching staff with parents and the child's school and there were written reports which recorded the work undertaken and learning achieved by the child. In these situations, teachers and assistants were sensitive to the individual medical needs of the children and young people. They had established harmonious relationships with hospital staff and parents and working arrangements that complemented the hospital's daily routines.

7.6 The factors that contributed to the effective education of children and young people in hospital settings included:

- good teacher-staff relations;
- the establishment of an atmosphere of mutual respect that was conducive to helping children within a medical care setting;
- regular communication between teaching staff and the children's schools;
- written agreements which set out the roles of the teaching and hospital staff and detailed how working practices could promote an integrated approach to the care and education of children and young people;
- time to plan on an interdisciplinary basis;
- an appropriate balance of education and personal social care which assisted children while they were in hospital and during convalescence at home;
- the sharing and discussion of good practice;
- well organised lessons and good management of time; and
- good teaching approaches matched to individual need.

7.7 The inspection demonstrated however, that there was a need to improve the educational service to children and young people in hospital by:

- better liaison between Trusts, Education and Library Boards and their hospital based staff to develop more systematically the policy and guidance necessary to establish a clear focus on the needs of children and young people in hospital from admission to discharge;

- availing of training to promote collaborative working practices;

- regular review of the level of educational support and making adjustments to ensure that provision is sufficient to meet changes in admissions of children;

- exploring the use of information and communication technology as a learning tool and recording and maintaining links between hospital and schools;

- ensuring that parents have full written and location specific information about how their child's educational needs will be met while in hospital;

- including educational needs within the child's care plan;

- ensuring that the process for children and young people who need a statement of special education needs whilst in hospital is carried out efficiently and where possible, temporary educational arrangements are made for the child pending the completion of the statementing process.

7.8 ***Education and Library Boards should establish a regional forum to enable the above issues to be addressed and promote strategic discussion and consensus to:***

- ***inform the development of consistent and cohesive practices in the education of children in hospital; and***

- ***create a framework that will assist hospitals in understanding the nature and importance of educational provision and how appropriate educational support can contribute to the overall wellbeing of children and young people in hospital***.

8. Workforce Planning, Staff Training and Support

Standard

There are sufficient staff with appropriate qualifications, knowledge and expertise to deliver effective services to disabled children and their families.

Workforce planning

8.1 The difficulties of planning services which potentially span several health and social care programmes have already been considered in Part 4.1-5 of this report. Workforce planning for disabled children's services is equally complex, in that more so than any other children's services, the medical, health and social care needs of disabled children require coordinated planning across a wide range of disciplines that provide services both within community and hospital settings. Although there were a number of Boards' and Trusts' documents that addressed workforce planning, these focused on discrete areas of professional practice rather than the strategic and holistic needs of patient or user groups. Even within clinical specialisms, paediatrics is a further specialist area that requires appropriate training across all hospital based disciplines. There were gaps in the multidisciplinary staffing in each of the hospitals inspected. In general, there was an insufficient pool of appropriately qualified staff to meets the needs of disabled children in hospital and the implications of this are clearly far reaching.

8.2 The Department, Boards and Trusts have already identified the need for multidisciplinary workforce planning. The Department is currently taking forward a pilot multidisciplinary workforce planning exercise to address the workforce implications of the Bamford Review (3.1). In view of the fact that part of this pilot will address the needs of child and adolescent mental health services, it is recommended that:

8.3 ***As a further multidisciplinary workforce planning pilot initiative, the Department should consider taking forward the findings of this inspection in relation to workforce issues in disabled children's services.***

8.4 ***In their workforce planning arrangements, Boards and Trusts should identify ways in which professionals should work together to more effectively secure the necessary quality of care for disabled children and their families.***

Social Work services

8.5 The need for social work support within hospitals providing services for children and young people has already been identified in Part 4.24-27. Whilst one hospital had not been able on the first trawl to recruit a social worker, in general, there did not appear to be staff recruitment or retention difficulties in hospital based social work services. Where there was no social work support for children and families, or insufficient staff to provide the full range of social work services required, the reasons for this appeared to be linked to lack of appropriate planning, poor recognition of the contribution social workers make to the care of children in hospital and their families, or pressures on resources.

8.6 ***Boards and Trusts should review workforce planning within Social Services to ensure that priority is given to the needs of disabled children in hospital and their families for adequate social work support.***

8.7 ***The Department's forthcoming regional review of the Social Services workforce should take into account the findings of this inspection in relation to social work workforce issues.***

Medical services

8.8 It was acknowledged that there were various and complex medical staffing issues across the region which are in the process of being considered and addressed at different levels outside the remit of the inspection. However the Inspection Team highlighted particular needs for urgent consideration:

- Medical posts in child and adolescent psychiatry to secure the current in-patient services;

- Consultant posts to take forward rehabilitative services to children and young people;

- Dually-trained consultants in child and adolescent psychiatry and learning disability to ensure quality of care in future services for learning disabled children and young people;

- More joint paediatric community and hospital based posts; and

- Consultants to be supported by multidisciplinary teams that are based on the assessed needs of children receiving the service and where necessary, include other medical staff.

8.9 ***The Department should take account of the above pressures as part of its ongoing assessment of specialist medical workforce needs.***

Nursing services

8.10 The Inspection Team found a general shortage of registered children's nurses in all areas, in particular, mental health and learning disability. Nurse workforce planning arrangements varied within hospitals and Trusts. In one Trust an 'over recruitment' policy was in place. Nurse managers, however, in this Trust reported a problem with retention of staff as registered children's nurses left to take up senior posts in other hospitals. This was in contrast to reports from local hospitals where nurse managers stated that the transfer of pre-registration nurse training to Belfast had exacerbated recruitment problems. Managers also considered that students, once qualified, did not return to fill post in local hospitals but preferred to remain in Belfast where career prospects were perceived to be better. In a number of hospitals nurses had been recruited from overseas to cover the shortfall of local staff.

8.11 There were significant recruitment problems in the area of mental health. Pay structures encouraged experienced nursing staff to take up post in community Trusts, thereby creating a gap in service provision in acute facilities. To some extent this may be resolved with the introduction of the 'Agenda for Change', a policy paper published by the Department of Health in 2004 which sets out the Government's workforce plans for number of professional groups, including nurses. The parents of children in mental health facilities and the young people reported that they very much valued the input from registered nursing staff but were aware that staff shortages affected the level of therapeutic interventions available to them. They were also concerned that this might subsequently lengthen their hospital stay as programmes of care or interventions may take longer to complete. In the regional children's mental health facility, bed capacity had been reduced from 20 to 16 and in learning disability services a significant dependence on bank and agency nursing staff and health care staff was evident. The Department has recently taken forward a recruitment campaign to encourage people to train as mental health nurses. This resulted in a significant increase in the numbers applying to mental health programmes.

8.12 ***The Department should continue to support an increased intake into mental health nursing programmes and address shortfall and deficit issues in the children's nursing workforce both within the required disciplines and on a geographical basis.***

8.13 Workforce planning in relation to new builds in the acute sector included assessments of general nursing staff requirements. None of the workforce plans, however, specifically identified the nursing resources required for the management and provision of children's or adolescent services.

8.14 ***Business plans for new builds in the acute sector should take account of the nursing resources required for the management and provision of children's and adolescent services.***

AHP services

8.15 Issues to do with the structure and organisation of AHP services that clearly had an impact on the quality of the treatment and care of children were identified in 4.38-42. Future workforce planning must take account of the right of children to receive AHP services that can respond to their individual needs. Planners at strategic and local levels should know what those needs are and be capable of identifying the range of professional expertise and the resource required in the workforce to meet those needs effectively.

8.16 ***Boards and Trusts should identify the needs of disabled children including those of children in hospital and the range of AHP expertise required to meet these. The Department should ensure that there is a collaborative approach to multiprofessional AHP workforce planning between the Department, Boards and Trusts that will enable strategic and operational responsibilities to be fulfilled.***

Psychology services

8.17 There is a general shortage of psychologists in all areas of children's services. Some hospitals had no access to services, others had sessional support which was in general not sufficient to meet demands or to provide help and support to children and their families when this was most needed (4.43-44). Although there has been a recent increase in the numbers of psychologists in training this is unlikely to meet current and future need in children's services.

8.18 ***The findings of this inspection in relation to psychology services for disabled children in hospital should be taken into account by the Department's workforce planning review of psychology services.***

Pharmacy services

8.19 Paediatric pharmacy is a critical area for future workforce development. The Department's current review of the HPSS workforce will provide an updated review of the pharmacy workforce. In view of the importance, however, of pharmacy services to the care and treatment of children in hospital and to effectively meet the requirements of the recommendation set out in 4.45-6, the Inspection Team made the following recommendations:

8.20 ***The Department's pharmacy workforce planning review should contain a recommendation for the development of specialist expertise in paediatric pharmacy services.***

8.21 ***The Northern Ireland Centre for Post Graduate Pharmaceutical Education and Training should seek to develop a curriculum to support paediatrics.***

8.22 ***In the commissioning, planning and delivery of services, Boards and Trusts should ensure that there is a dedicated pharmacist resource to support clinical paediatric services.***

Staff induction, supervision and appraisal

8.23 Most hospitals had an induction programme for all new staff. There were examples of good general induction information packs and ward specific induction arrangements and information for nurses. This was commended but did not always exist for other professionals in the hospital team. In a number of situations, doctors' handbooks required to be updated.

8.24 ***Up to date induction handbooks should be available for all key professional disciplines within hospitals.***

8.25 Annual appraisal had been established in most hospitals for a range of staff. Some Trusts were commended for having successfully introduced annual appraisal for consultant medical staff. Appraisal was not generally afforded to all disciplines within hospitals.

8.26 A number of Trusts were commended for having introduced national appraisal processes for medical Consultants who also reported that they had opportunities for continuing professional development and, in some cases, peer support. Social workers consistently received regular professional supervision and protected time was set aside for this. The Inspection Team noted that in some cases there were supportive arrangements, such as mentoring, in place for newly qualified nurses. Established nursing staff, however, rarely had formal clinical supervision and protected time had generally not been allocated to support staff in this way. In comparison with the other remaining professions, AHP staff had more regular supervision, although this varied between hospitals and in only a few situations had protocols been developed and protected time allocated to this process. Most psychologists reported that they had access to professional supervision and in some situations, they were able to avail of peer group support.

8.27 Supportive appraisal and clinical supervision arrangements provide an opportunity for reflective practice, specialised learning and professional development.

8.28 ***Trusts should establish a policy that supports annual appraisal and protected time for clinical supervision of all professional staff. They should promote the implementation of the policy across all children's services.***

Staff development and training

8.29 Each of the hospitals and their respective Boards had made available a range of training for professional groupings as part of their staff development and annual training programmes. Social workers had assisted in child protection training within hospitals although in a number of situations front line hospital staff were not familiar with child protection issues, policies and procedures. Social workers had also availed of and contributed to specialist training to improve skills and knowledge in complex clinical areas. Medical staff in each hospital had access to opportunities for continuing professional development. There were also examples of nurse training initiatives aimed at preparing nurses to take on new roles and enabling them to gain knowledge and skills quickly through the shortened branch children's programme. These were commended. In most of the larger hospitals there was evidence of good links with Nurse Education Commissioning Groups, Provider Support Units and the universities.

8.30 In terms of the range of qualifying training available to key professionals in children's services, however, it was noted that there was no AHP undergraduate training module on children and young people with mental health needs (see 4.41). There were also limited training opportunities for individual AHPs working with disabled children. Those that are available are delivered mainly through profession-specific national bodies. This deficit can lead to the feeling of isolation for AHPs working within under resourced services.

8.31 In the key area of multidisciplinary working, including assessment and care planning for children, there were few formal training initiatives. In at least one situation, however, a medical Consultant had introduced the team to a multidisciplinary assessment approach which worked well. This was commended.

8.32 In light of the range of training issues raised by the inspection the following recommendations were made.

8.33 ***Boards should ensure that there is an annual training needs analysis to identify the training and development needs of all staff working in children's hospital services. In addition to clinical care and individual staff development needs there should be a continuing emphasis on training in:***

- ***child protection;***
- ***multidisciplinary assessment and care planning and review; and***
- ***children's rights and safeguarding these in hospital (see 10.13).***

8.34 ***Boards should address with the Educational Partnership Forums the matter of AHP undergraduate training in working with children who have mental health needs. Boards and Trusts should also work in partnership with the Department and other relevant agencies to provide post qualifying training programmes for AHPs working with disabled children.***

9. Communication and Information

Standard

The hospital provides accessible and relevant information about its services to disabled children and their families.

9.1 The provision of appropriate and accessible information for service users is an important part of the wider responsibilities of all Trusts. Good information about the range of services available, the Trust's responsibilities and other matters to do with the delivery of services can be empowering for children and their families. Clear communication between professionals and agencies who are responsible for providing services and between professionals and those receiving services, will also help to determine the quality of service experienced by children and their families.

9.2 Professional communication issues between

- Trusts and professional staff;
- hospital staff and children and their families; and
- hospital and community services

were considered in Parts 4 and 5 of this report. The paragraphs to follow are concerned with more general information and how Trusts and hospitals made information available and accessible to children and their families.

Information

9.3 Hospital Trusts' Annual Reports contained information about children's services and included details of new initiatives, developments and the future planning of services. The Annual Reports of community Trusts provided general information about services for disabled children, although these did not always cover the full range of services provided. These reports were generally widely available within hospitals and could also be accessed on Trusts' web-sites.

9.4 The following examples of information initiatives were commended by the Inspection Team:

- displays containing information about medical conditions; community and voluntary services; child protection and disability;
- welcome packs for children and parents;
- in one situation, results of children's survey displayed in a child friendly manner; and
- attractive information booklets for children about the hospital's routines.

9.5 Some parents reported that they would have liked written information for themselves and their children about the various roles of professional staff in the hospital. Where other deficits in information occurred, these were generally related to a lack of suitable information for young people about health and health education matters.

9.6 ***Hospitals should:***

- ***develop information for children, young people and their families about their hospital stay, the roles of professional staff within the hospital and appropriate services available in the community; and***

- ***ensure that appropriate health and health education information is available for young people during their stay in hospital.***

Complaints, access to patient information and consent to treatment

9.7 Most hospitals had information about how to complain, either on poster display or in leaflet form. Within children's services there were few examples of user friendly information explaining how to access information held on the child's case file. Indeed, some of the parents who were interviewed were not aware that they could access their children's records. In situations, however, where parents exercised this right, they were pleasantly surprised at the extent of work undertaken for or on behalf of their children. Information on consent to treatment for children and young people was not widely available.

9.8 ***Information on complaints, access to personal records and consent to treatment should be sensitively communicated within the general written information given to parents and children.***

Communication with children and families

9.9 Most hospitals were able to access people skilled in Makaton and alternative forms of communication. There was generally little information available, however, on the types of assistance available to children and families with communication difficulties or those whose first language was not English. Written information and other forms of media can serve to enlighten families about what is available and to reassure them that their communication needs will be met,

9.10 ***Hospitals should produce information in leaflet form and other media about the range of assistance available to patients and families who by reasons of disability or ethnicity may experience communication difficulties.***

10. Equality and Human Rights

Standard

The Board and Hospitals Trust are fulfilling their statutory duties in respect of requirements under human rights and equality legislation. Human rights and equality principles are integrated into practice within all aspects of services for disabled children.

The rights of children

10.1 The United Nations Convention on the Rights of the Child (the UN Convention) places disabled children firmly within the full implementation of the rights of the Convention.

10.2 Disabled children in hospital experience an added level of dependency. Those responsible for their care and treatment need to give careful consideration to safeguarding and promoting their rights. In summary[1], Article 23 of the UN Convention states that

> 'a child with a physical or mental disability should enjoy a full and decent life, in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community. Children with disabilities have the right to special care, designed to ensure that the child receives education, training, healthcare services, rehabilitation services, preparation for employment, and recreation opportunities in a manner conducive to the child's achieving *(sic)* the fullest possible social integration and individual development, including cultural and spiritual development'.

10.3 This is the ultimate standard by which services and those who deliver them must be measured.

10.4 The Disability Discrimination Act 1995 (DDA) promotes the rights of disabled people to access the full range of public services. The Northern Ireland Act 1998 upholds the right of disabled people to be treated equally in all aspects of public life. The life quality of disabled children and their families, however, may at times be more affected by attitudes and disabling environments, rather than a lack of adherence to the letter of the law. Children who have a disability can be particularly vulnerable to unhelpful attitudes and environments that emphasise rather than minimise their dependency.

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[1] The summary statements of the rights of children under the UN Convention in this part of the report are those drawn up by the Commission for Social Care Inspection (CSCI), the national registration and inspection agency for social care services in England and Wales. The full text of the statements can be found on the CSCI internet site www.csci.org.uk.

Charters for children and young people

10.5 In the main, the Inspection Team found that staff who were immediately involved in the treatment and care of children and young people had a clear child and family focus. The rights of children were respected and valued. Some hospitals had developed Charters for Children which set out the child's rights and what children could expect whilst in hospital. These were commended. Where young people were provided with services, there were no equivalent charters aimed specifically at their age group, although most general hospitals had the DHSS Patient's Charter on display. The needs of young people and their rights can differ in important respects from those of children or adults, for example in areas such as consent to medical treatment and matters to do with the confidentiality of information. It would be helpful to see these rights expressed in the form of a charter developed specifically to address their needs.

10.6 ***Where hospitals provide services for young people, they should develop in partnership with young people, a Charter which sets out their rights and how they can expect these to be promoted whilst in hospital.***

Advocacy services

10.7 Article 12 of the UN Convention promotes the rights of children to be heard in all matters affecting them. Some hospitals had established forms of group support for young patients, and 2 hospitals had developed an advocacy service, one of which was a dedicated child advocacy service. This was commended. Disabled children and young people and particularly those in hospital or other care settings can face enormous challenges in getting their voice heard. It is vital that they are provided with support and encouragement to enable this to happen.

10.8 ***Hospitals providing children's and young people's services should encourage pro-active approaches, such as advocacy initiatives, which promote the rights of children and young people and enable their voice to be heard in any matters that concern them.***

Play, leisure and social activities

10.9 Article 31 of the UN Convention upholds the right of children to relax and play and enjoy a range of activities, regardless of their circumstances. This is a particular concern when children spend long periods of time in hospital and where the focus on the child's disability or illness may limit or detract from promoting their rights to social and leisure activities. A recommendation in relation to this has already been made in 6.5 of this report.

10.10 **Good practice example:**

The Royal Belfast Hospital for Sick Children was commended for its commitment to promoting innovative approaches to play. The hospital had established dedicated play specialists in each of the children's wards who provided a range of play and social activities. This helped to alleviate children's worries and distress and enabled procedures to be explained in a child friendly manner. The play specialists were integrated into the multidisciplinary team approach to children's care and used visual and multisensory material to prepare children for treatment and surgery.

Issues impacting on the rights of children

10.11 There was a strong commitment in the hospitals inspected to promoting the rights and equality of disabled children. The full expression of children's rights and equality issues were, however, constrained by the matters presented in Figure 2, which have already been considered in this report.

10.12 ***Hospitals caring for children should examine their services for children in the light of the inspection findings and in the context of the need to promote the human rights and equality of disabled children as set out in Figure 2. They should report any shortcomings to their respective Trusts and Boards with a view to agreeing strategies to address these.***

10.13 In general, there was a need for continuous staff training in children's rights and equality issues in order that matters such as those listed in Figure 2 and their implications for children's rights may be readily identified and acted upon by staff. A recommendation to this effect has been made in 8.33.

Figure 2: Inspection findings and implications in terms of the UN Convention[1] on the Rights of the Child

Matters for attention	Paragraph references	UN Convention Extracts from summary statements
Access by children to the full range of expertise necessary to promote their health and the support of families	3.3 8.1	**Article 24** Children have the right to the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health
Prolonged admissions of children or young people to specialist mental health or learning disability hospitals and lack of appropriate community care provision.	3.3 – 3.8 3.16-3.17	**Article 23** A child with a physical or mental disability should enjoy a full and decent life, in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community
Buildings and institutional practice	3.7 6.21	**Article 23** Children have a right to a standard of living adequate for their physical, mental, spiritual, moral and social development.
Children and young people in adult wards	3.9 – 3.14 6.9 – 6.10	**Article 3** Administrative measures shall be appropriate to ensure each child such protection and care as is necessary for his or her wellbeing
Use of hospital as a respite placement	3.22- 3.24	**Article 23** Children with disabilities have the right to special care, designed to ensure that the child receives …. healthcare services ….. and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development.
Child protection	4.16 –4.22 5.38 –5.41	**Article 19** Child protection should include support for the child and their carers, prevention, identification, reporting referral, investigation and treatment.

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[1] See footnote on UN Convention summary statements (Page 13).

Matters for attention	Paragraph references	UN Convention Extracts from summary statements
Care planning and review of children	5.4 5.19 5.31–5.33	**Article 25** A child placed for care, protection, or treatment of physical or mental health, has the right to periodic review of the treatment provided and all other circumstances relevant to his or her placement.
Addressing 'whole child' needs	5.10– 5.12 5.19	**Article 23** Children with disabilities have the right to special care …… in a manner conducive to the child's achieving the fullest possible social integration and individual development, including cultural and spiritual development.
Involvement of children in care planning and advocacy arrangements	5.17 10.7 –10.8	**Article 12** Any child who is capable of forming his or her own views shall be afforded the right to express those views freely in all matters affecting them. The views of the child shall be given due weight in accordance with the age and maturity of the child.
Access to creative therapies	6.4 – 6.5	**Article 13** Children have the right to freedom of expression. They have the right to seek, receive and impart information and ideas of all kinds, orally, in writing or in print, through art, or through any other media of the child's choice
Play, leisure and social outlets for children and young people	6.4 - 6.5 10.9	**Article 31** Children have the right to rest and leisure, to engage in play and recreational activities appropriate to their age, and to participate fully in cultural life and the arts. Appropriate and equal opportunities shall be encouraged in the provision of cultural, artistic, recreational and leisure activity.
Transport for families and visits home by the child	6.5 6.11– 6.12	**Article 9** A child separated from one or both parents has the right to maintain personal relations and direct contact with both parents on a regular basis, unless this is contrary to the child's best interests.

Matters for attention	Paragraph references	UN Convention Extracts from summary statements
Use of time out/restriction of liberty	6.13– 6.14	**Article 37** No child shall be deprived of his or her liberty unlawfully or arbitrarily …….. Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes account of the needs of a person of his or her age.
Access to education	7.3 – 7.8	**Article 28** Every child has the right to education. This includes making educational and vocational information and guidance available to children, making higher education accessible to all on the basis of capacity by all appropriate means
Qualifications of staff and professional supervision practice	8.1 8.25 –8.28	**Article 3** Institutions, services and facilities responsible for the care and protection of children shall conform with the established standards, particularly for safety, health, the number and suitability of staff, and competent supervision.

Equality Initiatives by Boards and Trusts

10.14 Each Board and Trust had an Approved Equality Scheme and programme to assess the impact of existing and new policies in accordance with Section 75 of the Northern Ireland Act. There had been some form of training in each Board and Trust on these issues. Several initiatives were commended, including:

- equality and human rights road shows;
- board wide forum for sharing good practice in equality and human rights issues;
- multidisciplinary equality steering groups;
- clear emphasis on the mainstreaming of human rights considerations in all areas of policy and practice;
- staff trained in access issues under DDA to conduct internal audits; and
- designated senior staff with responsibility for DDA implementation.

10.15 The Inspection Team noted that groups established by Boards and Trusts to implement the Act had not met for some time and this lack of regular strategic focus on disability had the potential for DDA matters to be approached in a reactive rather than proactive manner.

10.16 ***Disability Discrimination Act Implementation Groups should reconvene and meet on a regular basis to identify areas for action and agree strategies for promoting equality in disability issues.***

10.17 There was also scope for a more specific policy emphasis on promoting the rights and equality of disabled children in hospital, particularly those who stay for long periods. This should inform everyday practice in the care of children and the support of families while their child is in hospital.

10.18 ***Hospitals caring for children should develop a policy framework which sets out the rights of disabled children and provides guidance for staff on promoting rights and equality based care while the child is in hospital.***

11. Conclusion and Summary of Recommendations

Conclusion

11.1 This inspection has highlighted many areas of good practice in the care of disabled children while they are in hospital. But the care of the child is a continuum that starts with policy makers, commissioners and planners of services and extends beyond the hospital into the community. The care of the child is not just about the child. It's about strengthening and supporting families. It's about ensuring that there are proper clinical, social, educational and cultural networks in place to make the child's hospital stay as effective but as short as possible. The recommendations set out below are aimed at providing 'Care at its Best' at all of these levels. It is important that the Department, Boards and Trusts should now address the findings of this report as part of the pursuit of high quality children's services. The disabled children, their families and their advocates who contributed to the inspection, had an expectation that it would enhance services in the future. They deserve to see that expectation fulfilled.

Summary of the recommendations

THEMES TO INFORM STRATEGIC PLANNING FOR DISABLED CHILDREN

	Recommendation	Page
1	Boards should give priority to establishing Tier 4 child and adolescent mental health services. The services should provide for full and intensive multidisciplinary assessment, treatment and care of children in facilities that are specifically designed for specialist interventions (3.4).	12
2	The Departmental Regional CAMHS Development Group should take account of the findings of this inspection to inform strategic planning of services and the development of new inpatient provision for children and young people with mental health needs (3.6).	12

Recommendation		Page
3	In the context of the planned reprovision of regional inpatient services for adults and children with learning disabilities, commissioning Boards should formally recognise the needs of young people as being distinct from those of children or adults and should address these as a matter of urgency. (3.8).	13
4	Boards and Trusts should monitor the numbers of children and young people admitted to adult wards and the length of their stay with a view to determining whether there are sufficient children's specialist inpatient places and community based provision to meet their needs. Where there are deficits these should be addressed in a cross Board coordinated manner (3.13).	14
5	Boards should develop a regionally agreed protocol for referrals of young people aged 14 years and over to hospital and other clinical and community services. This should promote consistent approaches that take account of the young person's age and stage of development and enable appropriate expertise to be available to meet each young person's needs (3.15).	14
6	The 'Children Matter' Task Force should in its Phase 2 implementation consider the impact of impending reductions in children's specialist hospital places on current and planned community residential and other community provision with a view to informing strategic planning for future services to disabled children (3.17).	15
7	The Department should agree a regional policy to address the emerging needs of technology dependent children for community care services, including the skills base required in staff, parents and carers, to ensure minimum delay in progressing care plans for these children (3.21).	16
8	A regional review of respite provision for disabled children should be progressed by the Department without delay as part of the Implementation of the Children Matter Phase 2 initiative (3.24).	17

THE COMMISSIONING ARRANGEMENTS, STRUCTURE, ORGANISATION AND MANAGEMENT OF THE HOSPITAL'S SERVICES

Recommendation		**Page**
9	The Department's Children's Services Committee should address the need for an integrated policy on services for disabled children and establish arrangements across relevant Departmental interests to enable a coordinated approach to the matters outlined in 4.3 (4.5).	20
10	Boards should establish commissioning and management structures that are capable of addressing the needs of disabled children and enable services to be developed in a comprehensive, child centred and fully integrated way (4.7).	21
11	In fulfilment of the requirement of the Children Order and the need to inform service planning with reliable and comprehensive information, Boards should ensure that Trusts establish registers of disabled children as a matter of urgency (4.9).	21
12	In view of the importance of the links between hospital and community services for children who require periods of hospital care, the CSP should include representatives from hospitals providing children's services. (4.11).	22
13	From the outset of new service developments or new build projects for children's services, Trusts should establish planning reference groups that include children, parents and front line staff (4.13).	22
14	A designated senior manager within Trusts with a lead responsibility for children's services should be established in hospitals providing children's inpatient services to: • promote an integrated approach to clinical and social care matters and the planning of children' services; • support the development of the full range of policies governing the treatment and care of children in hospital, including the 'child' proofing of general hospital policies as well as providing a focus for child protection policies and related issues;	23

Recommendation		Page
	- ensure that child focused management of risk and clinical and social care governance concerns are reflected in appropriate planning and other groupings within the Trust (4.15).	
15	To ensure that hospital and community links are properly managed and that general hospital-related child protection issues are addressed, Hospital Trusts providing acute or specialist children's services should consider establishing a Child Protection Panel. As a minimum alternative, a senior hospital representative should have membership of an appropriate community Trust's Child Protection Panel. Community Trust hospitals providing children's services should be represented on their Trust's Child Protection Panel (4.18).	24
16	Boards and Trusts should determine whether child protection issues for children in hospital are adequately represented at ACPC level and in light of this consider whether hospitals providing children's services should have membership of ACPCs in their own right (4.20).	24
17	Hospitals should establish formal arrangements with local community child protection teams to ensure that hospital based nursing staff are appropriately supported by, and have timely access to, a child protection nurse specialist (4.22).	24
18	Dedicated and specialist children's social work services should be available to children and families in hospitals providing acute or specialist services for children and young people. Where social workers are part of a hospital based multidisciplinary team, they should have a clearly defined role, which ensures that the support needs of children and families are addressed in a comprehensive way (4.27).	27
19	Patient surveys should take account of the social care support needs of patients and their families (4.28)	27
20	Trusts should establish formal arrangements which ensure that hospital based social workers are aware of new initiatives and are inducted, together with community based workers, into new policies that have implications for their practice (4.30).	27

Recommendation	Page
21 Trusts should consider establishing joint paediatric and community based medical consultant posts to promote continuity of care for children and their carers (4.32).	27
22 Trusts should ensure that all adult trained nurses caring for children with a mental health or learning disability have access to advice and support from a qualified children's nurse (4.35)	28
23 Boards should assess the current provision of AHP services for children in hospital with a view to identifying unmet needs and addressing the need for future services. Formal arrangements should be established which ensure that children receive timely access to the full range of AHP services they need and staff are enabled to develop expertise in paediatric care (4.42).	30
24 Boards and Trusts should establish arrangements to prioritise the timely provision of psychology support services to disabled children and young people in hospital (4.44).	30
25 Hospitals providing children's services should establish dedicated expertise in paediatric pharmacy services and ensure that there is a sufficient pharmacy resource to contribute to each child's care as part of the multidisciplinary team (4.46).	31
26 Hospitals should address children's services as a discrete area within clinical and social care governance and include a report specifically on children's issues in annual governance reporting arrangements (4.49).	32
27 Trusts should ensure that the membership of clinical and social care governance (including risk management) groupings within hospitals represents as far as possible the range of professional disciplines working with child inpatients and families and includes the participation of child and parent/carer representatives (4.50).	32
28 Trusts should develop full multidisciplinary audit and monitoring of services for children in hospital (4.53).	33

Recommendation		Page
29	The Department's Standards and Guidelines Unit should take forward the development of multidisciplinary standards to inform the care of disabled children in hospital (4.57).	33

ASSESSMENT AND CARE PLANNING

30 Boards and Trusts should ensure that hospitals providing children's inpatient services have established, as a minimum, written policies and procedures on the following: 35

- pre-admission, admission and discharge of disabled children and young people, including emergency admissions and procedures covering children who require frequent admissions to hospital;
- philosophy of care of disabled children in hospital, including the role of parents, families and carers;
- multidisciplinary assessment and care planning, including contact with community care services;
- child protection, to include easily accessible copies of 'Cooperating to Safeguard Children' (DHSSPS, 2003) and the Area Child Protection Committee's Child Protection Policies and Procedures;
- the impact of domestic violence on children;
- consent to examination, treatment or care;
- intimate/invasive care of children and young people;
- anti bullying;
- notification to Social Services of children who have been or are likely to be in hospital for 3 months or more (this should include neonatal children); and
- discharge arrangements (5.3).

Recommendation		Page
31	Acute hospitals providing children's services should establish fast tracking arrangements for children needing frequent admissions to hospital (5.6).	36
32	To assist care planning and ease of communication, assessments completed by all professionals involved in the child's care should be integrated into one multidisciplinary assessment. In addition to the child's physical and clinical care needs, the assessment should address, in consultation with parents, 'whole child' needs such as social, cultural, spiritual, family support, education and children's rights issues (5.12).	38
33	Hospitals should, as part of the assessment process include a multidisciplinary assessment of risk on each child and young person which addresses the issues outlined in 5.14 (5.15).	39
34	Each disabled child should have a 'child centred', focused care plan based on the multidisciplinary assessment which: • covers the period from admission through to discharge; • takes account of the needs of the 'whole' child - including cultural, social and spiritual needs - in accordance with the period of time the child is likely to stay in hospital; • identifies key tasks to be undertaken by each professional, with timescales and arrangements for review; and • is easily accessible by staff, parents and children. Parents and children should be given the opportunity to document their agreement with the plan and if they wish, receive a copy (5.19).	40
35	As part of each child's care plan, a structured discharge process should be established which: • identifies a professional to take the lead in planning and coordinating discharge arrangements; • takes account of the ongoing support needs of children and families;	41

Recommendation		Page
	• ensures that appropriate community services (including voluntary sector and education services) are notified in a timely manner and where possible contribute to the discharge arrangements; and • provides for clear and consistent communication with families about the discharge process and follow up arrangements (5.22).	
36	Trusts should consider whether it would be helpful to take forward the assessment and care planning recommendations of this report on a regional basis with a view to developing jointly agreed protocols and proformas (5.23).	42
37	Where hospital staff are aware of inequities or gaps in the community service provision of Trusts, the hospital should ensure that Boards are formally notified of these (5.25).	42
38	Hospitals should ensure that they are fulfilling the notification requirements of the Children Order. This should apply to all children, including neo-natal children and those who are already known to the Trust. Notifications should serve to alert Trusts' senior management of children and families who may require a service or additional services. Community Trusts should establish procedures for responding to notifications by hospitals (5.28).	43
39	As children and parents may not be aware of the legal requirements regarding notification and the reasons for these, hospitals should liase with community Trusts to ensure that there is appropriate written information available for parents and children which explains the role of community services and the rights of children and parents within this process (5.30).	43
40	Children who cannot be discharged from hospital due to the lack of community provision should be notified to the relevant commissioning Board. Hospitals and community Trusts should ensure that the relevant Trust is fulfilling its responsibilities under the Children Order to assess and review children in these circumstances and plan to meet their needs (5.33).	44

Recommendation		Page
41	Boards and Trusts should establish a regionally agreed protocol to inform the transfer of children and young people to adult hospital or community services which: • takes account of chronological age and developmental issues; • provides for a flexible transition period; and • promotes a coordinated strategy across all disciplines that includes, with the consent of children and parents, the sharing of professional information (5.37).	45
42	Hospitals should review their child protection policies and procedures with a view to ensuring that procedures for dealing with the issues reported in 5.38 are included and that all staff working with children are familiar with the policy and procedural guidance in this area (5.40).	46
43	For children who are in hospital for extended periods, a member of the team should be appointed as a key worker to check that all aspects of the child's care are attended to, agreed actions (including those relating to child protection) are followed through and any delays or lack of action are reported to the ward manager or an appropriate line manager (5.41).	46
44	To assist multidisciplinary working in children's services, hospitals should consider establishing a single continuous record to which all disciplines contribute and which contains the child's multidisciplinary assessment and care plan (5.45).	47
45	Hospitals should establish a policy, in consultation with parents, on the use of the PCHR when children are admitted to hospital (5.47).	47
46	Hospitals should ensure that when files are not in immediate use they are at all times securely stored in accordance with agreed procedures to prevent breach of patient confidentiality (5.49).	47

THE RANGE AND QUALITY OF SERVICE PROVISION

Recommendation		**Page**
46	The needs of parents and families of disabled children for individual support should be separately assessed and addressed as part of the plan for the child's care whilst in hospital. Appropriate links with community services should also be established to ensure that parents and families continue to receive support in their own right when caring for their child at home (6.2).	49
47	Hospitals providing children's services should establish age appropriate special provision such as play, music and art therapy services aimed at offering children an opportunity for reflective individual expression. This is particularly appropriate for children and young people who spend extended periods in hospital (6.5).	50
48	Hospitals providing children's services should establish arrangements that promote best practice in each of the areas outlined in 6.6 and ensure that the needs of children and their families are addressed in a sensitive manner (6.7).	50
49	If, in exceptional circumstances, a child or young person is admitted to an adult ward, the Board and Trust should ensure that: • a full multidisciplinary assessment of risk is undertaken with actions identified to safeguard the child during the hospital stay; • the child and staff have access to professionals who have appropriate expertise in children's services; • there are plans to address the child's needs for leisure, social interaction with peers and an appropriate physical environment; and • there is a discharge plan to move the child quickly to a suitable alternative placement (6.10).	51

Recommendation	Page
50 When the child's care plan includes visits to family, staff should ensure that visits take place as planned. If matters unrelated to the child or family circumstances prevent this happening, staff should inform senior management immediately and seek advice on ensuring that children and families are not disadvantaged by events outside their control (6.12).	52
51 Where a hospital has a designated facility or makes use of behaviour management techniques to restrict the liberty of children: • The hospital should establish an appropriate policy which conforms to the Department's guidance on 'The Use of Restraint and Seclusion in Residential and other Settings' (DHSSPS 2005); • There should be clear procedures for staff covering the use of techniques to restrict the liberty of children, including an agreed level of staff training and supervision, as well as the recording of use and the circumstances surrounding this in children's case files; • Where there are designated time out areas in the hospital, the Trust should seek guidance on the physical aspects to ensure that this conforms with best practice guidance; • Senior management in the Trust should review policy and procedures to ensure that these do not breach the child's human rights; and • Parents should be given information about restriction of liberty; they should consent to the methods used and be fully informed of any incidents involving their child (6.14).	52
52 Hospitals caring for disabled children should explore whether children, parents and siblings would benefit from group support approaches and, if they wish, ensure that they are linked into hospital based or the group support initiatives of other agencies. The needs of parents and siblings for individual support should also be addressed (6.18).	54

Recommendation		Page
53	When families have suffered the bereavement of a child, professional social work support should be made available for as long as is necessary to meet the needs of the family for support during this difficult time (6.20).	54
54	Trusts should ascertain whether any of the matters identified in 6.22 apply to their hospitals and seek with parents, children and disability representative groups to identify areas of the physical environment that should be improved (6.24).	55

EDUCATION PROVISION

Recommendation		Page
55	All children who experience a long stay in hospital – or frequent hospital admissions – should be able to access an appropriate level of education. Where this is not the case, the care plan should contain an explanation and the appropriate Education and Library Board should be notified with a view to establishing, where this is possible and appropriate, an educational programme for the child (7.4).	57
56	Education and Library Boards should establish a regional forum to enable the issues identified in 7.7 to be addressed and promote strategic discussion and consensus to: • inform the development of consistent and cohesive practices in the education of children in hospital; and • create a framework that will assist hospitals in understanding the nature and importance of educational provision and how appropriate educational support can contribute to the overall wellbeing of children and young people in hospital (7.8).	59

WORKFORCE PLANNING, STAFF TRAINING AND SUPPORT

Recommendation		Page
57	As a further multidisciplinary workforce planning pilot initiative, the Department should consider taking forward the findings of this inspection in relation to workforce issues in disabled children's services (8.3).	61
58	In their workforce planning arrangements, Boards and Trusts should identify ways in which professionals should work together to more effectively secure the necessary quality of care for disabled children and their families (8.4).	62
59	Boards and Trusts should review workforce planning within Social Services to ensure that priority is given to the needs of disabled children in hospital and their families for adequate social work support (8.6).	62
60	The Department's forthcoming regional review of the Social Services workforce should take into account the findings of this inspection in relation to social work workforce issues (8.7).	62
61	The Department should take account of the pressures outlined in 8.8 as part of its ongoing assessment of specialist medical workforce needs (8.9).	63
62	The Department should continue to support an increased intake into mental health nursing programmes and address shortfall and deficit issues in the children's nursing workforce both within the required disciplines and on a geographical basis (8.12).	64
63	Business plans for new builds in the acute sector should take account of the nursing resources required for the management and provision of children's and adolescent services (8.14).	64
64	Boards and Trusts should identify the needs of disabled children including those of children in hospital, and the range of AHP expertise required to meet these. The Department should ensure that there is a collaborative approach to multiprofessional AHP workforce planning between the Department, Boards and Trusts that will allow strategic and operational responsibilities to be fulfilled (8.16).	64

	Recommendation	Page
65	The findings of this inspection in relation to psychology services for disabled children in hospital should be taken into account by the Department's workforce planning review of psychology services (8.18).	65
66	The Department's pharmacy workforce planning review should contain a recommendation for the development of specialist expertise in paediatric pharmacy services (8.20).	65
67	The Northern Ireland Centre for Post Graduate Pharmaceutical Education and Training should seek to develop a curriculum to support paediatrics (8.21).	65
68	In the commissioning, planning and delivery of services, Boards and Trusts should ensure that there is a dedicated pharmacist resource to support clinical paediatric services (8.22).	65
69	Up to date induction handbooks should be available for all key professional disciplines within hospitals (8.24).	66
70	Trusts should establish a policy that supports annual appraisal and protected time for the clinical supervision of all professional staff. They should promote the implementation of the policy across all children's services (8.28).	66
71	Boards should ensure that there is an annual training needs analysis to identify the training and development needs of all staff working in children's hospital services. In addition to clinical care and individual staff development needs there should be a continuing emphasis on training in: • child protection; • multidisciplinary assessment and care planning and review; and • children's rights and safeguarding these in hospital (8.33).	67
72	Boards should address with the Educational Partnership Forums the matter of AHP undergraduate training in working with children who have mental health needs. Boards and Trusts should also work in partnership with the Department and other relevant agencies to provide post qualifying training programmes for AHPs working with disabled children (8.34)	68

COMMUNICATION AND INFORMATION

Recommendation	Page
73 Hospitals should • develop information for children, young people and their families about their hospital stay, the roles of professional staff within the hospital and appropriate services available in the community; and • ensure that appropriate health and health education information is available for young people during their stay in hospital (9.6).	70
74 Information on complaints, access to personal records and . consent to treatment should be sensitively communicated within the general written information given to parents and children (9.8).	71
75 Hospitals should produce information in leaflet form and other media about the range of assistance available to patients and families who by reasons of disability or ethnicity may experience communication difficulties (9.10).	71

EQUALITY AND HUMAN RIGHTS

Recommendation	Page
76 Where hospitals provide services for young people, they should develop in partnership with young people, a Charter which sets out their rights and how they can expect these to be promoted whilst in hospital (10.6).	74
77 Hospitals providing children's and young people's services should encourage pro-active approaches, such as advocacy initiatives which promote the rights of children and young people and enable their voice to be heard in any matters that concern them (10.8).	74
78 Hospitals caring for children should examine their services for children in the light of the inspection findings and in the context of the need to promote the human rights and equality of disabled children as set out in Figure 2. They should report any shortcomings to their respective Trusts and Boards with a view to agreeing strategies to address these (10.12).	75

Recommendation		Page
79	Disability Discrimination Act Implementation Groups should reconvene and meet on a regular basis to identify areas for action and agree strategies for promoting equality in disability issues (10.16).	79
80	Hospitals caring for children should develop a policy framework which sets out the rights of disabled children and provides guidance for staff on promoting rights and equality based care while the child is in hospital (10.18).	79

APPENDIX A

INSPECTION OF SERVICES FOR DISABLED CHILDREN IN NORTHERN IRELAND

1. INTRODUCTION

1.1 The Children Order 1995 sets out the responsibilities of Boards and Trusts to provide services to children in need and their families. The powers and duties under the Children Order require disabled children to be treated as children first and to have access to a range of generic and specialist service provision in their own homes and in local communities.

1.2 This inspection is the first regional inspection of services for disabled children in Northern Ireland and will focus mainly on the provision of social care services. Health and education services are also vital, however, to ensuring that disabled children gain maximum benefits within the full range of life situations. The Children Order empowers Trusts to combine assessments under the Order with those under existing health and education legislation affecting disabled children. The inspection will therefore consider the extent to which social care services promote multidisciplinary and integrated approaches to care planning and assessment in partnership with children, parents and voluntary agencies.

1.3 A multidisciplinary team will be established to take forward the inspection which will be conducted in two stages. The first stage will consider children with disabilities who have been accommodated in hospital for a consecutive period of at least three months. The second stage[1] will consider services for disabled children in the community.

2. AIMS AND OBJECTIVES

2.1 The aim of the inspection is to assess the extent to which social care services for disabled children meet statutory requirements and reflect standards of best practice.

2.2 The objectives are to:

a) consider the structure, organisation and management of services for disabled children;

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[1] This has been deferred indefinitely.

b) determine the extent to which Boards and Trusts are complying with the requirements of the Children Order in respect of identification, assessment and care planning in relation to the social care needs of disabled children;

c) consider how services engage children and their families in partnership approaches and promote multidisciplinary working with key agencies and professionals;

d) examine the responsiveness of services to the needs of disabled children, the appropriateness of service provision and the choices available to children and their families; and

e) assess the extent to which services respect the lifestyle and culture of disabled children and promote equality of social, leisure and life opportunities.

3. SCOPE OF THE INSPECTION AND THE PERIOD COVERED

3.1 Stage 1 of the inspection will consider disabled children who were admitted to hospital for a consecutive period of not less than three months during the period 1 April 2000 to 31 March 2002.

4. STANDARDS

4.1 The inspection will consider practice against agreed standards in relation to each of the following:

- the structure, organization and management of services;
- the range and quality of service provision;
- assessment and care planning arrangements, including multidisciplinary and partnership working; and
- communication and information.

5. METHODOLOGY

5.1 A reference group[1] comprising representatives of HSS Boards, Trusts, voluntary agencies, and service users will be established to advise on the inspection process, including the instruments to be used.

5.2 The inspectors will:

- collate pre-inspection baseline data on the number and circumstances of disabled children, who during the target period were admitted to hospital for a period of 3 consecutive months and those who received community care services;
- undertake a census of disabled children who have been in hospital for a period of 3 consecutive months on the first day of the commencement of the Phase 1 fieldwork;
- carry out a desk analysis of current policies and procedures in each HSS Board and Trust;
- interview senior managers and other personnel in Boards and community and hospital Trusts regarding the commissioning, structure, management and organisation of services;
- select for analysis a sample of case files of children currently in hospital or admitted to hospital during target period. A sub sample will be chosen for in depth examination. The inspectors will interview:
    - children;
    - parents, carers and families;
    - staff within the relevant range of disciplines; and
    - key partnership agencies and user representative groupings.

6. FIELDWORK LOCATIONS

6.1 The pre-inspection information returned by Trusts will determine the number of hospital sites to be visited by the Inspection Team. Access to hospital staff, wards and facilities will be arranged directly with the Chief Executive of each Trust.

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[1] Coordinators were also appointed from each Board, community and hospital Trust to advise on the standards, assist the pre-inspection data collections and, in the case of the hospitals selected for inspection, coordinate the administrative arrangements for the Inspection Team.

APPENDIX B

THE INSPECTION TEAM

Inspection Manager

Mrs Maire McMahon, Assistant Chief Inspector, Social Services Inspectorate, DHSSPS

Project Leader

Ms Jacqui McGarvey, Principal Social Worker, seconded to the Social Services Inspectorate, DHSSPS

Inspection Team

Mrs May Anderson, Sessional Inspector, Social Services Inspectorate, DHSSPS

Ms Una Boylan, Professional Advisor to the Inspection, Allied Health Professions, by contract to Medical and Allied Branch, DHSSPS

Mr Ray Gordon, Lay Assessor

Dr John Hunter, Inspector, Education and Training Inspectorate, DENI

Dr Patricia McDowell, Deputy Principal Statistician, Community information Branch, DHSSPS

Dr Maureen Watson, Senior Medical Officer, Advisor to the Inspection on Medical and Psychology Services, seconded to Medical and Allied Branch, DHSSPS

Mrs Fiona Wright, Specialist Nurse Manager, Children's Nurse Advisor to the Inspection, seconded to Nursing and Midwifery Advisory Group, DHSSPS

Assisted by

Dr Hilary Harrison, Inspector, Social Services Inspectorate, DHSSPS

Mrs Nuala McArdle, Officer for the Allied Health Professions, DHSSPS

Mr Ken Wilson, Inspector, Social Services Inspectorate, DHSSPS

Policy Advisor

Dr Hilary Harrison, Inspector, Social Services Inspectorate, DHSSPS

Reference Group

Mrs Margaret Black, Assistant Director of Social Services, NHSSB

Mrs Arlene Cassidy, Director, PAPA

Ms Jennifer Creegan, Senior Clinical Psychologist,
Down and Lisburn Trust

Dr Brid Farrell, Consultant in Public Health, SHSSB

Mrs Arlene Greene, Team Leader, Sensory Support Services, Foyle Trust

Mr Bill Halliday, Director, Equality Commission

Dr Sandi Hutton, Consultant Community Paediatrician, Foyle Trust

Ms Geraldine Kerr, Acting Operations Manager, Sargent Cancer Care
for Children NI

Mrs Marina Monteith, Institute of Child Care Research, QUB

Mr Aidan Murray, Assistant Director of Social Services, EHSSB

Dr Janet MacPherson, Consultant Psychiatrist,
Muckamore Abbey Hospital

Mrs Nuala McArdle, Officer for the Allied Health Professions, DHSSPS

Ms Tonya McCormack, Regional Children Services Development
Manager, The Cedar Foundation

Mr David McDonald, Service User

Mr Brendan McKeever, Facilitator, Family Information Group

Dr Ian McMaster, Medical Officer, DHSSPS

Mrs Theresa Nixon, Assistant Director of Social Services, EHSSB

Mrs Nuala Norris, Contact a Family, NI

Mr Ken Wilson, Inspector, Social Services Inspectorate, DHSSPS

APPENDIX C

REGIONAL MULTIDISCIPLINARY INSPECTION OF SERVICES FOR DISABLED CHILDREN IN HOSPITAL

Draft standards and criteria

Introduction

These standards and criteria have been developed to assist the process of inspection. They provide a draft framework of best practice that will enable the members of the multidisciplinary Inspection Team to consider services for disabled children in a consistent and systematic way, as well as informing the planning and delivery of services. There are seven key standards, each of which is supported by a number of 'criterion' statements. These statements are the components that the inspectors will consider in determining the extent to which services comply with the expectations contained in the standards.

The standards and criteria have been developed in consultation with the inspection reference group and have been informed by the views of disabled children, their families and advocates, HSS Boards' and Trusts' representatives and voluntary agencies, as well as a wide body of literature and research in the field of disability. It is intended that the findings of the inspection will build on this work to establish a comprehensive quality standards framework to inform the future development of services for disabled children.

Terminology

In the field of disability, language is particularly important as it encapsulates current thinking and sensitivities and helps to form attitudes. What is considered to be acceptable language can change over time. It is essential to keep abreast of such changes and the reasons for them. It is vital that language and terminology should at all times respect and reflect the views of disabled children, their families and the organisations that work on their behalf.

The Inspection Team gave careful consideration to the use of the terms 'disabled children' and 'children with a disability' to describe the population of children who are the focus of this inspection. Both terms are in current use and both have validity. Having consulted widely, however, the Inspection Team and the members of the reference group agreed to adopt the term 'disabled children' throughout the inspection documentation. This was the preferred option of disabled children and their advocates. The term derives from the social model of disability, which highlights and recognises the part society plays in disabling individuals by virtue of its attitudes, social norms and physical barriers.

Finally, as in the Children (NI) Order 1995, the terms ‘child’ or ‘children’ are used throughout the documentation to describe children or young people up to the age of 18 years. Where the standards refer to ‘family’ or ‘families’, this should be interpreted as including parents, siblings or, where appropriate, extended family and non-relative carers.

Definition of disability

Definitions of disability are many and varied. They tend to change over time to reflect, for example, newly identified conditions, developing clinical knowledge and increasing social awareness. In 2000, a regional project was set up by the four Health Social Services Boards (Boards) to prepare for the establishment by Health and Social Services Trusts (Trusts) of a ‘Children with a Disability Register’ – a statutory requirement under the Children (NI) Order 1995. Having considered a number of definitions currently in use and consulted widely on this issue, the Inspection Team and the members of the reference group decided that the definition adopted by the ‘Register of Children with a Disability Project’ should be used (with minor modifications) to describe the children to be included in the inspection. This definition has received wide support throughout Northern Ireland:

> ‘A child/young person is disabled if he/she has a significant* impairment** and without the provision of additional assistance, resources and information, would be disadvantaged/restricted or prevented from participating in the life of the community, both in the manner which might be reasonably expected and in comparison to other children of similar age, respecting individual culture and circumstances’.
>
> **significant*
>
> As the definition of disability implies, ‘significant’ is determined by the impact of the impairment on the quality of life for the child and his/her family being such that the level of help, resources and information required is likely to be greater than that for children or young people of a similar age, culture and circumstances and their families.

***impairment*

Impairment is ‘a loss or abnormality of a body structure or of a physiological or a psychological function’ (World Health Organisation), i.e.

- sensory (hearing and/or visual) impairment
- communication impairment (including language disorder)
- developmental delay
- learning difficulties
- physical impairments
- severe illness
- severe mental health problems
- emotional and behavioural difficulties

Legislation underpinning the standards

In addition to the standards which have been drawn from best practice, policy guidance and professional literature, a number of standards and criteria have been derived from the following main areas of legislation which impose certain statutory duties on Boards and Trusts:

- the Chronically Sick and Disabled Persons (NI) Act 1978;
- the Mental Health (NI) Order 1986;
- the United Nations and Convention on the Rights of the Child 1989;
- the Disability Discrimination Act 1995;
- the Children (NI) Order 1995;
- the Education (NI) Order 1996;
- the Human Rights Act 1998;
- the Northern Ireland Act, Section 75 1998;
- Code of Practice on the Identification and Assessment of Special Educational Needs 1998; and
- the Carers and Direct Payments Act (NI) 2002.

Within the standards, the above legislation is referenced in an abbreviated form e.g. ‘The Children Order’.

Values and Principles

A number of important themes have been drawn from the legislation and relevant literature. These are summarised in the following values and principles statements which have informed the development of the standards:

1. Disabled children are children first.

2. Listening to disabled children and their families is crucial to ensure their full participation when decisions are being made that affect them.

3. Disabled children are entitled to express their individuality and to enjoy the opportunities for play, leisure and social activities the same as other children.

4. Disabled children are particularly vulnerable due to their disabilities. The design and delivery of services should therefore promote and safeguard their well-being.

5. Services should promote the inclusion and full citizenship of disabled children and be provided within an ethos that maximises their life chances, life opportunities and independence.

6. Disabled children must not be discriminated against by those planning, providing goods, facilities or services.

7. Services should be planned and delivered in ways that respect the personal dignity of disabled children, their social and cultural backgrounds, individual circumstances, and their rights to privacy.

8. Boards and Trusts have a statutory responsibility to provide a range of support services that empower disabled children to lead as full a life as possible.

9. Disabled children and their families should experience individual assessments of their needs and co-ordinated approaches to meeting these.

10. Disabled children have a right not only to equality of access to services, but access to services that best meet their assessed needs.

11. A hospital admission can involve physical and emotional stress for disabled children and their families and every effort should be made to minimise this.

12. Disabled children should not be admitted to, or remain in hospital unless they are assessed as requiring clinical/medical care.

13. When disabled children are in hospital, close links with their families should be encouraged, supported and maintained.

STANDARD 1

Commissioning arrangements, structure, organisation and management of hospital services

The commissioning arrangements, structure, organisation and management of hospital services promote optimum quality in the planning and the provision of services for disabled children.

Criteria

1.1 The views and aspirations of children and their families influence the structure, organisation and planning of services at all levels in the Board and Trust.

1.2 There is an ethos within the Board and Trust that promotes the independence, life quality, life opportunities and life chances of disabled children.

1.3 The organisational arrangements within the Board and Trust promote and facilitate a co-ordinated child and family centred approach to the provision of services.

1.4 The Board carries out assessments in partnership with the Trust, other agencies and users to identify the health and social care needs of disabled children in the Board's area. Information about unmet need is collated and informs planning within the Board and Trust.

1.5 The Board's commissioning arrangements and its Children Services Plan identify need and establish relevant targets to meet the needs of disabled children and their families.

1.6 Monitoring and review systems are in place which enable the Board and Trust to assess the effectiveness, efficiency and quality of services and identify any gaps or deficiencies in service provision.

1.7 The Board has appropriate policies, procedures and standards which promote multidisciplinary and interagency approaches to the provision of services to disabled children. The Board monitors and reviews the implementation of these by Trusts and other agencies.

1.8 The Trust has established policies, procedures and standards for services to disabled children, which are informed by best practice and regulatory requirements. These are implemented, reviewed and amended as necessary.

1.9 There are clinical and social care governance systems in place to promote effectiveness of clinical and social care interventions and continuous improvement in all aspects of service provision for disabled children. These include approaches to ensure that:

a) all staff are involved in multi-disciplinary audit;
b) standards are set, monitored and reviewed;
c) evidence based practice is introduced;
d) there is a process to measure outcomes;
e) critical incidents are reported and analysed (root cause analysis);
f) risk assessments are undertaken and risk management arrangements are in place;
g) complaints are monitored; and
h) there is a process to encourage cultural change.

1.10 The hospital makes effective use of information technology to support the delivery of services.

STANDARD 2

Assessment and care planning arrangements

The well being of disabled children is promoted through multi-disciplinary assessment, care planning and educational arrangements, which enable their needs to be identified and met in a co-ordinated manner.

Criteria

2.1 An appropriate assessment has been completed on each child, which indicates that the necessary criteria for admission to hospital have been met.

2.2 A post admission assessment, which includes a risk assessment, has been completed on all disabled children admitted to the hospital.

2.3 From admission to discharge there is a multidisciplinary, integrated approach to assessments, care planning and reviews, which draws on the expertise of other agencies, where appropriate.

2.4 There is a written plan which represents the disabled child's assessed needs, the actions and services required to address these and the arrangements for review.

2.5 Disabled children and their families participate in assessment and care planning. They are encouraged to ask questions and where necessary, are assisted in accessing further information. Their contribution is reflected in the care plan and the decisions taken.

2.6 The Trust maintains an up-to-date and confidential patient record on the disabled child which contains the child's assessment, written plan and the contribution of all professionals involved in the child's treatment and care.

2.7 The Trust fulfils its duties under the Children Order in respect of the notification of children, who have been in hospital for a period of 3 months, to community care services.

2.8 Where children are looked after, the Trust fulfils its duties under the Children Order in respect of:

- 'Looked After Children' reviews;
- comprehensive assessment;
- care planning;
- social work visits;
- complaints and representation;
- aftercare support; and
- reviews by Education and Library Boards of Statements of Special Educational Needs.

2.9 The Trust carries out assessments in respect of the services it is empowered to provide under the Chronically Sick and Disabled Person's Order.

2.10 In preparation for the introduction of the Carers and Direct Payments Act, the Trust provides information on carers' assessments and the provision of services to carers.

2.11 The Trust fulfils its obligations under the Mental Health Order in respect of compulsory admissions of disabled children to hospital.

2.12 The Trust fulfils its obligations under the Education Orders in respect of:

- informing Education and Library Boards (ELB) about pre-school children who might have special educational needs;
- contributing medical and social services advice when a ELB is carrying out an assessment of a child's special educational needs; and
- contributing to disabled children's transitional plans.

2.13 The Trust has partnership arrangements in place which ensure a smooth transfer for disabled children, and the sharing of information between relevant agencies including:

- hospital to hospital;
- children's to adults' services; and
- hospital to community services.

2.14 The Trust ensures that disabled children and their families are aware of and have access to advocacy services.

2.15 Children do not remain in hospital when it is clinically appropriate for them to be discharged.

2.16 There are effective planning and liaison arrangements in place to support disabled children and their families at the point of discharge from hospital.

2.17 Hospital and community staff are clear about respective roles in support of disabled children returning to the community from hospital.

STANDARD 3

The range and quality of service provision

The hospital provides responsive services that are child friendly and offer choice and flexibility to disabled children and their families.

Criteria

3.1 The hospital is a safe environment for disabled children.

3.2 Hospital services are provided in child and family friendly settings.

3.3 Early diagnostic and support services are available when the child's disability first becomes evident.

3.4 The hospital has effective systems in place which ensure internal referrals are made and appropriate actions are taken to address these.

3.5 Efforts are made to reduce the length of time disabled children wait for diagnostic, assessment, and treatment services.

3.6 Efforts are made to minimise the physical and emotional stress which many disabled children experience in hospital.

3.7 Families are supported and assisted in maintaining links with their child in hospital. There are appropriate facilities and visiting routines to enable this to happen.

3.8 The range and quality of service provision evidence that:

a) disabled children are respected as individuals with their own needs, wishes and feelings. They are involved in decisions about their treatment and procedures. Consent is sought appropriately;
b) personal care and treatment routines are delivered in sensitive ways that respect the child's dignity and privacy;
c) families are valued as having a unique knowledge of their child's needs;
d) the needs of families, including those of other children in the family are recognised and addressed; and
e) information regarding the child's condition is discussed with the child and the family, as appropriate.

3.9 When aids, adaptations and transport are required, these are suited to the individual needs of the disabled child and are provided in a timely manner.

3.10 Disabled children in hospital have access to and are encouraged to participate in appropriate play, social activities and educational programmes.

3.11 The care provided to children in hospital minimises the effects of their disabilities and as far as possible enables children and their families to maintain their typical patterns of living.

STANDARD 4

Education provision

Children in hospital are able to access educational support which is matched to their needs and is appropriate to the circumstances of the hospital setting.

4.1 Effective arrangements are in place to ensure that the relevant Education and Library Board, or its designated service provider, is informed of the need for educational support for a child on admission to hospital.

4.2 Links are established between the education providers and the child's school, which ensure that information in respect of the child's curriculum is available to assist the planning of an appropriate educational programme in the hospital setting.

4.3 The quality of educational provision supports the child's school programme and enables him/her to maintain progress and keep up–to–date with the work of his/her peers.

4.4 Arrangements for educational provision are integrated into the hospital setting and implemented in a collaborative manner by both hospital and education staff.

4.5 On discharge from hospital, an education report is available which informs arrangements for the child's continuing education.

STANDARD 5

Workforce planning, training and support

There are sufficient staff with appropriate qualifications, knowledge and expertise to deliver effective services to disabled children and their families.

5.1 The Board and Trust have a workforce planning strategy which meets present need and addresses the future needs of services for disabled children.

5.2 The Board and Trust, through contracts and service level agreements, ensure that contracted services have an appropriate human resources strategy.

5.3 Staff providing services for disabled children are:

- employed in appropriate numbers;
- subject to PECS and other checks to determine their suitability;
- appropriately qualified; and
- have sufficient knowledge and expertise.

5.4 The Trust has a development plan for staff working in services for disabled children based on an analysis of individual training needs and uni/multidisciplinary requirements.

5.5 Young disabled people, the families of disabled children and other service users with relevant experience, are involved in the ongoing training and development of staff.

5.6 The Trust has in place arrangements for staff:

- induction;
- supervision;
- support and consultation;
- appraisal; and
- performance management and review.

5.7 Disabled children and their families consider that staff are skilled in working with them.

5.8 Managers have established systems to monitor the quality of service delivery and this information is used to inform training plans.

STANDARD 6

Communication and information

The hospital provides accessible and relevant information about its services to disabled children and their families.

Criteria

6.1 The hospital publishes up-to-date information about the full range of services available to disabled children.

6.2 The hospital has written information which explains the rights and responsibilities of families in relation to their child's hospital care. This information is provided for families in accessible formats.

6.3 Appropriate information is provided for disabled children about their hospital stay. The information takes account of linguistic and cultural factors and the needs of children and families with communication difficulties.

6.4 Disabled children and their families consider that the information they receive is timely, accessible, appropriate and contains what they need to know about individual assessment, treatment and care arrangements and the services of other relevant agencies.

6.5 Hospital staff are aware of the services for disabled children provided by the community Trust and other agencies. They share this information with children and their families and encourage them to make use of relevant services.

6.6 Staff are trained in communicating with disabled children and members of their families who are disabled and have access to specialist help in communication, when required.

6.7 The hospital provides information for disabled children and their families about how to access personal information held on file or computer.

6.8 The hospital provides information for disabled children and their families about how to complain or make representations. Children and families who express concerns about their treatment or care are listened to and facilitated to resolve the concern, or where appropriate, assisted in accessing the complaints and representations procedures.

STANDARD 7

Equality and Human Rights

The Board and Trust are fulfilling their statutory duties in respect of human rights and equality legislative requirements. Human rights and equality principles are integrated into practice within all aspects of services for disabled children.

Criteria

7.1 The rights of disabled children under the UN Convention on the Rights of the Child and the Human Rights Act are respected, valued and promoted.

7.2 All relevant policies have been subject to appropriate consultation in accordance with Section 75 of the Northern Ireland Act.

7.3 Appropriate provision has been made for the specific needs of disabled children in line with Section 21 of the Disability Discrimination Act.

7.4 Service providers do not treat disabled children less favourably than others who do not have a disability, unless there is justification for this as set out in Section 24(1) of the Disability Discrimination Act.

7.5 The social circumstances of disabled children, their gender, sexual orientation, religious belief, political opinion, racial group and age are recognised and respected in planning and delivery of services.

7.6 There is consideration and respect for the diversities arising from differing cultural community identities and there is consideration of these in the provision of services to disabled children.

APPENDIX D

PROFILE OF CHILDREN WITH HOSPITAL STAYS OF 3 MONTHS OR MORE

Technical Note: Due to the effects of rounding, the percentages in some tables may not add to 100.

Table 1 Children with hospital (1) stays of 3 months or more

	Male	Female	All	
Altnagelvin	4	4	8	5%
Antrim	6	3	9	5%
Belvoir Park	3	3	6	3%
Craigavon	1	4	5	3%
Daisy Hill		2	2	1%
Forster Green	17	13	30	17%
Gransha		1	1	1%
Longstone	1	2	3	2%
Mater		1	1	1%
Muckamore	26	11	37	21%
Musgrave Park	1	0	1	1%
Royal Group of Hospitals	19	19	38	22%
St Luke's	1	1	2	1%
Stradreagh	3	1	4	2%
Ulster Hospital	3	4	7	4%
Young People's Centre	7	11	18	10%
Lagan Valley		1	1	1%
All hospitals	92	81	173	100%
	53%	47%	100%	

(1) For children who stayed in more than one hospital, the table shows the hospital to which they were most recently admitted

Table 2 Gender and age at most recent admission

	Male	Female	All	
Birth - 11 months	21	27	48	28%
1-4 years	5	7	12	7%
5-10 years	22	6	28	16%
11-15 years	29	31	60	35%
16-17 years	15	10	25	14%
Total	92	81	173	100%
	53%	47%	100%	

Table 3 Religion

	Male	Female	All	
Catholic	37	38	75	43%
Protestant	24	26	50	29%
No Denomination	9	3	12	7%
Other religions	2	2	4	2%
Not known	20	12	32	18%
Total	92	81	173	100%
	53%	47%	100%	

Table 4 Ethnic origin

	Male	Female	All	
White	80	65	145	84%
Other	1	2	3	2%
Not known	11	14	25	14%
Total	92	81	173	100%
	53%	47%	100%	

Table 5 Trusts in which children resided at time of admission

	Hospital of admission						
Trust	Forster Green	YPC	Muckamore	Royal	Other	All	
Armagh & Dungannon	1	0	2	3	6	12	7%
Causeway	0	0	1	1	1	3	2%
Craigavon & Banbridge	1	0	0	2	4	7	4%
Down Lisburn	6	2	4	2	1	15	9%
Foyle	0	1	0	0	12	13	8%
Homefirst	6	1	7	11	7	32	18%
Newry & Mourne	1	0	1	3	3	8	5%
North & West Belfast	4	7	8	6	3	28	16%
South & East Belfast	5	5	10	3	3	26	15%
Sperrin Lakeland	2	1	0	5	2	10	6%
UCHT	3	1	2	2	8	16	9%
Other	1	0	2	0	0	3	2%
Total	30	18	37	38	50	173	100%

Table 6 Length of most recent admission (children who have been discharged)

	Male	Female	All	
Under 3 months (1)	1	1	2	1%
3-5 months	47	34	81	59%
6-11 months	10	18	28	20%
1 year - under 2 years	6	10	16	12%
2 years - under 3 years	2	2	4	3%
3 years - under 4 years	2	0	2	1%
4 years - under 5 years	0	1	1	1%
5 years and over	1	0	1	1%
Not Known	0	2	2	1%
Total	69	68	137	100%
	50%	50%	100%	

(1) These children were included in the survey because they had previous admissions of 3 months or longer

Table 7 Number of previous admissions (1) (2)

	Male	Female	All	
In hospital continuously since birth	12	17	29	17%
No previous admissions	55	40	95	55%
One previous admission	11	16	27	16%
Two previous admissions	5	4	9	5%
Three previous admissions	0	2	2	1%
Four or more previous admissions	4	1	5	3%
Not known	5	1	6	3%
Total	92	81	173	100%
	53%	47%	100%	

(1) Previous admissions to other hospitals are included where known
(2) 29 children had been in hospital continuously or almost continuously since birth. For children who had been out of hospital for short periods, some hospitals recorded this as one continuous stay.

Table 8 Children who had been in hospital since birth

Length of Stay	Died	Discharged	All	
3-5 months	4	23	27	93%
13 months	0	1	1	3%
24 months	1	0	1	3%
Total	5	24	29	100%
	17%	83%	100%	

Table 9 Admissions to regional and other hospitals (1)

	Male	Female	All	
Forster Green	17	13	30	17%
Muckamore	26	11	37	21%
Royal Group of Hospitals	19	19	38	22%
Young People's Centre	7	11	18	10%
Other hospitals	23	27	50	29%
All hospitals	92	81	173	100%
	53%	47%	100%	

(1) For children who stayed in more than one hospital, the table shows the hospital to which they were most recently admitted

Table 10 Types of disability (1)

Disability	Male	Female	All	
Sensory (visual or hearing) impairment	8	10	18	10%
Physical disability	18	29	47	27%
Severe or chronic illness	27	22	49	28%
Learning disability	41	27	68	39%
Developmental delay	41	30	71	41%
Behavioural disorder	42	18	60	35%
Emotional disorder	26	28	54	31%
Mental illness	10	14	24	14%
Communication disorder	25	11	36	21%
Challenging behaviour	43	24	67	39%
Life limiting illness	13	10	23	13%
Traumatic brain injury	4	3	7	4%
Other disabilities (2)				
Epilepsy	5	4	9	5%
Drug misuse	1	0	1	1%
Hydrocephalus	1	1	2	1%
Spina bifida	1	0	1	1%
Burns	2	0	2	1%
Cerebral palsy	1	0	1	1%
Chronic lung disease	1	0	1	1%
Chronic ventilator dependency	1	0	1	1%
Seizures	1	0	1	1%
Prematurity	1	0	1	1%
Spinal muscular atrophy	1	4	5	3%
Intestinal obstruction	1	0	1	1%
Congenital heart disease	1	2	3	2%
Severe apneas	1	2	3	2%
Small bowel insufficiency	1	0	1	1%
Physical disability	0	1	1	1%
Spinal and head injuries	2	0	2	1%
URTI	2	0	2	1%
Total	92	81	173	
	53%	47%	100%	

(1) Many children had multiple disabilities
(2) Where more than one disability was included at ‘other disabilities’, only the first one has been shown

Table 11 Most important reason for admission

Reason	Male	Female	All	
Challenging behaviour	34	4	38	22%
Personal care	0	2	2	1%
Management problems	5	4	9	5%
Risk to others	3	4	7	4%
Risk to self	4	20	24	14%
Planned respite	0	0	0	0%
Emergency respite	4	4	8	5%
Emotional difficulties	3	2	5	3%
In hospital since birth	10	18	28	16%
Intensive care	8	7	15	9%
Surgery	2	6	8	5%
Appropriate equipment not available in the community	0	0	0	0%
Appropriate care not available in the community	6	4	10	6%
Physical illness	4	1	5	3%
Other reasons	3	5	8	5%
Missing	6	0	6	3%
Total	92	81	173	100

Table 12 Hospitals included (1)

	Male	Female	All	
Altnagelvin	4	4	8	5%
Antrim	6	3	9	5%
Forster Green	17	13	30	17%
Longstone	1	2	3	2%
Muckamore	26	11	37	21%
Royal Group of Hospitals	19	19	38	22%
St Luke's	1	1	2	1%
Young People's Centre	7	11	18	10%
All hospitals in the sample	**81**	**64**	**145**	**84%**
Other hospitals	11	17	28	16%
All hospitals	**92**	**81**	**173**	**100%**
	53%	47%	100%	

(1) For children who stayed in more than one hospital, the table shows the hospital to which they were most recently admitted

Table 13 Hospital settings

	Number of Children	
Learning Disability Hospitals(1)	44	25%
Mental Health Hospitals or Psychiatric Units of other Hospitals (2)	51	29%
Other Hospitals	78	45%
All Hospitals	173	100%

(1) Muckamore Abbey, Stradreagh and Longstone Hospitals
(2) Forster Green (Child and Family Centre only), Young People's Centre, Mater Hospital (Psychiatric Unit), Gransha Hospital, Lagan Valley (Department of Psychiatry) and St Luke's

Table 14 Hospital ward

	Children	
Stayed exclusively in children's ward during entire stay	136	79%
Did not stay exclusively in children's ward during entire stay	31	18%
Spent some time in Intensive Care Unit	6	3%
Total	173	100%

Table 15 Hospitals where children stayed in adult wards or wards accommodating adult patients

		Age on admission to hospital		
Hospital	1-4 years	11-15 years	16-17 years	All
Forster Green(1)		2		2
Gransha			1	1
Lagan Valley			1	1
Longstone			2	2
Mater			1	1
Muckamore		9	11	20
Musgrave Park			1	1
St Luke's		1	1	2
Stradreagh	(2)1			1
Total	1	12	18	31

(1) Excludes Child and Family Centre
(2) See paragraph 3.9 of the main report

Table 16 Formal notification to Community Trust of the child's hospital admission of more than 3 months

Yes – formally notified: Within one week of admission	11	6%
1 week – 1 month after admission	14	8%
1-3 months after admission	11	6%
3-6 months after admission	7	4%
6-12 months after admission	1	1%
1-2 years after admission	1	1%
3-4 years after admission	1	1%
Date not known	8	5%
All formal notifications	**54**	**32%**
No need - Community Trust already aware/admission arranged by Community Trust	35	20%
Original admission before introduction of Children Order	2	1%
Notified during previous admission	5	3%
Notified prior to admission (but no previous admission at date stated)	4	2%
Not notified	36	21%
Not known	37	21%
Total	173	100%

Table 17 Formal notification for children who had been in hospital since birth

Notified	10
Not notified	16
Not known	3
Total	29

Table 18 Children looked after at time of admission (1)

	Male	Female	All	
Looked after	24	22	46	27%
Not looked after	40	49	89	51%
Not Known	28	10	38	22%
Total	92	81	173	100%
	53%	47%	100%	

(1) This table is based on responses from hospital staff. Hospital and Community Trust staff responses did not always agree.

Table 19 Children remaining in hospital – reasons for not being discharged

	Male	Female	All
Appropriate care not available	6	3	9
Appropriate equipment not available in the community	0	1	1
Appropriate care not available, breakdown of previous placement, no other placement available	1	0	1
Appropriate care not available, no fostering placement after more than 2 years	1	0	1
Appropriate care/equipment not available and other reasons	4	5	9
Continuing assessment, treatment or both	8	3	11
No reason given	3	1	4
Total	23	13	36

Table 20 Children who stayed in a secure (locked) ward or facility at any time since admission

	Children	
Stayed in secure ward	17	10%
Did not stay in secure ward	153	88%
Not Known	3	2%
Total 173	100%	

Table 21 Age and gender of children who stayed in a secure ward or facility

	Age on admission		
	11-15 years	16-17 years	All
Male	3	6	9
Female	4	4	8
Total	7	10	17

Table 22 Children detained (under the Mental Health (NI) Order, 1986) at any time during their stay

	Children	
Detained	30	17%
Not detained	136	79%
Not Known	7	4%
Total	173	100%

Table 23 Age and Gender of children detained (under the Mental Health (NI) Order, 1986)

	Age on admission		
Gender	11-15 years	16-17 years	All
Male	7	8	15
Female	10	5	15
Total	17	13	30

Table 24 Number of children who died

	Male	Female	All	
Deceased	10	6	16	9%
Alive	66	56	122	71%
Not known	16	19	35	20%
Total	92	81	173	100%
	53%	47%	100%	

Table 25 Location of educational provision

Provision	Male	Female	All	
Off-site	17	8	25	30%
On-site	27	26	53	65%
Both	1	1	2	2%
Not known	1	1	2	2%
Total	46	36	82	100%
	56%	44%	100%	

Table 26 Educational provision during hospital stays (1)

	Male	Female	All	
Some educational provision	46	36	82	73%
No educational provision	5	8	13	12%
Not Known	15	3	18	16%
Total	66	47	113	100%
	58%	42%	100%	

(1) Table includes only children aged over 4 years at time of admission

Notes

Notes

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DELIVERING THE BAMFORD VISION

THE RESPONSE OF NORTHERN IRELAND EXECUTIVE TO THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY

ACTION PLAN 2009-2011

October 2009

Ministerial Foreword

I am pleased to publish this Action Plan in support of the Executive's response to the Bamford Review Recommendations. This Bamford Action Plan (2009-2011) will drive change over the coming years. This change will however only be fully realised through the commitment not just of health and social care staff, education professionals and an inter-governmental and agency approach, but also through the drive of service users, carers and the voluntary sector. In fact the issues addressed in this document are the business of local communities and the entire population of Northern Ireland. This is because improving population mental health and wellbeing, and promoting social inclusion and removing stigma is everyone's business.

One in six of our population has a mental health need at any one time, and there are an estimated 27,000 people with a learning disability. In addition, there are many others who have or will develop dementia in the future. Therefore, over the coming years, the contents of this Action Plan are likely to touch the lives of all in our society.

The promotion of dignity, social inclusion and assurance of human rights for those with a mental health need or a learning disability requires a culture shift in our thinking, which will be aided by a new legislative framework encompassing mental capacity and mental health legislation, and a continued emphasis on public service improvement.

We can be proud of what we have already achieved in service improvements, but more needs to be done. Actions speak louder than words – that is why this document sets out a range of key actions with associated timeframes for delivery. All Government Departments have endorsed these actions which are to be delivered by end 2011. Thereafter, there will be a review of progress and further action plans endorsed by the Executive.

The overall vision for mental health and wellbeing, and for learning disability, will take 10-15 years to achieve. I want to reiterate the commitment of my Department and the Executive to the promotion of population mental wellbeing and emotional resilience, and to the further development of public services for those who need them.

The implementation of this Action Plan will be monitored through an Interdepartmental Group on Mental Health and Learning Disability. New arrangements will also be put in place, through the Patient and Client Council, to ensure that the voice of those with a mental health need or a learning disability is heard and to ensure that we can learn from those who are experts by experience.

MICHAEL McGIMPSEY, MLA
Minister for Health, Social Services and Public Safety

CONTENTS

How to read this Action Plan

Setting the context – mental health services

Mental Health Action Plan

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting Carers and families (to include information and advice, respite)
- Providing better services to meet people's needs
- Providing structures and legislative base to deliver the Bamford Vision

Executive Summary

This Action Plan (2009-2011) sets out the Government's commitment to improving mental health and wellbeing of the population of Northern Ireland and to driving service improvement for those with a mental health need or a learning disability.

The document emphasises the requirement for integrated working, not just across Government departments, but also with families and communities and with the statutory, voluntary and private sectors.

Many factors adversely impact on the mental health of the population; for example, unemployment, social deprivation, low self esteem and educational attainment, poor physical health and environment, alcohol and drug misuse, and domestic and sexual violence. As a society, working together, we can improve outcomes for communities and for individuals. Population approaches to health and wellbeing are important, but so too are specific interventions which identify early and support individuals and vulnerable groups who are at risk. The new Public Health Agency will have a key role in promoting health and wellbeing and in reducing health inequalities. The Agency will promote cross-sectoral working and will be one of the HSC organisations pivotal to the success of this Action Plan.

Individuals with a learning disability, their families and carers are included in this focus on health and social wellbeing. For change to happen, a societal commitment to culture change is required that promotes social inclusion and recognises the specific needs of certain groups, their families and carers.

Linked to this, is the need for a continued emphasis on modernisation and reform of services and of development of a new legislative framework for mental capacity and mental health. At the heart of this framework will be the assumption that individuals have a right to make their own decisions about their treatment, care, welfare and assets. Where decision making is impaired, then additional powers and protections need to be put in place.

Regardless of the underlying condition, future services for mental health and learning disability need to support people to live as full a life as is possible through:

- early intervention and support;
- integrated care planning with the involvement of individuals, their families and carers;
- the promotion of independence, personal fulfilment and, where possible, recovery;
- effective interagency working and partnership with community, voluntary and private sectors, appropriate to the needs of individuals;
- the recognition of the needs of families and carers throughout the lifecycle of the individual and the importance of effective transition and succession planning, information and advice;
- development of services, including specialist services, which will be underpinned by standards outlined in mental health and learning disability service frameworks; and
- a focus on performance improvement to ensure that the patient/client experience and the quality of care delivered to individuals, families and carers is of the highest possible standard.

It is recognised that some of the issues in the Action Plan also impact on people with autism, people with acquired brain injury and people with physical and sensory disabilities.

The detailed Action Plan is divided into three sections.

Section 1 - sets out a summary of the Bamford recommendations, the Executive's vision for the future, the challenges ahead, resources, and the integrated "Bamford" structures needed to drive change. This section also includes a chapter on the importance of positive mental health, emotional resilience and suicide prevention. Legislative reform is also a key element of change; therefore, there is a separate chapter on this topic. Cross departmental working is fundamental to success of the action plan, but it is also recognised that health and social care services play a pivotal part in delivering services to meet individual need. Therefore, there are summary chapters on delivery of change within health and social care settings and how Bamford recommendations have been integrated into current DHSSPS policy and HSC commissioning and delivery.

Section 2 - This section starts by outlining how the detailed Actions should be read. The Action Plan is divided into two main sections- one for mental health and the other for learning disability. All actions are grouped under five themes. These are

Promoting positive health, wellbeing and early intervention;
Supporting people to lead independent lives;
Supporting carers and families;
Providing better services to meet the needs of individuals;
Developing structures and a legislative framework.

The mental health (and learning disability) sections of the action plan can be read as stand- alone documents. All actions are grouped under the above themes, and specify the ownership of the action, the outcome required, timetable for completion and benefits to people. Of necessity, some actions are repeated in both sections of the action plan. This is because the action will impact on many people in society, not just those who have a mental health need or a learning disability.

Section 3 - This section contains actions which relate to leaning disability. As with mental health, the actions are grouped under the five themes identified above. The focus within this section is an emphasis on an integrated, lifelong approach which recognises that a learning disability is a lifelong condition for the individual, their family and carers. In such circumstances people require more sustained support, and not just individual episodes of care, treatment and support. The goal is to help individuals with a learning disability to use their individual strengths to reach their full potential. In doing so, provision of services for people extend far beyond traditional health and social care services and require cross departmental and interagency action. Action contained in the plan outline outcomes, benefits, timetable for delivery and who is responsible for the action.

Infrastructure to deliver

The specific actions committed to, either by individual Departments or jointly in this Action Plan, will be monitored through the inter-Departmental Groups. The HSC Mental Health and Learning Disability Task Force will be responsible to DHSSPS for delivery of those actions attributed to the health and social care sector. With leadership from the Patient and Client Council, there will be a new Bamford Monitoring Group which will harness the views of service users, carers and relevant organisations to ensure that change is happening in front line services, recognising the contribution of all Departments.

Progress on this Action Plan (2009-11) will be reviewed by the Ministerial Group during 2011 and an updated rolling Action Plan will be published, subject to endorsement of the Executive.

SECTION 1

Setting the scene

The Vision for the Future

The Challenges Ahead

The Need for leadership and Integrated working

Mental Health Promotion and Suicide Prevention

Legislative Reform

Delivering the Vision in Health and Social Care sectors

Interconnected conditions

Progress to date on health and social care improvement

CHAPTER 1 – SETTING THE SCENE

1.1 Introduction

This cross-departmental Action Plan sets out the key actions that will be taken forward over the period 2009-2011 in response to the Bamford Review recommendations. It takes into account the responses received from the consultation during 2008 on *Delivering the Bamford Vision*, the Executive's response to the Bamford Review. The Action Plan re-affirms the Executive's commitment to protect and preserve the mental health of the population as a whole, where possible to promote better mental health for everyone and to improve the lives of those with a learning disability or a mental health need. The Action Plan includes actions with target dates for completion; these will be reviewed and rolled forward in 2011 in the light of progress, emerging issues and funding available.

1.2 Background

In 2002 DHSSPS initiated an independent review of mental health and learning disability law, policy and service provision, now referred to as the Bamford Review. The review produced a series of 10 reports between June 2005 and August 2007, which together represent a far-reaching vision for radical reform and modernisation of mental health and learning disability law, policy and services and an opportunity to deliver truly world class mental health and learning disability services. The scope of the review was such that everyone in Northern Ireland is affected to some extent by the recommendations made.

The NI Executive accepted the thrust of the recommendations made by the Review and set out its proposals for taking forward its response to the Bamford review in *Delivering the Bamford Vision*, a consultation document issued in June 2008.

1.3 Summary of responses

A summary of responses to the consultation is available on the DHSSPS website. Key messages from the consultation were:

- the NI Executive is perceived as not moving fast enough on implementing Bamford recommendations;
- the document did not contain enough hard targets;
- there was not sufficient evidence of joined-up working across Departments;
- learning disability was thought not to be adequately addressed in the document;
- concerns that the resettlement programme for people in long stay learning disability hospitals would adversely affect a significant number of people who had been in hospital for so long that betterment would be unlikely to be achieved through a placement in the community; and
- dissatisfaction with the proposals for the sequential development of new legislation.

The consultation however elicited support for much of the general direction of service reform and the actions proposed.

This Action Plan has been drawn up in the light of the responses to the consultation. It sets out specific commitments made by Departments and their agencies, mainly for the next two years, after which the Plan will be reviewed and rolled forward.

CHAPTER 2 – THE VISION FOR THE FUTURE

2.1 The Bamford Review Recommendations

The Bamford review called for:

- the mental health of the whole community to be promoted and protected through preventative action;
- people with a mental health need or a learning disability to be valued and given rights to full citizenship, equality of opportunity and self-determination; and
- reform and modernisation of services that will make a real and meaningful difference to the lives of people with a mental health need or a learning disability, to their carers and families.

The review envisaged a 10-15 year timescale for reforming and modernising services in line with its recommendations, the timescale being dependent to a large extent on the availability of additional resources, particularly within the HSC. To support its recommendations, the Bamford review called for a doubling of health and social care (HSC) resources currently dedicated to mental health and learning disability services.

2.2 The Executive's Response – the vision for the future

To make the Bamford vision a reality, the NI Executive will promote the mental wellbeing of the population as a whole. The Executive will also promote the health and wellbeing, and maximise the independence and full participation of people of all ages with a mental health need or a learning disability, underpinned by legislation and public services to include reform and modernisation of mental health and learning disability services. People with a mental health need or a learning disability using public services should expect to:

- be encouraged and supported to look after their own health, both mental and physical, and build up emotional resilience;
- be supported, as far as possible, in their own homes and communities, making best use of self-directed help;

- be supported, through effective collaboration between Government Departments and their agencies, in their life choices and in day to day activities of engaging in education, training, work and leisure;
- be consulted on and be able to influence the provision of services to meet their needs;
- be encouraged to access help at as early a stage as possible; and
- be supported towards personal fulfilment and full citizenship.

This is the vision for the future which will drive change over the next 10-15 years. It will be supported by all Government Departments and re-emphasised in future policies and strategies.

CHAPTER 3 – THE CHALLENGES AHEAD

3.1 Introduction

There are a number of challenges for the future which have a major influence on implementation of this action plan and future plans. These include a continued focus on population mental health and wellbeing, tackling the determinants of ill health including social deprivation and social exclusion. A focus on early intervention is essential as is the need to integrate treatment, care and support to meet the needs of individuals regardless of age or geographical location. As recommended by Bamford, investment in mental health and learning disability needs to continue for the next 10-15 years.

3.2 Population estimates

Protecting and improving mental wellbeing is relevant to each of us. In addition, it is estimated that in Northern Ireland:

- 250,000 adults and 45,000 children and young people have a mental health need at any one time;
- 26,500 people have a learning disability, of whom about half are aged 0-10; and
- 16,000 people have dementia.

Most families in Northern Ireland are therefore likely to be touched at some stage by issues covered by the Bamford Review.

3.3 Demographic change

Demographic changes, particularly our longer lifespans, and the increasing complexity of needs are likely to bring additional demand for services over coming years, in particular for a range of treatments to deal with depression and other common mental health needs, to support people with dementia and their carers and to support people in the community who have a learning disability. This will increase the need for effective collaboration between Departments and their agencies. It must also be recognised that people with a mental health need or a learning disability often have other health problems, which require treatment and care. There is, therefore, a need for joined-up working with other parts of the health and social care sector beyond mental health and learning disability services. This care, delivered by other parts of the health and social care community, must take account of the particular vulnerabilities of some of these people.

3.4 Investment in services

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

Within DHSSPS's area of responsibility just over £200m was spent in 2007/08 on mental health services and just under £200m on learning disability services. It is estimated that around £200m was spent on services for older people with dementia – together accounting for approximately £600m, almost one quarter of Health and Social Care Trusts' expenditure. However too high a proportion of mental health and learning disability funding is spent on hospital services; the aim is to provide more care in community settings.

As a result of the 2008-2011 Comprehensive Spending Review, in which the Executive agreed the allocations to Departments for 2008 to 2011, DHSSPS allocated from within its resources an additional £44m to be allocated to mental health and learning disability services (£27m for mental health services and £17m for learning disability services) and an additional £3m for mental health promotion over the three years.

In addition to the revenue budget described above, the Department's capital programme includes provision for mental health and learning disability facilities. The planned capital budget over the years 2009-10 to 2010-11 is some £476m of which it is planned that £48m will be spent on facilities for those with mental health needs or learning disabilities. When completed, these projects will represent an investment of £78m.

The Department of Education also provides significant funding in support of all children with special educational needs including those with a learning disability or other mental health needs. In order to address continuing increased needs, in addition to existing funding baselines, £82m has been provided from 1996 to date for the implementation of the Code of Practice on the Identification and Assessment of SEN. A further £53m was made available over the 2005/06 to 2007/08 period, through Spending Review 2004 and Budget and Priorities 2006-2008, to support children with special educational needs. This increased funding has resulted in approximately £185m being expended in 2007/08 for provision for children with special educational needs. This includes £100m for special schools and £55m to meet the additional costs of statemented pupils in mainstream schools and units. Also included is some £23m under the Targeting Social Need factor of the Local Management in Schools Formulae, which inter-alia, assesses the likely proportion of pupils who require additional support for learning.

DE has also allocated a further £2m in 2008/09 to sustain the Independent counselling support service for pupils in post primary schools and a regional anti-bullying helpline operated by Childline.

DSD also makes a substantial contribution, both in terms of capital funding for buildings and associated revenue, through the supported housing programme, but it is not possible to specify the amounts relevant to mental health and learning disability alone.

CHAPTER 4 – THE NEED FOR LEADERSHIP AND INTEGRATED WORKING

4.1 Introduction

Bringing about the strategic changes envisaged by the Bamford Review requires leadership and action across Departments, their organisations and agencies. Much of the action to deliver the Bamford vision is the responsibility of DHSSPS and its health and social care agencies, but many other Departments and their agencies, either individually or jointly, make significant contributions in areas such as education, training, employment, housing, transport and leisure. There are already good examples of strong cross-sectoral working to promote positive mental wellbeing and to identify and address the needs of individuals with disabilities and to support their families and carers; but more needs to be done.

4.2 The contribution of Government Departments

Table 1 outlines the broad contribution that other Government Departments plan.

TABLE 1 - KEY ISSUES AFFECTING PEOPLE WITH A MENTAL HEALTH NEED OR A LEARNING DISABILITY

Issue	**Lead Department**	**Cross-Departmental involvement**
Promoting human rights, equality of opportunity and social inclusion	All have responsibility (lead OFMDFM)	All Departments
Promoting positive mental health	All have responsibility (lead DHSSPS)	All Departments
Infant and early years health and wellbeing, supporting parents	DHSSPS and DE (early years services)	OFMDFM has lead responsibility on children and young people's strategy
Education Teacher training	DE	DHSSPS responsible for provision of some therapeutic services in schools
Further and Higher education, training and employment	DEL	DEL, DHSSPS and DE on transitions from school to training and employment DEL and DHSSPS on Pathways to Work and Condition Management

Housing	DSD	DHSSPS involved through Supporting People
Personal finance including benefits	DSD	DSD and DHSSPS on improving access to Psychological therapies as part of Welfare to Work programme
Health and social care	DHSSPS	
Transport	DRD	
Leisure, sport	DCAL	
Law and Order	NIO NI Courts Service	NIO and DHSSPS on healthcare in prisons

4.3 Structures to support integrated working and leadership

The table above illustrates the need for a strong co-ordination and leadership role to ensure that Departments and their agencies are working together in the best interests of the people who need public services. The breadth of the Bamford agenda requires an integrated approach to drive forward:

a) *mental health promotion and suicide prevention* - through promoting positive mental health and improving mental resilience

b) *legislative reform* - recognising that, where possible, people have the right to make decisions about their own treatment, care, welfare and finances

c) *modernisation of public services* - to respond effectively to the needs of individuals and families

b) *partnership working* - between Departments and between their local agencies, local government and the voluntary and community sectors.

Leadership must begin within the NI Executive, but reform must extend to local level within and between public sector agencies, local government and the voluntary and community sectors.

An inter-Departmental Ministerial Group on Mental Health and Learning Disability will oversee and drive forward changes across Departments and their agencies in a co-ordinated way. An inter-Departmental Implementation Group of senior officials will support the Ministerial Group. The Ministerial Group will be kept informed on issues relating to mental health promotion and suicide prevention through two other Ministerial groups which oversee these aspects. Issues relating to children and young people with a mental health need or a learning disability will also be considered by the Ministerial Sub-Committee on Children and Young People.

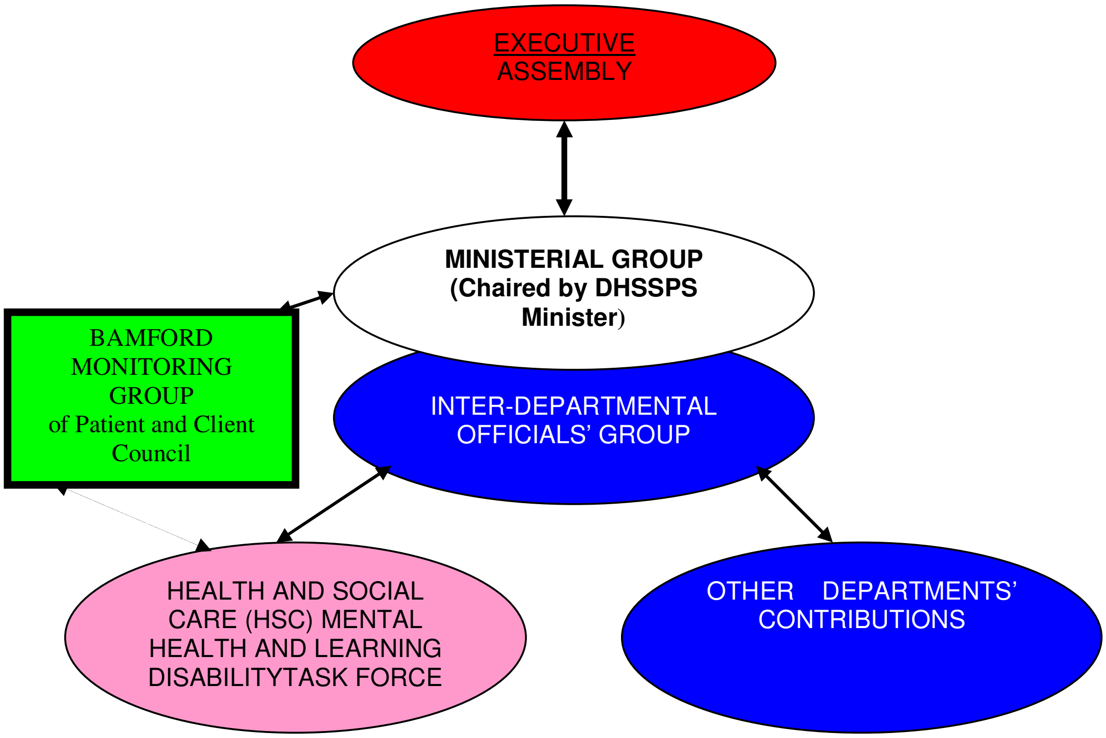
To operationalise the Bamford Action Plan in the context of implementing HSC actions, including those which require local cross-sectoral working, a Health and Social Care (HSC) Mental Health and Learning Disability Task Force will be established. The Task Force will drive forward action within the HSC and promote collaboration with other sectors across the while agenda, from promoting good health and wellbeing and early intervention through to high quality responsive services. This will be jointly led by the Health and Social Care Board and the Public Health Agency, with representation from other stakeholders, including the voluntary and community sector and service users and carers, and will report to the Minister for Health, Social Services and Public Safety on progress. Within the remit set by this Action Plan, the Public Health Agency and Health and Social Care Board will develop the detail of how they intend to ensure that appropriate actions are identified and implemented, progress is monitored and assurance provided along the reporting lines outlined above.

The Task Force structure and its reporting arrangements are designed to give a particular focus on mental health and learning disability issues and are complementary to the wider roles and responsibilities of the HSC Board and the Public Health Agency and their lines of reporting and accountability to DHSSPS.

Other Departments will put in place suitable arrangements to address issues relevant to them.

Service users and carers will be the ultimate judges of whether real change is happening. A Bamford Monitoring Group, with substantial representation from service users and their carers, will be established and supported by the Patient and Client Council to provide an independent challenge function on the extent to which the changes being put in place align with the Bamford vision. This group will report at least annually to the Minister for Health, Social Services and Public Safety.

Fig 1. BAMFORD MANAGEMENT STRUCTURES



4.4 Review in 2011

Progress on this Action Plan will be reviewed in full by the inter-Departmental Ministerial Group on Mental Health and Learning Disability during 2011 and an updated Action Plan will be published, taking account of progress to date and resource availability.

CHAPTER 5 – PROMOTING MENTAL HEALTH AND WELLBEING AND SUICIDE PREVENTION

5.1 Introduction

The need to promote and protect the mental wellbeing of the whole community through preventative action was a fundamental element underpinning all of the work of the Bamford Review. The burden of disease attributable to mental ill-health and the economic cost to our society are significant. Positive mental health and wellbeing is fundamental to a healthy society and a key requisite for a competitive and productive society.

5.2 Promoting mental health

Many factors affect mental and emotional health and these can be addressed at a number of levels, from individual action to population-wide initiatives. Work to promote mental health is not just a matter for health and social care services; it is cross-sectoral and multi-agency and there must be co-ordination of activities across sectors to maximise effectiveness. Lead responsibility for the work on mental health promotion will remain within the health and social care sector, as it is inextricably linked with other health improvement and health inequalities strategies and programmes. The Public Health Agency will play a lead role in taking forward the mental health promotion agenda, not just in terms of health and social care actions but also through its role in facilitating better cross-sectoral working to tackle health inequalities.

To ensure early intervention, work with children and young people must be a priority, with the health visiting service, parental support services and schools as key contributors. The mental health needs of other population groups, including older people, people from ethnic minority communities, people who are hearing impaired, or with other communication difficulties, prisoners, and people with a learning disability, also need particular attention.

In people of working age, mental health problems are an important cause of absence from work and of worklessness due to ill health. Evidence also suggests that they are one of the main causes of lower productivity due to the impact of illness on work. The stigma and discrimination attaching to mental ill health contribute to under-recognition and to delayed interventions.

The *Promoting Mental Health Strategy and Action Plan* (2003) set out a cross-sectoral agenda aimed at improving mental health and wellbeing. This was followed by more detailed work on suicide prevention. *Protect Life – A Shared Vision* was published in 2006 to address the rising trend in suicide. It includes a set of actions both at population level and targeted at people and communities most at risk. In 2008 the Health, Social Services and Public Safety Assembly Committee issued its Report on the Inquiry into the Prevention of Suicide and Self Harm, making a series of recommendations for further action. A cross-departmental response to the Committee's report and a timeframe for implementation were endorsed by the Executive in March 2009.

The *Promoting Mental Health Strategy and Action Plan* (2003) is currently being reviewed and a new Promoting Mental Health and Wellbeing Strategy will be published in autumn 2009. Work to inform the development of the new strategy, led by the Northern Ireland Association for Mental Health, was submitted to DHSSPS in July 2009. The Association has gathered evidence locally and considered international evidence on the most effective interventions for promoting mental health and wellbeing. The review is assessing implementation of the actions in the 2003 strategy including the various awareness raising campaigns, partnership working with the Department of Education, and development of training such as Mental Health First Aid.

The development of the new *Promoting Mental Health and Wellbeing Strategy* is also taking account of progress on *Protect Life* and the recommendations of the Bamford review. Under *Protect Life* a number of initiatives have been developed including "Lifeline" the regional 24/7 crisis response telephone line and support services, community-led prevention services, deliberate self harm pilot projects, guidelines for media reporting and research projects.

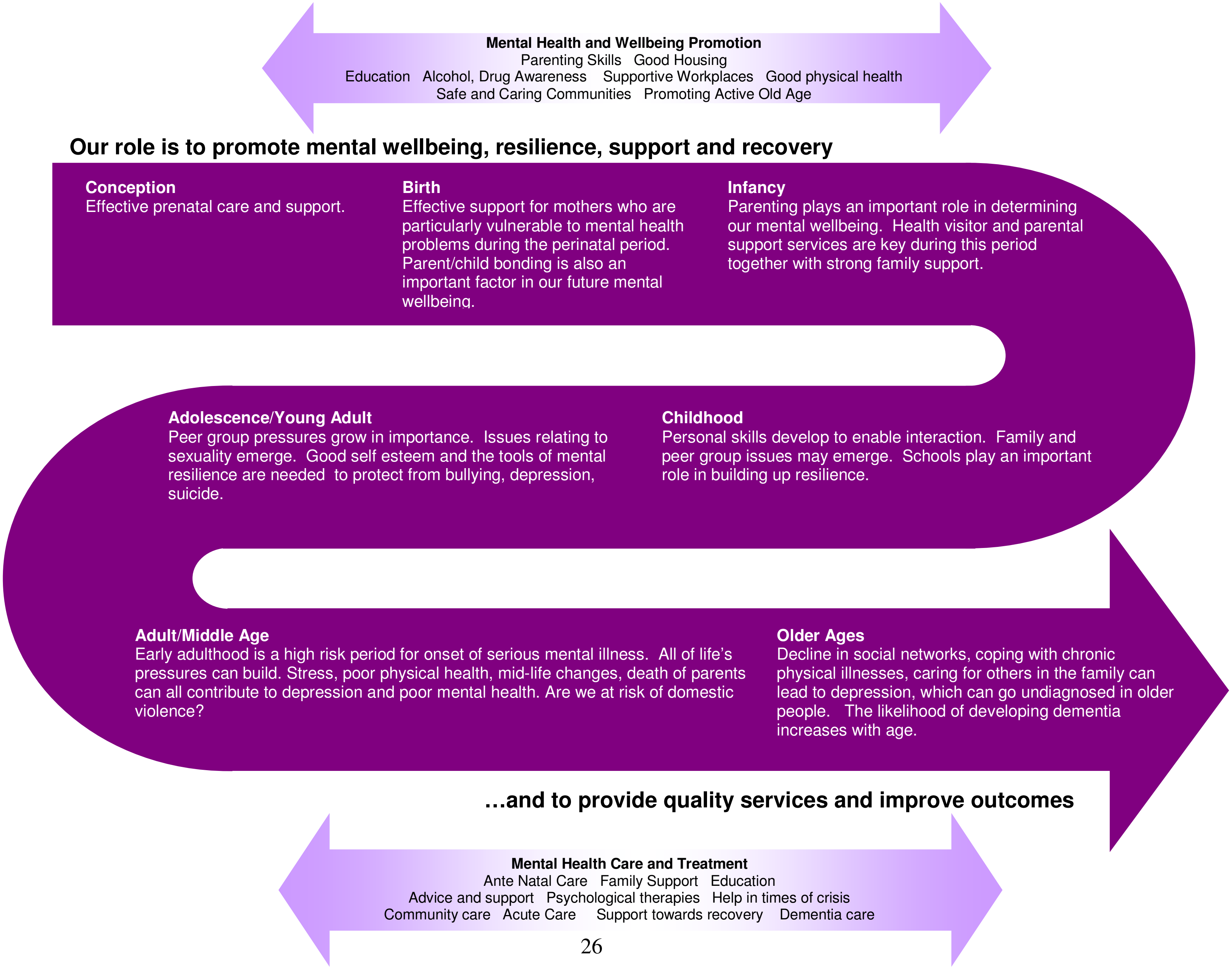
The new strategy will include a population based approach and targeted approaches to key groups such as children, and families facing difficulties. It will also identify key settings for the promotion of mental health and wellbeing such as pre-school groups, schools, workplaces and community settings.

Alcohol and drug misuse and domestic and sexual violence as contributors to mental ill-health, are also being addressed through cross-Departmental strategies and associated action plans.

Through the New Strategic Direction for Alcohol and Drugs (NSD) action is being taken forward to prevent and reduce the harm related to substance misuse in Northern Ireland. Within the NSD there is a specific focus on young people's drinking, binge and problem drinking, and the misuse of legal and illegal drugs, including the issue of harm reduction in injecting drug misuse. In this context, the recently developed Hidden Harm Action Plan should play a crucial role as parental problem substance use can have a significant impact on the mental and emotional well being of children and young people.

Figure 2 – *A Journey Through a Lifetime* – highlights the importance of mental health, social wellbeing, resilience and support throughout life. This begins before the birth of the baby with effective prenatal support and is continued throughout childhood and into adolescence and adulthood. Creating the environment which supports positive mental health and wellbeing is important throughout the life of the individual. Mental health treatment and care services extend beyond traditional HSC boundaries and such services can play a major role in promoting the recovery of an individual who has a mental health need. The overall aim is to facilitate the individual to become a fully integrated member of society, living with or without a mental health condition.

Fig 2. A Journey Through a Lifetime



Mental Health and Wellbeing Promotion
Parenting Skills Good Housing
Education Alcohol, Drug Awareness Supportive Workplaces Good physical health
Safe and Caring Communities Promoting Active Old Age

Our role is to promote mental wellbeing, resilience, support and recovery

Conception
Effective prenatal care and support.

Birth
Effective support for mothers who are particularly vulnerable to mental health problems during the perinatal period. Parent/child bonding is also an important factor in our future mental wellbeing.

Infancy
Parenting plays an important role in determining our mental wellbeing. Health visitor and parental support services are key during this period together with strong family support.

Childhood
Personal skills develop to enable interaction. Family and peer group issues may emerge. Schools play an important role in building up resilience.

Adolescence/Young Adult
Peer group pressures grow in importance. Issues relating to sexuality emerge. Good self esteem and the tools of mental resilience are needed to protect from bullying, depression, suicide.

Adult/Middle Age
Early adulthood is a high risk period for onset of serious mental illness. All of life's pressures can build. Stress, poor physical health, mid-life changes, death of parents can all contribute to depression and poor mental health. Are we at risk of domestic violence?

Older Ages
Decline in social networks, coping with chronic physical illnesses, caring for others in the family can lead to depression, which can go undiagnosed in older people. The likelihood of developing dementia increases with age.

…and to provide quality services and improve outcomes

Mental Health Care and Treatment
Ante Natal Care Family Support Education
Advice and support Psychological therapies Help in times of crisis
Community care Acute Care Support towards recovery Dementia care

CHAPTER 6 – LEGISLATIVE REFORM

6.1 Introduction

The need to update the current mental health legislation was a primary driver for establishing the Bamford review. The review's recommendations for changes to mental health legislation and for the introduction of new mental capacity legislation based on a common set of principles have been accepted by the NI Executive. The aim is to promote the dignity and human rights of those who lack capacity to make decisions for themselves, and to ensure that the law is fit for purpose so that people with a mental health need receive effective assessment, treatment and care in accordance with modern clinical and social care practice.

6.2 Principles based legislation for mental capacity and mental health

A major element of reform is to build on the Bamford recommendations and to embed a common set of principles in the face of the legislation. The main principle is autonomy - that is the assumption of capacity - respecting a person's right to decide and act on his or her decisions regarding treatment, care, welfare, finances and/or assets. Where decision making is impaired, the legislation will provide for substitute decision making and for additional powers and protections to be put in place which will act in the best interest of the individual.

6.3 Consultation on the Legislative Framework for mental capacity and mental health

The consultation document *Delivering the Bamford Vision* and the Department's subsequent consultation on its legislative proposals, proposed the parallel enactment of separate mental capacity and mental health legislation with a common set of principles. However arising from the later consultation there was a strong body of opinion, voiced by professional, carer and service user organisations, that there should a single Act encompassing mental capacity and mental health. These responses contended that a single Act was the best way of reducing the stigmatisation of those with mental disorder and improving protection of their human rights. After further consideration and consultation with Executive Ministers, the DHSSPS will lead on the preparation of a single Act.

This will be a very large and complex piece of legislation which has not been attempted in any other jurisdiction. It will be the largest ever Bill to be brought before the NI Assembly. Given the innovative approach of the single Bill approach, it will require detailed consideration; hence it will be the next Assembly (beyond 2011) before it can be enacted.

6.4 Interim Arrangements

In two areas the Department plans however to put in place interim arrangements to guard against challenge under the European Convention on Human Rights (ECHR).

(a) Nearest Relative Provisions in the Mental Health (NI) Order 1986

Currently under the 1986 Order patients do not have the right to apply to court to have their nearest relative replaced. Cases brought by patients at the European Court have established that this contravenes Articles 5 and 8 of the ECHR and this has been rectified in other UK legislation. The Department has decided this issue is sufficiently important that it cannot await the enactment of a new single Bill. Consequently the Department proposes to take forward within this Assembly a small amendment to the 1986 Order.

(b) Safeguards in respect of those Deprived of their Liberty for their Protection

Case law at the ECHR has again highlighted that those deprived of their liberty under the common law doctrine of Necessity for their care and protection contravenes Article 5 of the Convention in that they have no recourse to challenge the deprivation of liberty in a court. Statutory safeguards will be included in the proposed single Bill and in the interim the Department will provide guidelines for HSC Trusts on the need for managers of care homes and hospitals to be aware of the judgement and to comply with it within current practice.

6.5 Advocacy

People with a mental health need or a learning disability may require support in making their own wishes heard and advocacy services can help. Advocacy services in mental health and learning disability services have been developed locally using a variety of models, including peer advocacy, and these are being supported and enhanced with additional funding. The issue of a statutory right to advocacy for mental health and learning disability service users will be considered as part of the mental health and mental capacity legislative changes being proposed.

6.6 Wider Legislative Protections

Wider legislation and policies to protect people's human rights, promote equality of opportunity and promote social inclusion will also be used to support people with a mental health need or a learning disability in living as full a life as possible. A strategy to promote the social inclusion of people with a disability is being developed by the Office of the First and Deputy First Minister. The needs of people with a mental health problem or a learning disability will be included in this strategy. Should the need for further work emerge on mental health and learning disability, during the course of development of this strategy, due consideration will be given by the inter-Departmental Ministerial Group on Mental Health and Learning Disability on how this should be taken forward.

CHAPTER 7 – DELIVERING THE VISION IN THE HEALTH AND SOCIAL CARE SECTOR

7.1 Delivering HSC services to support people to live full lives

Cross-Departmental action is essential to the success of the Bamford Vision, but statutory, community and voluntary sector providers across primary, community and secondary health and social care services have a pivotal role in delivering services to meet individual needs. Within the health and social care sector, service provision to support people in living a full life in the community requires:

- integrated care planning with the involvement of individuals, their families and carers;
- early intervention and support;
- effective interagency working and partnership with community, voluntary and private sectors, appropriate to the needs of individuals;
- integration of people with a mental health need or a learning disability and their families into the community;
- the promotion of healthy lifestyle choices and effective chronic disease management;
- the recognition of the needs of families and carers throughout the lifecycle of the individual and the importance of effective transition and succession planning, information and advice;
- the promotion of independence, personal fulfilment and, where possible, recovery;
- development of services, including specialist services, which will be underpinned by standards outlined in mental health and learning disability service frameworks; and
- a focus on performance improvement, not just in waiting times and hospital discharge targets, but also to ensure that the patient/client experience and the quality of care delivered to individuals, families and carers is of the highest possible standard.

7.2 Partnership with Users and Carers in Planning and Delivering Care

Each person with a mental health need or a learning disability is different and has needs which are unique to that person and which will change over time. Services must be designed and delivered in a flexible way to allow people who need them to make informed choices about the care and support they wish to receive. There must be a partnership approach, where people with a mental health need or a learning disability are not passive recipients of services but active participants, along with their family and carers. A "whole life" approach must be part of the care planning process, where individuals, carers and families are actively involved in the development and proactive review of such plans.

In planning at a population level, the Health and Social Care Board and its Local Commissioning Groups should ensure that service users and their families and carers are involved in a meaningful way in decisions about the mental health and learning disability services to be commissioned and in their subsequent monitoring and evaluation. This is in line with guidance on strengthening personal and public involvement (PPI) in all health and social care services.

7.3 Self-directed support

There are other ways of helping service users and carers to design the services that they want for themselves. Self-directed support is about personalisation, choice and control and reflects how the system for providing social care for adults is being transformed. It should become part of the mainstream of social care delivery, empowering people to maximise independent living and to be active citizens in their communities.

Self-directed support builds on the platform provided by Direct Payments legislation and can be used instead of, or in addition to, services that are provided through the statutory sector. A person can buy self-directed support from a service provider, or by employing their own personal assistance. This support may be in the person's home, or to provide support to take part in a range of activities beyond the home setting, for instance attending college or enjoying leisure pursuits, or to facilitate a short break. Self-directed support is an opportunity to meet the assessed needs of the whole person in a creative and flexible way.

7.4 The valuable contribution of carers

The valuable contribution of informal carers requires recognition and support. Caring is often rewarding but can also be very demanding, and carers have their own needs, including mental health needs. Carers are entitled to have their own needs assessed, to have access to information, advice, training and emotional & practical support. This support is underpinned by the *Caring for Carers Strategy* (DHSSPS 2006).

In May 2008, Michael McGimpsey, Minister for Health Social Services and Public Safety and Margaret Ritchie, Minister for Social Development announced a joint review of Support Services for Carers. The purpose of the review is to examine the support for carers in a holistic way following on from the Review of the National Carers' Strategy. The Review is due to be completed in 2009.

7.5 New Health and Social Care Structures – a real opportunity for change

The health and social care sector is a complex structure and has recently undergone considerable re-organisation as a result of the Review of Public Administration. The Health and Social Care Reform Act established a number of new health and social care organisations including the Health and Social Care (HSC) Board, the Public Health Agency (PHA) and the Patient and Client Council. The Act also introduced a requirement on the HSC Board and PHA to develop a joint commissioning plan describing how the allocated health and social care budget would be invested to meet Ministerial priorities and improve health and social wellbeing and outcomes. The new structures therefore provide an opportunity to integrate fully, the twin aims of promoting mental wellbeing and ensuring high quality responsive services.

The HSC Mental Health and Learning Disability Taskforce mentioned in Chapter 4 will be jointly led by the PHA and HSC Board and will be supported by staff at local and regional level in the PHA, HSC Board and partner organisations.

Details of the working arrangements and programme structure will be developed by the Taskforce and will integrate the functions of each organisation – health and social wellbeing improvement, commissioning, performance, finance, safety and quality, patient and client experience, research and evaluation, and advice from health and social care professionals.

Recommendations agreed by the PHA and HSCB for reform and development of mental health and learning disability services will be reflected in the plans of Local Commissioning Groups and in the overall joint commissioning plan.

There will be nominated leads at senior level for mental health and learning disability for both adults and children in DHSSPS, the PHA, the HSC Board, and each Health and Social Care Trust.

7.6 Expanding the skilled workforce

A skilled and adequate workforce is essential to delivery of a modern and responsive mental health and learning disability service. The scale of service developments envisaged by the Bamford review will require increases in staffing numbers, particularly to develop more specialist services, along with a move of some existing hospital-based staff to community-based services.

There are current workforce shortages in mental health and learning disability services, traditionally seen as challenging work areas, which must be addressed. Many experienced staff are now approaching retirement age and for a variety of reasons, there has not been an adequate supply of new staff with the right skills for the future. New opportunities are afforded by new service models and increased emphasis on multi-disciplinary team working and in involving service users themselves in providing support for other service users. DHSSPS has commissioned a workforce planning study to support implementation of the Bamford Review recommendations, due to complete shortly. This will inform wider action to address workforce issues to complement reform and modernisation of the services.

7.7 The importance of linkage to the Independent Sector

The voluntary, community and private sectors make a valuable contribution to the range of mental health and learning disability services provided and some specialist mental health and learning disability services are also purchased from the private sector. The Health and Social Care Board will ensure that health and social care is commissioned from providers who can offer both quality and value for money, irrespective of sector.

7.8 Improving Quality of Services

New Service Frameworks for mental health and learning disability are currently being prepared as part of the development of a wider programme of Service Frameworks. These aim to set specific standards of care and improve health and social care outcomes through effective commissioning and delivery of care. These standards will underpin service delivery and will represent the quality benchmark that will be used to inspect services into the future. In doing so, this should lead to more uniform, regionally agreed models of care. The focus of these service frameworks is to promote health and wellbeing and drive performance improvement. The Mental Health Service Framework will be consulted upon shortly with the Learning Disability Framework following later.

Increased service user and carer involvement in design, delivery and monitoring of services will also help to drive up quality and ensure that they are responsive to people’s needs. It is also planned that by April 2010 there will be a lead officer in each Trust with responsibility for service improvement in mental health and learning disability.

7.9 Physical Infrastructure – capital investment

The shifts envisaged in service provision, from hospital to the community, will have major implications for the current stock of buildings used to deliver services, many of which are in poor physical condition and are not designed for a modern service. Upgrading of facilities is being taken forward as part of the ongoing programme of capital improvement and modernisation for the health and social care infrastructure across Northern Ireland.

In the next 2 years (up to 2011) there will be investment in Muckamore Abbey Hospital, the Regional Adolescent and Family Unit at Forster Green Hospital, Iveagh and Lisburn Assessment and Resource Centre. Over the following 7 years of the current Investment Strategy for Northern Ireland (up to 2018), there are plans for investment of £96m in facilities such as new mental health inpatient units in Belfast and Omagh and Oakridge SEC.

7.10 Information and Monitoring

DHSSPS, working closely with the Board and Trusts, will continue to examine how existing information systems need to be enhanced or replaced to support planning and monitoring. Work is in hand with the Board's Performance Management and Service Improvement Directorate to improve access to anonymised information about those using inpatient facilities to support planning and monitoring functions. Further work will be carried out in 2009/10 to improve information regarding those using community services and also about the range of mental health services available across NI. An exercise is also underway to improve the information available at regional level on respite care, again to support planning and better targeting of these services.

7.11 Performance Improvement

The Health and Social Care Board will have a key responsibility for performance management for mental health and learning disability services, as for all health and social care services. DHSSPS in collaboration with the Task Force will set performance indicators and targets which will be used to monitor the performance of the HSC to identify areas where services need to improve and to support the implementation of necessary changes. For mental health and learning disability services, there are a number of current priorities; improving access to services by reducing waiting times, ensuring timely discharge from hospital for those who have needed an admission for assessment or treatment, resettling people from hospital to the community with the necessary shift in resources to enable them recover as much of their lives as possible, supporting services that use evidence based and modern approaches to delivering care and ensuring that the full capacity of our services is used to maximum effect. It is recognised that as implementation of the Action Plan progresses, performance targets will change and will need to take account of the Task Force's implementation plan and any new evidence base.

People who use the services and their families and carers will provide another important dimension to the drive to improve services, through the Bamford Monitoring Group, described in Chapter 4.

7.12 Regulation, inspection and review of services

Monitoring, inspecting and encouraging improvements in the availability and quality of health and social care services in Northern Ireland are the responsibility of the Regulation and Quality Improvement Authority (RQIA). As part of the changes arising from the Review of Public Administration, the functions of the Mental Health Commission as prescribed in the *Mental Health (Northern Ireland) Order 1986* transferred to RQIA with effect from 1 April 2009.

RQIA has worked in partnership with the Mental Health Commission to ensure a seamless transition. RQIA has established a dedicated team responsible for inspecting and reviewing mental health and learning disability services across Northern Ireland.

RQIA will also work in partnership with Criminal Justice Inspectorate Northern Ireland and Her Majesty's Inspectorate of Prisons to monitor health and social care services for people detained in prison.

7.13 The importance of research and development

The Bamford review highlighted the need for research relating to some specific aspects of mental health and learning disability services. A prioritised plan for health and social care research relating to mental health and learning disability will be drawn up and taken forward within the overall programme of HSC research.

7.14 Conclusion

This chapter highlighted the importance of delivering the Bamford Vision in health and social care services. It summarised what needs to happen to facilitate people to lead fuller lives. In addition to mental health and learning disability services and infrastructure, there are a number of interconnected conditions which have the potential to impact on mental health and on learning disability; some of these are highlighted in the next chapter.

CHAPTER 8 – INTER CONNECTED ISSUES

8.1 Introduction

There are a number of interconnected issues which have the potential to impact on mental health or a learning disability. In such circumstances it is recognised that co-morbidities can often occur. Of particular note are:

- Autism Spectrum Disorder (ASD);
- Acquired brain injury;
- Physical and Sensory Disabilities; and
- Domestic or sexual violence.

These issues require significant cross-sectoral working, not just within the HSC but across education, housing, employment, transport and criminal justice.

8.2 Autism Spectrum Disorder (ASD)

It has been estimated that over 16,000 people in Northern Ireland are affected by autism. Approximately 200 people are diagnosed with autism each year and the number diagnosed is increasing. The Bamford review recognised that the needs of children and adults with Autism Spectrum Disorder (ASD) and their carers were wide ranging and complex.

In response to the emerging ideas from the Bamford Review and in acknowledgement of the increase in the numbers of young people in schools affected by Autism, the Department of Education supported the education and library boards to establish an Inter-board ASD group in 2003 to provide a support programme to children on the autistic spectrum within each education and library board (ELB) area.

The Minister for Health, Social Services and Public Safety convened an Independent Review Group in September 2007 to identify the gaps in current service provision to children and adults and to make recommendations on how to address these. The Terms of Reference for the Independent Review of Autism

Services in Northern Ireland included consideration of the needs of adults, and those making the transition from child to adult services.

Following on from this, the Autism Spectrum Disorder Strategic Action Plan was published in August 2008 for public consultation, and concluded on 12 December 2008. There was overwhelming support for the themes within the plan in the responses received and the final *ASD Strategic Action Plan 2008/09 - 2010/11* was subsequently published on the Departmental Website together with a summary of responses. A key focus within the plan is on improving access to diagnostic, treatment and care services for children, adolescents and adults so that they and their families receive support as quickly as possible and that, when a diagnosis can be made, person-centred care plans are developed and implemented as quickly as possible. In addition the ASD Action Plan recognises the importance of transitional support and improvements in adult ASD services.

Within the education service, the Inter-board ASD group has developed an ELB strategic action plan which is taken forward through ASD advisory teams established within each Board. The Education and Training Inspectorate (ETI) has recently evaluated the work of the 'Inter-Board Autistic Spectrum Disorder Advisory Service' and found evidence of some excellent work.

To progress the Bamford Vision further, the Department of Education proposes to develop a strategic policy for the education service. This would present an opportunity to draw attention to the many examples of good, innovative practice, particularly in relation to multi-disciplinary working, that have been developed in recent years. The ETI evaluation identified some evidence of useful collaborative action between health and education that needs to be directed at a strategic level. An autism policy would give strategic direction to the replication of local good practice on a regional basis, leading to more efficient utilisation of resources and more seamless and effective provision for families and children with ASD. The development of a strategic policy for education at this time would present an opportunity for plans across the education and health sectors to dovetail. A DE-hosted ASD conference is planned for November 2009, which is likely to have a practical focus, showcasing good practice in providing support to parents and professionals in the field of communication.

In 2007 a company was established, with funding from the Department of Education (DE) and the Department of Education and Science (DES) to oversee development of the Middletown Centre for Autism. The four key services to be provided by the centre are a learning support service, an educational assessment service, a training and advisory service, and an autism research and information service. The centre is to be multi-disciplinary in nature and will operate in support of local services, but will not offer a primary referral service. It will be dedicated to improving and enriching the educational opportunities of all children and young people with autism.

The services proposed for the Centre are being phased in order to coincide with the completion of the building refurbishment programme. The Centre has begun by offering the training and advisory service and the autism research and information service in the first instance whilst the delivery of the educational assessment service will be modelled during 2009. The learning support service will be the fourth service to be offered, as it requires completion of the new building. This is expected to be in late 2010.

The Bamford Action Plan must be considered together with the DHSSPS ASD Strategic Action Plan and the Department of Education's Strategic Policy, as service improvements and developments detailed in this Plan will also apply to individuals with ASD where their needs require it.

8.3 Acquired Brain Injury

There is growing recognition of the mental health needs of adults with neurological conditions, including acquired brain injury. Such conditions can lead to a range of impairments in physical and cognitive functioning, which in turn can result in reduced independence. People with acquired brain injury are at greater risk of mental ill-health, and this can often go undiagnosed, impacting negatively on morbidity and mortality.

Close collaborative working between mental health and physical disability services is essential in ensuring those affected by this condition have the services they require.

8.4 Physical and Sensory Disabilities

Disabled people encounter the same range of mental health needs as the general population, but coping with a disability – including discomfort or pain, the likelihood of increased social isolation, particularly whether there are communication difficulties through deafness, for example - can pose additional threats to emotional wellbeing.

It has become apparent that while Physical and Sensory Disability encompasses a wide and diverse range of disabilities, a general but over-arching strategy is required to cover all areas. For this reason, the Minister for Health Social Services and Public Safety has committed to producing a Physical and Sensory Disability Strategy, which will be issued for public consultation in early 2010.

In recognition that the expediency with which learning materials can be accessed by children and young people with a visual impairment is an area where further enhancements to service delivery could be made, the ELB Regional Strategy Group for Special Educational Needs (RSG) established a working group which is dedicated to the specialist area of visual impairment. The aim of the group is to promote a consistent approach across the five ELBs in relation to service delivery. The working group has consulted with the voluntary sector, statutory sector, parents and children.

The Group has recently reported its findings to RSG and the key recommendation of the report was that the consultation process produced a consensus view that, in the context of an overall strategy of achieving full educational inclusion and of improving levels of educational attainment amongst children and young people with a visual impairment, a resource base for the north of Ireland should be established. Under the direction of the RSG the Working Group is currently considering the strategic proposals and options.

8.5 Domestic and Sexual Violence

Research has shown that those people (mostly women) who suffer from domestic violence and abuse are more likely to suffer from depression, misuse alcohol and suffer from conditions related to post-traumatic stress, such as anxiety disorders and sleeping disorders.

Mental health impacts of sexual violence can include symptoms of post-traumatic stress disorder (PSTD), depression, anxiety and panic attacks, social phobia, alcohol and drug misuse, eating disorders and suicidal tendencies. Adult survivors of childhood sexual abuse may suffer the same impairments to their lives, with research indicating that 50% of female psychiatric inpatients in Northern Ireland report a history of childhood sexual abuse.

DHSSPS, in partnership with a range of other Departments, agencies and the community and voluntary sectors, is implementing the *Tackling Domestic Violence at Home* strategy through a series of annual action plans. A Government-wide strategy on Tackling Sexual Violence and Abuse is also being taken forward through annual action plans.

The Department of Education recognises that domestic violence is one of the key stressors on children and a barrier to achieving their educational outcomes. The Department is currently exploring a number of options for the Women's Aid Foundation to raise awareness within the education sector of the issues of domestic and sexual violence.

8.6 Conclusion

The importance of an integrated and multi-agency approach to treatment, care and support across a range of conditions has been highlighted in this chapter. The next chapter (chapter 9) illustrates the policy progress that has been made to date to implement the Bamford Vision.

CHAPTER 9 – PROGRESS TO DATE ON SERVICE IMPROVEMENT

9.1 Introduction

Over the course of the Bamford review, Government Departments have been aware of emerging themes around person-centred services and improved collaborative working and have already been working to address some of these issues. While much still remains to be done, government departments and agencies have been successful in taking forward a number of the recommendations contained in the Bamford Review, and are making continued progress on others, as was reflected in *Delivering the Bamford Vision*. Work has continued to progress since the publication of that document in 2008 and includes improvements in both mental health and learning disability services.

9.2 Mental Health Service Improvement

The following is a summary of a specific service improvement in mental health. In addition, other service improvement areas impact on both mental health and learning disability services. These include, for example, developments in children's services, nursing care particularly for those with complex needs, early intervention through changes outlined in the Review of Health Visiting and School Nursing, and additional services to support individuals and families who suffer from domestic or sexual violence.

Changes which have a direct impact on services for those with a mental health need include:

- A Directed Enhanced Service (DES) introduced in 2008/09 to encourage the provision within primary care of non-drug therapies in the treatment of mild to moderate depression, in line with NICE guidelines.
- Community mental health services have undergone a process of reorganisation across Northern Ireland.
- Access to services is improving rapidly through these new organisational arrangements and through better performance management arrangements.

- Home treatment as an alternative to in-patient treatment will soon be available in every part of Northern Ireland.
- A regional bed management protocol agreed across all Trusts to ensure that acute psychiatric beds are available for those who needed them.
- Arrangements have been put in place to ensure Computerised Cognitive Behavioural Therapy is available to all GP practices from April 2009.
- Work is well advanced to develop the service framework, which will support mental health service improvement.
- A review of priorities for capital developments was completed in September 2008.
- Over 80 long stay patients have been discharged from mental health hospitals since April 2008.
- A strategy to improve access to psychological therapies was issued for consultation in December 2008 and service improvement work is now under way.
- A strategy for personality disorder services was issued for consultation in December 2008.
- Guidance on the choice of the Selective Serotonin Re-uptake Inhibitors (SSRIs) antidepressants for the management of depression and anxiety in adults in both primary and secondary care settings was issued in October 2008.
- A multi-agency training needs analysis for practitioners and other relevant staff working in forensic services has been completed in 2008.
- Responsibility for healthcare in prisons, where there is a high prevalence of mental health needs, has transferred to the health and social care sector.
- DE, the SEELB and the Education and Training Inspectorate has produced a flexible educational model, to replace the provision in the former Lindsay School, for CAMHS patients with significant medical, social, emotional and behavioural needs. This model, which commenced in the 2007/08 school year, will be easily transferred to the new purpose built Regional Child and Adolescent Psychiatric Centre, which will include a Learning Resource Centre, when it opens in 2010. The aim is to ensure that the children and young people under the care of Child and

Adolescent Mental Health Service (CAMHS) receive the most appropriate support from both health and education services.

9.3 Learning Disability Service Improvement

A number of specific service improvements have taken place. These include:

- The learning disability resettlement target of 40 long-stay patients to be resettled by March 2008 was successfully achieved and the 08/09 target has also been achieved.
- The target to resettle all children has been achieved.
- 150 purposeful placements for young people on transition from special schools into the community have been created and funding is in place to maintain these placements.
- DHSSPS is working with the Equality Commission Northern Ireland to ensure all those with a learning disability have equal access to services and the appropriate information.
- Direct Payments have been promoted and developed, and use is increasing.
- Work is currently underway to improve services for people with Autistic Spectrum Disorder, including the establishment of a Regional ASD Network, through the development of terms of reference and appointment of relevant staff.
- A review of priorities for capital developments was completed in September 2008
- Work is well advanced to develop the service framework, which will support learning disability service improvement.
- There is an embryonic community forensic service in two of the Health and Social Services Board areas, however these community services need further strengthening. A learning disability forensic service also needs to be developed to cover all Health and Social Service Board areas. The Regional Group on Forensic Mental Health is currently assessing these needs and will recommend improvements to the new Health and Social Care Board.
- Education transition co-ordinators have been appointed to strengthen the transition planning of pupils from school to post school placements.

- Following the implementation of SENDO, the ELBs have established a Dispute Avoidance and Resolution Service and an Advice and information Service.

9.4 Other related service improvements

- A DHSSPS Autism Spectrum Disorder Action Plan (2008/9 – 2010/11) was published in June 2009.
- An Acquired Brain Injury Services Action Plan was issued for consultation in March 2009.
- A Physical & Sensory Disability Strategy will be issued for consultation in early 2010.
- A Speech and Language Therapy Action Plan is in development and will be published shortly.
- A cross Governmental Strategy of Sexual Violence and Abuse was published in June 2008. Annual Action Plans to implement the Strategy are being put in place.
- A cross Departmental Domestic Violence Strategy was published in 2005. Annual Action Plans are being put in place to implement change.
- The damaging consequences of underachievement for the child, their family, their community and for society as a whole are well documented. In these challenging economic times, raising educational standards and eliminating underachievement is now more important than ever. Through a number of reforms and programmes the Department of Education (DE) has prioritised tackling underachievement and inequality and promotes the raising of standards in all schools. DE wants to ensure that every child can succeed regardless of background, gender, sexual orientation, religion, race, whether or not they have a disability, come from the Travelling Community, or are newcomer pupils and will provide support for those who need it.
- The DE Review of SEN and Inclusion has highlighted the vital importance of an effective working partnership with the health sector. To this end, DE is working closely with health colleagues to strengthen

and develop links, from a strategic level through to delivery, to gain a shared commitment and ensure that planning, assessment and delivery of special education provision, interventions and therapies are timely and realistic. Due to the cross cutting nature of the draft policy proposals, the SEN and Inclusion Review's Policy Proposals are to be considered by the Executive, seeking agreement to issue for public consultation. It is hoped that this will happen before the end of the current academic year (2009/10).

9.5 Conclusion

Whilst much progress has been made over the last few years to enhance Health and Social Care services, more work still needs to be done. The following action plan sets out actions which need to be completed by respective Departments and organisations within the 2009-11 timeframe. Chapter 10 outlines how delivery, monitoring and review of the Action Plan will be achieved.

SECTION 2

THE MENTAL HEALTH ACTION PLAN (2009-11)

HOW TO READ THE ACTION PLAN

Four broad work areas emerged from the Bamford review:

- promoting and preserving mental wellbeing and building emotional resilience within the population as a whole;
- having legislation which promotes self-determination but supports those unable to make decisions for themselves;
- improving services for people of all ages with a learning disability and their families and ensuring better joining-up across agencies; and
- improving services for people of all ages with mental health needs and their families and ensuring better joining-up across agencies.

In this section of the Action Plan there is an introductory section on mental health services. This is to set the scene for the detailed Action Plan on mental health.

Because public service resources are agreed for three-year time cycles, this Action Plan concentrates on actions which can be achieved within the resources available up to March 2011, but also signals actions which will in the longer term contribute to the Bamford vision. It is anticipated that further additional resources will be needed in future spending cycles and the Action Plan will be reviewed in 2011 to reflect progress and the funding position. All actions are grouped 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 the needs of individuals;
Developing structures and a legislative framework.

Each action has a timetable for completion, who is responsible for it, the outcome required and the benefits for individuals and for society.

MENTAL HEALTH SERVICES

Introduction

The focus of mental health services in the future will be on the provision of a comprehensive range of safe and effective services that support people with a mental health need to achieve and maintain their maximum level of functioning. This will be achieved through a focus on the recovery model, by providing an early and appropriate service response, as far as possible within the primary and community care sector.

People's mental health needs may change with age. There are separate mental health services for children and young people up to their 18th birthday and some services for older people with mental health needs or dementia are provided alongside other services for older people rather than with mental health services for adults.

The following sections provide some background to mental health service development including:

- adult mental health services;
- children and young people's mental health services;
- services for older people with mental health needs and dementia; and
- forensic mental health services.

In addition, this section recognises that other conditions and circumstances impact on mental health, including alcohol and substance misuse.

The Recovery Model

A central thrust of the Bamford Review was the promotion of a system of care based on the recovery model, particularly for those people with more complex needs. The recovery model is an approach to mental ill-health or substance dependence that emphasises and supports each individual's potential for recovery. Recovery is seen as a personal journey, that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning (often gained through occupation or employment). The use of the concept in mental health emerged as deinstitutionalization resulted in more individuals living in the community. It has gained impetus due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that more people can recover than had previously been thought possible. Recovery-based services will support people with a mental health need to plan and build a satisfying life, engaging in work or other meaningful activities and contributing to and participating in society. Partnership between the service user and those providing services is fundamental to a recovery-based approach. Tools such as the Scottish Recovery Indicator have been developed to support use of the recovery model.

Involving Service Users

Involving those who have been mental health services users as “experts by experience” in providing support and advice to other service users gives strong backing to the recovery model and will be encouraged and supported. The contribution that can be made by former service users and their training needs will be taken into account as new mental health service models are developed.

Stepped Care

The Stepped Care model of service provision will provide the framework for future commissioning and delivery of mental health service provision in Northern Ireland. The Stepped Care model is advocated by NICE for common mental health conditions, with the number and precise nature of steps varying to address particular needs. As a general rule, however, the steps progress from awareness, recognition and assessment/ diagnosis, provided within primary care, at Step 1 through to the highest steps of inpatient or intensive treatment programmes, depending on level of need. By way of illustration, the stepped care model for depression, as advocated by NICE, is shown at Figure 3. This however is based solely on a healthcare model and does not take account of Northern Ireland’s integrated health and social care service.

The aim of the Stepped Care model is to provide services which are more timely and responsive and less stigmatising and enable a greater proportion of care to be delivered at an early stage within the usual primary care setting. The model aims to provide a graduated range of care options, including self help and the provision of support and treatment within the primary care setting (or non statutory / voluntary sector) before a referral to more specialist services would be considered.

Fig 3. STEPPED CARE MODEL FOR DEPRESSION (NICE)

		Who is responsible for care?	What is the focus?	What do they do?
Step 5	Inpatient treatment for depression	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4	Treatment of depression by mental health specialists	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3	Treatment of moderate to severe depression in primary care	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2	Treatment of mild depression in primary care	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1	Recognition in primary care and general hospital settings	GP, practice nurse	Recognition	Assessment

Source: From NICE guidance on depression

Innovating for Excellence

Ten High Impact Changes shown to make a difference to mental health services are:

- providing home based care and support as the norm for the delivery of mental health services;
- improving access to screening and assessment;
- managing variation in service user discharge processes;
- managing variation in access to all mental health services;
- avoiding unnecessary contact and provide necessary contact in the right care setting
- increasing the reliability of interventions by designing care based on what is known to work and that service users inform and influence
- applying a systematic approach to enable the recovery of people with long term conditions
- improving service user flow by removing queues
- optimising service users and carers flow through the service using an integrated care pathway approach
- redesigning and extending roles in line with efficient service user and carer pathways to attract and retain a effective workforce.

These will be progressed within mental health services in Northern Ireland through an Innovating for Excellence programme, led by the Health and Social Care Board working with the Trusts. The Service Improvement lead to be appointed in each Trust will play a key role in this work.

Primary Care Services

The vast majority of people with mental health needs are cared for entirely within the primary care setting. DHSSPS will seek to enhance such provision, as primary care services are universal, accessible and less stigmatizing. Because of their generalist nature, both mental and physical health needs can be dealt with as part of a holistic approach; many people presenting to primary care with physical health problems have a mental health component to their problem and people with mental health needs may also require support in maintaining their physical health.

Primary care professionals must have available to them a range of options for dealing with the mental health needs of people presenting to them, in line with the stepped care model outlined earlier. These options would include self-help, signposting to relevant groups and organisations which can provide support, medication and/or psychological therapies or, where necessary, referral to mental health services.

The voluntary and community sector has an important role in support of primary care services; many such organisations are run by or have input from people who have been mental health services users themselves and can therefore provide informed and sensitive support and advice. This partnership with statutory services requires both sectors to work together in a more concerted way.

Primary care staff will be supported to promote better recognition of mental health needs and ensure clear working arrangements to provide access to specialist mental health advice where necessary through the stepped care model.

The Quality and Outcomes Framework (QOF), part of the UK-wide General Medical Services contract with GPs, provides financial incentives to GP practices which maintain registers of their patients with some specific mental health conditions, review these patients at regular intervals and provide ongoing management of their care. The mental health conditions covered within QOF are depression, dementia and schizophrenia, bipolar affective disorder and other psychoses. Although QOF is voluntary, the majority of practices are achieving the required targets.

The prevalence of depression in those presenting to primary care services and the increasing numbers of people, particularly young men, at serious risk of suicide have been driving factors in the recent programme to raise awareness of depression among primary care staff. A Directed Enhanced Service (DES) has also been introduced in 2008/09 to encourage the provision within primary care of non-drug therapies in the treatment of mild to moderate depression, in line with NICE guidelines.

Beating the Blues is a self help computer based CBT programme, approved by NICE for use in the treatment of mild depression. Work is well advanced to roll a CCBT programme out to all GP practices in NI, with the aim to have regional access to the programme by March 2010.

Psychological Therapies

The evidence base for use of psychological therapies has strengthened in recent years. DHSSPS is developing a strategy for improving access to psychological therapies, which should be finalised during 2009 and will help to determine priorities for the use of additional resources secured for the period 2008/09 to 2010/11 to improve access to psychological therapies.

Mental Health Teams in the Community

Multi-disciplinary Mental Health Teams in the community are key in supporting service users and families in community settings. There has been a process of ongoing development of Community Mental Health teams for some years, including the reorganisation of teams, the development of Crisis Response, Home Treatment and Assertive Outreach Services and the development of specialist services for those with specific needs, such as eating disorders. The consistency and responsiveness of the variety of service models in place will need to be reviewed so that everyone in Northern Ireland can expect common standards of care no matter where they live. At the same time, service improvement efforts will focus attention on maximising the impact of investments to date and ensuring that future investment is targeted on those services that demonstrate effectiveness.

Other Community Mental Health Services

A range of services will be provided to complement the work of the community mental health teams, including day services, vocational training, respite and other support services for carers, supported accommodation and psychological therapies. Day support and vocational services need to become more recovery focused and integrated with the local communities that they serve. Respite care will need further development so that carers are supported in their roles. A range of supported living services are already in place but more will need to be done, particularly with regard the development of so-called ‘floating support schemes’. Much of this can and should be provided by the voluntary and community sector.

In-patient Facilities

There will still be a need for some people to be admitted to hospital for assessment and treatment. The continued development of community mental health services, however, should result in a 10% reduction in admissions to mental health hospitals by 2011. Over time there will be a shift from large psychiatric institutions to smaller psychiatric units and a network of step-up and step-down facilities closer to the community, with a smaller number of beds overall.

There will be a growing focus on the quality of care that is provided within hospitals so that it modernises and improves at the same pace as other services. Inpatient services must be of a high quality, with all the necessary resources and therapeutic interventions required to ensure swift access to treatment and care and timely discharge to the least restrictive setting.

Resettlement from long-stay psychiatric hospital inpatient units will continue to be a priority. It was estimated that additional funding secured for the period 2008/09 to 2010/11 for resettlement would result in 90 long stay patients being discharged over the 3 year period. That target has been virtually achieved within the first year alone, and resettlement from long stay mental health hospitals will continue to achieve the overall target of no person remaining unnecessarily in hospital by 2013. Partnership working with the independent sector and with other public agencies is vital in providing the support required to achieve this.

People with Special Mental Health Needs

The Bamford review identified a number of groups of people with particular needs for specialist mental health services. Actions relating to improving services for people with eating disorders, people with personality disorder and women with perinatal mental health needs are included in the later section of this Action Plan. In addition work relating to people with autism and with acquired brain injury is referred to later in this document. Other specialist needs will be addressed as resources permit.

Children and Young People's Mental Health

The Bamford Review highlighted the need for joint working between health and social care, education and youth justice sectors. The Ministerial Sub-Committee on Children and Young People will bring an increased focus at Departmental level on issues relating to children and young people with a mental health need.

Support for Parents

The NI Executive will continue to promote a range of strategies and programmes aimed at supporting parents in raising their children, as far as possible in partnership with the voluntary and community sectors. The mental health needs of looked after children, for whom DHSSPS has lead policy responsibility, will also be taken into account.

Schools

Work is being done in schools through the curriculum; Personal Development and Mutual Understanding at primary level and Learning for Life and Work at post-primary level provides opportunities to promote positive mental and emotional wellbeing among young people. A Pupils' Emotional Health and Wellbeing Programme is being developed initially for the post-primary sector, addressing how a pupil's emotional health and wellbeing is promoted by the school, what support systems are available to a pupil under stress and what support is available to a school in event of a crisis. An independent counselling service has been available to post-primary pupils since September 2007. Work is underway to determine the support that should be made available to primary and special schools. DE funds a regional anti-bullying helpline operated by Childline and is working with the local Anti-bullying Forum to promote good practice in tackling bullying in schools, including guidance on cyber bullying and a website providing advice and information. A DE/ DHSSPS group at senior level will continue to work on issues of mutual interest, including the emotional wellbeing of children and young people.

Special Education

The purpose of special educational provision is to remove or diminish the barriers to achievement, which children and young people with special educational needs may face. These may include the classroom approach to learning or the physical nature of the learning environment. The Department of Education and the Education and Library Board Regional Strategy Group for Special Educational Needs continue to be proactive in moving forward with a wide range of service improvements within the existing SEN framework.

Health and Social Care Services

Child and Adolescent Mental Health Services are provided for children and young people up to their 18th birthday and are being developed in line with the 4-Tier model advocated in the Bamford Review. The Performance Management and Service Improvement Directorate, as part of the new Health and Social Care Board, is leading a process of reform and modernisation aimed at ensuring that CAMH services respond in a more accessible way and maximise the significant investment that has occurred and is planned in coming years.

A comprehensive pattern of child and adolescent mental health services requires the development of primary care services and the build up of community mental health services in parallel with enhanced specialist services, including inpatient care. By 2010, 33 mental health inpatient beds will be provided for children and young people up to the age of 18 in Northern Ireland.

Older People's Mental Health and Dementia

Dementia is a major health concern for older people in society, but older people may also have a range of other mental health needs. Detection of mental health needs in older people tends to be poorer than for the rest of the population. The demographic changes anticipated in Northern Ireland could see the number of dementia sufferers rise by 30% by 2017 and are also likely to result in an increase in the number of older people with functional mental illness

Mental Health Promotion and Early Detection

The mental health needs of older people will be taken into account in the development of the proposed updated *Promoting Mental Health* strategy and action plan. Work to improve recognition of mental health needs by primary care staff will benefit older people as well as the rest of the population. Staff providing the wide range of health and social care available for older people need to be aware of and alert to dementia and mental health issues.

Assessment

Work has been completed to develop a Northern Ireland Single Assessment Tool (NISAT), which aims to capture a complete picture of the older person and his/her care needs, and will trigger more specialist assessment, including mental health assessment, where appropriate. An implementation plan is in place to roll out use of the tool by June 2010.

Mental Health and Dementia Services in the Community

Work to enhance mental health teams in the community and to agree common care pathways will include consideration of the needs of older people with mental health needs. The strategy for improving access to psychological therapies will include provision for older people, and DHSSPS, with service commissioners and providers, will examine ways to improve older people's access to other therapies which are proven to be beneficial.

Commissioners of services will take into account the needs of older people with dementia or mental health needs for the full range of community based services. The development of intermediate care and new approaches to delivering in-patient assessment functions will help to deliver the Bamford vision for older people with mental health needs or dementia. DHSSPS and health and social care bodies will work with DSD and housing bodies to encourage the development of a range of models which will meet the needs of older people with dementia or mental health needs and their families and carers and will exploit as fully as possible the benefits of assistive technology.

Decisions on the need for care home provision will be on the basis of an individual, multi-disciplinary, assessment of need, covering the physical, mental and social functioning of the person, taking account of the needs of their family and any other carers and, as far as possible, will be carried out in the person's own home environment.

Hospital Care

The requirement for inpatient provision for older people with mental health needs or dementia has been taken into account in the review of mental health inpatient provision. It is likely that further changes will occur as Trusts develop more modern approaches to in-patient care based on commissioner assessments of need and develop services specifically tailored to the needs of older people.

Dementia Services

DHSSPS has commenced work to develop a strategy for dementia services, covering all aspects from assessment and diagnosis through to highly specialised forms of care. This will be taken forward in partnership with all relevant agencies and interest groups.

Alcohol and Substance Misuse

The relationship between alcohol and drug misuse and mental health is complex, and can be problematic, particularly co-morbidity, or dual diagnosis – the occurrence of substance misuse with mental health needs – which is a major challenge facing mental health services. Through the New Strategic Direction for Alcohol and Drugs (NSD) action is being taken forward to prevent and reduce the harm related to substance misuse in Northern Ireland. Within the NSD there is a specific focus on young people's drinking, binge and problem drinking, and the misuse of legal and illegal drugs, including the issue of harm reduction in injecting drug misuse. There is also a specific acknowledgement of the impact that parental problem substance use can have on the mental and emotional well being of children and young people. This is being taken forward through the Hidden Harm Action Plan which encourages communication and cooperation between adult addiction services and children services.

Through the NSD, the DHSSPS will continue promote a unified approach across Northern Ireland on assessments and outcome measures. The 4-Tier model of service delivery described in the National Treatment Agency for Substance Misuse *Model of Care* document will be adopted and will incorporate rehabilitation services. There will also be a renewed focus on developing a regional commissioning framework for addiction services across Northern Ireland. Joint working between addiction services and mental health services will be supported.

Forensic Mental Health Services

The NI Executive is committed to improving safe, secure and supportive service provision for people who have a mental disorder and come into contact with the Criminal Justice System (CJS).

A Northern Ireland Forensic Network involving users of services and carers and the relevant agencies at senior level will be established to support development of forensic services in a strategic and co-ordinated manner.

To assist collaborative working and facilitate meaningful communication, a training needs analysis has been completed on a multi-agency basis for practitioners and other relevant staff working in forensic services and collaborative training initiated.

New purpose-built, in-patient facilities have been provided for people with a mental illness and for people with learning disability and community forensic teams have been established. By March 2010 a plan will be developed to review current provision of low secure and community forensic placements and assess the need for further investment.

People with a personality disorder are significantly over-represented in the CJS. In December 2008 a strategy for services for people with a personality disorder was issued for stakeholder consultation. Investment in this area has already been identified in each of the next two years,

Work will be undertaken to agree appropriate standards and protocols for dealing with people detained in police stations. The involvement of the Health and Social Care Trusts in leading prison healthcare should ensure the development of the service in keeping with that in the community and facilitate seamless transfer of care across the interface between prison and the community.

The following section of the Mental Health Action Plan outlines specific actions under 5 themes:

- Promoting positive health 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

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Publish a revised cross-sectoral Promoting Mental Health and Wellbeing Strategy	All Departments, led by DHSSPS Investing for Health Group	A renewed emphasis on building the emotional resilience of our population and on mental health and wellbeing promotion across all sectors, taking account of lessons learned from previous work	By December 2009	Better mental wellbeing in the population
Implementation of the Protect Life action plan	Relevant Departments, led by DHSSPS Investing for Health Group Public Health Agency (PHA/Board to lead on HSC actions	Reduce overall suicide rate by 15% by 2011 (baseline: 2004-06)	Ongoing	Decrease risk of people taking their own lives
Implementation of Health Committee recommendations on the prevention of suicide and self harm	DHSSPS Investing for Health Group, DE, DCAL Public Health Agency (PHA/Board to lead on HSC actions	Reduce overall suicide rate by 15% by 2011 (baseline: 2004-06) Reduce levels of deliberate self harming	May 2009 to March 2010	Decrease risk of people taking their own lives
Develop, consult and implement a 10 year Early Years Strategy	DE led Ministerial sub-committee for Early Years.	Consultation on Strategy Implementation Plan	Autumn 2009 Spring 2010	Prevention and lessening of emotional and behavioural problems in young children by ensuring access to - physical nurturing - nourishing food - exercise and play (particularly outdoor play - adequate sleep - emotional and social support

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Introduce a revised curriculum which provides opportunities through Personal Development and other areas for young people to develop the skills they need to cope with challenging personal situations such as violence against women and children; self-harm etc.	DE – Curriculum & Assessment Team	All schools to have implemented the revised curriculum	By September 2009	Pupils benefit from the opportunity to develop the skills they need to cope with a range of challenging personal situations; teachers receive guidance and support, including training, to implement the revised curriculum.
Produce guidance and support material for post primary schools on proactively promoting positive emotional health and well being among staff and pupils	DE – Pupil Support Unit	All schools understand their role in promoting positive outcomes for pupils	Commencing Autumn 2009	All pupils and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies
Produce guidance for schools on the management of critical incidents and ensure consistent support to schools across all board areas		There is consistent minimum provision across all post primary schools within the curriculum and pastoral care supports	Ongoing	

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Sustain the Independent counselling support service for pupils in post primary schools	DE – Pupil Support Unit	Continued access for all schools that wish it to a minimum of half day counselling support per week	Ongoing	Support, independent of the school, accessible for pupils experiencing stress
Develop proposals for developing resilience among primary aged pupils and those in special schools for consultation; to implement agreed new services	DE – Pupil Support Unit	Age and ability specific programmes which promote positive outcomes operating in primary and special schools	Commencing Autumn 2009.	All primary age pupils, those in special schools and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies
Support schools in their work to create an anti-bullying culture with guidance and materials which tackle all forms of bullying, including homophobic bullying, are up to date and reflect the dynamic nature of the problem	DE – Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils are confident that their concerns about bullying will be dealt with in an appropriate and timely manner
Progress ongoing work of the DE Safeguarding Co-ordination Group	DE- led by Supporting and Safeguarding Children Division	The DE Safeguarding Coordination Group will raise awareness of the range of safeguarding issues, including domestic violence, across DE business areas	Ongoing	Vulnerable children will be supported and signposted to appropriate interventions

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Promote Teacher Health and Wellbeing through: • Revision of *Promoting a Dignified Workplace* (a policy statement and code of practice on measures to combat bullying and harassment of teaching staff in school)	Teacher Negotiating Committee (TNC) (an amalgam of the Department of Education, employing authorities and teachers' unions responsible for negotiating all aspects of teachers' pay and conditions of service) Employing authorities	Reduction in incidence of bullying and harassment	Draft presented to employing authorities in December 2008. Once approved will go forward to the teachers' unions for comment and possible negotiation prior to ratification by TNC	Potential benefits to all teachers
• Centralisation of counselling services for teachers	TNC	Improved level of support available to teachers	Ongoing from 1 April 2009	Benefits to teachers who have been bullied or have other mental health issues
• Revision of guidance on violence and other abuse of teachers by pupils or third parties		Greater clarity for schools in dealing with and preventing this problem	A workshop to consider revised guidance was held in November 2008 and feedback is currently being collated. Guidance document will issue to schools in Autumn 2009	Will benefit schools whose staff have been abused

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Commission a scoping study of Pastoral Care arrangements in FE	DEL	To ensure that the FE sector is fully aware of and responsive to the needs of its students including having in place comprehensive pastoral care arrangements across all campuses to identify and address any problems experienced by students	Scoping study commissioned by Public Procurement commenced July 2009 Findings of scoping study by December 2009 Implementation plan for any identified actions by March 2010	More effective, comprehensive and consistent pastoral care services for students across all 6 regional colleges
Implement a 10 year Strategy for Sport and Physical Recreation	DCAL	A greater emphasis on the mental benefits of regular participation in sport and physical recreation	From September 2009	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation
Publish guidance for employers in general on “Creating a working environment that encourages Mental Wellbeing”	HSENI	All employers will be better equipped to address workplace mental wellbeing issues.	December 2009	Fewer employees will suffer from work related stress. More working environments will encourage mental well being. More employers will feel confident about employing someone who has mental health needs

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Set up a Stress and Mental Wellbeing Unit comprising health and safety inspectors and business advisors to focus on high stress risk work sectors	HSENI	The Unit will through the provision of advice and where necessary enforcement ensure that organisations in sectors, in which employees are at a high risk of suffering from stress related ill health caused by or made worse by their work, have adopted systems to manage such a risk	December 2009	In high stress risk work sectors see, as a result of reduced stress related ill health and associated absenteeism, increased productivity
Ongoing implementation and development of the New Strategic Direction for Alcohol and Drugs, and its underpinning Hidden Harm and Young People's Drinking Action Plan	DHSSPS (with other relevant Departments) PHA to lead on HSC actions	5% reduction in the proportion of adults who binge drink (baseline 2005) 10% reduction in the proportion of young people who report getting drunk (baseline 2003) 5% reduction in the proportion of young adults taking illegal drugs (baseline 2002/3) 10% reduction in the number of children at risk from parental alcohol and/or drug dependency (baseline under development)	By 2011	Reduce levels of harm related to alcohol and drug misuse
Progress the Tackling Sexual Violence and Abuse Strategy 2008-2013	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of sexual violence and abuse
Implement the domestic violence strategy *Tackling Violence at Home*	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of domestic violence and abuse

MENTAL HEALTH ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Implement the recommendations and associated actions arising from the Review of School Nursing and Health Visiting, once agreed post-consultation	**HSC**	Service delivery will be targeted on parenting support and mental health early interventions	As set in the Action Plan from the Review of School Nursing and Health Visiting	Children and young people's emotional health is promoted, all children are supported to lead happy healthy lives and problems are prevented from escalating to more serious mental health needs

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Publish a report on the 'Promoting Social Inclusion' work	OFMDFM, Equality / Rights & Social Need Division with input from Departments and the sector as appropriate	The work of the PSI Group for people with disabilities covers a range of topics and cuts across Departmental boundaries – The report will provide a composite set of recommendations for Executive consideration which will improve the quality of life for people with disabilities.	Autumn 2009	Improved social inclusion of people with disabilities across a wide range of areas and activities examined by the PSI Group including: • Access to Employment; • Children, Young People and their Families; • Housing, Transport, Information and Access; • Legislation, Citizenship, Language and Attitudes, and • Lifelong Learning, Arts, Sports and Culture
Publish an action plan for the implementation of recommendations arising from the PSI report (above)	OFMDFM Equality / Rights & Social Need Division (with input & agreement from other Departments as necessary)	As above. The action plan for this PSI work will be taken forward in the context of the wider 'anti-poverty and social inclusion' strategy - Lifetime Opportunities	Agreed action plan by March 2010	As above
Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment	OFMDFM, Commission for Victims and Survivors	Better information on the extent of the impact of the Troubles on the mental health needs of victims and survivors	September 2009	Better planning of services for victims and survivors

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Bring forward primary legislation to establish the Office of Commissioner for Older People	OFMDFM Equality, Rights and Social Need Division with input and agreement from other Departments as necessary	Legislation to establish a Commissioner for Older People, with a range of functions, powers and duties	Introduce legislation in May 2010	Will provide a strong independent voice for older people, including those experiencing mental ill health
"Health in Mind" programme to improve the quality of life of 25,000 adults affected by mental ill-health through the provision of information, learning and reading activities	DCAL (Libraries NI)	By project end: 40,000 people have accessed improved information about mental health; 20,000 people affected by mental ill health, their families and carers have improved knowledge and skills to enable them to access and use relevant information; 3.000 people affected by mental ill health, their families and carers have availed of enhanced opportunities for social interaction through reading and learning activities enabling them to play a fuller role in community life and to access further training or employment if they so wish; and 15,000 people in the wider community have enhanced levels of understanding of mental ill health and awareness of positive mental health, thus promoting tolerance and inclusion and enabling them to take action to prevent mental ill health	5 years from October 2009	People affected by mental ill health and their families have improved access to information and support

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Complete an analysis of DEL provision across the further education and training sector for those with a disability, including those with special educational needs or with mental health needs. This work to build on detailed reviews of Students with Learning Difficulties and/or Disabilities provision in FE, barriers to Training for Success and also recent inspection reports of provision	DEL Education and Training Inspectorate	Identification of areas for future DEL action where appropriate; also, an indication as to whether individuals have access to the services they require consistently across further education and training	Report finalised by June 2009	More effective services for individuals accessing DEL programmes and services
Consider the findings of the overarching review (above) and any strategic implications for DEL and develop an action plan	DEL	Strategic action plan to address cross-departmental issues identified that impact on individuals with mental ill health and /or learning disability	Action plan in place for 2010/11 Key milestones - consider resource implications, both staff and financial - identify delivery mechanisms - seek approvals to proceed	More effective services for individuals accessing DEL programmes and services

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Undertake scoping study of provision for those not in education, training or employment (NEET), including those with mental ill-health or learning disability	DEL in liaison with other organisations, including PHA	Determination of available provision	Scoping study completed by Autumn 2009	Improved information to enable consideration of need for cross-Departmental strategic approach/ further actions
Continue to deliver DEL provision to address the employment needs of Incapacity Benefit and Employment and Support Allowance (ESA) recipients including those with mental ill-health	DEL	Individuals with mental ill health issues are assisted via DEL programmes , including the Condition Management Programme offered in conjunction with DHSSPS to re-enter the labour market	Ongoing	Individuals with mental ill health issues can access the necessary training and support to enable them to re-enter the labour market
DEL to consider, following recommendations from the Disability Liaison Group, improved information and communications about provision, including the possibility of an “easy to read” directory of DEL provision aimed at individuals with mental ill health and/or learning disability and their families	DEL (in conjunction with the sector)	A range of clear and accessible information resources	Summer 2010	Better informed decision making in terms of future education, employment and training options available

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Examine the benefits for NI of adopting similar partnership arrangements to those put in place by the Scottish Executive that detail the roles and responsibilities of agencies involved in meeting the educational, health and social needs of people with additional needs accessing DEL provision	DEL jointly with DHSSPS/ HSC and other relevant Departments	Clear understanding of the respective roles and responsibilities including information sharing between DHSSPS and its agencies, DEL and its delivery partners and other agencies in addressing the needs of these learners (in particular assistance with assessment, personal care, transport etc), and that the findings are disseminated locally to DEL delivery partners and HSC	Stage 1: Scope benefits by end 2009 -Identify resource to undertake project - establish steering group for the project Stage 2 : Bring forward proposals to develop partnership working guidance in 2010. Report progress to Inter – Ministerial Group	Better awareness of the challenges of delivering provision to learners with profound and complex needs and clear signposting for individuals, families and providers Better informed healthcare and other professionals in relation to the education and training programmes and services relevant to and accessible by adults with mental ill health and/or learning disability
Carry out a policy evaluation of the Supporting People programme	DSD	Examination of the governance arrangements, commissioning process and funding arrangements, to ensure compliance with the policy intention that Supporting People is to fund advice and guidance for relevant individuals/organisations	March 2010	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Collaborative work between DSD, NIHE, DHSSPS and HSC	Supporting People Commissioning Body, chaired by the Northern Ireland Housing Executive	Ensure that the accommodation needs of vulnerable adults are included in the delivery of the Social Housing Development Programme in as far as resources are available at that time.	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
Publish action plan of how NICS will promote diversity	CHR to lead with all other NICS departments	Equal opportunities monitoring of the NICS workforce. Review the 2008 – 2011 NICS Employment, Equality and Diversity Plan.	December 2009	A working environment where everyone has a right to equality of opportunity and individual differences are valued and respected The NICS workforce will be more representative of the community by attracting a more diverse applicant pool for advertised posts including applications from those with a disability
Develop mandatory equal opportunities and diversity awareness training to all staff at all levels within the NICS	CHR to lead with all other NICS departments	Ensure that all employees are aware of their duties and responsibilities to ensure equality in the workplace and to fully include employees with disabilities, including mental conditions in the working environment.	Mandatory Training to commence in October 2009. To be complete by June 2010	To raise awareness of issues facing staff and customers with disabilities including those with a mental condition by ensuring all NICS employees are trained in equal opportunities and diversity awareness
Additional information and advice services for mental health service users and their carers	HSC	Improved information and advice services, at least some of which delivered by voluntary sector.	Ongoing	Better support for service users and carers in understanding the services available and in making their views heard

MENTAL HEALTH ACTION PLAN

THEME: Supporting people to lead independent lives

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Increase uptake of Direct Payments	HSC	Double the number of recipients of Direct Payments in mental health programme of care (baseline June 2007)	By March 2011	Give service users and their carers greater choice in the support they receive
Resettlement of long stay patients from mental health hospitals	HSC in collaboration with voluntary and community sector	10% reduction in the number of long-stay patients in mental health hospitals care (baseline 2007/08) No-one will remain unnecessarily in a mental health hospital	By 2011 By 2013 (Programme for Government target)	More people with a mental health need able to live in community settings with appropriate support.
Implementation of harm reduction strategies, including needle and syringe exchange and substitute prescribing	DHSSPS (with other relevant departments) PHA to lead on HSC action	Delivery of key harm reduction projects	Ongoing	Support for drug users to live less chaotic lives, and to reduce the harm they face in relation to their drug misuse

MENTAL HEALTH ACTION PLAN

THEME: Supporting carers and families

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Complete a joint Review of Support Provision for Carers	DHSSPS/DSD	Improved support services for carers who look after people of all ages who have a learning disability or mental health issues	Autumn 2009	People with a learning disability or mental health issues are supported to live independent lives in their own home for as long as possible and carers are supported in their caring role so that they can continue to care for as long as they wish and are able to do so
Improve regional information on provision of respite care	DHSSPS/ HSC	Pilot data collection and refine as necessary Monitor respite care provision in NI on a quarterly basis	By December 2009 Ongoing	Respite provision can be better planned and monitored
Improve respite care for people with dementia	HSC in collaboration with voluntary and community sector	Additional 2000 places per year (baseline 2007/08)	By March 2011	Improve access to respite care
Additional information and advice services for mental health service users and their carers	HSC Trusts, HSC Board, PHA in collaboration with voluntary and community sector	Improved information and advice services, at least some of which delivered by voluntary sector	Ongoing	Better support for service users and carers in understanding the services available and in making their views heard
Increase uptake of Direct Payments	HSC	Double the number of recipients of Direct Payments in mental health programme of care (baseline June 2007)	By March 2011	Give service users and their carers greater choice in the support they receive

MENTAL HEALTH ACTION PLAN

THEME: Supporting carers and families

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Implementation of Hidden Harm Action Plan – supporting the needs of children and young people born to or living with substance misusing parents or carers	DHSSPS (with other relevant departments) PHA to lead on HSC action	10% reduction in the number of children at risk from parental alcohol and/or drug dependency (baseline under development)	By 2011	Increased support (at local and regional level) for children and young people with substance misusing parents or carers

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Provide a service wide, supportive, quality driven environment to promote Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Submit consultation schemes under section 19 of the Health and Social Care (Reform) Act (Northern Ireland) All organisations to embed PPI consistently as part of organisational activity. Establish leadership and accountability arrangements for PPI. Monitor and Evaluate progress; agree priorities and targets for subsequent year; report annually	Jan 2010 Apr 2010 Apr 2010 From Apr 2010	• Improvements in service design. • Improvements in user and carer experience of services. • Promotion of social inclusion • Improved safety and quality of treatment. • Reduction in complaints • Improved management of demand • Understanding of how and when care goes wrong • Reduction of risk

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Re-direction of HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	60% of HSC spend on mental health services should be on community services.	By 2011/12	Greater access to community mental health services and fewer people need to be admitted to hospital
Develop a Service Framework for mental health services and commence implementation	DHSSPS/ HSC	Strengthen the integration of health and social care, enhance health and wellbeing, promote evidence – informed practice, focus on safe and effective care and enhance multidisciplinary and inter-sectoral working	By January 2010	Set out the standards of care that people who use services, their family and carers can expect to receive
Review range of facilities used to provide both inpatient and community based mental health and learning disability services and agree future pattern of provision	DHSSPS/HSC	An agreed plan for facilities required to deliver mental health and learning disability services	The Capital Priorities Review was completed in September 2008. A Policy Infrastructure Forum has been established to address new requirements and ongoing prioritisation.	Services will be delivered in appropriate, accessible, fit for purpose buildings
Complete a workforce planning study for mental health and learning disability health and social care services	DHSSPS (HR Directorate) in collaboration with HSC	Agree a prioritised action plan to take forward recommendations from the commissioned workforce study	December 2009	Adequate numbers of appropriately trained staff to deliver services needed
Develop and take forward a prioritised plan for research on mental health and learning disability issues	DHSSPS/ PHA/ R&D Office/ HSC	Plan agreed with a timetable	June 2010	Service provision informed by local research on needs and on evidence of what works

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Improve information systems on provision and use of mental health and learning disability services	HSC Board in collaboration with HSC	Anonymised database on inpatients in mental health facilities available at regional level for use by DHSSPS and HSC bodies Extend the database to include users of community based services	October 2009 April 2011	Services can be better planned to meet needs and monitored to ensure service improvement, based on up to date local information.
Complete and maintain a map of mental health services across Northern Ireland	PHA/ HSC Board in collaboration with HSC and voluntary and community sector	Compile mapping information on all mental health services provided	Mapping to be completed by March 2011 and maintained on ongoing basis	New services can be better targeted and gaps in existing services can be filled
Develop a stepped care model for mental health services	HSC Board/ PHA in collaboration with HSC and voluntary and community sector	A regionally agreed model across all HSC services	By March 2010	People should be able to access mental health services appropriate to their needs
Increase levels of community mental health services	HSC Board in collaboration with PHA and HSC Trusts	240 additional staff in community mental health services (baseline 2007/08) 10% reduction in admissions to mental health hospitals (baseline 2007/08)	March 2011 March 2011	Greater access to community mental health services and fewer people need to be admitted to hospital
Develop a strategy for improving access to psychological therapies	DHSSPS	Strategy to be agreed	By October 2009	Improved access to psychological therapies

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Introduce a computerised Cognitive Behavioural Therapy programme	HSC Board in collaboration with HSC	Introduce programme and monitor uptake and patient outcomes	Ongoing	Improved support for those with mild to moderate depression
Develop regional guidance on assessment and management of risk in mental health and learning disability services	DHSSPS and HSC HSC	Agreed guidance to cover full range of mental health and learning disability services with regionally agreed tools to support guidance. Implement guidance and supporting tools	By September 2009 From September 2009	People who may pose a risk to themselves or to other people or who may be at risk from other people will have such risks assessed and managed in an appropriate way as part of their treatment and care plan.
Develop regional prescribing guidance on anti-psychotic medicines for primary and secondary care sectors	DHSSPS, HSC Board, PHA and primary care leads	Provide regional guidance to those prescribing anti-psychotic medicines	March 2010	Ensure that anti-psychotic medicines are prescribed and managed appropriately
Develop pilot of community pharmacy medicines management initiative for people with mental health needs	DHSSPS, HSC Board, PHA, in partnership with HSC Trusts and primary care leads	Commence pilot and put in place evaluation	From September 2009	Provide better and more accessible advice and support to people with mental health needs who are taking medication

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Establish specialist medicines management clinics for people who have been prescribed benzodiazepines	DHSSPS/ HSC	Complete an initial assessment of effectiveness of such clinics Undertake formal evaluation of clinics	March 2011 During 2011/12	Provide better advice and support to people who have been prescribed benzodiazepines and, where appropriate, support reduction in use
Develop a strategy for services for people with a personality disorder	DHSSPS	Agreed strategy with implementation plan to provide a range of services to address the varying needs of people with personality disorders	By October 2009	Better access to services for people with a personality disorder and support for their carers
Establish procedures to ensure people leaving hospital who need continuing mental health care receive it	DHSSPS/ HSC	From April 2009, all mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within 7 days of discharge	Ongoing	Better community support for those discharged from hospital
Establish procedures to ensure people presenting at A&E departments who need continuing mental health care receive it	DHSSPS/ HSC	From April 2009, all mental health patients seen at A&E departments and assessed as requiring further mental health care should have an appointment made with mental health services before they leave the A&E department	Ongoing	Better follow up and support for those in need of mental health services
Improve and harmonise model for crisis intervention services	DHSSPS/ HSC	DHSSPS to issue regional principles for provision of crisis mental health services Trusts to ensure regional principles are complied with and that services are harmonised across Northern Ireland	October 2009 Action Plan drawn up by December 2009 and action taken to agree timescales thereafter	People in crisis will be able to receive appropriate care and support to a consistent standard

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Appoint a Service Improvement lead for mental health and learning disability in each HSC Trust	HSC Trusts in collaboration with HSC Board	Ensure that service improvement in mental health and learning disability services is given sufficient focus	April 2010	People using mental health and learning disability services have access to high quality, efficient and effective care and treatment
Introduce inpatient services for eating disorders	HSC Board and PHA in collaboration with HSC Trusts	Develop regional approach to inpatient services with appropriate in-reach	By March 2011	Continuity of care from community services for those who need to be admitted to hospital. Less people will require admission to a facility outside Northern Ireland
Improve perinatal mental health services	DHSSPS in collaboration with HSC	Take forward action plan to implement relevant NICE guidance across all Trusts and primary care	Consult on proposed action plan by October 2009 Agree action plan and timescales for implementation by January 2010	Better detection and treatment of mental illness during pregnancy and the post natal period
Improve interface between adult mental health services and child care services.	HSC	To explore and agree how best to ensure appropriate liaison between adult mental health services and child care services. Develop guidance for staff working across these services	Ongoing	Better service for all family where the parent has a mental health problem.

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Provide a mental health information resource for young people and their families	PHA to lead with HSC Board	Web-based resource including directory of mental health services for young people	By April 2010	Young people encouraged to look after their mental wellbeing and provided with information on sources of support
New facilities with 33 mental health inpatient beds provided for children and young people up to the age of 18	HSC Trusts in collaboration with HSC Board with DE/ ELB input on education provision	New linked units for children and young people who require inpatient mental health treatment	By 2010	Increased inpatient provision in new purpose-built facilities
Develop a strategy for dementia services, including the needs of younger adults.	DHSSPS with HSC and relevant agencies	Agree draft strategy and associated action plan and issue for consultation	By December 2009	Improved services for people with dementia and their families and carers
Support the Northern Ireland Dementia Services Development Centre	DHSSPS and HSC	Centre to deliver a range of training, educational, consultative and research services to HSC and to service users and carers	Ongoing to March 2012	Improved services for people with dementia and their families and carers
Establish a Northern Ireland Forensic Mental Health and Learning Disability Steering Group involving users of services and carers and the relevant agencies at senior level.	HSC with other relevant agencies	A co-ordinated approach across HSC and criminal justice agencies to improve forensic services	September 2009	Better joined up services for people who need forensic services

MENTAL HEALTH ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Conduct a review and produce a strategy to increase the provision of low secure and community forensic placements	HSC Board in collaboration with the Northern Ireland Forensic Mental Health and Learning Disability Steering Group	Current inpatient provision quantified and need for low secure and community forensic placements determined. A strategy developed for future provision based on assessed need.	March 2010 March 2011	Appropriate levels of support provided in the least restrictive conditions for those who need forensic services

MENTAL HEALTH ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford Vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Establish Health and Social Care Mental Health and Learning Disability Task Force	HSC Board and PHA to lead	A co-ordinated approach across HSC to improving mental health and reforming mental health and learning disability services in line with Bamford.	By October 2009	Mental health and learning disability services will be reformed and modernised in line with Bamford vision
Establish Bamford Monitoring Group	Patient Client Council	Provide a challenge function on the extent to which the reform of services is working.	By October 2009	Service users and carers will have an opportunity to feed back their views to Minister on how services are meeting their needs
Inter-Departmental Ministerial and Implementation groups to continue	DHSSPS (with other Departments)	A co-ordinated approach across Ni Executive improving mental health and reforming mental health and learning disability services in line with Bamford.	Ongoing	Better joining up of services across agencies
Introduce new mental capacity and mental health legislation	DHSSPS (with other Departments)	Commence new mental capacity and mental health legislation	Post 2011, exact timing depending on legislative programme	A consistent approach, with appropriate safeguards, to decisions - about care, treatment, property or assets – which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reason
Introduce a small amendment to the Mental Health (NI) Order to enable patients to apply to the court to replace their nearest relative.	DHSSPS	An amendment to the 1986 Order enabling patients to apply to court to replace their nearest relative	By March 2011	Patients will be able to challenge the appointment of a nearest relative. This will be important in situations where the relationship with the nearest relative has broken down or where there is a history of abuse by the nearest relative

MENTAL HEALTH ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford Vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS
Issue guidelines to health trusts advising of a European Court of Human Rights judgement requiring safeguards for those deprived of their liberty for their protection	DHSSPS	Guidelines issues to health trusts.	By December 2009	Those deprived of their liberty for their protection in nursing homes and hospitals and their relatives and carers will be consulted on the nature and extent of the deprivation

SECTION 3

THE LEARNING DISABILITY ACTION PLAN (2009-11)

HOW TO READ THE ACTION PLAN

Four broad work areas emerged from the Bamford review:

- promoting and preserving mental wellbeing and building emotional resilience within the population as a whole;
- having legislation which promotes self-determination but supports those unable to make decisions for themselves;
- improving services for people of all ages with a learning disability and their families and ensuring better joining-up across agencies;
- improving services for people of all ages with mental health needs and their families and ensuring better joining-up across agencies.

In this section of the Action Plan there is an introductory section on learning disability services. This is to set the scene for the detailed Action Plan.

Because public service resources are agreed for three-year time cycles, this Action Plan concentrates on actions which can be achieved within the resources available up to March 2011, but also signals actions which will in the longer term contribute to the Bamford vision. It is anticipated that further additional resources will be needed in future spending cycles and the Action Plan will be reviewed in 2011 to reflect progress and the funding position. All actions are grouped 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 the needs of individuals; and
Developing structures and a legislative framework.

Each action has a timetable for completion, who is responsible for it, the outcome required and the benefits for individuals and for society. In addition, the learning disability action plan has been informed by the values contained in the Bamford Equal Lives Report.

Equal Lives Values

1	Citizenship	People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.
2	Social Inclusion	People with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community.
3	Empowerment	People with a learning disability must be enabled to actively participate in decisions affecting their lives.
4	Working Together	Conditions must be created where people with a learning disability, families and organisations work together in order to meet the needs and aspirations of people with a learning disability.
5	Individual Support	People with a learning disability will be supported in ways that take account of their individual needs and help them to be as independent as possible.

All actions detailed in the following Learning Disability Action Plan will state which of the values they comply with, numbered 1 to 5.

The following text provides a summary of service development within learning disability services. This is designed to inform the reader and to set the context for the actions contained in the learning disability action plan.

LEARNING DISABILITY SERVICES – AN INTEGRATED LIFELONG APPROACH

Introduction

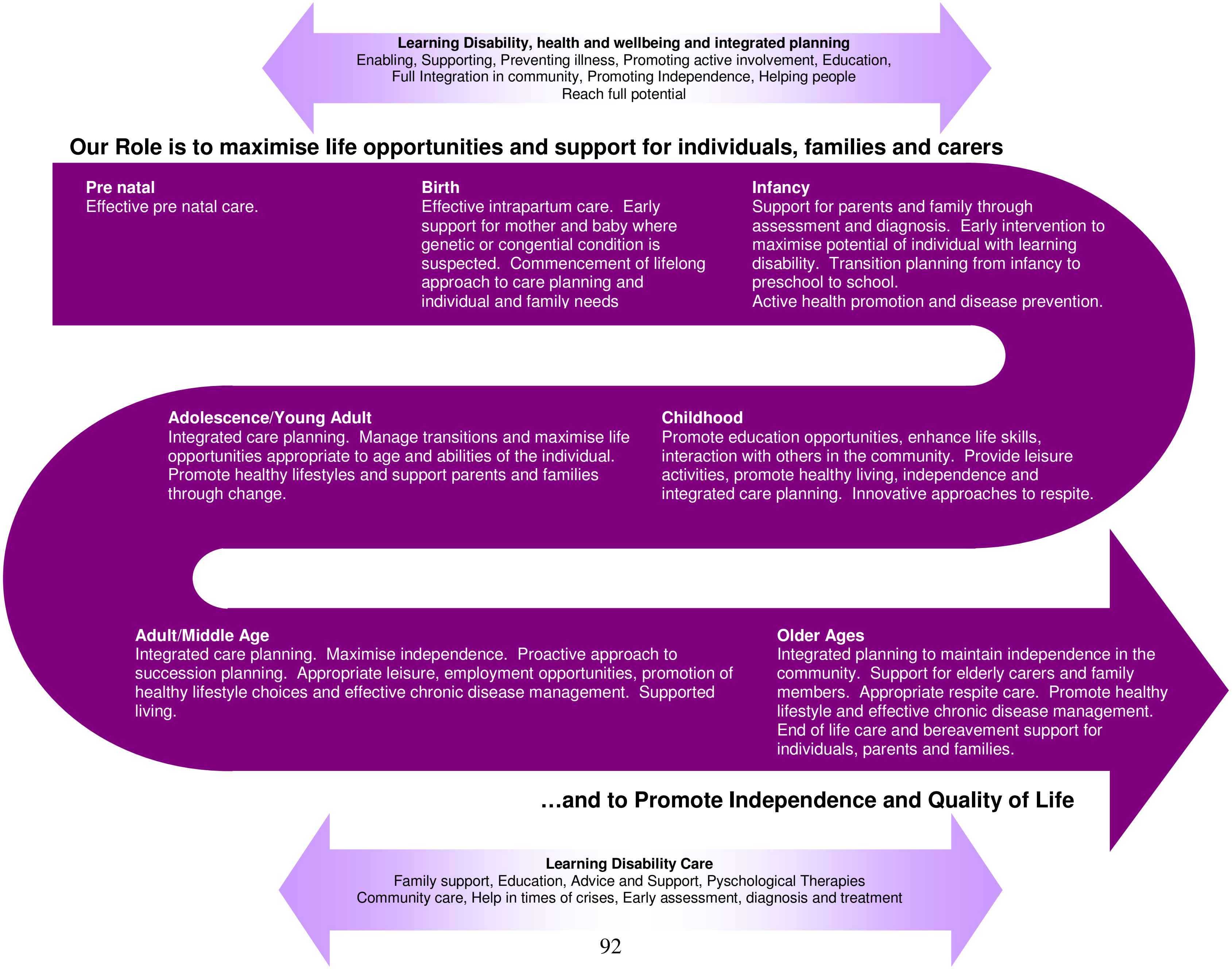
People with a learning disability must be treated as equal citizens, fully included in mainstream services and in the life of the community, empowered to participate actively in decisions affecting their lives, enabled to work together with their families and representatives and helped to use their individual strengths to reach their full potential. When developing services for people with a learning disability, we must not forget that a learning disability is a lifelong condition; as such, clients require more sustained services, not just individual episodes of care and treatment. It is also important to acknowledge that the provision of services for people with a learning disability is not solely a Health issue; it requires a multi-agency and integrated approach.

This life long approach encompasses:

- 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.

Figure 4 represents a life cycle approach to promoting health, wellbeing and independence for individuals with a learning disability, and support for family and carers.

Figure 4. A Journey Through a Lifetime



Learning Disability, health and wellbeing and integrated planning
Enabling, Supporting, Preventing illness, Promoting active involvement, Education,
Full Integration in community, Promoting Independence, Helping people
Reach full potential

Our Role is to maximise life opportunities and support for individuals, families and carers

Pre natal
Effective pre natal care.

Birth
Effective intrapartum care. Early support for mother and baby where genetic or congential condition is suspected. Commencement of lifelong approach to care planning and individual and family needs

Infancy
Support for parents and family through assessment and diagnosis. Early intervention to maximise potential of individual with learning disability. Transition planning from infancy to preschool to school.
Active health promotion and disease prevention.

Childhood
Promote education opportunities, enhance life skills, interaction with others in the community. Provide leisure activities, promote healthy living, independence and integrated care planning. Innovative approaches to respite.

Adolescence/Young Adult
Integrated care planning. Manage transitions and maximise life opportunities appropriate to age and abilities of the individual. Promote healthy lifestyles and support parents and families through change.

Adult/Middle Age
Integrated care planning. Maximise independence. Proactive approach to succession planning. Appropriate leisure, employment opportunities, promotion of healthy lifestyle choices and effective chronic disease management. Supported living.

Older Ages
Integrated planning to maintain independence in the community. Support for elderly carers and family members. Appropriate respite care. Promote healthy lifestyle and effective chronic disease management.
End of life care and bereavement support for individuals, parents and families.

…and to Promote Independence and Quality of Life

Learning Disability Care
Family support, Education, Advice and Support, Pyschological Therapies
Community care, Help in times of crises, Early assessment, diagnosis and treatment

Support for Families of Children with a Learning Disability

Children and young people grow and develop best in their natural families. Sometimes stress and/or financial issues can lead to families feeling under pressure or unable to cope, and requiring support and assistance from Health and Social Care services. The Equal Lives Review recommended that family support be remodelled to be more family directed and suited to the families' needs and wishes. To this end, respite services will be developed by moving away from inflexible residential provision towards a range of short break services, including home based support, community based activity, family placements and residential options.

Children with a Learning Disability

Enabling children with a learning disability to participate as fully as possible in education is a key element in maximising their potential in later life. The statutory responsibility for securing special education provision for pupils with special education needs (SEN) rests with the Education and Library Boards. There are approximately 13,271 (DE Census 2008) children with SEN statements, with increases in recent years both in the number of SEN children and in the complexity of their needs. Special education provision is matched to the individual needs of the child and can be delivered in a range of settings. The Department of Education provides a range of guidance material to schools, ELBs and relevant voluntary sector organisations to support their work in providing services to SEN pupils.

The Special Education Needs and Disability (NI) Order 2005 (SENDO) strengthened the rights of SEN children to be educated in mainstream schools. A Dispute Avoidance and Resolution Service (DARS) and an Advice and Information Service were introduced in 2005 to improve support for SEN children and their parents in dealing with schools and ELBs.

The Review of Special Educational Needs and Inclusion, due to be published in 2009, is expected to result in recommendations for improved interdisciplinary working between education and health professionals. A review of speech and language therapy provision has been undertaken and the recommendations will be considered jointly between DHSSPS and the Department of Education in relation to the way forward for speech and language therapy provision. An action plan is currently being developed, which will see a focus on pre-school interventions, and speech and language services for those children who attend mainstream schooling.

We want to see an emphasis given to adequate service provision as early as possible, or "right from the start" whereby health, social, developmental and education needs are identified and a coordinated plan of action put in place to address these needs. The joint DE/ DHSSPS group on issues of mutual interest will work to strengthen and develop links to ensure that planning, assessment and delivery of services is co-ordinated to meet children's needs.

Much of the work through schools to maintain and improve the mental wellbeing of children and young people, which is outlined in the Mental Health section of this Action Plan, also impacts on children with a learning disability.

Transition to Adulthood

A DE/ DEL/ DHSSPS inter-Departmental group to consider the transition arrangements to adult life for young people with SEN reported in early 2006 and recent monitoring indicates that all but one of the actions have been met in full. DE made available funding of over £2.4m from 2005/06 to 2009/10 to meet the DE-related recommendations, to strengthen the transition planning process in schools, by appointing 10 Education Transition Co-ordinators. Further funding, from the Children and Young People's Funding Package, of £200k over the period 2006/07 - 2007/08 was used to enhance life skills training and improve self-help and independent living for over 370 pupils in special schools through a range of school-based programmes.

A recent ETI survey, published in February 2009, has found that " the transition arrangements and provision for school leavers in almost all the school are of good and sometimes excellent standard. The work of the Transitions Co-ordinators, though at an early stage of development, is progressing well, a positive work ethic and approach is evident and good links have been established with the key stakeholders." As a result of this positive evaluation DE will mainstream the funding of the 5 Education and Library Board Transition Service.

DHSSPS also secured from the Children and Young People's Funding Package an additional £0.9m recurrent, for the improvement of day care for young people when they become 18 and are moving from children's services into adult services. 150 purposeful placements for young people on transition from special schools into the community have since been created. Funding has now been mainstreamed in order to maintain these placements.

DE, DEL and DHSSPS continue to work closely in developing joined-up services for children and young people with a learning disability, and especially for those young learning disabled people who are making the transition into adulthood. A sub-group of The Ministerial Sub Committee on Children and Young People is currently developing an Action Plan which is focussing on transition of young people from school to adulthood. The plan will contain actions to further strengthen policy delivery and post school provision. The timescales for the delivery of a range of actions are being considered at present.

Day Opportunities

A cultural shift away from a reliance on day centres will be encouraged, towards alternative options, including further education and supported employment, where appropriate. This will enable individuals with a learning disability to participate in society through education, and work based activities that will improve their skills and allow them the opportunity to integrate with others.

Succession Planning

Demographic changes mean that individuals with a learning disability are living longer, often being cared for by elderly parents and relatives. This can increase the burden on services for such individuals and their carers. Services need to be developed in line with these changes to the learning disability population, to ensure that all clients have access to the services they need.

Each individual should have an appropriate care plan to ensure they have access to all the services required to accommodate their needs and the needs of their carer/s. HSC Trusts must work together with the community and voluntary sector to achieve this.

Advocacy

The Equal Lives Review concluded that a new service model needed to be developed, drawing a line under the notion that people with a learning disability should be grouped together and segregated from services enjoyed by the rest of the population. This new model must be based on social integration and encourage people with a learning disability to fully participate in community life. This includes ensuring that people have greater choice and more control over their own lives. To do this, we must develop person-centred approaches in all services and ensure all users have access to Advocacy and Direct Payments, where appropriate to their need.

Many people with a learning disability find it hard to make their voices heard. Advocacy gives people the opportunity to get involved in decisions about their own care plan, and make their opinions heard.

Access to Health Care

An increasing number of people with a learning disability are living longer and healthier lives. Greater numbers of children with complex health needs and multiple disabilities are surviving into adulthood. People with a learning disability will be living in local communities rather than having their homes in specialist hospitals.

In order to ensure that people with a learning disability enjoy the benefits of such changing circumstances, commissioners and service providers will need to actively ensure that there is equity of access to the full range of healthcare provision enjoyed by the general population. This includes for example, improved and supported access to primary care services (GP, dentistry, optometry and the full range of health screening), secondary care services (particularly in-patient acute services), mental health services, sexual health services, and end of life services, if necessary.

Good health however begins with emphasis being given to promoting good physical and mental health, and ensuring that people with a learning disability, throughout their lives are involved in strategies and schemes to build resilience, and prevent the onset of ill health.

A Directed Enhanced Services for adults with a severe learning disability has been introduced. It is designed to improve primary healthcare through the introduction of annual health checks, and could enable the introduction of health facilitators and / or other options to liaise with individuals and their families and other relevant agencies to ensure healthcare needs are met.

Individual health actions plans will also be developed on a person-centred basis, and will involve people with a learning disability and their carers in effective multi-agency and multi-disciplinary care planning, prepared with and for the individual concerned and will identify the responsible professional or agency for addressing the health needs identified.

Optometry

There are already some examples of good practice in relation to people with learning disabilities accessing mainstream services. An example is vision screening for people with learning disabilities in the Belfast Trust. Staff from the low vision clinic in the Royal Hospital, supported by community learning disability nurses and sensory support workers have addressed a number of the barriers that prevent people from accessing opticians in their local community. People are provided with information before the assessment and prepared for the equipment and tests that will take place. The service is provided in a location that is familiar to the individual. An evaluation has demonstrated that this has been effective in identifying a number of people with vision difficulties who otherwise might not have been spotted.

Dental Services

The findings from a review of the literature related to the oral health of people with disability, confirm that people with a learning disability have similar oral diseases but poorer oral health and poorer health outcomes from care than the general population (Fiske et al 1999; BDA, 2003).
The care of patients with moderate to severe learning disabilities falls to the Community Dental Service (CDS), which is a small specialist Trust based service. While significant improvements have been made over the last number of years to dental services for people with a learning disability, more needs to be done. The Review of the Community Dental Service (2003) recommended that patients with special needs should be the focus for clinical activity for the CDS. For this shift in focus to be successful, there is a pressing need for training, both in terms of continuing professional development and in recognised training pathways, to provide specialist clinicians.

The DHSSPS undertook a Survey of Dental Services to People with Learning Disabilities in Northern Ireland in December 2005. While progress has been made on many fronts in relation to the recommendations contained in the survey, lack of resources and the absence of key staff has prevented others being taken forward. We must endeavour to ensure that these recommendations are implemented, so that individuals with a learning disability have the same level of access to community dental services, and can enjoy the same standards of oral health as the rest of the community.

Access to Health Information

The Equality Commission has produced a report on the ease of access to health information for people with a learning disability. The Department is working together with the Equality Commission to ensure that all those who have a learning disability have access to the health information they need in an appropriate format that best suits their needs.

Respite

Respite care is an important component of the wide range of health and social care services provided in response to assessed care needs. Funding has been secured in the Comprehensive Spending Review 2008 -2011 to invest in additional respite packages for people with a Learning Disability. This funding will be used to provide an additional 200 new or enhanced Learning Disability respite packages over the CSR period to benefit at least 800 people by 2011. This includes children, young people and adults.

The Department of Health, Social Services and Public Safety is piloting a new statistical data collection during the first quarter of 2009 to begin the process of monitoring respite care. This will inform the next Comprehensive Spending Review period.

Re-settlement in the Community

The resettlement of patients from Learning Disability hospitals has been a Departmental policy for many years, but the Bamford Review brought it to the fore as one of its key recommendations. An Action Plan was announced in January 2007 to ensure that by March 2009 no child would be permanently resident in a learning disability hospital. The plan also provides for an increase in the number of patients resettled each year. The Programme for Government (January 2008) set a goal to ensure that, by 2013, anyone with a mental health need or a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital.

The resettlement programme must be supported by improved community care services. The process of resettling patients is a complex one, involving both community and hospital multi-disciplinary teams along with the patient and family and DSD and the NI Housing Executive, as lead Department and lead provider of the Supporting People programme for supported living.

A patient is identified for resettlement only when it is clinically appropriate and it is clear that the patient's needs can be met and quality of life can be improved by the placement – the concept of "betterment". The Executive appreciates that there is apprehension among families of some people who have been in hospital for considerable periods of time and accepts that there will be particular challenges in ensuring betterment for some of these people.

The Executive remains committed to the goal of having no-one unnecessarily remaining in hospital. A target has been set for a reduction in long-stay inpatients by 2011, in line with resource availability up to 2010/11, and good progress is already being made to achieve this target. It is acknowledged that additional resources will be required in the following two years to achieve the overall 2013 goal.

Capital Planning

The principle of "betterment" must apply to individuals, who are part of the resettlement process. Targets set for the resettlement of patients from learning disability hospitals will present considerable challenges, and discussions are ongoing between the HSC, the DHSSPS and the DSD on the associated planning, financial and operational issues. For example, the HSC and the NI Housing Executive will need to agree proposals for the future development of new residential schemes to facilitate the resettlement of people into the community.

The relocation of children's services from Muckamore Abbey Hospital will also require additional residential schemes to be developed, which will offer long-term, shared care and respite provision for children. Further proposals for respite services must also be agreed to ensure the target of 200 extra packages will be available by March 2011.

Community Services and Support

The Resettlement programme goes hand in hand with investing in community infrastructure and appropriate support mechanisms. Multi-disciplinary Learning Disability teams provide a key service by supporting service users, their carers and families within the community, and will continue to do so as progress is made towards resettling all clients from learning disability hospitals into the community. However, with the shift towards community based service provision, reduction in utilisation of hospital based care, and the subsequent management of those with complex needs, there needs to be a clear understanding of what is required within community based services to address demographic change and new patterns of care delivery.

Voluntary and community groups also have an important role to play by providing various services to complement the work of the Learning Disability teams, such as day services, vocational training, supported employment and housing, respite, etcetera.

Complexity of Needs

There remains the potential for a new long stay population within learning disability hospitals to develop, especially those people who are experiencing frequent admissions and are involved in "revolving door" experiences. Many of these people present with very complex needs, associated with very challenging behaviours. It is essential, therefore, that community services are developed to meet such needs, and in particular the skills mix of community learning disability teams. Only when these challenging behaviours are addressed within the full range of community settings, will there be a reduction in potential new long stay population of our hospitals.

Assistive Technology for people with a Learning Disability

When considering the needs of people with more profound and multiple disabilities the potential for technological advancements to maximise opportunities for independence needs to be more fully considered. The Bamford Review recommended that housing planners and service providers should accumulate and disseminate detailed knowledge on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community. A consultation exercise is due to be taken forward shortly by the European Centre for Connected Health.

Forensic Issues

The Bamford Review recognised that individuals with a learning disability can be particularly vulnerable when in contact with the criminal justice system. This can occur in police stations, when attending court, in prison and young offenders' centres and on probation.

The Review recommended a full range of inpatient care, including high, medium and low security services. In addition, there is a need for Community Forensic Services to support the full range of people with a learning disability in the community, including those who have been discharged from hospital or released from prison.

In order to start developing these services, the HSC will be asked to produce a plan for the future implementation of forensic services. A new PfA target will be set for 2010/11 to achieve this.

A Service Framework for Learning Disability – Promoting Quality and Performance Improvement.

The Learning Disability Service Framework being developed will identify a range of service standards to ensure that people with a learning disability and their families are clear about the support they can expect from these services. While the basic premise of the Learning Disability Service Framework is that people with a learning disability should access the same HSC services as other people, there are occasions when special expertise or support is required. As services become more inclusive, the volume and range of separate services will decrease as learning disability expertise is developed within mainstream HSC services.

DELIVERING THE BAMFORD VISION – LEARNING DISABILITY ACTION PLAN

Equal Lives Values

1	Citizenship	People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.
2	Social Inclusion	People with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community.
3	Empowerment	People with a learning disability must be enabled to actively participate in decisions affecting their lives.
4	Working Together	Conditions must be created where people with a learning disability, families and organisations work together in order to meet the needs and aspirations of people with a learning disability.
5	Individual Support	People with a learning disability will be supported in ways that take account of their individual needs and help them to be as independent as possible.

These five values that underpinned the service development recommendations in the Equal Lives Review have been carefully considered during the drafting of this Action Plan. All actions detailed in the following **Learning Disability Action Plan** will state which of the values they comply with, numbered 1 to 5.

Themes:

1. Promoting positive health, well-being and early intervention
2. Supporting children, adults and older people to be independent and reach their full potential
3. Supporting carers & families (to include information and advice, respite)
4. Providing better services to meet people’s needs
5. Providing structures and legislative base to deliver the Bamford Vision

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Ensure that persons with a learning disability have equal access to the full range of primary health care services to improve the physical and mental health inequalities experienced by them A directed enhanced service (DES) to work in partnership with multi-disciplinary learning disability team and primary care staff will be developed across the region Develop individual health actions plans on a person centred basis involving people with a learning disability and their carers	HSC Primary Care, Acute Hospitals, Multi-Disciplinary Learning Disability Teams, Other Providers	A directed enhanced service (DES) will be rolled out regionally for adults with learning disabilities and will be provided in 90% of GP practices which will: • Develop and maintain a register of clients with a learning disability • Develop individual health action plans for children and adults with a learning disability. • Provide a recall system • Provide annual health checks integrated into the personal health record • Involve carers and support workers • Provide a review mechanism to include outcomes and actions from assessments	2011	• Better health promotion and interventions that focus on improving the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and dental health • Health problems detected and treated earlier to minimise risk to the person's health and well-being • Enhanced usage of generic health services • Promote a team based approach to care with improved liaison with carers, health and social care professionals • Seamless care provided • Provide accessible health & social care information to people with a learning disability and their carers	1, 2, 3,4 and 5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
		• Develop specific health facilitation posts where appropriate • Allow full access to the full range of health screening services that are available to the general population • Develop screening and early identification mechanisms regarding mental health			
Publish a revised cross-sectoral Promoting Mental Health Strategy	All Departments, led by DHSSPS Investing for Health Group	A renewed emphasis on mental health promotion across all sectors, taking account of lessons learned from previous work	By December 2009	Better mental wellbeing in the population	5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Increase oral health promotion programmes aimed at clients with a Learning Disability and their families	HSC Board in collaboration with wider HSC	Development of regional and local programmes that will empower LD clients, their carers and families to improve oral health	Ongoing	Increased awareness of oral health as a personal priority for people with a Learning Disability Increased knowledge of personal measures that can be taken to improve or maintain oral health Improved attendance at primary Dental Care services Reduced referrals to Specialist/Secondary Care	3, 4, 5
Develop, consult and implement a 10 year Early Years Strategy.	DE led Ministerial sub-committee for Early Years.	Consultation on Strategy Implementation Plan	Autumn 2009 Spring 2010	Prevention and lessening of emotional and behavioural problems in young children by ensuring access to - physical nurturing - nourishing food - exercise and play (particularly outdoor play) - adequate sleep - emotional and social support	5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Introduce a revised curriculum which provides opportunities through Personal Development and other areas for young people to develop the skills they need to cope with challenging personal situations such as violence against women and children; self-harm etc.	DE – Curriculum & Assessment Team	All schools to have implemented the revised curriculum	By September 2009	Pupils benefit from the opportunity to develop the skills they need to cope with a range of challenging personal situations; teachers receive guidance and support, including training, to implement the revised curriculum	1, 2, 4, 5
Produce guidance and support material for post primary schools on proactively promoting positive emotional health and well being among staff and pupils Produce guidance for schools on the management of critical incidents and ensure consistent support to schools across all board areas	DE – Pupil Support Unit	All schools understand their role in promoting positive outcomes for pupils There is consistent minimum provision across all post primary schools within the curriculum and pastoral care supports	Commencing Autumn 2009 Ongoing	All pupils and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies	2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Develop proposals for developing resilience among primary aged pupils and those in special schools for consultation; to implement agreed new services	DE – Pupil Support Unit		Commencing Autumn 2009.	All primary age pupils, those in special schools and all staff should benefit from the overall programme. Vulnerable pupils will benefit from the improved pastoral care within the school and the effective links with external support agencies	1, 2, 4, 5
Support schools in their work to create an anti-bullying culture with guidance and materials which tackle all forms of bullying, including homophobic bullying, are up to date and reflect the dynamic nature of the problem	DE – Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils are confident that their concerns about bullying will be dealt with in an appropriate and timely manner	1, 2, 4
Implement a 10 year Strategy for Sport and Physical Recreation	DCAL	A greater emphasis on the mental benefits of regular participation in sport and physical recreation	From September 2009	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation	1, 2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Progress the Tackling Sexual Violence and Abuse Strategy 2008-2013	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of sexual violence and abuse	2, 3, 5
Implement the domestic violence strategy *Tackling Violence at Home*	DHSSPS/ NIO as joint leads with other relevant Departments and agencies	Annual action plans implemented to achieve strategic objectives	Ongoing	Reduce levels of mental trauma as result of domestic violence and abuse through funding a range of support/education programmes.	2, 3, 5
Commission a scoping study of Pastoral Care arrangements in FE	DEL	To ensure that the FE sector is fully aware of and responsive to the needs of its students including having in place comprehensive pastoral care arrangements across all campuses to identify and address any problems experienced by students.	Scoping study commissioned by Public Procurement. Commenced July 2009 Findings of scoping study by December 2009 Implementation plan for any identified actions by March 2010	More effective, comprehensive and consistent pastoral care services for students across all 6 regional colleges	1, 2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Promoting positive health, well-being and early intervention

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Review of the NI Child Health Promotion Programme (Health for all Children -Hall 4) to ensure early identification and intervention from the ante-natal period through pre-school and school age years	DHSSPS; PHA; Regional Health for All Children Group; and HSC Trusts	Redesign of Child Health Promotion Programme to ensure best practice is being delivered	Implementation from 1 January 2010	Early identification of disability to secure early intervention and support	1, 2, 5
Increase access to dental hygienists for education and regular appointments	School of Hygiene HSC	To train increased numbers of Hygienists Develop Oral Hygiene Services Utilise skill mix in workforce to deliver increased oral hygiene programmes to the Learning Disability population	To progress by 2011 and review progress against longer term targets.	Improved oral hygiene for people with a Learning Disability Reduce levels of dental decay Reduced usage of dental general anaesthetic & intravenous services	2, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Publish a report on the 'Promoting Social Inclusion' work led by OFMDFM with input from Departments and the sector as appropriate	OFMDFM, Equality / Rights & Social Need Division	The work of the PSI Group for people with disabilities covers a range of topics and cuts across Departmental boundaries – the report will provide a composite set of recommendations for Executive consideration which will improve the quality of life for people with disabilities.	Autumn 2009	Improved social inclusion of people with disabilities across a wide range of areas and activities examined by the PSI Group including: • Access to Employment; • Children, Young People and their Families; • Housing, Transport, Information and Access; • Legislation, Citizenship, Language and Attitudes, and • Lifelong Learning, Arts, Sports and Culture	1, 2, 3, 4, 5
Publish an action plan for the implementation of recommendations arising from the PSI report (above)	OFMDFM Equality / Rights & Social Need Division (with input & agreement from other Departments as necessary)	As above. The action plan for this PSI work will be taken forward in the context of the wider 'anti-poverty and social inclusion' strategy - Lifetime Opportunities	Agreed action plan by March 2010	As above	1, 2, 3. 4, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Mainstream the funding of 5 Education and Library Board Transition Service Pilot Project, subject to positive outcome of ETI Inspection Report	DE - Special Education Branch	To strengthen the transition planning process in school and provide a co-ordinated approach to transition planning with other statutory agencies and advice givers	Consider and evaluate outcomes of ETI Inspection Report which has been published in February 2009 and, if positive, mainstream funding from 2009/10 financial year	This action will benefit all pupils with a statement of special educational needs (including those pupils with a mental health problem or a learning disability) by ensuring that Education and Library Boards/the Education Skills Authority provide a cohesive approach to transition planning and that pupils are supported and informed about post school options and placements	2,3,5
Consider and develop, under the auspices of the Transitions Sub-Group of the Ministerial Sub Committee on Children and Young People, an Inter-departmental Action Plan to further strengthen policy delivery and the provision for young people with special educational needs as they make the transition from school to adulthood	DE – Special Education Branch, as Chair and Secretary to the Sub-group. Action Plan to be implemented by all participating Departments, i.e.; DE, DEL, DHSSPS, DSD, NIO, JJS, OFMDFM	To implement, through inter-departmental working and collaboration, an action plan to consider and remove barriers to the successful transition of young people with special educational needs from school to adulthood and the provision of continuing education, work opportunities and appropriate health and social care interventions	May 2009	Benefits young people with special educational needs (including those pupils with a mental health need or a learning disability) as they make the transition from school to adulthood	2, 3, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Issue Review of SEN and Inclusion Policy Proposals for public consultation. Develop agreed guidance and quality indicators which will cover issues such as:- - early identification and intervention; - the effectiveness of strategies and services employed; the effectiveness of funding and delivery of resources	DE Review of SEN and Inclusion team	A shared commitment between DE and DHSSPS to the planning and timely provision of locally commissioned services which are child centred, easily accessible, effectively and consistently delivered to those children and young people who need them	During 2009 (subject to agreement of Executive to move to consultation phase).	Every child and young person, facing barriers to learning and social inclusion (in particular, those with disability or health needs and social and emotional factors) is given a fair and equal chance and provided with the necessary support as early as possible to help them achieve their potential	1, 2, 5
Commission research to ascertain the impact on people with learning difficulties of the policies and actions contained in the Accessible Transport Strategy	DRD	The research would provide an assessment of how accessible services supported by DRD are to people with a learning disability. It would also consider areas such as the provision of travel information, training provision and personal safety and confidence issues	Report commissioned April 2009 Date for delivery of draft report by end of October 2009	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability	1, 2, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Complete an analysis of DEL provision across the further education and training sector for those with a disability, including those with special educational needs or with mental ill health. This work to build on detailed reviews of Students with Learning Difficulties and/or Disabilities provision in FE, barriers to Training for Success and also recent inspection reports of provision	DEL Education and Training Inspectorate	Identification of areas for future DEL action where appropriate; also, an indication as to whether individuals have access to the services they require consistently across further education and training	Report finalised by June 2009	More effective services for individuals accessing DEL programmes and services	1, 2, 4, 5
Consider the findings of the overarching review and any strategic implications for DEL and develop an action plan	DEL	Strategic action plan to address cross-departmental issues identified that impact on individuals with mental ill health and /or learning disability	Action plan in place for 2010/11 Key milestones - consider resource implications, both staff and financial - identify delivery mechanisms - seek approvals to proceed	More effective services for individuals accessing DEL programmes and services	1, 2, 4, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Undertake scoping study of provision for those not in education, training or employment (NEET), including those with mental ill-health and/or learning disability	DEL in liaison with other organisations, including PHA	Determination of available provision	Scoping study completed by Autumn 2009	Improved information to enable consideration of need for cross-Departmental strategic approach/ further actions	1, 2, 4, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Examine the benefits for NI of adopting similar partnership arrangements to those put in place by the Scottish Executive that detail the roles and responsibilities of agencies involved in meeting the educational, health and social needs of people with additional needs accessing DEL provision	DEL jointly with DHSSPS/ HSC and other relevant Departments	Clear understanding of the respective roles and responsibilities including information sharing between DHSSPS and its agencies, DEL and its delivery partners and other agencies in addressing the needs of these learners (in particular assistance with assessment, personal care, transport etc), and that the findings are disseminated locally to DEL delivery partners and HSC	Stage 1: Scope benefits by End 2009 -Identify resource to undertake project - establish steering group for the project Stage 2 : Bring forward proposals to develop partnership working guidance in 2010. Report progress to Inter – Ministerial Group	Better awareness of the challenges of delivering provision to learners with profound and complex needs and clear signposting for individuals, families and providers Better informed healthcare and other professionals in relation to the education and training programmes and services relevant to and accessible by adults with mental ill health and/or learning disability	2, 4, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Develop new exhibitions / exhibits to include provision for those with learning difficulties	W5	Include exhibits/Exhibitions with sensory experiences, graphics and limited text to be inclusive to those with learning difficulties.	Ongoing	Inclusion and enjoyment in exhibition	1, 2, 4, 5
Carry out a policy evaluation of the Supporting People programme	DSD	Examination of the governance arrangements, commissioning process and funding arrangements, to ensure compliance with the policy intention that Supporting People is to fund advice and guidance for relevant individuals/organisations	March 2010	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it	1, 5
Collaborative work between DSD, NIHE, DHSSPS and HSC	Supporting People Commissioning Body, chaired by the Northern Ireland Housing Executive	Ensure that the accommodation needs of vulnerable adults are included in the delivery of the Social Housing Development Programme in as far as resources are available at that time	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it	2, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Publish action plan of how NICS will promote diversity	CHR to lead with all other NICS departments	Equal opportunities monitoring of the NICS workforce. Review the 2008 – 2011 NICS Employment, Equality and Diversity Plan	December 2009	A working environment where everyone has a right to equality of opportunity and individual differences are valued and respected The NICS workforce will be more representative of the community by attracting a more diverse applicant pool for advertised posts including applications from those with a disability	1, 2, 5
To develop mandatory equal opportunities and diversity awareness training to all staff at all levels within the NICS	CHR to lead with all other NICS departments	Ensure that all employees are aware of their duties and responsibilities to ensure equality in the workplace and to fully include employees with disabilities, including learning disabilities, in the working environment	Mandatory Training to commence in October 2009. To be complete by June 2010	To raise awareness of issues facing staff and customers with disabilities including those with a learning disability by ensuring all NICS employees are trained in equal opportunities and diversity awareness	1, 2, 5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Improve communication methods and access to information for people with a learning disability	PHA to lead in partnership with HSC Board and Trusts, working with DEL and DSD	Increase in information and advice services, at least some of which will be delivered by voluntary sector Provision of information in easily accessible formats to cater to users' needs – this will involve training for staff in contact with those with a learning disability Reasonable adjustments should be made to provide information to make services more accessible	Ongoing	Better support for service users and carers in understanding the services and making their views heard	1, 3, 4, 5
Education and Library Boards to continue to develop their information and advice service	DE	Improvement of statutory information and advice service	Ongoing	Better support and advice for parents, pupils and schools in understanding the services available	1,3,4,5

LEARNING DISABILITY ACTION PLAN

Theme: Supporting children, adults and older people to be independent and reach their full potential

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Resettlement of long stay patients from learning disability hospitals	DHSSPS HSC DSD NIHE	25% reduction in the number of long-stay patients in learning disability hospitals (baseline 2007/08) Anyone who has a learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital	By 2011 By 2013 (Programme for Government Target)	More people with a learning disability able to live independent lives safely in the community	2, 4, 5
Development of a plan by Local Commissioning Groups demonstrating what advocacy services are currently in place and the vision for the future	HSC	To enable individuals and carers to actively engage in care planning and quality assurance	By March 2011	People with a learning disability and their carers will be better informed to make their own decisions and will have a greater opportunity to have their voices heard and influence their care which will improve their independence	2, 3

LEARNING DISABILITY ACTION PLAN

THEME: Supporting carers

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Complete a joint Review of Support Provision for Carers	DHSSPS/DSD	Improved support services for carers who look after people of all ages who have a learning disability or mental health issues	Autumn 2009	People with a learning disability or mental health issues are supported to live independent lives in their own home for as long as possible and carers are supported in their caring role so that they can continue to care for as long as they wish and are able to do so	2, 4, 5
Improve regional information on provision of respite care	DHSSPS/ HSC	Pilot data collection and refine as necessary Monitor respite care provision in NI on a quarterly basis	By December 2009 Ongoing	Respite provision can be better planned and monitored	1, 2, 5
Support to families with a child with a learning disability	HSC	Family Support Plans which will identify unmet need and changing needs as children grow The appointment of a key worker to support families and carers at time of diagnosis and beyond and to co-ordinate and link in with other services required	March 2011	Families will be provided **with more co-ordinated support** at an earlier stage	3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Supporting carers

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Support for individuals with a learning disability and their carers and families by the provision of short breaks and respite opportunities	HSC in collaboration with voluntary and community sector	The provision of 200 additional respite packages benefitting 800 people (baseline 2007/08) There should be a move away from traditional respite to the delivery of a more flexible and responsive service, taking full advantage of Direct Payments, self-directed support and other innovative forms of respite	March 2011	People will be afforded more flexible respite options which will help maintain their care settings by supporting their carers.	3, 4, 5
Increase uptake of Direct Payments	HSC	Double the number of recipients of Direct Payments in learning disability programme of care (baseline June 2007)	By March 2011	Give service users and their carers greater choice in the support they receive	2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS	VALUES MET (numbered 1 to 5 – see above for definitions)
Provide a service wide, supportive, quality driven environment to promote Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Submit consultation schemes under section 19 of the Health and Social Care (Reform) Act (Northern Ireland) All organisations to embed PPI consistently as part of organisational activity Establish leadership and accountability arrangements for PPI Monitor and Evaluate progress; agree priorities and targets for subsequent year; report annually	Jan 2010 Apr 2010 Apr 2010 From Apr 2010	• Improvements in service design. • Improvements in user and carer experience of services. • Promotion of social inclusion • Improved safety and quality of treatment • Reduction in complaints • Improved management of demand • Understanding of how and when care goes wrong • Reduction of risk	1, 2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Maintain direction of HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	At least 80% of HSC spend on learning disability services should be on community services	Ongoing	Community services will promote integration of individuals into society	4, 5
Develop a Service Framework for learning disability services	DHSSPS	Strengthen the integration of health and social care, enhance health and wellbeing, promote evidence – informed practice, focus on safe and effective care and enhance multidisciplinary and inter-sectoral working	By December 2010	Set out the standards of care that people who use services, their family and carers can expect to receive	2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Increase levels of community learning disability services	HSC Board in collaboration with PHA and HSC Trusts	Increase the LD community based workforce commensurate with the improvement in community infrastructure to meet the needs of the learning disabled population.	2011	Greater access to community learning disability services	2, 4, 5
Improve information systems on provision and use of mental health and learning disability services	HSC Board in collaboration with HSC	Anonymised database on inpatients in learning disability facilities available at regional level for use by DHSSPS and HSC bodies Extend the database to include users of community based services	October 2009 April 2011	Services can be better planned to meet needs and monitored to ensure service improvement, based on up to date local information	4,5
Complete and maintain a map of learning disability services across Northern Ireland	PHA/ HSC Board in collaboration with HSC and voluntary and community sector	Compile mapping information on all learning disability services provided	April 2010 and ongoing	New services can be better targeted and gaps in existing services can be filled	1,2,3,4,5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Review range of facilities used to provide both inpatient and community based mental health and learning disability services and agree future pattern of provision	DHSSPS/HSC	Plan for facilities required to deliver mental health and learning disability services	The Capital Priorities Review was completed in September 2008. A Policy Infrastructure Forum has been established to address new requirements and ongoing prioritisation	Services will be delivered in appropriate, accessible, fit for purpose buildings	4, 5
Complete a workforce planning study for mental health and learning disability health and social care services	DHSSPS (HR Directorate) in collaboration with HSC	Agree a prioritised action plan to take forward recommendations from the commissioned workforce study	December 2009	Adequate numbers of appropriately trained staff to deliver services needed	4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Improve services for people with challenging behaviours and their carers	DHSSPS DE HSC	Production of agreed regional guidelines in partnership with service providers and the voluntary sector on the management of challenging behaviours within services	March 2011	Assist carers in managing challenging behaviours e.g. by directing to appropriate "behaviour services"	4, 5
Improve collaboration between education and health sectors in meeting the educational needs of children and young people with significant challenging behaviours	DHSSPS DE	Production of agreed agreed protocols	March 2010	Smooth transition between health and education services to appropriate placements	1,2,3,4,5
Training of primary dental care professionals to improve quality of care provided to patients with a Learning Disability	Consultant in Specialist Care Dentistry (SCD) Specialist network in SCD NI Medical, Dental Training Agency (NIMDTA)	Provide training in disability awareness and communication skills Undergraduate and postgraduate training in provision of dental care to people with a Learning Disability	2011 initially and progress towards longer term target	Increased local availability of dental care to Learning Disability population Increased local levels of dental care Reduced levels of secondary referrals to SCD specialist teams Increased access to mainstream primary dental care services	2, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Establish consultants in Specialist Care Dentistry (SCD)	DHSSPS School of Dentistry HSC	Appoint consultant in SCD Fund additional SCD consultant position	March 2011	Improved quality of services for patients with severe / complex Learning Disability needs Strengthen SCD network; provide absence cover; reduce waiting lists	1,5
Establish training pathways in Specialist Care Dentistry (SCD)	DHSSPS School of Dentistry HSC	Specialist registrar positions in SCD Training for community based specialists in SCD Training for Dentists with Special Interests in SCD Training for Primary Dental Care Practitioners	2011 initially and progress towards longer term target	Increased local availability of dental care to Learning Disability population Increased local levels of dental care Reduced levels of secondary referrals to SCD specialist teams Increased access to mainstream primary dental care services	1, 2, 5
To provide assessment and treatment for children with a learning disability Provide suitable respite facilities to ensure children do not have to remain in hospital	HSC Board and PHA in collaboration with wider HSC	Provide an 8 bedded assessment and treatment unit at Iveagh Provide 8 respite places. The location / locations of these respite places have to be determined and will provide residential and respite care for children who challenge services	January 2010 In line with agreed DHSSPS Capital Priorities	To ensure those children affected are looked after in the safest, most suitable location	4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Establish a Northern Ireland Forensic Mental Health and Learning Disability Steering Group involving users of services and carers and the relevant agencies at senior level	HSC with other relevant agencies	A co-ordinated approach across HSC and criminal justice agencies to improve forensic mental health and learning disability services	September 2009	Better joined up services for people who need forensic mental health & learning disability services	4, 5
Develop a plan for a community LD Forensic Service	HSC with other relevant agencies	A plan for the future implementation of services, providing specialist low secure community accommodation and community based forensic services	By March 2011	Improved forensic learning disability services delivered by appropriately trained staff	4, 5
Inclusion of learning disability in all service frameworks.	DHSSPS	The standard and quality of care for people with a learning disability will be improved. All services should be accessible to people with a learning disability and all service frameworks should explicitly reference the needs of people with a learning disability	Ongoing	The framework will improve the health & well being of people with a learning disability through promoting social inclusion, reduce inequalities in health & wellbeing, and improve quality of care. They will be better supported to live in the community which will reduce the need for them to be cared for in learning disability hospitals.	2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Completion of a needs assessment to inform the future need for and provision of learning disability services.	DHSSPS DSD DEL HSC Board and PHA DE, who already have a statutory assessment process in place within the SEN framework	To develop a joint policy to progress inclusive and co-ordinated planning processes for services to inform comprehensive spending reviews.	2010/11	This will improve the services provided to those with a LD as services will be co-ordinated.	4, 5
Improve the experience of those with a Learning Disability accessing the HSC in all care settings	DHSSPS HSC	Training of staff to make them more aware of the needs of people with a learning disability.	Ongoing	Staff will be better equipped to recognise the needs of people with a learning disability and to deal with them appropriately with respect to their disability The experiences for people with a learning disability in all HSC settings will be improved. This will help them achieve the best outcomes from interventions and improve their health	2, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Improve the information provided to people with a learning disability to ensure appropriate health and social care is given where needed.	DHSSPS HSC	Implementation of best practice identified in the Equality Commission Report into the accessibility of health information in Northern Ireland for people with a learning disability. Passporting for both children and adults should be developed and rolled out (for example, the Sixth Sense project in SHSCT)	Ongoing	Enhanced exchange of information between individuals, their families and carers and HSC Services.	2,4,5
Develop a Regional Bed Management Protocol for those with a learning disability.	HSC Board to lead in collaboration with HSC Trusts	A bed management protocol which will cover the 5 Trusts and 3 hospitals	December 2009	Safer and more effective access to care for those with a learning disability	5
Increase the provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community	DHSSPS DEL (Disablement Advisory Service) DSD (benefits)	Provide better day support opportunities, including employment opportunities, recognising the impact of demographic changes	March 2011	Opportunities tailored to the needs of people with a learning disability promoting their inclusion in society	1, 2, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing better services to meet people's needs

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Improve transitions planning for all children with statements of special educational needs	DE, Education and Library Boards, DHSSPS and HSC	A shared Transitions Plan between education and health and social care sectors. Multi agency planning to facilitate improved planning and delivery at local level	Ongoing	Person-centred planning to meet the needs of the individual	1, 2, 3, 4, 5

LEARNING DISABILITY ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Establish Health and Social Care Mental Health and Learning Disability Task Force	HSC Board and PHA to lead	A co-ordinated approach across HSC to improving mental health and reforming mental health and learning disability services in line with Bamford	By October 2009	Task Force will be charged with ensuring that services are reformed and modernised in line with Bamford vision	4, 5
Establish Bamford Monitoring Group	Patient Client Council	Provide a challenge function on the extent to which the reform of services is working	By October 2009	Service users and carers will have an opportunity to feed back their views to Minister on how services are meeting their needs	1, 2, 3
Inter-Departmental Ministerial and Implementation groups to continue	DHSSPS (with other Departments)	A co-ordinated approach across NI Executive improving mental health and reforming mental health and learning disability services in line with Bamford	Ongoing	Better joining up of services across agencies	1, 2, 5
Introduce new mental capacity and mental health legislation	DHSSPS (with other Departments)	Commence new mental capacity and mental health legislation	Post 2011, exact timing depending on legislative programme	A consistent approach, with appropriate safeguards, to decisions - about care, treatment, property or assets – which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reason	5

LEARNING DISABILITY ACTION PLAN

THEME: Providing structures and legislative base to deliver the Bamford vision

KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TIMETABLE FOR COMPLETION AND KEY MILESTONES	BENEFITS (to people with mental health need or a learning disability)	VALUES MET (numbered 1 to 5 – see above for definitions)
Introduce a small amendment to the Mental Health (NI) Order to enable patients to apply to the court to replace their nearest relative	DHSSPS	An amendment to the 1986 Order enabling patients to apply to court to replace their nearest relative	By March 2011	Patients will be able to challenge the appointment of a nearest relative. This will be important in situations where the relationship with the nearest relative has broken down or where there is a history of abuse by the nearest relative	5
Issue guidelines to health trusts advising of a European Court of Human Rights judgement requiring safeguards for those deprived of their liberty for their protection	DHSSPS	Guidelines issues to health trusts	By December 2009	Those deprived of their liberty for their protection in nursing homes and hospitals and their relatives and carers will be consulted on the nature and extent of the deprivation	5

Appendix 1

HUMAN RIGHTS AND EQUALITY IMPLICATIONS

Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 requires Departments in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between person with a disability and persons without; and
- between persons with dependants and persons without.

In addition, without prejudice to the above obligation, Departments should, in carrying out their functions relating to Northern Ireland, have due regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Departments also have a statutory duty to ensure that their decisions and actions are compatible with the European Convention on Human Rights and to act in accordance with these rights.

The Bamford Review

A Human Rights and Equality Sub-Group was established as part of the Bamford Review to consider the relevant legislation and other requirements particularly relating to human rights, discrimination and equality in relation to people with a mental health need and/or learning disability. The Sub-Group considered a number of situations where actual or potential human rights and/or equality issues arise for people with a mental health need and/or learning disability and made a number of recommendations that will be addressed as part of the ongoing reform of mental health and learning disability services. The Sub-Group also developed a set of overarching human rights and equality guidelines against which each of the Review's Working Committees could test their discussions and recommendations. The Sub-Group's report on Human Rights and Equality of Opportunity can be accessed at:
http://www.rmhldni.gov.uk/human_rights_and_equality_report.pdf

Background

Overall it is estimated that in Northern Ireland about 250,000 adults and 45,000 children under 18 have a mental health need. About 26,500 people have a learning disability, of whom about half are aged 0-10. About 16,000 people have dementia, the vast majority of whom are older people.

Policy Aims

The overall aims of the Bamford Review and of NI Executive policy as articulated in *Delivering the Bamford Vision* and in this Action Plan are to:

- promote mental wellbeing for the whole population;
- protect the rights of people with a mental health need or a learning disability;
- promote equality of opportunity for them; and
- improve the public services offered to them and their families and carers.

Delivering the Bamford Vision set out a broad statement of policy for services for all people with a mental health need or a learning disability. This Action Plan sets out specific action to be taken over the next two to three years. As this work is taken forward and more detailed policies and strategies are developed in response to specific elements of the Bamford vision, the equality implications of these policies and strategies will be taken into consideration. The human rights and equality implications of the proposed legislation referred to in this Action Plan will also be considered separately as the legislation is progressed.

Groups Affected by the Policy

The policy includes mental health promotion, which affects the population generally. Work is under way on revising the Government's strategy and actions in relation to promoting health, emotional wellbeing and the equality implications of this strategy will be considered as this work is progressed.

In relation to people with mental health needs or a learning disability, information from the sources listed below has been considered and will be taken into account as services are designed or re-designed.

Gender

Using a GHQ12 score of 4 or more as an indicator of possible mental health problem, the Health and Wellbeing Survey 2005/06 showed that such scores were higher for women (21%) than for men (16%).

Since women generally live longer than men, they are more likely to suffer from dementia.

DHSSPS Equality and Human Rights Literature Review *Access to Health and Social Services* (April 2005) found that men tend to be more vulnerable to mental health problems and suicide for a number of reasons including:

- many men are reluctant to talk about their problems or feelings or to admit that they may be depressed.
- the reluctance of many men to consult with their GP for mental and emotional health problems.
- unemployment and the adverse impact of the continued decline of certain industries (such as the manufacturing industry).

The Bamford Review also highlighted specific mental health service needs for some women in the perinatal period.

There is no evidence of a gender difference in relation to prevalence of learning disability.

Age

The Health and Wellbeing Survey 2005/06 found that GHQ12 scores increased with age group, from 16% for 16-24 year olds to 23% for 55-64 year olds and then decreased again to 16% for those aged 75+. There is some evidence that mental health problems such as depression are less likely to be detected and treated in older people.

Delivering the Bamford Vision and this Action Plan recognise the differing mental health needs of children and young people, adults of working age and older people and the need for good interfaces to facilitate transition between the services when people reach the upper age limits for particular services.

Dementia affects mainly older people, although some younger people can develop it.

Learning disability is a life-long condition, affecting all ages, so services for people with a learning disability have to provide a life long continuum. The need for specialist services for children and young people with a learning disability is recognised. Transition to adult life is a stressful time when decisions about further education, employment or other meaningful daytime activities are being made.

Religion

More Catholics (21%) and those of other religions (20%) had a high GHQ12 score than Protestants (17%) (Health and Wellbeing Survey 2005/06).

There are no data to suggest a difference in prevalence of learning disability.

Marital Status

Fewer currently married people had a high GHQ12 score (16%) than single people (18%) with widowed (24%), divorced (28%) and separated people (35%) having greater risk (Health and Wellbeing Survey 2005/06).

Few people with a learning disability are married.

People with Dependants

The 2001 Health and Wellbeing Survey found that people with dependent children were more likely to have experienced stress in the previous year – 16% of those with dependent children reported a great deal of stress compared with 10% of those without dependent children.

Few people with a learning disability have dependents.

People with a Disability

This policy relates to people with a disability – either a mental health need or a learning disability. There is also evidence to suggest that people with physical and sensory disabilities are more likely to have a mental health need. The 2005/06 Health and Wellbeing Survey found that those who reported their general health as not good were more likely to have high GHQ12 scores – 51% compared to 10% who reported their health as good. The particular mental health needs of deaf people was highlighted by the Bamford review.

People with a learning disability who develop mental health needs may also require specialised services.

Ethnicity

There are well-documented cultural differences in the way psychological distress presents, is perceived and interpreted. Different cultures also develop different responses for coping with psychological stress. As a consequence, mental health interventions that emphasise individualism may not be appropriate for all cultures and belief systems.

Sexual Orientation

National Institute for Mental Health in England found that Lesbian, Gay and Bisexual people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self harm than heterosexual people (*Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people – a systematic review (2008)*.

Conclusion

This Action Plan covers a broad range of policy and service developments for services for people with a mental health need or a learning disability. While the overall policy aim is to improve the lives of people with mental health needs or a learning disability, some of the actions relate to groups of such people who have been identified as having particular needs for targeted services and there is the potential for some service developments to impact negatively on particular groups. The NI Executive recognises that as more detailed policies and strategies are developed in response to specific elements of the Bamford vision, the human rights and equality implications of these will be considered separately and their impact monitored as they are implemented.

Abbreviations

ASD	Autistic Spectrum Disorder
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DHSSPS	Department of Health, Social Services and Public Safety
DRD	Department for Regional Development
DSD	Department for Social Development
ELB	Education and Library Board
FE	Further Education
HSENI	Health and Safety Executive Northern Ireland
HSC	Health and Social Care
NIO	Northern Ireland Office
OFMDFM	Office of the First Minister and deputy First Minister
PHA	Public Health Agency
PCC	Patient and Client Council
RPA	Review of Public Administration
SEN	Special Education Needs
SENDO	Special Education Needs and Disability Order

DELIVERING THE BAMFORD VISION

The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability

ACTION PLAN 2012-2015

Integrated Projects Unit

November 2012

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

Ministerial Foreword

The Northern Ireland Executive's response to the findings of the Bamford Review led to the publication in October 2009 of the 2009-2011 Bamford Action Plan. That plan contained agreed actions and timescales for Northern Ireland Government Departments and Health and Social Care sectors.

I am pleased to publish this follow-on 2012-2015 Action Plan that will continue to progress the enhancements to mental health and learning disability service started through the previous Plan.

The Evaluation of the 2009-2011 Action Plan, published in May 2012, establishes that over the last two years the joint working across Government Departments and the HSC sector has achieved much, and 80% of the actions have been delivered. It also highlights areas where services can still be improved and the need for more of a focus on outcomes rather than outputs.

The follow-on 2012-2015 Action Plan has been based on the lessons learnt from the 2009-2011 Evaluation, consultative workshops, new research and evidence based practice and the views of service users and their carers.

Government Departments have endorsed these actions which are to be delivered by end 2015. The Bamford Vision for these services though will only be fully realised through the commitment not just of health and social care staff, and an inter-governmental and agency approach, but also through the drive of service users, carers and the voluntary and community sectors.

The implementation of this Action Plan will continue to be monitored through the Interdepartmental Senior Officials Group on Mental Health and Learning Disability and monitoring reports will be published on a regular basis.

I believe it is important that Government and those who commission and deliver services are informed and guided by the views of those who use these services. The evaluation of this follow-on 2012-2015 Action Plan will therefore focus primarily on service user outcomes rather than outputs. An Outcome Evaluation Model for this Action Plan is being developed.

I would like to particularly thank the Bamford Monitoring Group of the Patient and Client Council for their invaluable assistance in the formulation of this Action Plan and their Outcomes Paper.

The Bamford Vision set out a 10-15 year timescale for the enhancement of mental health and wellbeing, and for learning disability services. A strong foundation has been established and a positive change is evident but we still have much to do in order to deliver that Vision.

I want to reiterate the commitment of the full Northern Ireland Executive to the ongoing development of mental health and learning disability services to meet the needs and expectations of those who use and rely on them.

EDWIN POOTS, MLA

Minister for Health, Social Services and Public Safety

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8 Monitoring and evaluation

SECTION B

2012-2015 Bamford Action Plan

Appendixes

SECTION A

1 SETTING THE SCENE

The Bamford Review of Mental Health and Learning Disability

1.1 The Bamford Review of Mental Health and Learning Disability, an independent review of legislation, policy and service provision, concluded in August 2007. Broadly 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 a number of specialist services, to include 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.

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

Bamford Action Plan 2009-2011

1.3 The Northern Ireland Executive accepted the broad thrust of the Review's recommendations. The 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.

1.4 The 2009-2011 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 improving services for those with a mental health need or a learning disability in line with the policy articulated in *Delivering the Bamford Vision*. The Action Plan contained agreed actions with associated timescales to be taken forward by a range of Northern Ireland Government departments and agencies, in particular the Health and Social Care sector.

1.5 An inter-Ministerial group, chaired by the Minister for Health, Social Services and Public Safety, was established to oversee the work and structures put in place to support this group. The structures put in place also provide a formal forum for the voice of service users and carers through the Bamford Monitoring Group.

1.6 Departments other than DHSSPS continue to make a substantial contribution to progressing the Bamford Vision, as evidenced by the Action Plan in Section B. The structures supporting cross-sectoral work on Delivering the Bamford Vision are shown below.

1.7 This Action Plan, covering the period 2012-2015, follows on from the 2009-2011 Action Plan. Some of the actions in this Plan continue work already started during 2009-2011, while others address issues raised by the Bamford Review which were not possible to progress during the 2009-2011 Plan. The plan also includes a number of issues which were not considered by the Bamford Review but which fall under the broader vision of the Review

1.8 In preparing this Action Plan, those who use the services and their families and carers have had opportunity to influence the Plan through:

- two initial workshops held in September 2011 to gather views on the key areas for renewed action;
- two workshops in March 2012 jointly hosted by the Inter-Departmental officials group and the Bamford Monitoring Group to consider how cross-sectoral working could be improved; and
- continued close working with the Bamford Monitoring Group.

Transforming Your Care

1.9 *Transforming Your Care*, TYC, – a review of health and social care in Northern Ireland published in December 2011 has many parallels with the Bamford Vision in respect of mental health and learning disability service provision and enhancement including;

- Early intervention and health promotion,
- A focus shift to community care,
- Promotion of recovery practices,
- Personalisation of care,
- Resettlement,
- Service user and carer involvement,
- Advocacy,
- Provision of clearer information, and
- Respite provision.

1.10 The Evaluation of the 2009-2011 Bamford Action Plan and the TYC Review both also acknowledge the many improvements in mental health and learning disability services over the last few years and the ongoing need to continue to drive forward more rapid progress.

1.11 The TYC Review reflects the Bamford Vision, with both committed to delivering the best outcomes, increasing independence, choice and service improvements for people with mental ill-health or a learning disability. This will enable accelerated service enhancement in line with the needs and expectations of service users and carers in a coordinated and consistent manner.

Bamford Implementation Structures 2012-2015

2 WHERE WE ARE NOW

The Bamford Vision

2.1 *Delivering the Bamford Vision* set out the broad direction in which mental health and learning disability priorities were to be addressed across Government and the health and social care sector in particular. The 2009-2011 Action Plan contained 80 mental health and 67 learning disability actions, with some actions common to both, to be undertaken over the period of the Plan. Many of the actions were supported by additional resources committed in the Comprehensive Spending Review for that period.

Evaluation

2.2 Progress on the Plan has been monitored on a regular basis and a more detailed evaluation carried out during 2011. This shows that about 80% of the actions committed to in the 2009-2011 Plan have been carried out. This was achieved despite a reduction in the anticipated allocations to the health and social care sector and the wider public sector in 2010/11 due to the generally worsening financial climate. The full evaluation report can be accessed at:

http://www.dhsspsni.gov.uk/show-publications?txtid=56444

2.3 The evaluation report acknowledges that some actions were preparatory steps in modernising and improving services, through developing strategies and new models of service delivery, and recognises that people who use the services may not yet have seen much difference in the actual provision of services.

2.4 Significant work and investment has however gone into:

- Inter-Departmental working across education, housing, training and employment, as well as within the health and social care sector, to ensure that as far as possible, people with a learning disability or a mental health need are supported within their communities;
- developing a range of strategies and plans for future service developments;
- improving mental health and learning disability services, with an emphasis on community based early intervention and a significant investment of new funding to support this;
- detailed preparations for the drafting of the new mental capacity legislation.

Learning

2.5 Despite this work and additional investment, there is still a long way to go in achieving the goal of improving the lives of people with a mental health need or a learning disability and their families and carers. Reports from the Bamford Monitoring Group, which was established to represent the views of these groups of people, indicate that:

- generally, people recognise that the Bamford Vision is beginning to make a positive difference to their lives, but there is frustration with the slow pace of change.
- people are concerned that funding and the other resources necessary to realise the Bamford Vision may be reduced due to the financial cutbacks.
- there is a perceived major deficit, at a regional level, in the provision of advice and information services for those who use and rely upon mental health and learning disability services.
- people with mental health needs, learning disabilities, parents, carers and communities want to be involved in the planning, design, delivery and evaluation of services in Northern Ireland.
- service users and carers believe there to be a considerable lack of cross-sectoral working on realising the Bamford Vision. This has the potential to be a major barrier in the delivery of essential services and cause stress to individuals, families and carers.

2.6 Much, therefore, remains to be done and there are many challenges to be faced in a difficult financial environment.

3 THE CHALLENGES AHEAD

Challenges

3.1 In committing to the delivery of the first stage of the Bamford reforms through the 2009-2011 Action Plan, the Executive was aware of the challenges for the future that would have a major influence on the implementation of that plan and future plans. These included demographic change, particularly our longer life-spans with increasing complexity of needs, and the levels of public sector funding that could be directed towards supporting the reform and modernisation of mental health and learning disability services, taking account of all the other pressures on public sector funding.

Our Ageing Population

3.2 These challenges remain. Numbers of older people continue to increase, and this is addressed in this Action Plan for 2012-15 mainly through two strands of work on dementia services and on the needs of people with a learning disability as they and their carers grow older.

Finances

3.3 As a result of the 2008-2011 Comprehensive Spending Review DHSSPS allocated an additional £44m to mental health and learning disability services, as outlined below, with a further £3m made available to support mental health promotion and suicide prevention over the three year period.

DHSSPS proposed additional funding for mental health and learning disability 2008/09- 2010/11

3.4

	2008/09 £m	2009/10 £m	2010/11 £m	Total 3 year 2008/09 to 2010/11 £m
Learning Disability	7.00	2.00	8.00	17.00
Mental Health	12.75	1.85	12.40	27.00
TOTAL	19.75	3.85	20.40	44.00

3.5 The widespread constraints in public spending in 2010/11 impacted on the amounts planned for mental health and learning disability as set out in the table below. The amounts allocated were reduced from £27m to £17.1m for mental health and from £17m to £12.4m for learning disability.

DHSSPS actual additional funding mental health and learning disability

3.6

	2008/09 £m	2009/10 £m	2010/11 £m	Total 3 year 2008/09 to 2010/11 £m
Learning Disability	7.00	2.00	3.40	12.40
Mental Health	12.40	1.90	2.80	17.10
TOTAL	19.40	3.90	6.00	29.50

3.7 While these reductions, along with the general requirement to deliver annual efficiency savings, have had some effect on the Health and Social Care sector's ability to deliver on actions in the 2009-2011 Action Plan, the evaluation of the Action Plan shows that actual spending by the HSC Trusts on mental health and learning disability services increased between 2007/08 and 2010/11 by sums considerably more than those actually allocated as additional funding by DHSSPS.

3.8 By the end of 2010/11, expenditure on mental health services had risen by £32.31m from the baseline of £195.69m in 07/08

Mental Health Expenditure

3.9

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
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

3.10 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 £200.20m in 07/08.

Learning Disability Expenditure

3.11

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
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

3.12 A wide range of Departments and agencies also 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.

3.13 Funding will continue to be a significant challenge in the period to 2015 and beyond. There is continuing pressure to achieve efficiencies. The only additional funding to the Health and Social Care sector earmarked for mental health and learning disability services over the budget period 2011-2015 is £9.20m - £2.80m for mental health and £6.40m for learning disability - to continue the resettlement programme. This contrasts sharply with the financial outlook at the start of the 2009-2011 Action Plan, when much more significant increases in funding were anticipated.

3.14 New actions or initiatives will require further financial analysis and their implementation will be subject to resource availability and prioritisation within the respective organisation(s). However, it is acknowledged that much can be achieved through reform, modernisation, and redesign of commissioning arrangements and service provision. In the context of health and social care services, such an approach is underpinned by *Transforming Your Care* (December 2011) and its associated consultation document *Vision to Action*[1].

New Challenges

3.15 A further challenge relates to emerging issues. It is now 10 years since the Bamford Review started its work. Over time service provision and inter-relationships between services change and evolve and the priorities attributed to particular issues by those who use the services, their families and carers and the general public change. Issues are emerging now which were not highlighted in the Bamford review, but need to be addressed. While not strictly a response to the recommendations of Bamford Review, actions proposed on such emerging issues will be taken forward in the broader framework of reform and modernisation envisaged by Bamford and in

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[1] *Transforming Your Care*(December 2011) and *Vision to Action* - A consultation document(October 2012 – 15 January 2013)

keeping with the Bamford ethos of support and care which is person-centred and enabling.

4 THE WAY FORWARD

The Bamford Vision

4.1 The Executive's Vision for the Future set out in the 2009-2011 Action Plan remains valid today and will continue to guide the service improvements across Government.

THE BAMFORD VISION

To make the Bamford vision a reality, the NI Executive will promote the mental wellbeing of the population as a whole. The Executive will also promote the health and wellbeing, and maximise the independence and full participation of people of all ages with a mental health need or a learning disability, underpinned by legislation and public services to include reform and modernisation of mental health and learning disability services.

People with a mental health need or a learning disability using public services should expect to:

- *be encouraged and supported to look after their own health, both mental and physical, and build up emotional resilience;*
- *be supported, as far as possible, in their own homes and communities, making best use of self-directed help;*
- *be supported, through effective collaboration between Government Departments and their agencies, in their life choices and in day to day activities of engaging in education, training, work and leisure;*
- *be consulted on and be able to influence the provision of services to meet their needs;*
- *be encouraged to access help at as early a stage as possible; and*
- *be supported towards personal fulfilment and full citizenship.*

4.2 This is the vision for the future, supported by all Government Departments.

4.3 The actions in this Action Plan consist of:

- actions carried forward from the 2009-2011 Action Plan due to the work not being completed;

- actions which are a consequence of the actions completed in the 2009-2011 Plan;
- new areas of work which had not been addressed in the previous Plan, some of which were highlighted in the 2008 consultation on the Executive's response to the Bamford review, but could not be made a priority in the 2009-2011 Plan.

4.4 As indicated earlier in Chapter 3, the actions in this Plan also take account of the financial outlook. Only actions which can be taken forward within the existing budgetary allocations are committed to in the Plan.

Work areas which support the Bamford Action Plan

4.5 The 2009-2011 Action Plan reinforced the message that mental health and learning disability issues are affected by actions much wider than just the provision of services which bear those labels. It was recognised, for example, that action in relation to tackling domestic and sexual violence contributes to the emotional wellbeing of many in our community. Work on promoting Personal and Public Involvement (PPI) throughout the health and care sector will promote the inclusion of people with a learning disability or a mental health need and improve services by making them more responsive to the needs of service users. Similarly work to support families and carers and the general drive to increase uptake of Direct Payments impact on people using mental health and learning disability services in parallel with other groups of people.

4.6 While work continues in all of the areas mentioned in 4.4, this new Action Plan does not include this work as specific actions in the Tables in Section B. The tables concentrate instead on actions which are focused on mental health and learning disability issues.

4.7 In addition many of the actions from the 2009-2011 Action Plan which were completed will continue to have an effect during the lifetime of this new Action Plan. These actions however are not repeated in this new Plan. For example, findings from the workforce study carried out as part of the 2009-2011 Action Plan will be taken forward as an integral part of the work to develop mental health and learning disability services in general as well as in actions relating to specific services being addressed within this new Plan.

4.8 Work which was carried out to improve information on the use of mental health and learning disability services will help those commissioning and providing services to improve service delivery. Further work is indicated in the Action Plan however in relation to provision of information for those seeking to access services; this has been highlighted by the Bamford Monitoring Group as an area where improvement is needed.

Criminal Justice Services

4.9 A High Specialist Support Services sub-group under the HSC Bamford Taskforce provides a coordinated approach across Health and Social Care and Criminal Justice Systems, CJS. The sub-group seeks to improve services provided to people with mental health and/or a learning disability who are, or have been, in recent contact with the CJS. Membership includes representatives from DOJ, DHSSPS, the HSC sector, PSNI and service uses and carers.

4.10 The cross sectoral working ethos of the sub-group has achieved much already and continues to focus on developing care pathways, quality and outcome measures, specialist learning disability services and a regional inter-agency training approach.

5 THEMES

5.1 The 2009-2011 Plan reinforced key Bamford messages by grouping the actions under five themes:

BAMFORD THEMES

1. *Promoting positive health, wellbeing and early intervention*
2. *Supporting people to lead independent lives*
3. *Supporting carers and families*
4. *Providing better services to meet individual needs*
5. *Developing structures and a legislative framework*

5.2 These will continue to be the themes within which the Bamford agenda will be progressed through this 2012-2015 Action Plan.

Promoting positive health and wellbeing

5.3 Promoting positive community and personal health and wellbeing was central to the Bamford Review's vision. DHSSPS continues to lead on the development of a new 5 year cross-sectoral Mental Health & Wellbeing Promotion Strategy to be issued for public consultation in late 2012. The new strategy for the period 2013 to 2018 will focus on building the mental and emotional resilience of the whole population and of specific "raised risk" groups. As with previous work on this issue, it will require effective collaboration across departments and sectors.

5.4 The new Mental Health and Wellbeing Promotion Strategy will have strong links with the Protect Life strategy on suicide prevention, which has been refreshed to run to March 2014. Action on these two strategies, with their emphasis on cross departmental/ sectoral commitment, will form a key strand of work within this Bamford Action Plan for the coming years.

5.5 The importance of promoting emotional wellbeing in children and young people, equipping them with coping skills and providing support where necessary, is recognised in a series of actions to be undertaken by Department of Education.

5.6 Helping people with a learning disability maintain their physical health is also recognised in this theme, through continued implementation of the Directed Enhanced Services and targeted action on dental services.

Supporting People to Lead Independent Lives

5.7 Leading a fuller life through active participation in the community and being able to engage in meaningful day-time activities was a key theme within the Bamford Review reports, particularly the Equal Lives report on people with a learning disability. The Office of the First Minister and Deputy First Minister continues to lead cross-sectoral work on promoting social inclusion for people with a disability. Work also continues on improving access to work, on training for work and on access to public transport, recognising their role in helping people be more independent.

5.8 The Bamford Review called for a renewed impetus to resettle into the community the substantial number of people who remained unnecessarily in long stay mental health and learning disability hospitals. The resettlement programme will continue during the period of the 2012-15 Action Plan, supported by funding earmarked for that purpose. At the same time processes will continue to ensure that patients admitted to hospital in more recent times are discharged back into the community as soon as their assessment and/ or treatment is completed.

5.9 Direct Payments can be used to increase choice and promote independence. They provide for a more flexible response to meeting the needs of the service user as users can opt to purchase services themselves by means of a Direct Payment from the HSC Trust in order to tailor their support package to their individual needs.

5.10 It is still DHSSPS policy to offer Direct Payments as an alternative to direct service provision, but a recent court judgement means that there is no legal basis to enter into a direct payment arrangement with an individual who lacks capacity. It is the Department's intention to amend existing legislation to make provision for another individual to receive Direct Payments on behalf of a person with eligible needs who lacks capacity to consent to such payments. It may, however, take some time to effect the necessary legislative change, so arrangements are being put in place to ensure that Direct Payments can continue to be offered in the interim period.

5.11 Direct Payments can increase choice to some extent. Many people who use mental health and learning disability services have said that they would like to be given greater freedom to arrange a package of support and care that truly suits their individual needs and their family circumstances. While there may be benefits to those who use services, there may also be drawbacks which would not make personalisation suitable for everyone. Over the life of this Action Plan, DHSSPS will undertake work to consider how best the policy of "self directed support" or "personalisation" can be progressed in Northern Ireland. This is reflected in the Action Plan in Section B.

Supporting Carers and Families

5.12 The contribution made by many families and other informal carers in supporting people with a mental health need or a learning disability is immense. Work continues on the recommendations contained in the earlier Joint Review of Support Provision for Carers, including provision of information for carers, both in booklet form and on the NI Direct website, and promoting the use of the Carers Support and Needs Assessment component of NISAT. RQIA will commence a review of the implementation of the DHSSPS Standards for Adult Social Care Support Services for Carers across relevant HSC services in 2012, which will inform future work to support carers. The work on personalisation referred to in paragraph 5.10 also has the potential to provide better support for families and carers.

5.13 Investment in respite services, with associated targets for increased provision in the 2009-2011 Action Plan, recognised the value of respite provision to carers and to service users. However attempts to monitor the targets highlighted difficulties with defining respite provision and with measuring consistently the extent of provision. The HSC Board has been engaged in a substantial exercise to bring fairer approaches to assessment for and provision of respite services. This work will continue during this Action Plan period and will take into account the issues raised in the recent Bamford Monitoring Group report on respite services.

5.14 Stakeholders have also highlighted that increased emphasis on managing mental health periods of crisis within the community puts an added burden on family and carers. Carers' needs have to be recognised and appropriate support and information provided as part of the further development of these services.

Providing Better Services

5.15 The publication of the mental health Service Framework in 2011 and the anticipated publication of the Service Framework for learning disability will serve to improve health and social care services through setting standards. Community mental health and learning disability services will continue to be built up, so that fewer people need to be admitted to hospital. Work will continue on many of the service improvement areas started in the 2009-2011 Action Plan:

- developing early interventions, including psychological therapies;
- building up specialist services, eating disorder, perinatal mental health and forensic services;
- ensuring timely discharge from hospital after assessment and treatment.

5.16 In view of the Bamford Monitoring Group's findings in relation to service users and carers being able to access information on services, work will continue on a service mapping project for mental health services with the aim of providing information to people who wish to access the services in their area. This project will then be extended to learning disability services.

Research

5.17 In 2011, 5 reviews of current research and research evidence were commissioned by HSC R&D Division in areas prioritised by key stakeholders including clinicians, commissioners, researchers and service users. The completed reviews were disseminated widely including a launch event in November 2011. Eight research questions, for which no robust evidence is yet available, led from these reviews and formed the basis of a further call for substantive research projects which closed in March 2012. Following the evaluation panel, five projects were funded. These projects, the titles of which are listed below, will run for a period of 18-36 months.

- A natural experiment investigating differences in how residential facilities support people with intellectual disabilities with challenging behaviour and/or mental health problems.
- Effective family support models during the transition of adults with intellectual disabilities (ID) into old age.
- Transitions & outcomes for care leavers with mental health and/or intellectual disabilities.
- Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of Family, Peer & School Processes, and
- Improving pathways and care for young people in NI with mental health problems in the transition from CAMHS to adult services (IMPACT).

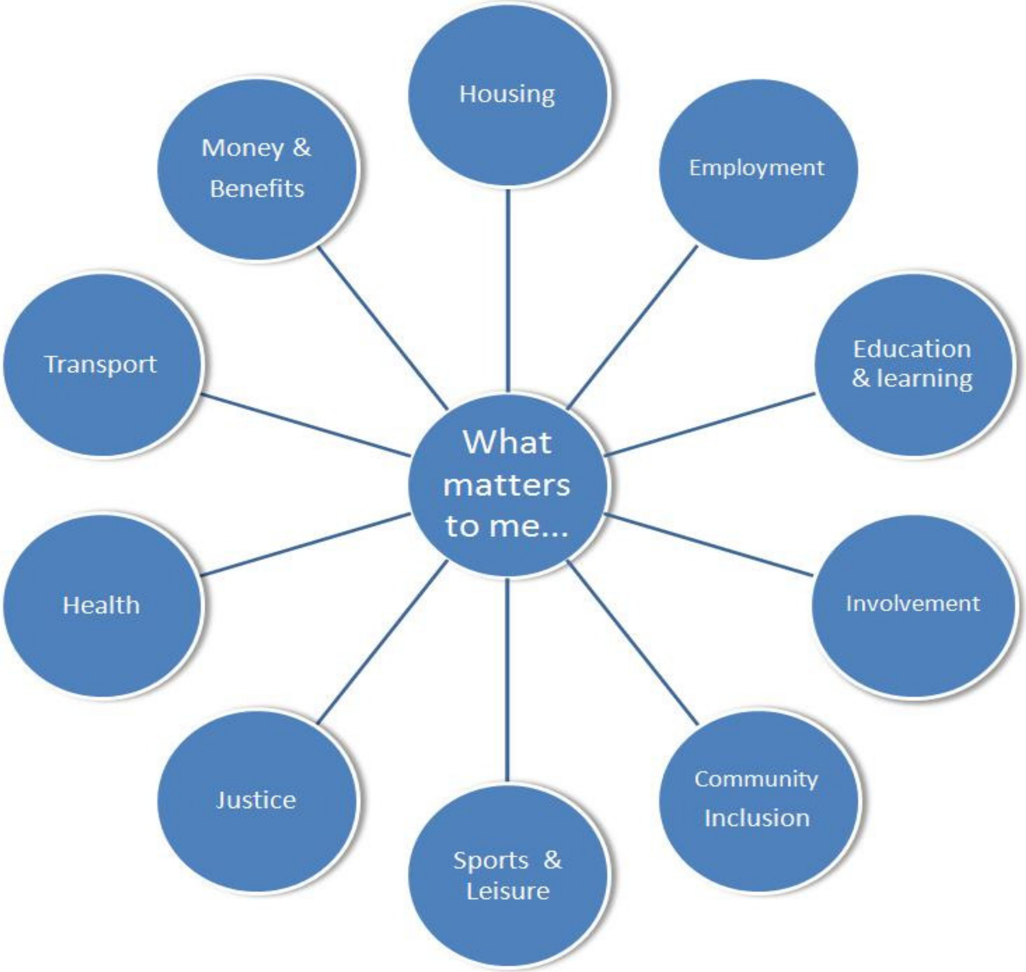
Developing Structures and a Legislative Framework

5.18 The structures supporting work on Delivering the Bamford Vision as set out in Chapter 1 will remain in place. There is however a need to address the concerns expressed by the Bamford Monitoring Group and by other stakeholders that cross-sectoral working is not seen at local level and that lack of joined-up working causes frustration for those who uses the services and for families and carers.

Workshops

5.19 To inform preparation of this Action Plan, two workshops were held in March 2012 under the auspices of the Inter-Departmental Senior Officials Group, IDSOG, and the Bamford Monitoring Group, BMG, to consider how cross-sectoral working could be improved to benefit those who use mental health or learning disability services.

5.20 Workshop themes



5.21 In response to issues raised at these workshops the IDSOG will sponsor work on local level cross-sectoral issues, involving the relevant stakeholders along with representatives from the Bamford Monitoring Group. This is reflected in the Action Plan in Section B.

Children and Young People's Strategic Partnership

5.22 A new regional cross-sectoral group will also contribute to delivering the Bamford agenda for children and young people through the HSC Board. The Children and Young People's Strategic Partnership (CYPSP) was established in January 2011. The HSC Board has a statutory duty to establish and lead the CYPSP and publish a Northern Ireland Children and Young People's Plan; the first of these has been issued for consultation. The Partnership and its Plan is multi-agency and multi- sectoral. The purpose is integrated planning and commissioning to improve outcomes for our children and young people, including those who have a disability.

5.23 Of particular relevance to the Bamford agenda will be three regional sub groups of the CYPSP:

1) children and young people with emotional and behavioural difficulties;
2) children and young people with disabilities;
3) transition for young disabled people from childhood to adulthood.

Mental Capacity Legislation

5.24 The need for new legislation was a key recommendation arising from the Bamford Review, which called for the development of a single legislative framework for the reform of the current Mental Health (NI) Order 1986 (the 1986 Order) and the introduction of new mental capacity legislation in Northern Ireland. The 2009-2011 Action Plan included an action to take forward work on new legislation, but recognised that it would be later than 2011 before new legislation could be introduced.

5.25 Preparation of a draft Bill is under way, with a previous intention of introducing the Bill into the Assembly in 2012 and enactment in 2013. A major element of this legislative reform will be to embed a set of principles in the legislation, as recommended by the Bamford Review. The Bill will also provide for substitute decision-making on behalf of those unable to make decisions for themselves provided safeguards set out in the Bill are engaged. However a recent decision by DHSSPS and the Department of Justice to extend the scope of the Bill to those subject to the criminal justice system has meant that the Bill's introduction to the Assembly is now scheduled for December 2013 with enactment following, at the earliest, in 2015.

5.26 The draft Bill will also include a new statutory right to an independent advocate in certain circumstances. To pave the way for this new right, draft policy guidance for commissioners of advocacy services was published earlier this year; further work on the new statutory right will be taken forward during the period of this Action Plan.

6 LEARNING DISABILITY

Core Values

6.1 The Bamford Review based its recommendations relating to people with a learning disability on 5 core values of:

- Social inclusion – people with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community;
- Citizenship – people with a learning disability are individuals and each has a right to be treated as an equal citizen;
- Empowerment - people with a learning disability must be enabled to actively participate in decisions affecting their lives;
- Working Together – conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability;
- Individual Support - people with a learning disability will be supported in ways that take account of their individual needs and helps them to be as independent as possible.

6.2 These core values will continue to influence the development of learning disability services as we move into this new Action Plan.

Service Framework

6.3 A Service Framework for Learning Disability, published in September 2012, sets out clear standards of care that people can expect. This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

Children and Young People with a Learning Disability

6.4 Work will continue across the health and social care and education sectors to ensure that children with a learning disability are supported and encouraged to develop to their full potential and to participate as fully as possible in school. The Education and Library Boards have statutory responsibilities in this regard. Recognising that transition to adulthood can be a particularly daunting time for young people with a learning disability, work will continue across Departments and their agencies to support young people during this period of their lives. The transitions sub-group of the Children and Young People's Strategic Partnership will play a significant role in this work.

Older People with a Learning Disability

6.5 Equal Lives, the Bamford Review report on learning disability, recognised that increasing numbers of people with a learning disability were living to old age, but that this brought added challenges. Family carers also grow older and become unable to continue with the caring role. Accommodation and day time activities may no longer be suited to the person's interests and physical abilities. Dementia can start at an earlier age than for most other people. This Action Plan includes a commitment to develop a plan to support people with a learning disability who are living with elderly carers where there is a risk of that caring arrangement breaking down.

Resettlement

6.6 There are currently around 200 long-stay patients in learning disability hospitals who no longer require hospital treatment and who could be resettled into the community. As with mental health, work will continue over the period of this Action Plan to seek alternative care arrangements for as many of these people as possible with the current funding of £6.4m identified for this and to identify options to achieve the long term objective to complete the resettlement programme by 2015. The principle of betterment will continue to inform decisions.

7 MENTAL HEALTH

Community focus

7.1 The overarching vision of the Bamford Review that people with a mental illness should be treated in the community unless there is a clear clinical reason not to do so has been widely accepted by users and carers and by those who provide services to them. However, the reform and modernisation of mental health services needs continued impetus to ensure the necessary shift in investment from hospital based services to community based services is achieved. The objective of redirecting mental health spend so that 60% of total spend goes towards community based services was not achieved during the 2009-2011 Action Plan and will continue to be an objective in this Plan.

Supporting Recovery

7.2 Further development of a range of community mental health services is required to enable people to be treated close to family networks. This should be complemented by a smaller inpatient service. The full range of services needs to be firmly based in a recovery ethos, whereby people are rehabilitated to live as fulfilling and independent lives as possible, even with limitations caused by illness. Since those who use the services should determine their own recovery goals, full involvement of those who use the services and their families and carers is a key requirement to promoting a recovery ethos. Since recovery can mean many different things, some of which are not necessarily related to the complete alleviation of the symptoms of the illness, the voluntary and community sector is well placed to complement statutory health and social care sector provision in supporting people's recovery.

7.3 The Action Plan in Section B includes a commitment to undertake a programme of work that will facilitate an enhanced culture of recovery across all mental health services. This is likely to include, among other things, the development of training initiatives, establishing effective communication systems with service users and carers and audit and evaluation mechanisms.

7.4 Reflecting what recovery means to those who use mental health services will also be a major influence in the work to measure outcomes and evaluate the success of the Bamford Vision, as outlined at Chapter 8. There is a range of measures of recovery outcome. One of the rapid reviews under the research programme in the 2009-2011 Action Plan recommended a number of these for further consideration.

Service Framework

7.5 Implementation of the Service Framework for Mental Health and Wellbeing, published in 2011 will be instrumental over the period of this Action Plan in improving the mental health and wellbeing of the population of Northern Ireland, reducing inequalities and improving the quality of health and social care in relation to mental health.

7.6 The Service Framework sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation of individuals and communities who currently have or are at greater risk of developing mental illness. The standards adopt a lifespan approach that will enable each individual to be seen in their own context at their own point in life.

Stepped Care

7.7 The stepped care model of providing the right level of services to the right people at the right time will continue to shape the development of mental health services. Early interventions in primary care will continue to be promoted, including better access to psychological therapies.

Resettlement

7.8 There are currently around 150 long-stay patients in psychiatric hospitals who no longer require hospital treatment and who could be resettled into the community. Work will continue over the period of this Action Plan to seek alternative care arrangements for as many of these people as possible.

7.9 A total of £2.8m has been allocated for the current spending review period, but the total cost to complete the mental health resettlement programme is significantly greater. Work will continue on options to achieve the long term objective to complete the resettlement programme by 2015.

7.10 The ongoing resettlement programme has also helped to identify an emerging group of people (about 100) in mental health inpatient facilities with quite challenging behaviours who require further longer term rehabilitation before they could be considered for community placement. These patients were identified in a review by the Department in 2010 which recommended 3 twenty bedded dedicated low secure units for Northern Ireland be established to facilitate such rehabilitation. Work will now be carried out to implement a regional approach to the provision of these facilities.

Children and Young People

7.11 In response to an RQIA review of Child and Adolescent Mental Health (CAMH) services, work is under way to develop policy guidance on a service model for these services. This policy guidance will confirm the preferred model for the organisation and delivery of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland and will also adhere to the overall strategic direction for CAMHS within the Bamford Review. A stepped model is proposed, building on the existing tiered approach, but making service delivery more user-centred. This is similar to the approach being adopted in adult mental health services. This stepped care approach will be more patient focussed and able to deliver the appropriate level of care that best meets the child or young person's assessed needs.

Older People

7.12 Work will continue to improve dementia services in line with the recent strategy, with its emphasis on ensuring that people with dementia are treated with awareness and respect, especially by those providing services, and that they are supported to maintain their independence for as long as possible. Older people with functional mental illness will benefit from the improvements being made to adult mental health services.

8 MONITORING AND EVALUATION

Evaluation of 2009-2011 Plan

8.1 The evaluation of the 2009-2011 Action Plan has shown progress, but recognises that much more needs to be done. The evaluation has also been mostly factual outputs – the actions were achieved or not achieved. It was also restricted in the extent to which it has been possible to reflect on whether those who use the services and their families and carers have seen any difference in the services delivered or in the way they are delivered to them.

Monitoring

8.2 The IDSOG will continue to monitor the implementation of the actions within this Plan. The Group will now publish its monitoring reports at regular intervals throughout the life span of this Plan in order that progress can be tracked by all stakeholders.

Outcomes over outputs

8.3 The qualitative/quantitative balance of the future evaluation of this Action Plan will reflect requests from those who use these services. The evaluation will therefore focus primarily on user outcomes over the more quantitative aspects of service delivery reflected in the monitoring reports.

8.4 The Bamford Monitoring Group under the Patient and Client Council has drafted a service user Outcomes Paper, enclosed at Annex A. This Paper is derived from the reports, feedback from conferences and workshops held by the group in the past 2 years and on the broad themes identified at the BMG/IDSOG Workshops in March 2012. The Paper proposes outcome measures for consideration within the context of the future evaluation of this Action Plan. These proposed outcome measurements should also enable the evaluation of this Plan to reflect more fully the views of those who use and rely on mental health and learning disability services.

8.5 This will be augmented by work being taken forward by the HSC Bamford Task Force to measure outcomes, and the development of indicators supporting Service Frameworks for both mental health and learning disability services.

8.6 All of this work will be underpinned by the principle that Delivering the Bamford Vision is about improving the lives of men, women and children who have a mental health need or a learning disability.

SECTION B

2012–2015 BAMFORD ACTION PLAN

In this Action Plan actions are shown within each of the 5 themes outlined at paragraph 5.1. Within each theme, actions which impact both mental health and learning disability services are shown first, followed by actions impacting only on learning disability and then actions which will impact only on mental health services.

HEALTH AND WELLBEING

Joint actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
1A	DHSSPS	Publish and Implement a revised cross-sectoral Promoting Mental Health Strategy	DHSSPS, with contributions from relevant Departments - led by DHSSPS Investing for Health Group	Publish a revised cross-sectoral Promoting Mental Health strategy, taking account of lessons learned from previous work	March 2013	Better mental wellbeing in the population
1B	DHSSPS		PHA	Implement Action Plan from Promoting Mental Health Strategy	Ongoing	
2	DE	Develop final proposals for Early Years Strategy	DE .	Early Years (0-6) Strategy implemented; early years providers deliver high quality experience for every learner.	November 2012	Children receive a high quality pre-school experience that promotes their healthy development and lays the foundations for the achievement of good outcomes in the longer term.

3	DCAL	Implement a 10 year Strategy for Sport and Physical Recreation	DCAL	A greater emphasis on the mental benefits of regular participation in sport and physical recreation	Ongoing	Improved opportunities for people to gain the mental well being benefits of participation in sport and physical recreation
4	DE	Promote an anti-bullying culture within schools in partnership with the NI Anti-bullying Forum	Pupil Support Unit	All schools have in place an effective approach to tackling all forms of bullying	Ongoing	Pupils and parents are confident that their concerns about bullying will be dealt with in an appropriate and timely manner

Learning Disability Actions

No.	**DEPT.**	**KEY ACTIONS**	**FOR ACTION BY**	**OUTPUT REQUIRED**	**TARGET DATE**	**OUTCOMES**
5	DHSSPS	Ensure that persons with a learning disability have equal access to the full range of primary health care services	HSC Primary Care, Acute Hospitals, Multi-Disciplinary Learning Disability Teams, Other Providers	Full implementation of Learning Disability Directed Enhanced Services across region	March 2015	Improve the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and mental health.

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
6A	DHSSPS	Progress the next phase of the suicide prevention strategy	DHSSPS	Carry out evaluation of the effectiveness of the implementation of the "Protect Life" strategy 2006, at both a local and regional level.	December 2012	Fewer people attempt to or take their own life
6B				Publish the next phase of the suicide prevention strategy, based on the latest available evidence and findings from the evaluation.	December 2013	

7A	DHSSPS	Develop and implement New Strategic Direction on drugs and alcohol Phase 2, and Strategy Evaluation	DHSSPS	Complete actions from NSD Phase 2 Implementation	December 2015	Reduce levels of harm related to Alcohol and Drug Misuse
7B				Undertake a regional commissioning framework across all four tiers of service delivery for young people, families and adults	March 2013	Consistent approach to service design and delivery
7C				Implement commissioning framework recommendations	December 2015	Evidence based services in place to meet regional and local needs

7D				Work in partnership with the Drug and Alcohol Co-ordination Teams to ensure a co-ordinated response to address current and emerging needs	Ongoing	Improved co-ordination through partnership working at locality and regional levels
8	DHSSPS	Respond to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in Northern Ireland 2011	PHA	Implementation of recommendations	March 2013	Minimise occurrence of suicide and homicide by people who access mental health services in NI.

9	DETI	Specialist health and safety inspectors and business advisors to provide advice and, where necessary, enforcement in high stress risk work sectors	HSENI	Organisations in sectors, in which employees are at a high risk of suffering from workplace stress related ill health caused by or made worse by their work, provide appropriate support	Ongoing	Reduce stress-related ill-health and associated absenteeism in high stress-risk work sectors and increase productivity.
10	DE	Promote a focus on pupils' emotional health and wellbeing through a programme of awareness raising and staff capacity building for all schools	DE – Pupil Support Unit	All schools proactively promote pupils' wellbeing as part of their raising standards agenda.	Ongoing	A caring and supportive environment exists in all schools and all pupils and staff benefit from the active promotion of positive mental health.
11	DE	Maintain access to counselling support which is independent of the school for all pupils of post primary age	DE – Pupil Support Unit	Counselling support remains accessible in all secondary and special schools	Ongoing	All pupils of post primary age have access to counselling support which is independent of the school.

SUPPORTING PEOPLE

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
12	OFMDFM	Publish a strategy for the implementation of recommendations arising from the PSI report on Disability.	OFMDFM	Publish a strategy document based on the recommendations arising out of the PSI Report on Disability, taking into account each strategic objective in relation to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).	June 2013	Improved social inclusion of people with disabilities across a wide range of areas and activities examined by the PSI Group including:• Access to Employment;• Children, Young People and their Families;• Housing, Transport, Information and Access.
13	DHSSPS	Resettle long stay patients from learning disability and mental health hospitals	HSC DHSSPS DSD	Resettle all long stay patients	March 2015	More people able to live independent lives safely in the community

14	DSD	Scope existing supported housing capacity/suitability to maximise resources	NIHE	Commissioning programmes for new provision will consider examining capacity/suitability to maximise existing resources	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
15	DSD DHSSPS	Ensure new build supported housing programmes are “future proofed” to ensure longevity/sustainability in terms of the tenants	HSC DSD DHSSPS NIHE	Needs assessments to take into account longevity/sustainability	Ongoing	Ensure that suitable, safe and supported housing is available for those with a mental health need or a learning disability who require it
16	DEL	To support and develop the Employment Advisor Teams to deliver services to people with mental ill-health or a learning disability	DEL Disability Employment Service.	Pilot roll-out of Employment Service Pathway Teams	December 2012	To deliver a more individually tailored service to all ESA clients.

17	DEL	Maintain support arrangements and extended eligibility for participants with disabilities on the Training for Success programme.	DEL's Training Programmes Branch	Maintained access and support arrangements.	Ongoing	Support provided, as necessary, to those with disabilities to facilitate access to and participation in training.
18	DEL	Widen Participation in Higher Education Strategy	DEL's Higher Education Widening Participation Branch	NI Executive has agreed the Widening Participation Strategy. To commence action/projects in support of the WP initiatives targeted at students with disabilities.	Ongoing	Provision of targeted support at students with disabilities who are at risk of being excluded from higher education.
19	DEL	Establish and progress effective Partnership Agreements and joint working arrangements with post-primary schools, further education, training and apprenticeship providers, HSC Trusts and organisations who act as advocates for young people with a variety of barriers, including disabilities.	DEL's Careers Service	Improved to careers services leading to better outcomes for clients.	Ongoing	Improved careers decision making and increased participation in education, training and employment

20	DEL	Lead on the implementation of a cross-departmental Strategy - "Pathways to Success" - for those young people Not in Education, Employment or Training (NEET).	The NI Executive agreed a cross-Departmental Strategy. A NEET Advisory Group will be established comprising officials from the main Departments involved, representatives from the voluntary/community sector, education and health and social care sectors, local government and the business sector.	Subject to economic conditions, help to prevent young people falling into the NEET category; and help reduce the number of young people within the NEET category by, for instance, improving their opportunities to move out of poverty. . The Strategy has committed to put in place a system to scope and develop more robust measurement metrics in relation to those who are at risk of falling into or in the NEET category.	Tracking system in place by 2014.	A reduction in the number of young people most at risk of remaining outside education, employment or training (NEET); a group which will include those with mental health and learning difficulties.
21	DEL	To develop Careers Service delivery to support the above mentioned "Pathways to Success" Strategy (for NEETs).	DEL's Careers Service	Case management of 17/18 year olds	June 2013	Increased participation in education, training and employment by 16-24 age group

22	DEL DE	Continue to work in partnership with DE to increase the level of information sharing in respect of relevant pupil data being shared with DEL's Careers Service including electronic sharing of pupil data via C2K.	DEL's Careers Service in conjunction with DE.	Improved service to young people. Data Sharing Agreements in place with schools, data sharing delivered via C2K.	Ongoing	Improved information sharing should lead to more focused support for young people moving into education, training and/or employment.
23	DEL	Continue to provide specialist support, as appropriate, for young people considering participating in Training for Success (TfS).	DEL's Training Programmes Branch	Improved service to young people.	Ongoing	Ongoing provision of appropriate targeted support to enable young people with significant barriers to enter, engage and achieve the best possible outcomes.
24	DEL	Incorporate provision within the design of the new Work Connect Programme to meet the employment needs of those who are claiming Employment Support Allowance and who have mental ill-health and learning disability.	DEL's Disability Employment Service (DES)	To monitor and review the level of participation and success of the new Work Connect programme.	March 2013	Providing targeted support to enable adults with significant barriers to improve their employability and, if appropriate, enter employment.

25A	DHSSPS	To support the uptake of self-directed support and individual budgets in line with Transforming Your Care	DHSSPS	Produce a Departmental high level vision for self directed support	March 2013	People will have options to choose the most appropriate services for their needs
25B			HSC	Increase the number of people with self-directed support and individual budgets	March 2015	
26	DE	Take forward and implement Review of Special Educational Needs & Inclusion	DE	Following July 2012 agreement by the Executive of a Policy Memorandum: draft instructions for OLC for primary legislation; draft subordinate legislation for consideration by Education Committee; draft new statutory code of practice for consultation. Following commencement of new legislation, begin to implement agreed legislation and statutory code over a 5-year transitional period.	Ongoing from 2012 until legislation is commenced and transitional arrangements put in place	Pupils with special educational needs supported to achieve to their full potential through early identification of need and early intervention

27	DHSSPS	Implement "Developing Advocacy Services - A Policy Guide for Commissioners"	HSC	Implement Advocacy Services Action Plan	March 2013	Principles and standards which should lead to greater parity and consistency in the commissioning and delivery of advocacy services.
28A	DHSSPS	To support the employment of experts by experience in the commissioning and delivery of mental health and disability services.	HSC	To move to a position where service users and carers are employed in the commissioning and delivery of services	Ongoing	Services meet the needs and expectations of those who use and rely on them.
28B				To move to a position where service users and carers are involved in the process of recruitment and selection.		

Learning disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
29	DRD	Investigate how information provision on transportation issues can be improved for people with learning disabilities	DRD, Imtac Translink	Implement measures in the Accessible Transport Strategy (ATS) action plan 2012-2015 in relation to the provision of information for people with learning disabilities	March 2015	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability

30	DRD	Examine options for improving the provision of travel training schemes	DRD	Evaluate pilot scheme in Ards & North Down area and consider regional rollout of the scheme.	March 2015	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability
31	DRD	Review the training of staff to ensure that its content covers the needs of people with a learning disability.	DRD	Learning disability awareness training in place for: 1. DRD staff 2. PSV licence holders under the terms of the Certificate of Professional Competence. 3. All Translink (non-driver) staff	Ongoing	Address a wide range of the barriers that impede the use of the transport system by people with a learning disability

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
32	DHSSPS	Promote recovery orientated practice throughout all mental health services	HSC in collaboration with voluntary and community sector	Introduce a range of actions/initiatives to facilitate an enhanced culture of recovery across all mental health services (to include the development of training initiatives, effective communication systems with service users/carers and audit/evaluation mechanisms)	March 2015	An improved and consistent understanding of recovery throughout mental health services, ensuring that a recovery based approach becomes embedded in the value base of practitioners and services and enabling service users to maximise their abilities, independence and their general health.

33	OFMDFM	Establish an initial assessment of the mental health needs of victims and survivors through a Comprehensive Needs Assessment	OFMDFM	Assessment of mental health needs for victims and survivors.	February 2013	Better planning of services for victims and survivors.
34	DEL	Continue to deliver specialist employment provision to address the employment needs of those clients who have disability related barriers to finding and sustaining work.	DEL's Employment Service, including the Disability Employment Service (DES)	Individuals with a disability, including mental ill health and learning disability are assisted via DEL programmes to enter and stay in work.	Ongoing	Increased participation on specialist programmes including Condition Management Programme, Work Connect, Workable and Access to Work, as well as local ESF Disability Employment projects.

35	DEL	Enhance and develop the services to assist clients who transfer from Incapacity Benefit to Job Seekers Allowance.	DEL's Employment Service, including the Disability Employment Service (DES)	To help ex- Incapacity Benefit clients to move towards and into employment through participating in the Condition Management Programme. To monitor and review the level of participation and success of the new Job Seekers Allowance clients .	March 2013	To assist clients with Mental Health conditions better manage these to improve their ability to participate on appropriate provision and to find and keep a job.
36	DCAL	“Health in Mind” programme to improve the quality of life of 25,000 adults affected by mental ill-health through the provision of information, learning and reading activities	DCAL (Libraries NI)	By project end: 40,000 people have accessed improved information about mental health; 20,000 people affected by mental ill health, their families and carers have improved knowledge and skills to enable them to access and use relevant information; 3.000	October 2014	People affected by mental ill health and their families have improved access to information and support

SUPPORTING CARERS

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
37	DHSSPS	Enhance the arrangements to meet demand for respite including emergency respite and short break care	HSC	Implement recommendation of HSCB Phase II respite report. Agreed description of respite and measurement and reporting mechanisms	March 2013	Enhanced flexibility of emergency respite and short break care targeted to meet specific, individual assessed need. Better range of options for short break/respite consistently across Trusts which meets assessed needs of individuals.
38	DHSSPS	To provide support to all carers in order that they may continue in their caring role	HSC	All carers offered carers assessment.	March 2015	The needs of the person cared for and the carer are identified through a carer-centred assessment process.

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
39A	DHSSPS	Carry out a scoping exercise to ascertain future caring requirements for people with a learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements	HSC	Report on the future caring requirements of people with learning disabilities who have elderly carers	March 2013	Identification of future service need/provision.
39B		Develop a rolling, costed plan to support those with learning disability living with elderly carers where there is a risk of a breakdown in caring arrangements		Annual costed plan developed in each Trust.	September 2014	Arrangements in place to support and maintain existing community and family arrangements

BETTER SERVICES

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
40	DHSSPS	Monitor/review departmental capital budget	DHSSPS/HSC	Progress relevant business cases from Trusts to achieve future agreed pattern of provision	March 2015	People can access services in appropriate and fit for purpose buildings
41	DHSSPS	Complete research into priorities highlighted by Bamford rapid reviews	DHSSPS PHA HSC Universities	To improve services developed in priority areas	October 2015	To provide new and effective interventions relevant to Northern Ireland
42	DHSSPS	To ensure Personal and Public Involvement, (PPI), in planning, commissioning, delivery and evaluation of services in line with guidance.	DHSSPS, HSC in collaboration with voluntary and community sector and the Patient and Client Council	Evaluate and review leadership, accountability and monitoring arrangements	March 2013	Future policies and services will seek to address the needs and expectations of service users and their carers

43	DSD	To carry out a qualitative research study into our customers who have a disability to allow us to obtain an insight into the thoughts and behaviours of this specific group of customers	SSA	To gain an insight into our disabled customers in terms of the challenges they face and the impact that disability has on their lives.	Ongoing	Contribute to a greater understanding of the use and impact of disability benefits; Increase the understanding of the difference made to people's lives by receipt of disability benefits; Inform and support the development of policy and strategy relating to disabled customers.
44	DSD	To develop and implement a strategy for increasing the uptake of benefits	SSA	A benefit uptake strategy.	March 2015	To maximise the uptake of benefits by targeting those likely to be eligible for unclaimed benefit
45	DSD	To work in Partnership with organisations and government departments which are impacted by Universal Credit.	SSA	Information is shared and input sought	Ongoing	All impacted organisations attend various Universal Credit governance (e.g. Programme Board, Steering Groups, Checkpoint meetings etc). Impacted organisations are also involved in the development of customer journeys, migration planning, staff communications, etc and are embedded into the programme team working in the Design Centre.

46	DHSSPS	To improve access to advice and information on services and support available	HSC and PHA	Develop a central point of access for information	March 2015	People with mental health problems, learning disabilities and carers have access to information about services and support in their area
47	DHSSPS DE	Improve services for children with challenging behaviours and their carers	HSC Board	Implement regional guidelines on the management of challenging behaviours	March 2015	Consistent service provision across region.

Learning Disability Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
48A	DHSSPS	Develop and implement a Service Framework for learning disability services	DHSSPS	Publish service framework.	December 2012	Improve the standards of care that people who use services, their family and carers can expect to receive against agreed performance indicators

48B	DHSSPS		HSC	Implementation of service framework	Ongoing from December 2012	
49	DHSSPS	Maintain direction of HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	At least 80% of HSC spend on learning disability services should be on community services	Ongoing	Community services will promote integration of individuals into society
50	DHSSPS DSD	Enhance provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community	DHSSPS HSC DSD (benefits)	Enhanced access to a range of opportunities in education, training, employment and social activity	Ongoing	Opportunities tailored to the needs of people with a learning disability promoting their inclusion in society Regional model produce by March 2013
51	DHSSPS	Complete and maintain a map of learning disability services across Northern Ireland	PHA/ HSC Board in collaboration with HSC and voluntary and community sector	Compile mapping information on all learning disability services provided	December 2013	New services can be better targeted and gaps in existing services can be filled

52	DE	Improve transitions planning for all children with statement of special educational needs	DE, Education and Library Boards, DHSSPS and HSC, CYPSP	A Transitions plan tailored to meet the needs of the young person. Collaborative working and multi agency planning to facilitate improved planning and delivery at local level.	Ongoing	Children and young people supported in making effective transitions, making good progress and achieving to their full potential.
53	DHSSPS	Development of UK wide framework for learning disability nurses	DHSSPS and other 3 UK Government departments	Publication of action plan	March 2014	Learning disability nurses utilise and develop their specialist knowledge and skills to ensure the best possible health outcomes for people with learning disabilities
54	DHSSPS	Develop a plan for community forensic learning disability services taking account of service to be provided with available resources and which makes full use of other forensic arrangements in place	HSC	Prioritised action plan to be taken forward within available resources	February 2013	Improved community forensic service for those with learning disability.

55	DHSSPS	Community Dental Service to undertake an annual oral health assessment for each L.D. client and produce an individual oral health plan, referring as appropriate for care.	HSC	LD clients regularly examined and treatment arranged	Ongoing	Oral health issues addressed and preventive strategies employed
56	DHSSPS	Community Dental Service to provide training/ training materials for staff in day care facilities re significance of oral health issues.	HSC	Deliver training interventions and educational resources.	Ongoing	Increased awareness of significance of diet, tooth brushing and use of Fluoride toothpaste
57	DHSSPS	Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines "Caring for people with a learning disability in general hospital settings"	HSC	Implement reasonable adjustments to support the pathway through acute care. Initiate staff training and development of easy read information. Develop coordinated links between hospital and community services.	March 2015	Improved delivery of safe and effective care within general hospital settings
58	DHSSPS	Implement a regional Bed Management Protocol for those with a learning disability.	HSC Board to lead in collaboration with HSC Trusts	Regional implementation of agreed Bed Management Protocol	March 2013	Safer and more effective access to inpatient care for those with a learning disability

Mental Health Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
59	DHSSPS	Re-direct HSC funding towards community based services	HSC Board to lead in collaboration with Trusts and PHA	60% of HSC spend on mental health services should be on community services.	March 2015	Better services for those in need provided within their community
60	DHSSPS	Implement the Mental Health Service Framework across HSC:	PHA	Review HSC performance against proposed framework indicators - this should include service user/carer input in terms of both development of indicators and monitoring of actual service performance.	Ongoing	Agreed standards of care that people who use services, their family and carers can expect to receive. Develop service improvement plans where progress against performance indicators is measured
61	DHSSPS	Provide information on children's, adolescent and adult mental health services for use by the public, GPs and other clinicians.	PHA/ HSCB	Develop and publish IT based resource on all Trust websites	April 2013	Identification of all general and specific MH services available.

62	DHSSPS	Implement service model for CAMHS services	HSC	Implementation of CAMHS action plan	Ongoing	Young people are able to access consistent and appropriate services across NI
63	DHSSPS	Improve and harmonise model for crisis response and home treatment services	HSC	Implement agreed regional model for crisis response and home treatment	December 2012	People in crisis will be able to receive appropriate care and support to a consistent standard
64	DHSSPS	Enhance availability of psychological therapies	HSC	Implement enhanced services in line with published strategy and available resources.	Ongoing	Improved access to psychological therapies
65	DHSSPS	Improve access to computerised Cognitive Behavioural Therapy programmes	HSC Board in collaboration with HSC	Promote and increase uptake of CCBT programmes	Ongoing	Improved support for those with mild to moderate depression

66	DHSSPS	Introduce legislation to extend the provisions of the Mental Health (NI) Order 1986 to private hospitals	DHSSPS	Provision for private hospitals to treat detained patients	December 2012	People are able to be treated in the most appropriate facility to meet their needs
67	DHSSPS	Evaluate implementation of regional guidance on assessment and management of risk in mental health and learning disability services	DHSSPS, HSC and RQIA	RQIA to review and report on progress to implement regional guidance	December 2012	People who may pose a risk to themselves or to other people or who may be at risk from other people will have such risks assessed and managed in an appropriate way as part of their treatment and care plan.
68	DHSSPS	Enhance medicines management services for vulnerable patients with mental illness living in the community	DHSSPS HSC	Develop a pilot medicines management service	March 2014	Joint working across Mental Health Medicines Management and relevant healthcare providers to enhance pharmaceutical services through education, brief intervention, alert systems and compliance aids where appropriate.
69	DHSSPS	Enhance services for people with a personality disorder	HSC	Implement enhanced services in line with published strategy and available resources.	Ongoing	Better access to appropriate services for people with a personality disorder and support for their carers

70	DHSSPS	Maintain the provision of specific eating disorders in-patient service capacity within each Trust	HSC Board and PHA in collaboration with HSC Trusts	Provision of eating disorder inpatient services available within generic units with in-reach support from community eating disorder service.	Ongoing	Continuity of care from community services for those who need to be admitted to hospital. Fewer people will require admission to a facility outside Northern Ireland
71	DHSSPS	Ensure provision of appropriate low secure and community forensic services in line with 2011 Review	HSC	Develop costed action plan to be implemented as resources permit	March 2013	More appropriate levels of therapeutic support and rehabilitation provided in the least restrictive conditions for those who need forensic services.
72	DHSSPS	Take forward action plan to improve dementia services in line with NI strategy.	HSC with DHSSPS and voluntary and community sectors	Provide range of services advocated in N I Dementia Strategy and associated action plan as resources permit.	Ongoing	Improved services for people with dementia, their families and carers
73	DHSSPS	Improve Perinatal mental health services	HSC/PHA	Implementation of Perinatal Mental Health Regional Integrated Pathway and Training Strategy	March 2015	Better detection and treatment of mental illness during pregnancy and the post natal period

BETTER STRUCTURES

Joint Actions

No.	DEPT.	KEY ACTIONS	FOR ACTION BY	OUTPUT REQUIRED	TARGET DATE	OUTCOMES
74	DHSSPS	Ensure relevant Inter-Departmental and cross sectoral structures are maintained	DHSSPS (with other Departments)	A co-ordinated approach to improve services in line with Bamford Vision	Ongoing	Better joining up of services across agencies
75	DHSSPS	Sponsor work on cross-cutting issues, involving the relevant agencies at local level along with service users and their carers.	Interdepartmental Group	Establish local-level cross-sectoral working groups under the IDG.	September 2013	To improve joining up of services for people with a mental ill-health or a learning disability.

76A	DHSSPS	New mental capacity legislation	DHSSPS DoJ	Preparation and consultation of draft Bill	October 2013	A consistent approach, with appropriate safeguards, to decisions - about care, treatment, property or assets – which have to be made for those unable to make decisions for themselves, whether because of mental disorder or for other reasons.
76B				Introduction to NI Assembly	December 2013	
76C				Enactment	March 2015	

ANNEX A

Patient and Client Council/Bamford Monitoring Group Outcomes Paper

The Bamford Monitoring Group has reviewed the reports, feedback from conferences and workshops held by the group in the past 2 years to identify the key issues and recurring themes. These are the issues that are most important to people with mental health needs, learning disabilities, parents, carers and families and must be central to the Bamford Action Plan 2012 – 2015.

The key issues / themes are outlined below linked to user / carer defined outcomes and suggested outcome measures required to evidence if the outcomes are being achieved i.e. is the action plan making a positive difference to people's lives?

The Bamford Monitoring Group strongly believes that there is a need to be clear and specific by including outcome measures for outcomes. Outcomes in the 2009 – 2011 Bamford Action Plan were described as "too woolly" and it was often unclear if they were being achieved.

The Bamford Monitoring Group would emphasise several key points regarding the Bamford Action Plan 2012 – 2015 and process of its development:

- Service users and carers must be involved in developing the Bamford Action Plan from the outset. It has been a difficult task to develop the outcomes and measures below.
- It is essential to create a robust process for service users and carers participation in development of future action plans.
- Focusing on measuring outcomes that are relevant to and valued by service users is vital. This is in keeping with a recovery orientated approach and reflects the purpose of services.
- Identifying progress in achieving the Bamford Action Plan must be monitored from an outcomes basis.

Outcome	***Theme / Key Issue***	***User / Carer defined outcomes***	***Linkage to Action Plan Actions***	***User / Carer defined outcome measures*** *(Evidencing progress)*
1	***Joined Up Working***	Increase Government Department partnership working	***74, 75***	IDSOG to provide an annual report on specific Inter Departmental initiatives being taken forward under the Bamford review. These should evidence genuine participation and capacity building.
2	***Involvement***	Service users and carers are involved in developing the next Bamford Action Plan.	**42, 74, 75**	People with mental health problems, learning disabilities and carers are involved as partners in developing the next Bamford Action Plan.
3		Service user and carer participation on all Bamford related groups	**42**	IDSOG to initiate audit.
4		Service users and carers are involved in the design, delivery, management, review and development of mental health and learning disability services (across all Government Departments)	***27, 28, 42***	Tool that evaluates involvement and participation required Service users and carers groups / forum / networks in the development of strategy and policy Service User and carer-led evaluation of mental health and learning disability services Staff recruitment panels that include service users and carers. The process should be accessible for people with a learning disability. Service users and carers input into the whole process of recruitment and selection e.g. job description, short listing, and interviewing,

Outcome	***Theme / Key Issue***	***User / Carer defined outcomes***	***Linkage to Action Plan Actions***	***User / Carer defined outcome measures*** *(Evidencing progress)*
				Service users and carers carry out training for non-service user and carer members of the interview panel. Service users and carers providing training for mental health and learning disability staff Advocates (Peer) employed in mental health and learning disability to support service users and carers.
5		Service users and carers are directly involved in all aspects of care.	**27, 32, 48, 50, 60, 67, 74**	People with mental health problems, learning disabilities and carers report positive experience of being involved in making decisions about their care and support. All people with mental health problems or a learning disability all have an individual care plan, which they hold personally. This care plan is subject to regular review.
6		All carers should be offered a carers assessment	**38**	Increased number of people supported to access Carer's Assessment All carers offered a Carers Assessment Increased number of people reporting positive experience accessing Carer's Assessment
7	***Information***	There is a central point of access for information and advice about all mental health and learning disability services and support available	**46, 51, 61**	Access to information should be readily available for people with mental health problems and learning difficulties. Increase the number of people with mental health problems, learning disabilities and carers reporting positive experience accessing information about services in their area Increase the number of people with mental health problems and learning disabilities are involved in the development of information about services in their area

Outcome	***Theme / Key Issue***	***User / Carer defined outcomes***	***Linkage to Action Plan Actions***	***User / Carer defined outcome measures*** *(Evidencing progress)*
				People with mental health problems, learning disabilities and carers report that staff are able to give appropriate information about services in their area
8	***Employment***	Move to a position where 'experts by experience' are directly employed in commissioning and delivery of mental health and learning disability care.	**12, 16, 20, 21, 22, 28, 34, 35**	Increase the number of people with mental health problems and learning disabilities are directly employed by Government Departments and the HSC sector. Evidence of reasonable adjustment as required by section 75 of the Northern Ireland Order put in place to enable more people to take up employment Appropriate support must be provided to those employed as a service user / carer reps and people who are employed with mental health needs and learning disabilities. Increase the number of people with mental health problems and learning disabilities entering and/or retaining paid employment: Full Time (over 16 hours a week) and Part Time (under 16 hours a week)
9	***Housing***	People with mental health problems and learning disabilities are supported to live independently. People have a choice who to live with and where, in a safe supportive community.	**12, 13, 14, 15**	Increased number of people with mental health problems and learning disabilities living independently year on year. Increased in the amount of supported independent living accommodation available for people with mental health problems and learning difficulties Increased number of people with mental health problems and learning disabilities report positive experience planning and arranging independent living.
10	***Benefits***	The new Welfare Reform system meets the needs of people with mental health problems and learning disabilities ensuring access to appropriate benefits and support	**35, 44, 45**	People with mental health problems and learning disabilities receive appropriate benefits Increased number of people with mental health problems and learning disabilities reporting a positive experience of

Outcome	*Theme / Key Issue*	*User / Carer defined outcomes*	*Linkage to Action Plan Actions*	*User / Carer defined outcome measures (Evidencing progress)*
				accessing advice regarding their finances, benefits or debts. Increased number of people with mental health problems and learning disabilities reporting positive experience accessing benefits All benefits staff are trained in mental health and disability awareness Specialist staff receive dedicated specific training to provide appropriate support to people with mental ill-health or a learning disability.
11		People with mental health problems and learning disabilities have support when accessing benefits	**43**	People with mental health problems and learning disabilities have access to advocacy service during benefits assessments/interviews.
12	***Education***	Better and more consistent planning and support is available to support young people on transition from education to adult services, including all young people with a learning disability or mental health problem – not just those with a statement of special educational needs	**26, 52**	Evidence that young people are involved and their views taken into account in decision-making about transition. Evidence that parents are involved in the transitions planning process for their son / daughter. Young people and their families receive appropriate accessible information about: - the transitions process - the options and support available on leaving school This allows young people and their families to make informed choices about the future.

Outcome	***Theme / Key Issue***	***User / Carer defined outcomes***	***Linkage to Action Plan Actions***	***User / Carer defined outcome measures*** *(Evidencing progress)*
13		People with mental health problems and learning disabilities are involved in making decisions about courses and subjects available in Further Education Colleges	**18, 19, 21, 22, 50, 52**	Evidence that there are increased numbers of courses for people with mental health problems and learning disabilities in Further Education Colleges Evidence that people with mental health problems and learning disabilities are involved in designing courses and subjects available in FE Colleges Evidence that people with mental health problems and learning disabilities are supported to find and participate in courses
14	***Self-directed Support***	People with mental health problems and learning disabilities have access to and control their own self-directed support.	**25**	Increased number of people with mental health problems and learning disabilities supported to access self-directed support. Increased number of people with mental health problems and learning disabilities supported to become more actively involved in decision making regarding their support. Increased number of people reporting positive experience accessing self-directed support.
15	***Transport***	People with mental health problems and learning disabilities are able to access transport to ensure their independence, choice and opportunity.	**12, 29, 30, 31**	Increased number of people reporting positive experience accessing transport

ANNEX B

Abbreviations

BMG	Bamford Monitoring Group
CYPSP	Children and Young People's Strategic Partnership
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DHSSPS	Department of Health, Social Services and Public Safety
DoJ	Department of Justice
DRD	Department for Regional Development
DSD	Department for Social Development
ELB	Education and Library Board
FE	Further Education
HSENI	Health and Safety Executive Northern Ireland
HSC	Health and Social Care
NIHE	Northern Ireland Housing Executive
NISAT	Northern Ireland Single Assessment Tool
OFMDFM	Office of the First Minister and deputy First Minister
PHA	Public Health Agency
RQIA	Regulation and Quality Improvement Authority

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